Witness Name: Anne-Maria Newham

Statement No: WITN0354001

Dated: 25 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ANNE-MARIA NEWHAM

I, Anne-Maria Newham MBE, will say as follows: -

Introduction

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

2. I make this statement to assist the Nottingham Inquiry ("**the Inquiry**") and in response to a request made under Rule 9 of the Inquiry Rules 2006, dated 23 October 2025 ("**the Request**"). In this statement, I discuss my career and role, governance, assessment of risk, serious incidents and learning from deaths, staffing levels and outsourcing, and information sharing.

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

4. I retired in June 2023 and have had difficulty in recalling matters from the period to which the Request relates (2020 – 2023). I have therefore requested various documents from the Trust to aid my recollections, which have been provided and which I exhibit throughout this statement.

5. The policies and other documents referred to in this statement relate to the position as I understood it during my tenure at the Trust. I was not involved in any changes made since June 2023.

Career and Role

6. After leaving school, I started my career in the NHS in September 1982.

7. I completed my adult nurse training in Canterbury then moved to Cardiff where I did my Children's nursing training. Whilst there, I also completed my Cardio Thoracic nursing training at Great Ormond Street.

8. In 1992 I moved back to the East Midlands where I worked at the Leicester Royal Infirmary, setting up the first Children's Intensive Care Unit.

9. In 1993 I completed my Paediatric Intensive Care training in Nottingham.

10. In 1998 I completed a BSc Hons degree in Advanced Professional Practice.

11. I worked at Queen's Medical Centre Nottingham as a Clinical Development Nurse in 2000.

12. I returned to the Leicester Royal Infirmary in 2000 where I worked as a Service Manager until 2003.

13. In 2003 I moved to a role in what was then Leicester Primary Care Trust as a Strategy and Planning Manager.

14. From 2005 - 2012 I was the Associate Director of Children's Community Health Services across Leicester and Leicestershire. During this time, I completed a master's degree in business administration (MBA) at Derby University. I also completed a Level 5 Coaching Course in 2011.

15. From 2013-2016 I was the Chief Nurse for Erewash Clinical Commissioning Group.

16. In 2016 I moved to a role at Lincolnshire Partnership Foundation Trust as Executive Director of Nursing, Quality and Allied Health Professionals ("**AHPs**").

17. In 2018 I was awarded an MBE in the Queen's Honours list, for services to nursing.

18. In 2019, I moved to a role as Executive Director of Nursing and Quality at Leicester Partnership Trust.

Roles at the Trust

19. In January 2020 I moved to the Trust as Executive Director of Nursing, AHP and Quality.

20. Following the retirement of the Trust's Chief Executive Officer ("**CEO**"), John Brewin, on 1 September 2022 I acted up into the interim CEO role until 31 December 2022.

21. The new CEO, Ifti Majid, started on 1 December 2022, although there was an agreement that he would use the month of December 2022 as an induction period, so I continued in the role of interim CEO until 31 December 2022.

22. From 1 January 2023 I became the Deputy CEO until I finished on 14 June 2023.

23. When the interim Executive Director of Nursing left the Trust at the end of April 2023, I took on the responsibilities of Executive Director of Nursing, as well as Deputy CEO.

24. On 14 June 2023 I retired from the NHS, having handed my notice in in November 2022.

25. In June 2024, I became a Non-Executive Director for another NHS Foundation Trust, a position which I still hold.

26. Throughout my career, I kept handwritten notes in notebooks. I had left my 2020 – 2021 notebooks at the Trust following my retirement and although I understand that searches have been undertaken, they are missing. I have my notebook from 20 December 2021 to 15 May 2023, which I have reviewed in preparation for this statement. I have provided any potentially relevant extracts to the Inquiry [18 extracts at WITN0354002 - WITN0354019].

Executive Director of Nursing, AHP and Quality

27. As Executive Director of Nursing, AHP and Quality, I contributed to the strategic and corporate direction and management of the Trust, reporting directly to the CEO. I provided nursing and AHP advice to the Trust Board, managers and clinicians. My role was set out in a clear job description which was given to me when I started at the Trust [WITN0354020], and set out the following key areas:

    a. Provide Nursing and AHP advice to the Trust Board, managers and clinicians in accordance with national policy. Provide highly visible leadership of the Trust's 5000 nurses and 700 AHPs.

    b. To be the Trust's designated Director of Nursing and Infection Prevention and Control (DIPC) and have the executive authority and responsibility for ensuring the implementation of strategies to prevent avoidable healthcare associated infections at all levels in the organisation.

    c. Provide leadership and management of the Quality agenda including a strategic direction and management of the Quality and Patient Experience agenda. Working collaboratively with the Medical Director to develop a culture which embeds

Clinical Quality and Governance and monitors its effectiveness.

d. Help ensure that the Board receives appropriate and timely information, including performance management information necessary for it to fulfill its duties, taking a particular lead in the reporting of quality information via the Quality report to the Trust Board.

e. To work as part of a unified team and where required takes lead responsibility for duties outside of their assigned accountability including cover in the absence of the CEO.

f. Provide leadership on the implementation of the National Quality Board requirements for safe nursing staffing and to develop and implement systems and processes to ensure productivity and value for money in relation to nursing and allied health professionals.

g. Hold executive accountability for professional leadership of the physical and mental health nursing and allied health professionals workforce, quality governance and compliance with Care Quality Commission standards, patient experience and involvement, Nursing and Allied Health Professional Strategy, reducing restrictive practice, Infection Prevention and Control, regulation requirements of the Nursing & Midwifery Council and the Health Professions Council, complaints management & duty of candour, quality account & quality priorities, carers strategy and support, tissue viability & physical healthcare, volunteering, quality improvement, and safeguarding (children and adults).

28. Initially on starting at the Trust, I had a very typical Executive Director of Nursing portfolio which included: patient experience, safeguarding, professional practice, representing the nursing and AHP's voice at Board level, serious incidents, safer staffing, preparation for CQC inspections, liaison with the coroner's office, restrictive practice, infection prevention and control, tissue viability, liaison with the Nursing and Midwifery Council, and representing the Trust within the Nottinghamshire system, regional nursing networks and national policy forums.

29. However, in March 2020, very soon after I had started at the Trust, Covid-19 cases started to populate our wards and as the Director of Infection Prevention and Control, I was required to chair daily Covid-19 meetings both internally and external to the Trust. I was doing regular media interviews, communication to all staff, team briefs, ward visits,

interpreting national guidance, being available seven days a week for advice, and signing off communication that was needed, often daily. Priorities therefore changed during the first two years of my tenure (2020 and 2021) to manage the Covid-19 outbreaks and staffing, whilst also managing priorities like incidents, staffing, and safeguarding. NHS England and NHS Improvement wrote to all NHS organisations outlining their commitment to support providers and commissioners in freeing up as much capacity as possible to prioritise workload and focus on doing what is necessary to manage the response to the Covid-19 pandemic. I exhibit to this statement the Emergency Terms of Reference for the Board and committees, to reflect what was required during that time [NHFT0005085; WITN0354021; WITN0354022]. Once Covid-19 cases reduced in our communities, around the end of 2021, I returned to a full Executive Director of Nursing schedule, which was the same as when I had started at the Trust.

30. As Executive Director of Nursing, I was a voting member on the Trust's Board. John Brewin was CEO at this time. He did not have a formal deputy but would use a few of the Executive Directors to deputise for him, including myself, without the formal title of "Deputy CEO" (as was envisaged by my job description).

31. As Executive Director of Nursing, I attended the following meetings on a regular basis. Following my appointment, additional meetings and forums were introduced, which I will introduce later in this statement:

    a. The Trust Board,

    b. Board Development,

    c. Executive Leadership Team ("**ELT**") Meetings,

    d. Serious Incident Review Group ("**SIRG**"),

    e. Quality Committee,

    f. Quality Operational Group (which I Chaired)

    g. Divisional Accountability Reviews,

    h. Rampton Improvement Group,

    i. Safeguarding Meeting (which I Chaired),

    j. Infection Prevention Control Meeting (which I Chaired),

k. CQC Provider Engagement Meetings, and

l. Director of Nursing Regional Meetings.

32. The Covid-19 Pandemic changed my role considerably during 2020 and 2021, meaning that I:

a. attended and chaired daily outbreak meetings,

b. attended weekly regional Chief Nurse meetings,

c. liaised with the National Infection Control Team on a weekly (sometimes daily) basis,

d. worked closely with the Trust's communications team to produce weekly (sometimes daily) briefings,

e. started doing clinical shifts on some of the wards,

f. trained as a vaccinator and took part in the staff vaccination programme,

g. liaised weekly with the procurement team to ensure we had enough masks, alcohol gel and gowns.

33. During the Covid-19 pandemic, my ability as Executive Director of Nursing to fully review and assure the Trust's quality and safety structures was constrained. Routine oversight, in-depth audits, and detailed performance reviews could not be undertaken as usual due to operational pressures and staff redeployments. To mitigate this, we prioritised critical risks, streamlined reporting, and maintained focused executive oversight to ensure accountability and transparency for patient safety.

Executive Director of Nursing's Team

34. At first, my team whilst I was the Executive Director of Nursing consisted of:

a. Executive Assistant,

b. Three Associate Directors of Nursing,

c. Associate Director of Safeguarding,

d. Head of Quality Improvement,

e. Head of Patient Experience,

f. Associate Director of Allied Health Professionals, and

g. Associate Director of Quality.

35. This structure changed at the end of 2020 in relation to the executive assistants' roles, which were removed from the Executive Director structures and were replaced with a Headquarters pool of administration staff, line managed by the Director of Corporate Governance. During 2020 I did not have a deputy director of nursing, but the ELT approved the role of a Deputy Director of Nursing, who was appointed in early 2021. In 2021 the Quality Improvement team moved to the Director of Strategy and Partnerships' portfolio therefore the Head of Quality Improvement no longer reported to me.

36. Whilst I was in post as the Executive Director of Nursing, AHPs and Quality, I had three Associate Directors of Nursing, one for each division. I have exhibited their job description to this statement [WITN0354023]. They did not have a direct reporting structure under them from the wards as they were part of the professional nursing structure, as opposed to the operational nursing structure. Having worked in several trusts including three mental health trusts, the operational structure and professional structure exist side by side but serve very different purposes:

    a. The operational structure focuses on service delivery, staffing models and rota management, budgets and resources, risk management and governance, and day to day operations on wards and in community teams. This structure includes ward managers, matrons, team leaders, service managers and general managers, who report to the Executive Director of the division they work in.

    b. The professional nursing structure focuses on quality, standards and clinical leadership. The purpose is to ensure the professional standards of nursing are upheld, developed and continually improved. This structure focuses on clinical quality and patient experience, professional standards (Nursing and Midwifery Council and Allied Health Professional Council), clinical supervision, nursing practice development, training and competencies, workforce development and recruitment, patient safety and improvement initiatives, oversight of nursing documentation and care planning, and learning from incidents.

37. The professional structure consisted of myself as the Executive Director of Nursing, the Deputy Director of Nursing, three Associate Directors of Nursing (one per division), and Heads of Nursing (usually three per division). This structure's key responsibility was to ensure that nurses were practising safely, compassionately, and in line with professional standards. The professional structure ensures that national clinical guidance and

policies are interpreted, support with revalidation, leadership for nursing-led improvements and escalation of any professional concerns.

38. We ran a "dual line" model meaning that staff had an operational manager to oversee the running of the ward/service and a professional nursing line to support quality standards and development. This meant that operationally staff would go to the service manager, and professionally they would go to the Associate Director of Nursing.

39. In mid-2020 I re-drafted a list of tasks I needed the Associate Directors of Nursing to do because we were in a Pandemic, and they needed to adjust their roles to manage this in the division. I have only been able to find a handwritten note, which I have exhibited to this statement [WITN0354002]. This was discussed and was then agreed with the three Associate Directors of Nursing.

Interim CEO

40. My role changed when I became Interim CEO in September 2022: chairing and attending different meetings, line management of the Executive Directors, and liaison with the Chair and Governors. During this time, Tabetha Darmon acted up into the role of Executive Director of Nursing.

41. My new role as interim CEO was clearly set out in a letter sent to me on 8 August 2022 from the Chair [WITN0354024]. The letter sets out my appointment period and the interim CEO duties expected of me. The Chair also made clear areas that were removed from the interim portfolio. I did not retain any of the Executive Director of Nursing meetings, line management or responsibilities, but I did support the interim Acting Executive Director of Nursing Tabetha Darmon as she had not been an Executive Director before.

Deputy CEO

42. Once the new CEO was substantively in position, on 1 January 2023, I became Deputy CEO. My Deputy CEO role was similar to what I had previously done during 2022 which was act up when the CEO was away, attend meetings on their behalf and share some of the liaison with external partners such as the CQC, coroners, and provider collaboratives.

43. I did not have a specific job description for the Deputy CEO role. A written outline of the duties expected in the Deputy CEO role was provided [WITN0354025]. This set out that

the role was at executive level, stating: '*the interim Deputy Chief Executive is a full member of the Trust Board. They are expected to make a significant contribution to the development and delivery of the wider Trust agenda, including the determination and implementation of corporate strategies and plans, and the corporate governance and affairs of the organisation as an Executive Director*'.

44. Responsibility for quality within the Trust was jointly held by the Executive Director of Nursing and the Medical Director, with both roles sharing oversight and accountability for clinical standards, patient safety and governance. There is a governance structure and a table from early 2020 [WITN0354009] and early 2021 [WITN0354010] which sets out the Medical Director's and Executive Director of Nursing's responsibilities. For example, the Medical Director was responsible for clinical effectiveness, learning from deaths, mental health legislation, whereas the Executive Director of Nursing was responsible for patient safety, quality standards, complaints, and patient experience. The Medical Director changed in May 2021, but the division of responsibilities continued as before.

45. Whilst I was Deputy CEO, Tabetha Darmon continued to act up into the role of Executive Director of Nursing, with my guidance and support. She was interim Executive Director of Nursing from 1 September 2022 until she finished on 30 April 2023. When she left, I took on the responsibilities of Executive Director of Nursing, as well as my Deputy CEO role, until I left the Trust, whilst the Trust awaited the newly appointed Executive Director of Nursing coming into post.

46. Throughout this statement, where I have referred to "the Executive Director of Nursing" rather than referred specifically to my responsibilities in the first-person, this is to reflect the roles and responsibilities of the person in post at the time, either myself or the interim Executive Director of Nursing.

Governance

Governance Structure

47. The Trust's governance structure during my tenure as an Executive Director was organised as follows:

    a. The Board of Directors,

    b. Board Committees sitting under the Board,

c. The ELT,

d. Management teams sitting under the ELT.

48. During the time I was at the Trust we ran a unitary Board that had legal accountability for the Trust's performance, quality of care, financial sustainability and strategic direction. There was an equal number of Non-Executive Directors to Executive Directors (who all had voting rights) as set out in the Trust Management and Leadership Structure [WITN0354026].

49. There were several committees reporting to the Board, including Quality, Audit, Finance and Performance, People and Renumeration. The names and remit of some of the committees changed during my tenure:

a. The committee covering quality:

i. In 2020 the committee was called the People and Quality Committee, as set out in its Terms of Reference [WITN0354027].

ii. In 2021 and 2022 it was the called the Quality Mental Health Legislation Committee, as set out in its Terms of Reference [WITN0354028].

iii. In 2023 it was the called the Quality Committee [NHFT0011973]

b. The committee covering audit:

i. In 2020, 2021 and 2022 the committee was called the Audit Committee, as set out in its Terms of Reference [CQCM0027255]

ii. In 2023 it became the Audit and Risk committee, as set out in its Terms of Reference [WITN0354029]

50. As Executive Director of Nursing I was a member of the Quality Committee, which was chaired by the same clinical Non-Executive Director for the whole period I worked at the Trust. The Medical Director and I would also be invited as attendees to the Audit Committee when there were agenda items relevant to our portfolios. From 1 September 2022 I was no longer a member of the Quality Committee, this role was taken by the interim Executive Director of Nursing, Tabetha Darmon.

51. The role of the ELT was to oversee the operational delivery of clinical and corporate services, monitor performance related to quality, finance, and workforce, promote the organisational values through leadership and culture, leadership development, and staff engagement. The ELT were also responsible for providing the Board with accurate and timely information on performance and risk.

52. Under the ELT were three clinical divisions and one corporate division. The Forensic Division was led by the Executive Director of Forensics, the Community Division was led by a Director of Community Services, and the Mental Health Division was led by an Executive Director of Mental Health Services. In the Corporate Division was the Executive Director of Nursing, Quality and AHPs, the Executive Director of Medical Services, the Director of Strategy and Partnerships, the Executive Director of Human Resources and the Executive Director of Finance and Performance. As part of the ELT, we also had a Director of Corporate Affairs and an Associate Director of Communications.

Governance Changes

53. There were many changes to governance structures whilst I was in the Trust. When I first arrived in early 2020 the three clinical divisions were very much run as three separate organisations. They had different structures, different reporting lines, and different meetings. Having worked in two previous mental health trusts, I was used to being sighted first-hand on matters such as incidents, complaints, nurse grievances, and suspensions, through the reporting lines to me. I found that at the Trust, reporting went up through the division to the Director of that division and not to the Executive Director of Nursing. In 2020 the CEO produced a paper for ELT (21 October 2020) titled "Nottinghamshire Healthcare NHS Trust; One Trust. Developing our Business Model" in which he said that this way of working was unhelpful with a *"degree of ambiguity which in some instances currently detracts from clarity and high-quality clinical engagement, support, operations and governance*" [WITN0354030 page 1]. The "One Trust" approach would ensure there was better oversight for the ELT and Board of operational issues and performance. This also meant that two of the quality posts that were managed within the divisions were moved into my portfolio, under the Associate Director of Quality. We then for the first time had a Trust-wide lead for complaints, clinical effectiveness and clinical audit and one person looking at patient safety, inquests and claims.

54. As part of these changes, we did a governance review and changed the structures under the Executive Director of Nursing, the Medical Director and the Associate Director of Quality, as set out in the Governance Review Presentation dated 6 October 2020 [NHFT0014979].

55. In my opinion, for the size of the Trust the quality team was very small, and capacity was an issue. I was concerned at the absence of several functions, namely: safer staffing, deputy director of nursing, family liaison team, suicide lead, quality lead for subcontracted beds, and restrictive practice lead, plus a need for more roles within CQC compliance. Over the period of 2020 and 2021 these posts were approved by the ELT and recruited to. In 2021 it became apparent that the Associate Director for Quality's time was being diverted into managing the Provider Collaborative governance functions and concerns regarding subcontracted beds. Patient safety and governance was still being managed within the divisions, and there was a patient safety lead for each division, but we had an issue with capacity in the Trust-wide leadership of this area. Therefore in 2022, the ELT agreed to fund a Deputy Associate Director of Quality to increase the capacity in the Trust-wide team, and this person started in early 2023.

56. Foundation trusts are required to commission an external view of how well led the organisation is every three years. I remember the Trust commissioned an external well-led assessment by Grant Thornton, which was received around August 2020 [WITN0354031]. The report contained several recommendations and one of them was that we needed to change the structure of the People and Quality Committee. The recommendation was to split the committee into a People Committee and a separate Quality & Mental Health Legislation Committee. I recall that this was because they observed the committees and felt that the combined People and Quality Committee's agenda was too broad and when they observed the committee it ran over its time allocation. It was therefore not able to give due scrutiny to both the quality and the people elements, so it was recommended that they each had their own dedicated committee. The ELT agreed with this recommendation and towards the end of 2020 this was enacted. This improved the governance and ability to address the issues connected with both extensive agendas.

57. Regular reports came to the ELT on the progress against the recommendations and actions needed to improve, such as the External Well-Led Review – Action Plan

[NHFT0004957] and Implementation of External Well-Led Actions report [WITN0354032].

58. Having recently re-read the Grant Thornton report for the purposes of this statement, I have remembered that the external review also recommended that a Risk committee be developed, which would be chaired by the CEO, to manage the risk management framework, as set out in its Terms of Reference [NHFT0015866]. This meeting ran monthly and reported up to ELT and then to Board. I am aware that the first meeting took place on 21 October 2020, which I could not attend, but I have had sight of the minutes [WITN0354033], and I was a regular attendee at subsequent meetings. This committee reviewed high level risks that had been identified in the organisation and that needed to be bought to the attention of the Board, and other risks that scored above 12 on a quarterly basis (risk scoring is done through a matrix that looks at the likelihood (probability) of the risk occurring against the impact (consequence) which is the severity if that risk occurs. The risk committee reviewed the BAF document (explained further at paragraphs [114 - 117 and 121 - 123], below) at every meeting and provided assurance to the Audit Committee and Board.

59. We had several new Executive Directors from 2020 – 2023. The Medical Director left the Trust for a role nearer to where they lived. The CEO then agreed to amalgamate two roles: the Executive Director of Forensic Services and the Medical Director. This amalgamated role was taken up by the then Executive Director of Forensic Services, Sue Elcock.

60. The Executive Director of Adult Mental Health retired in 2022. A new Chief Operating Officer ("**COO**") role was developed in 2023. This changed the reporting mechanisms for the divisions into the COO role. Each of the three divisions had reported into its own Executive Director of Operations. This change moved the three Executive Director of Operations into one role of Chief Operating Officer.

61. An Executive Director of Nursing would work quite closely with the Head of Governance, whose role was to ensure that robust governance arrangements were in place, including committee structures, policies, and reporting mechanisms. This enabled the Executive Director of Nursing to discharge their clinical and professional accountabilities effectively. Their role included advising the Executive Director of Nursing on matters relating to the Trust's regulatory compliance, and the effectiveness of assurance processes. Their expertise supported the Executive Director of Nursing's decision

making and enabled the role to fulfil the clinical and professional accountabilities. They should maintain a good administration function to support the Executive Director of Nursing. When the Trust had its well led review in 2020, the Head of Governance was responsible for pulling together the action plan and leading on the corporate areas highlighted in the review.

62. However, we had several changes in the headquarters team for the Director of Corporate Governance. In my time at the Trust (2020 – 2023) I worked with five different Corporate Heads of Governance with different titles. Having five different corporate governance leads over this period resulted in a lack of continuity and stability within the governance function. This frequent turnover disrupted the embedding of governance processes, created variance in expectations, and reduced the Trust's ability to sustain improvements. Relationships had to be built repeatedly, which weakened trust and reduced the effectiveness of any challenge and assurance. There was a recommendation in the 2019 CQC report to review the governance structures. Implementation was delayed as the Head of Governance role underwent these changes, resulting in reduced continuity and capacity to take this work forward.

63. During Covid-19 the Trust used 'derogations', which were formally approved, time limited exemptions from specific policies or operational standards. They allowed the Trust to adapt its practices in response to unprecedented service pressures while ensuring risks were clearly documented, monitored, and escalated through the governance framework. I have exhibited to this statement an example of the derogations we were using [WITN0354034].

64. The Director of Strategy and Partnerships retired and was replaced in April 2022. This role was instrumental in managing our engagement with external partners including the provider collaboratives (IMPACT), Healthwatch, and the Integrated Care Boards ("**ICB**"). The Director of HR and the Director of Finance changed during this time too.

65. We also introduced improvement boards and had several running across the Trust. These would be chaired by either the CEO or the Executive Director of Nursing. These improvement boards were initiated on the back of increased incidents, CQC concerns, and internal ELT concerns. We had a Rampton Improvement Board, an Adult Mental Health Improvement Board, and a Lings Bar Improvement Board. Once the service was able to evidence a level of stability, oversight and improvement the board was stepped down. I have exhibited to this statement a report to the ELT on Improvement Board

Governance in November 2022 [WITN0354035] and the terms of reference for the Adult Mental Health Improvement Board in June 2020 [WITN0354036].

66. In January 2023 we introduced a new meeting called the Trust Management Group ("**TMG**") which I initially chaired as Deputy CEO. This meeting replaced what was the Senior Leadership Team meeting (SLT). This meeting consisted of all the deputy directors across the Trust. The CEO identified the need for a forum below the executive level that could provide direct oversight and support to the divisions. I have exhibited to this statement the group's Terms of Reference and an example of its minutes [WITN0354037; WITN0354038].

The Relationship between Executive and Non-Executive Directors

67. In my experience, the relationship between the Executive and Non-Executive Directors was good. I had experience of sitting on several trust boards previously and felt that we had an honest, transparent and open working relationship. The Chair was keen for the Board to perform to the best of its ability and facilitated several Board development sessions for the Executive Directors and Non-Executive Directors to get to know each other and build trust. Board development was the responsibility of the Chair, who would agree the agenda with the CEO, and the other Executive Directors would support the agenda items with reports, presentations, and workshops. From when I started until I finished there were five Board development sessions a year, even during the pandemic when they were conducted virtually. The Board development sessions were varied and helped us to strengthen our skills in the oversight of quality, finance, workforce and risk. By way of example, I have exhibited to my statement the Board Development Agenda of 11 February 2020 [WITN0354039], the full papers of the Board Development session on 5 October 2021 [WITN0354040] and the full papers of the Board Development session on 23 February 2023 [WITN0354041]. The session in 2023 focussed on the Board and committee structures, operational governance, and changes to the BAF methodology.

68. Some Executive Directors had a committee that they specifically supported. They would meet the chair of that committee (a Non-Executive Director) and agree agendas going forward. The chair of that committee could also make additional requests for reports or presentations to that Executive Director. For example, when I was the Executive Director of Nursing, I was linked to the quality committee, the HR Director was linked to the people committee, and the finance director was linked to the finance Committee. If the

chair of the committee had any concerns with how the committee had gone or how papers had been presented, including content of the paper, the Chair would have the Executive Director to discuss this with. That way, we could ensure that future papers reflected what the chair wanted to see.

69. I felt that the Non-Executive Directors gave a great deal of challenge to the Executive Directors such as myself, and sought assurance on all papers presented, for example around finance and decisions that were made around the Trust's purchase of Sherwood Oaks. I also recall, by way of example, that in one of the meetings, one of the Non-Executive Directors challenged me about the recording of hate crimes and why was there a big increase. I personally found that Non-Executive Directors put a lot of thought into what they were going to challenge. I felt they had a great interest in the quality items and asked a lot of questions in relation to staffing, incidents, CQC action plans, and complaints. I did feel that there was adequate challenge, and I felt that there was a good and professional working relationship in terms of approachability and respect.

70. I think that an ineffective relationship would be one where there was no challenge from the Non-Executive Directors, and they would just accept what was presented. A bad relationship would be if they had undermined me or dismissed me or did not respect my explanation about something. However, I did not feel that this was the case at the Trust as I felt that the challenges raised were thoughtful, appropriate and constructive.

Monitoring of Mental Health Services

71. There were many mechanisms used by the Trust to monitor the adequacy of the mental health services provided by the Trust. These included:

    a. **Integrated Quality Performance Report** (IQPR): This was presented at every Board, and had a specific section related to the mental health services. It bought together all the metrics around safety, quality operational performance, workforce and finance. It would be presented in a Statistical Processing Chart (SPC) format so that the Board could see immediate concerns, escalations and trends. The IQPR would include data and narrative on matters such as Restrictive Practice, Incidents, Pressure Ulcers, and Complaints, as shown on pages 30 – 55 of the papers of the Public Board of Directors meeting on 5 July 2022 [NHFT0001173] and page 32 – 60 on the March 2022 board papers [NHFT0003849].

b. **Patient Experience both qualitative and quantitative:** This was a report that came to Adult Mental Health Improvement Board, Quality Committee and Board and gave a full account of all activities related to patient experience such as interviews, and forums. During 2020, 2021 and 2022 a patient involvement report came to the Adult Mental Health Improvement Board specific to that division, for example as shown at pages 12-17 of the AMH Improvement Board of 15 November 2021 [WITN0354042].

c. **Patient and Staff Stories:** At the beginning of all Board meeting, patient and staff stories were presented. These rotated around the Trust, so the mental health division presented at least 3 times during the year. There was a full programme of stories that were planned for the year ahead. We tried to ensure all areas of the Trust had an opportunity to present a story at Board. During the Covid-19 pandemic these were reduced but then we managed to facilitate stories through virtual meetings, that meant we were also able to hear the voice of patients and carers directly to the Board. The Executive Director of Nursing had the responsibility of ensuring we had stories prepared for Board, with the support of the ward managers and communications team. I have exhibited to this statement a summary report of Board stories, including the top concerns from the Mental Health division on page 5 [WITN0354043].

d. **National Staff Surveys as well as pulse surveys:** This was an annual survey sent out by an external company called Picker. We received this as a breakdown into teams and divisions and each executive received their results. They produced a report for the Trust on the responses and gave analysis of the content. The HR Director presented the findings each year to the Board and explained what actions were being taken to improve our position on any of the areas of concern. I have exhibited to this statement the Staff Survey details for 2022, which covers Mental Health Services at page 115 [WITN0354044]. There was also a quarterly National Pulse Survey to complement the overall staff survey. This was a Prime Ministerial request and was a requirement for all Trusts to report upon from July 2021.

e. **Speaking up data and stories:** This came as a report to Board from the Speaking up Guardian. The Speaking up Guardian reported directly to the CEO. The data was broken down into divisions but stayed like that so individuals could not be

identified.

f. **Coroner feedback:** This was done through meetings with the coroner. The coroner appreciated the opportunity to feedback directly to us as Executive Directors. I remember a meeting where she was very challenging about our oversight of the out of area providers [WITN0354005]. She wanted to hear that the Trust would provide better oversight and assurance on the care patients were receiving in other providers we commissioned [WITN0354004].

g. **Safer Staffing establishment reviews and reporting (this included vacancies, bank and agency usage**): This was a regular report both to the Quality Committee, and the Adult Mental Health Improvement Board, as well as to Board. They would also have gone to the People Committee as vacancies and recruitment spending fell under the HR Director. These reports were specific to each division and were presented as such. There was a safer staffing matron in post who provided these reports. I have provided examples of this later in my statement in the safer staffing section at paragraphs [182]- [200].

h. **Infection Control and Prevention data and audits:** These were provided by the Infection Control team and were escalated from the Infection Prevention and Control Meeting into the Quality Committee and then to Board. During the Covid-19 Pandemic these reports gave a highlight of how many outbreaks, how many ward closures, audits of handwashing and cleaning across all areas of the Trust. In 2020 we received a new National IPC Board Assurance template that we had to report against, and this went to Board annually. I held the responsibility of being the Director of Infection Prevention and Care (DIPC) throughout my time as Executive Director of Nursing.

i. **MHA audits and feedback:** These individual ward audits were conducted by an external body (I cannot recall if this was done by Independent Mental Health Advocates (IMHA's) or the CQC's Mental Health Act officers) that would then feedback to the Trust, these were pulled together into a report for the Quality Committee. This was the responsibility of the Medical Director who presented them to committee and Board.

j. **Board to ward visits:** During the peak of Covid-19 cases, we reduced the Board to ward visits but pre, and post-Covid-19 we conducted these important visits; gaining valuable insights and feedback from both patients, staff and sometimes

families. All Non-Executive Directors and Executive Directors were asked who could attend, and we all took it in turns to do the visits. The CQC always asked in the core inspections to see the list of visits as this gave an indication of the amount of visibility of the Board members in clinical areas. The pandemic was a really difficult time for this, and I understood that the Non-Executive Directors particularly felt that they were not getting to visit and see what was happening for themselves. As soon as we felt it was safe, and not a burden for the wards, we restarted the visits. Logs of the visits were maintained in the Executive Assurance Visits April 2019 to March 2020 [WITN0354045], Executive Assurance Visits April 2021 to March 2022 [WITN0354046], and Executive Assurance Visits April 2022 to March 2023 [WITN0354047]. There was a guide in relation to conducting and recording the visits [WITN0354048] and a template to complete after the visit that was collated by the HQ administration team [WITN0354049].

k. **Healthwatch:** Executive Directors also met regularly with Healthwatch where a two-way informal feedback loop allowed us to gain any insights from patients and families about services. These meetings were scheduled throughout the year, as I recall about 4 times a year. They were facilitated by the Head of Involvement and were attended by him and the CEO and sometimes the Executive Director of Nursing. The Director of Strategy and Partnerships took on this role of meeting Healthwatch when she started in April 2022.

l. **Quality First Team:** In 2020 we created a Quality First Team, as part of the changes outlined in the Governance Review of 2020 [NHFT0014979]. The Quality First Team conducted quality audits across the Trust. They initially concentrated on areas that had received 'inadequate' or 'requires improvement' from the CQC, but this was then widened to start including any areas that had concerning Mental Health Act visit feedback and increased incidents. These quality audits were initially fed straight to the senior nurse on the ward and were then followed up with reports. They were then reported to the Quality Committee. A template was used for these audits [WITN0354050] and I have exhibited to this statement some samples of reports produced following these audits by the team [WITN0354051; WITN0354052].

m. **Culture Awareness Tool:** In early 2021 we started to roll out a Culture awareness

tool [WITN0354053] where ward staff would conduct their own culture assessment. We used some of the CQC's self-assessment documentation and added some of our own questions too. This was ward and division specific rather than the Trust as a whole. Each division held responsibility for managing its own culture-of-care outcomes, including reviewing the results and taking forward the required improvement activity. We also produced 7 min briefing posters to support staff in their understanding of what a closed culture was and how to work towards an open culture [NHNB0015820].

n. **Place Audits**: Place audits primarily assessed the ward environment and safety, rather than the adequacy of clinical services. While they could highlight environmental factors that might affect care delivery, the adequacy and effectiveness of mental health services were evaluated through separate mechanisms such as service reviews, incident monitoring and patient feedback.

o. In 2021 Anna Pridmore (external consultant) was bought in by the Forensic Director to do a review of Clinical Governance for Rampton, as part of the follow up actions from the CQC inspection. Once she completed had that, she was asked by ELT to give a view of the Corporate Governance structures across the Trust. On 21 April 2022 she and the Associate Director of Quality facilitated a workshop with senior leaders from across the Trust to discuss and agree proposed changes to the Trust's clinical governance arrangements, as set out in the accompanying presentation [NHFT0014993].

Escalation of Issues

72. There were various ways in which issues with care provided by the Trust could be escalated to the ELT and / or the Board:

a. **Incident reporting:** This was done by any staff across the Trust onto an IR1 form. This form was then verified by a senior manager. This then was flagged to the Patient Safety Team who reviewed all incidents.

b. **Clinical Audits:** These would flag whether clinical practice met expected standards and in doing so would identify any gaps or risks in the care being delivered. Where standards had not been met, the audit would generate findings that were structured in an evidenced based way. Clinical audits were reported into the Quality Operational group and then to committees.

c. **Freedom to Speak up:** this is a national policy that encourages a positive culture to allow staff to speak up and have their voices heard, for example, concerns about unsafe practices, training or bullying. The Freedom to Speak up Guardian reported directly to the CEO, but if she felt there was an urgent matter relating to patient safety she could and would contact the Executive Director of Nursing or the Medical Director immediately. The Board received a report twice a year summarising concerns issues and actions [WITN0354054; WITN0354055].

d. **Direct communication from staff:** this would be from staff to the Management teams, and then through to Executive Directors via a phone call or an email. If an Executive Director was visiting any wards, the staff may ask to speak to them directly.

e. **Direct communication from families** to the CEO: This would be through emails, and phone calls. The CEO would then ask the relevant Executive Director to follow up the concerns and report back when it had happened.

f. **From Healthwatch:** This was when an email would arrive in a CEO's inbox. We met with Healthwatch regularly and they would give us a rundown of anything they had heard or any sort of intel that they had.

g. **During Board to Ward visits:** Patients and staff could talk directly to the Executive Director visiting. The Board to ward visits were a good way for staff to have access to senior leaders where they could freely discuss anything they were wanting to celebrate or had concerns about. During the pandemic I was working shifts on some of the wards, and I got to hear about any concerns and frustrations. I think it helped the staff to see Executive Directors supporting them directly. Some patients felt really isolated during Covid-19 and missed not having family and friends visit, so I spent time trying to fill a small gap by spending time with patients; listening and chatting.

h. **Directly from Mental Health Act visits:** These visits ensured that the Mental Health Act was being applied correctly on the ward. The reviewer would also talk to patients on the wards to see how they were and if they had any concerns, and check whether the patient felt involved in their care. These Mental Health Act visits were then sent as a report through to the compliance team who disseminated it to the wards. These reports were summarised into one report that went to Quality Operational Group and then to committee.

i. **Directly from any CQC visits and inspections:** The CQC would talk directly to patients and staff in clinical areas to understand how they were feeling and if they had any concerns. If there was any immediate patient safety concern, they would contact the Executive Director of Nursing or the Medical Director. Otherwise, it would be reflected in any reports written by the CQC that the Trust received.

j. **Through the Trust's formal complaints process:** Complaints were received in a variety of ways mainly handwritten letters or email. I have Exhibited a copy of the Complaints Procedure to this statement [WITN0354056]

k. **Directly from MPs:** this could come as a phone call or an email.

l. **Directly from the coroner:** as set out in paragraph [71f], the coroner gave constructive feedback about concerns she had at face-to-face meetings with me as the Executive Director of Nursing, the Medical Director and the Trust's Head of Medico Legal, as set out in notes of the discussion and follow up actions from a meeting in December 2021 [NHFT0005259].

m. **Quality First visits:** Staff and patients were asked about the care they were receiving during these visits. The Quality First team were established on the back of a structure change in the Quality and Patient Safety Team. It was recognised very quickly in 2020 that we lacked capacity in CQC compliance and surveillance. We increased this team from one person to three, as set out in the Organisational Change Proposal paper [NHFT0014990]. The team conducted many quality visits into clinical areas and produced reports for the ward manager and for reporting into the quality operational group (chaired by the Executive Director of Nursing), for example a Quality Standards Review feedback summary report for the Redwood 2 service in July 2022 [WITN0354052].

n. We had a pro-active involvement and experience team who sought regular feedback from both patients, carers, families and volunteers. They produced regular reports to Board providing assurance on the levels of engagement they were involved in, for example: a report from 2020 specific to Mental Health Services [WITN0354057]; and the annual report including an overview of all the work done to capture the experiences of patients and carers [NHFT0003784].

73. I would say overall these mechanisms were effective as we certainly received a lot of feedback across the Trust. The intelligence that we gleaned from these various mechanisms were collated into reports and presented up into the quality operational group and then to the Quality Committee.

Information Flows from Ward to Board

74. In my experience, there was a lot of information that flowed from ward to Board. This came through in a variety of different ways, including those mechanisms set out above. Activity and performance reporting also came up from wards to divisional meetings to Trust wide meetings. They would then come through sub-committees to the Board and into the Board reports. Information also came from Board members visiting wards and reporting directly to Board. We received the IQPR at every Board meeting that contained a variety of ward and community information, for example at pages 20 –30 of the Public Board of Directors meeting on 1 December 2020 [NHFT0003222].

75. In my view, information seemed to change for the better over time. Quality featured more in the IQPR and was also the first thing to be presented to Board within the IQPR, whereas previously performance was always the first thing. The serious incidents were discussed in the private part of the board in the reportable issues log. The reportable issues log was an important part of the Board; it was where the Executive Director of Nursing was able to highlight any serious incidents the Board should be aware of.

76. Whilst I was the Executive Director of Nursing I attended SIRG every week. I felt that this was an important part of that role, whether clinical, environmental or related to staffing as it provided an early warning sign of risk. I was then able to identify patient safety concerns and ensure they were addressed promptly as well as ensuring care standards remained consistent across the wards and community, themes and trends can be spotted before they escalate into serious harm. As a result, executives were sighted on incidents at an early stage because I was able to assess and escalate them swiftly. In July 2022 the Executive Director of Nursing began presenting the reportable issues log to the ELT each month in advance of board review, which enabled executives to be fully sighted on the issues and to request additional information they required. We also developed the Quality First team during 2020, which meant we had a better understanding of any quality issues happening in the clinical areas of the Trust. These were reported to the committees. As Executive Directors, we were also informed immediately if there were any areas of concern. We had several clinical audits done as

part of the agreed annual audit schedule by our internal auditors that did deep dives into various quality and clinical aspects. These audits were reported to Board and were monitored by the Executive Directors, for example a "Mortality Revisit" conducted by external auditors 360 Assurance in May 2020 [WITN0354058].

77. I think that an appropriate amount of information about what was happening on the ground did reach the ELT. Aside from the formal mechanisms set out above, there were additional steps that I took to further learn about what was happening at ward-level:

a. I used to be on daily calls with every ward that had an outbreak during the pandemic in 2020 and 2021, and I knew exactly what was going on in every ward. Although that is not normal practice, Covid-19 was not normal, so we delved into a lot more of what was happening in each area that had an outbreak. This would include their staffing situation, any incidents, and an opportunity to hear about the patients' experiences.

b. I also attended board to ward visits where patients and staff can talk directly to the ELT on a regular basis. Even during Covid-19, as Executive Director of Nursing, I thought it was important for me to visit the wards.

c. I also worked some shifts at Lings Bar Hospital for a short period to help people understand the importance of the visibility of an Executive, but also to add some capacity to the shifts when there was a lot of staff off sick.

d. During the winter of 2021, I also completed my training for the Covid-19 vaccination programme and became a vaccinator as I felt that it was important to demonstrate hands-on leadership at this time.

e. Furthermore, in early 2020 I initiated a scheme whereby if any member of staff had come under any moderate to severe harm at the hands of a patient, I wrote to them individually to check on their wellbeing and if there was anything I could do to assist. I learned this from another Trust which was CQC rated 'outstanding', and I felt this was a good thing to do with staff to connect with them individually. To do this, I set up an arrangement whereby the quality team would send me (as Executive Director of Nursing) a spreadsheet each week of anybody who had received harm from a patient, this was roughly 2-3 cases per week it meant that I had oversight of the number of such incidents, and where they were occurring. This process was handed over to the interim Executive Director of Nursing in August 2022.

78. During my time as an Executive Director, concerns were raised about the adequacy of adult mental health services provided by the Trust. These were brought to the attention of the ELT from the Executive Director of Adult Mental Health Services, Julie Attfield during 2020, 2021 and 2022.

79. These concerns ranged from staff sickness, vacancies, incidents, capacity of the service team to manage the amount of work coming in, shortage of beds, concerns about the quality of services at the Priory Hospital East Midlands (to which some services were sub-contracted), concerns about the estate and concerns about the poor condition of Sherwood Oaks when we purchased it and started the refurbishment of it.

80. I did therefore recognise that the situation within adult mental health was difficult and challenging.

81. The ELT discussed the concerns raised at several ELT meetings. We committed to attend a Friday AMH (Adult Mental Health) Huddle with at least one Executive Director, and the ward managers. This was a time when the ward managers could express any concerns they may have. However, these did not turn out to be particularly constructive meetings as every grievance or issue the ward managers might be facing was raised, and so there was little focus, and it was hard to take things forward as a result. As a result of the concerns raised and a few incidents that had happened we started an Adult Mental Health (AMH) Improvement Board as a more structured approach than the Friday AMH Huddle, chaired by either the CEO or me as Executive Director of Nursing.

82. I am aware of AMH Improvement Board Meetings taking place on: 18 June 2020, 12 April 2021, 16 August 2021, 15 November 21 [WITN0354042], 3 March 2022 [WITN0354059], and 16 May 2022 [WITN0354060]. These meetings presented and addressed a range of issues, such as what was happening with violence and aggression reduction, meaningful activity, out of area beds, safer staffing, and quality improvement plans. The AMH Improvement Boards were consistently well attended and demonstrated a high level of constructive engagement, which enabled effective discussion, shared problem-solving and sustained key improvement actions. Several constructive actions resulted from these improvement boards as evidenced in the attached minutes examples such as, looking at police presence at Highbury, the management of violence and aggression team to increase time spent on the wards, an agreement to recruit a physical healthcare lead for the division, an agreement to hold a workforce summit to look at different roles, and recruitment options.

83. Administrative support for some of the Executive Directors was variable. Executive Directors were supported by Executive Assistants ("**EAs**"), however, that changed in late 2020. EAs were replaced with a pool of people at a lower band, shared between the Executive Directors. Throughout my three and half years at the Trust, the administrative support provided to my role fluctuated and underwent several changes. This variability had an impact on continuity and the stability of core governance and support functions, and it meant that we did not know who was going to be able to minute meetings that we were chairing. For the AMH improvement board, the minutes may have been taken by Ms Attfield's personal assistant; they had their own administrative support outside of the headquarters based in the division. However, I understand that it has not been possible to locate the papers relating to the meetings on 18 June 2020, 12 April 2021, 16 August 2021.

CQC reports and the Trust's Response

84. The Request notes that the CQC published reports of its inspections of the Trust as follows:

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

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

c. In November 2022, the CQC published the report of its routine inspection of the Trust [CQCM0016478], which was carried out in March and April 2022. The overall rating was "*Requires improvement*". Four out of five areas assessed (including

"*safe*" and "*well-led*") were rated as "*Requires improvement*". The CQC issued a section 29 warning notice on 21 October 2022 in respect of its findings on [CQCM0001817].

Accountability for receiving and actioning CQC reports

CEO

85. Ultimate accountability was with the CEO, who held the statutory responsibility for the Trust's compliance with CQC regulations and for ensuring the Trust acted on CQC inspection findings.

86. The CEO ensured that there is a governance framework so that actions required by CQC reports were implemented across the organisation. This includes the well led domain of organisational leadership, culture, governance arrangements, ensuring effective management structures, strategic delivery and board level assurance.

87. All reports were sent directly to the CEO's office. All action plans and relevant documentation to be returned to the CQC were sent from the CEO's office.

88. However, the CEO does not personally manage all actions; this was delegated.

Chair

89. Whilst the CEO managed the executive leadership aspects, the chair was responsible for board effectiveness, ensuring Non-Executive Directors provide scrutiny and challenge and ensuring governance is functioning at board level. The chair was supported by the Director of Corporate governance for these aspects. The chair was also supported by the Director of HR around board behaviours and culture.

Executive Directors (Nursing, Medical, and Operations)

90. Operational responsibility for implementing improvements following CQC inspections typically sat with relevant executive directors:

    a. Executive Director of Nursing: patient safety improvements, particularly staffing, patient experience, safeguarding, infection control and clinical governance. Normally the Director of Corporate Governance would track completion of action plans and report to the CEO and board on compliance and progress, but this sat within the Executive Director of Nursing role delegated from the CEO.

    b. Medical Director: medical practice, clinical leadership, mental health legislation and patient outcomes.

c. Director of Operations (mental Health, community and forensics): operational delivery of CQC required improvements, oversees resources, staffing deployment, and systems to support improvements across services.

91. These executives usually produce an action plan in response to the CQC report and report progress to the board. These reports were normally written and collated by the CQC compliance team, which sat within the Executive Director of Nursing portfolio.

Quality Committee

92. The Quality Committee acted as a formal assurance and oversight mechanism. It reviewed all CQC reports, and the Trust's action plans, as well as monitoring progress and escalating any unresolved or high-risk issues to the board.

Director of Corporate Governance / Trust Secretary

93. The Director of Corporate Governance/Trust Secretary ensured the CQC report was formally received, recorded, and escalated.

94. There were several mechanisms for discussions at ELT / Board level in relation to the CQC reports.

a. Initially, the draft report would be sent to the Board and senior managers, for the Trust to make a factual accuracy submission. We were normally given a 10-day turnaround to respond to this deadline. During this factual accuracy period the report was embargoed.
b. Then once the report was published by the CQC on their website, we were allowed to disseminate it much wider for discussion and consideration. The reports were sent to all Board members, the Council of Governors, and senior managers.
c. We would then spend some time at a subsequent ELT discussing the report and the content of it, if there were any immediate remedial actions we could take, and who would take executive lead on actions needed.
d. Normally, the report would be written in divisions, for example, Adult Mental Health Services, Community Services, and Forensic Services. Therefore, each Operational Director would take their section and discuss it at length in their divisional meetings.
e. The Trust's CQC compliance team would then take the report and provide a summary of the content and actions that would be taken for it

to be presented to the next Board meeting, for example the Rampton inspection in late 2022 was discussed in a board report of the 26 January 2023 [NHFT0002627 pages 14 - 16].

f. The Executive Director of Nursing would normally present the CQC report, content, and the plan to manage the actions and recommendations made.

g. The compliance team would also maintain the amalgamated action plan that was reviewed at the Quality Operational Group.

h. If there was a Board Development session planned near to the publication of the report, we would have some time discussing the content and how we can improve services based on the CQC findings.

i. After this, regular reports would go to the Quality Committee, for example a CQC update that I presented to the Quality & Mental Health Legislation Committee on 12 August 2021 [WITN0354061].

May 2019 CQC Report (Trust inspected January 2019 – March 2019)

95. I recall that when I started at the Trust in 2020, the CEO said that he wanted me to concentrate on the recommendations that the CQC had made and any outstanding actions that had not been closed yet. He was concerned that some areas had been rated as inadequate. In response to this, I started 'CQC get ready sessions" for staff, met with the CQC inspectors, increased the CQC compliance team in the trust, provided regular status reports to ELT and Board on the CQC actions.

96. Following the 24 May 2019 CQC report being published, whilst I was not in the Trust at the time I was able to review the report and subsequent papers (after I started in January 2020) that were presented to the Board and Quality Committee. I could see that the Trust met the requirement to produce a plan by 4 July 2019 to bring services into compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. I was aware of several update reports to the Quality Committee throughout 2019.

97. We started a programme around CQC compliance. We did this because many staff were very nervous about inspections, and it was aimed at supporting staff to be the best they can be and to show the great work they were doing. I had some experience of CQC inspections in previous roles, and I was also an executive reviewer for the CQC on the well-led domain. We spent time going through any previous CQC reports to help teams understand what the CQC would be looking for. We also produced several '7-minute

briefings', staff found these particularly helpful, and we displayed them around the Trust. For example, there was one on restrictive practices [WITN0354062] and one in relation to professional curiosity and emerging risks in suicidality [WITN0354063]. The expectation was that the CQC would want to see that anything they found previously as requiring improvement, had been addressed and improved. We also did work on what good looks like to help teams aspire to be outstanding. We spent time looking at other trusts' reports to understand what would help us to be better and improved from our previous inspections. We reported regularly to the Quality Committee and Board about any outstanding CQC actions and what we were doing to address compliance across the Trust. I have exhibited to my statement:

a. The CQC update that I presented to the Quality Committee on 19 May 2020 [NHNB0010099].

b. The CQC update that I presented to the Quality Committee on 12 August 2021 [WITN0354061].

c. The CQC update that I presented to the Quality Committee on 14 October 2021 [WITN0354064].

d. The CQC update that I presented to the Quality Committee on 15 February 2022 [WITN0354065].

e. The CQC update that Tabetha Darmon as interim Executive Director of Nursing presented to the Quality Committee on 7 February 2023 [WITN0354066].

98. On 16 March 2020, the CQC announced they would suspend their routine inspection schedule due to the pandemic; however, they would still inspect if they had patient safety concerns. On 26 March 2020 in response to evidence of improvements submitted to the CQC, they lifted the conditions which had prevented the Trust from admitting patients to the Lucy Wade ward because of concerns around patient safety. At this point the ELT agreed to set a limit of twelve admissions into the 16 bedded unit to enable improvements to be fully embedded. At this point we were conducting risk review meetings in respect of Lucy Wade unit, which the CQC were attending as well.

99. In August 2020 the Board received a report which I presented outlining the status of the 36 compliance actions and the progress being taken by the divisions [NHFT0006170]. These compliance actions would remain open until the CQC were able to re-inspect. The Quality First team prioritised visits to services which had inadequate or requires

improvement ratings. The outcomes of these visits were shared with the senior leadership team within the division. ELT supported teams with a range of resources and meetings to support staff to complete actions and improvements as well as getting ready for further inspections.

100. In October 2020 the CQC announced the roll out of a new programme. Using the existing key lines of enquiry they would scrutinise patient safety, access to services and leadership before expanding and evolving this approach to include additional areas of focus. This was an important change for us because it meant they would then rate providers in terms of risk being low medium or high. This would then determine if they did a face-to-face inspection on site to target specific areas of concern. This also meant that ratings would not change but the provider would receive a short statement summarising the outcome. The monitoring by the CQC was also being done using information using their digital platform.

101. In the May 2019 core and well led inspection, the CQC issued 25 requirement notices these were all closed by February 2020 apart from one relating to 'trust governance'.

102. I understand that any requirement notices and ratings will always remain open until such time as the CQC are able to re-inspect those services. This was one of the reasons so many trusts kept the same ratings for so long during 2020 and 2021.

September 2020 CQC report (inspection between 19th and 29th July 2020)

103. The 2020 inspection was an on-site short notice inspection made to the Adult Mental Health in-patient wards. At this point the inspectors found the services were compliant with the standards assessed and did not issue further requirement notices. At this point they acknowledged the Trust had made various improvements since they last inspected in 2019, stating the '*service provided safe care*' [NHFT0001778].

104. In 2021 the compliance team provided learning boards, populated with the outstanding requirements notices for the wards with any outstanding requirement notices to support their conversations with the CQC.

105. In October 2021 I was asked to provide a report to the Quality Committee on any outstanding actions, resulting from any inspections to date [WITN0354064]. This is a detailed report outlining all outstanding actions. The committee wanted further assurances from the divisions that actions and improvements were being made.

106. In March and April 2022, the CQC conducted an inspection of nine of the Trust's 16 core services, including Acute wards for adults of working age, and psychiatric intensive care units, plus a "well-led" review. We received a warning notice for the use of dormitories in the Trust. [CQCM0019835]. Following this inspection, the Quality Standards Lead and I conducted joint visits to the wards to advise on CQC compliance and check some standards. Feedback from the visits were largely positive with some improvements to be made shared with the division.

November 2022 CQC Report (inspection conducted March April 2022)

107. On 26 July 2022, I met with the CQC's Head of Hospitals Inspection to discuss delays in issuing the remaining inspection reports, considering they had completed their inspection on 28 April 2022. They apologised for the delay and assured me we would receive them shortly. You would normally expect a CQC inspection report to be issued within a defined timeframe so that the Trust can understand the findings, respond promptly, and implement improvements. These delays meant that we were unable to begin formal action planning at the appropriate time, and in some cases, the issues identified during inspection had already evolved or new risks had emerged by the time the report was received. This created a lag between the problems identified and our ability to respond to them, which impacted the pace of improvement and limited our ability to provide timely assurance to the board.

108. On 7 February 2023 the Quality Committee received a CQC status report [WITN0354066] by the interim Executive Director of Nursing outlining the required actions and improvements required following the March/ April inspection.

109. The November 2022 report did find that the Trust's corporate governance structure had been reviewed, redeveloped and improved. This was a long-standing issue and had been resolved in the summer of 2022.

110. The Executive Director of Nursing's role is to ensure the CQC action plans were completed. This was done by the staff within the clinical area and collated by the CQC compliance team. The CEO then signed the action plans off (which I also did when I was interim CEO). CQCM0016735, NHFT0001320 and NHFT0001800 are action plans which the CQC request following an inspection

Trust learning from CQC inspections

111. I started as Executive Director of Nursing in January 2020 and was asked by the CEO to strengthen the oversight and governance of the improvements needed based on what the CQC report had found in 2019. I believe that we were learning from each of the CQC inspections, but that we still had a long way to go on improving and sustaining the changes that were needed. Some of the improvements could not be achieved overnight; they would need significant investment. An example of this was the need for the eradication of dormitories, of which the Trust still had many. This was a continual issue for the CQC, and we needed support from the wider system, through investment and canvassing support to make the significant changes the Trust estate needed. We spent a lot of time discussing how to eradicate dormitories at Board meetings and ELT. We worked up a plan to purchase Sherwood Oaks which would support our plan to remove dormitories from the estate, Sherwood Oaks did not open until late 2022.

112. However, this would take time and therefore continued to feature heavily in CQC feedback we received. We received a warning notice form the CQC in relation to dormitories [CQCM0019835]. Another issue we struggled with was recruitment of nurses and this was a national problem throughout my time in the Trust. All trusts and particularly mental health trusts struggled to recruit qualified nurses. This is one of the reasons we spent a lot of time discussing "golden hello's", retention payments, and what else we could offer to attract nurses.

113. Despite the Trust being rated 'requires improvement' for three inspections, I do not believe we were failing to learn. We had taken learning from incidents, audits and regulatory recommendations. We actively reviewed the CQC findings, implemented a range of improvement initiatives, and monitored progress through our governance structures. At the same time, some areas presented complex, systemic changes, and progress in these areas took longer than anticipated. The repeated rating was disappointing but reflected the scale and complexity of delivering sustained improvement across a large and diverse organisation, rather than an absence of learning or engagement with previous recommendations. I do feel that managing Covid-19 outbreaks which came with such high emotion, stress, and use of capacity took our attention away from managing improvements particularly through 2020 and 2021. The Trust's move from 'good' to 'outstanding' in the CQC caring domain represented a significant achievement. This upward shift indicated that improvements had been embedded since the previous inspection.

Assessment of risk

Strategic and Operational Risk Management

Board Assurance Framework and Strategic Risk Oversight

114. As an Executive Director and Board member, my role in monitoring strategic risk focused on ensuring that the Trust could achieve its long-term objectives safely, sustainably, and in line with regulatory expectations. Strategic risks were captured on the Board Assurance Framework ("**BAF**"), which was the mechanism we used to oversee principal risks to quality, patient safety, finance, workforce and regulatory compliance. Before every Board, the Risk and Assurance lead would meet with the Executive Directors on a one-to-one basis to update the BAF scores and actions relating to that Executive's Risks. I had oversight of Strategic Risk 2 (SR2) '*Inability to demonstrate compliance with and improvements to Standards and Safety of Care'*. Full details of SR2 is set out in the BAF from May 2021 [WITN0354067]. The Board monitored these risks with a regular review of the BAF at Board meetings and committees.

115. Operational risks were primarily managed at service and divisional levels by the managers, matrons, and general managers. These included risks such as staffing shortfalls, clinical incidents, or local environmental issues. Operational risks were recorded on divisional risk registers and escalated to the Trust-wide risk register, or BAF if they met agreed criteria for high-risk concern. The Executive Director of Nursing would not be sighted on operational risks unless they had the potential to escalate to strategic significance or impact patient safety at a broader scale. Escalation would come through the governance structures, risk Committee, quality committee or directly to the Board via an exception report.

116. The Executive Director of Nursing was also responsible for reviewing incidents, serious incidents, complaints, safeguarding issues, and clinical audit findings.

117. At each of the different Committees (i.e. Audit, Quality etc.), the BAF risks specific to that agenda were presented and discussed. For example, the Quality Committee would consider risks within BAF which fell under its agenda. The Committee would then agree if the risk scores set out in BAF reflected the discussions and reports presented during the meeting, or whether they needed to be updated.

Risk Management Policies and Board Oversight

118. The Board's and ELT's role in relation to risk management policies was one of oversight. Within the Trust, oversight was shared between the ELT and the board. The ELT held operational responsibility, we reviewed the policies, ensured they reflected statutory requirements and national guidance, and oversaw their implementation within the services. Changes to the policy arising from incidents, audits or external reviews were discussed at the ELT meetings before being recommended for approval. Risk management policies and strategies were developed, managed and updated by the Head of Corporate Governance. The Trust had a five-year strategy for risk management in the "Risk Management Strategy 2021 – 2026" [WITN0354068] and [CQCM0023094]. In October 2020 the Trust started a Risk Committee chaired by the CEO that reviewed: significant risks, outstanding audit recommendations, BAF, risk scoring, risk management policy and strategy, and reviewed the divisional risk registers. I have Exhibited to this statement, by way of example, papers from the Risk Committee meeting of 22 February 2021 [WITN0354069].

119. All Board members had a good understanding of the BAF; it featured in every committee meeting and every Board meeting. Board development sessions were held regularly to develop our approach to risk and our appetite for risk. The Board had many open discussions about the best way to present risk through the BAF, such as the level of detail, what constituted mitigations, and how committees could gain assurance not just reassurance.

120. I felt that I had a good understanding of the Trust's risk management approach. I understood that each ward had its own risks that escalated up to a divisional risk register, which was escalated into a Trust risk profile, which was reviewed on a regular basis. The committees were assured against key risks through the structured reports and assurance papers presented to them. These reports outlined the current risks, actions taken, and gaps requiring attention, allowing the committees to scrutinise the information and provide assurance upwards to the board. I would not have been involved in any localised risks or individual patient risks. I might have heard about a patient that was higher risk and that measures were being taken but that would be quite unusual and would have to be a high-profile patient or incident which had happened but generally the Executive Director of Nursing would not be involved in any individual patient risks, or even ward risks.

Board Training and Development on Risk

121. We had annual Board development sessions dedicated to the BAF, including what the Board's risk appetite was. We also had several development sessions throughout the year on the Board's role in assurance and strategic risks. We had annual training on the Board Assurance Framework, as set out in the Board Development Agendas [WITN0354070; WITN0354041]. The Head of Risk and Assurance would ensure that all new Non-Executive Directors and Executive Directors received training on the use of the BAF and risk register in the Trust. I received my training on 11 June 2020 [WITN0263046].

Effectiveness of the Board Assurance Framework

122. The purpose of the BAF was to help the Board have oversight of the Trust's strategic risks and to know there were systems of control in place to manage them. It was linked to our strategic objectives around high quality care and patient safety. The risks highlighted in the BAF were those that might threaten the achievement of our strategic objectives. The BAF is also used to inform our regulators that we understand our risks, and we are taking appropriate actions.

123. I think that the BAF was an effective means of risk management. This was my fourth chief nurse post and my third within a mental health trust, and I had only ever worked with a BAF. I understand that it is a required aspect of NHS organisations and was something that I was familiar with from my other roles.

124. I do not recall anything being raised to me in relation to the way strategic risk was assessed and managed at the Trust, but I do recall more operational risks that arose within wards, community teams, services, or directorates being raised. For example:

    i. I recall the coroner stating she had some concerns about how we had risk assessed our patients and the coroner had issued a Prevention of Future Deaths ("**PFD**") report (although I cannot recall which patients this was in relation to, or what the specific actions were). I have seen some minutes of the Learning Forum in November 2021 I chaired where we had a presentation on learning from inquests and PFDs [WITN0354071]. This included feedback from the coroner around risk assessments (pages 6-7). On 22 November 2022 I presented a paper to Board regarding 'Learning from inquests' in which I drew attention to risk assessments identified as an issue by the coroner [

NHNB0012321].

ii. We also had risks escalated to ELT in relation to the Trust's estate. I remember in late 2022 I had to have some difficult conversations with the CEO of Bassetlaw Teaching Hospitals NHS Foundation Trust, in relation to our patients residing in Bassetlaw Hospital where there was Reinforced Autoclaved Aerated Concrete (RAAC) issues. We had to assess the potential risk to our patients associated with RAAC, and whether we could move them to the recently acquired Sherwood Oaks site, which was not yet ready to admit patients.

iii. During 2021 concerns about our patients residing at the Priory Hospital East Midlands was raised with ELT from the Executive Director of Operations. We continued to discuss our concerns about our patients with the senior leadership team there and received a degree of assurance that our concerns would be addressed. I recall we as a Trust discussed these concerns in the board and agreed to reduce the reliance on subcontracted beds through the purchase of Sherwood Oaks.

125. The November 2022 CQC report acknowledged that the Trust had formally reviewed and updated the governance and risk-management framework, including the risk register and Board Assurance Framework. However, the CQC did find that governance improvements had not been consistently embedded within the services. At ward level and service level, essential safety systems such as alarms were not in place, and mandatory training and clinical supervision fell below required levels.

Audit and Risk committees

126. I have familiarised myself with the Terms of Reference for the Audit Committee, and latterly the Audit and Risk Committee [CQCM0027255; WITN0354029]. The Committee provided independent assurance to the Board about the effectiveness of the Trust's governance, risk management, and internal controls. It reviewed the BAF which is how the Trust linked its strategic objectives to its biggest risks, to check we had controls and mitigations in place. It worked in coordination with the Risk Committee that looked at the operational detailed risk issues. It is important to note that the "Risk Committee" is the one suggested by the Grant Thornton review (see paragraph [56] above) and was not a

Board committee in the same sense that the Audit Committee was, for example. It dealt much more with operation risks across the Trust.

127. The Medical Director and I were attendees of the Audit Committee and latterly the Audit and Risk Committee, but we were not members of the committee. I can confirm that I attended during 2020 and 2021. The membership of the Committee was confined to Non-Executive Directors (excluding the Chair of the Trust) and was comprised of four named Non-Executive Directors. The Chair in 2020/2021 and 2021/2022 was Stephen Jackson and in 2022/2023 was Sue Sunderland.

128. The Audit / Audit and Risk Committee does not draft risk management policies. That responsibility rests with the Risk and Assurance Lead. Instead, the committee reviews the risk management policies drafted by the Risk and Assurance Lead, to provide independent assurance (as it is confined to Non-Executive Directors) to the Board that risk policies and strategies are appropriate, comprehensive and effectively implemented.

129. The Audit / Audit and Risk committee does not directly manage or assess individual clinical risk. That is the responsibility of clinicians, ward managers or divisional leads. There would be clinical audits which would come up to the audit committee, but that would be Trust-wide audits, such as an infection control audit or a medical device audit or audits of incident review processes. These types of audits were done by our internal auditors during this time they were called 360. The committee would not see any ward risk assessments or ward clinical audits, other than those such as hand washing in Covid-19 or anything to do with cleaning these were bought through the infection prevention and control meeting that then went to the quality operational group.

130. In 2022 we introduced a clinical audit recording platform called AMaT (Audit management and tracking). I have exhibited to this statement a presentation providing an overview of the platform [WITN0354072]. It is a cloud-based governance system which supports clinical audit, quality improvement, compliance and other governance activities. We did this because it was very difficult to monitor progress against actions resulting from audits and inspections. This enabled everything to be in one place and could be viewed by anyone with access, and it was up to date.

Serious incidents and learning from deaths

Management of Significant/Serious Incidents

131. All serious incidents reported within the Trust were managed under Trust policies and the national guidance of the Serious Incident Framework 2015 [NHSE0000058]. Page 8 of the Trust's policy 15.02 "Managing Serious Incidents (SI) and Reporting and Learning from Deaths" which was in force throughout my time at the Trust sets out the "serious incidents requiring investigation process" [NHFT0016452]. The Trust reported all incidents using an Incident Reporting Form (IR1) which was then followed up by an Incident Reporting Manager (IR2). This was stored in a system called Ulysses. Ulysses is an incident reporting system which enables recording, tracking, management, and analysis of various incidents to improve patient and staff safety and support quality improvement. From November 2020 all reported incidents were reviewed by the Trust-wide Patient Safety Team. Prior to this they were managed by the divisions themselves. I am unclear how that process worked, which is one of the reasons we changed the process for all incidents to be reviewed by the Trust wide Patient Safety Team. This team would check the cause of risk and correctness of risk rating and appropriate escalation to other specialist teams within the Trust, such as safeguarding, infection prevention and control (IPC), and tissue viability. The cause of a serious incident might include clinical care issues, medication errors, patient safety, and staffing levels. By giving a serious incident a cause, we could then look at trends, systemic issues or recurring themes.

132. In 2021-22 we had 57,101 incidents. That equates to approximately:

- 4,758 incidents per month
- 1,098 per week
- 157 incidents per day (everyday, regardless of weekends/Bank Holidays)

133. NHS England collect data on serious incidents from all trusts through the strategic executive information system (StEIS). This allows for benchmarking against national or regional averages, showing how a trust's number and type of SIs compare to others. I cannot recall how the Trust compared to other trusts at the time.

134. Most incidents reported (52%) were recorded as no harm, an additional 37% were recorded as Minor or Low harm and 2% of incidents were near misses, as set out in the Patient Safety – Annual Report 2021 – 2022 [WITN0354073]. On a weekly basis, the SIRG (which the Executive Director of Nursing was a member) met to discuss the most serious of incidents either in terms of outcome for the individual involved, or where there might be reputational issues involved. A Serious Incident (SI) is defined in the NHS England Serious Incident Framework. In broad terms, serious incidents are events in

health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response [page 12 of NHSE0000058].

135. There is a wide multidisciplinary group in attendance at SIRG, including: the Executive Director of Nursing, AHPs and Quality, the Deputy Director of Nursing, the Associate Director of Quality, the Associate Directors of Nursing, and representatives from HR, Safeguarding, Commissioners, and Patient Safety. SIRG reviews the incidents and agrees where further investigation is required, or further operational actions are identified, as set out in the Terms of Reference for SIRG [WITN0354074].

136. The Quality Committee became aware of serious incidents through regular reports provided by the Safety Team, for example the Patient Safety Report (including Duty of Candour) which I presented to the Quality & Mental Health Legislation Committee on 16 December 2021 [WITN0354075]. This report shows the type of information the committee would receive regularly, including: numbers of incidents, nature of incidents, comprehensive investigations, and the learning arising (both as themes and for each individual incident). This paper also describes the developments that were taking place in the Trust around safety. Appendix 3 to that report shows all the completed investigations with the learning for each incident. Reports came from the divisions into the Quality Operational Group and were then summarised for the Committee.

137. The Board received a reportable issues log at every Board meeting. This log provided a structured way to ensure that significant matters were brought to the Board's attention, monitored for action, and managed appropriately through the Trust's governance framework. I have exhibited the reportable issues log, which I presented to the Board's private meeting on 1 June 2021, by way of example [NHFT0007053].

138. As well as the "Managing Serious Incidents (SI) and Reporting and Learning from Deaths Policy", as referred to in paragraph [131] above [NHFT0016452], the Trust had a "Reporting Of Accidents, Incidents And Near Miss Situations" policy that set out at page 16 the grading and definitions of harm from patient safety incidents, from near-miss, to death [WITN0354076]. The Board would not receive the operational detail of each incident, as its focus would be to monitor the safety culture, learning, adequate staffing, thematic issues and compliance with the framework being used.

Monitoring and actioning recommendations from serious incidents

139. All three divisions had a Clinical Incident Review Creating a Learning Environment (CIRCLE) Group meeting ten times per year. This group has responsibility for overseeing their divisions' serious incident investigation reports, ensuring that actions were appropriate and to monitor implementation and learning. I have exhibited to this statement the Terms of Reference for CIRCLE [WITN0354077]. Individual Quality Improvement Plans were managed operationally through the individual Directorate management team. The Board received reports on themes, trends and learning. I am aware that the Adult Mental Health division started a multi professional meeting on Fridays to sign off and approve serious incident reports. I was not a member of this but was aware it was happening.

140. Whilst I did not attend the Learning from Deaths Group as this was the role of the Medical Director, I am aware through the Patient Safety Annual Report of 2021/2022 [WITN0354073] that there was a meeting established for "Quality Oversight and Approval of Death related Serious Incidents Investigations". Attendance was:

    a. Associate Medical Director
    b. Deputy Director of Nursing
    c. Patient Safety Manager
    d. Deputy Head of Medico-Legal services
    e. Family Liaison Manager
    f. Trust wide Clinical Lead Suicide Prevention
    g. Head of Patient Safety

141. The report set out at page 15 that "*This group reviews all SI Investigations (Concise & Comprehensive) where they relate to the death of a patient. The group's remit is to review the overall quality of the report, examine family engagement, ensure the recommendations and resulting Quality Improvement Plans (QIP) are fit for purpose and where required feedback to investigators for appropriate amendments*". There was a mortality surveillance and learning from death report that came to the Learning from Deaths Forum then to Quality Committee and then to Board. This report would provide assurance to the Board and public that the Trust was reporting, reviewing, and learning from deaths as required by the National Quality Board: Learning from Deaths guidance, published in March 2017 [DHSC0000090]. I have exhibited to this statement some examples of this report: Learning from Deaths and Mortality Surveillance – Q1 2020/21

[NHFT0001184], and Mortality Surveillance and Learning from Deaths Report presented to the Board by the Medical Director on 23 May 2023 [WITN0354078].

142. Monitoring of the recommendations within these reports occurred within the divisions.

143. All incidents including near misses were logged onto a system called Ulysses. This ensured consistent data capture across clinical areas. Incidents were then coded into type, location, severity and contributory factors. This allowed for thematic analysis of the incidents across the Trust. Ulysses enabled the Patient Safety Team to run monthly trend reports, identify themes, highlight increased activity in particular wards and compare incident patterns over time.

144. The Patient Safety Team produced a monthly learning lessons bulletin that went on to the Trust's internal intranet site for all staff. These bulletins were used by ward managers and service leads as part of their ward meeting discussions for learning. I have exhibited bulletins from February, August, and November 2022 by way of example [WITN0354079; WITN0354080; NHFT0009445].

145. The Trust did work to explore themes and recurring issues arising from serious incidents. We had regular reports to the Quality Committee. For example, "Patient Safety Report - Serious Incidents, Family Liaison, Duty of Candour Update – Quarter 3 & Quarter 4 2021-2022" [WITN0354081] that went to the Quality Mental Health Legislation Committee in June 2022 describing incidents, investigations, assurance in relation to the managements of serious untoward incidents and the learning from those incidents. We also used the Trust wide Learning Forum to explore learning, themes and trends. I have exhibited to this statement minutes from 30 Sept 2021 looking at a Thematic review of Autism deaths [WITN0354082] and from November 2021 looking at Learning and themes from Inquests and PFDs [WITN0354071].

146. Our Head of Inquest and Bereavement Support also produced a report on the themes and learning from inquests that went to the Learning from Deaths Group [WITN0354083; WITN0354084]. There was significant learning from inquests for the Trust, and we welcomed an open dialogue with the coroner who gave us constructive challenge and support. A report in October 2021 to the Learning from Deaths Group gave a detailed summary and learning from three PFDs the Trust had received [WITN0354085] and a further report from July 2022 set out the details of PFDs received by the Trust over the previous 12 months [WITN0354086].

147. Investigating and reviewing incidents started within the division. Once an incident occurred, the reporting member of staff would complete an IR1 form onto a system called Ulysses. This would then be viewed by a senior member of staff in the division to agree the severity and actions, who would then complete the IR2 part of the form. Once the IR2 is complete the Trust's Safety team would view the incident on Ulysses. If the incident was serious, it would be presented to SIRG [WITN0354074]. If the incident needed a concise or comprehensive investigation, the Patient Safety Team would liaise with the division to allocate an investigator. The investigator would then be given a deadline to complete the drafts for approval by the service manager or general manager. The report would then be reviewed by the division's CIRCLE group [WITN0354077] who may make comments, changes and agree final sign off.

148. The Patient Safety Team issued a monthly 'Learning Lessons' bulletin, disseminated widely and accessible via the Trust intranet. It summarised incidents and highlighted learning from across the organisation, with the aim of promoting trust-wide learning and improvement. I have exhibited to this statement bulletins from June and July 2021 and January and April 2023 by way of example [WITN0354088; WITN0354087; NHFT0009494, NHFT0009447].

149. In 2021 I started a Trust wide Learning Forum which I initially chaired and then handed over to the Associate Director of Quality Improvement. I have exhibited to this statement its Terms of Reference [NHFT0004109] and minutes of meetings from May and July 2021 [CQCM0024584; WITN0354089]. The themes, trends and learning from all these incidents would come up to the Learning Forum and the Quality Operational Group. If there were any deaths involved, those reports would be viewed by the Learning from Death Group first and then come to the Quality Operational Group. The Quality & Mental Health Legislation Committee would receive two separate reports, one called Patient Safety Report [WITN0354081], and one called Mortality Surveillance and Learning from Deaths report [NHFT0003863]. These reports were also presented to the Board of Directors. A violence and aggression report which gave the number of incidents and what actions were being taken was also produced for each of the Adult Mental Health Improvement Boards through 2020, 2021 and 2022, for example as shown at pages 18-19 of the AMH Improvement Board of 15 November 2021 [WITN0354042].

150. I found that the quality of serious incident reviews / reports was variable depending on who the author was. In 2020 these reports were investigated and signed off in the

division. Towards the end of 2020 when we changed the reporting structures into the Trust wide Patient Safety Team, we changed who would sign off comprehensive investigations. This would be either the Medical Director, the Executive Director of the Adult Mental Health division, the Executive Director of Nursing, or the Deputy Director of Nursing. This was to give more oversight of these serious incidents, into the ELT. All other serious incidents were signed off by the senior managers within the division. Following a discussion with the Medical Director, we agreed to fund bank investigators to support report writing. We also invested in additional training for authors. From April 2021 to May 2023, we had offered ten two-day Systems Based Serious Incident Investigation Training. These sessions proved very successful and were fully booked. As a result, across the Trust, 250 people from a range of disciplines received training on undertaking Systems Based Investigations. This also supported the method of investigation being rolled out as part of PSIRF (discussed further at paragraphs [153] - [160] below). All participants were provided with a suite of analysis tools and templates to assist with investigations of different types, such as serious incidents and Complaints. I feel that this training improved the quality of the reports. The increased oversight in the Mental Health division from the serious incident group set up to approve and sign off reports also improved the quality of reports.

151. The Medical Director, the Head of Medico-Legal, and I met with the coroner to understand what she would like to see in the investigation reports and how they could be improved. In 2020 and 2021 there were three PFD reports from the coroner to the Trust. All three of these were responded to with the coroner having reported that the Trust's responses provided adequate assurance to close those cases. Implementation was monitored through the Learning from Deaths Group and Quality Operational Group. Family liaison is a crucial part of any incident or investigation, and it is imperative that the Patient/Family voice is both heard and represented within investigations. As part of the serious incident training, to support this, we established a Family Liaison Team who had been operational since the end of March 2022.The investment into developing this team was crucial and made a big difference in the quality of the reports. The coroner commented that she has seen an improvement in the reports since the family liaison team had come into post.

152. In 2022 the mental health division introduced a new meeting specifically to review the quality of serious incident investigation reports and to sign them off. Once these reports

started coming through to the Trust safety team there was a noticeable improvement in the quality of reports.

PSIRF

153. I am aware that in September 2022, NHS England introduced the Patient Safety Incident Response Framework ("**PSIRF**"), and NHS England stated that "Organisations *are expected to transition to PSIRF within 12 months of its publication, and transition should be completed by Autumn 2023*" [NHSE0000054, page 4].

154. Prior to NHS England launching the PSIRF framework in September 2022, the Trust held a Board development session on the 23 November 2021, [WITN0354094] where the Associate Director of Quality and the Trust's Patient Safety Lead led a discussion and workshop on patient safety. This session was in response to a letter dated 26 August 2021 from the National Director for Patient Safety in England (NHS England and NHS Improvement) [NHNB0004339]. In this letter all trusts were asked to nominate a patient safety specialist in the Trust and that within six months of receiving the letter the patient safety specialist was to have a direct discussion with the Board about expectations and responsibilities in patient safety. This session as I recall was well received and the Board were assured of the specialist role within the Trust.

155. Also prior to NHS England's launch of the new framework, on 3 August 2022 I presented a briefing for ELT on PSIRF [WITN0354090]. This paper brought to the attention of ELT what was expected and the plan going forward. Our patient safety specialist attended the patient safety specialist steering group for the Integrated Care System ("**ICS**") as well as the National Patient safety specialist meetings.

156. In October 2022 the Head of Patient Safety presented a paper to the Quality Operational Group outlining the new framework and how the Trust was going to implement this new framework [NHFT0015999]. At this time, I was the interim CEO and therefore the work on the introduction of PSIRF was overseen by the interim Executive Director of Nursing. The October 2022 paper outlined how the Trust was actively working with colleagues across the ICB and other Commissioners of our services, as part of the system Patient Safety Specialist Steering Group. Part of the work of that group was to adopt where possible a co-ordinated approach across all providers to the transition to PSIRF.

157. From this point on we were also starting to learn from the early adopter sites across England. The ICB's responsibilities in supporting trusts to implement PSIRF are set out

in the attached Midlands Quality and Safety newsletter from September 2022 [WITN0354091]. This included a requirement for the ICBs to collaborate with their providers in the development, maintenance and review of provider patient safety incident response policies and plans, oversee and support effectiveness of systems to achieve improvement following patient safety incidents, support co-ordination of cross-system learning responses and share insights and information across organisations/services to improve safety.

158. As per the October 2022 paper, the Patient Safety Team were working to implement the project plan which would take us through to October 2023. Whilst I was the interim CEO at this time, I am aware that from reading further minutes, that in November 2022 the Head of Patient Safety presented to the Learning Forum papers outlining the plan and timescales for implementation of PSIRF in the Trust, with oversight from the ICB [WITN0354092; WITN0354093].

159. The Family Liaison Team were also working to advise and guide in relation to the parallel programme of work "Engaging and involving Patients, Families and Staff following a patient safety incident". The Quality Operational Group became the Trust wide group which had operational oversight for the implementation of PSIRF. Capacity in the Patient Safety Team during 2022 was an issue and as such a business case to recruit a deputy Associate Director of Quality was developed and approved. This post was recruited to and started in early 2023.

160. The implementation of PSIRF was the responsibility of the Executive Director of Nursing. From September 2022 until her departure in April 2023, this was the interim Executive Director of Nursing, Tabetha Darmon. This responsibility then moved back to me from May 2023 until I finished on 14 June 2023. This was a difficult time with a lot of senior staff transitioning into different roles, sickness and retiring: the Associate Director of Quality retired on 31 May 2023; the new Deputy Associate Director of Quality started in February 2023; the patient safety specialist was off sick for the month of June 2023; the interim Executive Director of Nursing left for a chief nurse post on 13 April 2023; and I retired on 14 June 2023. Progress would have been closely monitored through regular verbal updates from the Patient Safety Team.

161. Following discussions with the ICS, it was agreed that providers in the system could work to a 12–18-month implementation timescale from when the framework was launched in September 2022. We had implemented several actions that would

contribute to our implementation such as, additional training for investigators, informing the quality committee and board of the new framework and the changes they could expect to see, we had delivered several presentations to staff informing them of the new framework, and we had started work on the patient safety policy. From January 2023 to June 2023 the Trust was expected to have the following in place: governance and quality monitoring, patient safety incident response planning and curation and agreement of the patient safety incident response policy and plan. These were all being developed and implemented within the Patient Safety Team with support from the senior leads in the divisions.

Volume of Serious Incidents and PFD Reports

162. In early 2023, there was a growing volume of serious incidents and PFD Reports issued by the coroner in relation to the Trust. I remember verbally raising the concerns to ELT, explaining the backlog of investigations, lack of report writers, capacity within the teams and the Patient Safety Team (see page 3 of the Notes of ELT on 10 May 2023 [WITN0354095]. We had an in-depth discussion. It was a challenging conversation as finances were tight, and no additional funding was available for patient safety. That same day I fed back via email what I had raised and the response and suggestions from ELT to my senior team [WITN0354096].

163. The CEO was supportive and said I needed to present the case to the TMG. I presented the report "Inquest Team and Serious Incident Resource" to the TMG on 17 May 2023 [WITN0354097]. It was agreed that capacity to support the Trust wide Patient Safety Team would have to be found from existing staff in the Trust.

Incidents of Serious Violence

164. Trusts do not automatically receive information if a former patient commits a serious violent act. It is important to note that a patient committing a serious violent act is not necessarily related to or caused by their mental illness. We typically became aware through multi-agency notifications from the police probation, or safeguarding bodies, or through formal reviews such as domestic homicide reviews. Occasionally such incidents may come to the attention via media reports, after which the Trust may undertake checks and reviews as appropriate.

165. In terms of incidents of serious violence involving patients or former patients of the Trust, we had the incident reporting to SIRG so the ELT would become aware if there had been

a serious incident involving patients currently in our care. If the patient was no longer in our care, we may find out via street triage, if they are notified through attending with the police, and Liaison and Diversion who get referrals from police custody and would have access to patients' records. If a former patient is involved in a serious crime, the police may notify the Trust if they consider there are safeguarding concerns. They also see many people in the police cells with vulnerabilities which could pick this up.

166. Occasionally the family may directly contact the service the patient used to belong to.

167. As part of the Adult Mental Health Improvement Board, we explored incidents of a violent nature from patients in our care. The report from 15 November 2021 (pages 18 – 19) gives a status report of the work that was being done [WITN0354042].

168. In cases involving a domestic homicide review, the safeguarding lead in the Trust would be approached by the Safeguarding lead from the Local Authority Adult or Children's team to provide information pertinent to the review. This could also be a multi-agency safeguarding (MASH) coordinator designated to lead the domestic homicide review.

169. I am not aware of any policies or procedures to deal with former patients in such incidents, if we were asked to investigate by the coroner or safeguarding board we would follow our serious incident policy.

170. Who in the Trust would be made aware of such an incident would be dependent on whether the patient was still in our care or no longer in our service. If the incident occurred on our premises, we would get to know from security through to the service manager for that estate. If it was a really serious incident involving one of our patients on the ward or in the community then the gold on call would know, but otherwise it would be managed at bronze and silver level. The ward or community team where the incident has occurred would ring the on-call manager immediately. This could also be done via a bleep system where the on-call manager receives a notification on their bleep to ring a ward. The on-call manager who is called Bronze on-call will then notify the Silver on-call who is normally someone covering the whole Trust. This would then come to the Gold on-call who would be an executive. If the patient is no longer in our care the service manager for that division may be informed, by our partners such as the police, local authority, ICB, and other care providers making contact. This would be reliant on someone contacting us. We would often be asked to provide a chronology, i.e. a detailed timeline of events compiled to support an investigation being conducted by an external

agency. It records when specific actions or decisions took place, by whom, and in what context, helping investigators understand the sequence and interrelation of events.

171. If the patient was no longer in our care, we would not investigate, but we may be asked by another provider like the police, local authority, or GP practice for information to populate their investigation. If the patient had recently been discharged (within 6 months) we would initiate an investigation or support another provider with their investigation. Occasionally the coroner requested the Trust to conduct investigations concerning matters that fell outside the patient's period of inpatient care.

172. If we conducted our own investigation, we would have learning outlined in the report and at the division's CIRCLE meetings. If the patient was no longer in our care, but we had provided a chronology or information relevant to another agency's investigation, we might be sent the report. We did receive notification of incidents from NHS England that had occurred in other mental health trusts, if there was learning across the NHS. These were disseminated in our reports and Learning bulletin that went out to all staff. For example, pages 12 and 13 of "Patient Safety Report - Serious Incidents, Family Liaison, Duty of Candour Update – Quarter 3 & Quarter 4 2021-2022" presented to the Quality & Mental Health Legislation Committee on 14 June 2022 sets out learning from National incidents [WITN0354081].

2 March 2021 Board meeting

173. At the Board meeting on 2 March 2021, I presented a serious incident investigation report concerning the death of a patient at GRO-D [NHFT0003044 pp.14-16] [NHFT0004299 pp. 4-7], which had previously been reported to the Board via the Reportable Issues Log of January 2020 [WITN0354122]. The investigation report was presented over a year after the incident because if the police were involved, the Trust cannot start or conduct its own investigation until the police let us know we can. In the cases of suspected homicide or suspicious death, the police are responsible for the criminal investigation. If the Trust starts its own investigation immediately it may disturb or contaminate evidence. This is why they were sometimes delayed. I started working for the Trust on 20 January 2020, shortly after this incident occurred. Once I had finished my induction to the Trust, I commissioned an external company (SANCUS) to do the investigation and report writing. I felt the incident required a level of independent scrutiny and capacity that we were unable to give at the time. We were also unable to receive a cause of death from the coroner for some considerable

time and when I presented the SANCUS report to Board in March 2021, we still did not have a cause of death from the coroner. The Pre-Inquest Review Hearings were on 19 May 2023, and I have been made aware that there were further hearings since I retired: one on 23 June 2023, with the Inquest on the 17 July 2023.

174. I have been made aware from the Trust that these recommendations were signed off and closed at the divisions CIRCLE meeting on 12 September 2023, after I retired from the Trust.

Reportable Issues Log

175. The Reportable issues log was a high-level description of any incidents deemed as medium to high level risk that the Board should be made aware of that had occurred since the last Board meeting. The Executive Director of Nursing role was to read the paper before it went to the Board and approve its content. They would then be responsible for presenting the content to the Board. They would also let the Chair of the Quality & Mental Health Legislation Committee know if there were any incidents on the log that she should be aware of and that we may need to consider further discussion at the committee.

176. I do not know when the reportable issues log was first introduced and why, but it was in place when I started in January 2020. I feel it was a good way for the Board to know of any serious incidents. The Non-Executive Directors would often ask clarifying questions related to the content of the reportable issues log.

4 May 2021 Board meeting

177. At the Board meeting on 4 May 2021, I presented the Reportable Issues Log [NHFT0003414 pp.5-8] [NHFT0004299 pp.8-11], which included an incident involving a patient GRO-C GRO-C GRO-D GRO-D Questions were raised in the meeting about the appropriateness of this discharge, but this was defended. The patient was being GRO-D GRO-D Therefore, I did not see this as being discharged from Trust services. My reflection would be that if the patient was not being monitored and reviewed by community teams then this would be a concern. I was not aware if the patient was on a CTO. Having read the minutes of the Board meeting I can see that the Medical Director responded to the questions at Board and was familiar with the case. I

understand that she had chaired the meetings relevant to their discharge. I was not personally familiar with this patient, so I worked closely with colleagues who had direct knowledge of their care and treatment to ensure the Board received accurate and comprehensive information. Given that this was a case where there was a history of violence and I am now aware that Valdo Calocane ("**VC**") had a history of violence (although I was not aware of VC at any point whilst I was at the Trust), I can see how parallels might be drawn, but I do not have enough knowledge of either case to make comparisons.

Incidents involving patients other than VC

178. The Inquiry has asked for my recollections in relation to a list of individuals who were under the care of the Trust at the time of, or shortly before committing serious acts of violence.

179. Having reviewed these cases I can see that a few of them were reported on and completed after I left the Trust on the 14 June 2023. I am unable to comment in detail on matters after I left the Trust.

    a. **Patient GRO-B who repeatedly GRO-C had been GRO-D and the incident was reported on StEIS [August 2021 Reportable Issues Log, NHFT0004539, pg. 10]**: I do not know when I was made aware and by whom, but this would be something that I would be made aware of through the SIRG if I had attended. I took this case to the ELT on 28 July 2021. I reported it to the Private Board meeting on 3 August 2021 as part of the reportable issues log [NHFT0004539]. This was a concise investigation report which means it did not come to a committee or board as a full report. I cannot remember why this was a concise and not a comprehensive investigation, but it may have been as part of the derogations allowed by the ICB. It was discussed within the division's CIRCLE meeting and was signed off by the general manager on 28 June 2022 and the Head of Nursing on 4 July 2022. There is a quality improvement plan attached as part of the learning and recommendations for change [WITN0354098].

    b. **A patient GRO-C. They were an inpatient at GRO-D immediately prior to the incident [NHFT0004539, pg. 10]:** I do not know when I became aware of this incident and by whom. This came to SIRG on 25 May 2021, I took it to ELT on 28 July 2021. I cannot remember what

discussion took place as part of me informing the ELT. I reported it to the Private Board meeting on 3 August 2021 [NHFT0004539]. The final report was completed on 5 May 2022 signed off by the Deputy Director of Nursing [NHFT0012101]. I cannot recall when and if this was discussed at committee or Board.

c. **GRO-B, who fatally stabbed GRO-C 2022. GRO-B was known to Liaison Psychiatry but had not been seen or assessed because GRO-D discharged:** I became aware of this incident at SIRG on 16 August 2022 and I have exhibited to this statement my handwritten notes from attending SIRG [WITN0354015]. I cannot remember telling ELT, but I have become aware from ELT notes that they were informed on 31 August 2022. This case was then presented to the private board on 6 September 2022 by the interim Executive Director of Nursing. The internal investigation was considerably delayed due to the police investigation and was completed after I had left the Trust.

d. **GRO-B also known as GRO-B who stabbed GRO-C strangers in GRO-C 2023 GRO-C was under the care of the EIP team GRO-D at the time of his offences**: I do not know when and if I became aware of this incident and who I reported it to. This is something I would have expected to know about. If I was unable to attend SIRG I would expect this to be escalated through to Executive Directors from the Patient Safety Team or the Clinical divisional senior team. A briefing went to ELT on the 16 February 2023, the incident was added to the StEIS system on the 22 February 2023, the Individual management review (IMR) was completed on the 24 February 2023. I am aware this was presented in the reportable issues log to the 30 March 2023 private board by the interim Executive Director of Nursing. I was not present at board that day. I am unable to say what happened to the report and follow up actions after I left the Trust. All serious incident reports of this nature have to be sent to the ICB for them to approve and sign them off after we have completed. If the Trust needed longer to conduct investigations, we would have to seek approval for this from the ICB. In this case it was delayed due to the police investigation. The Trust sought an extension from the ICB on 8 August 2023 which they approved.

e. **GRO-B who stabbed a person GRO-C in GRO-C 2023. He was under the care of a hospital run by the Trust in GRO-D**

GRO-D

GRO-D The Trust became aware of this incident on 9 April 2023. I became aware of this on 18 April 2023, as set out in my handwritten notes from SIRG [WITN0354016]. I am aware that a Level 1 concise investigation was completed after I left the Trust. I am unable to comment on what happened after this.

f. **GRO-B, who GRO-C on GRO-C 2023 and attempted to stab a member of the public. GRO-B suffered a fatal stab wound during the attack. GRO-B had been discharged by the EIP team for City**: My last working day at the Trust was 14 June 2023, this happened after I had left so I was not aware of this incident.

180. I would expect these types of incidents in the first instance to come to SIRG, then be presented to the private part of the board in the reportable issues log. I am unable to say if any changes were made in the cases relating to GRO-B and GRO-B as the investigation reports were completed after I finished in the Trust. I have reviewed the reports for GRO-B and can see there were several areas for improvement and change made. In the case of GRO-B they identified the importance of interpreting services and learning was distributed to the Local Mental Health teams. They were also re-sent the CPA criteria and a follow up audit was completed. Pharmacy were asked to complete an audit to monitor compliance on medicine management. For GRO-B they have re-visited training on professional curiosity for the crisis resolution and home treatment team (CRHT). They have also nominated a safeguarding champion to attend events and link meetings. The think family approach was not being used properly so this has been discussed at the team meetings. They have reviewed the process for checking contact details and 7 day opt in letter. A briefing was done on understanding domestic abuse.

181. The Request states that the Theemis report [NHFT0000530] noted 15 incidents between 2019 and 2023 of patients under the care of the Trust or who had been discharged from the Trust perpetrating violence towards members of the public. The Inquiry has asked for my understanding of whether this number of incidents is expected, and how these incidents could have been prevented. Without knowing the numbers of patients being cared for and the specific circumstances of each incident, it is difficult to determine whether this number is higher or lower than might be expected. This was my third role

as Executive Director of Nursing in a mental health trust, and in my experience the number of incidents reported aligns with what might be anticipated in a complex mental health service. Each serious incident represents a learning opportunity, and the Trust has systems in place for reporting, thematic reviews, staff training, and risk management processes. Prevention needs to focus on patterns, addressing contributory factors, and implementing change to clinical practice, environmental safety, and organisational systems to reduce the likelihood or similar incidents occurring. The Theemis report was developed after I left the Trust, and I am unaware of which patients would have been submitted as evidence to the investigation team, so I am unable to comment on how these incidents could be prevented.

Staffing Levels and Outsourcing

Staffing Guidelines and Policies

182. The Trust had a policy in place called 'In-Patient Safe Staffing – Essential Guidance to Defining and Managing Nurse Staffing Resources". This was published in July 2020 [WITN0354099] and was updated in June 2021 [WITN0354100]. It followed NHS England publishing a 'National Quality Board (NQB) guidance titled 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time; safe, sustainable and productive staffing' July 2016 and an 'improvement resource for mental health' document developed by NHS Improvement on behalf of the National Quality Board (NQB) 2018 [NHSE0000145]. Each year the Trust's safer staffing matron produced an annual report that went to the Quality Committee, and I have Exhibited the 2021 – 2022 report to this statement [NHFT0011896].

183. As far as I am aware, the Trust followed the guidelines as set out in the Trust policy which followed the guidance set out by NHS England and National Quality Board. The safer staffing reports came to Quality Committee and Board regularly though the year.

Staffing Level Monitoring and Oversight

184. Patients may be affected by a shortage in staff in a variety of ways; they may have less access to activities, access to outdoor sessions, care plan updates, one to one conversations with staff, they may feel unsafe, and unable to attend external events including appointments.

185. Staff may be affected by a shortage in staff in many ways: feeling unsafe on the ward, not being able to deliver all the care and treatments they need to, not having time to take

a break, not being able to complete care plans and paperwork, not having time to read emails, not having time to read communication sent out, not having time to access supervision, not being able to complete training and development, and not being able to finish their shift on time which may then lead to their families being affected.

186. The Executive Director of Nursing has overall accountability for ensuring the Trust has systems to monitor that staffing levels are safe, risk assessed and reported to the Board, and ensuring that trends are reviewed in staffing, skill mix, and patient acuity to advise the board on risks or actions required.

187. The operational director responsibilities are implementing staffing and service delivery on a day-to-day basis, which includes allocating staff to clinical areas according to rosters, patient acuity, and service demand. Managing short term staffing gaps and operational pressures, ensuring ward managers and service leads follow agreed staffing policies and escalation procedures. Reporting operational staffing issues up to the safer staffing group and ELT.

188. Safer Staffing reports came to various committees and Boards across the Trust. A safer staffing report came to every Adult Mental Health Improvement Board in 2020, 2021 and 2022. For example, pages 50 –55 of the papers from the meeting on 15 November 2021 [WITN0354042] and pages 16 – 20 of the papers from the meeting on 16 May 2022 [WITN0354060].

189. The AMH Improvement Board also received regular updates on workforce. This included a workforce dashboard, recruitment activity, recruitment pipeline, workforce developments including new roles, and additional payments to encourage staff to stay and start, as set out in pages 21-25 of the papers from the meeting on 16 May 2022 [WITN0354060]

190. Twice a year, the Board received an establishment review report to provide assurance on staffing levels, skill mix and workforce sustainability [NHFT0015909].

191. The Quality Committee had an oversight and assurance role in relation to staffing levels. It was responsible for assuring the Board that staffing levels were safe, appropriate, and aligned to our patients' needs. The Quality Committee received regular staffing reports which were discussed and challenged by attendees. For example, the Safer Staffing Annual Report was presented to the Quality & Mental Health Legislation Committee on 13 October 2022 [NHFT0011896] and a Safer Staffing report was presented to the

Quality & Mental Health Legislation Committee on 4 April 2023 by the interim Executive Director of Nursing [WITN0354101]. The data included staffing ratios, skill mix, vacancy rates, use of bank and agency, and staff turnover. The role of the committee was then to assess if any staffing issues were affecting the quality of care or were increasing clinical risk.

Safer Staffing Meetings and Establishment Reviews

192. Whilst I did not attend the Safer Staffing meetings, I was aware of them as I had delegated the responsibility for chairing the meetings to the Deputy Director of Nursing. The Safer Staffing meetings started in 2020 and were still in place when I finished in 2023. I have since been made aware that they finished in 2024. The purpose of the meetings was to ensure that all clinical services had sufficient and appropriately skilled staff, enabled to deliver safe, effective, and sustainable care, were responsive and centered on the needs of patients and were delivered by caring, compassionate, highly skilled and valued staff.

193. For inpatient services, the focus was on those staff that take part in the 24hr rotational roster, to safely care for their patients and conduct all the tasks necessary to provide excellent care and ward management. For community services, this focus was on all staff who deliver care.

194. Where effective staffing had not been achieved, the group would check the local mechanisms that were put in place to escalate the issues in a timely and effective manner, and those short-term actions used. Where the issues were more systemic, or occurred frequently, the group would explore which alternate solutions should be put in place, initiate a formal Establishment Review, and escalate the issues to the ELT and the Board as appropriate. An establishment review is a formal assessment of staffing levels on a ward or service. It compares the actual staff employed with the number and skill mix required to provide safe, effective, and high-quality care. The review considers patient acuity, dependency, and risk, as well as professional standards and regulatory guidance. Its purpose is to ensure that wards are appropriately staffed to meet patient needs and to identify gaps where additional resources or adjustments are necessary. These reviews were done twice a year on all wards. They would be presented to the Quality Committee and then to Board. The safer staffing group was responsible for setting the formal schedule of Establishment Reviews required across the Trust. They reviewed the outcomes of each review and monitored the progress of any actions put in

place. In addition, the group would regularly review and update the Trust Wide Safer Staffing Policy every year and confirm the operational actions and structures put in place on each site to maintain compliance with it. I have exhibited to this statement policy number 01.18 relating to safer staffing from 2020, 2021, and 2022 [WITN0354099; WITN0354100; NHFT0011889].

195. The group would set Safer Staffing standards, which meet both the National Quality Board (NQB) (2016) expectations, the Developing Workforce Safeguards (NHS Improvement, 2018) [WITN0263087] recommendations, and CQC's Fundamental Standard. The CQC Fundamental standards come from the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. This is a statutory instrument that sets out all the CQC fundamental standards including staffing, which is Regulation 18.

196. The Establishment Review Process would set the budgeted establishment for in-patient areas, defining what the optimal staffing is, monitoring the dynamic staffing requirements across all Trust in-patient sites and identifying those wards that fail to deploy at least 80% of the required Care Hour per Patient Day.

197. In the main, staffing levels are agreed following a twice-yearly establishment review which determines how many staff are needed in each ward. On a daily basis, staff may be moved from one ward to another to support sickness, higher levels of acuity or the need for additional observations of the patient. These daily changes are managed by the ward managers and service managers.

198. I have re-read the minutes of the safer staffing reports to help recall actions that were taken. I am aware that before I started in the Trust there had been investment in staffing in the Mental Health division, permanent staffing was agreed and approved by the ELT, equating to a total investment of £2.177m. In early 2020, further establishment reviews were completed across all areas of the Trust. This identified that the establishments were not sufficient to care appropriately for the high levels of clinical acuity present through the patient populations. I presented a paper to Board on 6 October 2020 [WITN0354102]. Investment was given to these areas with nursing posts at Band 2 – 6 and, in many areas, a full review of the ward treatment and leadership models was completed. Several changes were made, a re-alignment of wards at Rampton to better reflect a patient pathway through acute admission, rehabilitation and pre discharge wards, doubling of Clinical Team Leader resource across Local Mental Health Services designed to enhance the leadership and clinical coaching available on every ward, and

releasing time for the Ward Managers to become focused on quality development, and become more clinically engaged within multi-disciplinary teams. As recruitment of new substantive staff would take some time, they also recruited regular bank staff to ward areas, with regular hours built into the base line roster, who knew the patients well, were consistent in their application of the procedures and infrastructure of the wards, and in return were well trained, supervised and supported.

199. A "Safer Staffing" report was presented to the Quality Committee on 28 January 2020, to provide "an update on the key areas for development deemed essential for providing safe staffing compliments across in-patient settings" [WITN0354103]. Following another establishment review in early 2021, a case was put forward to ELT for additional staff across adult Mental Health services, which was approved [NHFT0005079].

200. In June and July 2021, it was identified that several wards needed additional staff (we call this 'hot spots'). This was due to the increase in acuity of the patients and the need for increased observations of patients. The divisions responded by moving staff from areas of lower clinical acuity to areas of higher clinical acuity, using professional judgement. These in the main were rehabilitation / low dependency environments and were monitored via the Trust wide safer staffing group. These events were reflected in the Safer Staffing 6 Monthly Report which was presented to the Quality & Mental Health Legislation Committee on 12 August 2021 [WITN0354104]. On the 18 August 2021 the Executive Director for Mental Health services presented a paper to ELT on AMH staffing concerns. ELT acknowledged the contents and accepted the recommendations presented [WITN0354105]. On 3 November 2021 the Executive Director of Mental Health services presented an update to ELT on the paper she presented in August 2021 on AMH staffing concerns. The paper presented the actions that had taken place and what was still outstanding, with further recommendations [WITN0354106]. On 17 November 2021 the Executive Director of Mental Health Services presented a paper to ELT requested a recruitment and retention premia for Registered Mental Health Nurses due to shortages being experienced [WITN0354107].

201. In early 2022 the Mental Health Services for Older People wards undertook an establishment review which showed they needed an increase in staffing, this went to Board, where it was approved. This is reflected in the Safer Staffing Update which was presented to the Quality & Mental Health Legislation Committee on 15 February 2022 [WITN0354108].

202. Establishment reviews that showed additional staff were needed were followed up with business cases to ELT, Committees and Board. The Board approved several business cases to increase staffing establishments in the time I was at the Trust. During Covid-19 outbreaks, ward admissions were stopped until the ward was clear of Covid-19. This reduced the number of patients on the ward, which in turn meant staff could manage the patients they had.

203. During Covid-19, any clinical staff working in corporate services were asked to do a few days' clinical work, which increased staffing in all areas. Quality matrons were redeployed back into ward areas during any reduction in staffing.

204. ELT addressed any issues with recruitment and retention delays. Targets were set for turnaround from advert to new staff starting. Additional work was done to support staff to return to work quicker following any bouts of sickness including a new well-being offer.

205. I am unable to say whether the Trust had any targets or requirements for its adult mental health services capacity as it is an operational capacity question best addressed by the director of Adult Mental Health Services.

Causes of staffing problems

206. There is a chronic shortage of qualified mental health nurses nationally. Over the years, training pipelines have not kept up the demand, and recruitment takes years to take a positive effect. Many senior mental health nurses can retire if they have “MHO status” (an NHS pension benefit for some staff who worked in mental health pre-1995) and with Covid-19 we saw more people make the personal decision to take early retirement at 55 years of age. We see competition between trusts where some trusts will offer “golden hello’s” to entice staff to work for them. Staff will move to a role where the pay and conditions appear better. Some areas in the Trust have high risk or distressed patients which can be emotionally draining and higher risk to staff. I attended weekly regional Chief Nurse meetings where all Chief Nurses experienced problems with staffing. During Covid-19 we had many staff off with Covid-19 themselves, but this was an issue everywhere.

207. At times, the impact of Covid-19 on staffing levels was significant, placing substantial pressure on the workforce and the continuity of care. I remember some wards had nearly 40% of staff off sick at any given point. I started doing clinical shifts at Lings Bar to help with staffing levels but also to show staff not to be afraid to work with Covid-19 patients.

Responsibilities changed substantially during the Covid-19 period, requiring additional duties such as completing Infection Prevention and Control audits, hand washing audits, and procurement for PPE. If there was an outbreak, then they needed to attend daily meetings to give a situation report of their ward. Staffing concerns were also raised with the Freedom to Speak up Guardian who would alert the relevant Director of that division, for example pate 75 of the report to Board 1 June 2021 [TCLT0000398].

Service Capacity and Out of Area Placements

208. We discussed service capacity and staffing at each Adult Mental Health Improvement Board that ran from 2020 to 2021. The Director of Adult Mental Health Services stated in the 16 August 2021 meeting minutes '*JA advised it is a challenging time for the inpatient services, admissions are not abating' and 'due to daily pressures, we are still accessing sub-contract beds;*' [WITN0354042 page 4]. Having had the opportunity to review some of the minutes of ELT I recall a discussion about current numbers of patients waiting for assessment with a Local Mental Health Team (LMHT) and the level of internal waits within the LMHT Service, the Executive Director of Mental Health Services presented in July 2021. The ELT was asked to note actions being taken [WITN0354109]. A paper was also presented to board by the Executive Director of Mental Health services on waiting time position and plan in March 2022 [NHFT0003849, page 61].

209. On 25 August 2021, the Executive Director of Mental Health Services presented a paper to ELT proposing an update to the scenario modelling of the mental health bed requirements across the ICS including acute, PICU and rehabilitation beds [WITN0354110]. A further paper came to ELT presented by the Executive Director of Mental Health Services on the 29 September 2021 on 'current waits for Mental Health Services' [WITN0354111]. ELT were asked to note the content. Adult mental health services faced sustained capacity challenges, leading to periods of reduced local bed availability. During these times, out of area beds were used as the Trust's capacity management arrangements. I am aware from discussions we had at ELT that this would be either within the geographical footprint of Nottinghamshire (in area private provision) or outside Nottingham (out of area private provision). Out of Area beds can be geographically located anywhere in the country. The use of out of area beds was a common occurrence in mental health trusts, having seen this in two previous trusts I worked in.

210. Between 2019 and 2023, to meet population need and improve access to appropriate care within patients' usual communities (as opposed to out of area beds), the Trust increased its subcontracted acute mental health bed provision from 21 to 59 (increase of 38 inpatient mental health beds) within Nottingham and Nottinghamshire. This provision was inclusive of 49 mixed sex acute mental health beds and 10 female Psychiatric Intensive Care Unit beds.

211. Improving our own bed capacity was one of the main reasons the Trust purchased Sherwood Oaks, which opened towards the end of 2022. This helped with bed capacity as well as reducing the use of dormitories across the Trust. The CQC consistently highlighted concerns about the use of dormitory accommodation in its inspections of the Trust, noting that it did not meet the modern standards for privacy, dignity, or safety. Patients experience calmer, safer, and more person-centred care when dormitories are removed

Risks and disadvantages

212. In January 2022 ELT introduced a new commissioning committee to provide strengthened oversight of all subcontracted provision and out of area placements. The committee had delegated authority from the Board and reported its activities to the Board. Its purpose was to ensure robust governance, consistent quality monitoring, and appropriate financial and clinical scrutiny of these commissioned beds. This committee was chaired by one of the Non-Executive Directors. I have exhibited to this statement the committee's Terms of Reference [WITN0354112], and papers from meetings on 25 March 2022 and 4 July 2022 [NHFT0005270, WITN0354113]. Pages 29 to 30 of the March 2022 papers demonstrate the upward reporting in respect of quality to the committee.

213. There are some risks and disadvantages to placing patients in out of area beds. These are clinical, ethical, and operational. There is a disruption to the continuity of care for the team that looks after the patient. If they are moved far, it can be hard for family and friends to visit. Different trusts use different clinical systems, risk protocols, and care planning. Being sent to a trust further away can feel frightening for patients, increasing their distress and anxiety. It may also delay discharge. Private providers do typically cost more, and this can affect the Trust's finances. Operationally this can be consuming on staff time managing contracts, and travel for reviews. Managing incidents can be complicated as to whose responsibility it is to do the investigations and liaise with

coroners. There was additional scrutiny and pressure from NHS England whilst we had patients in out of area beds, which came in the form of upward reporting to NHS England., Monthly and sometimes weekly submissions were monitored nationally as part of the drive to eliminate out of area placements, and high or persistent numbers triggered increased oversight or performance conversations with the regional NHS teams. The CQC examines the use of out of area beds as an indicator of service capacity and system pressure. Inspectors reviewed our out of area affected patients' safety, continuity of care, and access to therapeutic interventions. Out of area data was also reported through the IQPR at each Board meeting. The Board did scrutinise trends, causes, length of stay, financial impact, and associated risks to quality and safety.

214. I am aware that in 2020 and 2021, Adult Mental Health had a good process of monthly oversight meetings and separate contract and performance meetings for the out of area and sub-contracted beds. In cases where patients' safety needs do not allow admission to a specific unit and an admission to another unit was required, - wherever possible the patient would be prioritised for repatriation to their local inpatient unit within 7 days.

215. In December 2021, the Trust appointed a Clinical Quality Lead for subcontracted services who was responsible for ensuring that the care being delivered within subcontracted services meets quality standards. This did improve our oversight of these patients and the care they were receiving. I have exhibited to this statement their job description [WITN0354114].

216. The Bed Management Team and Out of Area Bed Co-ordinator supported the prioritisation of patients for repatriation to inpatient wards closer to their usual place of residence.

217. I am aware that the Adult Mental Health division held Daily Demand Meetings which provided an escalation pathway to monitor and explore any concerns, complaints or distress that may arise secondary to being in an out of area placement. Repatriation of patients back to their local area was monitored during this meeting as part of the assessment of overall daily capacity and flow. This included patients in an out of area A & E who were awaiting an inpatient bed. The Out of Area Bed Co-ordinator is responsible for actioning these plans and liaising with out of area providers and maintaining the patient's electronic record.

218. The in-area independent sector provision was provided by the Priory Group in 2019-2023. There was a subcontract arrangement in place, with subcontracted beds as an extension of the Trust's inpatient bed provision and were all classified as 'in area' beds.

219. Contract review meetings took place on a quarterly basis to ensure contractual compliance and oversight on the quality and performance of the service provision. Monthly operational meetings were scheduled to identify any service delivery issues, focusing on patient safety, incidents, safeguarding and complaints or compliments. Any subsequent issues were escalated up through the contract review meeting process. Priory Group were able to access patient records (on a read-only basis), and the Trust's services were able to directly refer patients to the hospital rather than via Priory Group's central referral system. Announced and un-announced quality visits also took place on a quarterly basis.

220. This changed over time with less reliance on subcontracted beds especially when we opened Sherwood Oaks at the end of 2022.

221. I can recall many conversations about the Trust's use of Out of Area beds at the Adult Mental Health Improvement Board meetings, for example at pages 45 – 48 of the papers for the meeting on 15 November 2021 [WITN0354042]. We also discussed this at ELT and Board. An example of this is from the public Board minutes of 5 April 2022, page 16, published at the 3 May 2022 Board [WITN0354115]. Here, one of the Non-Executive Directors commented on the '*overreliance of the independent sector in this area with the most complex, challenging patients who were being managed in the independent sector and how the Trust would get into the collaborative space, making sure the pathway for patients worked*'.

222. This is something we would always try and avoid, but if we did not have beds available then we would use beds commissioned from external providers. This was very commonly done in Mental Health Services. I am not aware of this being done due to staffing shortages; it was mainly done when we did not have a bed available. We regularly reviewed the numbers that were Out of Area at ELT and Board. The coroner also raised concerns about our oversight of these patients. This was recorded in notes from 31 March 2022 [WITN0354116]. We recruited a dedicated Quality Lead for our out of area patients. This role was new and needed to address any concerns we may have directly with the provider. This lead supported audits, meetings, and wrote reports back to the Quality Operational Group, which then went to the Quality Committee, for example

a Quality Standards Review Feedback Summary report on Priory Hospital Arnold (Bestwood Ward) in March 2022 [WITN0354117]. Shortly after this the Quality Lead for sub-contracted beds produced a paper providing an overview of some of the Trust's external providers [WITN0354118].

223. Adult Mental Health senior managers met with the Priory regularly but once the CQC gave them an inadequate rating, the Medical Director and I were asked to start meeting them as well. The Executive Director of Adult Mental Health, the Medical Director, and I started face to face discussions at the Priory in April 2022. We were concerned about using the Priory beds at this time, and so the Trust put plans in place to move those patients that were there as soon as possible. I was aware through Board minutes (NHFT0003414) of concerns raised by the Non-Executive Directors about a discharge from inpatients to community services of a patient. I can see from the document that the Medical Director and Operational Director answered the concerns around the risks and what was put into place for the patient to be sent into community services. I cannot recall any other discussions relating to inappropriate or premature discharge from our services.

224. I can recall one issue being raised directly with me regarding family involvement. A mother wrote directly to me when I was acting as interim CEO (late 2022); she was really concerned about her son who was serving a custodial sentence. She felt that CAMHS services had not listened to her when her son was accessing their services before he was sentenced. I invited her to come and meet with me. I listened to her and then put her in touch with CAMHS services. She wrote to me afterwards and thanked me for listening and putting her in touch with services. I have exhibited my handwritten notes of this meeting [WITN0354007].

225. I can recall the coroner having some issues with family involvement. She formally raised this as a concern in at least 5 inquests and, in most cases where this was not specifically cited in the findings and conclusions, it was referenced as being less than adequate, and I have exhibited the notes and actions from this meeting in December 2021 [NHFT0005259].

226. We had used the Learning Forum in November 2021 to explore how we can improve our approach to family involvement, as set out at page 7 of the minutes from that meeting [WITN0354071]. The introduction of the family liaison team went a long way to improve

our conversations with families. The coroner fed back in 2022 that their introduction had made a noticeable improvement to family engagement.

Information sharing

227. The Executive Director of Nursing held strategic responsibility for ensuring that information sharing and multi-agency working were safe, timely and effective across the organisation. The Executive Director of Nursing focused on professional nursing leadership, safeguarding, clinical quality, and ensuring lawful and proportionate sharing of information with partners such as social care, primary care, the police and wider system colleagues. At the same time, the Trust operated a structure in which each division had its own Executive Director, with overall responsibility for operational delivery. This meant that while operational leadership and day-to-day performance management sat within the divisions, the Executive Director of Nursing provided organisation-wide oversight and assurance that risks were escalated, that safeguarding and incident learning were shared appropriately, and that inter-agency communication was consistent across all services. We worked collaboratively so that operational teams, divisional executives and the Board were aligned in managing risk and protecting vulnerable people.

228. In my role as Executive Director of Nursing I also served as the Trusts Caldicott Guardian from September 2020 to 17 April 2021 when I handed this responsibility over to the Medical Director. This role meant I was the senior responsible officer for protecting the confidentiality of patients and service-user information and ensuring it was shared appropriately, lawfully and in the patients' best interests. I provided oversight of how personal information was used, advised on complex decisions about information sharing, and ensured that staff understood their responsibilities in relation to confidentiality and data protection.

229. I am aware we had in place multiple information sharing agreements and protocols. They were developed between the Trust and other providers that we worked with. Although the information sharing agreements were clear about what could and could not be shared, there were times appropriate for patients that we needed to share such as direct patient care, risk assessment and management, and safeguarding. Trust staff are supported in multi-agency working and information sharing by policies, procedures, protocols, information, and guidance held on the Trust Intranet (Connect). Additionally, they are able to contact members of the Data Security and Data Protection (formerly

Information Governance) team, the Trust Caldicott Guardian and Deputy Caldicott Guardian, the Senior Information Risk Owner (SIRO), Data Protection Officer, Deputy Data Protection Officer, and key senior colleagues who will assist, guide and advise on information sharing queries. I have exhibited the following policies to this statement:

a. 12.03: Clinical Information Systems Access and Audit [NHFT0015696].

b. 13.04: Police and Criminal Justice Liaison [WITN0354119].

c. 13.07: MAPPA procedure [NHFT0015705].

d. 12.09: Access to Information Policy issue 4 [WITN0354120].

e. 12.09: Access to Information Policy issue 3 [WITN0354121].

f. 12.19: Data Protection Policy issue 1 [PAGR0000099].

230. Information shared can include relevant and proportionate information taken from the patient's clinical record and content shared is dependent on the organisation making the request, the reason for sharing the information, and the level of risk at the time. It is expected that information relevant to direct care provision is shared in a timely manner with other health and social care providers, both to and from the Trust. This would include sharing relevant information with the universities.

231. During the care of the patient, requests for information sharing from other agencies and providers may be received. These requests are considered and responded to, again sharing information that is appropriate and proportionate. Requests can be received and responded directly by the clinical team, the Access to Information Team (within the Data Protection Service), and other Trust services who may be involved in the care provision of the patient. This sharing of information includes when patients from the Trust are transferred to, or directly admitted to, private healthcare providers. On these occasions, a minimum of two weeks' worth of the current patient records is shared with the private provider. Ongoing information sharing may take place throughout the duration of the patient's stay and may include Trust staff being asked to complete assessments and reports, especially in consideration of Mental Health Act requirements (for example Tribunals and Managers' Panels).

232. I had very little to do directly with the police. As far as I was aware the Trust maintained a generally good working relationship with the police. Operational managers within the divisions typically had direct contact with the police as part of their day-to-day

responsibilities. In addition, the safeguarding team would have more frequent contact with the police due to the nature of their work, which involved safeguarding and protection matters. I do not recall any concerns relating to multi agency working and information sharing. If there were concerns raised, then I would expect these concerns to be raised with the operational Director for that area. I would expect ELT to be informed of any concerns that related to reputational damage, safety, and any regulatory compliance risks. As far as I am aware, the Trust can only share information with a patient's family where it is lawful to do so. If the patient has capacity and gives consent, the clinical team can discuss aspects of their care with relatives or carers. If the patient has not given consent the Trust would generally not share personal information, except where there is a safeguarding concern, a significant risk of harm, or the patient lacked capacity and sharing was in their best interest. This does not stop the staff from listening to families and carers. They can still support families if they do not share personal information specific to that patient.

Reflections

233. I think it is important that as a Trust we reflect openly and objectively on the care provided to VC. My last working day at the Trust was 14 June 2023, the day after the attacks took place. I was therefore not involved in any of the immediate actions taken by the Trust following the incidents.

234. In relation to the care provided by the Trust to VC, there was no escalation that I was aware of regarding his care during my tenure.

235. I was not involved in the subsequent reviews and investigations into VC's care, therefore my reflections here on the care that he received are based purely on my reading of other reviews, such as the Theemis report, which I have read for the purposes of producing this statement. In my role as Director of Nursing at a previous trust, I was closely involved in investigations related to a homicide case, and I know from that experience that further information can come to light when the case is examined in court, as opposed to earlier reviews and reports. I am therefore cautious about expressing firm views on VC's care, based purely on reports that I have read, having not been involved in the investigation and having not reviewed the underlying factual information on which those reviews are based, and in the knowledge that the information may develop as the Inquiry proceeds and hears evidence.

236. Based on reading the Theemis report, I can see that whilst VC was an inpatient he was receiving care appropriate for his illness. He seemed compliant with his medications. He never caused any issues on the wards; there were no incidents attributed to him that I am aware of. When he was discharged into the community teams, I felt they really did try to engage him. They did attend his place of residence. Once a pattern of taking his medications in hospital and then not taking them at home was established, he should have been considered for a community treatment order (CTO). I also believe he should not have had such a say on not having injections (depot) especially as he could not prove he could take medication regularly without supervision.

237. I believe that the number of different teams VC had been under had the potential for fragmentation. Frequent transitions between services can lead to gaps in continuity, this would be relevant to any patient not just VC. The risk that no single service maintained an overarching view of his needs, risks and history. The potential for inconsistent risk formulation as different teams may assess risk differently. Without a shared risk formulation crucial pattern or escalating concerns may be missed. Information such as early warning signs, family concerns, previous incidents or medication history may not be communicated consistently. These different teams can cause confusion for the patient and the families, not knowing who is leading the patients care, what the plan for their care is, or how to access support.

238. From reading Theemis, it seems that, with hindsight, the patient's presentation and history indicate he should have been considered for a CTO, this would have provided a more structured framework for treatment, monitoring, and engagement in the community. The evidence in Theemis suggests that the option should have been formally explored and documented as part of the discharge planning process.

239. Again, based on Theemis, it seems that in this case, the family's perspectives should have been considered more fully, and their views actively sought as part of the assessment and care planning process. Their insights could have contributed to a more comprehensive understanding of the patient's presentation and risks. I think the community teams should have had more of a say in his treatment. He presented differently in hospital to when he was at home. The pattern of not taking his medication should have featured more in the decisions being taken.

240. I believe that the independent providers particularly the out of area placement and the subcontracted bed placement should have shared up to date clinical and risk

information. They should have shared patient history, risk assessments, interventions used, care plans and any incidents while they were under their care. There were limitations in what was being shared and the timeliness of this. This should have been shared at the time of discharge or transfer.

241. Key risk relevant information including changes in risk and safety concerns, safeguarding concerns should have been shared by the police during admission and in regular risk management reviews. Observations from his family about his mental state, behaviour changes refusal to take medication, warning signs of a relapse should have been shared with his healthcare team.

242. On reflection information was not shared as effectively as it should have been between the various agencies and healthcare providers. This did limit the ability to build a full, shared understanding of VC's needs and risks. A more coordinated approach, with timely and proactive exchange of relevant information could have supported better decision making and risk management.

243. I believe that to prevent a similar incident in the future improvements need to be made both locally and nationally. Locally there is a need for clearer, more consistent communication pathways between mental health services, primary care, police, social care and other partners. This should include use of multi-agency forums, timely sharing of risk relevant information and clear escalation routes when concerns are raised. We could consider joint training; I have seen this work well in the past for areas like legal frameworks, dementia and safeguarding training. I believe we need to make it easier for staff to understand when they can share information, because at the moment there is a reluctance because they think they shouldn't and can't. Nationally there needs to be a standardisation in the information sharing guidance, digital interoperability, and expectations around multi agency risk management. At the moment none of the clinical systems are linked across different providers. On occasion it still relies upon paper-based systems when working across providers. National frameworks could provide clarification about what information can and should be shared lawfully which would ensure all agencies are working to the same standards.

244. Mental Health services should receive the same level of priority, funding and strategic attention as physical health services do. The phrase 'parity of esteem' is used but it never feels that it gets the coverage and investment that it should. Parity would support the development of specialist risk teams, forensic liaison services, and crisis response

units to safely manage patients who may pose a risk to others. All too often when attending regional and national meetings the emphasis is on physical health in acute secondary care hospitals. Mental Health across the country is often still delivered in outdated not fit for purpose estate. We need to increase the availability of specialist inpatient beds, secure community placements, and intensive community support which would then reduce the reliance of out of area beds as we have seen here. We need investment in digital systems and information sharing platforms. All staff involved in the care of high-risk patients should receive specialist training in risk assessment, safeguarding, and mental health legislation. We need to develop a skilled confident workforce ensuring patients are managed safely and therapeutically, reducing harm to the patient and others.

245. Currently the supply of trained mental health nurses in the UK does not meet the demand, and there are significant workforce shortages that affect services. We were always showing a high vacancy rate around 10% which was also a national average. Rising demand for mental health services particularly for adults with complex needs and high-risk patients, outpaces the growth of the workforce. Vacancies were always an issue in specialist areas such as acute inpatient wards, secure units, and community crisis teams. Another area I believe would make a significant difference nationally is the need to recognise, through appropriate renumeration, the complexity, responsibility and challenges of nursing roles, particularly within mental health, secure and high acuity settings. These roles require advanced skills and sustained emotional and professional resilience, and national policy should reflect this.

Statement of Truth

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

Signed: GRO-B

Dated: 25 January 2026

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3.	WITN0354004	Coroner meeting notes 23.06.22(77963878.1)
4.	WITN0354005	Coroner meeting notes 31.03.22(77963880.1)
5.	WITN0354006	Handover to Ifti Majid Dec 2022(77963881.1)
6.	WITN0354007	[Patient's mother] notes 17.11.22(77963882.1)
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37.	NHFT0015866	Enc 017 Risk Committee Terms of Reference final.doc
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77.	CQCM0001817	Letter from Jenny Wikes [CQC] to Anne-Maria Newham [NHFT], re: Section 29A Warning Notice
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93.	CQCM0023094	uploaded - Appendix 1 Risk man strat on a page final v1.0.pdf
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159.	WITN0354105	AMH (Adult Mental Health) Staffing Report - 18 Aug 21ELTfinal.docx
160.	WITN0354106	Pages from Exec Team - 3_11_2021-2.pdf_

161.	WITN0354107	Pages from Exec Team - 17_11_2021.pdf
162.	WITN0354108	Safer Staffing Q&MHL (Quality & Mental Health Legislation) Committee 15_02_2022.pdf.
163.	TCLT0000398	FTSU (Freedom to Speak Up) from Public Board of Directors - 1_6_2021.pdf
164.	WITN0354109	ELT (Executive Leadership Team) Paper - Community Waits.docxl._
165.	WITN0354110	MH (mental health) inpatient beds modelling proposal ELT (Executive Leadership Team) paper Aug 25th 2021.docx
166.	WITN0354111	ELT (Executive Leadership Team) MENTAL HEALTH (mental health) Waits Paper Sept 21.pdf
167.	WITN0354112	Updated - Commissioning Committee Terms of Reference.docx
168.	NHFT0005270	Commissioning Committee 25_03_2022.pdf
169.	WITN0354113	Commissioning Committee 04_07_22.pdf
170.	WITN0354114	STT 1069 Clinical Quality Lead JD v3 PS_
171.	WITN0354115	Public Board of Directors - 3_5_22.pdf
172.	WITN0354116	Notes from the Senior Coroner Meeting.msg
173.	WITN0354117	PH Arnold- Bestwood ward Quality First report- 2022 Final.docx
174.	WITN0354118	CQC Overview- Priory Hospital Group Mill Lodge 13.06.2022.docx
175.	NHFT0015696	12.03-Issue-4-Clinical-Information-Systems-Access-and-Audit.pdf
176.	WITN0354119	13.04-Issue-6-Police-Ciminal-Justice-Liaison.pdf
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