

Joint Committee on the Draft Mental Health Bill

Oral evidence: Draft Mental Health Bill, HC 696

Tuesday 22 November 2022

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Written evidence from witnesses:

- [Care Quality Commission \[MHB0011\]](#)
- [NHS Providers \[MHB022\]](#)
- [NHS Confederation Mental Health Network \[MHB0065\]](#)

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Members present: Baroness Buscombe (The Chair); Dr Rosena Allin-Khan MP; Lord Bradley; Baroness Hollins; Baroness McIntosh of Hudnall; Dr Dan Poulter MP; Dr Ben Spencer MP; Sir Charles Walker MP.

Questions 163-176

Witnesses: **Jemima Burnage**, Deputy Director of Mental Health, Care Quality Commission; **Sean Duggan OBE**, CEO of NHS Confederation Mental Health Network; **Saffron Cordery**, Interim CEO of NHS Providers; **Peter Devlin**, Co-Chair of Mental Health, Drug and Alcohol Network at Association of Directors of Adult Social Services, and Director of Mental Health Social Care.

Q163 The Chair: Welcome to the Joint Committee scrutinising the draft Mental Health Bill. The purpose of this session is to listen to representatives from key providers in the mental health and social care system. It will primarily cover workforce and implementation issues, and address some key issues in the draft Bill. I thank the witnesses for coming today and those of you who have given us written evidence in advance. That is extremely helpful. We have two witnesses here in person today and two online. Let us start with the witnesses here in person.

Jemima Burnage: I am the deputy director of mental health at the Care Quality Commission, which is the independent regulator of health and social care in England. We have duties and responsibilities under the Mental Health Act.

Sean Duggan: Good afternoon. I am the chief executive of the Mental Health Network for the NHS Confederation.

Saffron Cordery: I am interim chief executive of NHS Providers, the membership organisation representing acute mental health community and ambulance trusts in England.

Peter Devlin: I am here representing the Association of Directors of Adult Social Services. ADASS is a charitable organisation that brings a voice from the leaders in local authority adult social care.

The Chair: Thank you very much indeed. Our first question goes straight to the heart of resourcing and workforce implications.

Q164 **Rosena Allin-Khan:** Hi, everyone. Thanks for coming today. In a few sentences, is the Government's impact assessment a realistic projection of the resourcing and workforce implications of the draft Bill? Do you have any particular concerns?

Sean Duggan: This is the main issue as far as I am concerned, and for most of our members. It is about getting the resourcing right for a programme that we all fully support: a review of and change to the Mental Health Act that is probably overdue. As always with good policies such as these, it is all about the implementation. To implement it, you need to make sure that the resourcing is correct. There are concerns here.

There are concerns anyway in running mental health services given the position at the moment. We are pleased that, with the Autumn Statement, there is more money in healthcare and of course we hope and expect an allocation from that to go into mental health so we can deliver on the long-term plan in the next couple of years and all the improvements that we want to make. Anything on top of that will need to be considered. I know that there is a long-term return on investment but, as always with these types of reform in my experience of 40 years in mental health services, you need a bit of resource up front so that the policies and staff are in place—we will come on to workforce shortly—and the resourcing links 100% with making sure that we get the workforce.

The resourcing issue is not just about revenue for staff, changes in staffing or more responsibility for staff, which all come out in the implementation. It is also about capital costs. We have an estate that, frankly, in a lot of cases is not fit for purpose. We know that anyway, and it was highlighted in the review of the Mental Health Act by Professor Sir Simon Wessely.

We have had capital programmes and the new hospital extra investment. Mental health has not fared well enough here and we need to reverse that if we are to ensure that we can implement reforms of the Mental Health Act. In providing therapeutic activities and that sort of thing, you need the estates to be looked after. As in ordinary hospitals, there are pockets where that is not quite right, so there are concerns.

Having said that, my experience is that whenever in the past we had a good, new policy, providers got themselves ready. We must give them a bit of resource, but they will ensure it is implemented and then we can do magical things. With the long-term plan, the *Five Year Forward View* and a little bit of investment over the years, we can do really magical, good things in mental health. We have proved that in the past, and we will prove it again by implementing the reforms of the Mental Health Act.

Rosena Allin-Khan: When you say “magical things”, such as what?

Sean Duggan: For example, there are the perinatal mental health care services across the country, or the bit of money that we put into crisis care during the pandemic. Everybody

quickly put up crisis lines; a lot of them are still there. We put bits of resource into crisis cafés and now we have a lot of those across the country. Some money was put into liaison and psychiatry a few years ago. It started in Birmingham, where we had psychiatric liaison nurses in accident and emergency, and immediately we got a return on investment. That was well published. It is of course now done right across the country, and we are looking at putting more liaison in other long-term clinics in hospitals. Those are really good things we do well.

Jemima Burnage: We broadly support the Bill's proposals. There are fragile services that are not able to meet people's needs. Currently, we know people are in hospital too long where there is no appropriate support in the community. Yet we do not feel that the impact assessment and the range of resourcing are sufficient to meet the ambitions of the Bill. There is a significant increase in the cost of the second opinion appointed doctor service, as laid out in that impact assessment. More broadly, we have thought about access to tribunals and the structures needed to support those systems. Services are under a huge amount of pressure. There needs to be expectation and investment in the workforce to deliver those ambitions.

Saffron Cordery: To add to those points, we need to think about not just the funding to support the provisions of this Bill but how we sustain services more broadly. For example, we must think about sustained funding for community-based specialist care, which will be important in mitigating the potential unintended consequences of some of the proposals. By that, I mean how we care for people who will not meet the new criteria for detention. We need to make sure that we not only implement these proposals, which are really solid and important, but also look after those people who no longer fall within the provisions. It is right that they do not fall within the provisions because it is an inappropriate tool to manage certain groups of people, but we must ensure that we are able to provide sustainable, community-based services so that those people do not reach crisis point.

Peter Devlin: I entirely agree with what has been said already about the ambition and intention behind the Bill, and about the impact assessment in relation to requirements for appropriate and sufficient community provision. At ADASS, we do not believe that that has been factored in. It is implied, of course, that the community mental health transformation programme and the building the right support plan will bring forward the community capacity required to support more people being cared for in the community, and therefore reduce detentions. Yet we feel, from our analysis of the investment for forward years, that it is insufficient to deliver on that.

We also suggest considering the extent to which funding flows into the right parts of the system to effect the biggest change. I ask the committee to consider the role that adult social care, and social care generally, has in the commissioning of community provision, in both the infrastructure and the existing relationships and knowledge of local communities.

The impact assessment assumes that some of the new roles, with the IMHA role, the changes in detention and the nominated person, will be relatively straightforward to implement. We think that there is much more complexity in some of those areas that would need to be worked through, and we suggest a rethink around the implementation and sequencing of some of that.

The Chair: That is really helpful.



Q165 **Dr Dan Poulter:** I have a very targeted question for Ms Burnage. You raised concerns about workforce and the consequences of the Bill. When the CQC inspects mental health providers, how often is either a lack of workforce or overreliance on temporary staff a significant factor when you rate them as being inadequate or requiring improvement?

Jemima Burnage: We see workforce as an issue in both our inspections and monitoring the Mental Health Act visits. Patients have shared concerns that staff do not have time to spend with them on proper care planning or really attending to their needs on the ward. There are brilliant staff doing great work but under extreme pressure.

On workforce, we see high rates of vacancies across most staff groups; it is higher in acute healthcare settings. We also see that impacting continuity of care and being able to staff shifts, to support people to go on leave or undertake meaningful activity during the day, for example. It has multiple impacts on patients within those wards.

Dr Dan Poulter: Is there a correlation between workforce shortages or a stretched workforce and an “inadequate” or “requires improvement” rating?

Jemima Burnage: There is a correlation of many factors. Leadership, having an infrastructure and having good oversight are the main, key factors around safety. Workforce builds into that picture of a struggling service in cases where we rate them in the lower range. Some services are able to do good things with vacancy factors, given the staff they have and how they use them, but there is definitely a pattern here with growing concern around the number of vacancies across the professions.

We may go on to the SOAD service later, but more people are leaving the psychiatry profession and others are not entering it, so the gap is growing in being able to provide a service with expertise and skilled, trained staff. Also, people are not able to access appropriate beds and settings when they need to. Some people end up going to A&E, while some are admitted into acute services and other unsuitable settings.

Q166 **Lord Bradley:** The independent review and the Government argued that the measures introduced in the Bill to reduce detentions will offset increased workload elsewhere in the system. How far do you share that view?

Sean Duggan: It will offset pressures. If it is done properly, it will be manageable. As I will probably say a number of times, and I apologise for repeating myself, it will all be in the implementation. If you reduce detention, you reduce hospital stays and so on, so that is bound to take pressure off the service.

Having said that, to do it properly, as Peter and Saffron said earlier, you must ensure that you put a lot of resources into the community. We are in the middle of the community mental health transformation plan, which is very useful and well led, but we will need good services in the community. Of course, that is not just for the mental health trust to provide; this is very much about social care.

We will probably come on to this shortly, but the deficit in social care provision is a problem now and will be exacerbated when we implement these reforms, so we really must do

something about it before the implementation process. There will be some pressures taken off but, as always, there will be other pressures, some of which we may not have even thought of. Keeping a focus on this will be important as we go forward.

Lord Bradley: Is the implementation timetable across the piece realistic, against that resource allocation? Take the example of the interface with the criminal justice system—banning the use of prisons and police cells, and the transfer from prison into mental health services. Do you agree that that requires investment in alternative provision, and is the timetable for that investment realistic against the Government's implementation plan?

Sean Duggan: We need a fairly long lead-in to this to get everything right. My view is that we must keep reviewing the timetable. If we do it too quickly, it will not work. As you say, with the criminal justice system we know very well that if you do not get it right you put pressures back into the Prison Service. Mental health encompasses all government departments. That is why the announcement of a cross-government 10-year strategy is really good. We should look at that and focus in on it to prepare ourselves for the implementation of the reform of the Mental Health Act.

Saffron Cordery: I have a quick point that builds on Sean's. We must make sure that in the early stages of implementing such an important policy change we are not in a position where resources are significantly stretched. Those early stages are critical in building the confidence of staff, patients, service users, their families and the whole system, across not just mental health services but the whole public sector that interfaces with this.

We believe that over time the reduction in the number of detentions will help offset the increased workload, but we also know that implementing something new always takes additional resources. To give this a fair shot, you must have those resources up front. Rather than it simply being the case that ultimately we will benefit, you need an extra injection of resources up front to make the policy rollout as effective as possible. It is about not spoiling the ship for a ha'porth of tar, and making sure that we give it a fair shot.

Peter Devlin: I agree with Saffron and Sean about the need for double-running capability, given the complexity of this. We are dealing with not only the provision of services but the culture of how services operate, so attention needs to be paid to building confidence as well as capability. My concern is that if community provision is inadequate, we will see unintended and inadvertent consequences of changes in reform. That has already been highlighted to the committee in the risk, for example, of people with learning disabilities and autism being detained de facto in mental health institutions under liberty protection safeguards and suchlike rather than under the Mental Health Act. We must guard against that. We also need to see the reforms in the context of the rising number of detentions already experienced in the system. We are dealing with not a steady state but an increasing issue, so some of the investment will need to attend to that aspect.

On the relationship between a reduction in detentions and an overall reduction in workloads, that is a difficult relationship to build. For example, the design, commissioning and management of small community provision is potentially far more resource intensive than larger-scale institutional care, so it is a slightly false notion to assume that there is a direct correlation between those two things.

Finally, we do not foresee a significant reduction in the volume of work to our approved mental health professional service as a consequence of these changes because, in fact, we are seeing a context of wider system restraints and pressures that add additional burdens to the AMHP service. While the numbers creep up, we also see wider system challenges in relation to the availability of Section 12-approved doctors, places of safety and hospital admission facilities. These place wider burdens and constraints on the service.

Q167 Dr Ben Spencer: My questions are mainly for Jemima Burnage, but everyone else can chip in. On the situation with second opinion appointed doctors, what is the current state of play in the time to get a SOAD, delays and the number of SOADs that we have? What is your appraisal of that?

Jemima Burnage: The current status is that we do not have enough SOADs to meet demand and we do not have enough funding or investment to deliver that service effectively or to get through all the backlogs. Investment is needed now to deliver the current business as usual and the demand for second opinions, as well as to start growing that workforce to deliver on the ambitions of the Bill.

There are real questions now about how that is funded and invested in, and the number of SOADs we have. Even if we had all the money, do we have the workforce to deliver this important work and its safeguard for patients? It is about investing and growing the psychiatry workforce. Then, incentivised by fees, structure and making it meaningful and enticing work, we will be able to deliver second opinion appointed doctor work in the future. That needs to start now to deliver both now and as per the ambitions of this reform.

Dr Ben Spencer: To unpack that a bit, how many SOADs, or people trained as SOADs and working, do we have at the moment?

Jemima Burnage: It is circa 150 SOADs, but I will follow this up in writing and give you the exact breakdown. We need a significant number of additional SOADs to deliver on the current demand and to offer a blended approach with both remote and in-person assessment. We want to see in the new provisions of the Bill that we can continue to offer a blended approach with remote and in-person assessments, not just for emergency ECT.

Dr Ben Spencer: Has the number of SOADs increased or decreased in the past few years? How does that compare to the number of people being detained under the Act?

Jemima Burnage: People are leaving the workforce. There is a certain demographic of people who, as part of their careers, do this type of work out of choice, and we are seeing them leave. High numbers of SOADs are leaving and we do not have new numbers coming in.

Dr Ben Spencer: What criteria must someone meet to become a SOAD, such as in time worked, experience or status? What are your reflections on that? Is the bar too high or too low? Is it an issue for SOADs coming through the pipeline?

Jemima Burnage: They need to be an experienced psychiatrist, they need to be a consultant and they need significant experience. We recruit them on that basis to be able to deliver this important work. If there was a call for workforce modelling to look at the skills required in

future, it currently sits with second opinion appointed doctors, the criteria needed to do their work and that we appoint them under the Mental Health Act. In essence, we currently oversee the delivery of this service under the Act, but it needs to be seen in the round as part of the wider workforce picture of the skills and types of staff that you need in future to deliver mental health services in the community and effective in-patient services.

Dr Ben Spencer: In workforce planning and trying to get more people to become SOADs, you mentioned incentives. Is it basically about money? Is it the amount that people are paid to do this sort of work or is there a bigger structural problem?

Jemima Burnage: In reflecting on the impact assessment, we need to look at inflation and at incentivising the current SOAD fee structure because there may be more attractive work for those doctors to do. They do work for tribunals and other work, given their role and expertise. So this needs to be commensurate for that role, their experience and the type of work they do. We think that structure needs to be looked at. This needs to be a position that people want to do in future. That has to start now, because we need that experience coming in and growing within the workforce.

Dr Ben Spencer: On the impact on people who, at the moment, need a SOAD to authorise treatment under the Act, how much is Section 62 used for want of a SOAD being in place to meet the treatment criteria? Have you seen that increase over the past few years or has it decreased?

Jemima Burnage: On how that has changed over time, I would need to refer to Mental Health Act data and provide that to you later. There will be specifics about how that is recorded and how it has changed over time. I would be happy to provide that in writing afterwards, if you would like me to.

Dr Ben Spencer: Thanks. Finally, though you probably need to respond to me in writing on this, given where we are now, have you done any modelling—or thought over and above that—on how much more we need to meet current demand?

Jemima Burnage: We are working with the department on modelling and we think there is a significant increase in the funding required to deliver that, what with inflation, fee rise and an infrastructure to manage an expanding pool of SOADs and the activity levels that they deliver. More SOADs are needed to deliver that activity in the future. Yes, we are modelling. We are working on that with the department and we think that a significantly higher number of SOADs—and funding—will be required to deliver that service.

Dr Ben Spencer: Does anyone else want to come in on SOAD provision?

Sean Duggan: A lot of second opinion appointed doctors work in multidisciplinary teams along with their colleagues. That puts into focus the whole problem of the workforce going forward to ensure that it is in the right place to deliver on the reforms to the Mental Health Act. We must start—and we are now—thinking very differently and being innovative and creative about addressing the workforce issues. We must make sure we get the right level of peer-support workers, who are expert by experience, to adhere with safety requirements.

We must also work with the voluntary community sector, or VCS. A lot of the big charities, such as Mind, Rethink Mental Illness and various others, now work alongside mental health trusts and you see that moving in quite a rapid direction. We will need to scale that up properly. They do their own business but have a ready-made workforce. I am not saying that we can just tap into that, because they have issues themselves, but we must start blending workforce and working much more in partnership with other parts of the sector, including the voluntary sector.

There are new roles such as the psychology assistants, associate nurses and physician associates, which we must scale up and embrace. We are doing so to an extent, but we probably need to do more of that. We must do all that to make sure that we meet the needs of the workforce, otherwise there will be a bit of a risk for this policy and others going forward.

Dr Ben Spencer: I realise that this might be more finger in the air than something underpinned by data, but do you have any idea how much time it would take to scale up the workforce to meet current needs in SOAD provision? It sounds to me that this is quite a substantial problem, and it is something that you are struggling with in trying to get provision today. Going at it full tilt, how long would it take, starting today, to get SOAD provision where you would like to see it?

Jemima Burnage: There is an interesting question about how you model that. This is against a backdrop of a national shortage of psychiatrists, so you need to start very early on with training, then advancing into consultant posts and on to SOADs. When you look at activity levels, we have a different view from the impact assessment because we think we need more now and will need more in the future. The modelling is on how long it would take to invest in that workforce to deliver it.

There may be other routes to look at. Some of our SOADs work independently and some of them, as my colleague Sean said, work within trusts or other organisations. Do we need to consider ways to deliver second opinion work by other psychiatrists across the workforce, rather than people who choose to do it? This is not to suggest work plans, but are there ways to make that work for the future across the board?

Dr Ben Spencer: That is helpful, because that is in one sense where my questions are going. Please correct me if I am wrong, but I think that to become a medical member on a tribunal you need three years' experience in a substantive consultant post. Given that this experience is defined, not in a very wishy-washy way but in the amount of time worked on things, and given that we have a limited pool of consultant psychiatrists, some of whom do not want to enter into that, do we even have the capacity now in the workforce to deliver on the SOADs? Will the pipeline have to be people going through medical school and specialist training and then getting that postgraduate consultant experience?

Jemima Burnage: Both routes need to be explored further and more deeply through the modelling. You need to look at who is coming in, where your levels in training are to be able to deliver that service and then how you attract the workforce. Both need to be included in the modelling.

Q168 **The Chair:** How many of those that you are referencing are part-time as opposed to

full-time?

Jemima Burnage: I do not know the exact split but the majority of SOADs are part-time. This is sessional work that they undertake both independently and as part of their trust and their work plan. They do this work separately, so they would all be part-time.

The Chair: So they are part-time as SOADs, but that is just part of their work, in other words.

Jemima Burnage: Yes. Some of them do other work. Some will be on tribunals. Some work in trusts or other organisations.

Sean Duggan: That is why other parts of the workforce must be taken into consideration when looking at this. That time will need to be freed up, particularly for those working in trusts, so other parts of the workforce should be looked at as well.

Q169 **Dr Ben Spencer:** Who is responsible for the workforce planning modelling for SOAD provision?

Jemima Burnage: We are working with the Department of Health and Social Care on the modelling of SOADs and will be looking at our current activities in the middle range. We have people who would deliver more second opinions, so we are looking at the middle range of activity levels to see how many SOADs we need. We are also looking at demand. The Bill is looking at going from three months to two months, so we are looking at the impact of that and the additional workforce you would need.

Dr Ben Spencer: This may be a silly question, but who is responsible for putting that SOAD workforce plan together and being held accountable for it? Is the CQC responsible for it or does it come under DHSC?

Jemima Burnage: It comes under DHSC to fund that through grant in aid funding. We will work with it on the modelling plan. Then, within our structures at CQC, we would oversee this work in both the appointment of SOADs and the delivery of that activity. It is a joint piece of work funded directly through grant in aid funding, not through our fees.

The Chair: That is really helpful. Thank you very much. We move now to approved mental health professionals.

Q170 **Dr Dan Poulter:** Mr Devlin, what would be required for you to feel confident that there were sufficient AMHPs to deliver the proposals in the draft Bill?

Peter Devlin: Thanks for the opportunity to speak on this. Just to set the context and provide some facts and figures, we currently have 3,800 AMHPs. That converts to about 1,800 full-time equivalent AMHPs. Most of those AMHPs, 95% of them, are social workers, 4% are nurses and 1% are OT. Over the past year, we have witnessed about a 3% reduction in the overall number of AMHPs. The age demographic for our AMHPs is that 35% of them are 55 years and over, so we have a disproportionately ageing workforce.

The context of working as an approved mental health professional has changed significantly over recent years, and I return to the challenges and constraints in the system. The Mental Health Act, at the time of its drafting, was built on a set of assumptions. These were that

when an AMHP received a mental health assessment referral, they would be able to secure the attendance of doctors, who would come out and support them to assess people under the Mental Health Act. Once they had concluded that assessment, and where it was necessary, they would be able to speak with a local NHS trust and organise a bed, then facilitate ambulance services to convey people to those beds. Those assumptions are no longer the reality that our AMHPs face. Our AMHPs continue in circumstances whereby there is no provision of a bed or of a health-based place of safety. The psychological burden on them is such that retention is our biggest challenge, as well as recruitment.

On what we think would be helpful, you will know that in the Act currently there is a responsibility on local authorities under Section 13 to provide AMHPs to consider making applications. We propose that the Bill could go further and introduce some mirror duties that extend to other statutory partners that have a responsibility for contributing to the provision of Mental Health Act assessments. We think such system ability is needed to ensure that we have a duty to co-ordinate and provide collectively as a system on these issues. We think that that will support the AMHP workforce.

On what would further support the AMHP workforce, coming back to my point about the composition, we are seeing over the course of the modernisation agenda and the community mental health transformation an increasing number of mental health social workers working in NHS provider organisations, particularly in mental health. We would like to see an expectation around co-operation on and provision for career development opportunities for AMHPs in those non-local authority roles to support and bolster the sustainability of our AMHP workforce to be able to suitably manage the new requirements in the Bill.

We propose one further step: the new ICBs, together with the health and well-being board, should be responsible at a local level for receiving information about mental health activity in the form of data, including population demographics, to address issues of racial disparity. The ICB, together with the health and well-being board, should provide annually a report outlining the demographics of individuals detained under the Mental Health Act, as well as the numbers and the extent to which they are taking remedial actions and planning to address those issues.

Dr Dan Poulter: Thank you. We will come to racial disparities a little later so I will park that for now, but it is an important issue that we want to return to. On the AMHPs issue, does anyone else want to make any quick points?

Jemima Burnage: I have a quick point relating to my colleague's suggestion about ICBs. Thinking about Section 140 and the current duties to have suitable provision and available beds, the suggestion is that there might be a duty to provide community services. The need to invest in and deliver community services has come up in several of the questions, so that could be something to raise here.

Also, on my colleague's suggestion about ICBs having an oversight role in the use of the Mental Health Act, we asked for the inclusion of ICBs in our Section 120 list so that we could call them to account and get information on how they deliver services to meet their local population needs in the use of the Act.

Dr Dan Poulter: Moving on, the draft Bill includes proposals for increased frequency of referrals of patients to tribunals. We have heard that increased workload could reduce the quality of tribunal reports and remove clinicians from day-to-day patient care. What could be added or changed in the draft Bill to address those issues while still achieving what it wants to do?

Sean Duggan: For me, this is absolutely part of the resourcing issue. The proposals around tribunals are sound and very well considered. All our members tell us that there will be an extra responsibility and extra time for their commitment. We must make sure that we get the workforce, and for that there must be an element of resource. They will be willing to do it, as this is all about improving the experience of service users and patients, which is what we are all about. Yet, as you say, it will take extra time away.

Dr Dan Poulter: Could anything be added to the Bill to recognise the increased demand on clinicians and the impact this will have on workforce?

Sean Duggan: I think just that: an acknowledgment and recognition that it will be an extra call on clinical resources, and that that needs to be part of the implementation.

Dr Dan Poulter: That relies on the Government recognising the consequences. If we were being cynical, we might suggest that the Government are optimistic about what the current workforce may be able to do under the provisions of the Bill. Is there anything that you would suggest could be put into the Bill to strengthen the requirements around workforce, safe staffing and having adequate staffing to deal with this?

Sean Duggan: We will have to think about that. My two colleagues might want to answer.

Dr Dan Poulter: You are very welcome to write to us. From a CQC perspective, is there anything worth adding?

Jemima Burnage: We would just like to recognise that this is a really important part, and we do not have a direct solution to it. More than 10 years ago, we used our monitoring powers to look at the activity and impact of tribunals more closely. We could do that again under our existing Section 120 powers. Also, could there be something about a duty and responsibility to monitor quality? Clinicians, particularly psychiatrists, have told us that they are really worried about the quality of reports and the time spent on patient care—to actively engage people in their care. It is not just the quality of reports; it is that they lead to quality outcomes for people at tribunal. We thought that there might be a duty to have an oversight role. This may be an additional burden, but there is a concern around the quality of tribunal reports and those outcomes.

Saffron Cordery: I have a small suggestion. The burden of report writing is clearly a concern and there is concern around taking clinical staff away from patient care. One thing that has been suggested to us is using other reports as a basis for the responsible clinician's report, such as the statutory care and treatment plan. There are perhaps ways of reducing that burden. We do not want to remove the provision because, as everyone has said, the frequency of tribunals provision is really important, but we may need to do things to ease that burden and that is one suggestion.

Peter Devlin: A further suggestion from us, which speaks to the human rights-based lens that we want to bring to this, is the prospect that, at the point of renewal of a Section 3 treatment order, the AMHPs and the responsible clinician are jointly responsible for deciding whether to renew. This was considered very early on following the recommendations made by Sir Simon, but it did not materialise into anything. It is a potential option to consider.

The Chair: Thank you very much indeed. Our next subject is advance choice documents.

Q171 **Baroness McIntosh of Hudnall:** We have heard quite a lot of evidence from people that advance choice documents would be and are very useful. They have not been included in the draft Bill on a statutory basis. We would be interested to know whether you think they should be. Who would be best placed in a health or social care situation to support and involve patients in drawing up those documents? We heard informal and formal evidence that service users—patients—would like to take more part in determining the kind of care they will get. On top of who should draw them up in the first place, is there sufficient capacity in the NHS infrastructure to allow advance choice documents to follow a patient through the various bits of the service?

Jemima Burnage: I am happy to start on this, though my colleagues will probably answer on documents following someone through. This is vital for people's choice and autonomy. That should be encouraged in all manners so that people are actively involved in their care and in making those decisions. Such documents are extremely important. We hear that people are too busy to do them, but these should really be started in the community. They are about someone's choices. They should think about such matters as, "What happens to me when I become unwell?", "Whom do I want to be told about that?", and "What care do I want—and not want?"

The document should follow into a person's care and treatment plans when they go into hospital. It should be under the oversight of the clinical team but, if this is really about patient choice, a nominated person such as an advocate, friend or colleague could help the person with it. The oversight of the clinical team is important, because at all times they must take into consideration people's choices and wishes about their care. There are multiple layers to the issue of who could do this, but where possible, I think the document should start with someone in the community. Then, when someone is admitted, that document needs to be part of the care and treatment plan, to take those wishes into account.

Saffron Cordery: There is an issue here. If this session is all about resources and implementation, we should focus on that. Advance choice documents are a very important part of what patients, service users and their families want to see developed. Yet we need to consider the circumstances in which they are used and whether there is genuinely capacity to deliver them. If a patient or service user moves from area to area and trust to trust, how can we ensure that there is access to that advance choice document and that the particular trust or service provider can actually fulfil its requirements? That would require a very high base level of service provision and flexibility across all mental health trusts in the country, which we would probably struggle to deliver. We need to think about this on that basis.

However, the underlying principle that sits behind this, about giving service users as much control as possible over what happens when they become unwell, is fundamental. We should aspire to that principle but not underestimate the practical obstacles in doing this, such as interoperability, digital infrastructure—which requires capital investment—and the right level of resourcing in every area to meet those needs.

Baroness McIntosh of Hudnall: Can I clarify what you are saying there? You are pointing to the value, in principle, of having advance choice documents—

Saffron Cordery: Yes.

Baroness McIntosh of Hudnall: —but I think you then say, “Actually, we cannot deliver this”.

Saffron Cordery: We need to recognise that there will be challenges in delivering it. There is an additional point to that: alongside drawing up the advance choice documents, we must be clear that there is mutual understanding about what is being asked for, making sure that there is a prescribed terminology and agreement about the basis on which the documents are written. We need to look closely at the ability to deliver that level of personalised care across every trust in the country.

Baroness McIntosh of Hudnall: Given that we must respond to the fact that the Government have not included this in the Bill even though it was recommended, am I right that you would counsel against including it now?

Saffron Cordery: We need to look carefully at it. We never want to see the quality of patient or service user care undermined, but we also need to look at the complexity of implementing it. This requires further engagement and investigation before we go nap on it, because it is complex.

Baroness McIntosh of Hudnall: Thank you. Mr Devlin, you have your hand up.

Peter Devlin: Yes, thank you. ADASS would absolutely support the advance choice document. Giving people agency and supporting them to self-determine and to ensure that their views are respected when there are changes in their mental health is the right thing to do. Yes, there are practical implications, but we need to search harder and push further on technology and on My Care Record in giving people greater control over what is written about them, how it is managed and how they interact with it.

On who is best to do that, we think it could be anybody. That is a relational aspect and is not necessarily about qualification, although obviously there must be some recognition of the parameters around what can be reasonably expected at any point in somebody’s journey through health and social care.

The Chair: Thank you. Mr Duggan, do you want to add anything?

Sean Duggan: No, it has been covered.

Jemima Burnage: I have an additional comment. Notwithstanding the workforce and implementation issues, and even though it is not a statutory requirement, there could be a

duty through an expansion of Section 132 to provide information on advance choice documents.

The Chair: That is helpful. Thank you very much indeed. Now we move to the next subject: black and ethnic-minority inequalities.

Q172 **Sir Charles Walker:** Sean, we met 15 years ago, I think, when we did the last iteration of the Mental Health Act in 2007. Our discussions then centred on the experience of Afro-Caribbean, black and Asian communities and their sense that they were treated more harshly and less fairly than white people, bluntly—let us not sugar the pill. That caused a lot of concern around community treatment orders, detention and policing. When you look at the latest iteration, Sir Simon’s review, what aspects do you pick out that are an improvement on where we are at the moment?

Sean Duggan: The improvement we have had already?

Sir Charles Walker: No. There was a general feeling in 2007 that the concerns of the black Afro-Caribbean community were not fully addressed, that community treatment orders were used disproportionately against them and that their interests did not get the same level of hearing or sensitivity as the interests of other communities. Sir Simon Wessely has done his review. We are talking about inequalities now and about greater equality. Can you point out where you think the improvements lie? It is important that we establish where the four of you think the improvements in the recommendations lie.

Sean Duggan: Thank you, Charles. First, we have to remember that one main reason for doing this review—we all backed Sir Simon in doing it—was to address this very issue of the overrepresentation of black and minority-ethnic communities. As I said earlier, having been in the service for some time, it is a source of embarrassment and shame that we have had various initiatives over the years—before you and I met, there was the delivering race equality plan, a whole financially backed programme to address this—and they have not worked.

Having this as an absolute theme of the review of the Mental Health Act is really important. We must keep telling people that that is why we are doing it, because it requires a cultural change to shift people’s decision-making and other processes so that we can reduce this overrepresentation of people from BAME communities, and reduce the administration of the Mental Health Act per se. I think that will happen. It is a cultural shift and the main reason we are doing this.

Secondly, as a by-product of having a focus on this, we have introduced the patient and carer race equality framework, or PCREF. That is led by Jacqui Dyer, who is very well known—she runs Black Thrive—and it is backed up by the NHS. It is a good programme. I recently saw an update that that will be rolled out next year across all mental health trusts and organisations. It involves a whole set of targets and guidance to have culturally sensitive assessments focus in on your behaviour and decision-making process regarding black and minority-ethnic communities. That is going very well. There is really good feedback. I really think it will take off.

It will be those sorts of initiatives that come out from this legislation. We must keep reminding everybody that this is why we are doing it. There are all sorts of other spin-offs,

but this is exactly why we are doing it—to move from such people being four times more likely to be under the Mental Health Act and 10 times more likely to end up under a CTO.

Jemima Burnage: We know that that is completely unacceptable and we know that it is rising, so this is not making a difference and we need to do more. There was a suggestion in relation to the Mental Health Units (Use of Force) Act about having a responsible person. A responsible person could oversee, represent and look at the data and at population engagement, outreach and support, and how that model can meet local population needs, which would be a legal underpinning of the PCREF, for example. That was one suggestion we had.

Another was thinking back to Section 140 of the Mental Health Act, which established legal commissioning responsibilities around the provision of beds in urgent admission and age-appropriate services for children and young people. Could the Bill similarly establish commissioning responsibilities over culturally appropriate outreach and community support to people, with a broader social aspect than just mental health? Could we look at the Section 120 list under the Mental Health Act and have us then overseeing and asking for information about how they meet the needs of those people?

We thought about whether there could be a specific requirement to commission culturally appropriate advocacy. We have seen early signs of that being successful in reaching into the communities that we serve, helping to promote recovery and keeping people well and not going to hospital—or, if they do, bringing them back from discharge.

Lastly, we thought about whether there are specific board-level duties for commissioners and service providers to collect this data on ethnicity, to use it, understand it and then provide services that meet their community's needs. We had a few suggestions.

Sir Charles Walker: You would have a statutory requirement for data collection.

Jemima Burnage: We suggest that a statutory requirement for data collection could be considered, alongside having a responsible person, culturally appropriate advocacy and the provision of services within the community.

Sir Charles Walker: Of all those things that are not in the Bill but might be, what two things would you like this committee to recommend?

Jemima Burnage: We all want to see a change for black and minority-ethnic people in terms of their experiences of detention under the Act and community treatment orders. We recently published a community treatment order report, which identified that people were not aware of how to be discharged. There was coercion around medication-taking in the community and they were not being used well. Part of the recommendation is that those undertaking community treatment orders and supervising people on a CTO in that way need to be much more aware of the impact and the nature of culturally appropriate services to meet those needs.

You asked about the things that work. There are early signs about PCREF and culturally appropriate advocacy. The current model of commissioning advocacy is for large, more generic types of services that are not meeting the specific needs of those ethnic-minority populations and communities. We need much more defined outreach and inreach into those communities around culturally appropriate services.

Saffron Cordery: If you are looking for specifics, I wholeheartedly support the culturally competent advocacy approach. It has been piloted and it is seen to be working, so that is an important element. We need the right resources in place to deliver that.

The other element that I would focus on is how we collect and use data. I make the plea that we build this into a wider system approach to the collection and use of data. We are talking about legislation that operates within the framework of mental health trusts, which operate within a system. We know that the whole point of integrated care systems is to focus on population-wide data and make sure that they really target health inequalities. From my perspective, one of the biggest health inequalities we have is the treatment of black and ethnic-minority patients and service users. That would close that loop. I would focus on those two things.

Peter Devlin: I would second and third mandated and standardised data collection and publication. That absolutely gets the vote. We should not divorce the disproportionate number of people from black and ethnic-minority groups who are assessed and detained under the Mental Health Act from the local societal aspects at play. We spoke about those wider determinants of health. It feels extremely important that we ensure that responsibility for overseeing mental health activity within the context of population health sits with an ICS or ICB—an integrated care system or integrated care board—together with the health and well-being board, and that should be enshrined in statute.

The Chair: Next, we turn to learning disability, autism and guardianship.

Q173 **Baroness Hollins:** To what extent will the new building the right support action plan be effective in meeting the needs of people with learning disabilities and autistic people, particularly those who are no longer detained under Section 3 of the Mental Health Act?

Peter Devlin: We think the ambition and aspirations behind the building the right support plan are absolutely sound. Again, the areas given in the action plan are the right ones to focus on. We are pleased that there is now a national board across government. Sean mentioned the wider societal factors that we need to engage with and have something in place for, such as housing, employment and the rest of it. The national board is now stood up and has cross-ministerial involvement.

It is the right ambition, but we feel that the resourcing of both workforce and finance that sits underneath it is still way short of what is required for us to realise that ambition of ensuring that we have the right community provision in future. We need to make sure that the mechanisms for supporting us to plan and design the future of community provision are set in the right parts of the system with the right engagement from those with lived experience, family carers, the local authority, providers and their NHS colleagues.

Sean Duggan: Peter is absolutely right. First, thank you for this section on learning disabilities and autism. We often do not pick that up where we should. It needs to be a priority. I agree with what Peter just said. He said earlier that some of these community solutions are not necessarily cheap. Some can be, compared to expensive institutional care, and some that are provided in combination with NHS commissioning, housing associations that do care and support or the voluntary sector are really good. There are so many good models—we can write to you with examples. These provide good-quality wraparound care

24/7. They fare very well comparatively and offer value for money. I support this but it will need—I know we are repeating ourselves—a proper resource envelope to make sure it happens.

Baroness Hollins: Jemima, did you see anything in the draft Bill that would further move this group away from long-term detention?

Jemima Burnage: It has probably been well covered in these committee sessions, but we are concerned about the unintended consequences of the change within the provision of the Bill for several reasons. Could we have a finding of exaggerated comorbidities? Could people be detained in terms of their liberty under other provisions and legislation with fewer safeguards? Will people end up in the criminal justice system or in prison—maybe not via the pathway of the Mental Health Act—for some of those behaviours when they are distressed? People may end up not moving back to the community because there is a lack of community provision. It is absolutely the right thing to do, but we are concerned about those consequences.

We fully support the building the right support action plan, but immediate actions must be taken. We have written widely—in our *State of Care* report, our *Monitoring the Mental Health Act* annual report and our *Out of Sight* report—about people being in restrictive environments in hospital for far too long when they do not need to be there, and we have not seen the pace of change happening. The actions set out in the action plan need to be implemented and there is continued need for ministerial support to deliver this programme of work.

Baroness Hollins: Is there anything else that could be added or done? We are worried about the unintended consequences that everybody has spoken about. Yes, it comes back to the resource issues, but is there anything else?

Jemima Burnage: Without laying out and repeating some of the problems, the only thing that we considered is that there are solutions in care that meets people's needs and wraps around them in the community. That means thinking about not just them coming out of hospital but how to support them well to live a good life within the community from the outset. It is about bringing people out of hospital but also having a different route and experience in the community that works for them, particularly when they become unwell or just stretched. This goes back to thinking about whether there are any duties and provisions around community services. We do not know the answer to that. We know that Section 117 is a duty of aftercare but it is often not acted on in a timely way with organisations coming together to deliver it. Could something be considered around provision of community care and support services for people?

Q174 **Dr Dan Poulter:** That is very interesting. We are talking about bringing the rhetoric together to make it reality. It is all very well to talk about community provision, but unless we have a mechanism to make it happen, it is very difficult to see, in the resource-stretched environment that we have discussed, how that will happen on the ground. There are perhaps two mechanisms for that. Would one way be to strengthen and perhaps put some sort of time limit on provision? What do you think from a CQC view? Secondly, could something be done with tribunals having some sort of prescriptive power to determine what the provision should be in some cases?

Jemima Burnage: As well as being a regulator and managing our responsibilities under the Act, we have done extensive work here. You may be aware of *Right Support, Right Care, Right Culture*, which lays out very clearly the types of services that people, communities and families tell us that they need and want, and that have been reviewed and would be suitable. We suggest the exploration of possible routes to make that happen. It is very clear what people need and want within the community, rather than going to hospital. It is just about making that happen in a timely way. Some people wait a very long time in a restrictive environment far away from home without that provision in the community.

Dr Dan Poulter: So, potentially, having some sort of time criteria in those aftercare provisions might be a helpful amendment to make things happen.

Jemima Burnage: I suppose both timescales and a duty to provide could be explored. Section 117 in particular is not always delivered, but it is an existing duty.

Saffron Cordery: I will just pick up on a couple of points. The issue around Section 117 is important. Where you use the phrase “getting it right for people with learning disabilities and autistic people”, it is actually about getting it right for everyone. One thing we need to think about is the provision of timely community placements, because we do not want the unintended consequence of people with learning disabilities and autistic people no longer coming under the aegis of this legislation then making it more difficult for them to receive the community placements they need.

There is something about the rising of the tide in general on this point of shoring up community services and placements to make sure that everyone has the support and care that they need in the right setting. There are some quite well-trodden pathways for different types of care that spin off from this legislation, so we must make sure that people do not fall outside that.

The other thing we need to be really clear about is that often the commissioning of learning disability and autism services can be a little fragmented and disjointed. There is a real need to make sure that we are skilling up those who do the commissioning to improve their awareness and to make sure that there are the specialist skills and expertise among staff. That is a general point, but it relates to the really welcome step of making sure that those with learning disabilities and autistic people who do not have a mental health condition do not fall within the auspices of this legislation. We must make sure that they are not then overlooked and that the right services are commissioned.

Q175 **Baroness Hollins:** Do you foresee any increased use of guardianship for people with learning disabilities and autistic people? What are the workforce implications if there is increased use of guardianships?

Peter Devlin: We see a likely increase in guardianship as a consequence of the changes to the treatment detention criteria. We think that implications will come with that around education, training and the availability of responsible clinicians. In the current context, it is difficult to secure a responsible clinician to support and oversee some of these treatments while individuals are under guardianship in the community, particularly when they are placed outside their normal areas. Often there are challenges and problems in the system around where the responsibility rests. We see responsible clinicians and the requirements there being a challenge.

Then, of course, there are the extended rights that individuals will have around things such as tribunals and the responsibilities of local authorities in this circumstance to convene and administer that. Some of this is picked up in the impact assessment, but the extent to which it has fully scoped the implications of guardianship probably needs to be looked at again. I also suspect that there is a degree of uncertainty around the extent to which guardianship will be used, but it certainly serves a function and, to some extent, it is perhaps underused currently.

Q176 Baroness Hollins: Thank you very much. Moving on to the quality of care, there have been high-profile cases of abuse in care settings recently. The Parliamentary and Health Service Ombudsman proposed using the draft Bill to clarify and streamline complaints routes for patients and families. Would you support this?

Jemima Burnage: Thank you for that question. First, the documentaries we see and the experience of patients within those hospitals are hugely concerning and worrying. It is unacceptable to be treated in that way in a place where you should be looked after. It is for all of us to look deeply into what more we and the services can do to disrupt such things and to nurture cultures and environments where people provide safe, compassionate care. We are doing a range of things to look at our part in that, as is appropriate.

Linked to that point, Wessely's review suggested an independent hospital visitor's role. We thought this might be the time not necessarily to review that role but to think about Mental Health Act reviewers and the frequency and nature of their visits. Would this be the time to revisit that in a different way, with the existing responsibilities for reviewing that we have under the Act?

On the Parliamentary and Health Service Ombudsman, we agree with the recommendation to clarify, streamline and introduce the mandatory signposting under Section 132 on provision of information. I gave evidence earlier this year to the Joint Committee on Human Rights about the wish to transfer the duty of complaints to the ombudsman. We do not consider that necessary because we use that information to signpost, support people and respond to queries. We have a duty to visit places of detention under our national preventive mechanism. We also use that to understand and regulate risk within those services. It is important for that duty to remain with us, but we recognise that there is some confusion here. That could be tightened up and clarified within the provisions of that section on information.

We might also think about how we can work with other organisations, such as local government and the Parliamentary and Health Service Ombudsman, to tighten up our memorandum of understanding and information sharing to ensure that they are right and effective. Internally, we are looking at how we can digitise and modernise the complaints service. We will need more investment to do that and would welcome the department helping us to carry out a proper quality improvement review so we can use that data well to enhance patient care and respond to those complaints. We recognise the need for modernisation and the use of data, themes and trends to inform patient care and improvement.

Baroness Hollins: Thank you. Those are some important points. You mentioned the interesting idea of hospital visitors. There is also the issue of whether families have access to patients in these circumstances, including in places where they are cared for. Should we address anything there?

Jemima Burnage: We gave evidence previously to the Joint Committee on Human Rights on visiting and access. Those connections are important, particularly in keeping people connected with their friends, family and loved ones when they are in places of detention for often long periods of time. It is important to enable that wherever and in whichever way possible.

It is vital that we understand people's experiences. We are looking to expand on that within our inspections, to think about our methodology and to build trust among care staff, families and people who use services so they tell us more about that, enabling us to respond. It is not the individual complaints; it is about how you get a picture of quality and experience. Using our expert experience, we are designing a more observation-based methodology. We are doing that in co-production with people who use services to think about our learning and what more we can do in our part to play.

Saffron Cordery: Rather than perhaps adding in the PHSO's specific proposal, we should think about the routes, tools and leverage we already have. The opening-up point is critical. We need that clarity for patients and families. We need better investigations undertaken locally and better co-ordination between the organisations already carrying them out. We have things such as the patient safety incident response framework, and the Healthcare Safety Investigation Branch is looking at how it supports local investigations. We have quite a lot of means at our disposal. It is about how we use those and use them better.

In the two terrible cases this year that have been highlighted, which are deeply concerning, we have seen this notion of closed cultures and wards. It is about how we open up and let light in on those parts of provision to ensure that we work on changing the closed cultures that exist and have the right leadership in place. I am not necessarily talking about leadership at the top of a trust but having the right leadership at ward or directorate level to ensure that quality can be maintained and reinforced. It is definitely about improving culture and practice, and letting light in, rather than necessarily overlaying more legislative routes, responses and resolutions to what are essentially cultural issues exacerbated by lack of resource.

Baroness Hollins: Does this opening up require any legislative change?

Saffron Cordery: This is predominantly a cultural issue rather than one that would be solved by legislation. It is about how we focus on changing the culture of places where this happens to ensure that we open up. In the best places, we see open cultures and do not see such issues come to light in the same way.

Sean Duggan: I support that last point. It does not require legislation but requires work. I have been quite impressed, since these two episodes came to light, by the way all organisations looked straight in on themselves and want to make improvements. It has taught us that you can look into an organisation at board level and get a view on culture, but you can then have toxic subcultures. This is about identifying those and ensuring the board knows about them quickly so that they can do something about them.

Dr Rosena Allin-Khan: We had Edenfield, the Huntercombe Group and the three young ladies who died. I met with the CQC and NHS, and have been given lots of reassurances about the future. What struck me most is that complaints were made

and issues raised for a good couple of years, particularly at the Huntercombe Group. What can we do going forward? As we know, when the CQC does an inspection, it is only a snapshot.

Sean, you spoke about subcultures. Is there anything we can do in this Bill to support a culture change to stamp out this toxicity, which, unfortunately, seems more common than we would like? For people to act with impunity, while knowing there were lots of complaints and issues raised for a couple of years beforehand, clearly a lot needs to be done to improve this. Sometimes, the only way to do that is to legislate for it, as well as all the good work you are already trying to do. I can see Saffron nodding.

I feel very strongly about this because as the shadow Minister I was involved in the UQs on both these issues, looked at all the evidence and spoke to the MPs for those areas. We knew for a long time that things were going wrong.

Saffron Cordery: I am nodding because I recognise the issues that you raise, the terrible situations that have come to light and that sense of helplessness people feel in the face of it. Yet I do not think that legislation is the means to change culture, which is what we need to get to the bottom of. Perhaps we need to look again at this, but quite far-reaching powers already exist within organisations to drive home these issues. We know that the CQC has the power to prosecute. I totally understand the motivation for wanting to add more into legislation to short-circuit what is going on and get a quick answer to these challenges. I just caution that we already have the tools; it is about how we use them.

Dr Rosena Allin-Khan: I completely agree that you cannot legislate for a culture change. There has always been good will toward getting things right for people who find themselves in the most difficult and vulnerable circumstances, but it has not been enough. Is there anything—it might be that Saffron thinks not—that we can do to make things easier for you to create that culture shift?

Jemima Burnage: Saffron covered a large part of that. Mainly, it is within practice and cultures rather than legislation. There can always be a tightening of what one does organisationally. Saffron touched on what goes on within a service. It is about justice, and understanding and hearing what people say. It is not always a manifestation of mental illness. When someone says, “Something happened to me”, it is about seeing it, feeling it, being on a ward and using those skills: all services can do that all the time.

There is also the need to feel trust. Some staff within those services will not behave in that way. How do you get them to speak up, share their concerns and want to make a difference to people? There is much to be done around disrupting patterns, being on those wards and using those sensing skills to really hear what people say and understanding it is not just that they keep saying something because they are unwell. I am sure we have seen what some of those people say about their treatment, as we noticed in the IC(E)TRs as well. How is that used to inform their care and take action locally?

As you know, we can go and inspect, and we can prosecute—in particular circumstances, around a provider and registered manager. The effort needs to come in trying to spot the signs early and do preventive work to create healthy cultures that nurture a workforce and the

compassionate care that everybody wants to receive. That is where we need to put greater focused effort—all of us together—on what each of us can do within organisations and services themselves to create that culture with people who really listen to those using services and their families.

Dr Dan Poulter: Quickly picking up on what Mr Duggan said about boards, ultimately the board should know what is going on in an organisation and should have collective accountability for what takes place in that organisation—notwithstanding the point about different directorates and service directors also having more day-to-day understanding. We know that throughout healthcare, in this case mental health care, the calibre of boards can vary. The type of people on those boards at a non-executive level can vary. Is there anything we can do, through legislation or the Bill, to strengthen boards and their reporting structures, or anything that would help make these manifestations of poor care less likely?

Sean Duggan: It is difficult to answer that. I will go away and think about what can be done, if anything. There is so much work going on around boards, such as monitoring boards and supporting boards, or identifying whether we have the right composition of boards. I regularly meet with chairs and they are constantly looking at their governance and how to strengthen it.

The issue is in reporting up. When subcultures are not going right, how is that reported up to the board? There are areas where that works very well, and we could do a lot more in sharing that. I do not know that anything could be put in legislation about that. However, we can all do a lot of work to ensure that where things go well, we pocket that up and share good practice, et cetera, so that others do it, too. I cannot think of anything straightaway that would be helpful to put in the Bill.

The Chair: We must end this session there. Thank you very much to our witnesses for their contributions; they are enormously helpful to our deliberations. We are very grateful.