

Witness name: Dr Eileen O'Regan

Statement No: WITN0491001

Dated: 28 August 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR EILEEN O'REGAN

I, DR ELLEN TERESA O'REGAN (known as EILEEN O'REGAN) will state 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 17 July 2026 (the "Request"). It was drafted on my behalf by Counsel and Solicitors acting for Nottinghamshire Healthcare NHS Foundation Trust ("the Trust"), with my oversight and input, and with assistance from the Medical Protection Society, following discussions in writing by email and by video conference.
2. At the outset, I would like to offer my heartfelt sympathy to the families of those who lost their lives, to those that were seriously injured, and to everyone whose lives have been profoundly affected by this tragedy.
3. I had no involvement in the care of VC. I worked in a different City Team to that which VC was treated in. My evidence relates to my experience as a Psychiatrist working in Nottingham, as do my recommendations, rather than to the care provided to VC.
4. In order to provide context for my responses to the questions put to me by the Inquiry, I have included in my statement background information regarding my personal knowledge and experience of the changes to the clinical services in which I have worked, in Nottingham, together with an outline of my current clinical role. I have worked as a Consultant Psychiatrist with EIP (Early Intervention in psychosis) patients

for over 21 years and with AO (Assertive Outreach) patients for nearly 9 years. I worked in the original standalone EIP service (2005-2017), the EIP pathway within the LMHT (Local Mental Health Team) (2017-2021), the re-established standalone EIP service (2021-current). I have also worked in the AO pathway within City North LMHT (2017 to current).

PROFESSIONAL BACKGROUND

5. I qualified as a doctor in 1994 from University College Dublin and started my training in psychiatry in 1995. I am a member of the Royal College of Psychiatrists. I am registered with the General Medical Council. I am a member of the British Medical Association.
6. My qualifications (including specialist qualifications and the dates obtained) to date are;
 - a. 1994 M.B., B.Ch.,B.A.O University College Dublin
 - b. 1999 MRCPsych
 - c. 2004 CCST (Certificate of Completion of Specialist Training). General Adult Psychiatry with an endorsement in Liaison Psychiatry.
7. Following a year working as an Intern (first year's post after qualifying in medicine where I worked for 6 months in medicine and 6 months in surgery), I decided to specialise in psychiatry in 1995. I completed my basic training on the Western and Southern Regional Training Schemes in Ireland. In 1999 I became a member of the Royal College of Psychiatrists. I then worked for a year as a Research Registrar, in Cork, where I was involved in two research projects.
8. I moved from Ireland to the UK in 2001 in order to continue my training in psychiatry and joined the Nottingham Higher Training Scheme. As a Specialist Registrar I worked in the following areas, Perinatal Psychiatry (Derby), Liaison psychiatry (Queens Medical Centre, Nottingham), Rehabilitation psychiatry, Community Mental Health Teams and psychiatric inpatient units in Nottingham City and South County.
9. Following completion of my Specialist Registrar training in Nottingham, I accepted a substantive post as a Consultant in General Adult Psychiatry in Nottingham in 2005 and I remain employed by Nottinghamshire Healthcare NHS Foundation Trust ("the

Trust") in this role, to this current date. I have therefore worked with the Trust for around 25 years, 21 as a Consultant Psychiatrist.

10. My first Consultant post was a split post, working in the original EIP (Early Intervention Psychosis) service in the community and on an inpatient mixed gender General Adult ward, at the Well's Road Centre, Nottingham, from 2005 to 2010 (I looked after around 10 to 12 inpatients). The majority of these patients were detained under the Mental Health Act (MHA).
11. From 2010 until September 2017, I worked full time in the original EIP service after my inpatient unit was closed and Highbury Hospital wards opened up. I requested to move solely to the community at that time as some additional EIP sessions became available, which I was able to slot into. I worked in the city and in Rushcliffe and Gedling boroughs when working full time in the original EIP service.
12. I worked full time clinically from 2005, working mostly 7.5 direct clinical care sessions (30 hours/week) until the transformation of services in 2017 took place (details of which are set out below), and at that point I reduced my direct clinical care sessions to 6 (24hrs) per week. There have been times when I have been given temporary additional hours due to workload, which are temporarily in place again at this time.
13. Between 2017 and 2021, I worked with both EIP and AO (Assertive Outreach) patients within the City North LMHT catchment area of the city. During this time, on occasion, I helped out in the LMHT, particularly when there were no other medical staff, due to sickness and or empty posts and during Covid, when I attended the team base in person daily.
14. After the EIP staff and patients were moved out of the LMHT's in Nottingham City (which was more of a process than a set date, described as a "phased uncoupling" that was implemented throughout 2020/2021, I understand), I continued to work in City North LMHT, with patients only on the AO pathway, and in the recreated standalone EIP service. The EIP staff (myself included), who worked in the City North LMHT, are now part of the standalone EIP service, remain co-located with the LMHT however I understand there is a plan to move all those working in the EIP standalone service in

the city in the near future, to one EIP team base. There is no plan at this time that I am aware of to change the medical input provided to the standalone EIP service.

15. As part of my Consultant role, I am a clinical supervisor (to core/higher trainees) and have medical students on placement. I do not have a Higher Trainee Resident Doctor allocated currently. For many years when working in the original (pre-2017) EIP service in particular, I did share a Higher Trainee with an inpatient Consultant. It is also part of my Consultant role that I am involved in a Consultant day duty rota for Nottingham City, and a 24 hour on call rota for the City and the South of the county.
16. I was an Educational supervisor for core (2015-2021) and Higher Trainees (2017-2021).
17. I was one of the Lead Consultants for a number of years in Nottingham City, from I believe 2010 to January 2021. This role involved managing complaints, supporting with job planning (with the oversight of the Clinical Directors), attending meetings such as the Quality and Risk meeting and Workstream meetings related to transformation of services, supporting with locums, discussing concerns when they arose with the Clinical Directors. I had no official line management responsibilities for the other Consultants. All Consultants had the opportunity to link in with the Clinical Directors if they had concerns about their roles and the Clinical Directors always attended the Adult Mental Health Consultant Forum. The Adult Mental Health Consultant Forum is a monthly meeting attended by Consultant Psychiatrists working in General Adult Psychiatry within the Trust. It provides an opportunity for Consultants to discuss clinical, operational and professional matters relevant to their roles. It is attended by the Clinical Directors and, where appropriate other Trust staff, such as managers or Pharmacists, who may attend by invitation to discuss specific topics. The forum also provides updates on matters relating to medical education, the Local Negotiating Committee (LNC) and other Trust meetings and groups, and other matters relevant to Consultant Psychiatrists. I had no budgetary responsibilities. Whilst I did express my views, this role did not confer any decision-making authority over service changes. This Lead Consultant role was an additional non-clinical role that I held alongside my clinical role, amounting to one additional PA (4 hours per week). In the last couple of years of my role, I was predominantly covering the City Central and City North LMHT's.

18. I have also had other roles over the years which I did during my non-clinical time such as the Medical Audit Lead with Nottinghamshire Healthcare NHS Trust for POMH UK (Prescribing Observatory for Mental Health), the Adult Mental Health LNC (local negotiating committee) representative, over the years. I also chaired the Adult Mental Health Consultant Forum in the past.
19. For 5 years (I believe from 2005 to 2010) I was a member of the EIP MIN (Managed Innovation Network), a Nottinghamshire-wide network established to bring together clinicians from the region to promote the implementation of evidence-based practice into clinical care. In addition, I recall that we organised EIP conferences at this time. This was at the time when the original EIP service was being established in Nottingham.
20. Although I have contributed to research over the years as either local principle investigator or recruiting patients I worked with into studies, I have never held a formal academic appointment. My contributions to research have been recognised through co-authorship in several peer-reviewed publications. I have also provided advice and support to the Zimbabwe Early Intervention in Psychosis Project (ZimEIP) and recently been asked to become a trustee in a charity connected with this, which is in the process of being established.

BACKGROUND TO SERVICE CHANGES

21. Over the years I have worked in Nottingham, community General Adult mental health services have had undergone a number of changes. When I first came to Nottingham as a Specialist Registrar (Higher Trainee) in 2001, there were Community Mental Health Teams (CMHT's) and the Consultants in these teams also tended to work in the acute mental health wards at the same time, looking after patients admitted from their own community catchment areas. All General Adult Mental Health patients were supported within these CMHT's.
22. In the early 2000's National Service Framework (NSF) Teams were established across the country, including in Nottingham and I was asked to work in 2005 in the Nottingham EIP service as a newly appointed Consultant when it was in the very early stages of formation alongside working on an acute admission ward. These new teams worked alongside the CMHT's which held the largest number of patients in their local areas,

including patients with psychosis. EIP patients at the end of their three years of care were mostly discharged back to the care of their GP's however some were transferred to the CMHT's and a minority to the AO standalone service.

23. From 2005, I helped set up and develop the original EIP team in Nottingham City and South County. I had no experience in EIP prior to taking the post as these services were relatively new in the UK at the time. When we were setting up the service I recall going to see some other EIP services. I recall going to Barnsley and to Birmingham and I believe going to see an inpatient EIP service in London, alongside some other members of the team and linking in with other Consultants in the Midlands working in EIP. I recall going to an EIP conference in Amsterdam and hearing from international experts. The team gradually built up in numbers in terms of patients and staff. We had a Managed Innovation Network (MIN) and used to have meetings regularly about how the service was being set up throughout the county so that it was evidence-based. It was quite an exciting and interesting time for me in terms of my career, and I developed a passion for working with patients with psychosis as most of my work both in the community and as an inpatient Consultant at the time, involved managing patients with psychosis. In terms of why we used the term psychosis, I feel the following statement reflects well the reasons why. "We recommended that Psychiatrists are very cautious about making a diagnosis of schizophrenia, in particular after a first episode of psychosis; at that point making such a diagnosis may do more harm than good. The term psychosis, though far from perfect, does not convey the same pessimism and fear" (Schizophrenia Commission report 2012).
24. In the original City and South County EIP team, that I worked in, I recall we had Occupational Therapists (OT), Social workers (at one point), peer support workers, Psychology and Community Psychiatric Nurses (CPN's) who were mostly working as care co-ordinators. There were other Consultants who had clinical sessions in EIP in Nottingham City and South County. However, throughout this period, I consistently had the greatest number of programmed clinical activity sessions dedicated to EIP and the largest EIP caseload.
25. The service was established through the collective efforts of a number of individuals, with Paul Prendergast, (now retired) Team Manager for the City and South County EIP, playing an important coordinating role and fostering a collaborative and inclusive approach throughout its development. We had social activity groups for patients, we

did health promotion events, I recall we had stalls at times at the Universities during fresher's week, which I attended on a couple of occasions, where we gave away little "freebies" with our contact details. We also did some carer events and work with families and I recall speaking at a couple of the GP Protected Learning Time (PLT) educational days and speaking on local radio e.g. Kemet FM (whose main audience was the African and Caribbean community) with one of the nurses on the team, in an attempt to raise awareness about psychosis and the help that can be provided. It was a service that staff were keen to be a part of, highly sought out when there were posts advertised and I recall we had low turnover of staff and low sickness rates. We were all based together as a team, with access to rooms at other team bases. I recall we were moved around a lot to various locations over the years but stayed together as a united team working with patients in the City and South county. We contributed to research, recruiting patients to studies and using service costs given for this, we helped fund social groups/activities for our patients.

26. I recall that we always had concerns that our (original EIP) team was potentially at risk and felt the need to demonstrate the value of the service particularly as we were aware that it was costly to run. We were providing care for patients with first episode of psychosis for up to 3 years, from 18 to 35 years for the majority of those years. Those with psychosis from 14 to 18 were managed by CAMHS (Child and Adolescent Mental Health Services). The service was subsequently extended to up to 65 years.
27. Our approach to working with EIP patients has always been assertive, in the sense that we do our best to engage our patients to work with us and accept the treatment on offer. At times we have worried that we might be crossing the line between assertive engagement and undue pressure. We were acutely aware why EIP services were established and the importance of patients engaging with the care offered to maximise their chances of achieving better outcomes. We also experienced significant challenges within the original EIP service at times, including managing high caseloads (pre 2017) due to resource issues, i.e. not having enough staff. I attended a Coroner's inquest, I believe in 2015. My recollection is that the Coroner expressed concern that the original EIP team had insufficient care co-ordinators and medical time and there was a possibility of a Prevention of Future Deaths report being issued. I believe this subsequently resulted in the commissioners agreeing to provide some additional funding, although I cannot recall the precise details.

28. I recall requesting a meeting with the Medical Director (Dr Julie Hankin) before the proposed changes to the original EIP service were finalised. I emailed Dr Hankin on 24 November 2015 to request a meeting and expressed that I was *"very concerned about the impact the changes will have on our patients, our outcomes(especially with the new targets for April 2016 of 2 week from referral to actual NICE treatments) and on the team itself here"* **(WITN0491002)**. She agreed to meet, and I believe this meeting took place on or around 27 November 2015. I arranged to meet with her to express my concerns about the direction being taken with the EIP services. I cannot recall the details of the meeting however I believe I would have discussed the concerns about the risks involved in changing the standalone EIP Service model and moving the patients and staff to the new LMHT's as part of an integrated model of care. I know I would have been concerned about the evidence base of the integrated model. I continued to raise concerns with Dr Hankin as more information about the proposed model became available **(WITN0491003)**.

29. In June 2016, an independent evaluation of the Nottingham EIP service was undertaken. This was on the back of NICE guidance published in February 2015 setting out 8 quality standards in relation to management of psychosis and schizophrenia **(WITN0491046)**. Prior to the 2017 transformation of services in Adult Mental Health, as I was working full time in the original EIP service, my focus was on advocating for that team. My view, which I recall was shared with the other EIP members, was that the original EIP service did not need to be included in the proposed 2017 changes to adult community services in Nottingham, which involved no longer having a standalone service for EIP, and for the patients and staff to be divided up into the new LMHT's. We believed it was functioning well and with some additional resources, would be able to meet any future targets. I did also believe that it was not only for financial reasons that EIP was moved into the new LMHT's as I understood that there was also a view from others not working in EIP that if EIP was no longer a standalone service it would lead to an improved offer of care to other patients within the LMHT's. My concern however was that it would reduce the care given to first episode psychosis patients.

30. I recall working with EIP colleagues to prepare a document setting out the importance of the EIP service as a standalone model and the reasons why we believed it should not be included in any of the proposed changes **(WITN0491004)**. I believe when we initially wrote this document in 2014, we had thought that it was only the south county

teams that were being reorganised, however the document was still relevant and we shared it with the workstream. We had also sought the views of patients regarding the proposed changes to help inform and strengthen our case (**WITN0491047**). I consistently expressed these views with colleagues in various meetings and in discussions with colleagues until the final decision was taken to integrate the EIP and AO services into the LMHT's. Thereafter, I raised concerns as and when they arose during the implementation and where possible, sought to identify practical solutions to address them. I raised concerns with Clinical Directors, Team Managers, Service Managers and Operational Managers and with the Transformation Lead. I did this in person and by email, although I cannot now recall the details of each email or conversation, I can recall raising these concerns on a number of occasions.

31. In September 2017 the transformation of adult community mental health services in the city began (I believe it had happened earlier for county areas), as the original EIP (pre-2017) team in the City was divided up into the 4 new City LMHT's. I knew I would no longer be working full time in EIP as I would not have been able to work across all the different teams and their bases, and it made more sense to be just with one LMHT. I requested to reduce my direct clinical care sessions to the 6 (24 hours per week) that were being allocated to the City North LMHT for the EIP and AO pathway patients. It meant I would have 4 EIP sessions (16 hours a week) working with the EIP patients in City North LMHT and I agreed to take on the Assertive Outreach (AO) team patients in the City North Catchment area, as well as the community rehabilitation patients, with the other 2 Clinical sessions (8 hours), I felt my strengths and interests lay with working with patients with psychosis. I also felt that my experience working in EIP would help with working with AO patients.
32. The EIP and AO services were moved into integrated pathways within the 4 City LMHT's that were created, in Nottingham City. I started to pick up AO work I believe towards the end of 2017/2018, as well as some of the Community Rehabilitation Patients (CRT) that were also were moved into the LMHT. With time the CRT patients became part of the wider City North LMHT and after that I worked only with the AO and EIP pathways going forward. I recall that the AO patients and staff were gradually moved from the old AO service into the LMHT's, some of them bringing some of their patients with them, this process took some time to complete.

33. Following the integration of EIP into the LMHT, the EIP pathways struggled to meet the treatment targets it was being monitored for, and it is my understanding that a decision was taken by the Trust to remove the EIP pathway from the LMHT's back into a standalone service because of this. I was not involved in the actual decision but was pleased that it was happening. On reviewing contemporaneous emails, I note that in May/June 2019, the Clinical Director at the time, Michelle Malone, did seek the views of Consultants and Team Managers within the LMHT's regarding the future management of the EIP patients (**WITN0491005**).
34. I subsequently received an email on 25 November 2019 (**WITN0491006**) stating that the EIP Team Leaders (one for North Team and one for South Team) had been appointed. A LMHT medics and team managers meeting took place on 03.01.2020 to reflect on what was working well and what was not, and to understand how the LMHT's would move forward (**WITN0491043** and **WITN0491044**). Dr Vidyah Adamson was also appointed as the Strategic Clinical and Transformation Lead for EIP to help with the move of the EIP pathways back into a standalone service, which took place during 2020/2021.
35. I believe I was fortunate in the City North LMHT as I tended to have a core group of care co-ordinators identified to work with me and my patients, both in the AO and EIP pathways. Whilst planning took place to remove the EIP patients from the LMHT to a standalone service, we continued to struggle due to staffing issues. On 02.07.2020 I emailed Dr Adamson, (and the Clinical Directors and EIP team managers), who had taken up the post in January 2020, expressing a number of serious concerns regarding the high caseload numbers of EIP pathway staff stating that one member of staff was on sick leave, another had handed in their notice and another was not able to attend MDT that day, as they were doing duty work for the LMHT (**WITN0462005_0001**). I stated in that email that we were not working as a "proper" first episode psychosis service and said we were firefighting and queried whether we should close to referrals. Dr Adamson's reply included an acknowledgement that the level of funding at the time had led to a critical shortage of care co-ordinators and she had been raising concerns with senior AMH staff, the Associate Director of Local Partnerships, the finance team and commissioners. I also mentioned in my subsequent reply that I was struggling medically but I was due to have a higher trainee join me for a couple of days the following month. I stated the main issue was the lack of care co-ordinators. I did also

ask at the time whether it was safe to continue to accept patients to City North LMHT EIP pathway due to the staffing issues that we were having at the time.

36. Removing the EIP patients and staff from the EIP pathway in the LMHT's took time to achieve during I believe 2020/2021. It took longer for some LMHT's than others because, if I recall correctly, EIP patients were held by a number of care co-ordinators within some LMHT's, while in other teams, there was more of a core group of care co-ordinators working on the EIP pathway. The staff working in the re-established standalone EIP service remained co-located with the LMHT's that they were previously part of. The main difference this reorganisation of EIP made was that the EIP staff were now part of a EIP service, with their own line management, with two Team managers, splitting the county and city areas between them. As the staff in the re-established standalone EIP model were no longer in the LMHT, they no longer had to do duty for the LMHT as well as other core LMHT work. They were able to focus only on their own patients and the care of EIP patients improved and the treatment target results improved.
37. No changes have been made to the AO pathway, and the AO patients have remained integrated within the structure of the LMHT since 2017. This means I now work across two different teams, the re-established standalone EIP service as is currently, and the City North LMHT. All of these patients on both the AO and EIP pathway have care co-ordinators allocated and some also have support workers.
38. The patients on the AO pathway all have a diagnosis of Severe Mental Illness, usually Schizophrenia, Bipolar Affective Disorder or schizoaffective disorder. All have experienced psychotic symptoms in the past and most have residual symptoms.
39. The AO pathway in the LMHT is there to care for the patients who have difficulties engaging, repeated hospital admissions, usually lacking insight, have medication concordance issues, they may have risk histories such as fire setting, use/carrying of weapons, assaults, suicide attempts, drug or alcohol misuse, homelessness, living in hostels/supported living, history of going missing, some have been transferred from forensic services, some have come from prison, the majority are patients that the other part of the LMHT have struggled to engage, we also take transfers from the EIP service when their 3 years with that team has ended. A significant proportion are also on

Community Treatment Orders (CTO) or Mental Health Treatment orders from the courts. Some are on DoLS (Deprivation of liberty safeguards). I believe most of my AO patients are treated with depot antipsychotic medication. Many of these patients have made good progress on this pathway, within City North LMHT and I have over the past few years successfully transferred some over to the wider LMHT and taken some off their CTO's.

40. Before the reconfiguration, my concerns related primarily to the proposed changes to the EIP service. Following implementation, my concerns extended to both the EIP and AO pathways.

41. Over subsequent years, I have continued to raise concerns at times about my own workload and broader clinical services and made suggestions, including in meetings, in person and by email. The concerns mostly reflected day-to-day matters such as staff sickness/ making a request to management for agency support to broader operational/ service issues. I have raised my concerns to my line managers, and to Team and Service Managers, pre and post the 2017 changes. It is my usual practice to escalate concerns and to try to help with finding a solution. I have a professional obligation to raise concerns of patient safety. I am usually quick to respond to others who express concern in relation to patient care. I believe that, in most instances, I received acknowledgement of the concerns I raised. My impression at the time was that it was a difficult time for all, including the management structure. I believe then and now that the main reason for these issues was lack of resources and the decision to create integrated EIP and AO pathways within the LMHT's.

CURRENT ROLE AND RESPONSIBILITIES

42. I currently work across two teams. The North EIP team, which is part of the reconfigured EIP Service and the City North LMHT. I do not have any additional roles, only clinical, at this current time, other than being on the Medical Scrutiny Rota (checking that the medical recommendation mental health section forms are completed correctly). Recently the amount of clinical work I am doing has led to discussions with my line manager and some extra temporary hours being provided, as I was using some of my non-clinical sessions to try to keep up with the workload.

43. **AO Clinical role:** I have 2 clinical sessions (8 hours per week) working with patients on the AO pathway in the LMHT. I only work with this group of patients in the LMHT, other than occasions when I may provide cross cover during leave to my Consultant colleagues in the wider LMHT. I attend a weekly 1½ hour AO pathway MDT (Multi-Disciplinary Team) meeting on Wednesday's, with the staff working on this pathway. At this meeting we discuss any new referrals, usually inviting the care co-ordinator of the patient for the discussion. We discuss any concerns that have arisen in relation to our AO patients and their mental health the previous week. We discuss the patients who are on CTO's (Community Treatment Orders). We aim to discuss all patients, but this is not always possible with the time we have, therefore there are occasions when we prioritised those that the care co-ordinators are particularly concerned about. My role in the MDT is to discuss the concerns raised and give my views on the patient's presentation and help with the decision making in relation to their overall care using a biopsychosocial approach. Others present in this MDT include the Team Secretary, who keeps a record of the discussion and actions, LMHT Team Manager &/ Clinical Lead, Community support worker (s), physical health worker, resident doctor (s), care co-ordinators who are CPN's (community psychiatric nurses), medical and nursing students. Each care co-ordinator is expected to write up the clinical notes on RIO for their own patients.
44. Outside the AO MDT meeting I am also regularly replying to MS Teams messages and emails about the AO pathway patients and speaking with care co-ordinators in person/on Teams. I also liaise with GP's and Consultants in secondary care regarding my patients when this has been needed. I am the main prescriber of medication for these patients.
45. Personally, I aim to see my patients on the AO pathway every 3 months, more often if required. These patients have a tendency to not always attend outpatient clinics, and many require home visits. I do find that the more we get to know each other, the better the attendance gets generally. Even if stable I try to see these patients as continuity of care and the therapeutic relationship is an essential part of working with these patients.

46. In terms of outpatient clinics, I hold mixed AO and EIP clinics on Tuesday's and Wednesday's and on Thursday mornings I tend to do 2 or 3 home visits and attend CTO managers and Tribunal panels in the afternoon.

47. **EIP Clinical Role:** I have 4 clinical sessions with EIP (16 hours a week). I have a 2-hour MDT on a weekly basis, where we discuss new referrals, inpatients, current concerns, discharges etc. Others present in this MDT may include the Team Secretary, who keeps a record of those discussed and actions, LMHT Team Manager & Clinical Lead, CBTp (Cognitive Behavioral Therapy for Psychosis) therapist, physical health worker(s), resident doctor (s), care co-ordinators, who are CPN's (community psychiatric nurses), OT (Occupational Therapy), Family worker, Employment support worker(s), peer support/community support workers, non-medical prescriber, medical and nursing students. Each care co-ordinator is expected to write up the clinical notes on RIO for their own patients.

48. I aim to review my EIP patients in clinic if possible but if they are not able to attend, I do home visits. I do on average 3 home visits a week (includes EIP and AO). I aim to see my EIP patients every 3 months, more often, however, following their initial referral and if clinical concerns arise. I also respond to MS Teams messages and emails and engage in face-to-face discussions with care coordinators regarding these patients throughout the week. I am also the main prescriber of medication for these patients and for the vast majority I take over prescribing when they are first referred to our service, to ensure monitoring takes place and for those who are students/low income not to have prescription costs as a barrier to concordance.

49. **Additional clinical responsibilities;** My role in both of these teams also involves being the Responsible Clinician for patients under my care who are on CTO's within the AO pathway and the North EIP part of the EIP service. For these patients I prepare Tribunal and Managers panel reports; I attend meetings with an AMHP (Approved Mental Health Practitioner) to give consideration to renewal of the CTO's; I attend Tribunal and Managers panels; I meet with patients to complete consent to treatment documentation or refer them to a SOAD (Second Opinion Appointed Doctor) to be reviewed if I am concerned they do not have capacity to consent to treatment; I recall patients on CTO's if they are not engaging with their treatment. I have also taken part in Mental Health Act assessments in relation to my patients. I have in my role working

with AO and EIP patients, attended meetings with the police, social care, midwifery, perinatal psychiatry, inpatient wards, forensic Consultants and sought advice from forensic services, psychotherapy, drug and alcohol Consultants and liaised with the CRHT (Crisis Resolution and Home Treatment Team), Trust Pharmacists, drug and alcohol services, liaising with GP's etc.

50. I also meet patients' families/carers/ housing support staff and others as part of my role in both the AO and EIP team. I also have discussions with the Clinical Psychologist working in the LMHT at times regarding some of these patients and on a couple of occasions I have referred AO patients to the Psychologist in the team. I regularly have discussion with the Trust pharmacists' around issues that arise in relation to medication. We are also supported by the CRHT (Crisis Resolution and Home Treatment Team) when there are concerns regarding admission as they are involved in gatekeeping and I do also discuss complex cases with the Consultants working in the CRHT.

EMAIL OF 26 APRIL 2016

51. I have been asked to provide information relating to an email I sent timed at 17:51 hours on 26 April 2019 [WITN0206043] in which I wrote:

"...Do you guys know how many on your case load currently and the proportion that are EIP and AO and others? Also the number on CTO? I feel my AO numbers are going up a bit and not sure if should be gate keeping more or not. Do you gate keep and decide as an MDT if you accept new ones or do you just take them if referred automatically? Should we arrange to meet some time to discuss how it is going for us currently in these pathways as medics?"

52. I have been asked to explain the context of this email, addressing the following:

- a. My concern as to AO numbers going up.*
- b. The proportions of my own case load that was AO, EIP, on a CTO.*
- c. The challenges that resulted from my AO numbers going up.*
- d. What I mean by 'gate keeping'.*
- e. My uncertainty as to whether I should be gate keeping more or not.*
- f. What I considered to be the benefits of more or less gate keeping.*
- g. Whether I dealt with gatekeeping at MDT.*

53. I have set out my responses below to the queries outlined above.

54. I have no recollection of sending this email, however on reading it at this time, I can see that I sent the email to my Consultant colleagues who were working in teams with similar patient groups to my own, within the city of Nottingham, as I was seeking their views. For context, I had not worked with AO patients myself prior to 2017 and the colleagues I emailed had worked in the original AO service. In essence, I wanted to understand the numbers in their case load, and how they managed the referral of patients to the AO pathway of their City LMHT team, to inform my own approach and to benchmark my own caseload with theirs. My recollection is that I sent the email during the period when patients were being transferred between LMHT's, so that they were in the correct catchment area, following the introduction of the new LMHT's. Although the relative numbers were small, it is important to keep a close eye on caseloads as patients on the AO pathway often remain on the pathway for many years. I also believe that my concern at the time may have related to whether patients were allocated to the appropriate pathway, by those doing the transfers between teams, and how we would know if we did not check.

55. I think at the time I would also have been concerned about the capacity of the Consultants and care co-ordinators to provide appropriate care to EIP and AO pathway patients, within the LMHT's. I believe I would have wanted to know what was a reasonable number of patients to have on a caseload that would be considered safe to manage given the additional roles within the LMHT.

56. At around this time, I believe that there were discussions about care co-ordinator capacity taking place within the different pathways. On 21 March 2019, I sent an email to the LMHT Service Manager and LMHT Team Manager in which I raised concerns about there being no qualified AO staff on the pathway in City North LMHT until the beginning of April 2019 (**WITN0491007**). I had needed an AO patient to be allocated a care co-ordinator urgently, who could not wait until then, which was why I was raising a concern. I was also concerned that a staff member working on the EIP pathway, within the City North LMHT, was having to get involved, taking away time needed for the care of the EIP pathway patients.

57. For further context, from the beginning of the new LMHT's I tried to have a core group of care-coordinators working with EIP patients and another core group of care-coordinators working with AO patients, as I felt this was the safest thing to do at the time. In my view, this helped maintain continuity of care, preserve the specialist knowledge and skills required to work with these patient groups, and support consistent multidisciplinary working and clinical oversight during a period of significant service change. I recall that my LMHT Team manager and Clinical Lead agreed with me. I was aware however that other LMHT's were not able to do this. Over previous years, when working in the original EIP service, I raised concerns about the workload for Consultants and care co-ordinators and have always been mindful of caseload numbers and the ability of the care co-ordinators and myself to work safely and therapeutically with patients with serious mental illness. For example, by way of email (dated 02.03.2017) I raised concerns about the number of EIP referrals we had in a single week in the city (12 referrals) and the lack of medical capacity to see them in a timely fashion **(WITN0491008)**.
58. I was also aware that AO patients generally remain under the care of the same team for several years, hence the need to only take the patients that needed to be on the AO pathway, otherwise it would become overwhelmed and unable to function, therefore even if the numbers were increasing unexpectedly even a little, it would be important to give consideration to potential reasons why, one of which might be that they did not need the AO pathway and screening/gatekeeping would help clarify.
59. I was also used to gatekeeping having worked in the EIP service. The EIP caseload is characterised by a much higher level of patient turnover. EIP services have a continuous flow of new referrals requiring assessment, not all of whom meet the inclusion criteria, or are accepted after a period of assessment (because not found to have psychosis), while other EIP patients are prepared for discharge as they complete the 3 years EIP care pathway.
60. I am not certain of my own case load numbers at that time. I did an email search and found it difficult to locate the information. The Trust also did a search however the numbers do not tally with what my caseload has been historically over the years. This may be because at the time patients were in the process of being transferred. It was a time of flux. I have asked the Trust to see if they can locate further information. I believe I would have asked about numbers of CTO, AO and EIP, due to concerns that my

numbers were high at the time, and therefore my workload, so I must have had a note of them somewhere or was planning to get them, my secretaries have always been good at keeping an eye on my numbers for me over the years. Various emails have been located that provide an indication of my caseload at various times.

- a. In a 2015 email, when I was working in the original EIP standalone service full time with 7.5 clinical care sessions (30 hr's) I noted that I was using non-clinical time, together with a temporary additional 0.5 PA, to help manage a caseload of approximately 180-200 patients, prior to the extension of the EIP age range from 35 to 65 years (**WITN0491009**). In the same email, I raised concerns about how the whole EIP service medical workload was being managed at that time and how it would be managed going forward with the anticipated changes to the age range, as it was due to increase. My recollection is that we were seeking the appointment of an additional full-time Consultant to support the medical workload across the service.
- b. I also note a series of emails from 2015 and 2017 referring to an expectation that EIP Consultants would have around 20 patients per clinical session (**WITN0491008 and WITN0491009**). This was also my understanding at the time and, to the best of my recollection was shared by the Clinical Director at the time, who worked within the EIP service. From when we first set up the EIP service the Consultants working in it had more or less agreed that 20 per session was manageable, even though we often went above this number.
- c. In an email in July 2019 (**WITN0491010**) concerning a job planning document that Dr Thangavelu was preparing, I raised concerns about the number of patients being suggested (20 – 25) per clinical session for those working in the AO and EIP pathways and referred to the PIG (Policy Implementation Guideline) that was created to help with the development of the NSF (National Service Framework) services, which included AO and EIP services (**WITN0491011**). This document was developed before CTO's came in and the numbers of those have gradually increased over the years. The job planning document has not been used in subsequent job planning with Consultants to my knowledge.

- d. In July 2020, following discussions with Dr Adamson, Clinical Directors Michelle Malone and Dr Seedat those working with AO and EIP patients were asked to provide information about how their clinical sessions were divided between the AO and EIP pathways. In particular, current caseload sizes per area, to map what medical resources were available, which they did to the best of their ability. My recollection is that this information was being gathered to help determine the workforce requirements for the EIP service following the decision to separate the EIP pathway from the LMHT, into which they had been incorporated into in 2017 **(WITN0491012)**.
- e. I have found an email I sent on 20 July 2020 in reply to the email referred to at paragraph 60(e) above, referring to my caseload at that time, when I would have had 6 direct clinical sessions (24hr's) which mentioned having around 12 patients on CTO's the majority were AO patients **(WITN0491012)**. In the email I said I had 142 patients in total and elsewhere in the email it says that there were 108 EIP patients in City North so I assume the rest (34) would have been AO patients. I was also covering Responsible Clinician for a handful of other CTO patients, as well as my own, in City North LMHT as there was no one else able at the time.
- f. Over the years I have contacted various colleagues from other Trusts seeking information about EIP caseloads. For example, I sent an email to a colleague in another NHS Trust in 2020, seeking information about EIP caseloads. This is consistent with my recollection that there were discussions regarding the number of patients I was expected to manage within my EIP clinical sessions, and I was seeking comparative information from other NHS Trusts **(WITN0491013)**.
- g. In August 2022, following queries at a job planning meeting about my caseload, I emailed the Clinical Directors explaining the composition of my caseload **(WITN0491014)** and referring to the Iris Workforce calculator **(WITN0491015)**. This is consistent with my recollection that I continued to raise concerns about the medical workload associated with the EIP service. My numbers at that time were 145 AO and EIP patients, with around 105 being EIP. By reference to the Iris Workforce calculator, it demonstrated we were understaffed in terms of

Consultant time in EIP. There are also further emails I have located which refer to my caseload at different points including:

- i. 07.06.2022 – 107 EIP patients (email does not refer to AO numbers) – **(WITN0491016).**
- ii. 14.07.2021 - 147 patients on 6 sessions plus 10 on CTO's – **(WITN0491017)**
- iii. 21.04.2021 – 121 EIP patients (Email does not refer to AO numbers) – **(WITN0491042).**
- iv. 29.01.2021 - 117 EIP patients (email does not refer to AO numbers) – **(WITN0491018).**
- v. 08.09.2020 – total of 151 on 6 clinical sessions – **(WITN0491019).**
- vi. 29.08.2019 – 80 EIP patients and 44 AO patients – **(WITN0491020).**

h. These emails and others demonstrate that over the years, probably since I first started working in EIP, I have felt that I had to defend my position in terms of the amount of patients I had per clinical session. My concern was that the complexity of the patients was not always being considered when numbers alone were looked at especially when my other colleagues in the LMHT had caseloads significantly higher and many of their caseload did not have care co-ordinators, whilst all of mine did. It may have been my anxiety about having to defend my capacity in terms of caseload per clinical session led to this email being sent also.

61. Currently I have around 137 patients and of these EIP are 104 and AO are 33 with 5 further patients on a waiting list for AO (3 of which are already on my EIP caseload, and 2 of those are on CTO's. Of the other 2, 1 is on a CTO and the other is in an LMHT). There are two other AO referral's to be discussed next week. This can change on daily basis, particularly for EIP patients, but this does reflect a recent average.

62. At this current time I technically have 15 patients on CTO's in the community under my care (included within the 137, a mix of AO and EIP). However, there are others not included within that 15, that are in hospital having been recalled and two were sent to prison and their CTO's could not be renewed. There are a couple of other patients on CTO's due to be transferred to me/discharged from hospital on CTO, and another due to be transferred by me, to another team. It is difficult to have an accurate number due

to the above. I also have a few patients on MHTR (Mental Health Treatment Requirement orders by the court). I had to speak to my line managers about the amount of clinical work I have been doing and a temporary increase in hours has been agreed until the end of this year. The only other medical support I have currently is a resident doctor who is a core trainee for approximately 1½ days a week.

63. I believe that my view at the time I sent the email to Dr Lloyd, including other colleagues [WITN0206043], was that AO patients required more intensive medical and care co-ordinator input than we were able to provide. The challenge was in trying to meet all these new patients, get to know them, allow them time to get to know me, review their notes, work out what was happening for them and to manage their risk, in circumstances where I felt there was insufficient medical capacity to provide the level of care I believed those patients required.
64. Another challenge was ensuring the patients were getting the right care in the right pathway or team. I believe one of my concerns at the time was whether some patients being transferred between teams, met the criteria for the AO pathway (see below regarding the SOP). I wanted to ensure that I was providing care to the appropriate patient group so that those patients received the level of medical input they required. I was also concerned about the size of the care coordinators' caseloads, their mixed caseloads and whether they had sufficient capacity to provide appropriate care to their patients.
65. My plan for my patients on the AO pathway, in City North LMHT, was to have a core group of staff responsible for these patients, so that they could provide continuity of care, even if the patients were no longer formally part of an AO Service.
66. When I referred to gate keeping in this email, I would have meant the process of reviewing whether patients met the inclusion and exclusion criteria for entry to the AO pathway within the LMHT.
67. All teams have inclusion and exclusion criteria that define the patients they are intended to work with. This helps to ensure that patients are managed within the service that is most appropriate to their needs. The LMHT SOP (Standard Operating Procedure) as of October 2019 (WITN0491022) which was distributed by email in November 2019 (WITN0491023), had embedded in it a document headed "**Support**

and engagement for enduring Psychosis pathway Clusters 16 & 17 Average episode of service duration is up to 36 months". It had a section which in it under **Thresholds / Admission criteria** which described the patients the staff on the pathway would be expected to work with. The document stated "*Usually these will 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*".

68. Patients on the AO pathway in the LMHT's were generally considered to be the most clinically complex and difficult to engage patients.
69. I recall that, at that time, patients were still being transferred from other areas of the city as part of the reorganisation of services. The process of moving patients and staff between teams took a considerable period of time. I believe one of my concerns would have been that more comprehensive handovers were needed during these transfers. I also think I may have had concerns about whether all of the patients being transferred were appropriate for the pathway to which they had been allocated, although I cannot now recall this with certainty. The contemporaneous emails include correspondence from August 2019 in which I raised concerns about gatekeeping arrangements. These included queries about patients being allocated to the AO pathway without recent medical review and concerns in relation to staffing of that pathway. My recollection is that this led to efforts to secure additional care co-ordinator support.
70. At the time, I was also conscious that the capacity of the AO pathway within the LMHT was limited, and this reinforced my view that patients' histories and clinical needs should be carefully reviewed before deciding the most appropriate care pathway.
71. Once patients entered the AO pathway, as previously mentioned, they often remained under that service for prolonged periods for valid therapeutic reasons. I believe I would have been thinking at the time that the new AO pathway

within the LMHT should apply similar criteria to the old AO service, through the gatekeeping process.

72. At the time, on looking again at this email I believe I was probably wondering if I was overthinking the issue and whether I should simply accept all patients referred to the pathway without question. However, I remained concerned that some patients would be more appropriately managed within a different pathway of care. I believe I would have wanted reassurance that my approach was reasonable and to understand how colleagues in similar roles were approaching these decisions. Opportunities for discussion as a small group were limited, as staff were extremely busy and worked across different sites. I don't think we had MS Teams at the time.
73. In my view, the purpose of gatekeeping was to help ensure that patients were allocated to the care pathway best suited to their needs. In addition, given the limited capacity within the AO pathway, accepting inappropriate referrals could reduce the availability of staff for patients who did meet the criteria. This then could have led to reduced level of care for those patients who needed it the most and, in my view, had the potential to increase clinical risk.
74. Initially, in 2017, I recall that all AO patients transferred to me were automatically accepted without a gatekeeping exercise being carried out, probably because they were being transferred from the original AO Service. For patients referred to the EIP team, there was always a gatekeeping exercise, although I cannot recall whether this took place via the MDT at the time of the new pathway being created, or a separate process.
75. We moved towards an MDT approach for gatekeeping AO patients once the team got up and running. I can't say precisely when this was, although I note my email to colleagues on 26 April 2019 was asking about a gatekeeping function, so I assume it was after this. I cannot precisely remember the process for this gatekeeping exercise at the time it was introduced but expect that it would have been akin to the process we operate now, as outlined below. As part of the MDT, I contributed to decisions about whether patients met the inclusion criteria for the pathway so we could ensure we had those most suitable for the service. Although these decisions were made collectively, I recognise that I had significant influence in my capacity as Consultant Psychiatrist. I

was also fortunate to work alongside colleagues with experience of the previous AO service, whose knowledge informed the team's decision-making.

76. Gatekeeping continues to operate within the AO pathway within City North LMHT. I cannot speak for what happens in other LMHT's. When the wider LMHT or the EIP team requests that a patient be accepted into the AO pathway, within City North LMHT, the referring care co-ordinator is invited to attend our weekly MDT to discuss the referral. I will also, where appropriate, discuss the patient with the referring Consultant. If the MDT agrees that the patient meets the pathway's criteria, we generally accept the referral promptly, when we have capacity to do so. I currently have patients transferring from my own EIP caseload into the AO pathway, and these referrals are considered in the same way. Due to capacity issues some patients are however having to be shared across the wider LMHT staff currently, increasing the number of care co-ordinators working with these patients leading to a reduction in a core group of care co-ordinators working with these patients.

77. When not accepted onto the pathway, in those circumstances, we would usually offer clinical advice to the referring team, who are aware they could seek further advice or make a further referral if the patient's circumstances changed/new information came to light.

REPLY TO THE EMAIL ON 30.04.2019

78. Dr Tuhina Lloyd replied to my email on 30.04.19, including two other Consultant colleagues working in the AO and EIP pathways in Nottingham City and to the Lead Consultant in Dr Lloyd's area of the city stating:

"we are currently under pressure from our team leaders to discharge high risk AO clients on the grounds that they are not engaging! There seems to be a lack of understanding about the nature and ethos of AO model."

79. In respect of this email, I have been asked to comment on the following and have done so below:

- a. *Whether I replied to the email and if so when, and what did I say and what thoughts/advice did I offer? I have been asked to exhibit a copy of the reply to my email.*

- b. *What my understanding was as to the nature and ethos of the assertive outreach model within LMHT?*
- c. *Whether I shared the concern that there was a lack of understanding about the model? If so, what was the lack of understanding of the model as I perceived it?*
- d. *My view at the time as to the appropriateness of discharging assertive outreach patients on the grounds of non-engagement? Whether my view has since changed? If so, when and why?*
- e. *Was pressure put on me, or whether I felt under pressure, to discharge high risk AO patients on the grounds they were not engaging? If so:*
 - i) *What was the source of that pressure?*
 - ii) *Which individuals were putting pressure on me?*
 - iii) *Did I, as a result of such pressure, discharge AO patients on the grounds of non-engagement? What assessment of risk, if any, would I undertake?*
- f. *If not:*
 - i. *What was my practice in respect of non-engaging assertive outreach patients? In what circumstances, if any, would I discharge such patients? What was the process of discharge?*

80. I have set out my responses below to the queries outlined above.

81. I cannot find any evidence that I replied to Dr Lloyd's email. I understand that the Trust has also carried out a search centrally and have also been unable to locate any response. I have no independent recollection of the email I sent proposing a meeting with my Consultant colleagues. As these events occurred before the COVID-19 pandemic, it is possible that I discussed the issues in person with Dr Lloyd subsequently, as we attended the same Consultant meetings, journal clubs and peer group, although I have no specific recollection of doing so.

82. It is my usual practice to respond to emails quickly. It would also be my usual practice to acknowledge such correspondence from colleagues, out of politeness, and I cannot explain why I have not done so on this occasion. For additional context, around that time, my recollection is that I was working under significant clinical pressure because of vacancy and sickness of colleagues, with locums providing intermittent cover. For example, I had taken on responsibility around this time for an additional 6 CTO patients due to a colleague's sickness absence, which significantly increased my workload all

at once. It is possible that these workload pressures contributed to me not replying to Dr Lloyd's email. I have no memory of this and do not know if there is a reply that has not been located, or if I spoke to Dr Lloyd about this.

83. Having reviewed this email correspondence, my reading of it is that it was an exchange between colleagues and I was not making a formal request for a meeting, more of a suggestion that we met up to discuss how we were getting on in the new LMHT's and to share our experiences. In Dr Lloyd's response to my email, there was no question, as such, for me to respond to or request for me to take a specific action, although she did say she would welcome a meeting. Dr Lloyd also included other colleagues in the email and again on reading it, I do not think it was specifically directed at me as I was the one with the least experience working on the AO pathway at that stage and I was the one who had asked for advice in the first email myself.

84. My understanding is that when Dr Lloyd referred to 'Team Managers' she would have been referring to the LMHT team manager for the City South LMHT (Helen Taff) and the Clinical Lead (I cannot recall their name), rather than medical management. To clarify, Team Managers, all nursing staff and other non-medical colleagues have their own line management structure and are not line managed by the Consultants. I also note that I copied Dr Thangavelu into the original email that I sent. I believe this may have been because he had either recently taken over, or was about to take over, responsibility for City South and City East LMHT's as Lead Consultant and may have had an interest in coming along to any meeting we did have. I cannot think of any other reason why I would have copied him into my email.

85. My interpretation of the email, particularly because of the exclamation mark in it, indicates to me, that Dr Lloyd had no intention of discharging any patients due to pressure. I have known Dr Lloyd since we were Specialist Registrars together and I do not believe that discharging high risk AO patients against her clinical judgment was something she would have done under pressure from anyone.

86. There would have been other opportunities also, after that email was sent, for Dr Lloyd to discuss any concerns about City South LMHT Team Managers putting pressure on her to discharge AO patients whom she believed were high risk. Had Dr Lloyd wished to speak further about the pressure she was being put under to discharge patients I believe she would have brought this up again. Dr Lloyd had a job planning meeting

with me on 17th July 2019. Contemporaneous emails and the job plan itself, suggest the service manager, Sarah Toone and Dr Thangavelu also attended. Dr Thangavelu had taken over the role of Lead Consultant for the part of the city, which included City South LMHT, where Dr Lloyd worked, and would be responsible for Dr Lloyd's next job planning meeting. I believe I attended as I had been involved in Dr Lloyd's initial job plan when she moved to City South LMHT (as we did not have a Lead Consultant for that area at the time) and this would have been an opportunity to handover to Dr Thangavelu. I was copied into an initial email on 8 May 2019 sent by Dr Lloyd to Dr Thangavelu, requesting a job planning meeting as she was stepping down from her role of Head of School, however she also said she was happy to do it with me, given my background in EIP (**WITN0491024**). Dr Thangavelu responded by saying he was happy for it to be done by whomever it was felt appropriate, between the two of us. There are further emails which refer to a suitable date being identified when I agreed to do it. Given the passage of time, I have no independent recollection of the meeting or the discussions that took place. However, if Dr Lloyd had ongoing concerns at that time that she wished to raise, the job planning meeting would have been a good place to speak to them, particularly as there was a senior service manager present who would be able to address any pressures felt by Dr Lloyd from the team she was working in, to discharge. When I completed the job plan I sent it to Dr Lloyd and Dr Thangavelu to ask if they were happy with it and it was subsequently signed.

87. On 18 June 2019, there was an email discussion between myself and Sarah Toone (Service Manager) (**WITN0491025**). I have no personal independent recollection of these emails. I understand from the emails we were organising a suitable time for Dr Lloyd's job planning meeting. To summarise the content, Sarah Toone asked if Dr Lloyd had mentioned anything to me about the City South LMHT Team Manager. I replied no and asked if Dr Lloyd was ok. She then referred to some concerns raised by others in Dr Lloyd's team related to the City South LMHT Team Managers leadership style and her own thoughts that the Team Manager was not supportive of the EIP pathway. I replied that Dr Lloyd might be waiting for her job planning meeting to speak about it. Sarah Toone's email indicated that she had plans to address the concerns with the Team Manager and she was going to visit Stonebridge (City South LMHT team base), that Thursday and would try to see Dr Lloyd to discuss further. I have not seen any further emails in relation to this, and I have no recollection of it being raised during the Job planning meeting in July 2019. In my view, job planning meetings provide a forum for concerns of this nature to be raised. Alternatively, any concerns

could be raised with Dr Thangavelu who had become the Lead Consultant for that part of the city.

88. I also understand that around the summer of 2019, the service managers organised workshops relating to service delivery within the LMHT. It is possible that concerns were raised during those discussions, although I have no specific recollection of what was said.

Nature and ethos of the assertive outreach model within LMHT

89. To confirm, I did not work in the standalone AO service prior to the transformation in 2017. It is my understanding from colleagues that the AO pathway within the LMHT differed significantly from the original Assertive Outreach service model following the service transformation in 2017. In the post 2017 model, there was no out of hours or weekend working, there were no team held caseloads, there were no daily meetings to discuss all the AO patients. To my understanding, post 2017, the AO patients continued to be clustered (a national system that groups patients based on the nature, severity and complexity of their presentation) so that they remained identifiable as group of AO patients, and specific Consultants were also identified to provide medical input to this specific patient group. Those on the AO pathway were all allocated care co-ordinators.

90. My impression at the time was that there was no clear, consistent model identified as to how these patients were to be managed within the newly created LMHT's and it was up to the various LMHT's to work out what to do in practice, which led to different teams doing different things. I also understood that the majority, if not all, of the LMHT Team managers would not have had experience working with the AO or EIP patients previously, which could have impacted on their understanding of the nature and ethos of those models of care.

91. I have only worked in City North LMHT, therefore feel only able to comment on how this team works.

92. I was fortunate that the Team managers I worked with at the beginning of the transformation of services, and the majority who followed, were happy for me to work out a plan on how to manage the patients on my caseload. I believe that the majority

of the Team managers in City North LMHT that I worked with (there were a number of changes in terms of team management following the reorganisation of services) had an understanding of the nature and ethos of working with AO patients at the time of the email, because they did not have an issue as to how I suggested we work with these patients. Due to limited resources, it was impossible to provide a level of care similar in intensity of support for these LMHT AO pathway patients to the previous AO service, and we had to accept this and work with resources we had.

93. The City North LMHT managers at the time of Dr Lloyd's email, agreed for the previous AO Service nurses to work with patients on the AO pathway and I believe they did have reduced caseloads, however they also had to work with LMHT patients and carry out other core roles of the LMHT such as duty, medication clinics and new assessments. Personally, I felt fortunate to have CPN's and support workers with previous AO experience working within the City North LMHT especially at the beginning, and I learned a great deal from their knowledge and experience.

94. I understand that in the City, City North LMHT managed patients on the pathway differently to other City teams around the time of Dr Lloyds email. I can recall from conversations with others around that time that other LMHT managers did not wish to work the way we did at City North LMHT. If LMHT's had been encouraged to have a core group of staff working with the AO patients, and separate MDT'S, this would have been evidence for me that there was an understanding of the model by more senior managers also. My impression at the time and now is that resource issues influenced the decision making.

95. Initially, if I recall correctly, in City North LMHT we attempted to discuss both the AO pathway patients and the EIP patients within the same MDT meeting, probably because these were the patients I was working with. However, this proved inefficient and we therefore decided to separate the AO pathway MDT from the EIP MDT to provide a more structured and focused discussion for each patient group.

96. It took some time for the new way of working with patients on the AO pathway in City North LMHT to become established. I recall I had to change the day of the AO MDT at one point as the core group of nurses I worked with on the AO pathway were routinely being allocated other LMHT duties on the day the meeting was originally held. I made

this change as I considered it essential that they were able to attend given their knowledge of the patients and their role in care co-ordination.

97. Most of the previous AO staff, who had worked in the original AO service in the Trust, have since moved on. Currently the care coordinators working with AO patients in my City North LMHT still hold a caseload of wider LMHT patients and are expected to carry out other LMHT duties as well as working with their own AO patients, with the amount of this other work also increasing.

98. Although the question relates to how things were in 2019, I feel it is also relevant to address more recent attitudes also. I do recall that at times over the years there appeared to have been questions asked (not from doctors but from other colleagues within the management structure) about my running two mini-teams for AO and EIP patients within the City North LMHT. On 6 May 2024 I emailed the Clinical Director raising concerns that management in City North LMHT at that time, were questioning why we were discussing all the AO patients every week in our MDT and appearing to suggest, if I recall correctly, that we did not need a weekly MDT or one that went on for 1 ½ hours (**WITN0491028**). It was also said that future AO patients were going to be allocated to the wider LMHT staff, which I felt could mean that inexperienced/newly qualified staff might be asked to work with the most complex patients with the most risk in the LMHT. For me this is an example of a lack of understanding of the nature and ethos of working with AO patients.

99. At the end of May/ start of June 2024, I raised further concerns with Dr Stephanie Summers (my line manager) about how it had been said directly to me by the Team Manager at that time that we did not have an AO pathway within the LMHT for Cluster 16/17 patients. I felt we had, as whilst we were not giving them the level of input we should be giving, as part of a standalone AO service, we did at least have some semblance of offering them more care than if they were in the wider LMHT held by multiple different care co-ordinators, who would not necessarily have had the experience of working with high risk difficult to engage patients. I also felt that the way of working I had had with these patients since services were reconfigured had been safe, despite the challenges related to lack of resources.

100. It could therefore be said that I had considerable concerns for the first time, in 2024, regarding the ethos of the AO model of care within my own City North LMHT and

the lack of understanding of it at that time. I had been aware of the concerns expressed by other Consultants working with these patients elsewhere in other LMHT's prior to this but had not actually experienced it myself with my own Team Managers until this point. I do not recall however experiencing any pressure to discharge these AO patients to primary care.

101. I have again more recently, in 2026, raised further concerns with my medical managers and the Team and Service managers about the staff on the City North AO pathway having to take on additional non-AO LMHT patients and being asked to do extra assessments, as I believe this particular instruction to staff further reduces the capacity of staff to provide the level of input required for AO pathway patients, and is not in keeping with the nature and ethos of the AO model of care. At the same time, I do recognise the significant pressures on the wider LMHT, particularly in relation to waiting times for assessment of patients referred into the wider LMHT, due to capacity issues.

The concern regarding the understanding of the assertive outreach model

102. I shared the concern that Dr Lloyd expressed in her email of 30.04.2019 about the lack of understanding of the AO model. I am of the opinion that the decision that was taken circa 2016, to integrate the patients that were in the original AO Service in the Trust, into the LMHT's, demonstrated that there was a lack of understanding of the AO model by the management structure. I also feel it demonstrated a lack of understanding about the importance in particular of continuity of care in engaging these patients and the time required to do so, given they are the most high risk, complex, and difficult to engage patients with psychosis, within Adult Mental Health services. I believe that the reasons why the AO services were established throughout the country in the first instance was not fully appreciated or understood, otherwise in my opinion, the decision would not have been taken. In addition, within the newly formed LMHT's, Team managers and care co-ordinators may not have previously worked within dedicated AO or EIP services and therefore had less experience and understanding of the specific needs, risks, and ways of working associated with these patient groups and the time needed to engage them.

103. I was concerned that patients on the AO pathway could become absorbed into the wider LMHT and, over time, receive little that distinguished their care from that of other LMHT patients, despite their higher levels of complexity and need. I was

concerned that as a result the level of awareness of these risks would be minimised over time. In my view, without deliberate measures to preserve key elements of the AO model (for example, time and persistence to build the therapeutic relationship over a longer period of time and to be able to monitor the risks closely), risks would increase.

104. Within my team, in City North LMHT, I therefore sought to retain some of the key features of the former AO service, including a dedicated MDT meeting and wherever possible, having a small number of CPNs as care coordinators of AO pathway patients, rather than dispersing them across the wider team. Although this approach was initially achievable, it has become increasingly difficult to maintain because of staffing pressures, including sickness absence and staff leaving, leading to patients being transferred to other team members at times. The patients are not team held within the LMHT's, meaning that when staff leave or go on sick leave, they could be supported by a number of different staff, unknown to them, which in my opinion, for these patients can potentially have an impact on their engagement.

105. It is my professional view that, since the service transformation in 2017, the patients on the AO pathway whom I have worked with have not received the same level of support and intensity of care that would have been available within a properly resourced, standalone Assertive Outreach Service. I was unable to attend a meeting that was arranged to discuss the AO pathway in June 2021, but provided my thoughts by email (**WITN0491045**).

106. In my practice, I aim to review patients on the AO pathway at least every three months, and more frequently where clinically indicated. I am not aware of any national guidance on this, but it reflects my preferred way of working with these patients. Many also require home visits. Even when patients are relatively stable, I consider regular face-to-face contact important to maintain continuity of care and the therapeutic relationship, which are key components of working effectively with this patient group.

107. The initial service transformation in 2017 resulted in both patients and staff being redistributed across various LMHT's, this process took some time to complete. The role of care co-ordinators working with EIP and AO patients also changed. In addition to care co-ordinating their existing patients, they became responsible for undertaking new assessments of referrals from primary care, participating in

duty rotas, medication clinics and other core LMHT functions. This remains the case still for staff working on the AO pathway in City North LMHT. For some former AO staff, these responsibilities represented a significant change, as they had not routinely undertaken new assessments for several years. These additional responsibilities reduced the amount of time available for care co-ordination of AO and EIP patients. However, to the best of my knowledge the patients all have care co-ordinators allocated and whilst I am not absolutely certain, I believe in other LMHT's also.

108. Around this time of the transformation of services, there was a noticeable turnover of staff, although I am unable to say how many left. This would have had an impact on the LMHT's as experienced staff left. There were also periods of staff sickness, further affecting the team's capacity.

Appropriateness of discharging assertive outreach patients on the grounds of non-engagement

109. Patients who meet the criteria for AO services are all high risk, to themselves and/or others. In my view, this means that discharge from secondary care mental health services carries an inherent level of risk for this patient group.
110. In my view, non-engagement alone should not be the determining factor for discharge for either EIP or AO patients, and any decision to discharge should involve careful consideration of the potential risks to both the patient and to others. I held the same view at the time.
111. I recognise however that there may be exceptional circumstances in which a patient with a significant risk history may be discharged, for example when they cannot be located despite sustained efforts to do so, including liaison with family, with the police and other relevant agencies. In such situations there may come a point where a decision has to be made about whether it is appropriate for the patient to remain under the service. Such decisions should be based on a careful assessment of the individual circumstances, the efforts made to locate and engage the patient, the level of ongoing risk and the services ability to provide effective care. No patient on the AO pathway is allowed to be discharged currently however due to non-engagement.

112. There are also patients who refuse to engage, and we know where they are, but who do not meet the criteria for detention under the Mental Health Act. In my experience, some such patients have remained open to services for prolonged periods despite the absence of direct engagement. During that time, it has sometimes been possible to provide support to family members or carers and to obtain information about the patient's wellbeing and any changes to their presentation. This indirect contact can assist in ongoing risk assessment and may also facilitate re-engagement should the patient's circumstances change.

113. In my view, the discharge of high-risk AO patients due to non-engagement from mental health services should be regarded as an exceptional event and should be subject to careful oversight and monitoring. Patients leaving the AO pathway, having benefitted from the approach, should be stepped down to the wider LMHT, rather than being discharged from mental health services altogether.

Pressure to discharge high risk AO patients on grounds of non-engagement

114. I have never felt under pressure to discharge high risk AO patients from mental health services due to non-engagement.

115. I do recall discussions in both AO and EIP MDT meetings about patients who remained on our caseloads despite not engaging with the service and what, if anything, we were able to offer them. However, I do not believe that patients were discharged solely because of those discussions. No one was putting me under pressure to discharge high risk AO patients, and I have never discharged AO or EIP patients due to pressure.

116. Where patients did leave the AO pathway, they would usually step down to the wider LMHT and remain under secondary mental health services on a long-term basis. In my experience, with sustained engagement and appropriate support, it is possible to work effectively with many of these patients, encourage adherence to treatment, reduce risk and improve their quality of life.

117. In terms of risk assessment, where an AO or EIP patient was not engaging or there were concerns about their whereabouts, we would discuss the patient at our weekly MDT meeting. There are also opportunities to discuss any patient concerns in

between MDT meetings. We would review the patient's historical records including previous risk assessments and draw on our own personal knowledge of the patient to identify known patterns of presentation, previous risks, and any factors that had previously indicated deterioration. We would make repeated attempts to see the patient to carry out an up-to-date mental state examination and assess their current level of risk. Where appropriate, we would seek information from family members, carers, housing support staff, housing area manager, or other professionals (e.g. probation, social care) in order to obtain collateral information about their current presentation and level of functioning. As part of our assessment we would consider the patient's living environment, including whether there was evidence of self-neglect or neglect of their property. We would establish whether they were taking their prescribed medication. For example, if a patient missed a depot (antipsychotic injection) or stated they still had medication despite being due a further supply, this could indicate non-adherence to treatment and would increase our level of concern. Where appropriate, we would contact their community pharmacy to clarify whether prescribed medication had been collected and liaise with the patient's GP practice to determine if there had been any recent contact. Where there were significant concerns about a patient's safety or wellbeing we would liaise with the Police to establish whether they had any recent contact and ask if they would do a wellbeing check. We have at times requested a PNC (Police National Computer) check to see if there was any relevant information that would be helpful.

My practice in respect of non-engaging assertive outreach patients

118. Over the years I have worked with many AO pathway and EIP patients who were initially reluctant or unwilling to engage with the service. It is my practice to avoid discharges due to non-engagement. It is a rare event for me to discharge any patients on the AO pathway from mental health services. In my experience, persistence and consistency are key to building therapeutic relationships. Engagement often develops gradually as trust is established over time. Practical support can also play an important role in facilitating engagement. For example, assisting a patient with benefits, housing issues or other practical difficulties can help build trust and strengthen the therapeutic relationship. The Trust also has in place a Did Not Attend (DNA)/Was Not Brought (WNB)/Cancellations and Management of Patients who Disengage from Trust Services Policy (**NHFT0002538 - 01.08 DNA Policy**) and I believe my practice adheres to the Policy.

119. In my experience it is extremely uncommon for a patient on the AO pathway to be discharged to primary care, whether in a planned manner or through disengagement. I do recall one patient who did have a planned discharge at the patient's request as they no longer wished to receive support from mental health services. There was no history of harm to others in this person's history. Our preferred option would have been to step the patient's care down to the wider LMHT rather than discharge to primary care. The discharge was carefully organised and as part of it the patients care co-ordinator accompanied the patient to their GP for the handover appointment, making sure they were on the SMI (serious mental illness register) and had regular reviews with their GP. The patient's family were very involved in this persons care and were aware and supported the request for the person to be discharged. At the time of discharge, the patient was in employment and expressed a wish to move forward with their life without the ongoing involvement from mental health services.

120. Following the request for this statement, I requested the Trust to provide a list of patients that had been under my care on the AO pathway from when I started working on that pathway in September 2017, that had been discharged to primary care, whether planned or due to disengagement. There appear to have been 3 patients in the last 9 years, two were discharged due to refusing to engage and one was a planned discharge of a patient who was engaging but no longer wished to have involvement with mental health services and had a planned discharge (mentioned in the previous example above).

121. One of the other patients had been uncontactable for a prolonged period despite extensive efforts to locate and re-engage them. We maintained regular liaison with both the Police and the patient's family for many months, in an attempt to establish their whereabouts and encourage re-engagement. Ultimately, after exhausting the available options, the decision was made to discharge the patient from the service.

122. Another patient was living in known accommodation but did not wish to engage with the team or take prescribed medication. At the time the patient did not meet the criteria for assessment under the Mental Health Act and was managing their day-to-day life without concerns being raised. At the time, the clinical view reached was that

repeated attempts at contact were causing the patient significant distress. The patient was living in accommodation with a housing manager that was there daily, who had not identified any concerns and understood that they should contact services if the patient's mental state deteriorated. Following discharge, the patient's family contacted mental health services, and the patient was subsequently admitted to hospital and re-engaged with services.

123. Around the time the aforementioned second AO patient' began to disengage, I recall that their care coordinator and support worker were absent due to sickness. This may also have affected the patient's engagement with the service due to a lack of continuity care, as well as reduced capacity within the City North LMHT to support during that period. However, I cannot say to what extent this contributed.

124. Both patients are back with the City North LMHT and continue to receive support at this time. I currently visit both patients at home as part of their ongoing care. Their subsequent re-engagement demonstrates that a period of disengagement does not necessarily mean that a patient will remain disengaged indefinitely. This highlights the importance of careful planning around any discharge, working with the family and others as much as is possible.

125. I have worked with many AO and EIP patients over the years who have disengaged from mental health services. In those situations, we review the risk assessments, note when and where they were last seen, review what their relapse signs are, ring, text and do home visits, put notes in the door, contact family/friends, speak with any housing support staff or patch managers, GP or any other professionals involved in their care and if unable to locate them we would then contact the police to report them as a missing person. We tend to message the person to let them know we are going to contact the police and at times this has led to the re-establishment of contact as they may not want police contact. Sometimes the police will say that the person is making themselves intentionally absent. We have at times contacted the police to ask them to put a note on their system that we are concerned about a particular patient. There is a Street Triage team also who would let us know if the police had contact with a patient and there were concerns identified. I have also obtained advice from forensic colleagues at times, referring to the forensic services or asking their opinion. We have also rung other mental health Trusts, when we have been made aware that a patient might be in a certain city, to let them know the person might be in

their area and that we were concerned or asking for them to take over care. I have also, on one occasion many years ago been involved in contacting the airport police, when we thought that a patient was going abroad that I was concerned about. We also contacted the homeless team and hostels when we have struggled to locate patients. I have also had some staff searching some areas of the city where we thought a person we were trying to locate might be. A significant amount of work takes place when a patient disengages, and we don't know where they are.

126. If we know where they are, for example they are at home, and we believe they are because we have noticed a window open or some movement or noise in the house and they do not open the door, we would then consider if there are sufficient concerns, arranging a Mental Health Act (MHA) assessment, after linking in with the CRHT (Crisis Resolution and Home Treatment Team) who gatekeep beds. Discussions will take place with the AMHP (Approved Mental Health Professional) who will help co-ordinate the MHA assessment and request a warrant from the magistrate if thought to be required. Often the AMHP will wish to attempt an assessment without requesting a warrant in the first instance.

127. Often when an assessment is taking place under the Mental Health Act, the CRHT band 7 staff will attend as the least restrictive option has to be considered when detaining someone under the mental health act and there are times when home treatment is an option. If the patient were for example to agree to home treatment which would include medication concordance and visits from the CRHT, and the CRHT and the assessing team, felt this was a viable option, then they will provide this input. If it is not an option, due to the patients lack of insight and unwillingness to engage, or degree of risk to self or others, then the patient will be detained under the Mental Health Act, provided they meet the criteria.

128. If a patient is already on a Community Treatment Order and is refusing to engage with their treatment plan, they will be reminded that they could be recalled to hospital. In my experience this reminder that they can be recalled to hospital, which our team tends to give verbally (although occasionally by text if they do not respond to phone calls or visits), alongside a copy of the conditions of their CTO, is often enough to ensure continued engagement and acceptance of treatment. However, there are times when patients are recalled to hospital, as they continue to refuse to accept

treatment or engage with their community team, or are becoming unwell despite being on treatment. These patients on CTO are often not as unwell as they have been previously in my experience when concerns arise, they will have been seen frequently by their care co-ordinator and any refusal or possibility that they are not taking their medication, or are becoming unwell, leads to prompt action, and recall to hospital if necessary. This means that generally their mental health does not deteriorate as significantly as it may have done in the past. Even when patients are on a CTO we still have to consider what the least restrictive option is and some patients may re-engage with treatment and can be supported at home. If they are recalled on their CTO to hospital, they will be assessed in hospital and a decision made for them to remain informally in hospital, be discharged or go back on a Section 3. In our team I would usually start the process to recall patients within a couple of days of missing their depot antipsychotic medication.

129. We are often faced with challenges around the CTO recall process however. On the CTO recall form, a receiving hospital must be identified before the recall can proceed. In my experience, locating a hospital that is able to accept the patient can take time and delay the recall process. A warrant is usually required to return the patient to hospital and, in my experience, will not be issued by the magistrate until the recall documentation has been completed in full, including the name of the hospital. On occasions, by the time a warrant has been obtained, a previously available bed has been allocated to another patient, resulting in further delay. This is similar to a section 3 medical recommendation, where a receiving hospital must also be identified. In contrast, a section 2 medical recommendation does not require a specific hospital to be named. In addition, the chronic shortage of psychiatric inpatient beds, in Nottingham and elsewhere in the country, also leads to delays in admission.

DISCHARGE OF ASSERTIVE OUTREACH PATIENTS

130. I have been asked further questions in relation to the discharge of high-risk assertive outreach patients on grounds of non-engagement and set out my responses below:
131. I have never pressurised colleagues to discharge high-risk Assertive Outreach patients or any other patient, on the grounds of non-engagement. Quite the opposite; my approach has always been to make every reasonable effort to engage patients on the AO pathway, recognising the complexity of this patient group and the importance

of maintaining therapeutic relationships. In my view, discharge on the grounds of non-engagement of AO and EIP patients should only ever be considered a last resort, after all reasonable attempts to engage the patient have been exhausted.

132. I sent an email to a LMHT colleague, in September 2020, who did not have patients on the AO or EIP pathway (**WITN0491048**). At the time, my colleagues caseload was very large and included a significant number of patients who were not engaging with the service (DNA's). My recollection is that this was, at least in part, because the colleague had experienced periods of sickness absence and there had been a number of locum Psychiatrists covering at times, meaning that routine caseload reviews and appropriate discharges had not always taken place. Both the LMHT team manager and I asked the colleague to review their caseload to identify whether there were any patients for whom discharge would be clinically appropriate and safe, rather than simply because of the size of the caseload. To confirm, these were not patients on the AO or EIP pathways, they were general LMHT patients and it is appropriate to have these conversations about effectively managing caseloads for this group of patients.

133. I do not know whether Consultant colleagues discharged AO patients on the grounds of non-engagement. I am not aware of a practice of colleagues discharging either, if it was not felt safe to do so and without assessing risks and exhausting all reasonable attempts to engage.

134. Aside from Dr Lloyd's email of 30 April 2019, I am not aware of any pressure being put on any other colleagues to discharge assertive outreach patients on the grounds that they were not engaging. I have no independent recollection however of the email that Dr Lloyd sent to me either. My understanding is that the question of whether a patient should be discharged from the Assertive Outreach pathway is a decision that would be taken by all those present in an MDT rather than one individual acting alone. My view is that there were at the time and are now, experienced Consultants working in the AO pathway, who would not be influenced by any undue pressure. I include myself in this group. In my MDT's for AO and EIP patients, everyone has to be in agreement with the discharge plan before it can go ahead. If there is anyone who is not in agreement, we would not discharge a patient before looking again

in detail at the case and reaching a consensus that we had done everything we could within reason to engage the patient.

135. I have no independent recollection of receiving or reading Dr Lloyd's email and I do not recall having a specific discussion about this issue with Dr Lloyd. I do not believe that there was a practice of discharging high risk AO patients from services in Nottingham. In my experience if an AO patient is discharged, then it only after all reasonable options had been exhausted.

136. There are no specific steps or actions that I can recall taking in response to Dr Lloyd's email. On reading the email I do not think she was asking me to undertake any specific action other than saying she would welcome a meeting, which I had suggested in the first instance, to talk about the LMHT pathways we were working in. As previously mentioned her email was sent to our other colleagues as well as myself and I believe I was the individual with the least experience working on the AO pathways. My reading of the email is that she wanted us all to meet up, as it appears did I, to talk about working in the LMHT's. However, I cannot recall there being a meeting between those in the email, Dr Lloyd and the two other colleague in the email and myself. There were however, as outlined above, various other means by which concerns around pressures to discharge AO patients could have been discussed such as in the Adult Mental Health Consultant Forum, the extended AMH forum that took place and in job planning meetings.

b. The lack of understanding as to the nature and ethos of the assertive outreach model?

137. I recall that Dr Lloyd and I did speak about the AO and EIP models in the LMHT and we both had concerns about the impact of no longer having these patients cared for in standalone services. I believe that we discussed the nature and ethos of the Assertive Outreach model and the EIP model, on a number of occasions over the years, although I cannot now recall the specific content of those discussions. What I do clearly remember is having concerns about the level of input my EIP and AO pathway patients were receiving following the formation of the new LMHT's. It appeared to me that patients on the AO pathway and EIP pathway were receiving a reduced level of care from that previously provided by their

respective dedicated standalone services. I recall that Dr Lloyd shared similar concerns.

138. I do believe that with the move of EIP patients back into a standalone service, although not the same as the original Standalone EIP service, work has been done by the Trust to create a better understanding for staff regarding the nature and ethos of how we should work with these patients.

139. In terms of the nature and ethos around AO patients care being addressed, I have seen little evidence of this personally other than discharges from the AO pathway being closely monitored/blocked. These patients remain within the LMHT's. As a result, all I have been able to do personally regarding the lack of the understanding and ethos of Assertive Outreach is to raise concerns when they arose in my own team.

140. When a decision was made to uncouple the EIP pathway from the LMHT back into a standalone team, I made every effort to have some involvement in this and did email Dr Adamson on a number of occasions. I also emailed when concern arose regarding lack of staffing on the AO pathway affecting the ability of staff on the EIP pathway to do their work.

141. I have consistently raised concerns with Management, both organisational (Operational, Service and Team managers) and Medical managers regarding the management of both AO and EIP models of care within the LMHT and did so before, during and after the transformation of services. My concern has always been that the EIP and AO patients within the integrated model of care (when they were imbedded in the LMHT's) were not receiving the same amount of input they had previously in the original standalone services and I could particularly relate to this in relation to EIP patients as I had previously worked for over 12 years in the original standalone EIP service by the time of the transformation of services and the move of EIP patients into the LMHT. I had concerns around the lack of care co-ordinators, mixed caseloads (i.e. staff having either AO/EIP patients and other LMHT patients on their caseloads), I was concerned about continuity of care within the community teams themselves. I was concerned about sickness levels amongst medical and LMHT staff and unfilled substantive Consultant posts filled intermittently by locum's (this placed additional pressure at times on the substantive staff who would at times have to do their own work and also help out) and experienced nursing staff in particular leaving the LMHT

to go and work elsewhere. I was concerned about former EIP staff no longer working on the pathway and moving away entirely from working in Adult Mental Health Services. I was concerned that the staff did not have time to provide the care they wished to provide to these patients and the impact this had on the patients but also the staff themselves. I was concerned about the impact of moving patients and staff in the creation of these new LMHT's, which meant some patients got both new care co-ordinators and doctors working with them. I was concerned that the AO and EIP patients needs were not being met and raised this also at various times over the years.

142. I was fortunate for the most part that the Team managers I worked with in City North LMHT agreed for me to create and keep my own little mini teams of AO and EIP patients, with for the most part a group of care co-ordinators that worked alongside me, who mostly care co-ordinated my patients. This meant that I, for the most part, had staff with experience of working on these AO and EIP pathways, working with these patients in my own LMHT. This was not possible in most of the other LMHT's to my knowledge. These staff were however also expected to support with other core LMHT jobs, including new assessments, medication clinics and duty. This meant they had less time with their own patients that they were care co-ordinating, compared to the time they would have previously had in standalone teams. In addition to this, we had reduced social activities and groups available for patients, we did not have OT input after our OT assistant left which was particularly noticeable in the EIP pathway and reduced input and after a while no input from clinical psychology for a long time, due to unfilled psychology posts within the City North LMHT and no psychologist in the EIP service. We did however have some CBTp therapy available if I recall correctly. It was a very difficult time working in the LMHT for everyone, especially in the first few years after the transformation of services and then we had COVID-19 to deal with.

143. Where I had EIP patients whom I felt required an Assertive Outreach model of care, my usual practice was to retain them in the EIP Service (or, following service reconfiguration the LMHT EIP pathway and now the new standalone EIP Service) until they had completed the three-year EIP offer of care. This provided continuity of care, allowing them to continue accessing the full range of support and interventions available through EIP. When EIP was a standalone service, I believed it provided a good treatment offer that generally met patient's needs, including those who were difficult to engage. EIP staff had considerable experience of working with this patient group and, rather than transferring them to AO and potentially placing additional

pressure on that service, I considered it appropriate for them to remain under EIP until the end of their 3-year period. Following the integration of EIP into City North LMHT alongside the AO pathway, I worked across both pathways. In my view, patients who remained within the 3-year EIP pathway were better (and still are) placed to continue under EIP, because although the EIP treatment offer had reduced compared with the standalone service, it remained more comprehensive than the care they would have received had they been transferred early to the AO pathway.

144. At the end of the 3 year period with EIP, where ongoing assertive outreach support remained appropriate, I would arrange a planned handover to the AO service or AO pathway, depending on the service model in place at the time.

145. With regard to EIP and its subsequent move from the LMHT's back to a separate EIP service, within a few weeks of her being appointed, I recall having contact with Dr Vidyah Adamson, Clinical Psychologist, who had been appointed by the Trust to oversee the changes to EIP and offering by way of email dated 29.01.2020 to arrange a meeting with EIP Consultants and her **(WITN0491026)**. Prior to her arrival I also emailed Consultant colleagues asking if we should arrange a meeting to discuss the EIP pathway when the Team Managers were appointed or whether to wait until Dr Adamson started **(WITN0491006)**.

146. By way of emails dated 14.07.2020 **(WITN0491029)** and February 2020 **(WITN0491030)**, I offered to help arrange meetings between Dr Adamson and the EIP Consultants to discuss the proposed changes. My intention in offering to arrange that meeting was to facilitate discussion and provide an opportunity for the EIP Consultants to contribute their clinical views and experience, on the proposed changes. I cannot recall being involved in the details of the planning to remove EIP patients and staff from the LMHT, although there is an email to her dated 03.02.2020 where I made some suggestions **(WITN0491030)**. When the gameChange virtual reality study finished and we were allowed keep some of the equipment used if we wished, I emailed on 27.07.2021 to ask what her thoughts were on this **(WITN0491031)**. I also offered my thoughts by email on 27.07.2020 on the Options that were being looked at, at the time **(WITN0491032)**. I raised concerns in an email dated 28.04.2020 about the lack of a Clinical Psychologist in EIP also **(WITN0491033)**.

147. On 2nd July 2020 I emailed Dr Adamson and others about EIP in my team at City North raising serious concerns about the ongoing problems with capacity **(WITN0462005_0001)**

148. In my own job planning meeting, 2018-19, it is documented I raised concerns about the 'dilution of care' in cluster 10 EIP pathways – by this I meant that I felt there was a reduced standard of care within LMHT compared to that which patients had received prior to the 2017 transformation. Over a number of years, I also raised concerns about Consultant capacity with management. Contemporaneous emails evidence that I raised concerns about the volume of my workload and its sustainability at times **(WITN0491034, WITN0491035, WITN0491020 and WITN0491009)**.

149. I also established a peer group specifically for AO and EIP Consultants in the Trust. I set this up because of my interest in this area, not as part of a management role. This is used as an opportunity to talk about our services as well as have clinical discussion about patients we might be concerned about, as well as sharing journal articles etc.

- a. There was also an East Midlands Doctors forum, which existed before services were disbanded which provided an opportunity for colleagues across local Trusts to come together. The forum had stopped over time and when I was contacted by a doctor from another Trust about setting the group up again. I shared this invite with my colleagues on 16 September 2020 **(WITN0491036)** and a meeting was arranged. I cannot recall who attended, but this was another opportunity to promote open discussions about the nature and ethos of AO and EIP models of care.
- b. Dr Lloyd and I would also check in with each other about our practices across our equivalent services, particularly when she began working in the city South LMHT, and I worked in the city North LMHT. We both had EIP and AO patients, so would peer check our practice with each other, and we were also in a peer group together for many years (different peer group to the EIP/AO peer group).
- c. I also recall emailing the Clinical Directors **(WITN0491037)** to suggest creating a new role of a Clinical Lead for EIP and AO pathways. I recall I did get a

response noting it was a good idea, but there was no funding for the role. The contemporaneous emails also show that in July/ August 2020, I contacted the EIP Consultants to ask whether anyone would be willing to act as a representative for the Consultant group (**WITN0491038**). My view at the time was that it was difficult for individual Consultants to advocate effectively for their own part of a much larger service and one of my colleagues agreed to take on this role, however, I'm not sure what happened with this subsequently. I suspect that COVID-19 pandemic would have had an impact on pace of service developments as maintaining patient care became the immediate priority.

- d. The contemporaneous emails also include an email I sent to Dr Lloyd in January 2022 (**WITN0491039**). At that time, I was not the Lead Consultant or acting in a managerial role but was writing to her as a Consultant colleague. In the email I suggested that EIP Consultants working in the area establish a regular peer support meeting to share experiences and discuss complex cases, as stated elsewhere in the statement. I also expressed my view that I felt that the EIP service had become "diluted" compared with the original EIP service reflecting my view at the time that the service did not feel the same as the original EIP model in which I had previously worked.

150. Although the concerns Dr Lloyd had were about pressure to discharge, I do not believe any Consultant would discharge high risk patients due to any perceived service led pressure, and I am not aware of this occurring. However, it is concerning that these pressures existed and that Dr Lloyd had to work in that environment.

151. There were wider concerns also about overall patient care, particularly around the time of the service transformation and thereafter. Over the years as previously stated, I have repeatedly raised concerns about the capacity of the EIP and AO pathway's and current EIP service to provide the level of care to patients that the staff working in these teams wish to deliver. My impression is that the managers did at times seek to support the teams where they could by employing agency staff. There were also opportunities created such as EIP away days to discuss the nature and ethos of EIP e.g. on the away day on 23 July 2019, the agenda (**WITN0491040**) included sections on the ethos and philosophy of EIP, Treatment standards, an external speaker, and breakout sessions looking at what was going well on the pathway, what

barriers there were and how to overcome them. I do recall John Brewin attending that particular meeting.

152. I do not recall anything similar being organised for patients on the AO pathway. Although there was a workshop organised in the Summer of 2019, I understand regarding LMHT's, an Adult Mental Health Collaborative event on 10 May 2019, and a Clinical Leadership Workshop on 17 May 2019. I have no recollection as to whether the nature and ethos of the AO model was discussed at these meetings or not.

153. There was also an extended Adult Mental Health Consultant forum organised on 25th September 2019 which was attended by the Medical Director, Associate Director and Associate Medical Director. At that meeting the agenda **(WITN0491041)** included fidelity to the CRHT, inpatient wards and other items. It was reported to be an opportunity at the time for Consultants to speak with the senior team. I am not aware of any minutes being kept or whether there were subsequent actions taken following the meeting.

154. For several years, there have been periods of Consultant vacancies and sickness absence within the Trust, and a number of Consultant posts remain vacant. The Trust has made efforts to employ substantive Consultants and locums to cover gaps when able to do so. In my experience, this has placed additional demands on the substantive Consultants who have remained in post.

155. I do, however, feel that the offer to EIP patients in City North LMHT has improved since EIP patients and staff were transferred out of the LMHT's and back into a dedicated EIP standalone service where their focus is only on their own EIP patients. Staffing, however, remains an ongoing challenge. When members of the team are absent e.g. long term sickness, the other are co-ordinators are required to cover both their own work and that of their colleagues unless it can be agreed by management that agency staff can be requested and if so, agency staff secured, which does not always happen. This increases workload and can affect continuity of care for patients. I also understand that at times their own caseloads are higher than they should be.

156. In the AO pathway very little has changed in terms of the offer to these patients since the AO Service was integrated into the LMHT's. In City North LMHT, I have continued to try to maintain an AO informed model with the limited resources we currently have to care for these patients and others within mental health services.
157. I do not have an independent recollection of the email itself, or the comments made by Dr Lloyd, following my suggestion in the email to organise a meeting. I have no recollection of a specific meeting taking place with the others in the email and myself.
158. Based on the contents of the email itself and my recollection of circumstances at that time, I believe I contacted my colleagues as I wanted to know what they were doing with their patients in their own LMHT's in the city and to benefit in particular from the experience of colleagues who had previously worked within the original standalone AO service. As I cannot recall any meeting taking place amongst those in the email, I do not think there was any change to my own practice as a result.
159. I do not think my practice has changed much over the time I have worked with AO pathway patients. Discharges from the AO pathway are usually to the other part of the LMHT. It is only in exceptional cases that I would consider discharging an AO patient from mental health services and this has always been the case.
160. In terms of discharging due to non-engagement, from the AO pathway, there is a complete block on this currently in the Trust and oversight by senior management if a patient on the pathway was being discharged from secondary care.
161. I did actually plan to discharge an AO patient in this past year after we had exhausted all options, had a meeting with police, discussed with forensics and having had repeated contact with the family, the patient had been missing for a considerable period but we knew he was alive as he had been seen elsewhere in the UK, by the police and the police were not concerned as it was felt he was making himself intentionally absent (which we did agree with) and there were no acute risks and I understand he had intermittent contact with family. We planned to put an alert on Rio to say if he did come back to Nottingham to let our team know and we would take him back on. Due to the block on discharges due to lack of engagement for AO patients (which I do not think I had been aware of) we were not allowed to take him off our

caseload. We are, however, back in touch with him again as he has returned to Nottingham and we have managed to re-establish contact. Therefore, from the above example, it could be said that my practice has changed as we are not allowed to discharge AO pathway patients currently, from mental health services, due to non-engagement, as it flags up in senior meetings.

162. Finally, the service transformation from the original EIP service into the LMHT's and the difficulties around delivery of patient care subsequently, had a significant impact on me personally. I had been involved in establishing the original EIP service and felt strongly about the model of care it provided. I found it very difficult to see the patients and staff transferred into the LMHT's because I was concerned that patients with first episode psychosis would no longer receive the same specialist focus and priority within a generic community mental health service. When I began working with AO patients, I also felt very strongly that they were also no longer the priority that they should have been. The City North LMHT staff working on the AO pathway and the EIP care co-ordinators I have worked with throughout all my years in EIP, despite all that has happened, remain dedicated to providing the best care that they can, to all the patients they work with.

RECOMMENDATIONS

163. I welcome the opportunity to provide my views on this issue. I have a number of recommendations which, based on my experience, I believe would improve the care provided to patients with serious mental illness and help reduce the risk of similar incidents occurring in the future.
164. I recognise the importance of this Inquiry in identifying lessons and improving future patient care. I hope that the Inquiry's recommendations both improve patient care and preserve public confidence so that those who need mental health services continue to seek help at the earliest opportunity.
165. I believe it is important that patients and their families know that recovery is possible and that engagement with treatment, using a biopsychosocial approach, can significantly improve a person's prognosis.

Resources, Workforce and Service Configuration

166. My first recommendation is that greater resources should be invested in the treatment of people with serious mental illness. In my opinion, services for these patients have been inadequately resourced for many years.
167. I recommend that there should be dedicated, stand-alone Early Intervention in Psychosis (EIP) and Assertive Outreach (AO) services across the country, with sufficient staffing and resources to deliver the specialist models of care for which they were designed.
168. Service redesign should include mechanisms to ensure that the views of people using mental health services, their carers and frontline clinicians are formally considered and documented alongside operational and financial considerations. There should be a transparent process demonstrating how feedback has been considered in reaching final decisions. Mental health services redesign should reflect that people with severe mental illness often require persistent, proactive and flexible models of care and that approaches that rely on patients initiating contact or engaging in the same way as other patient groups may not be appropriate for this population.
169. In my experience, there are insufficient inpatient mental health beds, both in Nottingham and more widely, resulting in some patients waiting in the community for admission under the Mental Health Act. This can include patients who are subject to CTO's and require recall to hospital but are unable to be admitted until a bed becomes available, leading to delays in their treatment and affecting the timely management of risk.
170. When beds are available, some patients are admitted to hospitals a considerable distance from their homes and families. This can make it difficult for relatives and carers to visit and to remain involved in the patients' care and recovery. In my view, this highlights the continuing challenge of achieving parity between mental and physical healthcare. Patients with severe mental illness should, wherever possible, be able to receive timely inpatient care close to their homes and support networks.
171. Greater emphasis should also be placed on protected time for liaison between inpatient and community Consultant Psychiatrists. Improved continuity and communication across the inpatient and community interface has the potential to enhance patient care and improve risk management.

172. There would be value in developing national guidance on Consultant Psychiatrist caseloads numbers and job planning, particularly within general adult psychiatry. Such guidance should recognise that workload is influenced not only by patient numbers but also by clinical complexity, statutory responsibilities, and other professional duties.
173. I believe that greater investment is needed in recruiting and retaining Psychiatrists, mental health Nurses and other mental health professionals. Consideration should be given to measures that encourage people to enter and remain in these professions. In my opinion, this should include exploring ways of reducing financial barriers to training, including consideration of whether tuition fees for mental health nursing should be removed.
174. I recommend that antipsychotic medication should be exempt from prescription charges. Cost should not be a barrier to accessing treatment, particularly for students and others on low incomes. Reducing financial barriers to medication would support treatment adherence and reinforce the principle of parity between mental and physical healthcare.
175. People with severe mental illness are disproportionately affected by obesity and metabolic disease, in part because many effective antipsychotic medications are associated with significant weight gain. This can have a considerable impact on quality of life and contribute to some patients reducing or discontinuing medication because of these side-effects. Timely access to evidence-based weight management interventions, including GLP-1 medication, should therefore be considered as part of the holistic management of people prescribed antipsychotic medication.

Clinical practice and quality improvement

176. National guidance on risk assessment should be reviewed to ensure that historical information is recorded in a way that meaningfully informs the assessment of current risk. For example, simply recording a previous "assault" provides limited information unless the nature of the incident, the circumstance in which it occurred, its severity, its recency and its relevance to the patient's current presentation are also documented.
177. In my experience, CTO's play an important role in supporting some patients with severe mental illness to remain engaged with services and treatment.

As the Mental Health Act reforms are implemented, consideration should be given to monitoring their impact on this patient group, including any unintended effects on engagement, relapse, hospital admissions and risk to patients themselves or to others.

178. Consideration should be given to the wider use of AI-Assisted documentation, where appropriate, to support the recording of multidisciplinary team meetings and potentially clinical consultations. This has the potential to improve the quality and consistency of documentation, reduce administrative burden, and allow clinicians to spend more time providing direct patient care. Appropriate governance, confidentiality, and clinician oversight should always be maintained.

Health promotion and reduction of stigma

179. There should be a national public health campaign to improve awareness of serious mental illness, including the early signs and symptoms, the support and treatment available, and the importance of seeking help promptly. The campaign should emphasize that early recognition and intervention can improve outcomes for patients and their families.
180. Greater efforts should also be made in communities where the incidence of psychosis is higher and where there may be lower levels of trust or engagement with mental health services.
181. Consideration should be given to delivering mental health education in schools to increase awareness and encourage young people to seek help at an early stage when concerns arise.
182. The campaign should also include education on the well-established association between cannabis use and psychosis, particularly focusing on young people and communities in which cannabis use is more socially accepted or prevalent. Clear evidence-based information about the potential mental health risks associated with cannabis use should be provided.
183. Efforts should also be made to reduce the stigma associated with serious mental illness, particularly psychosis and schizophrenia. Public messaging should reinforce that these are treatable conditions and that many people recover and are able

to lead fulfilling lives, especially when they receive timely assessment and appropriate treatment.

184. Greater opportunities should be created for people with lived experience of psychosis to share their stories, should they wish to do so. Public discussion of other mental health conditions, such as depression and eating disorders, has helped to improve understanding and reduce stigma. By comparison, psychosis remains a condition that is discussed far less openly.

185. Consideration should also be given to promoting accurate and balanced public portrayals of psychosis. Media coverage can influence public perceptions, and reporting that includes recovery, treatment and lived experience, alongside appropriate discussion of risk, may help reduce stigma and encourage people to seek help earlier.

Communication and collaborative working.

186. There should be better communication and information sharing between the NHS, social care and the police to support the safe assessment and management of people with serious mental illness. Where appropriate, professionals should be able to access relevant information from partner agencies in a lawful, proportionate and timely manner, with appropriate safeguards to protect confidentiality.

187. In my experience, having access to a dedicated police liaison officer, within our Trust, over the past few years, has been extremely helpful in facilitating timely communication and advice, obtaining relevant information, and supporting joint working. Consideration could be given to making similar arrangements available more widely.

188. Primary care services should develop more accessible pathways for people with psychosis and other serious mental illnesses. Many patients find it difficult to navigate current systems for booking appointments or requesting repeat prescriptions, which often rely on telephoning at set times or using online platforms. Consideration should be given to providing a named GP or other consistent primary care contact for this patient group to promote continuity of care, improve engagement and facilitate transition back to primary care following discharge from specialist mental health services such as EIP. Where appropriate, facilitated introductions or joint appointments between mental health professionals, patients and primary care teams at the point of

discharge may improve engagement with primary care and support a successful transition from specialist services.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, 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: 28.08.2026

Index to the First Witness Statement of Eileen O'Regan

Exhibit	URN	Document Description	File Name
1.	WITN0491002	Email from Eileen O'Regan [NHFT] to Julie Hankin [NHFT], re: EIP issues	Exhibit EOR001 - email from Dr Eileen O'Regan to Dr Julie Hankin 24.11.2015.docx
2.	WITN0491003	Email from Eileen O'Regan [NHFT] to Julie Hankin [NHFT], Re: AMH Leadership meeting agenda for 2nd December	Exhibit EOR002 - email from Dr Eileen O'Regan to Dr Julie Hankin 11.12.2015.docx
3.	WITN0491004	Report dated 01/07/2014, compiled by Paul Prendergast, Stephen Laird, Kevin Somerton and others, Re: Community Workstream	Exhibit EOR003 - Saving EIP document - community workstream - 01.07.2014.doc

4.	WITN0491005	Email from Eileen O'Regan [NHFT] to Ben Di-Mambro [NHFT], Bert Park [NHFT], Michelle Malone [NHFT] and others, re: EIP management	Exhibit EOR004 - email from Michelle Malone - May 2019.docx
5.	WITN0491006	Email from Eileen O'Regan [NHFT] to Tuhina Lloyd [NHFT], Bert Park [NHFT], Hemant Bagalkote [NHFT], re: EIP Team Leader appointment - please share with your TLs	Exhibit EOR005 - email re appointment of Team Leader - November 2019.docx
6.	WITN0491007	Email from Glew Owen [NHFT] to Eileen O'Regan [NHFT], Emma Robinson [NHFT] and Laura Humphrey [NHFT], re: 4091318 urgent issue	Exhibit EOR006 - email from Dr Eileen O'Regan to team and service manager re urgent clinical issue - 21.03.2019.docx
7.	WITN0491008	Exhibit EOR007 - Email from Dr Eileen O'Regan [NHFT] to Michelle Malone [NHFT], Mick O'Driscoll [NHFT], Faizal Seedat [NHFT] and others, Re: EIP medical time	Exhibit EOR007 - email from Dr Eileen O'Regan re EIP medical time - 02.03.2017.docx
8.	WITN0491009	Exhibit EOR008 - Email from Eileen O'Regan [NHFT] to Tim Constable [NHFT], Mark Smith [NHFT], Paul Prendergast [NHFT] and others, Re: EIP Medical Input	Exhibit EOR008 - email re caseload - 18.06.2015.docx
9.	WITN0491010	Exhibit EOR010 - Email from Eileen O'Regan [NHFT] to Karthik Thangavelu [NHFT], Faizal Seedat [NHFT], Michelle Malone [NHFT] and others, Re: Job planning and caseload review document for advice	Exhibit EOR010 - email re job planning document - July 2019.docx
10.	WITN0491011	Policy Document, Re: The Mental Health Policy Implementation Guide, Department of Health	Exhibit EOR011 - Policy Implementation Guide (PIG) DoH.pdf
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		others, re: EIP and medical time	
12.	WITN0491013	Exhibit EOR013 - email exchange Dr Eileen O'Regan and Dr Das - July 2020.docx	Exhibit EOR013 - email exchange Dr Eileen O'Regan and Dr Das - July 2020.docx
13.	WITN0491014	Exhibit EOR014 - Email from Eileen O'Regan [NHFT] to Karthik Thangavelu [NHFT] and Gareth Foote [NHFT], Re: EIP medical time	Exhibit EOR014 - email re caseload - 17.08.2022.docx
14.	WITN0491015	Report compiled by NHFT, re: EIP Workforce Calculator	Exhibit EOR015 - IRIS EIP Workforce Calculator.xlsx
15.	WITN0491016	Exhibit EOR016 - Email from Eileen O'Regan [NHFT] to Stephen Laird [NHFT], Re: EIP Numbers	Exhibit EOR016 - email re caseload - 07.06.2022.docx
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21.	WITN0491022	Exhibit EOR021 -SOP V6 October 2019.doc	Exhibit EOR021 -SOP V6 October 2019.doc
22.	WITN0491023	Exhibit EOR022 - email disseminating SOP 04.11.2019.docx	Exhibit EOR022 - email disseminating SOP 04.11.2019.docx

23.	WITN0491024	Exhibit EOR023 - Email from Tuhina Lloyd [NHFT] to Kathrik Thangavelu [NHFT] and Eileen O'Regan [NHFT], Re: Job planning	Exhibit EOR023 - email 08.05.2019.docx
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27.	WITN0491028	Exhibit EOR20 - Email from Eileen O'Regan [NHFT] to Karthik Thangavelu [NHFT], Stephanie Sommers [NHFT] and Shweta Mittal [NHFT], Re: City North LMHT	Exhibit EOR025 - email re MDT 06.05.2024.docx
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37.	WITN0491038	Email from Eileen O'Regan [NHFT] to Mohammad Katshu [NHFT], re: EIP pathway	Exhibit EOR037 - email seeking Consultant representative 08.07.2020.docx
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45.	WITN0491046	Report compiled by Mental Health Strategies, Re: Final Report: Independent Evaluation of the Nottingham Early Intervention Psychosis Service	Exhibit EOR045 - Nottingham EIP Evaluation - Final Report 29 June 16.pdf
46.	WITN0491047	EIP patient feedback form	patient and carer questionnaire and feedback