Report for the Lampard Inquiry:
An overview of inpatient units: their composition, function and what constitutes good nursing care

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Contents

Summary of Experience – Josephine Maria Nelligan

I, Josephine Maria Nelligan, am a registered nurse with the Nursing and Midwifery Council (NMC) in the field of learning disability. I also hold the following qualifications:
D.P.S.N BA (Hons) Health Diploma Community Nursing and MSc Practitioner Research.
Full details of my qualifications and experience are included in Appendix 1.

I am currently retired (as of July 2024) and work on a consultancy basis. I first qualified as a registered nurse in 1985 and have worked in inpatient and community settings, as well as in professional development roles until 2004. I then moved into a nurse leadership role focusing on practice improvement and professional development in mental health. The role of Deputy Director of Nursing required me to focus on nursing practice and the development of standards as part of leading the organisation's clinical policies. In my role as Deputy Director of Nursing/Associate Director of Nursing at Cheshire and Wirral Partnership (CWP), I was the author and lead of the following policies: admission transfer and discharge, supervision, therapeutic observations, physical health in mental health, Cardiopulmonary resuscitation (CPR), care planning and many more. These policies set out the standards of practice for nurses and other health professionals in the care of patients whilst on inpatient wards. This also required setting out the education requirements as Continuing Professional Development (CPD) lead. I was also the lead for monitoring processes linking with external standards, such as NHS Litigation Authority (NHSLA) and Care Quality Commission (CQC), where appropriate.

In 2014, when the requirement to review staffing on inpatients wards was introduced, I developed an approach in collaboration with ward staff to review staffing from a patient and staff experience perspective. This included walk arounds and interviews with patients and staff. With this approach, practice, environment and experience were triangulated with incidents and staffing numbers to set out a base line. It also included a new proposal for the skill mix and overall staffing for each ward which was presented to the Board of Directors for support and approval. I continued this work in three other organisations as executive lead until July 2024.

I have also held the roles of Chief Nurse and Quality Officer (Lancashire and South Cumbria Foundation Trust), Director of Nursing and Quality (North Staffordshire Combined

Healthcare NHS Trust) and Interim Lead for Learning Disability Services and Associate/ Deputy Director of Nursing (Mental Health) and Therapies (both at CWP NHS Foundation Trust). I am an experienced Chief Nursing Officer and have delivered large scale improvements in the quality of care of 3 Trusts with significant care quality challenges.

I have also contributed to setting out national standards for inpatient care, the most recent being Culture of Care Standards for Mental Health inpatient services (2024 NHSE). Additionally, I have contributed to the review of mental health nursing carried out by Baroness Watkins of Tavistock, "Commitment and Growth; advancing mental health nursing now and for the future" (NHSE 2022).[1]

Following my time as Chief Nurse and Quality Officer at Lancashire and South Cumbria Foundation Trust, I was seconded to Greater Manchester Mental Health Trust to support them with a particular focus on patient safety and nurse leadership following the significant incident at the Trust subject to the Independent Review.[2] I worked at the Trust from the 1st of April 2023 until my retirement in July 2024.

I am an executive reviewer for the CQC. This role involves providing external support to CQC inspections by bringing independent judgment and experience to the inspection process. I am not employed by the CQC and remain an independent professional who has not carried out any inspections of the Essex Trusts.

[1] https://www.hee.nhs.uk/sites/default/files/documents/Commitment%20and%20Growth%20Advancing%20Mental%20Health%20Nursing%20Now%20and%20for%20the%20Future.pdf

[2] https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2024/01/Final-Report-Independent-Review-of-GMMH-January-2024.pdf

Summary of Instructions and Approach

I was instructed on 12 March 2025 to provide a report from a nursing perspective to support the Inquiry's instruction of Dr Ian Davidson. I was instructed 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 relevant period.

The broad areas I have been asked to address in my report are:

a. The makeup (generally) of a mental health inpatient unit and the healthcare professionals that work on a unit.
b. What care should look like?
c. What should happen?
d. What are the minimum standards to be expected?
e. What should happen when things go wrong?

More specifically I have been asked to provide information and context on the following specific topics from a nursing perspective, including (but not limited to):

a. How a unit should be staffed, staff training, support, monitoring and supervision.
b. Background to roles on a mental health ward, shift frameworks, supervision and staff grade/professional mix.
c. Observations.
d. Reassessments.
e. Ward safety, management of risk, crisis management, and self-harm risk.
f. Sexual safety and mixed wards.

I am aware that the Inquiry has instructed a psychiatric expert, Dr Ian Davidson, and am aware of the contents of his report. I therefore do not seek to duplicate any areas which are addressed in Dr Davidson's report.

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.

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

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

a. Academy of Medical Royal Colleges "Acting as an expert or professional witness Guidance for healthcare professionals".[3]
b. The Criminal Procedure Rules 2020 and the requirements for a report set out in CPR 19.4. 2

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 nursing opinion.
c. Seek to identify any particular areas of disagreement within the nursing 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.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/05/Expert_witness_0519-1.pdf

Preamble

This report covers the relevant period between January 2000 and December 2023. Whilst this period of time saw significant changes in the NHS, including Mental Health services, it was also a period of significant change in organisational structures, professional education/leadership and the recognised voice of people with lived experience.

Purpose of the report

This report is prepared in line with my instructions. It does not review or address any individuals, teams or organisations during this time. It is intended to be a high-level report considering general themes across England during the relevant period. In preparing this report, I have had regard to the report of Dr Davidson and have focused upon providing additional detail from a nursing perspective.

The report is designed to set out a broad context to help the Inquiry better examine variations in care during the relevant period and the possible reasons for these.

1. Staffing

1.1 Inpatient wards in mental health are diverse and include units for: young people, mother and baby, learning disabilities, forensic, older people, substance misuse, adult mental health and psychiatric intensive care units (PICU). Each unit varies in size from 4 bedded units to as large as up to 30 beds. This report refers to patient care and nursing in general terms and is a broad overview of themes and issues. Inpatient wards are staffed by a core nursing team comprised of registered and non-registered nurses led by a Ward Manager who has 24-hour responsibility for the care of patients. Ward managers should be supernumerary, and their team comprises a deputy and nursing clinical lead who support and supervise the non-registered staff, coordinate the implementation of care plans, provide 1 to 1s (with patients and staff) and lead the delivery of patient care.

1.2 Whilst it is not possible to set out a typical staffing model in terms of numbers and ratios, in general each shift will have a:

i. Registered nurse in charge of the shift, who will coordinate the shift lead handovers and allocate tasks to the shift team.
ii. Second registered nurse who will support patients and staff deliver clinical interventions for example medication 1:1s and attend ward rounds.
iii. Number of Health Care Support Workers (HCSW) who will support patient activities on and off the ward.

1.3 Nurses, as part of the multidisciplinary team, also work with other disciplines at ward level. Titles differed from locality to locality over the relevant period, however following the implementation of Agenda for Change in 2004 (NHS terms and conditions) for all non-medical clinical staff, titles along with job descriptions and remuneration were standardised nationally.

1.4 The Nursing team provide 24-hour care through a shift-based system of 8- or 12-hour shifts. The latter 12-hour shift pattern has reduced time for handovers and are often financially driven as they are cheaper to run. It is good practice to have a mixture of shifts available for staff. Continuity of care between shifts is facilitated by a shift handover where patient care is reviewed in terms of progress or significant changes in the person's

presentation. It is good practice when handing over care to carry out a visual inspection of the patients on the ward at that time.

1.5 In general, it has been challenging to deploy a minimum of two registered nurses per shift to ensure that both patients and staff are supported and supervised appropriately. This became more challenging during the relevant period due to staff shortages and, as a result, there was increasing reliance on non-registered staff known by different titles, one of which is Health Care Support Workers (HCSW).

1.6 Nurses are supported professionally by Matrons who have a role in quality improvement and monitoring and usually have responsibility over 2-3 wards. They in turn will have professional accountability to the Director of Nursing (Chief Nurse) via roles such as Heads of Nursing and Associate Directors of Nursing.

1.7 Initially, staffing absences for nurses as a result of sickness, vacancies and acuity tended to be covered with local arrangements using bank staff over time and, to a lesser extent, agency staff. Bank staff tended to be regular staff who held a bank contract for a set number of hours. They could also have held a substantive contract, for example, part time staff doing extra shifts. Agency staff were employed by an agency and were less likely to know the ward and services. However, as the relevant period progressed, there was a move to develop a temporary staffing function centrally within organisations. This function centralised the recruitment and deployment of bank and agency staff known as temporary staff at corporate level moving away from local ward arrangements. This move was to strengthen governance and efficiencies, however, it may not have aided continuity in patient care as previously local arrangements enabled a greater number of bank staff to be deployed to the ward. These bank staff tended to know the patients and the specific ward. However, to mitigate against this, skilled temporary staffing teams would work with ward managers to match staff to wards they knew.

1.8 The medical team are led by a Consultant Psychiatrist, usually with one allocated per ward, however, they may be allocated by locality where the Community Consultant follows the patient after admission. The consultant takes on the role of responsible clinician (RC) whereby he/she has overall responsibility for patients detained under the Mental Health Act. Consultants work 9am-5pm 5 days a week and participate in an out -

of- hours call system. They are supported by junior doctors who respond to patient's medical needs in hours and out-of-hours and carry out admissions. Some of the junior doctors' role will rotate on a 6 monthly bases whilst more specialist higher trainee roles will have set contracts for a longer period of time during their training. The medical staffing of wards is set out by the Royal College of Psychiatrists guidance and for trainees via the local deaneries.

1.9 For medics, terms and conditions of employment have continued to be prescriptive and protected. For example, Consultants have agreed job plans with protected time for education, training and audit activities. This is seen as more favourable than those for non-medical staff and may cause a potential sense of being detached from the ward (as can be the case with some MDT members). Little has changed over the relevant period in terms of the "power differential" between medics and other members of the MDT. However as new roles have developed there has been greater empowerment for non-medical roles.

1.10 Staffing for Occupational Therapists, Psychology and other Allied Health Professionals was ad hoc with variations in allocation of resources from ward to ward and locality to locality. Cover for absences was not generally guaranteed which could have also resulted in gaps in the delivery of person-centered care plans and an individual's recovery. In the main, these roles would work 5 days a week rather than a 7-day shift pattern.

1.11 The nursing team are supported at ward level by house keepers, ward clerks (there is variation in the deployment of these roles) porters and domestic staff. These roles assist in the operations of the ward: domestics, for example, are responsible for hospitality, non-clinical cleaning, preparing and delivering meals to patients and are usually dedicated to a particular ward. Ward clerks assist the ward manager in the administration of the ward, and this would include basic admin tasks, processing mental health act papers and workforce administration. All roles are essential to ensure the ward functions and that patients are supported accordingly. In the absence of these support roles the tasks they would have performed, were and are, picked up by the nursing team which will take them away from direct nursing care.

1.12 Rosters for nurses at the beginning of the relevant period tended to be completed manually and coordinated by the ward manager. However, as the relevant period progressed, electronic rosters were introduced to Trusts. This followed a recommendation from the National Audit Office (2006 - Improving the use of temporary staffing in NHS acute and foundation trusts).[4] This enabled a system which was more efficient (where implemented appropriately) in the allocation of staff and also the monitoring of resources. There was also the function within one such roster known as "safe care" to be able to allocate staff to meet the dependency needs of patients on a shift-by-shift basis. This module, where available, was implemented to various degrees nationally.

1.13 Following the Francis Report,[5] the National Quality Board (NQB 2014) issued guidance to all Trusts to review their nursing staffing establishments on each ward and to report this review, along with any recommended adjustments, to their Boards for approval.[6] Further guidance for mental health staffing was published by the NQB in 2018.[7] The purpose of this requirement was to address low staffing levels and the potential harm to patients by ensuring that a process of regular review of nursing staffing establishments was put in place . It was not possible to direct the number of staff and ratios as no two wards were the same in size, layout and patient profile. The requirement of Boards to approve nurse staffing levels strengthened accountability and the focus on the nursing workforce. The guidance required these reviews to consider qualitative and quantitative data. In addition, nursing staff fill rates on a shift-by-shift basis were required to be displayed at ward level, reported to boards and centrally to the Department of Health. Shift fill rates refer to the actual number of staff on a shift against the planned number of staff the ward manager planned to have based on clinical need. For example, if a shift planned 10 staff but had only 8, the fill rate would be 80%. Requirements included an annual report to the Board with 6 monthly updates which included a review

[4] https://www.nao.org.uk/wp-content/uploads/2006/07/05061176.pdf
[5] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
[6] nqb-how-to-guid.pdf
[7] https://www.england.nhs.uk/wp-content/uploads/2021/04/safe-staffing-uec-june-2018.pdf

of an establishment's progress against previous actions and identified changes in practice where required.

1.14 Application of the national guidance varied by locality and at times could appear misleading. For example, some localities reported nursing staff fill rates against establishments (the allocated budgeted staff to a ward), which could be low and not reflect patient acuity. Some wards could show a fill rate above 100% where this was based on the budgeted establishment but would not in fact represent clinical need, therefore giving a 'false positive'. Whilst the application of safer staffing requirements varied, so too did the allocated resources to support this process.

1.15 Furthermore, evidence-based staffing tools were not designed for mental health wards initially and trusts relied on professional judgement. It was not until the Mental Health Optimal Staffing Tool (MHOST) 2019 was developed, that this option became available. The tool was commissioned and funded by Health Education England. The tool measured dependency and acuity levels for patients and enabled nursing staff to use this information to calculate the staffing they needed on a ward. The tool was not mandated or universally applied and, where it was it needed, it was adapted to take account of variations at unit level.

1.16 Up to this point, nursing establishments were, by nature, historically derived. In other words, there was no formal system or requirement to review nursing establishments. Ward managers had a baseline rota and deployed additional staff as and when required from the local bank dependent on the level of need. With the introduction of "Safer Staffing" requirements, more Trusts reset their establishments following review by the Director of Nursing. Over time, the NQB guidance was refined, and also required the multi-disciplinary team to be considered in staffing reviews.

1.17 In summary, it is not possible to dictate staff to patient ratio nationally due to a high number of variables at ward level. Each ward team should have sufficient substantive nursing staff (registered and non-registered) to deliver high-quality patient care while also having sufficient time to complete clinical and administrative tasks, with access to additional temporary staffing for increases in patient acuity. Reliance on healthcare support workers has often occurred for a variety of reasons and as a result, they may have taken over some tasks previously completed by registered nurses.

1.18 While two registered nurses per shift is the minimum to allow for breaks and nursing tasks etc., three registered nurses per shift is preferable to enable one registered nurse to always be “on the floor” with patients to support their needs and to supervise support staff. Of course, in some specialities this is achieved, but this tends to be the most difficult in acute mental health wards. This view may not be universally held and because of austerity measures there may be pressure to reduce registered nurses or replace them with lower cost roles such as registered nursing associates.

Multi-Disciplinary Team working

1.19 Whilst the nursing team provide 24-hour care to patients, along with the delivery of the care plan and therapeutic interventions, the multidisciplinary team also provided sessional interventions. These primarily consisted of occupational therapists and psychologists in addition to the nursing and medical workforce. Senior nursing and allied health professions (AHP) roles also developed with the support of NHSE over the relevant period including non-medical prescribers, advanced clinical practitioners, and consultant nursing roles. There remains significant variation in the development and deployment of these roles nationally.

1.20 In an effort to address vacancies, new support roles were created with funding from the Department of Health which included: registered nursing associates, non-registered physician associates and assistant practitioners. These roles provided support to clinical teams and a career pathway for people. The deployment of these roles varies by locality.

1.21 For physiotherapists, dietitians and podiatrists, these roles were often shared across a number of wards and were dependent on the specialty and whether there was a service level agreement with another organisation in place. Other roles, such as family therapists and art therapists, also played a significant role in young people’s services along with a plethora of roles under the psychological professions umbrella, such as counsellors, cognitive behavioural therapists. In general, resources have not been sufficient to meet all needs of people, and this became more acute with austerity measures in this period. With the greater focus on physical health in mental health, some organisations increased

resources in delivering physical health interventions along with the deployment of AHPs and physical health nurses.

1.22 In addition to providing individual assessment and treatment to patients, the MDT also participate in meetings which are generally held at ward level weekly. In these meetings, the care plan is reviewed with updates from each practitioner on the person's progress, changing risks and discharge arrangements. The meeting is usually led by the consultant whose team will support administration and recording the outcome of the meeting.

1.23 During the relevant period there has been a greater focus on service user and carer engagement as more and more organisations introduced peer support workers (paid roles) as part of the MDT. These roles were delivered by people with lived experience, who brought with them their experiences of successful recovery and were well placed to mentor patients. In addition, peer mentors were also introduced as an add on to volunteers. These unpaid roles often became a stepping-stone in to a career in the NHS.

Support and supervision

1.24 Each profession will have clinical supervision systems and processes in place which will be set out within Trust policy, informed by profession specific guidance. The policy will set out expectations in terms of clinical and managerial supervision and will identify the recording and monitoring of the implementation of this support on a regular basis. The purpose of supervision is to support the individual to deliver high-quality care and to ensure patient and organisational safety. The implementation of supervision is often delivered hierarchically. Specific clinical supervision is also available when required by a specialist practitioner in a particular field. The frequency of supervision also varies, but good practice would require for it to be given at regular intervals or monthly. For ward nursing teams, the access and delivery of supervision is often challenging as a result of staffing shortages, patient needs and administrative demands of the ward.

1.25 Clinical supervision is seen as essential in supporting patient safety and staff support. Its deployment is also key to delivering and monitoring standards of care and instilling

an environment which safeguards patients and provides person-centered values. There are a number of models of clinical supervision, however supervision sessions may be delivered in 1:1s or group sessions and are usually a minimum of hour in length. The focus is on considering and problem-solving clinical issues arising from a patient's care and the development of clinical practice. The compliance with clinical supervision has always been problematic for ward nursing teams. Where it is successful, there are good resources allocated to this activity.

1.26 In addition to supervision, there is the annual appraisal or personal development plan process, led by HR, where each employee will have a development plan agreed with their line manager as part of this process. Staff well-being is best delivered by local teams with support. It has been popular to have initiatives which may miss the point e.g. Wednesday night yoga. However, for shift workers, having breaks, rotas available on time which meet their family commitments, a supportive ward team with strong values and MDT away days in a good environment is more effective than centrally organised well-meaning, but often less practical, initiatives.

1.27 With the acknowledgement of the difficulty in staffing inpatient wards, in 2021 the Chief Nursing Officer of England established professional nurse advocate roles which focus on the wellbeing and careers of nurses.[8] Funding was made available, however, these roles were implemented in an ad hoc way nationally and it may be too early to assess their impact.

1.28 In general, a good ward will have little or no vacancies, strong values, a strong MDT and will promote a culture of person-centered care. The ward manager, as leader, will promote engagement and collaboration. In addition, one would expect to see high performance in clinical supervision appraisal rates and low absences.

[8] https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/professional-nurse-advocate/

Education and training

1.29 The year 2000 saw the introduction of a diploma in nursing, moving away from paid hospital-based training for nurses with trainees leaving the ward team. This training continued to evolve until nursing became a graduate profession in 2013. As a result, at the beginning of the relevant period wards were staffed by registered nurses with a certificate diploma and later a degree in nursing studies.

1.30 With this move was a change in nursing trainees on wards to one of university-based education with scheduled placements, rather than being permanently placed on wards throughout their 3 years of training. This was seen to reduce the sense of belonging to an organisation for student nurses and, as a result, a perceived reduced opportunity to recruit following registration. Over time, mature entrants along with others accessing the profession declined with the removal of the bursary in August 2017. A general decline in entry to nursing and other professions has impacted in the delivery of continuity of care for patients and put additional burden on the existing nursing workforce.

Continuing Professional Development (CPD*)*

1.31 Continuing Professional development (CPD) was well established for medical staff, however it was ad hoc for other professions until early 2000 when non-medical education funding was provided to Trusts from the Department of Health / Health Education England. This system is still in place and there were a number of initiatives to develop clinical education and new roles nationally. It was also essential that this funding was ring-fenced to support learning and not used for local budget pressures. To deliver high quality care, practitioners at all levels need access to clinical education to maintain and develop their skills and too often this was seen as desirable rather than an essential requirement.

1.32 For healthcare support workers, who made up a significant proportion of staff on the wards, access to training was very much locally implemented. The introduction of the care certificate in 2015 (a nationally developed programme for support workers) was well received. This programme included skills and values-based training. The implementation of this programme varied from locality to locality and replaced the

National Vocation Qualification (NVQ) system for the induction of new employees to health and social care.

Mandatory training

1.33 All trusts have in place a mandatory training program which includes statutory and local priorities. All employees, in line with a local training needs analysis (TNA), are required to attend this programme and this is usually delivered at different intervals dependent on the topic e.g. annually or one off. There is normally an attendance reporting requirement though each Trust's system, and in some instances nationally (for example, fire safety and data security). It could be suggested that mandatory training was seen by some as a tick box exercise and may not have always been the most attractive to employees, however, it contained essential training for the safety of patients including, CPR, crisis interventions, MHA and safeguarding to name a few.

2. A good ward environment for therapy

2.1 The purpose of the inpatient unit is to provide safe care in the least restrictive environment and, in doing so, to promote privacy and dignity for people. Should the ward environment be inadequate due to size, quality or location, it may contribute to discomfort and distress for patients. Consideration needs to be given to the needs of people with a disability and vulnerabilities, (e.g., neurodiversity or transgenderism) particularly as people may be detained and expected to live in a confined space with people who are unknown to them. Nationally the design size and location of units varies from locality to locality and within specialties.

2.2 Standards for inpatient unit estates have been set out by the Department of Health in the health technical memorandum. Examples include: Managing Health Care Fire Safety (HTM 05-01 (2013) and the Health Building Note adult acute mental health wards 03-01 S1 (HBN 03-01 (2013). This guidance supports builders, estates teams, clinical teams and services users where refurbishment and new developments are planned. Each unit is required to register with the CQC for the care which it provides and is expected to

deliver standards in line with the Health and Social Care Act, (2008), Regulation 15: Safety and Sustainability of Premises.

2.3 Units will have a range of communal areas in addition to space for therapy, staff and individual bedrooms for patients. There should also be facilities for families and visitors. It is good practice to have quiet areas for people and areas for de-escalation. Seclusion facilities may be required, however over recent years, dependency on this has been reduced with the promotion of, initiatives under the umbrella of, reducing restrictive practice.

2.4 Other functional areas may also be attached to wards, for example a place of safety (also known as a Section 136 suite), which provides a safe place for the assessment of people in crisis. Often these units are staffed by the ward nursing team which can provide an additional challenge in times of staff shortages. Alternatively, some areas have a discreet nursing team to support this function.

2.5 The unit should provide a clean environment with good quality furniture and fittings that are replaced regularly, and good practice would indicate that this is done proactively. Fixtures and fittings should be “ligature reduction” and there should be good lighting and visibility of patients and staff.

2.6 It is universally accepted that the environment where care is delivered needs to nurture and facilitate recovery. However, the provision of mental health wards has lagged behind other healthcare provision. For example, ward stock includes Victorian wards, purpose-built wards and wards within acute facilities. The quality of the environment is paramount for enabling person-centered care and recovery. Nationally, wards within specialties vary in size, amenities and location. For example, these vary from purpose-built units near local communities with access to transport and amenities to Victorian wards on old hospital sites. It is generally accepted that wards for people need to support recovery with access to technology and as a minimum require single bedroom accommodation (DH 2000 Same Sex Accommodation).

2.7 Bedrooms have been a focus of improvement over this period, moving from dormitories to single ensuite rooms which are now standard in New builds. The eradication of dormitories came very much into focus again with the Covid 19 pandemic. This is because of the requirement to deploy infection prevention and control procedures to deliver care and prevent cross contamination. As a result, funding was provided via the Department of Health to address their eradication.

2.8 Additionally to the ward environment, it is essential that there is access to fresh air in the garden area where the individual patient does not need to be escorted. Often there is provision of gyms, sports halls, cafes and occupational therapy departments off the ward areas where a patient can attend with support. The quality of the built environment can have a significant impact on access to therapeutic activities and on the workload and efficiency of the nursing team in delivering care.

2.9 The therapeutic ward can also vary by specialty where there may be a higher or lower concentration of therapeutic staff to support individuals in their recovery and rehabilitation. This is particularly true of rehabilitation and forensic wards where there tends to be a higher number of staff and programmed activities. For acute wards, this is often less achievable as a result of acuity of patients and staffing levels. In recognition of a need to have more engagement and therapeutic activities on wards, and to prevent boredom, the deployment of activity workers has been introduced in some localities. These roles are supernumerary to the ward's nursing staff and work with both nursing and occupational therapy to provide a more meaningful program of activities at ward level.

2.10 During the relevant period there was more emphasis on patient/service user engagement nationally with the development of the charity IMROC (Implementing Recovery through Organisational Change) in 2008, which supported engagement of people with lived experience in the delivery and the development of services. This included the development of roles for people with lived experience i.e. peer support workers but also the development of recovery colleges, where the focus was on recovery through rehabilitation and learning. These colleges were implemented across the country

and the charity still supports individuals and organisations. There was also work with carers of people with dementia and the “triangle of care” initiative was established by the Carers Trust, which was launched in 2010 and rolled out in older people’s wards. These initiatives were predominantly led by nursing and occupational therapy teams in partnership with people with lived experience. This movement helped to open up wards and to make them more transparent, compassionate and person- centered.

2.11 Other initiatives which intended to improve nursing practice were the Essences of Care (2001) programme which set out standards for direct patient care. This was launched with a toolkit to structure a patient focused approach to care which was evidence based. In 2016, the Chief Nursing Officer of England launched the nursing strategy known as the 6cs of Nursing: which are care, compassion, competence, communication, courage and commitment. This was very much a focus on strengthening compassion in delivering nursing care.

2.12 In summary, a good therapeutic ward, in addition to the environment, will have excellent engagement with patients and carers, with a positive culture of respect and compassion. There will be a general programme of meaningful activities at ward level with each patient having an individual timetable for one-to-one sessions with nurses, occupational therapists, doctors, pharmacists, and psychologists. There will also be activities programmed for evenings and weekends. The ward would also have a strong patient group to advocate for their needs which may be facilitated by the quality matron to support patients to feedback, concerns and issues.

2.13 Following a number of high-profile incidents and feedback from patients about the quality of care on inpatient wards, a collaboration with service users commenced in 2022 to develop standards leading to the development of the “Culture of care standards in mental health inpatient services” which was published in 2024 by NHSE.[9] This programme is currently being rolled out nationally.

[9] https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/

3. Ward safety, management of risk, crisis management and self-harm

3.1 For the ward manager and the nurse in charge of each shift, ward safety comprises of two main areas: patient safety (including staff) and the safety of the environment. As mentioned previously, the standard of the built environment needs to support safe care. That includes the appropriate access to therapeutic rooms and garden, and appropriate therapeutic activities both on and off the ward. In addition, there are a number of procedures that the ward needs to have in place to fulfil health and safety requirements. This includes designated fire officers, first aiders and a procedure for knowing who is on or off the ward at any one time.

3.2 With regards to clinical safety, there are a number of factors that need to be considered. The nurse in charge is responsible for monitoring patient and staff safety on a shift-by-shift basis and reporting on any risks within the agreed reporting system, as well as reporting to superiors for remedial action should it be required. This may include additional staff to meet shortages, responses to environmental incidents and the need to evaluate the safety of the ward as part of handovers, safety huddles and ward rounds.

3.3 In responding to incidents of violence and aggression, which may be a feature in all specialties, it is essential that staff have had the appropriate training to de-escalate situations as they arise and that they manage any physical interventions in a safe and respectful way for all concerned. This is usually delivered in teams of a minimum of 3 / 4 people comprising of registered and non-registered staff. More staff may be required depending on the severity and length of time of the incident and will generally be deployed via a call system. It is usual practice for additional members of staff to come from adjacent wards. An appropriate restraint could include a large number of people supporting the patient and allowing for breaks. Over the relevant period national guidance has been refined particularly following the Mental Health Units (Use of Force) Act 2018. The Act requires trusts to provide training to staff which complies

with the restraint reduction network training standards and is affiliated with the Bild Association of Certified Training.[10]

3.4 Responding to incidents may be challenging when faced with acutely distressed patients and where there may be deficits in staff skills to manage a situation and support patients in a competent and positive way. Registered nurses are very skilled in managing conflict and deescalating aggressive situations, however more and more of this work is carried out by HCSW with support from RNs. HCSW will also receive annual training in the prevention management of aggressive incidents, however it is essential that they are supervised and supported by a registered nurse who is experienced in this area. This is due to the potential physical and psychological complications that may arise from this intervention. Additionally, in some specialties, this part of the role can be overly distressing and can lead to staff burn out.

3.5 Self-harm behaviours are very distressing for the individual, their loved ones and the staff supporting and delivering care. Following assessment and the development of the care plan, it is essential that a balance is struck between reducing harm and promoting recovery. This role in managing risk of those who self-harm is very distressing for clinical teams and, in a desire to be helpful and promote safety, they may be more restrictive in their approach. An example of this would be the over use of enhanced observations and removal of personal items to prevent harm.

3.6 In recent years, Trauma Informed Care training has been made available with the input of people with lived experience. This training looks at how trauma impacts on an individual, their past and how to better understand their current behaviour from an understanding of their past adverse childhood experiences. In these circumstances, senior doctors, nurses and managers need to ensure that the nursing team are supported adequately, and the patients are in the best environment to meet their particular clinical needs.

[10] https://bildact.org.uk/

3.7 Increased supervision to prevent self-harm can lead to an increased risk in the individual's behaviours escalating when the opportunity arises. Therefore, managing self-harm is a balancing act between supervision (enhanced observations), promoting recovery and least restrictive practice.

3.8 The role of a nurse is critical in the patient's recovery alongside the support of families and the multi-disciplinary team. The nursing team are the first point of contact for everyone. By providing 24-hour care to people in distress, they are often working in volatile environments dealing with aggression and violence first-hand and frequently are hurt and injured. This can lead to absences and will compound staffing shortages.

3.9 Working on inpatient wards is complex with competing demands from patients, carers and MDT colleagues. Often these demands prevent the delivery of planned care such as 1 to 1. No two shifts are the same, with nurses having to be reactive to the ever-changing circumstances on the ward. Working in such conditions may feel isolating, particularly for newly qualified nurses. With staffing shortages and nurses moving to community roles it is commonplace for the registered nurse in charge of the shift to be relatively inexperienced. These circumstances may disrupt the responsiveness that nurses have for patients. A strong nursing team will be well led, know systems, patients, and will have skills that are proactive as well as reactive. Where this occurs, there will be a high level of continuity of care with strong values and mutual respect.

3.10 Those supporting the nursing team need to be conscious of the impact of staff shortages and the impact of stress on nurses in these conditions. They also need to be mindful for the potential for abuse to occur and ensure there are safeguards in place to prevent this. This would include walkabouts, out-of-hour visits, clinical supervision, training, regular breaks and feedback from patients.

3.11 The creation of specialist teams in the community has led to providing registered nurses with a more rewarding role which is often seen to have greater value and respect. However, it is essential that inpatient nursing roles are also well

understood and valued. It is too easy for a nursing team to become isolated from the MDT and wider services, and to become a closed culture where poor behaviours can thrive and lead to abuse.

3.12 With regards to ligature minimisation, there has been debate over the relevant period with regards to the management of fixed and non-fixed ligatures and making the environment safer for patients. One view has been that a “safe ward” is delivered by removing things and installing ligature reduction aids, such as door top alarms aimed at preventing all self-harm incidents.

3.13 However, as time has progressed, there has been a greater appreciation of the dynamics of delivering inpatient care. No environment can prevent all risk, and environmental modifications are not a replacement for therapeutic engagement and interventions delivered by the nursing team. The CQC published guidance in 2023 “reducing harm from ligatures in MH and learning disability”.[11] This included guidance on the environment, ligature point risk assessment and mitigations clinical and non-clinical. Nursing teams, in particular, grapple with this issue and are under significant pressure to manage care and prevent risks to patients on a shift-by-shift basis, within a least restrictive practice framework.

3.14 When things go wrong, the cost can be catastrophic to all concerned. It is distressing for staff working in these environments and may lead to burn out with nurses moving to a different area of practice. For families it will be even more distressing as they can be supporting their loved ones for decades and are desperate to see their recovery. Admission to hospital may seem like their last chance. As set out in Dr Davidson’s report, to control everything in the ward environment is practically impossible and would mean eradicating every potential risk leading to the ward resembling a custodial environment. This would be counter-productive in

[11] https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance

promoting recovery. It would also change the dynamics of the relationship between the nursing teams and patients and carers.

3.15 Even with the development of technology, as an aid to the environment and the delivering of care, it should be recognised that there are no guarantees that things will not go wrong, or people will come to harm. Technology is an add on to, rather than a replacement for the therapeutic environment and interventions which give people hope and support recovery. For example, things such as CCTV support the management of wards, but do not guarantee the prevention of incidents. In addition, one needs to factor in human error, system failures and gaps.

4. Access to basic and essential care standards

4.1 Following admission, assessment / reassessment of the patients' needs takes place in order to inform the care plan. The care plan should be jointly written with the patient, their carers, and the clinical team on admission. It should contain the wishes and goals for the individual and should consider discharge arrangements. Standards for this process are set out in local documents which are informed by national guidance such as the Care programme approach (CPA) 1991, NICE 2011 QS14 and CQC Regulation 9 Person – Centered Care. The process for review of the care plan will take place in the MDT meeting but will also be updated as things change via ward rounds and significant changes/incidents.

4.2 The overarching care plan will also be supported by specific intervention plans such as sleep hygiene, behaviour support, medication, or diabetics management. These plans will predominantly be developed and delivered by the nursing team. Once written by a registered practitioner they may be delivered by a Healthcare Support Worker or Occupational Therapy assistant who will have had training in the topic and will have supervision.

4.3 Standards of care will be set out in local policy documents and will be supported by training, supervision and audit to assess how well standards have been implemented

locally. It is predominantly the role of the ward manager and the quality matron to ensure that the standards of care are delivered to patients in line with policy and good practice. Additional training and support may be given following audit.

4.4 In addition to local internal systems for monitoring standards of care, the CQC are the national regulator which provides external scrutiny of the standards of care provided to patients. Different specialties also have the added support of improving and enhancing standards of care through one of the Royal College of Psychiatrists programmes. These include additional standards informed by guidance, training and evaluation leading to accreditation with the college.

4.5 Nursing interventions are essential to support the recovery of patients and deliver the care plan at ward level. Mental health nurses have significant skills in supporting individuals in distress. They have an underpinning knowledge of psychology, physical health, mental health assessment, and skills in counselling, active listening and the ability to remain calm in time of crisis. They also require highly developed engagement, interpersonal skills and the ability to observe changes in people's presentation.

4.6 The theory and practice of these skills are learnt in University, and on placement, and are built upon in practice following registration. They may, in addition, include solution focused therapy, cognitive behaviour therapy techniques and diversion and distraction. It is essential that registered nurses are given the opportunity to provide one-to-one sessions with patients to aid their recovery and to provide the therapy that they need on a daily basis. Each patient on admission is allocated a "primary nurse" (registered nurse) who fulfils this role and coordinates the person's care plans. This is part of providing person-centered care and moves away from a task or team-based nursing approach.

4.7 However, over the relevant period registered nurses have had less time available to complete psychological and nursing interventions with patients, due to the demands

of the ward, shortage of registered nurses and the increasing requirement to utilise a variety of IT systems to record patient records, report incidents, record medication, and roster. These systems are often reported to be cumbersome and can take nursing time away from direct patient care.

4.8 In 2003 the publication of "Personality disorder no longer a diagnosis of exclusion",[12] highlighted that people with personality disorders were being denied access to some mainstream services and challenged services to address this. It also set out principles on the development of specialist services. As a result, more people were admitted to mental health wards often for a 72-hour assessment period. This change put an increasing burden on nurses in terms of clinical administration and delivering complex care.

4.9 In recognition of ward managers raising concerns over the limited time to provide direct care to patients, a "productive ward series" was launched in 2008. This programme was funded by the Department of Health and provided opportunity for localities to carry out quality improvement initiatives at ward level, to release time back from administrative tasks to nurses for the care of patients. This initiative was well received, however, its application and sustainability over time has been uncertain. Not being able to deliver therapeutic interventions to patients is one of the key reasons registered nurses leave inpatient units. As a result, there has been significant turnover on the wards as registered nurses move to community teams for better remuneration and potentially improved working conditions.

4.10 The quality of care delivered to individuals may also be evaluated by feedback from them and their carers. This can be received informally at ward level and more formally at a corporate level.

[12] Snowden P, Kane E. Personality disorder: no longer a diagnosis of exclusion. Psychiatric Bulletin. 2003;27(11):401-403. doi:10.1192/pb.27.11.401

5. Observations

5.1 There continues to be discourse about observations within mental health settings. Over the relevant period, language has changed, and wards have become more dependent on this intervention as acuity increases and there is more focus on risk prevention/harm minimisation. Each locality has their own policy and there may be differing terminology. The purpose of observations is to monitor change in the person's presentation and to monitor and prevent risk associated with, for example falls, self-harm vulnerability and violence and aggression.

5.2 As a minimum, all patients on a mental health ward will be on general observations, also known as Level 1. This is carried out by a health care support worker at hourly intervals. Checks include the whereabouts of patients which are recorded as part of the observation policy and fire safety procedures. In general, enhanced observations are agreed by the multidisciplinary team and form part of the care plan. Enhanced observations include the following features:

a. Level 2: Intermittent observations e.g. 15 to 30 minutes.
b. Level 3 (1 to 1): Continuous observations within eyesight of staff.
c. Level 4 (1 to 1): Continuous observations within arm's length of staff (it may be necessary for more than 1 member of staff to carry these out).

5.3 Observations are seen more and more as being restrictive, however they are used routinely at ward level in all specialities. Observation levels will change for the patient dependent on the perceived/assessed risks and should always be allocated on the least restrictive basis, with the rationale clearly recorded agreed and reviewed. Observations take up a considerable amount of time from nursing staff and may take away from the time to do therapeutic activities.

5.4 Over the relevant period there has been debate as to whether nurses could allocate /prescribe enhanced observations, which was once seen as a medical decision. However, good practice determines that this is a multidisciplinary process. Local

policies will include roles and responsibilities of clinical staff in relation to the application of the policy at ward level. Each level of observations will have an agreed recording template completed by the member of staff allocated to carry out the observations and checked and signed by the nurse in charge of each shift.

5.5 To maintain privacy and dignity, the member of staff allocated to enhanced observations should be of the same gender. Where that is not possible, the nurse in charge must ensure that arrangements for any personal care tasks are by a member of staff from the same gender as the patient. There are also requirements in terms of ensuring that staff that are carrying out observations have training and set periods with individuals with appropriate breaks provided. The latter may be of benefit for both patients and staff.

5.6 However, it's well recognised that, for some patients, observations are not as therapeutic as they could be. Over time the word "therapeutic" has been added to the titles of policy documents to emphasise this requirement. However, in practice, many observations are carried out without therapeutic engagement and could be said to have become a process of "marking the patient". This becomes more common as a result of staff shortages and where there is a dependence on temporary staff who may not know, systems practices and patients.

5.7 There is still not an agreed national policy on therapeutic observations in mental health settings.

5.8 In summary, there is a trade-off between restrictive observations and the number and availability of therapy and meaningful activities at ward level. In the relevant period, the focus has become more on keeping the patient safe rather than engaging in a therapeutic approach. It is difficult to provide one-to-one therapeutic activities along with nursing interventions and group activities in wards where there are staff shortages and a reduced number of registered practitioners. One could observe a large number of staff on shift which may not be delivering therapeutic benefit to patients when the majority of those staff are solely carrying out 1 to 1 observations.

5.9 More recently, and worryingly, it has been identified through investigations that there were occasions where observation records may have been falsified. Some localities have developed electronic observation tools/systems to monitor compliance with standards to improve care and prevent this occurrence.

6. Reassessment / evaluation

6.1 Following an agreed assessment, every clinician considers any amendments to that assessment on every subsequent occasion that they are in contact with the patient. For example, nurses are educated to follow the Nursing Process which considers steps of: assess, plan, implement and evaluate on a continuous loop. Changes in presentation of the patient will also be formally and informally discussed by Nursing teams in Huddles, handovers and with the multi-disciplinary team routinely during ward rounds and MDT meetings.

6.2 The purpose of reassessment is to evaluate the care plan and the care that is provided to the patient to be effective and reach agreed goals. It is essential that the patient and their families and/or carers are part of this evaluation. In addition, no evaluation of care and treatment is effective without an accurate recording (update of the care plan) and the sharing of this document with the patient. The care plan may also indicate a planned timeframe for evaluation as agreed by the clinical team with the patient.

6.3 In summary, a thorough reassessment should take place following any significant incidents, both positive and negative. When considering assessment and reassessment of care, this includes all aspects within the care plan for example mental state, risks, physical health, social interaction and accessing the community discharge arrangements etc. The overarching purpose of any reassessment is to identify both improvements and deterioration in the person's presentation and well-being, and to enable successful discharge to the community. This practice is unchanged over the period of time under review.

7. Sexual safety and mixed sex wards

7.1 Over the relevant period, “mixed sex wards” were commonplace. It may be more difficult to provide sexual safety on mixed gender wards, however, single gender wards are not necessarily safer.

7.2 Delivering Same Sex accommodation (NHSE 2019) guidance updated previous guidance (2009 and 2010) with the requirement of national mandatory reporting of breaches mixed sex accommodation (MSA) in 2010. This requirement and focus brought improvements in privacy and dignity for patients. The premise of the guidance was that there should be zero tolerance to mixed sex accommodation in NHS funded accommodation. In 2014, the CQC included this requirement in the Health and Social Care Act 2008.

7.3 However, some specialties such as young people, learning disabilities and substance misuse wards, by nature of being specialist wards and often being a single standalone unit within a locality, had no option but to admit both genders.

7.4 Providing care on mixed sex/gender awards may well be more challenging as additional risks will need to be mitigated. In areas such as adult mental health, where each locality may have more than one unit, it is more achievable to establish single gender wards in an attempt to provide more respectful and person-centered care for people.

7.5 The CQC (2018 Sexual safety on mental health wards) carried out a review of incidents in relation to sexual safety in mental health wards and identified that incidents of assaults were a more common occurrence than once thought or reported.[13] Their recommendations included improving practice and additional resources towards single gender wards nationally.

[13] 20180911c_sexualsafetymh_report.pdf

7.6 Reported sexual assault/incidents may be unintended, and consideration needs to be in place to take account of the individual and their condition, for example, dementia where the patient is unaware of the implications of their behaviour on others. Each incident will need to be judged on a case-by-case basis with compassion, support of the safeguarding team and care planned.

7.7 In addition to providing a single sex/gender ward, the ward team also need to be mindful of safeguarding practice irrespective of gender. Assessments of an individual's needs should also include sexual safety and an assessment of their vulnerability. Appropriate safeguards should be put in place to support these needs for example, the location of bedrooms and one-to-one support from staff to meet their needs.

7.8 More recently, localities have been looking at how to support people who are transgender and decide which ward is appropriate to support their needs. This may vary on an individual basis depending on their circumstances, history, wishes and a person-centered approach should be the primary concern.

7.9 In summary, single sex/gender wards are seen to be safer and provide more privacy and dignity for people. They are well received, particularly by female patients, where they can feel safer during times of vulnerability and distress. However, the eradication of mixed sex/gender wards nationally still varies from locality to locality.

Expert Declaration

I, Josephine Maria Nelligan, DECLARE THAT:

1. I understand that my duty in providing written reports and giving evidence is to help 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 endeavored 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.

Maria Nelligan [Signed Electronically]

Josephine Maria Nelligan

27 March 2025

Appendix 1: Curriculum Vitae

Maria Nelligan

Membership of Professional Bodies: NMC

KEY SKILLS AND ATTRIBUTES

- Versatile leader, with 43 years' experience in health care working in Board, clinical and senior managerial roles in three different countries/healthcare systems; within mental health and primary care, championing a collaborative approach with the voluntary and private sectors
- Clinically and professionally experienced senior leader with a track record of leading and improving care delivery across the Health and Social care economy
- Commitment to developing, leading and improving the Nursing and Allied Health Professional workforce through strategy innovative practice and new roles
- Experienced CNO delivering large scale improvements in quality of care in 3 Trusts with significant care quality challenges
- Track record as board executive in leading clinical governance, CQC compliance and quality agendas across a wide range of services with demonstrable improvements.
- Experienced strategist with the ability to operational plans, including leading on large management of change programs and deliver transformation across large organisations
- Extensive experience of effectively communicating to a wide range of audiences, internally and externally, in a range of formats and settings, including delivering training from ward/team to Board and presenting at national conferences
- Experience of financial forecasting, delivering cost improvements, managing budgets and delivering projects to targets
- Track record in working with services users and carers to bring about improvement in service delivery
- Track record in developing quality initiatives and continuous improvement programmes
- Influential leader working across organisational boundaries supporting system working with statutory and voluntary agencies
- CQC Executive Well Led Reviewer
- A Values driven leader receiving the highest recognition from the Chief Nurse of England in 2021 for contribution to Nursing
- Secretary of the national Directors of Mental Health Nursing Forum 2017 - 2025

PREVIOUS RELEVANT WORK HISTORY

Grater Manchester Mental Health NHS Foundation Trust
Chief Nurse and Executive Director of Clinical Transformation
Secondment April 2023 –July 2024

Lancashire and South Cumbria NHS Foundation Trust
Chief Nurse and Quality Officer
September 2019 – March 2023

North Staffordshire Combined Healthcare NHS Trust Director of Nursing and Quality (DIPC)
October 2015 – August 2019

Cheshire and Wirral Partnership NHS Foundation Trust
Interim Lead for Learning Disability Service (Secondment)
October 2012 – May 2013

Cheshire & Wirral Partnership Cheshire & Wirral Partnership NHS Foundation Trust Acting Director of Nursing, Therapies and Patient Partnership Full portfolio responsibility
July 2011 - October 2011

Cheshire & Wirral Partnership Cheshire & Wirral Partnership NHS Foundation Trust Deputy Director of Nursing (Mental Health) and Therapies, Director of Infection Prevention Control
February 2004 – October 2015

Bebington and West Wirral Primary Care Trust
'PCT Nurse Board member / Professional Executive Committee (PEC) Vice Chair (secondment)'
Oct 1998 – Jun 2004

EDUCATION/CONTINUOUS PROFESSIONAL DEVELOPMENT

College/School	Year	Qualification
Manchester Metropolitan University	2005	Msc. Practitioner Research by Research
Liverpool John Moores University	1996	Diploma in Community Nursing ENB 807 - Distinction
Hugh Baird College of Further Education	1995	City and Guilds 730:7 Certificate in Teaching (16 and over)
Liverpool John Moores University	1994	B.A (Hons) Health Studies – 2:1
Liverpool John Moores University	1993	Diploma in Professional Studies in Nursing (D.P.S.N)
University of Newcastle N.S.W Australia	1989	Diploma in Applied Science Nursing – 1st year completed
St James School of Nursing Cope Foundation, Eire	1985	Registered Nurse in Mental Handicap (R.N.M.H)
Loretto Convent Fermoy Co, Cork, Eire	1981	Leaving Certificate