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Report for the Lampard Inquiry:
An overview of good care and minimum standards for delivery of care in mental health inpatients

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Summary of Experience - Dr Ian A. Davidson

I, Ian Alexander Davidson, am registered and licensed by the General Medical Council as a registered medical practitioner and on the Specialist Register as specialist in General Psychiatry. Full details of my qualifications and experience are included in Appendix 5.

I am a Consultant General Adult Psychiatrist at Cheshire and Wirral Partnership NHS Foundation Trust and am to retire from that role in March 2025. I first qualified in 1980 and have been a medical practitioner for over 44 years. My experience includes both inpatient and community general psychiatry and I have maintained direct clinical practice up until 2022.

In January 2019 I was appointed as the national clinical lead in one of the three Getting It Right First Time (GIFRT) programmes; a national NHS England programme designed to improve the treatment and care of patients and to present data-driven evidence to support change.

During my career I have made a number of contributions to the work of the Royal College of Psychiatrists, including as the College’s clinical lead through the original Lord Darzi investigation into the NHS.

I was appointed as the Royal College inaugural Autism Champion between 2017 and 2021.

My clinical leadership and management positions in respect of mental health care have included acting as Medical Director, Deputy Chief Executive and interim Chief Executive at Wirral Partnership NHS Foundation Trust. I also acted as Executive Lead during the Partnership’s inception of its first mental health electronic patient record system.

At a national level, I have worked for the Healthcare Commission, Public Sector Ombudsman and have been a clinical and professional advisor to the CQC and GMC respectively.

As Director of Mersdee Health Limited – a company offering mental health expertise and executive coaching to various organisations, I was employed as an expert in the

Edenfield’s Forensic Unit’s review and recovery process following the scandal at Edenfield Centre in Prestwich.

I have over 25 years of experience in medico legal work, in which time I have acted as an expert witness in civil and criminal cases spanning up to, and including, the High Court. I am also a medical member of the First Tier Tribunal in mental health.

Summary of Instructions and Approach

I was instructed on 3 February 2025 to provide a report to establish the appropriate benchmark for what should be expected by way of minimum standards of care provided to mental health inpatients during the Inquiry's relevant period.

The areas which I was asked to address were:

a. The process for admission and discharge.
b. The makeup (generally) of a mental health inpatient unit. The healthcare professionals that work on a unit.
c. What care should look like?
d. What should happen?
e. What was/is the relevant legislation/guidance in place (recognising this is also health professional specific?
f. What are the minimum standards to be expected?
g. What should happen when things go wrong?

After acceptance of instructions, it was proposed that more detailed topics be agreed at a further meeting with the Inquiry team. It was subsequently agreed that my report would be structured to focus on the following areas:

a. The national context to inpatient care in the relevant period
b. An explanation of Mental Health, Severe Mental illness and the main type of inpatient service
c. Assessment which could give rise to inpatient admission
d. Inpatient care and treatment
e. Pre discharge planning and post discharge care
f. Investigations, review and accountability

I am aware that the Inquiry has instructed a mental health nursing expert, Maria Nelligan, who will focus on addressing the makeup and running of an inpatient unit during the relevant period. I therefore do not seek to address this area in detail and defer to her expertise on those matters falling exclusively within the remit of the nursing profession.

I have also been made aware of the outline of the intended presentations by the King’s Fund addressing the national legislative, policy and regulatory background during the relevant period, and from the Royal College of Psychiatrists, addressing the development and implementation of NICE guidelines during the relevant period.

I have further been provided:

a. The Inquiry’s Terms of Reference.
b. The Inquiry’s List of Issues.
c. The opening statements published on the Inquiry website.

Except where otherwise stated and referenced, my opinion is based upon my professional experience.

My instructions have referred me to the following guidance and duties:

a. GMC “Providing witness statements or expert evidence as part of legal proceedings” 30 January 2024” NB principles at [12].
b. Academy of Medical Royal Colleges “Acting as an expert or professional witness Guidance for healthcare professionals”
c. 2.1.3 The Criminal Procedure Rules 2020 and the requirements for a report set out in CPR 19.4.3.

In writing this report I have been instructed to:

a. Base my opinion on national rather than local standards. However, if there are known significant local variations, then these should be identified in outline.
b. Seek to acknowledge the range of professional opinion on any particular topic and set out what would be agreed to constitute minimum standards by those falling within a responsible body of medical opinion.
c. Seek to identify any particular areas of disagreement within the medical profession as to relevant standards and the scope of that disagreement.
d. Differentiate between the minimum standards of care you would expect and what might be considered best practice or the “gold standard”.
e. Identify in outline the general risks associated with care falling below the minimum standard identified.

f. Identify in outline some of the challenges associated with providing care to the minimum standard identified.

Preamble

This report covers the relevant period from January 2000 to December 2023.

There were multiple societal changes during that time period as well as changes to mental health services. Mental Health Services come from many organisations not just the NHS. Mental Health (MH) is not a single entity. In relation to the NHS the two broad categories of mental health problems are usually referred to as Common Mental Disorders (CMD) and Severe Mental Illness (SMI). These two terms each cover many different conditions with different presentations, treatments and prognoses within them. The NHS provision for both broad sets of conditions varied considerably across the country, over time and across different types of teams and services.

The policies, guidance and laws under which services operated changed during the timespan. The way in which NHS services were funded and directed to priorities (commonly referred to as commissioning) varied over time, as did the nature and funding of different individual provider organisations.

There were changes to available treatments and to what was considered good practice at differing times. There were major changes to other non-NHS services which contribute significantly to preventing and addressing mental health conditions, in particular but not only local authority services including Social Services, Public Health and Drugs and Alcohol services and for children and young people Educational Services. Such non-NHS changes inevitably impacted on NHS services.

The final major complicating factor was Covid which impacted heavily in 2020-2022 but arguably through to and beyond December 2023.

Purpose of the Report

The report is prepared in line with my instructions, summarised above. The report does not, and does not purport to, review or address any individual case or any individual team or set of services during the time period. It is a high-level report talking about general themes across England during the relevant period. Within these general themes there will have been significant variation over time and between teams and services even within one provider organisation. The report sets out the major broad themes of good practice and what were common factors impacting positively or negatively on the ability to deliver good practice but at high level. It does not purport to capture the nuances that might apply in a particular place at a given time for a given service.

The report is therefore designed to set out a broad context to help the Inquiry better examine variations and the reasons for those – whether warranted or unwarranted in any cases it will examine. The Inquiry will also have the benefit of other expert opinions including on policies, guidance, the law and NHS structures and this report is therefore not seeking to duplicate information from other sources.

Due to the necessarily brief overview of the matters covered in this report, I have not offered my opinion on all aspects of each topic but can do so in response to any further questions arising.

Mental Health in the broadest sense as well as in particular aspects has a wide range of controversies i.e. there are many opinions on each topic some with more strong disagreements between one or multiple opinions than others. This report seeks to set out the broad themes and broad consensus on those themes but acknowledges that for every item there will be differing opinions. It will refer at a high level to some of the more significant controversies which have had most impact on service delivery.

1. Introduction: 2000-23 A time of many changes

1.1 At the start of 2000 the National Service Framework 1999 (NSF) had been published but not yet implemented across the country.[1] The NSF was a very significant attempt to change the downward spiral of mental health services in the 1980s-90s. In the 1970 and 1980s there had been, at best, over optimistic beliefs that closure of the Mental Health asylums would free up considerable resources for other (non-Mental Health (MH) health services) uses. This led to MH service funding being relatively under protected and significant portions of it being moved to support the acute (secondary and tertiary) physical health sector. This was patchy across the country with some areas more badly hit than others. This resulted in some high-profile cases, such as that of Christopher Clunis, but the same issues were playing out across the country.

1.2 Pressures included demand exceeding capacity leading to offloading of cases rather than continuity of care and pressures to see new referrals leading to too little time available for ongoing essential care and treatment time. At the same time the one local team model was working well in many parts of the country for the vast majority of persons in contact with MH services. This was especially so where those services had better MH funding but as pressures increased more gaps began to appear.

1.3 For adult services the old general psychiatry model prevalent in the early 1980s was gradually changing with the development of new specialities e.g. Old Age Psychiatry, Liaison Psychiatry but in most places the adult community MH team provided the core community assessment and treatment services. The adult Community MH team was linked via the consultant to the local allocation of acute inpatient beds.

1.4 The NSF built upon the principles of the Care Programme Approach already in place, brought significant new investment and abolished the one local MH team

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[1] https://assets.publishing.service.gov.uk/media/5a7a050040f0b66eab99926f/National_Service_Framework_for_Mental_Health.pdf

model – replacing it with multiple teams and splitting inpatient and community consultant roles.[2]

1.5 The extra investment meant that, generally speaking, the 2000-2010 period eased a lot of the pressures. Initially the new teams/models took workload from the community teams but at the cost of more fragmented and discontinuous models of care and treatment.

1.6 However, the new teams were never fully funded and so to create the required funding for the new posts, core community teams and acute beds were often reduced as were other parts of core community MH services e.g. day hospitals.

1.7 By 2010 the pros and cons of the new models were becoming clearer.

1.8 In general, for people who were accepted by the new teams, services were better with more funding per case and tighter boundaries which also made them better places for staff to work.

1.9 The downside was that core community and acute inpatient services had to absorb the increasing demand which wasn't eligible for the new services so time per case fell. This was exacerbated by the growth of internal referral forms and repetitive assessments at each team boundary all further reducing available clinical time per case.

1.10 The growth in multiple different types of teams also meant it was harder for people including primary care teams to know to whom to refer for what. There was an increase in people feeling (and being) moved from team to team or getting stuck between teams.

1.11 New Horizons "a Shared Vision For Mental Health" was a cross governmental mental health policy which was developed in 2009-10 to try to address the rising issues but was never implemented.[3] The result of not

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[2] See Appendix 2.

[3] https://data.parliament.uk/DepositedPapers/Files/DEP2009-3023/DEP2009-3023.pdf

implementing it was a relative policy update gap until the 5-year plan. This was therefore a lost opportunity to improve things.

1.12 Early Intervention in Psychoses (EIP) teams were one of the specialist teams from the NSF which started to operate from 2000 and continued to develop through this period getting closer to the original aims and ambitions.[4]

1.13 During the period from 2010 national economic policy led to a wide range of reductions in public service spending. Although direct NHS funded health services were relatively protected, many of the universal and non-NHS services which provide important scaffolding and support for people were reduced causing more demand to reach level where NHS input was required and more people not reaching mental health service thresholds for input but struggling.

1.14 The 5 year forward view in 2014 was the next significant change. It is generally considered that despite good intentions, investment in MH services did not keep up with rising demand therefore gaps between capacity and demand increased.[5] This is not to suggest that there was no investment or no progress. Improving Access to Psychological Services (now NHS Talking Therapies) developed and expanded through this period to the present. This provided services mainly for people with common mental disorders for whom previously there were large gaps. As with all interventions it does not work for everyone, but it has been very successful and has set a standard for publishing outcomes and for using this outcome data to further improve services.

1.15 The range of services as alternatives to admission and for people presenting in crisis increased but lagged behind demand.

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[4] See Chapter 5 on Early Intervention in Psychoses teams: https://intensivehometreatment.com/wp-content/uploads/2010/10/Mental-health-policy-implementation-guide-department-of-health-2001.pdf#:~:text=The%20Mental%20Health%20National%20Service%20Framework%20for,the%20full%20range%20of%20mental%20health%20care.&text=Since%201999%2C%20local%20implementation%20teams%20(LITs)%20have,to%20implement%20the%20NSF%20in%20their%20area. See further information here: https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf

[5] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

1.16 Cost Improvement Plans/Cost Efficiencies in Mental Health are largely, in effect, simply spend reductions. This is because lack of outcome reporting prevents analysis of whether these are delivering the same or better levels of outcome more cheaply or to more people. These reductions in spending continued to fall disproportionately on core community patients and acute inpatients as new teams continued to develop and were prioritised for available funding.

1.17 By 2017 it was clear that pressures were becoming very severe in the system and flowing into increased use of out of area beds.[6] Use of out of area beds are generally less effective and less safe with greater discontinuity of care than if admitted to a local acute bed. Unfortunately, the metric chosen (headline numbers of inappropriate acute MH out of area beds) did not deliver the desired impetus to ensuring a local bed was available when needed.

1.18 Instead, it created a whole new system of “grey beds” which were beds outside the local trust but not deemed inappropriate. They often didn’t appear in bed reports or data but over time standards were developed for them and they are now being better monitored and reported. It also led to “admission as a last resort” rather than admission when optimum to do so.

1.19 As pressures continued it led to increasing waits for MH beds in the community and in A&E (Accident and Emergency Departments – now often referred to as Urgent and Emergency Care UEC in NHS documents) of many hours and in the worst cases measured in weeks not days. All of these are harmful and tend to increase length of stay as by the time a person is finally admitted they are often in a much worse state. They also increase staff anxiety and burnout as they are juggling these competing demands trying to find the least bad option. It is important to note that throughout this period most admissions were to local beds, and most were timely. However, the minority for whom that wasn’t the case, increased in numbers in this period.

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[6] For definition of “out of area beds”, see Out of area placements in mental health services for adults in acute inpatient care - GOV.UK.

1.20 In 2019 the Long-Term Plan came into effect including the Mental Health Implementation plan.[7] This did bring significant new investment and an emphasis on supporting and strengthening core community and acute services (whilst continuing investment in more specialist services).

1.21 In 2019 the Community Mental Health Framework was published setting out the principles and values to be expected in delivering good community MH services.[8] It recognised that vast majority of MH interventions were and should be in the community and also that, if these were lacking, bed demand could not be stabilised or reduced.

1.22 In 2020 Covid impacted on all aspects of life including MH care and services. There was huge disruption in 2020-21 which reduced over time but the ramifications are not fully resolved even now. The impact of any pandemic is multifactorial. There is the direct impact on those who become ill, there are the impacts on others who are supporting those who become ill and/or grieving for lost ones killed by the pandemic, there are disruptions to social functioning across multiple sectors of life. Covid brought all of these.

1.23 In relation to mental health services the immediate impacts included seeking to keep people out of hospital to reduce cross-infection risks, staff off ill or in quarantine reducing service availability, restrictions on getting out limiting access to multiple types of things which help support peoples mental health and, especially but not only, for children disruption to normal learning about socialisation as well as disrupted education. Whilst there is debate about the total amount of long-term legacy of the Covid pandemic there is no real debate that it caused major issues for at least two years and ongoing issues including further episodic infections are continuing through to the present for at least some people acutely and chronically. The rise in mental health demand was exacerbated by Covid but the underlying trends were upward due to impact of adverse socio-economic factors over much of the 21st century.

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[7] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[8] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

1.24 In summary there was investment throughout the period but not always in keeping up with rising need and demand. There were, however, a wide range of new teams, services and therapeutic approaches developed. More people than ever are being treated. It is believed that most patients get significant benefit overall (not necessarily from interventions initially tried as none work well for everyone but through finding the best option for that person), however, other than Improving Access to Psychological Treatments (IAPT- now rebranded as NHS Talking Therapies) the lack of reporting of routine outcome data makes this hard to quantify. That overall success does not mean that there are not people who aren't significantly helped despite getting best evidence support, care and treatment nor does it imply everyone is getting best evidence support, care and treatment.

1.25 That some people got support, care and treatment that was below a reasonable standard was evident from multiple reports around the country during those decades. Nevertheless, many investigations/reviews focussed on what the key decision maker did rather than whether that was reasonable based on the information and practical options reasonably available to them. A key issue often overlooked was whether there was key information which the system had not made reasonably available to them in a usable, timely fashion.

1.26 The Inquiry has a remit covering all ages and all types of Mental Health NHS funded inpatient services and community services in the early post discharge period. Few people, even with severe mental illness, need or benefit from inpatient care and treatment. The vast majority of those who need an inpatient admission will need inpatient care and treatment for small parts of their life. There are relatively small numbers who need long term inpatient care and treatment lasting into years. Therefore admissions, in themselves, are very varied in purpose, duration and type. Whilst core principles will be the same, the ways in which these are best delivered will vary by service type and reason for admission.

1.27 It is important in reading this report to be aware that over the 21st century numbers in contact with Mental Health services in a given year grew substantially.[9] Nationally, rates of serious untoward incidents (including deaths) did not significantly rise over the same time period.[10] That is not a reason for complacency as each such case is tragic and traumatic. Whether an individual serious untoward incident was reasonably avoidable or not requires review of the specific circumstances of each serious untoward incident. The evidence is that the vast majority of people in contact with MH services in the time period under review did not have a serious untoward incident during that time.

1.28 The lack of published routine outcome data other than for IAPT/NHS Talking Therapies means we don't know how many significantly improved or how many relapses were prevented or rapidly successfully addressed across the country during that time period. It is very difficult to compare effectiveness of different services.

1.29 The report is set out in the following broad sections (which inevitably will overlap and be interdependent to some extent). These are:

2. Mental Health (including co-occurring conditions), Severe Mental Illness and service types
3. Assessments that could give rise to admission
4. Care and treatment during the inpatient episode (i.e. the time between admission and date of discharge back to a non-inpatient setting)
5. Discharge aftercare
6. Investigations, Reviews and Accountability

2. Mental Health, Severe Mental Illness, main inpatient service types

2.1 Mental Health (MH) is an umbrella term as is Physical Health. We all have both and to a greater or lesser degree will experience problems in both over the course of aa lifetime. Most MH problems do not require MH health service inputs any more

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[9] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis. See "Demand for Mental Health Services is Rising" section.
[10] https://sites.manchester.ac.uk/ncish/#:~:text=The%20National%20Confidential%20Inquiry%20into,in%20the%20UK%20since%201996.

than most physical health problems. Many are minor and self-limiting with little impact on the person's overall functioning and can be addressed by the person themselves and/or their social network and/or universal services.

2.2 There is controversy as to whether mental illness does exist and whether or even if it exists whether it is right to treat it. There are vocal proponents of those positions including amongst psychiatrists, psychologists and other health and social care practitioners. The much broader consensus, including amongst people with lived experience, is that mental conditions exist which have a significant impact on people's health and functioning which can, to some extent, be addressed and/or mitigated by care and treatment.

2.3 It would be impossible within the scope or timescales for this report to reflect the multiple differing views that different people have adopted over the years. Therefore, the reason for highlighting this here is that people accessing/seeking to access mental health services or being drawn into such services without their consent e.g. under the Mental Health Act 1983 (the MHA) will themselves have differing views which can also change over time. The same is true of the mental health workforce who will be influenced by wider societal debates and changing attitudes. This can, and at times does, complicate trying to get shared understanding of the issues and options to help address those issues at all levels.

2.4 Categorisation of Mental Health Conditions was fluid during the time in question even in relation to diagnostic coding. The two main diagnostic coding guides are DSM (Diagnostic and Statistical Manual – USA based there are various versions but mainly DSM V during that time) and the ICD (International Classification of Diseases World Health Organisation based, there are various versions) and mainly ICD10 during that time. ICD was the standard NHS system used for coding and reporting in NHS record systems but labels from both or either could appear in case notes. The advantage of these was that they gave a clear definition of criteria which anyone can read and hence accept/challenge. In addition to this a range of non-standard labels were used such as Complex Emotional Needs. These typically didn't have a standard guidance which people could read and so were harder to accept/challenge.

2.5 The fear of "labelling" led to a trend through the 21st century to try to avoid making clear diagnoses. This is controversial. In reality all human beings use labels for all sorts of things so inevitably some label was used. It was felt by some that not using diagnostic labels was less stigmatising. It was felt by others that not giving people a diagnosis (when it was clear) was, in itself, a form of stigmatisation similar to previous generations of healthcare professionals withholding a cancer diagnosis from people. It was also considered by some to be dis-empowering as the criteria for non-diagnostic labels was unclear, not published and couldn't be challenged by reference to source material. In theory it is a requirement for NHS funded services to give and share a diagnosis where one or more is/are made but actual recording in the Mental Health Service Data set (MHSDS) is typically well below 100% (higher for inpatient episodes of care).[11] The need for clarity also falls within the general principle of "nothing about me without me" a move from services paternalistically deciding which information to share to the expectation that to co-produce care and treatment plans information needed to be open and shared unless there were very clear explicit reasons why it should not be.

2.6 The Long-Term Plan 2019 category of Common Mental Disorders were people who were, by and large, receiving their NHS mental health input entirely within primary care services. The advent of IAPT (now called NHS Talking Therapies) in 2008 opened up new service offers for this group but ongoing care and treatment from the NHS was in primary care.[12] The scope of IAPT grew through the period from 2008 through to now, as did their outcome reporting.

2.7 Severe Mental Illness (SMI) has fluctuated in meaning. This report uses the model set out in the Long-Term Plan i.e. based on severity not by diagnostic exclusion criteria. All people with SMI are likely to have had input from secondary and/or tertiary mental health services as well as from primary care at some point in their lives. This can be short, long term or intermittent over many years or decades. Not

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[11] For Mental Health Data Set, see https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set.

[12] https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

everyone with SMI needs secondary or tertiary MH input all the time and many, in remission, may not need it for long periods.

2.8 CAMHs (Children and Adolescent Mental Health Services), have not historically used terminology such as SMI but recognise that for some people, at least some of the time, their mental disorder is significantly impacting on them and/or those around them. Therefore, some presentations are more severe than others.

2.9 Admission to a MH inpatient bed is not a neutral act. It carries potential benefits but also potential harms. As with all healthcare decisions it requires consideration of the balance between potential harms and benefits including for those detained under the MHA (Mental Health Act). For those detained under the MHA this includes the impact of being deprived of their liberty and significant limitations on their choices regarding care and treatment.

2.10 There has been a significant increase in numbers in contact with MH, Learning Disability and Autism (MH, LDA) services over the years. NHSE state that in 2023-4 there were 3,790,826 people in contact compared to 2,726,721 in 2018-19. Around 1 million of these were children.[13] Contact does not explain why the contact has happened or the outcome but this is a large increase.

2.11 In terms of inpatients, NHSE data shows 2.4% (92,199 people) of those in contact with MH, LDA services in 2023-4, spent some time as an inpatient. That percentage figure is lower than earlier years, but the total fluctuates a little. The 2023-24 total was slightly higher than 2022-23 but slightly lower than 2021-22The vast majority of admissions for adults are due to SMI as defined in the Long-Term Plan but some may be due to mental disorders linked to other matters e.g. Learning Disability to Learning Disability wards, Severe Cognitive Impairment/Dementias (to what were often labelled “organic wards”), Brain Injury Units.[14]

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[13] https://app.powerbi.com/view?r=eyJrIjoiN2QyZmIzNmYtN2I2Yi00ZjlkLTljMTItNDA1NTUzNzVkOTZjIiwidCI6IjM3YzM1NGIyLTg1YjAtNDdmNS1iMjIyLTA3YjQ4ZDc3NGVlMyJ9

[14] The main public summary report on Mental Health activity in England is published on NHS England’s website: https://www.england.nhs.uk/publication/nhs-mental-health-dashboard/. There are data quality caveats to this report, but it represents the best national level NHS information available.

Severe Mental illness

2.12 Mental Disorder is a very broad term which the World Health Organisation define as “A mental disorder is characterized by a clinically significant disturbance in an individual’s cognition, emotional regulation, or behaviour. It is usually associated with distress or impairment in important areas of functioning”.[15]

2.13 Mental health is something every human being has and, as for physical health, can vary over time. A mental health condition is broader than mental disorder and covers any form of poor mental health. As with poor physical health, poor mental health will include many things which neither need nor will benefit from NHS input. The Long-Term Plan uses the term Severe Mental Illness to capture a group of mental disorders which are the most disabling. These are a group of relapsing remitting illnesses which cause a severe impact on the person’s life and functioning and carry significant risks of chronic disability and premature mortality. Much of this harm is preventable by early effective treatment back to remission and by rapid relapse intervention when early relapse signs occur. Unfortunately demand exceeds capacity which can, and does, result in delays to being seen, reduced ability to deliver effective treatments, and poorer continuity of care. In the 21st century a model of care developed focussing on crisis intervention which meant MH services too often waited until a person was in crisis rather than working with people to intervene before an episode deteriorated to crisis point. It is important to have crisis services for people who have reached that point, but no one should have to be in crisis to be heard.

2.14 There is a tendency in Mental Health to use “caused by” very loosely. Just because something follows something in a person’s life doesn’t mean that thing caused it. There is also a difference between defining something as an essential and that being a sufficient explanation. For example, Post traumatic Stress Disorder by necessity requires evidence of some prior trauma but trauma is not sufficient for PTSD as many people exposed to same or similar trauma do not develop it. This is no different to physical health where to get an infection there

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[15] https://www.who.int/news-room/fact-sheets/detail/mental-disorders

must be exposure to an infectious bacteria/virus but not everyone exposed will develop the infection. Similarly, even if someone does develop an illness, the severity and course of that illness can vary considerably between people. This is why the usual approach is to consider vulnerability factors, precipitating factors and perpetuating factors. This can lead to a negative, impairment-based perspective meaning.

2.15 Therefore, it is recognised that there is also a need to take into account the person's strengths and aspirations in understanding the condition and how best to help them. There are genetic contributions to strengths and vulnerabilities, there are psychological contributions to strengths and vulnerabilities, and there are social contributions to people's strengths and vulnerabilities. Precipitating factors tend to be in the present and perpetuating factors are similar to vulnerability factors but tend to be more heavily influenced by things in the present. Each first episode is traumatic as is any subsequent relapse and the longer they continue to be ineffectively treated the worse the trauma and the lower the likelihood of getting back to previous best level of functioning even in remission. This is why early, effective treatment is essential.

Mental Health including SMI services are community based

2.16 As noted above a minority of people get admitted to hospital each year. The main stay of care and treatment is community based. Post the NSF in 1999, the new teams brought welcome new resources but were never fully funded. To meet the annual requirements resources had to be transferred from core community services and by reducing bed numbers. This pattern persisted as more types of new team developed. The names and function of teams varies considerably across the country and within the time period covered (see Appendix 2 for some examples of some common team types). The new teams were much better resourced than core services and typically had more funding per case, less turnover of cases per year and strong boundaries. This made the new teams more attractive to work for, further depleting staffing in core community and acute wards. The hope was that these new teams would take more work from core teams to balance this. This has not been the case as the bulk of the increased demand has gone to the core teams resulting in increasing wait times to be seen and more and faster discharges to keep within funding. This further reduced time and resources available per case resulting in care and treatment being more stretched. Coupled with the failures of NHS workforce planning in the 21st century this then led to more chronic vacancies, compassion fatigue, and burnout.

2.17 This does not mean that there was no investment or that nothing improved. There were more potential options for care and treatment by 2023 than in 2000 with far more people receiving services each year and better alternatives to admission which were developed and which worked for many people. Proving to what extent services improved or got worse is difficult in the absence of routine outcome data being published. IAPT/NHS Talking Therapies is the major exception to that and publishes the routine data. One result of not publishing routine outcome data is that the main data which comes to public attention are suicides and homicides. It is right that these are highlighted as each are individual tragedies but only focussing on them creates a negative image of MH services which can discourage people seeking early, effective treatment. That is not a reason for failing to learn from them and seeking to reduce them. The National Confidential Inquiry into suicides and homicides (NCISH) published data on suicides and homicides to 2022 but then was told to stop reporting on homicides (recently that decision has been reversed so homicides will be included again in the future). Suicide reporting has continued.[16]

2.18 These show that neither suicide nor homicide numbers of those in contact with MH services rose overall during the study period between 2012-2022 despite the great increase in numbers of people in contact with the service each year.[17] It should be noted that numbers of inpatient admissions dropped through those years with more people being treated in alternative ways to admission. Therefore, the best indicator of "acute" MH service linked suicide is by inpatients plus those within 3 months of discharge from inpatients and those under crisis resolution/home treatment teams. No one suggests that is a reason for complacency as the aim is

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[16] https://sites.manchester.ac.uk/ncish/#:~:text=The%20National%20Confidential%20Inquiry%20into,in%20the%20UK%20since%201996.

[17] See NCISH data referenced at [16].

to reduce both, but it highlights the limits of the only routinely published outcome data. This also does not address the reality that vast majority of suicides per year have not been in contact with MH services in the preceding 12 months.[18]

2.19 Therefore, there was a significant overall increase in numbers able to access services across all the different teams and services compared to 2000. One cost of this was greater fragmentation of services and greater discontinuity of care and treatment from the old neighbourhood model of one community team covering all. The neighbourhood model did not completely disappear but on top of the neighbourhood core team were multiple “specialist” teams and GPs and others often struggled to know whom to refer to which team. It also led to a large increase in repeat assessments, referral forms (often long and complex for no justifiable reason) and people getting stuck between services, all saying not us, or going from one waiting list to another.

2.20 People who did get into the more specialist services then get an overall higher level of care and treatment as these teams were better resourced per case per year than core community teams. There is general consensus now that fragmentation and discontinuity of care and treatment has gone too far even if there is less agreement about how to correct it. There are now 6 pilots going on in England to see if a neighbourhood model can be better delivered again without losing access to specialised skills when needed but without people having to be transferred/referred/moved between teams.

2.21 This fragmentation and discontinuity of care and treatment also became too common between community and inpatients. Inpatient care and treatment should be a “top up” to the ongoing community care and treatment and this requires continuity of care from the community team even whilst someone is an inpatient. It would be wrong to say this disappeared during the 21st century but it did become less common. People could be passed from team to team sometimes with inpatient services completely changing the care plan without recourse to the community

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[18] See NCISH data referenced at [16]. From 2006-2012 72% suicides had not been in contact with Mental Health service, and 74% from 2012-2022, with the overall rate of 73% for the relevant period.

team or the person's long-term needs. This pattern was not universal and, even where it occurred, did not mean things frequently failed but this is a common pattern to see in serious untoward incidents around the country. Each handoff (as opposed to top up) carries substantial increased risks of discontinuity of care and treatment and hence increased unwarranted, avoidable harms.

2.22 Therefore, SMI conditions need both a longitudinal and episodic approach. From the outset it should be made clear that relapse at some point is common, so it is better to prepare plans to rapidly address relapse for everyone no later than the first point of remission. Ideally these are co-produced, indicate early warning signs of impending relapse, what does/does not help that person in relapse and what harms are likely if effective care and treatment are not put in place to prevent full relapse/address relapse rapidly. Some people might never need to use such a plan, but we can't currently predict who won't relapse at some point in the future.

2.23 Longitudinally, the aim is to help keep a person in remission for as much of their life as possible so they can get on and lead their best life. Episodically there is the need to rapidly step up to address any early signs of relapse before reaching severe or crisis point. When done well this gives much better continuity of care and treatment no matter who is the point of contact at that moment and represents the most efficient use of health resources as well as delivering best the outcome for the person and those who care about them and the wider community.

2.24 Whilst good practice remains common, too often people and their families report being turned away as "not in crisis" or "not yet severe enough" without services recognising the early warning signs and hence avoidable, unwarranted harms occurring before action is taken. When things go wrong, too often, the key decision maker has not had ready access to key information in a usable way in the time available. Too often, people misunderstand information governance when information can legitimately be obtained or shared within the time available e.g. from families. Why those things happen will be considered later in the report.

Co-occurring conditions

2.25 SMI gives no known protection against any type of co-occurring conditions. Co-occurring conditions are common and more frequent than for those without SMI. They can be due to any type of physical health condition, any type of other mental health condition, neurodiversity (such as Autism or ADHD), Learning Disability, and/or Substance Misuse (alcohol and multiple drug types).

2.26 The key point to note is that none of them should exclude people from what are now grouped as Mental Health, Learning Disability and Autism (MHLDA) services where they have a condition requiring input from those services. There may and, typically will, be a need to take into account the impact of those conditions (including any treatments for those co-occurring conditions) on the mental health condition being treated, the impact of the mental health condition being treated (including treatment for the mental health condition) on the co-occurring condition, and the totality of all of that on the person’s overall life.

2.27 In general terms MH services should not be interfering or minimally interfering with any ongoing treatments for co-occurring conditions. In general terms they should be making “reasonable adjustments” to take account of those co-occurring conditions. “Reasonable” has to be that. Teams and wards will be working with multiple different people with multiple differing needs including for reasonable adjustments at any given time. Acute wards are dealing with multiple people at any given time who are acutely seriously unwell and all with their different needs. Acute wards also have many more people with differing needs each year compared to more specialised wards therefore balancing the needs and aspirations of one against the others is an ongoing daily challenge. There may be a need to take specialist advice from services for those co-occurring conditions as to what is a reasonable balance between care and treatment approaches in order to seek to get best overall effect within existing resources.

2.28 Co-occurring conditions can make it more difficult to be clear which condition/s are contributing, and how much, to the person’s presentation. This is often termed "differential diagnosis". In those circumstances there will need to be a "working" formulation i.e. on the basis of what is known at present and appears to be best way forward. There will then need to be ongoing review as to which conditions are present and to what impact. That would be good practice. Unfortunately, there are examples across the country of co-occurring conditions being used as exclusion criteria and people being rejected from a service/all services with sometimes tragic outcomes. This has also been identified as sometimes occurring when the stated other condition was never actually diagnosed by recognised criteria or as being present (drugs/alcohol and Autism all have been used in this way). A group of people often labelled as having "Personality Disorders" using different labels, both within DSM V or ICD 10, or not in any diagnostic manual, were often excluded despite "Personality Disorder: no longer a diagnosis of exclusion" being published in 2003.

2.29 A co-occurring condition should never be an exclusion criteria, but they can make treatment and hence overall prognosis more complicated. In terms of MH inpatient admission, a co-occurring condition should also never be an exclusion or delaying issue. Admission should be equitable based upon the same criteria as for anyone without a co-occurring condition. This will be addressed further in the next section on inequities.

Inequities of access and service in MH

2.30 There is no reasonable doubt that although mental health problems including SMI can happen to anyone there is very significant disparity both in who is more likely to get them and in relation to service access and prognoses. Public Mental Health tended to be less well developed than Public Physical Health during the relevant period but is now getting increasing attention. Services and service planning have therefore tended to be reactive, and anecdote driven rather than based upon community needs and strengths.

2.31 Mental Health services have large amounts of data i.e. information about who does access services, why, where and when and hence who/which communities/sub-communities are over or underrepresented at every stage compared to demographics, but these have historically been rarely analysed or reported. As a result, service planning and delivery has typically been too reactive and driven by anecdote rather than needs led. Again, this is slowly changing.

2.32 A group being over represented in one part of a service does not, in itself, mean they got equitable access to early, effective treatment. Indeed, for those who spend very large proportions of their life as an inpatient the opposite is often true. So, males from those identified in the data as being of black ethnicity are over represented in those detained under the MHA and having long periods of their life in inpatient settings. They are also less likely to present early to services and/or to gain access at an early point, if they seek help, and hence are more likely to present in crisis at a late stage with already acquired secondary and tertiary harms and disabilities. Those from areas of social deprivation tend to be similarly over-represented in the wrong parts of the system for similar reasons. It is becoming increasingly clear that the same applies to neurodiversity, especially Autism and ADHD.

2.33 We now know that all these communities/sub-communities face greater access issues for multiple reasons. These can be addressed but need to be recognised first in order to do so. When services are struggling, they too often fall back on saying “they didn’t tell us” or “they didn’t engage” or “they didn’t seek help” or (after things go wrong) “we didn’t understand what they were trying to tell us”. That is because such a response means they have an intellectually plausible reason not to do more work to effectively engage when they are already struggling to manage the rest of their caseload. There are ways of addressing this to make better use of available resources and improve equitable access without increasing staff burnout and whilst patchy these are increasing. It is important to stress that not everyone from a given community/sub-community experienced such barriers or rejection throughout the period, but it is generally true that marginalised groups overall faced more barriers at each step.

2.34 A major cultural change in the 21st century was a drift from focussing on care and treatment to “risk management”. Unfortunately, it has become increasingly clear that this has led to more unwarranted, avoidable harms. Risk management as an aspiration is not deliverable outside secure facilities where the person has no unescorted leave. It is completely undeliverable as a model in core community services where contact with services will be measured in minutes (typically less than an hour) per month. Risk assessment forms don't change risk or harm no matter how often they are completed but the question became "is the risk assessment up to date?" not "is the person getting effective care and treatment?". This distorted team and service priorities and took the focus off effective care and treatment and relapse prevention/management. As noted, it also led to people being excluded from services until harm was imminent or had already happened. This is recognised to have been an error.

2.35 The new Keeping Safe from Suicide policy guidance replaces the 2009 risk guidance.[19] The same principles apply to reducing all types of unwarranted, avoidable harms. If MH services deliver effective care and treatment, then harms associated with the condition and/or interventions for the condition will be prevented/minimised. Again, exclusion based on "risk" increased inequities and therefore overall increases do not decrease harms. SMI which is not effectively treated leads to high premature mortality as well as chronic disabilities much of which is preventable/avoidable as well as increased rates of sudden tragedies such as suicides, homicides and other serious untoward incidents.

2.36 Therefore clinicians/practitioners should and, in the vast majority of cases do, strive to strike the best balance that is reasonably available in the circumstances. The extent to which clinicians/practitioners can and do make decisions as to what to do or not do, requires them to take into account all the various competing pressures and requirements. It is also affected by many factors including the time available to make the decision, the known resources practicably available at that time and the competing needs of other patients at that time. It is also affected by how stressed/tired they are as practitioners. Burnout and compassion fatigue were and are real factors, as is the fear of being blamed where no matter which decision the clinician/practitioner makes, no choice will be perfect or ideal. Too often the

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[19] https://www.england.nhs.uk/long-read/staying-safe-from-suicide/

test of what is ideal is applied, rather than the test of what is reasonable. This can lead to more fear, and hence, poorer decision making.

2.37 Where staff are very overstretched this will impact on the quality of their decision making. This can be particularly marked where staff are coping with long term vacancies. However, 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.

3 Assessment that Could Give Rise to Admission

3.1 Each and every clinical contact contains within it the possibility that MH admission might be necessary. This is because the question is always how we best seek to deliver essential care and treatment for this person.

3.2 Some such assessments may be lengthy e.g. for a new person referred in for a first assessment, others might be as brief as a corridor conversation. It would be extremely wasteful and reduce therapeutic time available if every assessment was required to be like a first one. Additionally, for most people, being asked to go over the same things (which are historical and hence won’t change) over and over again each time they meet someone new is not just a mark of the NHS not listening but is actively traumatising.

3.3 Therefore, the key questions in every assessment are why this person, in this particular way, at this particular time. The more that is already known about each of those the more likely any opinions/recommendations will be most appropriate. The assessment is drawing upon whatever existing knowledge is readily available in a timely and usable format to make best use of the time available to reach an opinion, including is anything new or changed or not working as hoped. The person doing that assessment can be anyone. The key is the assessor knowing when the assessor can address anything which needs addressing and knowing when and how to escalate in a timely manner if other inputs or expertise are required. Collecting the information may be done in multiple ways by the same or different people to those who interpret and give the opinion/recommendations for whichever interventions are indicated and again who carries out any such interventions may be the same or different people.

3.4 During the relevant period, admissions to acute adult/older adult wards should have been made by the intensive home treatment team. Admission should have been where the person required some therapeutic care and treatment not currently possible in the community drawing upon all reasonably available community resource and where the benefits of admission would outweigh the harms of admission. This was not uniformly the case right through to the end of the relevant period but became increasingly common.

3.5 The same principles applied if the person was to be admitted to acute adult/older adult wards under the MHA but where the person was unable (due to lack of capacity) or did not consent to the admission care and treatment plan.

3.6 Admissions to tertiary or highly specialised wards and services followed similar principles but practicalities differed. For CAMHS similar principles applied but intensive home treatment teams were typically developed later.

3.7 Any assessment and any opinions/recommendations for care and treatment that came out of such assessments always involve weighing up the potential benefits and harms of reasonably available options and the benefits and harms of waiting for options not currently available but reasonably likely to be available in a timely manner.

3.8 As noted above in only 2.4% of those in contact with MH services does this lead to admission. This is because anything which needs doing can more frequently be done at least as well in the community. The range of community options including alternatives to admission (historically often labelled as crisis resources but as noted waiting until person is in crisis is too late) overall increased during the 21st century. This was sometimes from general funding and sometimes from specific funding for specific types of service. The increase was therefore not uniform or the same across the country but happened to some extent everywhere. At the same time other traditional community support and scaffolding services such as day hospitals and day centres often closed down and there was an overall reduction in universal public services in most areas. Therefore, some people experienced loss of services they valued whilst others gained and welcomed new service offers. Overall, today, as noted earlier, many more people are in contact with MH services per year and many more care and treatment options are available.

3.9 For each contact, admission is a possibility if the care and treatment plan is not proving effective. It is also a possibility if what is essential can't be delivered at that time in the community but can be delivered in an inpatient ward. Whilst the general principles apply to all sorts of admissions at all ages, the criteria for different types of ward type vary significantly. Therefore, if a bed is deemed essential at any age, then next question is which bed type. This will be covered in the section on ward types.

3.10 Admission is not a neutral act. Every admission carries the potential of harms as well as benefits. It is therefore always a balance as to whether the potential benefits outweigh the potential harms at that time, knowing what is reasonably and accessibly available in the community at that time. It should be based upon getting the necessary care and treatment underway/enhanced to bring the person as quickly as possible back to a sufficient level of remission so that community care and treatment can resume as rapidly as possible thus delivering maximum therapeutic benefit including preventing/mitigating unwarranted, avoidable harms to the person and/or others.

3.11 In practice this is often not clear cut. Practitioners were (and still too often are) hampered by a lack of access to the necessary information to make the best decision in an easily accessible, usable format. At the start of the 21st century most MH records were written by hand in paper files (casenotes). As MH is a predominantly community service these could be housed in a community team base and hence were often not physically accessible if a person was being seen somewhere else. In general, there were few if any MH services outside the hours of 9-5pm except at an Accident and Emergency Department (now often called Urgent and Emergency Care or UEC). It was likely that the person who did the assessment (in A&E) was a trainee psychiatrist and often with no prior knowledge of the person or access to the casenotes which would tend to be locked away in some other location. Even if admitted it could take days for the casenotes to physically reach the ward. Hand written entries tended to be scanty, but the neighbourhood teams often knew their caseloads and their neighbourhoods fairly well, and for local admissions the consultant was typically the same person on the community team as on the ward. This meant that although the initial decision to admit might have been lacking key information, this key information was quickly available making admissions in general more focussed on getting a person back to what they and community team knew typically worked for them in relapse. If the person had to be admitted to a different ward or unit this continuity was harder to deliver.

3.12 By 2023 nearly all MH records were in electronic patient records (EPRs) rather than hand written. In theory this should have made getting background information easier and quicker. Initially it did, but unfortunately MH EPRs developed as data capture systems not as tools to aid clinical decision making. The result was that as commissioners, regulators, and serious untoward incident inquiries made more and more recommendations for forms and repetitive entries it became increasingly more difficult to extract the vital information when needed amongst all the other material. There was therefore lots of information in the system but in practical terms the key information was not accessible in a usable, timely fashion. It would typically all be in there and could be found by regulators and reviewers who were given hours, days or weeks to find it. By contrast, often the staff needing it were effectively unable to see it clearly in the actual limited time available when it was needed. This is a known, common and recurrent problem and approaches to tackling it from reducing form filling to more networking of the EPRs have been tried with limited success. Based upon that further learning other approaches are being considered and trialled now to improve the practical usability of EPRs in the real world. Time lost to form filling remains huge and is overall getting worse and will be covered in care and treatment later.

3.13 In summary, through the 21st century some people were admitted when it might have not been the best option, but others were not admitted at the optimum time when it was the best option if the facts had been known to the decision maker.

3.14 On top of this were the pressures not to admit for non-clinical reasons. A culture of "admission as a last resort" developed which, not universally, but too often, 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 MHA and increasing lengths of admission. There were well intended national sound bites like "avoiding inappropriate out of area bed usage".

3.15 However, measuring acute admissions to certain types of acute out of area bed, or for Learning Disability and Autism targets, based upon reducing admission numbers, created huge pressures not to admit to meet a target. This was not based on clinical need. To be clear the NHSE national position was that everyone needing a (Mental Health Inpatient) bed should be admitted to the best bed for their needs that day and no one should be in a (Mental Health inpatient) bed for one day longer than essential. However, in practice, the things on which commissioners and providers were judged were the metrics above. A better metric such as how many people were not admitted within 12 hours to the local MH bed when essential, was not used.

3.16 It was always the case that some people could not be admitted to their local ward on at least some occasions in a year across the country during the 21st century. Mental Health admissions are rarely "elective" i.e. booked in for a date in the future. They are typically urgent and in acute services virtually always urgent. Therefore, on a given day demand could exceed supply or e.g. a ward might be closed to admissions for infection control reasons or a range of other factors including shortage of staffing. In general, throughout that time most people were admitted to a local bed on the day they needed it. As the century progressed a small, but increasing, number of people were not able to be admitted to a local bed on the day needed.

3.17 The inappropriate out of area metric spawned a whole grey area of beds outside the local trust in other providers but considered "appropriate" which helped keep the numbers deemed as "inappropriate" down. The decision as to whether an out of trust bed was deemed “appropriate” or “inappropriate” was subjective and essentially determined by the local commissioners of services throughout the period under review, although national guidance was issued to help inform that decision.[20] The degree of governance and commissioner/trust oversight for those beds was poor initially but has overall gradually improved as guidance from NHSE was made clearer. Where the NHSE guidance was fully followed these beds were well linked into Trust governance and services including with as good information sharing and continuity as if it were a Trust local bed. Whilst this has overall improved, even by 2023, not all Trust Boards/ICBs board papers were reporting these beds as part of the pathway in same way as for Trust beds or inappropriate out of area beds.

3.18 Beds designated by local commissioners, as inappropriate out of area beds, tended to be more likely to be further away and/or without the robust connections, information sharing and linkage to Trust/ICB governance.[21] They were more likely to be purchased “ad hoc” than to have a formal governance linkage to the home trust. This increased discontinuity of care and treatment and increased potential for poor discharge planning with increased adverse effects including serious untoward harm for at least some admissions when compared to local Trust bed usage.

3.19 In addition to that, from around 2019 onwards there were significant increases in delays getting into any Mental Health inpatient bed when essential. This led to increased delays in Accident and Emergency (UEC departments) and in the community. The issue in UEC was not more MH attendances (all ages) as these remained static despite the increases in community demand due to the investment in alternatives. The delays were caused by the increased time to get to a point where an empty MH bed was available as and when that bed was deemed essential. Those waiting for a bed in the community were often not visibly reported but also grew in number and delays. Reporting on all types of delay has significantly improved in last few years.

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[20] Out of area placements in mental health services for adults in acute inpatient care - GOV.UK

[21] ICB is used as a generic term for commissioner arrangements as make up and titles changed over the 21st century.

3.20 Every delay to being admitted on the day it is essential increases potential severity of illness (often called acuity). By the time of admission this can increase secondary and tertiary disability and can increase harm to the person or others (including inadvertent unintended harms). Delay to admission also typically makes length of stay longer once a person is finally admitted. The knowledge that such delays had substantially increased put added pressure on community and inpatient staff and impacted upon decision making about who to admit and when. Coupled with the "risk" culture this often meant that people deemed not to be about to do serious harm to themselves or others were de-prioritised until those harms were high and immediate. Therefore, admissions were increasingly reactive to harm rather than pro-active and at the optimum time to reduce/prevent harm due to the SMI. The increase in use of CTOs (Care and Treatment Orders) was, in part, an attempt by clinicians to mitigate this using the power of recall to expedite timely admissions but these became increasingly delayed as well.

3.21 Out of area bed usage typically has a worse harm to benefit ratio than admission to a local bed. However, not admitting at the optimum time has the highest harm to benefit ratio. The aim that all admissions should be for a clear essential purpose that couldn't be at least well met in the community was correct but the pressure to get certain numbers down too often distorted that. Ironically both use of out of area beds and delays leading to a person not being admitted at the optimum time contributed to driving up lengths of stay. This reduced local bed availability rather than reducing occupied bed days. It therefore failed to free up more local beds to be ready when needed. Increased length of stay in turn led to increasing numbers of people and longer waits for beds in the community and in UEC with the added associated risks. This also put more pressure on to discharge precipitately. The 100-day Discharge Challenge in December 2022 leading into the 10 High Impact Changes in 2023-4 was a significant step to address the above issues but had limited implementation in most parts of the country by December 2023.[22]

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[22] See Appendix 3.

3.22 The principles above apply to all assessments but there are also specific rules that apply to assessments for admission set out under the MHA and the Code of Practice. The core to these are the “statutory criteria”. The general principle is that people with MH conditions including SMI have the right to choose whether or not to accept any form of help or intervention for their mental health condition. The statutory criteria set out that for a small minority of people that right to consent/choice is constrained such that they can be detained for assessment followed by treatment or for treatment if those criteria are met.

3.23 There are different sections of the MHA referring to different detention types and who can make recommendations for detention and an application to detain someone. The Act and Code of Practice give detailed information on each of these matters so will not be covered here. The commonest are Section 2 (assessment or assessment followed by treatment) and section 3 (treatment). In general, the request for a MHA assessment can come from multiple sources. Both section 2 and 3 require that the person has been assessed by two doctors (one of whom must be Section 12 approved) and an Approved Mental Health Professionals (AMHP) will then decide whether or not to apply for detention under the MHA taking into account the issues identified in the recommendations, their own assessment and whether the issues can be addressed without the need for detention i.e. there is a viable alternate plan readily available.

3.24 The criteria are broad including for the person’s health and/or safety and/or for the protection of others. This is much broader than imminent likelihood that the person will seek to deliberately harm themselves or seek to deliberately harm others. To balance that risk, and seeking to prevent misuse, a key guiding principle in the Code of Practice is “Least Restrictive Practice and maximising independence”. This is an important safeguard but “least restrictive practice” as a term is often wrongly used in practice. The Code of Practice makes the definition clear “where it is possible to treat a patient safely and lawfully without detaining them under the Act the patient should not be detained”. It is important to be clear that detention is only applicable if the statutory criteria are met not just because someone is not consenting/following a treatment plan. Therefore, the use of the term “least restrictive” does not reduce the requirement on services/practitioners to consider how necessary treatment can be safely and lawfully provided. Whilst the 2007 update to the 1983 MHA was a real change, the underlying core principles and concepts remained the same throughout the period.

3.25 The Mental Health Act 1983 (MHA) precedes the Mental Capacity Act 2005 (MCA) and was not replaced by the MCA. The MHA is based upon consent to deliver the necessary treatment safely and lawfully not upon capacity although, of course, lack of capacity means a person cannot consent. Sometimes people are told nothing can be done as they have capacity to make a decision including to die by suicide. This is incorrect in terms of MHA if the statutory criteria are met – lack of capacity is not a requirement.

3.26 There is no real doubt that since death by suicide or attempting to die by suicide was de-criminalised in 1960 attitudes have gradually shifted in society. This is evident in current legislation going through parliament to potentially have active state intervention to help people die by suicide (Assisted Dying). The key is that having capacity to make a decision is not the same as having the necessary information to make that decision and SMI can distort the information that the person is considering. These changing societal and cultural beliefs as to at what point death by suicide is the only viable option can make it harder for staff to know to what extent mental disorder is distorting the way the person feels to the point that intervention by Mental Health services is required. The emphasis remains, if in doubt, treat the disorder effectively and then reconsider.

3.27 In the vast majority of cases a person in remission can see better alternatives than death by suicide. Similar principles apply to capacity to decide about other harms including to others, but their criminal justice or safeguarding issues may also apply or take precedence. Therefore, having capacity does not mean that treatment is not needed including admission under the MHA where the statutory criteria are met.

3.28 In summary, increasingly as the century progressed getting an admission at the optimum time to a local bed became harder but most admissions were, and are, to a local bed. Admissions have overall slowly dropped and at least some of this is due to better alternatives to admission being available locally. The bed pressures are mainly due to rising length of stay rather than rising admissions. Admissions at the optimum time could lead to more admissions but would almost certainly lead to fewer occupied bed days. Therefore, occupied bed days not admission numbers are the better metric for measuring actual usage of inpatient services.

4 Inpatient Care and Treatment

4.1 For adults and older adults, the vast majority (85% plus) are known to community MH services at the time of admission. As noted, SMIs are relapsing/remitting conditions so many will have had at least one previous admission. In 2000 paper records meant that the key decision maker at point of admission often did not have access to the existing records or care plan for that person. By 2023 electronic patient records meant this was rare. Over time admissions gradually moved in purpose from admitting to see if there was a mental disorder needing treatment to knowing there was an SMI requiring treatment and there being a lot of information on what were the necessary treatments available in the EPR. The issue became why care couldn't be at least as well delivered in the community at that time. The communication of the purpose/s of the admission did not overall improve and where there was discontinuity of teams, communication could get worse. The stated admission reasons were often vague and formulaic making it difficult for ward teams to identify and deliver what was needed to help a person back to community as soon as possible.

4.2 Even for the minority who were unknown to community MH services at point of contact, i.e., a first assessment, what was needed in terms of assessment, care and treatment were again, too often, vague and formulaic. The less clear that reasons for admission are set out the harder it is for the ward team to address with the person and significant others the goals necessary to get them back into the community with an effective aftercare plan. This increases delays, can increase harms and can make ineffective discharge planning more likely.

4.3 For CAMHs there may well be less history of how the person presents or responds to which types of intervention, but again similar principles apply. Wherever feasible goals are ideally agreed between the person, the service and significant others including key family. Some goals may be agreed by all whereas for others there may be disagreements. Disagreements may arise, especially but not only if the person is detained as not in agreement with some or all of the reasons for admission. Joint goals are therefore ideal but where goals differ then the different goals should be recorded to ensure that, as far as is feasible, they remain in consideration as the admission progresses.

4.4 The 10 High Impact changes set out what good should look like in terms of basic steps.[23] These codified what had been previously known and developed in the preceding years. If those 10 steps are taken in a person-centred way, then an inpatient admission should be more effective, it should take less time to ensure there is an effective aftercare plan in place and ready to deliver so the person does not spend one day longer in hospital than is essential. As noted, these were only disseminated from December 2022.

4.5 Fundamentally, they are about being clear why the person requires to be in hospital and what needs to change such that effective community care is delivered so the person can be back in the community as soon as inpatient care and treatment is no longer essential. For the vast majority of people inpatient admission is a top up to their ongoing community care and treatment so the 72-hour formulation incorporates that as well as what tweaks/top up are required and why. The admission goals are then driven by that, and the other steps are to ensure that every day everything necessary to be done that that day is done, or if not, is reallocated at the next morning’s team huddle. Any predicted or recurring delays or barriers are identified and, if in trust control, addressed by the trust or if requiring inputs/decisions/actions from others go to the Multi-Agency Discharge Meetings.

4.6 The estimated date of discharge is an estimate but gives everyone something to help frame timescales. Any changes to it should be notified to the person and significant others on the day they become apparent including reasons why and

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[23] See appendix 3.

what needs to be done to prevent further slippage. It also helps to ensure discharge does not come as a surprise to any key party and that no discharge is precipitate without at least 48-hour confirmation that the person will be leaving as planned.

4.7 What those goals are and how they can be best achieved will vary depending on the purpose of admission and type of ward. Those might look very different for a person on a medium secure ward to someone on an acute admission unit or to a person in a Tier 4 adolescent unit. The key is that people should know them and how the care and treatments being offered contribute to getting the person back to an effective plan in the community as soon as possible.

4.8 As noted, the daily huddles are for keeping track on progress, ensuring the plan is actually being delivered, flagging up barriers and delays as soon as they become apparent and ensuring that decisions that need making are made daily. They are also designed to free up more 1:1 clinical time (all disciplines) with the person so they are heard each day, kept informed of what is happening and why and for general therapeutic reasons. Uncertainty and delay cause great stress in an inpatient ward which is one of key reasons the weekly ward round was not good practice. The weekly ward round was driven more by custom and practice than any evidence base. This meant that decisions needing making could be delayed by up to a week, They were also inefficient and too often ineffective ways of communicating as for the person on the ward being expected to explain themselves and answer questions in front of a panel of people was often stressful. Change has been slow and patchy across the country. Ward meetings of that type should be check and confirm meetings rather than seen as clinical interactions and so can happen less often and only as necessary. During most of the relevant period most types of ward MDT decision making mainly relied upon the ward round with different frequencies depending on ward type. However, on an acute ward this would typically be once or twice a week.

4.9 The key therapeutic element of a ward is the therapeutic milieu. This sets the tone against which everything else plays out. The milieu has two main facets: the build environment and the staff culture.

4.10 The build environment. Capital investment was scarce throughout the period of the review. When available it typically came with significant restrictions and with schemes which had ongoing built in costs for basic maintenance, and restrictions on the ability to reconfigure as needs changed.

4.11 The general principles were well known by 2000. These were plenty of natural light, feeling of spaciousness, individual ensuite bed rooms, sufficient variety of room options to support confidential 1:1 discissions as well as a mix of rooms for mixing/socialising and specific therapeutic groups/activities.

4.12 At the same time visibility and lines of observation are important as are reduction/management of risk such as fixed ligature points. There would need to be balance between what would be homely and privacy and the need to reduce avoidable unwarranted harms to the person, other patients, staff and visitors. Access to outside space and ideally access to exercise facilities, a café or similar, a shop within easy reach (easy reach depending on type of ward/hospital – different for a secure unit with no unescorted leave to an acute or rehabilitation unit encouraging people to test out unescorted leave as part of the therapeutic plan).

4.13 Across the country in 2000 there were still a lot of dormitory wards although this was being phased out. Many units were looking worn and dark, and some were very run down. Many weren't fit for modern approaches including lacking adequate interview and therapeutic spaces. Gradually over the years improvements have been made but on a sporadic basis as opportunities and funding arose. In general, the better the physical ward build, the easier it is to create a therapeutic milieu whilst improving ability to help keep people safer. Again, whilst general principles apply, the build type for a medium secure facility will have significantly different requirements to those for an acute ward.

4.14 Ward culture is a critical part of the therapeutic impact of a ward over and above any specific therapeutic interactions. Culture is the interaction of peoples, beliefs and behaviours. There is little doubt that the fear culture rose amongst staff as the century progressed. The fear culture is well recognised as a toxic effect where staff can become fearful of making decisions because they fear they will be blamed when, and as, any untoward outcome occurs. The fear is that whichever decision they make, and record, this will breach some rules/guidance as it is impossible to meet them all. This fear in turn leads to not wanting to be the person making that decision and seeking to "offload" responsibility for that decision or that person. As "risk management" dominated over "effective care and treatment", wards became less therapeutically oriented and more custodial and part of that increasingly defensive practice. Both risk reduction and treatment will always be required in every ward and e.g. in secure wards the reason why people are there is because they need a level of security neither feasible nor appropriate on acute wards. However, over reliance on custodial approaches and things like restrictive practices, high levels of nursing observation, and low use of leave off the ward can actually lead to longer lengths of stay and overall, more harms occurring. No amount of restrictive/custodial practices can ultimately prevent significant harms to the person or others if the underlying driving factors are not effectively addressed. They can, however, buy time to address the underlying factors which in SMI are virtually always the person not being in best remission.

4.15 Therefore, the key to reducing risk is effective care and treatment i.e. a therapeutic model to get the person back to remission as soon as possible whilst seeking to prevent/reduce unwarranted avoidable harms. As ward staffing became chronically understaffed the pressure to complete forms and reduced time for therapeutic work led to more restrictive practices including increased observations further driving down therapeutic time. Suppressing unwanted behaviours can work in the short term but isn't sustainable if the underlying factors driving them are not addressed. Sooner or later a gap appears, and harm occurs. High levels of restrictive practice and observations also make it much harder to reintegrate the person back into the community. They also make discharge planning much harder to do effectively. It also requires very high staffing time to suppress behaviours.

4.16 Most "inpatient" suicides are on periods of agreed leave (51%), although some take place when a person is absent without agreed leave (8%). In total in the last NCISH reporting period around 40% of suicides actually occurred in the ward itself. Others happen in the first three months post discharge and so are often recorded as being in the community but are actually part of the acute care step down.

Overall, adding inpatient and post discharge suicides together, does not suggest a major decline in rates even as practices became more restrictive but average length of stay rose creating more bed access issues.[24]

4.17 Therefore, the aim is to have a therapeutic culture able to help a person back to sufficient remission to be successfully able to carry on with care and treatment in the community and to prevent/reduce unwarranted avoidable harms from the condition. The aim is also to prevent/reduce unwarranted avoidable harms from the interventions and for any added restrictions to be timely, necessary, only for purposes and time needed and stopped as soon as feasible. In good wards this was what was done. In struggling, especially understaffed wards, these could become blanket restrictions where people would often be frightened of blame so restrictive practice was used as a defensive not clinically therapeutic necessity. This could be especially prevalent if there were high rates of bank, agency, locum staff i.e. poorer local knowledge and less continuity of care. Such practices and restrictions on leave for staffing or other reasons not connected to the persons therapeutic plan and goals often leads to increased patient frustration and, at best, irritability and a reduced willingness to cooperate. It can also make aggression, violence, self-harm and abuse within a ward setting more likely including, in worst cases, abuse from staff.

4.18 Ideal/best practice ward staffing will vary depending on type of ward and nature of people whom it serves. Particularly in recent years it has been common for wards to be carrying vacancies across all staff groups. Trained nurse vacancy rates of 20% were not rare. Safer Staffing (this approach is being covered in the nurse expert report) was an attempt to set minimum standards but too often it became a "fill rate" which meant numbers were made up by anyone available. The vacancies most impacted on nurses as the largest group of professional staff but if staff from other groups left/were ill, cover could be very thin or absent altogether. In some wards across the country patients might have several consultant psychiatrists in one inpatient stay each with different approaches. If other key staff such as OT or Psychology were absent there could be gaps when the posts just weren't

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[24] https://documents.manchester.ac.uk/display.aspx?DocID=75284

filled/covered. At best these issues disrupted and delayed therapeutic progress. Continuity of care is a critical factor and whilst it can never rely on one person the more changes and handoffs the less likely it is to happen.

4.19 Over the relevant period there was an overall significant drop in NHS provided MH and LD (Learning Disability) beds and a rise in MH and LD beds in NHS funded beds from private providers. It is difficult to say to what extent the rise in private beds compensated for the reduction in NHS provided beds as no accurate figures appear to be available. NHS commissioned beds from private providers are more likely to be higher cost and less likely to be local but, in theory, should be commissioned to same standards. NHS staffing data does not tend to reflect how many or which types of staff were working in NHS funded private providers during this period.

4.20 The Long-Term Plan recognised that over and above issues of nurse and medical staffing there were also gaps in terms of availability of the other professionally qualified groups. Part of the investment was to address this to give the opportunity for more holistic working during an inpatient stay. The value of non-professionally qualified staff including, but not only, peer workers was also recognised and aimed to again enrich ward staffing by their addition.

4.21 The Culture of Care programme is part of the NHSE Quality Transformation programme which started in 2022.[25] The Culture of Care work itself started in January 2024 i.e. after the relevant period but represented what had been learned that was required to improve culture of care on MH and LD wards.

4.22 It is not possible to specify which types of care and treatment should be offered to a given individual during a given admission without looking at the circumstances in detail as care and treatment should be person centred. I understand that the Inquiry will have the benefit of a presentation from the Royal College of Psychiatrists (RCPsych)on NICE Guidance which sets out broad guidance on what at a population level good might look like for various conditions and interventions.

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[25] https://www.england.nhs.uk/mental-health/mental-health-learning-disability-and-autism-inpatient-quality-transformation-programme/

These will help inform decision making but even if they are fully funded and implemented do not replace the need for person centred care and treatment. They are therefore clinical decision aid resources which may/should influence what is commissioned and funded and hence practically available as part of decision making for a given person at a given time. Failure to adhere to NICE guidelines in inpatient mental health, will not in itself represent a clinical failing. As in all cases, the test will be whether any decision can be clinically justified in the particular circumstances.

4.23 The care and treatment plan should be informed by a formulation including what goals need to be met so that the person can continue care and treatment in the community. As noted above, they should be co-produced with the person and significant others as far as possible without that becoming a reason to delay necessary care and treatment. The longer the delay in starting necessary treatment the more difficult things become, and the long-term prognosis becomes worse. Delaying what can be done now in the hope that some preferred option might become available at some point in the future may be justifiable in certain circumstances but carries increased likelihood of harm and poorer outcomes the longer the delay. In general, if people have responded well to certain interventions in the past in similar circumstances, they are likely to do so now. If they have not had a good response to particular interventions in the past, they are unlikely to do so now. Therefore, teams should try what usually works before trying alternatives unless there are very clear reasons why an alternative is needed.

4.24 What is crucial is having clear systems in place such that if the plan is not working ,in whole or part, these are addressed in a timely manner. It should be noted that any interventions take time to impact positively or negatively. Therefore abrupt changes are unlikely to be useful and can be very harmful unless there is a very clear and specific safety reason to do this. In terms of inpatients the daily huddles with Red2green or equivalent, as set out in the 10 high impact changes, is now recognised to be a key component of tracking progress. In the community (with much higher caseloads and contacts typically measured in minutes per month) the review points for an individual will be much less frequent but should still be timely and responsive to any changing circumstances.

5 Pre-discharge Planning Through to Post Discharge

5.1 Pre-discharge planning should start no later than the 72 hour point as per the formulation in the 10 high impact changes. For many, and particularly people well known to services, it should have started as part of the decision to admit. When done well it means everyone is clear and the right steps can be taken at the right time to prevent any delays or setbacks. It is harder to do well if the person is unknown or their presentation is very different to previously. It is correctly said that one cannot be certain what will happen/change during an admission, but the broad picture is usually reasonably predictable including what needs to change so that the person can continue with care and treatment in the community.

5.2 The increased dis-continuity of services and increasing chance that a person would be admitted to a ward team who didn't know them and may not even know their local area meant that during the course of the century pre-discharge planning became more patchy and key issues may have been less obvious in early stages of the admission. This, plus rising community pressures for health and social care in general, could mean delays in key information coming to attention or delays in getting key decisions made. When things weren't working so well, care could get to late stage before e.g. anyone realised that person needed different accommodation. Things which were essential for creating an effective aftercare plan such as Care Act Assessments or having a named Care Coordinator should be clear after 72 hours but when systems were struggling often necessary steps only started weeks in, or at point where a person was ready for discharge. This caused, delays, frustrations and beds not being available when needed for people in the community. By not discharge planning early important things often didn't become apparent until late on and either caused delay or the person was discharged with no effective plan in place to address their care. Such precipitate discharges can occur after any length of stay including long stays. They have a worse prognosis and may be the least bad option available at that point, but precipitate discharges generally indicate a failure of planning. The 10 High Impact Changes are designed to reduce the likelihood of this occurring.

5.3 Inpatient care and treatment is 24/7 in nature. It is a significant jump from that to even intensive home treatment of 3 visits a day (and few can offer that) to core community input which might be once a fortnight or less. Therefore, care and treatment planning needs to look at what aftercare support is needed and who will provide what. This can often be on a tapering basis but how much can be tapered, when and what is needed, long term is individual and will be subject to ongoing review once in the community. For many people once the acute relapse factors which caused the admission to be essential have been addressed the pre-existing community care plan will remain the right one for them.

5.4 It is impossible to tell how a discharged patient will react to not being under scrutiny in the ward if this is not tested. This became increasingly the case as wards became more custodial and restrictive. Therefore, except for very short admissions of very well-known and supported people, discharge without any trial leave would be poor practice. All leave is “trial”. You can never be sure what someone will do or experience once they are away from the ward but if they never try leave, it can never be appropriate to discharge someone. Therefore, in general leave is stepped up with what is called ground leave tried first. This, as the name implies, is for short periods off the ward but in the hospital grounds. The grounds may or may not have a physical barrier to prevent the person going further (will do in secure, often don’t in acute). For each type of unit decisions will reflect the environment and the first amount of time out and whether with an escort or not.

5.5 Typically, trial leave away from the hospital grounds will then start with escorted leave and then move on to unescorted leave. There will be some form of time/distance restrictions on leave. Some people will breach leave conditions, and this then needs to be addressed, and the plan reviewed. Some people will come to harm on leave and some people may cause harm to others. We cannot prevent that except by never letting someone admitted go out. This is also not a harm free option and would also be very expensive and prevent many of those who could/should be successfully back in the community from getting back there. That is not to be complacent, but the best predictor of harm is whether or not the care and treatment has been effective at getting the person back into remission and stable enough for further care and treatment to continue outside hospital.

5.6 Restrictive practices such as enhanced observations, removing ward ligature points, video-surveillance etc can reduce some harms in a ward setting but provide no reduction in harms outside a ward setting especially once leave is no longer escorted. Therefore, the team have to consider whether sufficient progress has been made to test this with leave and if that goes well to move on to complete discharge. The more reliance is placed on restrictive and custodial practice on the ward and the less on therapeutic benefit, the more likely harms will occur once that person is away from that setting. It must therefore be emphasised that there are no “harm free” or “safe” options. The aim is to find the safest way forward, but any way forward involves uncertainty and testing and acknowledging harms which may occur at each and every step.

5.7 The test is therefore not “did harm occur” it is “was the decision to take that step reasonable”. Leave is also very important therapeutically. Getting time away from the ward reduces high expressed emotion and allows a break away from the stresses of being on a ward. Leave helps reduce deskilling and institutionalisation and, especially if in a local bed, better maintains engagement with the real world. By testing with leave, which is to some extent limited and controlled, this will reduce the likelihood of harms which would be higher if people were simply discharged without trial leave.

The aftercare plan

5.8 There is no perfect aftercare plan and once someone is out of hospital the ability to control or even influence what happens to or by them is extremely limited. Some types of ward discharge continue an element of ongoing use of the MHA for example Community Treatment Orders and Conditional Discharge. These both rely on recall to hospital as the main power within them although knowing a person can be recalled can increase concordance with the care and treatment plan. Neither can therefore control what happens day to day to or by that person, but they will have more explicit thresholds as to when an urgent/emergency recall to hospital is required. They also typically require more frequent follow up. As core community teams have struggled and chronically run short of time this extra need for follow up means that to at least some extent these cases are prioritised. This is especially true of conditional discharge.

5.9 Getting consistent aftercare overall became harder to organise and deliver as the century progressed. This contributed to under prescribing of Lithium and Clozapine despite the clear evidence base for their effectiveness including in cases where other treatments were much less effective. Both require closer follow up and monitoring for harmful adverse effects than most other interventions and both are long term treatments. Therefore, poor staffing made services reluctant to use them even where clinically indicated. The fear of the blame for not adequately supervising/monitoring them outweighed any consideration of the increased overall likelihood of harm and premature death by not using them (although people rarely considered this in that conscious way).

5.10 In practice, discharge planning is seeking to get the best plan for a person which is as consistent as possible with their needs, strengths and aspirations whilst preventing or minimising unwarranted harms from the condition or the interventions within available resources. The skill is pulling together the best ingredients from what is available rather than following a pre-set recipe. This is often possible without delays. In some cases, a vital element is missing and that needs escalating as soon as it is identified whether it is within trust control or external to trust control. The need to balance resources across all those who need them without diluting them so much that no one gets any real care and treatment is a daily challenge. The service aim has to be “good enough” rather than perfection as giving too much to one simply leaves less for the others. This can cause disputes and conflicts as to what is “good enough” in the eyes of all interested parties. In reality, there is generally enough consensus that a viable aftercare plan can be put in place and delivered. As with any other care and treatment plan the exact ingredients are person centred and need to reflect the purpose and goals of receiving care and treatment.

5.11 Discharge from hospital is a significant step even if going back to a place where the person feels comfortable and where there is a care and treatment plan that they feel is right for them. This is why the 72 hour follow up was introduced. 72

hours or less is too early to tell how the person will cope with being back in the community, but the aim is to check that at least the initial parts of the aftercare plan have happened as planned and that nothing in the person’s circumstances or their own state indicates that things are immediately going wrong and need rapid escalation. It also allows the person and their significant others to raise any questions about the plan or to clarify the next steps. As discontinuity of care became more common it became even more important to check that the receiving community team had the same understanding of the plan as the discharging team. It is an important step but not in itself an aftercare plan.

6 Investigation Review and Accountability

6.1 The first step is defining which types of incident require which types of review. Requirements and recommendations on this varied across the relevant period and to some extent between service types.

6.2 In general, throughout the relevant period there was a push to report more incidents including those with zero or low harm. The intention was to use these to try to learn about factors and thus seek to prevent such factors leading to more harm. The requirements to do this added to the form filling and loss of clinical time. The approach worked best for inpatients where many of the factors were amenable to intervention or under trust control and poorly in community where the reverse is true. Trusts would have an incident reporting system such as DATIX which fed into national data collection as well as allowing trusts to look at patterns and trends.

6.3 For low and zero harm there is a high degree of subjectiveness as to what needs reporting but for more severe harm the information is generally clear and more reliable. In theory the Trust/commissioners/regions/national bodies could analyse the data and issue guidance or alerts and this happened on multiple occasions over the century. These tended to be high profile and linked to deaths or “near misses”. It is less clear that the bulk of entries led to useful analysis or beneficial outcomes, but it was a success in getting people to think about the importance of such things.

6.4 Some incidents would then require a more focussed and thorough review. These were called Serious Untoward Incidents. Again, definition and reporting requirements changed for these through the time period but in general they were incidents where death or very serious harm had occurred/was narrowly averted. There would normally be a rapid local reaction i.e. on the day to look at whether any immediate learning or actions needing addressing could be rapidly identified.

6.5 There were various reporting processes over the years beyond that. The main reporting systems in this time period were called the STEIS (Strategic Executive Information System) and the National Reporting and Learning System. The definition of a reportable serious incident covered not just unexpected or avoidable death or serious harm but broader issues such as system continuity threats, abuse, reputational issues. Over time some types of incident became listed as "Never Events" i.e. things deemed so bad but reliably preventable that they must never happen but if they did require mandatory reporting. The Serious Incident Framework (2010 and updates) gave guidance on what counted as a serious untoward incident and what should be done.[26]

6.6 Within this was the 72-hour review. This was still a rapid relatively local response but was more in depth and was again to identify any immediate or very urgent issues needing addressing and to help decision making about what further review was needed. There could then be a further local review and some form of more external review and reporting to other agencies as set out in the guidance.

6.7 These processes could be and, often were, effective at identifying local learning and for sharing learning nationally and helping drive improvements. The main technique used in the reviews was "Root Cause Analysis" although at times other models were tried e.g. Appreciative Inquiry. In essence Root Cause Analysis was based upon finding the root cause and/or contributory factors to why an untoward event occurred and how do we prevent them. Appreciative Inquiry was more a strengths-based model focusing on what are the good things that reduce untoward occurrences and how do we do them more often.

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[26] https://www.england.nhs.uk/patient-safety/serious-incident-framework/

6.8 Over time concerns mounted about the effectiveness of the approaches in leading to sustainable service improvement. These came from clinical staff, operational managers, people in contact with services and their families, wider organisations (coroners, politicians, criminal justice system).[27] At same time the government introduced the duty of candour relating to concerns that organisations were concentrating too much on avoiding SUIs and reputational damage to the detriment of having an open learning culture by showing candour to help better address these.[28] It would not be correct to imply that duty of candour has now led to full transparency, but it has helped tilt the balance back towards a more learning than defensive mindset to some extent.

6.9 One criticism was that there was a tendency to look at what the last person to make a decision did (with the benefit of hindsight bias that person did not have). As noted earlier the sheer multitude of policies, guidance and recommendations mean that every clinician knows that they will not be following some or several of those in every single decision they make. Therefore, if the review stopped at that point, it found the person has not followed X and hence the answer was often more training on X or more forms to compete to demonstrate X without looking at benefit to harm impact of such recommendations. The person/team often felt they were blamed for issues outside their control enhancing the fear culture.

6.10 A good review should not have been based on that point but should have looked at why the person was put in the position of making that decision and whether they made a reasonable decision in the circumstances. It should also assess whether system issues impacted adversely on the ability to have the right information and to have the right options realistically available to allow different choice with a potentially better outcome.

6.11 There was frustration that recommendations did not lead to desired practice changes but often recommendations were driven by one case without considering the impact (negative as well as positive) of extrapolating that to hundreds of

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[27] For example, https://pubmed.ncbi.nlm.nih.gov/32339023/, published in 2020.

[28] The Duty of Candour was introduced in 2014 though Regulation 20 in the Health and Social Care Act 2008, see https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour.

thousands of cases. This was a major contributory factor to form filling taking precedence over therapeutic use of time which was even more negative when understaffed. Therefore, a feeling grew that in a minority of reviews, but too often, they did not identify factors or make recommendations that were robust and actionable. Further, that too many different bodies made recommendations which were too diverse and numerous to deliver within available change and clinical resources. As a result, many investigations and reviews did not lead to any identifiable sustained overall improvement.

6.12 The Patient Safety Incident Response Framework was introduced in 2022 with aim of it being operational by 1st April 2024, one of its aims was looking more directly at system issues and how these contributed to decisions and actions. Although implemented after the relevant period this was in response to multiple concerns in multiple healthcare fields over the relevant period. A key aim is to make recommendations more realistic and able to be sustainably delivered within resources available at any given time.

6.13 The role of the Health Service Safety Investigation Branch has also developed and expanded since it became operational in 2017 with more thematic reviews in the last few years. However, for mental health these are largely after the relevant period.

6.14 In Mental Health inpatients one inadvertent but adverse impact over the course of the 21st century was to create more custodial and defensive practices taking away the focus from delivering effective care and treatment needed to get the person back to best level of remission. Some of this was good and essential e.g. reducing fixed ligature points but others became counterproductive and simply displaced behaviours rather than effectively treating the mental condition. Effective treatment would ensure that the need/desire to do those things was no longer present or could be more safely managed. This was not to say this was the norm, but it became more prevalent as the fear culture increased.

6.15 The motivations were right. For example, if a person died due to a non-fixed ligature such as a plastic bag, then it is right and proper to weigh up the harms and benefits of allowing access to plastic bags but they are easily accessible and can have multiple uses. The question becomes do you try to stop any inpatient having access to any type of plastic bag at any point during an inpatient stay. If you do, then other than forensic units with no unescorted leave and very high-level security and staffing, such a policy is not only bound to ultimately fail but will cause multiple issues preventing therapeutic progress. Additionally, once a person goes on leave, they will have easy access. People can also die from multiple things e.g. socks. If you take away any non-fixed potential ligature or choking items that will include all shoelaces, belts, scarves, bras, and most clothes that can be cut/torn to make a ligature or to obstruct the airway. The result would be that person having no personal possessions or clothing. Even there, a person can still head bang on any hard surface (this is much more likely to cause severe irreversible damage/death than e.g. self-cutting). The only alternative would then be to put that person in a padded cell to avoid the potential for head banging. Even then they can choke on food or starve themselves. Therefore, it can be seen that the pursuit of the harm free space can be counterproductive where a person can simply change the form of harm. Such restriction could also never allow leave let alone discharge. It therefore sets everyone up to fail. That is not arguing that there should never be restrictions on items or personal choices.

6.16 Therefore, things which are not essential such as fixed ligature points are reasonable to remove, whereas others such as door tops can’t be avoided but door top alarms can reduce certain types of serious harm. Other potential harms may be person centred based on what that person might likely do with the items available in current their state. The question for clinicians will be how we manage the risk of harm to buy time to help them get back to remission. Too many blanket rules cause more harm than good, but some things do need blanket rules if, after impact assessment, the benefits substantially outweigh the harms. As with any restrictive practice, including increased observations over the course of days and weeks, at some point a gap in that restrictive practice will occur meaning that harm will occur unless the underlying issues driving the harm have been addressed.

6.17 Regardless of the reporting framework or the tools used the key questions for SUIs involving clinical care and treatment are:

a. Was the care and treatment plan in place a reasonable and deliverable one to maximise benefits and prevent/reduce unwarranted, avoidable harms or, if not, why not?
b. Was the care and treatment plan delivered as planned or, if not, why not (including availability of essential resources of which staff time is often most critical)
c. Did the key decision maker/s make a reasonable decision based upon the information reasonably available to them at that time or, if not, why not?
d. 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?
e. What can reasonably de 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.

Expert Declaration

I, Ian Alexander Davidson, DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to assist the Inquiry.
2. I know of no conflict of interest of any kind, other than any which I have disclosed in my report.
3. I do not consider that any interest which I have disclosed affects my suitability as an expert witness on any issues on which I have given evidence.
4. I have shown the sources of all information I have used.
5. I have exercised reasonable care and skill in order to be accurate and complete in preparing this report.
6. I have endeavoured to include in my report those matters, of which I have knowledge or of which I have been made aware, that might adversely affect the validity of my opinion. I have clearly stated any qualifications to my opinion.
7. I have not, without forming an independent view, included or excluded anything which has been suggested to me by others.
8. I will notify those instructing me immediately and confirm in writing if, for any reason, my existing report requires any correction or qualification.
9. I understand that;
    1. my report will form the evidence to be given under oath or affirmation;
    2. questions may be put to me in writing for the purposes of clarifying my report and that my answers shall be treated as part of my report and covered by my statement of truth;

STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

I A Davidson [Signed Electronically]

Dr Ian A Davidson

18th March 2025

Appendix 1: High Level Descriptors of Common Ward Types

Naming of ward types is not always consistent, but the following are the main types:

A.1.1 Ward Types –adults/older adults

a. Acute adult/older adult – these are the most frequent ward type, which essentially take people direct from the community. Lengths of stay can vary from a few days upwards, but averages are around 50 days now (increased over the course of the century)
b. Psychiatric Intensive Care Units – these are for short term intensive care top ups to adult/older adult acute wards. Some people go straight to PICU from the community and then step down through an acute ward. Designed to be for a few days but can last longer.
c. Organic wards – people with severe cognitive impairment and linked issues – typically dementia and usually older adults.
d. Forensic wards – typically take people through criminal justice system from police, prisons, the courts but may also take people from acute wards where level of harm is very high and can't be addressed outside a secure setting. 3 levels of increasing staffing per case and security- low, medium, high secure.

A.1.2 Ward Types – adults/older adults specialist non-secure

a. Perinatal Units – typically accept cases up to one-year post-partum. Lengths of stay variable but not typically long stay.
b. Specialist Eating Disorder units – for people with eating disorders for whom inpatient treatment is essential – varying lengths of stay.
c. Psychiatric Rehabilitation units – now classed as Type 1 (lower intensity of need) and Type 2 (higher intensity of need) but multiple names over the years. Typically take people from acute wards needing specialist inpatient rehabilitation. Typically, long lengths of stay – e.g. 2 years but rarely people are in them for decades.
d. Personality Disorder units – a different type of long stay and a wide range of names over the years. Typically exclude people with psychoses or eating disorders

A.1.3 Ward types – other specialist

a. Learning Disability units – for people with moderate to severe Learning Disability for whom inpatient stay is deemed imminent. Shorter term ones were often called assessment and treatment units but again names varied as did length of stay. Some LD units have very long lengths of stay into decades. In the last decade these should have had Care And Treatment Reviews (CTRs) or Care (Education) and Treatment reviews if children or still attending secondary level education. NB autistic people are rarely admitted due to autism. Typically admitted due to co-occurring LD to LD units or to SMI wards due to co-occurring SMI (not because autistic).
b. Drug and Alcohol units – over the century most of these transferred out of NHS delivery as they became commissioned by local authorities.
c. Brain injury units – these, as the name implies, are for people with brain injuries giving rise to serious mental health problems requiring specialist hospital treatment – typically longer stays rather than acute.

A.1.4 Ward types - CAMHS

a. Tier 4 (Tiers 1-3 are community). These are the general admission wards for children/adolescents – typically take people from age 12 – tend to be sub-regional.
b. There are a small number of children's wards for people up to age 13 – tend to be regional.
c. Children/adolescents with certain types of MH problem such as eating disorder may be placed in paediatric wards by local arrangements.
d. People under 18 being admitted to an adult MH unit became an event requiring rapid escalation/high level approval during the course of the century so became very rare.

A.1.5 Ward types – NHS and Private

a. At different times and in different places the mix between NHS funded NHS provided beds and NHS funded private hospital beds varied.

b. The same broad categories existed but which were provided where and by which organisation changed over time.
c. Most acute services were and are provided locally. The more specialised the service the more likely it will be sub-regional, regional or national.
d. The NHS has an overall aim of making beds as local as feasible and classes some acute/PICU beds as “inappropriate out of area” which it wishes to see at zero.

Appendix 2: Overview of Mental Health Treatment Team Types

1. In 2000 the Community Mental Health Team (CMHT) was the main community team offer in adult/older adult services. CAMHs and Learning Disability services had community teams covering similar broad functions for their populations.
2. By 2000 other teams were coming into being e, g. many adult CMHTs split into adults of working age and separate older adult teams. Specialist Eating Disorder and Hospital Psychiatric Liaison teams existed and were developing at different speeds across the country.
3. The NSF brought in three new tream types to take on functions that already existed to some degree but with enhanced funding.
4. Early Intervention in Psychoses sat alongside CMHT and was to be the point of access for first episode psychosis (exact role and age ranges evolved over time).
5. Crisis/Resolution Home Treatment teams were to provide extra input if someone went into crisis and/or these teams might deliver better option for that person than admission.
6. Assertive Outreach Teams – a tertiary service for those who had been deteriorated to point where they needed much more intense input for longer than could be provided by CRHT.
7. Over time other teams were created:
    a. Perinatal services for those who were pregnant to in post-partum period.
    b. Personality Disorder/Complex Emotional Needs teams for those falling under those labels.
    c. Substance Misuse including Alcohol Misuse services did exist but these were moved from Health to Social Care commissioned.
    d. Community Rehabilitation teams developed for those needing longer more intensive rehabilitation than could be offered via CMHT.
8. CAMHs had the 4-tier model with Tier 3 being the team below Tier 4 inpatients.

9. Learning Disability had community teams.
10. Other teams such as Gambling services arose in some parts of the country.
11. Confusingly team names often were different for teams with similar functions in different places and/or at different times in the Inquiry Period – so names like Single Point of Access, Recovery, Assessment, Primary Care MH team may appear in reviewing that time period. The key question to ask is what their function and role in that place at that time was.

Appendix 3: 10 High Impact Changes in Mental Health Inpatient Treatment

1. Identify the purpose of the admission, set an expected date of discharge (estimated discharge date (EDD)) for when this purpose will be achieved, and communicate this with the person, family/carers and any teams involved in the person's care post-discharge, e.g. community mental health team (CMHT) or crisis resolution home treatment team (CRHTT).

2. Complete care formulation and care planning at the earliest opportunity with the person, and within a maximum of 72 hours of admission.

3. Identify any potential barriers to discharge early on in admission and take action to address these. Where appropriate action cannot be taken, escalate this to the ICB Discharge Lead.

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.

5. Hold Multi Agency Discharge Events (MADE) with key partners on a regular basis, to review complex cases.

6. Ensure partnership working and early engagement with the person, family/carers and teams involved in the person's post-discharge support; agree a joint action plan with key responsibilities, for example for social care, housing, primary care, CMHT, CRHTT, etc.

7. Apply 7-day working to enable people who are clinically ready for discharge to be discharged over weekends and bank holidays and allow people who require admission timely access to local beds.

8. Identify common reasons and solutions to people being delayed in hospital once clinically ready for discharge e.g., housing support / accommodation.

9. Communicate notice of discharge at least 48 hours prior to the person being discharged, to the person, their family/carers and any ongoing support service.

10. Follow up to be carried out with the person by the CMHT or CRHTT at the earliest opportunity and within a maximum of 72 hours of discharge, to ensure the right discharge support is in place

Appendix 4: Therapeutic Benefit includes preventing/reducing unwarranted and avoidable harms

1. The therapeutic aim is to help a person get back to the best level of remission as soon as possible, allowing them to lead their best life whilst preventing/reducing unwarranted avoidable harms from the condition and/or the interventions. Therefore, all therapeutic decisions involve balancing the likely benefits of the harm of any intervention, compared to doing nothing, the combination of each action singly or in combination.

A.4.1 Prevention/minimisation of unwarranted and avoidable harm

2. Any therapeutic plan/intervention has two broad aims:
   a. To help improve the persons health so they get back as quickly as possible to their best level of heath and functioning.
   b. Preventing/minimising unwarranted, avoidable harms arising from the condition/s and/or the interventions for the condition/s.

3. Whilst ideally these two things are in tandem attempting to improve, one can at times make the other worse. The choice of the words unwarranted and avoidable are very specific. There are no harm free options as every decision/action in life, including doing nothing, has some risk of harm and some potential benefit. Therefore it is always seeking to find the best balance between competing options.

4. Although custodial/restrictive practices can be essential to addressing certain types of intensity of harm at certain times, if the harms are due to the SMI and/or treatment for SMI, then it is only an effective care and treatment plan which will deliver the desired outcomes. Other steps may buy time to put in place and deliver the effective care and treatment plan but of themselves don’t address the issues driving the unwarranted, avoidable harms.

5. There are four broad categories of harm:
   a. Harm to own health and safety;
   b. Harm to others;

c. Harm from others; and
d. Specifically in a healthcare setting, harm includes the interventions being used to address your health condition/s.

A.4.2 Harm to Self

6. All decisions, whether crossing the road or doing exercise or not, carry risks of harm to the persons health and safety. In mental health we are seeking to reduce unwarranted/avoidable harms and not pretend there are harm free or safe options.

7. Smoking is a classic example of a known harm to persons own health and safety not covered by the Mental Health Act. Therefore the harm itself has to be linked to the mental disorder, whether deliberate or inadvertent.

8. For deliberate, common examples are cutting oneself, ligaturing or overdoses but there are many other types e.g. food restriction.

9. For inadvertent, common examples are self-neglect or not recognising/being able to respond appropriately to common hazards.

10. The biggest contribution to premature mortality in SMI are untreated/undertreated physical health conditions, which often in turn are linked to poor choices when the person was too unwell to make better choices.

A.4.3 Harm to Others

11. The harm to others has to be linked to the mental disorder, otherwise it is purely a criminal/civil justice issue.

12. All the types of harms to others that can be done by human beings can also be done by people with SMI. It is not always clear cut whether the harm arises from the mental disorder, or from the multiple other factors which give rise to harm to others in society, but often it is clear that the mental disorder is driving/exacerbating that harmful behaviour.

13. Sometimes the first presentation is due to serious harm and therefore is not preventable by services. More typically for people known to services there will be warning signs as to when such harms are most likely, and typically these are most likely at times of ineffective or no treatment for a relapse.

14. In an inpatient context it is essential to get effective treatment in place as quickly as possible to reduce such harms. It is also crucial to consider which types of restriction might be necessary to minimise likelihood of harms, whilst seeking to get most effective care and treatment to point of delivering the required improvements. This includes which type of ward/service might be best to manage the harm. For some people there will be a need for treatment to occur in forensic services, either due to severity of the harm or because that severe harm is happening/is likely to persist/recur without such a level of security.

A.4.4 Harms from Others

15. At certain times in their illness, some people with SMI become at increased vulnerability to abuse, exploitation, and other types of harm from others.

16. Such harms can happen to any human being, and they can be significant factors in vulnerability or precipitating SMI for the first episode, but whilst the past cannot be changed, services have to work with the person to reduce the harms they are exposed to from others, and from that point onwards. This included helping a person to best level of remission so that they are less vulnerable.

17. It is important to identify such harms and help the person find ways of addressing them but often they fall outside the authority of health services. Safeguarding and general universal legal measures may help reduce/prevent some of the harms from others.

A.4.5 Harms from Interventions

18. All types of intervention (physical, psychological, pharmacological, social) will cause harms to some people at least some of the time.

19. Failure of treatment can cause harm if a person feels it is because they are too hard to help. Part of reducing harm from interventions is, in any intervention, explaining that no intervention works for everyone and if adverse effects are too high or the intervention is not working, then that is common and simply a reason to look at alternatives. Currently we cannot readily predict who will respond best to which at an individual level.

20. Informing people about likely adverse effects/harms is also crucial as well as encouraging them to say if anything doesn't feel right, to let us know, even if not listed as a known side effect.

21. Sudden discontinuation of any form of intervention can cause harm so it is important that patients inform the service as soon as possible if they are going to stop anything.

22. For certain types of intervention, specific reviews/monitoring need to be in place and must be explicit and delivered.

Appendix 5: Curriculum Vitae

Qualifications

M.B., B.Ch. B.A.O., (with commendation in midwifery and gynaecology)

Queen's University, Belfast – July 1980

M.R.C.Psych – November 1984

F.R.C.Psych - February 2001

MA Medical Ethics and Law Keele University 2006

Current NHS roles:

Two days seconded to Getting it Right First Time (GIRFT) programme NHSE/I as national clinical lead Crisis/acute Mental Health

Current non NHS funded roles:

Medical Member First Tier Tribunal Mental Health – judicial appointment.

Director Mersdee Health Ltd

Professional Profile

1. Experienced clinician – over 43 years in Psychiatry of which over 37 at consultant level.

2. Experienced manager – over 20 years experience of clinical management roles- 9 at executive director role including 15 months as interim chief executive.

3. Specific skills relating to design, implementation, sustainability and review of Mental Health, Learning Disability, Drug and Alcohol services.

4. Specific skills relating to reviews and investigations including use of root cause analysis.

5. Specific skills relating to handling and review of complaints.

6. Specific skills relating to service design through to implementation and review including through scrutiny and consultation.

7. Specific skills relating to development, delivery and review of integrated governance.

8. Specific experience of all major Trust committees including attendance at Audit Committees in chief executive and deputy chief executive roles.

9. Specific skills relating to highly regulated services including from regulatory as well as provider side.

10. Specific skills in relation to medico-legal aspects including Mental Health Act, Caldicott Guardian and Senior Information Risk Owner, Freedom of Information, interface between criminal justice and healthcare systems.

11. Specific skills relating to working for external regulatory bodies such as CQC and its predecessors Healthcare Commission and CHI

12. Specific skills in relation to contributing to and leading workstreams at regional and national level e.g. Department of Health, North West SHA, Royal College of Psychiatrists, Academy of Medical Royal Colleges.

13. Specific skills in relation to education, training and research.

14. Generic transferrable skills including project management, leadership including at executive level, the role of the accountable officer and board, chairing and facilitating effective meetings, projects and workstreams, coaching and mentoring, developing staff and succession planning, working effectively with users/consumers and purchasers of services, understanding of role of health and well being in wider societal and economic contexts, working with a range of elected representatives at local and national levels including politicians and interest groups of different types and in addition to media training I have experience as executive lead for communications and marketing.

15. My RCPsych Autism Champion role was UK wide covering all faculties and divisions; my NHSE/I role is England wide. In different ways they therefore involved work in multiple systems across England but also in Autism role comparing and

contrasting across the various jurisdictions. The NHSE/I role includes visits, presentations and workshops in systems across England. The Autism role involves visits, presentations and workshops across the UK. Both involve discussing and contributing to policy development and review through to governmental level.

16. The Complex Recovery Assessment and Consultation service (CRAC) which I jointly created and led was shortlisted for a HSJ award in 2017. It also contributed to CWP acute bed flow being a national exemplar including having the lowest number of people having an acute length of stay over 60 days in national benchmarking(NHSBN 2018 report). The Adult Autism Diagnostic service which I jointly created and lead received a “Highly Commended” at the Positive Practice in Mental Health awards 2018.

Academic and research

My higher professional training included included 3 years as Clinical Lecturer/Hon Specialist Registrar (1984-7) during which as well as clinical training I ran a major research project on behalf of Professor Copeland which led to over 40 publications for the team plus the gaining of a major MRC research grant. I also assisted in revising undergraduate and postgraduate training. I personally have over 40 publications half relating to that project and the rest on other topics- my extensive clinical and managerial roles meant that these were largely before 2000.
Researchgate https://www.researchgate.net/profile/Ian_Davidson7

Alongside my clinical consultant roles I was research programme lead for the Mersey regional Higher Training scheme in Psychiatry in mid 1990s. I was lead for research, audit and development in North Mersey Community NHS Trust 1995-9. I was on Liverpool Local Research Ethics committee 1995-9. In my executive roles for Cheshire and Wirral NHS FT 2002-10 I had executive lead for research.

Other non-clinical roles held alongside my clinical ones over the years

I have had extensive involvement with RCPsych initially as a trainee representative and then in a variety of regional and national committee roles through to 2010.

I have had extensive educational experience including helping to run and deliver courses since I was a lecturer and through my consultant career. In addition to being an educational supervisor I had two spells as Programme Director and one as research tutor for Higher Professional Training In General Psychiatry for Mersey Deanery.

I have had extensive clinical managerial experience since 1987 including as clinical and medical director, interim chief executive and regional and national roles such as Clinical Pathway Chair Mental Health (Darzi Review) - North West and England. From this I was on the New Horizons Board at DH through to publication.

At various times my Trust roles have included executive lead for Service Innovation and Development; Clinical Standards, Integrated Governance, Caldicott and Senior Information Risk Officer, Mental Health Act, Medical Appraisal.

In relation to regulation I have been an expert for the Commission for Health Improvement clinical governance reviews, for Health Care Commission on clinical complaints; for CQC as a clinical adviseer and as an inspector; I was a GMC associate (Health Assessor, Supervisor, Expert Adviser to FTP panels), Public Health Service Ombudsman clinical complaints adviser. I was a SOAD in England and Wales and Isle of Man.

Since 2010 have had my own business Mersdee Health Limited. In this business role I have undertaken investigations into clinical standards and serious untoward incidents, provided executive coaching, undertaken a range of medico-legal work and provided consultancy and training services.

Chronology of posts held

1980- 1981-Pre-registration house officer City Hospitals Belfast

1981-1984 General professional training in psychiatry -Mersey rotation

1984-1987 Clinical Lecturer University of Liverpool/ Hon. Senior Registrar Mersey Region Higher professional training scheme General Psychiatry

1987- 1999 – Consultant General Psychiatrist Liverpool (organisational names changed but continuity of role)- during this time had various non-clinical roles as previously listed

1999-2010 – Consultant General Psychiatrist Chester – (during this time organisational roles changed but continuity of role) – during this time was clinical director adult psychiatry 1999-2001 and then medical director 2001-2010 plus a variety of other non-clinical roles as previously listed (all alongside and not replacing clinical role)

2010-present Part Time Consultant General Adult Psychiatrist (from 2012 included lead Consultant Psychiatrist for adult Autism team until October 2022) plus a variety of other roles of which the major ones have been

A. Medical Member First Tier Tribunal Mental Health 2013-continuing
B. RCPsych Autism Champion 2016 – 2021 – this included participation in multiple national policy setting and other activities including helping shape research priorities
C. Clinical Adviser to the NHSE/I reducing out of area mental health bed usage support programme 2017-9
D. National Clinical lead GIRFT crisis/acute adult mental health 2019- ongoing