

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF ANN WRIGHT

I, Ann Wright, will say as follows: -

1. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with the matters set out in the Rule 9 request dated 05 June 2026 (the "**Request**").

Career and Role

2. I have been qualified as a Mental Health Nurse since 1991. I have worked clinically in Adult Mental Health Services at Central Nottinghamshire Healthcare from qualification until 1992 when I left to work in Secure Services at Rampton Hospital. I moved back to Nottingham to work in community rehabilitation services and then went to work in Adult Mental Health Community services in Derbyshire. I returned to Nottinghamshire in 1998 which became Nottinghamshire Healthcare and worked in Adult Mental Health, Community services as a Community Psychiatric Nurse and then Team Leader setting up the new Crisis Resolution and Home Treatment team.
3. In 2007 I started my first managerial role as Service Manager in Psychological Therapies. I then became Operational Manager developing the new (Improving Access to Psychological Therapies ("IAPT")) service and then Operational Manager for Specialist Services in and in 2016 General Manager. The title of General manager changed to Service Director as Community (physical) Health and Mental Health divisions were merged under one Executive Director and Deputy Director in 2017. In February 2019 I became Service Director in Adult Mental Health ('AMH'), this title reverted back to General Manager after Community (general) Health and Mental Health were separated again in April 2019. I retired on 12th February 2021.

4. The Purpose of the role as 'Service Director/General manager' was to operationally manage the Directorate. This included in-patient services, outpatient services and community services.
5. I have been asked to set out whether Dr Adamson or anyone else informed me of concerns and/or requests or related concerns regarding EIP resourcing, the ability of the EIP to deliver its service and/or the request for psychologists. I have also been asked to set out if concerns were raised, were they recorded; what actions were taken in respect of issues raised, and whether concerns or requests were escalated to others in the Trust.
6. When I commenced work in AMH in 2019, Early intervention into psychosis ('EIP') was known not to be performing as per the national standards, this was an area of concern for the Trust and was known widely. Julie Hankin, Medical Director was aware and there were ongoing discussions to identify how these issues could be addressed. My understanding of the initial concerns were following the Local Mental Health Teams functions being absorbed into the Local Mental Health Team in 2018. I was not part of the Adult Mental Health team during this time, but I was aware of the difficulties due to being employed by the Trust. Following the merger of the teams, there was less focus and ability to fulfil the service within Nottingham. The Five Year Forward View (2016) [NHSE0000002] and the Long-term plan in 2019 [NHSE0000014] set out clear expectations and requirements for the Trust to deliver the EIP service. Staff and IT systems needed to be developed so that the required data sets could be completed for accurate and timely data. Increased funding was essential to be able to meet these standards.
7. I discuss the plans the Trust worked towards surrounding the EIP service during my time as general manager below. Due to the passage of time, I do not recall the specifics of discussions with Dr Adamson, however AMH did have a work stream specifically focused on EIP. The workstream was where concerns, issues and progress would be discussed. Throughout AMH, several workstreams were in action and fed into the AMH Programme Board. The issues surrounding staffing would have been part of the staffing model and recruitment plans. Business plans were required to gain additional funding for the staffing model and recruitment process, which needed to be followed. Recruiting staff with the appropriate skills, knowledge and experience, specifically for CBTp Therapists was a challenge for the Trust however I understand this was also difficult nationally, due to the lack of professionals in this field. Training to support

clinicians to ensure we met the requirements asked was also sparse and therefore it was inevitable it would take time to improve the service.

8. From January 2020 I was Dr Adamson's line manager, **GRO-B**
GRO-B She would sometimes share an office space with me, and therefore conversations surrounding EIP and the difficulties it faced were either in general conversation, sometimes in supervision and more formally in meetings. Due to COVID-19 shortly after Dr Adamson's appointment, there was not always ability to discuss in person. At this time, I line managed the Deputy General Manager until her retirement around April 2020 as well as x 4 Operational Managers, the Step 4 Lead, the Psychotherapy Lead and Head of Nursing **[WITN0478015]**.

Adult Mental Health and the EIP service

9. The AMH Standard Operational Procedure ('SOP') v6 2019 **[NHFT0021656]** identified that teams' structure for each team at full establishment would be able to offer the following roles;
- a. Team Leader
 - b. Clinical Lead
 - c. Community Psychiatric Nurses
 - d. Occupational Therapists
 - e. Consultant Psychiatrist
 - f. Supporting Medical Team
 - g. Psychologists
 - h. Advanced Clinical Practitioners
 - i. Non-Medical Prescribers*
 - j. Individual Placement Support Workers
 - k. Cognitive Behavioral Therapy for Psychosis ("CBTp") Therapists*
 - l. Associate Nurses

- m. Support Workers (Healthcare Assistants, Peer Support, Occupational Therapy)
- n. Pharmacy Technician* (not all teams would have these)
- o. Administrative Support

10. EIP was identified as Cluster 10 pathway which is the Cluster for first episode of psychosis using the National Mental Health Clustering Tool. This tool provides an assessment which then assigns patients to an appropriate cluster, this then triggers a structured package of care designed to meet their needs and standardising care that is evidence based.

11. In respect of the AMH structure, I became Service Director in February 2019, which became General Manager as Michelle Malone left this post to become Clinical Director with Dr Faizal Seedat. Service Director titles had been introduced when the Community General Health Division and Mental Health Division were merged in 2017. Service Directors were managed by Clinical Directors. In 2019 when Community General Health and Mental Health were separated again, the title Service Director reverted back to General Manager and were line managed by the Associate Director, Chris Ashwell. Michelle and Faizal were responsible for the clinical leadership and governance, and I was responsible for the operational and business activity within Adult Mental Health services. I oversaw all Adult Mental Health inclusive of inpatient wards, outpatients and the community services across Nottinghamshire.

12. The Mental Health Senior Management Group (MHSMG), which I was part of, was a monthly meeting chaired by Julie Attfield. See 'Terms of Reference' Exhibit as [WITN0478051] which describes the purpose of the MHMSG, in that it was to collectively lead and oversee the performance management and governance arrangements for the Local Partnerships Division Mental Health services. It was to oversee the achievement of its financial, business and performance objectives and to support a high standard of organisational governance. Meetings for this group aimed to be held on the last Wednesday of each month between 2-4pm and considered all matters pertaining to governance for local partnerships mental health services relevant to;

- a. Divisional performance management, Finance Improvement Plans (FIPs) and monitoring.

- b. Financial performance including procurement.
- c. Workforce, Equality and Diversity.
- d. Reports and Action Plans from Internal and External Reviews as required.
- e. Risk Register monitoring, via the Mental Health Quality & Risk Group.

13. The MHSG had three sub-committees being;

- a. Mental health quality & risk
- b. Local partnerships workforce, equality and diversity
- c. Local partnerships health, safety, security & EPRR group.

14. The Adult Mental Health Programme Board was established prior to my tenure. It was to oversee and manage the transformation of AMH services. The programme covered the whole pathway of care, including work to determine and develop inpatient capacity for the short, medium and long term. The programme was a complex transition which included the redesign of the community offer, working with primary care and other stakeholders. The aim was to put into place a more coordinated and cohesive programme, by a range of projects and improvement initiatives. The Programme Board roles and responsibilities were to;

- a. Determine and mandate the programme of work required to deliver the strategic transformation;
- b. Establish and define roles and responsibilities;
- c. Manage and monitor the delivery of the programme, and associated projects, to ensure all key milestones were achieved;
- d. Identify and manage any associated risks;
- e. Develop effective internal and external stakeholder management, service user involvement and communications relating to the programme; and
- f. Identify and manage independencies.

15. The Programme structure is identified within the Terms of Reference at page 3 **[WITN0478014]**.
16. Upon my appointment in February 2019, as explained above, the EIP service was not meeting national standards; much work was required to address this including to increase staffing numbers and staff that were appropriately trained to meet the required standards in line with the Five Year Forward View (2016) **[NHSE0000002]** and Long Term Plan (2019) **[NHSE0000014]**.
17. The EIP team that been formed previously following investment attached to the Policy Implementation Guide ("PIG") 2001 **[WITN0478023]** I understand had been absorbed into the Local Mental Health team as part of the community developments that were made to meet cost improvement demands. As part of the difficulties, funding was known as a continuous issue when I was appointed. During my employment, we asked for 'stabilise and bolstering funding' to assist with the deficiencies in the EIP Team in September 2019, however funding still fell short to assist in getting out of this position. Multiple conversations were held with commissioners, to discuss what was realistic to ask for.
18. Prior to me starting in my role, the remodel within the community was a very difficult time for staff, as the Trust reduced the numbers of clinicians which left the services vulnerable. It was felt Trust wide and not just in EIP. I believe the remodel was around cost improvement. Historically Psychology had been reduced within Mental Health services as part of cost improvement plans. The impact of this was still felt as the Trust had lost some senior clinicians who as well as supporting patients had skills that supported staff i.e. supervision.
19. The further difficulties, as highlighted above, were that there was a national deficiency for specific training to ensure clinicians were being trained appropriately in CBTp and other required approaches. The Trust struggled due to there being so few courses available nationally.
20. As a trust in 2019 we had not yet familiarised ourselves sufficiently around the data and 'SNOMED' recording, which is a form of data coding. Once appointed into the role in January 2020 Dr Adamson worked with the IT team to get this set up due to her awareness in this area.

21. Prior to Dr Adamsons appointment, it was identified what the service needed was very different to what we currently had. In an email dated 15 July 2019 I raised that the team was in a critical position and they needed to make some serious changes and investment as soon as possible. During this discussion with senior leads, it was agreed to employ leads, and address the issues raised by other colleagues. [WITN0478035].
22. When Dr Adamson was appointed, the Trust were aware they were below the required standard, and this needed to be rectified. The Trust needed someone with the expertise, knowledge and experience around EIP. Dr Adamson had previously worked for Lincolnshire Healthcare and was the regional lead, therefore when she applied for the advertised post, she was hired due to her expertise and knowledge in EIP.
23. Senior Management Team (SMT) meetings were held weekly where AMH senior leaders and support service leads would attend and discuss current issues with the general manager and clinical directors. Leads of services including lead psychiatrists, finance, HR, etc would attend monthly. The aim of these meetings were to be a two-way communication within AMH so there would be awareness of developments and issues within the services and the wider Trust. I am informed that SMT meetings ceased following my retirement in February 2021.
24. Julie Attfield and Christopher Ashwell led the Programme Board meetings, discussing the developments in adult mental health which all workstreams fed into, holding the directorate to account. Actions and risks were identified during each meeting to be discussed at the next. If actions were outstanding, they would be discussed and continued until the next meeting. Please see the Terms of Reference for Programme Board Meetings [WITN0478014].
25. In 2020 a business plan was developed with commissioners and Dr Adamson for additional funding so that the EIP service could be a standalone service again [WITN0478025].

Concerns raised and actions taken

26. Any immediate concerns raised within the Trust, would be raised directly with management and discussed at weekly SMT meetings, Programme Board meetings, business meetings and via supervision. I would have been aware of concerns raised through these channels. Alongside the difficulties that the AMH Team were experiencing, COVID-19 also had an impact on the ability to deliver services. To

support staff through this unique and tremendously difficult time I arranged a daily Teams call for all managers to participate. This was opportunity to catch up, sense check, maintain open communication, highlighting areas of concern and operational issues, troubleshooting where possible or agreeing who and how to resolve. The aim was to support services running as smoothly as possible whilst supporting staff wellbeing. Concerns were escalated to the senior team when required as well as if part of ongoing work directed and monitored via the appropriate clinical workstream or other relevant meeting.

27. The ability to deliver the EIP service was raised throughout the course of my employment and within my role as General Manager. In September 2019 in the AMH Programme Board Minutes the EIP lead advert was externally advertised, alongside the agreement for two service manager leads for EIP **[NHFT0021473]**. This was following the leadership team identifying that the EIP service required an EIP expertise with knowledge and senior lead to support through a transitional change and development. Through each AMH programme board meeting, a recovery action plan was identified. This provided actions required to be set out and monitored, to support the progress following concerns and issues being raised. As an example, the September 2019 Recovery Action Plan ('RAP') is attached to this statement **[WITN0478020]**.
28. As part of addressing the concerns raised surrounding the service, in October 2019, it was identified in the AMH Programme Board meeting (11.1) that there was a workshop due to think about how the transformation money could be used to support backlogs in the Local Mental Health Teams ('LMHT's), and it was agreed that a working group with key people would be set up to discuss the LMHT/EIP transformation funding spend. Tracey Taylor and Tim Constable were tasked with this. See **[NHFT0023603]**.
29. Dr Adamson in her evidence to the Inquiry raised that in 2019 there were insufficient CBTp Therapists and efforts were made to recruit more **[INQT0000105]**. Dr Adamson was asked whether steps should have been taken to ensure therapists were in place earlier, for example agency therapists who were already competent. Agency staff were used throughout the Trust where required to fill staffing gaps where needed, however as clinicians were required to complete EIP training, and this was known to be only a few staff nationally, it is unlikely the Trust would have been able to recruit bank/agency staff to meet this requirement.

30. Within the Programme Board meeting in March 2020, **[NHFT0021752]** Dr Adamson raised a gap in the EIP resource (5.3), and it was further raised in the EIP workstream that support was required. This was flagged within the EIP workstream status report **[NHFT0021900]**. The risk was that there were current high caseloads, which may reduce the capacity to meet the two-week deadline and NICE standards required of the service. The two-week assessment target was however consistently achieved as identified in the chart demonstrating this **[NHFT0021425]**. Due to passage of time, I cannot remember specifically the actions taken from this, however this discussion would have been tailored around freeing up the EIP team from the wider LMHT workstreams, and the need to backfill the LMHT staff. A consultation process would have been necessary as staff were moving teams. Managing this was complex and ensuring the right staff were appointed was a challenge, as we needed to ensure the staff appointed had the correct qualifications.
31. During her employment, Dr Adamson as part of her EIP lead drafted funding proposals **[WITN0478016]** and an options paper **[WITN0478025]**, these documents had been created as an aside to the stabilising and bolstering business proposal due to the difficulties raised and known in the EIP service. It was identified that additional funding and recruitment was essential in order to improve the service.
32. The recruitment process would have been led by the HR department and the Team leaders, however recruitment remained an ongoing battle as the process would often take a substantial period of time. I know at the time Julie Attfield pushed this with HR; despite this, recruitment could take several months due to the process of DBS checks and other requirements needed, this was a challenge when staff were needed immediately.
33. As part of the EIP developments, there was the process for EIP to become a standalone service. During this time Dr Adamson identified the '*demand v funding*' we had within the team to address this with commissioners, which later resulted in her drafting the options paper; this document identified the caseload and discrepancies in the workforce between November 2019 and April 2020 which needed to be addressed **[WITN0478018]**. This was identified as it remained even in April 2020 that EIP were not able to meet targets. It was understood at the time the commissioners believed the EIP service was funded appropriately, however this did not operationally match what EIP workers identified **[WITN0478031]**.

34. In the Programme Board meeting of 18 May 2020 **[NHFT0021737]**, Dr Adamson raised issues for escalation, including consideration for supporting the delivery of CBTP and Family Interventions within the Child and Adolescent Mental Health Service (CAMHS) as part of the EIP service. CAMHS manager Gwen Morgan was identified in Programme Board minutes (5.3) March 2020 as picking this work up **[NHFT0021752]**. My understanding from this meeting is that Dr Adamson had already discussed this with CAMHS and therefore this information was simply an update.
35. An advert for a CBT therapist or Psychologist with CBTP qualifications went live in May 2020 as part of the continuing work done to address the gaps in the EIP service as per programme board minutes (6.4) June 2020 **[NHFT0021647]**.
36. In the SMT with leads meeting on 22 July 2020 **[WITN0478037]**, the EIP provision was discussed and raised significant problems, such as the business case being based on a caseload of 500 when the numbers were 650. Dr Adamson raised that the team were more than double this in areas, and she felt unsafe to move to a standalone service; the work done identifying the current funding and CCO ratios meant that it would only allow the Trust to achieve a level 1 rated service when they should be a level 3. Michelle Malone discussed the options paper and risks relating to managing EIP and how SMT could support, and the action arising from this was for comments to be sent to Dr Adamson, and oversight updates to be provided at the quality and risk meetings that took place **[WITN0478029]**; **[WITN0478030]**.
37. In August 2020, the EIP service was not yet a standalone service. Dr Adamson in her evidence has explained that there remained uncertainty on the decision for the commissioning model that was to be adopted following submission of the options paper **[INQT0000105]**. Despite this, we were supported by Julie Atfield to start recruiting 'at risk' in areas where staff needed to be improved. 'At risk' was a process where recruitment was started, despite not having approval for the funding, in hope this would be approved by commissioners. The difficulties we had during this time was waiting for commissioners to decide on the model delayed progress, which ultimately was having a detrimental impact on patients and staff.
38. On 21 September 2020, within the AMH Programme board meeting, it was addressed by Dr Adamson in the EIP workstream update that a CBTP Therapist was due to start in November as part of the recruitment process following concerns raised in this area **[NHFT0020807]**. It further raised one of the trainees had failed the course and

therefore the service would need to recruit a CBTp post or Clinical psychologist CBT Therapist with a view to undertake a yearlong top up course when these became available. There remained ongoing steps and actions in that;

- a. LMHT clinicians working in the EIP pathway were to move away from holding a mixed caseload to support the readiness to release staff into a standalone service;
- b. The process was to start for 'uncoupling' EIP from LMHT's;
- c. Recruitment was to be organised for additional posts in line with the workforce model agreed with commissioners which had been agreed by September 2020.

39. Throughout this time and even up until October/November 2020, the Trust attempted various recruitment drives to ensure staffing met the standard required.

40. In November 2020, the EIP service was alerted as an outlier from the National Clinical Audit of Psychosis ('NCAP') **[RCPS0000012]**, an outlier status meant that the Trust were failing in certain areas as other teams in different locations were performing better. The Trust continued to recruit 'at risk' as we needed to ensure staff were in place to provide patient care. I do not believe during my time at the Trust the NCAP provided action against this status, as my understanding for the outlier process was as long as the Trust could identify they were completing all they could to improve the service, this would simply be monitored. The rapid improvement plans ('RAP') drafted and reviewed at the AMH Programme Board meetings, identified that the Trust was doing all it possibly could to ensure the service was better **[NHFT0021425]**.

41. On 16 December 2020, I raised that although there were 116 posts, staff did not feel much had changed. COVID had an impact on service developments as well as the workforce, who were exhausted after 9 months of working within an increased stressful environment. The EIP service remained part of the LMHT, therefore there was a general fatigue across the board. Staff had been raising via managers that they were on their knees and managers being unable to manage their service **[WITN0478033]**; **[WITN0478032]**. These were ongoing conversations that were being addressed through the recruitment at risk, funding proposals to the commissioners, recruitment drives being held across the Trust and regular communication and support.

42. On 18 January 2021 in the AMH programme board meeting discussed allocation of Trust funding in terms of resource. Due to my imminent retirement, Andy Latham and Glen Owen were tasked with actions surrounding continuing to recruit in line with the workforce model **[NHFT0023620]**. The SMI pathway identified that initial meetings were also taking place regarding psychology and psychological interventions with intentions to commence work reviewing the current offer and resolve any identified gaps in provision.
43. I was tasked on the 3 February 2021 in the SMT Meeting to look into OPEL scoring and how this could be used in the community, to provide a uniformed approach to quickly describe demand and pressures in teams **[WITN0478036]**. This would allow for recovery action and pre-emptive action to take place in a timely manner. OPEL scoring is a nationally used tool – ‘Operational Pressures Escalation Level’, used to measure how busy and stressed a hospital is. The requirement was to replicate something to use with community teams. Due to my retirement on 12 February 2021, I believe I would have passed this task to Andy Latham or the community matron.
44. Programme Board EIP Workstream update February 2021 **[NHFT0021751]** completed by Tracey Taylor (Operations Manager) provides an overview of where the service had reached and what was required to do at the point of my retirement. The service was still in development, but I believe the standalone team went live later that month.

Conclusion

45. The Trust were aware of concerns surrounding the EIP service I understand from at least February 2019 **[WITN0478034]**, where the improvement plan was developed as staff had raised that the changes required were not happening quickly enough. The actions taken to try and address the concerns are highlighted above and remained a constant focus of the EIP management team throughout the period of my employment as general manager. The EIP pathway remained undergoing a substantial period of transformation from the previously embedded LMHT model to a standalone service. A lot of the work was also completed during the COVID-19 Pandemic, which understandably caused its own difficulties. The transformation to a standalone service remained a work in progress at the point I left the Trust, however I understand the service was launched and ‘live’ by the end of February 2021.

Statement of Truth

I believe the contents of this statement to be true. I understand that proceeding 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: 29 July 2026

Index to First Witness Statement of Ann Wright

No.	Exhibit	Document title	Description
1.	NHSE0000002	Mental-Health-Taskforce-FYFV-Final	'The Five year forward review for Mental Health', Report from the Independent Mental Health Taskforce to the NHS in England February 2016
2.	NHSE0000014	Nhs-long-term-plan-version-1.2	The NHS Long Term plan document – January 2019
3.	WITN0478015	AMH Structure May 20 (Including Bans 7's)	Adult Mental Health Directorate Organisational Chart
4.	NHFT0021656	SOP v6 October 2019	Adult Mental Health, Local Mental Health Teams Standard Operational Procedure document October 2019
5.	WITN0478051	Terms of Reference – Sept 19 – Final	Mental Health Senior Management Group (MHSMG) Terms of reference
6.	WITN0478014	AMH Transformation Programme Board Terms of Reference	Explanation document for the AMH Programme Board
7.	WITN0478023	Implementation Guide	The Department of Health Mental Health Policy implementation Guide.
8.	WITN0478035	RE_EIP senior lead (3)	Email correspondence: Discussing need for recruitment

9.	NHFT0021473	Adult Mental Health Programme Board Minutes 16.09.2019	Adult Mental Health Programme Board Minutes 16 September 2019
10.	WITN0478020	EIP RAP Sept 19 FINAL	EIP Recovery Action Plan from September 2019
11.	NHFT0023603	Adult Mental Health Programme Board Minutes 21.10.2019	Adult Mental Health Programme Board Minutes 21 October 2019
12.	INQT0000105	Nottingham-Inquiry-2-June-2026-AM-Final	Transcript of Dr Adamsons evidence to the Nottingham Inquiry on 02 June 2026
13.	NHFT0021752	Adult Mental Health Programme Board Minutes 16.03.2020	Adult Mental Health Programme Board Minutes 16 March 2020
14.	WITN0478014	EIP Workstream Status Report – 11.03.2020	Trust workstream status report to Adult Mental Health lead by Dr Adamson
15.	WITN0478015	NHFT0020002 – EIP Model options paper	EIP Workforce configuration options paper drafted by Dr Adamson
16.	NHFT0021425	EIP RAP Dec 19 FINAL	EIP Recovery Action Plan from December 2019
17.	WITN0478016	EIP Funding proposal August 2019	Early Intervention in Psychosis service funding proposal August 2019

18.	WITN0478018	EIP in LMHTs - Demand vs Funding	Excel spreadsheet identifying the discrepancy in the current model and funding needed
19.	WITN0478031	RE_COVID Meeting and EIP	Email Correspondence between Jo Horsely, Dr Adamson and Ann Wright RE ability to meet deadlines and workforce status /Operational pressures.
20.	NHFT0021737	AMH Programme Board Minutes 18.05.2020	Adult Mental Health Programme Board Minutes of 18 May 2020
21.	NHFT0021647	AMH Programme Board Minutes 15.06.2020	Adult Mental Health Programme Board Minutes of
22.	WITN0478037	SMT with Leads minutes 22.07.20	AMH Operational Senior management Team meeting with leads dated 22 July 2020
23.	NHFT0020807	AMH Programme Board Minutes 21.09.2020	Adult Mental Health Programme Board Minutes of 21 September 2020
24.	RCPS0000012	ORG45 – Confirmation of outlier status	Letter from Professor Mike Crawford, Director, College Centre for Quality Improvement to Nottinghamshire Healthcare NHS Foundation Trust regarding NCAP Audit of EIP 2019/2020 – outlier alert status
25.	WITN0478029	Quality and Risk Meeting minutes Aug 2020	Quality and Risk meeting minutes of 05 August 2020 1:30-3:30pm

26.	WITN0478030	Quality and Risk Meeting minutes Sept 2020	Quality and Risk meeting minutes of 01 September 2020 1:30-3:30pm
27.	WITN0478033	RE_EIP Pathway	Email correspondence between Glen Owen, Jo Horsley and senior managers in November 2019 re capacity and staffing concerns
28.	NHFT0023620	AMH Programme Board Minutes 18.01.2021	Adult Mental Health Programme Board Minutes dated 18 January 2021
29.	WITN0478032	RE_EIP Concerns City and County Teams	Email correspondence between senior managers and Kerry Watson raising EIP Team leaders on their knees dated January 2021
30.	NHFT0021751	EIP Workstream Status report - Feb 2021	Status report to the Adult Mental Health programme Board dated 10 February 2021
31.	WITN0478031	RE_SDIP Feb 19 final_docx	Email Correspondence surrounding action plan, reference to pace of change not happening fast enough and not assured all actions are being achieved
32.	WITN0478036	SMT Minutes 03.02.2021	Senior Management meeting minutes dated 03 February 2021