

Witness Name: Glen Owen
Statement No: WITN0490001
Dated: 27 August 2026

THE NOTTINGHAM INQUIRY

SECOND CORPORATE WITNESS STATEMENT OF NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

I, Glen Owen, will say as follows: -

INTRODUCTION

1. I have been Nurse Director of the Trust's Mental Health Care Group since October 2024. Since October 2023 the Trust has operated through three Care Groups: Mental Health, Community Health and Forensic Care (see paragraphs 81-84 of the First Witness Statement of Dianne Hull [WITN0133001]). Each Care Group is led by a team of Care Group Director, Care Group Nurse Director and Associate Medical Director. Prior to October 2024, my role was a General Manager within the Forensic Care Group for Low Secure services.
2. I am authorised to make this statement on behalf of the Trust. It 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.
3. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with an explanation of the Assertive Outreach ("**AO**") pathway that has been in operation at the Trust since 2019, what this pathway was and how it interacted with the Trust's Early Intervention in Psychosis service.
4. Before turning to address this specific query, it is helpful to briefly explain the arrangement of early intervention in psychosis and assertive outreach services more generally in the period from 2017.

CHRONOLOGY OF EIP AND AO SERVICES (2017-2023)

5. The Inquiry has been informed by others that the publication in 1999 of the National Service Framework ("**NSF**") for Mental Health led to the introduction of Early Intervention, Assertive Outreach and Crisis Intervention teams. These were part of the Adult Mental Health ("**AMH**") Directorate.
6. The Early Intervention in Psychosis ("**EIP**") Teams were developed as standalone teams to assess and provide intervention for people presenting with a suspected first episode psychosis. The NSF (1999) introduced national standards with a view to reducing untreated treatment delays by early detection and treatment within the critical period of the first 3-5 years to support recovery outcomes. The time period that someone could access EIP services at this point was typically up to three years.
7. The original Assertive Outreach teams were also introduced following the publication of the NSF (1999). Assertive Outreach is a form of intensive community based care for people with an enduring mental illness such as Schizophrenia that require intensive case management, are likely to have engagement challenges, multiple social issues (examples being unstable housing, limited social contact, frequent hospital admissions and possible contact with the justice system and / or substance misuse issues).
8. Due to engagement issues the person is likely to require a level of intensive input to maintain contact and support longer term engagement. I am aware that others have described this to the Inquiry, in particular Diane Hull has explained that Assertive Outreach teams were specialised community-based teams that worked with patients who experience difficulty in engaging with traditional mental health services, employing a proactive assertive approach to engage and support individuals in their own environments (see Statement of Dianne Hull, paras 310-312 [**WITN0133001**]).
9. Crisis Teams sat alongside but separate from the above, working with a view to providing an effective alternative to hospital admission, providing intensive home treatment, clinical intervention and risk management within a community setting.
10. My understanding is that those specialist teams remained in place at the start of 2017, with the Trust providing three separate and standalone services for each of EIP, AO and Crisis Intervention alongside a number of other community mental health services also provided by specialist teams (such as the Community Rehabilitation teams and Recovery teams).

11. The Inquiry has heard from others that from late 2016 the Trust was aware of a risk around the EIP service, particularly relating to the ability of the standalone EIP teams to manage their caseloads (see for example Ann Wright's statement to the Inquiry, paras 6 and 16 [WITN0478001] and the First Witness Statement of Andrew Latham, paragraphs 67-72 [WITN0466001]).
12. NHS England's Five Year Forward View for Mental Health was published in February 2016. One of the main national priorities became a strengthened approach to prevention and early intervention through new models of care. Funding from commissioners was aligned accordingly to implement this priority [NHSE0000003].
13. This led to the Trust carrying out a piece of transformational work around the way in which the AMH Directorate provided mental health services in the community (as distinct from in-patient services and outpatient services). I describe this further below but, in essence, it involved the creation of local mental health teams ("LMHTs") through which the AMH Directorate provided community care (see the First Witness Statement of Andrew Latham [WITN0466001], para 11) and a geographic realignment of GP services boundaries, with resulting locality arrangements being updated to reflect these boundary changes. One consequence of this change was that the previously standalone teams providing EIP and AO were all integrated into LMHTs. In practical terms, after a period of time staff in LMHTs moved to holding mixed caseloads covering individuals who would previously have been allocated to one of the legacy community teams (EIP and AO).
14. As a result of the move to an integrated LMHT offering, "pathways" were developed to help guide referrals and case load balance within the LMHT, initially having dedicated staff ringfenced to particular pathways however over time this model became unsustainable and wider mixed caseloads resulted. The Trust remained aware that a cohort of people would require both EIP and AO and staff continued to hold caseloads including EIP patients and patients who were receiving AO.
15. By late 2018 the Trust had recognised issues with the LMHT structure with regards to the EIP service and was considering a need to "decouple" the EIP pathway from LMHTs. This was in particular because the Trust was not meeting national targets for EIP: on 11 and 12 October 2018 NHS Improvement published an "EIP Review" [NHFT0021015], noting that the EIP service was "not stand alone (best practice)".
16. Through 2019 the Trust considered how best to deliver the EIP service. I am aware others have given evidence to the Inquiry regarding the concerns that existed at this time

about the quality of that service (see for example Statement of Julie Attfield, paragraph 193 [WITN0329001]; Ann Wright, paragraphs 17 and 20 [WITN0478001]).

17. Informed by those concerns and an audit of the EIP service against the requirements of the National Clinical Audit of Psychosis ("NCAP"), it became apparent that the integrated LMHT model was not supporting the EIP service to meet required standards. The general view in the Trust, which I shared was that integrating EIP into LMHT had resulted in a loss of fidelity to the EIP model, so ultimately bringing EIP within LMHTs did not work as it had been intended and instead illustrated the need for a focused service. Work was therefore undertaken to separate EIP from the LMHTs and re-establish standalone teams, often referred to as "uncoupling".
18. By September 2019 a Recovery Action Plan for EIP was in development [NHFT0020589]. A plan for de-coupling EIP from the LMHTs was developed for implementation in 2020 and 2021 (see the witness statement of Michelle Malone, paragraph 38 [WITN0462001]). I am aware that others more involved with the decoupling process have given evidence to the Inquiry on this, explaining the difficulties associated with the process of uncoupling and that it took time to implement owing in particular to recruitment and the Covid-19 pandemic, and the careful planning of extracting resource out of the LMHTs (see the witness statements of Ann Wright at paragraphs 38, 39, 41 [WITN0478001] and Michelle Malone at paragraph 39 [WITN0462001]).
19. By February 2021 the EIP pathway integrated within the LMHT was to be decoupled from the LMHT and functioning as a hub and spoke model with independent ringfenced EIP staff linked to specific LMHTs. AO remained within LMHTs.

CREATION OF LOCAL MENTAL HEALTH SERVICES TEAMS AND THE PATHWAY MODEL

20. As I have mentioned briefly above, LMHTs were created in 2017-2018. These brought together a number of teams into integrated community mental health services, with staff in LMHTs eventually moving to holding mixed caseloads covering individuals who would previously have been allocated to standalone community teams, including EIP and AO, Community Assessment & Treatment ("CAT"), Occupational Therapy, Community Rehabilitation and a City Recovery team that were all standalone community mental health teams or functions.
21. Creating LMHTs was a much bigger and geographic transformation or reconfiguration of services, influenced by changes to GP boundaries, and was not driven directly by concerns

about EIP. Rather, the philosophy behind the introduction of LMHTs bringing together a range of community services was to implement a model that was focused on early intervention and offered a whole pathway model of mental health care that was simple to access and navigate for service users and carers, as well as health professionals, and had a strong multidisciplinary team approach with comprehensive care packages. A useful outline of the transformation programme including the proposed clinical model and rationale for development of locality based teams is provided in a 2015 community services proposal document [WITN0490002], a February 2017 AMH community transformation paper [WITN0490005] and a March 2017 AMH community service transformation – programme overview presentation [WITN0490003].

22. A key part of the transformation was that LMHTs were aligned to GP practices, meaning patients were allocated to an LMHT based on the LMHT locality in which their GP practice was located. Staff from across the legacy community teams, who had previously been key workers for a particular patient cohort, e.g. EIP or AO, were allocated across the new LMHTs. The transformation involved two parallel processes. First, staff came with their existing caseload to their new LMHT so there was a 6-8 month period in which staff were working across different LMHTs to transition their patients' care to the appropriate LMHT in the locality of the patients' GPs. Secondly, patients in respect of whom the key worker had started planning for discharge within the next 3 months were not transitioned to other LMHTs because this was considered an unnecessary change in their care. Those patients stayed with their key worker linked to an LMHT that did not necessarily align to their GP. In addition, from the first day of the LMHT model, new referrals then came into the relevant LMHT from the local GPs.
23. Staff did not hold mixed caseloads initially as, when the services transformed in 2017, referral rates were looked at and based on that it was decided how staff from the different legacy teams should be split up into the different LMHTs to ensure a mix of skills and experience from the previously standalone teams were within each LMHT. For a period of time, staff were allocated to a specific pathway (see further below), so there was dedicated EIP staff, AO staff, wider LMHT staff, and so on. However, this changed over time as a result of staff sickness and turnover, demand and the need for urgent cover. As a result, it became an impossible task to have ringfenced staff within a LMHT, where for example you might have a patient that did not have a first episode psychosis but more of a Complex Emotional Needs formulation and presentation with risks of self-harm and suicide that needed a key worker and support and the only capacity in the team was someone with an EIP or AO caseload. So from a resource perspective, that is how the

Trust staff moved from ringfenced caseloads into covering more generic caseloads. Logistics and workforce resilience became quite complicated as previously dedicated Consultants to the separate standalone teams became sessional. Due to these factors and staff having mixed caseload staff had to attend multiple MDTs involving multiple Consultants: one for EIP, one for AO, and so on. In the South of Nottinghamshire and city localities, where the referral rates are higher, this became problematic and eventually led to the extraction of EIP from the LMHTs. I refer to statements already provided to the Inquiry regarding the decoupling process.

24. The move to integrated LMHTs led to the Trust carrying out a piece of work mapping out the service pathways an individual might follow with the Trust against nationally set "clusters" of care, correlating to HoNOS (Health of the Nation Outcome Scales) codes, which were developed as a clinician-rated measure for use with working-age adults in contact with mental health services. In this way the Trust developed clinical "pathways", linked to clusters, to help guide referrals and case load balance within the LMHT. In essence the pathways are what were developed locally to map the clusters onto.
25. Once these cluster-based clinical pathways had been developed, the next step was to identify the interventions that patients should receive. Based on what was put into HoNOS outcome measure by clinicians in terms of, for example, a patient's symptoms and severity, this gave an indication as to which cluster the patient fell within and, relatedly, what clinical interventions the patient should receive. There was guidance around the interventions linked to NICE or national guidance at that point in time. For example, in respect of AO, clinicians would usually have assessed the patient based on their history, severity and presentation and would have assigned them to the pathway for enduring psychosis (clusters 16/17), at which point the patient should receive interventions and input regarding assessment of risk, coping strategies, medical review, alcohol use, and so on. The clinician would then work through that pathway descriptor, and if a patient reached a point where the clinician thought they should be moving on, there was guidance for staff to follow in relation to next steps or transition from the pathway.
26. These LMHT processes, including the pathways and interventions, were documented in a Standard Operating Procedure ("SOP"). I am aware that the Inquiry has been provided with numerous versions of the AMH Service Local Mental Health Teams Standard Operating Procedure. There were several iterations of that SOP. I exhibit an early version of the SOP dated August 2017 showing that the integrated LMHT model made provision for an EIP

pathway (Cluster 10) and for AO, both as an important part of the pathway for Enduring Psychosis (Clusters 16-17) and as an intervention available across a number of pathways, such as that for Recovery from Psychosis (Clusters 11-15) [WITN0490004].

27. I also exhibit the SOP dated June 2020 [NHFT0016106], in place when the Trust was interacting with VC. This describes the pathway model of care provision, with standardised pathways across all LMHTs as follows:

- 1) Recovery from Anxiety and Depression (Clusters 4-7)
- 2) Support for complex Personality Needs (Cluster 8)
- 3) Early Intervention in Psychosis (Cluster 10)
- 4) Recovery from Psychosis (Clusters 11-15)
- 5) Support and engagement for enduring Psychosis (Clusters 16-17)
- 6) Living well with Neurodevelopmental conditions (0) (Criteria to be drafted)
- 7) Transitional Pathway (Clusters 18 and above) (Criteria to be drafted)

28. Embedded in the SOP was documentation for each pathway, including:

- a. the "Early Intervention in Psychosis (First Episode Psychosis) Pathway Cluster 10" [WITN0490007] for individuals presenting to the service for the first time with mild to severe psychosis;
- b. the Recovery pathway cluster 11-15 [WITN0490009] include a range of presentations associated to Psychosis ranging from Cluster 11 with low symptoms (this group of people have a history of psychotic symptoms that are adequately controlled causing minor if any problems) to Cluster 12 (with a higher degree of disability including a history of psychotic symptoms with a significant disability that has a major impact on their role functioning, social relationships and family) up to Cluster 15 which relates to a Psychotic depressive presentation with an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present.
- c. the "Support and engagement for enduring Psychosis pathway clusters 16-17" [WITN0490008]. Individuals on this pathway will "usually" be "adults with a history of severe mental illness; experiencing enduring psychosis or bipolar disorder and have complex health and social difficulties including substance misuse, anti-social behaviour or learning disability, unstable accommodation or homelessness and may

have involvement with the police and criminal justice system or have forensic psychiatric background. The individual may have frequent admissions to hospital. They may pose significant risk to themselves or others or they may be vulnerable and at risk from others. They may display difficulty or reluctance to engage with service providers, family or other informal carers." More detail regarding the enduring psychosis pathway is provided in a document titled "Support and engagement for enduring psychosis pathway", which explains that an essential referral criterion is that the patient requires more intensive support to work with services due to historical non-engagement [WITN0490010].

29. For some of these pathways it was clearer to identify patient cohorts than others. In particular, it was possible to track referrals into the EIP pathway on RiO and monitor progress against national targets on waiting times and allocation of key workers, but I do not recall staff using internal Rio clinical digital flags for pathways other than the EIP pathway.
30. An individual assigned to the EIP pathway would be an EIP patient and receive care aligned with NICE and national guidance at that point in time linked to the standards within the Five Year Forward View and broader EIP guidance standards. This did not work the same when assigning people to AO as there was no distinct digital classification for this patient group other than the HoNOS and Cluster, which required manual reviews and updates to remain in date. Instead, there was awareness in the Trust that a cohort of people would require AO and the associated AO pathway descriptors.
31. Each service had a degree of AO resource built in which was varied depending upon local demand and prevalence rates. Whether an individual assigned to any given pathway was identified as in fact needing AO depended on an individualised assessment of a number of factors including, but not limited to, compliance with medications, occurrence and frequency of hospital admissions under the Mental Health Act, the level of risk to self and others, clinical presentation, clinical judgement and level of engagement with their key worker. These would all be key factors considered within local MDTs. If accepted onto the AO pathway, their cluster should have also been reviewed and identified as a Cluster 16 or 17.
32. The SOP at the time set out discharge and transition criteria including that "The patient is not willing or able to engage with services and care within the Assertive Outreach pathway is not indicated" (later versions of the SOP removed reference to the pathway descriptors but I am unsure of the reason for this). From as early as February 2018 the SOP embedded a document setting out "Good Discharge Standards", which reiterated in respect of EIP that

while patients not offered further appointments within 3 months should be considered for discharge, this "does not apply to patients offered appointments and not engaging" [WITN0490011].

33. That meant if staff were considering discharging a patient from local mental health services they should think first about whether that patient would benefit from AO. For example, if there was an EIP patient who was not willing or able to engage or required a more assertive level of input then you would expect there to be a clinical review based on someone's illness to look at the fact that they are not engaging with EIP but also consider whether they require more intensive pathways such as AO.
34. If they did, they should become an AO case on the clusters 16-17 pathway, following an MDT review and discussion. If they did not, then you would look at other options, which may include discharge from LMHT. This discharge criteria can be seen as an overarching prompt for all of the pathways to consider whether AO is warranted for a patient, either within that pathway or by transitioning them to a more AO-focused pathway. The possibility of moving between pathways is mentioned in the SOP, which states that individuals could be described on RiO as: (1) placed on Pathway; (2) completed Pathway (which does not automatically mean discharged from service) or (3) transferred from Pathway (which is described as "Probably not frequently used, but means pathway was not completed, but client needed other pathway/service"). Therefore, it was possible for an EIP patient to move to a more AO-focused pathway either after completing the EIP pathway or as a transfer where this was assessed as clinically appropriate.

THE CURRENT POSITION ON EIP and AO

35. At present the Trust continues to provide an integrated AO model within the LMHT and still has EIP resource that is separate from the LMHTs. I would describe this as a place-based ringfenced resource for EIP as opposed to standalone EIP teams at present.
36. In 2024 NHS England asked ICBs to review assertive and intensive support services, following which the Trust conducted a review using the NHS England Maturity Index Self-Assessment Tool, which I completed on behalf of the Trust [see the witness statement of Diane Hull, at paragraphs 528-530 [WITN0133001], and the oral evidence of Diane Hull at page 51 [INQT0000093]]. As Diane says in her statement, the ICB noted that the Trust did not have a dedicated Assertive Outreach Team or associated SOP, which resulted in inconsistencies in practice. Following the review, an Assertive and Intensive Engagement

Improvement Plan was developed during October 2024 to address the gaps highlighted in the self-assessment. The completed self-assessment and Plan have been disclosed to the Inquiry [NHFT0004334]; NHFT0001278].

37. With regards to EIP, the plan is to move to standalone teams. For example, there is currently a North and South EIP team (Hubs) with dedicated, ringfenced resource allocated to each LMHT working with patients from specific locality based areas and GP practices (Spoke). Part of the improvement plan is to move to three place-based standalone EIP teams that would be able to utilise and maximise the current resource in a better way than the current configuration allows.
38. The Trust does not yet have any dedicated standalone AO teams, but it is preparing to have standalone teams by October 2026, as it is understood that this will enable the high fidelity model and be more effective than providing AO via an integrated pathway within the LMHT. However, I understand there is currently no national funding for AO teams. From late October 2024 I was involved in scoping out funding requirements to deliver AO and an application with costs of around £4 million was submitted to the ICB for the regional team but not responded to and latterly informed via regional meetings there is no additional funding available to develop AO pathways or teams. As no additional funding has been received, delivery of the standalone team is at risk and will need careful planning so not to de-stabilise current LMHTs in the extraction of resource. This has meant that we have had to go back to the drawing board and consider how we can extract and repurpose the necessary resource safely from existing LMHT resource.

Statement of truth

I believe the contents of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: 

Dated: 27 August 2026

Index to First Witness Statement of Glen Owen

No.	Exhibit	Description
1.	WITN0133001	Statement of Dianne Hull
2.	WITN0478001	Statement of Ann Wright
3.	WITN0466001	First Witness Statement of Andrew Latham
4.	NHSE0000003	NHS England guidance titled Implementing The Five Year Foward View for Mental Health
5.	NHFT0021015	NHS Improvement EIP Review
6.	WITN0329001	Statement of Julie Attfield
7.	NHFT0020589	Recovery Action Plan for EIP
8.	WITN0462001	Statement of Michelle Malone
9.	WITN0490002	2015 community services proposal document
10.	WITN0490005	February 2017 AMH community transformation paper
11.	WITN0490003	March 2017 AMH community service transformation – programme overview presentation
12.	WITN0490004	SOP dated August 2017
13.	NHFT0016106	SOP dated June 2020
14.	WITN0490007	EIP pathway documentation embedded int the June 2020 SOP
15.	WITN0490009	Recovery pathway documentation embedded in the June 2020 SOP
16.	WITN0490008	Enduring psychosis pathway documentation embedded int the June 2020 SOP
17.	INQT0000093	Transcript of Dianne Hull giving evidence to the Inquiry
18.	NHFT0004334	NHFT's self-assessment using the NHS England Maturity Index Self-Assessment Tool
19.	NHFT0001278	NHFT's Assertive and Intensive Engagement Improvement Plan
20.	WITN0490010	Description of the enduring psychosis pathway (clusters 16-17)
21.	WITN0490011	Good Discharge Standards, embedded in the LMHT SOP from February 2018