

Witness Name: Michelle Malone

Statement No: WITN0462001

Dated: 6 July 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF MICHELLE MALONE

I, Michelle Malone, will say as follows: -

INTRODUCTION

1. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 Request dated 5 June 2026 (the "Request").
2. I am providing this statement in my capacity as a retired mental health nurse, operational leader and former employee of Nottinghamshire Healthcare NHS Foundation Trust ("the Trust").
3. This witness statement was drafted on my behalf by 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. 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. To complete this statement, as I am no longer an employee of the Trust, I have relied upon information being made available to me by the Trust including some copies of emails from the relevant time, and documents such as minutes of meetings, which I have reviewed for relevance to the questions asked in the Request. I did not have

access to my full emails or documents due to the passage of time and timeframe to produce this statement.

5. I understand that this statement is made to assist the Inquiry into the tragic events of 13 June 2023. I did not have any contact with VC during my time at the Trust or have any knowledge of him until the press reporting following 13 June 2023. The only information I know of his contact with the Trust is that which is available publicly.

BACKGROUND

6. I have worked for the Trust for my entire career, since I was a student mental health nurse.
7. I qualified as a mental health nurse in 1992, and I completed a post graduate Diploma in psychological interventions in serious mental illness in 1995 via the Maudsley Hospital, London.
8. I completed a BA (Hons) degree in English Literature in 2000.
9. In 2010 I completed MSc studies in Health and Social Care Leadership, via Sheffield Hallam University.
10. During the course of my time at the Trust, I have had various clinical roles within the Trust, including inpatient, rehabilitation and community working.
11. Around the time that the National Service Framework was launched in 1999, I was team leader of a service that was transformed into an Assertive Outreach ("AO") team in Nottingham City and South County, which was one of three AO teams that were established at that time. I was involved in that transformation and then worked in AO for about seven years. From memory, this was around 2001/2002 to 2007/2008.
12. I then moved into management roles, in service management and then operational management for community services within Adult Mental Health ("AMH"). I was acting General Manager for AMH between November 2016 – February 2019. I was initially asked to cover this role for three to six months to cover the sickness of the post-holder, but this was extended on various occasions due to the changing circumstances of the post-holder and I ended up acting as General Manager for longer than previously envisaged.

13. I became AMH Clinical Director on 1 March 2019, until my retirement on 9 June 2022, albeit from recollection my last working day was at the end of May 2022.
14. I returned to the Trust between July 2022 and December 2023, on a part time basis, working two days a week as a clinical nurse specialist working on clinical pathways for personality disorders and autism, which was aligned to my previous Clinical Director work, but without the same scope, responsibilities and only some limited continued line management duties in relation to a small number of Multi-Professional Approved Clinicians ("MPACs"). I did not have an ongoing role in relation to EIP services during this time.
15. I have not worked in a healthcare setting since I fully retired in December 2023, and I no longer hold registration with the Nursing and Midwifery Council.

Clinical Director Role

16. The role of AMH Clinical Director was to oversee the whole of the AMH directorate, jointly with Dr Seedat who was also AMH Clinical Director at that time. I recall that Dr Seedat had been AMH Clinical Director for a few years prior to my appointment, and I took over from the previous non-medical Clinical Director who had been working with Dr Seedat but had retired.
17. I did not have any clinical duties, my full-time role was that which fell under the Clinical Director responsibilities at that time.
18. Dr Seedat and I worked closely with the AMH General Manager (Ann Wright, latterly Andy Latham) to maintain an overview of the AMH directorate as a whole. The directorate covered Nottingham City, Nottinghamshire and Bassetlaw including acute inpatient wards, psychiatric intensive care, the department of psychological medicine, psychology and psychological therapy services, crisis and home treatment teams, rehabilitation services and community services. At any one time, the directorate had approximately 10,000 patients under its care and employed approximately 1,000 staff from a range of disciplines and professional backgrounds.
19. Dr Seedat and I decided that we would jointly manage the responsibilities of AMH Clinical Director, but we would each take the lead in certain aspects. As Dr Seedat also had clinical responsibilities as an inpatient consultant, I assumed a wider set of responsibilities, principally linked to transformation projects within the Trust. I was the Workstream Lead for personality disorder services, which involved developing those

- services in line with a new model, and for autism pathways across all services. I also led on the development of new senior non-medical roles, including Approved Clinical Practitioner ("ACP") and MPACs. In addition, I worked jointly with commissioning colleagues on delayed discharges from both Trust beds and out-of-area placements.
20. In terms of the division of responsibilities therefore, I generally focused on community transformation, whilst Dr Seedat focused more on inpatient matters. With regard to staffing, I had line management responsibility for senior non-medical staff. My direct reports were the Nurse Consultant, the Consultant Clinical Psychologist for personality disorder services, the ACP Lead, and the MPACs (the number of MPACs changed over time, from initially two to later four). Dr Seedat and I jointly managed the six lead consultants, and they in turn managed their respective areas within the directorate.
21. Dr Seedat and I were based in the same office room, so we had regular informal discussions and I would say that we had a good working relationship. Although we made decisions together, due to his clinical commitments, I would say that I tended to be the one who would go to more of the meetings, forums, and day-to-day liaising with the wider directorate.
22. As part of my community transformation role, I led on a number of specific work streams. These work streams were informed by the NHS Long Term Plan and its associated ten-year strategic focus. I personally led on the personality disorder and autism work streams, whilst other individuals led on other areas.
23. I would assist Dr Seedat with the lead consultants' job planning, although in practice Dr Seedat took the primary role in conducting and signing off those job plans. The lead consultants were in turn responsible for the job plans of the consultants within their respective areas, which required sign-off by a clinical director. I signed off a small number of those, but my primary responsibility in respect of job planning related to non-medical staff. I also did the appraisals and supervision of non-medical staff who I line managed, as identified above.
24. As AMH Clinical Director, I reported to the Associate Medical Director, who was Dr Hazel Johnson, who retired approximately six months before me, so I reported to her replacement Dr Kiran Jeenkeri for that period.
25. The main route via which concerns/requests were identified was through the systems and processes in place within the AMH directorate and wider Trust. Specifically, in

relation to EIP transformation, via the AMH Programme Board, which received monthly status reports on progress of various services and development projects, including EIP services. Concerns and issues were also sometimes raised via other forums such as the AMH Consultant forum and with regards to day-to-day safety and capacity issues via the Daily demand meetings. Staff would also contact me directly via email, MS teams calls, and telephone calls. I discuss some of these escalation routes in further detail below.

26. I was a member of the AMH Programme Board. In or around March/April 2021 the AMH Programme Board was reconstituted as the Serious Mental Illness Transformation Board, reflecting that the scope of transformation extended beyond AMH (including, for example, all-age pathways and older peoples). I understand that it remained in operation until it was stood down in or around June 2024, but that post-dated my retirement from the Trust and I do not, therefore, have any personal knowledge of that more recent period of time. For the purposes of what I am addressing in this statement, there was no change following the transition from AMH Programme Board to SMI Transformation Board and so, for ease, I have referred to the Programme Board throughout. Similarly, on the whole, throughout the period 2019-May 2022 (when I retired from my Clinical Director role) key personnel remained relatively consistent but where relevant, I have noted changes.
27. The Programme Board comprised senior leadership within AMH together with certain individuals from outside the directorate, including Dr Hazel Johnson as the Associate Medical Director. It was chaired by Chris Ashwell who was the Deputy Director Local Mental Health Services, reporting to Julie Atfield, who was Executive Director of Local Mental Health Services at the time. All senior managers within the directorate were members of the group. The service transformation and development work was reported through the Programme Board on a monthly basis. Each work stream lead was required to complete a standardised reporting template and submit a monthly report to the meeting, setting out the actions taken during the preceding month, the planned actions for the following month, any issues of concern that needed to be raised, any risks, or any help that was needed. Early Intervention in Psychosis ("EIP") was one such work stream. I recall that due to the Covid-19 pandemic certain meetings were stood down, or reduced in frequency, but I cannot recall if, and how, the AMH Programme Board was affected.
28. The lead consultants within AMH were invited to attend AMH management meetings, although attendance was understandably subject to clinical commitments. Copies of

- meeting minutes would in any event be shared with them and it was the responsibility of the lead consultant to disseminate relevant information from those meetings to the other consultants within AMH, and to raise any concerns on their behalf.
29. There were AMH consultant forums, structured around the locality arrangements for services: City and South County; Mid-Nottinghamshire; Bassetlaw. These forums were specifically for all medical staff within the service, in the relevant locality. Each forum was chaired by one of the consultants.
30. My recollection is that the City and South County AMH consultant forum was chaired throughout the period 2019 to 2022 by Dr Hermant Bagalkote, but I understand that Dr Eileen O'Regan may also have chaired some of these meetings.
31. Dr Seedat and I would attend these forum meetings and there was a specific slot on the agenda for Clinical Director matters, which enabled us to share relevant information and respond to any questions raised by the consultant body. The forums were our primary means of engagement with the consultants as a group.
32. In addition, there was a MH SCMS consultant forum, which I understand many of our medical staff, including Dr Seedat, also attended. That forum was chaired by the Executive Medical Director, Dr Julie Hankin for the period 2014 to 2021 and then Dr Susan Elcock for the period 2021 to current.
33. A further mechanism for monitoring issues across AMH was the Daily Demand meeting, which took place at 09:15 each morning via MS Teams and was usually chaired by an operations manager from within AMH. I did not personally attend each daily meeting but did review the daily reports and aimed to attend once a week to get a feel for how things were directly. If I was specifically requested to attend then I would do so, for example if there was a high level of pressure across a range of services or an issue that needed my attention.
34. Representatives from all services within AMH attended, the Daily Demand meetings, with EIP and community teams usually represented by their respective service managers. Each service area completed a standardised template in advance **[NHFT0011876]** which was reviewed at the meeting. The Services provided a status update covering any matters that could affect their ability to operate safely that day or in the coming week, including individual patient issues, bed capacity, and staffing pressures such as sickness. Actions were assigned to key staff for resolution, with outcomes reported back either later that day or the following morning depending on

the level of urgency. Where necessary, actions were also assigned to the Clinical Directors or to senior staff outside of AMH. The completed template was distributed daily to the executive team and commissioners for oversight. It was an opportunity for directorate overview for any potential problems and risks that we might have in terms of safe delivery of care, and also served as a problem-solving meeting, as they would discuss what was going to be done as a result of that issue. It was our “business as usual” way of identifying pressures and issues across AMH and trying to support services that were struggling.

EIP SERVICE

35. During my time at the Trust, which spans a period of around 30 years, there were a number of changes in how services were configured. EIP was no exception. The reasons for these changes varied and usually involved a range of factors, including commissioning decisions; geographic realignments; pathway redesign; changes in national policy and prioritisation.
36. Although I cannot say from memory exactly when various changes took place, I do recall that the AO / EIP service was originally established and operated as a standalone team for a number of years, as I outlined in paragraph 11 of this statement.
37. A later, broader programme of work was undertaken to reconfigure community teams as a whole, from which the local mental health teams (“LMHTs”) were developed. The focus of that reconfiguration was on creating local services that incorporated all elements of care, and as a result both EIP and AO were absorbed into the LMHTs.
38. More recently and informed by an audit of the EIP service against the requirements of the National Clinical Audit of Psychosis (“NCAP”), it became apparent that this integrated model was not able to support the service meeting the requisite standards for the EIP service, so the EIP service was considered to be low fidelity to the model. I think that Dr Vidyah Adamson was brought in to address this in January 2020 and bring the EIP service up to NCAP standards. Work was therefore undertaken to separate EIP from the local mental health teams and re-establish standalone teams, often referred to as “uncoupling”. Dr Adamson presented a Workforce options paper to the AMH Programme Board in September 2020 [NHFT0020002] which was later approved (Option 2) by commissioners [WITN0462002]. A “go-live” plan was developed to implement the standalone teams from November 2020, with a slightly

slower time implementation date for the City team from January 2021 (note that there is a typographic error in the original document, which states January 2020 not January 2021 as intended) [WITN0462003]; [NHFT0019871].

39. I recall that there were significant difficulties associated with that process of uncoupling, not least because one of the original reasons for the merger of EIP and AO services into LMHTs had been that many of the EIP teams had experienced operational difficulties including in terms of functioning with the staffing numbers available to them, so the integration had been seen as a means of consolidating available resources across all services. A negative in doing so however was that it had resulted in a loss of fidelity to the EIP model.
40. I was aware of staff concerns regarding EIP staffing and functioning at this time. Some of this was via formal systems and processes as mentioned above. Some was from talking with staff more informally and I remember generally concerns both from EIP staff and staff working in the LMHT's about the uncoupling, and the potential impact for them and their patients.
41. As a leadership team, we had responsibilities both for EIP and the other community services, to ensure all pathways were able to function.
42. I think that my discussions with Dr Adamson would have happened mainly at the AMH Programme Board (likely via video-link due to the Covid-19 pandemic), as well as some more focused meetings to discuss workforce modelling and, in particular, options around medical staffing. I would say that I had an overall awareness of the work that she was doing.

Psychology provision within EIP

43. I do not recall issues being raised with me about specific difficulties in recruiting psychologists during the EIP uncoupling, but I do recall that there were difficulties recruiting psychologists across the board and it was a difficult profession to recruit into. I knew that psychology numbers were low in AMH, and in the Trust generally. I believe this was a national problem, but the issues relating to EIP as I recall, were related to Cognitive Behavioral Therapy for Psychosis ("CBTp") skills more generally rather than psychology specifically, as per the NCAP requirements.
44. I understand that there were difficulties in recruiting CBTp therapists. To my recollection, there was only one person fulfilling that role at the time, Gary Payne,

and there was no one else within the service who held the requisite qualification. The role required completion of a specific NHS England qualification. I would defer to Dr Adamson on this point, but my understanding was that the training sites were not located near Nottingham. The qualification was not recognised until the individual had completed the full course, which took approximately two years. I believe that approximately four individuals within the Trust had been identified to undertake the training, although one may have withdrawn. We were unable to recruit externally to the role because the training programme was relatively new and there was no established pool of qualified candidates from which to recruit; those who were undertaking the training were already working in their respective areas.

45. I recall that Dr Adamson sought to address this gap by recruiting to a combined CBTp and psychology post, utilising new funding that had been agreed, with a view to increasing the overall level of psychological input into the service. I would also note that, given the limited number of psychologists available, they tended to operate what might be described as a cascade model. Rather than providing direct therapy to all patients themselves, psychologists would deliver some direct therapeutic work but would also supervise other staff in the provision of psychological interventions, such as trainee psychologists, nurses who had completed CBT training, and other practitioners delivering psychological therapies. In this way, the psychologists fulfilled a senior oversight role in relation to the delivery of psychological interventions by more junior members of the team.

46. On review of emails provided to me, I can find no specific issues raised to me regarding psychology input to EIP, other than my general understanding as set out above. I attach a document that outlines what was available as of February 2020 [WITN0462004].

Care Co-Ordinator Resourcing

47. Following the Request from the Inquiry, I have had opportunity to review some contemporaneous emails provided to me by the Trust and can only find one explicit e-mail from Dr Eileen O'Regan, a consultant in City North LMHT who worked in the EIP pathway. She raises the concern of the risks related to the CCO numbers to patient ratios in her team [WITN0462005]. Other EIP consultants had identified the same issues to me, and this is reflected in the email correspondence between Dr Adamson and myself [WITN0462006]. I cannot remember how I came to be aware of these issues or which specific Consultants raised them. I have checked relevant Consultant

forum minutes, but no issues are documented there that fits this timeframe. I can only conclude that these were raised in direct conversations with me at the time. In my email to Dr Adamson, I request an urgent meeting and one is arranged for later that day 1pm 16/7/20. I have been unable, however, to find any further emails or documents that give an outcome to this meeting. Nor have I been able to find any further emails about this topic. I would presume that any immediate cover issues would have been dealt with and then monitored by local team management support. The ongoing work would have been pursued via the EIP workstream.

48. As a result of these concerns and workforce modelling led by Dr Adamson, it was agreed that there would be a phased implementation of the EIP transformation plan, with the City teams transitioning at a later stage, to allow for recruitment of additional CCOs in the meantime. My recollection is that there was also some immediate support put in place to address the issues raised, but I have been unable to find any emails or other documents to assist my memory on this issue.
49. Dr Adamson conducted a caseload review to ensure that the correct cohort of patients were receiving the service. This was in line with national criteria for EIP, which had changed to increase the age range for eligibility from 35 to 65. There were also some patients who needed to be discharged from the EIP service because they had been in the service longer than the three-year recommended period and needed to be moved onto an alternative appropriate pathway. Once this work was completed, workforce options were developed (and formalised in [NHFT0020002]) to set out staffing requirements to meet the needs of EIP patients and this identified a shortage of CCOs. As I have explained above, the shortage in CCOs identified delayed the complete “uncoupling” of the City teams.

Dedicated Psychiatrists

50. I have been asked by the Inquiry, through the Request, to consider Dr Vidyah Adamson’s evidence to the Inquiry on 2 June 2022. The Request sets out:

“Q: In terms of your requests for the dedicated [psychologists], who did you push that with? [...] Who did you raise that with and what were their reasons for not giving you that?

A: So it was raised with the clinical directors who were involved in job planning for [] within the Trust, or within the [] [...] I remember Michelle Mallone was one of the clinical directors [...]”

3. Please answer the following:

a. Did Dr Adamson or anyone else inform you of the above concerns/requests or related concerns regarding EIP resourcing, the ability of EIP to deliver its service and/or the request for **psychologists**? If yes, what concerns or requests were raised, by whom and when?" (emphasis added)

51. Having checked the transcript of Dr Adamson's evidence, it confirms that she was being asked about dedicated psychiatrists at this point, rather than psychologists [INQT0000105 internal page 35, lines 21 – 21], so I will address the point of dedicated psychiatrists here.

52. Prior to the uncoupling, my recollection is that Dr. Seedat raised that a draft version of the EIP options paper did not specifically provide for medical investment, because this was considered to form part of wider transformation resources. However, Dr Seedat and I both felt this did need to be expressly provided for and so we asked that this was included in the workforce calculations. To assist with this, I asked all of the consultants who did EIP work to write down what their sessions were (i.e. their split of sessions between EIP and wider LMHT work) and how they worked their sessions (they tended to do so flexibly rather than doing formally allotted time for each pathway). I sent that to Dr Adamson, with an email setting out what the situation was (based on the workforce calculator) and what I thought we would need. The reference to increasing by "1WTE" in order to achieve "partial compliance" was not a reference to one full-time psychiatrist but was the total considered necessary across the four locations/teams, as a sessional resource, and it could also in my view have included some NMP/ACP time, to help support senior clinical input overall and in recognition of the wider challenges the Trust experienced at the time in terms of medical staffing [WITN0462007]; [WITN0462008].

53. My understanding was that a high-fidelity EIP service required a dedicated multidisciplinary team comprising a full-time psychiatrist, a psychologist, nurses, an occupational therapist, a social worker and support workers, all of whom would work together as a cohesive unit within the EIP team. The team would be co-located at the same base, would meet regularly, and would discuss all patients on a routine basis. Although each patient would have an identified care coordinator, the wider skill mix within the team would be drawn upon according to individual patient need. Under this model, the consultant psychiatrist would have oversight of all patients within the team, would be readily accessible to other team members, would have dedicated sessions available to respond to more urgent clinical situations and to conduct

community visits, and would review patients on a regular basis. This was consistent with the model under which the AO teams had operated from around 2000. At that time, the Trust's geographic area was divided into sectors, each covering a portion of the city and a portion of the county, and there were coterminous EIP and AO community teams. Each wedge had a fully standalone team, covering a wider geographic area than the geographic regions of the LMHTs.

54. As briefly described above, there were many changes to services in the years between the National Service Framework implementation in the late 1990s and the 2020's. There were numerous different changes as I recall, including the separation of City and County Social services, and the withdrawal of jointly managed health and social care teams. This finally resulted in seven geographically localised teams; 4 in the City and 3 in the South County. Therefore, the amount of staffing resource, including medical resources were adjusted accordingly throughout this period.
55. At this point in time, there were four City teams and the newly created EIP team South was to remain in these 4 bases, with virtual meetings held as a whole. This enabled patients to access the teams more easily as they were geographically based; existing relationships within those geographies could be maintained both to offer continuity of care to patients and relationships with GP's, social care, and voluntary sector to continue without large scale disruption. I understand this remains the structure to date.
56. I recall that the consultants who were originally working within the standalone EIP teams or AO teams, had transferred into the LMHTs but retained their EIP or AO caseload, alongside a wider LMHT caseload, which would tend to be in relation to serious mental illnesses. Upon the uncoupling of EIP from LMHTs, it worked the same way, in reverse: consultants retained their EIP caseload, and did that work during their assigned EIP time, and continued with the rest of their caseload in their non-EIP sessions.
57. I do recall that there were between six and nine consultant psychiatrist vacancies at any one time across the directorate during my time as AMH Clinical Director, equating to around 10% of the total psychiatry number in AMH. The vacancies were covered by a combination of locum medics, additional paid sessions to Trust medics and some "acting up" arrangements for those eligible.

58. Regular recruitment to consultant posts took place approximately twice yearly, although it was unusual to attract more than one candidate per recruitment round, and on occasion no candidates were appointed at all. Vacancies remained as consultants left (through retirement, change of location or otherwise) at about the same rate as recruitments were successful. Notwithstanding the number of vacancies, all posts were covered by alternative means. This typically involved the engagement of locum psychiatrists or the provision of additional paid sessions to existing staff who wished to take on further work within their job plans. On occasion, psychiatrists who were approaching readiness for a consultant appointment were permitted, with the agreement of the GMC, to act up into the role. I do not recall a time when we were without medical input for the sessions that had been allocated. The ongoing management of these vacancies remained a persistent challenge throughout my tenure.
59. Once EIP had been uncoupled from LMHTs, I recall that the feedback was mixed. Those who favoured integration into the LMHTs generally felt that it enabled teams to work together and support each other, and that it achieved a more equitable distribution of resources and a more balanced prioritisation across all patient groups. Significant resources had initially been directed towards EIP and AO, drawn partly from new funding but largely from within existing services, which some staff considered to have been to the detriment of the broader patient population. Conversely, those who had previously worked within the standalone EIP or AO teams tended to feel that the specialist service was diluted by an integrated model and was more effective as a stand-alone service.
60. Reflecting on this issue, and having reviewed key documents from the time, my view is that there was careful consideration given to the medical workforce for EIP as part of the transformation work, including through involvement by medical colleagues.

AMH Programme Board

61. I set out above the purpose and working of the AMH Programme Board.
62. For the purposes of responding to the Request, I have reviewed the minutes and EIP status reports from 2020 and 2021]. The key issues identified relate to caseload review to ensure the eligible cohort of patients were receiving this service and data reporting to ensure that the National standards and the Trust performance against these were being captured. As I have described earlier in this statement, Dr

Adamson had instigated both pieces of work following her recruitment into post. It became clear that as caseloads were “uncoupled” from LMHT caseloads, the ratio of care coordinators to patients was higher than stipulated in the guidance and my understanding is that the Local Services senior management team, including Julie Attfield as Executive Director at the time, took the decision as a result to recruit “at Risk” prior to a decision by the CCG on increased funding options [NHFT0019871].

63. I can see that there is a reference in the EIP status report dated 10 March 2021 to meetings having been arranged to agree medical input for EIP [WITN0462016]. I have been unable to identify any other information about what this might have been referring to and have no recollection of any such meeting. There is a further reference to medical provision in the AMH Programme Board Minutes for [WITN0462009], where Dr Seedat is recorded as querying whether there have been “any issues for medical provision” and asking to be informed if so, so that this “can be resolved”. I have no recollection of any subsequent issues being raised on this topic. Human Recourses also presented a monthly status report to this meeting, so recruitment was tracked. There were issues with recruitment across all services and disciplines at this time, and this was a significant challenge with high vacancies rates and the use of Bank and locum cover [WITN0462010]. There was a specific AMH workstream and recruitment plan at the time to address these issues and particularly in relation to new monies coming in vis NHS LTP funding [WITN0462017]; [WITN0462017].

64. There are no specific actions identified for me in the EIP workstream reports within this period. I did have my own workstream at this time for the development of Personality Disorders Services, so most of my active work and involvement was with this area. My role was thus to have oversight and awareness of issues as a member of the Senior Management Team. Whilst issues were identified for EIP, such as CCO capacity and the need to support the service through the change process, actions were being taken, with responsibilities assigned and recorded in the workstream reports and minutes, to support teams both day to day, operationally and strategically. I note that compliance with the NCAP ratings had improved from Level 1 to Level 3 by the end of 2021 [NHFT0019664].

Risk register and risk logs

65. The Trust maintained a trust-wide risk register, with Divisional and Directorate registers feeding into this. Specific programmes of work would have a risk log in terms of the risks of them not being able to achieve the specified programme of work.
66. The pro forma for the Programme Board included a dedicated section on risks **[NHFT0020169]**. If a work stream lead identified a significant risk, such as persistent difficulty recruiting to a particular post that was giving rise to a clinical risk, it would be recorded in their status report and raised at the Programme Board meeting. The Programme Board would then consider what mitigations and support could be put in place, and whether the risk was of sufficient severity to warrant inclusion on the overarching Local Services ("LS") or Trust risk register. If so, the risk would be logged on the register, an owner would be designated as the person best placed to manage and reduce the risk, and a senior individual would be assigned oversight. The nature and duration of risks varied. Some, such as recruitment difficulties, were longstanding and remained on the register on an ongoing basis, subject to periodic review of the actions being taken to address them. Others were more specific and time-limited; for example, the identification of ligature risks on a ward requiring remedial action within a defined period, which could be tracked and closed once the necessary steps had been taken.
67. Where a risk log was maintained in connection with a specific meeting, I would expect that risk log to be a standing item on the agenda of that meeting and to be reviewed at each sitting. This provided a local mechanism for the ongoing monitoring of identified risks. Accordingly, if a risk log had been established in relation to a transformation plan, it would be reviewed by the relevant meeting on a regular basis.
68. Risks would generally be escalated to the trust-wide risk register where a common theme had been identified across multiple areas of the Trust. These tended to be systemic risks, such as difficulties with recruitment or financial pressures, but could also include risks relating to specific matters, such as the availability of appropriate discharge alternatives, or risks relating to specific services about which there were particular concerns. In terms of how recurring themes were identified across different local risk logs, there was a corporate governance team which had oversight of all such logs and was therefore in a position, alongside Directorates, to identify common risks. There was also a specific individual responsible for managing the Board Assurance Framework ("BAF"), of which the risk register formed part. The process

was intended to operate in both directions: risks could be escalated upwards from local logs to the trust-wide register, and trust-wide risks could inform local oversight. By way of example, at Julie Attfield's Local Services management meeting consideration would be given to whether any risks arising from within the directorate were of sufficient significance to warrant escalation to the trust-wide risk register.

AMH Consultant Forum

69. Having reviewed the minutes from these forums for 2019 and 2020, there are no issues raised in relation to EIP risks.

Daily Demand meetings

70. From my recollection, the main recurring issue at Daily Demand meetings was that of inpatient bed availability, and people would then be tasked for the day with ensuring that there were enough beds available to meet demand. I would say that EIP rarely came up in Daily Demand meetings, and it would be by exception. The main example I can recall was when one of the service managers said that there were no care coordinators in their service that day, they needed help from others within EIP, so we looked at who could be moved into that team as an emergency to do the key visits that were required.

71. If there were consultant issues, such as somebody off sick, that may have been raised in a Daily Demand meeting, it would usually just be flagged directly with Dr Seedat or me, and we would work out cover.

72. I do not recall any issues being raised regarding admin cover within EIP, and I expect that any issues with admin would have tended to be raised with people's direct line manager, or an admin team leader.

Overall

73. Concerns regarding staffing and caseload pressures existed across all services within the directorate. Throughout my tenure as Clinical Director, the directorate as a whole faced increasing patient numbers with increasingly complex needs, and resources stretched to meet all demands. There was some investments in relation to the NHS long-term plan commitments including into EIP services.

74. There was a persistent shortage of inpatient beds, the management of which consumed a significant amount of time on a daily basis. On occasion, it was

necessary to convene multiple meetings in a single day to satisfy ourselves that all patients were safe and that bed capacity was sufficient to meet demand. The Daily Demand meetings provided a mechanism through which operational staff raised issues relating to caseload and staffing, and on occasion it was necessary to redeploy staff at short notice to provide cover where a particular team was without adequate resources on a given day. These matters were escalated, and the minutes of those meetings were shared with the Trust board and the commissioners [WITN0462011]; [WITN0462012].

75. There were pressures in staffing across most teams in the Directorate due to resourcing levels and vacancies rates. Issues were managed daily to keep patients and services safe by having this overview and moving resources temporarily as needed.
76. These pressures were compounded significantly by the onset of the Covid-19 pandemic. From March 2020, there was a near-constant stream of new directives and guidance to be implemented, and the primary focus during that period was on maintaining the safety of both patients and staff, including the management of infection control on inpatient wards, the safety of staff and patients when conducting community visits, and the adaptation of services to meet rapidly changing requirements. The management of the pandemic and its impact on service delivery was the predominant focus of 2020.
77. Maintaining safe and adequate coverage across all services was a persistent and significant challenge, and the difficulties experienced by the EIP service were reflective of the pressures faced by the directorate as a whole. Our role as clinical directors was to maintain oversight of the directorate as a whole, and our focus in respect of staffing and resourcing was necessarily directed at the totality of the service rather than any single team. We were required to take a holistic view and to ensure safe and effective service delivery on a daily, weekly and monthly basis.

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: 6 July 2026

Index to First Witness Statement of Michelle Malone

No.	Inquiry URN	Document title	Description
1.	NHFT0011876	TEMPLATE Feb 2020 - AMH Daily Demand Management Meeting.docx	Service standardised template
2.	NHFT0020002	MM001 - EIP Model Options Paper V5.docx	Workforce options paper presented to the Board - September 2020
3.	WITN0462002	MM002 - AMH Programme Board Minutes 21.09.2020.doc	AMH programme board minutes dated 21.09.2020 approving option 2
4.	WITN0462003	MM003 - Strategy for Uncoupling EIP from LMHTs.docx	Plan for uncoupling EIP from LMHT
5.	NHFT0019871	MM004 - AMH Programme Board Minutes 19.10.2020.doc	AMH Programme Board Minutes dated 19.10.2020
6.	WITN0462004	_City LMHT's - Psychological Therapy Services available to service users Jan 2020.docx	Psychological Therapy Services available to service users within the City LMHT's 2020 - by Phil Houghton
7.	WITN0462005	MM009 - RE_ EIP LMHT City North	Email correspondence from Eileen O'Regan re: concerns about the lack of CCO's with regard to the uncoupling

8.	WITN0462006	MM005 - RE_ Catch up EIP	Email correspondence from Eileen O'regan re: raising concerns about the CCO numbers to patient ratio in her team
9.	INQT0000105		Inquiry Transcript: Dr Adamson
10.	WITN0462007	MM006 - FW_ Medical input into EIP.msg	Email correspondence re: current spread of medical sessions for EIP
11.	WITN0462008	MM))& - Copy of EIP Sessions V2.xlsx]	Spreadsheet of EIP sessions
12.	WITN0462016	EIP Workstream Status Report - March 2021.docx	EIP status report dated 10 March 2021
13.	WITN0462009	SMI Transformation Programme Board Minutes 19.04.2021.doc	SMI Transformation Programme Board minutes – 19.04.2021
14.	WITN0462010	AMH directorate risk register 29.08.2020.pdf	AMH directorate risk register dated 29.08.2020
15.	NHFT0019664	MM013 - EIP Workstream Status Report - 13.12.21.docx	EIP status report dated 13.12.2021
16.	NHFT0020169	MM008 - EIP Workstream Status Report - 11.08.2020.docx	EIP status report dated 11.08.2021

17.	WITN0462011	MM015 - 21.2.2020 - AMH Daily Demand Meeting.docx	AMH Daily Demand Management Meeting minutes dated 21.02.2020
18.	WITN0462012	MM016 - 27.3.2020 - AMH Daily Demand Meeting.docx	AMH Daily Demand Management Meeting minutes dated 27.03.2020
19.	WITN0462017	Risk 1975 attachment Draft August Workforce Status Report	Report to LMHT Board relating to workforce status
20.	WITN0462018	Risk 1975 attachment Recruitment plan	Plan for AMH Directorate recruitment