

**THE  
INDEPENDENT  
INQUIRY**

into Mental Health  
Services in Tayside

# Trust and Respect

Final Report of the  
Independent Inquiry into  
Mental Health Services in Tayside

February 2020  
David Strang CBE

# Independent Inquiry and Acknowledgements

## Chair

David Strang was appointed to chair the Independent Inquiry in July 2018. Prior to this he was, for five years, Her Majesty's Chief Inspector of Prisons for Scotland. This followed a 33 year career in the police service - in London and in Scotland. He was Chief Constable of Lothian and Borders Police from 2007 to 2013. He was awarded an Honorary Doctorate from the University of Stirling in 2018, and a CBE in Her Majesty's Birthday Honours in 2019.

## Secretary to the Inquiry

Denise Jackson was seconded to the Independent Inquiry by the University of Dundee in August 2018. She has worked in the University's Library and Learning Centre Services for 26 years, latterly as the Deputy Director. She is also an experienced complaints handler and an accredited mediator with Scottish Mediation.

## Acknowledgements

The Chair would like to thank the following for their contribution to the Independent Inquiry's work:

- All those who gave evidence to the Independent Inquiry - particularly those for whom it was no easy task
- Irene Oldfather, Director of the Health and Social Care Alliance (the ALLIANCE), for convening and supporting the Stakeholder Participation Group
- NHS Tayside staff who contributed to the Employee Participation Group
- The Clinical Advisors to the Independent Inquiry:
  - Paula Shiels, Senior Nurse, Mental Health and Learning Disability
  - Dr Ian Clarke, Consultant Psychiatrist, NHS Greater Glasgow and Clyde
- Samaritans in Dundee and in Perth for their support for people giving evidence to the Independent Inquiry
- The University of Dundee, who hosted and supported the Independent Inquiry
- Bill Nicoll, Director of Strategic Change, NHS Tayside, who acted as the key link between the Independent Inquiry and NHS Tayside
- The Independent Inquiry team for their research and support

# Contents

1. Introduction .....	6
Mental Health in Scotland.....	6
Independent Inquiry into Mental Health Services in Tayside.....	7
How to read this report.....	8
Opportunities .....	9
2. Executive Summary and Recommendations.....	10
Trust and Respect .....	10
What needs to change .....	11
Cross-cutting themes.....	11
Recommendations.....	14
3. Governance and Leadership .....	20
Structure .....	20
Integration of Health and Social Care .....	20
Implications for delivery of services.....	21
Risk Management.....	22
Accountability .....	22
Tayside Mental Health Alliance .....	24
Relationships .....	24
Staff.....	24
Patients and families .....	25
Boards.....	25
Partners and external relationships.....	27
Performance Management .....	27
Record keeping and document management .....	27
Learning Culture .....	28

Adverse event reviews.....	28
Fatal Accident Inquiries (FAI).....	29
Complaints.....	30
Monitoring.....	30
National Scrutiny .....	30
Management of Change.....	31
Lack of implementation of recommendations.....	32
Unplanned changes.....	34
Senior Staffing challenges.....	35
Need for whole system response.....	36
Summary.....	37
Recommendations.....	38
<b>4. Crisis and Community Mental Health Services .....</b>	<b>40</b>
Crisis Resolution Home Treatment Team (CRHTT) .....	41
Access to treatment .....	42
Universities .....	43
Out of hours/NHS 24 .....	44
Centralisation of Service.....	45
CRHTT location.....	46
Police .....	47
Distress Brief Intervention and Sanctuary Support.....	47
Context of Community Mental Health Services in Tayside.....	50
Waiting Times .....	54
Community-based therapies .....	54
Primary care mental health support.....	55
Third Sector .....	55
SAMH.....	56
Summary.....	57
Recommendations.....	57

<b>5. Inpatient Services</b> .....	59
<b>Ward Environment</b> .....	59
Physical environment .....	59
Patient experience .....	60
Staff experience .....	61
Smoking and illegal drugs .....	61
<b>Sense of safety</b> .....	62
Patient experience .....	62
Staff experience .....	62
Control and Restraint .....	63
<b>Availability of Services</b> .....	64
<b>Communication</b> .....	65
On admission.....	65
On discharge .....	65
Communication between services .....	66
Continuity and consistency of care .....	67
Management of Change .....	67
<b>Summary</b> .....	68
<b>Recommendations</b> .....	68
<b>6. Child and Adolescent Mental Health Services (CAMHS)</b> .....	70
<b>CAMHS – NHS Tayside</b> .....	70
Management and Governance .....	70
Services .....	71
The MacX Service (intensive outpatient outreach).....	72
Waiting Times .....	72
Neurodevelopmental Disorders.....	74
Crisis services .....	74
Workforce .....	75
Patient Confidentiality .....	76

Tayside Children’s Collaborative .....	77
Community and Third Sector .....	77
CAMHS Regional Inpatient Unit.....	77
Transition from CAMHS to General Adult Psychiatry (GAP).....	78
Summary.....	79
Recommendations.....	79
<b>7. Staff.....</b>	<b>81</b>
Staff attitude and behaviour.....	81
Workforce (Recruitment and Retention) .....	82
Staff concerns regarding patient safety .....	85
Responsibility.....	86
Accountability.....	87
Service Redesign Programme.....	87
Communication .....	88
Bullying and Harassment.....	89
Training and Supervision .....	92
Summary.....	93
Recommendations.....	94
<b>8. Implementation Plan .....</b>	<b>95</b>
<b>9. Abbreviations .....</b>	<b>97</b>
<b>Appendices .....</b>	<b>99</b>
Appendix A: List of organisations and groups which gave evidence to the Independent Inquiry.....	99
Appendix B: NHS Tayside news update January 2020.....	100
Appendix C: Review of arrangements for investigating the deaths of patients being treated for a mental disorder. Scottish Government, December 2018 (White report).....	104
Appendix D: Right person, right time, right care with no waiting times: Systems dynamics analysis of interim findings of the Independent	

---

Inquiry into Mental Health Services in Tayside and a group model building workshop with student practitioners. ....	106
Appendix E: Responding to Drug Use with Kindness, Compassion and Hope: a report from the Dundee Drugs Commission. Part One: The Report. Conclusions. 16 August 2019. ....	108
Appendix F: Cambridgeshire and Peterborough .....	113
Appendix G: Third sector/community mental health information.....	114
Appendix H: NHS Tayside. Staff vacancies: June 2018 - June 2019.....	123
Appendix I: NHS Tayside Response to NHS Highland / Sturrock Report. BOARD57/2019. Tayside NHS Board. 27 June 2019. ....	124
Appendix J: Adult Mental Health (Inpatient) Services Organisational Development Review: Summary of Diagnostic and Recommendations/ Adult Mental Health Services Organisational Development Plan.....	130

# 1. Introduction

## Mental Health in Scotland

- 1.1 There is no doubt that there has been a marked increase in the awareness of mental health issues in Scotland in recent years. Mental health and wellbeing have received a much-needed greater attention as the subject has moved from the shadows to a position of prominence in public awareness and debate. There is a welcome increased emphasis on recognising and addressing the underlying causes of mental ill-health and providing support and treatment for those affected.
- 1.2 Mental health disorders are the third highest cause of death and disability in Scotland, after heart disease and cancer. Across the UK, mental illness is the top cause of sickness absence from work and accounts for almost half of all ill-health of those under the age of 65<sup>1</sup>. The largest number of deaths of men under the age of 45 in the UK is by suicide. In 2018 in Scotland, 43% of all probable suicides occurred within the 35-54 age range and roughly 75% of these were of men<sup>2</sup>.
- 1.3 Research has shown that poverty increases the risk of mental health problems and can be both a causal factor and a consequence of mental ill-health. Across the UK, both men and women in the poorest fifth of the population are twice as likely to be at risk of developing mental health problems as those on average incomes<sup>3</sup>.
- 1.4 In 2017 the Scottish Government published its ten-year Mental Health Strategy<sup>4</sup>, in recognition of the significance and importance of promoting positive mental health and wellbeing for the whole population. The strategy emphasised the need to improve prevention and early intervention, access to treatment, the physical wellbeing of people with mental health problems, and the promotion of rights, use of information and involvement in planning for all. The strategy acknowledged the changes that had occurred in the previous decade and the excellent work of many people involved in the provision of mental health services across Scotland.
- 1.5 Tayside has seen a “gradual increase in the prevalence of mental health conditions since 2008, as recorded by primary care” according to the Tayside Director of Public Health. More specifically, all three of the local Health and Social Care Partnerships (HSCPs) have given examples of the prevalence of mental health issues in their respective strategic commissioning plans. For example, in Angus 1 in 20 people are affected by depression<sup>5</sup> and in Perth & Kinross, around a quarter of adults experience a mental health episode in a year, from anxiety and depression to “more acute symptoms.”<sup>6</sup> Within Dundee City, there was a 63% increase in hospital admissions for mental health and behavioural disorders between 2013/14 and 2019. Dundee has the fourth highest number of people across Scotland self-

1. NHS Tayside. (2018). Director of public health annual report 2017/18: Mental health and wellbeing. [http://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET\\_SECURE\\_FILE&dDocName=PROD\\_320152&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1](http://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_320152&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1).

2. Scottish Government/COSLA. (2019). Making suicide prevention everyone's business: The first annual report of The National Suicide Prevention Leadership Group. <https://www.gov.scot/publications/national-suicide-prevention-leadership-group-annual-report-2019-making-suicide-prevention-everyones-business/>

3. Mental Health Foundation. (2016). Poverty and mental health: a review to inform the Joseph Rowntree Foundation's anti-poverty strategy. <https://www.mentalhealth.org.uk/publications/poverty-and-mental-health>

4. Scottish Government. (2017). Mental health strategy 2017-2027. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf>

5. Angus Health and Social Care Partnership. Strategic commissioning plan 2019-2022. <http://www.angus.gov.uk/sites/angus-cms/files/2019-04/Report%2020-19%20Strategic%20Commissioning%20Plan%202019-2022%20Appendix%202.pdf>

6. Perth & Kinross Health & Social Care. Strategic commissioning plan 2016-2019. [https://www.pkc.gov.uk/media/38714/Health-and-Social-Care-Strategic-Commissioning-Plan/pdf/2016193\\_strat\\_comm\\_plan\\_CLIENT.pdf?m=636208505265700000](https://www.pkc.gov.uk/media/38714/Health-and-Social-Care-Strategic-Commissioning-Plan/pdf/2016193_strat_comm_plan_CLIENT.pdf?m=636208505265700000)



reporting a mental health condition.<sup>7</sup>

## Independent Inquiry into Mental Health Services in Tayside

1.6 Following widespread concerns raised in the Scottish Parliament in May 2018<sup>8</sup> about the provision of mental health services in Tayside, NHS Tayside commissioned an Independent Inquiry to examine the accessibility, safety, quality and standards of care provided by all mental health services in Tayside.

1.7 A Stakeholder Participation Group (SPG) was established to represent patients, families, carers and third sector organisations, and to enable stakeholders to engage with the Independent Inquiry. The SPG was coordinated and chaired by the Health and Social Care Alliance Scotland (the ALLIANCE), and met regularly with the Independent Inquiry team since its inception.

1.8 The Independent Inquiry was guided by five principles agreed in the Scottish Parliament debate, which were to:

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

1.9 The Terms of Reference for the Independent

Inquiry were finalised after consultation with the SPG and with NHS Tayside staff representatives and were published in September 2018<sup>9</sup>. A public call for evidence was issued across Tayside, which resulted in over 200 submissions of written evidence.

1.10 An Employee Participation Group (EPG) was also established, chaired by a representative from UNISON. The EPG consisted of representatives from all NHS recognised trade unions, professional bodies and employee relations representatives. The EPG conducted a survey of staff working in mental health services in Tayside and submitted a confidential report of the survey to the Independent Inquiry.

1.11 Between September and November 2018, the ALLIANCE held focus groups across the communities in Tayside 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 Independent Inquiry as evidence in December 2018<sup>10</sup>.

1.12 In addition to receiving written submissions, the Independent Inquiry team took oral evidence from individuals and organisations, including patients, families, carers, NHS and local authority employees, health professionals, and statutory and third sector organisations across 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.

1.13 A list of the organisations submitting evidence to the Independent Inquiry is at Appendix A.

7. Dundee Health & Social Care Partnership. Strategic commissioning plan 2019-2022. [https://www.dundeehsc.com/sites/default/files/publications/dhscp\\_strategic\\_plan\\_2019-2022.pdf](https://www.dundeehsc.com/sites/default/files/publications/dhscp_strategic_plan_2019-2022.pdf)

8. Official report of the Scottish Parliament 9<sup>th</sup> May 2018. <http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11516&mode=pdf>

9. The Independent Inquiry into Mental Health Services in Tayside. (2018). Terms of reference. <https://independentinquiry.org/terms-of-reference-for-inquiry/>

10. Health and Social Care Alliance Scotland (2018). The Independent Inquiry into Mental Health Services in Tayside: Hearing the voice of people with lived experience. <https://www.alliance-scotland.org.uk/blog/independent-inquiry-into-mental-health-services-in-tayside-hearing-the-voices-of-people-with-lived-experience/>

- 1.14 The Independent Inquiry published an interim report<sup>11</sup> in May 2019, which identified six key themes emerging from the evidence it had received.
- 1.15 These themes were:
- Patient access to mental health services
  - Patient sense of safety
  - Quality of care
  - Organisational learning
  - Leadership
  - Governance
- 1.16 Subsequent to the interim report, the Independent Inquiry conducted extensive investigation and analysis of the issues which had been identified. This final report of the Independent Inquiry, *Trust and Respect*, has been shaped by the voices of people who have provided evidence, many of whom had felt that their voices were not being heard. Over 1,500 people contributed evidence to the Independent Inquiry, including patients, families, carers, staff, partner organisations, professional bodies, third sector organisations and community representatives.
- 1.17 This report opens with a chapter focusing on *Trust and Respect*. This chapter provides an executive summary of the broad findings of the Independent Inquiry that are fundamental to how Tayside needs to improve mental health services. It elaborates five foundational issues which challenge all areas of service delivery. A table is provided bringing together all the recommendations emerging from the Independent Inquiry.
- 1.18 Governance and Leadership form the first evidence chapter because these are central to the delivery of mental health services in Tayside and where fundamental changes are required.
- 1.19 The next three chapters report the evidence relating to key areas of service provision – Crisis and Community Mental Health Services, Inpatient Services, and Child and Adolescent Mental Health Services (CAMHS). The Staff chapter addresses staffing issues and challenges raised with the Independent Inquiry. Each of these chapters summarises the evidence presented to the Independent Inquiry, together with a summary of what needs to improve and a list of the recommendations.
- 1.20 The final chapter outlines parameters for the development of an effective implementation plan. Whilst it might have been tempting for the Independent Inquiry to provide a checklist of what Tayside needs to do and how to do it, this would have been to miss the point. Rather, a fresh approach is needed, which engages patients, staff, partner organisations and communities in

## How to read this report

- 1.17 This report, *Trust and Respect*, is founded on the extensive evidence provided to the Independent Inquiry by a wide range of stakeholders. The Independent Inquiry received evidence relating to incidents and circumstances which had taken place over many years. The report's conclusions and recommendations are based on multiple sources of confirming evidence from the time period between January 2017 and December 2019. The report includes examples of positive experiences of service delivery, which reflect constructive work across the range of services in Tayside. The Independent Inquiry team were impressed

11. The Independent Inquiry into Mental Health Services in Tayside. (2019). *Interim report: inquiry update and emergent themes*. <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>

redesigning the services which are required.  
New voices need to be heard.

## Opportunities

- 1.22 The publication of this final report of the Independent Inquiry represents a major opportunity for Tayside to develop and put in place world class mental health services. Tayside's NHS Board and the Health and Social Care Partnerships, together with support from the Scottish Government, are in a position to tackle the underlying barriers to progress and to make the radical changes necessary. Tayside has the potential to become an attractive place for mental health service professionals to work, where the population are served with commitment and passion. The prize is the restoration of public confidence in mental health services, where staff at all levels are confident, supported and inspired by hope and ambition.

## 2. Executive Summary and Recommendations

### Trust and Respect

- 2.1 The provision of healthcare is fundamentally a relational activity. The successful delivery of healthcare services depends on good levels of trust between healthcare providers and patients, their families and carers.
- 2.2 However good the technical skills, expertise, facilities and environment available to patients, these will be insufficient for the delivery of effective health outcomes unless they operate in the context of well-functioning relationships.
- 2.3 Such constructive relationships need to operate at all levels and between all organisations involved in the provision of healthcare services. The key relationships essential for successfully delivering mental health services are between patients and healthcare professionals, between staff and NHS Tayside, between separate disciplines within healthcare, and between partner organisations, such as local authorities, Integration Joint Boards, third sector agencies, and Police Scotland.

### Trust

- 2.4 Three essential elements of trust relate to ability, reliability and motivation. Firstly, does the person believe that the provider has the skills, capacity, knowledge and ability to deliver what is required? Secondly, does the person trust that the provider will do what is required - that they will reliably deliver? And thirdly, does the person trust the integrity and honesty of the provider - that they are well-motivated to act with transparency and openness?

### Breakdown of trust

- 2.5 It is clear from the evidence presented to the Independent Inquiry that there has been a breakdown of trust in many aspects of the provision of mental health services in Tayside. Whilst there are undoubtedly examples of good relationships which have led to positive outcomes for patients and staff, there have been too many instances of relationships across Tayside which have suffered as a result of a lack of trust. For example:
- The shortage of consultant psychiatrists has undermined patients' belief that NHS Tayside are able to deliver the treatment and care they require.
  - As a result of NHS Tayside not always delivering what they say they will, a number of people do not have confidence in NHS Tayside. People see a gap between the stated values of the organisation and the behaviours they observe.
  - Some staff do not trust the organisation's motivation, experiencing a culture of fear and blame. They see a failure of the organisation to take responsibility, and evidence of defensiveness and lack of transparency.

### A lack of respect

- 2.6 Trust is built on the foundation of treating others with respect. The essential elements of respect include attitudes and actions. Whether someone perceives that they are being treated with respect will be as a result of the behaviour of the other person. Such behaviour patterns include how they are spoken to, the extent to which they are listened to and how reliable and truthful

are the messages communicated to them. This can be particularly challenging for staff when they feel that the respect is not reciprocated.

“the enemy” and not to be respected for their different roles.

## What needs to change

- 2.7 All people affected by or involved in the provision and receipt of mental health services should feel respected. This includes patients, families and carers; staff at all levels and in all disciplines and professions; partner organisations; elected representatives; community groups.
- 2.8 When people are treated with respect they feel listened to, valued, involved, consulted, and encouraged to participate. Concrete behaviour patterns should reinforce these values.
- 2.9 The Independent Inquiry team has received widespread evidence of a lack of respect in a range of relationships. Patients, families and carers have been described by some staff as troublesome, antagonistic, problematic and not to be trusted.
- 2.10 Many staff do not feel that they are listened to or their views seriously sought and respected. There are examples where people have put forward constructive suggestions, but these have been ignored or disregarded. This results in staff feeling they are undervalued, disempowered and less inclined to contribute positively to improvements.
- 2.11 It is apparent that there is hostility between professional groupings, with a lack of respect for the decisions and approach of different disciplines. There is a history of managers blaming clinicians and clinicians blaming managers.
- 2.12 Between organisations there are problematic relationships, such as between NHS Tayside, Integration Joint Boards and local authorities. Tensions are evident too in the relationships with the Scottish Government. Too often politicians and representatives of the media are seen as
- 2.13 A radical, new approach to restoring and building trust is urgently needed. This requires a change to the organisational culture in order to demonstrate openness, transparency and honesty, where all individuals are treated with respect, dignity and kindness. Each person should feel that they are valued and listened to. This will lead to positive, trusting relationships. Many of the solutions will lie within the staff and wider stakeholder groups - but only if they are listened to.
- 2.14 The prevailing culture should demonstrate a commitment to admitting errors, apologising early and seeking reconciliation and restoration of the relationship when these are damaged. There should be clear processes for dispute resolution and responding to conflict, which seek to listen to the other person and understand their position.
- 2.15 An attitude of candour should be evident, where those in authority choose to be open, transparent and honest - not when they are forced to, but because it is the right thing to do. Organisational integrity is the foundation on which trust is built.
- 2.16 A breakdown in trust and a loss of respect has undoubtedly led to poor service, treatment, patient care and outcomes. The breakdown in trust and respect is caused by the lack of effective, engaged strategic leadership and planning.
- 2.17 The challenges facing mental health services in Tayside have not just arisen in recent years; they are of a long-standing nature. Consequently, the changes that are

## Cross-cutting themes

required cannot occur overnight.

2.18 This Independent Inquiry report is intended to help a new direction to be set for mental health services in Tayside, which will lead to improvements in the services and outcomes for patients and communities. Following the publication of the Independent Inquiry's interim report<sup>12</sup> in May 2019, the issues discussed in this final report should not come as a surprise. Most of these issues were identified in the interim report. There have been opportunities to implement changes since May 2019, but these have only happened to a limited extent.

2.19 From the evidence received and the further research and analysis conducted by the Independent Inquiry team, five cross-cutting themes have emerged, which are the key areas which Tayside needs to address to improve mental health services.

### 1. Strategic Service Design

2.20 In recent years (and probably for many years prior), too much focus has been placed on short-term issues, to the detriment of long-term strategic planning. Whilst of course there will always be a need to address short-term and urgent issues as they arise, this should not mean that the necessary focus on long-term and strategic issues is neglected. Additionally, there has been too much focus on inpatient services to the detriment of wider community mental health services, where the vast majority of patients are treated.

2.21 Long-term planning is required to address the changing shape of the mental health services workforce. There needs to be a fundamental service redesign which will take into account the much-reduced level of consultant psychiatrists and focus on the wider needs of the whole community, with an emphasis on prevention and early intervention.

### 2. Clarity of Governance and Leadership Responsibility

2.22 It is acknowledged that whilst the governance arrangements for the planning and delivery of mental health services are complex, there is a lack of clarity about the current arrangements which hinders good governance and effective leadership. Too often, the complexity of governance arrangements is cited as a reason why decisions cannot be made in good time. Additionally, some managers feel that these arrangements disempower them from decision-making and are used more to identify fault and blame.

2.23 Between the four public sector organisations with key responsibility for the delivery of mental health services (NHS Tayside and the three Health and Social Care Partnerships), there needs to be a shared understanding of governance arrangements and leadership responsibilities in a way that is mutually supportive and accepted. Where the arrangements prevent this, they should be adjusted accordingly. A shared understanding of the governance arrangements should lead to greater cooperation and constructive engagements between the parties involved.

### 3. Engaging with People

2.24 It was apparent to the Independent Inquiry that there are many committed and dedicated staff working in mental health services in Tayside, but whose potential is not being realised. Many of these people felt frustrated that their voices were not being heard and felt that they were undervalued by some of those leading the services. Patients and carers too felt that they were not listened to or, worse, that they were not respected nor taken seriously. Some third sector organisations said that they were often marginalised.

2.25 Good relationships lie at the heart of the design and delivery of effective mental

12. The Independent Inquiry into Mental Health Services in Tayside. (2019). *Interim report: inquiry update and emergent themes*. <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>



health services. There needs to be much greater genuine engagement with people who are closely involved in or affected by the delivery of mental health services.

#### 4. Learning Culture

- 2.26 A learning organisation should use every opportunity for feedback to learn from incidents and events. On too many occasions, Tayside has adopted a defensive position, giving the impression of wanting to protect its reputation at all costs. Front-line staff feel that the organisation is more interested in identifying who is to blame and attributing fault than genuinely learning in a supportive environment. Patients, families and carers were told that they would be invited to contribute to a review following an adverse event, but were then not involved.
- 2.27 A culture of greater openness and commitment to learning needs to be developed, so that the gap between sound policies and their implementation is reduced.

#### 5. Communication

- 2.28 Public confidence in mental health services is a precious commodity. It is built on a relationship of trust and respect, where people engaging with services believe that there is organisational integrity. There has been a breakdown in trust in Tayside, between organisations, partners, staff, patients, families, carers and communities.
- 2.29 To restore a relationship of trust, a new approach to communication is required, which is based on treating others with respect, openness and transparency.

## Recommendations

2.30 The following table lists all the recommendations by chapter from the Independent Inquiry and identifies the cross-cutting themes associated with each recommendation.

Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
<i>Governance and Leadership</i>					
1. Develop a new culture of working in Tayside built on collaboration, trust and respect.		X	X		X
2. Conduct an urgent whole-system review of mental health and well-being provision across Tayside to enable a fundamental redesign of mental health and wellbeing services for Tayside.	X	X			
3. Engage with all relevant stakeholders in planning services, including strong clinical leadership, patients, staff, community and third sector organisations and the voice of those with lived experience.	X	X	X		X
4. Establish local stakeholder groups as a mechanism for scrutiny and improvement design to engage third sector, patients' representatives and staff representation.		X	X		X
5. Review the delegated responsibilities for the delivery of mental health and wellbeing services across Tayside, to ensure clarity of understanding and commitment between NHS Tayside and the three Integration Joint Boards. This should include the decision to host General Adult Psychiatry inpatient services in Perth & Kinross Integration Joint Board.	X	X			
6. Ensure that Board members (NHS and Integration Joint Boards) are clear about their responsibilities, confident and empowered to challenge and make sound decisions. Review their selection, induction and training processes in preparation for their important role.		X	X		
7. Provide sufficient information to enable board members to monitor the implementation of board decisions.		X			X
8. Deliver timely, accurate and transparent public reporting of performance, to rebuild public trust in the delivery of mental health and wellbeing services.			X		X



Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
9. Clarify responsibility for the management of risks within NHS Tayside and the Integration Joint Boards, at both a strategic and operational level.		X			
10. Ensure that there is clarity of line management for all staff and that all appraisals are conducted effectively.		X	X	X	X
11. Ensure that the policy for conducting reviews of adverse events is understood and adhered to. Provide training for those involved where necessary. Ensure that learning is incorporated back into the organisation and leads to improved practice.		X		X	
12. Conduct a national review of the assurance and scrutiny of mental health services across Scotland, including the powers of Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland.		X			
<i>Crisis and Community Mental Health Services</i>					
13. Ensure that there is urgent priority given to strategic and operational planning of community mental health services in Tayside. All service development must be in conjunction with partner organisations and set in the context of the community they are serving.	X	X	X		
14. Consider developing a model of integrated substance use and mental health services.	X	X			
15. Develop comprehensive and pertinent data-capture and analysis programmes, to enable better understanding of community need and service requirement in the community mental health teams.	X			X	
16. Prioritise the re-instatement of a 7 day crisis resolution home treatment team service across Angus.	X	X			
17. Review all complex cases on the community mental health teams' caseloads. Ensure that all care plans are updated regularly and there are anticipatory care plans in place for individuals with complex/challenging presentations.	X				

Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
18. Plan the workforce in community mental health teams in the context of consultant psychiatry vacancies with the aim to achieve consistent, continuous care provision across all community services.	X	X			
19. Prioritise the development of safe and effective workflow management systems to reduce referral-to-assessment and treatment waiting times. This should also include maximum waiting times for referrals.	X	X			
20. Consider the development of a comprehensive Distress Brief Intervention training programme for all mental health staff and other key partners to improve pathways of care for individuals in acute distress.		X	X		
21. Foster closer and more collegiate working relationships between the crisis resolution home treatment team and community mental health teams and other partner services, based on an ethos of trust and respect.		X	X	X	X
22. Develop clear pathways of referral to and from university mental health services and the crisis resolution home treatment team.	X		X		X
<b>Inpatient Services</b>					
23. Develop a cultural shift within inpatient services to focus on de-escalation, ensuring all staff are trained for their roles and responsibilities.		X	X	X	
24. Involve families and carers in end-to-end care planning when possible.			X		X
25. Provide clear information to patients, families and carers on admission to the ward, in ways which can be understood and remembered.			X		X
26. Make appropriate independent carer and advocacy services available to all patients and carers.					X
27. Provide adequate staffing levels to allow time for one-to-one engagement with patients.	X	X	X		
28. Ensure appropriate psychological and other therapies are available for inpatients.	X	X			
29. Reduce the levels of ward locking in line with Mental Welfare Commission for Scotland guidelines.	X	X			

Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
30. Ensure all inpatient facilities meet best practice guidelines for patient safety.	X	X			
31. Ensure swift and comprehensive learning from reviews following adverse events on wards.		X		X	
32. A national review of the guidelines for responding to substance misuse on inpatient wards is required.	X	X			
<b>Child and Adolescent Mental Health Services</b>					
33. Focus on developing strategies for prevention, social support and early intervention for young people experiencing mental ill-health in the community, co-produced with third sector agencies.	X	X	X		
34. Ensure that rejected referrals to Child and Adolescent Mental Health Services are communicated to the referrer with a clear indication as to why the referral has been rejected, and what options the referrer now has in supporting the patient.			X	X	X
35. Ensure the creation of the Neurodevelopmental Hub includes a clear care pathway for treatment, with the co-working of staff from across the various disciplines not obfuscating the patient journey. The interdisciplinarity of the hub may give rise to confused reporting lines or line management structures/ governance issues. A whole system approach must be clarified from the outset.		X			X
36. Clarify clinical governance accountability for Child and Adolescent Mental Health Services.		X			
37. Support junior doctors who are working on-call and dealing with young people's mental health issues.		X			X
38. Ensure statutory confidentiality protocols for children and young people are clearly communicated to all staff. The protocols should also be shared with patients and families at the outset of their treatment programme, so that parents and carers know what to expect during the course of their child's treatment.		X	X		X

Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
39. Consider the formation of a service for young people aged 18 - 24, in recognition of the difficulties transitioning to adult services and also recognising the common mental health difficulties associated with life events experienced during this age range. This may reduce the necessity for these patients to be admitted to the adult in-patient services.	X	X			
40. Ensure comprehensive data capture and analysis systems are developed to appropriately manage waiting lists and service users' expectations. Work should be undertaken to look at what data is available and what could be useful to inform decision making on service development/monitoring of services. This should be aligned to national reporting requirements.	X	X			
41. Consider offering a robust supportive independent advocacy service for parents and carers of young people who are engaged with Child and Adolescent Mental Health Services. This may include carer support groups.		X	X		
<b>Staff</b>					
42. Ensure all staff working across mental health services are given opportunity to contribute to service development and decision-making about future service direction. Managers of service should facilitate this engagement.	X	X	X		X
43. Prioritise concerns raised by staff by arranging face-to-face meetings where staff feel listened to and valued.		X	X	X	X
44. Arrange that all staff are offered the opportunity to have a meaningful exit interview as they leave the service. This applies to staff moving elsewhere as well as those retiring.		X	X	X	X
45. Prioritise recruitment to ensure the Associate Medical Director post is a permanent whole-time equivalent, for at least the next 2 years whilst significant strategic changes are made to services.	X	X			
46. Encourage, nurture and support junior doctors and other newly qualified practitioners, who are vulnerable groups of staff on whom the service currently depends.		X	X		X

Recommendations	Strategic Service Design	Clarity of Governance and Leadership Responsibility	Engaging with People	Learning Culture	Communication
47. Develop robust communication systems both informally and formally for staff working in mental health services. Uses of technology are critical to the immediacy and currency of communications.		X	X		X
48. Ensure that bullying and harassment is not tolerated anywhere in mental health services in Tayside. Ensure that staff have confidence that any issues or concerns they raise, will be taken seriously and addressed appropriately.		X	X	X	X
49. Ensure there are systems analysis of staff absences due to work-related stress. These should trigger concerns at management level with supportive conversations, taking place with the staff member concerned.		X	X	X	X
50. Ensure there are mediation or conflict resolution services available within mental health services in Tayside. These services should exist to support and empower staff in the rebuilding of relationships between colleagues, between managers and their staff, and between the services and the patients, during or after a period of disharmony or adverse event. This includes NHS Tayside's mental health services' relationship with the local press.		X	X	X	X
51. Ensure that all external review processes are embraced wholeheartedly and viewed as an opportunity to learn and develop. Managers should ensure that all staff receive details of the recommendations from reviews and are included in the analysis and implementation.	X	X	X	X	X

# 3. Governance and Leadership

- 3.1 Governance and leadership lie at the heart of the Independent Inquiry's final report because good governance and leadership are central to the effective delivery of mental health services in Tayside. Essential elements of governance and leadership inevitably shape how mental health services are planned and delivered. This chapter includes the structures which support the delivery of mental health services, the management of change, performance management, organisational learning and the impact of the quality of relationships between and within organisations.
- 3.3 As a result, some mental health services are currently delegated to the three Integration Joint Boards (IJB), whilst others are retained within the responsibility of NHS Tayside. The underlying rationale for these arrangements in 2015/16 is not clear; the Independent Inquiry was informed that decisions had been taken with limited consideration of the options and implications.

## Structure

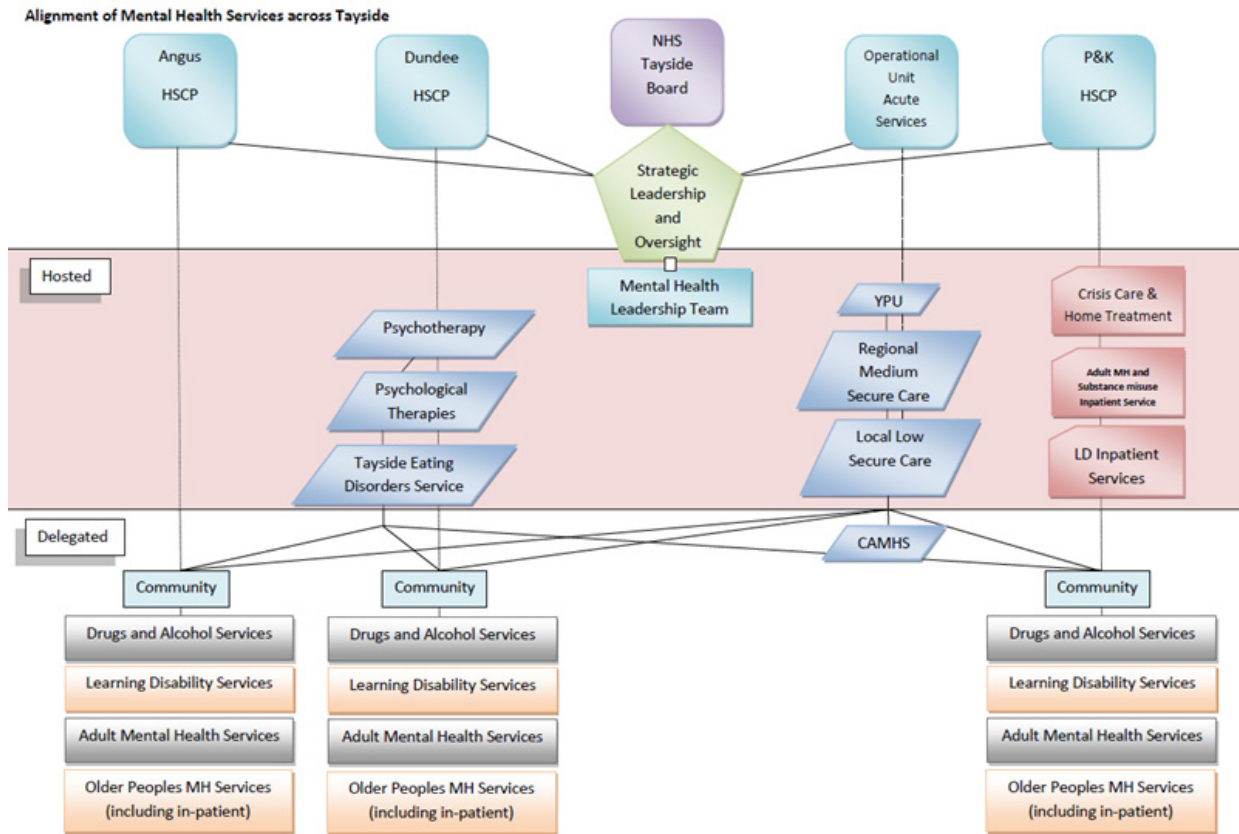
### Integration of Health and Social Care

- 3.2 The current structures of the organisations responsible for the delivery of mental health services in Tayside are a product of the integration of health and social care (Public Bodies (Joint Working) (Scotland) Act 2014<sup>13</sup>) and came into full operation in 2016. The resulting three Integration Joint Boards (IJB) are formed by joint representation of members of NHS Tayside together with members of the three respective local authorities – Angus, Dundee, and Perth & Kinross. In December 2017 the Audit Committee of NHS Tayside resolved that two distinct models of governance should operate in Tayside. Within Angus and Dundee, the governance of the delivery of delegated functions would be undertaken by the IJB. Within Perth & Kinross, the responsibility for delivery, including for hosted services, would remain with the parent bodies (Audit86/2017)<sup>14</sup>.

13. <http://www.legislation.gov.uk/asp/2014/9/contents/enacted>

14. Tayside NHS Board. Audit Committee. 14 December 2017. [Tayside NHS Board Integration Joint Board Governance](#). AUDIT86/2017.

Figure 1: NHS Tayside, schematics illustrating the alignment of functions and accountabilities across mental health: Alignment of mental health across Tayside<sup>15</sup>



3.4 As an example of the complexity of the arrangements for leadership in mental health services, the following describes the management of consultant psychiatrists. *“The Consultant grade medical workforce for inpatient care, crisis care/home treatment and community mental health services (CMHS) is managed on a region-wide basis by Perth & Kinross IJB via the hosted Mental Health and Learning Disability functions. However, day-to-day CMHS are managed within the three IJBs, who retain full accountability for the delivery of safe and effective services.”*<sup>16</sup> The complex interdependencies between different elements of service mean that difficulties within one component of service can lead to challenges in related areas.

3.5 Integration arrangements are intended to encourage positive joint working,

shared commitments and a common understanding and approach to tackling challenges. In practice, it is apparent that these differing arrangements add complexity to the governance mechanisms and do not aid clear lines of accountability and responsibility, resulting in a fragmentation of services and accountability.

### Implications for delivery of services

3.6 The Independent Inquiry found that in Tayside there was a widespread lack of clarity regarding responsibility for commissioning, delivery and performance monitoring of mental health services. Senior officers told the Independent Inquiry that they did not have confidence in the capacity of these complex and complicated

15. Evidence provided by NHS Tayside in 2019.

16. Evidence provided by NHS Tayside in 2019.



arrangements to enable the effective delivery of services.

IJB.

- 3.7 This perspective is reflected in the submission of the Royal College of Psychiatrists in Scotland (RCPS)<sup>17</sup> to the Independent Inquiry:

*“Our members strongly believe that there is a lack of leadership and governance and feel there is a considerable lack of accountability within services. The service’s structure is so unclear that there are no obvious lines of responsibility and governance from the top management, leading to a deficit of managerial oversight at present and a management vacuum. We have heard that there is little or no line management for some staff.”*

- 3.8 In 2019 Healthcare Improvement Scotland (HIS) and the Care Inspectorate (CI) reported on the effectiveness of strategic planning for services to adults in Perth & Kinross Health and Social Care Partnership.

*“The allocation and arrangements for hosted services were an area of difficulty for the partnership. The need for transformation of mental health inpatient services had already been identified when the service was delegated...”*

*“These hosted service arrangements placed a pressure and resource requirement on the partnership which impacted on capacity to focus on other aspects of integration. It was widely recognised as a contributing factor to the slow pace of integration.”<sup>18</sup>*

- 3.9 Senior officers from both NHS Tayside and Perth & Kinross IJB told the Independent Inquiry that they did not agree with or understand the decision to host mental health inpatient services in Perth & Kinross

## Risk Management

- 3.10 The responsibility for managing risks is an important element of improving the services. It requires an unambiguous clarity of responsibility. In Tayside there is uncertainty about the processes for risk management and the risks do not sit with people who are able to respond effectively to them. Strategic risks remain the responsibility of NHS Tayside, but the operational risks for mental health services are the responsibility of the three Health and Social Care Partnerships (HSCPs) and the Acute Services Unit. This can be an arbitrary distinction and does not provide the necessary clarity of responsibility. NHS Tayside’s response to the Independent Inquiry interim report<sup>19</sup> identifies at least five governance bodies with responsibility for risk management: Clinical Quality Forum, Strategic Risk Management Group, Clinical and Care Governance Committee, Audit Committee and the Tayside NHS Board.

## Accountability

- 3.11 The Independent Inquiry received evidence that the current governance arrangements create difficulties at multiple levels. NHS Tayside staff complained that the idiosyncratic arrangements across the three IJBs make them difficult to engage with.
- 3.12 At an operational level, senior practitioners felt that they did not have the means to make decisions effectively. *“We are at the mercy of the three IJBs”* *“We can’t make decisions; the IJBs are in charge.”* (senior NHS Tayside staff). IJB members argued that: *“NHS Tayside are quick to pass the buck when things go wrong”* and quoted the example of NHS Tayside’s response

17. Evidence provided by RCPS in 2019.

18. Healthcare Improvement Scotland and Care Inspectorate. (2019). *Joint inspection (Adults). The effectiveness of strategic planning in Perth and Kinross Health and Social Care Partnership.* [http://www.healthcareimprovementscotland.org/our\\_work/inspecting\\_and\\_regulating\\_care/joint\\_inspections\\_strat\\_com/perth\\_and\\_kinross\\_sep\\_19.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/joint_inspections_strat_com/perth_and_kinross_sep_19.aspx)

19. The Independent Inquiry into Mental Health Services in Tayside. (2019). *Interim report: inquiry update and emergent themes.* <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>



to Carseview Centre BBC TV programme *Breaking Point*<sup>20</sup> July 2018.

- 3.13 This ambiguity undermines staff morale and commitment as suggested by the RCPS<sup>21</sup>:

*“The Royal College of Psychiatrists in Scotland have, for some time now, been very concerned about the growing problems faced by the mental health services in NHS Tayside. Our members tell us of long-term disengagement between senior management and coal-face clinicians in the health board and – more recently IJBs.”*

- 3.14 Non-Executive Members (NEM) of the Tayside NHS Board have an important role to play in providing effective scrutiny and support for NHS Tayside. To perform this function effectively, there needs to be a good level of trust and cooperation between all the members of the Board. It was apparent to the Independent Inquiry team that there was a lack of trust between Non-Executive and Executive Members. NEMs felt that they were not treated with respect and that their requests for information and briefings were ignored. At the Tayside NHS Board meeting in June 2019, NEMs said that they had previously asked for (a) a copy of the organisational structure for mental health services (b) board papers to be issued with sufficient notice in advance and (c) a copy of the single consolidated mental health action plan. None of these had been provided. This was one example of many requests which the NEMs described to the Independent Inquiry team.

- 3.15 NEMs said they learnt of what was happening in NHS Tayside from what they read in the news or saw in the media, rather than coming from NHS Tayside direct. Board papers frequently amounted to over 500 pages, which NEMs felt were overwhelming. They did not feel equipped to challenge what they were being told by executive members. NEMs expressed the view that they were not able to take an informed position on subjects where they

were told that there were no real options for them to consider. This raises the question of how well new NEMs have been inducted, trained and prepared for this important role of governance of NHS Tayside and other health and social care business.

- 3.16 There are inevitably complexities in the delivery of such an important public service as the provision of health services. One of the consequences of the governance arrangements is the range of responsibilities which individual people are required to consider. A local authority councillor who is a member of the health board will be used to taking responsibility for making decisions affecting one particular local authority area; their role on the IJB or the health board requires them to consider matters which affect all three local authority areas in Tayside. Legitimate questions can be raised about the potential for conflicts of interest between responsibilities towards a local authority area and Tayside wide interests. Whilst the local authority members also have responsibilities within the health governance structures, a senior member of staff of NHS Tayside pointed out,

*“It’s NHS Tayside that will always be held accountable and answerable to ministers.”*

- 3.17 Following the BBC TV programme *Breaking Point* in July 2018, the Scottish Government set out the respective responsibilities of the IJBs and NHS Tayside as follows:

*“In practice, in this shared responsibility framework, the IJBs may wish to seek assurance from NHS Tayside as to how it, as the employer of staff delivering services, intends to investigate what has happened, how it intends to keep IJBs informed of its findings, and what action NHS Tayside will take to put right any matters that need to be addressed. The IJBs will then need to assure themselves that NHS Tayside’s plans are appropriate in line with the requirements set out in the Public Bodies (Joint Working) (Scotland) Act 2014.”*

20. <https://www.bbc.co.uk/programmes/b0b98nsd>

21. Evidence provided by RCPS August 2019.

- 3.18 There needs to be greater clarity about the responsibility for holding to account those who are responsible for delivering the services – in both the IJBs and in NHS Tayside.

## Tayside Mental Health Alliance

- 3.19 With the intention of addressing the apparent difficulties which the governance structures presented, in early 2019 it was proposed that a new structure, a Tayside Mental Health Alliance, should be established “to act as a key enabler for NHS Tayside and the three HSCPs to support the continuous improvement of mental health services across Tayside.”<sup>22</sup> The Alliance was intended to be a formal strategic and decision-making alliance between NHS Tayside and the three partnerships. The first meeting of the Alliance took place in June 2019, with meetings held in each subsequent month. Progress has been made in developing plans for reviewing pathways for patients in relation to a number of different conditions. The work of the Alliance would be enhanced if active membership included service users with lived experience, carers and third sector representatives.
- 3.20 By November 2019 the Terms of Reference and Memorandum of Understanding for the Alliance had been broadly established, but the finalised wording had yet to be agreed and was due to be approved at the Perth & Kinross IJB meeting in December 2019<sup>23</sup>. There remains a need to clarify how responsibility for decision-making can be delegated from the IJBs to the Tayside Mental Health Alliance, particularly on contentious issues.

## Relationships

- 3.21 In any organisation, people thrive on encouragement and appreciation. They work well where they feel that they are supported by good leadership. This includes having a clear sense of direction and purpose, well-defined job roles and responsibilities, sufficient training, resources and the time required to fulfil their responsibilities. There should be clear accountability structures, with identifiable line managers who are able to support and direct where necessary. Staff should be empowered to take responsibility for contributing to improving outcomes.

## Staff

- 3.22 Across Tayside many people felt that they were not treated with respect and were not valued. The high turnover of senior staff contributed to the deterioration of the quality of relationships at work. Staff widely reported a number of shortcomings in how they felt they were treated. Some did not know who their line manager was and were not informed when there was a change of line manager. This led to a lack of clarity about reporting lines. Those who did know who their line manager was felt that there was a lack of interest in listening to their views. Emails were not responded to and their views were ignored or not requested.

*“I can’t get senior people to listen.”*

- 3.23 On account of the high number of locum psychiatrists, trainee doctors were not able to receive the supervision they needed without continuity from suitably qualified psychiatrists. The RCPS view was that when concerns had been raised with senior management, they had been ignored. Letters to senior post-holders either received no response or a response that matters were “in hand”.

22. Evidence provided by NHS Tayside in July 2019.

23. Perth and Kinross Integration Joint Board. 17 December 2019. [The Tayside Mental Health Alliance](#). G/19/206

*“There has also developed a culture of fear and concern with regard to whistleblowing, as staff fear being reprimanded. This has led clinicians to have lost confidence in the system. Members report having been misled about recruitment of staff taking place at a national level and not in Tayside. A lack of honesty and transparency, and much misunderstanding, has developed within the mental health services in Tayside.”*

- 3.24 Staff felt that the critical reports in the media about inpatient services in Tayside had made their jobs harder and had had a negative impact on morale.

*“There had also been inquiries into the quality of care provided in the inpatient units. These highly publicised inquiries have had a damaging effect on staff morale.”<sup>24</sup>*

## Patients and families

- 3.25 The high number of locums working in psychiatry provided a particular challenge for patients, who experienced a frequent change of health professional and a lack of continuity of care. This made many patients feel badly treated. Where families, patients and carers felt that they were not listened to or they were misled in what they were told, this led to a breakdown in trust between the individual and the organisation.
- 3.26 A level of suspicion was evident in relation to patients, their families and carers, particularly when they requested information from NHS Tayside. The initial response from NHS Tayside seemed to be to not disclose information, rather than being open and transparent with information. There will, of course, be circumstances where disclosure would be inappropriate, but where non-disclosure is the default option, this can lead to a deterioration of trust and makes potential recipients more suspicious and less trusting of the organisation’s official position.

- 3.27 Written communication from NHS Tayside and from the IJBs was often poorly constructed. Formal jargon and official language were a barrier to clear communication. That Tayside had a “below Scotland average suicide rate” may have been factually accurate, but should not have been included in a letter to a bereaved family. Similarly, references to a patient experiencing “vanilla depression” left the family in the dark about what was being communicated.

- 3.28 A significant number of patients had experienced written communication from NHS Tayside or the IJBs which they knew from their own experience did not accurately reflect the facts known to them. Adverse event reviews in particular had been a source of dissatisfaction for patients, families and carers. Patients’ families had received letters from NHS Tayside informing them that they would be invited to attend an adverse event review meeting, but they then heard nothing more. Where they had attended a review meeting, the content of some of these reports did not match the patients’ or families’ recollection of events. They therefore concluded that the organisation was trying to rewrite history in a way that would show them in a more favourable light. There is a real danger of a perception that NHS Tayside is more interested in protecting its reputation than looking after the interests of its patients.

- 3.29 A lack of confidence in complaints handling, and the conduct and grievance processes was expressed both by patients and by staff.

## Boards

- 3.30 The Independent Inquiry received widespread evidence of poor relationships within the Tayside NHS Board and with other organisations across Tayside. It was apparent to the Independent Inquiry team that documents considered at

24. Healthcare Improvement Scotland and Care Inspectorate. (2019). Joint inspection (Adults). The effectiveness of strategic planning in Perth and Kinross Health and Social Care Partnership. [http://www.healthcareimprovementscotland.org/our\\_work/inspecting\\_and\\_regulating\\_care/joint\\_inspections\\_strat\\_com/perth\\_and\\_kinross\\_sep\\_19.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/joint_inspections_strat_com/perth_and_kinross_sep_19.aspx)

the Tayside NHS Board or IJB meetings sometimes presented an over-optimistic view, giving the impression of reassurance to board members, when such assurances were not appropriate. Some reports were criticised by members for presenting the strengths and risks of the options in a very one-sided way – i.e. all the strengths of the recommended action with no risks articulated, whilst at the same time articulating all the risks of the actions not recommended, with none of the strengths. Such reports undermined the validity and integrity of the arguments proposed.

3.31 It is understandable why someone might wish to present a positive response to events and circumstances, but when these result in board members being misled about factual positions, this becomes completely unsatisfactory.

3.32 The Mental Health Strategy Update<sup>25</sup> paper presented to the Tayside NHS Board in June 2019 is such an example. The four logos on the cover suggested that this was a paper to which the three HSCPs had contributed, but this was not the case. There were a number of inaccuracies in this paper, the results of which were likely to have misled the Board members into believing that more progress had been made than was the case. This related to the Tayside Mental Health Alliance (p3), the Mental Health Clinical Design Authority (p6), the Tayside Mental Health Leadership Team (p7), the Mental Health Improvement Action Plan (p9), Engagement and Communications (p11) and the Mental Health Stakeholder Engagement Group (p11).

3.33 Similarly, in July 2019 a previously publicised public meeting of Perth & Kinross IJB had been declared private at short notice. Members of the public who had attended did not understand the decision to make it a private meeting. The consequences were that this further undermined trust in the IJB

as an open and transparent organisation and impacted negatively on public confidence in the IJB.

3.34 There has been a high turnover of members of the Tayside NHS Board, with knock-on consequences for membership of the IJBs. Since April 2018 there have been four Chairs and three Chief Executives. In the same time there has been a significant turnover of non-executive members. This represents a substantial loss of corporate memory on the Board. There has also been a significant turnover of IJB chairs and membership in this period.

*“The IJB was at an early stage in developing its capacity to lead on strategy and direction for the partnership. It had experienced a high rate of membership turnover, with 34 voting members since its inception in 2016. The involvement of NHS Tayside members had been particularly inconsistent. The Associate Nurse Director was filling a non-executive vacancy, but had not attended meetings. The IJB had a full quota of four elected members. Encouragingly, the voting members on the IJB were motivated and enthusiastic, and keen to fulfil their role in direction and scrutiny of the partnership.”<sup>26</sup>*

*“The board membership has changed significantly since 1 April 2018, with 11 members leaving (nine non-executive members and two executive members) and 15 members being appointed (12 non-executive members and three executive members). This has resulted in significant changes to committee membership and chairs. NHS Tayside has supported new board members through a variety of training and development activities.”<sup>27</sup>*

25. Tayside NHS Board. 27 June 2019. [Transforming Tayside Mental Health Strategy Update](#). BOARD57/2019

26. Healthcare Improvement Scotland and Care Inspectorate. (2019). [Joint inspection \(Adults\). The effectiveness of strategic planning in Perth and Kinross Health and Social Care Partnership](#). [http://www.healthcareimprovementscotland.org/our\\_work/inspecting\\_and\\_regulating\\_care/joint\\_inspections\\_strat\\_com/perth\\_and\\_kinross\\_sep\\_19.aspx](http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/joint_inspections_strat_com/perth_and_kinross_sep_19.aspx)

27. Auditor General. (2019). [The audit of NHS Tayside 2018/19](#). <https://www.audit-scotland.gov.uk/report/the-201819-audit-of-nhs-tayside>

## Partners and external relationships

- 3.35 Partner organisations, including local authorities, considered that NHS Tayside did not engage well with partnership planning. NHS Tayside either failed to attend or were represented by someone who was too junior in the management structures and had no authority to make decisions.
- 3.36 It was evident that there was a particularly deep mistrust of the media, which was perceived as having an axe to grind. Staff told the Independent Inquiry team that they did not feel that NHS Tayside represented their views sufficiently in the media, with some saying that they felt they had been “thrown to the wolves” or “*thrown under a bus*”. Senior staff said that they felt unable to contribute to public meetings of the Tayside NHS Board or IJBs because of the presence of reporters from the media. Such an attitude of mistrust leads to an absence of openness and transparency, thereby fuelling the suspicions that the authorities are seeking to hide or obscure the facts.

## Performance Management

- 3.37 Effective management of performance requires robust and timely information and data to support decision making and judgement. Scrutiny should be delivered through consistent and thorough reviews of adverse events, Fatal Accident Inquiries (FAI) and complaints procedures. These are only effective where feedback is welcomed and there is robust monitoring and follow-up.
- 3.38 A gap between what is set out in policy and what happens in operational practice indicates poor performance management. In Tayside there are numerous examples of well-developed policies which are not followed in practice.

## Record keeping and document management

- 3.39 Throughout the lifetime of the Independent Inquiry, NHS Tayside have consistently struggled to provide documents which have been requested by the Independent Inquiry. Examples include Local Adverse Event Reviews (LAERs), Significant Clinical Event Analysis (SCEAs), action plans, and terms of reference. Long delays in responding to such requests raised the question of whether these related to an inability to provide the documentation or an unwillingness to do so. What became clearer as time went on was that many documents were not suitably stored or identified for access and retrieval, raising serious questions about the ability of NHS Tayside to track and monitor policy implementation.
- 3.40 Given the scale of the changes proposed within mental health services, the quantity and quality of mental health service reports to the Tayside NHS Board were quite limited. A greater level of performance data would have been required to ensure that there was meaningful scrutiny and monitoring of performance improvement in mental health services.
- 3.41 In 2017<sup>28</sup>, HIS identified a lack of fluency, capability and capacity with regard to quality improvement. In particular there was a lack of accurate data to drive improvement. The establishment of a Quality Improvement Team has led to greater involvement of front-line staff in initiatives to improve the quality of service for inpatients. The Mental Health Quality Improvement Programme is a whole system programme designed to assist adult mental health services in Tayside to improve performance across a range of different aspects of service provision.

28. Evidence provided by Healthcare Improvement Scotland of their correspondence with NHS Tayside following HIS's June 2017 visit.



## Learning Culture

- 3.42 An organisation committed to continuous learning and driving improvements must have robust systems in place for reviewing adverse events and learning from experience. This needs to be done within a supportive and non-blame culture. Such learning can come from complaints systems, formal external reviews, internal reviews and staff-initiated enquiries. In particular, the Independent Inquiry team examined three opportunities for organisational learning: adverse event reviews, Fatal Accident Inquiries and complaints.
- 3.43 This is an area where Tayside needs to improve its practice. A number of staff told us that they would welcome more openness in the scrutiny of the services provided in Tayside. Honest scrutiny is a powerful tool leading to improvements in service.
- 3.44 The culture of fear extended to the conduct of adverse event reviews, where there was a perception that the purpose was to apportion blame, rather than seek genuine organisational learning. The Independent Inquiry was told that some clinicians would not participate in such reviews unless they were accompanied by a legal representative. Some witnesses who gave evidence to the Independent Inquiry asked if it could be guaranteed that their giving evidence would not get back to their employer.
- 3.45 Many staff did not feel empowered to contribute to solutions. When they have had constructive views on improving the service, they have not put these forward. *“What’s the point? I wouldn’t be listened to. I wouldn’t get a reply.”* Even those in leadership positions of authority felt disempowered from leading and making decisions. *“I have no power or authority to tell others what to do.”* In addition, the disempowerment led to an attitude that it was somebody else’s responsibility, even if it was not clear who that somebody else was.
- 3.46 The outgoing Interim Associate Medical Director (AMD) for Mental Health in 2018 was requested by NHS Tayside to write a report of his views on what was needed to tackle the serious challenges facing the mental health services in Tayside. He submitted his report by November 2018, complete with recommendations for improvement. Eight months later the mental health leadership team in Tayside was unaware of this report and had not considered its contents. This represented a serious loss of opportunity to learn from the experience of the outgoing AMD and ideas for improving the service. Likewise, exit interviews with departing staff should be seen as an important source of views on the service and organisation.

## Adverse event reviews

- 3.47 Reviews of adverse events present an opportunity for constructive lessons to be learnt to improve the delivery of mental health services. Whilst the recently revised policy published in 2019 was thorough and comprehensive, the delivery of such reviews was found to be poor in many cases. The policy was not adhered to in terms of timescales and participants. Staff were not clear about the process and purpose of such reviews. Some were fearful of the consequences of attending adverse event reviews, fearing that its main purpose was to identify who was to blame.
- 3.48 In many cases, such reviews identified some actions to be taken or recommendations for system improvements. However, there were no clear processes for deciding whether such recommendations were to be approved and who was responsible for (a) implementing them and (b) monitoring that they had been implemented.
- 3.49 For many families, the adverse event reviews did not deliver what they had been led to expect. Some were told that they would be invited to participate in an adverse event review, but subsequently did not hear anything about such a review taking place. Where families had participated,

some reported that the review report did not accurately reflect the facts of the case or what was said at the review meetings.

- 3.50 Finalised reports were often incomplete, with key questions left unanswered, such as:

*“Could this have been avoided? Yes/No”.*

- 3.51 Such failings seriously undermined confidence in the integrity of the process and, more importantly, in NHS Tayside. HIS reviewed the Adverse Event Review policies of health boards in Scotland in 2019. They found that NHS Tayside were unique [among health boards] in not providing copies of adverse event reviews to families and carers unless they ask for them.
- 3.52 In October 2019 the Independent Inquiry team requested a copy of a report from an adverse event review for an event which had occurred in Carseview Centre in August 2017. The review report was delivered to the Independent Inquiry team in December 2019, dated December 2019. The family had not been involved in the review and had no knowledge it had taken place.
- 3.53 It was clear that there was not an easily accessible record of all LAERs and SCEAs in Tayside. If these were not readily available, it was hard to see how there could be consistent learning across the whole of Tayside from such adverse event reviews. A consultant psychiatrist provided the Independent Inquiry team with an analysis of recommendations from LAERs and SCEAs over a five-year period, which the consultant themselves had conducted. It was found that in less than five per cent of the recommendations could there be confidence that they had been implemented.

## Fatal Accident Inquiries (FAI)

- 3.54 Responsibility for deciding whether or not a Fatal Accident Inquiry should be held following the death of a patient rests with the Crown Office and Procurator Fiscal Service. The Scottish Fatalities Investigation Unit carry this responsibility (amongst others). The purpose of the FAI is to establish the circumstances of the death and to consider what steps (if any) might be taken to prevent other deaths in similar circumstances. The sheriff may make recommendations to the authorities in order to prevent similar future deaths. The purpose is not to establish civil or criminal liability. These are, therefore, opportunities to learn lessons and to improve the delivery of mental health services. In reality, very few deaths of patients lead to FAIs, it often being thought that the local reviews will have identified the lessons well in advance of a formal FAI.
- 3.55 Where there is to be an FAI, it can take many years from the death for the FAI to be held. In one Tayside case, it has taken more than five years to proceed to an FAI. Long delays reduce the value of the learning and place an intolerable burden on both the families and on the staff involved. Delays can be caused by the need to obtain expert evidence from medical specialists. It is not always transparent why one case should merit an FAI, when another death in apparently similar circumstances does not. This is hard for families to understand. When the death of a patient occurs who is compulsorily detained in hospital, there is no statutory requirement for an FAI (as there is for people who die in a prison in Scotland). The White Report<sup>29</sup> recommended a number of significant improvements to how the deaths of patients should be investigated. These are included in Appendix C.

29. Scottish Government. (2018). *Review of arrangements for investigating the deaths of patients being treated for a mental disorder*. <https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/5/>

## Complaints

- 3.56 Complaints should provide a rich source of information about how the service is performing and how it might be improved. Many people who have complained about mental health services in Tayside have been dissatisfied with how their complaints regarding standards of care and treatment have been addressed. The system does not appear to be designed around the needs of complainants.
- 3.57 Bureaucratic processes result in complaints being redirected to other organisations (such as from NHS Tayside to the relevant IJB). There can be long delays in responding to complaints, and letters of reply sometimes contain insensitive and inappropriate comments about the circumstances of the complaint. Most marked is the very defensive attitude towards dealing with complaints.
- 3.58 Dismissive comments have been expressed by NHS Tayside staff about people who make complaints or pursue legal action. They have been treated with suspicion and questions have been raised about their motivations for raising a complaint.
- 3.59 A number of investigations by the Scottish Public Services Ombudsman (SPSO) into mental health services in Tayside have identified the inadequacy of Tayside's internal complaints procedures. In these cases, significant failings were identified by the SPSO, when Tayside had not upheld any of the complaints. This is echoed by staff who report a lack of confidence in how allegations of bullying, lack of integrity or underperformance are addressed under NHS human resource policies.
- 3.60 All of these are indicative of missed opportunities to learn from experience and to improve the performance within mental health services.

## Monitoring

- 3.61 In relation to mental health services there was a limited availability of relevant and accurate information for those who were charged with driving improvements. Board members were not always equipped with the relevant information to enable them to fulfil their role of scrutiny and support. Actions that had been approved by the Board were not necessarily completed and there was not a robust system in place to report back on progress or variation of implementation from the approved plan.
- 3.62 Reports from HIS, the MWCS (Mental Welfare Commission for Scotland) and the SPSO contained recommendations for NHS Tayside to implement. These were often accepted by NHS Tayside at the time of the reports' publication, but there was not a systematic process in place to ensure that these recommendations were implemented or that progress was monitored. There needs to be a clear process in place to identify the response to review recommendations and whether such recommendations are being accepted or rejected.
- 3.63 Following the broadcast of the BBC TV programme *Breaking Point*<sup>30</sup> in July 2018, an internal review of Carseview Centre was conducted by senior NHS Tayside staff. A report<sup>31</sup> was produced, containing eleven recommendations for action, not all of which had been implemented (by October 2019). There was a lack of a clear mechanism for monitoring or scrutinising the implementation of these recommendations and no real clarity as to which were the responsibility of NHS Tayside and which of the IJB.

## National Scrutiny

- 3.64 At a national level there is limited scrutiny and oversight of mental health service delivery in Scotland. There is

30. <https://www.bbc.co.uk/programmes/b0b98nsd>

31. Evidence provided by NHS Tayside in 2019. [Report on mental health services provided at Carseview Centre, Dundee. November 2018.](#)



not a system of assurance for mental health services across Scotland. While organisations such as HIS and the MWCS make recommendations following their visits or reviews, they do not have any powers of enforcement to ensure that these recommendations are implemented. Similarly, there are no mechanisms for ensuring that the recommendations made by a sheriff in the determination of an FAI are implemented or monitored. There appear to be no consequences for the Board if they publicly accept such recommendations but do not proceed to implement them. This raises the question of whether these oversight and scrutiny bodies should have stronger powers to monitor the result of their recommendations.

*“We have put forward a range of recommendations that are intended to help NHS Tayside secure further improvements in the local service. The review team acknowledges the steps that NHS Tayside has put in place to strengthen the mental health service in recent months and the further work that is under way.*

*We have asked NHS Tayside to provide a detailed improvement plan and we will follow up to ensure that progress is made so that patients in Tayside continue to see further improvements in the quality of mental health services.”* Review team chair, HIS inspection of Carseview Centre, 2014<sup>32</sup>

- 3.65 Although the word “ensure” is used, HIS would not appear to have any real power to do so. They carried out a further two reviews in 2017<sup>33 34</sup> and a follow-up visit in 2018<sup>35</sup>, identifying similar issues to those initially observed in 2014.
- 3.66 The Sharing Intelligence Group (SIG), co-convened by NHS Education for Scotland

(NES) and HIS meets regularly to review the information, data and intelligence on each health board. The group comprises NES, HIS, the CI, Audit Scotland, SPSO and the MWCS. It was an alert to the SIG which triggered the visits to Carseview Centre by HIS and the MWCS in November and December 2017.

## Management of Change

- 3.67 Poor performance in mental health services in recent years in Tayside has led to significant external scrutiny. This has resulted in a programme of recommended improvements at both strategic and operational levels. It is disheartening for those involved in the delivery of services and – more importantly – for patients and communities, that there is not more evidence of effective change and transformation in the services.
- 3.68 Since 2017 – and possibly over a longer time period – Tayside has had a poor record of implementing coherent changes to its organisation and delivery of mental health services. There is evidence of credible plans being approved, but these plans not being comprehensively implemented.
- 3.69 On the other hand, a number of changes have taken place, often at short notice in response to a perceived urgency of need, where the planning and management of these changes have been poor.

32. Healthcare Improvement Scotland. (2014). *Findings and recommendations from a review of concerns presented to the National Confidential Alert Line: NHS Tayside*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/responding\\_to\\_concerns/nhs\\_tayside\\_jul\\_14.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/responding_to_concerns/nhs_tayside_jul_14.aspx)

33. Evidence provided by Healthcare Improvement Scotland of their correspondence with NHS Tayside following HIS's June 2017 visit.

34. Healthcare Improvement Scotland. (2018). *Review of adult mental health services in Tayside, 7-9 December 2017*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)

35. Healthcare Improvement Scotland. (2018). *Progress meeting (June 2018) following Healthcare Improvement Scotland review of Mental Health Services in Tayside (Dec 2017)*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)

## Lack of implementation of recommendations

3.70 The following are three examples of recommendations which were not implemented effectively:

### 1. Mental Health and Learning Disability Services Redesign Transformation Programme<sup>36</sup>

The most striking example of a planned change having an unsatisfactory journey related to what was entitled the ‘Mental Health and Learning Disability Services Redesign Transformation Programme’ when it was initiated in 2017.

Rather than being a programme designed to transform mental health services in Tayside, this was described to the Independent Inquiry team as a proposal to change “*beds and sites*”. In reality, it was a plan to manage the assets – wards, beds and staff – rather than a more fundamental strategic plan to tackle the serious challenges which were facing mental health services in Tayside. Its focus was solely on mental health and learning disability inpatient facilities and did not cover the wider issues affecting community mental health services, psychiatry of old age or CAMHS (Child and Adolescent Mental Health Services).

The Independent Inquiry team received evidence that there was widespread dissatisfaction about the consultative process in arriving at the decision to centralise adult inpatient beds in the wards at the Carseview Centre. Both staff and patients’ representative groups felt that the consultation was not genuine and had been tokenistic. The process lacked the confidence of staff, patients, families, community groups and partner organisations. The final decision was perceived as having been made without proper consideration of all the relevant information, data, options, resources and impact. Many respondents said that the NHS Tayside had already made up their mind before the consultation process began.

The final decision to implement the chosen option (3a) was made at the meeting of the Perth & Kinross IJB in January 2018<sup>37</sup>. The decision had not been implemented by the time of the publication of the Independent Inquiry’s Interim Report in May 2019.

3.71 Programme management throughout the changes has been poor, with milestones missed and actions not completed. Seemingly ad hoc alterations to the plan were introduced (such as the decision not to relocate Learning Disability Assessment Unit patients from Carseview Centre to Strathmartine).

36. <https://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthServiceRedesignTransformationProgramme/index.htm>

37. Perth and Kinross Integration Joint Board. 26 January 2018. [Mental Health and Learning Disability Service Redesign Transformation \(MHLDS-RT\) Programme Consultation](#). G/18/7

2. By June 2019, it was still recognised that a new Tayside-wide mental health strategy was urgently required.

An NHS Tayside and IJBs paper was presented at the Tayside NHS Board meeting in June 2019<sup>38</sup>, entitled “*Mental Health Services in Tayside – Mental Health Strategy Update*”. This stated that “... *the pace and scale of change required is significant. It is essential to set the strategic direction, design the future shape of the service and support, build the capability and capacity to provide assurance around the delivery of change and improvement.*”

In September 2019 a paper was presented to the Perth & Kinross IJB, entitled “*Adult Mental Health and Learning Disability; Service Redesign Programme Progress Report and Risk Review Paper*”<sup>39</sup>.”

This stated that “*The Tayside Mental Health Alliance has been established and tasked with mapping out the end-to-end clinical pathways for mental health services to ensure that the people of Tayside receive the best possible mental health and wellbeing, care and treatment, with a focus on early intervention and reducing stigma.*”

“*It is acknowledged that end-to-end redesign of mental health care and treatment pathways is required.*”

- 3.72 Despite the stated intentions of NHS Tayside and the IJBs to conduct a full review, this has not yet been undertaken. When the Independent Inquiry interim report was published in May 2019<sup>40</sup>, it emphasised the urgency of completing such a review in order to enable the planning of future services needed by the population of Tayside. Seven months on, this work remains incomplete.

### 3. General Medical Council Enhanced Monitoring

In the period since 2016, concerns had been raised about the training of junior doctors following visits from the General Medical Council and the East of Scotland Deanery. Concerns were initially focussed on Murray Royal Hospital in 2016, but were extended after further visits to include Tayside-wide General Adult Psychiatry. Following visits in 2017 and 2018, improvements had not been implemented, so the decision was taken to place NHS Tayside into enhanced monitoring status. Despite five visits and reports, training for junior doctors had not improved, particularly in relation to their supervision and on-call arrangements. Many of the locum psychiatrists were not in a position to provide the supervision required for trainees.

Normally when training is placed in enhanced monitoring, this would lead to improvements in the training and supervision arrangements. This had not happened in Tayside, with the risk of special conditions being applied or the removal of training of junior doctors in psychiatry completely. It is concerning that the training arrangements for junior doctors had not appeared to improve, despite the findings from the Deanery visits. The report from the latest Deanery visit in October 2019 included 13 requirements requiring action within six months, seven of these requirements having been continued from the previous visit in January 2019<sup>41</sup>.

38. Tayside NHS Board. 27 June 2019. [Transforming Tayside Mental Health Strategy Update](#). BOARD57/2019

39. Perth and Kinross Integration Joint Board. 27 September 2019. [Adult Mental Health and Learning Disability; Service Redesign Programme Progress Report and Risk Review Paper](#). G/19/159

40. The Independent Inquiry into Mental Health Services in Tayside. (2019). [Interim report: inquiry update and emergent themes](#). <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>

41. NHS Education for Scotland. (2019). [Scotland Deanery quality management visit report: General adult services, Tayside](#). Date of visit: 9<sup>th</sup> October 2019. <https://www.scotlanddeanery.nhs.scot/media/311194/191009-final-visit-report-pan-tayside-mental-health-web-version.pdf>.

## Unplanned changes

3.73 In contrast to the examples above, where planned improvements were not implemented satisfactorily, the Independent Inquiry team was made aware of a number of situations where changes had taken place, often at short notice in response to a perceived urgency of need, but where the planning and management of these changes had been poor. Where such changes had been expedited at short notice, there had been insufficient time to consult fully and develop options for careful consideration by the appropriate governing mechanisms.

3.74 Tayside NHS Board members and senior staff in both NHS Tayside and the relevant IJBs have felt these short notice decisions have been presented as *faits accomplis*,

with little real opportunity for scrutiny, challenge or decision making. *“Senior clinicians advised us that we had no choice but to accept their recommendation for reasons of patient safety.”* NHS Tayside Non-Executive Board Member

3.75 In particular a number of short-notice changes had been made in the last three years in relation to the closure of wards, without a process of consultation and consideration of options to generate confidence in the validity of the decisions made. The closure of the Mulberry Ward at Stracathro and its move to Carseview Centre in February 2017, the amalgamation of two wards at Murray Royal Hospital and the closure of the Craigowl Ward at Strathmartine all follow this pattern of short-notice changes which did not allow comprehensive consultation and planning.

### 1. Closure of the Mulberry Ward at Stracathro and move of the ward to Carseview Centre in February 2017.

This closure (described by NHS Tayside as a relocation, not a closure) was implemented at short notice as a contingency measure, on account of a shortage of suitably qualified medical staff. Staff, patients and families were given very short notice of the move. The result was that staff were required to travel to and from Carseview Centre from Angus, a distance of 35 miles, an arrangement which continued for more than two years. The ward environment at Carseview Centre was considerably poorer than that at Stracathro. The MWCS commented on the negative impact of the move on patients in their report of their visit in November 2017<sup>42</sup>. *“When the Mulberry Unit was based at Stracathro Hospital it was in a new build facility, with plenty of space and good access to gardens. The environment in Mulberry Unit at Carseview is more cramped and is much less attractive. We heard comments from both staff and patients about the fact that the building is much less comfortable and pleasant. Patients in Mulberry Unit also do not have the same ready access to a secure garden area which patients in Ward 1 and 2 have.”* At the time, NHS Tayside indicated that the move was a temporary one and that the ward at Stracathro would be reoccupied. It remains empty to date.

### 2. Amalgamation of two wards at Murray Royal Hospital

This again happened at very short notice and without consultation with senior medical staff, patients or families. There was not a detailed plan for these changes nor an indication of how they fitted in with the wider strategic developments for mental health services in Tayside.

42. Mental Welfare Commission for Scotland. (2018). *Report on unannounced visit to: Wards 1, 2 and the Mulberry Unit at Carseview Centre.* 4 Tom McDonald Avenue, Dundee DD2 1NH. Date of visit: 22 November 2017. <https://www.mwscot.org.uk/sites/default/files/2019-06/carseview-acute-admission-wards.pdf>

### 3. Closure of Craigowl Ward at Strathmartine

Once again, this was a contingency move, arranged at short notice, without full consultation with staff, patients and families. Many staff found out via Facebook that this was happening. The empty ward has been described not as “closed” but as “non-operational”. Senior medical staff were opposed to the closure and relocation of the patients to Bridgefoot wards because of the detrimental impact on the patients affected. Following these changes, the sickness absence levels of the staff increased, compounding the problems caused by staff shortages.

- 3.76 These short notice changes had the effect of undermining the confidence of the staff, patients and families that changes to the provision of mental health services in Tayside would be widely consulted on and implemented with a well devised plan.
- 3.77 Because of what is perceived as poor communication by NHS Tayside and the IJBs with staff, patients, families, carers and partner organisations, including statutory and third sector, consultation processes do not command respect and confidence. Many staff feel that they are either not consulted, or, if they are, that their views will be disregarded. Genuine consultation must be grounded in integrity and openness. To approach it in any other way is to undermine trust in the process and is worse than doing no consultation whatsoever.
- 3.80 A contributory factor will have been the lack of continuity in senior posts in recent years and the level of vacancies in key posts in 2019. Since (and including) 2017, there have been four AMDs for Mental Health and Learning Disability in Tayside. Some have been appointed as interim posts, the last two being part-time only. The post-holder in 2018-19 found that it was not possible to fulfil the strategic requirements of the role on a part-time basis on account of the operational demands on the post. The Independent Inquiry interim report stated at 4.5.2 *“The lack of a full-time Associate Medical Director for mental health services exacerbates the line management difficulties.”*<sup>43</sup>
- 3.81 In the HIS recommendations after their June 2017<sup>44</sup> review, one of their deliverables was:

### Senior Staffing challenges

- 3.78 The Independent Inquiry frequently heard that the need for the short-term urgent changes was as a result of a shortage of psychiatrists in Tayside – and that this was a common problem across Scotland and throughout the UK.
- 3.79 The serious shortage of consultant psychiatrists in Tayside and the resulting requirement to rely on locum staff to fill these responsibilities represents a major risk for the future of mental health services. The response to these shortages has not been strategic and coordinated.
- 3.82 A new AMD was appointed in September 2019, but on a part-time basis only. The previous two AMDs were of the view that the role needed to be full-time.
- 3.83 The level of vacancies in key posts has grown throughout 2019. In addition to an absence of an AMD for Mental Health from June to September, by November there were vacancies in lead clinician posts in all three GAP (General Adult Psychiatry) services, CAMHS, Learning Disability and there was no AMD in POA (Psychiatry of Old Age).

*“Full time Associate Medical Director employed who is a psychiatrist and has experience in leading organisational turnaround.”*

43. The Independent Inquiry into Mental Health Services in Tayside. (2019). *Interim report: inquiry update and emergent themes*. <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>

44. Evidence provided by Healthcare Improvement Scotland of their correspondence with NHS Tayside following HIS's June 2017 visit.

3.84 Additionally, there were significant vacancies in consultant psychiatry posts. In September 2019<sup>45</sup> the position was as follows:

Eight services with no substantive consultant psychiatrists

- Dundee Community Mental Health Team West
- Angus Community North
- Rehabilitation inpatient ward
- Intensive Psychiatric Care Unit at Carseview Centre
- Crisis Care and Home Treatment Service
- Moredun Ward at Murray Royal Hospital
- Ward 1 at the Carseview Centre
- Perth South Community Health Team

3.85 It is important to note that there were some examples of good leadership across Tayside. Amongst others, there were areas of good practice identified in Psychiatry of Old Age and Forensic services. The Young People's Inpatient Unit at Dudhope Terrace had also received positive reports, including from the MWCS's visit in July 2019<sup>46</sup>.

3.86 It is clear that Tayside mental health services have suffered from poor strategic leadership in recent years. This may have been true for longer, but the Independent Inquiry has only looked in detail at leadership since 2017. HIS worked with NHS Tayside during 2017 to assist them to identify and address the particular challenges facing mental health services at that time. Their report identified a number of challenges facing Tayside's General Adult Psychiatry Services, particularly in relation to leadership and culture.

3.87 These challenges included:

- "Leadership culture - everyone in the

system thinks the problems are someone else's fault; micromanaging and highly controlling; decisions being imposed with no team involvement or discussion; staff feeling belittled and dismissed; confrontational behaviours both verbally and in emails; poor behaviour of consultants reported by junior medical staff and non-medical staff; culture of fear and blame; risk averse culture; culture of fire-fighting with little headspace to think."

- "Leadership structure and roles - staff don't understand the Mental Health leadership structures; lack of clarity about who is making what decisions; quite significant differences in cultures and issues across the three IJBs; lack of forums for professional leaders; inability of the external [HIS] team to identify the key operational and decision making groups; consistent theme of managers blaming doctors and doctors blaming managers; sense of division between the NHS and the IJBs with both sides appearing to blame the other for the current state of services; no clear vision for mental health services across Tayside."

## Need for whole system response

3.88 The proposed reconfiguration of General Adult Psychiatry Mental Health Services requires a whole system response to mitigate the risks associated with the reduced inpatient capacity and reduced consultant grade medical workforce across Tayside's local community services.

3.89 There is no simple solution to addressing the current risks and challenges that General Adult Psychiatry services are facing. Analysis of capacity, demand and activity has failed to highlight any single solution. The high levels of patient occupancy across the inpatient unit, access and waiting time issues within the community mental health teams and growing demands into overstretched crisis care services indicate a whole system response is required.

45. Evidence provided by NHS Tayside in 2019.

46. Mental Welfare Commission for Scotland. (September 2019). Report on announced visit to: Dudhope Young People's Unit, 17 Dudhope Terrace, Dundee DD3 6HH. Date of visit 9 July 2019. [https://www.mwscot.org.uk/sites/default/files/2019-09/Dudhope\\_YoungPer-sonsUnit\\_20190709a.pdf](https://www.mwscot.org.uk/sites/default/files/2019-09/Dudhope_YoungPer-sonsUnit_20190709a.pdf)



3.90 In August 2019 and initiated by the Independent Inquiry, a participatory group model-building workshop took place with student practitioners and quality improvement managers working in NHS Tayside's mental health services. This was led by an external facilitator with expertise in healthcare systems improvement. In the workshop, participants focused on five of the themes highlighted in the Independent Inquiry's interim report published in May 2019<sup>47</sup>, (patient access to care, patient sense of safety, quality of care, organisational learning and governance) and identified areas of fragility and those suitable for improvement (Appendix D).

## Summary

3.91 As described in the Governance section above, there is an urgent need for the development of a long-term strategic review of the requirements for mental health services across Tayside. Until the outcomes of such a review are known, it is impossible to make sensible plans for managing the significant changes which are required. Without a proper assessment of the needs of the population of Tayside for mental health services, any changes can only be piecemeal and may not fit in with the longer-term plans which will emerge. It seems that the attention and effort of the leadership team has focused on trying to resolve the immediate problems with the result that there has not been the capacity to invest in the longer-term strategic planning that is required.

3.92 Good governance lies at the heart of any well-functioning public service. This is particularly true when a number of organisations have to work together; without good governance there would be scope for confusion, duplication, overlap and gaps.

3.93 Similarly, within a single organisation good governance is necessary to ensure

there is clarity about responsibilities, roles, accountability, performance and risk management. The distinctive functions and responsibilities of executive and non-executive members are important to understand, so that there is effective challenge and support, founded on relevant, accurate and up-to-date information and data, to enable proper decisions to be made and those decisions implemented and monitored. Clear values of transparency, integrity and honesty need to be demonstrated at every stage and by all people involved in the system.

3.94 Whether it is from the complexity of the governance and decision making arrangements or from a breakdown in relationships between NHS Tayside and IJB staff, there is a clear need for a restatement of the responsibilities for commissioning, decision making, delivery, accountability, performance management and risk management. To work successfully, the integration of health and social care must be built on good relationships, positive attitudes and constructive behaviours. The structure itself cannot guarantee effective outcomes, nor can the flaws in delivery be attributable solely to the integration structures.

3.95 The most striking failure of governance of mental health services in Tayside is the lack of a mental health strategy. In the light of the reduction in the availability of consultant psychiatrists and the requirements for providing care and treatment for patients with mental ill health in the community, there is a pressing need for a significant redesign of how mental health treatment and services are to be delivered in the 21<sup>st</sup> century in Tayside. There needs to be a strategy to deliver a whole system, end-to-end, multi-disciplinary, radical transformational redesign of mental health services.

3.96 In relation to the requirement for a strategic plan to address the need for a mental health

47. The Independent Inquiry into Mental Health Services in Tayside. (2019). *Interim report: inquiry update and emergent themes*. <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>

strategy for Tayside, two observations need to be made. Firstly, it was disingenuous to suggest that the fact of senior staff leaving was a cause of the need for urgent change; what should have been seen was that the departure of so many senior psychiatrists was a symptom of deeper problems within mental health services in Tayside, a result of the poor management of services and people and of poor strategic planning. Secondly, the shortfall of psychiatrists in Tayside and Scotland had not suddenly occurred in recent years. This had been happening over a number of years and was predictable from an analysis of ages and retirement patterns, and of recruitment rates to the profession.

- 3.97 There is a need for senior medical, nursing and allied health care professional leadership to be involved in shaping the development of a sustainable service model for mental health services in Tayside. To be enabled to fulfil these responsibilities it is essential that they have sufficient training, support and time allowed in the job planning process. NHS Tayside have indicated that they are moving towards a model of leadership which is “*clinically led and managerially supported*”. This is to be welcomed within the context of wider leadership development.
- 3.98 Any changes to services, organisational structures or operational procedures should be well planned and managed. Enough time should be included in all change management plans, to enable sufficient consultation with all relevant people and organisations. Consultation should be as wide as necessary and should be meaningful and genuine. Plans should identify clear actions, with timescales, resources and responsibilities articulated.
- 3.99 Implementation of plans should be regularly monitored to enable progress against plans to be assessed. The completion of actions and milestones should be reported at agreed timescales. This enables actions and decisions to be reviewed where necessary.
- 3.100 Positive relationships are fundamental to the delivery of good leadership. Continuity in post can be important for staff and for patients in mental health services. This contributes to effective performance management, appraisal and welfare support. Trust can then be built up in a supportive and open environment. The cultures in an organisation are the product of the values and behaviours – such as openness, transparency and integrity. The quality of relationships within an organisation and with partner organisations has an impact on the quality of service which the community and patients experience. Good communication forms a vital part of developing a positive culture (relationships). All people should feel that they are treated well. Other characteristics of a thriving service might be trust, cooperation, collaboration, inclusion and a learning organisation.
- 3.101 A learning organisation is committed at every level to learning from events and takes every opportunity to listen to feedback from others, so that performance and services can be improved. This is essential for the prevention of future 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. Tayside needs to develop a culture of being willing to listen to others and to learn from experience in order to improve practice.

## Recommendations

1. Develop a new culture of working in Tayside built on collaboration, trust and respect.
2. Conduct an urgent whole-system review of mental health and wellbeing provision across Tayside to enable a fundamental redesign of mental health and wellbeing services for Tayside.
3. Engage with all relevant stakeholders in planning services, including strong clinical



- leadership, patients, staff, community and third sector organisations and the voice of those with lived experience.
4. Establish local stakeholder groups as a mechanism for scrutiny and improvement design to engage third sector, patients' representatives and staff representation.
5. Review the delegated responsibilities for the delivery of mental health and wellbeing services across Tayside, to ensure clarity of understanding and commitment between NHS Tayside and the three Integration Joint Boards. This should include the decision to host General Adult Psychiatry inpatient services in Perth & Kinross Integration Joint Board.
6. Ensure that board members (NHS and Integration Joint Boards) are clear about their responsibilities, confident and empowered to challenge and make sound decisions. Review their selection, induction and training processes in preparation for their important role.
7. Provide sufficient information to enable board members to monitor the implementation of board decisions.
8. Deliver timely, accurate and transparent public reporting of performance, to rebuild public trust in the delivery of mental health and wellbeing services.
9. Clarify responsibility for the management of risks within NHS Tayside and the Integration Joint Boards, at both a strategic and operational level.
10. Ensure that there is clarity of line management for all staff and that all appraisals are conducted effectively.
11. Ensure that the policy for conducting reviews of adverse events is understood and adhered to. Provide training for those involved where necessary. Ensure that learning is incorporated back into the organisation and leads to improved practice.
12. Conduct a national review of the assurance and scrutiny of mental health services across Scotland, including the powers of Healthcare Improvement Scotland and the Mental Welfare Commission for Scotland.

# 4. Crisis and Community Mental Health Services

- 4.1 Crisis and community mental health services are key to supporting the mental wellbeing of the population. This is evident in Scottish Government's Mental Health Strategy 2017-2027 which identified three actions relating to unscheduled care:
- 4.2 Scottish Government: Mental Health Strategy 2017-2027<sup>48</sup>
- Access to treatment and joined-up, accessible services
  - Tackling inequalities in unscheduled care
 

*“Action 13: Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them.”*

*“Action 14: Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services.”*
  - Workforce
 

*“Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.”*
- 4.3 Mental health services in Tayside consist of CAMHS: child and adolescent under the age of 18 years (16 if not in secondary education); GAP: individuals between the age of 18 and 65 years (16-18 if not in secondary education) and POA: individuals over the age of 65 years. These services are provided by both community and crisis mental health teams.
- 4.4 In recent years, NHS Tayside service development and management strategy for mental health has been focused on inpatient services (6% of the patients in mental health), with staff in the CMHTs (Community Mental Health Teams) feeling increasingly neglected as they struggle to support the remaining 94%.
- 4.5 Community and crisis services should develop as a whole system and not as separate entities. This would reduce service fragmentation and silo-working of teams. It is critical that crisis provision complements and supports the wider mental health and wellbeing strategies across communities and adopts a trauma-informed approach whilst embracing all the components of a compassionate community service.
- 4.6 Community mental health can be unpredictable and complex and for that reason should be a focus of attention for managers of services. In terms of funding, community provision should be a priority. Ensuring there are appropriate services in the community will address the ‘upstream’ challenges of supporting early intervention and prevention of more complex mental health issues.
- 4.7 However because requirements of community services are difficult to predict, to do so, the CMHTs require detailed knowledge of the community they are serving - with comprehensive data made available to them to enable them to produce very clear strategies for appropriate service provision. Indeed, there is a requirement for all statutory and voluntary services to have a thorough knowledge of the communities they are serving. NHS Tayside,

48. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf>

in conjunction with the three Health and Social Care Partnerships, should empower communities through co-productive methods to sustain services across the region.

- 4.8 Crisis services have been a continuing key theme in the Independent Inquiry's evidence gathering. Recent evidence received by the Independent Inquiry from patients, families and carers raised repeated concerns about the centralisation of crisis services to Dundee from Angus and Perth & Kinross. The impact of the loss of these services in Angus and in Perth & Kinross is also felt by the police who immediately saw an increasing pressure on their services.
- 4.9 Effective local delivery of crisis and community services is essential to support Tayside's increasing demand on mental health services. These services should develop in conjunction with national service providers e.g. NHS 24; Police Scotland; Scottish Ambulance Service, as well as third sector agencies.
- 4.10 The NICE clinical guideline CG136<sup>49</sup> lists the following quality statements:
- People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship [QS4]
  - People can access mental health services when they need them [QS6]
  - People using mental health services who may be at risk of crisis are offered a crisis plan [QS9]
  - People using mental health services feel less stigmatised in the community and NHS, including within mental health services [QS15]
- 4.11 The evidence provided to the Independent Inquiry showed that mental health services in Tayside did not consistently achieve care and treatment for patients in line with these guidelines. There were many examples where the treatment had fallen short of the national expectation in quality of care. In addition to concerns raised by patients, families and carers, there was also a real concern amongst clinicians working in the services, that the lack of strategic analysis of community mental health services in Tayside over many years had generated an increased risk to patients' lives.

## Crisis Resolution Home Treatment Team (CRHTT)

**“Action 13: Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them”.** Scottish Government Mental Health Strategy 2017-2027<sup>50</sup>.

- 4.12 NHS Tayside's General Adult Psychiatry Crisis Resolution and Home Treatment Team operational protocol<sup>51</sup> states:

*“The multidisciplinary team will provide an alternative to acute hospital admission by providing emergency assessment and intensive intervention within the community. The team will act as the single point of access to all inpatient mental health admissions. Where hospital admission does occur, the CRHTT will assist in providing intensive home treatment to support early discharge back to community living.”*

- 4.13 Crisis provision should be available 24 hours a day, 7 days a week to anyone, who after assessment, would benefit from enhanced care and treatment. Immediate assessment and treatment is essential to prevent the situation worsening. There is a requirement

49. National Institute for Health Care and Excellence. (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services* (clinical guideline CG136). <https://www.nice.org.uk/guidance/cg136>

50. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/O3/mental-health-strategy-2017-2027/documents/O0516047-pdf/O0516047-pdf/govscot%3Adocument/O0516047.pdf>

51. Source: NHS Tayside, December 2018.

for crisis service provision to be seamless, regardless of the age of individuals. Crisis services which attempt to separate CAMHS and adult provision cause further distress to individual patients and their families and carers but also confusion and frustration for the other services involved (i.e. the police or A&E).

- 4.14 In Tayside, the crisis service delivers a 24 hour, 365 days per year service to people experiencing an acute mental health crisis so severe that, without intervention from the service, the person would require hospitalisation. It covers the whole of the Tayside health board geographical area - encompassing Angus, Dundee and Perth & Kinross localities. The multidisciplinary team act in specific mental health pathways, such as: crisis response; single point of access for General Adult Psychiatry hospital admissions, intensive home treatment; and early supported discharge.
- 4.15 The consultant staffing of the crisis service is currently two locum consultants.
- 4.16 At busy times, staff report it is not always possible to keep on top of paperwork, resulting in delays writing to GPs or to CMHTs.

In their review of December 2017 <sup>52</sup>, HIS reported that:

*“Crisis resolution and home treatment team was organised and well resourced.”*

- 4.17 However, staff reported the CRHTT often runs on a lower than optimal staffing model. This means the service does not have capacity to be responsive and can only operate in a reactive manner. Risk assessments in crisis services focus on the risk of serious harm/death. This may, at times, under-value a patient presenting in severe mental distress but with no imminent risk to life. If a risk assessment

indicates no risk to life, the patient is treated as a non-urgent referral to other services. The intensity of follow-up for those presenting with high risk to life is good. However, the quality of the decision on risk to life depends on the judgement of the staff assessing the patient and the use of risk-screening tools. Patients who are judged to have a low-risk to life but are in high-distress, may have a very poor level of community follow-up. The result is often that the patient is repeatedly referred back to crisis provision as GPs and families struggle to manage the patient’s declining mental health condition, without adequate community support. These circumstances often also show an increased risk of self-harm as patients feel they have no other way of getting help.

- 4.18 The CRHTT does not have good working relationships with the CMHTs and there is poor integration of the services. This has resulted in a lack of continuity in patient care with transfer back to community difficult to manage after a crisis event and, as a result, patients ultimately often return to crisis services.
- 4.19 The caseload of the CRHTT includes patients with personality disorders. Some clinicians question the appropriateness of this, as the very nature of the service is that it is short-term. The needs of individuals diagnosed with either a personality disorder or psychological trauma are not best met by a short-term and inconsistent approach to care. Therefore it seems that the structure of existing crisis services can at times exacerbate symptoms for these patients, rather than alleviate them.

## Access to treatment

- 4.20 The CRHTT accept referrals from:
- Accident and Emergency/ Minor Injury Units
  - Out of Hours Service

52. Healthcare Improvement Scotland. (2018). *Review of adult mental health services in Tayside, 7-9 December 2017*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)

- Tayside Substance Misuse Service
  - GPs
  - Mental Health Inpatient wards
  - Community Mental Health Teams
  - Police
  - Tayside Psychological Therapies Service
  - Liaison Psychiatry Service
- 4.21 There are a range of outcomes or types of support offered to people who are referred to the CRHTT, dependent on their clinical presentation and the outcome of their assessment.
- 4.22 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 outwith 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.
- 4.23 For patients requiring emergency assessment, the CRHTT arrange assessment within 4 hours of referral. However, CRHTT state they will not be able to assess individuals if they:
- Have a primary physical health need that requires immediate intervention or are undergoing immediate physical health treatment e.g. intra-venous infusion.
  - are currently prisoners.
  - are intoxicated to the extent that their responses are impaired
- 4.24 The ability of the CRHTT to assess individuals who are intoxicated is a contentious issue and is very much predicated on the judgement of those on duty at the time the individual is referred. Some psychiatrists' views are that it is possible to assess the person regardless of their level of intoxication, albeit with limited outcomes, which is preferable to being taken to a police cell or taken home. Others take the view that the person needs to be coherent and reasonably compos mentis before an assessment is carried out.
- 4.25 In many of these cases, the individual is with a police officer who has made the judgement that the individual is suitable for mental health assessment. There is not currently any facility in Tayside which can take responsibility for individuals who are displaying mental ill health symptoms and are under the influence of substances or alcohol.
- 4.26 The challenge of the comorbidities of mental health and substance use was addressed in the recently published Drugs Commission report for Dundee<sup>53</sup> (full recommendations in Appendix E), which made the following recommendation:
- “Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems.”*

## Universities

- 4.27 A significant component of the population within Dundee and Perth are students of the three universities. Many of these are young people away from home for the first time, who are adjusting to a significant change in

53. Dundee Drugs Commission. (2019). *Responding to drug use with kindness, compassion and hope. Part one: The report.* <https://www.dundeecity.gov.uk/sites/default/files/publications/part1reportfinal.pdf>

their life. These young people often come to university with previously diagnosed mental health conditions and who expect to receive support both from university services and Tayside mental health services. They often have no local support from family and are entirely dependent on friends and local services. Both universities in Dundee report they have seen an exponential growth in demand on university counselling services in recent years.

- 4.28 The ability for university mental health services to respond quickly to a crisis is critical. However, it is not currently possible for the university health services in Dundee or Perth to refer directly to CRHTT - despite employing mental health nurses who are able to assess students appropriately. The student is required to go to their GP in order to get access to crisis services. Other universities in Scotland do have referral pathways in place directly to crisis services.
- 4.29 Interestingly, it is possible for the CRHTT to refer to the universities' mental health teams but this can become problematic when a student is stepped down from the CRHTT. The university team may already have a full caseload and cannot take the student. This is not checked first - the assumption being that the referral is similar to the referrals made to the CMHTs where the CMHT have no choice but to accept the referral. For young people who are seriously mentally unwell, this carries a significant risk.
- 4.30 Given the size of population of the student communities in Dundee and Perth and the well-known risk of suicides in young men under the age of 30, a referral pathway into CRHTT for the universities' mental health services should be considered as a matter of urgency.

## Out of hours/NHS 24

**“Action 14: Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services.”**

Scottish Government Mental Health Strategy 2017-2027<sup>54</sup>.

- 4.31 Between 6pm and 8am daily and the full 24 hours on Saturday and Sunday, NHS services revert to out-of-hours services with NHS 24 providing the triage service.
- 4.32 In March 2019, NHS 24's Mental Health Hub was established as part of the 111 service. There is now an option to speak directly to someone about mental health, rather than going through the general assessment questions required of all callers to the 111 service. The Mental Health Hub operates 6pm-2am, Thursday to Sunday (busiest times for mental health-related phone calls to NHS 24). Initial calls are answered by a Psychological Welfare Practitioner who may be someone with a psychology or counselling background, but the calls can then be referred to a mental health nurse. There are different possible outcomes from the call e.g. ambulance called, referral to GP, call back by local out-of-hours team (1, 2 or 4 hours) or referral to mental health services the following day. The Hub has good links to police and social work services.
- 4.33 The Mental Health Hub is not a panacea, however. It is currently only available 4 nights a week. In terms of service, it is entirely dependent on the local provision it is referring on to, in whichever region the caller is based. Call-handling staff also only have limited access to patient information. Data can be entered by GPs (“key information summary”) but so far this is used in less than 5% of the cases.
- 4.34 The service is still under review, but initial evaluation has shown a desire to expand the service to 7 nights per week.

54. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/>



4.35 For NHS Tayside regions currently without a fully functioning CRHTT (Angus), the NHS 24 default position is to call the police when a patient is in distress. However, local advocacy services reported that this can be detrimental to patients who then shy away from calling NHS 24, for fear of the police arriving at their door.

## Centralisation of Service

4.36 The decision-making behind the centralisation of the CRHTT from Angus and Perth & Kinross to Dundee can be tracked through Tayside NHS Board papers as follows:

- BOARD57 /2017 Tayside NHS Board 29 June 2017<sup>55</sup>: Crisis Resolution and Home Treatment services for Angus locality have been delivered from Dundee locality in the Out of Hours period since August 2015 as an emergency measure to address the continued vacancies on the junior doctor rotas.
- BOARD102/2017 Tayside NHS Board 31 August 2017<sup>56</sup>: In February 2017, the contingency plan was invoked, triggering a significant operational planning in partnership across NHS Tayside and the three IJBs. The process was clinically led, worked up with staff organisations and the Scottish Government. From the 1st February the Perth & Kinross Out of Hours Crisis Response Service relocated to Carseview Centre between the hours of 15.00 and 09.00 and 24/24 at weekends.
- BOARD01/2018 Tayside NHS Board 16 January 2018<sup>57</sup>: Business Continuity plans were evoked in February 2017 by the AMD, Lead Clinicians and Heads of Service to temporarily relocate Mulberry Ward and Perth locality Out of Hours assessments to Carseview Centre as a result of current Junior Doctor workforce shortages to ensure

continued provision of safe services across Tayside. These arrangements continue and recent notification of availability of Junior doctors has extended the current arrangements for a further six months.

4.37 These reports show that the centralisation of the CRHTT to Dundee from Angus and Perth & Kinross was not planned. It was a response to a deficit in staffing at the time. By 2017, it was clear that whilst the centralisation had reduced the difficulties of adequate and appropriate staffing levels, it was now posing other challenges in terms of managing a different type of relationship with the community mental health teams.

4.38 In their December 2017<sup>58</sup> review, HIS stated:

*“The CRHTT sees all out-of-hours crisis assessments of adults in Tayside.... one of the biggest challenges in the CRHTT was engaging with community mental health teams in different localities, which offer different services. Senior management had recently established an ‘acute community interface group’ to help address some of these issues and to improve communication.”*

4.39 It was disappointing for the Independent Inquiry to hear in October 2019 that relationships between the CRHTT and the CMHTs were still poor, despite the establishment of a group specifically to address this issue in February 2018.

4.40 The report went on to include the following recommendation:

*“Lack of 7 day a week home treatment service for Angus patients needs to be addressed.”*

[documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf](#)

55. Tayside NHS Board. 29 June 2017. [Mental Health Service Redesign Transformation \(MHSRT\) Programme – Option Review and Consultation Plan Reports](#). BOARD57/2017

56. Tayside NHS Board. 31 August 2017. [Mental Health Services – Sustainability of Safe and Effective Services](#). BOARD102/2017

57. Tayside NHS Board. 16 January 2018. [Mental Health and Learning Disability Service Redesign Transformation \(MHLDSRT\) Programme Consultation Feedback](#). BOARD01/2018

58. Healthcare Improvement Scotland. (2018). [Review of adult mental health services in Tayside, 7-9 December 2017](#). [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)

4.41 At the following progress meeting with HIS in June 2018 (4 months later) the latter recommendation was revisited in the light of news that patients in Angus were having to be admitted to hospital in Dundee at weekends in the absence of any home-based provision. The response from the Angus IJB was to state that the earliest a 7 day a week home treatment service could be made available was April 2019<sup>59</sup>.

4.42 To date, there is still no 7 day a week crisis home treatment service in Angus.

4.43 The following appeared in the Angus IJB papers:

*“APPENDIX 1 AGENDA ITEM No 8 REPORT No IJB 63/19<sup>60</sup>*

*Community Mental Health Seven Day Service.*

*We will expand the existing Monday to Friday Community Mental Health Teams to deliver Enhanced Home Treatment to support people, who may require daily visits by professional staff in their own homes to manage an acute mental health episode, seven days per week, 52 weeks per year.*

***Seven Day working in place with North CMHT by January 2020.***

***Seven day working in South CMHT by December 2020.***

***We will have reduced the number of unplanned mental health beds days by 10%.”***

4.44 The 7-day CRHTT in Angus has been unavailable for 5 years. There is no doubt that during this time there has been detriment to patients discharged from Carseview Centre to the Angus community who did not receive adequate intensive home treatment or supported discharge.

## CRHTT location

4.45 Ideally, crisis services should be sited in the heart of the community they are serving.

4.46 The centralised CRHTT for Tayside is located within the Carseview Centre, Dundee. Whilst it is understood the initial decision to co-locate alongside inpatient services was taken some years ago to assist with staffing, there is no doubt its location is affecting patient, family and carers' expectations of care and treatment. After being assessed, the patient and/or their family invariably anticipate admission to the inpatient wards in the same building. Staff confirmed that crisis team location within the inpatient facility increases expectations of an admission to hospital and that families and carers often feel angry and concerned at the decision not to admit the patient. This leads to notions of being “turned away from Carseview Centre”, when in fact they were assessed well enough to be able to return home with community support.

4.47 Families and carers feel concerned when it appears the onus is put back to them to take the patient home to keep them safe. Again, this becomes even more acute when families have travelled 30 or 40 miles with a patient who is severely unwell, only to be told to take them home again. There is no doubt the location of the CRHTT inside the inpatient hospital is having an adverse effect on patient and family satisfaction with crisis services. This in turn is having an adverse effect on staff morale and confidence when making clinical decisions on patients' presentations. Doctors in CRHTT report the threshold for admitting a patient in crisis is much lower in Tayside than in other places, as the pressure to do so is high.

59. Healthcare Improvement Scotland. (2018). *Progress meeting (June 2018) following Healthcare Improvement Scotland review of Mental Health Services in Tayside (Dec 2017)*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)

60. Angus Health and Social Care Integration Joint Board. 30 October 2019. *Report 63 Angus Mental Health Services Strategic Priorities*. REPORT NO IJB 63 /19



## Police

- 4.48 The Community Triage Service is a service coordinated by local mental health services. The service is used when police are dealing with a suspected mental health incident. The individual is initially triaged via a telephone consultation which aims to assess the needs of the person whilst also assisting the police in their decision-making. This multi-agency approach aims to provide a timely intervention by mental health professionals where required, avoiding unnecessary detentions in police stations and hospitals and overall, making for better provision of services.
- 4.49 In terms of efficiencies, the triage service aims to reduce the amount of time police officers spend accompanying individuals who hitherto would have required face to face consultation, whilst also aiming to reduce the number of people seeing mental health professionals unnecessarily.
- 4.50 Police only take distressed individuals directly to Carseview Centre if it is clear that community triage is inappropriate. However, there is no walk-in service, so police accompanying an individual have to queue at Carseview Centre as any referral needs to come from within NHS itself. Geography is an issue, with police officers having to transport distressed individuals across significant distances in the Tayside region to Carseview Centre.
- 4.51 Research<sup>61</sup> shows that the most successful approaches to dealing with those in mental health distress in the community are centred around well-co-ordinated strategies between police and mental health services. In those cases, a high degree of information sharing and clear communication is essential. A 'co-response team' approach (one mental health nurse and one police officer) in other health board regions has shown a reduction in detaining,

hospitalising or charging individuals.

- 4.52 There is evidence that calls to the police which are related to mental health, including transportation requests, are not evenly distributed across geographical areas and in fact there are 'hot spots' where their occurrence is particularly high. A recent study in the US applied a co-response model to policing the hot-spots where a police and mental health worker had a regular presence in the communities in a pro-active rather than reactive manner. This proved successful for early intervention/prevention work and also allowed for a community-targeting of co-morbidity of mental health issues with substance use.<sup>62</sup>

## Distress Brief Intervention and Sanctuary Support

- 4.53 Crisis provision should function well enough to be able to differentiate and support acute mental illness (psychosis, mania, severe depression) as well as managing increasing distress.
- 4.54 There should be a clearly developed distress pathway.
- 4.55 Distress Brief Intervention (DBI) is explained:

*"A Distress Brief Intervention is a time limited and supportive problem-solving contact with an individual in distress. It is a two-level approach. DBI level 1 is provided by front line staff and involves a compassionate response, signposting and offer of referral to a DBI level 2 service. DBI level 2 is provided by commissioned and trained third sector staff who would contact the person within 24-hours of referral and provide compassionate community-based problem solving support, wellness and distress management planning, supported connections and signposting for a period of*

61. McGeough, Emma & Foster, Rebecca. (June 2018). *What works? Collaborative police and health interventions for mental health distress*. Scottish Government. <https://www.gov.scot/publications/works-collaborative-police-health-interventions-mental-health-distress/>

62. McGeough, Emma & Foster, Rebecca. (June 2018). *What works? Collaborative police and health interventions for mental health distress*. Scottish Government. <https://www.gov.scot/publications/works-collaborative-police-health-interventions-mental-health-distress/>

*up to 14 days.”<sup>63</sup>*

- 4.56 Crisis service provision needs to be underpinned by DBI training – across all areas of the community (i.e. primary care; emergency care; police) to help in the understanding and management of crisis whilst also providing more psycho-social and trauma-informed approaches to supporting individuals in distress.
- 4.57 The need to improve the response to people presenting in distress has been strongly advocated by people who have experience of distress and by front line service providers. The new Mental Health Strategy for Scotland 2017 – 2027<sup>64</sup> reaffirms the commitment to DBI through the inclusion of Action 11, which aims to “*complete an evaluation of the Distress Brief Intervention Programme by 2021 and work to implement the findings from that evaluation.*” The DBI programme for Scotland has four test sites (Aberdeen, Borders, Inverness, and Lanarkshire) and has recently won a Scottish Health Award in recognition of the work being done at national and local levels. The programme also now includes support for 16 and 17 year olds. There are several third sector agencies supporting DBI in Scotland, including Penumbra, SAMH (Scottish Association for Mental Health), Richmond Fellowship, Lifelink and Lanarkshire Association for Mental Health (LAMH).
- 4.58 Within the local community triage context, Police training on DBI has had a positive response. Officers feel the training has given them tactical options for dealing with people in distress, leading to reduction in instances of officers taking those in distress to crisis services at Carseview Centre for unnecessary assessment, or into police custody. It has helped police officers to look beyond the initial reasons for presentation when helping someone in distress.
- 4.59 Support for individuals in distress (using DBI) should be accompanied with additional ‘Sanctuary’ support being made available. Ideally this would be developed as a co-produced service with third sector organisations, as is in place in Cambridgeshire and Peterborough NHS Foundation Trust (Appendix F).
- 4.60 Dundee Mental Health and Wellbeing Commissioning Group is working on supporting people in distress. The following action tracker shows the intention to purchase premises in Dundee to operate 24/7, as a place of sanctuary for those in distress.

*“This workstream is to be overseen by the Dundee Mental Health & Wellbeing Commissioning Group and the funding delivered from Action 15 & DHSCP revenue budget monies.”<sup>65</sup>*

63. <https://www.dbi.scot/>

64. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf>

65. Evidence provided by NHS Tayside in 2019.

Workstream/Redesign Group	Action	Timescale
<b>Support for People Experiencing Distress</b>	Develop triage response with Ambulance Service / Police/ Accident & Emergency Department, including out of hours.	Phased implementation from early 2020.
	<b>Commission 2 properties with availability and provision of 24/7 short term mental health support.</b>	Summer/Autumn 2020.
	Create further opportunities for people to access tailored support when needed using a drop in approach.	Phased implementation from early 2020.

66

## Community Mental Health Teams (CMHT)

4.61 The CMHTs were set up to support the most seriously unwell psychiatric patients in the community. In Tayside there are CMHTs across the three HSCP areas, Angus, Dundee and Perth & Kinross. The CMHTs work with specialist services such as Learning Disability, Tayside Substance Misuse Services, Adult Psychological Therapies Services.

66. Modified from Dundee Mental Health & Wellbeing Commissioning Framework (2019-2024). [https://www.dundeehscp.com/sites/default/files/publications/mental\\_health\\_wellbeing\\_commissioning\\_framework.pdf](https://www.dundeehscp.com/sites/default/files/publications/mental_health_wellbeing_commissioning_framework.pdf)

## Context of Community Mental Health Services in Tayside

Locality (Areas)	Community Mental Health Team	Service
Angus (West; South East)	1.South Angus CMHT (Gowanlea)	-General Adult Psychiatry Psychiatry of Old Age (Community)
North West; North East; South	2.North Angus CMHT (Stracathro and Whitehills)	-General Adult Psychiatry
	3 Brechin/Montrose CMHT (Based in Brechin)	-Psychiatry of Old Age (Community)
	4.Forfar/ Kirriemuir CMHT (Based in Whitehills)	-Psychiatry of Old Age (Community)
Angus-wide	5. Substance Misuse	-Angus Integrated Drug and Alcohol Recovery Service (Community)
Dundee (Maryfield and East End; Strathmartine and Lochee; The Ferry and North East; West End and Coldside)	1.Dundee East CMHT ( Alloway Centre)	-General Adult Psychiatry (Community)
	2.Dundee West CMHT (Wedderburn House)	-General Adult Psychiatry (Community)
	3. Recovery@Dundonald (Dundonald Centre)	-General Adult Psychiatry (Community)
	4.Learning Disabilities Community Team (Wedderburn House, Hawkhill Day Hospital & White Top Centre)	-Learning Disabilities Community
	5.Dundee East/Dundee West (Kingsway Care Centre)	-Psychiatry of Old Age Community
	6.Dundee Integrated Substance Misuse Service (Constitution House)	-Community Service
Perth and Kinross (north Perthshire; South Perthshire & Kinross; Perth City)	1. North Perth CMHT, Blairgowrie (Strathmore) + Highland Perthshire (x 2)	-General Adult Psychiatry-community -Psychiatry of Old Age-Community x2
	2. Perth & Kinross Community team hosted in North locality (based at Murray Royal Hospital)	-Perth & Kinross Community Learning Disability Service
	3. South Perthshire CMHT Kings Centre, Crieff /Kinross	-General Adult Psychiatry (community) -Psychiatry of Old Age (Community)
	4. Perth City CMHT Perth Royal Infirmary - Cairnwell	-General Adult Psychiatry Community and Move Ahead -Psychiatry of Old Age - OPMHT Murray Royal Hospital
	5. Perth and Kinross Community Substance Misuse Drumhar Health Centre	-Community Service

4.62 The three Health and Social Care Partnerships have clear principles for how hosted services will be managed effectively and consistently and recognise that strategic planning responsibility for the services should be retained by all three IJBs in respect of their own population<sup>67</sup>.

Dundee	Angus	Perth & Kinross
<ul style="list-style-type: none"> <li>• <b>Psychology services</b></li> <li>• Sexual and Reproductive Health services</li> <li>• Homeopathy service</li> <li>• Specialist Palliative Care</li> <li>• The Centre for Brain Injury Rehabilitation (CBIRU)</li> <li>• <b>Eating disorders</b></li> <li>• Dietetics</li> <li>• Medical Advisory Service</li> <li>• Tayside Health Arts Trust</li> <li>• Keep Well</li> <li>• <b>Psychotherapy</b></li> </ul>	<ul style="list-style-type: none"> <li>• Locality Pharmacy</li> <li>• Primary Care Services (excludes the NHS Board administrative, contracting and professional advisory functions)</li> <li>• GP Out of Hours</li> <li>• Forensic Medicine</li> <li>• Continence service</li> <li>• Speech and Language Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Learning disability inpatient services</b></li> <li>• <b>Substance misuse inpatient services</b></li> <li>• Public Dental Services/ Community Dental Services</li> <li>• <b>General Adult Psychiatry Inpatient Services</b></li> <li>• Prison Healthcare</li> <li>• Podiatry</li> </ul>

\* In black, the hosted services related to Community Mental Health Service and, in red, the ones related to Inpatient Mental Health Services. There is a dedicated speech and language therapy input to mental health services.

4.63 Public awareness of mental health provision is inextricably linked with inpatient services at Carseview Centre and to a certain extent, Murray Royal Hospital. However, these two facilities represent only 6% of patients undergoing treatment for mental health conditions. 94% of patients within mental health services are treated in the community.

4.64 The CMHTs within Tayside region do not know their catchment area size or their

population demographics and therefore have no capacity to appropriately manage the service they are delivering. One community-based consultant reported repeatedly being unable to find out the size of their own caseload. As 94% of all mental health patients are treated by the CMHT services, there should be a real focus on changing practices to improve patient access to services. To do so however, requires significant investment in community mental health teams and co-produced services with third sector

67. Modified from: Perth and Kinross Health and Social Care. (2019). *Strategic Commissioning Plan 2016-2019*. (Final draft, September).

agencies.

4.65 The ability to deliver high quality, appropriate and proportionate care within a local community is imperative if there is a real desire to improve outcomes for all. Clear and consistent service provision is essential, with excellent communication and pathways of care developed across both the statutory and voluntary service providers. Unfortunately, some of the CMHT have been dependent on locum psychiatrists for many years which is detrimental to the continuity of care for patients. Many of the CMHTs have disjointed functionalities, with interfaces to other services not working well. The relationship with crisis services and the CMHTs is, at times, fractious. All referrals from crisis services must be seen in the CMHT (they cannot be rejected) but the decision-making around those referrals is not always understood by the CMHT.

4.66 Tayside operates a mixed model of medical staffing within mental health services, with most consultants being based either in the community or within the hospitals. Other health boards operate split posts - with consultants working both in the community and on the wards. Carseview Centre currently operates a regional approach to patient admissions to wards, mirroring geographical locations of CMHTs. It would therefore be possible to consider adopting a split-post model of working for psychiatrists - which would allow for patients to be treated by the same consultant as an inpatient and then in the community. It would also speed up discharge to the community, if the patient's needs were already well known. In fact, NHS Tayside have already considered this approach as evidenced by the two extracts from the minutes of the progress meeting with HIS in June 2018<sup>68</sup>:

*“The Associate Medical Director told us that there was inconsistency across the GAP inpatient beds in relation to psychiatrists*

*not having split posts. If a psychiatrist has a split post this means they provide consistent intervention and treatment throughout the patient's journey if they are treated in the hospital and the community. We were told that a consistent model of split posts for psychiatrists will be applied across all GAP services.”*

*“Increasing the numbers of psychiatrists and the consistent model of split posts will facilitate person-centred care and improve communication. We understand that this will take time to implement, again we would encourage NHS Tayside to ensure this is an immediate priority.”*

4.67 This shows there was recognition by both HIS and NHS Tayside in 2018 of the problems related to the lack of continuity of care between a patient's contact with a psychiatrist in hospital and then with someone else when returning to the community. There does not seem to have been any further consideration given to this HIS recommendation.

4.68 The staff in the CMHTs work hard and are well respected in the communities, but they are working within largely unknown parameters, making their jobs very difficult to carry out satisfactorily. The lack of caseload management is detrimental to service provision and development. In addition, internal waiting lists (i.e. for occupational therapies, psychology) and cumbersome internal referral procedures exacerbate the problems. CMHTs often become paralysed navigating the processes to admit a patient, and hours may be spent on a single patient moving from CMHT to inpatient facilities.

4.69 Many people known to mental health services either have a personality disorder diagnosis or their mental health is negatively impacted due to previous trauma or current social stressors.

68. Healthcare Improvement Scotland. (2018). *Progress meeting (June 2018) following Healthcare Improvement Scotland review of Mental Health Services in Tayside (Dec 2017)*. [http://www.healthcareimprovementscotland.org/our\\_work/governance\\_and\\_assurance/programme\\_resources/tayside\\_mental\\_health\\_review.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx)



These individuals require a consistent, compassionate approach to improve mental health and wellbeing and the ability to build trust is crucial if long term improvement is to be sustained. The recent increase in neurodevelopmental disorders diagnoses - Autistic Spectrum Disorder (ASD) and, Attention Deficit Hyperactivity Disorder (ADHD) - has had a significant impact on the CMHTs, with staff reporting a lack of capability to deal with these disorders but without knowing what they can do to address it.

4.70 As a result of the increase in individuals with personality disorder diagnoses, waiting times to see Community Psychiatric Nurse (CPNs) and consultant psychiatrists are long and GPs have become frustrated. They refer cases as urgent in the hope the patients will be seen quicker. They also refer, simply to get a patient on the waiting lists, so that if they themselves are not able to appropriately treat in general practice the patient will be closer to being seen by the CMHT at the point where the GP has run out of options. This causes waiting lists to be artificially inflated.

4.71 GP practices report referring to CMHTs only to receive rejected referrals with no real understanding of why the patient is not being admitted to the service. GPs repeatedly requested that CMHTs at least see their patient once, rather than rejecting simply on the basis of their referral. There is a feeling that their judgement to refer is being questioned, something which they do not experience when referring to other disciplines.

4.72 The lack of CRHTT in Angus has adversely affected the functioning of the CMHTs, as they have had to prioritise patients in crisis, and have not been able to engage with lower risk patients in community therapies. In these circumstances, crisis work runs alongside planned treatments. A member of staff stated:

*“CMHT staff are expected to offer crisis support to patients, formulate crisis and risk management plans whilst also managing the high-risk patients. This creates a bottleneck of patients who are categorised as ‘routine’, who are accepted for treatment in the community but who end-up waiting 6 months or more for the treatment.”*

4.73 The challenges being faced by the CMHTs are known to IJBs and NHS Tayside. At the November 2019 meeting of the Perth & Kinross IJB<sup>69</sup>, nine key issues were identified as challenges to supporting people with mental ill-health in the community:

### **“3.9 Emerging Issues**

*Although the review of community health services and supports is still ongoing a number of issues and themes are emerging.*

- Accessibility of services, especially in rural areas, needs to be investigated.
- More community-based supports, especially in Perth City, are needed to reduce the requirement for statutory supports at a later date and there is a need for increased Social Prescribing capacity to help people access them.
- The pathway for people with a Personality Disorder needs to be reviewed to ensure timeous access to appropriate support.
- Links between mental health and substance use services need to be improved especially for younger adults; integrated funding needs to be investigated and pathways need to be developed.
- A review of support to reduce the risk of people completing suicide is required, especially in Perth City.
- To reduce hospital admissions the support for people in crisis needs to be improved, including the development of A and E Liaison Service and improved Anticipatory Care Planning.

69. Perth and Kinross Integration Joint Board. 6 November 2019. [Emerging Issues for Community Mental Health provision, as outlined at Perth and Kinross Integration Joint Board, 6 November 2019. Update on Redesign of Community Mental Health Services and Supports in Perth and Kinross. \(G/19/171\).](#)

- *The reasons for people being readmitted to hospital need to be investigated to identify approaches that reduce the incidence of this.*
- *Investigation and benchmarking is required to identify the reason(s) for the rising number of people from Perth & Kinross being compulsorily detained.*
- *The potential of Advanced Mental Health Nurse Practitioners needs to be explored as a role that can developed to support people with complex mental health needs to remain in the community."*

week, mostly nominated for psychiatrist assessment. They reported:

*"We are already in the difficult position that we continue to accept patients for CMHT input at team referral meetings despite being aware there is no possibility of their being seen by a psychiatrist or trainee in the foreseeable future. Patients are being informed that they are on a waiting list to be seen when a psychiatrist becomes available, but the number being accepted vastly exceed the capacity of remaining doctors."*

## Waiting Times

- 4.74 There is no doubt it is challenging to manage demand and capacity across all systems in the services. However, by using data effectively, better flow through the system can be achieved. The service needs to understand three key components: a) the size of the population it is serving and b) the balance between rural and urban dwelling and c) the demographics of the constituents.
- 4.75 NHS Tayside data collection and usage is poor. Refining the data-entry would allow for better data-outputs which in turn will allow for better informed decisions to be taken on services. Data collection is a skill: only meaningful data required for strategic planning should be recorded and methodologies and consistencies need to be applied to the collection of this data.
- 4.76 There is a perception that the only way to reduce waiting times is to recruit more staff. As this is unlikely to happen quickly, if at all, the other option is to reduce the work by increasing the rejected referral rates. A properly informed strategy needs to be developed to manage waiting times/ workloads to ensure patients are treated appropriately and timeously. Addressing these issues is a matter of urgency, as staff are feeling completely overwhelmed with workloads within the CMHTs. One of the Dundee CMHTs received 25-30 referrals a

- 4.77 In Perth & Kinross the CMHTs reported that cumulatively the CMHTs will work with around 1,800 people at any given time. People will mostly be offered an assessment appointment within 12 weeks as per referral criteria however in reality many people will be offered an appointment within six weeks depending on referral demand and team capacity.
- 4.78 The transitions between services needs to be person-centred and needs-led. In Tayside, the pressure on caseloads has resulted in a caseload management system which ensures patients are 'transitioned' whether or not it is in their best interest, simply because they have reached a certain age. General Adult Psychiatry are under pressure in terms of caseload and so are motivated to move people on at 65 in order to get their numbers down. This does not fit with person-centred care - particularly if the person is getting along very well in GAP.

## Community-based therapies

- 4.79 Many patients, families and carers giving evidence to the Independent Inquiry reported waiting long periods for access to psychological therapy services. In August 2019, it was reported that over 800 patients had been waiting over 18 weeks to be seen by the psychological therapy services due to staff shortages. This situation was rectified with the recruitment of staff to the service in autumn 2019. The online CBT (Cognitive Behavioural Therapy) service:



Beating the Blues<sup>70</sup> has also been launched with the aim to reduce waiting lists significantly, once fully operational.

- 4.80 Once patients have accessed the services, they report the treatments they receive to be very good with supportive and helpful staff contributing to their recovery processes. The psychotherapy services in Perth & Kinross were very well received by patients who had been referred there. In all cases however, the services were reportedly under-resourced with staff absences not covered and patients having to wait for long periods between treatments if the specialist staff were unavailable. It was also reported that community-based therapies cease once a patient is admitted to inpatient services. This makes sense from a practical perspective, however the patients reported that the therapy was often something which was “keeping them going” and to withdraw it just at their point of crisis seemed detrimental to the recovery process. It also was not an easy process to get back into the therapy services after discharge.

## Primary care mental health support

**Action 15: Increase the workforce to give access to dedicated mental health professionals to all A&Es, all GP practices, every police station custody suite, and to our prisons. Over the next five years increasing additional investment to £35 million for 800 additional mental health workers in those key settings.”** Scottish Government Mental Health Strategy 2017-2027<sup>71</sup>

- 4.81 NHS Tayside and the three IJBs are developing low-intensity interventions to address the burgeoning instances of mental ill-health in the communities. Primary care mental health support, within GP practices is being developed to afford GPs more options for the high volume of patients who present with mental ill-health.

- 4.82 The primary care mental health staff give support to patients without them needing to be referred into the mental health system and without them needing to see a GP first. The service is designed to provide a high volume low-intensity response to common mental health issues, including mild to moderate depression, anxiety or phobias and offer various forms of self-help and psychoeducation. The easy-access and brief treatment model is highly effective. Data from similar services elsewhere in Scotland shows that 60% of patients display clinical and reliable change, following treatment. This model of low-intensity interventions is key to addressing service provision in the community.

## Third Sector

- 4.83 There are many third sector organisations providing services to those in crisis to complement the CRHTT services. However, for individuals seen by the CRHTT and assessed as not needing to be admitted to any NHS services (inpatient or community) there is not currently a clear understanding of what services/agencies are available for ongoing support for the individual. Individuals have said that they had not been able to find out where to go to get help. The Independent Inquiry team found a variety of examples of contact details for crisis services in Tayside. These lists were compiled by a range of organisations, both statutory and third sector, but links were often found to be broken or information not updated for months or years. An aggregated and mobile device-responsive site offering access to accurate and current mental service information, ideally produced as part of a cross-sectoral collaborative effort such as the Sheffield Mental Health Guide<sup>72</sup>, could be of real benefit to Tayside.
- 4.84 Dedicated services such as Peer-Recovery should be available to all patients who have

70. <https://www.nhstayside.scot.nhs.uk/BeatingtheBlues/index.htm>

71. <https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2017/03/mental-health-strategy-2017-2027/documents/00516047-pdf/00516047-pdf/govscot%3Adocument/00516047.pdf>

72. <https://www.sheffieldmentalhealth.co.uk/>

been in a hospital setting for a long time. Peer-Recovery allows for connection to a peer recovery worker who will accompany individuals after discharge and as they reintegrate in their community. There is no such provision in Carseview Centre at present, despite attempts to establish one by a third sector agency.

4.85 There has been a pilot peer link service in Angus at Carnoustie, Arbroath and Monifieth GP surgeries, available to anyone over 16.

4.86 The Social Prescribing Sources of Support (SOS) service was piloted on a small scale in 2011 and expanded incrementally to the current position of 10 link workers across GP practices in Dundee as part of the Scottish Government national Community Link Worker Programme and more recently within Action 15 of the national Mental Health Strategy. In November 2018, Audit Scotland's report "Health and Social Care Integration: an update on progress"<sup>73</sup> included a case study on the Sources of Support (SOS) service, based on Dundee:

*"Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem. Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness*

*of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16."*

4.87 There has been a lot of good work in Tayside in developing crisis support, particularly within the third sector (Appendix G).

## SAMH

*Tayside mental health services - SAMH alternative delivery*

4.88 SAMH have been working with various agencies/bodies including CAMHS, CPNs, GPs and CMHTs "to support the drive to increase access to preventative and short-term interventions." There is a hope that this work will help reduce NHS waiting times. The work includes development of bespoke, CBT-based services including short-term crisis response, medium-term resilience and capacity-building, and peer support. There is a belief that this approach could enhance existing mental health services infrastructure and: "reduce waiting times for access to psychological therapies & demand for mental health related support from NHS Tayside/Increase capacity across the region/Introduce a range of person-centered support options."

4.89 The portfolio of interventions includes:

- Distress Brief Intervention. (DBI)
- ALBA - physical activity and CBA behavioural change intervention.
- Living Life to the Full.
- Peer support.

73. Audit Scotland. (2018). *Health and social care integration: an update on progress*. <https://www.audit-scotland.gov.uk/report/health-and-social-care-integration-update-on-progress>.

## Summary

- 4.90 It is clear that a whole system approach to delivery of community services (CRHTT and CMHT) in Tayside is highly desirable. Co-production with third sector organisations is essential, rather than simply commissioning a service.
- 4.91 Community services need strong links to other services (Learning Disability, Criminal Justice and Substance Misuse) and should be playing key roles in transition from CAMHS to GAP and from GAP to POA. Patients need to feel they are part of one mental health service, not a series of fragmented services that do not have good internal relationships.
- 4.92 Each community service needs a multi-disciplinary/multi-agency approach to service delivery. Patients should not, as much as is practicable, be required to travel to receive alternative treatments. Consistency and continuity of services is paramount, with all staff from across the separate disciplines building up knowledge and understanding of patients within each community service. There needs to be a system of a good use of anticipatory care plans for complex presentations.
- 4.93 Community services need closer and better relationships with inpatient facilities and also with local GP practices, to build professional trust across the wider system which in turn fosters good and timely information sharing beneficial to patient care.
- 4.94 HIS have a further scrutiny visit planned for January 2020, to conduct a full Quality Assurance Review of Adult Mental Health Community Services. The review will cover Community (CMHTs) and Crisis Resolution Home Treatment (CRHTTs).
- 4.95 Action 15 monies have been made available from Scottish Government to all three Health and Social Care Partnerships to

support the mental health strategy for Scotland.

## Recommendations

13. Ensure that there is urgent priority given to strategic and operational planning of community mental health services in Tayside. All service development must be in conjunction with partner NHS organisations (NHS 24, the Scottish Ambulance Service), Police Scotland, third sector agencies and set in the context of the community they are serving.
14. Consider developing a model of integrated substance use and mental health services.
15. Develop comprehensive and pertinent data-capture and analysis programmes, to enable better understanding of community need and service requirement in the Community Mental Health Teams.
16. Prioritise the re-instatement of a 7 day Crisis Resolution and Home Treatment Team service across Angus.
17. Review all complex cases on the Community Mental Health Teams' caseloads. Ensure that all care plans are updated regularly and there are anticipatory care plans in place for individuals with complex/challenging presentations.
18. Plan the workforce in Community Mental Health Teams in the context of consultant psychiatry vacancies with the aim to achieve consistent, continuous care provision across all community services.
19. Prioritise the development of safe and effective workflow management systems to reduce referral- to-assessment and treatment waiting times. This should also include maximum waiting times for referrals.

20. Consider the development of a comprehensive Distress Brief Intervention training programme for all mental health staff and other key partners to improve pathways of care for individuals in acute distress.
  
21. Foster closer and more collegiate working relationships between the Crisis Resolution and Home Treatment Team and Community Mental Health Teams and other partner services, based on an ethos of trust and respect.
  
22. Develop clear pathways of referral to and from university mental health services and the Crisis Resolution and Home Treatment Team.

# 5. Inpatient Services

- 5.1 Given the scrutiny placed on inpatient care in Tayside to date, there are concerns that the needs of hospital-based care will continue to dominate a much needed system-wide review. Only a small proportion of overall patients are treated as inpatients (6% as opposed to 94% who are treated in the community).
- 5.2 Modern mental health services are based around Community Mental Health Teams, who act as gatekeepers to the services. They assess all referrals and develop care plans, which include the possibility of admission as inpatients. Most, if not all, patients with severe and enduring mental disorders will be known to the CMHTs. The care plans of patients who have had inpatient admissions will reflect their personal circumstances and will proactively include plans for possible future admissions. This is especially pertinent for patients who have multiple diagnoses, including substance misuse.
- 5.3 The provision of appropriate inpatient services is, of course, a critical requirement for a functioning mental health system. Hospital-based services care for some of the most vulnerable and acutely unwell patients, often after a point of crisis in their lives. It is therefore crucial that the treatment they receive should not only be of the highest quality but also person-centred and proportionate to their needs.
- 5.4 Inpatient services have therefore formed an important element of the work of the Independent Inquiry. Challenges have been identified in many aspects of the provision of these services, including in the governance and the leadership associated with inpatient services. These have been dealt with in greater detail in other sections of this report.

## Ward Environment

- 5.5 There is perhaps an inevitability that because some patients are detained in a psychiatric hospital, they may view their environment in a negative manner. If they do not wish to be in the ward/hospital, they will not feel positive about their experience of being treated there, for however short a period of time. That said, however, every effort should be made to make the environment as welcoming and supportive as it can possibly be. Many patients who are admitted will be in a vulnerable state, traumatised, fearful and potentially disorientated. The environment in the ward must be a safe place for them, in order to aid their recovery and positively to support their treatment. At a time of acute distress, a mental health setting should be a place of safety and comfort for the patient. This idea incorporates both the physical and the human relational aspects of the environment in the ward.

## Physical environment

- 5.6 Many patients described their experience of being in a mental health ward in Tayside as negative. The physical space, fabric, decoration and atmosphere at Carseview Centre are not conducive to a welcoming and safe space. The building itself is dated, with poor quality furniture and fittings, tired and in a poor state of repair. Patients have described it as feeling bleak, which impacts on the ability to improve wellbeing and deliver good therapeutic care.

*“There is nothing to do in Carseview – it is a wasteland environment. It is desperate, even the café area has wooden seats, there is no music, the tea and coffee is awful, there is no artwork on the walls – there is a real feeling of repression.”* (Third sector organisation)

*“In wards 1 and 2...the general ward environment was good, however, some bedrooms were sparse and lacked basic comforts such as a work surface or writing area.” (HIS<sup>74</sup>).*

- 5.7 Although a programme of refurbishment was approved and has commenced in 2019, concentrating on ensuring the bedrooms met required safety standards, it would have been helpful for the overall environment to be improved with better quality furnishing, artwork, music and facilities to make it feel more welcoming and supportive.
- 5.8 Some wards at Carseview Centre do not have ready access to outside space and fresh air. Patients have felt that the outside space that was available was dominated by patients who were smoking. The limited internal spaces and the bleak environment in the inpatient wards at Carseview Centre can heighten patient anxiety and concern.
- 5.9 The patients who moved in 2017 from the Mulberry Ward at Stracathro to the Mulberry Ward at Carseview Centre were very aware that the facilities were not as extensive as at Stracathro. The ward has limited facilities in comparison and does not have access to gardens, open air and to as much light, which were all features at Stracathro. A number of members of staff have also commented on this deterioration in the environment for Mulberry patients. Patients' access to telephones was more limited.

*“Patients in Mulberry Unit have no direct access to a garden area and some patients in Ward 2 also told us that, while they can access the garden directly from the ward, access to the garden can be very limited. Patients also raised a number of other issues about the physical environment in the ward. For example, we were told by some patients in Ward 2 that the layout of furniture in the lounge areas can feel very regimented, and can make it difficult for patients to chat*

*informally together in a group.”<sup>75</sup>*

- 5.10 It was not uncommon for wards to be locked for long periods of time. Whilst locking a ward may be appropriate in certain circumstances, there should not be general locking of acute wards. The reasons given by staff for locking wards include staff shortages, for a particular patient's safety, or to stop other people from entering the ward. They stated that wards were only locked for a short duration. Elsewhere in Scotland keypad systems enable effective control of entry and exit to wards. Patients who are required to be restricted for safety reasons should be known to staff and under enhanced observations.
- 5.11 There have been instances of young people under 18 years of age being admitted to adult wards. A child should only be admitted to wards which are designed for the care and treatment of children. There is a danger that they would find being placed in an adult ward disorientating and unsettling. This practice is completely unacceptable.
- 5.12 On a number of occasions wards have been closed or relocated at relatively short notice. This has had a detrimental impact on patients, as the quality of the environment has reduced and the short notice changes can be unsettling for both patients and their families and carers. The move to mixed gender wards and to wards where other patients display more challenging behaviour can be frightening for vulnerable patients, who are unsettled by the unpredictable and erratic behaviour of others.

## Patient experience

- 5.13 Patients have described feelings of isolation, boredom and loneliness. Their interactions with others on the wards - with both other patients and staff - have been

74. Evidence provided by Healthcare Improvement Scotland of their correspondence with NHS Tayside following HIS's June 2017 visit.

75. Mental Welfare Commission for Scotland. (March 2018). *Report on unannounced visit to: Wards 1, 2 and the Mulberry Unit at Carseview Centre, 4 Tom McDonald Avenue, Dundee DD2 1NH. Date of visit: 22 November 2017.* [https://www.mwscot.org.uk/sites/default/files/2019-06/carseview\\_acute\\_admission\\_wards.pdf](https://www.mwscot.org.uk/sites/default/files/2019-06/carseview_acute_admission_wards.pdf)



difficult and, at times, frightening. Some have described feeling frightened of other patients and having been bullied by other patients. Fights between patients have been witnessed. Whilst many patients felt that they were well cared for by the staff, some felt that the staff were not interested or were too busy to pay them the attention they requested. They sensed a lack of staff engagement with patients. Staff felt they had limited time for one-to-one interaction with patients. Patients with particular dietary requirements did not always receive suitable meals which met these requirements. As a consequence, patients may have gone without sufficient food.

supported by their management. Staff had an expectation that the police would attend to respond to illegal drugs, but this did not always happen. Although liaison arrangements had been developed with Police Scotland locally, staff were not able to control the availability of illegal drugs on the wards, nor had legal powers to do so. Patients and their families and carers reported seeing drugs being delivered, sold and taken within Carseview Centre site. Staff confirmed that this was a serious issue which was not being adequately addressed. These issues are not unique to Tayside; a national approach to guidance on managing illegal drugs in hospitals is required.

## Staff experience

5.14 Staff also expressed fear about the environment in the ward, potentially feeling isolated and unable to implement ward improvements which they thought were needed. Some felt that they would not be supported by senior managers. This was particularly so following the broadcast of the BBC TV programme *Breaking Point*<sup>76</sup> in July 2018. The subsequent internal review<sup>77</sup> of Carseview Centre conducted by NHS Tayside found staff were difficult to engage with and were defensive in their attitudes.

5.17 On occasions when illegal drugs were found in a patient's room, there was a possibility that the patient would be discharged from mental health services, as a consequence, against the patient and family wishes. Families often felt in those circumstances that they were not in a position to meet the needs of the patient.

5.18 An example of one month's incidents during 2019 in one ward at the Carseview Centre:

"Clear ward theme this month relating to illicit drug use and alcohol use challenges. Breakdown of Illicit Drug and Alcohol related adverse events:

- Patient found to be supplying other patient with amphetamines.
- Patient found to have a bag of white powder in possession – police contacted.
- Patient under the influence of illicit substances.
- Patient intoxicated with alcohol on ward.
- Patient's belongings searched following failed return from pass – bag of powder & tablets found, police informed.
- Patient smoking cannabis.
- Visitor observed supplying drugs to patient on ward.
- Patient smoking cannabis.

## Smoking and illegal drugs

5.15 The management of smoking in the wards has been a frequent source of complaint for patients and families. More seriously, the consumption of illegal drugs in the wards has been a consistent theme in the evidence submitted to the Independent Inquiry. This raises obvious security concerns and the potential for bullying, tension and disorder within the wards.

5.16 Staff were particularly vocal in expressing their fears and their sense of impotence in being able to make a positive difference. At times they felt that they were not

76. <https://www.bbc.co.uk/programmes/b0b98nsd>

77. Evidence provided by NHS Tayside in 2019. [Report on mental health services provided at Carseview Centre, Dundee. November 2018.](#)

*Update from [staff] relating to illicit drug use and alcohol incidents - "Although illicit drug use and alcohol incidents have risen this month, on discussion with [staff] police presence on ward has increased, meetings have taken place and this is under control and being acted on accordingly. No further support required at this time."<sup>78</sup>*

uncooperative and attention-seeking".

5.21 Such attitudes made patients feel more isolated and fearful, particularly when they were already feeling vulnerable. The tensions between patients resulted in arguments and fights, leaving other patients feeling intimidated and unsettled. This contributed to them feeling unsafe - a perception shared by their families and carers.

## Sense of safety

### Patient experience

5.19 The Independent Inquiry received evidence of excellent staff providing compassionate and professional care for patients, in what can be extremely challenging circumstances. The Staff chapter in this report details a number of examples of comments from patients, families, and clinical and medical staff, with descriptions of excellence in providing professional and compassionate care to patients in a variety of settings. However, other patients often reported that they felt that they were not treated with dignity and kindness. They felt that some members of staff were very judgemental in their attitudes towards patients and did not treat them with respect. Patients described a level of hostility from staff, a "them and us" culture, where the genuine concerns of patients were not taken seriously.

5.20 Patients who talked about suicide reported that they were told to "get a grip", "pull yourself together", "you wouldn't be here if you didn't harm yourself", adding to the perception that staff blamed the patients for their situation, rather than recognising that they were seriously unwell. This was particularly true for patients who were suspected of using illegal drugs, who felt that staff treated them particularly poorly. They felt as if they were treated as non-deserving, and that staff were quick to seek to remove them from mental health treatment. Some patient records confirmed unhelpful attitudes of staff towards patients with descriptions such as "manipulative,

5.22 The lack of visibility and presence of staff on the wards added to these fears and perceptions. The physical environment and the continuing presence of potential ligature points contributed to a heightened level of risk, which was recognised by all staff working in mental health services.

### Staff experience

5.23 Staff reported that they did not feel that they received the support they needed in managing volatile situations on the wards. Some staff had been subjected to negative criticism on social media, occasionally using photographs taken of them without their permission. This led to a further sense of being isolated and not supported by NHS Tayside. Some patients and their families were also reported to have threatened to report staff to the press and other media.

5.24 Nursing staff felt that too much of their time had to be spent on compiling reports, preventing them from spending more time with their patients. The Independent Inquiry heard in 2018 that plans were in place for clerks to be employed in wards, to reduce the time that nursing staff had to spend inputting to IT systems, but these were still not in post by November 2019. The situation was compounded by the lack of integrated IT systems and duplication through both paper records and different IT systems. Staff would like to be able to spend more time with patients and find themselves relying on night shifts in order to catch up on paperwork.

78. Evidence provided by NHS Tayside in 2019. [Quality management system for mental health GAP wards adverse events, 2019.](#)

- 5.25 A consistent theme submitted in evidence to the Independent Inquiry was the poor learning from adverse events and reviews. Many of these were completed well outside the timescales required in the review policy. Subsequent events and incidents in the wards where mistakes were repeated, indicated that there had not been practical learning from previous events.
- 5.26 Greater emphasis and focus is needed on prevention and proactive intervention before events happen, rather than only responding to incidents and events after they have occurred. There should be swifter and more comprehensive learning from the reviews following adverse events in the wards.

abuse, then actions such as a patient's trousers being lowered can provoke psychological trauma. Figures<sup>79</sup> for the use of restraint for mental health services from March 2018 to February 2019 show that six or more members of staff were involved in the use of restraint in 43 incidents in mental health services.

- 5.30 Some staff were described by patients as being gentle and calming when using restraint, whilst others were perceived as being aggressive, both verbally and physically. Staff reported that they found the use of control and restraint distressing and contributed to raising their own levels of anxiety. Responding appropriately to aggressive behaviour in an inpatient ward can be significantly challenging and demanding. The safety of staff is an important factor in decision-making when dealing with situations which may require the use of force.

## Control and Restraint

- 5.27 The use of control and restraint is a very sensitive issue within a hospital setting. There are, of course, instances when the use of physical restraint is necessary for the prevention of harm to a particular patient, to other patients and to staff and other people present. Any use of restraint must be appropriate and proportionate to the incident and use the minimum amount of force necessary.
- 5.28 For a patient subject to restraint, its exercise can cause anxiety, fear and feelings of humiliation. There is the potential for patients to feel violated and traumatised, particularly if they have suffered violent abuse in their past. Patients witnessing the use of restraint on another patient can also experience raised anxiety and fear. Physical and psychological trauma can be caused by the use of restraint.
- 5.29 Potentially traumatic treatment include being handled by a group of staff of up to six people, being held face down, having staff kneeling on the patient's back, intramuscular injection. If the patient has previously suffered any form of sexual
- 5.31 A number of staff members told the Independent Inquiry about their concerns about what they perceived as the overuse of control and restraint. Some staff were uncomfortable that they were being expected to carry out restraint without having undertaken the appropriate training. The variations in the use of control and restraint between different inpatient wards in Tayside would tend to corroborate this perception. It is essential that all staff are appropriately trained in the use of restraint and control techniques.

*“Prevention and Management of Violence and Aggression (PMVA): Confirmed PMVA trainers present in every ward. Feedback that 96% of Carseview staff have been PMVA trained. Mulberry Ward have the lowest number of staff trained and work is ongoing with senior charge nurse of ward to increase numbers of trained staff for this ward. Use of bean bags are being incorporated into the training. Feedback was that bank staff have been added on to recent courses.”<sup>80</sup>*

79. Evidence provided by NHS Tayside in 2019. [Mental health performance review presentation](#).

80. Evidence provided by NHS Tayside in 2019. [Least Restrictive Care 08.10.19 agenda and meeting note \(draft\)](#).

- 5.32 There is always the risk of an escalating cycle of increased distress and resistance from the patient resulting in even more intensive control and restraint. It is therefore clear that the limited internal spaces and the bleak environment in the inpatient wards at Carseview Centre are likely to heighten patient anxiety and concern.
- 5.33 Greater emphasis needs to be placed on the prevention of the need for the use of physical restraint, through the use of listening, talking and de-escalating the underlying causes. Measures need to be in place to reduce the use of control and restraint and to minimise its impact. Whenever possible, patients should not be placed in a prone position, which carries particularly high risks. Any use of restraint must be for the minimal length of time.
- 5.34 An internal review<sup>81</sup> of the use of control and restraint found that not all instances of their use were being accurately recorded. Without an accurate recording of such incidents, it is impossible for there to be meaningful monitoring of the use of restraint and control by managers. The power imbalance between staff and patients and the fact that it is staff who record the use of restraint without reference to the patient's view, add to the potential harm. The Quality Improvement Team have been implementing improvement processes to address the shortcomings identified in the review.
- 5.35 There is evidence from Tayside that they have been doing much more restraint reduction training, including trauma-informed training. It is too early to say whether this is having a positive impact on patient experience.
- 5.36 It is apparent that there has been a disconnect between services and treatments in the community and in the inpatient wards. Some patients who have been receiving particular treatments or therapy in the community find that such treatments or therapy may not be available for them when they are admitted as inpatients. In particular, psychological therapies and occupational therapy are not offered to the same extent as in the community. Support services and therapeutic treatment which were highly valued in the community were not available for inpatients, to their disappointment.
- 5.37 Services in Dundee that dealt with both substance misuse and mental health did not operate jointly to complement each other's work. Patients who needed to be referred to substance misuse services were discharged from Carseview Centre service without a relevant referral. For some patients in mental health services, if they took an overdose they were discharged from mental health services and referred to the Integrated Substance Misuse Service (ISMS).
- 5.38 For many inpatients there were insufficient constructive activities for them to take part in. A target has been introduced for 17 hours per week of activities for each patient. This led to some improvements in 2019, but many patients continue to feel that there is not enough for them to do, with a sense of boredom and aimlessness, while they seem just to be waiting to see a doctor. Where there was equipment in the wards, these were not always available for use by patients, such as the gym being locked because of a lack of staff to supervise, television remote controls with no batteries, or the removal of games console cords. Activities which had been advertised for patients were often cancelled at short notice due to staff shortages.
- 5.39 The Independent Inquiry heard that a number of third sector organisations had offered to provide programmes to support patients, such as recovery interventions, but these organisations felt that their offers were not always welcomed. They were

## Availability of Services

- 5.36 It is apparent that there has been a disconnect between services and

81. Evidence provided by NHS Tayside in 2019. [Report on mental health services provided at Carseview Centre, Dundee November 2018.](#)

either discouraged from attending inpatient facilities or even denied access on arrival. The Health and Social Care Alliance report published in December 2018 does however positively describe the staff-carers support group within Carseview Centre run by the voluntary organisation Cairn Fowk.

*“Cairn Fowk have developed a relationship with Carseview, having a carers’ group that meets with staff, enabling communication. Carers have reported positive outcomes with regards to developing positive relationships with the staff.”<sup>82</sup>*

## Communication

5.40 NHS Tayside’s communication plan for the Carseview Centre<sup>83</sup>, updated in August 2019, identifies the following challenges:

- “General Adult psychiatry Inpatient Service staff are based on two sites, which can make communication problematic.
- Staff, through their commitment to the delivery of clinical care, often find it difficult to “free up” time to attend meetings and often have to rely on meeting minutes for information.
- Intranet access is limited as each area has only one dedicated computer terminal therefore ward based staff find communication via e-mail and intranet difficult.
- Cascade of information to key people is often not timely (e.g. staff catching up on emails during periods of night duty rotation). This can make access to up-to-date information difficult.
- Provision of information to patients and their carers or significant others regarding service delivery/development remains an ongoing challenge and requires innovative resolutions, often compounded in relation to the client’s named person and the requirement for client confidentiality.”

## On admission

5.41 Patients felt that they were not given sufficient, clear information when they were admitted as an inpatient. In particular, some basic induction information about the ward routines, timetables, arrangements for meals, how to summon help or assistance, were not communicated in a clear and memorable way. This left some patients feeling uncertain about the rules and procedures, and anxious in case they got them wrong. This was particularly true for patients who were in hospital for the first time, who might otherwise feel disorientated. Clear information should be regularly provided in ways which can be understood and remembered.

5.42 Care and treatment plans for individual patients were not always communicated clearly to patients, leaving them uncertain about what was meant to be happening to them, what activities they could participate in and when they would be seeing healthcare professionals. Families and carers similarly felt that they were not made aware of all the information they needed to be able to support the patient during their time as an inpatient, nor what level of support was available for them as family and carers. Where possible, all patients should be involved in their care planning and should have regular access to their care plans.

5.43 An inconsistent approach to the production of care plans was identified in several visits by the MWCS although they noted improvements in subsequent visits.

## On discharge

5.44 Again, some patients felt there was a dearth of accurate and helpful information for them as they approached the time when they were discharged from the ward.

82. Health and Social Care Alliance Scotland (2018). *The Independent Inquiry into Mental Health Services in Tayside: Hearing the voice of people with lived experience*. <https://www.alliance-scotland.org.uk/blog/independent-inquiry-into-mental-health-services-in-tayside-hearing-the-voices-of-people-with-lived-experience/>

83. Evidence provided by NHS Tayside in 2019. *General adult psychiatry in-patient service (Carseview Centre). Communications plan*.



Patient care plans were not always clear and they were at risk of leaving the ward without being aware of what the next stage of their treatment was to be. This uncertainty caused a considerable level of stress and anxiety, particularly for patients who had been inpatients for an extended length of time.

- 5.45 There were instances reported to the Independent Inquiry where patients were medically discharged to return to their home late at night when there was no-one at home to care for them. This is unacceptable, in the same way that a patient with a physical condition would not be discharged home without there being suitable arrangements in place for social care. Mental health patients may be particularly ill-equipped to cope with such unsatisfactory arrangements. In those circumstances, the risks of the patient needing to re-engage with crisis services are obvious. The Carers (Scotland) Act 2016<sup>84</sup>, which came into effect in 2018, has implications for this part of the patient's journey. Carers have a legal right to be told when the person they care for is being discharged (unless they were detained under the Mental Health Act provisions).
- 5.46 Discharge planning should begin at point of admission with Multi-Disciplinary Team (MDT) reviews, which all the relevant professionals should attend. Advocacy groups should also be invited to step-down and discharge meetings. Similarly, CMHTs should always be informed when a patient is being discharged from hospital.
- 5.47 There should be clear step-down care plans for patients going home, so that there is continuity of care when they move from hospital back to the community. If patients' families and carers are expected to play a role in supporting the patient after their discharge, then clear and accurate information needs to be communicated to

them. Healthcare professionals have cited patient confidentiality as a reason for their not being able to pass on information about the patient to others. Patient confidentiality must, of course, be respected and adhered to within the context of the legal framework, but if the support of families and carers at home or in the community is so important, greater efforts should be made to seek the consent of the patient to such information sharing. Where information cannot be shared, greater efforts should be made to explain to families and carers why this is the case. The 'Triangle of Care' provides clear and unambiguous guidance on the sharing of such information.<sup>85</sup>

## Communication between services

- 5.48 The Independent Inquiry heard many examples of poor communication between services. Patients have reported that when they are referred from one service to another, they have to start again, as if they were a new patient in mental health services. Information from a patient's record does not always accompany them into the ward, leaving the hospital staff not well informed about up-to-date treatment and medications. In addition, there has been poor communication between clinical staff in Carseview Centre and other parts of NHS Tayside, such as Ninewells and CMHTs.
- 5.49 Family members found on occasion, that nurses did not appear to know the patients who were on the ward. This may have been attributable to shift patterns or other reasons for staff absence. Additionally, staff were not always clear about the rights of the named person, nor were patients informed of their rights to independent advocacy.
- 5.50 When patients have walked out of Carseview Centre unexpectedly, there has been inconsistent application of the

84. <https://www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016>

85. Carers Trust Scotland. (2019). *The triangle of care. Carers included: a guide to best practice in mental health care in Scotland*. Scottish Government. 3<sup>rd</sup> edition.

[https://carers.org/sites/default/files/media/the\\_triangle\\_of\\_care\\_carers\\_included\\_a\\_guide\\_to\\_best\\_practice\\_in\\_mental\\_health\\_care\\_in\\_scotland.pdf](https://carers.org/sites/default/files/media/the_triangle_of_care_carers_included_a_guide_to_best_practice_in_mental_health_care_in_scotland.pdf)



self-discharge protocol. Subject to the requirements for patient confidentiality, it might be expected that families and next of kin are informed of such a change in a patient's circumstances. However, this has not consistently happened. Police in Tayside have expressed concerns about the number of people reported missing from psychiatric inpatient facilities.

- 5.51 In particular, the police considered that challenges existed around the volume of people being reported missing from mental health services across Tayside who left without challenge. Often there was no clear information provided to detail what checks or attempts, if any, to contact the individual or family members, had been carried out by health professionals. Mental health services appeared to have limited provision to carry out the necessary welfare checks themselves, particularly during out of hours. Therefore the NHS was reliant on the police to undertake these tasks, when the police were often dealing with other demands. All inpatients should have a plan for the management of potential unplanned discharges, which should be completed on admission and updated at each MDT meeting.
- 5.52 Poor record-keeping has contributed to difficulties in communicating clearly between staff and services. The mixture of written and computer records means that unnecessary duplication and inconsistencies persist. Incomplete or unclear care plans have restricted communication between professional services.

## Continuity and consistency of care

- 5.53 Many patients found it unsettling to have appointments with multiple psychiatrists, rather than seeing one consultant consistently. This was exacerbated by the number of locum psychiatrists employed in Tayside, who often adopted different approaches to diagnosis and treatment. Families and carers were also frustrated at

the frequent change of consultants.

- 5.54 Consultants and community nurses did not attend community or ward team meetings regularly, resulting in care being disconnected.

## Management of Change

- 5.55 Both patients and staff reported to the Independent Inquiry that they found out about major changes to the ward arrangements at short notice. Patients found this particularly unsettling, as did their families and carers. Staff felt frustrated that they had not received more notice about ward moves, and felt disengaged and excluded from the decision-making processes. The poor management of change impacted both on staff and on patients, their families and carers.
- 5.56 It is always beneficial to involve carers and families in care planning, but too often such involvement was either absent or inconsistent. Advance statements are helpful in setting the expectations that carers and families will be involved in the planning of care.
- 5.57 Senior clinicians learnt that their ward was to be closed either without consultation or contrary to the clinicians' advice. On occasions, it was stated that such changes were to be of a temporary nature, but became, in reality, permanent changes. It was felt that services were being put through a rapid change process without fully understanding the needs of the service. Insufficient time was allowed to implement the changes smoothly and in a way that built confidence in those managing the changes.
- 5.58 Quality Improvement analysis shows that all staff need time to make changes, to build their knowledge and to adapt to new arrangements.

## Summary

- 5.59 Planning for inpatient services needs to sit in the wider context of a comprehensive, strategic plan for the delivery of mental health services in Tayside. To date, inpatient services would appear to have dominated the processes and decision making, at the expense of community services, including prevention and early intervention. There needs to be a major shift of focus from meeting the needs of the services and organisation to meeting the needs of patients and communities.
- 5.60 Despite the focus of NHS Tayside on the provision of inpatient services, the Independent Inquiry learnt of multiple layers of poor practice and dysfunctional activities in inpatient services. For the treatment of patients to be effective, inpatient wards should be places of safety and security, where patients feel cared for and respected.
- 5.61 In line with accepted national guidance, greater emphasis needs to be placed on the prevention of the need for the use of physical restraint, through the use of listening, talking and de-escalating the underlying causes. Measures need to be in place to reduce the use of control and restraint and to minimise its impact. Patients should not be placed in a prone position and any use of restraint must be for the minimal length of time.
- 5.62 There needs to be a clear care plan in place for every patient. Such planning should begin prior to admission and should continue throughout their time as an inpatient and then extend to planning for their return to the community after discharge from hospital. Care planning should involve and include all relevant people and services, such as the patient, their families and carers, community mental health services and third sector organisations. Any failure to support patients with adequate care plans would increase the likelihood of their being readmitted as an inpatient.
- 5.63 There needs to be greater clarity about the criteria for admission to inpatient wards. An absence of clarity can fuel misunderstandings and inaccurate expectations from patients, partner organisations and staff. A more structured and formal system for bed management is required, which would inform decisions about how long patients stay on the ward and ensure sufficient “flow” in the system.
- 5.64 Allied to effective care planning, there needs to be comprehensive communication and information sharing with relevant parties. A lack of clear and transparent communication has led to many of the problematic issues raised in this chapter.
- 5.65 Finally, there needs to be a greater willingness to learn from events and incidents, through the development of a learning culture. Such learning should result from swift and comprehensive reviews following adverse events.

## Recommendations

23. Develop a cultural shift within inpatient services to focus on de-escalation techniques, ensuring all staff are trained for their roles and responsibilities.
24. Involve families and carers in end-to-end care planning when possible.
25. Provide clear information to patients, families and carers on admission to the ward, in ways which can be understood and remembered.
26. Make appropriate independent carer and advocacy services available to all patients and carers.
27. Provide adequate staffing levels to allow time for one-to-one engagement with patients.
28. Ensure appropriate psychological and other therapies are available for inpatients.

29. Reduce the levels of ward locking in line with Mental Welfare Commission for Scotland guidelines.
30. Ensure all inpatient facilities meet best practice guidelines for patient safety.
31. Ensure swift and comprehensive learning from reviews following adverse events on wards.
32. A national review of the guidelines for responding to substance misuse on inpatient wards is required.

# 6. Child and Adolescent Mental Health Services (CAMHS)

6.1 In June 2018, the Cabinet Secretary for Health and Sport announced a joint Task Force with COSLA on Children and Young People's Mental Health in Scotland. In September 2018, Dame Denise Coia, Chair of the Task Force, published her preliminary view and recommendations<sup>86</sup>. In this, she identified three key system improvements, to improve children and young people's services for the whole of Scotland:

- There should be stronger focus on prevention, social support and early intervention;
- There should be a wider range of more generic, less specialist interventions to allow specialist services more time to see those in most need;
- There should be better information and understanding for the public and all agencies/services of where emotional distress and mental health and wellbeing problems are best supported.

6.2 To address these, the Task Force developed a framework which focused on four themes - each of which represented a grouping of characteristics of young people. The themes are not mutually exclusive and indeed it is essential that flexibility in delivery of services for young people is paramount to ensuring good quality and high standards of care.

6.3 The themes are:

- **Generic:** children and young people experiencing emotional distress and

anxiety.

- **Specialist:** children and young people with serious mental health problems who require rapid access, assessment and treatment.
- **Neurodevelopmental:** children and young people who may have early developmental issues which could indicate a neurodevelopmental disorder (e.g. autistic spectrum disorder; attention deficit disorder; or learning disability) requiring specialist assessment from paediatrics, psychology and/or third sector organisations. These disorders have significantly impacted CAMHS in recent years.
- **At Risk:** children and young people who have had serious or multiple adverse experiences in their lives, who may be in care or are looked-after and who may fall through gaps due to changes of address, unstable home environments and/or lack of school attendance. This group would include young people who have experienced addictions, homelessness and poverty.

## CAMHS - NHS Tayside

### Management and Governance

6.4 In NHS Tayside, the CAMHS service lies outside the managerial remit of mental health services. CAMHS are positioned managerially within the Women, Children and Families Division of NHS Tayside. The Associate Medical Director of the Division is a paediatrician. The Clinical Care Group

86. Children and Young People's Mental Health Task Force. (2018). [Preliminary view and recommendations from the Chair](https://www.gov.scot/publications/children-young-peoples-mental-health-task-force-preliminary-view-recommendations/). Scottish Government.

- Director is a paediatrician. Although in itself, this structure is not unique to NHS Tayside, the lack of managers with mental health expertise was raised as a concern in meetings with staff groups.
- 6.5 Locally, there are differing views as to where CAMHS should be managed. If CAMHS should be aligned with child development it is correctly placed in the Women, Children and Families Division. However others held the view that CAMHS could sit equally well within mental health services and have a link back to paediatrics. Irrespective of where CAMHS is located there is a need to clarify the provision of professional support for all staff.
- 6.6 The Clinical Lead for CAMHS resigned in September 2019 and has yet to be replaced.
- 6.7 In recent years there have been fractured working relationships with adult psychiatry services mainly due to the managerial disconnect between the two services. The location of CAMHS in another directorate creates issues which clinicians have difficulty navigating. One such issue is clinical governance where reporting processes are not clear, nor is it clear where responsibility lies. If there is a clinical governance issue with the psychiatric treatment of a child, medical staff are unclear as to whether this should be reported via their own directorate or passed across to mental health. Clinical governance is integral to the management of services.
- 6.8 Ideally, paediatricians and psychiatrists should be working together, irrespective of where the service is sited operationally. The present management structure and reporting lines seem at times to be an impediment to staff working in CAMHS. There is a feeling that communications are difficult: for example, making arrangements for a multidisciplinary team meeting (e.g. social work, CAMHS staff, GP groups, and crisis services) has proved difficult, although should not be impossible if the working environment supports the idea.
- 6.9 The newly-formed Tayside Mental Health Alliance which meets monthly and includes staff from CAMHS is chaired by the Associate Nurse Director for Mental Health and Learning Disability, should encourage all those working in mental health services to regularly meet together - thus fostering a culture of sharing practices and encouraging open communication. This should in turn ensure that CAMHS' location in a different directorate no longer isolates staff from others working in psychiatric services elsewhere.
- ## Services
- 6.10 There is a view in Tayside that CAMHS has been failing the community, due mostly to the number of rejected referrals and lengthy waiting times. All GP practices who submitted evidence to the Independent Inquiry cited CAMHS as being a service which was under pressure and therefore in their opinions, failing in the delivery of services.
- 6.11 There are many very capable and caring staff working hard to deliver services to children and young people in Tayside but there is also a recognition that there is so much to be done in terms of improving services and systems, it feels almost paralysing. A former interim Associate Medical Director for Mental Health produced a report on mental health services. He noted that whilst attending a team meeting with CAMHS staff it was *“one of the most depressing meetings I have attended in my career...some of the staff's personal reflections about their inability to provide the level of service that they knew was required were heart-breaking.”*
- 6.12 There is a strong feeling of a lack of managerial support (particularly at Board level) for the service, with the main focus being on adult inpatient services. CAMHS services are one of the most vulnerable parts of Tayside mental health services. They deserve support and resource to improve their services. There are mixed

views on CAMHS from the three local authorities where one feels the new CAMHS arrangements are working well but another records that NHS Tayside are not very holistic in their approach to the CAMHS service delivery agendas. There is a very clear need to invest in children's early intervention and prevention services, to truly improve adult services. By neglecting one area of mental health services (in this case CAMHS) NHS Tayside are accepting a risk of consequential detriment to other services, in the long term.

- 6.13 CAMHS is located in Dundee (Dudhope Terrace) and in Perth (St Leonard's Bank). The Dundee-based service currently also incorporates Angus patients. There are plans to source premises in Angus in order to be able to offer services within the Angus community. In total CAMHS has four psychiatrists. There is currently a consultant based in Dundee dedicated to the treatment of patients based in Angus.

### The MacX Service (intensive outpatient outreach)

- 6.14 The intensive outreach model ensures that suitably trained and qualified CAMHS nurses are available to provide ongoing and responsive support to the most unwell and high risk (Tier 4) children and young people in the community. The service supports young people aged 12-18 suffering from severe mental health difficulties or who have complex social and educational difficulties alongside mental health difficulties and whose needs were not being met within the current services. The MacX service engages with the young people and their families in order to provide a coordinated service. There are no waiting lists for MacX, which shows excellence in service management.

## Waiting Times

### Accepted Referrals

- 6.15 Long waiting times have been a predominant feature of CAMHS nationally but especially in Tayside. The most significant issue is the performance of the CAMHS outpatient service in Tayside against the 18 week target. Local Delivery Plan (LDP) Standards are set and agreed by Scottish Government and NHS Boards to provide assurance on NHS performance. CAMHS waiting time (LDP standard) quotes "90 per cent of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral."<sup>87</sup>
- 6.16 The 18 weeks target measures the number of patients who started CAMHS treatment within 18 weeks of referral. Performance in NHS Tayside in April, May and June 2019 averaged at 61%, (against the LDP target of 90%). This showed a significant improvement against November 2018's figure of 39%. The most recent data published in December 2019<sup>88</sup> for the quarter ending 30 September showed a Tayside performance figure of 54.2%.
- 6.17 CAMHS has been working with a privately-owned specialist online mental health and neurodevelopmental service called Healios to provide initial treatment assessments, in an attempt to ameliorate the length of time some children and young people are waiting to be seen. Healios is a team of highly experienced and qualified CAMHS doctors and nurses who deliver a service to children and their parents and guardians via a secure, video-based channel. Healios provide a range of psychological assessments, therapy services and wellbeing tools that are readily accessible, flexible and designed to fit around the lifestyle of the child, young person and their

87. Health Performance and Delivery Directorate. (2019). *NHS Scotland performance against LDP standards*. Scottish Government. <https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/camhs-waiting-times/>

88. National Services Scotland Information Services Division. (2019). *Child and adolescent mental health services in Scotland: waiting times. Quarter ending 30 September 2019*. <https://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2019-12-03/2019-12-03-CAMHS-WaitingTimes-Report.pdf>



family. This type of online assessment is used in other areas of the UK and has been reviewed and is supported by the CAMHS team. Since the service was launched, Healios have focused on patients in Tayside who have been waiting over 18 weeks to be seen.

6.18 Following the publication of the Independent Inquiry interim report, where the discrepancy of the age of transition to adult services was highlighted as a problem, and in conjunction with national policy NHS Tayside reviewed its transition policy and from October 2019 began to implement a staged change for CAMHS to include all young people under the age of 18 whether or not they are in full-time education. The target date for completion of this transition is August 2020. This shows a needs-led, patient-centred approach to addressing concerns about young people's ability to cope with treatment within the adult domain.

6.19 However, increasing the age-range scope for CAMHS patients will inevitably increase numbers of referrals to CAMHS and therefore waiting times and costs to the service. Analysis of costs by age are interesting. The costs of providing a service to patients aged between 0 and 16 years is the same as the cost of providing a service to patients aged between 16 years and 18 years. This shows that the decision to extend CAMHS services to aged 18 will have a significant impact on waiting times and costs and there should be appropriate resource transfer from adult services to address this.

6.20 There continue to be long internal waits for the ASD assessment and care pathways. There is a concern that patients who have waited a long time for their initial assessment and then have a further lengthy internal wait for the ASD pathways, may deteriorate, making the work of the CAMHS staff much more difficult in the long run. Moreover, these young people will quite likely transition to adult services

with serious mental health presentations and probable poorer outcomes in the longer term. It is therefore imperative that appropriate preventative responses to support the mental ill-health of children and young people are in place to improve the long-term mental wellbeing of the population.

6.21 CAMHS waiting time statistical analysis across health boards have until recently been impossible to compare, as not all boards recorded waiting times in the same way. National targets have now been given to health boards allowing for unified measurements. In NHS Tayside, data gathering on CAMHS waiting times has been inconsistent, with a lack of relevant data captured to actively manage waiting times.

## Rejected Referrals

6.22 GP practices are frustrated with the number of rejected referrals.

6.23 In June 2018, the Scottish Government carried out an audit<sup>89</sup> of rejected referrals to CAMHS and invited all 14 health boards to participate. Seven health boards participated in this audit but this did not include NHS Tayside.

6.24 In Tayside, waiting lists are controlled by the CAMHS Referral Management Group, which analyses each referral and either rejects or accepts it. The CAMHS staff consider that gatekeeping in this way is essential as, to their mind, some children are being referred inappropriately. The Referral Management Group make every effort to signpost rejected referrals. The group is aware of waiting lists being inappropriately long but are struggling with a significant increase in referrals associated with emotional wellbeing issues – a societal feature of young people's declining mental health. The distinction between these issues and mental ill-health are not clear to those working outside mental health services. The

89. Audit Scotland. (2018). *Children and Young People's Mental Health*. <https://www.audit-scotland.gov.uk/report/children-and-young-peoples-mental-health>

Innovations Team for CAMHS have created a toolkit, namely: Health and Wellbeing Toolkit to assist with supporting and assessing young people's mental wellbeing and assisting GPs to help the patients and their families.

6.25 Rejected referrals may occur for a number of reasons:

- Pending more information
- If the person is in the service already, the referral is rejected
- Do not meet the referral criteria because they are being referred for something that CAMHS cannot help with.

6.26 There are societal drivers for children being referred to CAMHS. Parents want children to do well academically but the schools will not offer intensive educational support until their child's condition has been diagnosed. Educational psychology do not undertake cognitive testing and so the child needs to be referred to CAMHS for their diagnosis. CAMHS staff question whether a specialist mental health service should be required to accept referrals for cognitive testing. CAMHS staff now audit all rejected referrals as part of the improvement services work. There should be care taken that the resource engaged in rejecting referrals could not be better used to assess a child instead. The clinical time spent per week discussing rejecting referrals should be quantified and routinely measured against clinical time available for seeing patients.

specialist mental health support to remain in CAMHS. The hub will be a multi-agency service involving education specialists, social work and parenting specialists as well as paediatricians, which should allow for more support to children presenting with neurodevelopmental disorders. The recommendation from HIS in November 2018 to redesign the neurodevelopmental pathway has been taken on board by NHS Tayside CAMHS and work continues to progress this initiative, although at a slower pace than initially expected due to resource issues. Once in place, CAMHS will be able to focus on service improvements in Tier 3 mental health disorders. All staff in CAMHS should manage appropriate and proportionate caseloads which utilise their knowledge and skill sets. There is currently a significant number of children with ADHD on the CAMHS caseload who need to be seen regularly. Sometimes these children have other mental health needs too. Socio-economic deprivation has a big impact on disorders such as ADHD. The Neurodevelopmental Hub should make it easier to address some of these children's needs, more quickly and with a targeted focus.

6.29 The creation of the hub will not however negate the need for flexibility across the whole system. Children should receive the treatment they need from the right people at the right time.

6.30 In terms of referrals to CAMHS, these should not be seen as a therapeutic intervention. There should be other types of support to children and their families in the community such as an advice line.

## Neurodevelopmental Disorders

6.27 Assessment for neurodevelopmental disorders for children over the age of 8 years within NHS Tayside is currently undertaken by CAMHS. In some other health boards this work is undertaken by neurodevelopmental paediatric staff.

6.28 There has been a decision to create a Neurodevelopmental Hub which will allow

## Crisis services

6.31 Young people in crisis are, on occasion, being admitted to adult inpatient facilities, which is unacceptable and potentially detrimental to the mental health of the child concerned. Young people's admissions to adult wards should become a never-event, and instead the community must develop

better intensive home-based support for children and young people.

- 6.32 The service for CAMHS switches to NHS 24 after 5 pm on Fridays and all weekend. There is no direct access to on-call CAMHS specialists anywhere in Scotland; children and young people require to be seen by GP or A&E first. Another impediment to crisis treatment for children is that trainee doctors (psychiatry) working on-call will only have access to a child's medical records if they have completed a rotation in CAMHS and been given the requisite login to the system. This concern was identified by the trainee doctors as an administrative obstacle which they felt could be easily remedied, but had not been, despite repeated requests.
- 6.33 Not all CAMHS consultants participate in the out of hours rota for mental health services in Tayside. However, workforce planning is currently considering how CAMHS consultants can be part of the out of hours rota to support general adult psychiatry colleagues.

## Workforce

- 6.34 In recognition that staffing models will need to change as the availability of psychiatrists diminishes, CAMHS is moving to a model of employment of Advanced Nurse Practitioners (ANPs). These staff are currently being trained and will be employed to enhance and extend the skills mix. Clinical support workers' roles have also been introduced to work within the intensive outreach teams, allowing the qualified clinicians to concentrate on delivering psychological and specialist medical treatments. There are however a number of barriers to the new working model of upskilling lower graded staff. Changes to working practices and roles need to be fully accepted by all involved,
- and a culture of professional reciprocity is essential to service delivery in an environment of declining availability of medical staffing. Strong leadership from Board level right through management hierarchies to those at operational level, should exist to support the processes of organisational change. This will ensure staff feel included and empowered and the changes are well-structured.
- 6.35 The process for replacing vacant posts is cumbersome, with unnecessary delays to get requests signed off in order to move to advertisement. This puts the service into reduced capacity for longer periods than is necessary. In addition, budgetary errors in recent months have removed vacant posts from workforce planning models. Although now corrected, this took time, whilst patients were waiting to be seen.
- 6.36 The HIS report in 2018 for Tayside CAMHS noted that a proportion of clinical staff time was being spent on non-clinical work, including administration<sup>90</sup>. This is typical in mental health services where drivers to reduce cost often eliminate clerical and support roles. However, with waiting list challenges and services working at maximum capacity, clinicians' time should be protected.
- 6.37 The Independent Inquiry interim report highlighted the removal of the community-based Primary Mental Health Worker roles as being deleterious to mental health care and support for children and young people. These posts were created under the *Framework for Promotion, Prevention and Care* (FPPC)<sup>91</sup> published in 2005 which was underlined by the *Action Framework for Children's Health (2006)*<sup>92</sup> and included a target that 25% of NHS specialist CAMHS activity would be primary mental health work by 2015. There seems to be confusion around the decision-making process for

90. Healthcare Improvement Scotland. (2018). *Tayside Child and Adolescent Mental Health Services Report for NHS Tayside on Opportunities for Improvement. Executive Summary*. Healthcare Improvement Scotland's Mental Health Access Support Team. November 2018. <https://ihub.scot/media/5454/20181123-final-dcaq-executive-summary.pdf>

91. Scottish Executive. (2005). *The mental health of children and young people: a framework for promotion, prevention and care*. <https://www.gov.scot/publications/mental-health-children-young-people-framework-promotion-prevention-care/>

92. Scottish Executive. (2007). *Child and Adolescent Mental Health Services Primary Mental Health Work Guidance note for NHS Boards/Community Health (and Social Care) Partnerships and other Partners* February 2007. <https://www2.gov.scot/resource/doc/167355/0045998.pdf>

the removal of the posts, with NHS Tayside stating the funding was withdrawn by local authorities at the point when the funding was mainstreamed in 2016. However, other viewpoints are that funding for these posts was actually mainstreamed in 2005 at the end of the initial Scottish Government funded programme “Changing Children’s Services”. In any case, there is a view that the roles are more wellbeing than health-related and better sited in education budgets rather than being funded by health monies.

- 6.38 Since the removal of the posts, some schools have used budgets to buy in access to similar services, but many have chosen not to do so. Inevitably the decision has had a significant impact on families who were benefiting from the support of these posts and has increased the load on CAMHS, as families who used to gain support from the Primary Mental Health Worker roles in the community are now being referred to CAMHS unless they can afford to pay for private support. The move to education now also represents an inequity of service provision across the Board area.

## Patient Confidentiality

- 6.39 Patient confidentiality and a perceived unwillingness of staff to involve parents and carers in a patient’s care planning is a significant concern to families and has repeatedly appeared in the evidence submitted to the Independent Inquiry. Parents and carers, in a heightened state of anxiety themselves regarding their child’s mental wellbeing, are often not included in discussions about care plans. Often parents or carers reported that parental involvement was discouraged and any feedback was given to parents in the waiting room in a snatched few minutes between appointments. Parents were not clear if they were allowed to ask to be involved in meetings regarding their child’s care. One family reported that any interaction they had with CAMHS staff regarding the care of their child was at the family’s initiation only.
- 6.40 Young teenagers referred to CAMHS are given the choice as to whether or not they want their parents and carers to be involved in further appointments. If the patient opts to speak to CAMHS staff alone, the parents are subsequently excluded from care planning and treatment. Parents in those circumstances reported they received no guidance on how to support their child at home. Some families reported that CAMHS advise children to contact a friend if they are in crisis. Parents, already excluded from a child’s treatment and care plans, felt this policy created more anxiety and concern for them.
- 6.41 There are clear guidelines about breaching confidentiality in conjunction with supporting a child with mental ill-health. Risk assessments are essential before any confidentiality is breached as there will be a breakdown in trust between the service and patient which will then be detrimental to the patient’s treatment. Parents can however contact the CAMHS duty worker for advice and support if necessary.
- 6.42 Working to the GIRFEC<sup>93</sup> (Getting It Right For Every Child) principles to promote the wellbeing of children, and supporting parents and carers with this role, practitioners require to be clear about how they engage with parents when working with a child with regards to sharing information or not sharing information about a child’s wellbeing. This should be well documented in patients’ records and form part of the overall risk assessment, with all clinicians working from the same understanding.
- 6.43 An independent advocacy service for parents and carers of young people who are engaged with CAMHS may help to ensure that families do not feel isolated during the period of their child’s treatment.

93. <https://www.gov.scot/policies/girfec/>

## Tayside Children's Collaborative

- 6.44 In 2017, government both locally and nationally worked together to develop regional Improvement Collaboratives (ICs) for education. The IC's aim is to *"improve education and life chances for all children, using data to identify gaps and to build on and learn from the good work already taking place, regionally and nationally."*<sup>94</sup>
- 6.45 The Tayside Children's Collaborative<sup>95</sup> partnerships is between the three local authorities: Angus Council, Dundee City Council, and Perth & Kinross Council and is the only regional collaborative to have included all children's services as well as education. This means that NHS Tayside is a partner in the collaborative too. The Collaborative has established five working groups to reflect the priorities identified in the Tayside Plan for Children, Young People and Families. One of the working groups is focused on Mental Health and Wellbeing.

## Community and Third Sector

- 6.46 In Perth & Kinross, there is an "Emotional Wellbeing Collaborative" (EWC)<sup>96</sup>. EWC is aimed at the 11-15 year old age group although it also includes one primary school. The Collaborative includes health and education professionals as well as third sector contributors and those representing young people, carers and parents. It aims to improving resilience through support.
- 6.47 The Collaborative includes:
- **"Bounce Back!"** initiative. Being rolled out at 3 schools from August 2019. Designed to build resilience in young people.
  - **Working together (engage and support)** - collaboration between NHS Tayside, Perth & Kinross Council and Third Sector Organisations. This focuses on various

areas such as building a positive learning environment; building a community understanding of resilience; building positive home environments and encouraging healthy lifestyles.

- **Working together (resilience through sport)** - collaboration facilitated by EWC. CAMHS and Schools piloted project based in Coupar Angus Primary School which worked on the theory that developing sporting skills will build resilience in other respects namely, *focus* (being able to listen and follow instructions) and *waiting their turn* (example of delayed gratification).

## CAMHS Regional Inpatient Unit

- 6.48 The CAMHS Regional Inpatient Unit known as Young People's Inpatient Unit (YPU) is located beside the CAMHS service, in Dudhope Terrace. It is a 12-bed purpose-built facility serving North Scotland (Tayside, Highland, Grampian, Orkney and Shetland) health board regions. Four of the beds in the unit are for Tayside. There are two consultant psychiatrists based in the YPU.
- 6.49 The unit appears to be functioning well, with the young people generally positive about their experience of care and treatment within the unit. There is good multidisciplinary input with two psychiatrists in substantive posts, supported by physiotherapy, dietetics, psychology, pharmacy, occupational therapy, and family therapy. Social workers and representatives from education also support the work of the unit.
- 6.50 It is essential to look closely at community services for children and young people. The four beds allocated for Tayside at the YPU are reserved for the most complex cases and clarity is required around the specialist provision available within this unit and the resources available in the community. There is a misunderstanding that these

94. Perth and Kinross Council. Tayside Children's Collaborative - November 2017. <https://content.govdelivery.com/accounts/UKPKC/bulletins/1d2ada3>

95. <https://www.taycollab.org.uk/>

96. <https://www.pkc.gov.uk/article/17401/Emotional-wellbeing-collaborative>



beds are available for the admission of any Tayside children out of hours and this misunderstanding gives rise to a great deal of difficulty both for the unit and those doctors on call out of hours. It is an excellent service in a very well-designed building with very skilled and committed staff and a very good manager<sup>97</sup>. However it cannot be the answer to the Tayside CAMHS difficulties.

- 6.51 There are also very good links with the local police, with an identified liaison officer. Local police visit the unit regularly to speak to the young people, in a community-type meeting. This establishment of a link with the local police is mutually beneficial - with the police better able to understand the role of the YPU and mental health needs of young people, whilst also helping young people to see the police as a supportive agency, rather than a punitive one. The relationship has also allowed the police to discuss specific issues with the young people, such as how to keep themselves safe on social media.
- 6.52 There is a strong ethos of person-centred care within the unit. The unit has recently been focused on improving safety and reducing harm through innovation and collaboration with staff, service users, families and carers by using quality improvement approaches.

## Transition from CAMHS to General Adult Psychiatry (GAP)

- 6.53 Patients and families reported difficulties in transitioning between services once the patient had reached the age of 16 or 18. The difficulties ranged from administrative errors in the transfer of patient records between services, to feelings of not understanding how adult services work and associated feelings of isolation and fear

within the adult inpatient services. Some medical staff in CAMHS reported that they would happily keep an 18 year old on their caseload until a time they were more able to cope with the transition, but this was not always the case. In terms of continuity of care, services should aim to provide a continuous programme of treatment rather than a stop/start process as the young person moves between services.

- 6.54 NHS Tayside's decision to change the age of transition to 18 should make a difference to the experiences of young people, some of whom at the age of 16 were transferred to adult services if they had left school. Scottish Government's *Transition Care Planning Action 21*<sup>98</sup> gives process-guidance for young people moving between CAMHS and adult services. The use of GIRFEC<sup>99</sup> wellbeing indicators are essential in making sure the young person's views are captured and incorporated into any planning process.
- 6.55 In terms of lived experience, there was a suggestion made by several families, that there should be a halfway service between children and adults which would bridge the age range 18-24. This would recognise the fact that most people in society are experiencing change in their lives during those six years as they leave school/home and move to further or higher education or attempt to find work. Those who already have a mental health diagnosis struggle more at this time than others. Equally, others who have never experienced issues with their mental health may find themselves seeking help from mental health services for the first time during this period in their lives. A service dealing with young people specifically within this age group would enable a targeted approach to supporting young people's mental health issues, before they move into adult services.

97. Mental Welfare Commission for Scotland. (2019). Report on announced visit to: Dudhope Young People's Unit, 17 Dudhope Terrace, Dundee DD3 6HH. Date of visit: 9 July 2019. [https://www.mwscot.org.uk/sites/default/files/2019-09/Dudhope\\_YoungPersonsUnit\\_20190709a.pdf](https://www.mwscot.org.uk/sites/default/files/2019-09/Dudhope_YoungPersonsUnit_20190709a.pdf)

98. NHS Scotland. (2018). Transition care planning action 21: ensuring good transitions. <https://www.gov.scot/publications/transition-care-planning-action-21-responsibilities-services-ensure-good-transition/>

99. <https://www.gov.scot/policies/girfec/>



## Summary

- 6.56 The mental health and wellbeing of children and young people in Tayside should be a clear and significant priority in the strategic development of NHS Tayside's mental health services. There is a need for NHS Tayside to prioritise support and resource to CAMHS. Investment in early intervention and prevention services to support children's mental wellbeing will almost certainly lead to less pressure on adult services in the future - thus improving the mental health and wellbeing of the population as a whole.
- 6.57 There is a national requirement to reduce waiting times for CAMHS and NHS Tayside have employed strategies in recent months to achieve this. Whilst there has been improvement in the last 12 months, there is still more to be done to achieve the 90% target of all accepted referrals being seen within 18 weeks. Rejected referrals to CAMHS are a concern across the whole of Tayside particularly for GP practices and also for families and carers. Whilst a service such as this must be permitted to manage its caseload, the nervousness in the communities around rejected referrals also needs to be managed in a supportive and collegiate manner.
- 6.58 The organisational position of CAMHS within NHS Tayside appears at times to be posing an impediment to the clinical service delivery. The co-location of the service with paediatrics within the medical directorate has clear advantages for the patients but has led to feelings amongst staff of being marginalised from mental health services and of being structurally 'lost' in the Board's managerial hierarchies. CAMHS is a high-ticket item in terms of public perception of mental health services in Scotland. NHS Tayside should ensure CAMHS is afforded adequate resource both financially and managerially and is fully supported in its delivery of services for the children and young people of Tayside.

## Recommendations

33. Focus on developing strategies for prevention, social support and early intervention for young people experiencing mental ill-health in the community, co-produced with third sector agencies.
34. Ensure that rejected referrals to Child and Adolescent Mental Health Services are communicated to the referrer with a clear indication as to why the referral has been rejected, and what options the referrer now has in supporting the patient.
35. Ensure the creation of the Neurodevelopmental Hub includes a clear care pathway for treatment, with the co-working of staff from across the various disciplines not obfuscating the patient journey. The interdisciplinarity of the Hub may give rise to confused reporting lines or governance issues. A whole system approach must be clarified from the outset.
36. Clarify clinical governance accountability for Child and Adolescent Mental Health Services.
37. Support junior doctors who are working on-call and dealing with young people's mental health issues.
38. Ensure statutory confidentiality protocols for children and young people are clearly communicated to all staff. The protocols should also be shared with patients and families at the outset of their treatment programme, so that parents and carers know what to expect during the course of their child's treatment.
39. Consider the formation of a service for young people aged 18 - 24, in recognition of the difficulties transitioning to adult services and also recognising the common mental health difficulties associated with life events experienced during this age range. This may reduce the necessity for these patients to be admitted to the adult inpatient services.

40. Ensure comprehensive data capture and analysis systems are developed to appropriately manage waiting lists and service users' expectations. Work should be undertaken to look at what data is available and what could be useful to inform decision making on service development and monitoring of services. This should be aligned to national reporting requirements.
  
41. Consider offering a robust supportive independent advocacy service for parents and carers of young people who are engaged with Child and Adolescent Mental Health Services. This may include carer support groups.

# 7. Staff

*“It is very well known how to make staff happy in a workplace. There is a wealth of evidence that staff need to feel they are paid fairly, have autonomy, mastery, a sense of purpose, and feel trusted, valued and supported.”* Dr Munro Stewart (Faculty Board, East of Scotland Royal College of General Practitioners)

7.1 There are a lot of very good, dedicated staff working in mental health services in Tayside, across all services. There is no doubt however that the public concern about the quality of the services detailed frequently in the local press, has made for a very difficult and challenging workplace for many of the staff in the last couple of years. It is therefore heartening to record that evidence was received by the Independent Inquiry from patients who had been treated well in mental health services and for whom NHS Tayside’s mental health services had been crucial in supporting their recovery. These patients were grateful to certain members of staff who showed care and concern throughout their periods of mental ill-health.

7.2 The Independent Inquiry talked to many compassionate, committed staff working across all the services in mental health in Tayside who shared their thoughts about what was wrong and what could be done to improve services but stated that these ideas and suggestions had not been listened to by their managers. Negative publicity about the services is, almost certainly, affecting NHS Tayside’s ability to recruit staff to the services. However, the problems with recruitment and retention are symptoms of the wider issues within NHS Tayside, rather than the root cause. Improvements to services are essential if mental health provision in Tayside is going to meet demand and expectation of the local populations.

7.3 The staff are critical elements to any strategic programme of improvement.

7.4 One local GP observed:

*“The best examples of good experiences are due to individual excellence and dedication [of staff]....I have seen numerous lives turnaround by the mental health services. The staff that do the amazing work should be cherished and celebrated.”*

## Staff attitude and behaviour

7.5 Nursing staff were reported by some people to be “absolutely amazing” in the care and treatment of patients in mental health services. Whilst recognising that the inpatient environment was not an easy one to work in, some patients described staff as being dedicated and hard-working, ensuring all patients were treated well.

7.6 One patient observed they were:

*“... Seen by two lovely caring staff of the crisis team... were very helpful and caring at what they did ...including following day when we called again...”*

7.7 A registrar who has now left NHS Tayside mental health service made this comment about nursing staff:

*“The vast majority are exceptionally caring, understanding, wise professionals that offer the bulk of the inpatient and acute therapy. This is a hugely undervalued resource. These people work in tough conditions constantly feeling undervalued. If they were not so dedicated to helping others, they would all be working in other jobs. These people should be empowered to do their best.”*

7.8 However, many of the reports from patients and families of good treatment by kind, helpful and supportive staff were presented alongside concerns about lack of available

staff resource. This was perceived by patients as being the constant challenge to good services, with observations of staff working with little or no support.

7.9 One family reported

*“In general, we feel that most of the staff within the service do care about their patients and try to do their best. However, it is abundantly clear that the entire service has been severely under resourced for some time, and from our recent interactions it appears to be close to collapse...”*

7.10 A doctor no longer working in the service stated:

*“The knowledge of how to treat mental health conditions is there. The barriers are resources, staffing, accountability, and cultural attitudes.”*

7.11 Recognising that service improvements were badly needed, some patients felt that the staff should be key to the development of service improvement and reform. One said:

*“... I got to know well many of the dedicated nursing and ancillary staff at IPCU and their expert views on reform of the system should also be at the heart of reform...”*

7.12 However, there does not seem to be recognition within NHS Tayside management structure that staff are key to service development strategies. Staff who worked hard for the services, who clearly cared deeply about the quality of care they were able to offer, reported that they were not listened to by managers and those involved in designing service provision. Consultant staff reported spending time thinking about what could be done to better manage services, detailing their thoughts into papers or emails only to receive no acknowledgement or any recognition for

the work they had undertaken. The same applied to key nursing staff, both inpatient and community-based, who reported feeling that their contribution to service development was not welcome.

7.13 The lack of value afforded to highly professional and committed staff has led to a level of despondency in the workforce, which in turn has led to higher than usual attrition rates. This also contravenes Quality Improvement methodologies where it is accepted that change should be led by the staff ‘up’ not by the management ‘down’.

## Workforce (Recruitment and Retention)

7.14 There is a well-recognised national shortage of psychiatrists, which impacts on NHS Tayside as it does with all other health boards. Interestingly, a General Medical Council publication<sup>100</sup> from October 2019 noted that there has been a small increase (2%) in doctors in psychiatry training programmes after years of stagnation and decline, which is encouraging in the longer term.

7.15 In November 2019, there were 7.85 whole time equivalent (WTE) consultant psychiatrists in post across Tayside mental health services against a required establishment of 23.6.

7.16 In September 2019, there were nine services without a substantive consultant psychiatrist and therefore fully dependent on locum consultants. A report showing the vacancies from June 2018 to June 2019 is shown in Appendix H.

7.17 In 2017 the NHS Tayside Assurance and Advisory Group’s Staging Report noted:

*“NHS Tayside should undertake an early and comprehensive review of staffing levels*

100. General Medical Council. (2019). *The state of medical education and practice in the UK: the workforce report 2019*. [https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk--workforce-report\\_pdf-80449007.pdf](https://www.gmc-uk.org/-/media/documents/the-state-of-medical-education-and-practice-in-the-uk--workforce-report_pdf-80449007.pdf)

*across all services and sites, including those delegated to or utilised by HSCPs [Health and Social Care Partnerships]. This review should aim to clarify key drivers of NHS Tayside's workforce levels compared to peer Boards and to identify safe options for bringing redesigned services and sites within available resources.”<sup>101</sup>*

7.18 A significant number of experienced consultants have left Tayside over the last 12 months either predictably (retirements) or by choosing to leave and work elsewhere. The Independent Inquiry received many notes of concern from patients when a community-based consultant psychiatrist left NHS Tayside to work elsewhere in recent months. A GP observed that the consultant had had “a huge personal impact on patients” adding, their “dedication, humility and expertise has transformed numerous lives.”

7.19 The experience of staff recently resigned from their posts in NHS Tayside is that there is no formal system of undertaking exit interviews. NHS Tayside's documentation Transforming Tayside: NHS Tayside Collective Leadership and Culture Strategic Framework 2018-2023<sup>102</sup> states under the progress measures that “NHS Tayside has a values-based employment journey. Target of >80% staff leaving the organisation complete exit questionnaires”. This is an ambitious target as it is difficult to compel those leaving the organisation to complete a questionnaire. It is also interesting to note that the target is the completion of a questionnaire, rather than an exit interview.

7.20 The concerns for the service to patients were recorded in the annual report of the Clinical, Care and Professional Governance Group of Dundee Health and Social Care Partnership in 2019<sup>103</sup>:

*“The number of Psychiatrists within the Community Mental Health service continues*

*to run well below required levels. The appointment of agency staff have supported the management of this risk, however, it is not tenable to sustainably manage this risk over the long term.*

*The absence of a medical management structure for Dundee Psychiatrists is a particular challenge in terms of implementing short term risk management measures. Medium term measures being progressed include a redesign of services, incorporating a job planning process for Psychiatrists.”*

7.21 Nursing staff raised concerns about the use of locum consultants who they observed work with varying levels of knowledge and motivation. It was also noted by a senior staff member that patients' diagnoses and treatments are changed as they are seen by different consultant staff. In these circumstances the nursing staff are the constant for the patients, as they try to support them through the changes to their care and treatment within mental health services.

7.22 In terms of addressing consultant vacancies, mental health service managers plan to create ten Advanced Nurse Practitioner (ANP) posts. Eight staff are already on the programme and a further two will start their training in 2020. Whilst this is an obvious solution to the lack of available psychiatrists, consideration must be given to the change in available skill-sets (e.g. certain Mental Health Act decisions cannot be made by non-psychiatrists). Medication prescribing is also less straightforward as ANPs need supervision from a doctor when working beyond the evidence-base. However, with good management and support this strategy has the potential to work well in addressing the medical workforce challenges, providing there is a willingness from all staff to adopt this different approach to patient

101. NHS Tayside Assurance and Advisory Group. (2017). *Staging report of findings and recommendations*. <https://www.gov.scot/publications/nhs-tayside-assurance-advisory-group-staging-report-findings-recommendations/>

102. Tayside NHS Board. 25 October 2018. *Transforming Tayside: NHS Tayside Collective Leadership and Culture Strategic Framework 2018-2023*. BOARD99/2018.

103. Dundee Health and Social Care Partnership. 25 June 2019. DIJB32-2019.

care. One suggestion which was made to the Independent Inquiry was that case-holders could be nurses, rather than the consultants, as is common practice across in other boards in Scotland.

7.23 Nationally, one of the factors affecting consultant recruitment and retention is the fact that medical staff often now fully retire from substantive posts, rather than partially retiring to return on reduced hours contracts. This factor is not unique to Tayside nor to mental health specifically and so should be considered at government level in medical workforce planning for the NHS in Scotland.

7.24 Medical staffing shortages are not the only challenges to workforce planning in mental health services in Tayside. Allied Health Professionals working within mental health feel they have an ever-increasing workload which is detrimental to patient journeys. One staff member from occupational therapy services said:

*“...As healthcare professionals we fire fight on a daily basis, Occupational Therapy posts have reduced... ...Occupational Therapists have a unique skill set and we deliver interventions at the point of moving people on from the service, which relieves pressures on crisis management in the service...”*

7.25 A Tayside NHS Board paper in October 2019<sup>104</sup> also showed a particular problem in the workforce data for psychological therapies:

- Establishment: 128.15 WTE
- Vacant Posts: 30.6 WTE
- Maternity Leave: 9.9 WTE

7.26 The availability of Mental Health Officers (MHO) within social work services is also reducing. Again, there are issues with recruitment nationwide, with a continuum of significant expertise being lost as staff

retire. This applies in Tayside with many employed in all three localities being in the latter part of their careers.

7.27 The nursing staff workforce also feel under pressure with lower than optimal numbers of nurses employed within the inpatient services. One staff nurse stated:

*“...beds are like gold dust, and are often filled with long-term drug users, people who have issues with alcohol, and people with a diagnosis of personality disorder. The patients I have listed above often have a great deal of needs, which probably require speciality care. People with ‘old school’ diagnosis such as Schizophrenia, Depression and Bi-polar disorder get no time from us at all. They get completely overlooked because our time is demanded elsewhere. They ask for nothing and get nothing from us.”*

7.28 There needs to be a sustainable model of staffing numbers per shift against caseload and paperwork requirements. Staff reported the use of pass-beds puts the ward over their patient allocation number, therefore increasing caseloads and associated paperwork without any corresponding increase in staff numbers.

7.29 In a paper tabled at the September 2019 Perth & Kinross IJB meeting, it was noted:

*“The current age profile of the RMHN (Registered Mental Health Nurse) workforce in Tayside is such that 36.5% of the workforce is over 50, who can either retire in the next five years or are already working past 55 years. This amounts to not only a significant reduction in workforce numbers, but also a loss of valuable skills, knowledge and experience. The main source of Registered Mental Health Nurse recruitment in Tayside is through the mental health undergraduate nurse programmes at the University of Dundee and the University of Abertay. Currently there are two opportunities each year to recruit Newly Qualified Practitioners (NQPs) from the local programmes.”*

104. Tayside NHS Board. 31 October 2019. [Annual operational plan 2019/20 action tracker](#). BOARD 87/2019.



*Recruitment of NQPs has consistently been between 45 - 50 NQPs a year, which enables recruitment to broadly keep pace with rates of retirement only.”<sup>105</sup>*

7.30 Tayside Substance Misuse Services need to prioritise workforce development to enhance capability in prescribing capacity. In Dundee there have been developments in relation to Scottish Government funding identified to support a nursing workforce to include specialist posts with prescribing capability. Due to the national shortage of these posts, trainee positions were created to work towards increasing the prescribing capacity but will take between 2 and 3 years to be achieved.

7.31 The recruitment process within NHS Tayside is cumbersome and long-winded. The length of time from completion of the forms to request permission to replace a post, to the advertisement of the post is four months. After that, the successful candidate is often required to work a notice period extending the delay to the process further. This protracted recruitment process is not unique to NHS Tayside, it is typical in many health boards. However, the process-inefficiency means that services are running on reduced capacity for longer than should be necessary, which is almost certainly adversely affecting the quality of patient care.

## Staff concerns regarding patient safety

7.32 Many staff members reported feeling worried about the safety of patients in conjunction with declining staffing levels and lack of available resources. They also reported that despite raising concerns with senior management, there is rarely an immediate response to address an issue. Wards are regularly run with half of the nursing staff on duty being bank staff - who do not know the ward, the patients or the routines. In some cases, the consultant on

the ward is also a locum. One staff nurse reported that in their opinion the constant reliance on bank staff is an enormous risk to patient safety.

7.33 Medical staff stated that they have reported that in their opinion some services are categorically unsafe for patients, but their concerns were repeatedly ignored.

7.34 A doctor stated:

*“Staff were discouraged on a senior adult mental health ward that I worked on from reporting staff shortages. This reporting is the only evidence the nurses had that they had raised concerns of unsafe care. When adverse events occur there seemed to be a blame culture of frontline staff and a complete lack of acknowledgement of previously raised concerns about obvious staffing and resourcing issues and the inevitability of an adverse event, with the resource issues. Accountability for resourcing must be escalated as far as required to protect patients and the frontline staff, but there is no accountability for short staffing on management, the health board or the government. Accountability seems reserved for those most vulnerable to losing their job. This strikes me as a gross injustice. Healthcare staff are put in the impossible position of either working in inadequate conditions at risk to their own career and reputation or quit and leave the health service in a worse position”.*

7.35 The use of locum doctors has also been raised as a patient-safety concern with the Independent Inquiry. All doctors in training to become consultants require to apply for a certificate of completion of training and join the Specialist Register or GP Register. Doctors working within mental health are required to complete a certificate of training in core psychiatry, with additional specialty training required for psychiatry of learning disability; forensic psychiatry; child and adolescent psychiatry; old age psychiatry advanced training. In October 2019, only

105. Perth and Kinross Integration Joint Board. (September 2019). Adult Mental Health and Learning Disability: Service Redesign Programme Progress Report and Risk Review Paper. Report No. G/19/159.

- 50% of the 13 locum doctors employed in NHS Tayside were holding a specialist qualification and were on the specialist register and therefore able to support the on-call element of rotational working.<sup>106</sup>
- 7.36 In their written evidence to the Independent Inquiry, the RCPS stated that as of August 2019 there were 18 Compulsory Treatment Orders (CTO) in Dundee which had no Responsible Medical Officer (RMO) oversight and that this was a direct violation of patient safety.
- 7.37 The Independent Inquiry has been told that senior medical staff have raised concerns with senior management on multiple occasions, only to be ignored. This includes writing letters to senior management - including the NHS Tayside Chief Executive and Chair of the Board - and either receiving no response at all or being told that they did not wish to meet with consultants and that their concerns were “in hand”. The lack of engagement with senior professional staff fosters a culture of anxiety and worries of being marginalised and excluded from helping to find solutions. This leads to poor confidence in the management and a complete lack of trust that concerns are even being taken seriously. This in turn leads to serious concerns about patient safety.
- 7.39 Many consultant staff reported that they have attempted to engage with senior management about their concerns over the years, only to be “*ignored, passed off or even lied to*”.
- 7.40 In recent years, staff workloads have increased, often without prior discussion and as a result, consultants felt they had a high level of responsibility with minimum power to influence decision-making.
- 7.41 There is currently a management void in several areas of mental health services, with many clinical lead posts vacant. Several staff have recently resigned from these posts feeling they were not given support or time to carry them out professionally.
- 7.42 Some consultant staff have felt over the last year that they have had no real line management and that they have been left to make their own judgements with no ongoing support when things go wrong.
- 7.43 The Independent Inquiry received many comments from frontline staff that consultants have strong viewpoints and are not open to discussion about new ideas or thinking. A more charitable view presented by longer-standing frontline staff was that many have been undermined, undervalued and treated unfairly for many years, to the extent that they have been forced to develop coping strategies which involve a level of intransigence. In this environment, innovative care based on a balanced risk approach is not possible.
- 7.38 There has been a long-standing lack of trust between the different groups of staff working in mental health services in Tayside. Decision making has, for many years, bypassed senior consultants in the management-led model of service delivery. The delivery of robust healthcare is the responsibility of Senior Management Teams and should be carried out in collaboration and consultation with all relevant staff groups.
- 7.44 The recent appointment of an Interim Associate Medical Director for Mental Health in September 2019 should go some way to addressing the lack of line management for the consultant staff, but this post is still only two days per week and is not a permanent appointment.

## Responsibility

106. Tayside NHS Board. Care Governance Committee. 5 December 2019. [Minute: Care Governance Committee, Open Business, 10 October 2019 Assurance Report on the Mental Health Services: Sustainability of Safe and Effective Strategic Risk](#). CGC/2019/76

## Accountability

- 7.45 The declining number of consultants has led to a consequential effect of trainee doctors being expected to be on-call with no consultant oversight. These situations are generally resolved with consultants eventually being willing to volunteer to cover, but sometimes not before the trainee had consulted their Medical Defence Union and advised not to work at all.
- 7.46 Accountability is a problem. A GP reported that he saw a patient in practice but had to look back five years to find a consultant's name in their notes - they had only seen trainee psychiatrists during that time.
- 7.47 A trainee psychiatrist told the Independent Inquiry:

*“... Getting in touch with consultants was really hard. I was stuck trying to detain someone when the crisis team had left at the end of their shift. Because there are no protocols written down anywhere it wasn't clear who is responsible for finding someone a bed. Everything gets pushed back to a junior doctor...”*

- 7.48 Management of staff absence is a continual problem at Tayside. It seems there is little or no contingency planning, meaning that staff absences have a negative effect on those left to cope.
- 7.49 One GP practice group observed:

*“CPNs are off sick. Our patients are receiving letters saying the CPN is off sick and their appointment is just cancelled.”*

- 7.50 It is accepted that all health boards struggle with staff absence, but if the focus of patient care in mental health is in the community, not addressing long-term absence of CPNs is simply transferring the

problem back to the GPs.

- 7.51 The lack of clear accountability and responsibility has led to an increasing culture of blame. The junior medical staff reported that they feel they are often made to be the scapegoat when things go wrong. This has led to a significant increase in risk-averse clinical decision-making by the junior doctors, for fear of reprisal. It seems to be an accepted philosophy that NHS Tayside will not support doctors who are the subject of an investigation or post-event scrutiny. One person observed that *“the strategy of the board has been to hang doctors out to dry whilst not giving them the resources to improve things.”* This was evidence of a high level of distrust of the board and has created a fundamentally defensive environment in which all staff operate daily.

## Service Redesign Programme

- 7.52 The service redesign programme should ensure staff are at the heart of the change process with managers listening carefully to those at operational and frontline service delivery. The context to the service redesign programmes is captured in the table below - where the distribution of patients accessing mental health services can be seen across all the various disciplines.
- 7.53 The NHS Tayside patient activities, from January to December 2018<sup>107</sup>, were described below:

<sup>107</sup>. Evidence provided by NHS Tayside in 2019.

<ul style="list-style-type: none"> <li>• Mental Health Inpatient Service</li> </ul>	<p>1,950 total inpatient admissions</p> <ul style="list-style-type: none"> <li>– 1,450 General Adult Psychiatry admissions</li> <li>– 400 Psychiatry of Old Age admissions</li> <li>– 35 CAMHS admissions</li> <li>– 30 Learning Disability Admissions</li> <li>– 25 Forensic Psychiatry Admissions</li> </ul>
<ul style="list-style-type: none"> <li>• General Adult Psychiatry Outpatient</li> </ul>	<p>93,500 total outpatient attendances</p> <p>85,700 return outpatient attendances</p> <p>9,300 new outpatient referrals</p> <p>7,800 new outpatient attendances</p> <p>19% did not attend rate</p>

7.54 The service redesign programme appears to have been very much focused on the inpatient facilities when considering improvements to supporting patients with mental ill-health. Staff recognise this should not be the main focus but feel that their marginalisation from decision-making gives rise to a feeling of being disenfranchised as service developments are taken forward without their views, as key stakeholders.

struggle with adequate communication to staff. NHS Tayside’s mental health services are no exception, exacerbated by services operating across a large geographical area and from multiple locations.

7.55 A doctor observed:

*“Services are being centralised at great inconvenience to patients to save money but there is no accountability for the impact on patient care taken by those who make the decision. Indeed, there is no apparent responsibility or transparency for these decisions, but frontline staff bear the brunt of dissatisfaction.”*

7.58 Because CMHTs are managed by the three local HSCPs, managerial approaches to services differ. Staff do not necessarily see themselves as part of a wider service operation. Tayside NHS Board region appears to operate as three cultural islands. The construct of integration may have inadvertently led to fractured services rather than a more shared approach to delivering care.

7.59 Relationship development and management is essential in these circumstances. All three HSCPs liaise with those responsible for inpatient services but have not in recent years had a system of communicating with each other habitually. Project management staff from Transforming Tayside are key to leading the initiatives and staff involved in the Tayside Mental Health Alliance report that the Alliance’s work is now starting to gain momentum with positive outcomes such as development of new care pathways.

## Communication

7.56 There are significant difficulties with communication in the NHS as a whole. One doctor commented:

*“There is a cultural problem in the NHS of inability to communicate maturely, openly and constructively.”*

7.57 It is fair to say that many large organisations

7.60 At the time of writing, the first edition of a newsletter reporting on the work of the Alliance had just been made available to staff. This is a step in the right direction in terms of keeping staff informed of activities, projects and decisions, but

communication is a two-way process and staff should be given opportunities to engage with decision-making processes.

- 7.61 The challenges of how a large organisation such as mental health services in Tayside encourages good communication between staff, is not easy to solve. The history of poor communication has resulted in a lack of trust amongst staff. Clinicians and front-line staff report that the management of change is poor, with a lack of accurate information available to staff. Meetings have a particular purpose of getting key staff together but are often not inclusive (not taking into account shift patterns) or their purpose is not clearly defined. One nurse working in the crisis service commented:

*“After the Carseview documentary there was an internal investigation. I wasn’t allowed to participate as I was a night worker and they only held the focus group meetings during the day. I asked if there was some opportunity as a night worker to contribute and the answer was no. The documentary was about restraint: there are patients being restrained every night.”*

- 7.62 Another staff member noted:

*“There are too many management meetings that do not result in anything positive, forward thinking, practical or problem solving for the staff. The Transformation is a prime example. I am part of this and have had nothing but unclear mixed messages.”*

- 7.63 Inpatient services have attempted to address the operational communication challenges by arranging staff ‘huddles’ for a few minutes in the mornings. However, thinking of more modern communication methodologies may be useful, bearing in mind that many staff joining the services each year are graduates who are familiar with university online environments and daily uses of the ubiquitous communication channels of social media. There are

significant efficiency gains associated with modern communication. A managed blog would allow for instantaneous themed communications. Another solution could be the development of a mental health services communications portal for any staff working within the service to access. This could be a dynamic communication tool for exporting of news but could also be used for accessing documentation, lists of staff (with photos if they are willing to provide them), calendar events of talks, training, seminars and social events, with an opportunity for staff to comment and engage with each other. The NHS Scotland-wide roll-out of Office 365 /Windows 10 by the end of 2020<sup>108</sup> will allow for the use of Microsoft Teams – a tool ideal to address the challenges of communications with staff working in many different locations. The isolation of community mental health teams in remote areas need not be an inhibitor to communication in Tayside’s mental health services with effort and a willingness to try new methodologies.

## Bullying and Harassment

- 7.64 Bullying and harassment are fundamentally unacceptable in the workplace. The 2019 Sturrock Report into NHS Highland’s allegations of bullying has been circulated to all Health Boards in Scotland. Appendix I shows Tayside NHS Board’s own response to the report. The Sturrock Report investigated cultural issues related to allegations of bullying and harassment in NHS Highland. A part of the Scottish Government’s response to the report was to highlight the “important learning and reflection” opportunity the report afforded all health boards in Scotland. The Cabinet Secretary for Health and Sport required all health boards to consider the effectiveness of their own internal systems, leadership and governance in this regard.

- 7.65 NHS Tayside noted that the core findings of the report were primarily cultural. The Board urged senior leaders within NHS Tayside to share the lessons from the Sturrock

108. <https://nhstaysidelowdown.com/2019/08/14/national-office-365-roll-out/>



report and to promote positive leadership values. An update paper was brought to the board at its meeting in June 2019. This report highlighted that NHS Tayside was actively promoting national initiatives which support a positive workplace culture. These included the continued use of iMatter<sup>109</sup>, the development of partnership working through local partnership fora, staff reward and recognition and the implementation of the board's Culture and Collective Leadership Framework. In each of these areas work is ongoing to ensure that they support a positive workplace culture. Progress across these areas is reported to the Staff Governance Committee.

7.66 The Independent Inquiry received evidence from many staff who felt that behaviours of other staff within their workplace were unacceptable. Whilst large organisations undoubtedly experience conflict within staff groups working together, there seemed in some cases to be an overall culture of unacceptable behaviours which remained largely unchallenged.

7.67 One junior doctor commented:

*“There is a broad cultural problem of judgement, lack of respect and bullying and a shortage of kindness and compassion...”*

7.68 Good working relationships between staff of all grades, professions and roles are fundamental to the quality of the delivery of services. In NHS Tayside's mental health services, a culture of bullying was noted by some staff members who felt it originated at management level but was now being adopted across the whole service.

7.69 There was evidence that territorial conflicts, professional hierarchies and reluctance of newer staff to be socialised into the cultural norms were impacting on services and on patient care. This was exacerbated by staff working at full-stretch with little support, who were prone to snap at colleagues due to the unduly high level of stress. There

were many descriptions of unacceptable behaviour, such as intimidation; undermining behaviours; unfair and unequal treatment of staff, and lack of respect shown towards other individuals.

7.70 As part of the Independent Inquiry the EPG conducted a survey of staff working in mental health services. This survey revealed that 29% of respondents considered that they had either experienced or witnessed bullying within their working environment. The impact of this was noted to affect general wellbeing, morale, confidence, motivation and work performance, resulting in increased levels of stress. This induced feelings of helplessness and overall was considered to be contributing to feelings of wanting to leave NHS Tayside. There was also recognition that the bullying behaviours were contributing to staff sickness absence, the management of which causes lengthy distractions from clinical work. All of these behaviours result in an overall loss of trust within teams.

7.71 The culture of poor communication appeared to be a contributory factor in the allegations of bullying behaviours. Staff reported feeling intimidated by consultants as they responded to staff who were giving them feedback or critique on service issues, whilst a number of respondents noted newly qualified staff being derogatory about established staff practices. Paradoxically, senior staff felt they were not able to express professional judgement without accusations of bullying.

7.72 The stressful working environment was noted as a factor causing a rise in unacceptable behaviours from staff. There was also evidence of upwards bullying with the undermining of leadership roles in order to prevent unpopular changes taking place.

7.73 Failure to address the reported bullying in the workplace has resulted in a loss of trust and faith in the managers and in NHS Tayside's HR processes. A consultant who recently left NHS Tayside's employment

109. <https://www.imatter.scot/>



reported:

*“I was told early on in my time in Tayside that ‘bad behaviour gets results’. There seems to be a culture that if someone is difficult, they get what they want or are even promoted to positions of authority.”*

Another current employee stated:

*“I am still deciding whether to pursue a number of grievances but given the nature of these and the lack of action on the bullying I have experienced, I have no confidence in the organisation to undertake these fairly.”*

7.74 There are distinct disincentives to raising concerns, such as lack of confidence any action would be taken by the organisation, previous notifications of bullying simply being ignored and fear of retribution for reporting the matter.

7.75 A consultant psychiatrist commented:

*“...there are a great many very committed staff in NHS Tayside Mental Health Services... the personal cost of raising concerns remains inhibitory of professional candour (in my opinion). The management behaviour towards staff has damaged relationships and in some instances goodwill has been lost; the NHS has long depended on goodwill so this is a catastrophic outcome, occasioned by poor processes, leadership and an obfuscation of responsibility...”*

7.76 A member of nursing staff reported on their experience when they had attempted to raise an issue of bullying:

*“My account is highlighting the degree of victimisation and attempts to denigrate staff, causing high anxiety levels and stressful working environment. I was moved department for my apparent misconduct, for merely trying to professionally highlight and make members of management aware of the issues the staff were experiencing (as*

*per the whistleblowing policy) and getting no support whatsoever...”*

7.77 Many staff identified that the ripple effect of the publicly reported difficulties and criticisms of Tayside mental health services resulted in a challenging working environment for staff, with one respondent noting that *“I do feel bullied by the press.”* Another noted *“I’ve never seen anything like it before I came to work at NHS Tayside.”* Some observed that they felt vulnerable to threats of physical and verbal abuse and to the bullying power of social media whilst also noting they felt there was no clear structure in place to protect or support staff.

7.78 One employee observed:

*“NHS Tayside have a zero tolerance to verbal and physical aggression. Too many times this appears to be untrue. Informal patients admitted who display aggression on the ward while under the influence of alcohol or illicit drugs are not removed or arrested...”*

7.79 Again, the perceived lack of support publicly for staff by management was highlighted as a significant influence on low staff morale. The local press reports are apparently often inaccurate, but staff feel that *“no-one speaks out for us”* in response. They noted that they are not allowed to speak to the press themselves without risk to their registration and so feel powerless and vulnerable, knowing the patients they are looking after have misinformation about the service they are delivering.

7.80 The working environment for staff in mental health services is often poor. Office spaces on wards are cramped and there are insufficient computer stations for staff on duty. The workload is so great that staff reported often not having time for breaks or being able to take adequate numbers of days off within the shift patterns.

7.81 All of this leads to low morale across the

workforce, who feel under-valued and demotivated in their work.

7.82 A senior member of nursing staff stated:

*“If staff do not feel that their basic needs are being met by the organisation that they are employed within they are then left in the impossible position of caring for patients within a system that is not caring for them.”*

7.83 Staff reported participating willingly in external reviews of services and speaking candidly to review teams in the hope that things will change. They are then frustrated that NHS Tayside have the capacity to ignore any suggestions and recommendations included in the subsequent reports. There is a joint feeling that internally no-one is listening, and externally people listen and make recommendations for improvement but have no authority to mandate their implementation.

7.84 A staff member working at Carseview Centre noted:

*“Whenever questions have been raised by bodies such as HIS or Mental Welfare Commission sudden poorly thought-out changes are put in place, statistics are produced, and public embarrassment is averted. Trust in upper levels of management is non-existent..... this would have been clearly reflected in previous pieces of work such as ward climate survey had we ever been shown the outcome of these.”*

## Training and Supervision

7.85 In the Independent Inquiry’s interim report<sup>110</sup> in May 2019, it was noted that some staff reported that the chronic staff shortages were impacting on their ability to attend training and supervision events.

7.86 The Draft Training Plan 2019<sup>111</sup> stated that:

*“NHS Tayside will ensure that all staff should have equity of access to training irrespective of working arrangements or profession, and without discrimination on any other grounds.”*

*“NHS Tayside staff will ensure that they do not undertake any roles or undertake to deliver any aspect of care unless they are appropriately trained to perform them in a competent manner.”*

7.87 Since the publication of the Independent Inquiry interim report, staff have reported they are more able to attend development sessions as new training programmes and seminars are now organised within the inpatient facilities. There is still a concern for the ability of those based in the community or those who work permanently at night to be able to attend centralised training events held during the standard working week. Again, as with the communication issues above, consideration should be given to more use of online training resources which would be available to all staff. The concerns raised in the Independent Inquiry interim report that some staff were not allowed to attend training due to long waiting lists are now no longer applicable. Staff training and supervision sessions have now been prioritised and all mandatory training completion rates are monitored.

7.88 The consultant staff reported that a former Interim Associate Medical Director had instigated Continuous Professional Development (CPD) sessions at Murray Royal Hospital on Thursday mornings during his tenure. The consultant, no longer employed within NHS Tayside, continues to organise these events in the absence of any other regular CPD programme being organised. The sessions are open to all psychiatrists working in Tayside and are

110. The Independent Inquiry into Mental Health Services in Tayside. (2019). Interim report: inquiry update and emergent themes. <https://independentinquiry.org/wp-content/uploads/2019/05/Independent-Inquiry-Interim-Report-May-2019.pdf>

111. NHS Tayside. (2019). [GAP Inpatient LD training and continuing professional development Plan. Training for nursing staff.](#)

regularly well attended. These sessions are also development opportunities for trainee psychiatrists who are welcome to attend alongside the substantive consultant staff. It was noted by a number of consultants that they had to meet Royal College of Psychiatry CPD mandatory regulations of 50 hours per year and so these CPD events were essential to their professional licence.

7.89 The Independent Inquiry heard several times of the stark contrast in approaches to patient care across the wards in Carseview Centre. Consultant staff covering unfamiliar wards commented on worryingly different approaches in the use of restraint from one ward to another; patients reported very different care experiences from one ward to another - to the extent that some refused to be admitted to certain wards; nursing staff who had moved wards within Carseview Centre also noted very different cultures of management and care of the patients. It is apparent that disparate cultures have developed to the detriment of collegiality of working and to commonality in approaches to patient care. The geographical affiliation of the wards reinforces the silo-working, as both staff and patients are aligned to a particular ward and its idiosyncrasies, with no real opportunity for shared organisational on-the-job learning. Training and development programmes should combine theory of improvement with daily practices across all inpatient services.

7.90 Training for staff in mental health services has undergone a significant change during the course of the Independent Inquiry. The Quality Improvement team have developed training programmes and CPD programmes for nursing staff. As well as formal training initiatives, frontline nursing colleagues need to be given time and support for on-the-job learning. One consultant observed that the context of improvement initiatives is vitally important. Quality improvement analysis shows that staff need time to build their knowledge in a shared learning environment. Knowledge-building has been outsourced to the Quality Improvement team and consultant staff commented that

when they make suggestions about training of nursing staff, their comments are often disregarded. There is a real feeling from clinicians that learning from analysis of different patient journeys should form the basis of any knowledge-building for staff.

7.91 In November 2018, NHS Tayside's internal review<sup>112</sup> into Carseview Centre (in response to the BBC TV *Breaking Point* programme) stated:

*“An organisational development programme should be undertaken within the service as a matter of priority to address cultural and attitude issues identified, based around the caring and compassionate leadership approach.”*

This organisational development exercise began in February 2019 and was carried out by an independent organisational development consultant (Appendix J).

## Summary

7.92 It is clear that mental health services in Tayside are currently operating according to a short-term vision, placing emphasis on reacting to increases in service demand rather than reflecting on how best to meet the long-term trends of mental health and wellbeing across the population.

7.93 The patient demand challenges have resulted in managers responding with service stabilising strategies (rationing and increasing waiting times) and increased uses of medicalised approaches to care. Staff have adopted this management approach and as a result the service has been kept afloat in the short term. However, this strategy has not fostered a good relationship within staff groups many of whom could see what needed to be done but were not able to influence managers taking the short-term approach. Staff have been left feeling disenfranchised and

112. Evidence provided by NHS Tayside in 2019. [Report on mental health services provided at Carseview Centre, Dundee November 2018.](#)

demoralised and this culture of working has led to many broken relationships within teams and internally between services. The consequential effect on the service reputation has led to resentment in communities which in turn has also adversely affected staff morale.

7.94 In addition, coordination amongst different service providers (within the NHS services and also with the third sector) is key to ensuring smooth patient journeys but this has also been neglected due to the 'fire-fighting' necessary to ensure services were maintained at all.

7.95 In all of the analysis above it is the relationships between teams, individuals, services and sectors which need to be rebuilt in order to restore a mutual trust between those employed within NHS Tayside's mental health services and also between the NHS and the agencies outside who are involved with NHS Tayside in co-production of services.

significant strategic changes are made to services.

46. Encourage, nurture and support junior doctors and other newly qualified practitioners, who are vulnerable groups of staff on whom the service currently depends.

47. Develop robust communication systems both informally and formally for staff working in mental health services. Uses of technology are critical to the immediacy and currency of communications.

48. Ensure that bullying and harassment is not tolerated anywhere in mental health services in Tayside. Ensure that staff have confidence that any issues or concerns they raise, will be taken seriously and addressed appropriately.

49. Ensure there are systems analysis of staff absences due to work-related stress. These should trigger concerns at management level with supportive taking place with the staff member concerned.

## Recommendations

42. Ensure all staff working across mental health services are given the opportunity to contribute to service development and decision-making about future service direction. Managers of service should facilitate this engagement.

43. Prioritise concerns raised by staff by arranging face-to-face meetings where staff feel listened to and valued.

44. Arrange that all staff are offered the opportunity to have a meaningful exit interview as they leave the service. This applies to staff moving elsewhere as well as those retiring.

45. Prioritise resource to ensure the Associate Medical Director for Mental Health and Learning Disability post is a whole-time equivalent, for at least the next 2 years whilst

50. Ensure there are mediation or conflict resolution services available within mental health services in Tayside. These services should exist to support and empower staff in the rebuilding of relationships between colleagues, between managers and their staff, and between the services and the patients, during or after a period of disharmony or adverse event. This includes the NHS Tayside's mental health services' relationship with the local press.

51. Ensure that all external review processes are embraced wholeheartedly and viewed as an opportunity to learn and develop. Managers should ensure that all staff receive details of the recommendations from reviews and are included in the analysis and implementation.

# 8. Implementation Plan

## Lead Person

- 8.1 As has been identified by the Independent Inquiry, there are considerable challenges facing those with responsibility for delivering improvements to the provision of mental health and wellbeing services in Tayside. It is imperative that this Independent Inquiry report leads to positive improvements to services and is actioned through a constructive and comprehensive programme. NHS Tayside have stated that they will respond positively to the work of the Independent Inquiry.
- 8.2 There is a clear need for one individual to be identified as the lead person with responsibility for the implementation of the Independent Inquiry's recommendations. The Chief Executive of NHS Tayside has indicated to the Inquiry team that he would be responsible for leading the response to the Inquiry's report. The identified lead should be supported by a leadership team with representation from across NHS Tayside and the three IJB/ HSCPs.

## Actions and timescales

- 8.3 The first requirement is to tackle the Inquiry report's first recommendation - to develop a new culture of working in Tayside built on collaboration, trust and respect. This is fundamental to the successful delivery of the subsequent recommendations.
- 8.4 A detailed action plan should be developed by 1 June 2020 to set out the programme of work to be undertaken. This should include key milestones and realistic deadlines for completion.

## Monitoring progress

- 8.5 As the organisation which commissioned the Independent Inquiry, NHS Tayside will wish to provide detailed oversight and scrutiny of the progress that is being made in implementing the Independent Inquiry's recommendations. They will wish to do this in conjunction with the three IJBs. There should be regular public reporting at least quarterly of progress to these Boards to ensure that the required improvements are delivered.

## External scrutiny

- 8.6 There are a number of organisations and bodies external to Tayside who have indicated that they will take an interest in the progress which is made in implementing the Independent Inquiry's recommendations. As part of their regular engagement with services in Tayside, it is anticipated that bodies such as Healthcare Improvement Scotland, the Mental Welfare Commission for Scotland, the Audit Commission and the Care Inspectorate, will seek to be informed in their work by the progress that is made in improving services following publication of this report.
- 8.7 Additionally, the Health and Sport Committee of the Scottish Parliament has stated that it will maintain an interest in developments in mental health services in Tayside and will seek details of NHS Tayside's response to the report of the Independent Inquiry.<sup>112</sup>
- 8.8 The Stakeholder Participation Group, established by the Health and Social Care ALLIANCE, has provided valuable support to the Independent Inquiry throughout its lifetime and has received regular

112. Letter from the Convener of the Health and Sport Committee to Chief Executive NHS Tayside, 18 December 2019.

updates and progress reports. NHS  
Tayside should engage with this group of  
people, to provide details on progress and  
continue to seek their views and feedback.



# 9. Abbreviations

<b>Abbreviation</b>	<b>Definition</b>
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AMD	Associate Medical Director
ANP	Advanced Nurse Practitioner
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CI	Care Inspectorate
CMHS	Community Mental Health Service
CMHT	Community Mental Health Team
COSLA	Convention of Scottish Local Authorities
CPD	Continuous Professional Development
CPN	Community Psychiatric Nurse
CTO	Compulsory Treatment Order
CRHTT	Crisis Resolution Home Treatment Team
DBI	Distress Brief Intervention
EWC	Emotional Wellbeing Collaborative
FAI	Fatal Accident Inquiry
FPPC	Framework for Promotion Prevention and Care
GIRFEC	Getting it Right for Every Child
GAP	General Adult Psychiatry
GMC	General Medical Council
GP	General Practitioner
HIS	Healthcare Improvement Scotland
HSCP	Health and Social Care Partnership
IC	Improvement Collaborative
IJB	Integration Joint Board
IPCU	Intensive Psychiatric Care Unit
ISMS	Integrated Substance Misuse Service
LAER	Local Adverse Event Review
LAMH	Lanarkshire Association for Mental Health
LDP	Local Delivery Plan
MDT	Multi-Disciplinary Team
MHO	Mental Health Officer
MWCS	Mental Welfare Commission for Scotland
NEM	Non-Executive Member
NES	NHS Education for Scotland
NQP	Newly Qualified Practitioner

<b>Abbreviation</b>	<b>Definition</b>
OT	Occupational Therapist
PMVA	Prevention and Management of Violence and Aggression
POA	Psychiatry of Old Age
PWP	Psychological Wellbeing Practitioner
QS	Quality Standard
RCPS	Royal College of Psychiatrists in Scotland
RMHN	Registered Mental Health Nurse
RMO	Responsible Medical Officer
SAMH	Scottish Association for Mental Health
SAS	Scottish Ambulance Service
SCEA	Significant Clinical Event Analysis
SIG	Sharing Intelligence Group
SPSO	Scottish Public Services Ombudsman
TMHA	Tayside Mental Health Alliance
VBRP	Values-Based-Reflective-Practice
WTE	Whole Time Equivalent
YPU	Young People's Inpatient Unit

# Appendices

## Appendix A: List of organisations and groups which gave evidence to the Independent Inquiry

- Abertay University Counselling & Mental Health Service
- The ALLIANCE (Health & Social Care Alliance Scotland)
- Angus Council
- Angus Independent Advocacy
- Audit Scotland
- Community Mental Health Teams
- Crown Office & Procurator Fiscal Service - Scottish Fatalities Investigation Unit
- Dundee Association for Mental Health (now Wellbeing Works)
- Dundee Autism Service Hub
- Dundee City Council
- Dundee Commissions (Fairness; Drugs)
- Dundee Independent Advocacy Service
- Dundee Voluntary Action
- Edinburgh Crisis Centre
- Employee Participation Group (EPG) NHS Tayside
- GP practices in Angus, Dundee and Perth & Kinross
- Health & Social Care Partnerships
- Healthcare Improvement Scotland
- HMP Perth
- Independent review of Learning Disability and Autism in the Mental Health Act
- Insight Counselling
- Integration Joint Boards
- Manchester Metropolitan University
- Mental Welfare Commission for Scotland
- Mersey Care NHS Foundation Trust
- National Suicide Prevention Leadership Group
- NHS 24
- NHS Education for Scotland: Scotland Deanery, East Region
- NHS Tayside Hospitals: Murray Royal, Carseview Centre, Rohallion Secure Care
- NHS Tayside staff working in all aspects of mental health services
- Penumbra Dundee
- Perth & Kinross Council
- PLUS Perth
- Police Scotland
- Royal College of Psychiatrists in Scotland
- Samaritans
- Scottish Association for Mental Health
- Scottish Government
- Scottish Public Services Ombudsman
- Stakeholder Participation Group SPG
- Support in Mind Scotland
- Trainee GPs / Psychiatrists
- Universities of Abertay and Dundee - Nursing Students
- University of Dundee Counselling Services
- University of Dundee Health Service
- Voluntary Health Scotland
- VOX: Scotland's National Voice on Mental Health

# Appendix B: NHS Tayside news update January 2020

# NHS Tayside News Update

**NHS**  
Tayside  
January 2020

## In this issue...

Carseview team wins national award

Mental health nurses recognised

COSLA Award for Angus team

Recovery cafés in North Perthshire

Second year of positive reports for YPU

MWC visit reports welcomed

Tayside Mental Health Alliance launched



COSLA EXCELLENCE AWARDS WINNERS  
ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP  
AIDARS SOUTH LOCALITY TEAM  
ANGUS INTEGRATED DRUG AND ALCOHOL RECOVERY SERVICE







### Carseview team wins national award

The Intensive Psychiatric Care Unit (IPCU) team at Carseview Centre has been recognised with a national award for improving observation practice.

The team picked up the award for Inpatient Care at the Mental Health Nursing Forum Scotland Awards for its project 'From Observation to Intervention'.

In August 2018, the IPCU team set an aim of a 50% reduction in one-to-one observations by July 2019. By changing the model and concept of traditional 'observation', the team was able to exceed this target and achieve a reduction of 95% in March 2019, five months ahead of schedule.

This has led to staff being able to reinvest the time saved on observations into therapeutic engagement with patients.

Acting clinical team manager Michelle Pocula said, "The change and feel in the ward over the last year has been significant and being the initial pilot ward for improving observation practice in NHS Tayside has been one of the contributory factors."

NHS Tayside also had two other teams shortlisted at the ceremony.

Senior nurse practice development Jenny MacDonald and mental health improvement advisor Wendy Tait were highly commended in the Inpatient Care category for their work to implement new person-centred care planning standards.

The standards have now been presented to all clinical teams and were referenced by the Mental Welfare Commission in their recently published 'Person Centred Care Plans, A Good Practice Guide'.

A social media project undertaken by NHS Tayside and the University of Dundee was highly commended in Innovations in Education.

'#OneProfessionManyStories' was a series of short videos which showcased the education and work of mental health nurses in hospitals and the community with the aim of encouraging more people into mental health nursing as a career. The films featured service users, students, lecturers, and mental health nurses and senior staff from NHS Tayside.

"The change and feel in the ward over the last year has been significant"

"These awards recognise the contribution, compassion and dedication to their role and profession"



### Mental health nurses recognised

Five NHS Tayside mental health nurses have been recognised with awards at the University of Abertay 2019 Prizegiving Ceremony.

Catherine Buchan, who is a staff nurse in Older People's Mental Health Services in Angus, won the Tayside NHS Board Prize.

This accolade is awarded by NHS Tayside to the student in the honours year of pre-registration BSc (Hons) Mental Health Nursing Programme who achieves a high level of performance and is deemed to be the best overall student.

Ruth-Ann Welsh, staff nurse in the Behavioural Support Unit at Strathmarine Centre, was awarded the Sheila Nimmo Prize for Compassionate Practice.

This is the second university prize that Ruth-Ann has won and both prizes recognise her compassionate practice and exemplary professionalism in both the university and clinical practice.

Acting senior charge nurse in the Rohallion Clinic Sara Kettles was recognised with two prizes.

Sara won the Armistead Prize, which is awarded to the student on a part-time programme who achieved a high level of performance and was deemed the best student overall.

She also picked up the Queens Nurse Institute (Scotland) Prize which is given to the student who has the best dissertation on the MSc Mental Health Nursing programme.

The Sarah Fletcher Memorial Prize for Compassionate Practice was awarded to Stephen Johnston, who is a staff nurse working in the Child and Adolescent Mental Health Outpatient Service.

The prize is given to a third year student on the BSc (Hons) Mental Health Nursing course who, during their time at Abertay, has shown exemplary compassion.

Staff nurse Jordan Livie, who works in the Dudhope Young People's Unit in Dundee, won the George McKenzie Memorial Prize.

This award is for the third year student on the BSc (Hons) Mental Health Nursing course who achieved a high level of performance in mental health nursing practice.

Associate Nurse Director for Mental Health and Learning Disabilities Keith Russell said, "We are absolutely delighted to have so many award winning nurses in our mental health and learning disability services in Tayside."

"These awards recognise the contribution, compassion and dedication to their role and profession. Congratulations to Catherine, Ruth-Ann, Sara, Stephen and Jordan for their achievements."



### COSLA Award for Angus team

The Angus Integrated Drug and Alcohol Service (AIDARS) has picked up a COSLA Excellence Award for Service Innovation and Improvement.

AIDARS brought together the previous substance misuse services from health and local authority sectors in 2017. The service aims to provide best practice and develop innovative approaches to ensure the needs of people and their families affected by substance misuse are met within their own communities.

This has provided earlier access to a wider range of treatments, person-centred outcomes, and support to the wider family and communities of Angus.

Bill Troup, Head of Service for Angus Health and Social Care Partnership, said, "I'm delighted that the team has been recognised for their hard work and for the difference they make to people's lives locally."

"Since AIDARS started the team has increased the number of people they see and reduced waiting times meaning people are getting into treatment faster."

Before the team was established it took an average of 53 days, now it's 18 days. The service also offers evening appointments which make it easier for patients who are employed, in training or education or who have caring responsibilities to access treatment."

Substance misuse continues to be a significant issue which impacts on whole families and communities.

Angus Alcohol and Drug Partnership (ADP) is focused on building local services that will best meet the needs of people in Angus. Recent developments include

joint working between the ADP, Police Scotland and Scottish Ambulance Service colleagues to offer support for anyone who experiences a non-fatal overdose.

Resources have been put in place to create 'Recovery Communities' led by people in recovery across Angus to provide a social hub for people in recovery.

"The team has been recognised for their hard work and for the difference they make to people's lives"

"The cafés allow people to access advice and support as close to their local community as possible"



COSLA EXCELLENCE AWARDS WINNERS 2019  
ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP  
AIDARS SOUTH LOCALITY TEAM  
ANGUS INTEGRATED DRUG AND ALCOHOL RECOVERY SERVICE



### Recovery cafés in North Perthshire

Three community recovery cafés are now running in towns across North Perthshire with support from NHS Tayside.

Community support worker Audra Webster has helped develop the support groups in Aberfeldy, Blairgowrie and Pitlochry.

The recovery cafés have a community focus and are intended to be led by people in recovery or with an interest in recovery.

They are supported by staff and mentors from Perth & Kinross Alcohol & Drug Partnership (ADP), Hillcrest Futures and NHS Tayside, as well as local community volunteers.

Audra said, "From my role in the community I first became involved with the existing café in Aberfeldy which was looking for some support and we identified that there was a similar need for recovery cafés to be established in other areas of North Perthshire."

"We were delighted to be able to secure funding from the Perth & Kinross ADP to help develop these cafés. Having them in these more rural towns allows people to access advice and support as close to their local community as possible, where previously they would have had to travel to Perth or other areas."

"The funding assists with advertising, activities and the ongoing development of the groups."

"The drop-in cafés provide a very relaxed and welcoming environment to support people

to improve their wellbeing during recovery from substance use and/or mental health issues in rural areas of North Perthshire."

Breadalbane Recovery Café takes place every Wednesday from 2-4pm at Aberfeldy Parish Church, with an interest in recovery.

Strathmore Recovery Café has recently been established with its first session taking place at the beginning of December. It takes place every Monday from 1-3pm at SCYD, Wellmeadow House in Blairgowrie.

The Pitlochry Recovery Café also had its first drop-in session in early December. It takes place between 1 and 3pm in the Atholl Centre every Thursday.

There's no need to book a place, all are welcome to drop in during the sessions.



Second year of positive reports for YPU

The North of Scotland Regional CAMHS Young People's Inpatient Unit (YPU) in Dundee received two positive service review reports for the second year running.

The Mental Welfare Commission for Scotland (MWC) published its report following a visit to the unit in July, where they met with patients, families, carers and staff. This year's report is extremely positive with no recommendations made.

Young people did not raise any concerns regarding their care and treatment with the only suggestion being to increase the activities available. Care planning was person-centred and comprehensive, reflecting the needs of each individual, with young people being fully involved in the development of these.

A strong emphasis on engagement and communication with families and carers was commended, particularly the introduction of a new link charge nurse/case manager role which provides dedicated support to a young person's family during admission and to ensure that families and carers are fully involved in the child's care. The person-centred approach to young people being involved in multidisciplinary meetings and reviews was also noted.

The report concluded that the service provides a strong emphasis on staff development and training opportunities. Finally the report commended the partnership working that has been undertaken with Police Scotland and voiced support for the continued development of this working relationship.

The Royal College of Psychiatry Quality Network for Inpatient CAMHS (QNIC) review team highlighted that since their last review there have been a number of positive service developments and also commended the new link charge nurse/case manager role.

Strengths of the unit were noted as: the environment is bright and spacious with space for relaxation and recreation whilst showcasing art work of Scotland's rural locations as a reminder of home for young people; staffing for the service is managed well, particularly in relation to bank staffing induction with all staff having access to development opportunities and strong support systems; and a variety of therapeutic interventions and groups are available for young people with a positive school provision.

As the service has been given above 96% in the review's criteria scoring, the multidisciplinary team will now be able to work towards national accreditation with the Royal College of Psychiatry early next year. If successful it will become the first unit in Scotland to achieve this.

CAMHS regional network manager Lesley-Ann McGregor said, "The service has been extremely pleased with this year's reports as both demonstrate the continued improvements by the multidisciplinary team to improve care and treatment for young people and their families/carers."

**"Both demonstrate the continued improvements by the team to improve care and treatment"**

**"Staff and relatives gave positive feedback about the care and treatment provided"**

MWC visit reports welcomed

Mental Health and Learning Disability services across Tayside have received a series of positive reports following visits from the Mental Welfare Commission (MWC) Scotland.

Since May this year, the MWC has visited the Willow and Rowan Units in Susan Carnegie Centre at Stracathro and the Prosen Unit at Whitehills Health and Community Care Centre in Forfar. The quality of care and attention to the patients' physical health needs was highlighted positively in all three units.

Inspectors observed supportive interactions between nursing staff and individuals in the Willow Unit and relatives gave positive feedback about the care and treatment provided. Care plans were highly detailed, person-centred and based on the assessed needs of the individual patient.

Following a planned visit to the Rowan Unit, inspectors were complimentary about a range of areas, in particular the quality of care plans, the inclusion of psychology, excellent pharmacy input and support.

The Prosen Unit was reported as supporting a partnership approach to care and treatment and that staff encourage relatives and carers to be involved. They noted the attention to individuals' physical health needs and support from other professionals.

The MWC also visited learning disability services in Dundee.

Patients at the Learning Disability Assessment Unit at Carseview Centre spoke positively about their

care. Care plans were person-centred, patients have good access to independent advocacy support, a number of individuals are engaging in activities in the community and there are breakfast sessions, and art and baking, gardening, art therapy and exercise groups.

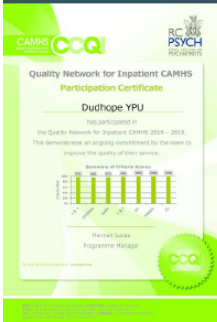
Patients in Flats 1, 2 and 3 at Bridgefoot House, Strathmarine Centre felt involved in decisions about their treatment and described a range of activities available in the centre and in the community.

Patients said that staff responded well to any issues raised and inspectors observed supportive interactions between staff and patients which reinforced this feedback.

The MWC gave very positive reports following their visits to Esk and Lyon dementia wards at Rohallion and Garry and Tummel low secure wards at Murray Royal Hospital.

Patients who were seen at Esk and Lyon wards spoke positively about the support provided by all staff working in the unit and it was clear they were involved in discussions about their care, treatment and discharge planning.

Family members at Garry and Tummel wards spoke highly of the staff and of their relative's care, saying they found staff were always available and supportive of them particularly during difficult periods of their relative's stay.







## Tayside Mental Health Alliance launched

**NHS Tayside and the Integration Joint Boards have set up the Tayside Mental Health Alliance to work together to improve mental health and wellbeing services across Tayside.**



The majority of these services are delivered in local communities and delegated to the health and social care partnerships (HSCPs).

Inpatient mental health and learning disability services are hosted by Perth & Kinross HSCP, while psychological services are hosted by Dundee HSCP. Regional medium secure care and local low secure care, regional young people's inpatient unit and child and adolescent mental health services are hosted and managed by NHS Tayside.

These arrangements allow us to work together to provide safe, accessible, high quality, locally attuned services across all services in Tayside which deliver care, treatment and support for people with mental health problems.

This includes secondary care mental health, primary care, criminal justice, housing, community planning, public protection, homelessness, local third sector and providers of self-directed support.

The establishment of the Tayside Mental Health Alliance will further support this partnership working across Tayside.

The initial priorities of the Tayside Mental Health Alliance are:

- *Workforce*
- *Community Mental Health and Crisis Care & Home Treatment*
- *Learning Disability*
- *Rehabilitation Pathway*
- *Emotionally Unstable Personality Disorder Pathway*

**“The Tayside Mental Health Alliance will further support partnership working across Tayside”**

For each of these, a design group has been set up to develop and implement new models. They will have a number of stakeholders, importantly service users and carers, and ensure there is opportunity to help design and develop services.

The Tayside Mental Health Alliance is fully committed to engaging with staff, service users, carers, and third sector and partner agencies, in particular engaging directly with local communities across the three HSCPs through their established community participation and engagement structures.

The Tayside Mental Health Alliance will seek to ensure that all voices are heard and that they work with people to transform mental health and learning disability services across Tayside.

## Appendix C: Review of arrangements for investigating the deaths of patients being treated for a mental disorder. Scottish Government, December 2018 (White report).

<https://www.gov.scot/publications/review-arrangements-investigating-deaths-patients-being-treated-mental-disorder/pages/5/>

### Action Plan

1. “The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended).  
  
This process should take account of the effectiveness of any investigation carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.
2. The Scottish Government will consider the further actions required to better support multi-agency co-ordination of investigations.
3. The Scottish Government will begin an options appraisal in conjunction with partner organisations, to determine an appropriate process of review for the deaths of people who are in hospital on a voluntary basis for treatment of mental disorder. This will support delivery of action 10 in the Scottish Government’s ‘Suicide prevention action plan’ to review every death by suicide and ensure the importance of clarity, alignment and integration of review and investigation processes for maximum impact.
4. The Scottish Government will work with the Mental Welfare Commission for Scotland, Healthcare Improvement Scotland, and NHS National Services Scotland to identify an appropriate set of publicly reportable measures that reflect best practice in the investigation of deaths and can be used to identify where improvement is required.
5. The Scottish Government will ask Healthcare Improvement Scotland to make changes to its Suicide Reporting and Learning System to immediately reintroduce the suicide notification requirement and scrutiny of NHS boards’ suicide reviews. Healthcare Improvement Scotland will also be asked to describe how it will support boards to continuously improve the quality of the suicide review reports. There should be a clearer link between the scrutiny of these reports and specific improvement support that is directly designed and targeted around the common contributory processes identified in suicide review reports. This will be aligned to the new investigation process referred to in action 1.

6. The Scottish Government will work with partner organisations to produce resources for carers and families which provide information on how deaths are reviewed.
7. The Scottish Government will work with partner organisations to improve the co-ordination of support available for families and carers. This will include the creation of a single point of contact for families and carers in relation to all investigations and reviews. It will also include investigation of any barriers that need to be addressed in order to ensure that co-ordination of support is able to operate effectively across the various organisations involved.
8. The Scottish Government will establish an implementation group to oversee the implementation of actions arising from this report. This group will include equal representation from carers and families.
9. The Scottish Government will work with partner organisations to consider what support and advice staff need to involve families and carers in a meaningful way.
10. The Scottish Government will work with the Mental Welfare Commission for Scotland and Healthcare Improvement Scotland to improve the ways in which investigation findings and recommendations are disseminated, and explore options to support healthcare providers to use this information to commission improvement support. The new system of investigations referred to in action 1 should include a mechanism for transparent follow up and public assurance of changes.”

## Appendix D: Right person, right time, right care with no waiting times: Systems dynamics analysis of interim findings of the Independent Inquiry into Mental Health Services in Tayside and a group model building workshop with student practitioners.

Dr Karin Diaconu. September 2019

<https://independentinquiry.org/system-dynamics-analysis-report/>

### Systems dynamics study

Analyses of the evidence collected by the Independent Inquiry is ongoing, however preliminary findings are summarized in the Independent Inquiry's Interim Report (2019). Complementarily, the Independent Inquiry has sought to conduct a study exploring the underlying dynamics of the mental health system in Tayside. The purpose of this systems dynamics analysis is to a) identify interactions and pathways influencing the services' function and quality of care currently and b) identify areas suitable for improvement alongside concrete recommendations for intervention.

The systems dynamics study was organized in two phases, offering the chance for triangulation of findings. In Phase 1, the Interim Report (2019) was reviewed to identify variables and pathways affecting patient access to care, patient sense of safety, quality of care, organizational learning and governance (including issues of leadership). An initial concept model capturing the pathways of action between these variables was then developed and analysed, and three sub-models focused on crisis service and community care, general practice and mental health care services (in- and out-patient) and leadership and human resource capacity were elaborated.

In Phase 2, a participatory group model building workshop with student practitioners and quality improvement managers active in the mental health service in Tayside was convened. In this workshop, participants were prompted to elaborate a concept model focused on the same five themes as above (patient access to care, patient sense of safety, quality of care, organizational learning and governance). Participants were further invited to identify areas where the service is particularly fragile and those suitable for improvement; and to additionally elaborate and prioritize intervention strategies.

### Aim

The purpose of the systems dynamics analysis was to identify the underlying dynamics affecting service function and quality of care and identify concrete recommendations for improvement of the mental health service in Tayside.

### Participants

Student practitioners active in the delivery of mental health services in Tayside were invited via email to take part in a one-day workshop. Invitations were issued to students from Dundee and Abertay Universities. Overall 14 participants agreed to take part, approx. 50% of which were women. The workshop was additionally joined by two quality improvement advisors for the mental health

service in Tayside. Participants were split into two groups initially, however worked as one group to elaborate the causal loop model and for further exercises.

### Concluding remarks: triangulated findings

The systems analysis of findings presented in the Interim Report of the Independent Inquiry and the analysis of the group model building session identify three core themes which speak to the underlying dynamics of the mental health service in Tayside. First, it is clear the service is operating according to a short-term vision which places emphasis on reacting to current increases in service demand rather than reflecting on how to meet long-term trends in the burden of mental ill-health in communities. Both group model building participants and findings of the report highlight how challenges in meeting patient demand have largely driven the service to enact demand stabilizing strategies (e.g. via rationing and enacting increased waiting times) and further led to the service emphasizing a medicalized approach to care (i.e. emphasizing care for severe cases and in medical form, likely via medication). While this approach has kept the service afloat in the short term, it has also now bred resentment within communities and affected the services' reputation.

Second, both sources of evidence emphasize that coordination among different types of providers - both within the service and with the third sector - presents a challenge currently. Coordination is key to ensuring smooth patient flow yet is now a neglected area given the high workload pressures placed on staff. Group model building workshop participants highlighted the need for coordination with specialist teams in particular; practitioners spoke of the need to have teams focused on personality disorders and the report highlighted the need for substance use specialists.

At the core of the services' difficulties, findings presented here highlight the limited availability of trained staff, and further, the lack of organizational learning and likely.

## Appendix E: Responding to Drug Use with Kindness, Compassion and Hope: a report from the Dundee Drugs Commission. Part One: The Report. Conclusions. 16 August 2019.

<https://www.dundee.gov.uk/sites/default/files/publications/part1reportfinal.pdf>

### Conclusions

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement and will also require strong and dedicated leadership over many years to make Dundee a place that delivers on its belief that truly ‘every death matters’ and, more positively, ‘every life matters’. This will require an honest and transparent acknowledgment of the failings that have taken place in the delivery of drug treatment services (in a ‘no-blame’ environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings.

We have scrutinised and discussed the evidence that has been received and have also looked for examples of best practice from elsewhere in order to:

1. identify immediate steps that can be taken to start improving the situation; and
2. begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Dundee Partnership to deliver. This is why a series of ‘national considerations’ are also offered below. We sincerely hope that these will be responded to by the Scottish Government and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will require a renewed determination to work much more effectively across local, regional and national structures to deliver them. Our insight of best practice from countries such as Canada, Iceland and Portugal would, similarly, require changes in national policy and legislation and systems/practices in order to allow Dundee to implement fully the changes that are required.

The political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated. The time is now right to hand back the evidence and findings of our work to our elected leaders and ask them to set the standard for the leadership and accountability that is going to be required in Dundee (and beyond) to turn around the national emergency that is epitomised by the severe rates of drug-related deaths across Scotland.

### Local Recommendations

The following are our set of sixteen (16) ‘headline’ recommendations that we believe are within the abilities of the Dundee Partnership to progress. Our Part 1 Report provides full detail of what will be required to see each recommendation fulfilled.



The recommendations are grouped under the following three headings:

A. Culture and systems;

B. A holistic system model - including integrated Primary Care provision; and

C. Causes and effects of drug use.

## A. CULTURE AND SYSTEMS

This first suite of recommendations (1-6) is focused around the need for cultural change across drug treatment services, related disciplines and communities of Dundee, and changes in local systems that will help facilitate such cultural change.

Recommendation 1: The Dundee Partnership must do all that is necessary to achieve the required standard of leadership - the test of which will be that agreed changes are owned and supported by the statutory and third sectors, recovery communities, service users and families.

Recommendation 2: Challenge and eliminate stigma towards people who experience problems with drugs, and their families, across Dundee to ensure that everyone is treated in a professional and respectful manner.

Recommendation 3: Language matters. People who experience problems with drugs, and their friends and families, are part of our communities - let's make them feel like that.

Recommendation 4: Level the 'playing field' to ensure that all partners, statutory and third sector are held equally accountable. This is necessary to enhance patient safety and quality of provision. The balance between current centralised statutory and other provision needs to be changed.

Recommendation 5: Meaningful involvement of people who experience problems with drugs, their families and advocates.

Recommendation 6: Learning from the things that have gone wrong - attention to continuous improvement to benefit others who are vulnerable.

**B: A HOLISTIC SYSTEM MODEL - INCLUDING INTEGRATED PRIMARY CARE PROVISION**

The second suite of recommendations (7-13) is concerned with the provision of drug treatment and support services in Dundee. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that is not fit-for-purpose.

Recommendation 7: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to people in Dundee.

Recommendation 8: The provision of services currently offered by ISMS should be delivered through the development of a new 'whole system' model of care. This should be structured via a joint and equal partnership with both primary care and the third sector, with the key purpose of utilising the unique strengths of all partners.

Recommendation 9: Reframe all substance use services to prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base including, but not limited to: improved retention through having an unambiguous 'no unplanned discharges' policy; optimised OST; psychological treatments; assertive outreach; and broad integrated care.

Recommendation 10: Involvement of primary care and shared care models.

Recommendation 11: Review and refresh the community pharmacy model for OST engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use substances. Look to establish a new Community Pharmacy model with additional support.

Recommendation 12: Commission a comprehensive independent Health Needs Assessment for people who experience problems with drugs.

Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice - and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems.

**C: CAUSES AND EFFECTS OF DRUG USE**

The third suite of recommendations (14-16) is concerned with a wider understanding of the causes and effects of drug use in order to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups in Dundee.

Recommendation 14: Address the root causes of drug problems.

Recommendation 15: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.

Recommendation 16: Attend to the intergenerational nature of substance use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents. Explore the creation of family support workers in the third sector that can provide support ahead of families reaching crisis point and requiring social work intervention.

## National Considerations

In considering how to achieve the significant improvements that are required in Dundee, there are a number of areas that are outside of Dundee's powers to change - resting either with Scottish Government or the UK Government. For Dundee to succeed in its ambitions to effectively tackle the challenges it faces, the Commission needs to highlight the following matters for national consideration:

1. The Commission would ask Scottish Government to consider equal regulation of the whole substance use services/treatment sector.
2. The Commission would ask the Scottish Government to consider how it can change the funding systems in Scotland to allow ADPs to control the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of ADPs to ensure they can function as fully independent commissioning bodies.
3. The Commission welcomes the Scottish Government declaring the drug deaths crisis as a public health emergency. In Scotland, at present, it is unclear whether such a declaration will unlock any new powers or resources. International examples exist that can be learned from, for example in British Columbia, Canada in response to a provincial emergency. The Commission welcomes the moves by the Minister for Public Health and Sport to set up a National Task Force to advise on what further changes, in practice or in law, could be made in Scotland.
4. The Commission is aware of the current inquiry into problem drug use in Scotland being run by the Scottish Affairs Committee and would support the calls for petitioning the UK government to have increased devolved powers to allow for a full 'Scottish' review of drug laws to be conducted and action taken as a result. In the short-term the Commission would ask the Scottish Government to consider how they can make the most of the powers that they already have (including policy) - such as police and enforcement practice.
5. The Commission would ask the Scottish Government to consider convening a National Learning Set for Drug Death Review Groups (including standardisation of processes).
6. The Commission would ask the Scottish Government to consider how 'real time' data (without extensive delays in getting these data into the public domain) can be achieved in order to enhance the ability to respond both locally and nationally.

7. The Commission would ask the Scottish Government to consider allocating appropriate resources to national toxicology testing to enable more effective and quicker reporting.

8. The Commission would ask the Scottish Government to consider developing a plan of work to address the findings in the 2018 Scottish Government report on women and drug-related deaths.

## Appendix F: Cambridgeshire and Peterborough

<https://www.cpslmind.org.uk/what-we-do/the-sanctuary>

<https://www.cpft.nhs.uk/UEC%20Vanguard%20mental%20health%20Dec2015.pdf>

“The Sanctuary provides a safe place for individuals experiencing an emotional or mental health crisis. It offers practical and emotional support in a warm, welcoming and friendly environment. Access to the sanctuary is strictly via the first response service telephone 111 option 2.

Cambridgeshire, Peterborough and South Lincolnshire Mind is proud to host this vital new initiative in partnership with Peterborough & Fenland Mind, Lifecraft, Richmond Fellowship, Centre 33 and Inclusion Drug & Alcohol Services.

The Sanctuary is funded by Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) as part of the wider Vanguard First Response approach to offering system wide 24/7 help for individuals in crisis.”



The Sanctuary is open 6pm-1am and allows the emergency services to take people there rather than A&E or a police cell. People from CPSL Mind are present. No assessment is carried out at the Sanctuary, just someone to listen and signpost, providing practical and emotional support in a moment of crisis.

### CPFT & Vanguard

The Sanctuary and other initiatives have been developed as part of the “Vanguard” programme.

*“In July [2015], the Cambridgeshire and Peterborough CCG was awarded the status to become one of eight, national urgent and emergency care Vanguard sites. As part of a national NHS England programme, Vanguard sites are designed to test, evaluate and accelerate change, by piloting a range of new models of care. The local Vanguard programme has been split into five work streams, which will all be clinically-led and will involve patients and their carers throughout their development.”*

## Appendix G: Third sector/community mental health information.

Evidence provided by NHS Tayside.

NHS Tayside and Locality Mental Health and Learning Disability known services: third sector and community led support.

### NHS Tayside

<p>Police Scotland D Division / NHS Tayside Community Triage Service</p>	<p>The Community Triage Service is a service run by local mental health services. It was implemented in January 2017 in Dundee and has since been rolled out across all areas of Tayside.</p> <p>The service is used when police are dealing with a suspected mental health incident, with persons initially triaged via a telephone consultation, assessing the needs of the person and assisting the police in their decision making.</p> <p>This multi-agency approach intends to provide a timely intervention by mental health professionals where required, and avoiding unnecessary detentions in police stations and hospitals.</p> <p>This should result in the provision of a better service for persons requiring mental health treatment, reduce the amount of time police officers spend accompanying individuals requiring face to face consultation, and reduce the number of people seeing mental health professionals unnecessarily.</p>
--	---



## Angus Health and Social Care Partnership

<p>Mental Health Wellbeing Service (MHWS)</p>	<p>People, who phone their surgery / present to their GP surgery in distress or have seen their GPs, are then directed to / given an appointment to be seen by the Mental Health and Wellbeing Worker (MHWW). MHWS is provided in 7 practices across Angus currently:</p> <ul style="list-style-type: none"> <li>• - Brechin Health Centre (1 Practice), commenced in August 2016</li> <li>• - Links Health Centre (3 Practices), commenced in July 2017</li> <li>• - Parkview Primary Care Centre (1 Practice), commenced in April 2018</li> <li>• - Monifieth Medical Centre (1 Practice), commenced in April 2018</li> <li>• - Forfar (1 Practice), commenced in July 2018</li> </ul>
<p>Angus Mental Health and Wellbeing Network (AMHAWN) which incorporates Suicide Prevention</p>	<p>AMHAWN is responsible for setting the strategic direction for mental health, wellbeing and suicide prevention across Angus. AMHAWN comprises representatives from a range of statutory and third sector agencies:</p> <ul style="list-style-type: none"> <li>• Angus Health and Social Care Partnership</li> <li>• Angus Council</li> <li>• Angus Carers Centre</li> <li>• Carers Trust Scotland</li> <li>• NHS Tayside</li> <li>• Police Scotland</li> <li>• Penumbra</li> <li>• New Solutions</li> <li>• Scottish Fire and Rescue Service</li> <li>• St. Andrew's Church</li> <li>• Insight Counselling</li> <li>• Angus Alive</li> <li>• Angus Voice</li> <li>• Support In Mind Scotland</li> <li>• Scottish Ambulance Service</li> <li>• Angus Independent Advocacy</li> <li>• Richmond Fellowship Scotland</li> <li>• Voluntary Action Angus</li> <li>• Dundee Samaritans</li> <li>• Dundee and Angus College</li> </ul>

## Dundee Health and Social Care Partnership

<p>Carers Wellbeing Point</p>	<p>Penumbra were awarded funding through the Dundee Carers Partnership to continue implementation of the Carers Scotland Act 2016. The ethos of the Project is that by providing an easily accessible point of information, carers will feel they can access support when they need it in a locality venue suitable for them. It is hoped these workshops will help to provide help and information about finance, benefits, substance misuse, carers and various other topics.</p> <p>Wellbeing Point activities started in January 2019 after some initial consultation and making connections in various community venues including: community cafes based in Whitfield, Lochee and Colonsay areas; The Maxwell Centre; Brooksbank Centre; Broughty Ferry Library; Community Centres based in Kirkton, Menzieshill, Fintry and Charleston. The pilot will run until May 2020.</p>
-------------------------------	--

<p>Dundee Collaborative Group</p>	<p>In April 2016 DHSCP constituted a formal collaborative group of care providers who provide support services to people with a learning disability and/or autism in the city. This was later extended to providers of mental health services. The purpose of this group was to:</p> <ul style="list-style-type: none"> <li>• Look at way providers and the DH&amp;SCP could work together to consider more efficient ways of delivering support, sharing resources and improving the lives of people we all support.</li> <li>• Explore a different way of commissioning new developments and services, taking account of capacity, strengths, local knowledge and added value.</li> <li>• Work together to ensure social care support is in line with anticipated completion dates of planned housing developments.</li> <li>• Undertake this work as a test of change to ensure a more collaborative approach to procuring social care whilst ensuring best use of available resources and increasing third sector influence in commissioning processes</li> </ul> <p>The following providers formed the collaborative group:</p> <ul style="list-style-type: none"> <li>• Capability Scotland</li> <li>• Cornerstone</li> <li>• Carr Gomm Scotland</li> <li>• Dundee Health and Social Care Partnership</li> <li>• Dundee Voluntary Action (DVA)</li> <li>• Gowrie Care</li> <li>• Penumbra</li> <li>• Scottish Association for Mental Health</li> <li>• Scottish Autism</li> <li>• Sense Scotland</li> <li>• The Richmond Fellowship Scotland</li> <li>• Dundee Association for Mental Health (DAMH)</li> <li>• Turning Point Scotland</li> </ul>
-----------------------------------	--

<p>Making Recovery Real (MRR)</p>	<p>MRR is a multi-agency cross sector initiative supported by the Scottish Recovery Network. MRR Dundee involves a mix of people and organisations with an interest in promoting the best possible mental health for people in Dundee. MRR commenced in June 2015, with meetings amongst the partners:</p> <ul style="list-style-type: none"> <li>• NHS Tayside,</li> <li>• Dundee City Council,</li> <li>• Dundee Association for Mental Health (DAMH),</li> <li>• Dundee Voluntary Action (DVA),</li> <li>• Hearing Voices Network (HaVeN),</li> <li>• Penumbra,</li> <li>• The Richmond Fellowship Scotland (TRFS),</li> <li>• SAMH,</li> <li>• Art Angel,</li> <li>• Dundee Independent Advocacy Support (DIAS).</li> </ul>
<p>Navigator Peer Support Service at Ninewells Hospital Emergency Department</p>	<p>This is an Emergency Department based intervention programme that was developed and continues to be led by the Scottish Violence Reduction Unit and at present runs in partnership with the Scottish Government, NHS Scotland and Medics against Violence. The navigator team provide credible individuals to de-escalate their presentation and via interaction, support the notion of a positive lifestyle change. The major aim of Navigator is to engage those who ordinarily refuse to engage with services. Following a highly selected recruitment process our first Dundee Navigators are to commence their posts on 28th October 2019.</p>

<p>New Beginnings CLDN (Community Learning Disability Nurse) initiative</p>	<p>The New Beginnings Team consists of children’s social workers, mental health workers, specialist midwife, and family support workers. Both the New Beginnings Team and CLDN Team identified a gap in service provision which may impact on being able to provide the appropriate care at the appropriate time by the appropriate individual for parents with a learning disability. The New Beginnings CLDN aim:</p> <ul style="list-style-type: none"> <li>• support the New Beginnings Team to ensure that assessments for parents with a learning disability comply with both local and national guidelines, policies and instructions</li> <li>• share specialist skills and knowledge with all professionals within the team, enabling them to offer parents interventions which are specific to their particular needs</li> <li>• give practical advice, relevant literature and guidance on various aspects of enabling parents to engage, participate and interact with plans designed to address risk and reduce concern</li> <li>• co work alongside the New Beginnings Team Members to ensure that all assessments involving a parent with a learning disability is proportionate, acknowledges their specific needs and addresses issues in a way that parents can understand</li> <li>• ensure parents have adequate access to community-based supports, legal advice and Independent Advocacy</li> <li>• contribute to team around the child meetings, the legal process for children and child’s plans in line with GIRFEC.</li> </ul>
<p>Patient Assessment, Management and Liaison Service (PALMS)</p>	<p>PALMS pilot commenced on 11th February (at Muirhead and Hawkhill Medical Centres) and clinics have been running since 27th February 2019. This service puts a specialist psychologist at the heart of the primary care team. People registered with the GP practice can book an appointment directly and most people are being seen within a few days. Anyone needing specialist mental health care will then be referred directly to the most appropriate team. Over the next two to three years it is hoped that every GP practice in the City will have a PALMS specialist available to them.</p>

Peer Recovery Support Workers	<p>Transitions are often a point of weakness in current systems, but they can also present opportunities for Peer Workers to engage and have positive impact. The following peer recovery positions already operational in mental health organisations in Dundee:</p> <ul style="list-style-type: none"><li>• Informal positions at: Art Angel, Dundee Therapy Garden, Dundee Voluntary Action (Peer Recovery Network), SAMH-Horticulture-Cultivate.</li><li>• Volunteering positions at: Dundee Therapy Garden, Dundee Voluntary Action (Friary Drop-In), Feeling Strong, Hearing Voices Network, Penumbra, Wellbeing Works.</li><li>• Paid: Dundee Voluntary Action, Feeling Strong, Hearing Voices Network, Penumbra, SAMH, CMHTs, Veterans First Point.</li><li>• There is also a 2 Year Project currently starting up in the substance misuse field. This provides for paid posts at Volunteer Dundee, Addaction, TCA, and Gowrie Care.</li></ul>
-------------------------------	--



## Perth &amp; Kinross Health and Social Care Partnership

Mental Health Pathways	<p>Current services and supports for people with mental health issues in Perth and Kinross have been scoped. The services listed are accessed by self-referral, signposted by agency, or GP referral and categorised as:</p> <ul style="list-style-type: none"> <li>• Self-Referral and Community Based Prevention and Early Intervention Support:</li> <li>• Beating the Blues</li> <li>• Books on Prescription</li> <li>• Breathing Space</li> <li>• Healthy Minds Book List</li> <li>• Live Active Compass Membership / GP Referral</li> <li>• Money Worries Crisis App</li> <li>• Moodjuice</li> <li>• NHS Living Life 24</li> <li>• Suicide Help App / Website</li> </ul> <p><b>Wider Mental Health Support &amp; Wellbeing</b></p> <ul style="list-style-type: none"> <li>• Andy's Man Club</li> <li>• Access Team</li> <li>• Employment Support Teams</li> <li>• Mindspace</li> <li>• Perth Six Circle Project</li> <li>• Perthshire Women's Aid</li> <li>• PKAVS Mental Health and Wellbeing</li> <li>• Rape and Sexual Abuse Centre</li> <li>• Social Prescribers</li> <li>• Suicide and Self-Harm Support Group</li> <li>• Support in Mind</li> <li>• Tayside Council on Alcohol</li> <li>• Victim Support</li> <li>• Wellbeing Support Team</li> <li>• OWLS</li> <li>• Barnardo's</li> <li>• Floating Housing Support</li> <li>• Perth Creative Community Collaborative</li> <li>• Listening Service,</li> <li>• Men's Shed</li> <li>• Crieff Recovery Cafes</li> <li>• Wellbeing Cafes</li> <li>• MoveAhead</li> </ul>
------------------------	--

	<ul style="list-style-type: none"> <li>• Crisis and Out of Hours</li> <li>• Samaritans</li> </ul> <p>Street Pastor</p>
PLUS Perth (Independent Advocacy)	<p>“PLUS is a member-led mental health charity and social movement in Perth and Kinross. Our values include trust, honesty, equality, justice, community spirit, partnership working, love and compassion”. PLUS works on the founding principle that every single person is valuable and assists people in making better lives for themselves</p>
Primary Care Mental Health and Wellbeing Nurses (PCMHWN)	<p>PCMHWN are based within GP Practices and are managed by P&amp;K HSCP Perth City Locality MoveAhead Team. Two Registered Mental Health Nurses have been appointed for Perth City locality to work within GP practices assessing and signposting patients with predominantly mild to moderate mental health/ wellbeing needs. A nurse has been allocated to each of the GP Practices within the two Clusters. The first PCMHWN commenced employment on 22nd April 2019 within Cluster 2 of Perth City Locality covering:</p> <ul style="list-style-type: none"> <li>• Drumhar Health Centre Yellow and Mauve Practice</li> <li>• Perth City Medical Centre</li> <li>• Glover Street – Kings and Victoria Practice</li> </ul> <p>Access to a clinic appointment with the PCMHWN is via GP Practices either through reception staff or practice staff directly accessing the practice booking systems. Appointments are available for booking up to 4 weeks in advance. Patients will be asked to phone back when further appointments are released if this is necessary. As yet there has been no requirement for this.</p> <p>Referrals are accepted for any person</p> <ul style="list-style-type: none"> <li>• Over 16 years of age who is registered with a Perth City GP practice</li> <li>• Who has a mental health/ wellbeing need (any person who has a disruption to one or more of the five essential elements of wellbeing) which is affecting their overall health/wellbeing) which requires further assessment to identify appropriate sign-posting</li> </ul>

## Appendix H: NHS Tayside. Staff vacancies: June 2018 – June 2019.

SNHS Tayside Staff Governance Committee 15 October 2019. Item 7.1. [https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET\\_SECURE\\_FILE&dDocName=PROD\\_328375&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1](https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_328375&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1)

	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19
<b>Psychiatric Specialties</b>	<b>5.0</b>	<b>6.0</b>	<b>8.0</b>	<b>14.0</b>	<b>14.0</b>
General psychiatry	2.0	5.0	5.0	8.0	8.0
Child and Adolescent psychiatry	2.0	-	-	2.0	2.0
Forensic psychiatry	-	-	-	1.0	1.0
Old Age psychiatry	-	-	-	2.0	2.0
Psychiatry of learning disability	1.0	1.0	1.0	1.0	1.0
<b>All hospital vacancies</b>	<b>223.4</b>	<b>159.7</b>	<b>151.1</b>	<b>147.0</b>	<b>215.8</b>
Adult	182.9	131.8	128.2	118.2	173.7
Paediatrics	1.0	4.4	7.2	6.6	1.0
Mental health	27.5	13.8	6.9	16.0	15.9
Learning disabilities	7.0	2.2	0.0	-	-
Midwifery	5.1	7.5	8.8	6.2	25.1
<b>All community vacancies</b>	<b>38.7</b>	<b>33.4</b>	<b>39.9</b>	<b>40.0</b>	<b>46.4</b>
Health visiting	4.0	11.0	5.0	3.0	-
District nursing	12.6	0	9.4	14.0	16.5
School nursing	3.0	13.8	-	-	-
Paediatrics	-	1.9	2.9	1.0	6.5
Mental health	11.0	1.0	15.6	22.0	19.3
Learning disabilities	4.0	2.0	3.0	-	-
Midwifery	-	-	1.0	-	-
Other	4.2	3.8	3.0	-	4.0
<b>Allied Health Professional</b>	<b>79.4</b>	<b>53.1</b>	<b>41.8</b>	<b>68.9</b>	<b>82.6</b>
Dietetics	29.0	4.3	5.9	9.5	12.1
Occupational Therapy	11.0	6.5	5.7	16.0	22.9
Physiotherapy	21.0	25.8	9.3	19.2	23.2
Podiatry	1.5	2.1	3.6	3.6	3.8
Radiography - Diagnostic (inc. Sonography)	12.0	4.9	6.3	13.6	12.1
Radiography - Therapeutic	2.0	0.0	0.0	0.0	-
Speech and Language Therapy	2.0	7.5	9.0	7.1	6.5
Orthotist	-	-	-	-	-
Orthoptists	1.0	-	1.0	-	2.0
Multi skilled support worker	-	1.0	1.0	-	-

## Appendix I: NHS Tayside Response to NHS Highland / Sturrock Report. BOARD57/2019. Tayside NHS Board. 27 June 2019.

[https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET\\_SECURE\\_FILE&dDocName=PROD\\_322931&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1](https://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_322931&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1)

### 1. SITUATION AND BACKGROUND

In May 2019 the report commissioned by Cabinet Secretary for Health and Sport in to “Cultural Issues related to allegations of Bullying and Harassment in NHS Highland” (‘the Sturrock Report’) undertaken by John Sturrock QC, was published, along with the formal response from the Cabinet Secretary on behalf of the Scottish Government.

In response to the Sturrock Report findings, the Cabinet Secretary committed to ensuring these would be reflected on across all NHS Scotland Boards, and underpin wider NHS Scotland work on engendering a positive workplace culture and behaviours that reflect NHS Scotland’s Values.

The Cabinet Secretary has since written to all Boards on 20 May 2019, seeking assurance on:

- Immediate actions the Board has taken/plans to take on the back of the recommendations made in the Sturrock Report.
- Support the Board in place / will put in place for any member of staff who has been affected by bullying and harassment.
- Details of Board plans for staff engagement to consider these recommendations and the timeline of when this will be carried out.

The Director of Workforce, Employee Director and Associate Director of HR are leading NHS Tayside’s response to the Cabinet Secretary. This paper summarises that proposed response.

### 2. ASSESSMENT

2.1 The ‘Sturrock Report’ describes findings and makes recommendations across a wide range of matters of culture and behaviours - from support and governance around bullying and harassment and whistleblowing, to matters such as HR policy, person-centred leadership, the role of trade unions, engagement, collaboration, and responsibility. The ‘Sturrock Report’ and the Scottish Government response to it are available online as follows: <https://www.gov.scot/publications/report-cultural-issues-relatedallegations-bullying-harassment-nhs-highland/>

2.2. The core findings of the ‘Sturrock Report’ are primarily cultural, and specifically those aspects that describe appropriate leadership and acceptable behaviours.

NHS Tayside’s existing framework and action plan around ‘Culture and Collective Leadership’, originally agreed by the Board in October 2018 offers a platform for addressing many of the issues

raised through 'Sturrock'. Through actions embedding a Values-Based approach to staff experience and engagement, promoting leadership in every role, and underpinning an ethos of team-working and respect across all parts of NHS Tayside, we should ensure that the learning from 'Sturrock' is adopted throughout our services.

2.3 'Sturrock' also, however, challenges all NHS Boards to look again at elements of their approach in implementing and applying workforce policy, in promoting support for and understanding of the NHS Scotland approach to whistleblowing, and in addressing concerns of bullying and harassment wherever they are raised.

In each of these areas, the Cabinet Secretary has asked each Board to take action and offer assurance, alongside similarly seeking leadership teams to consider their approach to culture, promotion of iMatter, and the Staff Governance Standard itself. Specifically, the Cabinet Secretary asks for assurance from all Boards on a range of specific areas, as detailed in Appendix One.

To help ensure NHS Tayside is well placed to respond proactively in these areas, the Director for Workforce and Employee Director, with the support of the Associate Director of HR&OD - Business Support, are leading the Board response. This includes ongoing engagement with the Executive Leadership Team, Area and Local Partnership Fora, Operational Management Team, and through line manager on in to our services on the delivery of our response.

The proposed response to the Cabinet Secretary's key points is detailed within Appendix One.

### 3. RECOMMENDATIONS

The Board is asked to note the publication of the 'Sturrock Report', and NHS Tayside's developing response.

#### APPENDIX ONE

In her letter to the Board dated 20 May the Cabinet Secretary asks for explicit assurance on a

number of key areas:

1. (Boards) Are fostering opportunities for open and active dialogue with all staff in the spirit of Everyone Matters Workforce Vision and Values.
2. Senior Leaders are challenging themselves and their teams to ensure that a culture in which our vision and values are routinely modelled, and that positive behaviours permeate throughout the whole organisation.
3. Remain assured that their local Staff Governance Monitoring arrangements effectively scrutinise implementation of the Staff Governance Standards, in particular that staff continue to be treated fairly and consistently, and with dignity and respect, in an environment where diversity is valued.

4. Are using systems for staff engagement and feedback, including iMatter, effectively and that Boards continue to take action where issues are identified.

5. That Boards review the implementation of workforce policies relating to bullying and harassment and whistleblowing; that they promote staff awareness of these policies including how they can safely and confidentially raise concerns, the sources of support available, and that staff are supported throughout the process.

6. That Boards review their existing workforce training and development needs and make use of the talent development and management programmes NHS Scotland has in place, including Project Lift, to ensure that we are equipping all our staff with the skills and abilities they need to be effective managers of people.

Taking each of these areas in turn, the following is proposed to form the Board response and action plan:

1. (Boards) Are fostering opportunities for open and active dialogue with all staff in the spirit of Everyone Matters Workforce Vision and Values.

The Board recognises that engaging staff openly and honestly in decisions which affect them is a key aspect of Everyone Matters. NHS Tayside has been working in partnership with its local trade unions and staff organisations to refresh the operating principles of the Area Partnership Forum to ensure that there is a robust staff voice in relation to the key strategic issues facing the organisation. In addition Local Partnership Fora have been established across key service delivery areas. These Fora are explicitly tasked within their terms of reference with providing an overview of such issues as iMatters themes, staff governance, finance, workforce planning.

A Partnership Conference was held in April 2019 which sought to engage staff and staff side representatives from all parts of NHS Tayside to review how staff engagement and partnership working can be strengthened. That Conference included input from the Co-Chairs of the Scottish Partnership Forum and an outcome report is to be delivered to the Area Partnership Forum so that key actions can be developed.

NHS Tayside would also look to iMatters and TURAS as providing opportunities for team leaders and their team to have open and honest discussion about how to ensure that the local work area adheres to the vision and values of Everyone Matters.

2. Senior Leaders are challenging themselves and their teams to ensure that a culture in which our vision and values are routinely modelled, and that positive behaviours permeate throughout the whole organisation.

NHS Tayside has formally committed to developing a positive, value-based working environment, where all staff feel supported to deliver the best possible outcomes for those we serve.

In October 2018, the Board agreed a 'Collective Leadership and Culture Strategic Framework' focused on building NHS Tayside's culture around the following principles:



- NHS Tayside is a values-based organisation
- Leadership and management are an important part of every role
- Teamwork is the cornerstone of the organisation's approach
- Support and development is system-wide, and available to all

To underpin this commitment, within its 'Transforming Tayside' plan for 2019-2022, the Board set a primary organisational objective relating to delivery of a 'Better Workplace', modelled against the NHS Scotland Staff Governance Standard, and described as:

**BETTER WORKPLACE:** "We will have a valued and diverse workforce who are well informed and appropriately trained, can access development opportunities, and have a strong voice throughout the organisation"

As an initial priority, the Board has focused on creating the conditions to embed our values to ensure these are understood, owned, and reflected in how our staff, our leaders, and our Board and its governance structures are expected to act and behave. As such, NHS Tayside is, in individual senior objective setting, prioritising demonstration of the values that are expected throughout the organisation in the actions and behaviour at the most senior levels of the organisation, as evidenced through iMatter and TURAS.

Alongside this, Board members have themselves committed to values modelling as individual members and throughout its Committee structure in its Good Governance provisions.

3. Remain assured that their local Staff Governance Monitoring arrangements effectively scrutinise implementation of the Staff Governance Standards, in particular that staff continue to be treated fairly and consistently, and with dignity and respect, in an environment where diversity is valued.

In line with national requirements, NHS Tayside submits for Scottish Government scrutiny the National Self Assessment Monitoring Return. That Monitoring Return reflects staff experience and NHS Tayside implementation of the Staff Governance Standard, as described through local line and partnership input, alongside highlighting corporate initiatives aimed at supporting continuous improvement of overall staff experience and management.

Consideration and sign-off of the NHS Tayside Monitoring Return formally flows through, and is subject to scrutiny by, the Area Partnership Forum to Staff Governance Committee. Assurance e reporting in this way recognising the contribution of partnership working to the issue of positive staff experience.

The evidence provided within the Monitoring Return reflects both those Corporate initiatives led to improve staff experience, and the actions taken locally in response to iMatter and other matters by the network of Local Partnership Foras established across key service delivery areas.

NHS Tayside also produces a quarterly report across a suite of employee data submitted to the Staff Governance Committee for scrutiny and Board assurance purposes. That report offers reporting around matters of diversity, wellbeing, grievance, bullying and harassment, whistleblowing, and other areas of workforce policy application.

4. Are using systems for staff engagement and feedback, including iMatter, effectively and that Boards continue to take action where issues are identified.

The use of iMatter, and our ensuring high participation and action plan conversion rates, has been established as part of the NHS Tayside performance framework, and one of the key performance measure agreed as part of the 'Transforming Tayside' plan for 2019-2022:

- iMatter Employee Engagement Index Score of 80, Participation rate: 70%

Consideration of iMatter outcome report themes and ensuring local action planning are delegated core standing items on Local Partnership Fora, while the Area Partnership Forum is tasked to consider and respond to the Board's overall iMatter outcome, reporting any agreed actions to the Staff Governance Committee for assurance. This is in addition to the regular quarterly workforce data reporting outlined above.

Additionally, NHS Tayside has a suite of internal corporate staff communication routes, including regular newsletters and publication of Board and Committee minutes and papers online. Staff engagement sessions are currently ongoing around the NHS Tayside Transformation programme to promote staff awareness, understanding, and local engagement.

5. That Boards review the implementation of workforce policies relating to bullying and harassment and whistleblowing; that they promote staff awareness of these policies including how they can safely and confidentially raise concerns, the sources of support available, and that staff are supported throughout the process.

NHS Tayside has established a range of support mechanisms for staff who feel bullied or harassed. These include the establishment of Diversity and Equality Champions to signpost staff to appropriate advice. A Wellbeing Centre which provides a values based approach to supporting staff. There is also an occupational health service which provides one to one counselling for staff. Support is also available from staff side representatives and NHS Tayside actively seeks to work in partnership with the staff side in looking at the Tayside approach.

Alongside the appointment of a new Whistleblowing Champion, a revised reporting tracker has been developed to provide assurance to the Whistleblowing Champion that cases of whistleblowing are being actively addressed. The Whistle blowing Champion leads a small group, which includes the Employee Director, to review and make recommendations as to the key priorities for NHS Tayside.

A corporate communication about whistleblowing is to be issued on a 6 monthly basis to heighten staff awareness of the Whistleblowing Policy. The Whistleblowing Champion provides an update to each Staff Governance Committee and an Annual Report will be brought to the NHS Tayside Board. A quarterly report across a suite of employee data is submitted of the Staff Governance Committee for scrutiny.

The introduction of new Once for Scotland policies will provide an opportunity to refresh skills and enhance awareness with regard to the handling of these key employment issues.

6. That Boards review their existing workforce training and development needs and make use of the talent development and management programmes NHS Scotland has in place, including Project Lift, to ensure that we are equipping all our staff with the skills and abilities they need to be effective managers of people.

In line with its commitment in October 2018 under the 'Culture and Collective Leadership Framework', NHS Tayside has agreed a 'Collective Leadership' Training Plan for 2019. This Plan will continue the Board's commitment to enhance leadership capabilities at all levels of the organisation, developing the knowledge, skills, attitudes and values of individuals so that they model compassionate collective leadership.

A suite of training and development programmes are already in place or being piloted and developed that create a new leadership culture where our leaders are accountable for outcomes like high employee engagement and meaningful career management that have been shown to significantly impact financial stability, productivity, and growth. These include Core Senior Leadership and Business Skills programmes, ILM Level 3 Leadership and Management team leader programme, SVQ Level 3 in Management in place for supervisor and first line manager roles, and a Supervisors Development pilot programme.

Alongside this NHS Tayside is an active participant in the NHS Scotland programmes, including, for example 'Leading for the Future' (both with participant attendees and supporting formal programme delivery, and Project Lift, with both participants, promotion of the self assessment tool as an appraisal aide for senior leaders, and formal Project Lift link to the Chief Executive's Executive Leadership Team established.

The introduction of TURAS also underpins assurance reporting on the degree to which core statutory and mandatory training, and regular performance development discussions are happening across all parts of our workforce. These two domains also feature as key performance measure agreed as part of the 'Transforming Tayside' plan for 2019-2022:

- Statutory and mandatory training for all staff. Annual rate compliance: 90%
- Appraisal & PDPs for all staff, including medical appraisal compliance via TURAS: 95%

## Appendix J: Adult Mental Health (Inpatient) Services Organisational Development Review: Summary of Diagnostic and Recommendations/Adult Mental Health Services Organisational Development Plan.

### Introduction

“The Adult Mental Health Services Leadership Team engaged with the Organisational Development (OD) Department during 2018 to explore how the Tayside Collective Leadership Culture Framework might be taken forward within the Service; the leadership team came together in workshop in December 2018 and produced an initial Cultural Vision for the Service. This is reproduced as Appendix 1 and 2 of this Plan. This Vision shows the aspiration of the leadership team to engage with staff, patients and partners of the service to take forward activities that will support a transformation of culture in the coming years.

This initial work was followed, in February 2019 by OD conversations held with key members of the leadership team and their support staff to review how their current experience of working in the service. It is hoped that the suggested actions and activity outlined below will support work already underway to bring about a process of successful change.

Any OD input will be designed to support the team in the wide range of positive change activity already being progressed through clinical and quality improvement, practice development, human resources, governance & structure review and management role, accountabilities and skillset development (It should be noted that when the ‘Leadership Team’ is referred to, this is taken to mean those with a managerial and clinical responsibility and authority for taking forward change and improvement in the service).”

Prior to its disclosure to the Independent Inquiry in October 2019, no mention had been made of this Organisational Development exercise having taken place. It is not cited in the “consolidated action tracker” document which the Independent Inquiry had received in July and which had been presented as a document representing all of the various recommendations from both external and internal reviews.

23 Staff were interviewed in February 2019 (a combination of personnel from Management, Medical, Nursing, Administrative, Trainee Doctors and Quality Improvement teams).

### Universal positives

- All staff presented as motivated and hardworking.
- All wanted to do a good job and improve things for the service and the patients.
- Most staff reported enjoying their work, whether this was directly with patients or as a support service.

### Historical themes reported

- Carseview Centre, internally focussed and cut off from other areas, things done the “Carseview Way.”
- Approach not always best practice or up to date.
- Rivalries and divisions between areas within In-patient care.
- Difficult for patients to navigate pathways between services/internally.
- New ideas from other places not encouraged, a culture of control, reported; passive aggression and blame (sometimes threat) when any attempt made to “speak up to power” (Low levels of Psychological Safety).
- Power and control held at middle managerial level, little responsibility or empowerment encouraged at frontline level/Hierarchy and permission seeking.

### Missing stakeholders (at system level)

- Patients - limited reports of actively engaging with patients for feedback and improvement.
- Medical staff - limited engagement and representation of medical staff at Leadership Team level: exhaustion and over-burdened roles.
- Trainee doctors/Trainee nurses/Allied health professionals - in an ideal position to provide feedback and input as to how their and patients’ experiences can be improved.

### What happens in “closed systems”?

- Strict Hierarchy - control centred around gatekeepers to the system.
- Responsibility and problem solving pushed upwards.
- Managers with GOOD INTENTIONS protect the staff below.
- Failure not tolerated or encouraged (experience of blame rather than accountability) coming from top-down (and bottom-up).
- Low levels of Psychological Safety.
- Disconnected from the outer system and outer world.
- Input from outside system experienced as criticism or attack.
- Problems dealt with through policy application rather than discussion.

## History - what contributed to this system?

- Limited opportunities for training and exposure to new knowledge
- Power and decision-making centralised - limited distributed leadership
- System exhaustion and experience of being constantly under attack - need for the system to defend itself
- Organisational and personal trauma
- Lack of clear Vision for the Service, Strategy for the future
- Lack of clarity about objectives, expectations and accountability
- Lack of clarity of what a healthy culture would look like/feel like for both staff and patients
- Engagement events as opposed to engagement processes
- Lack of connectedness between/amongst professional groups (e.g. medical)
- Parental interactions and communications

## What has begun to improve (6 months)?

- Staff at frontline level being given responsibility and empowered to act within their role.
- Engagement processes beginning (still needs work to connect professions and leaders).
- Clearer idea of what kind of culture is needed and what kind of behaviours expected.
- Staff involved in decision-making.
- Changing approach to management and leadership.
- Patient Safety Programme.
- Staff Training.
- Values-based ALS and opportunities to develop.
- Action Plans?!?!



## Recommendations

- Increased engagement with Medical staff.
- Trainee engagement & local feedback.
- Trainee involvement in clinical model development & improvement (Role/task reviews).
- Identified Medical Clinical Leaders - supported and developed.
- Clinically - focussed 'Triumvirate' management & leadership team & structure.
- Cultural Visioning/Strategy Development Day for Ward-based cultures (Acute Services) - (including partners & stakeholders) (OD).
- Follow-up session/s to focus on & articulate goals & objectives to deliver Vision/Strategy for culture (OD).
- Development Programme/Action Learning Set for SCNs/Senior AHPs (OD).
- Development Programme for Leadership (OD).
- Individual Development discussions & plans for all managers & leaders.
- Development Session for Admin Team (OD).
- Training & development for all staff.
- Engagement and partnership with patients and other stakeholders.



Independent Inquiry into Mental Health Services in Tayside

15/16 Springfield, Dundee, DD1 4JE

Website: [www.independentinquiry.org](http://www.independentinquiry.org)

ISBN: 978-1-5272-5739-9