

Witness Name: Kelly Simpson

Statement No: WITN0460001

Exhibits: See index

Dated: 2 June 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF KELLY SIMPSON

I, Kelly Simpson, will say as follows: -

1. This statement is provided to assist the Nottingham Inquiry ("the Inquiry"). It responds to the Rule 9 request dated 7 May 2026 and to subsequent questions that were raised in a Rule 9 request dated 21 May 2026 and directed to my former employer, Nottinghamshire Healthcare NHS Foundation Trust ("the Trust"), where these are matters that I am able to address.
2. I am providing this statement in my capacity as a mental health nurse and operational leader and former employee of the Trust.
3. Where matters are based on my direct knowledge, I say so. Where they are based on information shared with me by others or on my understanding of relevant documentation, I have indicated that accordingly.
4. 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

5. I have the following qualifications.

- a. An advanced diploma in Mental Health Nursing Studies from Sheffield Hallam University, obtained in 2009.
 - b. Post Graduate Certificate in Cognitive Behavioural Family Interventions for Bipolar & Psychosis, studied at Kings College London, obtained in 2025.
6. I graduated in 2009 from Sheffield Hallam University with an Advanced Diploma in Mental Health Nursing Studies. I joined the Trust that same year as a newly qualified, Band 5 nurse. Until I left to take up a role at East Midlands Ambulance Service in January 2026, I had spent my entire working life at the Trust.
7. My first role at the Trust in September 2009, was as a Band 5, newly qualified nurse. This was working on Ward B2, a mixed-sex adult assessment and treatment ward.
8. In or around 2011, I was seconded to lead the County Peer Support Service, part of a Closing the Gap project. This role involved setting up a new service to work alongside the existing team (inpatient & community within Adult Mental Health). This was a peer support service: it employed people with lived experience to support service users with mental health difficulties, and their families achieve their recovery goals. The role was at Band 6.
9. In October 2012 I left the Peer Support Service for a period of maternity leave. I returned to work, in the spring of 2013, to the Staff Nurse role at Ward B2. Around the same time, in March 2013, I also trained in Behavioural Family Therapy (BFT), with the aim of using the new skills and knowledge within my current inpatient role. I was promoted to Charge Nurse, taking on a Band 6 position akin to a deputy ward manager role, with more leadership, senior clinical and managerial responsibilities.
10. In March 2016 I underwent further training that allowed me to train and supervise in BFT. I joined the BFT Training & Supervision Team, alongside my existing Charge Nurse role, with the expectation that I would deliver BFT training 10 days per year and host a monthly supervision group.
11. In or around spring 2017, following my return to work after a second maternity leave, I took on a split role. I worked both as part of the Family Intervention Team in a Band 7 clinical nurse specialist role, delivering and training family interventions, providing clinical work (mainly for people with psychosis) as well as continuing to work three days a week as a Charge Nurse at Ward B2.

12. In 2018 I left my post at Ward B2, to work full time in the Family Intervention Team. A core part of that role was training people in Family Intervention, supervising other BFT trained staff, and co-working with other staff to deliver BFT to service users and their families. I also line managed a Peer Support worker and 2 admin colleagues.
13. In 2020 I was seconded to my first service managerial role, as Bassetlaw service manager. This was a promotion to a Band 8a with more responsibility, accountability and senior oversight. My portfolio of services included Bassetlaw local mental health team, Ward B2, the Mental Health Liaison Team at Bassetlaw A&E department and, in addition, I service managed the Family Intervention Team, which was based at Bassetlaw but covered the whole of Nottingham and Nottinghamshire.
14. In Spring 2021, I moved to the EIP service, set out in further detail, below.
15. On 1 February 2026 I left the Trust. I am currently a Senior Mental Health Clinical Advisor in the Clinical Assessment Team, East Midlands Ambulance Service NHS Trust.

Training

16. As set out above, during my time at the Trust, in common with many of my colleagues, I underwent training in BFT. The 2002 NICE guidelines for the treatment of First Episode in Psychosis (FEP) [WITN0460002] recommended family intervention as an appropriate psychological intervention. In 2012, the Trust began training staff in BFT and soon adopted a "train-the-trainers" model, to roll out training to staff across Adult Mental Health.
17. The initial priority was training all the EIP team members, who, at the time, were still working in the original standalone EIP model. This initiative of training all EIP staff in BFT continued; when the EIP was brought back out of the LMHT into its own standalone model once again in 2020, it was with the expectation that BFT training would be mandatory for all EIP staff. The training involved a five-day, in-person course, with the expectation that staff would attend monthly group supervision afterwards. I have reviewed the Trust records of BFT at the Trust [WITN0460003] and can confirm that the following staff received five-day BFT training:
 - a. Claudia Birtles: September 2015;
 - b. Abigail Parsonage: May 2018;

- c. Emma Robinson: November 2018;
- d. Sharon Heath: September 2021;
- e. Gary Carter: November 2021.

18. As part of the new 2020 EIP model, there was also an expectation that each staff member would receive training in the comprehensive assessment of at-risk mental state (CAARMS). This training was initially offered as a one day online training session, conducted in-house by the Strategic Clinical Lead, Dr Vidyah Adamson as there were no external training courses available at the time. I understand that it has only been possible to locate partial information as to who received that training, and when. However, I have had sight of the presentation used in that training [WITN0460020] and recall that it was offered to everyone in the service, online in April 2021 [WITN0460019]. I recall that a lot of staff attended the online training. I have also found evidence of in-person training being offered to some members of the service in December 2021 [WITN0460023]. After her departure from the Trust, CAARMS training was provided as part of a rolling training programme funded by NHS England and delivered by the University of Hull. This training included the assessment of people who may be experiencing an At-Risk Mental State (ARMS) or First Episode of Psychosis (FEP) or neither. I understand that data as to this training post-October 2023 is available to the inquiry at [NHFT0003241]

Arrival at the EIP

19. In or around Spring 2020, while I was working as Service Manager for Bassetlaw, I became aware of plans for the EIP service to become a standalone pathway, separate from the local mental health teams, once again. The proposed model had implications for the Bassetlaw local mental health team and I recall attending Microsoft Teams meetings in which Vidyah Adamson explained the proposed model, including both the anticipated benefits and the challenges, and outlined the mobilisation plan [NHFT0020010].

20. As part of the wider service restructure within Adult Mental Health between 2020 and 2021, a Service Manager post was established for the EIP and Family Intervention Team. I applied for and was appointed to that post following interview.

21. When I joined the EIP service in spring 2021, the Adult Mental Health Directorate included community, inpatient, and urgent care services. At that time there was a

General Manager, Andy Latham, who had operational managers, service managers, and team leaders beneath him.

22. During my time in service and strategic leadership roles, the leadership structure changed more than once. There was initially one General Manager for the whole Adult Mental Health Directorate, followed later by a structure involving both a General Manager (Andy Latham) and a Deputy General Manager (Joanna Hill). Joanna Hill took on the role of line managing me in around Spring 2023: her role involved more focus on community services. The principal route for escalation of concerns across services was a daily demand meeting attended by the service managers for the various teams across adult mental health and chaired by an Operational Manager. The purpose of the meeting was to highlight areas or topics that required extra discussion and wider support. Topics discussed included the pressures across the services, for example staffing, bed availability, estate issues; we also discussed day-to-day operational issues.

23. The EIP service consisted of two teams, EIP North and EIP South. Each team in turn had a number of localities within it, these were known as "bases". My initial priorities on joining the EIP service in 2021 were to establish effective working relationships with the team leaders, Emma Robinson (South) and Stephen Laird (North), and to maintain a visible presence across the ten bases covered by the service. The geographic make-up of the service was as follows:

EIP North Team	EIP South Team
City North	City East
City Central	City South
Ashfield & Mansfield	Gedling
Newark & Sherwood	Broxtowe & Hucknall
Bassetlaw	Rushcliffe

24. VC was cared for by the City South part of the EIP South Team.

25. I found it challenging to maintain a visible presence across ten bases because of the geographical spread of the service and the restrictions in place during the COVID-19 pandemic, including limitations on attendance at base and mandatory face coverings. As a result, I worked from home more than I would ordinarily have wished, but I sought to remain accessible to staff through Microsoft Teams and regular communication.
26. At the same time, there were other urgent operational issues. These included the departure of our only CBT for Psychosis supervisor, Gary Payne, in 2021 and the resulting need to commission external supervision so that trainees could continue to practise safely and meet their training requirements. I recall this being a specific pressure during my first six to twelve months in post.
27. It also became clear to me that one of the areas requiring additional resource was clinical team leader capacity. At that time, Emma Robinson and Stephen Laird were each overseeing five bases and carrying responsibilities across all interventions and multidisciplinary meetings within their respective areas. I was very conscious of the pressure this placed on them, and, following feedback from them and the wider clinical workforce, a plan was agreed that enabled us to recruit two additional clinical team leaders, one for the EIP North team, and one for the EIP South team.

Line Management

28. Dr Vidyah Adamson was the Strategic Lead for Psychosis Services however she was on leave when I initially joined the EIP. In Dr Adamson's absence, from October 2020 to October 2021, I was lined managed by Tracey Taylor (Operational Manager for City LMHT's). On Dr Adamson's return to work in October 2021, she managed the strategic aspects of the various services while I led on operational matters.
29. Dr Adamson left on a career break in January 2022: following her departure, I was line-managed by Kerry Watson (Operational Manager for Mid & North Notts LMHT's).
30. Dr Adamson left the service in January 2022; her role was not recruited into until January 2023 when I successfully applied for and was appointed to the role of Strategic Lead for Psychosis Services. Around three months later, Jonathan Guy was appointed to fill my previous role as EIP Service Manager.

Managerial Responsibility

31. Upon joining the EIP service, I assumed line management responsibility for Emma Robinson. I can confirm that, during both formal and informal supervision and within our regular team leader meetings, Emma did discuss service pressures. I have found notes of a number of supervisions with Emma Robinson [NHFT0019616] in which she raised issues regarding pressures of work, admin resources and the absence of a clinical lead. I note that on two occasions, difficulties with Gary Carter seeing patients while absent on leave and more generally were raised and discussed.
32. These pressures included occasions when caseloads for some care co-ordinators exceeded the intended ratio of 15 service users to one whole-time equivalent care co-ordinator. The situation regarding staffing levels in the EIP was fluid, with fluctuating levels across the EIP service (North & South). Compared to other community teams, however, EIP had a higher rate of staff retention and successful recruitment drives.
33. I attended supervisions with the individuals I line managed on a monthly basis albeit that the timeframe could slip from strictly once per month as other commitments demanded. A record of all of the instances of formal supervisions that I undertook is exhibited to this statement [WITN0460004]. I generally made handwritten notes of these supervision sessions although there will have been occasions on which I did not make a formal note. I did not always follow a formal template but tended to maintain a pattern in my notes of recording: this was separated into areas relating personally to the staff member for example a wellbeing check in, overview of training and annual leave, followed by team update/ feedback.
34. I also held ad hoc discussions with my staff which were not always recorded. I have been asked for and have found the notes of some of my supervisions with Emma Robinson which I have exhibited above. I have also found a small number of handwritten records of my supervisions with Sharon Heath which I exhibit here [WITN0460005 ; WITN0460006 ; WITN0460007 ; WITN0460008]. Not all of our discussions are recorded and evidenced. We worked as a close leadership team, with opportunity for ad hoc supervision or discussions; we also utilised Microsoft teams to keep in touch throughout the day.
35. Emma Robinson raised issues regarding the current service model as soon as I joined the EIP in 2021. Her concerns included the geographical areas covered, her ability to have a physical leadership presence, the opportunity for ad hoc discussions and for

staff to feel supported. She also voiced concerns about having smaller teams in locality bases, the need to move around the Nottingham City and South County localities and the increased number of weekly MDT meetings.

36. When Emma Robinson left the EIP, I assumed line management responsibility for Sharon Heath for a period of months until Jonathan Guy took up post as Service Manager and I moved into the role of Strategic and Managerial Lead for Psychosis Services.
37. During the period from April 2021 to April 2023 as service manager and then as strategic lead from 2023 onwards, I generally attended the weekly EIP managers' meeting team leader and service management meetings until I left the organisation in January 2026. I recall ongoing discussions with Sharon and others regarding caseload pressures, administrative difficulties, inconsistent medical presence, and the impact of not having psychologists within the service. The issues faced by the EIP were issues common to most NHS services where there are pressures regarding staffing gaps, increase in referrals and caseload sizes – this was true of my whole time with EIP not just between 2022-2023.
38. My experience was that both Emma and later Sharon were proactive in raising concerns and seeking solutions. Where issues were capable of being addressed locally, we worked with the wider service leadership to identify options. Where the issues were outside local control, for example medical staffing, it was my responsibility as the Service Manager, later Strategic Lead, to escalate them through the appropriate management and governance routes.

Psychological Support

39. I think it is important to note that the EIP service did have six whole-time equivalent CBT for Psychosis therapists within the first episode psychosis pathway. However, there was no further recruitment for the at-risk mental state pathway when that pathway was launched in the North in 2021, despite CBT for Psychosis being a core intervention for that service user group. My understanding was that the aspiration, following piloting and evaluation of the North pathway, was to secure additional psychological practitioner or CBT for Psychosis posts through a further business case.
40. Psychology leads within the Trust did, in my experience, seek to advocate for the EIP service and, in addition to their substantive duties, provided ad hoc training,

supervision, and consultation in order to support both staff and service users. I got the sense from colleagues involved in the planning and delivery of psychological therapies across AMH (such as, for example, lead psychologist for County Community Services, Michael Day), that it was not that they were unaware of the gap, nor that they did not want to offer support and resources, it was more a case of having limited resources, high demand and that it was difficult to spread the resource any further.

41. Where concerns were identified, I would ordinarily seek to address them through the most appropriate route. Depending on the issue, this could include raising matters directly with the relevant manager, professional lead, for example a consultant psychiatrist or their medical supervisor, or escalating through the operational and service management structure in my own supervision and in meetings that I attended on behalf of the EIP service. We had embedded feedback and escalation methods in place and this included a weekly EIP Managers' meetings, attended initially by myself, Emma Robinson, Stephen Laird and admin support (i.e. my PA rather than a team-wide admin provision) and, as the service grew, this meeting expanded to include clinical leads, service manager, CBT for psychosis lead and the clinical lead for families and carers. The meeting included a fluid agenda which covered team updates and escalations, wider services feedback, specific items added to the agenda and was supported by an action log.

42. Emma Robinson and I repeatedly discussed the lack of psychological support in the EIP, and I in turn raised it in supervision with Kerry Watson and with Tracy Taylor, who were fully versed with the EIP model previously and the newer version. I exhibit here records of my supervisions with Kerry Watson [WITN0460009]; [WITN0460010]; [WITN0460011]; [WITN0460012]; [WITN0460013]. I am unsure whether the records of my supervision with Tracy Taylor have been recovered. I note that I discussed the difficulties in psychological support for the EIP with Kerry on a number of occasions.

43. Some issues, for example short term care co-ordinator sickness, would be worked though as a team, whereas other more longer-term issues fell outside our remit to resolve – like the resource for admin, psychology and medical input, all of which required a directorate or Trust-wide approach. I believe I took all steps available to me to escalate these issues as much as I could.

44. Throughout my time working with EIP, I continued to advocate for the service and to feedback concerns to others and to escalate the service needs and position to the best of my ability. This included in formal meetings such as the Transformation Programme Board [NHFT0019927; WITN0460014]; WITN0460021 }; WITN0460022 seeking input from psychology colleagues on a case-by-case basis, both prior to the 2023 tragic attacks and afterwards.

45. I do not specifically recall the absence of psychology input specifically being a regular subject of formal supervision discussions with Emma Robinson or Sharon Heath, but it was an ongoing concern and source of frustration within the EIP leadership team and the wider adult mental health service.

Administrative Support

46. I recall repeated discussions within management meetings about administrative support across the EIP service. Those discussions included comparisons between the North and South teams and concern that, in some localities, the service was not always seen as requiring the same level of administrative support as local mental health teams. I raised this in discussions with my line manager, Kerry Watson, albeit I cannot now recall if there are formal records of such discussions; further discussions took place with the business and administrative lead, which improved the situation somewhat. The issue extended beyond support for multidisciplinary meetings and minute-taking; it also included referrals, appointment and room bookings, correspondence, discharge letters, and the collection of routine internal and external performance data.

47. As I became more established within the service, I discussed with the business manager and administrative leads (Debbie Dolan and Mandeep Rana) a proposed model of more clearly designated administrative support for the EIP. The aim was to ensure protected time for pathway-specific tasks, including referral processing, appointment and room bookings, support for multidisciplinary meetings, discharge correspondence, and performance reporting.

48. Through at-risk mental state investment, the service secured two additional Band 4 administrative and performance roles (1 whole time equivalent ("WTE") for the North team and 1wte for the South) who joined EIP in 2022 with the intention of reducing pressure on team leaders and clinical team leaders. We also explored, during 2022 to

2025, whether a pilot model could be implemented using designated support from the local mental health team administrative pool together with recruitment to an additional Band 3 post. My recollection is that this was intended to provide more consistent support for access and waiting time standards and other operational requirements. However, because of financial pressures and recruitment difficulties, that additional post was not fully recruited to during my time in post, although further discussions continued in 2025 following reconfiguration of some community bases.

Note-taking at MDTs

49. In relation to multidisciplinary team (“MDT”) meeting records, practice varied across the service. Some teams had dedicated administrative support present at meetings and others did not. I acknowledge that this may have placed additional pressure on team leaders. My own preference as Service Manager was not for full clinical minutes to be recorded by administrative staff and then inserted directly into the service user’s record but rather for individual clinicians to take on the responsibility for recording discussions of their respective patients.

50. My expectation had been that the clinician bringing the discussion to the MDT meeting would record the clinical discussion and agreed actions in the service user’s notes and not rely on an administrative member of staff to carry out this task. In hindsight, this was an assumption on my part that this was what the teams would be doing, based on my understanding as to what good practice record-keeping would involve, and so it was not formally cascaded. It was only in the following the tragic incident in 2023 that I became aware that this was not being done consistently across the service, nor was an MDT meeting agenda or guidance for documentation included in the original EIP standard operating procedure. I accept that this was a shortcoming in my understanding and oversight.

51. In the immediate aftermath of June 2023, changes were introduced so that administrative support would assist the chair by maintaining an action log, while the clinician presenting the service user would record the clinical discussion and agreed actions in the electronic record. I acknowledge that the lack of documentation in the relevant case is unhelpful and fell below the expected standard because it did not accurately reflect the ongoing clinical discussions that took place. I exhibit to this statement the Standard operating Procedures for EIP V1 [**WITN0460015**], EIP Operational policy – V 1.3 [**NHFT0020007**] and EIP Internal Working Instructions V5 [**NHFT0019995**].

Care co-ordinator caseloads

52. The Inquiry has asked for confirmation as to the caseload allocated to Claudia Birtles at the material time; and whether and how frequently, if at all, Ms Birtles' caseload was in excess of 25. It has also asked when and how frequently, if at all, Gary Carter's caseload was in excess of 25. This information has been provided to me by the Trust and is as follows:

Report Month	Birtles, Claudia (Miss)	Carter, Gary
Jun-20	19.4	
Jul-20	20.8	
Aug-20	20.5	
Sep-20	19.3	8.3
Oct-20	18.1	17.7
Nov-20	17.8	21.3
Dec-20	17	21.6
Jan-21	16.5	18.5
Feb-21	16	15.7
Mar-21	16	17.8
Apr-21	16.8	17.4
May-21	17.9	17.6
Jun-21	16.9	19.3
Jul-21	16.8	19
Aug-21	17.3	18.3
Sep-21	17.5	17.6
Oct-21	16.2	18.7
Nov-21	16.4	19
Dec-21	17	20.1
Jan-22	16.8	21
Feb-22	14.9	20.5
Mar-22	14.8	18.4
Apr-22	15.3	17.9
May-22	15.2	19.2

Jun-22	13.8	19.8
Jul-22	13.5	20.5
Aug-22	12.4	20.9
Sep-22	9.4	19.6
Grand Total	16.5	18.7

53. I would note that we are unable to distinguish between: patients added to the care co-ordinator's caseload whereby only an assessment was performed; and those who were on the care co-ordinator's active caseload and receiving regular input. Therefore, the base number does not give the full picture of a care co-ordinator's workload. In relation to Claudia's case load, I understand that she worked 22.5 hours a week in 2020, and her case load during that time would have been a mixture of LMHT and EIP pathway patients, prior to the uncoupling of the services. I understand that from 2021, her hours had increased to 30 hours per week. An ideal caseload for that working pattern (i.e. roughly 0.8 WTE) would be around 12 – 14 people, but this would be fluid depending on acuity, service pressures (referrals vs discharges) and the time of the year, for example, during the summer months, the demands lessen due to university holidays.

54. My understanding is that this data was collated by the Trust as part of a review that was undertaken in relation to Mr Carter's Investigation Report. While I had no involvement in that Investigation itself, I supported with gathering the caseload data for Mr Carter's investigation and liaised with applied informatics and communication colleagues from the RiO team who confirmed that the numbers included all referrals open to the CCO's caseload at the time, regardless if this was for several days or remained on it for a greater amount of time. The figures above are in-line with what I recall being the case at the time I was in post. I understand that the Investigation report has been disclosed to the Inquiry [NHFT0004872] and that the full set of care co-ordinator caseload review data is included at Appendix 14 of the Investigation report [NHFT0004919].

55. I have been asked by the Inquiry how many practitioners had a case load of over 25. Appendix 14 shows that between June 2020 and September 2022, Abigail Parsonage had a caseload of 25.3 in July 2020, 25.5 in July 2021, 26.1 in August 2021. No other practitioner within the City South Team (the Team who cared for VC) had a case load of over 25 in that period. On the data available to me, I am not able to say why Abigail's

case load numbers were higher than her colleagues' in this period. It is possible that some of the factors set out at paragraph 53, above, applied. I also recall that Abigail was always quick to pick up extra work to support her colleagues and service users, therefore she may have picked up more assessments, which would be reflected in her case load numbers, even if the service user did not remain on her caseload for her to care co-ordinate. Another possibility is that she was covering for any colleagues on periods of absence, and so their service users may have been temporarily transferred to Abigail. Given the months where Abigail had increased caseload numbers, it could also have been that some of her usual caseload had been university students who had returned home for the summer and therefore Abigail may have taken up more assessments in an otherwise quieter period, which would have added to her numbers on paper, but without her actively care co-ordinating that number of service users.

Consultant Psychiatric Support

56. In terms of access to consultant psychiatric support, this was also an issue that I was made aware of by Emma Robinson. While we only had limited consultant resource – Dr Tuhina Lloyd – we did have alternative resources of psychiatric help: advanced clinical practitioner Amanda Bateman was brought into the EIP South as a prescribing clinician; Matthew Roberts was recruited as a pharmacy prescriber.

57. I was aware when I joined the EIP service that the business case provided for a defined number of consultant psychiatrist sessions and that this model had been agreed with medical leads and clinical directors. My understanding was that this was based on caseload size and the number of care co-ordinators across the geographical areas covered by the service. Those sessions included routine outpatient appointments, urgent appointments, and attendance at weekly multidisciplinary meetings. It was common for consultant psychiatrists providing sessions to the Early Intervention in Psychosis service also to work within local mental health team psychosis pathways. In some respects, this model had advantages because it brought in medical colleagues with skill, experience, and commitment to working with service users and families affected by psychosis. However, it also limited access because medical input was available only on specific days and at specific times and cover during annual leave or sickness was often limited.

58. Where cover was provided, it was usually by local mental health team consultants who already had full job plans and significant caseloads. There was also, in my experience, an ongoing difficulty in obtaining clear and timely information about consultant leave

and short-term absence, and the Early Intervention in Psychosis management team repeatedly sought clarity about who would provide cover and when.

59. After I took on the Strategic Lead role in January 2023, I raised these issues on a number of occasions with members of the leadership and medical teams within the Adult Mental Health Directorate, including the Clinical Director, Dr Thangavelu. Post June 2023, I also sought information from NHS England leads and from the Royal College of Psychiatrists' National Clinical Audit for Psychosis (NCAP) lead regarding caseload size and the level of medical sessions required for a safe and effective early intervention service. This included arranging discussions involving consultant psychiatrists from other Early Intervention in Psychosis services, the NCAP lead, myself, and the Clinical Director. I exhibit relevant emails that I have been able to locate: [**WITN0460016** ; **WITN0460017** ; **WITN0460018**].

60. My recollection is that one practical consequence of the EIP medical model whereby clinical resource was limited and shared, was that outpatient appointment capacity was sometimes shared with local mental health teams and, because those teams often had larger psychosis caseloads, appointment availability for EIP service users could become restricted. On occasion, routine and urgent appointments for EIP service users were not readily available, leaving team leaders and service managers to negotiate access to limited clinical slots. This matter was raised with the Clinical Director who embedded a change whereby outpatient appointment slots were ringfenced for EIP services users. I believe this took effect in 2024.

61. Generally speaking, I and all of my team at the EIP were alive to the issue of resources and I raised it frequently at the weekly senior management meeting. That said, we did manage: we made the best of what we could, which is how a lot of the NHS works. We used colleagues around us in an informal way; we upskilled our own staff where we could. Even though it was difficult, we still made some really positive changes with that team for the benefit of services users and their loved ones: it was not, in my view, a failing service. We worked really hard together under enormous pressure, I found my EIP colleagues dedicated, caring and passionate about providing a good quality EIP experience. Both Emma Robinson and Stephen Laird were working without any support from a clinical lead in the early years of the EIP and with limited dedicated line management support in Dr Adamson's absence and in the period before I was recruited. In my view, they worked extremely hard to create the best service they could.

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.

GRO-B

Signed:

Dated: 2 June 2026

URN	Document name	Document Description
WITN0460002	CG1 NICE guideline	2002 NICE guidelines for the treatment of First Episode in Psychosis (FEP)
WITN0460003	Copy of BFT trained staff total	BFT trained staff spreadsheet
WITN0460020	CAARMS training for Staff V8 – 2020	Comprehensive Assessment of At Risk Mental States (CAARMS) BRIEF VERSION. Dr Vidyah Adamson
WITN0460019	Training Dates for CAARMS	Email Dr Adamson to Various, 31.03.2021. Subject: Training Dates for CAARMS
WITN0460023	RE: CAARMS training	Email chain between Kelly Simpson and various at NHFT, November 2021. Subject: CAARMS training
NHFT0003241	Report undated, compiled by NHFT Re: CAARMS training records with staff names and email addresses, populated 02/10/2023 to 08/07/2025	Report undated, compiled by NHFT Re: CAARMS training records with staff names and email addresses, populated 02/10/2023 to 08/07/2025
NHFT0020010	Early Intervention in Psychosis update for staff	Mobilisation plan

NHFT0019616	Emma Robinson - suprvisions	Emma Robinson supervisions
WITN0460004	Simpson, Kelly 01- May-200631-May- 2026 Supervision	Record of formal supervisions
WITN0460005	Scan-2026-05-21-08- 53-17-003-15993,	Sharon Heath Supervisions x 4
WITN0460006	Scan-2026-05-21-08- 53-28-865-15994,	
WITN0460007	Scan-2026-05-21-08- 53-45-192-15995,	
WITN0460008	Scan-2026-05-21-08- 53-56-872-15996	
WITN0460009	Scan-2026-05-14-14- 00-01-541-9477,	Kerry Watson Supervisions x 5
WITN0460010	Scan-2026-05-14-14- 00-19-783-9478,	
WITN0460011	Scan-2026-05-14-14- 00-47-246-9479,	
WITN0460012	Scan-2026-05-14-14- 01-02-576-9480,	
WITN0460013	Scan-2026-05-14-14- 01-15-404-9481	
NHFT0019927	EIP Workstream Status Report - Feb 2021	Transformation Programme Board 2021
WITN0460014	EIP Workstream Status Report - 10.11.22	Transformation Programme Board 2022
WITN0460021	EIP Workstream Status report Dec 2023_	Transformation Programme Board 2023
WITN0460022	EIP Workstream Status report March 2024	Transformation Programme Board 2024
WITN0460015	EIP Standard Operational Procedures (SOP) V1	EIP Operational Policy v1
NHFT0020007	EIP Operational Policy - V1.3	EIP Operational Policy v1.3

NHFT0019995	Version 5 EIP-IWI-V5-17.11.2025	EIP internal working instructions
NHFT0004872	Report dated 18/06/2025, compiled by Mark Sherburn and Rebecca Keating [NHFT] Re: Investigation Report v.2, Gary Carter	Report dated 18/06/2025, compiled by Mark Sherburn and Rebecca Keating [NHFT] Re: Investigation Report v.2, Gary Carter
NHFT0004919	Report dated 14/11/24, compiled by NHFT, Re: Average Daily Patients on the Caseload for Selected HCPs by Month	Report dated 14/11/24, compiled by NHFT, Re: Average Daily Patients on the Caseload for Selected HCPs by Month
WITN0460016	EIP referral data Workforce calculator	Email re: workforce calculator
WITN0460017	FW EIP medic caseload NCAP	Email re: medic caseload
WITN0460018	RE EIP doctor's peer group meeting	Email re: doctor's peer group meeting