THE
INDEPENDENT
INQUIRY
into Mental Health
Services in Tayside

Trust and Respect

Progress Report 2021

July 2021

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Independent Inquiry Review Team

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1. Executive Summary

- 1.1. In the year since the publication of the <u>Trust and Respect</u> report in February 2020, every area in Scotland has had to respond to the COVID pandemic. This has understandably placed extraordinary demands on those charged with delivering health and social care.
- 1.2. At the time of publication of the *Trust* and *Respect* report, the Minister for Mental Health asked the Independent Inquiry team to revisit Tayside's mental health services in 2021 to review the progress which had been made in implementing the report's recommendations. Throughout the year 2020-21 the Chair of the Inquiry was kept informed of the development of Tayside's mental health services by the Director of Mental Health and the Director of Strategic Change for NHS Tayside.
- 1.3. The purpose of this review has been to give everyone the opportunity to have their voices heard in relation to the progress made in addressing the issues raised by the *Trust and Respect* report. Contributions were invited from everyone working in mental health services in Tayside, as well as from a wide range of partner organisations and other interested stakeholders. The feedback and evidence provided to the Review team has informed the conclusions of this review.
- 1.4. The Review team was assisted by a user survey conducted by the Stakeholder Participation Group and a mental health services staff pulse survey conducted by NHS Tayside. The Review team is grateful to everyone who contributed evidence to the review.
- 1.5. The formal Progress Review began in February 2021, with a request to NHS Tayside and its partners to provide an assessment of the progress that had been made in implementing the relevant recommendations in the report. It was understood that it would not have

- been possible to have implemented fully the longer-term changes which were planned, but an accurate self-assessment of progress to date was requested. One of the issues the Review team was concerned about was to what extent were the assessments by Tayside a realistic reflection of the true extent of the changes accomplished.
- 1.6. It is important that Tayside has a realistic understanding of the scale of the task ahead of them in transforming the delivery of mental health services following the *Trust and Respect* report.
- 1.7. This Progress Review is intended to assist the delivery of improvements in the provision of mental health services in Tayside and highlights the key elements that need to be addressed over the next two to four years in order to deliver the desired outcomes.
- 1.8. The Review team has found a great deal of positive changes in progress and has been impressed with the commitment and dedication of staff, partner organisations and others seeking to make a difference for patients and the wider community in Tayside. There have been some very positive developments such as the mental health discharge hub and the local mental health hubs planned in each Health and Social Care Partnership (HSCP) area.
- 1.9. There have, too, been some missed opportunities for listening to people and engaging with partners in order to build trust. It is hoped that this Review will provide a fresh opportunity to build on the early response to the *Trust and Respect* report.

Key findings

- Tayside responded positively to the *Trust and Respect* report, establishing an early foundation for developing a new approach to delivering mental health services in Tayside.
- There remains a long way to go to deliver the improvements that are required.
- Questions have been raised about the level of confidence in the accuracy of the reported progress against Tayside's Listen Learn Change Action Plan.
- Some key relationships remain problematic and unresolved. There is scope for building the respectful relationships which are necessary for the delivery of effective mental health services.

2. Response to the *Trust and Respect* report

- 2.1. The final report of the Independent Inquiry into mental health services in Tayside (entitled *Trust and Respect*) was published in February 2020.
- 2.2. It was recognised that Tayside faced a considerable challenge in responding to the *Trust and Respect* report and in addressing the long-term difficulties which were evident in the delivery of mental health services. These were long-standing challenges; they would not be fixed in a short time.
- 2.3. Nevertheless, Tayside partners welcomed the report and accepted all its recommendations. There was a commitment to make the delivery of mental health services a priority for Tayside and a standing item at every Tayside NHS Board meeting.
- 2.4. The Chief Executive of NHS Tayside and the Director of Nursing had an early meeting in February 2020 with the Stakeholder Participation Group, who had made significant contributions to the work of the Inquiry. The Chief Executive expressed his personal commitment to deliver the recommendations of the report and to improve the delivery of mental health services.
- 2.5. An important decision was taken to appoint a new Director of Mental Health to lead the response to the report. This was a one-year appointment, with a specific remit to develop an action plan and a long-term mental health strategy for Tayside.
- 2.6. The Tayside Executive Partners (TEP), comprising the Chief Executives of NHS Tayside, Angus, Dundee City and Perth & Kinross Councils, and the Tayside Police Scotland Divisional Commander, issued a joint statement of intent, committing their organisations to work collaboratively to deliver the

improvements identified in the *Trust* and *Respect* report.

"Together with people living with lived experience of mental health conditions, their families and carers, and our staff, we will continue to work on addressing the issues raised from the Independent Inquiry and set out in the *Trust and Respect* (2020) to build high quality mental health services that meet people's needs and build a working environment that supports our staff." Tayside Executive Partners.

Listen Learn Change Action Plan

- 2.7. The *Trust and Respect* report recommended that a detailed action plan should be developed by 1 June 2020. This was achieved through the development of the Listen Learn Change (LLC) Action Plan. This was accompanied by an extensive engagement programme to hear the voices of relevant stakeholders, including patients, families, carers, staff, third sector and partner organisations. Consultation events for LLC were well attended.
- 2.8. A comprehensive response was developed for each of the 49 (Tayside) recommendations, which included an identified lead person and a target timescale for completion. Separately, the Scottish Government developed responses to the additional two recommendations which applied across Scotland.
- 2.9. Regular progress updates were produced throughout the year for NHS Tayside, the three Integration Joint Boards and other relevant organisations, staff and stakeholders. The status of each recommendation's progress was reported using a Red/Amber/Green (RAG) status for each

recommendation.

2.10. Throughout the year, a number of challenges emerged:-

Consultation and inclusiveness of processes

- 2.11. In developing the LLC Action Plan, there was a real opportunity to involve staff from partner organisations other than NHS Tayside in leading the responses to the recommendations. In the event, however, nearly all the people who were appointed to lead the Action Plan were from NHS Tayside.
- 2.12. The process of allocating lead people was rushed, with partner organisations feeling that there was insufficient time to consider the Action Plan in detail before it was finalised. As a result, they felt that their opportunity to contribute to shaping the Action Plan was limited. Some people who were identified to lead responses had not been asked if they would contribute, and subsequently withdrew.
- 2.13. Some contributions and responses to the early documents went unacknowledged and ignored. Some people feared that consultation events for LLC were a tick-box exercise, because their questions went unanswered and their contributions ignored.
- 2.14. The LLC document itself was subject to a number of revisions throughout the year, including the definitions of the RAG status. This made comparisons difficult to make; some people found the document and reporting hard to follow.

Use of RAG status

2.15. The May 2021 LLC Action Plan (Appendix 2) showed that 34 (of 49) recommendations were graded with a Green status. A Green status indicated that the outcome for the recommendation was complete.

- 2.16. A Listen Learn Change Progress Overview was presented to the Tayside NHS Board meeting on 24 June 2021 (Appendix 3). There were now 35 recommendations graded with a Green status. The Progress Overview used a different format, which made it clearer to identify the updates for each recommendation. Each section included "Next Steps", describing what action is still to be undertaken, irrespective of whether the recommendation had been graded Complete or Ongoing. However, there was a less detailed response to each of the recommendations compared to the May 2021 Action Plan. Individual action points were no longer listed, there were no timescales indicated for completion. and the person leading each response was no longer identified in the report.
- 2.17. Two particularly important recommendations of note are Recommendation 1 (Develop a new culture of working in Tayside built on collaboration, trust and respect) and Recommendation 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).
- 2.18. Despite these being long-term cultural change recommendations, they were both designated Green status within 11 and 13 months of the Trust and Respect report's publication. It is not credible or realistic that culture change of such magnitude could be implemented in such a short time. In the June 2021 LLC Progress Overview the grading for Recommendation 1 had been changed to Ongoing, in recognition of the long-term nature of this recommendation. At the time of publication of the Trust and Respect report, it was anticipated that these two recommendations would require a much longer timeframe to implement (perhaps over several years).
- 2.19. The May 2021 status of
 Recommendation 48 is assessed as
 being Green, with the accompanying
 text indicating a relaunch of the Dignity
 at Work policy. Relaunching the Dignity

at Work policy would be necessary, but not sufficient to ensure a new culture among the workforce. The status report of this Recommendation states that [a number of actions] will be undertaken or completed. Despite this indication that further work is required, the status is shown as Green, "Recommendation complete" and has remained so in the June Progress Overview report.

- 2.20. This response suggests that Tayside has not fully appreciated and understood the cultural change requirements that were identified in the Trust and Respect report.
- 2.21. Direct feedback to the Review team demonstrates that these cultural issues are far from being resolved.
- 2.22. Further examples of Recommendations which have been graded Green but which the Review team had concerns about are:
- 2.23. 13 (Ensure that there is urgent priority given to planning of community mental health services. All service development must be in conjunction with partner organisations and set in the context of the community they are serving.) The status report in October 2020 shows all actions complete.
- 2.24. 22 (Develop pathways of referral to and from university mental health services and CRHTT.) Although the June Progress Overview indicates the pathways are now in place, thier success or otherwise is yet to be tested.
- 2.25. 51 (Ensure that all external review processes are embraced wholeheartedly and viewed as an opportunity to learn and develop.) The status report in October 2020 shows an action plan tracker and Standard Operating Procedure was established in 2019. The action plan sets out suitable actions to implement this recommendation, but with insufficient progress to warrant a Green assessment.

Implications for effective oversight and governance

- 2.26. Many of the recommendations with a Green status still have outstanding actions awaited. The Green RAG status may mistakenly give the impression that there is no further action required. This potentially provides the Board with the impression that the task is completed, rather than a work in progress that needs further effort and scrutiny. To be satisfied that a recommendation has been completed and that the recommended changes have in fact occurred, there must be sufficient evidence to provide the assurance that the task is complete. It is not enough to report that a committee has been tasked with examining the issue or that a new policy has been developed and published.
- 2.27. For example, three of the recommendations graded Green (numbers 44, 48, 49) in the May 2021 update have the following as the final comment in the status updates:

All actions complete. The responses to this recommendation have provided a platform upon which to build an ongoing Workforce Development Programme to raise awareness and enhance understanding of associated guidance for staff. The programme of sessions will be extended through April, May and June 2021. Recommendation complete.

2.28. Over-optimistic use of the RAG system is problematic for the Board (and others with responsibility for the oversight of the LLC Action Plan). There should be a clear distinction between those recommendations that have been implemented in full with no further action required and those which are simply "in progress" with further actions required and which will therefore need further scrutiny. The completion of tasks in themselves may not be sufficient to discharge the recommendation; there needs to be an assessment of the impact on the underlying issue which gave rise to the recommendation. Have the desired changes taken place? There is a danger that over-optimistic

reporting may undermine the effective functioning of the Board.

Living Life Well – a lifelong approach to mental health in Tayside

- 2.29. One of the foundational recommendations in *Trust and Respect* is Recommendation 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). This has been a substantial task for Tayside throughout 2020-21, resulting in the publication of its Living Life Well (LLW) strategy in February 2021 (Appendix 1).
- 2.30. Tayside undertook a substantial consultation process involving a wide range of stakeholders in order to hear the voices of people with an interest in mental health and wellbeing in Tayside. Participants and contributors included people with lived experience of services, staff in NHS Tayside and other partner organisations, third sector and community groups.
- 2.31. The result was a new mental health and wellbeing strategy: Living Life Well a lifelong approach to mental health in Tayside. Living Life Well is a well-designed and professionally produced document, with positive photographs throughout. It is commendable that there is a comprehensive, well presented document setting out the vision for mental health services in Tayside. Such a strategy has been missing to date.
- 2.32. The LLW strategy is a substantial document (with 131 pages), setting out the aspirations for mental health services in Tayside. Its content focuses on the strategic intent and high-level outcomes for patients and communities.

Implementation

2.33. The final chapter of LLW ("Delivering the Strategy") sets out how the strategy

- will be implemented. "This strategy must have a full three to five-year implementation plan to match the expressed and identified needs of those described in this strategy." (p.118).
- 2.34. However, to date there is no implementation plan for the LLW strategy.
- 2.35. "Implementing the Strategy (2020-2025)" p.123 identifies that a number of cross-cutting themes will see full and detailed plans developed. These include:
 - Risk management strategy and plans
 - Communication and engagement plans
 - A Transitions strategy and plan
 - A digital/new technologies plan
 - A workforce strategy and plan
 - A financial plan
- 2.36. The Board (and other scrutineers such as Healthcare Improvement Scotland; Mental Welfare Commission Scotland; Scotlish Government Quality and Safety Board) should ask to see the LLW Implementation Plan (p.118) and the cross-cutting detailed plans (p.123), and should regularly monitor progress against these plans.
- 2.37. The Director of Mental Health had been instrumental in ensuring the delivery of the response to *Trust and Respect* (through LLC) and the development of the new mental health strategy – Living Life Well. The Director of Mental Health left Tayside in March 2021 and is yet to be replaced. The earliest appointment date for the replacement is anticipated to be September 2021. This raises the question as to how the strategy will be implemented in the absence of the Director of Mental Health. There was concern around NHS Tayside and amongst partners that the momentum of the last year may be lost.
- 2.38. In addition to the above, there needs to be a more systematic approach to managing the change programme,

providing administrative support, following up actions from decisions in meetings and ensuring scrutiny and assurance. There needs to be a more detailed design of actions undertaken and detail of monitoring the effectiveness of the changes that have been introduced.

- 2.39. The role of the TEP in the implementation phase is unclear. The Listen Learn Change Scrutiny Panel comprises predominantly NHS Tayside staff, with only one Local Authority Chief Executive a member.
- 2.40. Community Mental Health Teams (CMHT) continue to struggle with the demands placed on them. It seems there is a lack of communication about the difficulties the service is experiencing. Cluster 4 CMHT had no psychiatrist for several weeks, but those working in primary care making referrals did not know. Primary care teams supporting their patients with mental ill-health report that it is difficult to feel optimistic about services improving when there is little or no communication.

Resourcing

2.41. The three Integration Joint Boards in Tayside approved the LLW strategy in principle, subject to more details about the funding of the strategy. Plans for funding the new strategy are laid out on p.120 of LLW "Funding the Strategy".

"The public sector organisations in Tayside will work together in early 2021 to set out the financial framework that acknowledges the strategic priorities set out in this strategy."

2.42. There is still a focus on inpatients/ hospitals rather than on developing community mental health services which should be the first priority.

Scottish Government response

2.43. The Scottish Government undertook to lead on the response to two of the *Trust and Respect* recommendations - Recommendation 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) and Recommendation 32 (A national review of the guidelines for responding to substance misuse on inpatient wards is required). The Scottish Government's update in response to these recommendations is in Appendix 4.

3. Leadership

- 3.1. The first substantive chapter of *Trust and Respect* was Governance and Leadership. This reflected the importance of good governance and leadership in the effective delivery of mental health services in Tayside. One year on, the delivery of a major improvement in mental health services still requires clear, confident, engaged leadership.
- 3.2. The establishment of the Tayside Executive Partners (TEP) was a positive step forward in stating the intention to lead collectively on such a major change programme in Tayside. At an individual level, the Director for Mental Health was able to provide energy and focus to develop the Listen Learn Change (LLC) Action Plan and the development of the Living Life Well strategy (LLW) (Appendices 2 and 1 respectively).
- 3.3. However, it is clear that the leadership of mental health services in Tayside is still divided. The Review team received conflicting messages about how the leadership team is working in practice. This impacts at two levels. Firstly, the leadership partners are not united in their assessment of progress. There is not a sense of shared collective ownership and responsibility for the delivery of mental health services. Secondly, there continues to be a gap between what is stated publicly at a Board level and the reality of the experience of those delivering the service and of patients, carers and families.

Leadership of staff

3.4. A number of people reported to the Review team a gap between the stated values of the public sector organisations and the behaviours exhibited at a senior level in NHS Tayside. There had, at times, been low levels of respect shown to those engaging with the response to the *Trust*

and Respect report. The Review team received feedback that some people felt that undue pressure was exerted on them to deliver the recommendations of the Action Plan – simply to allow for 'Green' status. Leaders may have to be firm in managing the performance of staff, but this experience of pressure is inconsistent with respectful working.

Leadership/collaboration of partners

- 3.5. One of the most important and pressing recommendations of the report was Recommendation 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).
- 3.6. In the May 2021 LLC Action Plan this has been assessed as Amber 25%, indicating that work has started to scope actions and an implementation plan is under development. It was clear in evidence to the Review team that little progress had been made in developing such a shared understanding and commitment.
- 3.7. The major thrust of this recommendation relates to the relationship between the four organisations and the need to develop a shared understanding of and commitment to the respective roles and responsibilities of each organisation.
- 3.8. Tayside are aware that this recommendation remains to be completed. There is an acknowledgement that the level of trust between the partner organisations needs to improve. Until relationships have improved, it is difficult to see how progress can be made in implementing the changes that will flow from the greater clarity that is needed.

3.9. Some felt that the decision made by the Scottish Government in February 2020 that GAP inpatient responsibility should move from Perth & Kinross Integration Joint Board to NHS Tayside had exacerbated the situation.

"I have had loads of ideas of how to change things following *Trust and Respect*, but they have just fallen on deaf ears".

Stability of Leadership team

- 3.10. There is a need for strong and clear leadership to take forward the mental health strategy for Tayside - Living Life Well. With the level of changes of senior staff in recent months, there is a risk of the implementation of the strategy losing momentum and direction. An unsuccessful recruitment process for a new Director of Mental Health was undertaken in October 2020. Another recruitment process is underway in summer 2021, but this process should have been completed in advance of the previous postholder's leaving in March 2021. This delay has resulted in a significant and unnecessary gap in mental health leadership.
- 3.11. A recruitment process was undertaken in response to Recommendation 45 of *Trust and Respect* (Prioritise recruitment to ensure the Associate Medical Director (AMD) post is a permanent whole-time equivalent, for at least the next two years whilst significant changes are made to services), but without success. A second process is underway, but 17 months after the report's publication there is still no permanent whole-time equivalent AMD.
- 3.12. CAMHS: A lack of leadership is still a major concern within CAMHS. There needs to be identifiable leadership at a clinical level in both Paediatrics and CAMHS, in order to progress some of the much-needed initiatives.
- 3.13. In the Relationships chapter of this report it is noted that communications were still inadequate. Members of staff reported that they did not know who to go to for decision making and leadership. Staff were not encouraged to share their thoughts and ideas.

4. Relationships

4.1. Organisations with good working relationships can demonstrate a culture of respectful personal interactions and collegiate practices. These should be evident in all relational activities, regardless of circumstance or the status of individuals. The Trust and Respect report identified many cases of poor working relationships in Tayside mental health services (between staff; between staff and patients/ carers; across services/partnerships) and urged a much greater genuine engagement with people who are closely involved in or affected by the delivery of mental health services.

Partnerships

- 4.2. Respectful and collegiate working relationships between the three Integration Joint Boards (IJBs) and Health and Social Care Partnerships (HSCPs), and NHS Tayside are critical to the successful delivery and quality of care in mental health services in Tayside.
- 4.3. The Trust and Respect report identified that these relationships were generally not functioning well. The Review team have ascertained that little has changed since then. Delegations of responsibilities continue to be poorly understood, with Chief Officers reporting that there remains a lack of clarity of who oversees what. Furthermore, communication between the partnerships and the NHS on operational matters remains poor. Leadership in NHS mental health services reported finding out about changes decided by individual HSCPs from the Press.
- 4.4. Initially, the Tayside Executive Partners (TEP) responded positively to the *Trust and Respect* report, appearing to have a genuine desire to work together on the recommendations and production of the strategy. However, there is uncertainty within TEP members about

- there being a collaborative approach to the next stages. They expressed concern that NHS Tayside is asserting control over strategy implementation without adequate collaboration.
- 4.5. The three HSCPs do not have strategies for working together in the delivery of community mental health services and in conjunction with crisis and inpatient services. Each locality has remained focused on its own area. Whilst this has been understandable during the pandemic, it has created a risk that Tayside-wide issues are currently being overlooked. There is a view that in fact most of the current challenges facing community mental health provision are the same across all three localities and could therefore be addressed more efficiently through a collective approach. This would allow each partnership to focus on the remaining issues unique to its own area.
- 4.6. The quality of mental health services in Tayside is dependent on the four organisations (and associated partners such as Police Scotland) working well together, both legislatively and relationally. There should be a concerted effort at executive level to work collaboratively and respectfully. This in turn will set the tone for operational relationships to develop and flourish, creating a real prospect of improved mental health services for the people of Tayside.

Staff

- 4.7. The *Trust and Respect* report identified many cases of committed and dedicated staff in mental health services being overlooked or simply not listened to. Staff felt undervalued by some of those leading the service.
- 4.8. The Review team found that in responding to the recommendations

in the *Trust and Respect* report, the interim leadership developed good working relationships within services and the staff involved felt they had enjoyed a clearly defined sense of strategic direction and agreed that they had felt supported in their work. The creation of short-life working groups within the Listen Learn Change (LLC) Action Plan had worked well and staff had enjoyed working together with a positive focus on a better future.

- 4.9. However, since April 2021 the leadership void in mental health services has begun to impact on the energy and enthusiasm of the staff involved in the change process, creating a significant risk that newly created and well-functioning relationships will wane.
- 4.10. Staff are aware of key leadership resignations and interim contracts coming to an end but are not being advised of a strategy to cope with these vacancies. There is a feeling that the open and transparent decision-making which had been in place during the response to *Trust and Respect* is no longer existent. Staff are not being answered when raising their concerns, creating an environment of worry and concern where once again, they feel disenfranchised or that their views and opinions are of no value.
- 4.11. Whilst it is understood that the multiplicity of resignations, retirements and expiry of interim contracts is challenging to navigate for senior leaders, experienced and dedicated staff feel there is a real need to work together collegiately. Service continuity planning alongside the development of a clear implementation plan for the Living Life Well (LLW) strategy are both critical to the future of mental health services. Inclusion of senior staff from across the services is encouraged, to share the problem and to canvass alternative views on the solutions.
- 4.12. The Review team also found that there had been some progress in the development of better working relationships within service delivery, but this was not universal. There were some examples of good strong

- leadership which had impacted positively on staff, encouraging a feeling that there was now more of a sense of a team working approach. Disappointingly, the leaders who have effected these changes did not report that they themselves felt supported in their roles and instead stated that their relationship with line managers was poor.
- 4.13. There is a continuing concern about relational difficulties across the whole of mental health services arising from the conflict between the need for progressive change against the concerns of the impact of the change on staff at operational levels. The employee-employer partnership relationship has, at times, created an impediment to the change processes rather than actively supporting it.
- 4.14. NHS Tayside recently conducted a survey of NHS mental health services staff which showed that there is still low confidence that staff feel their ideas are listened to and acted on or that their employer is concerned about their wellbeing. Good working relationships are predicated on staff feeling valued and listened to, particularly those working at operational levels. Staff feel valued if they are empowered in their roles, trusted to make the right decisions and to feel supported when they don't.
- 4.15. A culture of trust is still lacking in many aspects of mental health services, with the relationship between frontline staff and senior managers at times to be more that of a distrust. Many of those in leadership and management roles felt that staff were being asked excessively to evidence the rationale behind their decision-making. Whilst it is understood that decisions on patient care must be documented and evidenced, there is a need to balance that requirement against the risk of discouraging creativity and disempowering staff. This culture seems to exist throughout the management hierarchy and, unsurprisingly, is pervasive within and across teams who are trying to work closely together. The result is that there are still many staff who feel their working relationships are not good, with

- several saying they feel undervalued and undermined almost daily.
- 4.16. Many of the clinical staff who agreed to lead on the short-life working groups, now feel they have unmanageable workloads which in turn has become a disincentive for others to be willing to engage in change processes at all. It is important to support staff who are willing to be part of the solution to the problems in mental health services. Overwhelming them by not giving them appropriate time to engage with projects creates more stress and anxiety which impacts the whole service, and ultimately the service users.
- 4.17. There continues to be conflict between managers deciding on operational changes and clinicians not agreeing with the changes, due to the practicalities of their application. The clinicians often feel excluded from the decision-making processes and are not listened to if they register concerns. This unresolved cycle of disharmony has almost become a self-fulfilling prophecy, rehearsed regularly as changes are mooted or strategies are developed.
- 4.18. For services to improve staff must feel they are part of the changes; they need to have the ability to see where they fit into the service redesign and to feel they are listened to if they have comment or concern. Some staff who were keen to engage with the LLC process and who took the time to comment and engage extensively, reportedly received no acknowledgement of their feedback or commentary. This is disappointing as these were individuals with enthusiasm and a genuine desire to help, who then felt despondent and disrespected. These included individuals who were not NHS Tayside staff but were from areas of mental health services working in partnership. To involve these people would have created an opportunity to engage with others whose work may not be at the centre of NHS mental health services but who do have an important role in supporting the people in Tayside with mental ill-health.

- 4.19. Good working relationships require good quality communications particularly during a time of significant change. Many staff who gave feedback to the Review team noted that the communications regarding the strategy development and action plans have been excessive and beyond what many had time to read and digest. Paradoxically, this has resulted in reports of "poor communication" as staff were in fact unaware of changes being made. They described having feelings of waiting for something to happen without having time to find out what that might be. It is important that communications are finessed, with consideration given to the amount, type and nature of the messaging if staff are to feel part of the change process.
- 4.20. In summary, there is still much work to be done in the development of good working relationships in mental health services. The development of a culture of collegiality – where staff feel valued and respected - is critical if the LLW and LLC Action Plans are to be delivered successfully. The culture of healthy working relationships is set by the organisation itself, in its values and the actions of its leaders. There needs to be an urgent top-down review of how well staff feel supported and treated and a sincere drive to address disrespectful and unsupportive behaviours if mental health services are to develop and improve for the people of Tayside.

5. Operational Issues

Adverse Event Reviews

- 5.1. The May 2021 Listen Learn
 Change (LLC) Action Plan shows
 Recommendation 31 (Ensure swift and
 comprehensive learning from reviews
 following adverse events on wards)
 to be Amber status 75%. There are
 several identified tasks which still have
 a status "to be completed in April/May
 2021" or are simply a narrative of what
 needs to happen, without a timescale.
- 5.2. From the status reports, the greatest impediment to progress seems to be a lack of staff availability and capability to undertake these reviews. This impacts on the speed of the reviews taking place (as staff are reluctant to move from clinical time to conduct the reviews). Correctly, consideration is being given to using personnel from other Boards or using retired clinical staff. So far this has not been resolved and no one person has been recruited to undertake this work.
- 5.3. There has nevertheless been a significant amount of work to consider the processes and procedures for learning from reviews of adverse events and staff reported feeling that the procedures are generally now more robust and are operating more within a learning and no-blame culture. The Review team also received feedback from staff who had been involved in a significant incident on a ward in recent months, saying that they had felt supported by line management during and immediately after the incident, which in turn gave them confidence (and not fear) to be involved in the future review of the event.
- 5.4. So far, the work undertaken on this recommendation shows positive steps in the direction of the development of a learning culture for staff within mental health services, and with a continuity of leadership and support from the Quality Improvement Team, there should be

- confidence that a supportive learning culture will develop.
- 5.5. There are some outstanding concerns from families and carers of patients regarding the post-event engagement between themselves and NHS Tayside following a significant incident. There are currently several examples of a lack of response from NHS Tayside to concerns raised in connection with Local Adverse Event Reviews (LAER) which remain unresolved. The concerns from the families and carers have been further compounded by senior staff in NHS Tayside who promised to investigate and made offers to family members to meet to discuss, but then the family heard nothing more. One family is still waiting for a meeting with Executives which was promised in May 2020 - to correct inaccuracies in a LAER report from 2019. It is likely there are understandable mitigations for the delay to responding to these individuals (particularly given the pandemic) however, the families feel a lack of respect and kindness being shown to them by false-promises giving rise to false-hopes. It also must be concluded that learning opportunities are being delayed or missed altogether or that the learning outcomes may be misguided if they are based on inaccurate or out-ofdate information and data.
- 5.6. As Recommendation 31 moves to its completion, it should be borne in mind that learning outcomes from adverse events are achieved by fully understanding the situation, by engaging with everyone involved in a supportive and compassionate manner. Staff clearly are important to the process and should feel supported throughout an incident review, but families and carers also need to understand what happened and why, and to feel included in a compassionate manner. Families and carers, whilst upset and maybe angry, mostly are keen to assist in the reviews and potential learning outcomes for future

service development. This is extremely important, if families and carers are to trust the service and those responsible for its delivery.

Inpatient and Community Services

- 5.7. There has been good progress on improvements to inpatient services across NHS Tayside since the publication of the *Trust and Respect* report.
- 5.8. The work to develop better ways to support patients on the wards has been welcomed, with patient handouts relating to admission information and protocols for family and carer involvement in care-planning now in place. Patients should expect to feel more comfortable when being admitted to a ward they are unfamiliar with, and to feel there is support from those who know them best in the development of their care-plans.
- 5.9. Some of the desired improvements to inpatient services are being impeded by staffing issues particularly where recruitment has been difficult. Notwithstanding that, the Review team feel that the decision to create new posts to effect these changes is correct as many of the initiatives reflect new ways of working or an organisational change, both of which require a level of ownership beyond existing staff roles.
- 5.10. Recommendation 30 (Ensure all inpatient facilities meet best practice guidelines for patient safety) will not be completed until 2022. The implementation plan includes an aim to achieve standards set by the national Scottish Patient Safety Programme and by the Royal College of Psychiatrists. The work towards accreditation for these standards takes time and the Review team recognise that it has been difficult to build the evidence required during the challenges of the last year. Nevertheless, the Review team would urge that these standards be satisfied and accreditation sought, if public confidence in NHS Tayside's inpatient mental health services is to be restored.

- 5.11. There are some policy-practice gaps becoming evident where new protocols or policies have been devised within the action plan and introduced operationally but without success in achieving their aims. An example of this is the Intervention Observation Policy (IOP) which is working well in Intensive Psychiatric Care Unit (IPCU) due to the small number of patients but not on the other busier wards. There are also examples of policies which are clearly in place but after initial promotion become invisible (e.g. access to external independent advocacy services).
- 5.12. An ongoing concern is the location and redesign of General Adult Psychiatry (GAP) inpatient services. During the Independent Inquiry (August 2018 February 2020) there were proposals and consultations for redesign of GAP inpatient services with no conclusion reached at the time of the publication of *Trust and Respect* in February 2020. In June 2021, the issue remains unresolved.
- 5.13. The current debate regarding the redesign of GAP inpatient services continues to raise several concerns which have been shared with the Review team. These are: -

The proposal to reduce the numbers of GAP inpatient beds in Tayside

- 5.14. The Review team recognises the concerns about the strategy to further reduce the number of GAP inpatient beds before community provision is enhanced. Statistics show that there are currently a third fewer beds than 20 years ago, but there is no evidence that community provision has correspondingly increased over that time and no confidence this will be addressed during the current redesign.
- 5.15. The effective delivery of good mental health services in Tayside is at risk unless action is taken to significantly enhance services in the communities before inpatient bed numbers are reduced. Mental health service strategies are required from each Health and Social Care Partnership

- (HSCP), to complement the LLW strategy and to ensure alignment of community mental health service provision and outcomes.
- 5.16. Concerns about the lack of community strategies and service enhancement are echoed in primary care services where an increase in community mental ill-health (at the mild to moderate level) has already been noted by GP practices during the pandemic. It was noted that there are more referrals being made to the Community Mental Health Teams (CMHT) than anticipated in 2021, resulting in waiting times increasing. GPs across Tayside agree that they expect that this trend will continue for the next few years.
- 5.17. Increased demands on community mental health services should be noted as an early warning for a likely increase in demand on inpatient service provision long-term. Likewise, inpatient services are also reliant on adequate community resource at the point of discharge.
- 5.18. The Review team learnt that community services have struggled to cope during the last year. Medical staffing shortages in CMHTs were not communicated to primary care and instead patients were simply told appointments were cancelled with no explanation or indication of when they may be rearranged. Locum staff are now in place but once again the lack of continuity in patient care is destabilising and distressing. It appears that there are still some patients who feel the only continuity is their GP as the person who truly knows and understands them.

Location of GAP inpatient services

- 5.19. Currently, the decision to move to a single site for inpatient services has been largely accepted (although not universally welcomed) but its location is yet to be decided.
- 5.20. To redesign an inpatient service in Tayside which is resource-sustainable (both human and financial), safe for patients and effective in the delivery

of patient care is extremely difficult. The continual churn of proposals and consultations which seem only to lead to more indecision is unhelpful and is without doubt affecting the morale of staff, patients and stakeholder groups. A decision must be made and in conjunction with consideration of community service provision across Tayside.

Learning Disability

- 5.21. Since the publication of *Trust and Respect*, the Learning Disability service has continued to operate within a culture of instability and uncertainty. The 2019 decision to close Craigowl ward at Strathmartine was made at short-notice and without full consultation or consideration of options. This was noted in *Trust and Respect*.
- 5.22. The consequences of this sudden change are still, 23 months later, being felt. There are several outstanding grievances raised by staff, which remain unaddressed or unresolved causing stress and anxiety to the staff concerned. Medical staffing continues to be a challenge since the resignation of the substantive consultant in 2019. There is reportedly no visible leadership on site regularly and as a result staff feel there is little or no support in their day-to-day work.
- 5.23. The Review team found there to be ongoing concerns and anxiety from staff and from family and carers regarding the quality of care currently being delivered. It was noted in the May 2021 LLC Action Plan that within the Whole System Change programme, the "rapid review of Learning Disability Inpatient Services requires immediate and ongoing attention". This stated "rapid review" will be welcomed, as the lack of decision-making, alongside the lack of investment in the Strathmartine site, is causing significant concerns for staff and for patients, families and carers.

CAMHS

5.24. There have been several improvements in CAMHS during the last year.

HEALIOS

5.25. At the time of the publication of *Trust* and *Respect*, waiting times for CAMHS were long. This has much improved, aided by the use of the external online HEALIOS service for certain referrals. At the time of writing, 85% of referrals to CAMHS are seen within the 18-week target waiting time.

Primary Care - referrals

5.26. The relationship with GP practices in Dundee has improved following the introduction of a pilot system of telephone consultations for patients before they are referred to CAMHS. This was part of a Covid-response in primary care. The telephone consultations triaged patients and, in some cases, prevented inappropriate referrals to CAMHS, instead giving opportunity for signposting to alternative services for families, where appropriate. Now there are plans in place to roll this out to other GP clusters and across other HSCP areas.

Website

5.27. A new website has been developed for CAMHS. This was done in conjunction with families, carers, children and Allied Health Practitioners. It includes important information such as referral guides, scope of CAMHS and confidentiality. The website has been very well received.

Clinical governance

5.28. CAMHS is based in Women, Children and Family services but the clinical governance matters are now also shared with mental health services. The quality of data collection has improved which is informing decision making.

- 5.29. However, despite these positive changes, there remain some concerns about the provision of mental health care for young people in Tayside.
- 5.30. The leadership challenges currently experienced by CAMHS have made operational changes difficult in the last year. It has been difficult to recruit to clinical leadership roles. It is thought it would be helpful if both CAMHS and Paediatrics had clinical leaders in post. Some recommendations from *Trust and* Respect have not been implemented and without any clear leadership, these will be challenging to action. The creation of a neurodevelopmental hub has not been achieved despite funding being made available. This is disappointing as there is a significant increase in young people being referred for assessment on the Paediatric Neurodevelopmental Pathway. These young people and their families are currently waiting an unacceptably long time (more than 6 months in some cases) to be seen.
- 5.31. The transition age of young people from CAMHS to Adult Services has not yet fully moved to being 18 although this change is in progress, in an incremental manner. The recommendation in the *Trust and Respect* report to consider developing a separate service for 18-24yr olds was reviewed by CAMHS staff but it was felt better to work on improvements in the transition processes of young people to adult services instead.

6. Actions

The Review team considers the following actions are necessary to progress appropriately the implementation of the recommendations made in the Independent Inquiry's *Trust and Respect* report.

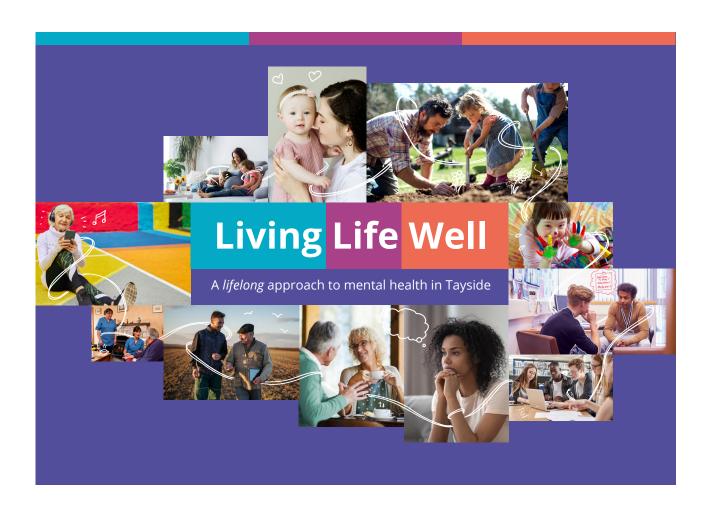
- 1. Recommendation 5 must be revisited urgently to resolve the relational issues which still exist in Tayside.
- 2. The response to all recommendations should be subject to some form of independent scrutiny to assess more accurately the progress that has been made. This would result in a more realistic assessment of the rate of progress and how much remains to be implemented further.
- 3. An implementation plan is urgently needed for the Living Life Well Strategy.
- 4. Ongoing oversight of Tayside's response to the recommendations should be provided by the Scottish Government's Quality and Safety Board for Mental Health Services.
- 5. Senior leaders should engage meaningfully with staff, patients, families and carers in the development of future plans.

Appendices

Appendix 1 - Living Life Well

The "Living Life Well" document can be accessed at:

https://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthandLearningDisabilityServices/PROD_342608



Appendix 2 - Listen Learn Change Action Plan May 2021

The Listen Learn Change Action Plan can be viewed here:

https://independentinquiry.org/listen-learn-change-action-plan/

Listen Learn Change

Status update

Listen Learn Change Action Planour Tayside response to the Trust and Respect' Independent Inquiry Report

May 2021 (Update Version 11)



Appendix 3 - Listen Learn Change Progress Overview June 2021

Board paper 8.1 of board meeting 24 June 2021.

https://www.nhstayside.scot.nhs.uk/YourHealthBoard/TheBoardanditsCommittees/TaysideNHSBoard/index.htm



An Action Plan for mental health services in Tayside 2020 in response to 'Trust and Respect' Independent Inquiry Report



Listen
Learn
Change
Progress
Overview
June 2021

Appendix 4 - Scottish Government Response to Recommendations in *Trust and Respect*

SCOTTISH GOVERNMENT PROGRESS AND UPDATE TO INDEPENDENT INQUIRY RECOMMENDATIONS

RECOMMENDATION 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.

The Scottish Government has confirmed its commitment to this recommendation in the Mental Health Covid-19 Transition and Recovery plan which was published in October 2020. The following wording was included:

16.7 – Patient Safety. Through the Quality and Safety Board we will review the assurance and scrutiny of mental health services across Scotland, including the powers of Healthcare Improvement Scotland and the Mental Welfare Commission, as recommended by the Independent Review of Mental Health Services in Tayside. This will seek to ensure safe delivery against the new standards outlined above.

What do we want to achieve?

We want to make sure that people who access mental health services are safe and receive person-centred and effective care. We want to have the correct arrangements in place to assess the quality and effectiveness of services, to ensure they are safe and to drive improvement. Mental health service users, especially when acutely ill, are vulnerable to a number of potential risks. We want to improve the safety and quality of experiences, as well as prevent unwanted inequalities for those experiencing mental illness. We want to support and empower services to be transparent and demonstrate accountability at a local and national level to the people who use them, their families and carers. This will ensure continuous improvement in support provided, greater trust in mental health services and ultimately better outcomes for the people who access them.

How do we want to achieve it?

Our approach will seek to strengthen improvement, scrutiny and assurance mechanisms aimed at driving continuous quality improvement by working closely with our partners at both a local and national level. We will aim to do this by working with the Quality & Safety Board for Mental Health Services to undertake a scoping exercise into how we can support local governance mechanisms which are key to improving quality and safety nationally. This focus will enable us to better understand variation within the system and any gaps in national provision. Through this exercise we will aim to:

- Collect key local data to aid our understanding of common themes and variation in the safety and quality of mental health care across Scotland
- Identify and support the sharing of good practice
- Scope the governance assurance arrangements at a local level, benchmarking this against the national guidelines
- Develop recommendations to further strengthen improvement, governance and assurance
- Support and empower both local and national governance bodies' oversight of these complex services in their drive to improve care quality and safety.

Next Steps

We will commission a programme which will:

- gather local quality indicators
- map local governance arrangements
- produce a rapid evidence review of effective scrutiny and assurance mechanisms
- undertake engagement with local governance leads.

From this we will produce a series of recommendations to our Quality and Safety Board to support future policy development.

The work identified above and any improvements made to local scrutiny and assurance processes will inform the wider review of assurance and scrutiny of mental health services across Scotland, including the powers of Healthcare Improvement Scotland and the Mental Welfare Commission.

We have begun a series of engagement with partners who have been supportive of the need for this work. A working group has been established to support the local government mapping exercise which will host its first meeting in June 2021. We will continue to work with the Quality & Safety Board to develop a scoping exercise over the summer. This will provide an evidence base for a further review of the scrutiny and assurance of mental health services.

RECOMMENDATION 32

A national review of the guidelines for responding to substance misuse on inpatient wards is required.

What do we want to achieve?

We want to make sure that those who come into hospital for mental health support are also provided support for co-occurring substance use. We recognise that mental health treatments cannot take place in isolation and that where possible, patients need to receive help and treatment in hospital and to ensure that this is followed up upon discharge into community services.

It is also recognised that inpatient substance use can affect other in-patients and staff in the ward. We want to ensure that inpatient wards and all mental health settings are safe places for those who use them and work there.

How do we want to achieve it?

We want to support action to improve treatment and management of those on mental health wards using substances through various means:

Medical Managers & Nurse Leads Group

The Scottish Government attended the first meeting of Mental Health Medical Managers & Nurse Leads Group in May this year (delayed due to Covid) where the issue of substance use on inpatient wards was identified as a priority. Scottish Government officials have agreed to act as secretariat to the national group as well as a dedicated Short Life Working Group (SLWG) which is being established to address substance use on inpatient wards. This SLWG will work collaboratively with other agencies as part of this work and will enable us to ensure the voice of staff is included and heard to inform our guidelines and response.

Lived Experience

Also critical to this work is to ensure the voice of those with lived experience is included. We are working with Drugs Policy colleagues to connect with their lived experience groups and Mental Health Division is establishing a Lived Experience Panel to inform our work which we will also engage with.

Improving integration of Mental Health and Substance use services

Health Improvement Scotland (HIS) are currently working in Tayside to prototype a new model and pathway of care, with a view to spreading good practice, innovation and learning about "what works" Scotland-wide to drive improvement and change in developing and delivering integrated and inclusive mental health, alcohol and drugs services. This work is currently taking place in

Dundee, however, we are currently in discussions negotiating with HIS with regards to expanding this work, with an opportunity to look at the connection to inpatient wards and upon discharge to community services. Learning from these areas will be shared throughout Scotland to ensure better integration of services nationwide.

• Mental Welfare Commission

The Mental Welfare Commission (MWC) has made dual diagnosis the focus of their themed visit programme for 2021. The MWC has assembled a team to take forward this work which includes people with lived experience, care experience and addiction workforce experience. It is expected that these visits will identify good practice, current protocols as well as gaps. The report is expected to be published in April 2022 and this work will be used to inform any set of standards or principles for care of those with a dual diagnosis.

Mental Health Quality & Safety Board

We will be bring the outputs and recommendations emerging from this work to the Mental Health Quality & Safety Board for advice and input. The Board is made up of a cross-section of those working in and leading mental health public services and scrutiny and lived experience representation. We will also ensure that the work being taken forward to develop quality standards for adult secondary mental health services, and the Medication Assisted Treatment (MAT) Standards which were recently published by the Drug Deaths Taskforce, will inform any guidelines that are developed on substance use on inpatient wards.

THE INDEPENDENT INQUIRY

into Mental Health Services in Tayside

www.independentinquiry.org