Witness Name: Dean Fathers
Statement No.: WITN0410001
Exhibits: WITN0410002-WITN0410092
Dated: 6 February 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DEAN FATHERS

I, Dean Fathers, will say as follows: -

1. I am the former Non-Executive Chair of Nottinghamshire Healthcare NHS Trust ("the Trust").

2. This witness statement is made to assist the Nottingham Inquiry (the 'Inquiry') with the matters set out in the Rule 9 Request dated 9 December 2025.

3. Before I make my statement, I wish to first extend my heartfelt condolences to the families of Grace, Barnaby and Ian. I cannot imagine the pain they have been put through and hope that this statement, and by extension the Inquiry, provides them with answers to their questions. I also wish to pass on my condolences to all those injured in the attack by VC, both mentally and physically.

4. The information contained within this statement is based on my recollection of events focusing on the period leading up to my departure from the Trust on 16 December 2019. In order to prepare this statement and respond to the questions raised by the Inquiry, I have received assistance from my legal representative and have been provided with a number of documents by the Trust.

Background

Early Career and Qualifications

5. In 1983, I graduated from Bradford and Ilkley Community College with a degree in Organisation Studies, and I subsequently obtained a Masters in Organisation Development from Sheffield Hallam University in 1992. In 1993, following completion of my master's degree, I became a Visiting Lecturer at Sheffield Hallam University, lecturing on Business Strategy on their MSc in Engineering and Executive MBA Programmes until 1996.

6. In 1995, I obtained a Diploma in Company Direction from the Institute of Directors (IoD). I remained a Member of the IoD for nearly two decades, completing learning exercises as part of my personal continuous professional development requirements and joining the Institute of Directors' Diploma Delivery Team as a part-time lead tutor, delivering most of their programmes, including one about "the role of the Chair". I spent 17 years as a Course Leader. In January 2010 I became the Chair of the Centre for Health and Social Care Enterprise and an Honorary Professor in the Practice of Health and Care Leadership at Cass Business School. Whilst in this role, the Centre was Contracted by the NHS Confederations Foundation Trust Network (which later became NHS Providers) to run the Chairs Academy.

7. In 1995, I also started my own business as an Organisation Development Consultant and initiated a three stranded (Business, Academic, NHS) portfolio career path, joining the NHS as a Non-Executive Director ("NED") of a Health Authority in 1999. I became Interim Chair of the Doncaster Health Authority at some point shortly after joining the Board and was given the mentorship of a senior, experienced Health Authority Chair from the adjoining District to support my personal development and ensure I understood my role as a Non-Executive Chair.

8. In 2001, I was substantiated as the Non-Executive Chair. Whilst the Non-Executive Chair at Doncaster Health Authority, I attended several learning events related to my role that were provided by the NHS Trent Region. In addition to my allocated mentor, I was also mentored informally by the Regional NHS Chair. I

attended the "Understanding Whitehall" programme at the Sunningdale Civil Service College, where I first gained insight into the complexities of the NHS, its interdependencies with other Agencies and the role of a Non-Executive Chair in the various parts of the Public Sector.

9. In 2002, I left Doncaster Health Authority to become a NED of the South Yorkshire Strategic Health Authority and was asked to co-chair the South Yorkshire Workforce Committee. On 1 October 2006, I became the Non-Executive Chair of NHS Bassetlaw (Bassetlaw Primary Care Trust). In this role I conceived and piloted the "Board Apprentice Programme" designed to enable people from underrepresented groups to develop insight and the relevant experience necessary to enable them to gain a non-executive appointment with an NHS body. This initiative subsequently transferred into Nottinghamshire Healthcare, where, having created a multi-partner steering group, the scheme was adopted by the Trust Development Authority (an executive non-departmental public body in England, established in 2013 to oversee the performance, governance and clinical quality of NHS Trusts, particularly in supporting their progression toward NHS Foundation Trust status) rebadged as the NHS NExT Director Programme and rolled out across England.

10. In addition to my Primary Care Trust Chair duties, I was asked by Sir John Brigstock, East Midlands Regional Strategic Health Authority Chair, to be a co-chair of the East Midlands Regional Workforce Committee and to deputise for him on a National Training Group, exploring leadership talent in the NHS and which created the genesis of the NHS Leadership Academy (which was founded in April 2012).

11. After leaving NHS Bassetlaw on 31 December 2010, I took other roles associated with the NHS, including the Non-Executive Chair of an Acute Trust (1 March 2016 – 30 November 2017) and NED of the Parliamentary and Health Service Ombudsman (PHSO) (1 January 2018 – 31 December 2024), where I was also a member of the Equality Diversity and Inclusion Committee. In July 2022, I became Chair of Quality at the PHSO. In this role, I supported the introduction of the PEAG (a public engagement advisory group), the deployment of the NHS

National Complaints Competency Framework, and the introduction of Statistical Process Control and information technology to enable the introduction of an analytical AI capability.

12. In January 2011, I was appointed as the Non-Executive Chair of the Trust. I continued in this role for three consecutive three-year terms, concluding my tenure as Chair at the end of 2019. On leaving the role, I facilitated a transfer of information between the Chair designate, the CEO and myself before I left. This allowed momentum to be maintained and appropriate scrutiny to take place with immediate effect. The transfer of power and accountability was publicly made on the 16 December 2019 when the Chair designate addressed the Trust's assembled senior leaders at the "Leadership Council" management conference, immediately after my farewell address.

13. In my capacity as Non-Executive Chair of the Trust, I was nominated by the Trust Chief Executive (Mike Cooke) and elected by the Membership to be a member of the NHS Confederation's Mental Health Network Advisory Board from 2011 - 2016, taking on the role of Vice Chair in June 2014. In 2018, the Trust Chief Executive (Ruth Hawkin) nominated me to become a Member of the NHS Providers Board to represent Mental Health Trusts, and my NHS peers duly elected me to this role.

14. I have received honorary visiting professor roles at various universities, including Cass Business School (2011 - 2017), Leeds Business School (2016 - 2021), Nottingham Business School (2017 - present), Lincoln International Business School (2019 - present) and Liverpool Hope Business School (2023 -present). These are Honorariums and carry no time commitment, however I have supported a variety of research centres on their behalf.

15. I have also been a trustee for colleges and charities including the Royal Association for the Deaf and Portland College during my tenure at Nottinghamshire Healthcare.

16. I am currently Non-Executive Chair of a regional Health Innovation Network and a NED of the Academy for Healthcare Science.

Roles and Responsibilities of the Non-Executive Chair

17. The role of Non-Executive Chair of an NHS Trust is an honorarium, meaning that it does not attract employment status within the NHS. As per the Nolan principles requiring independence from the Trust, the role is classed as an "independent or non-executive role" meaning that it carries no budget, management or resource responsibilities. My appointment was made by the Secretary of State for Health and Social Care on recommendation from the Chair of the East Midlands Strategic Health Authority and the designated members of the recruitment panel, supported by a variety of stakeholder panel representatives.

18. As Non-Executive Chair, I was expected to work up to 3 and a half days a week, or up to 10 days per month. A large part of my day-to-day role involved preparing for regular Board meetings and meeting with key stakeholders. This involved consideration of briefings and papers to ensure I could have effective oversight of meetings taking place. Due to commitments arising out of the Strategic Transformation Partnership ("STP") (which is explained in more detail later in my statement), I would often work between 14 and 18 days a month (see for example, my letter to Steve Banks before my appraisal in 2019 where I raised concerns about my working hours (**Exhibit WITN0410002**). Since the introduction of Integrated Care Boards in 2022, I believe there is no longer a requirement for NHS Provider Board Chairs to attend ICB meetings.

19. Unlike many of my peers occupying a similar role, I had no full-time executive director role in any other organisation, having exited my business in 2012. My other remunerated roles (April 2018 - March 2019/April 2019 - December 2019) were: NED at the PHSO (up to two days per month), Chair of two Research Centres at the University of Lincoln (two days per month) and a Member of the Academy for Healthcare Science Regulatory Board, which met four times annually (this was not a Board position).

20. The role of Chair is to facilitate effective governance and board leadership. The specific day-to-day roles and responsibilities of a Non-Executive Chair can be found in the NHST Chair Information Pack (**Exhibit WITN0410003**). They can be summarised as follows:

    (a) Provide leadership to the Board, the Trust, the other non-executives, the Chief Executive and executive directors.

    (b) Ensure the effectiveness of the Board and direct the organisation towards achieving the Government's objective of all trusts achieving Foundation Trust status.

    (c) Ensure the provision of accurate, timely and clear information to the Board and directors to meet statutory requirements.

    (d) Ensure effective communication with the Board, staff, patients, service users, carers and the public.

    (e) Arrange the regular evaluation of the performance of the Board, its committees and individual non-executives, directors, and the Chief Executive.

    (f) Plan and conduct Board meetings, with the Chief Executive and facilitate the effective contribution of NEDs.

    (g) Ensure constructive relations within the organisation and between executive and NEDs.

    (h) Direct and manage the development of major Board decisions.

    (i) Hold the Chief Executive to account for the effective management and delivery of the organisation's strategic aims and objectives.

    (j) Ensure that the Board develops and oversees strategies which result in tangible improvements to clinical services.

    (k) Ensure that the Board establishes clear objectives to deliver agreed strategies and regularly review performance against these objectives.

    (l) Play a key role in building strong partnerships with Local Authority partners and other stakeholders in the community and nationally.

    (m) Ensure the interests of all stakeholders are fairly balanced.

    (n) Provide the leadership needed by the Board to shape the organisation and develop a culture which supports the values of the NHS.

    (o) Assist in the appointment of executives and non-executives and ensure systems of support and appraisal.

21. The role of Chair focuses on strategic matters, meaning I would not normally be briefed or tasked with day-to-day matters relating to the operation of the Trust.

STPs

22. Whilst my role as Chair evolved between 2016 and 2019 as STPs and integrated care systems were introduced, my core job description stayed in place until 2019, when a new job description was drawn up in anticipation of my successor (**Exhibit WITN0410004**). This updated job description was based upon the additional roles and their associated activities, that had been generated by the Secretary of State for Health and Social Care, who stated in December 2015 that his aim was to design a more integrated local Health and Care System, which would be facilitated by bringing organisations together to plan more effectively. This became part of the NHS Planning Guidance and was supported by key stakeholders such as the Royal College of Physicians. In March 2016, NHS England published the "footprints" for a new STP structure.

23. In 2016, STPs were introduced, firstly as the 'Sustainability Transformation Plan', which covered the 2016/17 financial year, becoming the 'Sustainability Transformation Partnership' in 2017 and then the 'Strategic Transformation Partnership' in 2018. Over time, the STP's responsibilities and accountabilities increased and the independence of the Trust to govern its own affairs was aligned to conjoined decision-making with local partners. The STP was developed by the Government as a mechanism for delivering the NHS' priorities through greater collaboration between services. STPs brought together GPs, hospitals, mental health services and social care partners to keep people healthier for longer and integrate services around the people who needed it the most. STPs provided a forum in which services could link together to share expertise and drive real changes to care.

24. STPs were designed to focus system collaboration between NHS organisations and address and promote consistent care within a relevant locality. In 2017, STPs became the primary mechanism for accessing NHS Transformation

Funding, amounting to a major shift in governance processes. There were 44 STPs planned nationally, replacing the 211 Clinical Commissioning Groups, with the Trust being part of the Nottingham and Nottinghamshire STP. However, the Trust had an "associate" role to South Yorkshire, meaning I was required to attend the Nottingham/Nottinghamshire and the South Yorkshire Board meetings. I was additionally engaged with conversations with the STPs in Lincolnshire and Leicestershire, as the Trust had services in those areas too.

25. From 2018, as part of my role as Non-Executive Chair, I was required to engage actively as a Member of the Nottingham and Nottinghamshire Strategic Transformation Partnership Board and as an Associate Member of the South Yorkshire and Bassetlaw Strategic Transformational Partnership Board. Both of these STPs were working towards making themselves an Integrated Care System by 2021, as part of the NHS' long-term goal. Integrated Care Systems are local partnerships that bring health and care organisations together to develop shared plans and commission joined up integrated services.

26. As Chair of the Trust, I attended partner meetings in the STP. A central focus of a Non-Executive Chair is to foster partnerships with local authority partners and other stakeholders at a local and national level. During the "Your job, My job, Our job" meeting with the new CEO John Brewin in January 2019, he identified the development and maintenance of key stakeholder relationships as a priority. The CEO wanted to ensure strategic insight could be brought back to the Trust (**Exhibit WITN0410005**). My involvement with the STPs contributed to the positive feedback given by the Care Quality Commission ("CQC") in their May 2019 Inspection Report (NHFT0002015) (which is detailed further at paragraphs 142-148 below). It was noted by the CQC that the Trust had aligned its strategy to local plans in the wider health and social care economy, and they noted how we had planned our services to take into account the needs of the local population.

27. In furthering this objective and ensuring the Trust gained valuable insight from other providers, I would regularly attend in-person meetings with a variety of stakeholders:

(a) I chaired the Nottinghamshire Healthcare Charity Board and attended meetings alongside the Trust Senior Independent Director (Peter Parsons) with philanthropic individuals and organisations who understood how to raise funds within the Charity sector, to enable the Trust to invest more in patient and staff wellbeing through increased charitable fundraising activities.

(b) Attended quarterly meetings with the chairs of NHS Improvement ("NHSI") and the CQC, as a member of the NHSI/CQC Chairs Advisory Group.

(c) Participated in quarterly board meetings as an elected member of the NHS Providers Board. NHS Providers is the membership organisation for NHS hospital, mental health, community and ambulance services. The NHS Providers Board is comprised of 20 chairs and chief executives, all nominated by and elected by member trusts.

(d) Attended the East Midlands NHS Leadership Academy Board and the Midlands and East NHS Regional Talent Board.

(e) Joined the quarterly IMROC (a mental health charity hosted by the Trust) advisory board meetings and had ad hoc meetings with the IMROC Director.

(f) Attended quarterly NHSI Midlands and East formal Regional Chair Meetings and Regional Networking events. This was to facilitate a good working relationship with NHSI and key stakeholders across the Midlands, gain a better understanding of what was going on within the region, benchmark priorities, identify concerns and transfer knowledge and understanding back to the Trust.

(g) Attended external conferences as necessary to gain insight on innovation at other providers. For example, at the NHS Confederation's Conference in June 2019, I received insight into the benefits gained by other Trusts from using the Oxehealth technology that was currently also being piloted within the Trust.

(h) Engaged with the leadership of the East Midlands Academic Health Science Network and the East Midlands Clinical Leadership Applied Research Collaborative (now known as ARC) to ensure the Trust

remained at the top of the research league table and fixed on the innovation, improvement agenda.

(i) Met with research active medical and clinical staff engaged in innovation and provided mentorship through the NHS Clinical Entrepreneurs Programme.

(j) Engaged with the University of Nottingham's Institute of Mental Health's MindTech initiative and attended its annual Conference to discover what new technologies might exist that could help the clinical workforce.

28. I was also a member of several NHS working groups:

(a) The NHS Culture Working Group.

(b) Public Health England, Nottingham and Nottinghamshire Work and Inclusive Growth Working Group (which led to the national NHS Work Well Programme).

(c) The NHS England People Plan Working Group (to gain insight into workforce issues and solutions the Trust could adopt if deemed appropriate by the executives).

(d) The NHS England Board Competence Framework Steering Group which focused on addressing the talent deficiency at the top of provider organisations and ensure greater consistency and supply of executive and non-executive talent.

(e) The NHS England Conflict of Interest Task and Finish Working Group meetings to help them define principles and associated practices.

(f) The NHS Workforce Race Equality Standards Strategic Advisory Group.

(g) The Defence and National Rehabilitation Centre 'National' Steering Group (whilst titled 'National', this was a local collaboration led by Nottingham University Hospitals and supported by the local Universities and the CEO of the Trust).

29. In June 2018, I trained as a CQC Executive Reviewer, to gain insight into the CQC's assessment approach and to help understand how to improve quality within the Trust.

30. In addition to the above external stakeholder focused activities, I conducted other exercises to ensure that I was able to hold the CEO to account. This allowed me to gain secondary data to supplement primary data gained from board papers and conversations with Executive Directors.

31. I would conduct site visits, observe board committees annually and attend informal gatherings. I also:
    (a) Attended irregular informal Chair meetings with the local CCG (Clinical Commissioning Group) Clinical Chairs and other provider chairs.
    (b) Sought informal evidence of good practice from each Executive Director, and from senior leaders on ward visits I made, so that I could send cards of appreciation from the Chair to show staff that their work was being noticed and valued.
    (c) Held regular informal 1-to-1 listening events with key culture informers, chaplains, Freedom to Speak Up Guardians, the Head of Equality and Diversity and the Chairs of various diversity committees or staff-side representatives.
    (d) Attended Trust's involvement centres which were informally visited at least twice a month at lunchtime to gain intelligence on how service users viewed the Trust's services and learn what the challenges were.
    (e) Visited the Trust library services to find out what topics were most important to staff and service users to read and learn about.
    (f) Held informal meetings with the Trust's Complaints Manager.
    (g) Held informal meetings with senior local leaders of key stakeholders (e.g. Nottinghamshire Citizens Board, Framework, Carers Federation, Awaaz, Nottingham/Nottinghamshire Adult Safeguarding Board and Nottingham Children Safeguarding Board and Healthwatch).
    (h) Attended Nottingham Recovery College to engage with staff and gain feedback on service users' experience of the Trust's services.

Governance at the Trust

Board Structure

32. During the period that I was Non-Executive Chair at the Trust, the Trust was governed by the Board of Directors which was collectively responsible for its performance and under a general duty to promote its success. The Trust Board holds ultimate accountability for the strategic leadership, governance, safety and performance of its services. It sets the vision and defines the values that describe the organisation' s culture for efficiently delivering the quality and sustainability of care for patients. The Board is ultimately responsible for assuring that risks to the Trust and the public are managed and mitigated.

33. The Board operates as a " unitary" body, meaning both executives and non-executives share collective responsibility for decisions associated with strategic direction, quality governance, performance accountability, risk, culture and leadership and partnership working. The Board operates in collaboration with other health organisations to improve services for the benefit of patients within its locality.

34. The Trust Board operated under a shadow Council of Governors arrangement before it was made a Foundation Trust in 2015. After becoming a Foundation Trust, this changed to a full Council of Governors (" CoG") with specific statutory duties outlined in the NHS Act 2006. In 2018, the Trust' s Constitution was revised. This revised constitution set out the composition of the Board of Directors and its duties, stipulating that the Board needed to include a Non-Executive Chair, a maximum of 7 other NEDs and a maximum of 7 Executive Directors (**Exhibit NHFT0000001**).

35. Under the Trust' s constitution, Executive Directors needed to fulfil specific roles at the Board. One of the Executive Director roles needed to be held by the Chief Executive. Other Executive Director roles needed to be filled by the Finance Director, a registered medical practitioner under the Medical Act 1983 (Medical Director) and a registered nurse or midwife (Executive Director of Nursing). One of the Executive Directors also had to be accountable to the Board for the Trust' s High Secure Psychiatric Services.

36. In 2018, the Trust's Constitution allowed for 21 public, patient, service user and carer members of the CoG. There were 8 staff Governors comprised of 1 medical, 2 nursing, 2 allied health professionals, 2 clinical support staff and 1 non-clinical support staff. A further 8 Governors were appointed, one of whom had to come from each of the following organisations: University of Nottingham, the Framework Housing Association, the Carers Federation, an undesignated 3rd Sector organisation, the Nottingham Office of the Police and Crime Commissioner, Derbyshire and Nottinghamshire Chamber of Commerce, Nottingham City Council and Nottinghamshire County Council.

37. The Chair of the Trust Board is also the Chair of the CoG and presides at Council Governor meetings. The CoG are under a general duty to:
    (a) Hold the NEDs individually and collectively to account for the performance of the Board of Directors.
    (b) Represent the interests of the members of the Trust as a whole and the interests of the public.

38. The Governors were trained and met regularly to hold non-executives to account. If the CoG believed that the Board was not delivering against required performance requirements, they had the right to refer a "Question to a Monitor Panel" (or a NHSI panel after 2019) and state that the Board is failing. This power was never exercised during my tenure as Chair.

39. The Trust had 3 tiers of governance scrutiny: the executives act as the first tier, non-executives as the second and the CoG as a third. The Board's competence was assessed by regular governance reviews and compliance checks conducted by the Trust Secretariate and through bi-annual appraisals of the Board members, assisted by a 360-degree feedback tool annually. Executive Director appraisals were shared and discussed at the Remuneration and Nominations Committee. The Chair and NED appraisals were shared with CoG and the Regional NHSI team.

Committee Structure

40. The Board of Directors also worked through the following Board Committee structure:

Audit Committee

41. Chaired by Stephen Jackson (an FCMA, experienced former Chief Financial Officer and Chief Operating Officer), the Audit Committee provided assurance to the Board regarding the continued effectiveness of the Trust' s system of integrated governance, risk management and internal control. Risk assurance was strengthened in the Audit Committee' s Terms of Reference in February 2018 (**Exhibit** CQCM0027255) following the findings of the Independent PWC Well Led Review (detailed at paragraphs 58-60 below) (**Exhibit CQCM0027715**). Audit Committee meetings were held at least 5 times a year and had a quorum of 2 members. The Chair of the Board is prohibited from being a member of the Audit Committee, but I was allowed to attend annually to observe and assess if it was being Chaired effectively.

Quality Committee

42. The Quality Committee was chaired by Professor Di Bailey, NED a Professor of Mental Health and Pro-Vice Chancellor of Research at Nottingham Trent University). The purpose of the Committee was to maintain oversight and undertake scrutiny to inform the Board of the level of assurance identified that robust quality governance arrangements are in place throughout the Trust and that these are working effectively. Quality Committee meetings were held at least 6 times a year with a quorum of 4 members, including 2 NEDs and 2 Executive Directors. The Director of Nursing was responsible for the Committee (**Exhibit NHFT0004747**).

43. The Committee was comprised of:
    (a) 3 NEDs
    (b) An Executive Director from nursing
    (c) An Executive Director from Local Partnerships
    (d) An Executive Director from Forensic Services

(e) The Medical Director

(f) The Director of Human Resources

(g) The Associate Director for Quality Governance

(h) The Associate Director of Nursing

(i) The Director of Business Development & Marketing

44. Some of the key duties of the committees were as follows:

(a) To maintain a strategic oversight of quality governance environment and context in which the Trust operates and associated risks.

(b) To inform the Board of the level of assessed assurance with regard to quality governance arrangements across the Trust.

(c) To monitor and review the Trust's Quality Strategy and Quality Priorities, and the implementation and the production of the Trust's Quality Report.

(d) To monitor, review and assess the level of assurance received on the quality risks, control and governance processes identified in the Board Assurance Framework ("BAF") delegated to the committee by the Board, providing reports to the Board of Directors and or Audit Committee as requested.

(e) To monitor and assess the level of assurance received on the quality impact of Cost Improvement Programmes.

(f) To assess the level of assurance received regarding compliance with the Trust's quality policies.

(g) To monitor the implementation of agreed Internal Audit review recommendations relating to the Committee's remit.

(h) Monitor risks detailed on the Trust's BAF for which the committee is responsible for.

(i) Monitor ongoing compliance with CQC outcomes and implementation of agreed actions following CQC inspections or visits.

(j) To promote learning and sharing for all areas of activity, benchmarking areas of recognised "best" practice.

(k) To review and approve annually the terms of reference of reporting sub-committees, monitor their activities and assurances and consider any issues they escalate.

The Workforce, Equality and Diversity ("WED") Committee

45. The WED Committee was chaired by Stephen Banks (a clinically qualified and experienced Superintendent Pharmacist, and former Director of Human Resources and Transformation). The purpose of this Committee was to gain and provide assurance to the Board that robust workforce and equality & diversity arrangements are in place throughout the Trust and that these are working effectively (**Exhibit WITN0410010**). Committee meetings were held at least 4 times a year with the same quorum as the Quality Committee.

Finance and Performance Committee

46. The Finance and Performance Committee was chaired by Trevor Orman (a former Transformation Director with Rolls Royce). The purpose of this Committee was to oversee and give detailed consideration to all aspects of the financial arrangements of the Trust, provide the Board with assurance that the financial issues of the organisation are being appropriately addressed and to have oversight of the Trust' s Performance Framework, including the incorporation of quality metrics (**Exhibit WITN0380079**). The Committee would meet at least six times per annum with the same quorum as the Quality Committee.

Mental Health Legislation ("MHL") Committee

47. The MHL Committee was chaired by Carolyn White (a qualified nurse). This Committee oversaw the Trust's compliance with both the Mental Health Act ("MHA") and the Mental Capacity Act. The Committee would consider the Trust's discharge of its functions under the MHA delegated to officers and establish local working groups where necessary to make recommendations. The MHL Committee met quarterly, with a quorum of 2 Mental Health Associate Hospital Manager Representatives, the Committee Chairman (or the Vice Chairman) and at least one Executive Director (**Exhibit WITN0410012**).

Nomination and Renumeration Committee

48. The Nomination and Remuneration Committee was chaired by me. This Committee was delegated responsibility from the Board to review and evaluate the structure, size, and composition of the Board, oversee the Trust' s talent management strategy and succession planning arrangements, and Board remuneration matters. In my role as the Board Chair, I was prohibited from becoming a member of any of the committees except for this Committee. The Committee met at least twice a year and had a quorum of myself and at least two other non-executive members (**Exhibit WITN0263012**).

Operation of Committees

49. All committees' terms of reference were reviewed annually at the relevant committee meeting and presented to the Board for approval and amendment if required. Under the Trust's Constitution, the only mandated board committee was the Audit Committee. Other committees are at the discretion of the Board, meaning their function or terms of reference may be varied as appropriate. A board committee is always chaired by a non-executive, as the committee's functions are to enable a level of scrutiny that cannot be done within the time constraints of a formal board meeting.

50. Following scrutiny, the Board would be provided with an update from the committee stating either:
    (a) That there are no outstanding issues.
    (b) That there are outstanding issues, but resources are in place to deal with matters in a planned and appropriate timescale with risks mitigated.
    (c) That the committee has identified a matter that cannot be resolved by the committee alone and that the Board or the wider system will need to deal with the matter.

51. These updates were referred to as "matters for raising to the Board" and at the end of every Committee briefing to the Board, this specific question would be raised by either myself as Chair or by the Vice-Chair (Sheila Wright).

52. Full schemes of delegation were in place to ensure that committees were suitably authorised to make decisions as and where appropriate, detailing responsibilities and accountability from and to the Board and down the sub-committee structures. These schemes were reviewed annually alongside the Board's risk appetite.

53. In addition to these delegation schemes, the Trust Secretary conducted an annual review of the effectiveness of the Trust's governance processes, pursuant to NHS Foundation Trust reporting requirements. This was incorporated into his annual Code of Governance report and showed the Trust's governance processes to be to be compliant with the NHS Foundation Trust Code of Governance.

Foundation Trust

Transition to Foundation Trust

54. The first structural change to governance during my tenure was when the Board, supported by the then Shadow Council of Governors, decided to attain Foundation Trust status. This was in line with my job description (see paragraph 20 (b)), "direct the organisation towards achieving the Government's objective of all trusts achieving Foundation Trust status". This was granted in 2015 after rigorous Board assessments, two independent Governance reviews and detailed assessment of the application process by the Trust Development Authority and then Monitor.

55. In my view, this change strengthened the Trust Board's capability, giving it more oversight over its own budgets, and importantly the ability to retain surpluses for reinvestment and make local decisions on how to meet NHS standards. Foundation Trust status also gave oversight powers to the CoG, who were now a legitimate third tier of assurance. This ensured that there was alignment between the first and second tier of governance and the public benefit priorities, whom the Council represented as public members. During this period (2015-

2017), Monitor (which became NHSI by merging with the Trust Development Authority) rated the Trust as a 'tier 1' body on the NHS Single Oversight Framework, the highest level of performance for any Foundation Trust, and CQC rated the Trust as Good, with a care rating of outstanding.

56. After securing Foundation Trust status, the governance arrangements at the Trust remained substantially unchanged until the STP was created (see paragraphs 24-25 above). Concerns at this time were expressed within the Trust by Governors, who were unsure how they would obtain oversight of the actions of the STP and how the STP's decision making would impact the Trust. The Trust non-executives also had concerns over the loss of sovereignty, especially in relation to investment capital, which was now part of a STP controlled "Provider Sustainability Fund" (PSF). Further, system targets were set which had the potential to be punitive, increasing uncertainty, risk and concern within the Trust, as well as making it more difficult to make independent decisions. Up until 2018, the Trust had always been in surplus and able to allocate investment funds from reserves to meet strategic capital project demands. The freedom to do this was reduced because of the new financial and oversight regimes and, in effect, the Trust Board was required to substitute its financial freedoms and be collegial.

57. These changes brought about further complexity at the time, as instead of one line of accountability through the CoG to NHSI, the Trust now had two STPs to service, both operating in different regions (the Midlands and Yorkshire and Humber). This meant that Board focus became diluted, as the Trust went through two separate governance realignments, whilst continuing to be held to account by the Single Oversight Framework operated by NHSI in the Midlands.

2017 PWC 'Well-Led' Review

58. Foundation Trust status brought external insight to the Trust, which resulted in changes to the Governance approach. As part of the Trust's compliance with the NHS Foundation Trust Code of Governance, the Trust was required to carry out

an external review of its governance every three years. In 2017, this independent governance review was undertaken by PWC (**Exhibit** **CQCM0027715**).

59. PWC's 'Well-Led' review found that the Board had a supportive culture, was well sighted on risk management and had good governance processes and service user engagement. The review recommended that the Trust needed to rectify how scrutiny of risk was conducted at Committee level. The report found that due to the scale of the data and layered system, risks in sub-committee meetings could be obscured or be missed as the data was aggregated. Following this report, the Trust Secretary took the action to change the BAF quality and risk assessment systems (**Exhibit WITN0410014**).

60. After the majority of PWC's recommendations were addressed, outstanding recommendations were delegated to relevant committees to complete. I attended a subsequent Quality Committee in May 2018 **(Exhibit WITN0410015)** meeting to confirm whether improvements were being embedded. I gained assurance that good progress was being made, for example, in ensuring managers felt supported and enabled to meet the Well-Led actions.

Board Relations

Relationship between Executive and NEDs

61. Relationships between Board members were good, critically constructive, professional and suitably appropriate to the function required of the Board. The Board members functioned as an effective unitary 'learning' Board. The Trust's values were reflected in how the Board operated towards each other as well as to other stakeholders.

62. The Trust's "POSITIVE" values were role modelled by the whole Board: people, openness, safety, involvement, trust, innovation, value and excellence. People

were placed at the heart of the Trust's operations. Steve Banks (NED) had taught the Board a mantra from his work with Boots, "be kind on the individual but hard on the issue".

63. Constructive challenge operated well through promoting openness and candour, putting safety first, working collaboratively with key stakeholders on improvement and innovation, being trustworthy and valuing care. These values drove all decision making and challenge at Board level.

64. In 2019, the CEO, Dr John Brewin recognised the need to refresh these values to ensure they remained relevant to the workforce. The Board affirmed the following strategic objectives and used them to guide their decision making:
    (a) Deliver safe sustainable services
    (b) Make the Trust a great place to work
    (c) Provide the best possible care and support
    (d) Demonstrate best value

65. Discussion on how these values would change continued throughout 2019, with staff workshops arranged to gain feedback on how they could or should change. The Trust's updated values were finalised after the conclusion of my time as Chair.

Board Meetings

66. Board meetings at the Trust would primarily be held in public. All operationally or financially sensitive issues would be discussed in the private session. A private session of the Board would begin with the Chief Executive Officer providing an "Environmental Scan" opportunity. This was primarily for the CEO to brief the Board of any confidential issues they wished to raise and for the Board to raise any matters that they had not wished to discuss in the public meeting.

Relationship with the CEO

67. One of the most important Non-Executive and Executive relationships is between the Chair and CEO. Throughout my tenure I worked with 3 CEOs and 1 interim CEO:

    (a) Mike Cooke (2011 - 2015)
    (b) Ruth Hawkins (2015 - 2018)
    (c) Julie Attfield (Interim CEO, (September – December 2018)
    (d) Dr John Brewin (from January 2019).

68. As part of my role as Chair, I worked with NHSI, the Trust Secretary and the CoG on the appointment of the CEO, chairing the appointment interview panel which was always supported by associated stakeholder panels (governors, staff and system partners).

69. Following Ruth Hawkins' tenure as CEO, the Trust felt that it was important to bring in a CEO who was medically qualified. This was to demonstrate to clinicians that the Board valued their expertise and experience in patient care. When Peter Wright (Executive Director for Forensic Services) joined the Trust, there was some concern amongst clinicians. Peter had a prison background, and clinicians were keen to ensure that the Trust was viewed as a hospital and not a prison. I feel that this concern was unfair, as Peter was one of the most caring executives that I had worked with. However, the Trust's appointment of a CEO with a clinical background would send a clear message that the Trust prioritised being safe, clinically effective, caring and well-led.

70. This meant that Ruth's replacement would have a medical pay grade. The Trust invited applications and offered the role to Dr John Brewin. However, John's appointment was delayed by the Cabinet Office due to the increased clinical grade salary. This meant that the Trust could not appoint John until January 2019. Julie Attfield (the Trust's Director of Nursing) stepped in as Interim CEO for 3 months. The Cabinet Office approved John's appointment with a caveated salary and clawback condition. This caused complications at a time when the Trust was already operating under an Interim CEO.

71. In January 2019, when Dr John Brewin eventually joined the Trust as CEO, he brought extensive executive experience and professional medical skills through his qualification in psychiatry. John was cited in a CQC publication for regaining a "good" rating at his former mental health trust. My working relationship with John was open, transparent and built on a solid foundation of mutual respect and clarity of our respective roles. Prior to John taking up his appointment, I met him on several occasions to keep him up to speed so he could take responsibility as soon as possible.

72. It is noteworthy that when Dr John Brewin joined the Trust, one of the things he tried to do to create capacity and reduce waste was to introduce the new role of Chief Operating Officer. This was unfortunately not successful as the Trust was unable to secure a suitable candidate for the salary on offer.

Challenge at Board-Level

73. Operating the Trust Board as a 'unitary' function, meant that unless the Accounting Officer specifically exercised their unique authority to take an individual decision within the Accounting Officers Standing Orders, all decisions were made through informed processes that reached consensus following rigorous debate and appropriate constructive challenge. No votes or majority decisions were ever taken during my tenure.

74. In a unitary board, constructive challenge should be done by both non-executive and executive directors. For this reason, I would often invite Executive Directors to provide a challenge when appropriate or ask them to share with the Board the constructive challenges put forward during the Executive meetings before papers had been finalised. I also asked Executive Directors to recap the conclusions of the Board at the end of each matter and state any actions that were to be taken away, who would be responsible for them and when they had to return to the Board. This ensured clarity of action, informed the minutes and provided the opportunity for a second set of constructive challenges if the Executive Director recapped inappropriately or omitted something important. Throughout my tenure, the Board underwent extensive development to ensure all Directors knew their

responsibilities and were less defensive. This also allowed the Directors to build their capability to scrutinise decision making.

75. All of the non-executives were experienced Board Directors outside of their role at the Trust and brought with them a wealth of skills and experience. Appraisals of NEDs were conducted by me bi-annually (using a 360-appraisal process during one of the two appraisals). The feedback I received from stakeholders indicated that the non-executives were well respected and competent in their roles. Executive Director appraisals were conducted bi-annually by the CEO (again using a 360-degree appraisal tool annually). The CEO's appraisals were conducted by me and discussed by the Non-Executive Committee members at the Nomination and Renumeration Committee which I chaired.

Briefing of Board Members

76. To ensure that NEDs were appropriately briefed ahead of meetings, comprehensive Board packs were provided. Papers were categorised into sections with a time for discussion allocated to the board agenda for the use of the Chair to facilitate debate and to indicate the relative importance of the papers. All Directors were expected to read papers in advance of the meeting.

77. Each paper was supplemented with a cover page containing an executive summary stating the purpose of the paper and concluding with an equality and diversity impact statement. This process was emulated in the board committees.

78. Sufficient time was allocated prior to the Board for papers to be read, in case clarity or further information was required for questions to be asked in advance of the meeting. If papers didn't contain sufficient detail for a decision to be made, they would be sent back for further analysis.

79. NEDs were expected to triangulate information received through Board papers with intelligence they gained through, for example, site visits, reverse mentoring and engagement with relevant stakeholders. NEDs were also expected to challenge not just data presented but the process too, for example the choice of

methodology used or how a member reached a particular conclusion and the associated confidence levels in the data provided.

80. I recall on one occasion in June 2018, the Chair of the WED Committee challenged the number of deaths presented in the Integrated Performance Report ("IPR"). The response from the Executive to this was questioned, which resulted in the Medical Director taking on an immediate action to revise the Board's Reportable Issues Log mechanism for future reporting and to give the Board both greater and more immediate insight into issues.

81. During my term as Chair, I tried to increase the use of technology in the Trust to enable more effective scrutiny and facilitate better Board decision making. Two examples of this were the creation of an electronic Board pack system and the introduction of a statistical process control tool. These tools enabled the NED's judgement to be better informed, turning data into intelligence in a timelier manner.

Oversight of Services

IPR

82. The Board had a systematic approach to monitoring the adequacy of mental health services through an Integrated Performance Reporting system, a Quality Reporting Framework and BAF.

83. The IPR was presented by the CEO and supported by separate Executive Directors through individual Board reports (**Exhibits NHFT0007595 WITN0410017, WITN0410018 and WITN0410019**). The purpose of the IPR was to update the Board on where there had been a significant change to performance or where performance was below expected target levels. The IPR always contained a patient and staff voice report that was supplemented by the physical attendance of service users and staff. In line with the Trust' s values, it was important for the Board to have firsthand awareness of the needs of service users, staff, and carers. Chair of committee reports came towards the end of the

integrated performance reporting process to ensure scrutiny practices were being applied robustly and for matters of concern or importance to be raised to the Board from the committees.

84. For example, during the public board meeting in January 2018 (**Exhibit WITN0410020**), the then-CEO Ruth Hawkins presented the IPR, highlighting the NHSI rating remaining '2' due to outstanding actions arising from the CQC inspection at the Rampton Hospital. This IPR was also interrogated by the CoG 2 days earlier (**Exhibit WITN0410021**).

85. The IPR focused on the Trust's Commissioning for Quality and Innovation ("CQUIN") targets, which were agreed in collaboration with both the relevant clinical commissioning groups, the STP leads, NHSI and NHS England. This incentivised the Trust to improve metrics such as length of hospital stays, improved mental health support, reduced restrictive practices, Child and Adolescent Mental Health Services ("CAMHS") Screening and Inpatient Transitions. In 2018 and 2019, CQUIN targets were mandated by NHS England. In 2018, NHS England also brought in the Provider Sustainability Fund Model, which tied the Trust into STP finance and performance management systems. This encouraged more collaboration, generated shared decision making and enabled risk sharing across the STP.

STP and Performance Management

86. In 2018, the STP was given the role of performance management for the Trust across Nottingham and Nottinghamshire, and the Trust CEO was held to account by the STP for certain performance indicators. In addition to the IPR, the CEO always provided the Board with a report, including an environmental scan where relevant. In 2019, to ensure a stronger strategic alignment between the STP and the Trust, the CEO introduced a series of revisions to the IPR and the BAF.

87. Several developments in quality reporting indicated that there was value in the new STP process. For example, in the May 2018 public board minutes (**Exhibit WITN0410022**), it is recorded that Adult Mental Health (AMH) management had

worked with CCG colleagues to agree, in line with national guidelines, a zero target for Out of Area (OOA) placements by 2021. An OOA placement (discussed further at paragraphs 209-215) is when a patient is admitted to a unit which does not form part of their usual local Community Mental Health Team (CMHT) catchment area. This can occur within the same NHS provider (if it covers a wide geography like the Trust) as well as between different NHS trusts or the independent sector. A new discharge procedure had also been introduced, with a new admissions procedure to be introduced in June 2018. Delayed transfers of care (DTOC) processes had also been streamlined in collaboration with social services with greater identification and escalation of problems.

88. Where concerns identified at Board related to quality metrics, action plans to rectify issues were put in place and progress against plan monitored through the board committees. If a system solution was required, this would be reported to the Board for wider discussion at Board and, if appropriate, within the STP and commissioning system (for example CCGs and local authorities).

The Patient Voice Report

89. The Patient Voice Report was presented by the Head of Involvement every month to the Board and monitored service quality ratings taken directly from a patient or service user's perspective. The service quality rating metrics were generated by analysis of between 4,000 and 5,000 patient, carer and service user survey responses obtained quarterly. The data was often used by NEDs for scrutiny at their respective committees or during site visits. Each month, a different element of the Trust was focused on which generated debate, learning and plans for improvement.

90. The Head of Involvement would also report on the Trust data obtained from "Care Opinion", an independent system for service users, carers or family members to post their opinion publicly on the Trust's services. The Trust monitored the ratio of complaints to compliments, the speed at which both were responded to and the number of postings that resulted in a learning improvement or innovation. This system was an effective tool for the early identification of issues. As Chair,

I ensured that I obtained login rights and would check the posts fortnightly to help inform my conversations with the Head of Involvement, the Complaints Manager, the NEDs and for challenge at the Board, if needed.

91. In April 2019, the Trust supplemented the Patient Voice Report with an in-person patient story, inviting a person with lived experience, or latterly one of the carers of a Trust service user, to start the Board meeting (**NHFT0000829)**. This was designed to ensure the Board remained focused on real people, put lived experiences at the heart of the Trust' s purpose and mission, and ensure the Board' s values remained aligned and empathetic. This also prevented the Board becoming desensitised by dehumanised data analysis, keeping it emotionally intelligent.

92. National quality metrics were used to assess the mental health services provision. These were monitored by the Quality Committee through a Quality Reporting Framework which set out the quality priorities for the Trust. The Trust adopted several quality improvement initiatives led by the Executive Director of Nursing. In September 2018, the Trust introduced a " quality first" approach, designed as a sustainable way of achieving quality standards.

Board Oversight of Issues

93. As part of its oversight function, the Board would have oversight of issues raised through a variety of escalation procedures. For example, the Chief Executive's environmental scan, the IBR, quarterly, bi-annual and annual reports from the Medical Director, Nursing Director, Director of Human Resource and the Trust Secretary, and committee reports from committee chairs. As a matter of course, any concerns raised would be noted and shared following any board meeting (if discussed in the public session). Issues would also be shared with the CoG through meetings with me, the Vice-Chair, the Trust Secretary and the Lead Governor or through reports prepared for the Council meetings. Key partners would also be informed of issues through the executive functions. For example, single oversight meetings, single oversight framework review meetings, STP meetings or Trust Commissioner meetings.

94. An example of routes for the escalation of issues with the Trust's services can be seen at the 25 January 2018 board meeting (**Exhibit WITN0410020**). This began with a discussion about the action log, with an update given on actions relating to mortality surveillance, the state of care report, the Board's medical strategy and the external Well-Led review. The CEO Ruth Hawkins then presented her report and environmental scan of internal and external developments of relevance to the Trust. This included an update on local systems, providers within the STP and various divisions within the Trust. After this, the Head of Involvement, Paul Sanguinazzi presented the Patient Voice Report, which showed no notable change in the indicators for Service Quality. There was also discussion about a noise complaint on the Cherry Ward, which I said should be taken seriously as noise pollution can contribute to mental illness.

95. In this meeting, I also sought assurance that a complaint about aggressive staff had been investigated. Updates to the Board were also given by the MHL Committee, the Quality Committee and the Finance & Performance Committee. The CEO then presented her IPR explaining that the Trust's NHSI rating remained at '2' due to outstanding actions arising from the recent CQC inspection of Rampton Hospital. The Director of Nursing then advised of the intention to progress work in resolving the CQC actions with the Senior Management Team.

96. In this same meeting, the Trust Secretary Craig Sharples gave an update on the implementation of actions following PWC's Well-Led review, with actions either noted as complete or in progress with a defined timescale. The CEO then discussed the open conversations initiative which allowed the Board to gain feedback from staff on their experience of working at the Trust.

97. Many of the issues raised to the Board could only be resolved through a multi-agency or collaborative approach. For this reason, the Board would engage key system partners in the resolution of issues. For example, NHS England, NHSI, the STP, the primary care partners or CCGs would all be consulted where appropriate in the event of concerns reaching the Board.

Incidents at other Trusts

98. As part of my engagement with other organisations, I would ensure that incidents raised at other trusts were considered by the Board. As mentioned previously, in January 2018 I joined the Board of the PHSO. In March 2018 the PHSO published their " Maintaining Momentum" report (**Exhibit** PHSO0000006). Based on an analysis of over 200 upheld mental health complaints, this report identified common failings grouped into five themes: diagnosis and failure to treat, risk assessment and patient safety, dignity and human rights, communication, inappropriate discharge and provision of aftercare. During the private board meeting that month (**Exhibit WITN0410025**), I ensured this was raised for discussion in the CEO Report and Environmental Scan. The Trust actioned consideration of this report to the Quality Committee.

99. There were some limitations on the action that the Board could take to resolve certain issues. For example, much of the AMH estate was not owned by the Trust, which caused the Board concern about its ability to expand or change mental health services. This was because the Trust would be prohibited in making alterations within the Trust estate due to contractual constraints or maintenance costs attached to any proposed works. To alleviate these concerns about a lack of beds, the Executive team undertook a review of alternative provision within the system and engaged in active dialogue with relevant partners.

100. Throughout the duration of my tenure the Board worked collaboratively with all the partners to develop and resource appropriate plans to resolve concerns where possible. Where the resolution of issues was not possible in the way the Trust envisaged, the Board would mitigate or share the risk with partners as appropriate.

Freedom to Speak Up

101. The Board would also be made aware of issues at the Trust through the Freedom to Speak Up Initiative. In November 2018, the Trust received the case review

undertaken by the National Guardian Office (NGO) which made 13 recommendations that were all accepted by the Trust (**Exhibit WITN0410026**). An action plan was developed to oversee progress in acting on the recommendations and this was tasked to the WED Committee. A Board Development Session was also set up. Before the NGO' s review, I invited Dr Henrietta Hughes (the then-National Guardian for the NHS) to give in-person guidance on best practice.

102. At this time the Freedom to Speak Up Initiative was relatively new, and the NGO was in its infancy. This meant that there were some difficulties in its implementation from a practical perspective. For example, there was a specific remit for a protected disclosure under Freedom to Speak Up, involving patient or worker safety concerns, bullying or harassment or inappropriate attitudes or behaviours. However, the Freedom to Speak Up process would often be misconstrued as a grievance procedure, a distinct HR process. Over time, awareness of Freedom to Speak Up improved and became more embedded across trusts nationally.

Single Oversight Framework

103. The Trust CEO held regular Single Oversight Framework meetings with NHSI regionally. Under the Single Oversight Framework, Trusts are assessed and graded an assurance level between one and five. A 'one' grading is the highest and is for organisations consistently high performing across all domains. A 'two' grading applies where specific issues exist, but the organisation had a good performance across most domains. The lowest level, a 'five' grading is for trusts with low performance across a range of domains and a low capability to improve.

104. At the beginning of 2018, the Trust's position on the Single Oversight Framework was dropped from a one grading to a two. This indicated that NHSI had identified specific issues. The CEO would work with NHSI on associated action plans and update progress to the Board in their Environmental Scans or CEO reports.

105. The Single Oversight Framework operated across the STP and was considered in system conversations between executives. The STP co-designed the Strategic Mental Health Plan in collaboration with the Trust and commissioned services from April 2019 in line with this shared strategy.

106. Periodically, NHSI would hold regional chair events. These events were an opportunity for concerns relevant to the region to be raised. OOA placements, staff turnover, medical and nurse vacancies, and finance were all risks raised as regional issues by NHSI at these meetings, showing such issues were not unique to the Trust. These matters would be discussed at national NHS provider chair and CEO events too.

107. There are several other processes by which issues in care could reach the Board:
    (a) Complaints reports
    (b) Equality champion reports
    (c) Staff voice
    (d) Staff surveys
    (e) Patient surveys
    (f) The Care Opinion system.

108. Certain issues reaching the Board would need to be discussed during the private session. For example, the February 2018 private session (**Exhibit WITN0410027**) addressed four items on the reportable issues log. Two incidents related to patients that had been on leave and were being investigated. Two others related to domestic homicide reviews, for which the Trust had been identified as a partner. The process for writing up and reporting of serious incidents was formalised in the March 2018 review, which recommended the Board to consider the implementation of the national guidance on the Learning from Deaths Framework and learning opportunities from the current mortality data (**Exhibit WITN0410028**).

Patient-Led Assessments of the Care Environment ("PLACE") Audits

109. PLACE audits and 15 Step Challenge Reports from NEDs following site visits, often escorted by a Trust Governor, were an effective way of identifying issues with care and preventing a closed culture. PLACE audits allowed local people (known as patient assessors) to observe how their local hospital environment supported the provision of clinical care. Patient assessors would consider privacy, dignity, food, cleanliness and general building maintenance. The Board also made the decision to start holding public Board meetings on Trust sites (for example Wathwood in July 2019 (**Exhibit NHFT0004331**), Arnold Lodge September 2019 (**Exhibit** NHFT0004320) and Rampton Hospital in October 2019 (**Exhibit NHFT0002372**). Each of these Board meetings would be followed by a full site visit for non-executives to gain insight and meet staff and service users in situ. Governors would attend Board meetings to observe and would also join the site visit if the meeting was held at a service.

Sign Up to Safety Campaign

110. The Trust ran a successful "Sign Up to Safety" Campaign over a three-year period (2015 - 2018). The final report on this initiative was presented to the Board in May 2018, which highlighted the improvements made in the Trust's safety reporting culture, with a 30% increase in the number of issues raised resulting in a learning outcome. The Sign Up to Safety report also found that no harm reporting had increased and moderate harm incidents had reduced.

Serious Incidents

Escalation of Serious Incidents

111. Serious incidents could be escalated at pace to the Board through the Board's Central Alerting Risk System "Ulysses". The Trust invested in updating this system and the reportable issues logging system at the beginning of 2018, which enabled speedier intelligence alerts to the relevant executives. This meant that incidents could be analysed more effectively before being presented to the relevant committees.

112. In February 2018, it was decided that there would be a full review of the serious incident investigation process and that the Trust would participate in a Serious Investigation Accreditation Peer Group run by the Royal College of Psychiatrists (" SIRAN") (**Exhibit WITN0410028**).

113. SIRAN offered a peer-reviewed accreditation programme for mental health service incident investigations. The peer-review team comprised of up to four professionals from other member services and a network representative. These reviewers would visit a site following a " self-review" and conduct an audit against observed standards. These visits would typically last a day and include interviews with stakeholders, patients and carers. All reviewers were required to attend training provided by the Royal College of Psychiatry' s Centre for Quality Improvement (which focussed on identifying best practice).

114. The SIRAN accreditation gave the Board assurance through external evaluation that the Trust was operating to best practice and learning from mistakes. In the November 2018 public board meeting (**Exhibit WITN0410026**), the Interim Executive Director of Nursing (Fiona Illingworth) presented the Learning from Deaths Mortality and Surveillance report, noting that " principles for investigation to improve standards and consistency were being developed" and a new tool for the review of case notes had been published by the Royal College of Psychiatry.

115. The Trust' s Managing Serious Incidents and Reporting and Learning from Deaths Policy (**Exhibit WITN0410033**) set out the requirements for reporting serious incidents to external stakeholders (for example the Coroner, NHS England, NHSI, clinical and other commissioning bodies, and the CQC). It also defined the requirements for reporting and review of deaths where the serious incident threshold was met.

116. Other policy documents relating to serious incidents included:
    (a) The Risk Management Strategy (**Exhibit NHNB001890**)
    (b) The Reporting of Accidents, Incidents & Near Miss Situations (**Exhibit WITN0410035**)

(c) Reporting & Managing Legal Claims against the Trust (**Exhibit WITN0410036**)
(d) Public Interest Disclosure (Whistle Blowing) (**Exhibit NHFT0014778**)
(e) Being Open and Duty of Candour (**Exhibit WITN0410038**)
(f) Dealing with Multiple Enquiries (**Exhibit WITN0410039**)
(g) Domestic Violence and Abuse (**Exhibit WITN0410040**)
(h) Safeguarding Children (**Exhibit WITN0410041**)
(i) Safeguarding Adults at Risk (**Exhibit NHFT0015343**)
(j) Allegations of Abuse Made Against an Employee, Agency Worker, Volunteer, Student or Bank Worker (**Exhibit WITN0410043**)

Learning from Deaths and Mortality Surveillance Report

117. As per the Managing Serious Incidents and Reporting and Learning from Deaths Policy (**Exhibit WITN0410033**), the Medical Director was responsible for the monitoring of serious incidents and would bring quarterly " Learning from Deaths and Mortality Surveillance" reports to the public board and monthly serious incident reports to the private board.

118. In 2018 and 2019, there were changes in the operation of the Trust' s learning from deaths and serious incident systems. In the May 2018 board meeting (**Exhibit WITN0410022**), the implementation of the Learning from Deaths policy report was presented **(Exhibit WITN0410044)**. The report summarised the work undertaken with reconfiguring reporting of deaths, changing the investigations framework, core support to families and external benchmarking. The work was focused on transforming the investigation methodology into a manageable investigation and learning process. The Medical Director also reported that the implementation of the policy was reviewed by the CQC who reported that the Trust had " robust processes that were fully compliant with the framework to investigate and learn from deaths" .

119. The " Learning from Deaths and Mortality Surveillance" report (**Exhibit WITN0410044**) provided assurance that the Trust' s divisional sub-committees were operating effectively, and the Mortality Surveillance Group were monitoring

deaths appropriately. The report would also show that where concerns with clinical care were raised, these would be investigated appropriately.

120. At the February 2019 public board meeting (**Exhibit WITN0410045**), the Medical Director (Julie Hankin) presented her Learning from Deaths and Mortality Surveillance report (**Exhibit WITN0410046**). This report indicated that there had been 637 deaths during quarter 3, of which 36 cases were subject to an initial management review, 18 of which were followed up by a serious incident report. Whilst the report stated that there were 15 cases where some learning had been identified taken from the 637 reported deaths, no deaths were attributed to problems in care.

121. The Medical Directors report did however alert the Board to several " recurring themes" that had come through the Trust CIRCLE (Clinical Incident Review Creating a Learning Environment), relating to issues such as record keeping, policy and procedure, communication between teams and risk assessment. These themes suggested that learning from previous deaths had not resulted in sustained improvement. The Medical Director assured the Board that there was an action plan to address these themes:
    (a) A review of the Trust' s approach to serious incident investigations with a focus on quality not quantity and resources to undertake investigations.
    (b) Implementation of a learning forum for 2019/20 to consider the learning from a variety of information sources.
    (c) Implementation of the Trust' s quality priorities for 2019/20 using quality improvement methodologies.

122. Although the report of recurring themes was concerning, I gained assurance that the Medical Director was alert to the problems, that no deaths were attributable to the care provided and that the Medical Director was making the necessary innovations to the process.

123. The Trust continued to participate in the regional mortality group to share learning with other providers of mental health, learning disability and community services.

As part of this, the Trust would refer deaths to the national Learning Disability Review Programme where appropriate to do so.

Learning from Serious Incidents

124. Several groups existed to consider serious incident reports and identify any learning from such incidents. There was an evolution of the process between 2018 and 2019, with the separate SIRG (Serious Incident Review Group) and CIRCLE groups both becoming divisional CIRCLE groups, which met weekly to review all new serious incidents and reported into the QOG (Quality Operational Group) Meetings. This provided trust-wide oversight of the reporting and management of serious incidents and ensured that immediate risks were managed with an appropriate level of investigation. The duty of candour would be applied when required, so that staff were supported and incidents communicated in an appropriate and timely manner.

125. The Trust also had the Managing Serious Incidents and Reporting and Learning from Deaths Group alongside the QOG. The Trust QOG provided a high-level forum for executives to oversee and monitor the reporting and review of Serious Incidents and ensure that recommendations arising from Serious Incident Investigations were implemented. The QOG would report and escalate any appropriate risks to the Quality Committee for inclusion on the BAF or the Trust' s risk register.

126. The Medical Director was accountable for taking lessons from serious incidents forward and would work with system leaders nationally and regionally to develop improved systems for dealing with serious incidents.

127. Work was also taking place to improve the support given to bereaved families and a " Making Families Count" workshop had been run in October, (as advised during the August 2018 public board meeting (**Exhibit WITN0410047**). It was reported that there had been good engagement and more data was now being

shared with wards and teams to help identify and explore outliers. Further, a "Quality Learning Forum" (Quality Operational Group) would be established in the New Year.

128. The Medical Director worked closely with the Chairs of the Quality and Mental Health Legislation Committees to guide their agenda and ensure the appropriate levels of scrutiny required. To my knowledge, all committees replicated the Board process of monitoring actions and recommendations through action logs and learning reviews.

Incidents of Serious Violence

129. Incidents of serious violence were also covered by the Managing Serious Incidents and Reporting and Learning from Deaths Policy (**Exhibit WITN0410033**). Dependent on the severity of the violent act and its locality, it would be reported to the Board through a number of different processes.

130. The monthly serious incident report would identify serious acts of violence. If the violent act was within the Nottinghamshire region and resulted in a fatality, this would be identified through the quarterly mortality or the bi-annual EPRR (Emergency Preparedness, Resilience, and Response) report. If an incident occurred out of area, the Trust would have to wait to be alerted by one of the regional or national agencies investigating the incident, such as the police, the coroner or the CQC. I am not aware of any out of area incident having been reported to the Board during my tenure.

131. In the February 2018 private board meeting (**Exhibit WITN0410027**), two incidents relating to domestic homicide reviews were reported, for which the Trust had been identified as a partner. Learning from the process of writing up and reporting these serious incidents was formalised into the Spring 2018 review conducted by the Medical Director (**Exhibit WITN0410044**). In the Serious Incidents report to the April 2018 private board meeting (**Exhibit WITN0410048**), the Medical Director (Dr Julie Hankin) reported on the stabbing of a family

member by a service user that was under a full investigation, and criminal proceedings were taking place.

132. These reported acts of violence were tragic incidents that were the source of deep concern at the Board. The immediate response was to take any learning where possible and, from a governance perspective, three assurances were taken. Firstly, that the alerting system was working, as all board members were made aware of the incidents in the appropriate and timely way. Secondly, the incidents were being dealt with at an operational level openly and transparently and the Trust was collaborating with other agencies. Thirdly, the operational system being used to learn from these incidents was being benchmarked with peer organisations under the RCP's SIRAN peer accreditation process.

Implementation of Serious Incident Policy

133. All Executive Directors were responsible for ensuring the Managing Serious Incidents and Learning from Deaths Policy (**Exhibit WITN0410033**) was implemented across the Trust. An " on-call duty" executive would be allocated and always available in the event of an emergency. Executive directors were also responsible for ensuring that staff under their responsibility had the capacity and capability to implement the policy, have appropriate structures and processes in place to manage serious incidents and reviews of deaths and report confirmed serious incidents to appropriate bodies, where relevant.

STEIS

134. Information on serious incident investigations would be reported externally through the Strategic Executive Information System (STEIS), the national database for reporting and learning from the most serious incidents. Through STEIS, commissioners and the CQC were informed of all serious incidents reported in accordance the NHS Serious Incident Framework. Some incidents would not meet the definition of reportable incident under the framework but would be reported on Ulysses (the Trust's system) and considered internally at

the weekly serious incident review/issues group or CIRCLE and reported into QOG.

135. Incidents resulting in death would result in an inquest overseen by a coroner who can issue a prevention of future deaths report if he or she feels that there is a risk of other deaths occurring in similar circumstances. The Medical Director is responsible for liaison with the coroner, and the Trust must reply within 56 days to say what action it plans to take or has taken already.

National Reporting and Learning System

136. The NHS National Reporting and Learning System (NRLS) provided the Trust with a central database for all patient safety incident reports. The Trust data submitted to this national database would be analysed nationally to identify hazards, risks and opportunities to continuously improve the safety of patient care on a national basis. Reports are produced every six months by NHSI and information on incidents is shared to the CQC.

Reviews of Deaths at the Trust

137. All deaths at the Trust would be investigated. If a death was considered to have been attributable to the clinical care provided, a review of that death would be conducted and included in the quarterly learning from deaths report. This report would be submitted to the appropriate board committee and presented to the Board by the Medical Director.

138. Death investigations would analyse what happened, how and why, drawing on physical evidence, witness accounts, policies and observation. The process aims to identify any issues in care that require changes in service provision, to reduce the risk of future occurrence of similar events. Internal death investigations can be either level 1 or level 2 as per the NHS Serious Incident Framework. Level 1 investigations are concise and suited to less complex incidents which can be managed by individuals or a small group at local level. Level 2 investigations are

comprehensive and suited to complex matters which should be managed by a multidisciplinary team involving experts or specialist investigators.

Non-Fatal Serious Incidents

139. For serious incidents that didn't result in death, a similar process existed. The Quality Committee provided oversight and scrutiny of the Trust's reviews of the care provided to patients prior to such incidents, who reported their finding back to the Board, escalating matters, if required. Incidents involving severe or serious harm to one or more people would also be reviewed.

140. Reportable issues on the log were escalated by the Board or Medical Director to NHS England when appropriate. For example, in the private session of the April 2018 board, the Medical Director reported on an item related to the use of a mechanical restraint following a surgical procedure to prevent a patient from further harm.

CQC Engagement

CQC Report May 2019

141. Between 22 January and 7 March 2019, the CQC carried out a routine inspection of six of the Trust' s core services **(NHFT0002015).** The inspection was led by Kathryn Mason with two executive reviewers, Dawn Slater and Lisa Quinn.

142. Before the publication of the CQC' s report in May, the Board was provided with an update by the CEO in the public board meeting on 25 April 2019 (**NHFT0000829**). The Trust' s CEO, Dr John Brewin explained that the initial summary and feedback from the CQC had been received and was being reviewed for factual accuracy. The CEO also explained that though the full report would be made available in May, a rating of " requires improvement" was expected. From this meeting, the Board understood that an action plan and improvement learning approach was to be developed to ensure that the Trust would return to a " good" rating as soon as possible.

143. During the public board meeting on 30 May 2019 (NHFT0001208), the CQC report was discussed as part of the Chief Executive' s Environmental Scan and under its own agenda item. Dr John Brewin expressed his disappointment in the rating but praised staff for maintaining " a good level of care" . The Interim Executive Director of Nursing (Deborah Wildgoose) and the Associate Director for General Health (Lisa Dinsdale) presented a paper, stating that the Trust accepted the rating and was committed to improving all aspects of the services identified as a concern. It was also noted that the board was taking steps collectively to address leadership concerns.

144. The CQC report contained 25 legal requirement notices where the Trust had breached regulations and 54 additional recommendations. Where requirement notices are issued, the Trust must send the CQC a report within 30 working days of receipt of the report setting out actions that it will take to meet these requirements. The discussion at board level focused on these requirements and recommendations relating to AMH inpatient areas, as well as how to improve the Trust' s approach and learn from executives' experience of improving Trusts elsewhere (particularly Dr John Brewin who regained a good rating at his former trust).

145. During a Quality Committee meeting on 13 May 2019 (**Exhibit WITN0410049**), there was discussion on how to respond to the CQC report. It was agreed that the required actions would be taken systematically, with key policies, training and safe staffing to be reviewed subsequently. Additional work would then take place in underpinning clinical leadership changes to ensure the right clinical leaders were engaging ward leaders and community team leaders in the improvement approach. The NHSI Quality team would need to be engaged, given that the CQC had identified certain areas as inadequate. This approach meant that the Trust' s response would be more comprehensive in improving care outcomes, instead of focused just on compliance with the CQC' s notices through an action plan.

146. To deal with issues identified in AMH inpatient staffing, leadership and environment, the Board concluded that it needed to generate closer links with clinical leaders, engage their thoughts on the findings and listen to their feedback. It was agreed in the May 2019 board meeting that the next step was to provide a report to the CQC by 4 July 2019 detailing the Trust's response to the requirement notices to ensure breaches in regulation were addressed.

147. One of the difficulties of a CQC inspection is that it occurs during a fixed point in time and does not take into account transformation. The CQC's inspection began in January 2019, just after John Brewin's appointment, which was delayed due to the Cabinet Office intervention. When any changes are brought to a Trust there is an initial period of destabilisation before improvements become embedded.

Actions Taken Following the CQC Report

148. In the same May 2019 meeting, the Trust Secretary was tasked with organising a board development session to pick up on the specifics of the ' alternative methodology' and a series of workshops took place:
    (a) 27 June 2019 - Vision, values and purpose (**Exhibit WITN0410050**)
    (b) 29 August 2019 - Effective board, developing a board purpose and leadership culture; leadership connectedness and working together (**Exhibit WITN0410051**).
    (c) 22 October 2019 - Quality, diversity and inclusion values and behaviours (**Exhibit WITN0380020**).
    (d) 8 December 2019 - Information governance, making data count (**Exhibit WITN0380021**).

149. In September 2019, the Chair of the MHL Committee reported that the Committee had received the CQC report, discussed its findings at the Mental Health Local Operational Group (LOG) and completed CQC compliance reviews (**Exhibit WITN0410055**). The Chair of the Quality Committee reported in its CQC Inspection Report Progress Update (**Exhibit WITN0410056**) that they had confidence that work in operational services was underway to address the issues

and, going forward, the evidence supporting this would be reported to the Committee with timescales and milestones for assurance.

150. A " Core and Well Led Plan" was initiated to monitor the Trust' s progress, with regular updates given during board minutes. At the public board meeting on 26 September 2019 (**Exhibit NHFT0004320**), updates on progress in addressing the CQC' s findings came through the CEO' s Environmental Scan and Chair reports of both the Mental Health Legislation Committee and the Quality Committee. The work to address CQC actions was scrutinised by the Chair of the Quality Committee, who gave an update to the Board on sign off of Quality Impact Assessments and FIPs (Financial Improvement Plans).

151. As part of the CQC Core and Well Led Plan, an action plan was created (**Exhibit WITN0410057**), which monitored all of the CQC' s concerns relating to AMH inpatient, AMH community, CAMHS, CLDT (Community Learning Disability Teams), crisis, forensic inpatient and well-led. The tracker also included a section for actions the Trust was taking in relation to each concern, the assurance level that the standard is being improved and the available evidence that compliance is achieved.

152. This action plan would be made available to the QOG and Quality Committee who would feedback and provide any further recommendations. At the October 2019 public board meeting (**Exhibit NHFT0004372**), the Board received a report from the Head of Compliance providing a detailed update on the Core and Well Led Plan (**Exhibit** **NHFT0005214**). It was noted that a quality improvement plan was in place to address compliance actions associated with the report, which was due to go back to the CQC in November. Fifteen of the core and well-led actions were noted as progressing on time, with three subject to delay. The Quality Committee would scrutinise the quality improvement plan at the next committee meeting in November.

153. The Trust' s action plan shows the Trust taking action in response to the CQC' s findings. For example, under AMH inpatient it was noted that the CQC found that staff could were not conducting physical observations consistently whilst staff

were administering rapid tranquilisation. It was noted that the Trust were engaging in Prescribing Observatory for Mental Health (POMH) benchmarking audits (POMH is a subscription service for mental health services improving prescribing practice). A local audit was also being developed and would be undertaken once the rapid tranquilisation policy review was completed. The action plan also addressed staffing concerns (see paragraph 196).

154. Regarding physical health checks and planning during admission, the Trust brought in weekly physical health clinics on every ward from October 2019. The Lester tool was to be completed on admission. This is a poster to guide health workers to assess the cardiometabolic health of people experiencing psychosis and schizophrenia. The Lester tool was to be applied across the six National Early Warning Score (NEWS) areas: respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness and temperature.

155. The CQC found inconsistencies in how privacy and dignity was preserved at the Lucy Wade Ward. A review of practice was initiated in response, with weekly live reports on physical observations reviewed by ward managers. The CQC lifted the enforcement in response to these improvements in October 2019.

156. The CQC found governance issues at ward-level, with inconsistent evidence of ward meetings and low supervision compliance. The Trust initiated a short-term task and finish group utilising the Trust's QI methodology. Team meetings were minuted and shared with operational managers for oversight and supervision. This action was complete by 31 November 2019.

157. Some of the CQC's findings required greater resources to address. For example, the CQC found that 23% of the records they reviewed within AMH inpatient services did not have a fully developed plan to manage known risks. To address this concern, the Trust needed to develop a Quality Improvement Project Plan, led by the Quality Improvement Facilitator. The Peer Support team committed to provided two days of inpatient training for all staff covering risk assessment and management, care planning, team working and the role of a key worker or inpatient nurse. Two days of trauma-informed care training was also scheduled

for staff at all seeded sites. Also, a risk assessment and care plan buddy was assigned to every ward to support the Ward Manager to review all risk assessments.

Risk Assessment

Risk Management Strategy

158. The Trust' s assessment of risk begins with the creation of the Trust Strategy (**Exhibit NHNB0001890**), which sets out strategic priority and quality and performance targets by which the Trust can measure risk. In 2018/2019, this was the responsibility of the Strategic Programme Executive (SPE), led by the Director of Business Development and Marketing. The Trust' s strategy was set out in the Annual Business Plan, which was co-designed and approved annually by the Board after consultation with the Executive Leadership team and key partners. The SPE would then provide quarterly reports to the Board on the annual business plan. Quality and performance metrics were monitored by respective committees, utilising the BAF which sat above divisional risk registers.

159. Every board meeting would include a " Matters Arising and Action Log" review, to address outstanding actions or review item previously discussed. Under this item, executives and committee chairs were expected to confirm the status of any previous actions (i.e. whether they were complete, or if not, when they would be completed). At the end of every private board meeting, I would conduct a " review of the meeting" learning exercise, where I would reflect on how much attention had been paid by the Board to safety or risk and whether sufficient challenge had been given. The Board would also invite patients, carers and staff to Board meetings to have an open conversation about their experience of services, to identify areas of improvement, aid learning and improve outcomes, all of which contributed to the identification and management of risk.

160. Each Board committee had a responsibility for a feature of risk set out in the BAF. To prevent this approach from becoming siloed, I would meet with the NEDs quarterly without Executives present. Each committee chair would report back

on their focus, any concerns they had and risks with which they required NEDs support. These would then be raised as appropriate in their next Committee and/or at the next Board meeting. I would also ensure that risks identified during NHSI's Single Oversight Framework meetings or STP/integrated care system meetings, were brought back to the Board through the CEO's environmental scan report. I would notify the Board if system risks had been identified during any of my external stakeholder meetings.

161. The Trust had additional monitoring systems for risk in place. For example, monthly environmental scans, monthly divisional board reports, quarterly learning from deaths reports, monthly serious incident reports and bi-annual safeguarding reports were all of use in ensuring that risks reached the Board.

162. As part of its annual report and accounts system, the Trust would be required to undertake an annual reflective exercise on quality and performance in line with good governance practices. This exercise would be agreed by the Board and the CoG, and reported back by the Trust Secretary.

163. When managing strategic or operational risk, the Board would ensure transparency with its partners. For example, in May 2018, the Board recognised the learning from the Kirkup review of Liverpool Community Health and referred to the CQC and NHSI for consideration.

Creation and Review of Risk Management Policies

164. From 2016 - 2021, the Trust's Risk Management Strategy set out the Trust's objectives for the management of risk at a strategic and operational level. This strategy set out the processes for the creation and review of all policies relating to risk. These policies comprised some of the key controls which enabled the Trust to manage risks that threaten the achievement of its objectives.

165. The Trust's Risk Management Strategy had six objectives:
    (a) Increase the likelihood of achieving the Trust's strategic objectives.

(b) Prevent or reduce events or actions that could adversely impact on patient safety or damage the reputation and public confidence of the Trust.

(c) Encourage, develop and embed risk management as an integral part of the Trust's culture.

(d) Ensure that the Trust is compliant with statutory and regulatory requirements.

(e) Improve decision making and planning and seeking best value for money, thereby maximising resources for patient services and care.

(f) Ensure that lessons are learned and changes in practice are implemented.

166. As per Appendix 3 of the Risk Management Strategy, risks would be identified using a scoring matrix to identify likelihood and impact to inform the risk management process. Where risks were identified, reviews of the effectiveness of policy would be conducted to gain internal assurance where appropriate. The Board never created policy, as this was delegated to competent professionals as appropriate. When policies were updated, these were overseen by the Policies team headed by the Trust Secretary.

167. Compliance with trust policies and procedures was monitored through a Trust Policies and Procedures Update Report prepared by the Audit Committee and presented to the Board. This was overseen by the Policies team in consultation with the Trust Secretary. The report monitored the dates and status of policy reviews and assured that formal consultation and stakeholder engagement had taken place before policies were updated.

168. The Trust Secretary would also produce an annual Governance Compliance Report, in accordance with the Trust annual reporting requirements. This would assess the Trust' s compliance with the NHS Foundation Trust Code of Governance. In 2018 and 2019, the Trust Secretary' s report affirmed that the Trust' s governance was fully compliant (**Exhibits WITN0410060 and WITN0410061**).

Board Learning and Development

169. Board Directors were assessed for their individual capabilities on appointment and given the necessary training on the relevant systems as part of their induction. Individual Directors were appraised bi-annually and provided with further training if necessary. NEDs who chaired committees were observed annually and given feedback or mentorship, if required.

170. The Board operated a " Board Development Process" , that was overseen by me in collaboration with the CEO, the Head of Learning and Development and the Trust Secretary. This meant that development opportunities were made available to members, with regular themed learning exercises involving the whole Board. A similar approach was adopted for governor training with the Lead Governor.

171. In July 2019, following a conversation led by the Chair of the Audit Committee, the Board agreed that it needed to update its understanding of the Trust' s risk appetite (i.e. the amount and type of risk the Trust was willing to seek, accept, or tolerate while pursuing its strategic objectives) (**Exhibit NHFT0004331**). The Trust Secretary (Craig Sharples) was tasked with planning a session for board discussion and, at the September board meeting (**Exhibit NHFT0004320**), he confirmed that he had organised this session and the action was completed. During the meeting however, the Chair of the WED Committee expressed concern relating to a few risks that had been stagnant without sufficient assurance. After some debate, it was agreed that this should be discussed further during the future Board development session on risk appetite. Instead of one workshop, this became a series of learning events that carried on beyond the end of my term of office.

172. The December 2019 Board Development Workshop (**Exhibit WITN0410062**) was the last board learning event I attended. At this meeting, training on the interpretation of data was provided to the board. This covered statistical process control and enabled the Board to better understand data analytical tools and how

to apply them more effectively. This learning was valuable in assessing risks associated with quality and performance or identifying learning improvements.

BAF

173. The NHS BAF was a governance tool that provided a single source of information designed to enable a board to identify, manage and gain assurance on issues. In practice, the BAF requires a Board to first identify its key strategic priorities and the subsequent risks that might prevent these priority objectives from being achieved. The BAF provided the primary mechanism to manage risk, acting as a key source of information enabling the Board to identify, manage and gain assurance.

174. The BAF must provide detailed controls and associated actions to be put in place to mitigate risk. Close monitoring, oversight of these controls and actions at committee-level help reduce the risk and deliver the Trust' s strategic objectives. Should a committee not be assured an issue is being appropriately managed, then they must report their concerns to the Board. To ensure that committees and those responsible for developing the BAF are informed of potential risk, the Board would conduct regular ' risk appetite reviews' so that the level of risk the Trust was willing to accept was continually assessed.

175. The BAF allowed the Trust to engage with their strategic partners to allow assurance alignment exercises between organisations. The BAF was aligned to the single oversight frameworks of NHSI and the STP/Integrated Care Board. Aligned reviews were conducted at an executive level with their outcome reported to the Board through the committee structures or directly to the Board through the CEO environmental scan update, if appropriate. The BAF is a live and dynamic process, which evolves as risks emerge or are resolved.

176. In January 2018, the Board conducted a director development session, which used the recent November 2017 CQC inspection report to inform its consideration of the BAF (**Exhibits WITN0410064 and WITN0410065**). Priorities identified within the CQC report were considered in light of the Trust' s four

strategic objectives (provide best possible care, demonstrate best value, be the service provider of choice and make the trust a great place to work). The development exercise provided insight and generated the creation of associated actions that were subsequently included in the BAF.

177. The BAF was reviewed annually by the Board at a board development session. This would assess whether its operating systems were fit for purpose, risk priorities were still correct and Executive and NEDs had a common understanding of risk. Following the review and any accompanying debate, actions were taken back to the Board, agreed and the Trust' s risk appetite would be reaffirmed or recategorised. In the March 2018 BAF review, attention was given to the top 5 risks. These were: recruitment in high secure services, retention in high secure services, maintaining quality, financial risk and workforce wellbeing.

178. In December 2018, in advance of CEO Dr John Brewin' s appointment, the BAF was discussed (**Exhibit WITN0410066**). It was observed that there was insufficient alignment between the BAF, the IPR, the Single Oversight Framework and the STP. The Trust Secretary had noted that there was a need to ensure discussions at committee-level were included on the BAF. In introducing the IPR in January 2019, the CEO highlighted the report incorporated externally reported frameworks to " enable the Trust' s performance to be measured against both the ICS and national reporting frameworks" (**Exhibit WITN0410067**).

179. In the 28 March 2019 public board meeting (**Exhibit NHFT0007588**), the BAF was presented to the Board. It was noted that there were 25 risks recorded on the BAF. The Trust' s top 5 organisational risks had changed to include
    (a) Inability to manage admissions into AMH in-patient beds.
    (b) Recruitment issues at high secure services.
    (c) Trust-wide Recruitment and retention.
    (d) Financial strategy and sustainability.
    (e) Health, well-being and resilience of workforce.

180. This demonstrates the BAF's status as a live document, responsive to the changing needs of the Trust. The subsequent Board debate also highlighted the "lack of progress on some BAF actions" and it was agreed that a more detailed review of the BAF would be undertaken by the Executive Leadership Team.

181. The effectiveness of a BAF is dependent on the data it receives, how this is prioritised and the technology used to analyse it. In 2018 and 2019, it was my ambition to gain investment in digital resources that could be interrogated electronically to produce better statistical analysis of process and control tools. The discussion related to the BAF at the March 2019 public board meeting raised a "challenge in relation to a lack of risk identified for technology and IT." The Director of Finance agreed with the challenge and explained that the Digital Strategy Group was reviewing and the risk around the IT strategy would be realigned. I was particularly interested in the greater utilisation of statistical process control (SPC) technologies to monitor data. The Trust subsequently organised an SPC training event with NHSI which I chaired in December 2019.

Executive Challenge of Risk Assessment

182. Internal challenge would often be given by the executives about the way risk was assessed and managed in the Trust. For example:
    (a) At the conclusion of every private board meeting, I conducted a reflective learning review. At the end of the private board session in April 2018 (**Exhibit WITN0410069**), I asked if safety had been sufficiently considered. A NED, Christine Lovett questioned if there had been enough space to discuss risk on the agenda and consequently her risk concerns were raised to the Board.
    (b) At the June 2018 board meeting (**Exhibit WITN0410070**), I challenged the Trust' s safety and risk culture by asking the Board about how staff could be engaged more to consciously raise health and safety as a risk matter and to help improve the Trust' s CQC safety ratings. This resulted in executive action being taken.
    (c) During the same meeting, the then CEO (Ruth Hawkins) and Director of Nursing (Julie Attfield) both challenged the MHL Committee to gain

greater assurance that actions relating to committee reviews or CQC compliance were being implemented.

(d) In December 2018, Laura Saxton, (Head of Performance) highlighted that there had been some " misalignment" between the BAF and the IPR (**Exhibit WITN0410066)**. I challenged how effectively the BAF was being scrutinised at committee-level, having recently observed the Quality Committee and found it to be lacking depth. The Company Secretary took an action to ensure committees were appropriately providing the required level of scrutiny). My challenge was picked up by the CEO in the March 2019 board meeting (**Exhibit WITN0410072**), and two new performance dashboards and a thematic review were introduced. This ensured alignment between the NHSI Single Oversight Framework, the BAF and the Divisional Performance and Risk systems.

Staffing

Staffing Requirements

183. The Trust adhered to the National Quality Board' s (" NQB") staffing guidance outlined in " Safe, Sustainable and Productive Staff: An Improvement Resource for Mental Health" published January 2018 (**Exhibit NHSE0000145**). This set out the guiding principles of " Right Staff, Right Skills, Right Place and Time" and offered insight on quality improvement methods that could identify waste and make changes at service level to improve quality. The guidance also explained how to review shift patterns and provide e-rostering to support the efficient delivery of care and treatment.

184. The NQB publication was developed to help commissioners and providers of NHS mental health services to create, review and sustain safe, effective, caring, responsive and well-led services and recommended boards to seek assurance that:

(a) Right Staff

- The organisation has systems to monitor staffing across all services (based on acuity of demand) and that these are measured and

reviewed against actual team staffing levels. Should significant issues affect safe staffing, the Board should be assured that there is an agreed process for escalation.

(b) Right Skills

- Processes are in place to identify, analyse and implement evidence-based practice across services.
- Systems and processes are in place to promote staff well-being and prevent fatigue and burnout; the organisation has a clear strategy for staff retention, which clearly states learning and development opportunities for all staff, and plans for attracting, recruiting and retaining staff that are aligned with the workforce plan.

(c) Right Place and Time

- Standard approaches across services to identify and prevent unwarranted clinical variation in service provision
- Embedded quality improvement methods enable clinical teams to identify waste and make changes at service level to improve quality
- Regular reviews of shift patterns and e-rostering support the efficient delivery of care and treatment.

185. As acknowledged by the NQB in the publication, models of care are complex. Different local solutions to issues can emerge over time, so provision can vary locally and regionally, with no two provider organisations offering an identical mix of core, specialist or community services.

186. The Trust would use the Keith Hurst methodology in assessing staffing. This was a multi-disciplinary, evidence-based system that enabled clinicians to assess patient acuity and dependency and convert this data into a workload index that ensured ward staffing reflected patient needs.

187. Workforce issues were discussed at every board meeting, and the Workforce Capacity and Capability Report would be presented bi-annually by the Director of Human Resources. In the public board of March 2018 (**Exhibit WITN0410072**), the Director of Human Resources outlined the Trust' s approach

taken in regard to in-patient establishment reviews, where staffing capacity had fallen below the planned or required levels, and the actions taken in response, including a trust wide recruitment and retention plan, review of the staff voice approach and establishment reviews of in-patient areas.

188. At the same public board meeting in March 2018, the Director of Nursing (who was the Executive Director responsible for safe nurse staffing levels), informed the Board how establishment and safe staffing reviews were being conducted more robustly within the " Safe, Sustainable and Productive Staff" guidance published by the NQB. For mental health settings, a specific adaptation of the Keith Hurst model was developed called the Mental Health Optimal Staffing tool (MHOST). This tool accounted for the specific characteristics and varying dependencies of patients across different mental health specialisms.

189. At my last board meeting on the 28 November 2019 (**Exhibit WITN0410073**), the bi-annual Safer Staffing Update was presented to the Board for the very last time under my tenure (**Exhibit NHFT0005109**) and specifically noted how the Trust met the NQB' s expectations. This report was considered by the Quality Committee and noted that the Trust was compliant with the national requirements for safe staffing reporting and was meeting expectations set by the NQB, except for expectation 6: *systems to create local plans to support and retain staff, ensuring they have the right skills, values and behaviours, they are placed in the right locations to meet service needs and these local plans are integrated into the sustainable transformation plans*.

190. Though the Trust noted its need to address recruitment and not just the retention issues highlighted in the Safer Staffing Update (voluntary turnover and Trust vacancy rates remained high), staffing breaches were reviewed in the report and not found to correlate to any harm.

191. Whilst the safer staffing report provided the Board with assurance that there was compliance with the NQB requirements, it did not provide assurance that staffing capacity and capability requirements overall were being met within the Trust. The

challenge of meeting workforce resourcing requirements was becoming more difficult, and the following actions were highlighted to address the issues:

(a) Continue a schedule of establishment reviews, prioritising high acuity areas (e.g. psychiatric intensive care units).
(b) Continue to recruit staff and develop new roles that fit the resourcing plan (e.g. peer support workers, activity managers).
(c) Work with nursing bank colleagues and local units to enhance quality of care and improve shift rates.
(d) Continue to focus on enhancing staff well-being.
(e) Embed safe care across the Trust.
(f) Refresh visibility of staffing level notifications in patient area of wards.

192. Safe staffing reviews would come to the Board via both Quality and WED Committee meetings, both of which would have provided a higher level of scrutiny to the integrated reporting papers before the Board.

Staffing Reviews

193. Staffing is an ongoing concern of any trust executive and in 2018, workforce was one of the greatest challenges facing the NHS. As stated above (at paragraph 191), reviews of staffing breaches had found no correlation to harm. However, inevitably there were concerns at board level to ensure staff wellbeing and engagement was maintained. The challenges to the workforce were represented in the Trust Risk Register and reported through the BAF.

194. In addition to the bi-annual Safer Staffing Update, staffing concerns would also be raised through the IPR. This occurred for example in February 2018 where the Director of Nursing (Dr Julie Attfield) and the Medical Director (Dr Julie Hankin) raised safe staffing in AMH services (**Exhibit WITN0410032**).

195. Staffing issues were also picked up in the May 2019 CQC report (**NHFT0002015)**, which found that safe staffing levels were not met consistently across adult acute admission wards, health-based place of safety and forensic

services. In response, a staffing review was completed and increases agreed **(Exhibit WITN0410057).** Any subsequent actions taken extended beyond my tenure as Chair.

196. The Board would respond to staffing issues through recruitment drives at universities or job fares, consideration of agency staff and incentives to promote the retention of existing staff. The Trust workforce strategy plan was discussed during the May 2019 public board meeting (**NHFT0001208**). This plan provided strategic direction regarding workforce as part of the Trust' s People and Culture strategy. This was to be overseen by the WED Committee and had been produced to ensure that a long-term structural solution to staffing was applied, with focus on workforce risks the Trust was facing and alignment with national and local drivers. One of these local drivers was the results of the National Staff Survey (NSS), in which the Trust scored below average in all 10 areas. The Board under John Brewin was committed to acting on these results, with its strategic objective of making the Trust a great place to work and beginning staff consultation on the updating of the Trust' s values.

197. At the end of my tenure as Chair I was acutely aware that staffing was a national issue but satisfied that this was being managed as effectively as practicable, with Trust in compliance with the national requirements for safe staffing reporting and the vast majority of the expectations set by the NQB (**Exhibit NHSE0000145**). However, I was aware this came with significant caveats. Nationally, the NHS was facing recruitment issues such that nursing had been classed as a shortage occupation. The Trust analysis showed that it had high voluntary turnover levels across the Trust, with a high proportion of staff leaving within the 12 months of starting their employment, notably nursing (15.0%), healthcare assistants and support staff (26.5%), allied health professionals (15.9%) and scientific, therapeutic and technical staff (13.3%) to take roles within the NHS elsewhere.

198. Analysis of workforce demographics showed an ageing staff population with 8.6% of the total nursing workforce as of September 2018 holding Mental Health Officer status, meaning they could leave at age 55. East Midlands Supply Intelligence showed negative fluctuations in the number of nursing commissions

between 2016/17 to 2018/19. Overall, adult and learning disability nursing placements were set to reduce, with increases in mental health and child nursing. These factors were compounded by a potential contraction across the nursing workforce as well as a predicted reduction in supply over the following 5 years. The shortages of specialists in psychiatry and general practice, high level of pressure of increased workloads, posts situated in remote locations, reduced morale and lack of strategic deployment of junior doctors all had a direct impact on staff and agency usage.

199. There were considerable pressures on Improving Access to Psychological Therapies (IAPT) services, specifically Psychological Wellbeing Practitioners (PWPs) where there was a 44% turnover rate. To support the recruitment and retention of these staff, a run through grade for pay Band 5 and 6 Psychological Wellbeing Practitioners was to be introduced. The Trust had completed a review of psychology across all Trust services and benchmarked these in the Workforce Strategy Plan. It explored a range of potential new roles and new ways of delivering therapy to address staffing requirements, including looking at digital platforms that allow remote working by therapists in other geographical areas.

WED Committee and Staffing

200. The WED Committee had responsibility for workforce issues and the following core duties (**Exhibit WITN0410010**):
    (a) To review the delivery of the People and Culture Strategy.
    (b) To ensure that assurance is provided on robust strategic workforce planning and ensure alignment to the Annual Business Plan.
    (c) To maintain a strategic insight of the equality, diversity and workplace environment in which the Trust operates.
    (d) To provide assurance to the Board with regard to all legal matters concerning workforce management and equality and diversity arrangements across the Trust
    (e) To monitor the Trust's approach towards staff engagement, enabling staff voice and Freedom to Speak Up.

(f) To review the findings of the national staff opinion survey, and Trust staff engagement survey monitoring the implementation and effectiveness of resultant actions.
(g) To monitor progress on workforce audits.
(h) Maintain ongoing review those risks detailed on the Trust's BAF for which the committee is responsible.
(i) To escalate issues of concern requiring Board attention.
(j) To develop and maintain an annual work programme to reflect and enable assurance in relation to the above duties.

Quality Committee and Staffing

201. The Quality Committee would have a role regarding staffing where the risk or impact of staffing levels required greater scrutiny. If NQB guidelines were not met, the Quality Committee could review, consider the impact on quality and take appropriate actions. Both chairs of the WED and Quality committees were clinically qualified and would triangulate with insight from the Chair of the MHL Committee to challenge the executives and generate improvement actions effectively.

Staff Engagement

202. The Trust had a much more diverse workforce than other trusts, meaning that there was a broader range of groups that the Trust needed to engage with. After John Brewin was appointed as CEO, there was a renewed focus on staff engagement. Several board development sessions were scheduled, bringing in different stakeholder groups to engage with the Board. The Trust's values were refreshed (see paragraph 65), and workshops were run to discuss these.

Safer Staffing Meetings

203. The Heads of Nursing and Forensic Matrons would conduct monthly retrospective reviews of safer staffing performance. These reports would be discussed by the Associate Directors of Nursing with the aim of developing plans

to support specific wards. The exception reports and associated management plans were discussed at a monthly Safer Staffing Group chaired by the Associate Director of Nursing for the Mental Health Division, who had a trust-wide responsibility for safer staffing.

204. If the management plan in place was not having the desired impact or was assessed by the group to be insufficient to resolve the staffing challenges, a bespoke establishment review would be scheduled. Once the exceptions and associated management plans were agreed, progress against them was monitored by the monthly Safer Staffing Group, and, if necessary, escalated to the Trust Board through the Quality Operational Group and Quality Committee. I am unable to comment or offer any insight into the safer staffing meetings as I would not attend.

Factors Affecting Staffing

205. The factors impacting staffing can be complex and multi-dimensional. These factors were regularly considered by stakeholders nationally, regionally and within the Trust, as disclosed in the Trust Workforce Strategy Plan. In addition to these, the following causes were shared with me anecdotally, either at exit interviews or through various other channels.
    (a) Pensions: Senior executives and clinical leaders were personally affected by changes in the Personal Pension Limits and were made aware by financial advisors that it was no longer financially to their advantage to contribute to their pension or stay within the NHS, this combined with the staff demographic profile, meant the many retirees coming through the system felt they had to retire for their personal economic benefit, removing not only a number of people out of the workforce but their experience, leadership and ability to role model appropriate values and behaviours were lost too.
    (b) Research indicated that many registered nurses of working age were not engaged with the NHS or the healthcare system in employed roles. Active campaigns were mounted by the system (and the Trust) to get them back into NHS employment.

(c) NHS nurse annual pay increments: The traditional system of annual pay increments being awarded by passage of time, was changed and linked to performance as part of an annual appraisal. This meant that many younger staff sought to develop their pay salary levels by seeking career progression through higher graded roles in different trusts, instead of staying within their own Trust.

(d) Loss of nurse bursaries: NHS bursaries for new nursing, midwifery and allied health students in England stopped in 2017, with students instead relying on the standard student loan system for tuition fees. This caused a significant drop in applicants in 2018, improving only marginally in 2019, making the supply of these staff groups even more scarce.

(e) Working Time Directive and Brexit: The European Working Time Directive became an issue for the Trust, limiting the way how staff were able to work between trusts. At the same time, Brexit was causing concern, not just because of potential drug shortages, as reported in many of the Board papers, but also because of an increase in staff abuse. In response, the Trust launched a "Respect Campaign", though many staff members returned to Europe to rejoin their former health systems.

(f) Increased demand, lack of respect and increases in violence and verbal abuse put physical and emotional strain on employees. Well-being activities became a focus for the Board; I helped to initiate a Pan-Midlands initiative called the Mental Health Productivity Pilot to help bring new research and better well-being practice back into the Trust. The Trust joined this initiative as a collaborative partner with Nottingham City Council in 2019.

AMH Capacity

206. The Trust would set targets and requirements for its AMH service capacity in collaboration with partners in the STP. There was focus in moving aspects of the AMH service into low-cost community support to decrease the number of expensive beds. This meant that investment between the services needed to be

coordinated. For example, before one service was reduced (such as bed stock), the other service (such as community support) would need investment.

207. Concerns of service capacity for AMH services had been building throughout 2018 due to unprecedented increases in demand. In June 2018, an " Adult Mental Health – Progress and Pathway Paper" (**Exhibits WITN0410070 and WITN0410075**) was presented to the Board to provide an update on the programme of work to determine future bed capacity. This paper updated the Board on the work to determine future bed capacity needs in AMH and was driven by the immediate need to eliminate OOA placements, assess future capacity requirements and the quality priorities to address dormitory style wards. The precautionary forecast from May 2018 projected an increased demand valued at £7.2m. Detail was provided at the meeting of the recovery plan, which had been submitted, prior to the Board, to NHSI.

OOA Placements

208. The rate of OOA placements became a Board concern from January 2018. This was assessed to be caused by an unprecedented increase in demand for both crisis care and in-patient beds, which was significantly higher than the Trust' s earlier forecasts and planning assumptions. Mental health services across the NHS were under strain at this time, with NHS statistics showing 1,168,973 patients in contact with children, young person and adult mental health services in December 2017 (**Exhibit WITN0410076**), increasing to 1,255,196 in December 2018 (**Exhibit WITN0410077**).

209. This, along with the consequential financial challenges it created, was one of the reasons why the Trust was dropped from a ranking of ' 1' to ' 2' by NHSI on the Single Oversight Framework assessment. Whilst a more strategic and longer-term solution was found, urgent action was taken with Priory Hospital (a private healthcare provider) commissioned to provide resourced services within the area on behalf of the Trust.

210. In May 2018, it was reported during the public meeting (**Exhibit WITN0410022**) that an Out of Area Acute Bed Manager had been appointed to oversee all OOA admissions, ensure quality assurance and manage repatriation. The Board' s wish was to get patients repatriated to the proximity of the Trust' s CMHT (Community Mental Health Teams) at the earliest possible opportunity to ensure that quality care could be provided causing the least distress and anxiety possible and to add the service user's recovery and reduce risk.

211. In June 2018, a full review of OOA placements was initiated as part of an AMH Beds Progress and Pathway Review (**Exhibit WITN0410070**). This was consequently picked up by a STP taskforce and resulted in both a system wide consideration of the concerns and the creation of a full business case being approved by the Board in March 2019 to increase capacity, address crisis care and bring the system into alignment with best practice (as demonstrated by the Cheshire and Wirral Partnership NHS Foundation Trust (CWP)). During the January 2019 public board meeting (**Exhibit WITN0410067**), the first improvements in OOA placements were reported. This was due to the change in reporting through the Priory Pathway.

212. In July 2018, the Trust Board received intelligence on the progress to address concerns related to its OOA Placements, bed capacity, access, crisis resolution, home treatment and waiting times (**Exhibit WITN0410078**). There was challenge during this meeting as to the current position of the Trust, with 16 beds per 100,000 of the population, compared to a reported national benchmark average of 22 per 100,000 of the population. In response to this challenge, the Executive Director of the Local Partnerships Division, Paul Smeeton stated that the Trust were working with CWP, which was a national exemplar. The CWP had developed a clinical ' philosophy' approach around its crisis resolution and home treatment workstream that was being emulated in the Trust' s strategic bed review. This was initiated in June 2018 and was due to be completed by August 2018. The full requirement of the AMH bed provision would be progressed through two distinct but connected streams:

    (a) Stream 1 – Determining the future capacity for the City and South County population and for female PICU.

(b) Stream 2 – Mid-Nottinghamshire and Bassetlaw requirements.

213. During the August 2018 private session (**Exhibit WITN0410048**), the Board received a strategic outline business case for AMH beds, presenting eight options for consideration with input from a workshop facilitated by the STP and held in conjunction with clinical leaders from CWP. After significant debate, the Board agreed to progress a new 32 - 36 unit on an existing Trust site in the Nottingham area. An outline business case (" OBC") was to be submitted to the Finance and Performance Committee in December 2018.

214. During the August meeting, the Deputy Director of Local Partnerships (Liz Hallam) summarised her understanding of what was agreed. The Trust would progress on Option 8 for an OBC to be created for December, with the provision of two wards to be built on the Highbury Site to increase the bed population for Greater Nottingham. There was also the need to:
    (a) Incorporate work on the crisis pathway on AMH capacity.
    (b) Work closely with NHS England in terms of getting bed stock reclassified.
    (c) Give consideration to the reduction of bed-stock at the Millbrook unit and address the quality issues.
    (d) Mitigate short term risk by further commissioning the Priory Hospital who could offer the Trust an additional 16 Acute AMH beds and a further 5 female PICU beds immediately at Calverton Hill.

System Wide OOA Placement Taskforce

215. In August 2018, the STP established a System Wide OOA Placement Taskforce. The first meeting of the taskforce was held in September 2018 to provide a strategic direction for the system. The Trust's analysis showed that the Greater Nottingham Area required between 110 - 115 beds, against a current stock of 64, leaving a top-level gap of 46 - 51.

Trust Estate Developments

216. In the December 2018 private board (**Exhibit WITN0410079**), the Finance and Performance Committee identified several areas that needed further review to ensure that the OBC was robust, meaning they were unable to recommend proceeding to a full business case. The proposal was to be returned to Committee in February 2019 following the resolution of queries and after the new CEO (Dr John Brewin) had taken up appointment in January 2019.

217. Whilst the proposal to delay was deemed by the Board as appropriate, in the December meeting I expressed concern " that part of the estate was not fit for purpose" . Whilst there was a strategic need to agree bed numbers and models of care, there was also the need to address patient dignity. This lack of progress was impacting on staff morale, making them feel uncared for and remote from senior leadership.

218. During the December 2018 public meeting (**Exhibit WITN0410066**), the Board received a paper detailing the Trust' s five-year Estate Strategy from 2019-2023 (**Exhibit WITN0410080**), which set out how supply could match demand more effectively with innovative and transformational use of land. The strategy was challenged by Stephen Jackson (Non-Executive and Chair of the Audit Committee) who stated that " a significant issue was that the strategy did not state whether the Trust had the capital or the staff resources to deliver it." Peter Parsons (Non-Executive and Chair of the Finance and Performance Committee) picked up this challenge stating that he " failed to see the commercial realism" and queried whether it could be delivered. The strategy was missing alignment with the available capital.

219. During this time, I understood that the Trust had provisionally set a target of between 92 and 100 beds, founded on the clinical ' philosophy' approach adopted at CWP. This clinical philosophy required investment to increase the capacity of the Crisis teams to meet service user demand urgently, which in turn would potentially reduce in-patient admissions the need for bed stock and OOA placements.

220. The Trust's bed targets required the preparation of a full business case. Due to the large sums and difficulties in securing the necessary capital, when I departed the Trust, these objectives were still being pursued. At the time of my departure, trajectories were looking favourable for targets to be achieved by 2021 (see paragraph 230).

AMH Capacity Developments

221. In the December 2018 public meeting (**Exhibit WITN0410066**), the Board received a report on the National Community Mental Health Survey, having taken part in benchmarking along with 55 other equivalent NHS Providers. The survey ranked the Trust 7th overall, with an overall rating of 7.5. Although the Trust shared the same rating with the top provider, the Trust was dropped to 7th place because it was in the bottom 20% rated on its crisis services from 2,000 survey respondents. This strengthened the Board' s resolve to take appropriate action to invest in the provision of better crisis resolution services.

222. During the February 2019 public board meeting (**Exhibit WITN0410045**), it was reported that work to improve patient flow and reduce length of stay had escalated, the number of AMH OOA placements had dropped in December. It was also reported that, though data for February showed an increase in demand, a new bed management process had commenced that week and recruitment for the Crisis Team was ongoing. The Medical Director reported that the most prominent increase in demand was related to the younger generation aged 15 - 25. The CEO reflected that there " was a national trend, but the Trust needed to develop more sophisticated thinking about its response to the increase from a strategic perspective."

223. At the March 2019 public board meeting (**Exhibit NHFT0007588**), the Director of Local Partnerships presented the Board with an update on the bed situation in AMH Acute Inpatient and PICU services. This referred to the " significant challenges" experienced in relation these services, particularly in relation to OOA placements and the impact this was having on the quality of care, finances and

the performance of the Trust. The paper recommended that the Trust block sub-contract beds, rather than the more costly option of building a 32-bed unit. This was agreed as the best option and an action was given to the Quality Committee to ensure that there was oversight of the new beds. A second paper was also presented requesting the Board approve the appointment of Priory Healthcare as provider of 16 additional beds for AMH. The recommendation was approved.

224. In the private Board meeting that month (**Exhibit NHFT0002482**), the CEO reported in his Environmental Scan that there was a possible opportunity to acquire bed provision from St Andrews Healthcare. St Andrews had asked the Trust whether it would be interested in purchasing their mental health unit in Mansfield. The CEO explained that this would be an excellent opportunity to replace the bed provision at Millbrook and Bassetlaw, which needed refurbishment.

225. In the July 2019, public board meeting (**Exhibit NHFT0004331**), the Executive Director responsible for the Local Partnerships Division reported that the OOA placement target for Q1 had been achieved. In the subsequent Private Board meeting, the CEO provided an update on the St Andrews transaction and the clinical model for the new site was discussed.

226. In September 2019, it was noted during the public session (**Exhibit NHFT0004320**) that the Out of Area Placement Days (OAPD) trajectory for August had not been achieved. Although there was an overall reduction in bed days, this had been below the targeted trajectory due to increased length of stays. Despite this, the Director of Mental Health (Julie Attfield) " felt that there were appropriate changes and things were starting to move in the right direction." In the private meeting (**Exhibit NHFT0004458**), the Board received another update on the St Andrews transaction. The details of the strategic outline case presented a " compelling case to support the option to acquire St Andrews' s site and use that for AMH provision whilst retaining MHSOP (Mental Health Services for Older People) at Millbrook" , which would " create sufficient bed capacity and significantly improve the quality of care received by patients" .

227. In October 2019 (**Exhibit NHFT0002372**), the Interim Director of Mental Health reported during the public meeting that there had been improvements to the OOA placements situation. The Trust was performing better than trajectory for quarter 3 and using less beds. Over recent weeks there had been real bed flow which had been further supported by increased street triage in the city. Spot beds had been reduced by four and clinical teams in AMH felt confident about further reductions from March 2020. The senior management team were pleased with these improvements, though lengths of stay remained quite high and would take time to follow.

228. The LMHT (Local Mental Health Team) was expected to have increased investment within the year, and further improvements to EIP (Early Intervention in Psychosis) staffing would also have positive impact on OOA placements. It was also reported by the Director of Finance that " the good news around AMH Out of Area placements" had reduced the Trust' s biggest risk, with AMH and agency spend the two main areas of focus. It was also reported that there was continued " work ongoing between Crisis and LMHT" , with " crisis service being able to treat more urgent cases."

229. In my last board meeting, November 2019 (**Exhibit WITN0410073**), the Director of Mental Health reported that " Out of Area Placement days had dropped at month 7" . In the private meeting (**Exhibit WITN0410083**), the Board noted that the Trust had now engaged solicitors in the purchase of the St Andrews site and a full business case would be presented to the Board in February 2020. I felt assured that AMH capacity issues were well understood, with actions being taken that were positively impacting on patients care and safety in line with the Trust' s strategic objectives.

Factors Influencing OOA Placements

230. Consideration of factors influencing OOA placements were discussed regularly at Board. Demand and the Trust's service model were two of the most influential factors affecting OOA placements.

231. Predicting service demand was difficult. For example, in the June 2018 public board meeting (**Exhibit WITN0410070**), Christine Lovette (NED and qualified clinical therapist) " highlighted the danger of assuming one could predict demand given the number of drivers, many of which were outside of the Trust' s control" . Christine emphasised the need to focus as much effort on improving community care as the case for beds. In response Paul Smeeton (Executive Director of Local Partnerships) " provided an outline on how CWP had successfully managed demand" and that the directorate had reviewed actions taken by CWP which could improve the financial pressures and patient care and the Trust.

232. At the same meeting, Di Bailey (NED and Chair of the Quality Committee) also raised a number of questions in relation to crisis resolution and home treatment services, noting that " Bassetlaw was the only area served by the Trust that was close to the Crisis and Resolution Home Treatment Standard." Paul Smeeton responded that, as a consequence of improvements in Bassetlaw, the area' s utilisation of beds had dropped from " 8% in 2013 to 6%" in 2018, " which was a good indication that community interventions would have more impact" . Further discussion on AMH beds was actioned for the next meeting.

233. In the July 2018 public board meeting (**Exhibit WITN0410078**), a triangulated challenge was presented by the NEDs. Peter Parsons (NED) queried how the Crisis Resolution and Home Treatment (CRHT) Workstream sat with recruitment, as there was a need to understand how many staff were required to meet demand. I challenged if technology could be utilised and enquired if CWP had invested in appropriate technologies to support the process. Paul Smeeton reported that there weren' t any technological differences, with CWP' s better performance a result of " the rigour of their processes."

234. In the November 2018 private board (**Exhibit WITN0410084**), Paul Smeeton presented the report outlining the role of CHRT services as part of the national Five-Year Forward review for Mental Health. The paper outlined progress to reduce length of stay in the AMH bed stock. Steven Banks queried the impact of " the 24/7 assessments ceasing due to the staffing safety issues." In response, Paul Smeeton " explained that a safe service could not be provided due to the

inability to get staff" and the "paper was about investing more in staff so that a robust and resilient service could be provided".

235. The non-executives and I regularly discussed OOA placements and CHRT in the quarterly NED meetings. At these meetings, we prepared a triangulated response to ensure a systematic constructive challenge process was in place. This meant that OOA placements and CHRT issues were addressed strategically from a whole system perspective. We were acutely aware that the solution to these issues could not be found in isolation and had to be done at a system level.

Premature Discharge

236. I cannot recall concerns of premature discharge reaching the Board, except for in January 2019 (**Exhibit WITN0410067**) when nurse recruitment at Lings Bar Hospital was identified as an issue. The Senior Independent Director (Peter Parsons) sought assurance that given increased winter pressures, patients would not be discharged prematurely should these pressures become a reality. This assurance was given with an explanation that discharge planning work was underway.

Multi-Agency Working

237. I would not normally be sighted on information shared with other agencies, unless it was elevated through a board report. However, I was aware that the Trust had the following policies in place to address how information should be shared between the Trust and the multiple agencies that were working across the system:
    (a) Policy for Trustwide Information Sharing Between Professionals, Service Users and Carers (**Exhibit WITN0410085**)
    (b) Information Governance Policy (**Exhibit NHFT0015702**)
    (c) Emergency Preparedness, Resilience and Response Policy (**Exhibit WITN0410086**)
    (d) Crisis Concordat Policy (**Exhibit WITN0207010**)

(e) Gold, Silver and Bronze Command Deployment Policy (**Exhibit WITN0410088**)

(f) Multi-Agency Public Protection Arrangements (MAPPA) Policy (**Exhibit WITN0410089**)

(g) Safeguarding Adults at Risk Policy (**Exhibit NHFT0015343**)

(h) Safeguarding Children Policy (**Exhibit WITN0410041**)

238. The first two policies provide the foundational protocols relevant to confidentiality and candour which were applied to all communication undertaken by Trust employees, not specific to " Multi-Agency" working.

239. The Head of Emergency Preparedness Resilience and Compliance (Caroline Brookes) would report annually on the 10 core standards that the Trust needed to be complaint with regarding emergency preparedness. This would give assurance that the Trust was compliant across all ten standards (for example, the August 2018 meeting (**Exhibit WITN0410047**). Caroline was also responsible for the bi-annual EPRR report which gave assurance that the Board was fulfilling its statutory duties.

240. In 2014, the " Crisis Concordat" was published by the Department for Health and Social Care. This was signed by 22 national organisations including NHS England, the Association of Chief Police Officers and the Local Government Association. The concordat set out shared principles to ensure that people experiencing mental health crisis received timely and appropriate care from all public services. The Trust consequently set out, in collaboration with its partners, a Mental Health Crisis Accessibility Policy (**Exhibit NHFT0000981**), detailing how agencies would collaborate to ensure service users receive a safe and therapeutic environment. From the Crisis Concordat, the Street Triage initiative was initiated. This was a partnership between the Trust, Nottinghamshire Police and local CCGs to join up mental health practitioners and police officers to provide a specialist response to people with mental health issues. The initiative involved trained mental health nurses joining police officers on callouts where vulnerable individuals need immediate mental health support. This collaborative approach aimed to ensure

patients receive the appropriate care, reduce their unnecessary detention in police custody suites or in section 136 suites, and provide specialist support directly in the community. The approach was designed to also free up valuable police time and resources.

Safeguarding

241. The Trust' s Safeguarding Adults at Risk Policy (**Exhibit NHFT0015343**) required the Board to receive an annual report on safeguarding. This was presented to the public board in August 2018 by the Director of Nursing, Julie Attfield (**Exhibits WITN0410047 and WITN0410090**). The report demonstrated that " continued progress had been made in all areas" with a " commitment to partnership working" . The Report further identified that new strategies had been developed and the executive leadership " was confidence that a strong culture of safeguarding and leadership would continue to be provided." The 2019 Report on Safeguarding was received during the July public meeting with no further challenge (**Exhibit NHFT0004331).**

Major Incident Multi-Agency Working

242. In the event of a serious incident, the Trust would operate a Gold, Silver and Bronze Command structure, and the Board would be kept informed of such an incident. Executive Directors were trained to fulfil appropriate leadership roles within these Command structures. To my knowledge this Command structure was only enacted once, to deal with the extreme weather events of the winter of 2017. From what I can recall, communication between agencies had worked well.

MAPPA Policy

243. The Trust' s MAPPA policy (**Exhibit WITN0410089**) set out how it operated in the statutory multi-agency public protection arrangement through which the police, probation and prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community. The Trust was a " responsible agency" , and therefore had a duty imposed by law to have regard to national MAPPA guidance in exercising its functions. The structure of

the Trust with both forensic services and local partnerships encompassing community mental health services meant that the Trust had a responsibility to participate in the safe management of relevant MAPPA offenders.

244. Under MAPPA, the Trust was required to identify any patients who qualified as a Category 1 or 2 offender before allowing discharge and must notify the relevant MAPPA seven months before a patient's intended release into the community. Senior representatives of each of the agencies involved in MAPPA form a Strategic Management Board (SMB) which was required to meet three times a year to monitor the arrangements and direct any necessary improvements. The Trust's representative on the Strategic Management Board was the Executive Director for Forensic Services (Peter Wright), though this appointment was permanently delegated to the General Manager of the Low Secure & Community Forensic Directorate (Andy Latham).

245. Due to my role as Chair, I would not be directly involved in MAPPA meetings, but I would be aware of the process.

Relationship with the Police

246. The Trust' s relations with the police were very good. The Chief Constable would attend various functions around Nottingham and Nottinghamshire and we would meet socially. For example, the Sheriff of Nottinghamshire Legal Service Church Service or the University of Nottingham and Nottingham Trent University Social Functions). Although I was aware of the Chief Constable, I did not have any formal meetings with him. In 2017, Sheila Wright (Vice-Chair, herself a senior executive in the local Probation Service) and I visited Mansfield police station and the Mansfield Forensic Services Team, where we witnessed collaborative working and feedback from the Custody Desk Sergeant about his respect for the value of our embedded team. The Trust also collaborated effectively with the Police as part of the Street Triage Programme (explained at paragraph 241).

247. The relationship between the Police and the Trust was controlled through the Trust Police & Criminal Justice Liaison Policy (**Exhibit NHFT0000456**). The

policy supported all memoranda and joint protocol between Nottinghamshire Healthcare NHS Foundation Trust and those police forces and criminal justice agencies within whose boundaries the Trust operated. The purpose of the policy was to ensure consistency with regard to criminal justice liaison across the Trust. Where a serious incident occurred involving the Trust and the police, this would be reported to the Board via the committee system where necessary (for example the April 2018 private board meeting (**Exhibit WITN0410069**) where the Medical Director reported on a stabbing investigation involving a patient and a criminal investigation).

248. General managers also had responsibility for Police liaison and representation at the Local Operational Group. General managers had to ensure that any problems or concerns relating to the police or other criminal justice agencies were referred to the appropriate local group. High secure, medium & low secure hospitals all had a nominated Single Point of Contact (SPOC). SPOCs would assist the police by providing appropriate information for all criminal investigations into crimes that occurred on Trust sites. The LSMS (Local Security Management Specialist) had a statutory role to ensure all crime committed against staff, premises or property of the NHS was recorded, reported and investigated. Where the victim of the crime was either the member of the public, patient or visitor the LSMS could assist in offering advice on reporting the incident.

249. The Police and Crime Commissioner (Paddy Tipping) was one of the stakeholder governors on the CoG. I had a good working relationship with the Police and Crime Commissioner and found him to be highly interested in the work of the Trust and very insightful. The Commissioner was transparent and an excellent contributor to the Council. To the best of my knowledge, no concerns in Trust or police working practices were ever expressed during my tenure.

250. I would also engage on behalf of the Trust with other agencies (local authorities, universities, police, various faith community leaders, Nottingham Forest FC, Nottinghamshire County Cricket Club, Nottingham Panthers, charities, such as Framework, plus others) at 'Bishops Breakfast' meetings, convened by the

Bishop of Nottingham and Sherwood for local partners/agencies to discuss community challenges (such as crime, poverty, unemployment, homelessness, addiction). Individual meetings would also take place annually with the Chairs of Adult and Children Safeguarding Boards at both a City and County level and with the Chair of Healthwatch.

251. To the best of my knowledge all the systems and procedures relating to Police liaison were working and the Trust had good relationships with the Police for the duration of my tenure. I was not aware of any issues being raised to the Board as a concern in relation to multi-agency working.

Sharing of Patient Information

252. The Trust had signed an Information Sharing Protocol with other care provider organisations and partner agencies in the Nottinghamshire area, which supported information sharing across boundaries to support the care process.

253. As per the Trust' s Data Protection Policy (**Exhibit NHFT0015703**), the use of a patient' s information must be supported by their informed consent. The individual must also:
    (a) Have the capacity to make an informed decision.
    (b) Receive sufficient information to make an informed decision.
    (c) Not be subject to coercion, incentive or condition.

254. If a patient is unable to provide consent, the decision can be made on their behalf by considering their best interests, the views of their carers or others close to the individual. At the Trust, advice would be sought from the Information Governance Department, the Divisional Mental Capacity Act Lead, the Trust' s Caldicott Guardian or the appropriate Service Manager.

255. A Caldicott Guardian is a senior person in a UK health or social care organisation who is responsible for ensuring that personal or confidential information is handled legally, ethically and appropriately. They protect patient privacy while enabling necessary data sharing, upholding the 8 Caldicott principles to guide

complex information decisions and ensure data is used for justified, necessary and minimal purposes. All NHS trusts and local authorities are required to have a Caldicott Guardian. The issue of consent to information sharing would be discussed and documented when care is being planned with the individual and reviewed and documented regularly thereafter.

256. Whilst everyone has a right to information that they don't want to be shared kept confidential, there are occasions when that right of confidentiality can be breached such as when there is a statutory duty to do so, or it is in the public interest. Examples of when it is appropriate to breach confidentiality include:
    (a) When there is a requirement by statute in law.
    (b) When there is a requirement in the public interest.
    (c) When required in the private interest of a person lacking capacity to decide whether to consent to disclosure.

257. The decision to disclose information in any circumstance without consent would only be made by a senior healthcare professional involved in the individual's care. Advice from the Information Governance service, or Trust's Caldicott Guardian would also be sought. If information was disclosed without consent, then the reasoning for the decision and the decisionmaker would be recorded in the individual's records, in addition to details about to whom it was disclosed.

258. In 2018, to ensure that non-executives were updated on their responsibilities in respect of personal data and MHA matters, a one-day training event was provided by a qualified external provider. Stephen Jackson (NED and Chair of Audit) consequently went on to become a Mental Health Act Manager within the Trust.

259. Compliance with the Information Sharing Protocol was monitored through the annual audit of care planning documentation within patient records and an annual review of local care planning procedures. There was also a three yearly organisational audit programme, which monitored information across the

divisions provided by carer surveys, complaints and the evaluation of staff training needs.

260. If issues regarding compliance with policy were picked up by Audit, Quality or MHL Committees, this would be escalated to the Board. The Board also received regular reports from the Director of Nursing in respect to her Caldicott Guardian duties.

Reflections

261. Between 2018 and 2019, the Trust entered a new set of operating circumstances through the STP and Integrated Care system. There was flux in terms of the new system governance arrangements, leadership movement, and quality and performance metrics.

262. Despite this, at the time of my departure, the system seemed to be aligning collaboratively to jointly address concerns. A new Mental Health Strategy (2019 - 2023) (**Exhibit WITN0410093**) had been developed for the mental health service that was jointly owned by the system in consultation with NHSI and this strategy was being deployed. Quality and performance metrics were coming back into agreed trajectory and projected to meet both NHSI and CQC requirements within agreed timelines. The Core and Well-Led Plan showed good progress against the CQC' s findings (**Exhibit WITN0410057**), with some compliance Enforcement Notice requirements already lifted. Under John Brewin, changes to culture had commenced and staff behaviours addressed through a robust and systematic QI approach. At the October 2019 board meeting (**Exhibit NHFT0002372**), I was assured that steps were in place to return the Trust back to a " Good" CQC rating.

263. In my estimation, the CEO and newly appointed Chair were in a good position to build another strong board, with clinical executives at the heads of divisions focusing on the cultural and quality changes needed to make the Trust a great place to work and for service users to receive good care. Quality and leadership skills were being invested in through a range of initiatives and at scale, with a

wider leadership forum to ensure collaboration and joint working. A plan was agreed across the system to address deteriorating health, improve performance, address quality concerns, motivate and develop the workforce, reduce staff turnover, improve staff wellbeing, improve or enlarge the Trust's estate (through the acquisition of St Andrew's facilities) and invest in technology.

264. With the promise of the ICB becoming a stable platform, an upturn in the number of qualified nurses and other health professionals and parity between mental and physical health being supported by new funding from 2020, I felt that from 2021 the necessary improvements would be made.

Parity of Esteem

265. The parity of esteem (ensuring equality between physical and mental health services) had long been an issue within the NHS. I believed in 2019 that mental health crisis processes were about to be resourced equally well and targets aligned with physical crisis intervention targets.

266. Solutions in mental health are complex and require greater insight into the unique needs of the individual patient with greater information sharing as a consequence. By way of example, work at Mersey Care NHS Foundation Trust has shown how inappropriate mental health interventions can exacerbate risk, for example, generating safety concerns by the inappropriate use of restraints. The Trust's use of Street Triage in collaboration with the police has enabled information sharing so that service users known to the Trust can be quickly identified and treated appropriately with respect, care and compassion, like they would be treated in an A&E department. Where service users are not known to Trust personnel, the lack of intelligence could result in their support needs not being identified. Technology could be developed for consenting service users, to alert professionals to their needs, especially in times of crisis, enabling them to be known as service users regardless of their patient status elsewhere in the NHS.

Staff Disengagement

267. In the 2024 Report on the NHS by Lord Ara Darzi (**Exhibit WITN0410094**), the NHS was found to be in " serious trouble" , with severe underinvestment, disengaged staff and record waiting times. I believe that a transactional approach to cost improvement within the NHS has resulted in some inappropriate long-term decision-making. The cost efficiency metric has resulted in behaviours that were neither intended nor desirable, for example identifying staff learning and innovation opportunities as a cost to productivity, when this may drive efficiency within the Trust.

268. I also believe that within the NHS there is undue focus on negative, rather than positive metric targets. For example, reducing sickness absence rather than increasing days worked, reducing clinical incidents rather than increasing the number of days since the last reportable incident, reducing waiting times rather than increasing the number of people returning to health within the targeted clinical time or reducing OOA placements rather than increasing the number of people being treated at the place of their choice.

269. The NHS has an immense number of negative targets, which I believe acts as a demotivating factor for staff and contributes to burnout. This in turn, causes issues with staff disengagement as identified by Lord Darzi. My experience in business has led me to believe that successful organisations focus on positive targets to inspire and aspire to, rather than negative targets to reduce.

Innovation (Including Technology)

270. The NHS invests significantly in research but spends less on the adoption and spread of innovations that come from the research. I believe that the adoption of innovative process improvements and technology (physical and digital) is essential for the improvement of both the Trust and the NHS generally. Adoption of innovation requires protected learning time and investment in active learning. It also requires technologies, physical and digital to be interoperable and transferable. I hope that innovations in electronic monitoring and reporting systems are brought in to allow for whole system communication, collaboration

and solution, whilst remaining compliant with GDPR in the handling of sensitive patient data. I believe that coordination of data systems would improve interoperability between services (for example, the Trust and the police). In turn, this would improve patient outcomes.

271. Innovation should also be evaluated using whole system, value enhancing, economic methodologies, not by cost improvement drivers.

Management Learning

272. The NHS has been working to create learning frameworks for the development of better management in line with national standards. This creates an opportunity, not just for organisations to demonstrate compliance against fit and proper person criteria, but for standards to be worked from with reference to improvement of patient outcomes. Action learning methodologies should be considered to ensure training and development doesn't just bring qualifications, but innovation and improvement. Consideration should be given to ensuring sufficient time is allocated for the learning of senior leaders, with appropriate coaching and mentoring skills to drive cultural change, especially in regard to innovation (see paragraph 271).

Recommendations

273. Throughout the NHS, there is a drive to improve productivity, measuring the efficiency of how NHS resources are used within a year. This puts pressure on the present, reduces the thinking horizon of staff and results in longer-term strategic outcome related solutions not being considered when they should.

274. From my observation of current practice from an external perspective, protected learning and development time seems no longer to be incorporated into the NHS productivity consideration, as it is a cost. I believe this is likely to have a negative impact on staff wellbeing, team development and shared innovation, which will consequently impact patient care. In the long-term, this reduces the

attractiveness of the NHS as a workplace, focusing the attention of staff on remuneration as opposed to a vocational purpose.

Quality Metrics

275. National quality metrics were used to assess the Trust's mental health services provision and were monitored by the Quality Committee through the Quality Reporting Framework. Whilst the NEDs on the Trust's Committees were experienced and competent individuals, none were data scientists with an in-depth understanding of how information technology systems and data could be utilised differently. I believe consideration should be made as to how artificial intelligence is currently planned to be used to assist the interpretation of data at Board level and appropriate qualified executive and NEDs appointed. The addition of a Chief Clinical Information Officer to the Executive Board function, supported by the appointment of a clinical data scientist as a NED could also provide value and assurance against inappropriate use of artificial intelligence.

The Private Finance Initiative (PFI)

276. The adaption and utilisation of the Trust's estate was constrained by physical and financial issues associated with ownership. Highbury Hospital by way of example is a PFI. This is where a hospital facility has been funded, built and is subsequently maintained by a private company with a long-term payment system (25-30 years) with a higher interest rate than government borrowing. The regular fixed payment costs of Highbury created a financial burden on the Trust that could have been better spent on patient care.

277. The variable cost was improvements above normal scheduled maintenance. Maintenance and building enhancement could only be done by the PFI company which extracted a long-term repayment mechanism. Expansion (i.e. the building of a 36-bed unit) could only be done on site with the permission of the PFI company and only completed by them. I believe these cost impediments prevented necessary and cost-effective investments from being made by Executives as they were prohibitively expensive.

Staff retention

278. If trusts continue to struggle to retain existing workers, there is a risk that staff with less experience are promoted to fill management vacancies. If staff are promoted with less experience and training than their predecessors, this will affect patient outcomes. It would also mean that less experienced staff will be observing less capable leaders as their role models, resulting often in inappropriate leadership behaviours and toxic cultures. Active leadership and management learning supported by coaching and mentorship is a key solution.

The Mental Health Act (MHA)

279. I believe that there should be a centralised or regionalised development function for board non-executives (including chairs) on the components of the MHA requirements, especially those related to the Caldicott Guardian and former learning from inquiries. This would ensure consistent application of the MHA. These matters are currently overseen by Trust or the NHS Confederation's Mental Health Network, which risks subjectivity and variation entering decision-making. Annual one day refresher courses on the MHA and system learning events, like inquiries, should be offered or mandated for NEDs to ensure these requirements remain in their focus.

Independent Lay and Professional Oversight Groups

280. The Inquiry may consider recommendations related to how intelligence from Foundation Trust membership could generally be used more effectively. By way of example, the PHSO created a PEAG (a public engagement advisory group) which provided valuable intelligence about the PHSO's performance back to the PHSO Board. A PEAG could be used to supplement the work of the CoG at trusts.

281. The PHSO also gained insight using independent clinical advisors, who would provide advice to complaint handlers, offering a professional medical or clinical

independent second opinion where an objective judgement was required. This was similar to Martha's Rule (where patients can request an urgent review if they feel a patient's condition is worsening and their concerns are not being heard), but different to PALS (Patient Advice and Liaison Service) where members of the public could go to engage with clinically/medically qualified independent professionals if they felt their concerns were not being heard.

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: 02/18/2026

Index of Exhibits to the Witness Statement of Dean Fathers

Exhibit No.	New URN	Document Description
1	WITN0410002	Letter from Dean Feathers to Steve Banks – 8 May 2019
2	WITN0410003	NHST Chair Information Pack - 2010
3	WITN0410004	Trust Chair - Candidate Appointment Pack
4	WITN0410005	"Your job, My job, Our job" Meeting Notes – January 2019
5	NHFT0000001	Foundation Trust Constitution – February 2018
6	CQCM0027255	Audit Committee – Terms of Reference
7	CQCM0027715	PWC 'Well-Led' Review
8	NHFT0004747	Quality Committee – Terms of Reference
9	WITN0410010	Workforce, Equality and Diversity Committee – Terms of Reference
10	WITN0380079	Finance and Performance Committee – Terms of Reference
11	WITN0410012	Mental Health Legislation Committee – Terms of Reference
12	WITN0263012	Nomination and Remuneration Committee – Terms of Reference
13	WITN0410014	Board Paper on Well Led External Review
14	WITN0410015	Quality Committee Meeting Notes – 15 May 2018
15	NHFT0007595	Integrated Performance Report – April 2019
16	WITN0410017	Integrated Performance Report – August 2018
17	WITN0410018	Integrated Performance Report – September 2018
18	WITN0410019	Integrated Performance Report – December 2018
19	WITN0410020	Board Public Session Minutes – January 2018
20	WITN0410021	Council of Governors Minutes - January 2018
21	WITN0410022	Board Public Session Minutes – May 2018
22	PHSO0000006	Parliamentary Health Service Ombudsman "Maintaining Momentum" Report
23	WITN0410025	Board Private Session Minutes – March 2018
24	WITN0410026	Board Public Session Minutes – November 2018
25	WITN0410027	Board Private Session Minutes – February 2018
26	WITN0410028	Mortality Surveillance and Learning from Incidents Report
27	NHFT0004331	Board Public Session Minutes – July 2019
28	NHFT0004320	Board Public Session Minutes – September 2019
29	NHFT0002372	Board Public Session Minutes – October 2019
30	WITN0410032	Board Public Session Minutes – February 2018
31	WITN0410033	Managing Serious Incidents and Reporting and Learning from Deaths Policy
32	NHNB0001890	Risk Management Strategy
33	WITN0410035	The Reporting of Accidents, Incidents & Near Miss Situations Policy

34	WITN0410036	Reporting & Managing Legal Claims against the Trust Policy
35	NHFT0014778	Public Interest Disclosure (Whistle Blowing) Policy
36	WITN0410038	Being Open and Duty of Candour Policy
37	WITN0410039	Dealing with Multiple Enquiries Policy
38	WITN0410040	Domestic Violence and Abuse Policy
39	WITN0410041	Safeguarding Children Policy
40	NHFT0015343	Safeguarding Adults at Risk Policy
41	WITN0410043	Allegations of Abuse Made Against an Employee, Agency Worker, Volunteer, Student or Bank Worker Policy
42	WITN0410044	Learning from Deaths and Mortality Surveillance Report – May 2018
43	WITN0410045	Board Public Session Minutes – February 2019
44	WITN0410046	Learning from Deaths and Mortality Surveillance Report – February 2019
45	WITN0410047	Board Public Session Minutes – August 2018
46	WITN0410048	Board Private Session Minutes – August 2018
47	WITN0410049	Quality Committee Meeting Notes - 13 May 2019
48	WITN0410050	Board Development Session Agenda - 27 June 2019
49	WITN0410051	Board Development Session Agenda - 29 August 2019
50	WITN0380020	Board Development Session Agenda - 22 October 2019
51	WITN0380021	Board Development Session Agenda - 10 December 2019
52	WITN0410055	Mental Health Legislation Committee Highlight Report - September 2019
53	WITN0410056	Quality Committee Highlight Report – September 2019
54	WITN0410057	Core and Well Led Tracker
55	NHFT0005214	HoC Report on Core and Well Led Plan
56	WITN0410060	Code of Governance Report - February 2018
57	WITN0410061	Code of Governance Report - February 2019
58	WITN0410062	Board Development Agenda - 10 December 2019
59	WITN0410064	Board Development Agenda – January 2018
60	WITN0410065	Board Development Write-up – January 2018
61	WITN0410066	Board Public Session Minutes – December 2018
62	WITN0410067	Board Public Session Minutes – January 2019
63	NHFT0007588	Board Public Session Minutes – March 2019
64	WITN0410069	Board Private Session Minutes – April 2018
65	WITN0410070	Board Public Session Minutes – June 2018
66	NHSE0000145	National Quality Board Staffing Board Guidance - January 2018
67	WITN0410072	Board Public Session Minutes – March 2018
68	WITN0410073	Board Public Session Minutes – November 2019
69	NHFT0005109	Bi-Annual Safer Staffing Update Report – November 2019
70	WITN0410075	Adult Mental Health – Progress and Pathway Paper – June 2018
71	WITN0410076	Mental Health Services Monthly Statistics - December 2017 to January 2018
72	WITN0410077	Mental Health Services Monthly Statistics – December 2018 to January 2019
73	WITN0410078	Board Public Session Minutes – July 2018

74	WITN0410079	Board Private Session Minutes – December 2018
75	WITN0410080	Trust Estate Strategy – 2019-2023
76	NHFT0002482	Board Private Session Minutes – March 2019
77	NHFT0004458	Board Private Session Minutes – September 2019
78	WITN0410083	Board Private Session Minutes – November 2019
79	WITN0410084	Board Private Session Minutes – November 2018
80	WITN0410085	Policy for Trustwide Information Sharing Between Professionals, Service Users and Carers
81	NHFT0015702	Information Governance Policy
82	WITN0410086	Emergency Preparedness, Resilience and Response Policy
83	WITN0207010	Crisis Concordat Policy
84	WITN0410088	Gold, Silver and Bronze Command Deployment Policy
85	WITN0410089	Multi-Agency Public Protection Arrangements Policy
86	NHFT0000981	Crisis Operational Procedure
87	WITN0410090	Annual Safeguarding Report – August 2018
88	NHFT0000456	Police & Criminal Justice Liaison Policy
89	NHFT0015703	Data Protection Policy
90	WITN0410093	Mental Health Strategy – 2019-2023
91	WITN0410094	Report on the NHS By Lord Ara Darzi – September 2024
92	NHFT0000829	Board Public Session Minutes – April 2019
93	NHFT0001208	Board Public Session Minutes – May 2019
94	NHFT0002015	CQC Inspection Report – May 2019