Interim Report
Inquiry Update and Emergent Key Themes

Capturing Experiences of
Mental Health Services in Tayside

May 2019

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1. Introduction

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

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

2. Purpose of Interim Report

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

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

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

3. The Independent Inquiry

3.1. Background

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

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

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

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

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

3.2. Terms of Reference

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

3.3. Call for Evidence

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

3.4. The Inquiry Phases

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

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

Stage 2 (Evidence gathering) [complete]

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

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

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

3.5. Responses to the Call for Evidence

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

3.5.1. Written

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

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

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

3.5.2. Oral

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

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

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

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

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

3.6. Evidence - Analysis

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

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

4. Key Themes

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

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

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

4.1. Patient Access to Mental Health Services

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

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

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

4.1.1. Crisis Service

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

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

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

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

4.1.2. Risk Management

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

4.1.3. Police Scotland

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

4.1.4. GP Referrals

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

4.1.5. Rejected Referrals

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

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

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

4.1.6. Allied Health Professionals (AHP)

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

4.1.7. Child and Adolescent Mental Health Services (CAMHS)

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

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

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

4.1.8. Mental Health and Substance Misuse

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

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

4.1.9. Multiple Diagnoses

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

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

4.2. Patient Sense of Safety

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

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

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

4.2.1. Ward Safety

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

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

4.2.2. Restraint

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

4.2.3. Patient Self-discharge

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

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

4.2.4. Illegal Drugs on Wards

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

4.2.5. Staffing Levels

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

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

4.2.6. Community Mental Health Teams (CMHT)

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

4.2.7. Training

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

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

4.3. Quality of Care

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

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

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

4.3.1. Communication

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

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

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

4.3.2. Ward Environments

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

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

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

4.3.3. Continuity and Consistency of Care

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

4.3.4. Availability of Services

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

4.3.5. Carer involvement

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

4.4. Organisational Learning

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

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

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

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

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

4.4.1. Policy and Practice

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

4.4.2. Adverse Event Reviews

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

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

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

4.4.3. Fatal Accident Inquiries (FAI)

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

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

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

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

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

4.4.5. Recommendations from Reviews

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

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

4.5. Leadership

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

The issues emerging within the *Leadership* theme are:

- Responsibility and Accountability
- Relationships

4.5.1. Responsibility and Accountability

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

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

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

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

4.5.2. Relationships

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

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

4.6. Governance

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

The issues emerging within the *Governance* theme are:

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

4.6.1. Performance

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

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

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

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

4.6.2. Risk Assessment and Management

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

4.6.3. Management of Change

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

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

4.6.4. Service Redesign Transformation Programme

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

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

4.6.5. Communications

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

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

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

5. Next Steps

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

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

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

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

David Strang

Chair of Independent Inquiry **May 2019**

6. Appendix 1

Summary of organisations
who submitted evidence
to the Inquiry

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

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

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