Thursday, 8 May 2025

(10.00 am)

THE CHAIR: Ms Harris, good morning.

MS HARRIS: Good morning, Chair. Chair, today the Inquiry will be hearing evidence from two experts, Dr Davidson and Ms Nelligan.

Further details of their roles and experience will be given by them when they come to the witness table in just a few moments. Between them, Dr Davidson and Ms Nelligan will give evidence relating to the provision of mental health services in the UK. They will consider and will give evidence about what constitutes good care and they will address the key principles and standards relating to the delivery of that care to mental health patients.

At this stage of the Inquiry, Dr Davidson and Ms Nelligan will not be looking at any specific details or any individual case but they will be providing an overview of how care is provided. This will be important, explanatory and contextual evidence.

There may be aspects of today's evidence that are difficult to listen to, however, and for some people it may not be possible to sit through the two sessions. As with the other days, anyone in the Inquiry room should feel free to leave at any time.

May I take this opportunity, however, as previously outlined, to remind those engaging with the Inquiry that emotional support is available for all those who require it and the well-being of those participating in the Inquiry is extremely important to the Inquiry. Again, as outlined, we have present here today, again, emotional support staff from Hestia, an experienced provider of emotional support at these types of hearings, and they are currently in the room, I believe, and they have raised their hands, I am very grateful. They can be identified by their orange-coloured scarves.

There is a private room downstairs where anyone who needs emotional support can talk to the Hestia support staff. If you prefer, you can speak to a member of the customer team, as has already been indicated, we are wearing purple-coloured lanyards and we can put you in touch with the emotional support staff.

For those following the hearing online, information about the emotional support that is available can be found on the Lampard Inquiry website at lampardinquiry.org.uk and the "Support" tab is near the top right-hand corner.

We want everyone engaging with this Inquiry in whatever way they are engaging to feel safe and supported.

Chair, I will now hand over to another member of the Council to the Inquiry team, Tom Coke-Smyth. He will ask questions of Dr Davidson and Ms Nelligan, who I can see are waiting in the front row ready to come forward.

Thank you, Chair.

THE CHAIR: Thank you.

MR COKE-SMYTH: Thank you. I should make clear, firstly, as was said in opening, that this is introductory evidence and both experts will be covering a significant amount of ground at a high level. Dr Davidson will first be dealing with some of the historical context and background to mental health inpatient care, before dealing with admissions, and I then intend to focus on care whilst an inpatient with Ms Nelligan, from a nursing perspective, before finishing with post-discharge planning and examination of some key principles in respect of reviews and investigations.

Chair, I just say that, given that their evidence is very much complementary to one another, we will be hearing from both experts together and the benefit is that will allow each to comment on one another's evidence from their respective professional standpoints as we go along.

So, Chair, can I now call please Dr Davidson and Ms Nelligan.

DR IAN DAVIDSON (affirmed)

MS MARIA NELLIGAN (sworn)

Questioned by MR COKE-SMYTH

MR COKE-SMYTH: Thank you.

Dr Davidson, can I start, please, by asking you to confirm your full name?

DR DAVIDSON: Ian Alexander Davidson.

MR COKE-SMYTH: It is right that you are giving evidence in your capacity as a consultant psychiatrist?

DR DAVIDSON: Yes.

MR COKE-SMYTH: It is right that you have provided a report which is dated 18 March 2025?

DR DAVIDSON: Yes.

MR COKE-SMYTH: I think you have got that in front of you --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- but for anyone who is following, that report is signed at page 57 and, although dated 18 March, it's also right it was updated with some corrections and further references on 2 May of this year?

DR DAVIDSON: Yes, yes.

MR COKE-SMYTH: Just looking at the report, you have signed it and you have a statement of truth, you have also completed an expert declaration and, as part of that, you made clear that you understand your duty as

an expert --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and that nothing in that report has been included or excluded without you forming your own independent view?

DR DAVIDSON: Yes.

MR COKE-SMYTH: I think you have got that in front of you and please do refer to that report at any point during my questions, and I will be referring to various paragraphs within it.

DR DAVIDSON: Thank you.

MR COKE-SMYTH: Can I confirm at this stage that, to the best of your knowledge and belief, that report is accurate?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Do you wish for the contents of that report to stand as your evidence to the Inquiry?

DR DAVIDSON: Yes.

MR COKE-SMYTH: As a result, I am not going to ask you about every aspect of that but I will be going into certain details and asking certain questions on aspects of it.

Ms Nelligan, can I turn to you, please?

Can you tell the Inquiry your full name please.

MS NELLIGAN: Josephine Maria Nelligan.

MR COKE-SMYTH: It is right you are giving evidence in your

capacity as a registered nurse?
MS NELLIGAN: That's right.
MR COKE-SMYTH: You have provided a report dated 27 March of this year?
MS NELLIGAN: Correct.
MR COKE-SMYTH: We have got that in our bundle at page 995 and at page 35, internally of that report, you signed the report; is that right?
MS NELLIGAN: Yes.
MR COKE-SMYTH: You have completed the same declaration and statement of truth as Dr Davidson?
MS NELLIGAN: Yes, I did.
MR COKE-SMYTH: Again, do you have that in front of you?
MS NELLIGAN: I do.
MR COKE-SMYTH: Again, please do refer to that at any point during my questions. Can you just confirm that the contents of that report remain accurate to the best of your knowledge and belief?
MS NELLIGAN: Yes.
MR COKE-SMYTH: Again, do you wish for the contents of that report to stand as your evidence to the Inquiry?
MS NELLIGAN: I do.
MR COKE-SMYTH: Again, as with Dr Davidson, I am not going to go through every aspect of that report, that will obviously stand as your evidence in addition to my

questions.

Can I start now then, please, by, Dr Davidson, just dealing with your experience and you set that out in your report for those who have got that in front of them at page 3. Perhaps I could just summarise in the following way: you are registered with the GMC as a doctor?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You are on the specialist register in general psychiatry?

DR DAVIDSON: Until 31 March when I retired.

MR COKE-SMYTH: Thank you. Your most recent role, prior to retirement in March this year was as a Consultant General Psychiatrist at the Cheshire and Wirral Partnership NHS Foundation Trust?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You first qualified in 1980 and you have been a practitioner there for over 44 years?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Your experience includes both inpatient and community psychiatry?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You maintained direct clinical practice up until 2022?

DR DAVIDSON: Yes.

MR COKE-SMYTH: In the course of your career, is it right you have contributed to the work of the Royal College of psychiatrists?

DR DAVIDSON: Yes.

MR COKE-SMYTH: That included acting as the college's clinical lead during Lord Darzi's investigation into the NHS?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You were also appointed as the Royal College Inaugural Autism Champion between 2017 and 2021?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You have held a number of clinical leadership and management positions in respect of mental health?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Those have included Medical Director --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- Deputy Chief Executive and Interim Chief Executive at the Cheshire and Wirral Partnership NHS Foundation Trust?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Nationally, you have had experience working for the Healthcare Commission, the Public Sector Ombudsman and also as a professional adviser to the CQC?

DR DAVIDSON: Yes.

MR COKE-SMYTH: It's also right to say that you have over 25 years experience acting as an expert in legal proceedings?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also sit as a medical member of the First-tier Tribunal in mental health?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Ms Nelligan, then turning next to you and your experience set out at page 3 of your report. You are a Registered Nurse in the field of learning disability, you also hold a diploma in community nursing and MSc in practitioner research; is that right?

MS NELLIGAN: Correct.

MR COKE-SMYTH: You retired from practice in July 2024; is that right?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You first qualified as a nurse in 1985?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You worked in inpatient and community mental health settings up to 2004?

MS NELLIGAN: Yes.

MR COKE-SMYTH: From 2004, is it right that you moved into various nursing leadership roles with a focus on practice improvement and professional development in mental health?

MS NELLIGAN: Yes.
MR COKE-SMYTH: You have been a Deputy Director of Nursing, which has involved focusing on nursing practice and standards and leading in respect of the organisational clinical policies associated with that?
MS NELLIGAN: Yes.
MR COKE-SMYTH: You have also been responsible for monitoring processes linked with external standards such as those from the CQC?
MS NELLIGAN: Yes.
MR COKE-SMYTH: You have held roles as Chief Nurse and Quality Officer and you have had experience of delivering improvement at three trusts which have had significant care quality challenges; is that right?
MS NELLIGAN: Yes.
MR COKE-SMYTH: You have also contributed to setting national standards of inpatient care, most recently with the culture of care standards for mental health inpatient services 2024; is that right?
MS NELLIGAN: Yes, yes.
MR COKE-SMYTH: Finally, it is right you also work as an external executive reviewer for the CQC?
MS NELLIGAN: Yes.
MR COKE-SMYTH: Turning then back to Dr Davidson, if I can, please, and just dealing with your report and your

instructions firstly.

It's right that you have been instructed to provide a report to establish appropriate benchmarks for what should be expected by way of minimum standards during our relevant period?

DR DAVIDSON: Yes.

MR COKE-SMYTH: It is right that, during your report, what we can see is that you have generally focused on general principles, rather than minimum standards; is that a fair summary?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: Can I just ask you this, given the period under review and the breadth of the topics, how practical is it for you to provide minimum and, indeed, gold standards throughout?

DR DAVIDSON: Extremely difficult because there is a lot of variety.

MR COKE-SMYTH: It's also right that your report is intended as an introduction, so you don't go into detail in various different areas, but it is designed for context, is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: You have set out there broad themes and consensus and you also set out common factors influencing care; is that right?

DR DAVIDSON: That's correct.
MR COKE-SMYTH: Is it also the case, unless you have stated otherwise in your report, your opinions are based on your professional experience?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: That comes from your many years as a practitioner?
DR DAVIDSON: Yes.
MR COKE-SMYTH: It's also right to say your report is national, it doesn't purport to address Essex; is that right?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: And it doesn't comment on any particular case or individual?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: Ms Nelligan, do all those points also apply to your report?
MS NELLIGAN: Yes, they do.
MR COKE-SMYTH: So, Dr Davidson, can I start then, please, by dealing with your section 1, and this is where you set out, by way of introduction, some of the key changes between 2000 and 2023. I am just going to start by looking at your first paragraph, 1.1.
You deal there -- the first significant event that you identify at the start of 2000 is the National

Service Framework?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: You describe that as a significant event and you set out how the aim of that was to stop what was described there as a downward spiral of mental health services. Can you just in outline tell the Inquiry what was significant about the NSF, please?

DR DAVIDSON: The key things about the NSF were (1) it was an attempt to set out principles and what it could look like; another important point about the NSF was it brought significant new resources into mental health; another important point about the NSF was it tried to pull together the existing evidence that existed at the time to support clinical decision-making at a very high level.

MR COKE-SMYTH: You set out at 1.2 of your report the fact that there were pressures, which included demand exceeding capacity, and you say that that would often lead to offloading of cases, rather than continuity of care, and pressure to see new referrals leading to too little time for ongoing essential care and treatment.

Can I just be clear, are you referring there to that period prior to the NSF, prior to 2000?

DR DAVIDSON: In this section, I am.

MR COKE-SMYTH: You also deal there with the model of the

one local team that you refer to?
DR DAVIDSON: Yes.
MR COKE-SMYTH: Can you just start by telling us what you mean when you use the term "one local team"?
DR DAVIDSON: So, first of all, a team is not like a football team, it isn't defined as you will have 11 players on the pitch at any given time. A team is more like a band or an orchestra, it varies enormously from one place to another as to who is in the team but the purpose or the principle behind the one local team was that a particular team had responsibility for a particular catchment area, that meant they couldn't refuse to see people from that catchment area, everyone from that catchment area was their responsibility.

Initially, back in the time we are talking about here it was very, very common, it was in fact normal practice that the same consultant psychiatrist who worked on the community team would also be allocated a certain number of inpatient beds to which those team patients would normally be admitted and would therefore be the consultant psychiatrist for them whilst they were an inpatient as well.

MR COKE-SMYTH: In terms of one local team, we have heard and we have seen reference in your report to the CMHT --
DR DAVIDSON: Yes.

MR COKE-SMYTH: -- Community Mental Health Team. Where does that fit when you refer to one local team?

DR DAVIDSON: At that time, they were almost entirely called Community Mental Health Teams. Over the course of the next 25 years, various names have come into play for teams doing similar but not quite the same. So CMHT is the generic team -- is the generic name still.

MR COKE-SMYTH: Again, just looking at the beginning of the period and the one local team model, where was the mental health inpatient care being provided?

DR DAVIDSON: So the mental health inpatient care would be in whichever local inpatient unit was for that area. That particular team would have an allocation of beds, typically on one ward but sometimes on different wards, and the expectation was that, wherever possible, a person who was admitted from that catchment area went to that team bed and had the same team psychiatrist providing continuity of care.

It didn't always happen, sometimes people would end up in different beds because of bed pressures but the vast majority of times that was the model.

MR COKE-SMYTH: So just perhaps summarising there: at the beginning of the relevant period, one local model, looking at a Community Mental Health Team, and, as I understand your evidence, there is also acute

inpatient beds linked with that Community Mental Health Team; is that right?

DR DAVIDSON: Yes, and just to specify here I am talking about adults and older adults. For children, things were slightly different, even back in those days, but the same principles applied.

MR COKE-SMYTH: Thank you. So that's the model at the start of the period and you describe the NSF abolishing the one local team model and replacing that with multiple teams; is that right?

DR DAVIDSON: It wouldn't be true to say that national policy abolishes things; it would be true to say that national policy recommended doing other things. So over time, different places would do different things at different times, it's not that a national edict comes out and from tomorrow you must do this. The recommendation is that you should be going down a different route.

So it gave very strong recommendations that certain specific new teams should be developed. Other new teams had been developing, as I say in my report, such as older adults, so -- but the NSF made a very distinct set of recommendations about new teams, yes.

MR COKE-SMYTH: Is it right that the Community Mental Health Team split generally into adults of working age and

separate older adult teams.

DR DAVIDSON: That became increasingly common, yes.

MR COKE-SMYTH: You refer in your report to three new teams and you describe those as the Early Intervention in Psychosis team --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- the Crisis Resolution Home Treatment team --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and the Assertive Outreach team.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You describe in your report that one downside was more fragmented and discontinuous models of care and treatment; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Can I just pause there and ask you to explain in a little bit more detail what you mean by that, please?

DR DAVIDSON: So every time there is a handover, some information gets lost, some information doesn't get transmitted correctly, that's the way human beings operate. There was also potential barriers, so that you might have a referral form and then someone might be deemed inappropriate for this team, so they would not -- not get access.

So there were various types of barriers which come in when you set up multiple teams. They are inevitable when you set up multiple teams but, unlike the old team where one team is responsible for everything in that catchment area and they couldn't say it's not us, you now had a situation where different teams could say "not us".

MR COKE-SMYTH: So essentially more people involved, more opportunities for things to be potentially missed?

DR DAVIDSON: Or misunderstood.

MR COKE-SMYTH: It might just be helpful at this stage just to look at some of the teams that you refer to. I believe you set those out in your Appendix 2.

DR DAVIDSON: Yes.

MR COKE-SMYTH: That's your page 61.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Perhaps we could have that up on screen, please. So it is Dr Davidson's report, Appendix 2, page 61, please.

So this is an "Overview of Mental Health Treatment Team Types", and we can see, firstly in 2000, we had the Community Mental Health Team as the main community team, you have referred to that.

We also had CAMHS and learning disability services, you then describe the teams splitting. The three new

teams we can see at paragraphs 4, 5 and 6, and just dealing with those briefly: the Early Intervention in Psychosis team, you say it was the point of access for a first episode psychosis. Can you just explain a little more about what the purpose of the Early Intervention in Psychosis team was and how it operated.

DR DAVIDSON: So the purpose was -- lots of research evidence shows that the longer someone is in an untreated state of psychosis the more harms they will suffer, the more disabilities that will occur and the harder it is to treat. So the purpose was to get people in to a specialist team as quickly as possible, so they have got access to what was recommended as the best treatment for early psychosis as soon as possible. It was based on international models and the idea was that there should be no delay and, therefore, rather than having to go through multiple teams to get to that point, you could be directly -- as soon as someone suspected you of psychosis, you could be referred directly to the Early Intervention in Psychosis team and hopefully within two weeks be on treatment.

MR COKE-SMYTH: The next team you refer to there is the Crisis Resolution Home Treatment team. How does that fit in, in respect of the Early Intervention in Psychosis team?

DR DAVIDSON: It doesn't directly. The Crisis Resolution Home Treatment team was really to address the fact that some people were presenting in crisis, particularly out of hours, when there had been historically no service. However, if one presented to the Crisis Resolution Home Treatment team and was identified as having a first episode of psychosis, they should refer them directly on to the Early Intervention in Psychosis team but they might be seeing a lot of other people who didn't have psychosis.

MR COKE-SMYTH: Finally there, we have got the Assertive Outreach teams. You describe that as a tertiary service for those who were deteriorated to the point that they needed much more intense input for longer than could be provided by the Crisis Resolution Home Treatment team.

In terms of other teams, just in overview, so we can see, and a familiar -- those include the Perinatal Services, Personality Disorder and Complex Emotional Needs teams, Substance Misuse, and Alcohol Misuse Services, Community Rehabilitation teams, separately we also have CAMHS; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: CAMHS, am I right, was in existence at the start of the relevant period?

DR DAVIDSON: Yes.

MR COKE-SMYTH: So not a new team?
DR DAVIDSON: CAMHS developed new teams within CAMHS services and, at the beginning of the period, CAMHS services were often not 16; by the end, they were often -- more often going up to 18. So there were changes within CAMHS services but relatively fewer new teams.
MR COKE-SMYTH: We also see Learning Disability and Community teams and other teams such as Gambling Services, for example.
DR DAVIDSON: A wide variety of teams developed, yes.
MR COKE-SMYTH: So, in summary, a number of further teams, many of them new?
DR DAVIDSON: And tended to be focused on specific issues, yes.
MR COKE-SMYTH: So going back to section 1 of your report, and I am looking now at your paragraph 1.9, you say that the downside was that core community and adult inpatient services had to absorb increasing demand, which wasn't eligible for the new services, so time per case fell.
Can you just explain what you mean by that, please?
DR DAVIDSON: So, as the earlier paragraph set out, when these new teams were recommended nationally, there were often annual targets about filling them and these were not usually fully funded. So funding -- if you

prioritised funding them, you have to deprioritise funding something else. So the result was that, if you got into the specialist teams there were much lower case loads, much more time per case, they were much more attractive places to work, by and large, and they were also much better if you were a patient receiving a service because you were getting much more intensive services.

The result of that was that staff left the core community and acute services to go into these more attractive teams but also there was less funding per case available for those teams, even as demand continued to rise, so the funding per case gradually dropped for those other teams.

MR COKE-SMYTH: So, in summary, you have got more teams and, for the core teams, so the Community Mental Health Team for example, in real terms less money per case; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: In your report, moving on to 1.17, you say:

"By 2017 it was clear that pressures were becoming very severe in the system and flowing into increased use of out-of-area beds."

Just pausing there. I want to ask you about out-of-area beds. Firstly, in very basic terms, what

does that mean: out-of-area beds?

DR DAVIDSON: Out-of-area beds is a very loosely used term. NHSE, as I put in my report, did try to produce some guidance to help people identify what was called an "inappropriate out-of-area bed". In a general sense, an out-of-area bed was a bed not local to and directly connected with your community services. That could be within the same trust, it could be a different organisation, it could be geographically the other end of the country, so it was a very broad term.

And NHSE then tried to bring in this definition of "inappropriate out-of-area beds" to define a group that they were particularly concerned about but that left, as I say, the situation which was there were a group who were not in a local trust bed, were in some other bed, but were not very visible.

MR COKE-SMYTH: So just focusing on where you use the term "out-of-area beds".

DR DAVIDSON: Yes.

MR COKE-SMYTH: Which definition are you using there?

DR DAVIDSON: So I am obviously -- in terms of the formal thing, the inappropriate out-of-area beds is the national NHSE one; in terms of out-of-area beds, the broader term is, for me, that you are not in a local unit which is linked to your local team.

MR COKE-SMYTH: The inappropriate use of out-of-area beds, that term from NHS England, can you just help us what exactly does that mean: what makes it inappropriate?

DR DAVIDSON: So sometimes it will be totally appropriate, for some things there are regional or national, because they need such specialist services you will need to go to a regional or national centre and that's totally appropriate. Sometimes a person will end up -- for example, someone from the North of England could end up in London and have to be admitted to a London bed whilst you make arrangements to transfer them back up to the North of England because you can't transfer them in a day. That, again, would be considered appropriate for that period to emergency admission to get them back.

However, where you are sending someone from your local area to a bed, potentially hundreds of miles away, that would be considered inappropriate. Then the NHSE definition tried to make some caveats on that, so that if it was to a commissioned bed, a local commissioned bed, with the same access to your local services as you would have from, say, a trust bed -- so for example the argument was, if this was a trust unit and across the road there was a non-trust unit, in practical terms it may not be out-of-area for the person, even though it is technically not in the trust.

So it is complex to try and cover this in a very general report like this. But, essentially, the further away you are from your local team and the less information sharing there is with your local team and the less direct contact you have with your local team and your family and friends and relatives, whilst you are in that unit, the more likely it was to get deemed as being out-of-area.

MR COKE-SMYTH: Who makes that judgement ultimately?

DR DAVIDSON: Ultimately, that was a local decision by local providers and commissioners.

MR COKE-SMYTH: Sorry, perhaps slightly different aspect of that question: who makes a judgement as to whether it's inappropriate?

DR DAVIDSON: The same: local providers or commissioners.

MR COKE-SMYTH: You say in your report use of out-of-area beds are generally less effective and less safe, with greater discontinuity of care than if admitted to a local bed.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just briefly, why is it that they are generally less effective and safe?

DR DAVIDSON: Particularly in the early stages, particularly when people were using paper records, if you went somewhere that was 100 miles away, your records may not

be there, so someone would turn up completely unknown, they may have little knowledge of your local area, of what the local nuances, the culture or what services were available locally, it would be much more difficult for you to be visited by family and friends. If you did get leave, it was much more difficult to test how you were doing on leave back in your local area because you had to get there, and information sharing was often not good.

So there were potentially situations where someone was discharged from such a unit without the local team even knowing they had been discharged or the local team having asked for something for an inpatient admission but not -- the receiving team in the knowing that.

So, again, in a very general report, there are lots of reasons, I am just setting out there were complications.

THE CHAIR: Sorry to labour this point, but I think what you are identifying is that you have set out a number of principles which might identify something as inappropriate --

DR DAVIDSON: Yes.

THE CHAIR: -- less access to information, further away from family, further away from -- but you could still have

a local commissioner suggesting that that was appropriate?

DR DAVIDSON: Yes.

THE CHAIR: Thank you.

MR COKE-SMYTH: Thank you, Chair. Just moving on slightly and still dealing with out-of-area beds. It is also right that, within that equation, there are private providers?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Is it right a private provider could be within area or it could be outside area?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Generally speaking, what if any downside might there be to a private provider?

DR DAVIDSON: Again, particularly at the early stages, private providers typically did not have access to the records that the trust would hold and, equally, the trust would not have access to records that the private provider held. Over time, for what became called appropriate out-of-area beds, information sharing protocols improved but it was still generally more clunky and it was not so good.

Private providers have got a different financial basis to public providers and so they have a duty to return profits to their shareholders, which means that

they generally would be charging higher prices.

The continuity of care, for example, if your Care Coordinator wished to come and see you, particularly in the early stages, was more difficult. They couldn't just pop in like they could do into your local unit, they would have to make appointments and sometimes you would go to a unit and you would be asked to see the person not on the ward but in an interview room off the ward. So there -- I am not saying these things applied everywhere, I am saying, in general, these were the sorts of things that did happen.

MR COKE-SMYTH: Just perhaps being a bit more specific on that: in terms of out-of-area beds, so moving on from providers but out-of-area beds in particular, to your knowledge is there any correlation between out-of-area inpatient treatment and negative impact, so for example increased recovery times, increased instance of self-harm, suicide, et cetera?

DR DAVIDSON: The general consensus is that the evidence suggests that those things do increase.

MR COKE-SMYTH: You also deal in paragraph 1.18 with the pressure and you deal with this also above, but the pressure to provide beds which wouldn't be deemed inappropriate. You describe this leading to a culture of an admission as a last resort, rather than admission

when optimum to do so.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Can I just focus on that point there: when optimum to do so. When is it optimum to admit someone as a mental health inpatient, generally speaking?

DR DAVIDSON: That's obviously very individual and situation specific but, in general, it's at the point where you have reached the point where your community care is no longer viably likely to improve -- to provide the necessary improvement. It's very difficult to personally define that on an individual case without looking at an individual case.

MR COKE-SMYTH: Of course. How did that admission of last resort issue come about?

DR DAVIDSON: The admission of last resort: if you -- if you have run out of local beds and the only beds are available far away, the pressure not to admit to an inappropriate out-of-area bed was huge and, therefore, there was huge pressure to try and muddle on with someone in the community or to keep someone sitting in what's often called A&E -- in NHS terms is often called Urgent Emergency Care, but it is the A&E department. So you were keeping someone in an inappropriate place waiting for a local bed to come up, rather than getting them into a bed and it also led

to increasing focus upon risk in a way -- which was defined in a way which was immediate likelihood of harm.

So there is always risks in life, everything in life has risks, but it became how likely was harm to occur in the next day or two, rather than, "If we bring you in now, are we likely to prevent serious harm in the near future?" And there was also the financial thing that these out-of-area beds were usually not in a block commission, so they had to be paid for separately, which then came out of the budget for providing other services.

MR COKE-SMYTH: Just moving on in the chronology, in terms of the background and context. It's right that in 2019, the long-term plan came into effect, including the Mental Health Implementation Plan and you describe that bringing significant new investment and an emphasis on supporting and strengthening core community and acute services. Did that include CAMHS?

DR DAVIDSON: The long-term plan does include CAMHS, yes.

MR COKE-SMYTH: You then set out at 2019 the Community Mental Health Framework was published, setting out the principles and values to be expected in delivering good mental health services.

The next significant event you describe is Covid and you describe a rise in mental health demand which was

exacerbated by Covid; is that right?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: So, in summary, pressures increasing towards the end of the relevant period; is that right?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: In summary, looking at your paragraph 1.24, you describe investment throughout the period but not always in keeping with rising need and demand.
DR DAVIDSON: That's correct.
MR COKE-SMYTH: You say there were a wide range of new teams, services and therapeutic approaches, and you say that more people than ever were being treated.
DR DAVIDSON: That's correct.
MR COKE-SMYTH: You then make this point: there was a lack of routine reporting data, other than in respect of what's now called NHS Talking Therapies; is that right?
DR DAVIDSON: Outcome data, yes.
MR COKE-SMYTH: The result of that is that we can't accurately measure how effective that care in that period was; is that right?
DR DAVIDSON: That's correct.
MR COKE-SMYTH: Am I right, is that a major limitation to assessing the relevant period and those changes?
DR DAVIDSON: It is and, compared to other areas of healthcare, it is very unusual.

MR COKE-SMYTH: We know routine data wasn't reported: are you able to explain why that was or not?

DR DAVIDSON: I can give an opinion on it. I can't verify that that opinion is the full opinion.

Essentially, for about 40/50 years there was a lot of debate in mental health about what constituted an outcome and, in one sense, this went from helping the person to have a perfect life, with all their needs met, at one level, to specific changes, at another level, and no -- there was never a national consensus on how to measure what we were trying to achieve.

Compared to other things -- for example when I did the work on GIRFT report, it came out of orthopaedic surgery, in terms of hip replacements, it was very, very clear, there were reporting measures that they did for that. There were no equivalent measures for mental health. So the problem was lack of consensus about what would be acceptable as an outcome measure. That has recently changed, as I have said in my report and there are now agreed outcome measures that should be done.

Early Intervention in Psychosis did do outcome measures but they tended, the reporting of them was unfortunately at national level on whether or not there were two outcomes, two separate outcome data points recorded, not what was the change between them.

So we knew that outcomes were being measured but there was no national reporting as to what changed -- or happened between those points.

MR COKE-SMYTH: Does it follow from what you have said that you would support, going forward, national recording of outcome data in mental health?

DR DAVIDSON: I don't see how we can drive significant improvement without that.

MR COKE-SMYTH: Can you just tell us, as we stand now, how far is there left to go, in your opinion, to achieving that?

DR DAVIDSON: We are at a point where in terms of community mental health, adults and older adults, and CAMHS as well, in different ways, there should now be routine reporting.

What isn't yet -- we have not reached yet reached the stage where that routine reporting has been going for long enough and consistently enough for national reports to have been produced, to my knowledge. They were hoping to produce the first reports in '25/'26, which is the year we are in. They will be provisional reports because when you recommend that something is done, it doesn't mean it gets instantly done, and so the data quality may be poor it may be patchy, but we should start to get outcome data routinely reported by this

year, at some point, was the expectation.

Obviously, there have been a lot of changes at NHSE since that, so I can't comment on whether that's still true, but that was the last expectation that I was aware of.

MR COKE-SMYTH: Thank you. I want to move on now to another aspect of your introduction and you say that few people, even with severe mental illness, need or benefit from inpatient care and treatment; is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: Just following on from that. In a general way, what type of patient or condition does benefit from mental health inpatient care?

MS NELLIGAN: So you can't say condition because all conditions can be treated at home, if you get them early enough, and you can do intensive support if needed too. So even back in the 1980s and '90s some people with psychosis were being treated at home, never needed admission, so it would not be condition specific. It would however be in terms of what's practically viable and that's the critical thing.

So, for example, it's much more difficult to do intensive home treatment if someone has no fixed abode, as a practical example. It's more difficult to do effective treatment if the person is declining to accept

the necessary effective treatment and, therefore, if they need to be detained under the Mental Health Act, that would be to a bed to enable that to be done.

So it can also be that, for example, certain medications, like clozapine, particularly in the early stages, people were very reluctant to do clozapine titration in the community, so people, even if they were willing to have it, were told "You have to come into hospital so we can start it in hospital, and then you can come out again".

So it's based upon pragmatics and practicalities of what's reasonably available at that time in that area to try and best meet that person's needs, and if it's not viable to do it in the community but it is viable to do it in hospital, then you would bring them into hospital. Clearly, if it's not viable to do it in hospital either, then there's no point in bringing them to hospital.

MR COKE-SMYTH: So not condition specific but, just to summarise, a major factor might perhaps be the severity?

DR DAVIDSON: Severity comes into it and it is a question of how you can help the person and their family and anyone else involved to manage that severity. Severity is not the overriding issue but it is one of the factors you take into account.

MR COKE-SMYTH: From what you have said, the other key

factor is personal circumstances of that individual?

DR DAVIDSON: It is very much patient-centred care, yes.

MR COKE-SMYTH: At 1.27 of your report, you highlight the growth over the 21st century of numbers in contact with mental health services and you say that, nationally, rates of serious untoward incidents, including deaths, did not significantly rise during the relevant period. You make reference in your report to data taken from the National Confidential Inquiry into Suicide and Safety in Mental Health, referred to as NCISH; is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: Can I just ask you some questions about that, please?

DR DAVIDSON: Yes.

MR COKE-SMYTH: My first question is: what is NCISH?

DR DAVIDSON: So NCISH is a non-governmental body which was commissioned by, I think, DHSC, Department of Health and Social Care, originally, to set up a national review of deaths by suicide and homicide linked to mental disorder. It's been running for a long time. It has sequences, as I refer to in my report, and the first reporting goes back to, I think, 2009. So it has a very longitudinal view, which enables trend charts to be done.

Trend charts are very important when you are looking

at things because, when you talk about small numbers, there can be month-to-month/year-to-year variation. Trend charts smooth that out so that you can see whether or not there is actually real change or it is just fluctuation.

So they produced trend charts and they produced trend charts in terms of numbers of such incidents, deaths, but they also produced trend charts in terms of rates. Clearly, the same number of deaths that you see in a lot more people is a reduction in the rate. So, you know, the rate is not necessarily the same as the number.

MR COKE-SMYTH: You say, nationally, rates of serious untoward incidents, including deaths, did not significantly rise over the same period. Am I right that, when considering that, that what they consider is those who have been in contact with mental health services; is that right?

DR DAVIDSON: So NCISH do two types of commentary in their reports, one is the general population one, and one is those who have been in contact with mental health services. They define contact with mental health services as contact in the last 12 months.

MR COKE-SMYTH: So just focusing on that contact with mental health services, you are saying those rates didn't

increase?
DR DAVIDSON: No, I am saying those rates have not significantly increased and they do fluctuate.
MR COKE-SMYTH: Yes.
DR DAVIDSON: They are still well below the rates for, say, 1980, they have slightly upped in the last few years and but if you, if you -- in terms of statistical process charts, which is a way of looking at whether or not there is significant trend, they would fall within a sort of mean that suggested they were fluctuating rather than there was necessarily a trend. But only time will tell whether that will continue. So, overall, the position would be they have been relatively static for the last 20 years.
MR COKE-SMYTH: And --
DR DAVIDSON: They went to the lowest level about 2009/10. That was historically the lowest level but they are slightly up from there.
MR COKE-SMYTH: Some might suggest the NCISH data underestimates harm from mental health or harm experienced by mental health patients: what would your response to that?
DR DAVIDSON: Clearly harm comes in multiple forms and being miserably unhappy, not being able to cope, self neglect, all sorts of things come as harms from untreated or

ineffectively treated mental disorder. They are only capturing things like deaths, which is only one aspect of harm.

MR COKE-SMYTH: So just limited in terms of what we can tell from that data and again not helped by the lack of outcome reporting data in the relevant period?

DR DAVIDSON: Yes, and that's why suicides and homicides are not a good single measure of the quality of mental health services.

MR COKE-SMYTH: I want to move on now, please, to section 2 of your report and you deal there with mental health, severe mental illness and some of the main inpatient service types.

The first thing which you identify at the start is that at 2.2 you say:

"... controversy as to whether mental illness does exist and whether or even, if it exists, whether it's right to treat it."

But the broader consensus which you identify is that it does exist and it can have a significant impact on people's health and functioning.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also say that, to some extent, they can be addressed and mitigated by care and treatment; is that right?

DR DAVIDSON: That's correct.
MR COKE-SMYTH: For the purposes of your report, am I right then that you deal with principles and practice which apply to those who subscribe to that view, that there is such a thing and you can treat it?
DR DAVIDSON: Yes.
MR COKE-SMYTH: At 2.4, you set out there some of the categorisation of mental health conditions and is it right there are two main categories: DSM, Diagnostic and Statistical Manual, which is a USA-based system; is that right?
DR DAVIDSON: Correct.
MR COKE-SMYTH: And, more commonly used in the NHS, is the International Classification of Diseases or the ICD?
DR DAVIDSON: Which is from the World Health Organisation, yes.
MR COKE-SMYTH: You refer in your report to then non-standard labels such as "complex emotional needs". So am I right those aren't included and defined within the DSM and ICD?
DR DAVIDSON: So some terms which start off as being not in there, get in there in revisions, other terms don't. But the point I was trying to make there is that a lot of terms that you might read in notes -- and I am not referring to any specific case or notes here -- but you

will find terms in there that you would find it very difficult to track it back to either DSM-5 or to ICD-10, which was the most common one, and that has the big disadvantage that people can't go and check whether or not they think that applies to them or to their relative because there is no defined definition of that.

So it is the lack of definition which is the issue. We also know that sometimes labels were used -- for example, "personality disorder" was often used without it being linked back to a proper diagnostic set of criteria, even though there may be diagnostic criteria in one of those things.

MR COKE-SMYTH: One of the things which you identify in your report at 2.5 is the fear of labelling, and you say that led to a trend through the 21st century of trying to avoid making clear diagnoses and you identify that that is controversial; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You point out that, for NHS-funded services, you will normally need to give and share a diagnosis; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also, against a lack of labelling, say that the need for clarity also falls within the general principle of "nothing about me, without me", so the

point about being open and clear with a person about any diagnosis; is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: So you would be a supporter of offering a diagnosis; is that right?

DR DAVIDSON: I would, with the caveats that the diagnosis does not define each individual person; it is a broad category.

MR COKE-SMYTH: Can I just get a feeling for how prevalent your view is within the profession?

DR DAVIDSON: I think within the broader professions, because mental health is made up from multiple professions, I think the broader consensus is it is right to give people clarity and a diagnostic label can be very helpful. There are some people who don't think it is helpful because it can lead to people believing that that's labelled them for life.

So there is controversy but the majority believe and the NHS mental health service dataset, which is what we are all required to complete -- it's not always completed -- in that you are meant to put in a diagnosis and that should be a diagnosis in ICD-10 currently. So if you go to put it in there, you should at least be sharing that with the person.

MR COKE-SMYTH: I understand. So the system is asking you

to put in the diagnosis and your point is, if you have to put it in the system, you should then share that with the individual?

DR DAVIDSON: Yes.

MR COKE-SMYTH: At 2.7 you deal with the term "severe mental illness" or SMI for short --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and you point out that has fluctuated in meaning. You describe that you use that term in the report in the same way as set out in the long-term plan, i.e. based by severity, not by diagnostic exclusion criteria. Can you just explain what you mean by that, please?

DR DAVIDSON: So what was called QOF, which was Quality and Outcomes Framework for primary care, there was a definition for GPs to have a register of SMI, which was primarily based upon psychosis and bipolar affective disorder, that's one more narrow one.

The one in the long term plan is more inclusive than that, so if you have got very severe depression, very severe obsessive compulsive disorder, very severe anything, you would fall within the definition of severity, whereas some of the older definitions would exclude you on the basis that your particular diagnostic label didn't fit and that's not -- that's not a good

approach.

MR COKE-SMYTH: You go on to define, within your 2.12 a "mental disorder", and that is, according to the World Health Organisation, defined as:

> "... a mental disorder characterised by clinically significant disturbance in an individual's cognition, emotional regulational behaviour. It is usually associated with distress or impairment in important areas of functioning."

DR DAVIDSON: Yes.

MR COKE-SMYTH: You point out that the term "SMI", or severe mental illness, is a term used to capture a group of mental disorders, which are the most disabling; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You describe those as a group of relapsing, remitting illnesses which cause a severe impact on the person's life and functioning --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and they carry significant risks of chronic disability and premature mortality.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You point out much of this is preventable by early treatment back to remission --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and also by rapid relapse intervention when early relapse signs occur.

DR DAVIDSON: And plans to reduce the frequency of relapse as well as -- three components: so early treatment; relapse prevention, as far as possible; and early intervention in relapse, if it does start.

MR COKE-SMYTH: Set against that objective, you point out that, in the 21st century, a model of care developed focusing on crisis intervention, and you say that meant mental health services often waited too long until a person was in crisis, rather than working with people to intervene before an episode deteriorated to crisis point.

DR DAVIDSON: I do. I want to make it clear that was not the national intent; it's the way that the world developed. But if you focus on seeing people in crisis, then there are real examples around the country of people trying to get help and being told, "You are not in crisis yet, so we can't help you". So it inadvertently led to crisis being seen as a key criteria for access, which I am saying in my report is too late, in my opinion.

MR COKE-SMYTH: You very much emphasise the need for early treatment intervention.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Can you just explain in a bit more detail why that is so important, please?

DR DAVIDSON: Every time that someone relapses it is very traumatic for them, it's very traumatic for their family, it's very traumatic for people who care about them. The longer that you are in relapse for any condition -- whether this is cancer or anything else, for diabetes anything else, this is general -- the longer that you are in a relapse state without being effectively treated, the more likelihood that secondary and tertiary harms and disabilities will occur. That makes the treatment more difficult, it also means that getting you back to your normal activities is more difficult. In terms of severe mental illness, if you have, for example, got to the point where you have been acting out inappropriately in the street or threatening neighbours, even when you have reduced that relapse back to remission, the person still has to deal with the consequences of what they were doing during that relapse. So the longer the relapse goes on, the more harms, disabilities and social consequences are attached to it, as well as the prolonged trauma and disruption to your life.

If you are ill for a day or two, you can quickly get back to work. If you are very unwell for weeks or

months, getting back into work is much more difficult, so it is at all levels of social interaction.

MR COKE-SMYTH: You deal in your report with the fact that it is a very small proportion of those in contact with mental health services who become inpatients.

DR DAVIDSON: Yes.

MR COKE-SMYTH: I believe the figure you give is 2.4 per cent; is that right?

DR DAVIDSON: That's from the national data, yes.

MR COKE-SMYTH: You note in your report that the mainstay of care and treatment, in fact, is community based; is that right?

DR DAVIDSON: And has been throughout the period I have been working in mental health, yes.

MR COKE-SMYTH: So it is important to understand that mental health inpatient care is a small but very important aspect of a much bigger, wider system.

DR DAVIDSON: It is an intensive necessary top up for some people for some stages of their illness, yes.

MR COKE-SMYTH: So when we look at mental health inpatient care, we need to look at it in the context of treatment potentially in the community before and potentially after?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You refer at 2.16 to the new teams which

were brought in post the NSF, and you have described that there were new resources but that they weren't fully funded. You describe how new teams were better resourced than core services, with typically more funding per case, less turnover per year and strong boundaries.

Just pausing there. The term boundaries, "strong boundaries", what do you mean by that: is that geographical or is that boundaries of acceptance?

DR DAVIDSON: Primarily boundaries of acceptance. There would be some geographical in it as well, but it is primarily boundaries of acceptance. Tertiary teams can decline referrals from secondary teams -- well, secondary teams can decline referrals from general practice but each time you have got that sort of thing, there is the potential for disagreement as to who needs what. But, also, tertiary teams were able to say, "No, we have reached our capacity", whereas that was much more difficult for secondary teams to do that because they were having the influx of referrals from primary care continually and to make room to see those new people you either had to discharge people or to move them somewhere else.

MR COKE-SMYTH: So describing tertiary terms as being perhaps slightly firmer at accepting or not, you refer

to secondary teams: who do you mean by secondary teams?

DR DAVIDSON: That's who I'm talking about, the core community teams, whatever they were called during that period.

MR COKE-SMYTH: So the Community Mental Health Team?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You say that the hope was that the new teams would take more work from the core teams, and that hasn't been the case, as the bulk of increased demand has gone to the core teams, resulting in increasing wait times to be seen and faster discharges to keep within funding.

DR DAVIDSON: So I am not saying that the new teams didn't take cases, they clearly did. What I am saying is that they weren't keeping pace with the increasing demand, so the overall effect was that the core teams had more demand than was being taken away by the new teams.

MR COKE-SMYTH: You then say:

"This further reduced time and resources per case, resulting in care and treatment being more stretched."

You say:

"Coupled with failures in NHS workplace planning, in the 21st century that led to more chronic vacancies, compassion fatigue and burn out."

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just pausing there and dealing with compassion fatigue: just, firstly, what do you mean by "compassion fatigue".

DR DAVIDSON: Every human being has got a limited ability to be compassionate and empathic. The more we are stressed, the more -- as individual human beings, the more we are rushed off our feet, the less time you have to think or to provide a compassionate response. You are trying just to do things to get from one job to the next, not having time to think about it.

Particularly when you are talking about community and acute -- core community and acute services, there is high turnover and, you know, if you are doing a clinic, you might be seeing 10 people for 15 minutes each. You have to be able to devote 15 minutes to one person, shut your mind down, go on to the next person, shut your mind down, go on to the next person.

If you are being overstretched and you are being asked -- having interruptions and being asked to do four of five different tasks at the same time, your ability to have that clear focus on each person goes down. If you are tired and exhausted because you have been doing extra shifts or covering overtime you are less likely to be able to deal with that, you are more likely personally stressed. When the person is stressed, we

don't think as well, we make more mistakes.

So it is a combination of all those things. That's not the only factors that lead to compassion fatigue: things like the feeling that no matter what you did you were going to be wrong, and other types of factors like that, also played into that.

MR COKE-SMYTH: So that was going to be my very next question: so staffing and resources is obviously a significant part of compassion fatigue but, just summarising, you have also described the fear of getting things wrong as potentially being part of it. Can you just explain a bit more, well, firstly, what you mean by that and, secondly, how that feeds into compassion fatigue?

DR DAVIDSON: Yes. So I was talking generalisations here, I just need to be clear about that. But, in general, over the course of the last 25 or so years, a culture of fear has developed in mental health and the fear is that, no matter what you do, you are going to get blamed. So if you do do something, you will get blamed; if you don't do something, you will get blamed.

Just to take an example, if you are sitting on a Community Mental Health Team and there are 50 people waiting to be seen, if you go above four-week waiting for that, then the team gets told off for too long

waits. In order to see more people, you then have to discharge more people but if you discharge someone and something goes wrong, you get blamed for that. If you don't discharge people and try and increase your caseload, then your time per case goes down. So if then some things happens because someone didn't get a visit for several weeks, you get blamed for that.

So the culture built up that no matter what you did you were going to be in the wrong anyway and that created the culture of fear and it created a lot of defensive practice, so writing notes to try and explain that it wasn't your fault.

THE CHAIR: Can I go back to compassion fatigue and you spoke about, in a sense, the stress that a staff member will be under --

DR DAVIDSON: Yes.

THE CHAIR: -- having to do too many roles in too short a space of time. One thing you didn't talk about was how that might appear to the person you are speaking with and, in particular, whether or not an element of that will also perhaps appear as a sort of lack of kindness, a lack of empathy.

DR DAVIDSON: Yes, that is precisely what I was trying to convey. For the person or the family, they may see someone who is rushing; you know, still appears to be

thinking about the previous case; still appears to be thinking "Oh, I've got five more people to see, I've got to rush this one through"; doesn't appear to be fully engaging with you, they seem to be distracted by something else. So it comes out in multiple ways and that tends to undermine trust and that tends to undermine therapeutic relationships.

THE CHAIR: Thank you.

MR COKE-SMYTH: Thank you. You have touched upon the impact of the new teams and you have explained about the funding and you have just explained about the impact of compassion fatigue.

You also say in your report that there is now a general consensus that fragmentation and discontinuity of care and treatment has gone too far, even if there is less agreement about how to correct it.

So when you say consensus, is that within the profession or is that more broadly?

DR DAVIDSON: I think it's more broadly but it is certainly within the NHS there is a recognition that there are a lot of teams, each team is -- and new sort of handovers. A lot of staff spending time filling in referral forms and doing repeat assessments, which are not value adding, by and large, and they're also very frustrating for people and their families to get asked

the same questions, over and over again, every time you have to go to see someone new. This can be actually very traumatising because you're digging back through things in your life that you may have dealt with but they're suddenly re-opened because someone asked you all the same questions.

So there is a recognition that the system is not working effectively. In the NICE lecture that you got, I saw reference up to 13 teams in one patch. Clearly, if you've got that number of teams, you know -- I'm familiar with smaller numbers than that but still very large numbers of teams -- and then people aren't sure which team you should be under, people aren't sure of the criteria, people can get stuck between teams, you can have three or four teams arguing "It's not us".

And that's difficult for the teams but, as you can imagine, that's extremely difficult for the patient and the family to be told that you need something but everyone says, "You need it but not from us", that's extremely frustrating and it tends to mean that you are not getting treatment, which means going back to all the other things we talked about earlier: delays in treatment leading to more harms.

MR COKE-SMYTH: You refer now to a move to pilot six pilots in England to see if a neighbourhood model can be better

delivered again. Just in summary, what is it that that is piloting now, by way of comparison to what you have described previously?

DR DAVIDSON: Yes. So it is really important: no one is talking about going back to the one team model in the 1980s; we have got so much more information now, so much more opportunities to do things that no single practitioner or team can know everything.

So -- but the aim of those teams is that you will stay with one team but expertise will be brought in from other teams, rather than you will leave this team to go to that team and then, if that team doesn't think you are right, you will leave that team to go to another team. So it is trying to move to you having a core team that works with you and brings in expertise, rather than you are transferred from one team to another. They are pilots, we do not know whether or not that's going to work.

MR COKE-SMYTH: Moving on now if I can, please, to the final area within section 2. I want to ask you about co-occurring conditions and perhaps, after that, it might be a convenient moment, Chair, for a break.

You deal with that from your paragraph 2.25 and you say that co-occurring conditions are more common and frequent in those with severe mental illness, and you

describe those including physical conditions but also mental conditions, such as neurodiversity, learning disability or substance misuse.

Can I just start, please, can you just define, please, what you mean by "co-occurring"?

MS NELLIGAN: So a co-occurring disorder is not the one that's the primary reason for you being in contact with that service. So, for example, if someone was coming to a mental health service and Early Intervention in Psychosis service with psychosis, they might also have diabetes, they might also have rheumatoid arthritis. So you are not coming to the EIP team for treatment of those, they are not specialists in those, you are getting treatment for those elsewhere, but they have to take into account that you have got those conditions.

MR COKE-SMYTH: Just at a high level, to what extent can and do those, so those co-occurring conditions, affect prognosis for someone with a mental health condition?

DR DAVIDSON: In general, in healthcare, the more co-occurring conditions you have got, the less good is your overall prognosis. That's a general thing, it doesn't just apply to mental health, that applies to any type of co-occurring condition. This is because the treatments for one may interfere with the treatments for another. It is that having one may actually make it

more difficult for you to be able to deal with the necessary help and support for another one.

So that's a general thing. So, in general, the trend would be that the more co-occurring conditions you have got, in general, the poorer the prognosis. That doesn't mean your prognosis is hopeless, it doesn't mean that lots can't be done but, in general, the prognosis is poorer, therefore you have to be thinking much more carefully about how you do manage the various different components, and where I refer to not interfering with other things, what we know -- and for example GIRFT did work on surgery and diabetes -- what we know is if you have people who aren't experts trying to adjust treatments on which they are not expert, that tends to cause more harm. So if you have got someone with a co-occurring condition, you may actually have to have lots of consultations with other people but how much depends on the severity and nature of the impact, I am talking very broad generalisations here.

MR COKE-SMYTH: Perhaps just to summarise: it increases complexity and it also increases the importance of coordination of care?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also say in your report that the key point to note is that co-occurring conditions should not

exclude people from mental health, learning disability and autism services, MHLDA services, where they have a condition requiring input from those services, and you make the point there will be typically a need to take into account those conditions and you have described that.

You refer to situations where people are excluded by virtue of a co-occurring condition. Can you just give an example of when that might happen?

DR DAVIDSON: There will be multiple examples but just one example: if someone has got an alcohol or drug problem, they can be told that, "Until you sort your alcohol and drug problem out, we can't deal with your mental health problem". They will then go to a drug and alcohol service, who will say, "Until you get your mental health sorted out, we can't deal with your drug and alcohol problem". I am not saying that's common, you know, there are often very good working relationships but what I am saying that's an example of what can happen.

Another example can be, "Because you have got a personality disorder, we can't treat your other mental disorders". That is not true, personality disorder is not a diagnosis of exclusion but you will hear people being told that up and down the country over this time period that you are looking at.

MR COKE-SMYTH: You emphasise the importance that, in treating severe mental illness, there is a need to take account of and make reasonable adjustments for any co-occurring condition; is that right?

DR DAVIDSON: Absolutely.

MR COKE-SMYTH: Can I just ask a very specific question on that. What role do care plans have in taking that into account, so taking into account co-occurring conditions?

DR DAVIDSON: The care plan clearly should reference that there are co-occurring conditions, if there are very significant things that need to be considered, they should be in the care plan. And, in terms of reasonable adjustments, reasonable adjustments are person specific but they are also situation and time specific. So you can't say something should be in a care plan to cover every eventuality but you can say, "This is something that needs flagging up, you need to look at this if circumstances change".

MR COKE-SMYTH: You describe that adjustments based on a co-occurring condition need to be reasonable. Can I just ask, can you give an example of what reasonable adjustment might look like in a particular patient with a co-occurring condition, what reasonable might be?

DR DAVIDSON: At the simplest level, one issue that, particularly in older adult services, people used to

complain about was people were being asked to read things but their spectacles had been lost. Clearly, if you took away my spectacles, that's a reasonable adjustment I have lost and I am struggling. Similarly, with dentures people -- "Oh, they haven't eaten their food but nobody can find the dentures".

So at the very simplest level, it could be something as simple as that. At more complex level, it might be, for example, if someone's got a particular hypersensitivity to noise, it's how you can manage that in an acute ward, which is, by nature, going to have lots of disturbances/noise in it. There are going to be different people in that ward every day, admissions might be occurring any time of the day, the person themselves might be actually making a lot of noise, which is distressing other people. So it is how you manage that.

So sometimes they are simple to fix and sometimes it is a matter of trying to balance what is reasonable against what's necessary.

MR COKE-SMYTH: I think --

DR DAVIDSON: So, for example, if someone has got a needle phobia and they need a drip, then you have got to overcome that, you can't just say, "Because you've got a needle phobia, we won't give you a drip", you know.

So I am slightly oversimplifying it there but I am trying to make a general point.

MR COKE-SMYTH: I understand. Perhaps just -- I think you may have dealt with this already, but to summarise, you would perhaps also expect, as a matter of good practice, those sort of reasonable adjustments ought to be recorded in things like care plans?

DR DAVIDSON: Where there are ones that are known to be generally applicable to that person, it would be ideal for that.

There is also the opportunity in most electronic patient records to have a flagging alert system for that. So you can take account of -- what we want people to do is read and take account of that. You then have to decide how much of that is reasonable in the current circumstances. But it tells you that these are things you need to consider and, if you are not going to do them, why wouldn't you be doing them; if you think there is a better way of doing it, then that's a different thing.

So it's not that they mandate what should be done but they highlight things that need to be taken into account.

MR COKE-SMYTH: I think it follows from your evidence, you have touched on it already, but it would be good

practice for those dealing with mental health inpatient care to work with others who are treating co-occurring conditions, so there needs to be a degree of cooperation?

DR DAVIDSON: There does. I mean, how much depends on individual circumstances but, yes, as a principle, yes.

MR COKE-SMYTH: Also co-ordination as well?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Thank you, Dr Davidson. That brings me to the end of that section of your report.

Chair, if that's a convenient moment perhaps we could take a break?

THE CHAIR: Yes. 10 minutes or 15 minutes? 15 minutes. Good.

(11.25 am)

(A short break)

(11.44 am)

THE CHAIR: Mr Coke-Smyth, please carry on.

MR COKE-SMYTH: Thank you, Chair. Dr Davidson, I want to continue and deal with a section of your report concerning inequities of access and service in mental health from your paragraph 2.30 onwards.

You highlight there the significant disparity in who is more likely to experience mental health problems and service access and prognosis. This is a very large

topic.

DR DAVIDSON: Yes.

MR COKE-SMYTH: The first point to make is that you only touch upon this by way of introduction.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Similarly, my questions are only going to touch upon this by way of introduction. At 2.31, you make the point that, although there are large amounts of data available about who accesses services, that's rarely analysed and reported.

DR DAVIDSON: Yes.

MR COKE-SMYTH: So that's another limitation in what we know and what we can deduce.

At 2.32, you give an example of those overrepresented in the data of those of black ethnicity, particularly males, who are overrepresented in those detained under the Mental Health Act and those spending long periods in inpatient settings.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also set out there that it's becoming increasingly clear that those with neurodiversity, especially autism and ADHD, are overrepresented; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Again, I am not going to deal with that in

any detail now because that is a very large topic indeed --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and the Inquiry intends to deal with that in some detail in itself. But right to make clear that neurodiversity and ADHD are very much issues which the profession is becoming more alive to; is that fair to say?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just one question on that, if I can, just to touch on. In outline, are you able to just identify some of the key reasons why those with neurodiversity tend to be overrepresented in inpatient admissions?

DR DAVIDSON: So, in general and in my GIRFT report in 2021, I talked about marginalised and excluded groups, so it is a wide range of different types of groups.

Specifically, in relation to something like autism, at a very high level, autistic people often present atypically to what might be conventionally expected. So this can lead to misinterpretations, not just in mental health but in physical health. So an autistic person may be in severe pain but may have a smile on their face. Someone looking at them might think the pain can't be significant because they are smiling but it doesn't necessarily link. So there are

miscommunications that occur, there is also differential use of language, autistic people tend to be -- and I am making sweeping generalisations here -- tend to be more logical and precise with the use of language, whereas non-autistic people are often fast and loose with language.

So autistic people will tend to use language the way they were taught at school and correctly and grammatically whereas non-autistic people will use a lot of loose language, yes, which is very difficult for the autistic person to interpret. So communication issues don't go in one direction; communication issues go in both directions. Those things therefore make you more vulnerable at all stages of your life to misunderstandings, misinterpretations.

They also -- autistic people, on top of that, tend to have smaller social networks for a variety of reasons, which I won't go into here because it's too much detail. But if you have smaller social networks, you are more vulnerable to things like bullying and abuse because you have got fewer people around you to protect you. You are also more vulnerable if bad things happen in your life, for any reason -- in all of our lives bad things happen. If you have got a good social network around you, you have got that extra support,

people to go to, people who can give you advice. The smaller your social network, the less you have got to fall back on, so the more vulnerable you are to every day stresses and strains. Every day stresses and strains can, of themselves, if they are sufficient in number and quantity, tip someone into becoming unwell, physically and mentally.

So that's a very broad outline.

MR COKE-SMYTH: Thank you. I am sure you will appreciate we are only touching on this. We are going to, as an inquiry, come back to it.

You then deal in your report from paragraph 2.34 to the question of risk management, which I am going to deal with now but is it right to say that what you are referring to is risk management of those admitted as inpatients?

DR DAVIDSON: So in this particular context, I'm using risk management in a broader sense because the Inquiry is also looking at people who are post-discharge, but in that sense of acute.

MR COKE-SMYTH: I just want to ask some general questions about risk management at this stage, although I appreciate it is something which spans all of your report and the various different stages of inpatient care.

My first question is this: in overview, what do you mean when you use the term "risk management", as you do there in your report?

DR DAVIDSON: So I am using it in the sense that it has become an abused term. People talk about, "Have you done a risk assessment, have you risk managed". In safety-conscious industries you don't use those terms in that way, you are looking at: what are we trying to achieve; what are the risks associated with trying to achieve that; and how do we minimise unwarranted avoidable harms?

In mental health, it has become, "Have you done a risk assessment, have you done a risk management plan", but it doesn't define which types of things you are trying to do and it doesn't define what benefits you are trying to achieve and are those benefits worth it, despite those harms. For example, to take a non-mental health example, in cancer, cancer treatments will cause you harm but the aim is that the benefits they will give you, for most people but not for everyone, will outweigh the harm. The same in mental health.

But what's become is risk management is like almost you can prevent any risk occurring; that's clearly impossible.

MR COKE-SMYTH: So just to refine that a little bit more,

what you are really focused on is you are saying there is obviously a difference between risk management in the broader sense and risk elimination?

DR DAVIDSON: And the two get conflated.

MR COKE-SMYTH: Your criticism, to be clear, is primarily directed at trying to eliminate risk which, in your view, is simply unachievable.

DR DAVIDSON: That's one aspect. The other aspect is, if you are not looking at what you are trying to achieve, you can't do the balance. So in order to achieve anything in life you have to accept there are risks attached to it and you can't -- you have to weigh these -- what I am trying to get across is that, you know, the safest way to avoid motor traffic accidents would be to ban motor vehicles, there are huge consequences to banning motor vehicles.

So, you know, in safety-conscious industries, what you are looking at is what is the reasonable things that you can do in order to still achieve the purpose you are trying to do. So to treat someone, you are going to cause them harm with most of the treatments we do. As I say, some people will be harmed by any type of treatment, whether it's physical or psychological, pharmacological or social, you can't say, "We will risk manage to the point where there is no harm". What you have to say is, "Does

the benefit outweigh the harm?" And if you focus purely on the risk management, you ignore "Are we achieving the benefits", and if you don't achieve the benefits the person is left in an ineffectively treated state.

MR COKE-SMYTH: I am going to come back to that in a bit more detail but, before I do, can I just ask this: you refer in your report to a move during the relevant period to a focus on risk management.

DR DAVIDSON: Yes.

MR COKE-SMYTH: By that, you mean the focus on filling in risk assessments, et cetera, rather than necessarily treatment. What was the cause of that, so far as you understand it?

DR DAVIDSON: This is a personal opinion. I can't verify this. But part of that was the sense that a lot of inquiries -- a lot of both internal inquiries as well as external inquiries, a lot of regulation, they use very loose terms. So they say things like "you will prevent" or "you will meet someone's needs", et cetera, rather than -- so a problem was that, for the practitioners, they were often faced with things that were focused on "Did you complete the risk assessment form?", rather than, "Did you give good care and treatment?".

And, obviously, if you know you are going to be marked on something and if something goes wrong your

professional career will depend on that, you tend to put more focus on that which can end your career, than on what -- and that's a dilemma for people because you go into -- the vast majority of people go into caring professions because they want to help people. I am not saying there aren't some people who are not of that category but the vast majority are, that's why you go in. But then if you know that if something goes on, you are going to be marked on whether or not a document was completed, then the document takes precedence over care and treatment.

MR COKE-SMYTH: I understand. So just sort of drawing some of that together, if I can, would it be right to say that you are not critical of risk management as part of a course of treatment but you are critical of risk management in isolation, as it were?

DR DAVIDSON: Yes, and what we are trying to do, and you will see it's reflected in the stuff you got from NICE, you can see it reflected in other documents, we are trying now to move to people thinking in terms of the safety culture, which is balancing the therapeutic gains against the harms.

MR COKE-SMYTH: So does it follow then that, if there is risk management, as part of a holistic treatment plan addressing the underlying illness and treating the

underlying illness, you wouldn't be critical of that?
DR DAVIDSON: I don't -- I strongly endorse that we should be trying to, as I say in my report, prevent or mitigate unwarranted, avoidable harms. That therefore is a form of risk management but it is a very focused form of risk management on what you can practically do, while still achieving what you set out to do.
MR COKE-SMYTH: Just perhaps following through to an example. One of the risks in treating someone with serious mental health illness is the risk of relapse. That's something you would want to plan for --
DR DAVIDSON: Yes.
MR COKE-SMYTH: -- and that would be, in your view, an appropriate risk management measure, as opposed to simply a risk assessment.
DR DAVIDSON: Yes, with, with the -- I know we are not going into detail, I don't want to go into too much detail, but we cannot prevent relapses.

Many, many things in life can precipitate a relapse. The person can't prevent relapse, we can't -- some relapses are more preventable than others but some just come out. You know, for example, Covid coming in devastated some and tipped a lot of people into relapse. We couldn't know that was going to come. So in terms of this, that's why we are talking about relapse prevention

and mitigation plans.

So it's (1) if we can reduce the things that are going to lead you into relapse, we should be working to do that, but there will be a whole variety of things that we can't control but may tip you into relapse and, therefore, we need to be able to rapidly recognise you are slipping into relapse and do something to support you in relapse, rather than pretending we can stop all those risks happening.

MR COKE-SMYTH: You also make reference in your report to the focus on risk management being recognised to have been an error. When you say "recognised to have been an error", who are you referring to there: is that the psychiatric professional or is that healthcare more broadly?

DR DAVIDSON: Healthcare more broadly, and for example you will see that in the NICE presentation you've got, which is moving away from risk asssessment -- one of the other points we focus on risk is that, like I said earlier, you might then reject someone because the perceived immediate risk isn't high enough now and so, you know, you wait until something has gone wrong then you intervene so that focus on risk as the sole determinant, rather than what you are trying to help the person to achieve, is now widely recognised to have been an error.

MR COKE-SMYTH: I want to just ask about some of the factors

influencing that move to risk management and can I just explore whether some of these were at play. Would those factors include resourcing and staffing pressure: would that be one of the reasons for the reason for the move to risk management?

DR DAVIDSON: They increase the risks because, obviously, if you haven't got the resources to deliver the therapeutic benefit, more harms are likely to occur. So I am not saying that they of themselves drove a risk-management focus but they drove a very defensive focus because you knew that you couldn't do what was necessary, so you then had to try and define that in a way which would hopefully, as an individual, mean that, if something did go wrong, you were less likely to be found at fault, which is not the right way to approach care and treatment.

MR COKE-SMYTH: Would you say that fragmentation and discontinuity of care was also a factor?

DR DAVIDSON: Yes, because again they introduce a lot more risks and a lot more variables, and the aim of a lot of the forms was to try and show that things had been looked at but the problem with multiple forms is no one has got time to fill them in properly and no one has time to read them properly, so they give an illusion of managing risk but they actually increase risks, if they are too complex and too long.

MR COKE-SMYTH: Now, I am going to just pause there Dr Davidson because it is now 11.59 and we are going to be observing a two-minute silence at 12.00 so I am going to pause my questioning at that point.

DR DAVIDSON: Thank you.

THE CHAIR: Can I ask everybody to stand for two minutes.

(Pause for two-minute silence)

DR DAVIDSON: Apologies. Can I just add something extra?

MR COKE-SMYTH: Yes, please do.

DR DAVIDSON: Very, very brief. One of the other consequences of the risk-management approach is one of the ways of managing risk to yourself, or your team, or your service, or your trust, or whatever, is to decline to accept people because you define them as being too risky or to decline to do things that may be necessary because they carry a risk that there may be adverse consequences. So it led to people being excluded from services as well.

MR COKE-SMYTH: So just still on those factors driving that approach, I think you have dealt with staffing, you have dealt with discontinuity, you have dealt with also acceptance. What, if any, other factors would you say were also driving that risk management focus?

DR DAVIDSON: Fear. Fear of staff that they would get blamed if something went wrong.

MR COKE-SMYTH: Now, you also deal with, in your report and generally, assessment of risk and can I ask you on a more practical basis but how reliable were the tools in the relevant period for actually assessing risk? How reliable or how helpful are those?

DR DAVIDSON: So most of the indicators are actually useful at a population level. So, for example, if we are looking at suicide, males from 25 years upwards are much more likely to die by suicide. That doesn't help you at an individual level as to whether this particular male who is 30 is likely to die by suicide or not. So an awful lot of the things that are there are things that work at the population level but are not of much use. And, for example, having a serious mental illness is a risk factor for serious untoward events but everyone that you will be seeing has got serious mental illness.

So a lot of them, at public health population level, they are really important for identifying things that you can do to reduce the population risk of suicide but a lot of them are -- or homicide -- a lot of them are not modifiable by a mental health team and a lot of them don't help you when you're faced with an individual, in knowing whether that person has got a lifetime likelihood of doing it and, even if they have a lifetime

increased probability, what does that mean in practical terms in the next day, two days, week, month or whatever?

MR COKE-SMYTH: So perhaps just to summarise that the risk management tools which a practitioner has, would it be right to say, are not particularly effective in accurately predicting risk?

DR DAVIDSON: All the evidence, including from NCISH, is that many, many people who end up dying are regarded, using those tools, as low risk, yes.

MR COKE-SMYTH: And the best thing a practitioner can do is to focus on delivering the therapeutic care to address the underlying illness?

DR DAVIDSON: Yes. So one of the key roles of staff in mental health is holding hope for people. People tend to die by suicide when they have lost hope. So one of our key roles is keeping hope. It's not falsely reassuring people but it is saying, "There are things that can be done to help, we will work with you to help with that, we will explore with you one of the best ways of trying to help with that and, if the first we try doesn't work, there are other things we can try". Unfortunately at times, people were told "You need this or you must have this", then if it didn't work, it actually made them more suicidal because they thought,

"Oh, that just confirms I have no future".

So language is very important in this but, yes, absolutely, a key bit of this is holding hope for people by working with them to explore what options there are that might work for them.

MR COKE-SMYTH: Can you explain, by way of example, perhaps, why a focus on risk management rather than treatment, in your view, is unworkable?

DR DAVIDSON: To take an example for an inpatient, you can try and risk manage someone's risk of harm by high levels of observation. That will suppress the behaviour but won't alter the reasons why that behaviour exists.

So if you are not actually altering the reasons why the behaviour exists, as soon as a gap appears, so if someone doesn't do the observation when they are meant to, or the person gets leave, or the person is discharged, those behaviours which have been suppressed just come out again.

So you can suppress unwanted behaviours by things like high levels of observation, by high levels of supervision, by very restricted practices. But suppressing it is not the same as addressing it.

MR COKE-SMYTH: Finally, Dr Davidson, in relation to that risk management question at this stage, it will come up again in different areas, but is there anything in your

view which still needs to be done, from a practitioner's perspective, to rebalance the focus between therapeutic care and risk management?

DR DAVIDSON: There is work ongoing, that's why, increasingly, NICE and everybody else is talking about safety plans, that's why we are trying to move away from talking about crisis plans to safety plans. So there is a lot to do, you are changing a culture that's built up over 25 years, we have to change that culture, we have to work with people doing investigations, locally and nationally. That's why -- I can't remember what it stands for PSIRF has come in, Patient Safety whatever. It is in my report, sorry.

But the focus is moving more and more to how we actually focus on are we achieving what we need to achieve in the way in which is least harmful.

MR COKE-SMYTH: Just pausing you there, Dr Davidson.

I am aware, Ms Nelligan, I haven't asked you many questions at this stage. You also deal with this in your report. Can I just ask at this stage, in broad terms, do you agree with Dr Davidson's evidence in respect of the need for approach on therapeutic care over risk management?

MS NELLIGAN: I do.

MR COKE-SMYTH: Is there anything you want to add at this

stage from a nursing perspective on that point?
MS NELLIGAN: No.
MR COKE-SMYTH: Moving on then please in your report, Dr Davidson, you deal with next -- at 2.37, you say where staff are over stretched -- you have referred to this already -- it will impact the quality of their decision-making and you say it's particularly marked where staff are coping with long-term vacancies. But you say the test remains: was the decision a reasonable one in the circumstances and, if not, what factors contributed to that decision by the person and from the system?

So just finishing off that section of your report, is it right to say, when we look at care, you need to look very much at the system as much, if not more, than the individual?
DR DAVIDSON: Yes.
MR COKE-SMYTH: I want to move on to a third section in your report where you deal with assessment that could give rise to admission and, after that, I hope to move to Ms Nelligan to deal with some of the practicalities of what happens when someone is admitted, and I am hoping that we will get to that before lunch, if possible.
THE CHAIR: Sorry, can I ask one very quick question, I missed what you were saying about supervision, high

levels of observations suppressing unwelcome behaviours which will only reassert themselves when all of that stops. Are you also saying that that in itself might increase the behaviours, the issues that are being dealt with?

DR DAVIDSON: There is little doubt that if you stop some types of behaviours people will find other ways of trying to release that stress and frustration. So for example, if you stop people, say, cutting themselves --

THE CHAIR: Yes.

DR DAVIDSON: -- they may end up head banging on a wall. Cutting yourself is very unlikely to cause you to die, head banging can kill you the first time you do it.

THE CHAIR: Thank you.

MR COKE-SMYTH: Thank you. We will come back in due course to things like observations and other forms of what might be termed restrictive practice.

Turning then to assessment that could give rise to admission. You start that section of your report by saying -- in fact, perhaps before I go into that, it's right, firstly, to say that, whilst general principles apply, the criteria for admission to any inpatient unit will vary very significantly depending on the type and the ward; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: In your report, you deal with this at a high level in overview?

DR DAVIDSON: Yes.

MR COKE-SMYTH: The first point you make at 3.1 is that each and every clinical contact contains within it the possibility that mental health admission might be necessary. When you say clinical contact, how broadly are you referring to there: is that any contact with any clinician or just with a mental health clinician? What do you mean by that?

DR DAVIDSON: So I think this is where the issue of assessment versus decision-making comes in. Many, many people contribute to an assessment, a family member might contribute to an assessment, a support worker, a homeless worker, so an assessment is pulling together information.

In terms of what I am talking about clinical contact, it is therefore to some clinician who is going to be making a decision, information has come to light, that could be from me bumping into someone -- for example, I could be visiting someone in a supported accommodation and, whilst I am there, I notice that someone else who is a patient of mine is not looking right and I might then go and have a conversation with them to say, "Are you all right?".

So it can be as opportunistic as that. So people tend to think of assessments as being sort of like a big interview, whereas in fact it is a continual process. You know on an inpatient ward -- and Maria can deal with this much better than me -- but on an inpatient ward nurses are looking at people all through the day. If someone is not looking right, you will probably go and have a conversation with them say, "What is going on?" That, of itself, is an assessment. I know it's not about admission but similarly in the community people -- and it has happened, people might say, from another team, "I saw someone that you deal with down at the shops and they weren't looking right, perhaps someone might need to go and see them". That's part of the assessment. So assessment is a very, very broad term.

MR COKE-SMYTH: You refer to the breadth there. I think that example is with you as perhaps a psychiatrist but, to give a complete different context, might a contact with GP or, for example, A&E also result in some form of assessment and referral?

DR DAVIDSON: Yes.

MR COKE-SMYTH: So in effect, the potential for assessment spans a very wide range of different healthcare contexts and scenarios?

DR DAVIDSON: Every healthcare contact and a lot of social

care contacts contain within them an element of assessment.

MR COKE-SMYTH: Can you just help us, you have described a very informal process of assessment, bumping into somebody in the corridor. But can you help us as to an example of how you might conduct a more formal assessment of somebody?

DR DAVIDSON: So in terms of what might happen, so you might get a referral from a GP, who says, "Can you see X for me", and, if it's not urgent, you would probably book them an outpatient appointment or a home visit and you would probably in most cases set about an hour aside for that. That's what was common during this period.

During that hour you would then be trying to elicit as much information as you could, either from what was in the referral letter, from what other sources of information -- so if the person was already known to services, you would have looked on the case records and, more recently, the electronic patient record, to see what was already known and you would go and see the person. If there were informants with them, you would try and get information from informants as well.

For some types of assessment, we would actually ask people to sort of bring an informant with them to -- so it is quite variable but, essentially, what you are

trying to do is, in a relatively short period of time, pull together enough information to come up with a working plan.

MR COKE-SMYTH: So would that be the key point: in any given situation, you need enough information for a plan in effect?

DR DAVIDSON: Yes, in acute, you are often scrambling. So if you are asked to see someone, for example a homeless worker, when I worked in homeless teams, they may know nothing about the person, there may be no records on this person, you may have a limited length of time the person is willing to talk to you. So you are making the best use of what is available, rather than there is an ideal that must be available, otherwise you won't do an assessment, otherwise you would not see an awful lot of people who need assessing.

MR COKE-SMYTH: You say in your report that the key questions in every assessment are: why this person, in this particular way, at this particular time?

DR DAVIDSON: Yes.

MR COKE-SMYTH: So that would be presumably a principle spanning any -- in effect, all assessments.

DR DAVIDSON: Yes, each person is unique and if you're going to do person-centric care, it has to be around that person.

MR COKE-SMYTH: Just clarifying who might carry out an assessment: am I right from your previous answers that could, in effect, be any healthcare professional?

DR DAVIDSON: It can be much more broader than a healthcare professional. As I say, it might be a homeless worker. So people contribute to an assessment, that's not the same as necessarily them being the final decision-maker about whether admission is necessary but lots of people contribute to an assessment, potentially can do.

MR COKE-SMYTH: So it would be wrong for us to think about assessment in a rigid, narrow way of a psychiatrist sat in a room going through lots of questions with an individual. It is much broader than that and that psychiatrist may do that but they rely on information from a number of others and it's not a static process?

DR DAVIDSON: Yes, it is a very mobile and varied process.

MR COKE-SMYTH: You say at 3.4 that, during the relevant period, admissions to acute adult and older wards should have been made by the Intensive Home Treatment team. We touched on this earlier but can you just explain why you say that?

DR DAVIDSON: So the purpose of the Intensive Home Treatment team is, as I say, to make sure that the person can't receive treatment and current treatment as effectively in the community as they can do in hospital.

If they can receive it in the community, it is generally going to be much better to receive it in the community. You don't have all the distress of having to go into a ward with lots of other people, you don't have the dislocation from the things you are familiar with. So in general, the preference is to treat people at home, if possible. The home treatment team are the people who are best equipped to know what's actually practically available in that local area at that particular time.

It's all very well in theory, a whole range of things might be available, they know what is practically available. They also know, for example, given the staffing shortages, if you have a Home Treatment team that should be able to do three visits a day but is so short-staffed they can only do one visit a day, the threshold for admission will change. So they are the best people to judge what's reasonably available at that time in that local area.

MR COKE-SMYTH: Again, just in summary, what type of benefit not available in the community tends to favour an inpatient admission, so something you can only get from being an inpatient?

DR DAVIDSON: So an inpatient stay is a huge increase in input. You are getting 24/7 skilled nursing care.

I know there are issues about how much nursing care is available on wards but you are getting that. You very rarely in the community will be getting 24/7 anything. If it is anything, it may be from a care worker in supported accommodation, whatever. I am not knocking that, those are extremely valuable but it is not the same as 24/7 specialist nursing care.

Like I say, a Home Treatment team -- a general community team might be able to see you once every fortnight, they can for a short period of time possibly step that up to several times in a week but they can't sustain that because, if they do sustain that, then they are not seeing new referrals, et cetera. So the Home Treatment team is meant to come in and provide -- Crisis Home Treatment team -- come in and provide extra support but their support will typically be of a number of visits per day, rather than 24/7.

So the intensity of support you need is one factor. The ability to deliver that care practically in your home environment is another. So, for example, like I said, a lot of places wouldn't do clozapine titration at home. So there are practical things like that but there is also, obviously, the fact of whether or not you are able and willing to consent to that treatment at home, whether or not, even if you are willing to consent

to that treatment at home, you are practically able to cooperate with that treatment at home. For example, if you don't have a stable home environment, it may theoretically be possible to treat you at home but it may practically be very difficult.

So it tends to be what is it that you can't do and can we do that better in hospital.

MR COKE-SMYTH: Would one of the factors there also be the fact that in an inpatient unit there is a greater degree of control over the environment?

DR DAVIDSON: Absolutely. So, like I say, you have got 24/7 nursing care, which means that, if you are at a position where you might be likely to harm yourself or harm someone else, there is a lot more support to try and work out with you ways of not doing that, right through to, at the extreme, including things like restraint, which are not feasible at home. So it is much more intensive.

And, therefore, the issue is can you manage it at home and, if you can't manage at home, do you need the more intensive support that an inpatient unit will offer?

MR COKE-SMYTH: At 3.10 of your report, you say the purpose of admission is getting necessary care and treatment to bring the person back as quickly as possible to

sufficient remission to allow community care and treatment?

DR DAVIDSON: Yes.

MR COKE-SMYTH: In doing that, you are seeking the maximum therapeutic benefit from the admission?

DR DAVIDSON: Yes.

MR COKE-SMYTH: That, in turn, is likely to prevent or mitigate unwarranted or avoidable harm. You also say in your report that admission is not a neutral act?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You highlight that there are potential harms associated with admission?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Again, just very briefly, can you just set out what some of those potential harms would be?

DR DAVIDSON: In very general terms, there is the immediate dislocation from your normal support services, et cetera, your normal things that comfort you, your own bedroom, that sort of thing. So that tends to make people's mental state a bit worse.

There are things like there are other people on the ward who have got their own problems and sometimes they can be loud or aggressive or can actually try and attack you. You can get robbed on the ward. You are more likely to get -- for example, in the Covid example but

it happens all the time -- infections are more likely to occur in wards than in the community because you are in more close proximity with people, so if someone's got the flu or some other condition, you are more likely to get it. The longer you are in a ward the more deskilled you become and, therefore, getting back into the community gets harder. You are also dislocated, so you have got more explaining to do when you go back, which is quite stressful for a lot of people.

So one of the problems in mental health was people often talked about things like, "We will admit you to the ward to keep you safe", and that's just not true. We will admit you to the ward because it is necessary and we will try and make it as safe as possible but it is not a safe place to admit someone to.

MR COKE-SMYTH: You go on in your report to highlight some of the difficulties that practitioners face in balancing therapeutic care and also risks to patients. Some of the challenges you identify, again looking at 3.11, is in the early part of the 21st century the fact that most mental health records were handwritten; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: The result of that meant that community notes for a patient would often not be accessible if that patient was admitted as an inpatient; is that

right?
DR DAVIDSON: It wasn't infrequent. I wouldn't say how common it was but it was a distinct and known problem.
MR COKE-SMYTH: You also highlight the difficulty with mental health services generally being 9 to 5 and, out of hours, individuals tending to be seen by a unit like A&E, and that also had the disadvantage they wouldn't have any prior knowledge of the individual.
DR DAVIDSON: Yes.
MR COKE-SMYTH: Presumably, again, the issue, if there were handwritten patient notes, they wouldn't have access to those.
DR DAVIDSON: Obviously, for some people who might be return attenders, they may have something but, in general, yes, that's correct.
MR COKE-SMYTH: Given those difficulties, would you agree that the family or carers of a patient should also have been seen as a key source of information?
DR DAVIDSON: Families and carers are always a key source of information, if it's practically available.
MR COKE-SMYTH: It would follow, presumably, that, given limits to patient records, it would always be good practice to seek information from the family as far as possible?
DR DAVIDSON: As far as reasonably practical, yes.

MR COKE-SMYTH: Can you just explain why that's so important?

DR DAVIDSON: When any of us is in crisis, we are not in a good position to describe our life. When you are in crisis you are not thinking very straight. You -- really your priority is just get out of this. You know, you have got very high adrenaline levels. So people are not good at giving a proper balanced view of themselves when they are in a crisis.

It's very difficult for them to -- our memory is mood dependent, so if we are in a very distressed state we will tend to give a history of our lives which is full of distress and not reflect other things. So it can be very difficult to understand what the person's normal baseline is and how much this is a variance from the normal baseline when they are in distress. The family might say, "This is not very dissimilar to the normal baseline", or, "This is radically different to the normal baseline and we have never seen them like this before". So they can give you a lot of context.

I am not saying that you would necessarily -- in all cases that the family can do that, I am not saying in all the circumstances that the family has got an accurate picture of that because not everyone shares everything with their family but they are a very

important source of information.

MR COKE-SMYTH: This is touched on later in the report and I also appreciate that this is a very complex issue that we are not going to be able to go into in any detail but, generally speaking, is there any confidentiality issue or prohibition which prevents practitioners seeking information from families or relatives, even if the person being treated doesn't consent to information being shared about their care?

DR DAVIDSON: So if the people don't know the person's there, there may be confidentiality issues, for example, the fact that someone is on a ward, they may not want even their family to know they are on a ward. So there can be but too often, historically, people would cite confidentiality. In general, there is much less limitation on you listening to someone because you are not sharing anything confidential then -- but there may be certain circumstances where even telling them the person is in the ward is breaching confidentiality but, in general, listening to somebody is something you can do. I think you might go on later but, in terms of Caldicott Rules, they were brought in in the 1990s and then strengthened in the 2000s because staff were often misunderstanding confidentiality and thinking that they couldn't do things when, in fact, they could.

So a lot of guidance has been brought in on that but it is still too commonly misunderstood.

MR COKE-SMYTH: So to give perhaps a very simple example, say the family member is fully aware that someone has been admitted as an inpatient, they know they are there, they perhaps ring up or visit. Nothing in terms of the rules of confidentiality to prevent someone, a practitioner from that ward or unit, or healthcare professional, from asking for information from that family member?

DR DAVIDSON: So a key test there is: is it already in the public domain? And so if the people already know it, it's in the public domain, so you're not breaching any -- that's no longer confidential. The same, you know, with anything; the test is: is this confidential or not? If it's in the public domain it's not confidential. So if a family said, "Can you tell us about the likely prognosis for, say, schizophrenia?" That's in the public domain. That's not about anything confidential to the individual.

So there are things you can discuss with people without breaching confidentiality even if someone said, "I don't want you to discuss anything confidential".

MR COKE-SMYTH: So perhaps just to summarise. Would you agree then perhaps room for improvement in terms of

seeking information from family members dealing with inpatient care?

DR DAVIDSON: What -- if you, if you look at NHS IT training, which we all have to do annually, it's very much about don't, don't, don't and it's about protecting the organisations from reputational damage by stuff leaking. There's much less emphasis on do.

The Caldicott Rules do try to balance that by setting that out, but the training that we get, the annual -- the national requirement to do annual training tends to focus very much on don't rather than do.

MR COKE-SMYTH: Just moving on in your report to 3.12, where you deal with the advent of electronic patient records. That obviously improved the situation in terms of making access quicker to patient records. You highlight that there were still challenges with lots of information on the system, some of that not being easily accessible to those who needed it and you make the point in your report that often there would be an incident after which those investigating would be able to find information on the system but that information wasn't necessarily available to those at the time, is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just following on from that, would you suggest that there is still a need to rework electronic

patient records to make information more easily accessible to practitioners?

DR DAVIDSON: Yes. So just in terms of that, back in the 1980s, the problem was we had a lack of access to information. Now, by and large, we have got information overload and trying to find the key stuff amongst all the masses of forms and everything else is extremely difficult.

So one of the issues of the EPRs in mental health is they are very good at collecting forms and data, they are not so good at what we would call supporting clinicians in making critical decisions. So it's about how we make sure the right information is available to the clinician when they need it.

If you have got 15 minutes to assess someone and make a decision and come up with a working plan you can't be going through hundreds and hundreds of forms.

MR COKE-SMYTH: You go on in this section at 3.13 to set out that through the 21st century, some people were admitted when it might not have been the best option perhaps reflecting some of the disadvantages you have just told us about, but others were not admitted at the optimum time when they would have been or should have been had the relevant facts been known to the decision-maker.

DR DAVIDSON: Yes.

MR COKE-SMYTH: At 3.14, you go on to set out there pressures not to admit for non-clinical reasons and a culture of admission as a last resort developing where you say:

"Not universally, but too often this meant that by the time people were admitted they had passed the optimum point for admission and further harms and disabilities had occurred leading to more complex needs, more use of the Mental Health Act ..."

By that you mean the Mental Health Act in terms of the powers to detain someone?

DR DAVIDSON: Yes.

MR COKE-SMYTH: "... and increasing lengths of admission."

Can I just ask this. What would be an example or a common example of a non-clinical reason for not admitting somebody in a relevant period?

DR DAVIDSON: So it goes back to the things that people are measured on. So regions, Commissioners, trusts were measured on things like how many people you had in an inappropriate out-of-area bed. So if there was no bed available, except an inappropriate out-of-area bed, people would say we shouldn't admit to that because that will notch it up. There was a pressure to do that. I'm not saying that would be a final decision, but there was enormous pressure not to increase use of beds away from

your area.

There were also financial consequences to using extra beds because they weren't in your budget, so that was a pressure.

If you take learning disabilities and autism, one of their requirements was to reduce the number of admissions over a number of years. It wasn't measured on: are you improving the care for these people? It was measured on the number of admissions and reducing the number of admissions. And that's still -- a national priority for learning disabilities and autism is to reduce the number of admissions; not to measure whether people are getting better because we don't measure outcomes.

If you were reducing the admissions because you were delivering better outcomes, that's fine, no one's got a problem with that. If you are just focusing on reducing admissions that's a non-clinical reason for not admitting.

MR COKE-SMYTH: So that's one example. You have also referred to the out-of-area bed use metric.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You are critical of that, as well as not being helpful for judging delivery of treatment and care?

DR DAVIDSON: I'm not critical of the sense that we want to reduce out-of-area bed usage for the reasons we've said. I am critical that the metric is set on numbers of people in those beds rather than the more important metric, which is: do people get into a local bed where they need it? And that's my criticism of that.

MR COKE-SMYTH: So your preferred metric would be that: do people get into the bed when they need it?

DR DAVIDSON: Yes. I mean, a local bed within 12 hours, as I say, would be my preferred metric, yes.

MR COKE-SMYTH: Does it follow that the problem would also be helped by better outcome data being used to measure rather than necessarily just focusing on beds?

DR DAVIDSON: Yes, and if we also focus more on occupied bed days rather than admission numbers that would help as well.

MR COKE-SMYTH: You refer at 3.17 to the:

"... inappropriate out-of-area metric of beds spawning a grey area of beds outside of the local trust in other providers but considered appropriate, which helped keep down numbers deemed inappropriate."

Grey beds there, in the local area, are you referring there to private providers?

DR DAVIDSON: It can be private providers, it can also be other NHS organisations. So some trusts which at

a particular time had a surplus of beds of the local needs might offer a ward to, or beds on a ward, to another local Trust. So it's not about which sector you are from. It's about you're not a bed in the local provider.

MR COKE-SMYTH: At 3.19, you go on to describe that from 2019 onwards there were significant increases in delays getting into any mental health inpatient bed when essential.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You say that the delays are caused by the increased time it would take to get to a point where an empty bed was available.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Are you able to help us as to what was causing that delay in beds becoming available?

DR DAVIDSON: So there were two distinct factors in a broad sense. One is, as I have said earlier, if you delay admissions people tend to come in in a worse state so it takes longer for them to get to the point where they can go back to the community. There's more likelihood that their existing community support has broken down, so it can be more difficult to come up with an aftercare plan. So that's one.

The other one is what are called clinically ready

for discharge delays. So there are multiple of those, but for example a common one is simply there is no accommodation for the person to go back to, so they no longer need to be in hospital but for one reason or another they no longer have accommodation in the community and trying to find accommodation in the community can be very difficult and can be very lengthy because local authorities and housing providers are cash strapped themselves and there are often national shortages of this. It's not necessarily discrimination against people with mental health problems. It's just there is a simple shortage.

But obviously there's a tendency to think: Well, they're in a bed so they're less priority than someone who isn't in a bed. So that caused a lot of problems. If you look at those who are waiting for beds, clinical ready for discharge delays , in most parts of the country, exceed the number of waiting for beds on any given day.

MR COKE-SMYTH: So to summarise that very quickly: if you were more efficient at dealing with those who are inpatients that would reduce delays to those waiting for beds?

DR DAVIDSON: "Efficient" is not the word I would use.

"Efficient" is true in terms of getting them to the

point where they are clinically ready for discharge. But no matter how efficient you are at getting them clinically ready for discharge if there's nowhere for them to go to you can't do that.

So this is about the whole system. It's not about the mental health provider. You've got them as well as you can do. It's the whole system and that's why in here there is reference to MADE, so Multi Agency Discharge Events. That's where you work with the whole system to say what are the reasons why these people can't get out and what are the potential options to prevent those delays in future?

MR COKE-SMYTH: This is something you deal with later in your report where you set out something called the 10 high impact changes?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Those presumably being designed at improving mental health inpatient care and improving that process of making sure people can be discharged at the right time?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also say at 3.19 that those waiting in the community for beds were not visibly reported. Can I just ask for clarification: what do you mean by that, "not visibly reported"?

DR DAVIDSON: So they didn't appear on national reporting by and large. They didn't often appear in trust board papers, they didn't often appear in commissioner, regional or ICB. At different times things were called different things, but they didn't appear in those higher level commissioning reports.

They tended to appear in what were called daily bed management meetings. So the local provider would know we've got four people bidding for a bed, we've got three people out-of-area, we've got two discharges coming up, how do we juggle that? But that was then not centrally collated in any way. So those people were invisible.

And that puts pressure on community teams, to try and keep muddling through with people who had been identified as needing inpatient beds, but -- (1) it was very frustrating for those staff and very frightening for those staff sometimes because you are trying to manage something you know you can't manage. But, secondly, it also took a lot of time away from dealing with other people because you were having to put extra time into them to try and do the best you could.

So there were -- and because they weren't being reported they were, like, not considered, whereas we have now moved to trying to move to more transparency, more trust boards and we have pushed, in my GIRFT

report, we were pushing ICBs as well to include in-your-bed figures, those waiting in the community, those waiting in UEC, as well as those occupying beds of different types on a given day.

MR COKE-SMYTH: Just going back to the question of delay, you deal with the impact of delays at 3.20 and you say there typically that subsequent admission would be longer. There is an increased risk of harm to the patient and others, presumably while they are waiting for admission, there would also be more pressure on community and inpatient staff. You also say that people not deemed at risk of serious harm to themselves or others would often be deprioritised.

DR DAVIDSON: Particularly, they were using this very narrow framework of immediate crisis and immediate risk rather than preventative.

MR COKE-SMYTH: I want to move on now within assessment to deal with assessment admission under the Mental Health Act and again we are only going to touch on this in outline and deal with the key principles. You deal with this from 3.22 onwards.

There are specific principles and guidance and indeed statutory provisions that apply to detention under the Mental Health Act, is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: The Mental Health Act in summary provides that, in some circumstances, someone can be detained for assessment and indeed treatment without their consent?

DR DAVIDSON: Yes.

MR COKE-SMYTH: At 3.23, you highlight the fact that Section 2 of the Mental Health Act provides for detention for assessment followed by treatment, and Section 3 provides for detention for treatment?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You set out there that a request for assessment under the Mental Health Act can come from a number of sources.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You describe there how assessments under Section 2 or 3 of the Mental Health Act require two doctors.

DR DAVIDSON: Yes.

MR COKE-SMYTH: One has to be approved in line with Section 12 of the Mental Health Act.

DR DAVIDSON: Yes, yes.

MR COKE-SMYTH: There also has to be an Approved Mental Health Professional; is that right?

DR DAVIDSON: That's the bit that was corrected and is not in the report. So an approved health professional or the nearest relative. Nearest relative is extremely

rare, but they legally, in some circumstances, can make the application.

MR COKE-SMYTH: Just pausing there and just perhaps to illustrate the breadth of where requests for assessment under the Mental Health Act might come from. What's the sort of range of places you could receive that request from?

DR DAVIDSON: So it could come from the family. The family might phone the Community Mental Health Team, they might phone the social services department and say, "Can someone come and assess this?" The police might do that, an A&E department might do that, a GP might do that. The whole -- the courts may do that, the police, the criminal justice system may do that.

There's a whole range of -- there is no limit really on who can raise the issue about: is a Mental Health Act assessment required?

MR COKE-SMYTH: So, in effect, anyone but might you expect to see it coming through for example A&E? Might that be one source?

DR DAVIDSON: A&E is one source, like I say. Technically, you can't just ask that an assessment is done on your neighbour but, you know, there may be circumstances where that would be appropriate.

So I'm not saying anyone could just ask for it and

it will happen. But you can ask is it appropriate for a Mental Health Act assessment to be done, and then someone has got to decide whether or not an assessment under the Mental Health Act is warranted based on the information they have received.

MR COKE-SMYTH: Generally speaking, the decision as to whether the assessment is warranted, where does that happen?

DR DAVIDSON: That will probably be most often with the Community Mental Health Team, the psychiatrists on that particularly. But it may be with the social services department, it may be with a social worker, it may be with an AMHP. So it depends where the request has gone to and then who knows the person and, you know, things like that. So it is very difficult to say this is what must be done.

In general, it's a pragmatic decision based upon who is likely to be in the best position to decide whether or not this is right thing to do.

MR COKE-SMYTH: In your experience, is it common for Approved Mental Health Professionals and Section 12 approved doctors to be unavailable for those types of assessment? Is that a problem that was common during the relevant period?

DR DAVIDSON: Unavailable, no, but available quickly and in

a timely manner, yes. So it isn't that they were never available, but there may be a long delay whilst waiting.

MR COKE-SMYTH: So would it be fair to say delay was perhaps one issue associated with those assessments?

DR DAVIDSON: Delay is one issue, particularly out of hours when there may be very few staff available to do it.

MR COKE-SMYTH: Again, it may be an obvious question given your previous answers or an obvious answer but, what impact do those types of delay then have on the person being assessed?

DR DAVIDSON: One, there is no legal framework under which people can manage the situation. So if that person says, "Right, I'm not going to wait, I am going to go", there is no legal framework for addressing that.

So if you were seeing someone at home and they said: Right, I'm leaving, you couldn't actually prevent them leaving or whatever. So practically it might make the assessment more difficult. So sometimes you would end up having to chase people to try and get an assessment done. They would become -- generally speaking, you know, the longer you wait for something the more anxiety arises, the more frustrated you get. So by the time the assessment was done they may be in a worse state, less cooperative and less willing to consider other options. So it's -- it's not a good thing.

Sometimes they would abscond and a harm would occur whilst you -- whilst waiting for that assessment to take place. "Abscond" is not the correct word there. Sometimes they would leave because they weren't detained at that point. They would sometimes leave where they were and by the time they were found again harm might have occurred.

MR COKE-SMYTH: Thank you. Moving on to the criteria and again just touching on this in overview. You deal with the criteria under the Mental Health Act at 3.24 and you make the point the criteria are broad, including detention being for the person's health and/or safety and/or for the protection of others.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You point out that's much broader than imminent likelihood that the person will seek to deliberately harm themselves or others.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You set out that balancing any risk and seeking to prevent misuse, a key guiding principle in the code of practice -- the code of practice being what sits alongside the Mental Health Act, is that right --

DR DAVIDSON: That's correct.

MR COKE-SMYTH: -- is least restrictive practice and maximising independence?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You say that important safeguard of least restrictive practice is a term often wrongly used in practice.

You say the code makes the definition clear that where it's possible to treat a patient safely and lawfully without detaining them under the Act the patient should not be detained?

DR DAVIDSON: Yes, and what I mean by that is that sometimes people say, "Least restrictive practice is we don't treat them at all, which is not what the code of practice says".

MR COKE-SMYTH: Can you just explain that?

DR DAVIDSON: People will say, because someone is not willing to co-operate with the plan, there's nothing we can do because that's their choice, least restrictive practice.

Often you can negotiate with people about which aspects of the plan they would be willing to go along with. It's not a binary thing. For admission it's a binary thing, you either consent to the whole care and treatment plan or you don't. But for a community it's often not a binary thing. It's often a discussion, a haggle about which bits you are willing to accept, which bits you aren't.

So saying least restrictive, they don't want to do this, therefore, you know.

So the person's got capacity, they say they are going to kill themselves, we don't think they are detainable under the Mental Health Act, therefore under least restrictive, there's nothing we can do. And it's a complaint which came up not infrequently during that time from families and indeed people who survived. And the answer is that was wrong.

What you should still have been doing is trying to work out how you could safely and lawfully give them the best treatment you could in those circumstances.

MR COKE-SMYTH: I am just going to --

DR DAVIDSON: And I know that's difficult to do in general. You know, it's about specific cases, but it's --

MR COKE-SMYTH: I'll come back to that if I can. It might make that point clearer.

But in terms of the principles from the code of practice and the guidance relating to the Mental Health Act, is it right they essentially remained the same throughout the relevant period in terms of the core principles?

DR DAVIDSON: Yes. The 1983 Act, although it was amended and updated in 2007, the basic principles didn't alter.

MR COKE-SMYTH: Just asking about least restrictive

practice: that's one principle from the code of practice and that's a guiding principle amongst a number of other guiding principles; is that right?

DR DAVIDSON: Yes. The code of practice had a lot of different principles in it, absolutely.

MR COKE-SMYTH: The code of practice is, however, guidance only?

DR DAVIDSON: It's statutory guidance but it still is only guidance. It can't -- it can't cover every eventuality.

MR COKE-SMYTH: In your view, is that guidance adequate generally speaking?

DR DAVIDSON: There has been a recent revision of the Mental Health Act, as you will be aware, and I understand that part of that will now be looking again at the code of practice and whether or not, with further experience, it needs revising.

I'm not party to how much revision will take place, but I understand that revision of the code of practice is planned. So it's fair to say that there is a view that it's not currently as fit for practice as it was when it was designed, but I don't know whether that's a minor alteration or will be major alterations.

MR COKE-SMYTH: Can I just deal now with the interaction between the Mental Health Act and also the Mental Capacity Act. Again, this is a complicated area

so perhaps I am only going to deal with it in short form.

Is it right that, in summary, a person who has full capacity can nevertheless be detained under the Mental Health Act if the criteria in section 2 or 3 are met?

DR DAVIDSON: Yes.

MR COKE-SMYTH: So just to give an example, would it follow there may be circumstances where somebody has capacity and where detention under the Mental Health Act may still be required to stop them taking their own life?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just finishing this section of your report. At 3.28, you say that, in summary:

"Increasingly, as the century progressed, getting admission at the optimum time to a local bed became harder but most admissions were and are to a local bed."

DR DAVIDSON: Yes.

MR COKE-SMYTH: You also say there that bed pressures were mainly due to the rising length of stay rather than rising admissions.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You make the point that more timely admissions would likely reduce the length of stay.

DR DAVIDSON: Which, in turn, would free up more beds to be available when needed.

MR COKE-SMYTH: Dr Davidson, that deals with your section of the report on assessments leading to admission. I want to now come on to what happens when a patient is admitted and arrives on an inpatient ward and I am going to turn my questions now to Ms Nelligan.

But, Chair, I am conscious of the time. I don't know whether that might be a convenient moment to break.

THE CHAIR: Thank you.

MR COKE-SMYTH: Thank you.

(12.54 pm)

(The short adjournment)

(2.00 pm)

THE CHAIR: Mr Coke-Smyth.

MR COKE-SMYTH: Thank you. Before I turn to you, Ms Nelligan, Dr Davidson, I just want to go back to one aspect of your evidence from before lunch and, just to summarise, you gave evidence about the form-filling risk management approach versus therapeutic approach, for want of better shorthand, and you were critical of that form-filling, risk-based approach; that's right, isn't it?

DR DAVIDSON: It is. I am not saying there should be no forms at all but overemphasis of it, yes.

MR COKE-SMYTH: You made clear that that was an issue which was common in respect of mental health inpatient care

during the relevant period --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and you made clear that the proper approach would be to focus on treatment of the underlying condition?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You have given evidence this morning about why you think there came to be an undue focus on form filling and reasons included, for example, fear culture and you gave a number of other factors.

It would, however, be important to make clear, would it not, that that issue with form-based risk assessment, that wasn't something being driven by national clinical guidance, so there wasn't, for example, guidance from NICE or anyone else saying that's what you should be doing. That was a problem associated with practice, for the reasons you have given?

DR DAVIDSON: It accumulated over time, rather than being driven by any particular organisation or person, yes.

MR COKE-SMYTH: Just by way of example, it may be that you need to go away and check, but just to give one example of national guidance, national guidance from NICE in 2012 on preventing suicide in England -- so the middle of the relevant period -- that is an example of clear guidance making clear the need to reduce risk by

treatment of the underlying problem?

DR DAVIDSON: That was always the national position. It wasn't always, as I say, the way it worked out in practice.

MR COKE-SMYTH: Yes, so I think that very much captures the point. To be crystal clear, the national guidance was clear but the problem was one that developed in practice, not because anybody said, "That's what we think you should be doing at a national level"?

DR DAVIDSON: And the need and desire, including from regulators and others, is they wanted simple ways of being able to evidence check. So forms were often written for external bodies, rather than to actually do therapeutic practice.

MR COKE-SMYTH: So put very simply, it was an unintended consequence of a number of other factors that you have been through this morning?

DR DAVIDSON: Absolutely.

MR COKE-SMYTH: Thank you.

Ms Nelligan, can I now turn to you, please. I want to start by asking you some questions from section 1 of your report, where you deal with the staffing of a mental health inpatient unit. The first thing to make clear is that inpatient wards in mental health are diverse and they can include units for young people,

mother and baby, learning disabilities, forensic, older people, substance misuse and a number of others.

MS NELLIGAN: Yes.

MR COKE-SMYTH: What you have done is to try and give an overview of general features but, of course, we would need to look at any particular ward in any particular speciality to understand how that worked in practice?

MS NELLIGAN: Yes.

MR COKE-SMYTH: It's right that wards or units can vary in size from four beds to as many as 30 beds?

MS NELLIGAN: Yes.

MR COKE-SMYTH: In your report, you try and give an overview, just to assist, by setting out some common features, although you accept those would vary between different wards.

MS NELLIGAN: That's right.

MR COKE-SMYTH: So whilst it's not possible to set out a typical staffing model, in terms of number and ratios, you say at 1.2 of your report:

"Each shift will have, firstly, a Registered Nurse in charge of the shift, who will coordinate the shift, lead handovers and allocate tasks to the team."

Is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: You will also, in any ward, have a second

Registered Nurse, that nurse will support patients and staff, deliver clinical interventions, and you will also, generally speaking, have a number of what are called in your report healthcare support workers; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: Is another name for "healthcare support workers", healthcare assistants?

MS NELLIGAN: So healthcare support workers is a term which is broader, so it would include healthcare assistants and also, potentially, assistant practitioners.

MR COKE-SMYTH: What's an assistant practitioner?

MS NELLIGAN: Assistant practitioner is somebody that has done two years of a foundation degree and can work at a higher level than a healthcare assistant.

MR COKE-SMYTH: You refer in your report to the model for nursing staff on a ward to include a Deputy Ward Manager and a Clinical Lead Nurse. Can I just be clear, are these roles assigned to the two Registered Nurses that you have already set out?

MS NELLIGAN: So, in general, a ward would have, say -- a 20-bedded ward would have, say, 30 staff on that establishment, of which there will be the Ward Manager, Deputy Ward Manager and a number of Band-6s, often known as Clinical Leads, and the rest of the Registered Nurses

would be Band-5s and Band-3s.

So that would be -- that would constitute your staffing establishment.

Then, on a shift-by-shift basis, you will have what I described here as the Nurse in Charge, a second Registered Nurse, and healthcare support workers. So on duty, through the shift, you might have either one of those Deputy Ward Managers or a clinical lead on shift.

THE CHAIR: As one of the two?

MS NELLIGAN: As one of the two --

THE CHAIR: I see, thank you.

MS NELLIGAN: -- not as well as, because the only person that's supernumerary is the ward manager.

MR COKE-SMYTH: That leads me to my next question: you say the Ward Manager should be supernumerary, what do you mean by that?

MS NELLIGAN: So they are not working as part of the shift for that day, they are in addition to that shift.

MR COKE-SMYTH: They are in addition to those two nurses that you have already referred to?

MS NELLIGAN: Yes, and they often work 9 to 5.

MR COKE-SMYTH: Why should they be supernumerary?

MS NELLIGAN: So as Ward Managers, their role is quite diverse in terms of making sure that the ward runs smoothly, both from a staffing perspective, quality of

care perspective, and also in terms of patient safety.

So often they will be doing tasks that are administrative in nature. For example, making sure that the Mental Health Act papers have been done correctly, looking at supervision, for example, and carrying out supervision with staff and also they will also do some work with individual patients as well.

Where they come in really importantly is when you do have shortages, they are able to support the ward in times of shortages as well.

MR COKE-SMYTH: Presumably that is limited however to their time working, which I think you have described would be normal working hours.

MS NELLIGAN: 9 to 5, normally.

MR COKE-SMYTH: 9 to 5. You go on in your report at 1.4 to 1.6 to describe how the nursing team provide 24-hour care, either through a shift-based system of eight hours or 12 hours; is that right?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You describe how 12 hours would reduce the time for handover, over an eight-hour shift. Can you just explain why that would be?

MS NELLIGAN: Potentially that's the case because when you have a 3-hour, three shifts potentially, you have a longer handover time and handover times vary from

locality to locality and shift by shift. But, normally, a shorter shift has a longer handover time.

MR COKE-SMYTH: You describe there that, on handover, it is good practice to carry out a visual inspection. Can you just tell us what a visual -- sorry, a visual inspection of patients.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Can you just tell us what that visual inspection ought to involve?

MS NELLIGAN: Well, the inspection should be by the two Registered Nurses, the nurse that's handing over shift and handing over the care of the patients and the nurse that's receiving that care. And the inspection is -- and probably "inspection" is probably a strong word here but it is reviewed to make sure that the patients are safe and everybody is where they should be and that there isn't any untoward issues in the ward at that particular time.

So it's safety of patients and safety of the environment.

MR COKE-SMYTH: You also refer to the challenges of being able to deploy two Registered Nurses per shift, due to staff shortages.

MS NELLIGAN: Yes.

MR COKE-SMYTH: And you also refer to increasing reliance on

healthcare support workers.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Just pausing there and asking you a bit about that. In summary, what is it that a healthcare support worker can't do that you would need a nurse for?

MS NELLIGAN: A Registered Nurse?

MR COKE-SMYTH: Yes.

MS NELLIGAN: So, in summary, the Registered Nurse assesses care, develops a care plan and supervises more junior staff, including healthcare support workers, gives medication, gives evidence-based practice and delivers evidence-based practice. That's not to say that healthcare support workers don't do valuable work, they do, and also receive training.

But it's not at a high level and the accountability is different than it is for a Registered Nurse.

MR COKE-SMYTH: One key difference being also "Registered Nurse", the clue is in the name: they are registered --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- with the NMC --

MS NELLIGAN: That's correct.

MR COKE-SMYTH: -- which is a professional regulator that sets certain standards and also lays down certain minimum training?

MS NELLIGAN: Yes, yes, and they are accountable for their

actions and they are accountable for their practice.

THE CHAIR: What do you mean by evidence-based practice in this context?

MS NELLIGAN: So looking at any interventions on the wards, making sure that there is some evidence base for that and that they would deliver that themselves as well.

MR COKE-SMYTH: You have described there being an increasing reliance on healthcare support workers in the relevant period of time.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Apart from staff shortages, what if any other reasons were there for that?

MS NELLIGAN: So, over time, there has been various levels of commissioning of registered mental health nurses and that's over this period of time that has increased/decreased. Currently, there was a -- the last review that was done in 2023 said that the commissioning numbers of Registered Nurses met the demand. However, the Registered Nurses were not all coming into the NHS and a lot of those Registered Nurses were going into private sector and other areas.

Therefore, the gaps needed to be filled by other practitioners, in this case healthcare support workers, and that would include also your Assistant Practitioners and later Nursing Associates. There was also periods of

time where there was an emphasis on reducing costs and healthcare support workers are cheaper than Registered Nurses, and that was also a factor that came in during that period of time and that informed some workforce plans as well.

MR COKE-SMYTH: So key factors, one being lack of available Registered Nurses and the second key factor being cost?

MS NELLIGAN: Cost. As well as looking at planned care there's also a consideration of times of acuity, so to be able to bring in temporary staff in times of additional acuity, it is easier the supply of healthcare support workers is greater than the supply of Registered Nurses from an agency and temporary staff in perspective.

MR COKE-SMYTH: Thank you. So moving on then in the make up of the ward. It's right that the medical team, and I was looking at your 1.8, are led by a consultant psychiatrist. A consultant psychiatrist is a doctor who is obviously a specialist, on the specialist register, and you would expect one consultant psychiatrist to be allocated per ward; is that right?

MS NELLIGAN: That's correct, generally speaking.

MR COKE-SMYTH: They also take on the role of responsible clinician, which is a specific role which relates to patients detained under the Mental Health Act; is that

right?
MS NELLIGAN: That's right.
MR COKE-SMYTH: They tend to work, again, regular hours, like the ward manager, 9 to 5, but have an out-of-hours on-call system, generally speaking.
MS NELLIGAN: Generally speaking.
MR COKE-SMYTH: They are also supported by more junior doctors?
MS NELLIGAN: That's correct.
MR COKE-SMYTH: Now, you deal in your report, from 1. 12 onwards, with staffing and the process of deciding how many staff you need on a ward. It's right that at the start of the relevant period you describe that being done generally manually.
MS NELLIGAN: Correct.
MR COKE-SMYTH: Can you just explain what you mean by that? Manually allocating staff to a ward.
MS NELLIGAN: So there are two elements, there is the element of staffing a ward on a shift-by-shift basis and there would have been manual rosters to do that and then in terms of allocating establishments, I think maybe that's later on, that was something that was done manually, if at all, at that time.
MR COKE-SMYTH: Is it right that at the beginning of the relevant period, the decisions as to how many staff you

had on a ward would have been a matter for the professional judgement of the person in charge of that ward; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: You describe how -- and I am looking here at 1.13. Sorry, just to be clear, the person who would have been allocating those numbers or using that judgement would have been the Ward Manager?

MS NELLIGAN: Correct.

MR COKE-SMYTH: As you set out in your report, following the Mid Staffordshire Inquiry and the Francis report in 2014, the National Quality Board was set up and guidance was issued to all trusts to review their nursing staffing establishments on each ward and to report that review along with any recommended adjustments to their trust boards for approval. The purpose of that was to address potential harm to patients; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: It also sought to provide greater accountability and oversight in respect of staffing; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: One aspect of that was that something called staffing fill rates had to be displayed.

MS NELLIGAN: That's right.

MR COKE-SMYTH: A staffing fill rate, am I right, that is where a number of staff required on a ward are identified, say, for example it is identified that there are 10 staff needed on a ward, the fill rate would be the percentage of those staff that actually worked on shift on that ward?

MS NELLIGAN: That's right. There is two elements. So the staffing on the ward would be displayed and normally that would be by numbers. So clinically required five staff, two Registered Nurses, three Healthcare Support Workers, and actually on duty there was one Registered Nurse and four Healthcare Support Workers.

So it was visible to everybody on the ward what the nurse in charge thought that they needed to deliver clinical care on that particular shift and what was actually achieved on that particular shift. That then was reported, then, through the systems and processes, corporately, to come up with a fill rate for that particular ward and then the fill rates then were all put together into a monthly report that went to board and went in nationally to the Department of Health.

MR COKE-SMYTH: So at a very basic level, if the requirement was identified as 10, but in fact only eight members of staff worked --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- you would have a fill rate of 80 per cent?

MS NELLIGAN: That's right.

MR COKE-SMYTH: Just focusing on the NQB and the impact of that and those systems, how effective was that in your experience of ensuring safer ward staffing?

MS NELLIGAN: I think the application of the guidance and the requirements differed and varied across the country but, in my own personal experience, I think it was very positive because it put a focus on nursing and staffing of patient care and safety at the very front line, and brought that through to board, so that it was visible and boards knew where they had shortages and where the potential harm to patients could come. And, as a result, a lot of organisations reinvested in their staffing of their establishments and adjusted their establishments to meet those needs and that looked at the skill mix of those establishments as well.

So where it was done correctly it was very effective in raising up the establishments of wards.

MR COKE-SMYTH: To what extent would you say staffing of nursing continues to be an issue nationally in mental health units?

MS NELLIGAN: It's still an issue. There's a number of vacancies nationally on mental health wards and in

mental health in general. And those vacancies -- and it's vacancies and absences, so there is a number of things that are impacting on shortages -- and they are filled by temporary staffing but also recruitment overseas, and the last count that I saw that there was 13,000 vacancies for mental health nurses in England in 2023 and there was a 26 per cent reduction in applications to do mental health nursing in the UK.

MR COKE-SMYTH: So still very much an issue today?

MS NELLIGAN: Still very much an issue.

MR COKE-SMYTH: You go on at 1.15 to deal with more recent evidence-based staffing tools and you describe there the introduction of the mental health optimal staffing tool in 2019 and that was something commissioned and funded by NHS -- sorry, by Health Education England -- and you describe how it measured dependency and acuity levels for patients and enabled nursing staff to use that to calculate the staffing they needed on a ward. You say it wasn't mandated or universally applied and where it was needed it was adapted to take account of variations at unit level.

Can I just understand how that tool differed to previously using electronic roster. So what's the difference between that tool and what you had previously?

MS NELLIGAN: So we still require both tools the eRoster, the rostering tool, looks at rostering on a shift-by-shift basis over a period of time, with the number of staff that are allocated to that particular roster.

The MOHOST tool, what that did was when you were doing staffing reviews, and you were looking to review how many staff you needed in an establishment for a particular ward, that work had been done up to this point by using professional judgement. What this tool did was give an objective database tool to add to that professional judgement and to be able to triangulate the information in terms of your professional judgement, what the tool gave you in terms of calculation of numbers and quantitative data, and also you would use your patient experience and your staff experience to come up with what -- the number of establishment you should have for a particular ward.

MR COKE-SMYTH: How effective has that tool been in your experience?

MS NELLIGAN: I think it varies from speciality to speciality and ward to ward. I think, in my experience, it is a tool that works to support the process of staffing reviews. But I don't think it's a tool that would necessarily be a blanket approach to all staffing

reviews and/or to be used on its own. You still require the professional judgement.

MR COKE-SMYTH: You have identified issues with shortages of nurses in particular. Are you able to summarise the factors, the key factors, which, in your experience, have driven that or affected that shortage?

MS NELLIGAN: I think I touched on it in terms of the recruitment and the commissioning of Registered Nurse placements but also, over time, wards have not -- have become quite complex areas to work in and also with the development of community teams and services in the community, a lot of -- and I am speaking in general terms -- Registered Nurses have moved from inpatient areas to community teams.

There's also the terms and conditions are better in community teams. So the majority of Registered Nurses, for example, on a ward would be a Band-5, which is entry level remuneration, and in community teams it is the next level up. So that's one factor of people moving.

Also, there's a lack of career progression working on a ward. If you go back to when I described one Ward Manager Deputy and a number of clinical leads, it means there is limited ability to -- for career development. So often people left. And then the work also is quite complex and can be distressing and it also affects

people's morale and sickness levels.

MR COKE-SMYTH: Thank you. You have described the increasing reliance on Healthcare Support Workers. Again, just in general terms, are you able to help us as to what the impact of that has been, so the increased use of Healthcare Support Workers?

MS NELLIGAN: Yes, in general terms. Healthcare Support Workers are valued members of the team and -- however, as time's progressed, with the shortage of Registered Nurses, it's not necessarily the right balance.

So, for example, if you think if you had maybe six or seven staff on a ward and you have one or two Registered Nurses, the ratio is very heavily on the Healthcare Support Workers and, if you think about the discussions that we had earlier today about the complexity in patients, it is my opinion that the most complex patients should have the person supporting them with the most skills and education.

THE CHAIR: We talked earlier about therapeutic treatment a bit and you have in your statement. Is that something you would expect in terms of observations, for instance, that a healthcare support worker would be able to do as a therapeutic treatment or --

MS NELLIGAN: I think there's levels, that the Healthcare Support Workers will have training and will have

development and support but it is not to the same level that a Registered Nurse will have. So I don't think we can expect the same intervention and the same outcome.

THE CHAIR: Thank you.

MR COKE-SMYTH: One of the things you refer to in your report is the minimum of two Registered Nurses for a ward to allow at least a break and to have someone always on the ward.

MS NELLIGAN: Yes.

MR COKE-SMYTH: But, in your view, in fact, it would be preferable to have three nurses and that's because that allows someone to always remain supervising and it allows obviously more ability to deliver one-to-one care; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: How practical or achievable is that, in your view?

MS NELLIGAN: I think, first of all, there has to be an acceptance that that is a good thing to do and there has to be the resources available to meet that. And, of course, the next thing then is getting the Registered Nurses to fill the posts.

However, in my opinion, if you increase the Registered Nurse and you strengthen the retention of Registered Nurses on the wards, you will improve the

quality of care provided to patients. You will improve the morale of the clinical team and the outcomes can be better for everybody. But to do that, you have to take a step in that direction.

Now, in some areas -- and there will be shifts where there is more than three Registered Nurses on, for example in older people's service, but predominantly in my report I am focusing on acute care and, in acute care, it predominantly tends to be two Registered Nurses per shift.

MR COKE-SMYTH: You also set out other staff who support and also work with the nursing team by way of the multi-disciplinary team, and it's right there are a number of other professionals who will also assist on an inpatient ward and in terms of sessional interventions, that would include, you describe at 1.19, primarily occupational therapists and psychologists; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: You also describe various other roles, shared across a number of wards normally, roles such as physiotherapists, dietitians, podiatrists; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: There, as you describe, that would not be

just for one ward, they would be across a number and, generally speaking, would be not 24 hours but 9 to 5?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: You also describe at 1.22:

"In addition to providing individual assessment and treatment of patients, the MDT also participate in meetings which are generally held at ward level weekly."

There's also been reference in the report to "daily huddles". Can you just help us as to the difference between the daily huddle and what you are talking about there, the weekly MDT meetings?

MS NELLIGAN: So over the period of time, there's been a number of variations of meetings that have evolved within mental health units and, generally, there has always been a multi-disciplinary team meeting, which tended to be weekly, there had been a ward round that was weekly. But, in recent times, huddles have come to the fore and they tend to be, generally, daily and the objective of those meetings is to speed up decision-making in a multi-disciplinary way, bringing the team together to make decisions to support the recovery of the patient and to support the delivery of their care plan on a shift-by-shift basis and those meetings normally take place in the morning.

So they are looking forward to the day in terms of

any activities for patients: are they still safe, for example, to go on leave; are there any changes in their presentation; is there anything that we need to make a decision on, in terms of discharge arrangements? Those types of discussions and decisions.

MR COKE-SMYTH: So just to summarise, the daily huddle is preferable to the weekly MDT and that's something that has developed as the period has gone on?

MS NELLIGAN: Yes.

MR COKE-SMYTH: The daily huddle is something which you would expect to be a multi-disciplinary meeting, as it were?

MS NELLIGAN: Yes.

MR COKE-SMYTH: I think it might be helpful just to bring in Dr Davidson at this point because he's referred to the weekly consultant ward round and you have described, I think, in your report better practice also being the daily huddle; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: The reason for that being that the weekly ward round is not frequent enough, it can often lead to delays in decisions about care and, in summary, the daily huddle is more effective; is that a fair summary?

DR DAVIDSON: It is. In addition to that, weekly ward rounds are very stressful for patients on the ward. You

are brought in, in front of a group of people and questions are fired at you. You are supposed to remember all the things you want to raise for the next week. It, so it was not a very good. So it was often used to try and assess someone's clinical state and it was not fit for purpose for that that's much better done in one-to-one meetings. So the old-fashioned weekly ward round tried to do both those things and wasn't the best way of doing either of them.

MR COKE-SMYTH: In terms of the relevant period and timeframe, and I don't know who can best answer this, but at what point would you say, roughly, the move happened between the weekly ward round or meeting and the daily huddle?

DR DAVIDSON: So I don't think you can put a date in the calendar on it but, over the last decade, huddles have become more frequent. It didn't mean the weekly ward round went but, gradually over time, as huddles have become more established and people have got more confidence in them, the weekly ward rounds have gone. It doesn't mean there can't be multi-disciplinary meetings, for example, or discharge meeting but the old-fashioned weekly ward rounds are gradually being phased out as the huddles have become more embedded.

It would be wrong to say that's the norm, it is

moving towards being the norm but I don't think it is yet the norm.

THE CHAIR: To be clear at the huddle the patient is not there but somebody will have spoken to the patient on a one-to-one basis?

DR DAVIDSON: Absolutely. The intention is there should be no surprises. So the intention is the person will have a one to one, they will know what should have happened yesterday. The huddle has two basic functions, as Maria said: one is did we do everything yesterday we should have done, and, if not, maybe multiple reasons why it didn't get done, we need to reallocate it today to avoid further delay; the second is, "What is it that needs doing today to move things forward?"

So there should have been discussion each day with the person on a one-to-one saying, "This is what was discussed this morning", you know, but it does the idea is not to reduce the ability to do one to ones. It's not to reduce the time you might spend with your consultant psychiatrist, or your psychologist, or your OT. It is to help to bring that into more dynamic process that you are not having to repeat yourself all the time and you are not having to try and remember everything in one very highly stressful meeting.

MR COKE-SMYTH: Thank you.

I want to move on now please to another aspect of your report, Ms Nelligan. You deal in section 4 with access to basic and essential care standards and, just before I go into that, would it be right to say that, in terms of the patient experience, once a patient is admitted or a person is admitted to the inpatient ward, their day-to-day care and contact will be the responsibility of the nursing team?

MS NELLIGAN: Yes -- excuse me. Yes.

MR COKE-SMYTH: It's also right, isn't it, that the nursing team will be responsible for the safety of the ward environment --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and the nursing team are also primarily responsible for delivering much of any care plan; is that right?

MS NELLIGAN: That's right, in general.

MR COKE-SMYTH: So looking at 4.1, so once a patient has been admitted, it is right that the first thing that will happen is that there needs to be an assessment or reassessment of the patient's needs to inform the care plan; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: You say there that that should be a jointly written care plan with patient, careers and families and

the clinical team on admission.

MS NELLIGAN: That's right.

MR COKE-SMYTH: It is right that that process will be governed by local documents but that local document or policy will be informed by national guidance?

MS NELLIGAN: That's right.

MR COKE-SMYTH: You set out at 4.1 some of that national guidance and it may be helpful just to pause there and identify what that is because it is right that that's what is going to feed into any local policy we see --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- or certainly ought to.

The first national guidance you refer to there is the Care Programme Approach 1991.

Can you just tell us, in very brief overview, what the Care Programme Approach was?

MS NELLIGAN: So in terms of the Care Programme Approach, it set out some standards and principles that I think are also reflected in guidance that came afterwards, like the NICE guidance, and those principles around person-centred care, around treating people as individuals, treating people with respect, around having a written care plan, around engaging with families and carers and having their views taken and listened to and being part of developing that care plan and the delivery

of the care plan.

It's true to say that the CPA, over that period of time, evolved and changed and the intention was to try and standardise things across the country. And, obviously, it was implemented at various levels and a lot of that standardisation was in the form of documentation but it was fair to say that there was two levels within that, and one was enhanced CPA and one was standard CPA, and the enhanced CPA had specific conditions with that, in terms of the resources that people received, one of those being the allocation of a care coordinator, which I think we picked up in Dr Davidson's report.

And just in terms of when a patient is admitted to the ward, obviously there will be some handover and some discussion with that Care Coordinator and the receiving team on the inpatient ward.

MR COKE-SMYTH: So just focusing then on how that developed into the relevant period. You have referred to, in your report, NICE guidelines.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Did those NICE guidelines, in effect, pick up aspects of the Care Programme Approach and put them into guidelines?

MS NELLIGAN: In general, the principles were the same and

those principles around person-centred care, involving families, having a written care plan that was written collaboratively with, with the service user and the patient and their families, and the patient having access to that care plan, and then NICE went on further and talked about the types of interventions that patients should have, the time that they should have with different individual practitioners.

So it expanded on some of the elements in the Care Programme Approach, in terms of the services that should be provided to patients as an inpatient.

MR COKE-SMYTH: I think it may be helpful if we just look at the NICE guidelines you refer to, which are from 2011. Those guidelines you reference in your report are, "Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services"; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: I am just going to ask if we could have those NICE guidelines up on screen. We can see them there, so published December 2011.

MS NELLIGAN: Yes.

MR COKE-SMYTH: If we move on to page 2, we can see there "Your responsibility", and we can see:

"The recommendations in this guideline represent the

view of NICE, arrived at after careful consideration of the evidence available."

It states there:

"When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian."

If we go forward and look at page 4. We can see in overview this covers components of good experience of service use. It aims to make sure that all adults have the best possible experience, and we can see:

"Who is it for?

"Health and social care professionals and practitioners ...

But it also applies to non-clinical staff as well, and, moving forward, we can see some of the areas it addresses.

Firstly, if we look at page 7, 1.1.1, one of the principles here is:

"Work in partnership with people using mental health

services and their families or carers."

If we look at 1.1.14, page 11, we see there "Involving families and carers", it says there:

"Discuss with the person using mental health services if and how they want their family or carers to be involved in their care."

And we can see it makes clear, looking at the final sentence:

"... involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and also managing issues relating to information sharing and confidentiality."

So we see that's an important principle.

MS NELLIGAN: Yes.

MR COKE-SMYTH: We heard earlier from Dr Davidson about some of the issues in respect of information sharing. If we can move forward to page 15, please. 1.3.1 deals, from there on, with assessment. Moving on to 1.4.2, page 17, at 1.4.2 it deals there with developing care plans jointly, this is referring to community care. But is it right that a care plan it follows the patient, as opposed to the other way round.

So there ought to be one care plan whether or not the patient is in the community or an inpatient; is that

right?

MS NELLIGAN: That's right the care plan follows the patient, as you said. That's obviously if the patient is known to the community and has already gone through that process.

MR COKE-SMYTH: We can see also -- I am just going to touch on some of the other areas this guideline covers, page 23, at 1.7, covers the "Discharge and transfer of care", and the first bullet point there:

"Such changes, especially discharge, should be discussed and planned carefully beforehand with the service user and are structured and phased.

"The care plan sports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis.

"When referring a service user for an assessment in other services ... they [should be] supported [in] the referral period and arrangements for support are agreed beforehand with them."

I am not going to touch on this in any detail at this stage but it is also right, if we look at page 26, it deals with some principles in respect of control and restraint and compulsory treatment. So there we have some of the formal guidance from NICE, which you would

expect to feed into local policy and that came into effect in -- or it was published in 2011?

MS NELLIGAN: Yes.

MR COKE-SMYTH: Thank you. I think we can have that down from the screen. Another formal regulation was Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and that also required or had certain requirements in respect of service users, which built upon those principles we have just looked at; is that a fair summary?

MS NELLIGAN: Yes.

MR COKE-SMYTH: So just summarising some of the initial aspects of care, insofar as families and carers, would it be right to say involvement of carers and families is an important part of the initial care plan process?

MS NELLIGAN: Yes, it is an essential part.

MR COKE-SMYTH: In practice, it's right, isn't it, that they will often have best knowledge and best information about the individual?

MS NELLIGAN: Generally, yes.

MR COKE-SMYTH: Is it right that there should be a written care plan?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: That will be a crucial part of coordinating any care?

MS NELLIGAN: That's correct.
MR COKE-SMYTH: And as we have detailed before, the care plan should follow the patient between the community and inpatient care?
MS NELLIGAN: Yes, and back to the community again.
MR COKE-SMYTH: In terms of ensuring standards are monitored, you deal at 4.3 of your report, "standard of care will be set out in local policies and they will be supported by training and supervision", but in terms of ensuring that those are followed, is it right that will be the responsibility of the Ward Manager and also the Quality Matron.
MS NELLIGAN: That's correct.
MR COKE-SMYTH: We have heard about the Ward Manager who is the Quality Matron.
MS NELLIGAN: So Quality Matron is a role that usually is delivered by a person over maybe two, three, four wards and their role is around quality improvement and quality standards and quality assurance and they support the Ward Managers in delivering quality in standards in their wards.
MR COKE-SMYTH: Perhaps just focusing at the lower level on the Ward Manager, can you just give an example of how you might expect them to be monitoring compliance with standards and the policy locally?

MS NELLIGAN: Yes. For a general simple example, for example monitoring of medicine fridges. There will be a procedure, there will be a checklist and there will be an audit to make sure that that's completed and I would expect a Ward Manager to oversee that. But the matron would audit that on a monthly basis.

Now, there is variation in how that's done but I have some experience of doing inpatient safety matrix in a number of organisations where there is a number of quality standards that are monitored by peer to peer on a monthly basis. So in general, in terms of monitoring standards, some of those will be daily, weekly and monthly and they would be carried out by the Ward Manager and the matron.

Other people might be involved in that as well. But, in general, that's their responsibility to oversee.

MR COKE-SMYTH: That would be internally?

MS NELLIGAN: Yes.

MR COKE-SMYTH: It's also right that there is -- we have heard some evidence about this but there is also external monitoring and the external monitor of standards would be the CQC; is that right?

MS NELLIGAN: Ultimately they are the external monitors. Usually organisations will have internal audit as well and that provides another tier of auditing standards and

quality that's delivered in all services.

MR COKE-SMYTH: In terms of care whilst on the ward, you describe at 4.5 nursing interventions as being essential to support the recovery of patients and deliver the care plan at ward level.

Just pausing there. Are you able to just give us an example of a typical nursing intervention at ward level?

MS NELLIGAN: There is a number of interventions from administering medication to giving health education advice to patients, to doing some education work around diabetic management, then to talking and reinforcing their care plan, and down to the details. So, for example, somebody that is self-harming and is maybe on enhanced observation, having conversations and exploring with that patient how they feel, how they are progressing, what makes them keep themselves safe, and exploring how that can be formulated into the care plan and enhance the care plan and reassessing.

So the Registered Nurse is reassessing all parts of the care plan on behalf of the multi-disciplinary team on a shift-by-shift basis and then that's fed back into the huddles that we discussed earlier, as well as informing the nursing team as well.

So it's, it's quite diverse and it's varied, and it

differs from shift to shift, and obviously the experience of the Registered Nurse will also play a part in that. Obviously the more experienced the Registered Nurse is, the more complex those interventions will be.

MR COKE-SMYTH: So you have described that those are nursing interventions which are part of delivering the care plan. Can it be appropriate for those to be delegated to non-registered staff, such as Healthcare Support Workers?

MS NELLIGAN: Yes.

MR COKE-SMYTH: Can you just give an example of that, please?

MS NELLIGAN: So for example, obs, doing observations -- temperature pulse and respirations -- taking bloods, doing support with the individual patient, escorting patients to appointments, escorting them for walks. There is a variety of things that the Healthcare Support Workers do and that's supported by training and obviously supervision.

MR COKE-SMYTH: Can you give an example of something it would never be appropriate for a Healthcare Support Worker to do?

MS NELLIGAN: Well, it wouldn't be appropriate for them to make -- to write a care plan, to do an assessment. They would contribute obviously, but they wouldn't be

accountable for doing -- writing that on their own or putting that together or giving out medication.

MR COKE-SMYTH: In terms of those boundaries and restrictions, would you expect that to be covered in local policy?

MS NELLIGAN: Yes, I would.

MR COKE-SMYTH: Moving on to your 4.7, you identify that over the relevant period, Registered Nurses had less time available to complete psychological and nursing interventions with patients, and you describe that as being due to demands of the ward, shortage of nurses, and increasing requirements to use a variety of IT systems to record things like patient records, incidents, medication, and roster.

I just want to start and explore some of those a little bit more but starting with shortage of nurses. Just in practical terms, can you give an example of how a shortage of nurses might affect a shift on a ward in terms of delivering one-to-one interventions?

MS NELLIGAN: Yes, I can. So going back to identifying the number of Registered Nurses you would need to deliver care clinically on the ward, we mentioned that in terms of the safer staffing question earlier. So it's been identified that clinically there is a need for two Registered Nurses on a particular shift and you only

have one Registered Nurse on that particular shift, the nurse in charge of that shift will have to make a decision about what things are going to continue as planned on the ward, bearing in mind there will be things that are not planned that will happen on the ward, like an admission might come in, there might be a disturbance, there might be an aggressive outbreak. So as well as responding to reactive things that happen on the ward, the nurse also needs to decide what of the planned work that was planned for that shift is going to have to be postponed.

That can include supervision, it includes the one-to-one supervision of other members of staff, it can include also any meetings, and also that one Registered Nurse would also have to seek some support, for example, if there was a multi-disciplinary team meeting on that day, if there was a pre-discharge meeting, a number of things would have to be changed on that particular day and they would have to look to see what the must dos that they would have to do on that shift.

MR COKE-SMYTH: Thank you. One thing that arises in respect of shortages of staff is it might be argued that that can -- certainly, you deal in your report, it increases pressure --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- on the staff that are left. Can that, in turn, lead to an increased use of things like observations or blanket restrictions?

MS NELLIGAN: Potentially, yes. With those pressures and shortages, the Nurse in Charge is going to have to make decisions as I said. With shortages, you might have staff that are in from temporary staffing, that do not know the patients, that do not know the ward. So they will be less likely to do any therapeutic interventions with patients and, as a result the impact on patients can be added to their distress, added to their anxiety and potentially added to any aggressive behaviour or deterioration in people's mental well-being.

MR COKE-SMYTH: You deal with in your report, again, some of the issues arising from lack of available time and the demands on Registered Nurses and, at 4.9, you say that in recognition of Ward Managers raising concerns over the limited time to provide direct care to patients a productive ward series was launched in 2008. That was aimed at releasing time back from administrative tasks to nurses; is that right?

MS NELLIGAN: That's right.

MR COKE-SMYTH: You say that the application of sustainability over time was uncertain.

You then go on to say that not being able to deliver

1 therapeutic interventions to patients is one of the key
2 reasons Registered Nurses leave inpatient units; is that
3 right?
4 MS NELLIGAN: That's right.
5 MR COKE-SMYTH: It's fair to say, in turn, that could be
6 said to be a vicious circle because, part of the reasons
7 nurses can't deliver therapeutic interventions is there
8 not being enough nurses, and you are saying that, in
9 turn, can also impact people wanting to remain as
10 nurses?
11 MS NELLIGAN: That's correct.
12 MR COKE-SMYTH: You say, as a result, there's been
13 a significant turnover onwards as Registered Nurses move
14 to community teams for better remuneration and
15 potentially improved working conditions.
16 MS NELLIGAN: That's correct.
17 MR COKE-SMYTH: Can I just ask this, just to finish this
18 section, to what extent is it still a problem, in your
19 view today, that nurses don't have enough time for
20 one-to-one patient care and interventions?
21 MS NELLIGAN: It's still, still an issue. There's still
22 shortages and, added to that, with the more experienced
23 Registered Nurses, leaving to go and work in the
24 community, more junior Registered Nurses are on the
25 wards and they are still finding their feet and

developing their skills, in terms of nursing. So that then dilutes what, what the nursing team are able to deliver to patients.

MR COKE-SMYTH: Thank you.

I am going to move back now to Dr Davidson. But, Chair, that might be a convenient time for a short break before I do.

THE CHAIR: 15 minutes?

MR COKE-SMYTH: Could I say 10 minutes, so until 3.15, please.

THE CHAIR: Yes.

(3.05 pm)

(A short break)

(3.16 pm)

MR COKE-SMYTH: Thank you.

Dr Davidson, I want to turn back to you and your report, where you deal with inpatient care and treatment at section 4. Can I just perhaps start by summarising some of the aims and just understanding whether you agree that these are aims of inpatient admission or inpatient treatment. Is one of the aims to get the patient to remission?

DR DAVIDSON: Yes, or to sufficient level of remission to carry on treatment in the community, yes.

MR COKE-SMYTH: Is another to prevent or reduce unwarranted

avoidable harms?
DR DAVIDSON: Yes.
MR COKE-SMYTH: Is another to suppress unwanted behaviours or immediate risks to themselves or others?
DR DAVIDSON: Yes.
MR COKE-SMYTH: I think you have already said, in respect of remission, that the point of remission is to get them to a point where they are suitable to discharge to community care.
DR DAVIDSON: With an effective aftercare package, yes.
MR COKE-SMYTH: So, in effect, is it a combination of those things that you are trying to achieve?
DR DAVIDSON: Yes.
MR COKE-SMYTH: Going back then to basic steps, you deal -- and, in fact, before I do, one of the points you make in your report at 4.1 is you describe problems with reasons for admission often being vague and formulaic.
DR DAVIDSON: Yes.
MR COKE-SMYTH: You describe that the problem with that is it makes it hard for the inpatient team to know what they are aiming to do or seeking to do?
DR DAVIDSON: Yes.
MR COKE-SMYTH: Can you just explain what you mean or, if it helps, give an example of that, of vague formulaic reasons which wouldn't be helpful?

DR DAVIDSON: So historically -- and we have done a lot of work on this in the last few years, including through the GIRFT programme, but, historically, reason for admission could be put down as something like assessment. It didn't tell you what needed assessing, why it couldn't be assessed in the community, what was the purpose of it. It would say things like "Detained under the Mental Health Act". Detained under the Mental Health Act is not a reason for admission. It is a vehicle for admission but there has to be a purpose as to why you are being admitted. It would say things like "To keep the person safe". We have already discussed that you cannot guarantee to keep anyone safe.

So it was a meaningless statement, it was a question of what harms were you trying to address here and in what way did you think an inpatient stay would contribute to addressing those harms.

MR COKE-SMYTH: So by contrast, what would helpful or clear reasons for admission look like, as an example?

DR DAVIDSON: So we have now reached -- to take a very simple example, we have now reached a point where person "X" needs "Y", is currently not consenting to "Y" because of them meeting the statutory criteria for admission under the Mental Health Act. They are being admitted for the purpose of "Y" being delivered,

whatever the "Y" was.

MR COKE-SMYTH: Thank you. You deal, in this part of your report with some basic principles at a high level, which represent good practice in respect of inpatient care.

DR DAVIDSON: Yes.

MR COKE-SMYTH: At 4.4, you identify the 10 high impact changes which set out what "good" should look like in terms of basic steps.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Before we look at those, it's right to say that they codified what had been previously known and developed in the preceding years up to 2022; is that right?

DR DAVIDSON: Building on knowledge and best practice over that time, yes.

MR COKE-SMYTH: You say in your report that, if those 10 steps are taken in a person-centred way, that an inpatient admission should be more effective, should take less time to ensure there is an effective aftercare plan in place and ready to deliver, and it ensures the patient doesn't spend longer than necessary in hospital.

DR DAVIDSON: Yes.

MR COKE-SMYTH: You say, fundamentally, they are about being clear why the person requires to be in hospital and what needs to change to let them get back to the community.

DR DAVIDSON: Yes.

MR COKE-SMYTH: I think it would be helpful if we could have up now, please, your Appendix 3 of your report, that's page 63. So there we have the 10 high impact changes in mental health inpatient treatment. Just going through those briefly:

1. Identify the purpose of the admission, set an expected date of discharge, when that purpose is achieved, communicate this with the person, their family and carers and any teams involved in the person's care post-discharge, for example Community Mental Health Team or Crisis Resolution Home Treatment team.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Secondly, complete care formulation and care planning at the earliest opportunity, within a maximum of 72 hours.

DR DAVIDSON: Yes.

MR COKE-SMYTH: So that means at the latest, 72 hours after admission, you will have had an assessment and there will be a plan as to what's going to happen; is that right?

DR DAVIDSON: There should be at least a working plan, so that everyone knows what they are trying to do, which may include need for further specific types of assessment but there should be a plan in place.

MR COKE-SMYTH: Thirdly, identify any potential barriers to discharge early on in admission and take action to address these.

Just by way of example, to illustrate that, what might be a barrier to discharge commonly experienced?

DR DAVIDSON: As we referred to earlier, people can get to the point of being ready for discharge but have no accommodation to go to. Historically, there was too often a tendency to focus on treating the symptoms and then only thinking about need for accommodation when they were well, which obviously creates enormous delays. So the aim is, if it's clear within the first 72 hours that this person is not going to be able to go back to the previous accommodation or indeed has no accommodation to go back to, that you are working on that in parallel with whatever you are doing, rather than sequentially. So the aim is to get things done in parallel as much as possible, rather than in sequential things, which simply adds delay.

MR COKE-SMYTH: 4. Conduct daily reviews, such as the red to green approach, to ensure each day is adding therapeutic benefit for the person and is in line with the purpose of admission.

Again, can you just explain or give an example of something that would be monitored, so an aim that might

be monitored on a red to green approach and how that would work?

DR DAVIDSON: Yes, so, for example, it might be this person needs an occupational therapy assessment, which is due to take place yesterday. If it took place yesterday, that's green; if it didn't take place yesterday, that's red, which means we have to reallocate that today. We would also want to know why it didn't take place but what we can't do is say, "Oh, it didn't take place yesterday, we must think about it, we have to reallocate it". Historically what used to happen is you would see things like "needs referral for this" but day, after day, after day. The aim of this is that you don't do that. You say, "Okay, it didn't happen yesterday, why it didn't happen we can sort out afterwards, but we need to reallocate it today".

MR COKE-SMYTH: So it's ensuring greater visibility and accountability?

DR DAVIDSON: And explaining to the person in the one to one, "We are sorry it didn't take place yesterday but we have set this in train to make sure it happens today".

MR COKE-SMYTH: Number 5 is to hold Multi Agency Discharge Events with key partners on a regular basis to review complex cases.

Number 6, ensure partnership working and early

engagement with the person, family or carers and teams involved in the person's post-discharge support, agree a joint action plan with key responsibilities.

DR DAVIDSON: Yes.

MR COKE-SMYTH: 7 is to apply seven-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays.

DR DAVIDSON: On that one, can I just clarify. Seven-day working in mental health isn't about necessarily having the whole multi-disciplinary team in on a Saturday and Sunday because what often delays discharge is the availability of community services. So seven-day working is that no one should not be able to be able to be discharged on a Saturday or Sunday because there is no service to pick them up. So it's about what are we doing to make sure that if someone is ready to go home on a Saturday that they can go home on a Saturday.

MR COKE-SMYTH: Number 8, identify common reasons and solutions to people being delayed, and you have already given that example there of accommodation.

DR DAVIDSON: Yes, and this is broader than that. It's historically -- as I have already said, we collect tonnes of information in mental health. We actually use and analyse very little of it and even that which is used very rarely is it analysed intelligently. This

helps you to start thinking about people from that area have great difficulty finding accommodation, so we need to be working on that, not on an individual case basis but we have identified now there is an issue in that particular borough or locality, so it enables you not to just reactively respond to things but proactively start to take steps to make sure that is less likely to happen to the next person.

MR COKE-SMYTH: The next one, number 9, is communicate notice of discharge, at least 48 hours prior to the person being discharged, to the person, their family or carers and any ongoing support service and, finally, the follow up to be carried out with the person by the Community Mental Health Team or CRHTT at the earliest opportunity and within a maximum of 72 hours of discharge to ensure the right discharge support is in place.

DR DAVIDSON: Yes.

MR COKE-SMYTH: So two 72-hour formulations, one assessment and plan within 72 hours for admission.

DR DAVIDSON: That's a formulation, the second is more of a check that the plan that was agreed is actually in place.

MR COKE-SMYTH: After discharge?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just to be clear, we know that these were not codified and disseminated formally until December 2022. But to what extent would you say these apply to the whole relevant period?

DR DAVIDSON: The principles apply to the whole period, the specific guidance about how to apply these principles, which is what the 10 high impact changes are, wasn't available. But you should have been planning from the beginning for discharge, and we know that precipitant discharges where people are not given adequate notice and teams aren't given adequate notice they're coming up are harmful.

So the principles applied but, in terms of actually setting out guidance as to how you do it, this is new. But the principles, like I say, were built on long-established practice.

MR COKE-SMYTH: In terms of just involving a family, there is reference to family and carers throughout this, what would you expect by way of minimum in terms of trying to involve the family or carers?

DR DAVIDSON: The minimum is that you should be -- as it said earlier in the NICE guidance, you should be talking with the person about how much they are willing for you to share that's confidential. As we discussed earlier, that does not mean you can't listen to the family or

discuss stuff that's not confidential, so in practical terms, how much involvement there will be, will be variable but, as a principle, you should be seeking to have contact and seeking to establish how you maximise and make the most use of that contact.

MR COKE-SMYTH: So to summarise, there may be reasons why it's not possible but, at a minimum, you would need to at least explore that.

DR DAVIDSON: If it's not possible, to be clearly documented why it's not feasible.

MR COKE-SMYTH: I want to move back to section 4 in your report and your paragraph 4.9. You say that the key therapeutic element of a ward is the therapeutic milieu. This sets the tone against which everything else plays out and it has two main facets: the build environment and the staff culture. So, in effect, one physical to do with the actual place, and the other to do with the people?

DR DAVIDSON: Yes.

MR COKE-SMYTH: I am going to ask Ms Nelligan about those aspects of the report but, before I do, it is perhaps helpful to ask you about some of the high level principles. You deal at 4.12 in terms of the environment, with the need for visibility in lines of observation as a means of reduction and management of

risk, such as fixed ligature points. So that's clearly about creating a safe environment; is that right?

DR DAVIDSON: Yes. A safer environment, yes.

MR COKE-SMYTH: You say there -- and this is perhaps the principle -- that there needs to be a balance between what would be homely and privacy, and the need to reduce avoidable, unwarranted harms to the person, other patients, staff and visitors; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Now, I am not going to go into this in detail now but it's also right that in terms of self-harm, and that's obviously one of the risks on an inpatient ward?

DR DAVIDSON: Yes.

MR COKE-SMYTH: There are specific NICE guidelines which deal with that; is that right?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Those set out key principles of assessment management and prevention. In terms of the environment as well, there are various types of technology, such as video recording and cameras, for example, that have a role in assisting safety. So those are part of the safer environment. Are you able to help us as to just some of the key principles that you believe any practitioner should have in mind when using

technology, so things like CCTV, like video recording?

DR DAVIDSON: They do not replace therapeutic activities, so they should never be used as a reason for reducing staffing levels or saying you can have fewer staff. So they never replace therapeutic activities. What they can do, retrospectively they can tell you if something went wrong what went wrong, they don't tend to help you to prevent something going wrong but they can help to identify that something did go wrong retrospectively, from which you can learn.

They can sometimes alert people to things that they may not otherwise have noticed. Those are the positives. The negatives are that people become over-reliant them and become blind to things that are in front of them, start to believe that these solutions will alert them to everything when they don't, and they also are perceived by many, many people coming onto the ward as very intrusive and counter therapeutic.

For example, you know, most people would say that they would be very uncomfortable if they knew that in their bedroom there were cameras watching them doing things, whether you are in hospital or not. So that is an additional harm that they cause, which then has to be balanced against the benefits.

So with all of these things, whether you are talking

technology, whether you are talking about one to ones or two to ones, you are always weighing up is the harm of this enhanced restrictive practice justified by the benefit for that person at this time? So they should always be on a person-centred basis, they should always be for specific purpose, that purpose should be recorded in the notes, and it should be stopped as soon as it is no longer needed or appropriate.

They also can create a huge cliff face when you come to discharge because, when you come to discharge, the person will not be under that level of scrutiny, they will typically be having perhaps two or three visits in a week. So if you have been suppressing behaviours by using technology to stop them, and then you suddenly remove those suppressors at the point of discharge, you are making it extremely more likely that that behaviour will suddenly become resurgent in the period post-discharge. So, again, if you are working towards discharge, you should be stopping those things well before you get to discharge.

MR COKE-SMYTH: You recognise in your report, obviously, risk reduction and treatment will be required but you go on to say at 4.14 that over-reliance on custodial approaches and things like restrictive practices, such as high levels of nursing observations and low use of

leave off wards can actually lead too longer lengths of stay and overall more harms occurring.

DR DAVIDSON: Yes, I think I go on to discuss leave possibly later in my report but it is fairly critical, yes.

MR COKE-SMYTH: It might be worth just -- I am conscious that we have got limited time so it might be worth just dealing with that now --

DR DAVIDSON: Okay.

MR COKE-SMYTH: -- if we can because it perhaps explains part of your conclusion there. I think in your report you deal with leave and say, in almost all cases, there should be a period of leave before discharge.

DR DAVIDSON: Yes.

MR COKE-SMYTH: The reason for that is that you need to trial leave.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Can you just explain why that is, why that's important?

DR DAVIDSON: Several reasons. One which applies to virtually all cases, is that there is a huge difference between the artificial environment of a ward and being back in the community, so even if someone appears to be doing well in the ward with all the restrictions all the supervision, you can't be sure how they will react when they are out in the real world.

So real world testing is important. If you do it on the basis of structured increased leave, so ground leave, escorted leave, unescorted leave, you are doing it in a step-wise direction and you'll be seeing how they respond to that. That can be about whether or not they will harm themselves or someone else but it can also be about are they able to remember to come back to appointments when they are due to, are they able to time manage themselves and can they, sort of, get themselves to the shops and back. So it's not just about risk in the sense of harm to themselves or others, it is about their wider ability to cope back in the community which you are testing.

If you don't test that and you simply discharge someone from 24/7 inpatient care into the community, that's a huge cliff to go through. You have suddenly lost all that support. If you are out for 15 minutes' leave, and you start to panic, you can come back to the ward and you can get support. If you are out in the community and been discharged, it might take a day or two to get someone to see you. So it is a huge jump for the person, not just in terms of, like I say -- so sometimes we can see it in terms of testing out harm to themselves or others, but it is testing out much more than that.

MR COKE-SMYTH: In terms of assessing that decision on leave, I think you say in your report that the test should not be whether or not harm occurred, the test in your view -- or the question which should be asked in judging that care is whether the decision was reasonable based on the information at the time; is that right?

DR DAVIDSON: That's always the case. You have no control over, apart from when someone's actually on the ward and has no leave given to them, you have no control over what happens once they leave the ward. Even with the escorted leave, people can run off and the nurses that are with them may not be able to keep up with them. So there is a big difference between someone going absent who has no authorised leave and someone who has authorised leave perhaps not using it exactly as you planned.

You can't guarantee that if you give someone leave they will not do something harmful, and going back to this issue about self-harm, we have a paradox in mental health that we don't like certain types of self-harm, such as cutting, which is actually very stress-relieving for a lot of people but we allow people to self-harm through smoking, which is actually much more dangerous, and on wards you will be given time to go smoking but we will restrict your leave if you cut.

Some people, when they go out definitely will cut because that's their favourite way of releasing stress. The aim is to get to the point where you are not needing to do that, rather than it's not happening you have suppressed it because, if it happens when they go out on leave, what it tells you is they haven't actually been able to develop other ways of coping that mean they don't have to do that, which is an important test. It is a safer way of testing it than discharging someone.

So you are testing a lot of things and I probably lost track of your original question, I apologise for that. But it is an essential part. This is why, going back to what Maria was saying earlier, staffing problems which lead to leave being cancelled when there are not enough staff to do escorted leave or when there are not enough staff to check you in and out of the ward, they are extremely frustrating for people who have been promised leave and then can't get it because being couped up with 18 or 20 other people is quite difficult. They lead to more likelihood of people getting upset and behaving in ways that people don't like, like self-harming or whatever.

So leave is a really important therapeutic part of the ward environment and testing and the culture of the ward. If you can't get leave from a ward because people

are frightened that if they send you on leave they might get in trouble, it's not a therapeutic environment.

MR COKE-SMYTH: Thank you. Just going back to the topic we were dealing with, which was the ward environment and how that affects outcomes, just generally speaking, can you just very briefly describe how it is ward environment can improve or worsen patient outcomes?

DR DAVIDSON: Yes, so back in 2000, there were an awful -- I'm not saying they are all wonderful now but, back in 2000, a lot of wards were badly designed, not just dormitories. I mean, dormitories were sort of culturally more common back then, you know, but obviously, being in a dormitory with six or seven other people means that your sleep is more likely to be disturbed, et cetera, et cetera, you don't have privacy. So that was one aspect which has gradually improved.

Another aspect was that they were frequently not designed for one to ones, so actually getting personal time to talk with your nurse or someone else was quite difficult in the ward environment because all the rooms were mixed rooms and the other aspect of this was, by about 2000, we had become more aware that natural light and access to fresh air are critical. That was not perhaps so well -- in the older asylums that was quite common but it sort of got lost when we went into the

acute units and then it got rediscovered that actually natural light is actually therapeutic.

So natural light, space to move about in, space to be on your own when you want to be on your own, but also space to mix with others when it is appropriate to mix with others. It is that milieu.

MR COKE-SMYTH: I am not going to go into any detail but it is right, Ms Nelligan, you deal with there are specific requirements in relation to mental health inpatient wards, you have set those out in your report at paragraph 2.2; is that right?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You also deal there with the need for a good therapeutic environment and you make clear that it's universally accepted that the environment where care is delivered needs to nurture and facilitate recovery, and you also identify some of the historic issues with some of the physical ward environments.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Moving on then to culture. You deal with that in your report, Ms Nelligan. You make clear the importance of ward culture --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and that primarily being the staff; is that right?

MS NELLIGAN: The staff, yes.
MR COKE-SMYTH: You deal with that at 2.12 of your report. You say, in summary:

"A good therapeutic ward, in addition to the environment, will have excellent engagement with patients and carers with a positive culture of respect and compassion."

You also say:

"There will be a general programme of meaningful activities at ward level with each patient having an individual timetable for one-to-one sessions with nurses."

MS NELLIGAN: Yes.
MR COKE-SMYTH: And also other professionals. You also say there will be activities programmed for evenings and weekends --
MS NELLIGAN: That's right.
MR COKE-SMYTH: -- and the ward will have a strong patient group to advocate to their needs which may be facilitated by the Quality Matron.
MS NELLIGAN: That's right.
MR COKE-SMYTH: You refer in your report to, most recently, the Culture of Care Standards in Mental Health Inpatient Services. That was published in 2024 and currently being rolled out nationally; is that right?

MS NELLIGAN: That's right.
MR COKE-SMYTH: Would that contain relevant principles to that issue of culture?
MS NELLIGAN: Yes.
MR COKE-SMYTH: Again, does that represent an accumulation of experience that would be relevant here in terms of -- I appreciate it's been published in 2024 but does it reflect learning up to that point?
MS NELLIGAN: It does.
MR COKE-SMYTH: I am just conscious of time, so I am going to move to just deal very briefly, if I can, Dr Davidson, with the question of therapeutic benefit that you deal with. I am not sure if we are going to have time to go into this but it's right that you prepared an appendix to your report, Appendix 4, and that essentially sets out the key principles in terms of the interaction between therapeutic benefit and reduction of harm; is that right?
DR DAVIDSON: Yes.
MR COKE-SMYTH: You make very clear there, just to summarise in the interests of time, any therapeutic plan or intervention, two broad aims: help improve the person's health to get them back as quickly as possible to their best level of functioning; and, secondly, preventing or minimising unwarranted, avoidable harms. The key point

is that, whilst ideally these two things improve in tandem, one can at times make the other worse?

DR DAVIDSON: Yes.

MR COKE-SMYTH: So it's not entirely straightforward, is the point you make?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You are very clear it is about avoiding unwarranted and avoidable harm?

DR DAVIDSON: Yes.

MR COKE-SMYTH: The key is it is unwarranted and avoidable --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and you make clear that there are no harm-free options in any treatment?

DR DAVIDSON: Yes, that's correct.

MR COKE-SMYTH: I want to deal, Dr Davidson, if I can, with NICE guidelines. Again, very quickly, if I can.

Could we have up, please, the transcript of the lecture provided on NICE guidelines, please, and could we look at page 2. So this is a transcript of a lecture from Professor Kendall and Professor Pilling and, if we look at the bottom of the page, this deals with the status of NICE guidelines. Professor Kendall says this:

"Okay, so what exactly is the status of NICE guidance? So, as I've said, NICE guidance is there to

support the clinician and the service user to make decisions. It's not a substitute for decision-making because decision-making has to take into account preferences, has to take [just going over the page] into account values that the patient's got and so on. So it's there to support that process."

So just pausing there. From your perspective as a practitioner, would you agree with that characterisation of NICE guidelines?

DR DAVIDSON: I do. The other bit which goes into the "and so on" is the practical availability of various types of resource to deliver those NICE guidance so the "so on" is quite a broad term but I agree with the statement, yes.

MR COKE-SMYTH: You say in your report, and for anyone who has got the report it is 4.22, you say, as in all cases, the test will be whether any decision can be clinically justified in the particular circumstances; that's right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: That spans a number of areas, doesn't it?

DR DAVIDSON: It does.

MR COKE-SMYTH: So to summarise, in respect of your view and NICE guidelines from a practitioners' perspective, you agree they are relevant?

DR DAVIDSON: Yes.

MR COKE-SMYTH: You would presumably agree practitioners should have regard to them and be aware of them?
DR DAVIDSON: Yes.
MR COKE-SMYTH: Whether or not doing so is a failure will depend on the particular circumstances -- sorry, whether or not having regard or not having regard is a failure will depend on the circumstances of the patient?
DR DAVIDSON: Yes.
MR COKE-SMYTH: In judging that, from your perspective, it's important to have regard to the information available at the time?
DR DAVIDSON: And the resources available to deliver any particular interventions, yes.
MR COKE-SMYTH: And the resources.

Again, Ms Nelligan, NICE guidance is obviously relevant not just to psychiatrists, it's also relevant to nurses. Is there anything you would add from a nursing perspective or does your opinion accord with Dr Davidson's?
MS NELLIGAN: I would concur with Dr Davidson, and it also applies to multi-disciplinary teams as well.
MR COKE-SMYTH: So, again, expect people to have regard to them, whether or not not having regard is reasonable or not will depend on the circumstances?
MS NELLIGAN: Yes.

MR COKE-SMYTH: I want to turn back, please, to the ward safety environment and you deal with that, Ms Nelligan, in your report in section 3. You identify there that, for the Ward Manager and Nurse in Charge of each shift, ward safety comprises two main areas: patient safety and safety to staff; and the safety of the environment. To be clear, clinical safety is the responsibility of the Nurse in Charge on any shift.

MS NELLIGAN: Yes.

MR COKE-SMYTH: One issue that can arise is instances of violence and aggression?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You deal with that at 3.3. This is, it is fair to say, a very big topic --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and we are only going to touch on this at this stage by way of introduction. But you deal with some of the principles there at 3.3. But do some of the key points include the following: there's got to be adequate training of the staff involved?

MS NELLIGAN: Yes.

MR COKE-SMYTH: There's got to be enough staff to be able to do it safely --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and that may require staff from other

wards.
MS NELLIGAN: That's right.
MR COKE-SMYTH: And it's also right that there is particular guidance now following the Mental Health Units (Use of Force) Act 2018.
MS NELLIGAN: That's right.
MR COKE-SMYTH: That Act requires trusts to provide training to staff, which is adequate to allow them to carry out restraint in a safe way.
MS NELLIGAN: Yes.
MR COKE-SMYTH: You deal with the need for skill in responding to issues such as restraint, and you deal with the challenges at 3.4 in your report, and you refer there to nurses being well equipped to deal with those situations.
MS NELLIGAN: Yes.
MR COKE-SMYTH: But you say it is essential for a Healthcare Support Worker to be supervised by a Registered Nurse --
MS NELLIGAN: Yes.
MR COKE-SMYTH: -- and that's due to the potential complications and presumably risks associated with that restraint?
MS NELLIGAN: That's right.
MR COKE-SMYTH: Just a few questions arising from that, please. Generally speaking, in your experience -- and

I appreciate this is your experience, it's not a scientific evidential question -- but have Healthcare Support Workers generally been adequately trained in the use of restraint?

MS NELLIGAN: Substantive staff, yes. So if we think about the earlier conversation around staffing the wards, the substantive Healthcare Support Workers will have had training the same as the Registered Nurses but temporary staffing may not.

MR COKE-SMYTH: You refer to the requirement for supervision --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- by Registered Nurses. Can I just be clear, is that a national policy or is that something just recognised by the profession more generally: where indeed does that requirement come from?

MS NELLIGAN: I think more generally it is a practice that is required in terms of all interventions that happen on the ward, that could cause harm to patients, need to be supervised by the registrant because they are accountable for the safety of those patients at any one time and for that particular shift.

So this is a very intense intervention, restraint is. So I think that will be reinforced by the training that's delivered now, the training has now been

standardised and is delivered to the standards set out by billed accreditation. I don't think that was as clear maybe back at the beginning of this period.

MR COKE-SMYTH: It may sound like an obvious question but does that supervision require the Registered Nurse to be physically present during the restraint?

MS NELLIGAN: Yes, and to be clear, the Registered Nurse might be participating in the restraint if they are there. But if they are not there, then somebody needs to alert them that this has taken place, so that they can supervise it accordingly.

MR COKE-SMYTH: Again, in your experience, has it been common for there to be instances where restraint takes place in the absence of a Registered Nurse?

MS NELLIGAN: I think it takes place in that it's initiated but I am sure there will be occasions where it may take place without the registrant's knowledge. But I would like to think that that's rare.

MR COKE-SMYTH: But from your perspective, if it does develop, it ought to be quickly supervised by the Registered Nurse.

MS NELLIGAN: Correct.

MR COKE-SMYTH: So you would be critical if there was an absence of that supervision?

MS NELLIGAN: Yes, I would.

MR COKE-SMYTH: One of the environmental risks, and a very common one, again this is a very big topic, so I am only going to touch on it, but one common issue is the issues of ligatures --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- in mental health inpatient wards. You deal with that at 3.12 of your report where you set out that there has been debate over the relevant period with regards to management of fixed and non-fixed ligatures and making environments safer for patients. You say there that one view has been that a safe ward is delivered by removing things and installing ligature reduction aids, such as door top alarms aimed at preventing all self-harm incidents.

You go on to say at 3.13, as time has progressed, there's been a greater appreciation of the dynamics of delivering inpatient care?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You say that no environment can prevent all risk, and environmental modifications are not a replacement for therapeutic engagement and interventions delivered by the nursing team.

MS NELLIGAN: Yes.

MR COKE-SMYTH: Very briefly, you have referred to there being a debate but can you just summarise the two sides

of that debate, so we are clear what was being argued?

MS NELLIGAN: Yes. Over a period of time, I guess, whether -- the debate was that if we remove all the potential harms and the potential ligatures, then we are in a better position to keep people safe but, of course as we have heard and we have discussed through Dr Davidson's report, it's not as simple as that.

So through the period of time there's been, I suppose, discourse, rather than debate, about how we should be supporting people, what kind of environments there should be and I guess making sure that we keep at the front of our minds the importance of engagement in therapeutic interventions. So the balance about the environment is just one element about people's care, it's not the sole and the front of preventing risk within inpatient care.

So it's been a kind of an evolved discussion that has got us to this point, where the point being now: the environment is there to support the delivery of care, it's not the primary focus on delivering care, and we are more considerate about the realignment of that focus being on therapeutic and therapeutic engagement in care and not reliance on the environment to keep people safe.

MR COKE-SMYTH: You refer in your report to guidance published towards the end of our relevant period in 2023

by the CQC reducing harm from ligatures in mental health and learning disability. Has that had the effect of resolving or clarifying that debate and giving greater certainty to those practising?

MS NELLIGAN: Yes, it does really focus very much on that therapeutic and that engagement and interventions with people and that the environment is secondary to that focus.

MR COKE-SMYTH: I want to turn briefly now, if I can, please, to observations. You deal with that at section 5 of your report and you describe there how there's been a discourse about observations and, over the relevant period, language has changed and you say that wards have become more dependent on this intervention as acuity increases and there is more focus on risk prevention or harm minimisation, and you say:

"Each locality has their own policy and there may be differing terminology. The purpose of observations is to monitor change in the person's presentation and to monitor and prevent risks associated with it."

So just pausing there. When you say there has been a discourse about observations, is that part of that same discourse of balancing restrictive practice against therapeutic benefit?

MS NELLIGAN: Yes.

MR COKE-SMYTH: So similar issues to that which you have referred to in respect of ligatures perhaps?
MS NELLIGAN: Yes.
MR COKE-SMYTH: You then go on to set out the different types of observation and perhaps we can just summarise those. You say, at a minimum, all patients on a mental health ward should be on general observations, known as level 1 and that involves observations carried out by a Healthcare Support Worker at hourly intervals and essentially checks include whereabouts of patients which are then recorded; is that right?
MS NELLIGAN: That's right.
MR COKE-SMYTH: Enhanced observations would be from level 2 to 4; is that right?
MS NELLIGAN: That's correct.
MR COKE-SMYTH: Level 2 generally being intermittent observations, 15 to 30 minutes.
MS NELLIGAN: Yes.
MR COKE-SMYTH: Level 3, one to one continuous observations within eyesight.
MS NELLIGAN: Yes.
MR COKE-SMYTH: Level 4, continuous observations within arm's length of staff; is that right?
MS NELLIGAN: That's correct.
MR COKE-SMYTH: You say at 5.3, they should be allocated on

a least restrictive basis --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and there should be a rationale recorded.

MS NELLIGAN: Yes.

MR COKE-SMYTH: You describe at 5.4 debate over who could, in fact, prescribe or allocate enhanced observations, so beyond level 1 --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and, in your view, good practice dictates that should be a multi-disciplinary decision; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: That's also going to be informed by local policy?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: Is it right there's no -- we have heard about the CQC guidance on ligatures but is it right there is actually no national guidance in respect of observations?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: From a practitioner's perspective, would further guidance on that be of assistance?

MS NELLIGAN: It would.

MR COKE-SMYTH: Just in outline, what would you expect that to say or require?

MS NELLIGAN: I think the terminology and some standardisation of the terminology would be really helpful and beneficial to improve practice because people move from different hospitals, different localities, and communication is so important for making sure that there is an understanding of what people are communicating in terms of observations and in terms of different frequencies in terms of the time. I think it would also help in terms of when things go wrong and when there are incidents and reviews post-incident, that there is a set of standards and principles that we all are aware of and we all understand and have signed up to. And that in turn would support the staff at the front line that are carrying out this policy and these interventions.

MR COKE-SMYTH: So it would help by giving a degree of consistency and clarity for staff?

MS NELLIGAN: Consistency, yes.

MR COKE-SMYTH: I want to turn now, very briefly if I can, to reassessment and evaluation, or re-evaluation. You deal with that at section 6 of your report.

Just summarising briefly, if I can, you say that, following an agreed assessment, every clinician considers any amendments to that assessment on every subsequent occasion they are in contact with the patient

and, for nurses, they would need to consider the steps of assessing, planning, implementing and evaluating on a continuous loop. So that happens every time they see the patient they don't just assess them at the beginning and come up with a plan, they have got to keep looking at that, essentially, every time they see them?

MS NELLIGAN: Correct.

MR COKE-SMYTH: Changes in presentation will be formally and informally discussed by nursing teams in huddles, handovers and with the multi-disciplinary team, and you say that the purpose of reassessment is to evaluate the care plan and the care that's provided to the patient, and you are checking that it's being effective in reaching the agreed goals; is that right?

MS NELLIGAN: Yes.

MR COKE-SMYTH: You also say it is essential that the patient and their family and carers are part of that evaluation --

MS NELLIGAN: Yes.

MR COKE-SMYTH: -- and you also make plain that no evaluation or re-evaluation of care and treatment is effective without it being accurately recorded.

MS NELLIGAN: Correct.

MR COKE-SMYTH: The reason for that being it's not recorded, someone else picking up care isn't going to know about

it and they can't do anything about it; is that right?
MS NELLIGAN: Exactly.
MR COKE-SMYTH: The document also has to be shared by way of a care plan with the patient and, in summary, you say that reassessment should take place following any significant incidents, both positive and negative; is that right?
MS NELLIGAN: Yes.
MR COKE-SMYTH: I want it turn back, please, to Dr Davidson for the final stage of the inpatient care journey, which is pre-discharge planning and post-discharge care. You deal with that at section 5 of your report, and it's right, actually, in summary, much of the principles here are codified and reflected in the 10 high impact changes; is that right?
DR DAVIDSON: Correct.
MR COKE-SMYTH: So far as those deal with post-discharge planning, we can say those that are contained in the 10 high impact changes, all relevant here, so the 72-hour follow up?
DR DAVIDSON: Yes.
MR COKE-SMYTH: There's got to be some form of plan?
DR DAVIDSON: Yes.
MR COKE-SMYTH: There's got to be some form of mechanism for it to be checked up upon?

DR DAVIDSON: Yes.
MR COKE-SMYTH: And that has to take place in 72 hours?
DR DAVIDSON: As a minimum.
MR COKE-SMYTH: At 5.8 of your report, you deal with the aftercare plan and you say there, "There is no perfect aftercare plan", and you make plain there the limited ability to influence what happens post-discharge from the perspective of those practising on an inpatient unit.
DR DAVIDSON: Yes.
MR COKE-SMYTH: You refer at 5.8 to some elements of ongoing supervision or control. You refer to the community treatment orders and conditional discharge under the Mental Health Act and, just pausing there, can you just tell us very briefly what those are, so, firstly, the community treatment order?
DR DAVIDSON: So in essence the community treatment order is that there will be certain elements of the care plan which are in there as being necessary to be agreed to by the person to get discharged, so they have got to agree to those things, and then, if they don't adhere to those things, you can't just recall them because they haven't adhered to those things, but if they haven't adhered to those things and, as a result of that, they are starting to relapse or you expect them to relapse, then you can

recall them to hospital to carry on treatment.

You can't use it to compel treatment in the community but, obviously, the knowledge that you may be recalled to hospital has an effect upon people's decision-making that it might be better to take the treatment than go back to hospital. It also has things like where you should reside, that you should have contact with the care team, that they can actually review how things are going. But what it doesn't do is enable treatment in the community. What it enables you to do is more rapidly bring that person back to hospital if the indication is they are not complying with the aftercare plan and this is likely to cause significant issues.

MR COKE-SMYTH: So you don't have the added hurdle of Section 2 and Section 3, if they are already on a community treatment order; is that right?

DR DAVIDSON: It is a much simpler process to call someone back, yes.

MR COKE-SMYTH: Conditional discharge, again, just an overview?

DR DAVIDSON: So conditional discharge comes with more restrictions, it comes as a result of court decided what are called Part 3 Sections of the Act, but it's similar in principle that there will be certain elements of the

aftercare plan you must agree to, to be discharged, and again it doesn't enable treatment in the community to take place but, again, if you don't comply with those compulsory elements of the aftercare plan, that should trigger reviews and reassessments and such that if there is reason to believe that you are relapsing or about to relapse, then you can be brought back to hospital for necessary treatment. That's a very simplistic view of both.

MR COKE-SMYTH: I appreciate that and grateful for the overview. I am sure we all understand that's a very short summary.

You say at 5.10, you identify there the need to balance resources across all those who need them and this is in terms of dealing with discharge planning and you say that the service aim has to be good enough rather than perfection, as giving too much to one leaves less for others. So the point you are making there, going back to resources, whatever you plan post-discharge must be deliverable within the resources available.

DR DAVIDSON: And it is a delicate balancing act. If you go back to the issue about Care Programme Approach that Maria and you were covering, enhanced requires a care coordinator. Most teams have a limited number of slots

per care coordinator. So who -- you might, for example, have 90 slots for care coordination on a caseload of 300, so which 90 get it and which 210 aren't getting it, they all have SMI, the question is which ones. And it is therefore an ongoing process in the community as to how you balance who most needs that input at the present time. It's not fixed that you will get this forever, it is a question of balancing the needs of different people, which is -- as Maria said, things can change unexpectedly and you have to make sudden critical decisions.

MR COKE-SMYTH: I want to finally just deal with one other aspect of inpatient units and that is sexual safety in mixed wards, which you deal with, Ms Nelligan, at section 7 of your report. Again, I am going to deal with this quite briefly.

You say at 7.1 that over the relevant period mixed-sex wards were commonplace and you say it may be more difficult to provide sexual safety on mixed-gender wards, however single-gender wards are not necessarily safer.

Can I just start by exploring that a little bit, if I can, please. When you say single-gender or single-sex wards aren't necessarily safer, do you mean aren't necessarily safer from a non-sexual safety point of

view?
MS NELLIGAN: Both. So I think the assumption is that by addressing same-gender wards, that there will never be any sexual assault, and that's not necessarily the case because it's not necessarily the perpetrator is from the opposite sex.
MR COKE-SMYTH: So the point you are making is that it can cross sexes?
MS NELLIGAN: Yes, yes.
MR COKE-SMYTH: It's right, just in terms of guidance, you set that out at 7.2, "Delivering same-sex accommodation", NHS England 2019 guidance, updated previous guidance from 2009-10, with the requirement of national mandatory reporting of breaches of mixed-sex accommodation. The requirement and focus, you say, brought improvements and privacy and dignity for patients and the premise of the guidance was there should be zero tolerance to mixed-sex accommodation in NHS-funded accommodation.
MS NELLIGAN: Yes.
MR COKE-SMYTH: You highlight that, in 2014, the CQC included this requirement as part of an amendment to the Health and Social Care Act 2008?
MS NELLIGAN: Yes.
MR COKE-SMYTH: But you point out that in some specialities,

such as young people, learning disabilities and substance misuse wards, by nature of being specialist wards and standalone units, it's not always possible to achieve that?

MS NELLIGAN: Correct.

MR COKE-SMYTH: In summary, at 7.9, you say that single-sex or gender wards are seen to be safer and provide more privacy and dignity for people. They are well received particularly by female patients where they can feel safer during times of vulnerability and distress. However, you say that eradication of these wards nationally varies from locality to locality; is that right?

MS NELLIGAN: That's correct.

MR COKE-SMYTH: Thank you, Ms Nelligan.

The final topic I want to touch on is with you, Dr Davidson, and that's section 6 of your report where you deal with investigation, review and accountability.

It's right that we have heard evidence from the CQC and others about the formal incident reporting framework, so I am not going to go into that here, but I am going to ask you about some of your experiences from the perspective of a practitioner during the relevant period.

You say in your report at 6.2 that there was a push

to report more incidents through the relevant period including incidents with zero or low harm; is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: Can I just understand where that push came from in your experience?

DR DAVIDSON: That's broader than healthcare. In safety-conscious organisations one of the lessons is that if you wait for harm to occur, you have probably waited too long.

So though it is right that there should be focus on things that might have led to serious harm, unfortunately sometimes in the Health Service it went too far the other way and so things were being categorised as near misses when they weren't. For example, someone coming back five minutes late from their leave is not a near miss, but it was categorised as a near miss and then that led to people not wanting to report them or not wanting to send people on leave because they've got to fill in the form. So there were unexpected, inadvertent consequences of broadening it too wide.

But the general principle is that you shouldn't wait for harm -- if something was a near miss, it should be reported, even if no harm occurred.

MR COKE-SMYTH: From you having described that being a push to report more incidents, does it follow that there was, insofar as you experienced, an increase in incident reporting over the relevant period?

DR DAVIDSON: I believe there was an increase. I believe it was very patchy and, as I say, there were a lot of factors which went into whether or not people did report it or whether or not they didn't report it, which you would have to look at on a case-by-case basis, rather than a general answer.

MR COKE-SMYTH: You say at 6.8 of your report, dealing with reviews, you say:

"Over time, concerns mounted about the effectiveness of approaches in leading sustainable service improvement. These came from clinical staff, operational managers, people in contact with the services and their families and wider organisations."

You say:

"At the same time, the Government introduced a duty of candour relating to concerns that organisations were concentrating too much on avoiding serious untoward incidents and reputational damage, to the detriment of having an open learning culture by showing candour to help better address these."

You say it wouldn't be correct to imply that the

duty of candour has now led to full transparency but it's helped tilt the balance back towards a more learning than defensive mindset to some extent.

DR DAVIDSON: I would agree with that. I have not spelled it out well, in the sense that I have no objection to trying to reduce serious untoward incidents. I was talking about the emphasis on serious untoward incidents of a reputational type taking precedence over other types of serious untoward incidents.

So I have no objection to trying to reduce, as I say, unwarranted, avoidable harms but reputational management sometimes gets in the way of dealing with that.

MR COKE-SMYTH: You have highlighted there the duty of candour but it's fair to say you are not unequivocal in your report about the impact of that. Would it be fair to say perhaps still some way to go in practical terms?

DR DAVIDSON: It is a good thing. It's a good thing. It is not clear that it is being done routinely, as you might expect from the guidance, but I think it's improving.

MR COKE-SMYTH: Put simply, it remains an issue?

DR DAVIDSON: It remains an issue.

MR COKE-SMYTH: One final question on that paragraph: over the relevant period and when you're looking at incident investigations and reviews, generally speaking, would

you expect family members and carers to be informed and involved in those processes?

DR DAVIDSON: I would. I would also expect that, wherever feasible, there should be family liaison officers because it's very stressful for families and others to be involved and, without the support of family liaison officers, that can be much more difficult to practically do. So, yes, it is important to involve them but it's also important that they have proper support while they're involved.

MR COKE-SMYTH: Finally, Dr Davidson, I just want to deal with some of the principles that you identify, not necessarily taken from a written policy or bit of guidance, but from your experience as a practitioner and also somebody who has conducted and been involved in these types of reviews. You set those out at 6.17; is that right?

DR DAVIDSON: That's correct.

MR COKE-SMYTH: It may be helpful to have those on screen. That's page 55 of your report -- page 54 on to page 55. You see there, you say at 6.17:

"Regardless of the reporting framework or the tools used the key questions for SUIs involving clinical care and treatment are:

"Was the care and treatment plan in place ...

reasonable and deliverable ... to maximise benefits and prevent/reduce unwarranted, avoidable harms or, if not, why not?"

DR DAVIDSON: Yes.

MR COKE-SMYTH: So, again, consistent with what you have already told us:

"Was the care and treatment plan delivered as planned or, if not, why not ..."

DR DAVIDSON: Yes.

MR COKE-SMYTH: "Did the key decision maker/s make a reasonable decision based upon the information reasonably available to them at the time ..."

DR DAVIDSON: Yes.

MR COKE-SMYTH: "... if not, why not?"

DR DAVIDSON: Again, yes.

MR COKE-SMYTH: That may well involve a focus on systemic factors?

DR DAVIDSON: Yes.

MR COKE-SMYTH: "Was the essential information to make the best decision reasonably available to the key decision maker/s in an accessible, timely format or, if not, why not?"

DR DAVIDSON: Yes.

MR COKE-SMYTH: Finally:

"What can reasonably be done to reduce the

likelihood of further such harms occurring without disproportionately reducing therapeutic benefits to the overall caseload and individuals within it and thus increasing other unwarranted, avoidable harms?"

DR DAVIDSON: Yes.

MR COKE-SMYTH: So perhaps tying together some of your themes and opinions throughout that report and condensing there into that paragraph?

DR DAVIDSON: Yes.

MR COKE-SMYTH: I think we are going to take a break there, Dr Davidson. I am conscious we don't have much time left, but if we could have a short break.

MS HARRIS: Yes, Chair, could we please have a 10-minute break to confirm whether there are any other matters arising. I am not sure, Chair, whether you have any further questions you would want to ask now.

THE CHAIR: I've got no further questions, but we will ask if anybody else has.

MS HARRIS: It will be clear to everybody that we are not going to finish by 4.30 but I understand that we will all be finished by 5.00. That is the latest that we will be sitting, or we are able to sit, but we would welcome 10 minutes to confirm whether there are any other matters to deal with. Thank you, Chair.

(4.24 pm)

(A short break)

(4.39 pm)

THE CHAIR: Mr Coke-Smyth.

MR COKE-SMYTH: Thank you. Dr Davidson, I want to come back with a few further clarificatory questions for you to start with, please. You gave, during your evidence, the example of self-harm and cutting.

DR DAVIDSON: Yes.

MR COKE-SMYTH: Can I just put that evidence into a broader perspective by dealing with some of the other evidence in respect of that which is available.

Would you agree that, on that particular issue, there is also evidence to show that there is a risk of suicide amongst those who self-harm and that evidence suggests it is greater in those who self-harm than the general population?

DR DAVIDSON: It is greater in those who have to manage intense emotions of all types. That's why it's greater in those who smoke more, drink more, use more drugs. So what it's telling you is the person is in an emotionally distressed state. Simply blocking that behaviour does not of itself address the emotionally distressed state and, in fact, if you take away a coping strategy, you can make the distressed state much worse. So it's not an either/or.

MR COKE-SMYTH: No, I understand that. But no dispute that certainly you have said amongst other self-harming behaviours, but it is also an indicator of an increased risk?

DR DAVIDSON: It is, absolutely.

MR COKE-SMYTH: Just a question on the NICE guidance for you, Ms Nelligan. We had up on screen earlier, and it might help to have it up again now, the NICE guidance on service user experience. If we could have that up on screen.

This is just a correction which we are not going to be able to deal with in detail. This was first published in 2011 but it's, in fact, right that it was updated subsequently and the version we are looking at is the most recent version currently in effect. So just as a matter of record, there would have been an earlier version which was first published in 2011?

MS NELLIGAN: Yes.

MR COKE-SMYTH: Thank you.

Another question for Dr Davidson, please. You referenced resourcing at several points in your evidence, for example there being faster discharges to keep within funding. Which clinical decision makers have knowledge of the funding situation and how does that influence clinical decision-making generally

speaking?

DR DAVIDSON: Generally speaking, people don't know the intimacies of the funding situation, but they know what resources are available to them and what demand is available to them and they know that there is a ceiling on what they can do.

So they may not know how much money the Trust has been given by commissioners to do "X" or how much the commissioner has been given by national to do "X", but they will know that they have got a ceiling on what they can do with the resources they have got, and then they have to try and juggle, as I said earlier, the needs of the various people, the people waiting to be seen, the people already on the caseload. You have to keep juggling that.

So you probably are not thinking of it in terms of pounds, but you are thinking of it in terms of what have we got available to deploy here, and how do we do that the best way we can?

MR COKE-SMYTH: A question really for both of you, but perhaps I will start with Dr Davidson because you have referred to this, to compassion fatigue.

To what extent, if at all, would you say there is a correlation between high rates of bank agency and locum staff and increased compassion fatigue and

burnout?

DR DAVIDSON: It goes both ways. So if you have got a lot of compassion fatigue and burnout, you are more likely to have high sickness rates. You're also more likely to have people leaving the job or leaving the profession, as Maria has already said, so you'll end up with more bank agency and locum. It's also true that you have got more bank agency and locum because there is less continuity of care. They may or may not know the unit, they certainly are less likely to know the patients. Those staff who are not bank agency or locum end up having more responsibility placed on their shoulders.

So it's a two-way thing. High levels of bank agency and locum are indicators that there is something seriously amiss.

MR COKE-SMYTH: Ms Nelligan, would you agree with that?

MS NELLIGAN: Absolutely.

MR COKE-SMYTH: Is there anything you would like to add to that?

MS NELLIGAN: No, I don't think so.

MR COKE-SMYTH: This is a question for you, Dr Davidson.

Going back earlier to thresholds. What is the threshold for identifying whether a patient is presenting with signs of relapsing psychosis and clinical risk sufficient to warrant referral to the

Early Intervention in Psychosis team?

DR DAVIDSON: So that's not in terms of relapse, then. That would be in terms of first presentation to Early Intervention team. So is that what you asked about, at what point you get referred to the Early Intervention team or are you asking about how we manage relapses?

MR COKE-SMYTH: I think perhaps, put another way, it's often family members who report symptoms --

DR DAVIDSON: Yes.

MR COKE-SMYTH: -- and they are often reporting the onset of psychosis. At what point will that trigger the Early Intervention in Psychosis team involvement?

DR DAVIDSON: So in terms of the ideal, as soon as there is clear evidence being brought to some clinical team, whether that be a GP, an AMHP, A&E, or whatever, by someone that person "X" is displaying some form of psychotic symptoms, they should be referred to an early intervention team for an assessment as to whether or not that fulfils the criteria for acceptance by that team.

So that's a very -- it's very difficult to pin it down to something specific. But it is designed to be a high index of suspicion. So if there is reason for suspecting this might be psychosis, you err towards referral to an Early Intervention in Psychosis team, rather than not referring. But the Early Intervention

in Psychosis team may or may not determine that it reaches their threshold.

But in terms of everyone else, the thrust should be you err on the side of caution and, if there is any suspicion of psychotic symptoms, you should refer. That's the principle.

MR COKE-SMYTH: This is a question for Ms Nelligan, related to daily ward huddles and you described those earlier in evidence. How does the move towards daily ward huddles impact the approach in inpatient care to family involvement? So who would you routinely expect to be invited to be involved in that process?

MS NELLIGAN: So the daily huddles is not to replace family involvement. The purpose of the daily huddles is around improving decision-making and in relation to the care plan and making sure that things that were agreed to be done the day before, for example, an assessment -- I think Dr Davidson mentioned an assessment has taken place and reallocation. So it's more about allocating more, checking that things have been done, making sure that things are working smoothly.

It doesn't replace the multi-disciplinary team meeting that still happens on a weekly basis with the family advocates and service users there.

MR COKE-SMYTH: So just to be clear, it's the weekly

multi-disciplinary team meeting where you would expect the family involvement, rather than the daily huddle; is that right?

MS NELLIGAN: Yes. In general, yes.

DR DAVIDSON: Can I just add in there, increasingly what's happening is more emphasis has been put on one-to-one meetings so that people have more time, rather than being rushed into a multi-disciplinary team meeting. So it's actually about increasing time to give one-to-one time to families and to people on the ward.

It's not designed to reduce that time. It's designed to increase the availability of staff to have those discussions.

MR COKE-SMYTH: Just still on the topic of daily huddles, are those governed by any particular clinical or national guidelines or is that something that's just developed through practitioners' experience?

DR DAVIDSON: So red to green is an improvement tool, which has been used in the NHS for a number of years. So when I said red to green or equivalent, you should be using that sort of principle.

MR COKE-SMYTH: The daily huddle?

DR DAVIDSON: But that's one of the tools that you would be using in the daily huddle. So the daily huddle is about the multi-disciplinary team coming together each

morning, as Maria said, and checking whether what was done yesterday was done.

So in terms of formal -- is that in NICE guidance? No, that's not NICE guidance. In terms of is that established practice? It has become established practice and it's now underpinned by the 10 high impact changes.

MR COKE-SMYTH: So just to be clear,the daily huddle itself is not something taken from any particular guidance or policy but I think the way you have described it, the red to green system is something that is referred to in the 10 high impact changes?

DR DAVIDSON: Yes.

MR COKE-SMYTH: And the red to green system is something you would expect to use within the daily huddle?

DR DAVIDSON: Yes.

MR COKE-SMYTH: Just one final question for Ms Nelligan: how does the expectation that the care plan will follow a patient throughout their clinical pathway work in practice, particularly given situations where service providers might often have different or fragmented information systems, so how does the move of the care plan work in practice?

MS NELLIGAN: Well, in practice, the care plan is electronic. So moving from community to inpatients

within the same organisation, there's not an issue with that. But it obviously becomes more complicated if the person is going to move to a different organisation and the electronic systems are unable to synchronise. So therefore arrangements will have to be made to send that electronically and also not to forget that the service user would also have a paper copy of that as well and they can also be provided to another provider.

MR COKE-SMYTH: Would it be fair to say that that can create challenges?

MS NELLIGAN: Potentially, yes.

DR DAVIDSON: It's also important to note on that, as I said, the difference between enhanced and standard. You may not be enhanced CPA at the point that you get admitted. In fact, historically, even if you got admitted you didn't necessarily get put on enhanced CPA, whereas now you would.

So this idea of a written care plan, for many, many people the written care plan was simply the note from the psychiatrist that was written to your GP to which you should be copied in or, ideally, it should be written to you and the GP copied in. So it may be as simple as a letter, for people who are on standard, which was -- the bulk of people with SMI were on standard, not enhanced.

MR COKE-SMYTH: Thank you. Those are all the questions I have.

Chair, did you have any further questions?

THE CHAIR: I don't, thank you.

MR COKE-SMYTH: Thank you very much, Dr Davidson and Ms Nelligan.

MS NELLIGAN: Thank you.

THE CHAIR: Thanks both of you, very much indeed.

(4.55 pm)

(The Inquiry adjourned until 10.00 am on Monday, 12 May 2025)

I N D E X