

Witness Name: Vidyah
Adamson
Statement No.:
WITN0459001
Exhibits: see index
Dated: 27 May 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF VIDYAH ADAMSON

I, Vidyah Adamson, will say as follows: -

1. This statement is provided to assist the Nottingham Inquiry (“the Inquiry”) and responds to the Rule 9 request dated 7 May 2026.
2. It was drafted on my behalf by the external solicitors acting for the Trust in respect of the Inquiry, with input from counsel, with my oversight and input, following discussions in writing, by email and by video conference.

Career and Role

3. I have the following qualifications:
 - a. BSC in psychology from Lincs and Humberside, 1997-2000;
 - b. Doctorate in Clinical Psychology University of Lincoln, 2005-2009
 - c. Post-Doctoral Specialist Qualifications 2022 Autism Diagnostic Interview Revised (ADI-R- Clinical Reliability Level) Hogrefe
 - d. 2011 -2012 EMDR, Levels 1, 2, 3 & 4; EMDR Extra
 - e. 2014 Cognitive Analytic Therapy Skills Training, Association for Cognitive Analytic Therapy
 - f. 2016 – 2017 Cognitive-Behavioural Therapy for Psychosis, Oxford Cognitive Therapy Centre
 - g. 2017 Behavioural Family Therapy and BFT Trainer Meriden Family Programme

h. 2022 Autism Diagnostic Observation Schedule (ADOS-2 – Clinical Reliability Level) Hogrefe

4. I first worked for the NHS in 2002. My first post as a qualified clinical psychologist was as a Specialist Clinical Psychologist in Trauma and Self-Injury at the National High Secure Service for Women at Rampton Hospital – part of Nottinghamshire Healthcare NHS Foundation Trust (“the Trust”) – where I had a specialist remit to support the design, delivery and evaluation of a support and treatment service for trauma and self-injury.
5. From 2010 to 2014 I worked as a Clinical Tutor for the Trent Doctorate in Clinical Psychology at the University Lincoln where I was responsible for the design, delivery, co-ordination and assessment of clinical practice elements of the syllabus. My role involved planning and organising a broad range of complex activities, including supervisor training and the assessment of trainee core competencies, providing teaching in CBT assessment and treatment and qualitative research methods.
6. During the same period, I held a post as a highly specialised Clinical Psychologist and Clinical Lead for IAPT for Offenders (Improving Access to Psychological Therapies for Offenders) for Lincolnshire Partnership NHS Foundation Trust (“LPFT”).
7. For six years, from 2014 to January 2020, I was a Highly Specialised Clinical Psychologist and Clinical Lead for Early Intervention in Psychosis (“EIP”), for LPFT.
8. During this time, in 2018, I also took on the role of Regional Lead for EIP services for NHS England (“NHSE”) across the East Midlands. I retained this post until 2022.
9. In 2020, I moved back to working for the Trust, taking on the role of Strategic Clinical Lead for Early Intervention in Psychosis. I also took on an additional NHSE part-time role as Regional Lead for Psychological Therapies for Serious Mental Illness (“SMI”) across the Midlands.
10. I remained in my Strategic Clinical Lead role at the Trust from January 2020 to October 2020 when I went on maternity leave for a year. I did some keeping in touch days during 2021 and then returned to my post in October 2021. I left the Trust for a career break in December 2021. I did not in fact return to this post and ultimately left the NHS entirely and have worked in private practice since that time.

Role at NHFT

11. I rejoined the Trust in January 2020 as Strategic Clinical and Transformation Lead for EIP. The purpose of the role was to support transformation and redevelopment of the EIP function / pathway in Nottinghamshire in order to improve fidelity to the national EIP model and improve clinical standards in line with NHSE's National Access and Waiting Time Standards for EIP services.
12. My recruitment took place in the context of the EIP pathway uncoupling from Local Mental Health Teams ("LMHT"). Prior to my rejoining the Trust, the Nottinghamshire EIP service had been integrated into the LMHTs and, owing to this model of delivery, there had been challenges in meeting the access and waiting time standards to deliver a high quality EIP service. At a regional level, the Nottinghamshire EIP pathway was considered, prior to the subsequent uncoupling, to be a struggling service.
13. I exhibit to this statement a presentation from March 2020, that I gave at a regional EIP meeting regarding the EIP Live dashboard, which provides some further context as to what the service was like when I joined the Trust **[NHFT0020001]**.
14. My role was primarily strategic and transformational rather than holding operational responsibility for day-to-day aspects of service delivery. My responsibilities included supporting service redesign, workforce and pathway development discussions, development of business cases, implementation of evidence-based EIP interventions, and improvement of systems for monitoring activity and performance against national standards.
15. As part of this role, in August 2020 I drafted a Workforce Configuration Options Paper **[NHFT0020002]**. I provided this document to the commissioner of the service, Kate Burley, Deputy Head of Mental Health Commissioning at what was then the NHS Nottingham and Nottinghamshire Clinical Commissioning Group **[NHFT0020003]**: commissioning decisions lay with the CCG, which was the funder of this project, rather than with the Trust. At this point, the EIP pathway was still part of the LMHTs, as explained in an email from Emma Robinson, dated 19 August 2020 **[NHFT0020004]**.

16. The EIP Model Options paper set out various options for members of the senior leadership, i.e. the Trust's adult mental health board, to consider in the process of decoupling EIP services from the LMHT. It outlined funding requirements, and what the various options would be able to achieve vis a vis access and waiting time standards, the standards outlined in the National Clinical Audit of Psychosis (NCAP) **[NHFT0020005]** and the Early Intervention in Psychosis Network standards (EIPN) **[NHFT0020006]**. As set out in for example Model 2, the requirement was for 4.5 whole time equivalent ("WTE") "medic" i.e. consultant psychiatric input, and 5 admin support across the entire EIP service. Model 3 provided a greater level of resource but was not commissioned by the CCG. Model 2 was ultimately chosen as the preferred option and that was what was commissioned by the CCG. I was also responsible for drafting the EIP Operational Policy which I exhibit here **[NHFT0020007] [NHFT0020008]**.
17. On 21 September 2020, I updated the AMH Programme Board with progress on the EIP Workstream, including that the Options paper had been shared with commissioning colleagues, with agreement to recruit in line with Model 2 **[NHFT0020009]**. These minutes record that "*LMHT clinicians working within the EIP pathway to move away from holding mixed carloads to support readiness to release staff into standalone service*", showing that at this point there was an EIP pathway within the LMHTs, but no Standalone EIP Team / service yet.
18. In September 2020 I prepared and delivered a presentation across the Trust's LMHTs on how the uncoupling of the EIP pathway from the LMHTs would be achieved **[NHFT0020010]**. This was part of the EIP transformation and workforce planning work being undertaken by the Trust. I was mindful that many staff would be experiencing "transformation fatigue", having been present when the previous standalone EIP was moved into the LMHT, and were now being asked to be involved in its uncoupling once again.
19. Page 6 of the presentation set out the context for the transformation of EIP, noting that the "'New' workforce model did not resolve high care coordinator to service user ratios". Here, I was describing the set-up of the EIP when I joined the Trust, the 'new' model being the EIP service as part of the LMHTs when I joined. I understand that this was what was agreed in a business case in September 2019 with EIP still integrated into the LMHTs with the additional posts funded by the CCG under Community Transformation monies and termed 'Stabilisation and bolster' posts.

'Stabilisation and Bolster' posts were funded by the CCG improve the Trust's EIP provision in line with the access and waiting times standards. These can be seen in the EIP Model Options Paper labelled as 'S&B' posts. My understanding is that these posts were intended to improve the EIP provision that was being delivered in the LMHTs so included money from the former standalone EIP service and the new 'stabilisation and bolster' posts, including my post as strategic clinical lead, 2 EIP manager posts, 1 CBTp therapist post, 6 additional care coordinators, 4 physical health leads, 3 support workers (as shown on page 5 of the EIP Model Options Paper). This did not resolve the issue of high caseload to care coordinator ratios, or significantly improve the ability to deliver NICE. concordant interventions.

20. I describe on page 6 that in terms of care coordinator to service user ratios, "25:1 or more 'dangerous levels' where patient safety is placed at risk". This reflected my professional judgement at the time regarding the level of clinical and operational risk associated with very high EIP care coordinator caseloads. This was based on conversations with my NHSE regional counterparts and recommendations regarding EIP caseload size on page 8 of the 2019/2020 NCAP national report which state that

"Caseloads should be at an appropriate level to ensure care coordinators have capacity to deliver interventions and ensure sufficient time to engage with complex individuals and their families. Anything beyond a caseload of 25 would typically prevent this and is likely to adversely impact on EIP outcomes"
[WITN0329044]

21. The NCAP national audit reports emphasises the importance of maintaining caseloads at appropriately low levels to ensure care coordinators had sufficient capacity to engage with complex individuals and families and to deliver required interventions. The report also highlighted the need for adequate staffing investment and sufficient care coordinator capacity to deliver the full range of EIP interventions. My view is that significantly elevated caseloads of 25:1 or more when the nationally recommended caseload size is 15:1 reduces a service's ability to safely and effectively deliver NICE-concordant EIP care, including proactive engagement, psychological interventions, family work, relapse prevention, risk monitoring and multidisciplinary coordination.

22. Page 6 also includes a table setting out the five team areas, their caseload, "WTE" and patient to care coordinator ratio. The WTE column referred to the Whole Time

Equivalent number of care coordinators allocated to each locality/team area. Whole Time Equivalent (WTE) is a workforce planning measure used to describe staffing capacity relative to a full-time post. For example, 1.0 WTE represents one full-time equivalent member of staff. The patient-to-care coordinator ratio was calculated by dividing the total caseload by the relevant care coordinator WTE figure. My recollection was that the LMHTs in the city were viewed as one service within the workforce options paper and NCAP audit of 2019/2020 reflecting CCG area boundaries. The CCGs cover a particular geographical footprint and all the 'city teams' fell under one CCG. The EIP teams data submitted for the NCAP audit was based on CCG area not individual LMHTs .

23. Following a review of the service model, as set out in the Model Options Paper, it was identified that further workforce redesign and additional staffing capacity would be required to consistently deliver the full specialist EIP model expected within national policy, including reduced care coordinator caseloads, delivery of psychological interventions, family interventions, physical health support and multidisciplinary care.
24. The history and context set out above resulted in the EIP Model Options Paper, and the presentation to LMHT staff set out an agreed Workforce Model (p.7) including funding for additional staffing.
25. This presentation was part of the strategy for uncoupling EIP from LMHTs [NHFT0020011]. Both the Model Options Paper and the Strategy Paper were on the agenda for the next AMH Programme Board meeting, on 19 October 2020 [NHFT0020012], and I updated that meeting with the progress made on the EIP workstream and next steps [NHFT0020013]. Due to my maternity leave commencing in October 2020, I was not at the Trust to continue with the actions set out in these documents, which I expect will have been taken on by other colleagues in my absence. I was not in post long enough to see how the Model was put into effect. The strategy document shows that at the point that I went on maternity leave, the EIP pathway was still within the LMHTs and the plan was that the standalone EIP teams would go "live" from November 2020 [NHFT0020011]. I believe that the team that VC would have come under would still have been part of the LMHT until January 2021.
26. As a team, and despite the challenges posed by the Covid-19 pandemic which commenced in March 2020, we developed evidence-based business plans with commissioning colleagues for additional funding for EIP to become its own dedicated

service once again; created a Live EIP dashboard to monitor progress against national standards with the IT department [NHFT0020014], began recruiting to dedicated EIP posts and supported the implementation of evidence-based EIP interventions through staff training. I consider this an achievement given the difficulties in which we were functioning, not least the Covid-19 pandemic, which required a reassessment of many of our working practices.

Line Management

27. When I joined the Trust in 2020, two EIP managers, Emma Robinson and Stephen Laird, had already been appointed. I became their line manager as an interim arrangement whilst the new dedicated EIP service structure was being developed and implemented. At that stage, staff holding EIP cases remained within the LMHTs and were managing mixed caseloads consisting of LMHT, Assertive Outreach ("AO")¹ and EIP patients. Emma Robinson and Stephen Laird therefore did not initially hold direct line management responsibility for those staff members but would provide clinical support for staff holding EIP cases and supported the re-design of the EIP service. I exhibit a record of Supervision between myself and Emma Robinson dated 05.05.2020 which shows that Emma (and Stephen) were not line managing staff until after the decoupling of the LMHTs and moving to a dedicated EIP service [NHFT0020015]. This was as set out in the Presentation to staff, as page 17 sets out that EIP Managers were not line managing staff - EIP cases and the delivery of EIP remained with the LMHTs [NHFT0020010] I understand that no further records of supervisions that I held with others have been located by the Trust.

28. By the time I left for maternity leave in October 2020, we had started to recruit nursing staff and Emma and Stephen took on new roles as their line managers. These nurses held caseloads aligned with national standards: that is, in contrast to EIP being delivered within LMHTs where staff had caseloads of 30 plus, EIP was designed to have a caseload of 15 which might go up to 20, but ideally should not go higher.

29. On my return from maternity leave in 2021, for a brief period from October to December 2021, I was responsible for line managing Kelly Simpson. I understand from Trust

¹ I understand that the Inquiry has already heard evidence to the effect that AO should be a stand alone service. This is correct, however, within the LMHTs many patients were considered to need an "assertive outreach approach" due to difficulties with engagement and so were typically referred to within the LMHTs as "AO patients".

records that I had supervision meetings with Kelly Simpson in October and November 2021, but I cannot now recall the contents of these meetings and documentation related to these have not been located by the Trust owing to the passage of time. I did not have any direct dealings with Sharon Heath as far as I recall:

30. My line manager was the General Manager for Adult Mental Health, Anne Wright. On my return from maternity leave in 2021, Anne Wright had retired: I had a small number of supervisions with the then General Manager, Andy Latham. From memory, these focused primarily on my imminent career break.

Concerns raised

31. When I first joined the team, at the point at which the EIP was still part of the LMHT, both EIP Team Managers, Emma Robinson and Stephen Laird, raised issues regarding staffing pressures in the integrated (i.e. pre standalone) EIP model: staff holding high mixed caseloads with some holding 30+ cases, workforce capacity, access to psychology, access to dedicated psychiatry input, access to administrative support within the LMHTs. These issues were also discussed during wider operational discussion in Adult Mental Health Programme Board. Concerns raised by Emma and Stephen were recorded in monthly supervision sessions, but I understand that at the time of writing, the Trust has only been able to locate one of these documents due to the passage of time (see above). These were issues I was already aware of due to my NHSE role.
32. With respect specifically to admin and psychiatry support, I highlighted these issues with the pre-standalone service with my line manager, during AMH Programme Board meetings and with commissioners. I have been unable to find any evidence relating to this, as it does not appear within the AMH Programme Board documents I have had access to, and I understand that it has not been possible to retrieve my email inbox due to the passage of time. I understand that similarly, it has not been possible to locate the records of my supervisions with my line manager. In my view, in order to address these issues in the new, standalone model, there was a need for dedicated admin and psychiatry support in EIP and so these were proposed in the EIP Workforce Options paper. Unfortunately, psychiatry, workforce planning and job planning did not come within the scope of my remit and sat within wider AMH operational and medical leadership structures.

33. Before I came into post, an arrangement was in place whereby EIP funding effectively “bought” a portion of psychiatry time and administrative support from the LMHTs. Unfortunately, my understanding from Emma Robinson and Stephen Laird was that this support was very inconsistently implemented: in some LMHT bases it was very good; in others, it was more of a struggle to get sufficient psychiatry and admin support for EIP.
34. In discussions held in the period prior to uncoupling, I raised the issue of a need for dedicated psychiatrists for EIP, in senior leadership team meetings; with commissioners in business case discussions: this influenced the model I suggested in my EIP Model Options Paper referred to above.
35. In terms of psychology, we were actively trying to recruit clinical psychologists into the EIP before I went on maternity leave [NHFT0020000]. The difficulty we faced was that, as a service, we were trying to recruit candidates with training in CBT for psychosis (CBTp) and ideally behavioural family therapy [NHFT0020016]. Formalised CBTp training funded by Health Education England (HEE) had only taken off nationally a couple of years prior to this recruitment exercise and there was a shortage of qualified practitioners nationally. With respect specifically to Clinical Psychologists, we only attracted applications from third year Clinical Psychology Trainee candidates with no CBTp qualifications in our first round of recruitment and consequently were unable to recruit a Clinical Psychologist but did recruit a qualified CBTp Therapist. We did what a number of services nationally were doing, and aimed to recruit clinical psychologists or CBT Therapists who would be able to offer CBTp to service users. In this regard I believe the Trust were following a national trend at that point in time. A “Vacancy spreadsheet” dated 29 July 2020 shows that “only 10 people in East Midlands have necessary qualifications” to deliver CBTp so it was a significant recruitment issue to recruit a Clinical Psychologist / CBTp Therapist [NHFT0020017]
36. Despite these challenges, we bolstered our psychological provision through workforce training. When we started to expand the new, standalone EIP service and to recruit nursing staff, CCOs, physical health practitioners, and CBTp therapists we delivered CAARMS (comprehensive assessment of at-risk mental states) training and family intervention training was to be delivered to EIP staff without this training.
37. During my time as Strategic Clinical and Transformation Lead, the EIP pathway was undergoing a substantial period of transformation from an embedded LMHT model

toward a dedicated standalone EIP service. Most of this work was done during the Covid pandemic. This transformation remained a work in progress at the point I left the service for maternity leave.

Statement of truth

I believe the contents 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: 27/05/2026

Index to First Witness Statement of Vidyah Adamson

| Document name | URN | Document Description |
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| EIP Model Options Paper V5 | NHFT0020002 | Workforce Configuration Options Paper dated August 2020 |
| 38. FW EIP options paper | NHFT0020003 | Email to Kate Burley, Deputy Head of Mental Health Commissioning |
| FW_Vacancy Tracker_Stabilise and Bolster vacancies | NHFT0020004 | Email from Emma Robinson dated 19 August 2020. |
| ncap-eip-standards-2020_21 | NHFT0020005 | National Clinical Audit of Psychosis |

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| epin-standards-first-edition | NHFT0020006 | Early Intervention in Psychosis Network standards |
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| AMH Programme Board Minutes 21.09. | NHFT0020009 | AMH Programme Board Minutes 21.09.2020 |
| Early Intervention in Psychosis update for staff | NHFT0020010 | Update to staff presentation – September 2020 |
| | WITN0329044 | Report undated, compiled by NCAP, RC PSYCH and HQIP, Re: National Clinical Audit of Psychosis Early Intervention in Psychosis Audit |
| Strategy EIP uncoupling from LMHTs | NHFT0020011 | Strategy EIP uncoupling from LMHTs |
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| EIP Live Dashboard Presentation - 18.03.2021 | NHFT0020014 | Live EIP dashboard |
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| CBTp JD Sep 21 | NHFT0020016 | CBTp JD Sep 21 |
| Copy of Copy of AMH Vacancy Management spreadsheet 29.07.2020 | NHFT0020017 | Vacancy Spreadsheet 29 June 2020 |