Freedom of Information (Scotland) Act 2002
Response to correspondence dated 22 May 2019
Request: Independent Inquiry into Mental Health Services in Tayside
Applicant: Parliament
Reference: IGTFOISA6328

NHS Tayside has now considered your request dated 22 May 2019.

NHS Tayside wishes to advise you that there are exemptions applicable to the information requested. Please refer to the exemptions section of this correspondence.

Extract from Request

1. "All draft versions of the Interim Report published by the Independent Inquiry into Mental Health Services in Tayside which had been sent to NHS Tayside before publication of the final document.
2. All communications between the Independent Inquiry into Mental Health Services in Tayside and NHS Tayside about these draft documents and the final document."

Response

Please see NHS Tayside's response to your request appended below.

Where information has been withheld (redacted), information relates to personal information of third parties and will not be provided in response to your request.

Exemptions Section – application of Freedom of Information (Scotland) Act 2002 exemptions and Data Protection Act 2018 Principles.

Document Ref.	FOISA Exemption Applied	Justification
IGTFOISA6328	Section 38(1)(b) – Personal Information	Disclosure of information would be in breach of Confidentiality and Data Protection Principles.

Freedom of Information (Scotland) Act 2002
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Under section 20 (1) of the Act, if you are dissatisfied with the way NHS Tayside has dealt with your request, you have a right to request a review of our actions and decisions in relation to your request, and you have a right to appeal to the Scottish Information Commission.

A request for an internal review must be made in writing no later than forty working days from receipt of this response and addressed to:

Tayside NHS Board Secretary
Tayside NHS Board Headquarters
Ninewells Hospital & Medical School
Dundee
DD1 9SY

If you are not content with the outcome of the internal review, you have the right to apply directly to the Scottish Information Commissioner for a decision. The Scottish Information Commissioner can be contacted at:

Scottish Information Commissioner
Kinburn Castle
Doubledykes Road
St Andrews
Fife
KY16 9DS

Or via the online appeal service: www.itspublicknowledge.info/Appeal

If you have any queries about this correspondence, please contact:

Information Governance Team
Maryfield House
30 Mains Loan
Dundee
DD4 7BT

Telephone - 01382 424413
E-mail: informationgovernance.tayside@nhs.net

Information Governance
NHS Tayside
15 July 2018

Independent Inquiry into mental health services -Interim Report

DELETE REPLY REPLY ALL FORWARD •••

Denise Jackson (Staff) <d.r.jackson@dundee.ac.uk>

Mark as unread

Tue 21/05/2019 12:52

To: NICOLL, Bill (NHS TAYSIDE);

Cc: TAYSIDE, Chiefexec (NHS TAYSIDE); TAYSIDE, Chairman (NHS TAYSIDE);

1 attachment

Independent ~.pdf

Dear Bill,

Please find attached the Interim Report for the Independent Inquiry into mental health services in Tayside The report is subject to a press embargo until **Wednesday 22nd May** when a copy will be made available on the Inquiry's website: www.independentinquiry.org

This Interim Report aims to provide an update on the progress of the Inquiry and to identify key themes emerging from the initial evidence-gathering phase. These themes have emerged after listening to all the evidence and will provide the main focus and shape the next stage of the Inquiry.

The Inquiry will now proceed to investigate and analyse these themes, before drawing conclusions and making recommendations to improve the provision of mental health services in Tayside.

David will be available on Wednesday 22nd and Thursday 23rd for interviews and comment.

If you have any questions/queries please don't hesitate to contact us.

Kind regards
Denise

Denise Jackson
Secretary to the Independent Inquiry into Mental Health Services in Tayside

Email Independentinquiry@dundee.ac.uk

Tel 01382 381835

15/16 Springfield

Interim Report
Inquiry Update and Emergent Key Themes

Capturing Experiences of
Mental Health Services in Tayside

May 2019

Contents

1. Introduction

Following widespread concerns raised in the Scottish Parliament in May 2018 about the provision of mental health services in Tayside, an Independent Inquiry into Mental Health Services in Tayside (the Inquiry) was commissioned by NHS Tayside to inquire into the accessibility, safety, quality and standards of care provided by mental health services in Tayside. The Inquiry is examining end-to-end mental health services, including suicide prevention services and those provided by partner organisations and third sector providers. A commitment was given by the Inquiry team to report on the findings and to make recommendations for improvement.

A detailed description of the work of the Inquiry to-date is at Section 3.

2. Purpose of Interim Report

Since the public call for evidence in September 2018, the Inquiry has received a substantial quantity of evidence from a wide range of people and organisations.

In the analysis of this evidence, the Inquiry team has identified a number of key themes for further investigation. This Interim Report aims to provide an update on progress of the Inquiry and to identify the key themes emerging from the initial evidence-gathering phase. The themes have emerged after listening to all who wished to share their evidence - namely patients, carers, families, NHS staff and representatives from other organisations. The themes will provide the main focus and shape the next stage of the Inquiry.

It is important to recognise that this report identifies only the issues which have been raised in the evidence submitted to the Inquiry. Investigation and detailed analysis will be required before any conclusions can be drawn or recommendations made by the Inquiry.

3. The Independent Inquiry

3.1. Background

The Inquiry is being guided by the five principles agreed in the Scottish Parliament debate which are to:

- be open and transparent
- be truly independent
- include and involve staff from NHS Tayside, its partners and third sector providers
- include and involve patients, families and carers
- include a public call for evidence to ensure everyone's voice is heard.

Following the announcement of the Inquiry, a group was established to represent patients, families, carers and third sector organisations which would enable stakeholders to engage with the Inquiry and to ensure a high level of transparency in its work. This group, known as the **Stakeholder Participation Group** (SPG) is coordinated and chaired by the Health and Social Care ALLIANCE Scotland (the ALLIANCE).

Following a formal interview process convened by the ALLIANCE and advised by the SPG, Mr David Strang was appointed by NHS Tayside as Chair of the Inquiry in July 2018. The Inquiry then appointed a Secretary to the Inquiry, administration and clerical support staff and a researcher. Professional advisors based in other Health Boards in Scotland were also appointed to assist the Inquiry team in an advisory capacity, when required.

An **Employee Participation Group** (EPG) was also established, chaired by a representative from UNISON. The EPG consists of representatives from all NHS recognised trade unions, professional bodies and employee relations representatives.

3.2. Terms of Reference

The Terms of Reference for the Inquiry were finalised after consultation with the SPG and with NHS Tayside staff/employee representatives, and were published on 5 September 2018. The purpose was to inquire into the accessibility, safety, quality and standards of care provided by all mental health services in Tayside, to report on the findings and make recommendations for improvement. The Terms of Reference are available on the Inquiry website: www.independentinquiry.org

3.3. Call for Evidence

The public Call for Evidence was issued on 5 September 2018, with wide media coverage in Tayside: BBC News, STV News, The Courier, Evening Telegraph, and Tay FM. Posters were distributed to GP practices, libraries, prisons and hospitals across Tayside. The Call for Evidence invited people to come forward with accounts of their experiences both positive and negative of mental health services in Tayside. The closing dates for submission of evidence were extended to allow as many people as possible to engage with Inquiry. The Call for Evidence information is available on the Inquiry website: www.independentinquiry.org

3.4. The Inquiry Phases

The Inquiry is being conducted through a five-stage Project Plan, detailed below:

Stage 1 (Set-up and launch) [complete]

Stage 2 (Evidence gathering) [complete]

Stage 3 (Analysis and Investigation) [currently in progress]

Stage 4 (Final report with conclusions and recommendations) [date to be confirmed]

Stage 5 (Dissemination of Findings) [date to be confirmed].

3.5. Responses to the Call for Evidence

In total 1310 individuals have engaged with the Inquiry during the call for evidence. This number represents patients, families, carers, organisations and NHS staff.

3.5.1. Written

Over 200 submissions of written evidence were received by post, email and in person. This represents more than a 1000 documents, all of which have been processed, coded and stored securely pending further analysis.

Between September and November 2018, the ALLIANCE held focus groups across the NHS Tayside area to capture the voices of those with lived experience of mental health services in Tayside. This was a significant piece of community research which produced a range of valuable recommendations. The ALLIANCE report was submitted to the Inquiry as evidence in December 2018 and is available here: https://www.alliance-scotland.org.uk/blog/resources/independent-inquiry-into-mental-health-services-in-tayside-hearing-the-voices-of-people-with-lived-experience/

The EPG conducted an online staff survey during November and December 2018 and held focus group meetings for all those employed to work in NHS Tayside mental health services. 53% of all staff surveyed responded to the survey; a total of 524 individual returns. The EPG submitted their report as evidence to the Inquiry in April 2019.

3.5.2. Oral

Over 70 oral evidence sessions were held with patients, families, carers, NHS employees, other health professionals and third sector organisations in Angus, Dundee and Perth & Kinross.

Volunteers from both the Dundee and Perth Samaritans provided emotional support for patients, families and carers after oral evidence sessions.

Evidence was also submitted (oral and written) from other organisations such as Police Scotland, University Student Welfare Teams, Dundee Fairness Commission, Dundee Drugs Commission and third sector organisations.

Additional meetings were held with a range of health professionals and clinicians such as Consultant Psychiatrists, Psychologists, General Practitioners (GP), Allied Health Professionals, staff at the Carseview Centre, student nurses, and trainee GPs. This enabled the Inquiry team to gather views on mental health provision in Tayside. The team also met with Integration Joint Board (IJB) representatives and key personnel from Local Authorities.

Please see Appendix 1 for a summary of organisations who have submitted evidence to the Inquiry, either in writing or orally.

3.6. Evidence - Analysis

The analysis of the evidence is ongoing. The evidence currently being analysed includes all written and oral submissions, as described above, as well as relevant reports and reviews,

published papers, benchmarking data and internal review documents relating to mental health services in Tayside. The analysis is a complex process designed to identify emergent themes.

4. Key Themes

The Inquiry heard many examples of good quality care and high level professional practices across mental health services in Tayside, evidencing a clear person-centred care approach in the treatment of patients. However, as the evidence was analysed there were key themes emerging where the quality and care was not good and these themes will be the subject of further analysis and investigation by the Inquiry team.

The Key Themes arising from the evidence submitted to the Inquiry are as follows:

- Patient Access to Mental Health Services
- Patient Sense of Safety
- Quality of Care
- Organisational Learning
- Leadership
- Governance

4.1. Patient Access to Mental Health Services

There is no doubt that one area of challenge for both patients and health professionals is ensuring that the appropriate care and treatment is in place and available for all patients in need of support and intervention when they need it. It is clear that accessing mental health services and support can at times be difficult for patients.

The issues emerging within the *Patient Access to Mental Health Services* theme are:

- Crisis Service
- Risk Management
- Police Scotland
- GP Referrals
- Rejected Referrals
- Allied Health Professionals (AHP)
- Child and Adolescent Mental Health Services (CAMHS)
- Mental Health and Substance Misuse
- Multiple Diagnoses

4.1.1. Crisis Service

Many patients and families report receiving care and support from "professional and caring" staff within the Crisis team when they needed it. However the Crisis team struggles to respond to sudden surges in demand on the service; there are occasions when the length of time to wait to be seen is long and families supporting someone in crisis are advised to phone the police or

NHS24, if they are worried. This advice is unexpected and concerning to carers coping with a crisis in a domestic situation.

The centralisation of the out-of-hours Crisis team to Carseview Centre has had a detrimental effect on those patients in Angus and Perth & Kinross who are experiencing mental health crisis. The GPs in Angus report that the community service at Stracathro does not take referrals for crisis assessment after 3.30pm on weekdays and the out-of-hours referral service at Carseview Centre does not begin to take referrals until 5pm for those outside Dundee.

There is a perception that whilst the Crisis service has expanded in recent months, the situation has worsened in terms of patients being assessed then not being offered any crisis intervention, or referred back to the GP.

4.1.2. Risk Management

Many patients report that in the early crisis assessment, there is a lack of adequate risk assessment in their risk management plans. Patients report telling staff they were suicidal but the risk was not taken seriously until they made a serious attempt to take their own life. Patients are sometimes left to get the support they need from their family during a crisis.

4.1.3. Police Scotland

Access to services for a person in crisis frequently involves Police Scotland, who report many hours of police time spent supporting and transporting those in crisis and/or waiting with them to be seen by the clinical teams at Carseview Centre. A police officer with a patient in crisis can speak directly to the crisis team on a dedicated phone line and receive advice on the best course of action which may be to take the patient to be assessed by the crisis service or to advise them to go to their GP or to return to the Community Mental Health Team. However, it is the police officer who is managing the patient in crisis throughout this assessment.

4.1.4. GP Referrals

Many patients and GPs report that once they have been seen at their GP practice the wait for the referral to mental health services is long, during which they receive no contact from the service. This adds to the patients' anxiety and distress. Patients with mental health issues are sometimes referred by their GP as urgent cases but this may be downgraded by mental health services to routine and added to the waiting list, or even rejected. Even after a first appointment for an assessment by mental health services, waiting time for appropriate ongoing treatment may be as long as a year. In the meantime, patients may be referred to third sector alternative support agencies by signposting but this approach is inconsistent and details of pathways to support are not always accurate or even available.

4.1.5. Rejected Referrals

The GPs report that rejected referrals present problems in General Practice where there is limited expertise or time to support patients with ongoing mental ill-health. GPs feel that their serious concerns for patients are not understood or accepted by those processing the referrals within mental health services. Cases are rejected on the basis that the patient did not meet the required criteria, however GPs do not know what the required criteria are, in order to understand which of their patients they can expect to be seen by the service. Their frustrations were evidenced by

a comparison with referral of patients to Acute Services (for example - Orthopaedics) which are unlikely to be rejected outright without the service seeing the patient at least once. There is a lack of understanding as to why this does not apply in referrals to mental health services. Moreover, rejection letters generally do not give the GP any guidance on how to continue to manage the patient's continuing mental ill-health.

There are also concerns arising from the two different response times to referral options: urgent referrals (seen within 72 hours) and routine referrals (weeks or months). The difference between the two waiting periods gives rise to concerns that the referral process is not fit for purpose and is forcing GPs to use the Urgent referral category just to ensure patients are seen timeously and not because they clinically match this referral category.

4.1.6. Allied Health Professionals (AHP)

Post-referral waiting times to AHP services may be as long as a year. Evidence submitted to the Inquiry stated that waiting times for Psychological Services were significant and patients were often not told at the time of their referral how long they could expect to have to wait.

4.1.7. Child and Adolescent Mental Health Services (CAMHS)

The latest figure (Feb 2019) shows 39.5% of new patients waited longer than 18 weeks to be treated by CAMHS. In addition, rejected referrals are high. Families with the means to do so, are choosing to make provision for their children to be seen privately. The removal of certain community-based services (e.g. Primary Mental Health Workers) is perceived to have had a deleterious effect on mental health care and support for children and young people.

The definition of a young people in NHS Tayside is also problematic, with 16 year olds who have left school being treated by adult services and a 16 year old still in school continuing to be treated by CAMHS. Furthermore, the waiting times are such that referrals to CAMHS are often rejected on the basis that the young person will have become an adult whilst waiting to be seen by CAMHS, particularly if they have left school in the meantime.

There are also many reported difficulties with the transition from CAMHS to General Adult Psychiatry (GAP) for young people. Many report feeling scared and frightened to be admitted to adult inpatient facilities at Carseview Centre or Murray Royal when they have hitherto been treated in the Dudhope Young Persons' Unit in Dundee.

4.1.8. Mental Health and Substance Misuse

Patients presenting to mental health services following alcohol or drug consumption, report rejection from crisis assessment. People with addiction to alcohol and/or illegal drugs may be refused access to mental health services.

Third sector services with a responsibility for substance misuse report that clients complain they are only receiving treatment for their substance misuse issues and are not receiving any treatment for their mental health problems, either because they are on a long waiting list or have been rejected from mental health services due to their substance misuse issues. There does not seem to be a holistic approach to treatment in these circumstances.

4.1.9. Multiple Diagnoses

Patients who have multiple mental health diagnoses are often streamlined into a single service to address one of their diagnosed conditions. This results in their waiting a long time for a particular service which may ultimately not be the most appropriate course of treatment by the time they are seen, as another of their conditions may, by then, be more critical. They are then re-referred to a different treatment service, which may involve another lengthy waiting time.

In these cases, patients should receive a multi-service (team) approach in their care pathways.

4.2. Patient Sense of Safety

There are concerns about safety of patients, both within the inpatient facilities and also in the community. The patients themselves expressed serious concerns about feeling unsafe within wards, particularly young adults who felt threatened by other patients. Staff also expressed concerns about patient safety in terms of staffing levels and high caseloads.

The issues emerging within the *Patient Sense of Safety* theme are:

- Ward Safety
- Restraint
- Patient Self-discharge
- Illegal Drugs on Wards
- Staffing Levels
- Community Mental Health Teams
- Training

4.2.1. Ward Safety

Patients report that wards in both hospitals can feel unsafe and that staff are often not available or visible. Some patients report being frightened of certain staff on the wards who have a poor attitude to the patients in their care. Others mentioned that another patient had assaulted them whilst they were on the ward. Patients report witnessing fights breaking out on the wards and staff report that they often do not get support in managing volatile situations on the wards.

Patients repeatedly report not being given an induction to the ward on admission, resulting in feelings of disorientation and fear.

4.2.2. Restraint

The use of restraint within inpatient facilities is of great concern to patients, both to those who have experienced it and those who have witnessed it taking place. Patients feel violated and traumatised, particularly if they have personally suffered violent abuse in the past. Some staff are reported as being gentle and calming when using restraint, whereas others were reportedly aggressive both verbally and physically. Staff voiced concerns about the overuse of restraint on the wards, with some also reporting being expected to carry out restraint without any formal training in its effective and appropriate use.

4.2.3. Patient Self-discharge

It appears to be possible for patients to self-discharge from inpatient facilities without any notification being made to family or carers and with no ongoing care plans in place. After discharging themselves some patients have subsequently been found in a heightened state of distress or disorientation by police patrols. On occasion patients have discharged themselves with a particular focus on harming someone, giving rise to public safety concerns.

It is also possible to leave on a day pass and not return at the appointed time, or simply to walk out of the inpatient facility without notifying anyone on the ward. In both cases, it seems staff are slow to notice or respond to the absence, which is a serious patient safety concern.

4.2.4. Illegal Drugs on Wards

Staff seem unable to control the availability and use of illegal drugs on the wards in the inpatient facilities. Both patients and families report seeing drugs delivered, sold and taken within the Carseview Centre site. Staff confirm this is a serious issue which is not being adequately addressed. There is a lack of support from management for front-line staff attempting to address this issue and it is having a detrimental effect on patient care and treatment regimes.

4.2.5. Staffing Levels

There is a perception within some staff groups that staffing levels are lower than they should be in some services. There are many vacant posts in the system. Inpatients wards have been relocated due to medical staff shortages. These shortages have raised concerns about patient safety because of the need to provide sufficient staff to meet the needs of the patients. Psychiatric services are being bolstered by the procurement of locum consultants which results in inconsistencies in treatment and a lack of continuity of care.

There is a shortage of consultant psychiatrists UK-wide and as a result Tayside is experiencing recruitment challenges. Recruitment in Tayside is further hampered by the negative publicity surrounding NHS Tayside's mental health services.

4.2.6. Community Mental Health Teams (CMHT)

Staff feel that workloads are at times overwhelming in some of the community teams, which causes concerns about satisfactory levels of patient care. Strategic decisions to relocate inpatient facilities were not matched by increasing and improving staff resource in the community and home treatment services in some localities. This has created difficulties with discharge planning from inpatient facilities, and delayed discharges are common.

4.2.7. Training

Serious concerns about safety have arisen in conjunction with the lack of staff training. In Psychological Services, Continuous Professional Development (CPD) events were suspended in order to address concerns about the length of the waiting times. Many staff report not being able to attend training events due to staff shortages. Some staff report their own supervision meetings are not taking place as recommended by professional bodies. Mandatory training is not always being completed as required.

Further concerns arising regarding training have resulted in the GMC placing training in NHS Tayside's General Adult Services, including General Adult Psychiatry into Enhanced Monitoring status.

4.3. Quality of Care

Many patients reported being treated well as inpatients by dedicated and highly motivated staff. For others, the lack of care impeded their recovery or exacerbated their condition.

The issues emerging within the *Quality of Care* theme are:

- Communication
- Ward Environments
- Continuity and Consistency of Care
- Availability of Services
- Carer Involvement

4.3.1. Communication

Patients who were admitted to inpatient facilities, report a lack of communication and information about what they could expect to happen during their stay. They were not given accurate information about the ward routines or activities, nor how they could call for help if necessary. Internal communication appears poor at times, with patient notes occasionally going missing or being temporarily unavailable.

There are concerns about the standards of internal communication between the divisions of mental health services. Patients report that when they are referred to another service (e.g. from psychiatry to psychology), they have to start again - as though they are a new patient into the whole of mental health services.

Some patients report appointments with community teams being cancelled or rescheduled but they are only informed on their arrival for the appointment. Other patients complain about how they are discharged from the Community Mental Health Teams by phone with no explanation.

4.3.2. Ward Environments

The ward recreational facilities are often in a poor state of repair with damaged pool tables, TVs and permanently locked gym facilities. A lack of available staff to supervise patient activities means that many patients report that whilst on the ward there is nothing to do all day. Some wards do not have access to outside space which is seen as detrimental to recovery by both patients and staff.

Concerns raised about inpatient environments include: safety, sleep deprivation, sexual behaviours of other patients, lack of protection of property, inadequate recreational opportunities, nutrition, noise and heat.

Outside agencies within the voluntary sector offering support to patients within inpatient facilities, report being discouraged in their endeavours or are made to feel unwelcome on the wards.

4.3.3. Continuity and Consistency of Care

The use of locum psychiatrists, particularly within the CMHTs, has in some cases resulted in patients not seeing the same consultant twice. This is viewed as a "never-ending circle of frustration" by patients and families. Several patients report having been treated by many different psychiatrists when engaged in mental health services and diagnoses may change as each consultant takes a professionally different view of a patient's presentation, which in turn results in changes to medication with associated side-effects.

4.3.4. Availability of Services

Mental health services may differ between Angus, Dundee and Perth & Kinross patients. This has a direct effect on the patient journey. Patients discharged from Carseview Centre's Mulberry Unit (residing in Angus) until recently did not have the benefit of a home treatment service, which has been available to all Dundee and Perth & Kinross patients discharged from inpatient facilities. Other third sector services (e.g. Penumbra) are required to charge patients in Dundee, but their services are free to patients in Angus.

4.3.5. Carer involvement

Inclusion of carers in a patient's care plan is often highlighted as inconsistent or absent. Whilst it is important to respect confidentiality, carers feel they are not always seen as a valued part of the care pathway for a patient. Advance Statements are not actively encouraged in the anticipatory care management process. Carers report they would have welcomed information, education and support - with help and advice on suicide awareness and strategies for the management of self-harm, violence and aggression.

4.4. Organisational Learning

A healthy organisation needs to develop a culture of learning when things go wrong, both at a local level and at an organisational level. This is essential for the prevention of harm.

Whilst an adverse event in the past cannot be undone, there is always an opportunity to learn from a comprehensive review of the circumstances surrounding it. Such a review could potentially reduce the risk of a similar event being repeated. There have been instances in NHS Tayside where organisational learning has not been gathered and disseminated. There is evidence of a widespread lack of understanding amongst professional staff about internal processes following adverse events or critical incidents.

Learning should come from good practice as well as from adverse events. There is evidence of repeated poor practice, when lessons have not been learnt from previous incidents.

The issues emerging within the *Organisational Learning* theme are:

- Policy and Practice
- Adverse Event Reviews
- Fatal Accident Inquiries (FAI)
- Complaints, Scottish Public Services Ombudsman (SPSO), Litigation
- Recommendations from Reviews

4.4.1. Policy and Practice

Organisational policies and operational practices appear to be disconnected, at times. This raises a number of questions: is there a lack of awareness or knowledge about the policy? Is there a lack of support and supervision? Is the policy impractical or impossible to implement, and if so, how does this feed back to the policy developers?

4.4.2. Adverse Event Reviews

The process for reviewing local adverse events and critical incidents raised some important concerns with the Inquiry. Staff are not clear about the process and purpose of such reviews and guidance on conducting reviews is not being followed. It is not known whether this is due to a lack of training or *ad hoc* decisions to take a different approach. In addition, staff are fearful of the consequences of attending adverse event reviews. Staff report a perception that blame is the primary purpose of such reviews, rather than learning. There is an apprehension about the legal consequences of taking part in the review and how their attendance might impact on any future litigation. Timescales for holding reviews are regularly not met.

All of this raises questions about the training of staff who are responsible for such reviews and how quality assurance processes ensure that appropriate lessons are learnt.

In many cases families have been told that they would be invited to participate in adverse event reviews, but have never heard anything about such a review taking place. Where families have participated, some have reported that the review report did not accurately reflect the facts of the case or what was said in the review meetings. Finalised reviews are often incomplete with key questions left unanswered e.g. *Could this have been avoided? Yes / No*. These seriously undermine confidence in the integrity of the process and, more importantly, in NHS Tayside.

4.4.3. Fatal Accident Inquiries (FAI)

There appear to be inconsistencies in relation to the circumstances surrounding the decision taken by the Crown Office and Procurator Fiscal Service (COPFS) as to whether or not an FAI should be held. It is not clear to families why an FAI was held in one case, when an FAI was not held in another very similar circumstance. Deaths of inpatients who are compulsorily detained are not always subject to an FAI. When an FAI is held, there is always a long delay. Such long delays undermine the value of the lessons learnt and prevent useful organisational learning being passed on promptly.

4.4.4. Complaints, Scottish Public Services Ombudsman (SPSO), Litigation

Many complainants are dissatisfied by how their complaint regarding standards of care and treatment by NHS Tayside is addressed. The system is not designed around their needs; bureaucratic processes result in complaints being redirected to other organisations (such as from NHS Tayside to the relevant Integration Joint Board). There can also be long delays in responding to complaints and letters of reply sometimes contain insensitive and inappropriate comments in relation to the circumstances of the complaint. Most marked is the very defensive attitude towards dealing with complaints – in stark contrast to other organisations that view the complaints process as an opportunity to learn and improve standards and quality. Dismissive comments have been expressed by NHS Tayside staff about people who make complaints or

pursue legal action. There is a balance between recognising and supporting hard-working staff whose work environment is often stressful and demanding, and responding objectively to complaints.

Several investigations into NHS Tayside mental health services by the SPSO have revealed the inadequacy of their own internal complaints procedure. In these cases significant failings were identified by the SPSO, when NHS Tayside had not upheld any of the complaints. As a result, public confidence in NHS Tayside complaints procedures is lacking. This is echoed by staff who report a lack of confidence in how allegations of bullying, lack of integrity, or underperformance are addressed under Human Resource policies.

4.4.5. Recommendations from Reviews

It is not clear how decisions are made as to whether to accept or reject recommendations arising from event reviews or complaints. Staff felt that some recommendations are accepted by NHS Tayside which are impractical and therefore cannot be implemented. There are no clear methods of implementing agreed recommendations, nor monitoring processes to ensure that they are implemented. There also appears to be a lack of reporting to the relevant governance authority.

In NHS Tayside there appears to be no central point where the lessons and recommendations from adverse event reviews are considered, either within the immediate context of the event itself or organisationally across NHS Tayside's mental health service as a whole. This represents a major lost opportunity for organisational learning and improvement.

4.5. Leadership

Employees will flourish in an environment where encouragement and appreciation is prevalent. In NHS Tayside the importance of clear line management structures and managerial support for staff is not always recognised, with a lack of continuity in key leadership positions being identified in recent external reports. This was also articulated by many staff at all levels of the organisation. Many felt that there was a lack of care and concern for issues around welfare, training, performance and appraisal. The organisation's concern for staff well-being does not always seem to be effective. A high turnover of senior and managerial level staff has undoubtedly contributed to this, resulting in a lowering of expectations in terms of support for staff.

The issues emerging within the *Leadership* theme are:

- Responsibility and Accountability
- Relationships

4.5.1. Responsibility and Accountability

In relation to NHS Tayside's mental health services, it is not clear who is responsible for leading the service. There is also a lack of awareness of how issues and problems arising in the service should be resolved or addressed.

The number of vacancies and the reliance on locum psychiatrists contributes to a lack of continuity for both staff and patients. Staff can be unsettled by a frequent turnover of senior

staff. Inevitably this results in inconsistencies in decision-making, delayed decision-making or even no decision-making. This is poor for both patients and staff. There are some alternative solutions being explored to identify new ways of working in terms of responsibility management, such as employment of Advanced Nurse Practitioner posts.

Some key questions are necessary for leaders to understand the quality of relationships amongst staff: Do people feel valued, respected, supported, listened to, trained, and appropriately rewarded?

4.5.2. Relationships

There is a lack of clarity of reporting lines. Some medical staff were unsure who their line manager was; others reported that whilst they did know their line manager, they did not hear from them and the manager did not respond to contact from them. Line managers are changed without the member of staff being informed of the change. There is a lack of confidence in professional supervision and appraisal arrangements and individual members of staff are therefore forced to make their own arrangements. The lack of a full-time Associate Medical Director for mental health services exacerbates the line management difficulties.

There were good examples of managerial practice but these were the exception.

4.6. Governance

Governance structures should ensure that processes and systems are in place to monitor the overall direction, effectiveness and accountability of an organisation. Good governance should be able to demonstrate that the organisation is well-run and efficient; that problems arising within the organisation are identified and attended to appropriately, all of which ensures the integrity of the organisation's values are preserved.

The issues emerging within the *Governance* theme are:

- Performance
- Risk Assessment and Management
- Management of Change
- Service Redesign Transformation Programme
- Communications

4.6.1. Performance

There is little visibility of mental health service performance monitoring and management at a senior level in NHS Tayside committees.

There is widespread lack of clarity regarding responsibility for the commissioning, delivery, governance, and performance monitoring of mental health services in Tayside. There are complicated governance and delivery arrangements, which some people find hard to understand or explain. The Integration Joint Board arrangements put in place in 2016 were rushed (due to national decisions), with a lack of time to plan the delivery of mental health service provision

properly. There is a lack of confidence that the current arrangements are working and for services to be delivered well, there needs to be a good understanding of governance and accountability. [See **Management of Change** below for example of lack of clarity].

IJBs are not always clear about their responsibility for managing performance around mental health services. There is a need for greater understanding of their responsibilities. A recent review of responsibilities has led to the establishment of an alternative leadership and decision-making structure (Mental Health Alliance).

4.6.2. Risk Assessment and Management

There needs to be clarity for the ownership and management of risk at a senior level for mental health services. There continues to be uncertainty about ownership of the risk register and responsibility for monitoring the risks and taking action to reduce them.

4.6.3. Management of Change

Significant changes to services do not appear to be managed in a comprehensive and coherent manner. Changes appear to be very reactive, without proper planning and careful consideration of when and how such changes would be most appropriate.

As an example, the urgent move of patients from the Mulberry ward at Stracathro to Carseview Centre in 2017 shows evidence of poor change management processes within NHS Tayside. The decisions surrounding this move were based on a shortage of psychiatrists (at Carseview Centre) and appeared to be made and implemented very suddenly with only a few weeks' notice. The number of psychiatrists was known well in advance of this decision. Little consideration seems to have been given to the impact on patients, families, other staff, quality of environment and care available at Carseview Centre, compared to Stracathro.

4.6.4. Service Redesign Transformation Programme

This is not so much a service 'redesign transformation' as a review and change of 'beds and sites'. The process lacks confidence amongst staff, patients, families, communities and partner organisations. Planning was perceived as being poor and the decisions made without proper consideration of full information, data, options, resources and impact. *Ad hoc* decisions were made as the programme developed (such as the move of Learning Disability Assessment Unit to Strathmartine which is now not happening).

In the light of the Independent Inquiry, there is clearly a need for a comprehensive review of mental health service strategy rather than simply undertaking a move of beds and sites. The proposed changes should not be implemented before there is a comprehensive review of the wider needs of the community, beyond inpatient requirements.

4.6.5. Communications

Communications have been consistently described as poor. As in the section on complaints (at 4.4.4.), the tone of communications to patients is often defensive, high-handed and patronising, with the use of inappropriate technical language. Staff feel that they are not informed of changes in advance (closure of ward at Murray Royal; removal of the roles of the Primary Mental Health workers). Consultation does not command respect unless it has integrity and is genuine. Staff

feel that either they are not consulted, or their views are not respected. Similarly public consultation on wider changes to mental health service delivery is not perceived to be genuine, with views not being listened to or respected. There is a lack of genuine engagement with or involvement of the public, staff and partner organisations.

Several GP practices either do not know the means by which they can influence NHS Tayside policy and practice or have tried and failed to have their voices heard.

5. Next Steps

The identification of these key themes at this stage will enable the Inquiry to focus on next steps, drawing firm conclusions and making specific recommendations. The key themes in this report are not exhaustive; evidence still to be analysed may highlight more concerns. These themes will inform the next phase of the Inquiry, which is to undertake further investigation and analysis.

The Inquiry will consider the plans for improving services which NHS Tayside and IJBs have developed or are in the process of developing. These will help to shape the conclusions and recommendations the Inquiry wishes to make.

The Inquiry is concerned with much more than just inpatients and psychiatry. Its remit is to consider end-to-end mental health services. These include the provision of treatment in the community, with an emphasis on prevention and support at the earliest appropriate time. New thinking is required to address the serious challenges that are facing the provision of mental health services in Tayside. To ensure that the Inquiry will lead to improvements in the provision of mental health services in Tayside, the recommendations will need to be supported by a credible implementation plan. The Inquiry's final report will address how this can be achieved and monitored.

There is now a real opportunity for Tayside to transform its provision of comprehensive mental health services to meet the needs of all people living in Angus, Dundee and Perth & Kinross. The Inquiry team is grateful to everyone who has provided evidence to the Inquiry so far, recognising that for many people, it has taken courage and commitment to do so.

David Strang

Chair of Independent Inquiry **May 2019**

6. Appendix 1

Summary of organisations who submitted evidence to the Inquiry

Written Evidence	Meetings / Visits
* The ALLIANCE	* The ALLIANCE
* Associations supporting mental ill-health	* Associations supporting mental ill-health
* Community Learning & Development teams	* Community Mental Health Teams
* Churches Action for the Homeless	* Crown Office & Procurator Fiscal Service - Scottish Fatalities Investigation Unit
* Community Mental Health	* City Councils
* Dundee Commissions (Fairness; Drugs)	* Dundee Commissions (Fairness; Drugs)
* Employee Participation Group NHS Tayside	* Edinburgh Crisis Centre
* GP Practices in Angus, Dundee and Perth & Kinross.	* Employee Participation Group NHS Tayside
* Groups supporting People affected by Alcohol/Substance Misuse	* GP Practices in Angus, Dundee and Perth & Kinross
* Health and Social Care Partnerships	* Health & Social Care Partnerships
* Independent Advocacy organisations	* Healthcare Improvement Scotland
* NHS Tayside	* HMP Perth
* Service User Networks	* Integration Joint Boards
	* Independent Advocacy organisations
	* Independent review of Learning Disability and Autism in the Mental Health Act
	* Mental Welfare Commission for Scotland
	* NHS Tayside staff working in all aspects of mental health services
	* NHS Tayside Hospitals: Murray Royal, Carseview Centre, Rohallion Secure Care
	* Police Scotland

	* Scottish Government * Scottish Public Sector Ombudsman * Scotland Deanery – NHS Education for Scotland * Stakeholder Participation Group SPG * Trainee GPs / Psychiatrists * Universities of Abertay and Dundee - Nursing Students * Universities - Counselling & Mental Health Teams * Voluntary Health Scotland

Independent Inquiry into Mental Health Services in Tayside

15/16 Springfield, Dundee DD1 4JE

Phone: 01382 381835

Email:IndependentInquiry@dundee.ac.uk

Website: www.independentinquiry.org

Comments

DELETE REPLY REPLY ALL FORWARD •••

Denise Jackson (Staff) <d.r.jackson@dundee.ac.uk>

Mark as unread

Tue 14/05/2019 13:07

To: NICOLL, Bill (NHS TAYSIDE);

Flag for follow up.

Dear Bill,

I'm sure you will know that the Chairman and David have agreed to hold the publication of the Inquiry's report to allow for comments from NHST to be considered by the Inquiry team. The agreement is that these comments will be sent to David and me by 5pm on Monday (20th) - which will allow us to publish the report on Weds 22nd May.

Many thanks
Denise

Interim Report for the Independent Inquiry into Mental Health Services in Tayside

DELETE REPLY REPLY ALL FORWARD ...

Denise Jackson (Staff) <d.r.jackson@dundee.ac.uk>

Mark as unread

Mon 13/05/2019 09:11

To: NICOLL, Bill (NHS TAYSIDE);

Cc: David Strang (Staff) <d.strang@dundee.ac.uk>;

Flag for follow up. Start by 13 May 2019. Due by 13 May 2019.

1 attachment

Independent ~.pdf

Dear Bill,

Please find attached the Interim Report for the Independent Inquiry into mental health services in Tayside The report is subject to a press embargo until **Wednesday 15th May**. It has been sent to yourselves and to Scottish Government this morning as we felt it appropriate that both of you see it before it is released publicly. It will be sent to Stakeholder groups and to the Employee Participation Group tomorrow and then released publicly on Wednesday, when a copy will be made available on the Inquiry's website: www.independentinquiry.org

This Interim Report aims to provide an update on the progress of the Inquiry and to identify key themes emerging from the initial evidence-gathering phase. These themes have emerged after listening to all the evidence and will provide the main focus and shape the next stage of the Inquiry.

The Inquiry will now proceed to investigate and analyse these themes, before drawing conclusions and making recommendations to improve the provision of mental health services in Tayside.

David will be available on Wednesday 15th and Thursday 16th for interviews and comment.

If you have any questions/queries please don't hesitate to contact us.

Kind regards
Denise

Denise Jackson
Secretary to the Independent Inquiry into Mental Health Services in Tayside

Independent Inquiry into Mental Health Services in Tayside

Interim Report
Inquiry Update and Emergent Key Themes

May 2019

Contents

1. Introduction

Following widespread concerns raised in the Scottish Parliament in May 2018 about the provision of mental health services in Tayside, an Independent Inquiry into Mental Health Services in Tayside ("the Inquiry") was established to inquire into the accessibility, safety, quality and standards of care provided by mental health services in Tayside. The Inquiry is examining end-to-end mental health services, including suicide prevention services and those provided by partner organisations and third sector providers. A commitment was given by the Inquiry team to report on the findings and to make recommendations for improvement.

A detailed description of the work of the Inquiry to-date is at Section 3.

2. Purpose of Interim Report

Since the public call for evidence in September 2018, the Inquiry has received a substantial quantity of evidence from a wide range of people and organisations.

In the analysis of this evidence, the Inquiry team has identified a number of key themes for further investigation. This Interim Report aims to provide an update on progress of the Inquiry and to identify the key themes emerging from the initial evidence-gathering phase. The themes have emerged after listening to all who wished to share their evidence - namely patients, carers, families, NHS staff and representatives from other organisations. The themes will provide the main focus and shape the next stage of the Inquiry.

It is important to recognise that this report identifies only the issues which have been raised in the evidence submitted to the Inquiry. Investigation and detailed analysis will be required before any conclusions can be drawn or recommendations made by the Inquiry.

3. The Independent Inquiry

3.1. Background

The Inquiry is being guided by the five principles agreed in the Scottish Parliament debate which are to:

- be open and transparent
- be truly independent
- include and involve staff from NHS Tayside, its partners and third sector providers
- include and involve patients, families and carers
- include a public call for evidence to ensure everyone's voice is heard.

Following the announcement of the Inquiry, a group was established to represent patients, families, carers and third sector organisations which would enable stakeholders to engage with the Inquiry and to ensure a high level of transparency in its work. This group, known as the **Stakeholder Participation Group** (SPG) is coordinated and chaired by the Health and Social Care ALLIANCE Scotland ("the ALLIANCE").

Following a formal interview process convened by the ALLIANCE and advised by the SPG, Mr David Strang was appointed Chair of the Inquiry in July 2018. The Inquiry then appointed a Secretary to the Inquiry, administration and clerical support staff and a researcher. Professional advisors based in other Health Boards in Scotland were also appointed to assist the Inquiry team in an advisory capacity, when required

An **Employee Participation Group** (EPG) was also established, chaired by a representative from UNISON. The EPG consists of representatives from all NHS recognised trade unions, professional bodies and employee relations representatives.

3.2. Terms of Reference

The Terms of Reference for the Inquiry were finalised after consultation with the SPG and with NHS Tayside staff/employee representatives, and were published on 5 September 2018. The purpose was to inquire into the accessibility, safety, quality and standards of care provided by all mental health services in Tayside, to report on the findings and make recommendations for improvement. The Terms of Reference are available on the Inquiry website: www.independentinquiry.org

3.3. Call for Evidence

The public Call for Evidence was issued on 5 September 2018, with wide media coverage in Tayside: BBC News, STV News, The Courier, Evening Telegraph, and Tay FM. Posters were distributed to GP practices, libraries, prisons and hospitals across Tayside. The Call for Evidence invited people to come forward with accounts of their experiences both positive and negative of mental health services in Tayside. The closing dates for submission of evidence were extended to allow as many people as possible to engage with Inquiry. The Call for Evidence information is available on the Inquiry website: www.independentinquiry.org

3.4. The Inquiry Phases

The Inquiry is being conducted through a five-stage Project Plan, detailed below:

Stage 1 (Set-up and launch) [complete]

Stage 2 (Evidence gathering) [complete]

Stage 3 (Analysis and Investigation) [currently in progress]

Stage 4 (Final report with conclusions and recommendations) [date to be confirmed]

Stage 5 (Dissemination of Findings) [date to be confirmed].

3.5. Responses to the Call for Evidence

3.5.1. Written:

Over **200 submissions** of written evidence were received by post, email and in person. This represents a substantial volume of paperwork, all of which has been processed, coded and stored securely pending further analysis.

Between September and November 2018, the ALLIANCE held focus groups across the NHS Tayside area to capture the voices of those with "lived experience" of mental health services in Tayside. This was a significant piece of community research which produced a range of valuable recommendations. The ALLIANCE report was submitted to the Inquiry as evidence in December 2018 and is available here: https://www.alliance-scotland.org.uk/blog/resources/independent-inquiry-into-mental-health-services-in-tayside-hearing-the-voices-of-people-with-lived-experience/

The EPG conducted an online staff survey during November and December 2018 and held focus group meetings for all those employed to work in NHS Tayside mental health services. 53% of all staff surveyed responded to the survey; a total of 524 individual returns. The EPG submitted their report as evidence to the Inquiry in April 2019.

3.5.2. Oral:

Over 70 oral evidence sessions were held with patients, families, carers, NHS employees, other health professionals and third sector organisations in Angus, Dundee and Perth & Kinross.

Volunteers from both the Dundee and Perth Samaritans provided pastoral support for patients, families and carers after oral evidence sessions.

Evidence was also submitted (oral and written) from other organisations such as Police Scotland, University Student Welfare Teams, Dundee Fairness Commission, Dundee Drug Commission and third sector organisations.

Additional meetings were held with a range of health professionals and clinicians such as Consultant Psychiatrists, Psychologists, GPs, Allied Health Professionals, staff at the Carseview Centre student nurses, and trainee GPs. This enabled the Inquiry team to gather views on mental health provision in Tayside. The team also met with Integration Joint Board (IJB) representatives and key personnel from Local Authorities.

[Please see Appendix 1 for a summary of organisations who have submitted evidence to the Inquiry, either in writing or orally].

3.6. Evidence - Analysis

The analysis of the evidence is ongoing. The evidence currently being analysed includes all written and oral submissions, as described above, as well as relevant reports and reviews, published papers, benchmarking data and internal review documents relating to mental health services in Tayside. The analysis is a complex process designed to identify emergent themes.

4. Key Themes

The Inquiry heard many examples of good quality care and high level professional practices across mental health services in Tayside, evidencing a clear person-centred care approach in the treatment of patients. However, as the evidence was analysed there were key themes emerging where the quality and care was not good and these themes will be the subject of further analysis and investigation by the Inquiry team.

The Key Themes are as follows:-

- Patient Access to Mental Health Services
- Patient Sense of Safety
- Quality of Care
- Organisational Learning
- Leadership
- Governance

4.1. Patient Access to Mental Health Services

There is no doubt that one area of challenge for both patients and health professionals is ensuring that the appropriate care and treatment is in place and available for all patients in need of support and intervention when they need it. It is clear that accessing mental health services and support can at times be difficult for patients.

The issues emerging within the *Patient Access to Mental Health Services* theme are:

- Crisis Service
- Risk Management
- Police Scotland
- GP Referrals
- Rejected Referrals
- Allied Health Professional
- CAMHS
- Mental Health and Substance Misuse
- Multiple Diagnoses

4.1.1. Crisis Service

Many patients and families report receiving care and support from "*professional and caring*" staff within the Crisis team when they needed it. However the Crisis team struggles to respond to sudden surges in demand on the service; there are occasions when the length of time to wait to be seen is long and families supporting someone in crisis are advised to phone the police or NHS24, if they are worried. This advice is unexpected and concerning to carers coping with a crisis in a domestic situation.

The centralisation of the out-of-hours Crisis team to Carseview Centre has had a detrimental effect on those patients in Angus and Perth & Kinross who are experiencing mental health crisis.

GPs in Angus report that the community service at Stracathro does not take referrals for crisis assessment after 3.30pm on weekdays and the out-of-hours referral service at Carseview Centre does not begin to take referrals until 5pm for those outside Dundee.

There is a perception that whilst the Crisis service has expanded in recent months, the situation has worsened in terms of patients being assessed, not offered any intervention and then being sent home.

4.1.2. Risk Management

Many patients report that in the early crisis assessment, there is a lack of adequate risk assessment in their risk management plans. Patients report telling staff they were suicidal but the risk was not taken seriously until they made a serious attempt to take their own life. Patients are sometimes left to get the support they need from their family during a crisis.

4.1.3. Police Scotland

Access to services for a person in crisis frequently involves Police Scotland, who report many hours of police time spent supporting and transporting those in crisis and/or waiting with them to be seen by the clinical teams at Carseview Centre. When a police officer is with a patient in crisis, they can speak directly to the crisis team on a dedicated phone line and receive advice on the best course of action. This may be to take the patient into Carseview, to advise them to go to their GP or to return to the Community Mental Health Team. However, it is the police officer who is managing the patient in crisis throughout this assessment.

4.1.4. GP Referrals

Many patients have reported that once they have been seen at their GP practice the wait for the referral to mental health services is long, during which they receive no contact from the service. This adds to their anxiety and distress. Patients with mental health issues are sometimes referred by their GP as “urgent” cases but this may be downgraded by mental health services to “routine” and added to the waiting list, or even rejected. Even after a first appointment for an assessment by mental health services, waiting time for appropriate ongoing treatment may be as long as a year. In the meantime, patients may be referred to third sector alternative support agencies by signposting but this approach is inconsistent and details of pathways to support are not always accurate or even available.

4.1.5. Rejected Referrals

GPs report that rejected referrals present problems in General Practice where there is no expertise or time to support patients with ongoing mental ill-health. GPs feel that their serious concerns for patients are not understood or accepted by those processing the referrals within mental health services. Cases are rejected on the basis that the patient did not meet the required criteria, however GPs do not know what the required criteria are, in order to understand which of their patients they can expect to be seen by the service. Their frustrations were evidenced by a comparison with referral of patients to Acute Services (for example - Orthopaedics) which are unlikely to be rejected outright without the service seeing the patient at least once. There is a lack of understanding as to why this does not apply in referrals to mental health services.

Moreover, rejection letters generally do not give the GP any guidance on how to continue to manage the patient's continuing mental ill-health.

There are also concerns arising from the two different response times to referral options: urgent referrals (seen within 72 hours) and routine referrals (weeks or months). The difference between the two waiting periods gives rise to concerns that the referral process is not fit for purpose and is forcing GPs to use the 'Urgent' referral category just to ensure patients are seen timeously and not because they clinically match this referral category.

4.1.6. Allied Health Services

Post-referral waiting times to allied health services may be as long as a year. Evidence submitted to the Inquiry stated that waiting times for Psychological Services were significant and patients were often not told at the time of their referral how long they could expect to have to wait.

4.1.7. CAMHS (Child & Adolescent Mental Health Services)

The latest statistics (Dec 2018) show that nearly 60% of patients are waiting longer than 18 weeks to access CAMHS and in some cases the waiting times are as long as 6 months. In addition, rejected referrals are high. Families with the means to do so, are choosing to make provision for their children to be seen privately. The removal of certain community-based services (e.g. Primary Mental Health Workers) is perceived to have had a deleterious effect on mental health care and support for children and young people.

The definition of a child in NHS Tayside is also problematic, with 16 year olds who have left school being treated by adult services, and a 16 year old still in school continuing to be treated by CAMHS. This definition is unusual: other health boards in Scotland treat all under 18s as children, regardless of whether or not they are still in school. Furthermore, the waiting times are such that referrals to CAMHS are often rejected on the basis that the young person will have become an 'adult' whilst waiting to be seen by CAMHS, particularly if they have left school in the meantime.

There are also many reported difficulties with the transition from CAMHS to General Adult Psychiatry (GAP) for young people. Many report feeling scared and frightened to be admitted to adult inpatient facilities at Carseview or Murray Royal when they have hitherto been treated in the Dudhope Young Persons' Unit in Dundee.

4.1.8. Mental Health and Substance Misuse

Patients presenting to mental health services following alcohol or drug consumption, report rejection from crisis assessment. People with addiction to alcohol and/or illegal drugs may be continuously refused access to mental health services.

Third sector services with a responsibility for substance misuse report that clients complain they are only receiving treatment for their substance misuse issues and are not receiving any treatment for their mental health problems, either because they are on a long waiting list or have been rejected from mental health services due to their substance misuse issues. There does not seem to be a holistic approach to treatment in these circumstances.

4.1.9. Multiple Diagnoses

Patients who have multiple mental health diagnoses are often streamlined into a single service to address one of their diagnosed conditions. This results in their waiting a long time for a particular service which may ultimately not be the most appropriate course of treatment by the time they are seen, as another of their conditions may, by then, be more critical. They are then re-referred to a different treatment service, which may involve another lengthy waiting time.

In these cases, patients should receive a multi-service (team) approach in their care pathways.

4.2. Patient Sense of Safety

There are concerns about safety of patients, both within the inpatient facilities and also in the community. The patients themselves expressed serious concerns about feeling unsafe within wards, particularly young adults who felt threatened by other patients. Staff also expressed concerns about patient safety in terms of staffing levels and high caseloads.

The issues emerging within the *Patient Sense of Safety* theme are:

- Ward Safety
- Restraint
- Patient Self-discharge
- Illegal Drugs on Wards
- Staffing Levels
- Community Mental Health Teams
- Training

4.2.1. Ward Safety

Patients report that wards in both hospitals can feel unsafe and that staff are often not available or visible. Some patients report being frightened of certain staff on the wards who have a poor attitude to the patients in their care. Others mentioned that another patient had assaulted them whilst they were on the ward. Patients report witnessing fights breaking out on the wards and staff report that they often do not get support in managing volatile situations on the wards.

Patients repeatedly report not being given an induction to the ward on admission, resulting in feelings of disorientation and fear.

4.2.2. Restraint

The use of restraint is of great concern to patients, both to those who have experienced it and those who have witnessed it taking place. Patients feel violated and traumatised, particularly if they have personally suffered violent abuse in the past. Some staff are reported as being gentle and calming when using restraint, whereas others were reportedly aggressive both verbally and physically. Staff voiced concerns about the overuse of restraint on the wards, with some also reporting being expected to carry out restraint without any formal training in its effective and appropriate use.

The use of restraint in NHS Tayside will be investigated against NICE Guidelines and best practices operating in other UK Health Boards.

4.2.3. Patient Self-discharge

It appears to be possible for patients to self-discharge from inpatient facilities without any notification being made to family or carers and with no ongoing care plans in place. After discharging themselves some patients have subsequently been found in a heightened state of distress or disorientation by police patrols. On occasion patients have discharged themselves with a particular focus on harming someone, giving rise to public safety concerns.

It is also possible to leave on a day 'pass' and not return at the appointed time, or simply to walk out of the inpatient facility without notifying anyone on the ward. In both cases, it seems staff are slow to notice or respond to the absence, which is a serious patient safety concern.

4.2.4. Illegal Drugs on Wards

Staff seem unable to control the availability and use of illegal drugs on the wards in the inpatient facilities. Both patients and families report seeing drugs delivered, sold and taken within the Carseview Centre site. Staff confirm this is a serious issue which is not being adequately addressed. There is a lack of support from management for front-line staff attempting to address this issue and it is having a detrimental effect on patient care and treatment regimes.

4.2.5. Staffing Levels

There is a perception within some staff groups that staffing levels are lower than they should be in some services. There are many vacant posts in the system. Inpatients wards have been closed and relocated due to medical staff shortages. These shortages have raised concerns about patient safety because of the need to provide sufficient staff to meet the needs of the patients. Psychiatric services are being bolstered by the procurement of locum consultants which results in inconsistencies in treatment and a lack of continuity of care.

There is a shortage of Consultant Psychiatrists UK-wide and as a result Tayside is experiencing recruitment challenges. Recruitment in Tayside is further hampered by the negative publicity surrounding NHS Tayside's mental health services.

4.2.6. Community Mental Health Teams (CMHT)

Staff feel that workloads are at times overwhelming in some of the community teams, which causes concerns about satisfactory levels of patient care. Strategic decisions to close inpatient facilities were not matched by increasing and improving staff resource in the community and home treatment services in some localities. This has created difficulties with discharge planning from inpatient facilities, and delayed discharges are common.

4.2.7. Training

Serious concerns about safety have arisen in conjunction with the lack of staff training. In Psychological Services, Continuous Professional Development (CPD) events have been suspended in order to address concerns about the length of the waiting times. Many staff report not being able to attend training events due to staff shortages. Some staff report their own 'supervision'

meetings are not taking place as their professional accreditation/registration requires. Mandatory training is not always being completed as required.

Further concerns arising regarding training have resulted in the GMC placing training in NHS Tayside's General Adult Services, including General Adult Psychiatry into *enhanced monitoring* status.

4.3. Quality of Care

Many patients reported being treated well as inpatients by dedicated and highly motivated staff. For others, the lack of care impeded their recovery or exacerbated their condition.

The issues emerging within the *Quality of Care* theme are:

- Communication
- Ward Environments
- Continuity and Consistency of Care
- Availability of Services
- Carer Involvement

4.3.1. Communication

Patients who were admitted to inpatient facilities, report a lack of communication and information about what they could expect to happen during their stay. They were not given accurate information about the ward routines or activities, nor how they could call for help if necessary. Internal communication appears poor at times with patient notes occasionally going missing or being temporarily unavailable.

There are concerns about the standards of internal communication between the divisions of mental health services. Patients reported that when they are referred to another service (e.g. from psychiatry to psychology), they have to "start again", as though they are a new patient into the whole of mental health services.

Some patients report appointments with community teams being cancelled or rescheduled but they are only informed on their arrival for the appointment. Other patients complain about how they are discharged from the Community Mental Health Teams by phone with no explanation.

4.3.2. Ward Environments

The ward recreational facilities are often in a poor state of repair with damaged pool tables, TVs and permanently locked gym facilities. A lack of available staff to supervise patient activities means that many patients report that whilst on the ward there is nothing to do all day. Some wards do not have access to outside space which is seen as detrimental to recovery by both patients and staff.

Concerns raised about inpatient environments include: safety, sleep deprivation, sexual behaviours of other patients, lack of protection of property, inadequate recreational opportunities, nutrition, noise and heat.

Outside agencies within the voluntary sector offering support to patients within inpatient facilities, report being discouraged in their endeavours or are made to feel unwelcome on the wards.

4.3.3. Continuity and Consistency of Care

The use of locum psychiatrists, particularly within the CMHTs, has in some cases resulted in patients not seeing the same consultant twice. This is viewed as a "*never-ending circle of frustration*" by patients and families. [redacted] reported having been treated in community mental health services for 10 years and had seen 17 different psychiatrists in that time. Diagnoses may change as each consultant takes a professionally different view of a patient's presentation, which in turn results in changes to medication, with associated side-effects.

4.3.4. Availability of Services

Mental health services may differ between Angus, Dundee and Perth & Kinross patients. This has a direct effect on the 'patient journey'. Patients discharged from Carseview Centre's Mulberry Unit (residing in Angus) until recently did not have the benefit of a crisis-home treatment service, which has been available to all Dundee and Perth & Kinross patients discharged from inpatient facilities. Other third sector services (e.g. Penumbra) are forced to charge patients in Dundee, but their services are free to patients in Angus.

4.3.5. Carer involvement

Inclusion of carers in a patient's care plan is often highlighted as inconsistent or absent. Whilst it is important to respect confidentiality, carers feel they are not always seen as a valued part of the care pathway for a patient. *Advance Statements* are not actively encouraged in the anticipatory care management process. Carers report they would have welcomed information, education and support - with help and advice on suicide awareness and strategies for the management of self-harm, violence and aggression.

4.4. Organisational Learning

A healthy organisation needs to develop a culture of learning when things go wrong, both at a local level and at an organisational level. This is essential for the prevention of harm.

Whilst an adverse event in the past cannot be undone, there is always an opportunity to learn from a comprehensive review of the circumstances surrounding it. Such a review could potentially reduce the risk of a similar event being repeated. There have been instances in NHS Tayside where organisational learning has not been gathered and disseminated. There is evidence of a widespread lack of understanding amongst professional staff about internal processes following adverse events or critical incidents.

Learning should come from good practice as well as from adverse events. There is evidence of repeated poor practice, when lessons have not been learnt from previous incidents.

The issues emerging within the *Organisational Learning* theme are:

- Policy and Practice

- Adverse Event Reviews
- Fatal Accident Inquiries (FAI)
- Complaints, SPSO, Litigation
- Recommendations from Reviews

4.4.1. Policy and Practice

Organisational policies and operational practices appear to be disconnected, at times. This raises a number of questions: is there a lack of awareness or knowledge about the policy? Is there a lack of support and supervision? Is the policy impractical or impossible to implement, and if so, how does this feed back to the policy developers?

4.4.2. Adverse Event Reviews

The process for reviewing local adverse events and critical incidents raised some important concerns with the Inquiry. Staff are not clear about the process and purpose of such reviews and guidance on conducting reviews is not being followed. It is not known whether this is due to a lack of training or *ad hoc* decisions to take a different approach. In addition, staff are fearful of the consequences of attending adverse event reviews. Staff report a perception that blame is the primary purpose of such reviews, rather than learning. There is an apprehension about the legal consequences of taking part in the review and how their attendance might impact on any future litigation. Timescales for holding reviews are regularly not met.

All of this raises questions about the training of staff who are responsible for such reviews and how quality assurance processes ensure that appropriate lessons are learnt.

In many cases families (and patients) have been told that they would be invited to participate in adverse event reviews, but have never heard anything about such a review taking place. Where families have participated, some have reported that the review report did not accurately reflect the facts of the case or what was said in the review meetings. Finalised reviews are often incomplete with key questions left unanswered e.g. *Could this have been avoided? Yes / No*. These seriously undermine confidence in the integrity of the process and, more importantly, in NHS Tayside.

4.4.3. Fatal Accident Inquiries (FAI)

There appear to be inconsistencies in relation to the circumstances surrounding the decision as to whether or not an FAI should be held. It is not clear to families why an FAI was held in one case, when an FAI was not held in another very similar circumstance. Deaths of inpatients who are compulsorily detained are not always subject to an FAI. When an FAI is held, there is always a long delay. Such long delays undermine the value of the lessons learnt and prevent useful organisational learning being passed on promptly.

4.4.4. Complaints, SPSO, Litigation

Many complainants are dissatisfied by how their complaint regarding standards of care and treatment by NHS Tayside is addressed. The system is not designed around their needs; bureaucratic processes result in complaints being redirected to other organisations (such as from NHS Tayside to the relevant Integration Joint Board). There can also be long delays in responding

to complaints and letters of reply sometimes contain insensitive and inappropriate comments in relation to the circumstances of the complaint. Most marked is the very defensive attitude towards dealing with complaints – in stark contrast to other organisations that view the complaints process as an opportunity to learn and improve standards and quality. Dismissive comments have been expressed by NHS Tayside staff about people who make complaints or pursue legal action. There is a balance between recognising and supporting hard-working staff whose work environment is often stressful and demanding, and responding objectively to complaints.

Several investigations into NHS Tayside mental health services by the Scottish Public Services Ombudsman (SPSO) have revealed the inadequacy of NHS Tayside's own internal investigations. In [redacted], 12 significant failings were identified by the SPSO, after NHS Tayside's own internal complaint procedure had not upheld any of the 12 complaints.

Public confidence in NHS Tayside complaints procedures is lacking. This is echoed by staff who report a lack of confidence in how allegations of bullying, lack of integrity, or underperformance are addressed under HR policies.

4.4.5. Recommendations from Reviews

It is not clear how decisions are made as to whether to accept or reject recommendations arising from event reviews or complaints. Staff felt that some recommendations are accepted by NHS Tayside which are impractical and therefore cannot be implemented. There are no clear methods of implementing agreed recommendations, nor monitoring processes to ensure that they are implemented. There also appears to be a lack of reporting to the relevant governance authority.

In NHS Tayside there appears to be no central point where the lessons and recommendations from Adverse Event Reviews are considered, either within the immediate context of the event itself or organisationally across NHS Tayside's mental health service as a whole. This represents a major lost opportunity for organisational learning and improvement.

4.5. Leadership

Employees will flourish in an environment where encouragement and appreciation is prevalent. NHS Tayside appears to lack understanding of the importance of clear line management structures and managerial support for staff, with a lack of continuity in key leadership positions being identified in recent external reports. This was also articulated by many staff at all levels of the organisation. Many felt that there was a lack of care and concern for issues around welfare, training, performance and appraisal. The organisation's concern for staff well-being does not always seem to be effective. A high turnover of senior and managerial level staff has undoubtedly contributed to this, resulting in a lowering of expectations in terms of support for staff.

The issues emerging within the *Leadership* theme are:

- Responsibility and Accountability
- Relationships

4.5.1. Responsibility and Accountability

There is a noticeable gap between what is decided in 'committees' and what happens at an operational level.

In relation to NHS Tayside's mental health services, it is not clear who is responsible for leading the service. There is also a lack of awareness of how issues and problems arising in the service should be resolved or addressed.

The number of vacancies and the reliance on locum psychiatrists contributes to a lack of continuity for both staff and patients. Staff can be unsettled by a frequent turnover of senior staff. Inevitably this results in inconsistencies in decision-making, delayed decision-making or even no decision-making. This is poor for both patients and staff. There are some alternative solutions being explored to identify new ways of working in terms of responsibility management, such as employment of Advanced Nurse Practitioner posts.

Some key questions are necessary for leaders to understand the quality of relationships amongst staff: Do people feel valued, respected, supported, listened to, trained, and appropriately rewarded?

4.5.2. Relationships

There is a lack of clarity of reporting lines. Some medical staff were unsure who their line manager was; others reported that whilst they did know their line manager, they did not hear from them and the manager did not respond to contact from them. Line managers are changed without the member of staff being informed of the change. There is a lack of confidence in professional supervision and appraisal arrangements and individual members of staff are therefore forced to make their own arrangements. The lack of a full-time Associate Medical Director for mental health services exacerbates the line management difficulties.

There were good examples of managerial practice but these were the exception.

4.6. Governance

Governance structures should ensure that processes and systems are in place to monitor the overall direction, effectiveness and accountability of an organisation. Good governance should be able to demonstrate that the organisation is well-run and efficient; that problems arising within the organisation are identified and attended to appropriately, all of which ensures the integrity of the organisation's values are preserved.

The issues emerging within the *Governance* theme are:

- Performance
- Risk Assessment and Management
- Management of Change
- Service Redesign Transformation Programme
- Communications

4.6.1. Performance

There is widespread lack of clarity regarding responsibility for the commissioning, delivery, governance, and performance monitoring of mental health services in Tayside. There are complicated governance and delivery arrangements, which are hard to understand or explain. The Integration Joint Board arrangements put in place in 2016 were rushed (due to national decisions), with a lack of time to plan the delivery of mental health service provision properly. The current arrangements lack the confidence of senior people within NHS Tayside and within the IJBs. There is confusion over which services are delegated, which are hosted, which fall under the responsibility of one of the three IJBs, and which are the responsibility of NHS Tayside. For services to be delivered well, there needs to be a good understanding of the governance and accountability arrangements. [See **Management of Change** below for example of lack of clarity].

There is little visibility of mental health service performance monitoring and management at a senior level in NHS Tayside committees.

IJBs are not always clear about their responsibility for managing performance around mental health services. There is a need for greater understanding of their responsibilities. A recent review of responsibilities has led to the establishment of an alternative leadership and decision-making structure (Mental Health Alliance).

4.6.2. Risk Assessment and Management

There needs to be clarity for the ownership and management of risk at a senior level for mental health services. There continues to be uncertainty about the risk register and who has ownership and responsibility for monitoring the risks and taking action to mitigate the risks.

4.6.3. Management of Change

The following examples of (a) Service Redesign Transformation Programme and (b) the urgent move of patients from the Mulberry ward at Stracathro to Carseview Centre in 2017 show evidence of poor change management processes within NHS Tayside.

(a) See Service Redesign Transformation Programme (SRTP) below.
(b) The decisions surrounding this move were based on a shortage of psychiatrists (at Carseview) and appeared to be made and implemented very suddenly with only a few weeks' notice. The number of psychiatrists was known well in advance of this decision. Little consideration seems to have been given to the impact on patients, families, other staff, quality of environment and care available at Carseview, compared to Stracathro.

Changes appear to be very reactive, without proper planning and careful consideration of when such changes would have been most appropriate.

4.6.4. Service Redesign Transformation Programme

This is not so much a service 'redesign transformation' as a review and change of 'beds and sites'. The process lacks confidence amongst staff, patients, families, communities and partner organisations. Planning was perceived as being poor and the decisions made without proper consideration of full information, data, options, resources and impact. *Ad hoc* decisions were made as the programme developed (such as the move of Learning Disability Assessment Unit to Strathmartine which is now not happening).

In the light of the Independent Inquiry, there is clearly a need for a comprehensive review of mental health service strategy rather than simply undertaking a move of beds and sites. The proposed changes should **not** be implemented before there is a comprehensive review of the proposals to meet the wider needs of the community, beyond inpatient requirements.

4.6.5. Communications

Communications have been consistently described as poor. As in the section on complaints (at 4.4.4.), the tone of communications to patients is often defensive, high-handed and patronising, with the use of inappropriate technical language. Staff feel that they are not informed of changes in advance (closure of ward at Murray Royal; removal of the roles of the Primary Mental Health workers). Consultation does not command respect unless it has integrity and is genuine. Staff feel that either they are not consulted, or their views are not respected. Similarly public consultation on wider changes to mental health service delivery is not perceived to be genuine, with views not being listened to or respected. There is a lack of genuine engagement with or involvement of the public, staff and partner organisations.

Several GP practices either do not know the means by which they can influence NHS Tayside policy and practice or have tried and failed to have their voices heard.

5. Next Steps

The identification of these key themes at this stage will enable the Inquiry to focus on next steps, drawing firm conclusions and making specific recommendations. The key themes in this report are not exhaustive; evidence is still to be analysed which may highlight more concerns. The themes will inform the next phase of the Inquiry, which is to undertake further investigation and analysis. It will be important to identify areas of good practice from both within NHS Tayside and elsewhere. These will help to shape the conclusions and recommendations the Inquiry wishes to make.

The Inquiry is concerned with much more than just inpatients and psychiatry. Its remit is to consider end-to-end mental health services. These include the provision of treatment in the community, with an emphasis on prevention and support at the earliest appropriate time. New thinking is required to address the serious challenges that are facing the provision of mental health services in Tayside.To ensure that the Inquiry will lead to improvements in the provision of mental health services in Tayside, the recommendations will need to be supported by a credible implementation plan. The Inquiry's final report will address how this can be achieved and monitored.

There is now a real opportunity for Tayside to transform its provision of comprehensive mental health services to meet the needs of all people living in Angus, Dundee and Perth & Kinross.The Inquiry team is grateful to everyone who has provided evidence to the Inquiry so far, recognising that for many people, it has taken courage and commitment to do so.

David Strang

Chair of Independent Inquiry **May 2019**

6. Appendix 1

Summary of organisations who submitted evidence to the Inquiry

Written Evidence	Meetings / Visits
* The ALLIANCE	* The ALLIANCE
* Associations supporting mental ill-health	* Associations supporting mental ill-health
* Community Learning & Development teams	* Community Mental Health Teams
* Churches Action for the Homeless	* Crown Office & Procurator Fiscal Service - Scottish Fatalities Investigation Unit
* Community Mental Health	* City Councils
* Dundee Commissions (Fairness; Drugs)	* Dundee Commissions (Fairness; Drugs)
* Employee Participation Group NHS Tayside	* Edinburgh Crisis Centre
* GP Practices in Angus, Dundee and Perth & Kinross.	* Employee Participation Group NHS Tayside
* Groups supporting People affected by Alcohol/Substance Misuse	* GP Practices in Angus, Dundee and Perth & Kinross
* Health and Social Care Partnerships	* Health & Social Care Partnerships
* Independent Advocacy organisations	* Healthcare Improvement Scotland
* NHS Tayside	* HMP Perth
* Service User Networks	* Integration Joint Boards
	* Independent Advocacy organisations
	* Independent review of Learning Disability and Autism in the Mental Health Act
	* Mental Welfare Commission for Scotland
	* NHS Tayside staff working in all aspects of mental health services
	* NHS Tayside Hospitals: Murray Royal, Carseview Centre, Rohallion Secure Care
	* Police Scotland

	* Scottish Government * Scottish Public Sector Ombudsman * Scotland Deanery – NHS Education for Scotland * Stakeholder Participation Group SPG * Trainee GPs / Psychiatrists * Universities of Abertay and Dundee - Nursing Students * Universities - Counselling & Mental Health Teams * Voluntary Health Scotland

CONFIDENTIAL Mental Health Services in Tayside

DELETE REPLY REPLY ALL FORWARD •••

Mark as unread

TAYSIDE, Chairman (NHS TAYSIDE)

Mon 20/05/2019 09:26

To: d.strang@dundee.ac.uk;

This message was sent with high importance.

2 attachments

Strang Davi~.pdf

Interim Dra~.pdf

Download all

Dear David

Please find enclosed a letter and associated document in respect of the draft report you submitted to me last week.

I look forward to the opportunity to discuss these with you.

Regards

John
John Brown CBE
Chairman
NHS Tayside

01382 740708 / 07720 261801

Tayside NHS Board
Ninewells Hospital and
Medical School
DUNDEE
DD1 9SY
01382 660111
www.nhstayside.scot.nhs.uk

Mr David Strang
Chair
Independent Inquiry into Mental Health Services in Tayside

Sent by email: d.strang@dundee.ac.uk

Date	20 May 2019
Your Ref	
Our Ref	JB/mh Strang 1705
Enquiries to	John Brown
Extension	40708
Direct Line	01382 740708
Email	chairman.tayside@nhs.net

Dear David

Firstly, I would like to thank you for all the work you and your team have put into the Mental Health Inquiry in Tayside. I appreciate this has been a difficult and challenging task and is by no means complete. The publication of your interim report and emerging findings is welcomed by the NHS Tayside Board and we look forward to receiving your final report and recommendations.

As we previously agreed, I have asked the Associate Medical Director responsible for the oversight of Mental Health services in Tayside to review the latest draft of your interim report to ensure factual accuracy and completeness. Professor Matthews and his senior leadership team have completed this stage of the review process and I am enclosing their report on behalf the NHS Tayside Board. Thank you for providing this opportunity to enhance the input already in the draft interim report from a patient and a staff perspective.

You will note from the Board's response that in addition to correcting several factual inaccuracies, we have also we have highlighted a significant number of paragraphs where we believe that the assertion made is open to misinterpretation and misunderstanding. As you would expect, we have provided the evidence to demonstrate that is the case.

It is also important to stress that the Board's response should not be seen as challenging their contribution but it is intended to assist you in providing the public, staff and the Scottish Parliament with evidence relating to not only the past but also the current situation in Tayside.

As we discussed last week, I am concerned that publishing this level of detail of the patient experience and staff feedback at this stage of the Inquiry, without describing the Board's response in the same depth, could be misinterpreted as a failure by the Board to take these issues seriously and respond appropriately. Clearly, that is not the case and I would like to give some assurance that, following our conversation last week (where you expressed some concerns over the pace of the implementation of the Tayside Mental Health Improvement Plan), the Chief Executive and I have conducted our own in-depth review of the activities being undertaken to improve the safety, access and quality of care being delivered to our patients and their families.

Given the amount of activity being undertaken by a large number of people across the organisation this was a significant piece of work and, while the Chief Executive and I were assured that good progress was being made across many areas of the mental health services, it did highlight the need for a communications update for patients, service users, staff and the public. Therefore, NHS Tayside is publishing an overview document to describe the work under way to improve the delivery of mental health services in Tayside. Our Communications Director is working with colleagues across Tayside to

quickly produce this document and we intend to publish this at the same time as the Inquiry's interim report. I'd welcome any comments you may have on this approach.

I'm also pleased to be able to report that the Chief Executive has been having discussions with colleagues in the Scottish Government to identify additional support for NHS Tayside that would assist us to increase the pace of change in Mental Health services. We will provide the details to the Inquiry once these discussions have been concluded. I expect the nature of this support to be confirmed by the end of this week.

Returning to the interim report, should you decide to include detailed patient and staff feedback to illustrate the emerging themes, I think it will be important to not only balance this with the Board's response but also to separate out those issues that are historical and have already been addressed. It would also be helpful if the report could make it clear whether the statements about the care received or delivered are simply transcripts of the evidence or are broad conclusions from the Inquiry.

I am also concerned that although it was not expected at this stage of the Inquiry, you have made a recommendation without discussing the implications of implementing it with the Board. Specifically, the suggestion that the Board's plans to realign inpatient services should be put on hold while the Inquiry is completed raises serious issues for the Board. In a service where there are currently 11 in-patient Consultant Psychiatry vacancies, the Board do not consider it appropriate to delay its immediate plan to address this particular pressure in order to ensure the continuing safety and quality of the current service.

I appreciate that the Board's response to the draft interim report might require significant redrafting of the report, not only to correct the factual inaccuracies but also to either include the Board's response or to wait until the final report before including the detailed feedback from the patients and staff in support of your recommendations. The Chief Executive and I would be keen to meet with you before you finalise your interim report as we would wish to avoid being perceived as challenging the purpose and value of the interim report. I am confident we can reach a consensus on the way forward.

Of course, I am aware of the public, staff and the Scottish Parliament's interest in receiving the interim report as soon as possible but as the body that commissioned the Inquiry, the Board would rather delay its publication for a few more days in order to ensure it was as accurate, complete and inclusive as possible. I would be grateful if you could let me know whether or not you think you will be able to publish the interim report as originally planned. You will note we have not publicly committed to a publication date for this or for the final report and therefore I don't expect a short delay to be a cause for concern as long as we do announce when the interim report will be available.

I'm sure you would agree that it is important that the interim report is well received by all interested parties, including the public and the staff. We would not wish the outcome of the report to be a reduction of patient and public confidence in the service, nor an undermining of the commitment of the professional staff, many of whom are personally involved in the initiatives and activities currently being implemented to improve the safety and quality of care.

Therefore, I hope you will find this letter and the attached report a helpful contribution to your efforts to provide an accurate, complete and inclusive view of what has happened in the past and, perhaps more importantly, where we are now and what more we are doing to address the legitimate concerns that prompted the Board to commission the Independent Inquiry 12 months ago.

I look forward to receiving your response to this letter and the issues I have raised around the delivery of the Inquiry's interim report.

Yours sincerely

John Brown CBE
Chairman
Tayside NHS Board

Enc

The Independent Inquiry into Mental Health Services in Tayside

DRAFT Interim Report Inquiry Update and Emergent Key Themes May 2019

NHS Tayside factual accuracy check and comments to ensure completeness of evidence

General Comments

The commentary in the interim report does not reference any particular timeframes to accompany the assertions being made. Therefore it is difficult for us to identify if the comments/events/experiences are contemporary or happened in previous years. It would be useful to consider temporal references in future reports.

Also, for future reports, we would like consideration to be given to the separation of thematic feedback from NHS Tayside and thematic feedback from other agencies to ensure that all agencies involved in mental health services in Tayside are given the opportunity to consider themes and recommendations and take appropriate actionFeedback for NHS Tayside could also be further split into service areas e.g. Child and Adolescent Mental Health Services, General Adult Psychiatry, Psychological Therapies, etc. This would facilitate the checking of the key themes against improvement work under way and support a gap analysis to identify where systems/processes/improvement efforts can be strengthened.

Factual accuracy check and supporting evidenced comments on content of draft interim report

4.11 Crisis Services

Factual accuracy - The reference to a service gap between 15.30 and 17.00 in Angus is factually incorrect. Whilst there are local differences in the response to crisis within the community health teams the crisis care service provides a universal out-of-hours service for the population of Tayside.

Evidenced comments - Whilst we recognise some of the themes highlighted, it must be acknowledged that Crisis Care is an unscheduled care service and thus may experience surge demand on occasion, as is the case with all unscheduled health and care services. We have good quality referral data that will help us in our Crisis Care and Home Treatment redesign programme across 2019-2020. A stakeholder workshop with service providers has been held, and feedback from service users within the ALLIANCE report (published December 2018) is already influencing our improvement programme.

In response to the perception stated in the report *that "patients...not offered any intervention and then being sent home"*, there are a range of outcomes or supports offered to people who are referred to the Crisis Response Home Treatment Team (CRHTT), dependent on their clinical presentation and the outcome of their assessment.

These include:

- Discharge back to GP care only (no ongoing mental health service involvement / no referral required to another agency)
- Referral/signposting to another agency out with mental health service
- Referral to another agency within mental health service
- Continued contact with an existing mental health service
- Admission onto the caseload of the Home Treatment Teams
- Admission into Hospital.

Therefore, it is appropriate in some circumstances for people to be sent home and the data does not substantiate the assertion about the number of people being sent home.

4.1.2 Risk Management

Factual accuracy – It is not correct to assert that patients are left without support from the service. All patients referred to the crisis team and accepted onto the caseload for home treatment have a documented risk assessment and plan. All patients, regardless of referral source, have a telephone triage to determine the priority status of the referral.

All assessments are carried out by two Health Professionals (generally, Registered Mental Health Nurses) who will consider in detail:

- Patient history
- Mental State Examination
- Risk Assessment
- Formulation of treatment

The home treatment case load as of 14 May 2019 was 29 patients. Of those patients, all have a risk assessment and all but [redacted] a risk management plan which is currently being developed.

Therefore, the assertion made of a lack of risk assessment is incorrect based on the evidence of patient records.

4.1.3 Police Scotland

Factual accuracy – The Police Scotland D Division/NHS Tayside Community Triage Service review for the period, 1 February 2017 to 31 March 2018, states that the police triage service has **reduced** the time that police officers spend dealing with referrals to mental health team.

Evidenced comments - The purpose of the police triage service delivered through the Crisis Care Home Treatment Team is to provide specialist mental health advice at the earliest opportunity to police officers to support their decision making. This ensures people in

mental health crisis are triaged and signposted to the appropriate service. There are many situational crises that may require involvement of Police Scotland but do not necessarily require the input of specialist mental health care and treatment services. The CRHTT is also actively involved in the training of police officers in relation to mental health and the role of the CRHTT in Tayside.

Therefore, the evidence of Police Scotland's own assessment and review of the Community Triage Service would suggest that it would be factually correct to assert that partnership working is REDUCING the time spent by police officers dealing with people in mental health crisis.

4.1.4 GP Referrals

Evidenced comments - Investment in primary care and mental health funding through health and social care partnerships has included the funding of posts to address alternative support for people in a primary care setting and these are being implemented now.

This issue is recognised under Action 15 of the National Mental Health Strategy, and there are plans to create 800 new mental health workers across Scotland with funding increasing incrementally to support this change. There has been funding of £726,000 this year across the health and social care partnerships to enable the partnerships to begin to recruit to these posts in each area, supported by Modernising Primary Care Funding.

Therefore, it would be more factually correct to acknowledge that this is a national issue that is being addressed across Scotland and that, with available funding now coming through, recruitment to primary care based mental health worker posts is now progressing across Tayside.

4.1.5 Rejected Referrals

Evidenced comments – As above, investment in primary care funding and mental health funding has included the funding of posts to address alternative support for people in a primary care setting.

Therefore, it should be acknowledged that each of the health and social care partnerships in Tayside have prioritised their funding and have plans for General Practice Mental Health liaison roles.

4.1.6 – Allied Health Services

Evidenced comments – We recognise this as an issue. Waiting times for Psychological Services have been affected by staff vacancies and shortages. Out of 135 whole time equivalent posts in Psychological Services, there are 20 whole time equivalent vacant posts due to difficulties in recruitment and maternity leave.

The NHS Tayside Board Policy is for patients to be advised of the likely time they may have to wait to be seen. Lead clinicians in Psychology Services have been asked to ensure that indicative timescales are provided to patients, particularly in the specialisms where there are likely to be longer waits .In keeping with new national guidance, we are introducing a written communication to all patients who have waited beyond their guaranteed waiting time. The end-to-end review of service provision to be undertaken through the newly formed Mental

Health Care Alliance, will look to introduce new models of care which will improve our waiting times performance.

Therefore, we would acknowledge that we need to improve waiting times in Psychological Services and will ensure that the policy to advise patients of the likely length of time they may have to wait is consistently applied.

4.1.7 CAMHS

Factual accuracy – The December 2018 data shows 64.2% of CAMHS patients treated within 18 weeks from referral to treatment and not '*nearly 60% of patients waiting longer than 18 weeks'.* The latest Tayside data shows that despite rising referrals, the latest performance data at April 2019 evidences a sustained performance of 63% of patients treated within the 18 week target.

The data supplied to the Inquiry Team showed that the rate of rejected referrals was in line with the average levels across Scotland, based on national data. This is indicative of the range of needs and demands being referred into Child and Adolescent Mental Health Services, in the absence of a stratified range of services for children to meet the range of differentiated needs. This is the subject of a national review programme and is being addressed in Tayside through a CAMHS Improvement Programme.

The Primary Mental Health Workers posts highlighted were funded through an earlier Scottish Government funding programme, "Changing Children's Services", which was provided through local authorities. These were **NOT** NHS Tayside posts. This funding was subsequently withdrawn by councils when the funding was mainstreamed in 2016.

Evidenced comments – NHS Tayside CAMHS do have a policy currently of seeing all children up to the age of 16 and children up to 18 where they remain in full time education. This policy will change and all children up to the age of 18, who meet the criteria, will be seen by the CMHS services. Transitions from Children and Young People's Mental Health Services into Adult Mental Health Services can be difficult and a lead clinician is taking forward a test of change designed to improve transitions so that this can be mainstreamed.

Therefore, it is accepted that waiting times for access to CAMHS must continue to improve in Tayside and the CAMHS Quality Improvement Programme must redesign services to ensure that children and young people experience a range of mental health issues will be supported appropriately and timeously. We will move to change the age threshold to include all children and young people up to the age of eighteen and implement improvements to transitions, learning from the test of change.

4.1.8 Mental Health and Substance Misuse

Factual accuracy – No patients are "continuously refused access" – all patients are seen within the current guidelines. This means that on occasion for people it would be clinically unsafe to treat.

Evidenced comments – We recognise the themes highlighted, however, there are occasions where it would be clinically unsafe to undertake a specialist mental health assessment when an individual is under the influence of alcohol or drugs. People are assessed and access services based on their clinical presentation. If case examples were

available where an individual who has a co-morbid mental health disorder and an addiction has been continuously refused access to services, we would be happy to look into this issue.

As part of our commitment to review end-to-end mental health care and mental health crisis the NHS Tayside Chief Executive has commissioned a meeting with the Police Scotland Chief Superintendent, the Chief Executives Angus, Dundee and Perth and Kinross Councils and the Chief Officers of Angus, Dundee and Perth and Kinross Health and Social Care Partnerships to review the management and support to people presenting in crisis including those who are under the influence of alcohol and/or drugs. This will ensure we develop consistent processes to support those individuals.

Therefore, it is acknowledged that we need to improve the care and treatment for people who experience both mental health and drug / alcohol problems as we redesign our end-to-end pathways of care for people, recognising holistic needs.

4.1.9 Multiple Diagnoses

Evidenced comments – We do recognise the issues being described in this particular circumstance. Further explanation/ clarification would be appreciated.

Therefore, we would seek greater clarification of the type of situations alluded to in this section.

4.2 Patient Sense of Safety

Factual accuracy – The patient safety evidence is presented as being of a contemporary nature. There is no evidence that this would represent current patient experience.

Evidenced comments – We recognise some of the issues in the commentary identified under the *Patient Sense of Safety* themes and our current action/improvement plans address these.

Therefore, it may be more factually correct to describe that, in the recent past, there have been patients who have expressed such concerns about experiences within inpatient services. Our NHS Tayside Culture and Leadership Programme and Quality Improvement Programme is currently progressed within mental health inpatient services to address these issues.

4.2.1 Ward Safety

Factual accuracy – The patient safety evidence is presented as being of a contemporary nature.

Evidenced comments – We are uncertain of the timeline for the experiences described, however, our quality improvement programme which has been underway for 12 months has a range of activities aimed at improving the safety and care experience for patients. Central to the quality improvement programme is the ongoing feedback from our staff, patients and carers. Current improvement activity focuses on Improving Observation Practice (IOP) which is a national Healthcare Improvement Scotland priority. The IOP approach in Tayside's Intensive Psychiatric Care Unit has been highlighted by HIS in their annual IOP report as an

example of best practice, with clear evidence of reduction in hours spent observing patients, releasing nursing time for other meaningful activities. Two wards in the Carseview Centre are currently testing a 17-hour-per week target of meaningful activity for each patient. There is no national standard for meaningful activity within adult wards which places Tayside mental health at the forefront of this key element in supporting patient recovery.

Standards for person-centred care planning have been developed in partnership with staff, carers and NE London Mental Health Foundation trust. These standards have been shared with the Mental Welfare Commission and will be launched this month.

All General Adult Psychiatry wards in Tayside have been reviewed by the Mental Welfare Commission since November 2018 and reports are published on the MWC website.

Therefore, it may be more factually correct to recognise that concerns expressed by patients may relate to past experiences of inpatient care and that recognition should be given to the evidence of recent inspection and the progress made to address issues through the ongoing improvement programme.

4.2.2 Restraint

Factual accuracy – There is a reference to an investigation being undertaken within NHS Tayside of the use of restraint measured against NICE guidelines as best practice. It is not clear if this is a reflection of evidence submitted to the Inquiry or an assertion by the Inquiry itself?

Evidenced comments – Mental Health Services in Tayside have a clear focus on reducing restrictive interventions and this is led through a Multi-Disciplinary Least Restrictive Care (LRC) Steering Group chaired by the Quality Improvement Lead for Mental Health. All wards have a LRC Lead and jointly we are pursuing the aim of a 50% reduction of restraint by the end of December 2019. National benchmarking through the Scottish Patient Safety Programme in Mental Health Safety evidenced that NHS Tayside Mental Health Services are not an outlier in the use of restraint. The rate of restraint within general inpatient wards in Tayside is between two and four episodes per 1000 bed days. This is higher in the Intensive Psychiatric Care Unit, where the rate is 26 episodes per 1000 bed days, due to the nature of patient acuity. However, this compares with a national average rate of 41 episodes per 1000 bed days for IPCU services across Scotland. The aim is to reduce the level of restraints by 50% by December 2019 and to develop and embed a philosophy and practice of “least restrictive care” across all ward areas.

Training in Prevention and Management of Violence and Aggression is up to date for more than 95% of staff across all areas (it is not 100% as some members of staff may be on long-term sick leave or maternity leave and their annual training will be completed when they return to work).

We have commissioned a review of the infrastructure around the delivery of training and application of the Prevention and Management of Violence and Aggression across Mental Health and Learning Disability services. This commission will be a desktop review of the content of the current Prevention and Management of Violence and Aggression Policy, staff training programme, a mapping exercise against Scottish, UK and international best practice guidance and recommendations for areas for improvement.

The Scottish Patient Safety Programme Mental Health Safety Principles are used, as well as LRC steering group-developed initiatives, which include an aim of a minimum of 17 hours per patient per week of structured therapeutic engagement. This is currently being tested across two inpatient wards and based on the Royal College of Psychiatry Forensic standards, which we are adapting and working alongside service users and teams to formulate the best possible 'menu' of activities that will establish engagement and sustainable activity programmes across all wards.

Further interventions that look at prevention, recognition and response include the use of self-soothing boxes as a patient-led early intervention in response to stress and distress. The contents of the boxes have been developed listening to patient feedback and are used frequently. Another example is the alternatives to self-harm interventions which support patients with safe alternatives to manage their risk behaviours. These interventions are again based on patient feedback and learning from lived experience.

We must also acknowledge the high-quality interventions, skilled and sophisticated interventions that are compassionate, and evidence-based in their origin that staff deliver daily.

Therefore, the reference to restraint practice should take account of contemporaneous evidence around the benchmarking of restraint practice and the improvement work being undertaken.

4.2.3 Patient Self Discharge

Factual accuracy – No patient would self-discharge without arrangements for ongoing checks and care in place.

Evidenced comments – A key requirement within contemporary mental health practice is to care for people in the least restrictive manner possible and there are clear legal safeguards in place to enable this. The daily hospital operational safety huddle for inpatient services identifies any patient who has taken their own discharge against medical advice. This is to ensure that appropriate support is made available to the patient. On occasions when people take their discharge against medical advice they are referred to the crisis team who will make contact with the individual within 24 hours.

We work with patients to safely maximise the time they spend away from the hospital. There are procedures in place for patients who do not return to the inpatient ward as agreed. There is an information leaflet within the Adult inpatient wards providing information for informal patients regarding use of Time Out and Passes. This was developed in partnership with service users, carers, and multi-professional team members.

The policies adopted within NHS Tayside require mental health services to have awareness of all patients at all times and regular checks are carried out to ensure that patients are safe and accounted for depending on patient needs.

There is rapid escalation of action in line with our "Missing Patients Policy", to ensure that patients are quickly traced should they not return to the ward within the agreed periods and police Scotland alerted as appropriate.

Therefore, the assertions made are not balanced by the evidence and awareness of policies and procedures in place within NHS Tayside Mental Health Services designed to balance a least restrictive approach with the duty of care to ensure patients are safe and accounted for.

4.2.4 Illegal Drugs on Wards

Evidenced comments – We are aware this is an issue and we are working in partnership with Police Scotland to support staff and patients with this challenging issue. We routinely provide information to patients in relation to the use of substances within our in-patient wards due to the impact this can have on individual patients, the wider patient group and staff within our wards. We are clear in our communication that substance misuse on our wards is not acceptable and provide clear advice and guidance to patients.

Therefore, in acknowledging that the availability and use of drugs within mental health inpatient areas is a challenge, it would be more factually correct to recognise the evidence of work with Police Scotland to address this and the limitations to prevent drugs coming into the wards.

4.2.5 Staffing Levels

Factual accuracy - No inpatient wards have been closed. Mulberry Ward was relocated from Stracathro Hospital to Carseview Centre in February 2017, with a minor reduction of 4 beds.

Evidenced comments – Sustainable and safe staffing levels are a key element of service planning and delivery. In hosted inpatient services, ward establishments were reviewed as part of the Transformation Programme. The reviewed establishments have:

- a non-case holding band 7 Senior Charge Nurse
- Increased the number of Charge Nurses from 1 to 2 per ward. Recruitment for this change is complete and the new Charge Nurses Induction Programme is planned for the 5 and 6 June 2019.
- a 60:40 Registered/Unregistered Staff Skill Mix
- a minimum of 2 Registered Nurses available on each shift
- a dedicated ward clerk role to reduce the administrative burden on Nursing Staff.

These changes will improve the skill mix, leadership and administrative support available to the teams.

We endorse the view that there is a UK-wide shortage of Consultant Psychiatrists.

Therefore, while the report rightly acknowledges the national shortages of Consultant psychiatrists, it would be more factually correct to also recognise the strength of the staffing models within Tayside and to correct that statement concerning closure of inpatient wards.

4.2.6 Community Mental Health Teams (CMHT)

Evidenced comments – On the issue of strategic decisions to close inpatient services, the decision to relocate inpatient services was part of the planned inpatient redesign programme which was subject to significant engagement and consultation before being approved.

We recognise that there are concerns amongst some community teams in relation to overall caseloads. Home Treatment services will be available in North Angus by August 2019 with a view to delivering home treatment services in South Angus from late 2019 or early 2020.

Therefore, while acknowledging the caseloads being carried by staff in CMHTs, it would be more factually correct to acknowledge that community mental health resources are above the Scottish Average (based on current benchmarking) and to correct the statement that wards have closed.

4.2.7 Training

Evidenced comments – On the issue of CPD for Psychological Services staff, CPD training – not mandatory training – was temporarily suspended by agreement with staff to enable a backlog of patients to be seen. This decision was made by the staff in the best interests of the patients and our commitment to seeing them as quickly as possible. This temporary suspension was lifted five months ago at the end of 2018.

Enhanced monitoring is in place for General Adult Psychiatry and there is an action plan in place to address the issues highlighted by the East of Scotland Deanery.

Therefore, it would be more factually correct to acknowledge that the temporary suspension of non-compulsory training for CPD within Psychology Services was a decision taken with staff in the best interest of patients to reduce waiting times and was re-instated last year.

4.3.1 Communication

Evidenced comments – The patient commentary attesting to a lack of communication with patients admitted to inpatient areas is noted. However, each ward has Ward Information Leaflets available, created by service users for service users. This outlines key information on what to expect during the hospital stay.

Patient feedback mechanisms are embedded into each ward and actions are taken in response to this. Service users, service user groups and carers have been undertaking walk rounds in line with the 15 Step Challenge methodologies. Feedback from the walk rounds has been shared directly with the ward teams.

There is an annual patient climate tool used to gather service user feedback supported by third sector. In addition to this, there is a monthly ward patient feedback using ‘how are we doing’ methodology and a ‘You Said, We Did’ feedback board. Further work underway involves the development of a cultural design plan led by our Quality Improvement Adviser.

In response to missing records commentary, internal communication is now supported by EMIS Web which is an electronic patient record system providing real-time patient data which can be shared between different services. This was rolled out to adult mental health services in June 2018. This means that clinical information is readily available without reliance on paper-based health records.

Therefore, in acknowledging the patients' experiences of communications on admission, between services and advising of changes to appointments or status, it may be more factually correct to balance this with good practice illustration.

4.3.2 Ward Environments

Evidenced comments - We recognise that there are different challenges within the ward environments across parts of the inpatient estate and note the specific concerns raised regarding the inpatient environments. We are actively engaging with patients, carers and other stakeholders regarding the refurbishment plans for hosted inpatient service as part of the Transformation Programme which will deliver significantly improved care environments for patients.

One ward within the Carseview Centre does not have direct access to outside space (it is located on the first floor) but garden areas and outside space are accessible to patients on the ward. We have had feedback from patients regarding the level of meaningful activity available and are testing a standard of 17 hours of structured activity per patient per week. The pool table on the Intensive Psychiatric Care Unit has been repaired and the ward recently opened a gym which is accessible to and well used by patients. We have recently increased the budgets available to staff to support ward based activities.

There are three separate gym areas in Carseview Centre. These are in the Allied Health Professional physical exercise room, Mulberry Ward physical exercise room and the Intensive Psychiatric Care Unit (IPCU) physical exercise room. This is supplemented by other physical health activities including walking groups and ward based activities e.g. seated exercise.

The gyms and other activities are promoted by ward nursing staff. This is further supported by the Physiotherapy Technician attending all wards to review new admissions. The Physiotherapy Technician will then assess and devise a physical activity program around the patient's interests and abilities. This is shared with the nursing staff that who then supervise and support patients following these activity plans.

The Physiotherapy Technician will support patients to transition to community-based therapies should they be keen to do so e.g. hydrotherapy, walking football, rebound therapy.

We are not aware of any outside agencies within the voluntary sector being discouraged or made to feel unwelcome. It would be helpful to understand the timeline this refers to. Healthy Minds Dundee is very active in Carseview supporting the patient feedback and 15 step walk round.

Therefore, the assertions made concerning ward environments are acknowledged, but it would be more factually correct to balance this perspective with the positive aspects highlighted and in recognition of plans to improve ward environments as part of the inpatient redesign programme.

4.3.3 Continuity and Consistency of Care

Evidenced comments - We recognise the themes highlighted and plan to address this through the newly-established Tayside Mental Health Services Alliance. As stated, it is recognised that there is a UK-wide shortage of Consultant Psychiatrists and suitable locum

Consultant Psychiatrists. The Board has made extensive efforts to secure permanent appointments (including via international recruitment) and locum Consultant Psychiatrists on longer contracts. Given the current recruitment challenges across the country, NHS Tayside will pursue alternative models of services provision through the Mental Health Services Alliance.

Therefore, it is acknowledged that the national shortage of Consultant Psychiatrists and reliance on locum Consultant Psychiatrists, may affect continuity and consistency of care, but it would be more factually accurate to balance this with the fact that NHS Tayside has striven to maintain services where possible and to recognise the plans to develop alternative models of care and roles that reduce the dependency on psychiatrists.

4.3.4 Availability of Services

Factual accuracy - On the aspect of third sector organisations' charging policies, this is a matter for each organisation and not prescribed by commissioning bodies, such as the Health and Social Care Partnerships. It is possible that certain third sector organisations are grant funded or commissioned to provide services in one area and not in another. This does not necessarily imply that services are offered on a variable basis.

Evidenced comments -Seven-day home treatment services are being reinstated in Angus on a phased based starting in North Angus in August 2019 and progressing into South Angus thereafter. ***Therefore, it is factually incorrect to infer that a crisis home treatment service has been re-established in Angus (although a phased re-introduction is planned) and to suggest that third sector bodies are "forced" to charge for services.***

4.3.5 Carer Involvement

Evidenced comments - We recognise the themes highlighted and are addressing these through existing action/improvement plan around standards for person centred care planning and the use of the Triangle of Care with carers.

The Carseview Centre recognises the important role carers have in the lives of our patients. As a service we also recognise that carers will have their own needs and we are committed to supporting carers. The Carseview Centre has run a Carers Meeting for a number of years. This meeting provides the opportunity for carers to input into service changes, to meet clinicians and discuss care delivery and to view clinical areas. This meeting has a changing membership and is supported through word of mouth of existing attendees

Engagement with Carer Groups is built though existing networks and it is acknowledged that relationships with some Carers Groups could be strengthened and further developed. This is being taken forward as a priority and representatives from adult mental health services attended the Dundee Cairn Fowk Annual Conference and presented joint work around Carer Engagement and Feedback.

. Mental Health Services are directly involved with a number of external agencies such as Healthy Minds Dundee. Other services include::

- Penumbra, an external agency, is the contracted provider of the Dundee Carer Support Service encompassing community and inpatient support. Penumbra

provides advice, information and flexible support on a one to one, group or telephone basis. This service is actively promoted by the healthcare team and through leaflets and posters within the hospital.

- The Dundee Mental Health Cairn Fowk, an external agency (Charity), supports the wellbeing of mental health carers and to engage with the wider community to promote awareness of mental health issues. The service is run by carers with lived experience. This service is actively promoted by the healthcare team and through leaflets and posters within the hospital. The Cairn Fowk also provide social activities within the hospital in the form of tea/coffee afternoons, live music (Ukulele band) and Christmas carol singing.
- Dundee Independent Advocacy Service (DIAS), external agency, provides independent advocacy to patients within the Carseview Centre. This can be individual or collective (Group) in nature. DIAS attends the Carseview Centre for collective advocacy every two weeks and will attend upon request e.g. Mental Health Act. DIAS provides a range of services including supporting patients to make sure their views are listened to, find information to help patients make choices (Including making links regarding finance support), support patients to prepare for meetings and to attend those meetings with the patient, support patients to write letters, support patients to make phone calls and inform the patient on their rights and responsibilities.
- Hearing Voices Network (HaVeN), external agency, provides group peer support to patients at the Carseview Centre. This service is provided by peers with lived experience of mental health recovery to support and inspire hope in patients on their own recovery journey. HaVeN have also provided entertainment events within the Carseview Centre including live music, Christmas carol singing and craft making. HaVeN visits the Carseview Centre wards every two weeks.
- Alcoholics Anonymous/ Al-Anon provide weekly sessions at the Carseview Centre. This is open to inpatients and is promoted by ward based staff.
- Narcotics Anonymous have recently trialled running drop in support sessions within the Carseview Centre rear foyer area. It is hoped that this pilot will lead to a regular future service.

Although these examples relate to the Dundee area, there are similar arrangements in place in Angus and Dundee.

Therefore, it would be more factually correct to acknowledge the extensive range of carer supports and carer involvement available.

4.4.1 Policy and Practice

Evidenced comments - We are unable to respond to this and would welcome specific information relating to policies which are disconnected from practice. This would enable us to look into this and take forward any corrective actions.

Therefore, we would ask that more specific references are made in relation to the assertion that policies and practice are disconnected.

4.4.2 Adverse Event Reviews

Evidenced comments - Adverse events and their recording and review are not unique to mental health services and are the subject to a broader policy and approach across NHS Tayside. Every adverse event is identified, logged (recorded on the DATIX risk system), and acted upon.

The NHS Tayside Adverse Event Management Policy aims to achieve a positive safety culture which is open, just and informed and focused on reporting and learning from adverse events. The policy provides timeframes in which local adverse event reviews should be complete.

Adverse event review is a component part of Induction Training and the NHS Tayside Adverse Event Management Policy is a core policy covered by our online learnPro training module.

However, there are challenges with how Local Adverse Event Reviews are conducted within the services and in particular how families and carers can participate in the review process. We are committed to ensuring that our Reviews are conducted in an open, transparent way that supports families to participate in the process in a meaningful way.

Learning from events at a ward level are incorporated into the ward level dashboards and routinely and regularly shared across services.

We plan to link with the Scottish Mortality and Morbidity Programme currently underway within other Specialist Services in NHS Tayside to help develop structures that enable shared learning

The Adverse Event Management Policy was reviewed this year for Tayside and we are undertaking an awareness campaign to further embed the Policy for all staff across NHS Tayside.

Adverse events and Local Adverse Event Reviews (LAERs) are reported through the NHS Tayside Clinical Quality Forum.

Therefore, we acknowledge the need for continuously learning and improvement from adverse events, however, it would be more factually correct to balance this with recognition of the evidence of the adverse events management policy, adverse event management training modules, the local adverse events review and the established reporting governance.

4.4.3 Fatal Accident Inquires

Evidenced comments - Unexplained, suspicious or sudden deaths are reported to the procurator fiscal. It is the procurators fiscal decision as to whether an unexplained death is investigated and to request a Fatal Accident Inquiry.

Therefore, it may be more factually correct to recognise that these decisions fall within the jurisdiction of the relevant Procurator Fiscal, not NHS Tayside.

4.4.4 Complaints, SPSO, Litigation

Evidenced comments - The newly-appointed Chief Executive has commissioned a review of the overall performance of the Board on their complaints performance and handling with the Nurse Director. This is not specifically in relation to mental health, but is regarding all services under the remit of the Board.

Therefore, the perceptions of people using our complaints and feedback service are acknowledged and will be the subject of a wider review of service and performance, commissioned by the NHS Tayside Chief Executive.

4.4.5 Recommendation from Reviews

Evidenced comments - It is difficult for the service to challenge recommendations from external and independent reviews or local events reviews. However, comment is always provided when there is an opportunity for factual accuracy checking. All recommendations from reviews are considered by the organisation on the basis of their evidence-base and a risk-assessment for implementation.

A single action tracker has been created which details all of the actions from external and internal reviews of the mental health services in Tayside since 2014. The single action tracker will be presented to NHS Tayside Governance Committees to ensure that there is confidence in the robustness and detail of the action tracker. This will be the subject of a report to the Care Governance Committee at its next meeting on 6 June 2019.

Therefore, it may be more factually correct to reflect that there is a process for implementing actions arising from external and internal reviews and a single action tracker for all such recommendations from reviews across mental health services.

4.5. Leadership

4.5.1 Responsibility and Accountability

Evidenced comments - We do not recognise the lack of continuity in key leadership roles being identified in recent external reports.

While there have been changes in Medical Leadership over the last two years, operational and professional leadership posts have been in place since the establishment of the Health and Social Care Partnerships from 2016.

We do not understand the issue referred to as a gap between what is decided in committee and what happens at operational level. It would be useful to have some examples to illustrate the issue and enable us to consider improvements in this area.

We can confirm that nine mental health nurses are undertaking the Advanced Nurse Practitioner programme with the University of Dundee and will complete the programme in summer 2020.

The Mental Health and Learning Disability Service won the innovation in education award at the Scottish Mental Health Nurse Forum annual awards ceremony in recognition of the support for Newly Qualified Practitioners via action learning during their first year of practice.

A further educational programme commences in May 2019 across both Murray Royal and Carseview Hospital sites.

Adult and Older People Mental Health and Learning Disability Services are delegated to Health and Social Care partnerships, with Inpatient services only hosted in one partnership in accordance with the national guidance for hosting arrangements. There was a significant period of shadow operation of the partnership arrangements before full implementation.

The Integration Schemes set out clearly the responsibilities and accountabilities for each of the Health and Social Care Partnerships in Tayside for hosted and fully delegated services and functions.Leadership and management appointments were very clearly established through organisational change and transition policies with all staff and resources effectively delegated in accordance with legislation, guidance and integration schemes.

The resultant organisation and leadership structures were fully agreed and in place prior to moving to full implementation.

The NHS Tayside Collective Leadership programme, based on Staff Governance Standards is aiming to embed compassionate, caring leadership at every level and across the organisation.

Therefore, in acknowledging some of the issues relating to clinical leadership within teams arising from the reliance on locum doctors, it is not factually correct to assert that there is a noticeable gap between committee level decisions and operational action or a lack of clarity for leading the service.

4.5.2 Relationships

Evidenced comments - We recognise the themes highlighted in this section, in particular relating to medical staff given the challenges associated with the medical workforce. Progressing towards a robust clinical leadership structure is a priority for us over the course of 2019. The Associate Medical Director and the Medical Director are leading on this.

However, there should be no lack of clarity of reporting lines as EVERY member of staff will have a clear line of management and supervision.

There is clear professional governance structure for nursing and medical staff throughout NHS Tayside.

Therefore, in acknowledging the perspectives obtained by the Inquiry, it is difficult to align the assertion with the evidence of the well-established management and professional governance structures in place.

4.6.1 Performance

Evidenced comments - It is surprising that there is reported widespread lack of clarity around responsibility for the commissioning, delivery, governance and performance reporting of mental health services in Tayside. These arrangements are all clearly set out within the Integration Schemes for each Health and Social Care Partnership in Tayside. The adult and older people mental health and learning disability services are all delegated to health and

social care partnerships in accordance with legislation and guidance. This provided for the need for certain services and functions to be hosted by one partnership on behalf of the others where these were either too small to be sub-divided or too strategically important to be disaggregated.

In Tayside the collective agreement was that, for example, Inpatient adult mental health and learning disability services should be hosted in Perth and Kinross HSCP and Psychology and Drug and Alcohol Services hosted within Dundee HSCP. This is in the nature of the integration agenda and is fully described in the Integration schemes. All leadership, management, staffing and resources have been allocated accordingly. There are clear schemes of delegation in place for each Integrated Joint Board which includes hosting and integration arrangements.

Leadership and performance review comes through the Integration Joint Boards, the NHS Tayside Executive Leadership Team, Performance Resources Committee and NHS Board.

The Mental Health Performance Review process is currently under review with the Health and Social Care Partnerships to ensure effective system wide and service specific performance monitoring.

A Mental Health Leadership Team was established last year with a triumvirate approach, clinically-led and managerially supported to provide leadership and direction across mental health across Tayside.

Whilst governance processes and systems are in place across the three Integrated Joint Boards and NHS Tayside we acknowledge the challenges in developing whole system level understanding of mental health. The new Tayside Mental Health Services Alliance will address this as it brings together the four organisations with responsibility for Mental Health Services in Tayside i.e. three Integrated Joint and Boards and NHS Tayside to establish system-wide priorities for mental health and the strategic priorities for each part of the system. The driver behind the establishment of the Tayside Mental Health Services Alliance is the acceleration of the pace of integration in order to drive forward the strategic priorities and to improve end-- end mental health services in partnership.

Therefore, it is factually incorrect to state that these arrangements are not clear or that they were rushed and that there was a lack of time to plan for their introduction as there were shadow and transition periods, prior to implementation. The introduction of the Mental Health Leadership Team and the development of the Tayside Mental Health Services Alliance are evidence of a strengthening of a collaborative approach towards strategic change, transformation, quality and performance improvement.

4.6.2 Risk Assessment and Management

Evidenced comments - There is a strategic risk for mental health services logged on the risk register, with the Medical Director as risk owner and the Chief Officer for Perth and Kinross Integrated Joint Board as risk manager. The risk is reported through NHS Tayside

Governance Structure, including Clinical Quality Forum, Strategic Risk Management Group, Clinical and Care Governance Committee, Audit Committee and Board.

Operational risks for mental health are the responsibility of the three health and Social Care Partnerships and the Acute Services Unit aligned with the service line management responsibilities

Therefore, the assertion in this section is not factually correct.

4.6.3 Management of Change

Evidenced comments - The inpatient redesign programme was an extensive programme of re-design supported by an extensive consultation and engagement, undertaken over a lengthy period and with an extensive series of development and engagement events to enable as many stakeholders as possible to be involved. There was a formal three-month public consultation on the proposals.

The resultant option appraisal process culminated in a recommendation on a preferred solution to the configuration of inpatient mental health and learning disability services and facilities across Tayside. The work was taken forward in partnership with Scottish Health Council.

The final decision to support the recommended preferred option was taken by Perth and Kinross Integration Joint Board as the host authority.

The relocation of Mulberry Unit (Susan Carnegie Centre), Stracathro, Angus to Carseview Centre, Dundee was undertaken to ensure sustainable delivery of safe, patient care. This was undertaken as a result of a requirement to enact a contingency plan to maintain safe and effective services in the context of significantly reduced medical staff. There was significant engagement and participation with Staff Side Representatives and HR colleagues to logistically plan and support staff through this service change and was considered by staff partners to be an exemplar of staff partnership working.

This change was, however, consistent with the overall strategic redesign programme plan.

Therefore, it is not factually correct to state that changes are reactive and without proper planning.

4.6.4 Service Redesign Transformation Programme

Evidenced comments - The Mental Health and Learning Disability Redesign Transformation Programme preferred option was approved by Perth and Kinross Integrated Joint Board in January 2018 following an extensive period of public consultation and stakeholder engagement. The current plan to provide a single General Adult Psychiatry inpatient service at Carseview Centre and a Learning Disability Service and Rehabilitation Service at Murray Royal continues to be NHS Tayside's strategic direction. This critical piece of work optimises the use of workforce resources and enables the environment of care for patients to be transformed creating person-centred and safer environment for care delivery. There is no change to the plan other than the schedule of service relocation and timeframes.

Therefore, it is not correct to make the assertions around poor planning and ad hoc decisions as the reconfiguration of inpatient services is part of the overall, planned strategic change, transformation and improvement plans going forward.

4.6.5 Communications

Evidenced comments - Whilst there is a clear communication strategy in place for the Mental Health and Learning Disability Redesign Transformation Programme we recognise that communication about a project of this scale may not always be considered to be inclusive of all people. Regular newsletters are provided, open meetings are held across the three Inpatient General Adult Psychiatry / Learning Disability sites and information posters with event dates for the year have been provided to each inpatient area.

The logistical planning for the Transformation Programme is detailed and a range of options for interim ward moves have been considered. It is important that we provide as much certainty as we can to staff, patients and their families regarding the scheduling of the programme. Family members, staff and advocates for patients on the Learning Disability Assessment Unit have visited Rannoch Ward at Murray Royal Hospital to familiarise themselves with the ward and changes have been made to the environment in line with their suggestions.

There is a clear professional advisory and governance structure in place in NHS Tayside and this has been recently strengthened by improvements to the Board Governance programme. This includes the GP Sub-Committee and Area Clinical Forum that enables GP practices and primary care to be represented at an advisory level within NHS Tayside. The Associate Medical Director for Primary Care is a member of the Executive Leadership Team and the HSCP GP Clinical Directors are represented on a number of policy and operational groupings within NHS Tayside.

There are also regular meetings between the office bearers of the GP Sub Committee with the Chief Executive and Medical Director of the Board.

Within the IJBs, as well as the Clinical Directors, there is GP representation through the HSCP structures. In addition, there are established GP Locality Clusters across each HSCP to enable GP practices to influence directly the shape of local services.

Therefore, it is difficult to conclude that communications are generally poor and that GP practices would not have opportunities to influence policy and practice within NHS Tayside.

Letter to Chairman - NHS Tayside

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Tue 21/05/2019 16:19

To: TAYSIDE, Chairman (NHS TAYSIDE);

1 attachment

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Dear John

Please find enclosed a letter in response to the letter and associated documentation you sent yesterday regarding the Inquiry's interim report.

Regards

David

Chair - Independent Inquiry

Tel 01382 381835

15/16 Springfield
Dundee
DD1 4JE

THE INDEPENDENT INQUIRY into Mental Health Services in Tayside

Independent Chair : David Strang

John Brown CBE
Chairman
Tayside NHS Board

21 May 2019

Dear John

Independent Inquiry – Interim Report

Thank you for your letter of 20 May 2019, accompanied by NHS Tayside's comments on the Independent Inquiry's draft Interim Report. It was useful to speak on the phone yesterday and this morning.

I am grateful for the detailed comments on factual accuracy, some of which have led to amendments to the Interim Report. As you know, the Interim Report has now been finalised and will be published tomorrow, 22 May 2019.

As you know, the Interim Report provides an update on the progress of the Inquiry and identifies the key themes emerging from the initial evidence-gathering phase. Over 1300 people have contributed evidence to the Inquiry, including a significant number of people from NHS Tayside and other organisations in Angus, Dundee and Perth and Kinross.

It has been useful to receive from you the details about plans that have been developed or are in the process of development. In the next stage of the Inquiry, we will examine in more detail how these have led to improvements in service delivery. As they stand, it is not appropriate to include these plans in our emerging themes report. I look forward to receiving further evidence from NHS Tayside during the next phase of the Inquiry.

In relation to our comments about the service redesign transformation programme, I am still of the view that the logical approach is to conduct a comprehensive review of the wider needs of the community, beyond inpatient requirements, before proceeding with the moving or closure of wards.

I would welcome the opportunity to discuss these issues further – and the Interim Report more widely – with you and the Chief Executive.

With best wishes,

David

David Strang
Chair
Independent Inquiry into Mental Health Services in Tayside

Address: **Independent Inquiry into Mental Health Services in Tayside, 15/16 Springfield, Dundee DD1 4JE**

Email: **independentinquiry@dundee.ac.uk** Website: **www.independentinquiry.org** Phone: **01382 381835**