

Witness Name: Andy Latham

Statement No: WITN0466001

Dated: 6 July 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ANDREW LATHAM

I, Andrew Latham, 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 Registered Mental Health Nurse, operational leader and 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. 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.

BACKGROUND

5. I am a Registered Mental Health Nurse on the NMC register, qualifying with a Bachelor of Science degree in 1994.

6. I have worked across each of the 3 Clinical Care Groups within the Trust during my career. Following qualification in 1994, I worked at Arnold Lodge, a Medium secure unit in the Forensic Care Group, in a range of clinical roles leaving the site as a Ward Manager. In 2006, I took up a Modern Matron role within the inpatient arm of the Low Secure and Community Forensic Directorate in Nottinghamshire. This role combined clinical and operational leadership responsibilities, where I was the professional lead for the nursing workforce, as well as being operationally responsible for all in-patient wards on the site.
7. In March 2010, I became the General Manager of the Low Secure and Community Forensic Directorate, with operational responsibility for the in-patient service, and a range of teams offering treatment to patients in the Community, and within criminal justice sites including Police stations across the city and county, and within Magistrate and Crown Courts.
8. In June 2019, I became Acting Associate Director of Nursing for the Mental Health Division and held this acting position until I secured the Adult Mental Health (AMH) General Manager role.
9. I secured the AMH General Manager post in August 2020, with a gradual start between November 2020 and January 2021, which allowed for an extended handover with the outgoing General Manager Anne Wright, and the handover of my previous role to the incoming staff member.
10. On 9 September 2024 I became Associate Director of Operations of the Specialist Services Care Unit, within the Community & Specialist Services Care Group of the Trust, a role I continue to hold.

AMH GENERAL MANAGER ROLE

11. The Adult Mental Health Directorate General Manager role had a large portfolio of teams, of which I was operationally responsible for. This included three acute mental health in-patient units (later becoming two) and two longer stay rehabilitation sites. The Directorate provided acute care to those in the community experiencing a mental health crisis via Crisis and Home Treatment Teams, including Street Triage teams who worked alongside the Police, and operated two Health Based Places of Safety – often known as 136 Suites. In addition, the Directorate provided community care via Local Mental Health Teams (LMHT), and after 2020, standalone Early Intervention in Psychosis (EIP) teams. These teams operated out of multiple bases across the city and county of Nottinghamshire. The Directorate also provided longer term

interventions through its Step 4 Psychology and Trauma service, and had small teams offering care to those with a substance misuse history, or who were homeless [WITN0466002].

12. As General Manager of AMH I reported directly to the Deputy Director of the Division, Mr. Chris Ashwell, and through them to the Divisional Executive Director Dr Julie Attfield.
13. I worked alongside two Clinical Directors throughout my time in this role, with them leading on clinical care and clinical strategy, including the leadership and resource management of the medical workforce, and me leading on the operational and performance aspects of the Directorate. The Clinical Directors when I took up my post were Dr Faizal Seedat and Michelle Malone. In May 2022, both the above had either stepped down or retired from their roles (in that order), and two new Clinical Directors, Dr Karthik Thangavelu, and Dr Gareth Foote were recruited. Both clinicians had long standing and active experience within Adult Mental Health.
14. The Operational structure in place at the time was that Operational Managers responsible for a wide portfolio of services and teams reported to the General Manager. Each Operational Manager had several Service Managers as direct reports, each responsible for smaller sub sections of their portfolio.
15. GRO-B and I did not meet Dr Adamson prior to, or when I took up the General Manager role.
16. When I came into the General Manager post in November 2020, I received a handover from Anne Wright about each of the teams, their leadership structure, and specific actions or challenges related to the provision of care. This included a summary of the EIP service.
17. I had a limited knowledge base associated with the EIP work from membership of Divisional forums such as the Mental Health Senior Managers Group and Divisional Quality and Risk forums.
18. I had a wider understanding of the workforce challenges experienced across the Trust and had led Nursing Establishment Reviews across many in-patient services in my role as Acting Associate Director of Nursing. As such I was aware that nurse recruitment was difficult, that the market for employing nurses local to Nottingham was crowded, and that in order to maintain a suitable workforce we needed to champion roles such as Non-medical Prescribers, and Advanced Clinical

Practitioners, as well as support our unqualified workforce to access Nursing Associate Training and further top up qualifications.

19. In that role, I had previously presented a quality paper at the Divisional Accountability Review, chaired by the then Chief Executive [WITN0466028]. The August 2019 paper included a summary of the Outlier Status finding in the 2019 EIP Spotlight Audit. This identified a low compliance rate of annual physical health checks and cardio metabolic assessments completed for those on the EIP caseload. The paper also reflected that similar low completion rates were identified across the Divisions in-patient services, featured in a CQC report and a Quality Improvement Project was underway to improve annual assessment rates. I hadn't been involved with the EIP team, or the Spotlight Audit process prior to its publication, or involved in the team's development afterwards. Information presented in the report was shared by the Divisional Deputy Director.
20. Other than the above I had limited understanding of the EIP service and quality challenges that they experienced.
21. I do not recall Anne's handover description in detail; however, I believe it included feedback that Dr Adamson was extremely talented and motivated, was the lead for the service, and had designed a new EIP service model that had received transformation monies. Decisions around funding the new model and service change were managed through the AMH Transformation Board, of which the General Manager was a member. I do not recall issues of concern being flagged to me concerning the new EIP model or the process of decoupling.
22. I quickly became aware however, that during the change period where individual EIP teams were separating from their Local Mental Health Teams (LMHT's), there was high levels of pressure experienced by the EIP leaders conducting the transition. One of the Service Manager raised this on the COVID check in call that occurred weekly and separately alerted me and the outgoing General Manager of the impact this was having on the team leaders, and their need for additional support [WITN0466003].
23. In response, I asked the Operational Managers responsible for each of the LMHT's to offer support with the transition, and to check in with the team leaders.
24. The outgoing General Manager, who had been involved in the staffing model's creation and funding decisions, met with the staff member escalating the concern and reassured them that additional posts including clinical leads and a dedicated Service

Manager responsible for the day-to-day leadership of the EIP teams, were being recruited [WITN0466004]; [WITN0466005].

25. At the time I considered the high activity required whilst the teams separated as challenging but understandable, and that the recruitment of additional key leaders to support the EIP team was sufficient for the risk to be mitigated. It was therefore not raised on the risk register.
26. Shortly after Kelly Simpson was recruited into the Service Manager role and remained a consistent leader for the team, reporting to identified Operational Managers until after I left the service in 2024.
27. In response to Dr Adamson's [GRO-B] Tracey Taylor had been identified as Operational Manager for EIP alongside other services. I was not involved in allocating this role and I am unsure of the level of handover between Dr Adamson and Tracey Taylor. I have however had sight of a handover document that was created at the time which summarised the service, reporting routes and has identified actions for Tracey Taylor [WITN0466006].
28. I first met Dr Adamson on the 6th of April 2021 [GRO-B] via a Teams video call.
29. My interactions with Dr Adamson at that stage were focused on providing support for her on-going involvement in the EIP team, and discussing her desire to return to work balanced alongside her caring responsibilities. Dr Adamson and I discussed her providing an At Risk Mental State (ARMS) training session to the team on one of her Keeping in Touch (KIT) days, plus she briefed me on some information on Serious Mental Illness (SMI) pathways being developed nationally.
30. We also discussed her desire to remain significantly involved in the developments and strategy of the service [GRO-B] This included attending the EIP monthly meetings and retaining oversight alongside the leadership team. Following the meeting I linked with the Operational Manager to advise her of Dr Adamson's intent, my request that a contact and involvement plan was agreed, and that pre-meets should be set up to ensure the leadership team could lead consistently [WITN0466007].
31. Later in the year Dr Adamson and I agreed that following [GRO-B] she would use some of her accrued leave entitlement between mid-August and October 2021, and she returned to work in October 2021.

32. Dr Adamson assumed the leadership of the EIP teams on her return, authoring workstream reports and linking with her team.
33. After some weeks, however, Dr Adamson approached me stating that she had decided to resign from her post due to personal reasons. We talked through options and agreed that she would access a career break instead, in the hope that in a year she would feel more able to come back to her previous role. The career break started on 5 December 2021 and continued until a year later when she again confirmed her intent to resign. This is recorded on the Trust's electronic staff record as 5 December 2022.
34. Tracey Taylor's portfolio of services had been amended when Dr Adamson had returned in October, and she did not have the capacity to resume oversight for the EIP team in response to Dr Adamson's career break. As a result, Kerry Watson assumed operational oversight, again with Kelly Simpson supporting as the service manager.
35. Throughout my line management of Dr Adamson, our conversations were mostly focused on personal / pastoral matters rather than on staffing or operational matters within the EIP team.

EIP Team Development and Progress

36. There were two main governance and performance monitoring forums in place within the AMH Directorate during my tenure. These were the Business and Performance Meeting, which became the Directorate Management Team (DMT) meeting in 2021 and was chaired by me; and the AMH Programme Board, which became the Serious Mental Illness (SMI) Transformation Board in April 2021, chaired by the Divisional Deputy Director. These are described below.
37. As AMH General Manager I chaired the Business and Performance meetings for the Directorate, at which monthly briefings from services would be received. In July 2021, I introduced the Directorate Management Team meeting ("DMT") and stood down the previous Business and Performance meeting. With the new meeting, I introduced a new agenda designed to elicit comprehensive feedback from each service, generate discussion, and identify escalations that should be made. The DMT agenda included a monthly EIP update report reflecting performance against the National Clinical Audit of Psychosis (NCAP) standards. It also included two standing items at the end of each meeting, 1) any risks identified for addition to the Risk Register, and 2) any messages to be communicated to staff teams (see, for example, [WITN0466008]).

38. The monthly EIP discussions at DMT did include updates on recruitment challenges, and personnel changes, however focused more on performance against 7 NCAP standards, and actions that were required. Three of these areas required improvement and were rated at a level 2 in early 2021 **[WITN0466031]**.
39. In the 2019/20 cycle of the National Clinical Audit of Psychosis – EIP Spotlight Audit, the Trust had been identified as an alarm outlier, with a 58% completion rate of annual physical healthcare assessments being completed annually. This was significantly lower than national averages **[WITN0466009]**.
40. In addition, the EIP teams needed to evaluate their service delivery through increased use of Paired Outcome measures, where treatment outcomes were measured on a clinician rating scale, and a patient scored rating scale; plus increasing the amount of formal Carer focused Education & Support offered by clinicians. Included as **[WITN0466010]**, is the report that came to the July 2021 DMT.
41. The October 2021 DMT received a report showing increased performance across each of these areas with annual physical health assessments and Carer Focused Education and support both rated as a strong level 3 against national standards **[WITN0466011]**. Paired outcomes remained a challenged area but showed improvement.
42. The report reviewed at the December 2021 DMT identified a recording code error through manual reviews of patient records. This created an over reporting of Family Intervention through 2021 where we believed the team were completing many more interventions than they were. A thorough review of all patient notes followed through Dec and January 22 to ascertain the correct data, and an associated action plan was created and followed through Spring and Summer 22 **[WITN0466012]**; **[WITN0466030]**.
43. Monthly reporting at DMT continued to focus on the EIP teams' performance against the NCAP standards, and this formed part of updates, and bespoke reporting to Divisional Mental Health Senior Management Team and Quality and Risk meetings chaired by the Executive Director. An example of this is an EIP Summary Report produced by the EIP Service Manager and presented at the June 22, Divisional Mental Health Senior Management Team meeting **[WITN0466013]**.
44. On reflection however, whilst the monitoring of the number of patients offered interventions linked to national standards was an important measure of quality, the reports received and discussion that ensued did not focus on Care Coordinator

caseload sizes. Large caseload sizes were one of the issues that stopped Care Coordinators from providing focused interventions before the EIP teams decoupled from the LMHT's.

45. A more detailed review of the use of EIP transformation investment, associated recruitment and service delivery was presented at the AMH Programme Board as detailed below.
46. The AMH Programme Board was in place when I joined the Directorate and was focused on Transformation schemes taking place across the Directorate. This became the SMI Transformation Board in April 2021 and continued to focus on 6 major workstream, with the Transformation of the EIP services being one of them [WITN0466014].
47. The AMH Programme Board/SMI Transformation Programme Board (I will use the latter title going forward in this statement) was the overarching mechanism for delivering and monitoring the Transformation Program. The Programme Sponsor was the Divisional Executive Director, Dr Julie Attfield; Programme Director and Chair of the meeting was the Divisional Deputy Director, Mr Chris Ashwell, and the Programme Manager was Mrs. Kazia Foster, Divisional Transformation Lead.
48. Although I was not present at every monthly meeting, I did attend this forum regularly from 2021 through to October 2022 when I then had a period of absence for two planned surgeries lasting approximately six months.
49. In preparing this statement, I have reviewed the SMI Transformation Board minutes, Agendas and Action Logs relating to EIP, covering the period from when I started in the General Manager role through to August 2023.
50. Having reviewed those records, I note that they map the development of the EIP Team over time, with monthly progress updates being provided in a written workstream report and presented by the workstream lead or nominated deputy.
51. To show how this process worked I have summarised the feedback presented to the Board in my first 6 months in post below.
52. In January 2021 [WITN0466015]; the Strategic Lead for the EIP service had started GRO-B and an Operational Manager, Tracey Taylor, had been identified to manage the service whilst she was away. Colleagues fed back that the last EIP teams were scheduled to soon separate from the Local Mental Health Teams (LMHT) and operate independently, that recruitment to the team was a high priority, however low compliance with physical health assessments of those on the caseload was a

clinical risk which needed increased focus across several months. Health Improvement Workers had been redeployed to help increase the volume of assessments/actions and a significant improvement was seen between January and June 2021 [WITN0466016].

53. In February 2021, the feedback was that all EIP teams were now decoupled from their base LMHT and functioning independently. The main actions related to on-going team recruitment, focus on improving the monitoring of physical health needs of the client group and agreeing medical input [WITN0466037].
54. The March 2021 Board identified the same actions; however, noted that a discussion was planned with the Clinical Commissioning Group (CCG) to discuss the At-Risk Mental State (ARMS) requirements, and further investment to increase the workforce to deliver this [WITN0466017]; [WITN0466038].
55. The April 2021 Board minutes details that Clinical Director, Dr Faizal Seedat asked for feedback about medical sessions delivered to the team, and asked to be contacted directly if there were any problems. The Board also received feedback that Dr Adamson was due to provide ARMS risk training to the EIP team [GRO-B] [GRO-B] [WITN0466018]; [WITN0466029].
56. In May 2021's Board meeting recruitment challenges were discussed, and it was described that a "dry period" was being experienced after the initial positive recruitment earlier in the year (September 21 minutes state that recruitment is going very well when compared to the spring "Dry Spell"). In addition, the Board focused on the treatment's being delivered, and performance against national standards. The Board noted an improvement and that the trajectory was to attain level 2 compliance shortly [WITN0466019]; [WITN0466034].
57. June 2021's Board meeting minutes continued to detail efforts taken by the team to recruit, and identified that an ARMS business case was being developed to support a request for additional funding from the CCG [WITN0466020]; [WITN0466035].
58. I have reviewed each of the SMI Transformational Board documents through 2021 to August 2023 and can confirm that this monthly progress update was presented and scrutinised each month. Throughout this time recruitment plans were referenced and communicated to the membership including myself. Themes that were present included recruitment and turn over dynamics of the nursing and care co-ordinator workforce, challenges recruiting additional medical sessions for the team, and

attempts to mitigate this through the recruitment of prescribing pharmacists (Aug 2021), difficulty recruiting 2 additional qualified Cognitive Behavioural Therapist in Psychosis (CBTp) to the team which whilst partially resolved in March 22 remained an issue, challenges accessing Health Education England training places to allow staff to be trained as CBTp therapists, and the development of the ARMS business case through early 2022, its eventual support and recruitment to an additional 7 wte staff through Oct – Dec 2022 [WITN0466021].

59. I believe medical sessions remained unfilled throughout my role in AMH, and alternate plans and mitigations were explored. These included recruiting non-medical prescribers through Nursing and Pharmacy routes and supporting colleagues to complete the Advanced Clinical Practitioner (ACP) training [WITN0466022].
60. The SMI Transformation Board maintained its own internal risk register log [WITN0466023], which identified a risk matrix score based on the potential impact of an issue, multiplied by the probability of it occurring.
61. Between 2019 and 2023, 11 EIP risks were identified on the register. Three were added between 2019 – 20 detailing: (1) the creation of standalone EIP teams; (2) the pace of change; and, (3) potential vacancy challenge LMHT will experience as staff leave to join the new EIP teams. These risks were rated as medium risks with an overall score of 9.
62. In 2021, 3 risks were added including: (1) Highlighting the lack of clinical assessment training nationally for the delivery of ARMS interventions; (2) New national guidance that those requiring ARMS interventions should stay on the caseload for 3 years, and (3) the need for business case support to fund additional EIP staff to deliver the ARMs treatments were raised. In December 2021 a fourth risk linked to performance against the NCAP Family Interventions standards was raised. These risks were rated as medium risks with an overall score of 9.
63. In 2022, 3 risks were raised regarding: (1) workforce challenges in LMHT as a result of EIP colleagues transferring patients back to them; (2) the on-going challenge to recruit to our final CBTp post; and (3) the continued lack of national training places for CBTp and Clinical Assessment of At Risk Mental State. Risk 1 was rated as a high risk with a score of 12, whilst risk 2 and 3 were rated as medium risks with an overall score of 9.
64. Each of these risks were monitored in the SMI Transformation Board. The risk relating to LMHT's struggling as cases were passed to them by EIP workers remained

live in May 24 and continued as a high risk with an overall rating of 12. All other risks were closed by the Board however a corresponding date when this occurred is not often captured.

65. As each risk was recorded and progressed through the SMI Transformational Board, and did not receive a high-risk rating, they were not subject to additional scrutiny at the DMT meeting and long delays in recruiting key staff members such as the CBTp therapists, were not recorded as risks as part of the Directorate local risk register.
66. In hindsight, the link between the SMI Transformation Risk Register Log, and the formal Risk Register process used across the Trust should have been clearer.
67. To aid my statement I have discussed with the Trust Risk Manager to understand when risks relating to the EIP service were last identified through Directorate, Divisional or Trust Board risk registers (known as the Board Assurance Framework).
68. They have fed back that the Board Assurance Framework report considered by the Trust Board in September 2016 referenced a risk linked to the EIP teams **[WITN0466024]**.
69. Between 2016 and 2018, there was an organisational risk (ORG0000087) detailing the EIP teams' reduced ability to manage demand, their large caseloads, and challenges in assessing and treating those on their caseloads **[WITN0466025]**.
70. The organisational risk was discussed by Executive Directors of the Trust in their governance forums. The Trust Risk Manager has reviewed the history and has confirmed that the organisational risk was last discussed at Executive Leadership Team level in August 2018 and was closed as an organisational risk the following month, in September 2018.
71. Between 2016 and 2017, there was an AMH Directorate risk relating to capacity and demand in the EIP teams, and their ability to manage their caseload whilst being conjoined with LMHT's **[WITN0466039]**.
72. In 2017, the above risk relating to the EIP team was closed on the Directorate Risk Register, after the responsible managers assesses that the core mitigation actions had been completed.
73. Having checked for the purposes of this statement, I believe that EIP risks did not return to the Directorate risk register until 2024, when there was very briefly a risk around medical staffing shortages and how that impacted the EIP team **[WITN0466027]**.

74. In summary, I believe that I, and my management team; plus, colleagues leading the AMH Transformation programs and attending the SMI Transformation Programme Board, were all aware of staffing challenges within the EIP teams. These challenges were profound in 2019-2020, impacting caseload size and compliance with the delivery of treatment interventions. As a result, the Trust received transformations funding to recruit additional staff as they de-coupled from the LMHT's.

75. Recruiting the new teams was a significant action and took time and focus from those involved. The new model and approach was viewed positively, as caseload sizes were reducing, and improvements in the therapeutic offer were measured and benchmarked.

76. There were some extremely hard to recruit posts, such as CBTp therapists, and this struggle to recruit was compounded by the lack of Health Education England training places which stalled our ability to grow our own staff.

77. This was acknowledged and monitored by the SMI Transformation Programme Board, which I was a member, and assessed as medium level risk.

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.

GRO-B

Signed:

Dated:

6 July 2026

Index to First Witness Statement of Andrew Latham

No.	URN	Document title	Description
1.	WITN0466002	AMH Structure Dec 20	Organisational chart of the Adult Mental Health Team
2.	WITN0466003	EIP Concerns City and County Teams	Email from Kerry Watson to Andy Latham 28.-1.21
3.	WITN0466004	RE_Staff wellbeing	Email from Anne Wright to Andy Latham 28.01.21
4.	WITN0466005	Funding EIP	Email from Anne Wright to Andy Latham 11.02.21
5.	WITN0466006	EIP Handover	EIP handover information
6.	WITN0466007	just had a 121 with Vidyah	Email from Andy Latham to Tracey Taylor 07.04.21
7.	WITN0466008	DMT Agenda 21 st July 2021	DMT Agenda 21 st July 2021
8.	WITN0466009	NCAP 1920 Audit – Outlier Investigation Report	National Clinical Audit of Psychosis – EIP Spotlight Audit 2019/20
9.	WITN0466010	EIP report to the Directorate Management Team – July 21	EIP report to the Directorate Management Team – July 21
10.	WITN0466011	Schedule 6 EIP Dashboard	EIP dashboard October 2021
11.	WITN0466012	QiPP EIP Benchmarking FI v2	Quality Improvement Plan for EIP Family Interventions
12.	WITN0466013	EIP Summary May 2022	EIP Summary May 2022
13.	WITN0466014	Transformation Programme Board	Transformation Programme Board Terms of Reference

		Terms of Reference	
14.	WITN0466015	SMI Transformation Programme Board Minutes 18.01.21	SMI Transformation Programme Board Minutes 18.01.21
15.	WITN0466016	Risk log R 19 and Physical health improvements needed across EIP	Email from Andy Latham to Tracey Taylor 18.01.21
16.	WITN0466017	SMI Transformation Programme Board Minutes 15.03.2021	SMI Transformation Programme Board Minutes 15.03.2021
17.	WITN0466018	SMI Transformation Programme Board Minutes 19.04.2021	SMI Transformation Programme Board Minutes 19.05.2021
18.	WITN0466019	SMI Transformation Programme Board Minutes 17.05.2021	SMI Transformation Programme Board Minutes 17.05.2021
19.	WITN0466020	SMI Transformation Programme Board Minutes 21.06.2021	SMI Transformation Programme Board Minutes 21.06.2021
20.	WITN0466021	ARMS Milestone planner 15.3.23	ARMS Milestone planner 15.3.23
21.	WITN0466022	email entitled RE_ACP_TACP for EIP in the EIP Concerns email folder	
22.	WITN0466023	SMI Transformation Risk Log from 17 June 2024 meeting.	SMI Transformation Risk Log from 17 June 2024 meeting

23.	WITN0466024	BAF and Risk Register Paper Sept 2016	BOARD OF DIRECTORS, 29 September 2016, Board Assurance Framework Executive Summary (Exceptions Report) & High Level Risk Registers
24.	WITN0466025	ORG0000087	Trust Risk Register 17.02.16
25.	WITN0466026	SMI Transformation Board Risk Log from 21.03.2022 meeting	SMI Transformation Board Risk Log from 21.03.2022 meeting
26.	WITN0466027	2490 Risk Report	Trust Risk register 12.11.24
27.	WITN0466028	-Quality Briefing for LP Accountability - 08 Aug 19	Quality Briefing for LP Accountability, 9 August 2019
28.	WITN0466029	EIP Workstream status report – April 2021	EIP Workstream status report – April 2021
29.	WITN0466030	EIP Dashboard	EIP performance update December 2021
30.	WITN0466031	NCAP England national report 2021-22	National report for England, Early Intervention in Psychosis Audit, NCAP, 2021/2022
31.	WITN0466032	DMT Minutes 17th November 20212	DMT Minutes 17th November 20212
32.	WITN0466033	DMT Minutes 15th December 2021	DMT Minutes 15th December 2021
33.	WITN0466034	EIP Workstream Status Report – May 2021	EIP Workstream Status Report – May 2021
34.	WITN0466035	EIP Workstream Status Report – June 2021	EIP Workstream Status Report – June 2021

35.	WITN0466036	EIP Workstream Status Report – 13.01.2021	EIP Workstream Status Report – 13.01.2021
36.	WITN0466037	EIP Workstream Status Report – Feb 2021	EIP Workstream Status Report – Feb 2021
37.	WITN0466038	EIP Workstream Status Report – March 2021	EIP Workstream Status Report – March 2021
38.	WITN0466039	1540 Risk Report	Trust Risk Register 17.0216