2. Introduction.

This document describes the high-level, whole system Clinical Services Strategy for NHS Tayside general mental health services for adults aged 18 – 64.. It encompasses community supports and services and hospital based services provided by General Adult Psychiatry and associated clinical services. It includes the links and relationships between general psychiatry services and the sub specialism's of Child and Adolescent Psychiatry, Learning Disabilities, Substance Misuse and Psychiatry of Old Age but does not otherwise include these services which are included in other strategic plans. It does not address services for adults under 65 with dementia which are included in the older people's clinical service strategy.

The Strategic Framework is intended to provide a coherent, overarching direction for clinical services for the next five years and supersedes "A Five Year Strategy for NHS Tayside Mental Health Services 2011 to 2016". It draws upon current plans and work programmes including NHS Tayside Mental Health improvement Plan, Steps to Better Healthcare Mental Health Programme, and local partnership plans.

This strategy is underpinned by our *Visions and Values* of patient centred, evidence-based, safe and effective care; a whole system approach to prevention, treatment and support; efficiency and best value; and of 'mutuality', equity and inclusion. It supports and should be read in conjunction with NHS Tayside Clinical Services Strategy, *"Reshaping Clinical Services for the Future June 2015"*.

This document draws upon a wide range of earlier work to develop services and deliver improvements that involved clinical staff from teams and services across Tayside. It also draws upon professional and clinical guidance from a number of national bodies including the medical Royal Colleges, SIGN, NICE, the Scottish Government and the Department of Health. It has been developed with input from clinical and service leads and with the support of a reference group drawn from psychiatry, mental health nursing, clinical psychology, AHPs, primary care and the mental health leadership team.

3. Context

3.1 Strategic Drivers

3.1.1 The Scottish Governments 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and that we will have a healthcare system where:

- We have integrated Health and social care
- There is a focus on prevention, anticipation and supported self management
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate with minimal risk of re-admission to hospital

3.1.2 Scotland's Mental Health Strategy 2012-15 published in August 2012 it follows on from and replaces "Delivering for Mental Health" and "Towards a Mentally Flourishing Scotland." The document has seven themes as follows:-

- Working more effectively with families and carers
- Embedding more peer to peer work and support
- Increasing the support for self-management and self help approaches
- Extending the anti-stigma agenda forward to include further work on discrimination
- Focusing on the rights of those with mental illness
- Developing the outcomes approach to include personal, social and clinical outcomes
- Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services

Each of these themes is reflected in the four key change areas that the strategy is structured around as follows:-

- Child and Adolescent Mental Health
- Rethinking How We Respond to Common Mental Health Problems
- Community, Inpatient and Crisis Mental Health Services
- Work with Other Services and Populations with Specific Needs

The national strategy is set to run until the end of 2015 and work is now being set in train by the mental health and protection of rights team to refresh or update this. It is therefore reasonable to assume that no policy changes are imminent and a revised strategy will not be published until spring of 2016 at the earliest.

3.1.3 With the advent of Health and Social Care Partnerships responsibility for the delivery of most mental health services will pass to the newly created bodies. They will also have responsibility for the development of "Strategic Commissioning Plans" for such services. It is anticipated that this strategy will help inform the collective planning and strategic commissioning responsibility of the three IJBs for health and social care in Tayside and provide the basis for more detailed planning.

(*A review of national and local plans was undertaken as part of the development of this strategy and a short synthesis of these plans is attached at appendix 7.1*)

3.2 Population Profile

Large scale population studies have shown mental health problems to be common. The World Health Organisation (WHO) report that a systematic review of data and statistics from community studies in European Union (EU) countries, Iceland, Norway and Switzerland: 27% of the adult population (here defined as aged 18–65) had experienced at least one of a series of mental disorders in the past year (this included problems arising from substance use, psychoses, depression, anxiety, and eating disorders).

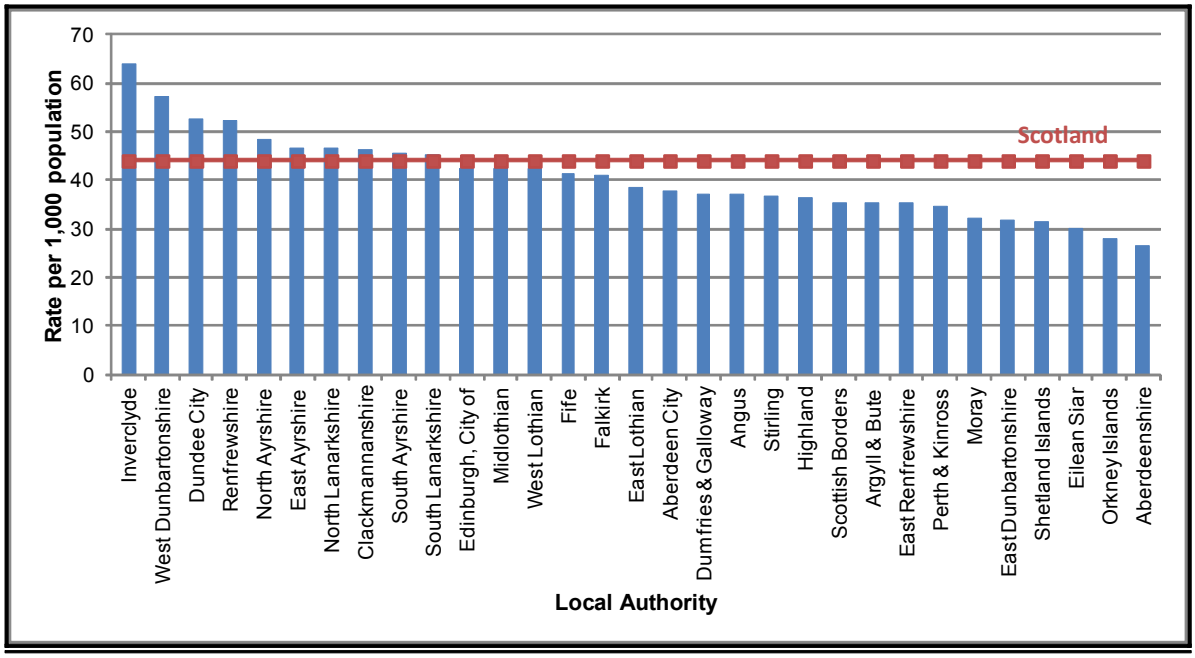
The WHO also reports that in Europe every year about one out of 15 people suffer major depression and if anxiety and all forms of depression are included nearly 4 out of 15 are affected.

Mental disorders are by far the largest contributor to chronic conditions afflicting the population of Europe. According to the most recent available data (2012), neuropsychiatric disorders rank as the first cause of years lived with disability (YLD) in Europe, accounting for 36.1% of those attributable to all cause.

A profile of mental Health in Tayside has been prepred in support of this strategic framework and is attached as an appendix. The dfollowing is extracted from that report.

The 2011 Census asked respondents whether they have a mental health condition that is expected to last. Figure1 compares the rate of self reported mental health conditions across Scotland per 1,000 population and shows that mental disorders are more prevalent among those living in deprived areas. Dundee City had the third highest rate and was higher than the Scottish average at 53 per 1,000 while the rates reported in Angus and Perth & Kinross were 37 and 35 per 1,000 respectively.

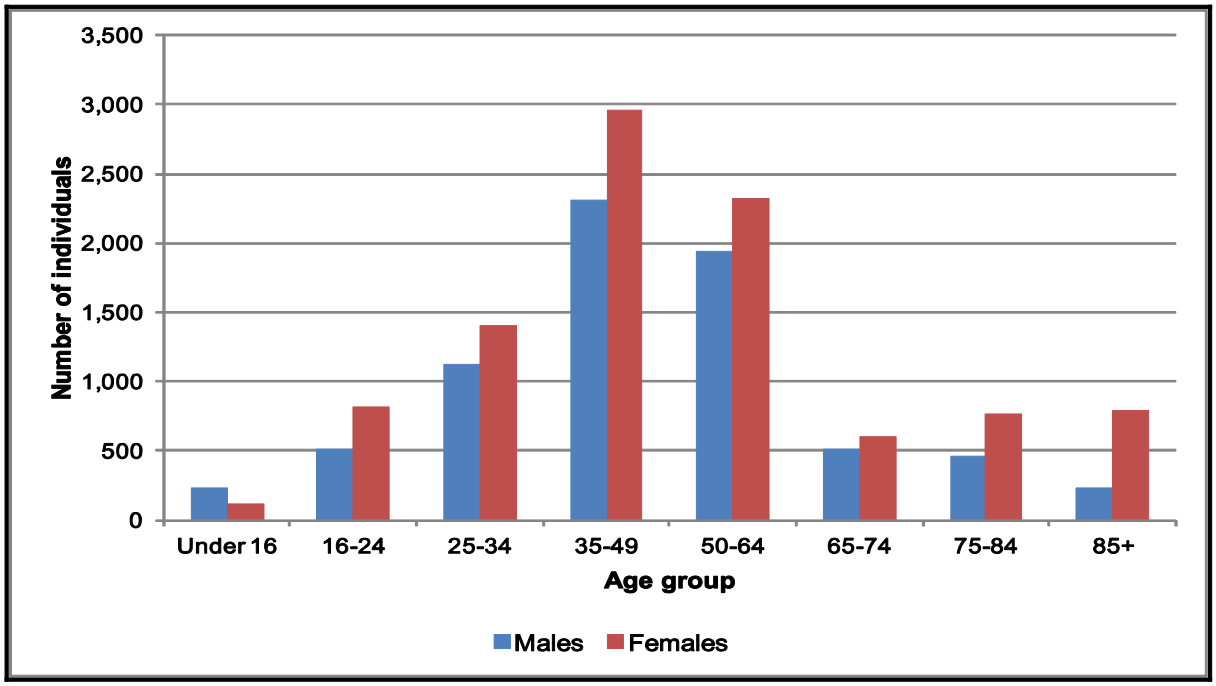
Figure1 *Crude rate of individuals reporting a mental health condition by local authority, 2011*



(Source: Census 2011)

Of the Tayside respondents, 17,122 (42 per 1,000) reported having a mental condition. Figure 2 shows the breakdown by age and gender. Ten percent were young people aged under 25 years while 20% were aged 65+ years.

Figure 2 Number of Individuals reporting a mental health condition, Tayside 2011



(Source: Census 2011)

3.3 What matters to people with mental health problems?

People have long complained about having to repeat their "story" to successive professionals and at each time they attend a service.

People value being looked after by clinicians whom they know and who know them and their history.

People value safe, confidential, compassionate and understanding responses from the staff they meet

They value being taken seriously, listened to and not dismissed (but this was not always what they experienced)

(The above has been taken from earlier consultations with patients and service users in Dundee)

3.4 What matters to our staff?

Having the contribution they make recognised and valued.

The support of their peers.

Having enough time to do the job properly.

The opportunity and support to reflect on practice

The opportunity and support to develop their skills and expertise including formal training or and experiential learning.

Being clear on what is expected of them.

(The *above has been taken from development work undertaken with teams in Perth and Kinross and Angus general Adult services)*

3.5 What are the values, goals and ambitions of the service?

3.5.1 NHS Tayside mental health services espouse the **values** of the organisation and will:-

- Put patients first
- Show compassion, caring and kindness
- Treat everyone with dignity and respect
- Take the time to have good, open communications and be accountable for our actions and behaviours
- Do the best that we can by working as a team to provide excellent treatment and care.

3.5.2 We want to ensure that we engender and nurtures a culture which supports and empowers our staff to deliver care that respects **patients' rights**.

Mental health care and treatment is delivered in the context of Scotland's distinctive and rights based mental health legislation. Only a small proportion of people treated for mental health problems are subject to restrictions placed upon them under the Act. Nevertheless the principles set out in the Act are applicable to the delivery of all mental health care and treatment whether that is being delivered as a function of the Act or not. These principles are that the following must be considered when delivering care and treatment:-

- The present and past wishes of the patient
- The views of the patients named person, carer or welfare attorney or guardian
- The importance of the patient participating as fully as possible
- The importance of providing the maximum benefit to the patient
- The importance of providing appropriate services
- The needs and circumstances of the patient' carer
- Involving the minimum restrictions on freedoms where these appear necessary in the circumstances.
- To encourage equal opportunities

3.5.3 We aim to enable **person-centred recovery** by building upon people's strengths, management of individual risk, and by maximising choice and equity of access to evidence-based interventions in each locality.

We will ensure that our approach recognises the importance of co-production and adoption of asset-based approaches.

To achieve this:-

- We will deliver services that are person-centred and focus on the needs, personal assets and recovery of the patient.
- Our services will be caring and provide treatment with kindness and compassion.
- We will provide standards of care that ensure patients and their carers do not come to harm

- We will engage and involve patients in the planning and delivery of their care.
- We will deliver services that are flexible and sensitive to the needs of patients. Services must 'own' referrals at the point of access and have processes in place to ensure that patients are not left without appropriate support or fall between services.
- We will provide a range of specific, evidence-based treatment and therapy modalities, appropriate to best practice in managing the clinical work of the team these will be offered by clinical teams with sufficient experience, training and time

3.5.3 We aim to be **efficient** in the way that services are organised and delivered.

To achieve this:-

- Our services will be responsive and timely, and provide appropriate timescales for response to emergency, urgent and routine referrals, with no substantial wait for routine appointments and no internal waiting lists.
- Our services will be organised so that patients are not referred and assessed by different parts of the service before being provided treatment

3.5.4 We will have a **skilled and compassionate** workforce that are valued and feel supported.

Successful delivery of optimum mental health care and treatment is almost entirely dependent upon the attitudes, knowledge and skills of the staff involved. Delivering the changes described in this strategy will require the commitment of a confident, competent professional workforce who feel supported and valued. This will be achieved by:-

- Visible clinical leadership across professions and localities.

- Engaging and involving staff in the development and delivery of services and nurturing a culture of openness and collaboration

- Supporting staff to develop and maintain the relevant skills and training in delivering a range of pharmacological interventions and psychological therapies as well as an understanding of the impact of social factors and how to influence them.

3.5.5 We will work in **partnership**.

We will work to ensure people with mental health problems and their families and carers are kept informed and are involved in the delivery of the strategy. As implementation of the strategy develops we will ensure that our approach recognises the importance of co-production and adoption of asset-based approaches.

Effective treatment and recovery from mental ill health is not solely determined by clinical interventions. The supports and opportunities required for people to gain and sustain mental well being lie within their local communities and with other services and organisations. In order that people can access and benefit from these assets and services care and treatment needs to be delivered as part of collaboration between agencies and individuals including primary care social work services, housing services, voluntary organisations and local communities. The establishment of health and social care partnerships should make such partnership working easier.

Being skilled and efficient in providing the clinical service s and interventions of clinical services will provide a firm base for mental health services to be fundamental to local

delivery of each of the following nine national health and well being outcomes that Health and Social Care Partnerships are expected to deliver.

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services.

3.5.6 We will put research, **innovation and learning** into practice. Services will routinely collect clinically relevant patient outcomes and reflect on and respond to the result

3.5.7 We will develop a service that is **sustainable**. To achieve this we will have

- Services that are able to demonstrate that they are cost-effective and comparable with similar services.
- Services that have access to the range of appropriate resources necessary to deliver the care required

4. Strategic aims

4.1 Focus on prevention, maintaining existing health through participation, co-production and self management.

4.1.1 There will be a strong focus on prevention approaches that are in accordance with the best evidence. Much of this evidence relates to the impact of early years development and child hood experiences on mental health in later life. Devoting organisational energy and targeting resources on children most at risk (.e.g. looked after children) and on effective interventions are likely to reduce the burden of mental ill health in future years.

4.1.2 There is also evidence that those living in the most adverse social circumstances are more likely to experience mental health problems and to have poorer health outcomes. While access to good mental health services is important for those who require specialist treatment; for many access to non –clinical interventions and supports will be effective in addressing their underlying problems and will support their recovery. To this end the availability of social prescribing in primary care and assistance in developing self-help approaches should be expanded with areas of greater social deprivation being prioritised.

4.1.3 Women are more at risk of developing mental health problems during the peri-natal period and suicide is the leading cause of maternal death in the UK. It is therefore important to ensure that those providing ante natal and post natal care are skilled at identifying those most at risk and of symptoms of mental illness and are able to direct women to appropriate care and treatment.

4.1.4 People with long standing mental illness are at greater risk of poor physical health and of dying at a younger age. They should be targeted and receive support to access routine health screening and to help them improve their own health e.g. smoking cessation, good nutrition, weight management). Patients being treated with specified psychotropic medicines should receive additional monitoring of their physical health.

4.1.5 There is clear evidence that those with chronic physical illnesses are more likely to suffer from mental health problems, particularly depression and that those with co-occurring chronic physical health problems and mental illness have poorer outcomes. Screening for depression in specific long term conditions should therefore be carried out and appropriate treatment provided

4.1.6 In the context of mental illness recovery is defined by the Scottish Recovery Network as "being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms". There are multiple determinants of a person's ability to lead "meaningful and satisfying lives" including their economic and social circumstances and the practical and emotional support available to them from others. Clinical services have an important role to play in the recovery of a good quality of life and the mitigation of distressing symptoms by ensuring ready access to effective care and treatment.

4.1.7. In Tayside suicide rates have been falling over the past decade and are now at rates not seen since the early eighties, however, suicide remains the leading cause of death in young people in Scotland and is potentially preventable. Organisational energy and resources should continue to in addition to the provision of be devoted to targeted prevention approaches in collaboration with local community planning partners.

The National Confidential Inquiry into Suicide and Homicide (NCISH) indicates that most people who die by suicide are suffering from a mental disorder and that one in four people who die by suicide in the UK have a history of contact with mental health services within the previous 12 months. Further studies by NCISH into the impact of improvements to community mental health services and into in –patient care provide evidence for suicide prevention measures that can be delivered by clinical services including the provision of specialist community care, a physically safe ward environment and a learning culture based on multi- disciplinary review.

4.2 Joined up pathways between primary and secondary care and between clinical services

This document is primarily about the provision of general adult mental health services, but to be effective these need to be delivered as part of a whole system of mental health care and the key roles and relationships required to create such a whole system are described in this section.

In general most psychiatric care and treatment occurs in a planned and scheduled manner. Access to mental health services will be predominately via General Practice with care and

treatment provided in a community setting on an out- patient basis. The way in which such scheduled care is to be provided is set out in paragraphs 4.2.1 to 4.2.5 below.

There are however circumstances where the perceived risk to an individual's safety or well being or to the safety of others or the level of distress is such that an urgent response is required. The way in which such unscheduled care is to be provided is set out in paragraphs 4.2.6 and 4.2.7 below.

Mental health problems do not occur in isolation and may be consequential to or have an impact on other co-occurring health problems. The role of mental health services in working with other parts of the health service in these circumstances is set out in sections 4.2.8 and 4.2.9 below

4.2.1 Treatment in Primary Care

A general practitioner (GP) is usually the first health professional to whom people turn when they develop symptoms. They are, therefore, ideally placed to elicit patients' concerns about their symptoms, as well as providing appropriate investigation and management. The majority of patients who are treated for a mental health problem receive that treatment within primary care. It is important that for GPs to successfully treat milder mental health problems that they are able to access a range of interventions matched to patients needs. These include access to support to address underlying problems and issues (e.g. social prescribing); support and materials for self help and access to counselling services.

4.2.2 Access to mental health care and treatment: Psychological therapies

Other patients require to be seen and treated by specialist mental health staff. GPs can directly access psychological therapies provided by the psychological therapies service in their locality. Patients who would benefit from this include Individuals with a diagnosable mild to moderate psychological disorder reasonably likely to respond to a brief, time limited period of psychological therapy: usually 8-12 sessions and with an exceptional upper limit of 20 sessions. This includes individuals experiencing:

- Mild – moderate depression
- Bulimia nervosa with no physical complications
- Panic disorder
- Generalised anxiety disorder
- Agoraphobia
- Specific phobia
- Social phobia
- Post traumatic stress disorder
- Obsessive compulsive disorder
- Other psychological disorders where the presenting problem is likely to respond to brief psychological treatment.

4.2.3 Access to mental health care and treatment: Psychiatry

Generally access to psychiatry will be by referral to the relevant Community mental health team for the area in which the patient resides. All referrals will be triaged and urgent appointments arranged where required.

Access to advice and assistance to General Practitioners on the management and treatment of mental health problems from adult psychiatry will be developed in a manner similar to that provided by Psychiatry of Old age including an e-mail advice line.

4.2.4 Access to specialist mental health care and treatment: Community Mental Health Teams.(CMHT)

Multi- disciplinary Community Mental Health Teams are well established in Tayside with teams working in identified localities. Such teams will continue to be the mainstay of clinical care in the community providing treatment and support to people with mental health problems where these are of a severity, complexity or duration that require a multi-disciplinary approach to assessment and management including:

- Severe and persistent mental disorders with significant effects on day to day functioning. This will predominately be people with psychotic illness such as schizophrenia, bipolar disorder and other types of psychosis.
- Other long term non-psychotic disorders which require care and treatment that require a level of support and expertise that cannot be delivered by the primary care team alone.
- Any disorder where there is also a significant risk of self harm, harm to others or risk of suicide.
- Severe Personality Disorder where these can be shown to benefit from a care package involving secondary care mental health services.

Each Community Mental Health Team will ensure processes are in place for liaising with General Practices in their catchment area.

4.2.5 Access to mental health care and treatment: specialist services

There are cases when evidence indicates that specialist services provide better patient care than generic mental services, for example eating disorder services. Although these services may not provide care over years, they usually provide continuity of care over an episode of illness. The provision of such specialist services to adults in Tayside includes:-

- Rehabilitation and long term treatment service
- Eating Disorder service,
- Psychotherapy service
- Autistic Spectrum Disorder Service.

Access to such specialist diagnosis and treatment is normally by referral from the generic mental health service. Apart from the psychotherapy service these more specialised serviced include in-patient facilities with medium secure care facilities and eating disorder in –patient unit being provided on a collaborative basis with the other north of Scotland Boards with the former located in Tayside and the latter in Grampian. NHS Tayside also has access to specialist Mother and Baby in–patient facilities in Lothian which are provided in collaboration with the North of Scotland and the South and East of Scotland Health boards.

We will sustain such specialist provision ensuring that where it is clinically indicated patients have ready access to high quality care by the efficient and effective management of these resources.

A brief summary of the functions of these specialist services is set out in Appendix 7.3

4.2.6 Access to mental health care and treatment: Unscheduled care and urgent responses.

We will provide a 24 hour, 7 day a week response to urgent referrals for psychiatric assessment and onward care and treatment where this is indicated will be provided via a Crisis Resolution and Home Treatment Service (CRHT).

Referrals will be accepted from a range of sources including GPs, CMHTs, In-patient areas, Police surgeons, Liaison Psychiatry, Tayside Substance Misuse Service, Psychology, Social Workers, Out of Hours Doctor, Specialist Registrar or Consultant, A&E and NHS 24 (the most frequent source of referral)

Referrals are made by telephone and following triage by a nurse a response will be provided. Depending on the nature of the presenting problem the response provided will range from.

- Telephone advice and sign posting to other services and resources*
- Onward routine referral to Community Mental Health Team
- Onward urgent referral to Community Mental health Team
- Emergency assessment by Crisis Resolution and Home Treatment Team
- Urgent admission to hospital
- Emergency detention and admission under the Mental Health Act

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

The CRHT is composed of mental health nurses, psychiatrists and support workers and has 24 hour access to consultant psychiatrists via on -call arrangements.

4.2.7 Access to mental health care and treatment: Acute In Patient Care

A balanced system of mental health care includes the provision of in –patient services.

People who need urgent medical assessment, or who are experiencing severe psychiatric relapse and behavioural disturbance, or are at high risk of self-harm, self neglect or harm to others will usually require high-intensity immediate support in acute in-patient hospital units. With such admissions the least restrictive arrangements should be made but not infrequently this will involve the patient being subject to compulsory admission and detention under the Mental Health (Care and Treatment) (Scotland) Act 2003

A small number of patients will require to be admitted to hospital to establish and administer treatments where this is the only clinically appropriate and safe setting to provide that treatment.

In Tayside such acute in-patient facilities are provided in three locations, urgent access to these facilities will be managed as if they were a single entity ensuring equitable access wherever the patient resides and to make most efficient use of this resource.

Urgent access to in-patient care will be following assessment by the crises response and home treatment teams as described above.

We will ensure processes are in place for effective liaison between hospital and community mental health services. This is to ensure that both CMHS and in-patient staff are aware of all cases awaiting admission, those that are currently in-patient and those awaiting discharge

4.2.8 Co-occurring mental health problems and substance misuse

It is widely accepted that there are significant levels of co-occurring mental health and substance misuse problems present in the general population. Around a half of consultations for alcohol problems were found to relate to either mood or anxiety disorders (as opposed to one-fifth of those patients not using alcohol). 40% of patients in Scotland seeking treatment for their drug related problem for the first time did so due to mental health reasons. 44% of CMHT patients reported past year drug use and/or alcohol problems. Within substance misuse services, two-thirds of drug patients and four-fifths of alcohol patients had anxiety or affective disorders.

It is important to recognise that each patient will have differing severities of mental illness and problem substance misuse in combination. This fact, combined with rigidly defined referral criteria for services, can lead to patients being excluded from appropriate care.

Given this, it is important that individual services – both GAP and Substance Misuse - are equipped with the necessary skills and expertise to deliver the appropriate level of interventions to what is clearly a standard part of their core client group. Services also need to recognise when a patient requires a more advanced intervention requiring referral to more specialist services. Each patient's circumstances should dictate which service is best equipped to deliver care and treatment and the following set of principles has been developed to support such assessments.

1. No mental health service operational policies will exclude those with substance misuse and mental health problems.
2. Whichever service receives the initial referral will be able to identify the level of care required for both aspects of the co-morbidity and if necessary discuss with the other service in order for the patient to receive the intervention required. Referrals should not be sent back to the referrer with an expectation they will re refer to another service.
3. Substance misuse services should be able to deliver interventions for those patients under its care who have mental health problems that occur commonly within their treatment population. This would include psychological interventions for mild – moderate depression and anxiety, and trauma related psychological problems.
4. Mental health services should be able to deliver interventions to patients under its care who have substance misuse problems that occur commonly within their treatment population. This includes brief interventions for alcohol problems, as well as broader motivational enhancement and relapse prevention techniques for a wider range of substance misuse problems. They should also be able to deliver or access harm reduction interventions for their patients.

5. Patients whose level of need requires input from both community mental health service and substance misuse services should be jointly managed with mental health services taking the lead.
6. If patients decline input from substance misuse services but continue to have a mental health problem that would benefit from interventions provided by mental health services, they should not be excluded from accessing services that can provide these interventions. Mental health services could also use this as an opportunity to enhance the patient's motivation to the point they wish to access substance misuse services.
7. Patients referred to mental health services for urgent assessment of risk of harm to themselves or others should be assessed by mental health services regardless of the presence of a co-morbid substance misuse problem. This will enable the right service to assess presence or absence of a mental health problem and put in place necessary interventions in a timeframe that is consistent with the urgency with which the referral was made.
8. Services should have clear pathways for referrals between agencies. If it is felt that referral to another agency should also result in discharge from the existing service, the referring service should continue to provide care for the patient until the new service formally reviews the patient and agrees to take over their care.

4.2.9 Co-occurring physical and psychological problems and medically unexplained symptoms.

It is well known that many people present to GPs with physical symptoms that often have an underlying psychological component. Careful and sensitive handling of such consultations can result in positive outcomes with the resolution of symptoms and the person feeling understood.

Depression and anxiety are common in physical illness, particularly in chronic or life-threatening illnesses. Identification and treatment of those conditions is likely to have a positive impact on a patient's physical well being.

Many presentations to Accident and Emergency Departments are as a result of deliberate self-harm, rapid access to psychiatric assessment and onward care and treatment is therefore an essential requirement in the effective operation of such departments.

Evidence suggests that identifying and treating the mental health needs of acute inpatients early has a direct impact on the recovery of their physical health. Psychiatric liaison services can improve care and reduce the length of stay in hospital if patients' mental health needs are met.

Of all new referrals to general hospital out-patient departments 30% have no demonstrable organic illness to account for their symptoms. Psychological treatment of many such medically unexplained symptoms can be effective. The mental health service includes specialists in clinical health psychology who accept referrals from GPs and other secondary care services, this should be sustained.

Liaison psychiatry brings together the diagnosis treatment and management of patients with co-morbid physical and mental health problems. Multi – disciplinary liaison psychiatry services work most effectively when they are embedded into general hospital work. Such services can also provide valuable community support and training for staff, including GPs, and other primary care professionals. The existing psychiatric liaison service should be

consolidated and expanded to cover all general hospitals. Opportunities to collaborate with alcohol liaison and psychiatry of old age liaison services and with clinical health psychology should be explored to maximise efficiency and to support the development of skills across all disciplines and in all settings.

4.3 Enhanced community provision

4.3.1 Access to matched/stepped Psychological care including e-care.

To treat milder mental health problems it is important that GPs are able to access a range of interventions matched to patients needs. Investment in psychological therapy services and alignment of these with primary care in each locality has resulted in a significant reduction in waiting times and an increase in the number of patients referred. Sustaining and improving upon the HEAT standard of patients waiting no longer than 18 weeks to commence treatment will continue to be a minimum requirement.

Computerised Cognitive Behaviour Therapy (CCBT) has been provided in Tayside for a number of years and a European commission funded national evaluation of this programme and other e-mental health services is currently being led by NHS 24.and hosted in NHS Tayside. We will continue to promote the use of these approaches and increase the number of people receiving treatment and support in this way.

Not all patients require this level of intervention and a range of other options should be available to GPs.

Work has been done to provide access to self help materials this will be sustained and built upon. NHS Tayside will host the national update of the Moodjuice self help website.

GPs and patients also value access to counselling services where patients can talk to a trained counsellor about their life and their concerns. Such services are provided locally by voluntary organisations. NHS Tayside has provided grant support to these organisations that also rely on income from other grant providers and fund raising. However this arrangement does not provide the level of access and service that meets the demand from Primary Care and the means to resolve this issue and increase availability to primary care should be found.

4.3.2 Crisis Response and Home Treatment – A multi disciplinary team will provide an alternative to hospital admission by providing emergency assessment and intensive intervention within the community.

The team will act as the single point of access to all inpatient mental health admissions. Where hospital admission does occur, the CRHTT will assist in providing intensive home treatment to support early discharge back to community living.

4.3.3 Longer term support - Major mental illness is commonly a chronic relapsing condition. Mental ill health accounts for just under 40% of all ”years lived with disability” across Europe. Many with such illnesses will therefore need long term support; others will require intensive episodes of support care and treatment throughout their lives. Provision of such continuing care and treatment and periodic intensive interventions is a core component of the work of Community Mental Health Teams.

Individual care plans should recognise and build upon individual strengths and support networks to promote and maintain their recovery. The informal support provided by families

and friends is often a key component in establishing and maintaining a person's well being and such supporters are often the first to be able to identify deteriorating mental health. Care plans should recognise the part such support contributes

Establishing and maintaining greater mental well being is also dependent upon access to a range of services including accommodation, personal care and support, assistance to access training and education and opportunities for social cultural and recreational activities. Working collaboratively with services and agencies that provide such support is a further requisite of a community mental health team.

4.4 Unnecessary hospital admissions are prevented and when admitted there are no delays to discharge

4.4.1 We aim to deliver efficiently organised and effective in-patient care. This will be achieved through the development of clear clinical pathways derived from evidence based practice that will support consistency in the standard of care delivered and improve the quality of that care and the outcomes achieved. Delivering care in this way will be the key determinant of how long people will require to be in hospital.

A reduction in hospital stay is also contingent on effective multi-disciplinary and multiagency arrangements to expedite discharge. Liaison and collaboration with community services on the planning for discharge and follow up care is essential. Adherence to joint protocols for discharge processes and pathways will be expected.

The engagement and involvement of patients in the planning and delivery of their care while in hospital will help improve patients experiences and help promote their recovery.

4.4.2 We aim to establish new arrangements for patients to receive intensive home treatment. The CRHTT will commence treatment within 24 hours of assessment. Patients will be provided with short term, time limited (4-6 weeks) intensive care packages within their community. Face to Face intervention will be delivered to patients between the hours of 0800 – 2000 hours, 365 days per year, when patients can be visited up to twice daily if required. For the initial 72 hours patients can expect to be visited at least daily. Patients and their carers in receipt of intensive home treatment team can expect to be provided with a direct telephone number to contact the CRHTT for support and advice between visits.

4.4.3 Following a period of in-patient care people will be routinely followed up by community mental health services either through home visits or out-patient attendances. For some patients we will aim to provide Early Supported Discharge (ESD). This will entail a pathway of care for people transferred from an inpatient environment to a community setting to continue a period of recovery at a similar level of intensity and delivered by staff with the same level of expertise as they would have received in the inpatient setting.

The aims of such an approach is to allow patients to return home from hospital earlier than usual and continue their recovery at home and to provide care in a less restrictive environment in

4.5 Safe, efficient and high quality care

4.5.1 Clinical standards for the delivery of care to people with mental illness will be developed and adopted. Delivered consistently across Tayside will achieve measurable, safe effective and high quality care and treatment.

4.5.2 The development and adoption of clinical pathways will provide consistency in the access to and flow through treatment and of the quality of care that is provided. This will also allow for the efficient deployment of our resources.

4.5.3 The work undertaken to develop patient safety programmes in in-patient settings (e.g. medicines management, datix reporting) will be sustained and extended to all areas of mental health service delivery.

4.5.4 The collation, analyses and scrutiny of activity and performance data will be further developed to better understand the means to improve service efficiency. This will include the use of a suite of Key Quality Indicators

4.5.5 A consistent clinical audit system will be used across mental health services which will provide evidence of the consistency in and standards of the quality of care and treatment that is being delivered.

4.5.6 The programme of staff development focussed on risk assessment and formulation in relation to self harm and suicide will be extended.

4.6 Enabling infrastructure, workforce and organisational culture.

4.6.1 We will work to ensure people with mental health problems and their families and carers are kept informed and are involved in the delivery of the strategy.

The importance of engaging patients and those who support them in their care and treatment is described earlier in this document. Service users and carers are also important partners in the design and delivery of services. People receiving care and treatment are often the greatest experts in what works well and what doesn't. We will continue to work to involve them meaningfully through structured and systematic arrangements to improve clinical services. Such arrangements will include regular feedback on services, consultation and engagement in advance of service changes, participation in formal service reviews and in the training and development of staff.

4.6.2 Successful delivery of optimum mental health care and treatment is almost entirely dependent upon the attitudes, knowledge and skills of the staff involved. Delivering the changes described in this strategy will require the commitment of a confident, competent professional workforce who feel supported and valued.

We will have in place arrangements which ensure that clinical and professional guidance is available and accessed by our staff. Where they exist, SIGN guidelines will be adopted as the service standard and where Scotland specific guidance is unavailable then NICE guidelines will be adopted with local adaptations to reflect the legislation and service delivery arrangements in Scotland. Other local professional and clinical guidelines will be developed and endorsed via robust clinical governance arrangements.

We will nurture an environment where learning and development is valued and supported. We will provide practice placements for undergraduate trainees, support post-graduate study and make further training available relevant to the roles and responsibilities of clinical staff. Systems will be in place to provide clinical supervision to all clinical staff tailored to the nature and complexity of the clinical work they perform

4.6.3 Good access to efficient information systems and equipment is an essential requirement. This can present challenges when staff work across many community sites and

bases. Information systems should be accessible at the point of clinical contact. This means that clinical staff should be able to access the system in a range of settings, for example: the outpatient clinic; inpatient wards; patient's homes; and in GP surgeries. The user experience should be as similar as possible in all settings.

Information sharing is integral to the delivery of clinical services and will become more important with the integration of health and social care. Clinical systems need to facilitate the sharing of information within a robust governance framework. Simultaneously, such systems (and data sharing agreements) need to be pragmatic and flexible.

5. Delivering the strategy

5.1 Available resources

5.1.1 Finance

NHS Tayside continues to spend more per capita on general psychiatry* services than other Health Boards in Scotland when that population is weighted for social circumstances, demographic profile and population density. However the proportion of that expenditure that is for community services remains below the Scottish Average. This disparity can be partly explained by the new investment made by NHS Tayside in modern in-patient facilities in Murray Royal and Stracathro. One element of the Steps to Better Healthcare programme has been to examine how these facilities are being used to ensure that maximum benefit is to obtained from this investment. Bringing this work to fruition will be an important step in creating a sound financial framework for the delivery of this strategy.

(*N.B. Expenditure for 'general psychiatry' refers to costs for all mental health specialities comprising general psychiatry, child/adolescent psychiatry, forensic psychiatry and psychotherapy, geriatric psychiatry and psychiatry of old age)

Further re-balancing of expenditure between hospital services and community mental health services will require further improvements and efficiencies in resource use.

5.1.2 Staffing

Information collected by the National Mental Health Benchmarking Project indicates that NHS Tayside has amongst the highest levels of staffing in its mental health services in Scotland. The number of Consultant Psychiatrists per head of population is second only to Greater Glasgow and Clyde; it indicates NHS Tayside has the highest number of hospital based nurses and of AHP staff per head of population. It would therefore appear that the mental health service is well resourced. However the report also indicates that NHS Tayside has one of the lowest rates per capita of community mental health nurses, perhaps indicating that our staffing resources are not currently deployed to meet the requirements of a modern mental health service. (NB the report includes numbers working in all adult mental health services, including psychiatry of old age, secure care etc.)

Detailed information on the current number, discipline grade and deployment of staff within the mental health service has been collated. This information will be used in conjunction with validated and reliable guidance such as the National Nursing Workforce Planning Tools for Mental Health & Learning Disability to establish workforce plans that support the delivery of safe and effective clinical services. .

5.2 Partnership

5.2.1 Health and Social Care Integration

Collaborative working between Health services and Social Care services has been an important component of mental health care and treatment for many years. A number of structures and arrangements have been established to create the conditions for the delivery of more "joined up" care and the more efficient use of resources (e.g. the Care Programme Approach, co-located and aligned community teams, resettlement programmes and resource transfer). It is recognised that such arrangements can deliver significant benefit to patients. However it is also recognised that the way that health care and social care services work together could be more efficient.

The Public Bodies (Joint Working) (Scotland) Act 2014 transfers the responsibility for the planning and delivery of many services, including Mental Health Services, to new authorities: Integrated Joint Boards (IJB). In Tayside community mental health services are to be delivered by each Integrated Joint Board, in-patient services and some of the more specialised and small community services are to be hosted by one IJB on behalf of all three Boards. This offers an opportunity to build on previous collaboration and establish systems that deliver efficient and effective clinical services in tandem with social care supports and interventions that are key determinants in supporting recovery from mental illness and the maintenance of mental well being.

5.2.2 Our patients, our staff and the public

We have described above the importance of recognising the knowledge and expertise of those who receive and those who deliver mental health care and treatment and of the benefits that will be gained by their involvement in the design and delivery of the services.

There are structures and supports in place in each locality for mental health service user and carer involvement, these will be utilised to engage with people. Individual teams and services will ensure there is a dialogue with the people about the care and treatment they receive and how that might be improved.

The formal staff partnership arrangements in place across NHS Tayside will provide an important means of ensuring that there is staff engagement and involvement in any service change. The knowledge, experience and enthusiasm of staff directly involved in the care and treatment of patients will be a key determinant in creating values based, recovery oriented approaches to delivering mental health clinical services. Their direct involvement in shaping services is essential to success.

Mental health services do not always attract public interest and at times any public interest that is generated can be negative and stigmatising. It will be important to have a clear and effective approach to communicating with local communities and their representatives to generate a better understanding of mental illness and its treatment.

6. Summary

We want to create an attractive service that is widely acknowledged and admired for its quality of care delivery. In doing so we can increase our recruitment of talented staff who value people with mental health problems and also feel valued, thus perpetuating the conditions that deliver excellence in the delivery of mental health care and treatment.

7. Appendices

7.1 A review of national and local mental health plans

7.2 A profile of Mental Health in Tayside

7.3 A brief description of specialised mental health teams and services

7.4 References and sources

(Attached as separate Documents)

The Scottish Government

The Adult Support and Protection (Scotland) Act 2007

An Easy Guide to Part 1 of the Act

1016

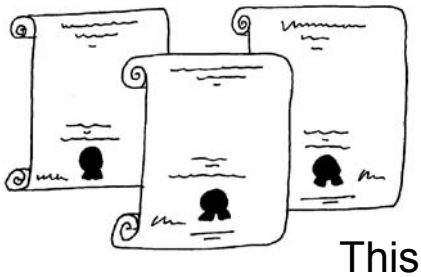
What this guide is about

This guide tells you about Part 1 of The Adult Support and Protection (Scotland) Act.

This Act will come into use in autumn 2008.

The Act has 5 parts to it. This guide only talks about Part 1.

What is The Adult Support and Protection (Scotland) Act?



This is a piece of law to try and protect people from being harmed.

This is because there are certain people who might find it more difficult to stop harm happening to them.

The Act calls people in this situation ‘adults at risk’.

‘Adults at risk’ might include people over 16 who:

- find it difficult to keep themselves or their property (their home, the things they own) safe;
- might be harmed by other people;

- might be more vulnerable because of a disability, illness or mental disorder (this could mean people with mental health problems, people with dementia, people with learning disabilities).

It doesn’t mean that all people with learning disabilities, mental health problems or illnesses or disabled people are always ‘at risk’.

It means that there are certain people in this situation who find it more difficult to keep themselves safe.

The Act talks about people being ‘harmed’. The ways the Act thinks people can be harmed are:

- getting physically hurt (for example punched, hit, kicked);

- being really frightened or bullied by someone making you feel really upset;

- having your money or personal things taken away from you, stolen or damaged;

- hurting yourself.

What does Part 1 of The Adult Support and Protection Act say?

Part 1 of the Act is all about things that can be done to help keep 'adults at risk' safe.

The kinds of things that can be done to help keep someone safe are:

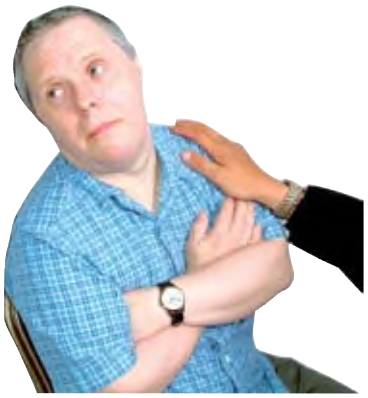
- Advocacy Services
  An advocate is someone who will speak up for you. They tell people what you want to happen.

- Inquiries (finding out information)
  If the council thinks someone is at risk, they must ask about how that person is doing, and if their home or money is being properly looked after.

- Investigations (asking questions)
  The local council can visit and speak to the person they are worried about.

They can also ask to look at the person's money and ask a doctor or nurse to look at the person's health records.

They can also ask the person to be examined by a doctor or nurse.



The person doesn't have to answer any questions they are asked and can refuse to be examined by a doctor or nurse.

- Co-operation
  The law says that other organisations should work together with local councils when they know or think a person is being harmed.

- Protection Orders
  These are explained on the next page.

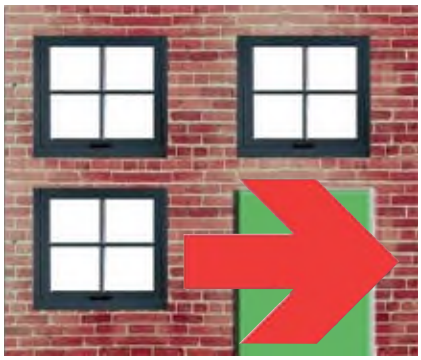
What are Protection Orders?

There are 3 different types of protection orders - assessment orders, removal orders and banning orders.

A sheriff (someone who makes decisions about laws) would decide if someone needs a Protection Order.

- Assessment (talking to someone to help them decide what support they might need) orders.
  Sometimes it might be hard for people to talk about any harm they're facing in their usual place or with other people about.

- If the council needs to talk to someone in private to find out if they are being harmed they can ask a sheriff to allow the council to take the person to somewhere private to ask them questions or be examined by a doctor or nurse.



- Removal orders

  If the council thinks that someone is likely to be really seriously harmed if they stay where they are, they can ask a sheriff to allow them to take that person to a safer place, but only for a short while.

- Banning orders

  Local councils can ask a sheriff to ban someone from a place if they think that person might harm another person there.

  The person could be banned from the place for up to 6 months.

  It should only be used if it would keep the person at risk safer than them being taken away from the situation.

When will the orders be used?

The different orders in the law should only be used in special circumstances and it's important that other things to keep the person safe are tried first.

If the person at risk of harm refuses to consent to an order, the sheriff shouldn't make the order.

But if the sheriff thinks that the person at risk was put under pressure to say no to the order then they can decide to make the order without the person agreeing to it.

What about the person's rights?

The law says that a person's right to choose what to do in life should always be respected.

Their feelings and thoughts should always be listened to.

They can refuse to agree to an order, to answer questions or be examined by a doctor or nurse.

They also have the right to ask for a banning order so that someone who's harming them can be banned from a place.

When the sheriff looks at their situation, people will have the chance to add their views to this.

Where can I get more information about the Adult Support and Protection Act?

If you need more information about the Act you can contact

Adult Support and Protection Act Implementation Team
2 East Rear
St Andrews House
Regent Road
Edinburgh
EH1 3DG

Telephone 0131 244 3287
E-mail ASPunit@scotland.gsi.gov.uk
Website Adult Support and Protection (Scotland) Act 2007

scottish consortium for learning disability
Building respect in the Scottish community

This guide was written by the Scottish Consortium for Learning Disability on behalf of The Scottish Government.

With thanks to

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HEALTH EQUITY STRATEGY 2010

Communities in Control

Contents

1. Executive Summary

NHS Tayside's 2003 Health Inequalities Strategy laid out that health inequalities are the differences found in various aspects of health between different groups, especially between those who are best off and those who are worst off in society. The 2003 strategy resulted in progress in many areas, however, this strategy suggests a far more radical approach. It describes the devastating effect that health inequalities caused by relative poverty have on the communities we serve. That effect is the enormous scale of poor mental health and wellbeing, long term physical ill health and early death in the poorest communities. It sets out the aim of closing the inequalities gap by aiming for health equity in a generation. That does not mean aiming to completely remove all unfair variation in health, but it does mean reducing the avoidable differences dramatically, to the point where they do not represent the appalling and systemic unfairness we now face. For example, it means reducing the years of life lost annually to poverty in Tayside from being measured in thousands to being measured in hundreds. This goal requires fundamentally different approaches to health from NHS Tayside, not just working harder at our current efforts.

Comprehensive evidence suggests that the one of the main ways relative poverty causes harm is the chronic stress it causes when people experience society's unfairness. Unhealthy lifestyles such as substance misuse which help people cope with this stress are passed on at very early ages. Teenage pregnancy is both a product of this cycle and an accelerant. Teenage mothers from deprived areas are most at risk of lacking skills to raise children with normal development. Breaking the cycle of deprivation leading to ill health early is therefore vital for future generations. Having a sense of worth, aspiration and confidence can protect people from such harm – it can give them resilience. We can help to build on existing confidence and resilience, and rebuild aspiration where it is harmed by supporting communities to take control of their environment and the services that surround them. This is a very different goal than just aiming for faster or closer services.

This is primarily a strategy for investing in community resilience, investing time and effort in promoting social capital and community enablement. We will primarily do this by offering social responses to social problems. In particular we will support co-production: helping people to plan services and to take back elements of services which do not need to be delivered by health professionals so that in total, services are co-produced by communities and the NHS. This promotes social capital - the importance of a connected and caring society - over institutions. In short we will ensure that our services promote more patient and community enablement, not more dependency on the NHS.

Our range of effort will need to look different in every area of Tayside because people's needs are different, and the community networks which can support them are different. The key is to see people as the start of the solution, not the start of the problem – to recognise that people know what will make a difference and can tackle problems themselves with our help. This is much healthier, in every sense of the word, than the NHS setting out to do things to people and fix things for them.

This is therefore a strategy for NHS Tayside to promote health as much as it cares for ill health. It is about making a cultural change that is already starting to happen consistent throughout NHS Tayside and its partners, so that through joined up effort we can help communities become stronger and healthier. This needs to happen jointly with our traditional partners such as local authorities but also with the parts of the voluntary sector that we tend to have less contact with, such as small charities, self help groups and informal community groups that are in touch with people who are not in touch with us.

We need to see all these actions as related despite some being for shorter term results and some for longer term. For example, actions to make services easier to access or to

promote healthier behaviours are needed in the short to medium term, but they must never be conducted in a way that harms resilience or promotes dependency on our services. Ideally such efforts should inherently promote social capital and empowerment, whether by using co-production, by supporting community networks, by sharing services with the voluntary sector, by offering social prescribing or by increasing empathy of our staff and our organisation.

Throughout the strategy we commit to specific actions, but more importantly we describe the sort of actions that will help and declare our intention to support our staff and communities develop other ideas jointly as we go. In particular we want to focus all these ideas, culture change and actions on breaking the vicious cycle of poverty and ill health early by prioritising the improvement of children's early years.

What is not included in this strategy is a list of all the actions NHS Tayside and its partners will take in the five years that it covers. Strategies need to give direction without being directive. This strategy lays out the culture change and outcomes required in five years, and gives illustrative examples but does not prescribe detail. Specific and detailed actions are laid out in NHS Tayside's annual commissioning plan, in Single Outcome Agreements, in the plans of its Community Health Partnerships and in the plans of partner organisations such as Local Authorities, Colleges, etc. Each year these plans will detail the specific changes (and the associated costs and timescales) that will be undertaken in the coming year. Those plans will include actions for the coming year which will achieve outcomes during that year such as improved access to services, as well as those which will take longer than one year to show benefit. For convenience, a summary list of all commitments which are included in this strategy is in section 2. The rest of the strategy goes on to explain why they are needed and explain them in more detail.

As health equity is such an important topic, NHS Tayside will enhance its already rigorous performance management and scrutiny mechanisms to ensure that this strategy is fully implemented: that the scale of actions are appropriate to the scale of the problem and to the ambition of achieving health equity within a generation.

2. Summary of Commitments

Throughout this strategy a range of commitments are made. To make it easier to see them all they are listed here, broadly grouped by the parts of NHS Tayside which will lead actions. Many actions will affect all areas so this should be treated as a grouping for convenience of reading rather than a strict allocation of tasks. This is also represented as a driver diagram in Figure 1 below.

Board Policy

- Make "Contributing to achieving health equity within a generation" our most important aim, integrating the ideas in this strategy in all work.
- Only approve strategies/plans that are responsive to very local needs and the variations in such health and social needs across our communities, including those in rural areas.
- See all these actions as necessary and inter-related despite them covering short, medium and long term actions.
- Systematically redesign mainstream services within resources instead of using projects based on non-recurring funding.
- Manage performance so that the whole strategy is implemented fully, and in a co-ordinated way across NHS Tayside and our partners.
- Target new resources and those freed up by redesign at these priorities.
- Take progressively bolder actions to re-allocate resources if these approaches fail to achieve the required changes within three years.

Commissioning Early Years Improvements

- Prioritise the improvement of “Early Years”, supporting parents to help themselves, and creating communities which are positive places to grow:
    - identify vulnerable young families and provide preventative interventions
    - tailor ante-natal programmes to meet health and social care needs
    - develop evidence-based young parenting programmes
    - promote mutual support networks for parental collaboration
    - work with young people to help them improve their environment and create opportunities for active recreation and fostering aspiration
    - support young people’s mentoring and befriending programmes
    - develop measures of childhood development as proxies for long term success in reducing inequalities

Organisational Development

- Promote community networks, resilience and social capital for example by:
    - involving people more in the design of services, especially where they can also take back the delivery of services (co-production)
    - developing time-banks
    - building a community development programme with our partners
    - supporting mainstream services to promote social capital
- Develop reporting mechanisms covering current positions, trends and trajectories for services and committees.

Workforce

- Develop training and development so that all staff see health inequalities as the most important issue, and understand how they can help.

Public Health and Health Strategy

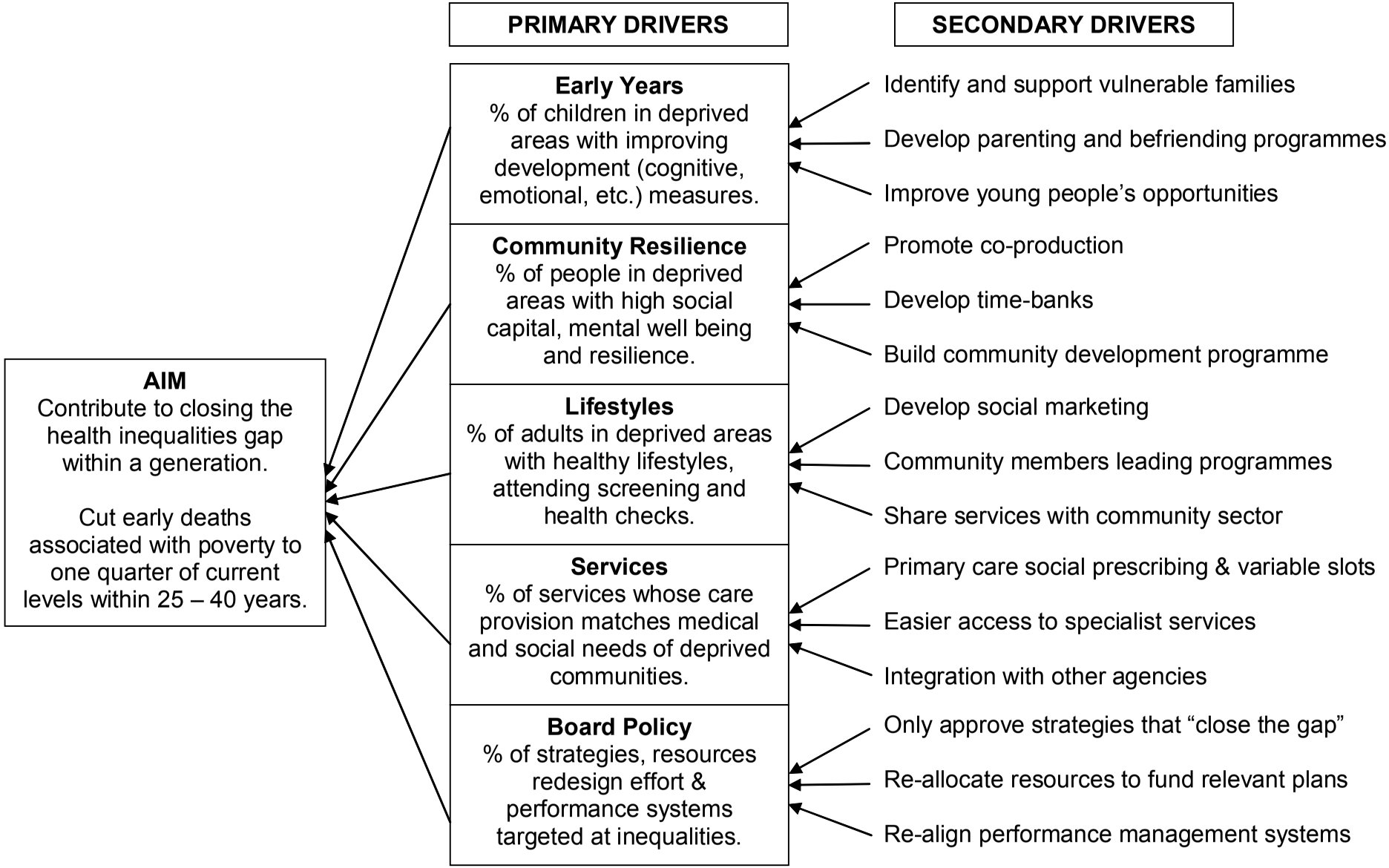
- Support behaviour change more effectively for example by:
    - using social marketing techniques
    - asking people who have already changed to healthier behaviours to help us lead the continued effort
    - asking employers, charities, voluntary groups etc. to carry out health checks and support people with desired changes
- Increase screening uptake in deprived areas using social marketing and community development techniques.
- Continue to refine ideas and build evidence on effective means of tackling health inequalities.
- Develop and agree measures of progress with our communities and partners including:
    - progress on integrated measures of improved mental health and well being, less long term ill health and less early death
    - social capital and childhood development
    - replacing targets that seek average improvements with targets on closing the inequalities gap
    - improving our evaluation capacity
- Develop understanding of differential sources of mental well being, ill health and early death.
- Expand capacity on inequalities health intelligence. For example, to link monitoring systems and expand them to include other useful measures.
- Alignment of staff and strategies in line with the topics in this strategy

Delivery Unit

- Improve service access in areas of greatest need for example by:
    - extending the reach of services that are known to be effective specifically to increase uptake by people in poorer areas
    - adapting principles from the Unmet Needs Pilots to services caring for poor mental health, long term ill health and early death

- Ensure that increased access to care does not promote dependency, but ideally promotes resilience and social capital as well as addressing needs.
- Improve primary care's ability through for example:
    - increasing social prescribing
    - longer consultation times for people with socially complex problems
    - increasing GP empathy and patient enablement
- Integrate services with partner agencies so they are easier to access, and provide more holistic services for people's social and health needs.
- Engage fully with the voluntary sector as part of all these efforts.
- Systematically support volunteering in a much wider range of settings.
- Improve wealth of poorer communities by, for example:
    - expanding the HealthCare Academy so that we routinely employ significant numbers of people from deprived areas
    - expanding work like Discover Opportunities
- Use Improvement Methodology and Triple Aim as methods of co-producing further ideas and implementing this strategy.
- Ensure that work to implement the Scottish Government's "*Towards a Mentally Flourishing Scotland*" and "*Equally Well*" is integrated with this work.

Figure 1: Driver Diagram of NHS Actions



3. Aiming for Health Equity

Contributing to achieving health equity in a generation is NHS Tayside's single most important aim. This is because in the people, families and communities we work with relative poverty is the largest single cause of:

- poor mental health and wellbeing,
- long term physical ill health, and
- early death.

Poor health associated with relative poverty is the most severe form of inequality in society. Our population profile shows that at the worst extreme the poorest people in Tayside have around 10 years more ill health and live 23 years less than the richest people. Whilst NHS Tayside should continue to consider links between the different 'strands' of equality and poor health no other disadvantage systematically cuts healthy life expectancy by over 30 years from around 80 to around 50. This is not just a problem for a few people: over 84,000 people in Tayside live in some of the most deprived areas in Scotland. A snapshot analysis by David Shaw, a GP in Dundee, suggests that over 180 deprived people die early every year. If they had the same life expectancy as people from richer areas they would together live about 3,700 years longer.

Poverty kills.
It kills life, it kills health and it kills spirit.
It kills on a devastating scale.

One of the most surprising facts, explained in section 4, is that relative poverty does not just harm poorer people, it harms richer people too, so it is in everybody's interest to tackle the problem. Society must act not just for these moral reasons, but for economic reasons too. All those extra decades of ill health that kill hundreds of people early every year are also a massive drain on the NHS, and on taxpayers.

This is not a strategy about reacting to these health inequalities, or about reducing them a little. As the World Health Organisation's (WHO) radical report "*Closing the Gap in a Generation*" urges, this is a strategy for **dramatically reducing** them. It is unrealistic to aim to completely remove all variation in health, but we need to abolish its systemic unfairness: to aim for health equity within a generation. If Tayside's early deaths were reduced to a quarter of their current level within 25 to 40 years (to less than a thousand years lost annually), we would be close to Health Equity. That needs all measures of the health gap which are currently widening to stop within five years, and all measures which are currently stable to narrow.

This is such a large scale and long term problem, especially in Tayside, that it will only be solved by wholesale adoption of new and radical approaches to improving health and wellbeing. Promoting community control as a health solution is not new or radical in itself. Many of our partner agencies already understand and adopt it in many aspects of work, but for an NHS Board to adopt it throughout all its work, and for all partners to work systematically together in the same vein to achieve a critical mass of effort **would** be new and radical.

Charles Leadbeater of the Public Service Design Agency describes this shift well:

> "Radical public services innovation will only come from a markedly different starting point. The key will be to redesign services to enable more mutual self-help, so that people can create and sustain their own solutions. The best way to do more with less is to enable people to do more for themselves and not need an expensive professionalised public service... Services do a better job when they leave behind stronger supportive relationships for people to draw on and so not need a service… For most of the last decade, we have seen public services as systems and standards, to be managed and rationalised. Instead, we should re-imagine public services as feeding relationships that sustain us in everyday life".

NHS Tayside cannot achieve such a far reaching ambition of handing control back to people easily or alone, we must work with the people we serve in a completely different way and that will be challenging for everyone. All of the public sector must work in the same way, and the local authorities are ready to lead this change with us. However, we must realise that in setting out to do things differently for ever we will not be able to prescribe in detail how we will do it. Instead, as Harry Burns, the Chief Medical Officer has said, we must describe the culture change we are aiming for and then learn as we go, being nimble to adopt the tactics which work and abandon those that do not. However, to understand why such wholesale changes are needed we need to understand the detail of why and how poverty kills.

4. Understanding Why Poverty Kills

Systematically worse health does not just affect the poorest people. Health worsens with lower salary and social status at every level. This is related to not being able to afford healthy food, pleasant environments to exercise in, transport to health services, etc. However, it is not a problem that can be solved just by increasing salaries: evidence from around the world compiled in Richard Wilkinson and Kate Pickett's book "*The Spirit Level*" shows that health is significantly better when the wealth gap between the rich and the poor is smaller. Rich people in unequal countries like the UK, where that gap is large, are far less healthy than rich people in more equal countries like Sweden where the gap is narrow.

What other people earn affects your health as much as what you earn.

People throughout unequal societies see that they are much worse off than the very rich. We feel conscious of low status and the more relatively deprived we are, in terms of poverty, but also job insecurity, debt, education, housing etc., the more chronic stress and poor mental wellbeing we suffer and the less able to take positive action we become. Whether our behaviours are healthy or not becomes irrelevant when poor mental wellbeing in the form of stress, anxiety and depression dominates, and when the community support networks which protect from harm do not function. The Scottish Government's plan "*Towards a Mentally Flourishing Scotland*" says mental wellbeing includes both *how people feel*: their emotions and life satisfaction, and *how people function*: their self-acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy.

Without positive mental wellbeing we naturally concentrate on individual coping and stress relief rather than healthy behaviours and supporting each other. Income is more likely to be spent responding to peer pressure and expectations instead of on health, and on children's health. Stress relief in these circumstances often comes from physically and

socially harmful habits such as smoking, drinking and taking drugs. These behaviours lead to more poverty and crime and to a dysfunctional and distrustful society generally.

Poor parenting and early childhood experiences affect development and behaviour throughout life, perpetuating the cycle of ill health from one generation to the next. Social pressure is intense: when people all around you indulge in harmful habits, the likelihood of joining in is high. This vicious cycle is social in nature, depending on unfair income distribution, peer pressure and social expectations to sustain it. However, whilst this fact lies at the heart of the problem, it also points to the solution to breaking the cycle and creating a virtuous cycle instead of a vicious one. A virtuous cycle that helps tackle not just health problems but many other problems communities face.

5. Understanding Community Resilience

Social support is as powerful as peer pressure and when people, families and communities come together to support each other, they can improve health as well as addressing many other problems. Studies in the WHO report "*Mental Health, Resilience and Inequalities*" by Lynne Friedli show that whilst narrowing the relative poverty gap improves health, improving mental wellbeing also protects from harm – it gives resilience. Richer communities are naturally more resilient than poorer ones, but poorer communities can boost resilience and hence health by increasing social capital. So when people know, help and trust each other, when one good turns deserves another and when a community feels like a community, not just a place where individuals live, people are able to be healthier, happier and safer.

Community networks are the very immune system of society.

This does not mean that stronger community networks, targeted employment practices or better mental wellbeing, social capital, aspirations and enablement that flow from them will stop people from indulging in health harming behaviour, eliminate teenage pregnancy or remove all inequalities in health. Many other factors influence health and need to be tackled by all public sector agencies together. But they do represent the background against which other problems should be viewed. They represent some of the most effective ways to improve life circumstances and despite being more social problems than medical ones, the whole NHS has a large and significant role to play - a very different role to the one it is currently playing. This role is about how the NHS and other agencies can help communities take more control of their own affairs including health, rather than what the NHS or other agencies can do to, or for, communities to improve their health.

An illustration is that people believe that fixing the obvious causes of ill health such as poor housing will help solve people's problems. Yet studies in an evidence review commissioned for this strategy show this will only help if done in the right way. Some initiatives to improve community housing actually harm physical health. One reason suggested was that in a particular improvement programme, subsequent rents doubled, worsening people's poverty, and reducing their chance of affording a healthy diet. In contrast the Hunter Crescent estate of Perth (now known as Fairfield) was well known for its social and health problems. In the early part of this decade the council, crucially, gave control of the estate redevelopment to the residents. Those residents worked with developers to decide the policies and changes for the area. Not only is housing improvement sustained, but people report that the area is a happier place, and is a viewed by others as a desirable place to live. The people in Fairfield say they feel more enabled than they used to.

Another example is in Malcolm Gladwell's book "*Outliers*". Gladwell describes the "mystery" of the good health of people in a small town called Roseto in America (studied in the American Journal of Public Health). Most people had moved there from Italy and experienced much better health than neighbouring towns and much better than most of America. When the reasons for this were analysed it turned out that superficially the people had similar lifestyles and genetics to others. They ate as badly as others in America (worse than in Italy), took similar amounts of exercise; and people with similar ancestors elsewhere had worse health. The only aspect that differed significantly was the sense of community and subsequent resilience. People talked on doorsteps, spent time in each others houses, socialised together and had strong community networks – they had social capital.

In "*The Wee Yellow Butterfly*" Cathy McCormack writes that for those trapped in a toxic mixture of economic circumstance life can be hard but a strong spirit and a refusal to accept what is given can release energy and creativity for individuals and their communities. In the Cliffburn and Hayshead areas of Arbroath, residents' Association Chairman, Margo Reilly "encourages volunteers to better their community by looking at what the community wants to achieve" she then "helps that to happen by encouraging partnership action which uses the time and talents of the local residents in community planning".

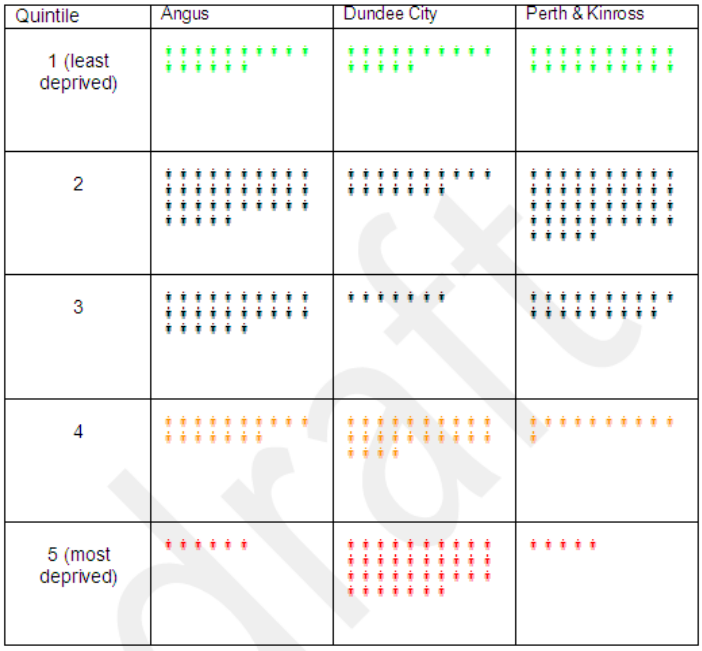
The significance of these lessons to the NHS is huge. Most of us accept that the NHS should improve access to its services in deprived areas, and should enable poorer people to make better lifestyle choices. But if we "do things to" people, without thinking through the consequences on the social and community aspects of health – whether people feel in control of their environment (enabled), and whether they support each other (social capital) - we will be unlikely to help, and more importantly, despite our best intentions, we may even harm inadvertently.

Increased access to traditional NHS services can harm health even more than poor housing action. Not just because imposing solutions on people undermines their own control in the short term, but because people can become dependent on the NHS in the long term. If people seek, and the NHS provides, medical solutions to social problems, people become less able to protect themselves from things that harm health, and less able to cope with all forms of harm. The NHS therefore needs to help people find alternatives to seeking healthcare as a solution to social problems as well as providing appropriate services for medical needs. It might be as simple as letting people know what is going on in their community that they could be part of, or it might be as complex as whole new programmes of community development. The point is that our current style and scale of effort on these types of problems will not come close to solving the problems, no matter how hard we try, which is the main reason this strategy is needed. However such work is supported by the Government's "*Meeting the Shared Challenge*" programme which aims to support a shared understanding of, and a strategic commitment to, a community led approach to health improvement and addressing health inequalities.

6. Understanding Communities in Tayside

Problems of poor health, poverty, teenage pregnancy, crime and addiction are not spread evenly throughout Tayside. In developing this strategy we thoroughly updated our population profile and published it with this strategy. It shows that the majority of severe poverty, ill health and early death is concentrated in Dundee where almost two thirds of the population live in some of the most deprived areas of Scotland (see Figure 2 below). However the concentration of deprivation is not evenly spread: walk through small neighbourhoods in Dundee and see affluence and people with good health; walk to the next street and see the absolute opposite.

Figure 2: Differences in Tayside's Population: Scottish Index of Multiple Deprivation



Data Source: SIMD 2006 & GRO(S) SAPE populations 2007

Similarly, towns of Angus and Perth and Kinross with far less overall poverty and deprivation, still have discrete pockets of severe deprivation where health needs are very different to the rest of the town. Outside towns, rural areas have poverty which is less easy to spot. This poverty is characterised by a combination of low income and isolation from services and communities which are important to health. When taking these aspects into account, almost a quarter of people in Angus, and one sixth in Perth and Kinross, live in some of the most deprived areas in Scotland.

Think about the important points covered already:

- extreme relative poverty destroying wellbeing
- poor wellbeing leading to unhealthy coping behaviours and chronic stress
- individual coping behaviours harming health
- poor parenting harming child development
- family behaviours and peer pressure reinforcing and repeating the cycle
- local communities needing to be resilient and powerful
- community networks being the immune system of society
- agencies taking well intentioned but actually harmful actions

Add to this the differences in poverty, community and health needs comparing one small area with another. It becomes clear that centrally re-allocating resources to push more, say, secondary care services at all poor communities, irrespective of whether they want or appear to need them, and without considering what their whole (especially social) needs are would be inappropriate. The challenge is to work with communities, not to find out what they want and then provide it, but to enable them to take control and provide their own solutions. Communities need to be involved in the delivery of services, behaviour change initiatives and solutions, as well as in their design. This enablement and related ideas are called co-production.

7. Promoting Co-production

On a simple level co-production is about involving people in the delivery of public services. This helps people change the relationship with services from dependency to genuinely taking control. It helps improve public ownership and helps services improve by increasing their relevance. The new economics foundation (nef) pamphlet "*Co-production*" describes deeper and more important reasons for promoting co-production. The skills and values involved are also those that communities need to improve the social capital which is so critical to wellbeing. Co-production on this level is about valuing and rewarding fairly people's everyday contributions to society. One tool which does just this is timebanking. Timebanking is in use in Tayside. For example, Dundee Association for Mental Health's Orbit Approach rewards users for time they commit with complementary therapies.

nef describes other examples of timebanking, both generally and in relation to changing public services. It also describes other examples of co-production. A powerful example is from Lehigh Hospital, Philadelphia. On discharge you are told that someone will visit you at home to make sure you are OK; see if you have enough heating, food etc. That person will be a former patient, not a health professional, and when you are well, you will be asked if you will do the same for someone else. The result is more than a significant cut in re-admission rates: more than people in communities taking back over-professionalised services. It promotes communities looking out for each other, and reduces the dependency that convinces many patients they have nothing worthwhile to offer. It promotes enablement and social capital.

People are at the heart of the solution,
not the heart of the problem.

Co-production as supported by the public sector in general and the NHS in particular should always:

- view people as assets who have skills vital to improving our services
- break down barriers between service provider and user
- promote people supporting each other
- include an element of reciprocity
- build community
- support resilience

The nef pamphlet suggests 10 measures which NHS Tayside and partners could use to gauge our collective success in promoting co-production working with our staff and partners, as well as with communities – these are listed at Appendix 1. We are working with nef to help us develop these ideas and work which will support them. An important note is that the heart of this strategy was created using co-production by many relevant agencies in a dedicated event in Perth.

8. Developing a New NHS Culture

The new NHS culture is therefore not to assume that a policy designed for the average person with a particular health need or demographic label will suit everyone with that need. It is not to lay out precise actions that NHS Tayside has decided to do to, or for, people, even if it has listened carefully. Instead, the new culture is to acknowledge that despite many of the wider determinants of health such as housing lying outside traditional health care, we can act with partners and communities to directly improve wealth, community resilience and social capital. We can do this as well as supporting behaviour

changes and improving access to services. If done to genuinely help communities take control, these actions will improve health just as directly as the wider determinants. They will not just improve health through the direct observable outputs such as better services; they will lay the foundations for communities mentally flourishing and becoming "*Equally Well*".

The NHS can be more of a health service - improving health
Less of a sickness service - delivering care

NHS Tayside will tailor those efforts to be truly responsive to very local needs - not just responsive to obvious health needs, but by working with partners and communities, responsive to all individual, family and community needs. It will promote co-production so that local communities can not only be involved in delivering care and other services, but also in creating or developing community networks that take control of environments and do what is needed for their children to grow up in aspirational families that live in caring, supportive environments.

This approach forms the fundamental context or philosophy that all service improvement effort must adhere to. It forms the essence of the cultural change needed consistently in all services, not just in those departments with staff working on community development. In particular this creates a different perspective from which to evaluate our current efforts. In the old culture where local access and increased uptake were part of the ultimate goal, putting specialist services into communities despite extra cost and decreased efficiency was a good thing, as was offering more local access to screening. In the new culture of empowering people, promoting social capital through co-production and community networks which look after each other in the widest sense, and in particular in decreasing unnecessary and unhealthy dependency on services, these efforts need to be thoroughly re-evaluated to check that access is not at the expense of dependency.

9. Integrating Agency Efforts

A theme of this paper is that health is about more than health care but that the NHS needs to be fully engaged with that wider agenda. That helping people to take control of virtually any aspect of their environment or improve social capital is just as important to improving health as helping them take control of services. In other words, as Derek Wanless described in his series of public health reports, a fully engaged population is part of a public health agenda. The key point here is that this is an agenda every public service needs to be part of. We need to build on existing partnership work particularly in Community Planning Partnerships and evidenced in Single Outcome Agreements. We need to work in a thoroughly co-ordinated way so that communities are not faced with the NHS talking about community networks for health, and police talking about different ones for safety, and the council promoting different ones for climate change solutions. It is also about agencies sharing learning with each other and acting to deliver services in a thoroughly joined up way.

10. Engaging Community and Voluntary Sectors & Promoting Volunteering

The community and voluntary sectors have many vital roles in aiming for health equity. They are often in the best position to promote social capital and develop community engagement. The NHS needs to support such organisations to share community information, support parents, promote healthy choices, spot health problems, deliver aspects of care and develop links with health workers.

We will engage fully with these sectors so that they have a more equitable and esteemed relationship with NHS Tayside and with the public sector generally, so that they are part of the joined up approach across agencies. One aspect where such organisations are well

placed to recognise, develop and support opportunities is in the promotion of volunteering, including the volunteering of our staff. Volunteering can range from informal arrangements to 'help out' through to more formal arrangements, such as Befriending, Buddying, joining Patient Partnership Groups, being a Community Activist, becoming an Expert Patient, training Lay Workers, joining a Peer Supporter network etc.

Volunteering benefits the person receiving support, but it also enhances self-worth and self-esteem, increases wellbeing in the volunteer and can be a strong part of a virtuous cycle of support and development within communities. Often those receiving support go on to help others in similar situations. This encourages continued benefits and improved wellbeing and capitalises on their unique position to understand and support others facing similar issues to their own.

Examples of volunteering abound in Tayside but we need to support them more systematically, including rewarding our staff for volunteering. The Angus Community Health Partnership and Volunteer Centre recently published "*Beyond the Trolley Service*" discussing the benefits of volunteering and how the NHS can support it. An example is Kirriemuir's Friday Night Project, which organised for a sports centre to be available at night. Up to 120 young people attend and it wouldn't happen if it wasn't for the efforts of young people who volunteer to raise young people's awareness about drugs, alcohol and health issues and as befrienders to ensure that young people with learning disabilities and other challenges were able to participate.

11. Towards a Mutual NHS

"Better Health, Better Care" stated that we need a more inclusive relationship with the Scottish people; a relationship where patients and the public are affirmed as partners rather than recipients of care. We need an NHS that is truly publicly owned and accountability is shared with the Scottish people and with the staff of the NHS. These concepts are fundamental building blocks on which ideas in this strategy like co-production and community resilience rest. When we consulted with people in the most deprived areas of Tayside about this strategy they told us about the things they felt would help, and that are perhaps obvious:

- that unhealthy behaviours start with children learning them from their parents and friends so that is where we should focus most of our efforts
- that the reason some neighbourhoods feel unsafe is young people hang around because they have nothing to do and nowhere to go

They told us they could see these things for themselves and could tackle them if they were not prevented by laws, or hindered by distant bureaucracies and were instead helped by local services using a little local discretion, effort and flexibility. This is consistent with the Scottish Government's drive to 'shift the balance of care'.

12. Seeing Long Term Connections

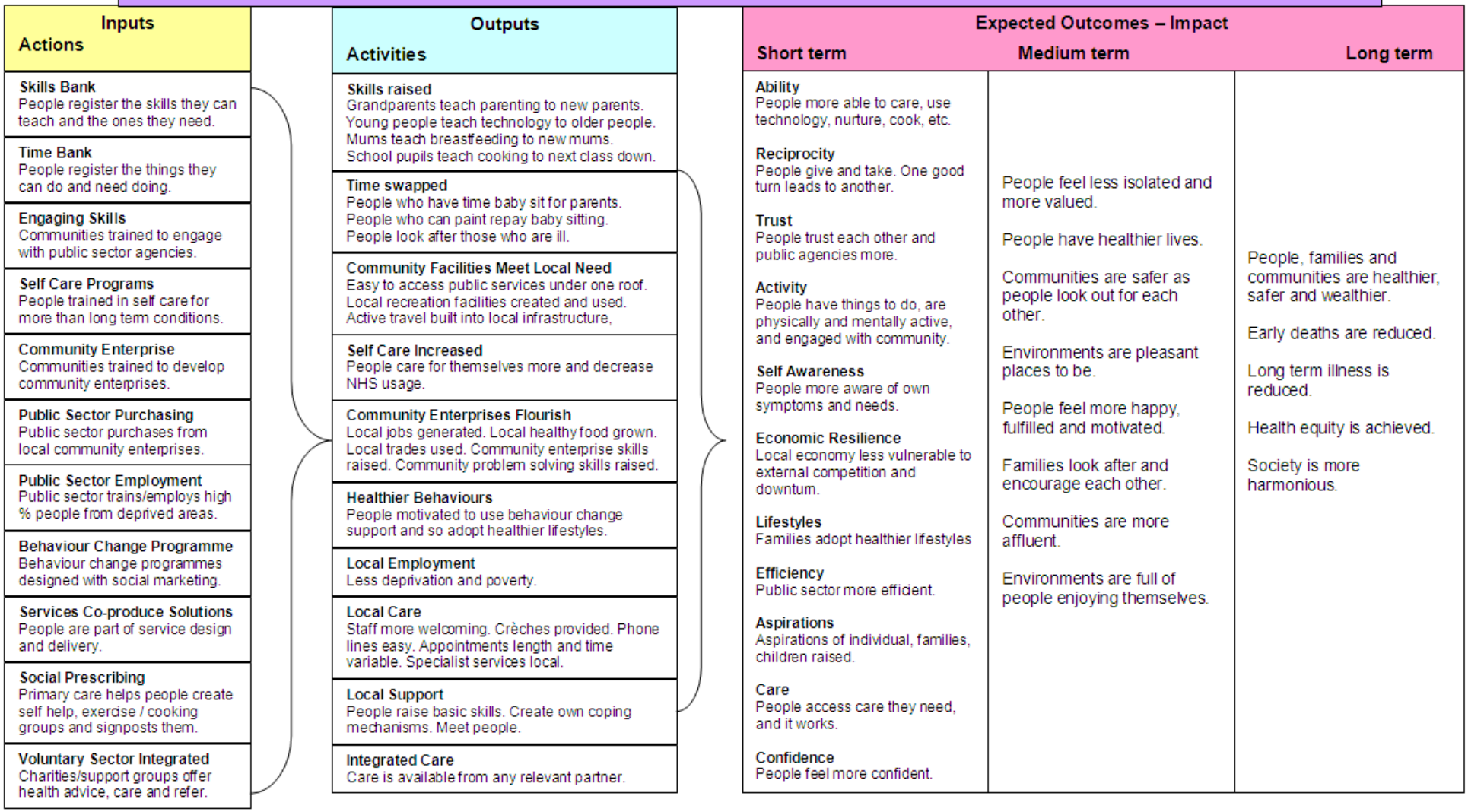
This strategy covers some of the big causes of poor mental health and wellbeing, ill health and early death. It highlights that these problems are far worse in the most deprived areas, where people suffer most poverty and have less enablement and social capital. Individual solutions might appear to be isolated but if we follow their impact we see that they are not. Again paraphrasing Harry Burns, Scotland's Chief Medical Officer, it might look like we can pick and choose aspects that we will work on, but we cannot if we truly want to improve a whole system, as opposed to being seen to do something. The approach of pilots that target single issues and rely on ring fenced funding but then stop might seem attractive, but they are not.

The real issue is that, as with all “wicked” problems, the various factors are not simple or isolated from each other but are complex, entrenched and inter-related. They will not go away if we find some time or money to do extra things in addition to the usual services and ways of doing things. This is why it is difficult to measure the success of individual actions and why it is dangerous to try to list all the actions we will take. It would be impossible, and would imply that they were exhaustive.

Instead this strategy describes the cultural change needed and lists the sorts of actions that ought to help. It is particularly important to say that some actions may have a relatively quick impact, whereas others may take years to make a difference. This does not mean we can delay actions which will take a while to bear fruit, nor can we treat the actions with quicker impact as independent of them.

A good analogy is that of planting a garden. When planting you need to plant the acorns that will take twenty years to grow to oaks, at the same time as taking cuttings for medium sized bushes in a few years, at the same time as planting this year’s annuals. In particular you need to see the various actions as related because it is important to plant things where they won’t harm each other, and to think about how it will all look in the end. The diagram in figure 3 shows the various types of action in this strategy relating to each other. It shows that we should see some results in the short term, but will have to wait longer for the more systemic changes. Whilst all these actions and benefits are probably needed, and need all agencies to work together, they are not exhaustive. Work must continue to develop the actions that will sustain the culture change at the heart of this strategy.

Figure 3: Relationship between wide range of actions (logic model) to aim for Health Equity



Inputs Actions	Outputs Activities	Expected Outcomes – Impact Short term	Medium term	Long term
Skills Bank People register the skills they can teach and the ones they need.	**Skills raised** Grandparents teach parenting to new parents. Young people teach technology to older people. Mums teach breastfeeding to new mums. School pupils teach cooking to next class down.	**Ability** People more able to care, use technology, nurture, cook, etc.	People feel less isolated and more valued. People have healthier lives. Communities are safer as people look out for each other. Environments are pleasant places to be. People feel more happy, fulfilled and motivated. Families look after and encourage each other. Communities are more affluent. Environments are full of people enjoying themselves.	People, families and communities are healthier, safer and wealthier. Early deaths are reduced. Long term illness is reduced. Health equity is achieved. Society is more harmonious.
Time Bank People register the things they can do and need doing.	**Time swapped** People who have time baby sit for parents. People who can paint repay baby sitting. People look after those who are ill.	**Reciprocity** People give and take. One good turn leads to another.		
Engaging Skills Communities trained to engage with public sector agencies.	**Community Facilities Meet Local Need** Easy to access public services under one roof. Local recreation facilities created and used. Active travel built into local infrastructure,	**Trust** People trust each other and public agencies more.		
Self Care Programs People trained in self care for more than long term conditions.	**Self Care Increased** People care for themselves more and decrease NHS usage.	**Activity** People have things to do, are physically and mentally active, and engaged with community.		
Community Enterprise Communities trained to develop community enterprises.	**Community Enterprises Flourish** Local jobs generated. Local healthy food grown. Local trades used. Community enterprise skills raised. Community problem solving skills raised.	**Self Awareness** People more aware of own symptoms and needs.		
Public Sector Purchasing Public sector purchases from local community enterprises.	**Healthier Behaviours** People motivated to use behaviour change support and so adopt healthier lifestyles.	**Economic Resilience** Local economy less vulnerable to external competition and downturn.		
Public Sector Employment Public sector trains/employs high % people from deprived areas.	**Local Employment** Less deprivation and poverty.	**Lifestyles** Families adopt healthier lifestyles		
Behaviour Change Programme Behaviour change programmes designed with social marketing.	**Local Care** Staff more welcoming. Crèches provided. Phone lines easy. Appointments length and time variable. Specialist services local.	**Efficiency** Public sector more efficient.		
Services Co-produce Solutions People are part of service design and delivery.	**Local Support** People raise basic skills. Create own coping mechanisms. Meet people.	**Aspirations** Aspirations of individual, families, children raised.		
Social Prescribing Primary care helps people create self help, exercise / cooking groups and signposts them.	**Integrated Care** Care is available from any relevant partner.	**Care** People access care they need, and it works.		
Voluntary Sector Integrated Charities/support groups offer health advice, care and refer.		**Confidence** People feel more confident.		

13. Enacting the New Culture

The new NHS culture of acting on the wider determinants of health through empowerment and enablement at all levels needs to permeate our thinking and our actions. The aim is to improve mental health and wellbeing so that people are more able and likely to choose healthy lifestyles, more likely to tolerate and control existing illness, and less likely to need care in the future. In the meantime, people who still have much greater health problems still cannot or do not access the sort of health care they need, and should be supported to choose healthier behaviours. The more traditional NHS aims of improving access and supporting behaviour change are still therefore relevant, but they need to be done in a different way with different end goals in mind. That means the three main types of specific action are:

- supporting communities, especially the poorest ones, to improve enabling community networks and so improve their own mental health and wellbeing;
- enabling poorer people and families to choose and maintain behaviours which lead to good health, and reject behaviours which damage health;
- ensure health care and other services are designed to integrate and match people's overall needs (not just obvious health needs) much more closely.

These approaches of supporting mental health, enabling behaviour change and improving access must be integrated so that care becomes more holistic, with staff and services thinking about people's social needs, not just their medical needs. The staff of 'Discover Opportunities in Dundee' already strive for this ideal. They provide help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related. They also recognise that work and socialising are good for health and that confidence and skills help people want to work as well as making it more likely that they will find work.

If this integration is not done there is a real danger that we will make inequalities worse. This is because just giving people with poor mental health extra care for physical illness, without supporting them to improve their wellbeing, and take control of their own health can de-skill them further, creating an unhealthy dependency on the NHS and on medicine in general.

Giving anti-depressants to people with minor depression who do not need them happens regularly. These drugs are no use unless people have major depression, so the NHS wastes money and creates a dependency beyond unwarranted repeat prescriptions. We need to recognise that many problems of low wellbeing are inherently social and lead the way in actively seeking non-medical solutions. This is the essence of why these proposals are radical. The NHS puts most of its effort into faster, more cost effective access to the newest treatments for physical health, but if it forgets that mental health and its social sources are as important as physical health, it can harm health.

This approach makes lifestyle interventions such as well designed smoking cessation programmes more likely to work because people have the strength, will and support to use them. Similarly, training on eating healthily and cheaply is not enough if people do not have access to fresh affordable fruit and vegetables. Exhorting people to exercise without helping them ensure their environments are safe and pleasant is futile. We need to ensure our efforts are truly joined up and thought through, without thinking for people. When we consulted about this strategy it was striking that people could describe the solutions more clearly than many policies. Young people for instance described that they need places to enjoy sports and activities together. Where they do not, and where they lack social support to make better choices, they hang about street corners which scares people, they turn to

drugs, alcohol and smoking for lack of anything else to do, leave school with no ambitions and are more likely to become teenage parents as a result. In this context helping young people get what they need, whether it is a pool table or a father figure, is a bigger priority than more traditional approaches to public health.

A final important point about the new culture is that we are learning all the time about what helps to tackle health inequalities. Current evidence points to social capital, mental health and employment practice as solutions, but it is constantly evolving. We therefore need to constantly monitor ideas and assess our efforts to improve.

14. Improving Early Years

All of the points in this strategy apply especially to children. Reports in the past two years have put the UK bottom of the league of industrialised nations for child wellbeing. 1 in 3 children across Tayside, and more than half of children in Dundee, are from families with low income. Children living in the most deprived areas experience much poorer health, wellbeing and life chances than their more affluent counterparts. Less able richer children overtake more able poorer children by the age of six. The UK has the highest rates of substance misuse and teenage pregnancy in Europe, both of which are symptoms as well as causes of ongoing inequalities.

> ***Our deeply unequal society damages children most of all.***
> Child Poverty Action Group in Scotland

All too often agencies respond to crisis situations and the consequences of failure when it is too late to alter established behaviour. We also tend to treat social problems such as substance misuse, young offending, teenage pregnancy and poor educational attainment as if they were separate from one another, instead of addressing their root causes.

The family is the biggest single influence on young people's lives. Families work with what they know and experience and children copy what they see and hear. The experiences of very early childhood affect the creation of the adult brain and influence behaviour and personality for life. A child brought up in a stable and loving environment is better placed to succeed in life, than a child from a less secure background. It is in the first years of life that inequalities in health, education and employment opportunities are passed from one to generation to the next.

Improving the early years experiences of such children is key to breaking the repeated cycle of poor outcomes. What makes the most difference is a nurturing and secure home environment, and in particular where there is interaction and communication between a parent and child from birth, as well as opportunities for play, learning and developing aspirations.

There is a need to transform the way public services interact with families and young people and the community. We need to shift the focus from crisis management to prevention, early identification and early intervention.

> ***The biggest gains will come from supporting parents – to help themselves - and creating communities which are positive places for children to grow up***.
> *"The Early Years Framework"*, Scottish Government

14.1 Identifying and Providing the Best Start for Vulnerable Families
Identifying, engaging with, and supporting more vulnerable parents and families to provide a stimulating and supportive early years environment, as well as making sure that there is good access to high quality pre-school and school education, is central to improving the life chances of young people and the overall efforts to combat inequality. Yet we know that those parents most in need are often the least likely to access services.

The NHS comes into contact with almost all women during their pregnancy. It is well placed to identify where women and families need additional support and to work with others, including the voluntary sector, to tailor more holistic ante-natal programmes that meet health and social needs and offer children the best start in life. Newborn babies respond to positive interaction from parents and carers. The importance of communication in the first years of life should be included in the advice that expectant and new parents are given.

Services such as those treating adults with addiction problems, mental illness, learning or physical disability or chronic disease, many of whom have children, should also play a key role in identifying families at risk and referring them for support where appropriate.

Whilst identifying parents at an early stage and providing preventative intervention needs to be a greater priority, we also need to make sure that there is effective access to intensive family support for those who need it.

14.2 Positive Parenting
There is now considerable evidence on the importance of good parenting and the benefits of evidence-based parenting programmes. Parenting programmes have been shown to:

- Improve communication and family cohesion
- Improve academic attainment
- Reduce behavioural problems
- Reduce risk taking behaviours
- Reduce levels of anxiety and depression (amongst parents and children)
- Improve aspiration and wellbeing
- Improved long-term life chances for the children

A Cochrane Review investigating ways to prevent alcohol misuse also identified a parenting programme as the most promising of all interventions in preventing substance misuse and other risky behaviours among young people. "*Pathways to Problems"* noted that the most important factors which influence whether young people will use tobacco, alcohol or other drugs hazardously are family relationships, circumstances and parental attitudes to substance misuse. It concluded that good parenting and stable family life can reduce these risks. This is particularly important as problem drug use is both a symptom of, and one of the most significant contributors to, health inequalities and is a significant factor in child abuse and neglect.

There is also emerging evidence to suggest that parenting programmes have wider protective benefits for communities through breaking the negative cycle. Older children who have been through the programme act as positive peer models for younger children and parents on the programme also spread their learning to families and friends and many go on to develop support networks.

14.3 Positive Economic Return

The argument for investing most effort and resources in early years and parenting is backed up by a strong economic case. The Government's "*Early Years Framework"* highlights the costs of current systems failure and cites the example of providing intensive secure care for a teenager at a cost in excess of £200,000 each year and the costs of impaired health, lack of employment and criminality throughout life at many times that. By contrast, parenting programmes typically involve a modest outlay. Similarly the cost of caring for children looked after by the state is around £170,000 per year and could be avoided.

Economic evaluations of parenting and pre-school programmes have shown a return of up to 27-fold on investment through decreased health, social care and criminal justice costs and higher earnings potential. In the US one parenting programme, the Strengthening Families Programme, was adopted in a number of US States mainly on the grounds of its economic benefits.

Both *"Towards a Mentally Flourishing Scotland"* and a recent economic evaluation by Lynne Friedli and Michael Parsonage "*Mental Health Promotion: Building an Economic Case"* also cited supporting parents and early years and parenting skills training/pre-school education as the **"best buys"** to improve mental health and wellbeing.

14.4 Parental Collaboration

Relying on professionals and professionally delivered programmes will not be enough to tackle the scale of the problem and will not by itself provide the stable and loving families and communities that children need to thrive and aspire. We need to harness the skills, knowledge and commitment of parents, grandparents and communities themselves to provide the positive and safe environment for all our children to grow up healthy, happy and resilient.

In her book "*Detoxing Childhood"* Sue Palmer stresses the importance of parents taking back control of the business of raising their children, and finding their own ways of overcoming the damaging aspects of 21st century life. She gives the example of a father in inner city London who got together with parents living in the adjacent streets to talk about how children didn't play outside any more. They agreed to keep an eye on them so they could play out and agreed boundaries that would ensure that they were safe. Another example is a group of parents in the north-east of England that raised money to turn an unused allotment into a wilderness play area where children make dens and explore the outdoors. In Tayside, we've seen the positive results of mums living in the most deprived areas supporting one another to breastfeed.

As well as directly benefiting from participating in parenting programmes and sharing their experiences, parents can also gain accreditation and help to deliver support to other parents. Parents can form *mutual support networks* for parents to meet up, chat and swap ideas.

14.5 Engaging Young People

Encouraging young people to become actively involved in mutual support networks is vital to increasing the capacity and resilience of individuals, families and communities and in tackling the underlying causes of inequality and some of the more serious social problems facing our community. Just as with their parents, we need to listen to the experience of children and young people and encourage them to use their own resources to be part of the solution.

The new economic foundation (nef) highlights the example of engaging disaffected 16 year olds in the most deprived schools in Chicago to act as tutors for 14 year olds, and the positive impact this has had on academic achievement and on the incidence of bullying.

Many young people are already actively involved as peer educators or in befriending schemes as mentors. Befriending is a supportive and supported relationship offered to vulnerable people finding community living difficult. Mentoring and befriending have benefits for community-led development. As well as improving the young person's experiences of social interaction with a positive role model, it encourages participation in new activities or situations and develops more trusting relationships which can build confidence, self-esteem and recovery and lead to wider community participation as volunteers. A nationwide survey by *Big Brothers Big Sisters* (www.bbbs.org) found that participants in mentoring and befriending services were 52% less likely to skip school, 46% less likely to begin using illegal drugs and more likely to get along with their families and peers.

This type of community development is an example of readily achievable, inexpensive ways of engaging and supporting more vulnerable young people without the need to resort to more traditional medical or other professionally-led interventions. By encouraging young people who have benefited from interventions of this type to themselves volunteer as friends, supporters and mentors to other people, we can begin to create a 'virtuous cycle'.

14.6 Measuring Impact

Waiting a generation to see the impact of action we take today to improve life expectancy or reduce the rate of cancer among the poorest communities can hamper innovative interventions and lessen individual and organisational commitment to tackling inequalities. Measuring the improvement of child development in early years may provide an answer to the difficulty in being able to demonstrate shorter-term impact. Professor John Franks, Director of the Scottish Collaboration for Public Health Research and Policy, advocates that Scotland should adopt sensitive indicators, such as childhood cognitive and educational outcomes (physical health, social and emotional maturity and language and communication skills) which are quicker to show change and have a strong predictive power for lifelong health and wellbeing.

Intervention in the early years of life is the best way to encourage healthy lifestyle habits, build emotional resilience, support aspiration and ultimately break the cycle of deprivation and inequality. It needs to be an overriding priority for NHS Tayside and the work we do with partners and the community.

15. Committing to Specific Actions

The previous sections of this strategy have explained:

- the scale and nature of the problem (that poverty kills)
- the long term ways in which these problems can be lessened (equality of wealth and resilience)
- how these will help in the long term (less chronic stress, better mental health and wellbeing)
- the sorts of actions that will help (co-production and community networks)
- the understanding that is needed (of different needs in different communities)
- the culture change that is needed (seeing wider determinants of health as relevant to NHS work as much as to its partners)
- the style of integrated working that is needed (working with communities, statutory partners, the voluntary sector and volunteers)
- the need to focus on early years (to break the cycle early)

All these elements are necessary to lay out the direction, without listing the specific actions individual services need to take. However, we do need to identify the concrete actions which apply to all of NHS Tayside, and examples of things that will be done differently by specific services. This section lays out concrete actions and examples. Some of them need to be done as described, while others are just illustrations. The people that manage and deliver our services need to take them and work with communities and partners to develop them and related ideas.

Specific service by service actions will be created within annual commissioning plans. They must of course demonstrate adherence to all the principles in this strategy, and demonstrate that they will deliver the sort of progress required. There is a risk in listing examples in this way that they will be deemed as correct and should be imposed on communities, whereas the whole point is that they should be developed **with communities**. In addition the examples are not exhaustive. In other words, services cannot rest if these examples are implemented. They are the start of a process of developing new ways of doing things.

15.1 Building a Community Development Programme

To help communities develop strengths and skills we need to help empower them. This is about helping people, families and communities develop skills and confidence to solve the problems they prioritise. Our communities tell us that this can be about developing fundamental skills that are lost such as cooking healthy foods cheaply. It can be about bringing up children positively to play their full role in society, or caring for each other with less dependency on the NHS. We might help communities create employment, exchange skills and services, or influence public agencies. These and others skills and values are at the heart of healthy, strong communities. They are what communities need most for health equity.

These skills and the values behind them are often called social capital, and helping communities build social capital is one of the most important things the public sector can do. We will systematically co-produce, ideally with our partners, a Community Development Programme which communities want. It will focus on supporting and developing the social capital of communities with most needs, and ensure a scale of ambition and progress adequate to achieve their agendas.

An example is the Perth and Kinross Healthy Communities Collaborative. This project is led by older people and professionals. Community members make improvements for themselves and their communities based on their local knowledge. This enhances relationships and networking between organisations and helps sustainability. In year one they raised awareness about falls through looking at footwear, vision, environment, medication and exercise. Falls reduced in a number of areas by 30% and social capital increased by 10%. In year two indoor curling was introduced to sheltered housing units, lunch clubs, care homes and public events. Eleven curling groups are now established with 110 people taking part. Professionals and community members also qualified as chair based exercise instructors and 16 groups are now running. Year three focuses on mental health and well-being in later life.

However, it is not just such dedicated staff that affect social capital. The way mainstream services work can either help or hinder, so we will work with them to develop ways to help. For example if we can help develop community enterprises, our Supplies Department will purchase all supplies and services legally possible from such enterprises. This will re-invest money in local communities, create local jobs and, importantly, jobs that develop wider skills not just those of the task at hand.

We will look to our community development partners such as Dundee Healthy Living Initiative (DHLI) to help us develop services in ways that our communities need. This helps our services improve and helps communities increase their social capital and enablement. Staff at these organisations too often have to re-apply for funding. We acknowledge the importance of these organisations in delivering this strategy and whenever possible will work with others to transfer funds to recurring sources. In return such organisations will need to ensure that communities build such skills themselves, and do not become reliant on ongoing support from them.

15.2 Improving Service Access for Poorer People

All services need to be easier for people with more health needs to access, and to be more integrated and holistic in their approach. However, increasing access generally can widen health inequalities because people with less health needs often respond more. We therefore need to take services that are known to be effective and extend their reach specifically to increase uptake by people in poorer areas. We will continue offering initiatives disproportionately or exclusively to people from poorer areas, and will adapt the principles from our Unmet Needs Pilots. Those principles were that three key issues facilitated service uptake:

- Perceived and actual ease of access
- Feeling welcome and valued
- Perceived importance and effectiveness

Services that met these criteria appeared more likely to facilitate uptake and longer term engagement. These three issues appeared to be achieved through five potential service characteristics: **proximity, responsiveness, convenience, timing and continuity.**

We will roll out these ideas across services, starting with those whose needs are the greatest, such as those with poor mental health and long term ill health. This will be done on a long term sustainable basis, not with more pilots. This does not mean deciding a final pattern of service delivery from the outset, it means continuing to learn and adopt better ways to improve prevention and access, but as part of the usual way of delivering services, not as projects with fixed term funding. Such efforts should reduce unnecessary

dependency on the NHS and promote social capital. Every opportunity must be taken to work with deprived communities to promote self care and deliver care in an integrated way with other services through partner agencies, community development organisations, community enterprises, the voluntary sector, volunteering and other relevant approaches. To improve basic access by removing the need to visit multiple venues, and to promote this more integrated and holistic approach, services from various agencies will be co-located whenever possible. The joint aims of such efforts are to:

- improve mental health and wellbeing through social capital and community networks;
- motivate people to adopt healthy lifestyles using co-production, social marketing and other techniques;
- ensure that levels of care match need but distribute care appropriately between self care, social network support, community care and NHS care.

There are a number of specific tools and approaches already in use in small areas which will help services to develop in the ways described. We will help priority services adopt these approaches more systematically, and in the process of learning from this, develop toolkits or learning packages which other services can use to roll out the approach more widely. The NHS Scotland Quality Strategy currently in development will also be relevant when developing services.

15.3 Improving Primary Care in Deprived Areas

People and GPs alike tell us that sometimes GPs do not have options available to respond to people with mental health and wellbeing problems. As described above, people in deprived areas have far more mental health and wellbeing problems than those in affluent areas. The response in some cases is to prescribe medicines which provide symptomatic short term relief without addressing the root cause. Different responses such as social prescribing **are** available but we need to work with practices to develop them.

One example is already being trialled in Erskine Practice in Dundee, where patients who need time to talk through their issues but do not need a GP can discuss them with a chaplain. Patients and GPs alike describe the difference that this approach makes. "*When I go to see a GP he does things to me like referring or prescribing. You don't even give me advice; you listen, say things differently and help me make sense of them*". This is about helping people take back ownership of solutions which in the past social support networks would have done.

Because practices with a high proportion of patients from deprived areas face such a high volume of mental health and wellbeing problems and have too few effective means of responding, they are often overwhelmed. The time for consultations is often too short to get into meaningful discussion about the root cause of the problems, and the types of social prescribing or self help that could be useful. Stewart Mercer and colleagues in the West of Scotland have shown that if GPs have a couple more minutes to discuss problems they can get to the root cause, and instead of prescribing medicines can increase the patient's power to take control of the situation. They have also shown that patients who have consulted with GPs with higher empathy levels also have higher enablement. Higher enablement seems to lead to patients being more likely to do what they intended to do at the consultation one month later.

These are just three things that we will support in practices serving the most deprived communities: social prescribing, longer consultations and ways of increasing empathy and patient enablement, such as training and support for GPs.

15.4 Supporting Behaviour Change

Most specific behaviours which continue the cycle of ill health are worse in deprived areas. More smoking, worse diets, less exercise, more problem drinking and drug taking, more teenage pregnancy and less breastfeeding are all significant problems. As described throughout this strategy we need to understand the causes of these problems and address them at source. That is the reason the thrust of the strategy is about promoting enablement through social capital and helping communities take control. We must also do more to help people choose healthier behaviours by helping motivate them to change, and making it easier to change. This work includes a range of tools including social marketing which help staff understand what is important to people. Examples of using social marketing in Tayside include the “Give It Up For Baby” and “Quit 4U” programmes. These pay people from deprived areas in grocery vouchers for quitting smoking in a bid to motivate them through the difficult cravings period.

We will roll out these approaches to other areas including the development of a social marketing toolkit for services, but the culture running through this strategy will be applied. That means that wherever possible such programmes will be tailored to the very specific needs of communities. They will take account of a range of related needs, not just a narrow behaviour, and they will involve those communities in delivering the help. Such help will ideally promote social networks and self help rather than more NHS or state services.

Similarly where we know that it is difficult, despite motivation and support, to choose healthy behaviours we will work with partners to address this. For example, people tell us that they need cooking skills but they also need to be able to buy fresh fruit and vegetables in local communities. We will address these problems, ideally through community enterprises or similar approaches mentioned above.

15.5 Increasing Screening Uptake in Deprived Areas

Some ill health prevention work, such as supporting behaviour change described above, is about avoiding the behaviours that lead to diseases. However we can also reduce the incidence, prevalence and burden of disease by catching diseases early. For example, people in deprived areas develop far more cancers at far younger ages and die from them far more than people in more affluent areas. Cancer screening programmes can detect cancers very early and either prevent them altogether or significantly reduce their harm, extending life by many years but uptake is low in deprived areas. We must therefore work to increase uptake in these areas. However we must not do it by simply sending more screening units or invitation letters to deprived areas. We must work with small communities in the ways described throughout this paper: within the context of a community development programme; to involve people in the understanding of why these are helpful; to find out what would motivate them to attend screening; and to involve them in the programmes we might then develop, both in their design and their delivery. Similarly, health checks can be carried out at people’s place of work or training, and they do not need to be done by NHS staff. We will work to increase the number of people who can do this such as small employers, charities, voluntary groups etc. These are prime examples of opportunities to promote co-production, to build communities and to build social capital as well as opportunities to increase uptake of screening and reduce ill health and early death.

15.6 Increasing Employment in Deprived Areas

As in most areas, the public sector is a large employer in Tayside. We are leading the way in helping people from deprived backgrounds get employment with our Healthcare Academy. The academy gives people work experience in a supportive environment, and guarantees them a job interview. People who have been through the programme tell us

about the difference it has made to their lives, not just to themselves by becoming motivated and confident to go out and earn, but to their children who then see working and taking holidays as a normal way of life. These changes have a dramatic effect in helping to break the cycle of deprivation, but only help relatively small numbers. We will expand these efforts to the point where we routinely employ large numbers of people from deprived areas. This will be in line with expanding the Discover Opportunities approach mentioned above.

16. Delivering

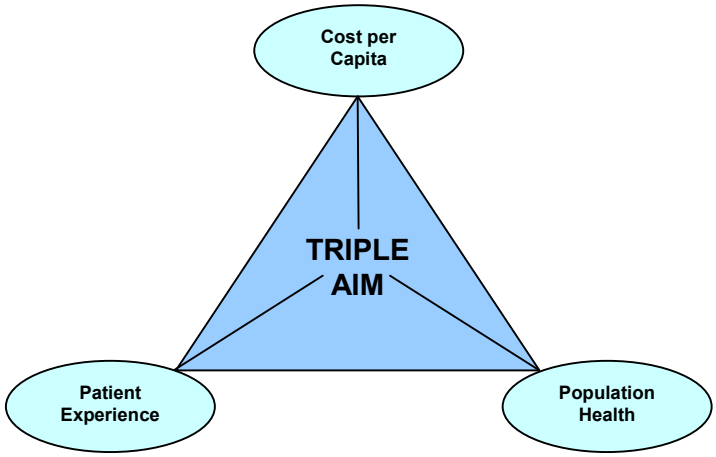
In planning to deliver the improvements this strategy promises we acknowledge that, as illustrated by the examples throughout, we are already using a number of very helpful initiatives, and have many others to draw on from elsewhere. Much of the challenge is about moving from using ring fenced temporary pilots as the way of doing things, to working differently in mainstream services. Much is about the cultural change that's needed for these efforts to gain a critical mass, or perhaps the critical mass of effort which will indicate a change of culture.

Most of the ideas are not new or additional to other strategies and initiatives. It is the systematic adoption and integration of aims that this strategy, crucially, aims to promote. For example, many staff in NHS Tayside already thoroughly understand the concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes. This "Improvement Methodology" is appropriate for delivering this strategy so long as it continues to adapt to working with communities to promote enablement and social capital. Similarly, the concepts of understanding detailed needs of communities, looking at more than health needs and working together with partners and communities is embodied in the Institute of Healthcare Improvement's Triple Aim programme. Growing numbers of staff have been trained and supported in developing these approaches already, and these efforts are being integrated.

16.1 Triple Aim

The Triple Aim Framework is the simultaneous pursuit of:

1. The health of a defined population
2. The experience of care by the people in this population
3. The cost per capita for providing care of this population



These three dimensions pull on the health care system from different directions. Changing any one of the three has consequences for the other two. With the goal of optimising performance on all three dimensions we recognise the dynamics of each

dimension while seeking the intersection of best performance on all three. Over emphasis on any one aspect will distort the system.

Through Triple Aim there is a focus on quality, innovation and productivity, addressing unwarranted variation, procedures and technological usage. It enables discussion between primary and secondary care, uses data to drive decisions, spreads best practice, and prompts the termination of low value interventions.

The WHO has issued a report by Thomson, Foubister & Mossialos on health financing schemes in all of the EU countries. One of the recommendations is to avoid confusing efficiency with expenditure control. Spending on healthcare should not be conditional, rather it should always demonstrate value for money. System level metrics are required which include healthcare, social care and public health.

In Bolton they are using Triple Aim in relation to health equity through community health and wellbeing partnerships. Bolton has developed five themes with the community that guide the work of all the partners within Bolton: Healthy; Achieving; Prosperous; Safe; Cleaner and Greener; Strong and Confident. Measures to monitor progress on each of these themes have also been developed with the community. Through the 'Healthy' theme there will be a balance between individuals receiving what they need alongside wider health gain for the community within a specific healthcare resource.

Our Community Planning Partnership's Single Outcome Agreements are key to integrating effort so we will work with them to maximise the opportunities for joint working. We commit to co-producing the next phases of agreeing this strategy and implementing it with those partners and with the communities we jointly serve.

Many staff across different agencies have recently welcomed the creation of the Scottish Government's report and action plan "*Towards a Mentally Flourishing Scotland*". Again the concepts there have synergy with this strategy and the key will be ensuring effective joint working towards common goals. Similarly the Scottish Government's report and implementation plan "*Equally Well*" helped trigger the creation of this strategy so the concepts are thoroughly aligned. There are however some elements of the "*Equally Well Implementation Plan"* which are too detailed for this strategy but still need to be delivered and monitored. To act on and deliver these strategies NHS Tayside will use its recently agreed framework for Strategic Effectiveness. The commitments in this strategy will be reflected in the annual commissioning plan. Each year they will list the actions that our services will take to deliver these strategies. These will be specific actions and will detail the sections of this strategy to which they relate, the timescales within which they will be achieved and the expected outcomes.

17. Managing Performance

NHS Tayside's Director of Public Health (DPH) is responsible for liaising and agreeing with managers throughout the organisation to ensure the range of actions being taken each year comprehensively cover this strategy over time. In other words the DPH will ensure that the next five annual commissioning plans between them include enough actions to fully implement the five years that this strategy covers. The DPH will also ensure that these actions are coordinated within the NHS and with our community planning partners, and then delivered in a co-ordinated way.

Once those actions are clearly identified and co-ordinated in the relevant commissioning plan and the Delivery Unit's Delivery Plan, it will be the responsibility of each relevant manager throughout NHS Tayside to ensure they are implemented. Performance management of these actions is carried out by senior management and co-ordinated by

the DPH. In any of the above cases the senior manager must take remedial action if the actions being taken are not adequate, and refer persistent irresolvable problems to the Chief Executive.

This range of performance management activity is aggregated at the Chief Executive's TayStat meeting, and the Chief Executive has overall accountability for monitoring that the strategy is being delivered. As this is such an important part of the work of NHS Tayside, we will ensure that the aggregation forms part of a Strategic Review which ensures that individual strategies are being implemented, and that the right strategies are in place. NHS Tayside's Board will annually dedicate meetings of it and its committees to such Strategic Reviews.

18. Developing Our Workforce

As mentioned, the culture of NHS Tayside needs to change so that ALL staff see health inequalities as the most important health issue. In particular we all need to see it as an issue which we can affect, whatever our role. We recognise that this will be extremely challenging as many of the ideas are unfamiliar to many staff focused on treating ill health rather than incorporating ways to prevent it. We will develop our existing training and development for all trainees, new staff and existing staff to incorporate these topics. This will cover a range of issues including understanding:

- the size and nature of health inequalities in Tayside;
- that poor mental health affects lifestyles and leads to ill health and early death;
- that mental health and wellbeing are affected by social and community networks as well as wider sources such as housing, employment, etc.;
- that all services need to be more accessible and responsive to need;
- that attitudes of public sector bodies and employees can help or hinder.

The last issue addresses the "softer side" of attitudes and culture including:

- Wanting people to take responsibility for their own health, but the NHS still tending to tell them what to do.
- Wanting people from deprived populations to use our services but people reporting that some staff are still abrupt, off-putting and make them feel inferior. Some of those services are in the wrong place or delivered at the wrong time to be accessible.
- Wanting people to act on our advice but we are still using leaflets which are photocopied several times making it hard for highly literate people to read them, as well as those with reading difficulties.

19. Measuring Progress

Many of the actions described here can be started immediately but as described, most will need to be developed and will take time to show results. We will therefore agree a range of measures to assure our communities and partners that together we are taking enough actions, committing the right sort of effort and adopting the right approaches. These actions will be priorities for our communities and will be based on as sound health economics as possible to ensure that cost effectiveness is built in. Every action committed to in this strategy will be monitored systematically to ensure it is carried out across the whole of NHS Tayside, promoted in every service development or strategy and reflected in agreements with our partners.

We will also measure medium term objectives such as stabilising the measures of the health gap which are currently widening, and narrowing those measures which are currently stable. Another critical medium term objective is measuring child development.

As mentioned in section 14.6, because life outcomes are predicted by the developmental progress of children as early as three years old, they represent good markers of whether we are making progress on life expectancy without having to wait thirty to fifty years to find out. Finally we need to measure long term progress towards health equity through the ultimate health objectives for the poorest communities of:

- improved mental health and positive wellbeing
- less long term ill health and
- less early death

It is most important that we do not view these objectives or the actions that lead to them as separate issues. We now understand more clearly than ever before the role that poor mental health and wellbeing plays in causing preventable ill health and early death in the most disadvantaged communities. Without good mental health and positive wellbeing, people do not feel motivated or able to take the lifestyle choices which lead to good health. However, our current indicators measure years of life with or without illness separately to years of life with or without mental wellbeing and so inhibit integrated decision making. This is such a fundamental issue that we wish to create new measures of heath that combine the three views. This effort will be linked to national Mental Health indicators work and the development of a HEAT target on mental wellbeing. For example, we need to be able to measure wellbeing and social capital. However current measures are contentious so this will need developmental work. We are currently building the level of health economics expertise needed to ensure all this.

As well as agreeing new actions and measures, we will review our current measures of progress. Too many targets require average improvements in service or health. Such targets allow for large improvements in the health or care of affluent communities and small improvements or even worsening in deprived populations, hence widening inequalities whilst appearing to succeed. We will ensure every target and objective possible focuses on closing the inequalities gap instead of requiring average improvements in health or service delivery.

In developing this strategy we commissioned a review of evidence from around the world which is published with this strategy. It was conducted jointly by the Social Dimensions for Health Institute (SDHI) and NHS Tayside. The review showed that very few initiatives properly evaluate their effect on health inequalities. As we deliver the actions we commit to, we will build in evaluation so as to expand the evidence base. We do not have, and are never likely to have, the research skills and capacity for one central team to assess all these efforts throughout NHS Tayside. Instead we aim to work with SDHI to create capacity to help services redesign and evaluate themselves.

20. Developing Information Systems

We will improve our systems for gathering and reporting up to date information regarding health equity. This is because we currently do not systematically gather or report enough indicators of inequalities in health and wellbeing, or service usage and quality. We will develop reporting mechanisms covering current positions, trends and trajectories so that:

- all services report comprehensively on their inequality efforts;
- all services, performance management and scrutiny receives specific relevant reports on the degree of success in closing the inequalities gap in their area;
- NHS Tayside, its partners and communities understand which factors are the major contributors and determinants of poor mental health and wellbeing, long term ill health, and early death in poorer communities by local area.

All this work on information systems and the progress reporting requirements described above will be detailed specifically for monitoring purposes. We will need to develop our capacity to do this, in particular the linking of financial information, performance information, and public health intelligence. For example, there are specific helpful reports, showing how causes of early death vary with place and age of death, but we cannot currently create them systematically and hence target effort accordingly. Similarly we can show how much spend is dedicated to people from each GP practice but do not currently link that to deprivation or health need. Other technical measures of deprivation such as the GINI co-efficient are also useful but are not currently used and will be developed.

21. Aligning Strategic Aims

NHS Tayside has already agreed that its four strategic aims are:

To improve healthy life expectancy by supporting people to look after themselves

To contribute to closing the health inequalities gap within a generation

To ensure services meet minimum quality standards, especially patient experience

To be cost effective in all decisions, actions and services

Whilst this strategy primarily addresses the second aim (health inequalities), it says as much about supporting people to look after themselves albeit from a community empowerment perspective. Whilst that effort is to be targeted at deprived communities the principles are applicable to all communities. Similarly, whilst the point of promoting community engagement, empowerment, social capital and co-production are the mental wellbeing and physical health benefits that they confer, these also address quality and cost effectiveness. Services which focus more on providing the things that are so specialist that they need to be delivered by the NHS, and to deliver them in a way that communities want are inherently both more cost effective and high quality. In particular, services that deliver help which communities, the voluntary sector etc. could provide better and cheaper waste money. Services which foster unhealthy dependency on the NHS harm health.

22. Working within Financial Constraints

The cost of failing to support disadvantaged communities in tackling health inequality would be continued increases in caring for more and more long term ill health. As stated at the beginning of this strategy, poverty kills early but it also causes decades of ill health before it kills. It is caring for this ill health that costs the NHS, and the taxpayers who fund it, so much money.

NHS Tayside will not be able afford to care for the predicted future burden of ill health and even if it could, it could not recruit enough staff to achieve it. Removing health inequalities and helping the people of Tayside to choose lifestyles which are naturally healthy by supporting them in mental health and wellbeing is therefore needed not just morally, but for NHS Tayside to survive in the long term, and to care for people's remaining ill health which will always be present.

NHS Tayside currently spends around £4.2m on efforts which are knowingly and deliberately targeted at deprived communities. That figure is not exact because methodologies vary when calculating such figures. Specifically it does not include services which are global but which also therefore support people in the poorest communities.

For example the funding for the Scottish Government's "Keep well" programme is included in the £4.2m but funding which pays for health visitors who support anyone including the poorest people is not. The figure represents less than 1% of the 2008/09 revenue available to NHS Tayside.

Severe financial constraints mean that there is likely to be little or no additional money with which to fund the actions to which we commit here. However most of them cost little or no new money, and will generate large savings in the medium to long term. They will mostly be carried out by changing the way we use our current effort and resources in the ways described throughout this strategy. The Directorate of Public Health for example probably used to target less than 10% of its resources at health inequalities, but this has risen to over 30% in the last five years despite its budget having shrunk by around 10% in that time. The directorate plans to continue this rise despite continuing financial challenges. We will go further than this and ensure our staff and strategies are aligned to the key topics in this strategy such as improving Early Years.

Some changes will cost money and NHS Tayside must optimise the use of all available resources in order to significantly reduce this inequity. We must remember though, that without the changes signalled in this strategy, financial balance in the future will be even more difficult than the apparently unprecedented financial challenges we face today.

If, as we monitor the delivery of the strategy, this approach (of advocating that everyone in NHS Tayside changes the way they work) appears to be insufficient within three years we will take progressively bolder action to centrally re-allocate resources. Some people will be disappointed at the implied delay in this stance as they feel that being radical is about, for example, taking health visitors from affluent areas and targeting them at working for deprived areas. However we firmly believe the correct approach is to work differently by us all helping communities to tackle the root causes of ill health, not to throw more traditional resources at ill health. That is why this strategy is called Communities in Control.

Appendix 1 - nef Measures of Co-production

1. Reward reciprocity in funding regimes. Assess the extent to which the ultimate beneficiaries of funded services have been enabled to play a role – and reserve part of the grant to reward this involvement.

2. Reward people for their efforts in the local neighbourhood, and review the benefits system so that it stops discriminating against voluntary engagement to support services by people outside paid employment.

3. Shift the way professionals are trained so that frontline staff are able to learn about the values and skills of co-production and are recognised for putting these skills into practice.

4. Develop ways of capturing the real benefits of co-production and the loss when it is absent so that public service commissioning and measurement recognise and record what is important about mutual support.

5. Set a duty to collaborate not just between services, but bringing together services, their clients and the public, and require all public bodies to involve clients in the design and production of services.

6. Embed networks of exchange, such as timebanking, within public service institutions, including surgeries, hospitals, schools and housing estates.

7. Swap targets for broad measures of well-being that enable practitioners to demonstrate the value of co-production approaches in terms of individual and social well-being.

8. Review current health and safety measures to ensure that unnecessary regulation and a culture of risk aversion doesn't present a barrier to the involvement of service users and the communities based around public services.

9. Launch a co-production award scheme and a co-production fund to encourage innovation in the public and voluntary sectors.

10. Acknowledge the importance of size and innovation rather than looking to roll-out 'scaled up' blue print models of co-production. Recognise instead the importance of human-scale interaction and the ongoing innovation of this approach that leads to the development of appropriate local responses.

Appendix 2 Glossary

Community	Community most often describes a group of people living in the same area. It can also describe a group of people with common attitudes or interests or who work or study in the same place.
Community Resilience	Resilience is the capability to anticipate risk, limit impact, and recover quickly. When a community is resilient it is the network within the community that provides this strength.
Co-production	Active input in the development and delivery of services by the people who need services, as well as – or instead of – those who have traditionally provided them.
Cost Per Capita	The cost of a service divided by the number of people in a defined population.
Discover Opportunities	An organisation in Dundee which provides help for people to develop their skills for work, helping them with social confidence as well as helping them with health problems and many other issues, recognising that these needs are inter-related.
Driver Diagram	A tool used to conceptualise an issue and to determine the components of a system which will then create a pathway to achieve a goal.
Empowerment	Gaining greater influence and control over health and quality of life.
Enablement	Optimising independence and wellbeing at home (or in a homely setting) through self management and rehabilitation.
Healthcare Academy	Part of NHS Tayside which gives people work experience in a supportive environment, and guarantees them a job interview.
Improvement Methodology	The concept of testing changes, learning from them and developing them to become more systematic and lead to bigger changes.
Partner Agencies	All of the organisations that work along with the NHS. This includes other public sector organisations as well as those in the voluntary sector.
Relative poverty	A standard of poverty that compares what an individual or group has compared to most people in that society. This is in contrast to absolute poverty where people are said to be in poverty at a particular

	level regardless of the society around them.
Social Capital	The collective value of all social interactions and networks and the motivation that comes from these networks to do things for each other.
Social Marketing	The systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and reduce inequalities.
Social Prescribing	Signposting that seeks to link patients up with non-medical facilities and services available in the wider community that they can access to address factors that influence their wellbeing.
Time banks	A way for people to come together to help others and help themselves at the same time. Participants 'deposit' their time/skills in the 'bank' by giving practical help and support to others and are able to 'withdraw' time/skills when they need something done themselves.
Triple Aim	A framework, developed by Institute of Healthcare Improvement, for the simultaneous pursuit of: 1. The health of a defined population 2. The experience of care by the people in this population 3. The cost per capita for providing care of this population
Unmet Needs Pilots	Pilot studies in Tayside funded by the Scottish Government that were focussed on the issue of inequalities in access to and use of both primary and secondary healthcare services.
Voluntary Sector	Also known as the third or not-for-profit sector. This is different from volunteering.
Wellbeing	A contented state of being happy and healthy.

Appendix 3 – Bibliography

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NHS Tayside

Local Delivery Plan 2015 - 2016

20 March 2015

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INTRODUCTION

The Local Delivery Plan (LDP) is the delivery contract held between the Scottish Government and NHS Boards in Scotland. The LDP focuses upon the priorities for NHS Scotland and supports delivery of the Scottish Government's national performance framework, the 2020 Vision for health and social care, and the health and social care outcomes that are being developed.

The LDP will be considered alongside the new strategic commissioning planning arrangements for Integrated Joint Boards.

Each year, the LDP evolves to support the delivery of the national priorities, for example last year saw an increased focus on delivering outcomes for the people of Scotland. The LDP for 2015/16 builds upon last year and requires NHS Boards to develop plans focused on new actions planned in a small number of strategic priority areas.

The LDP 2015/16 begins by stating that NHS Tayside is reviewing its approach to strategy. This will concentrate upon the pace and reach – as opposed to the direction - of change. The new Integrated Strategy that will be produced over the course of 2015 will have an important impact on the LDP 2016/17, although the responses to the NHSScotland Improvement Priorities 2015/16 have already begun to map out the actions for next year as part of the ongoing process of improvement and movement towards the 2020 Vision.

Structure of the LDP 2015/16

Three elements – underpinned by finance and workforce planning – form the structure of the LDP for this year -

- Response to NHSScotland Improvement Priorities for 2015/16
- Implementation Plans for 2015/16 to support delivery of 'Everyone Matters': 2020 Workforce Vision
- NHS Board's Contribution to Community Planning Partnerships

Response to NHSScotland Improvement Priorities for 2015/16 sets out the improvement actions being taken forward in the following strategic priority areas:

Health Inequalities and Prevention	Safe Care
Antenatal and Early Years	Primary Care
Person Centred Care	Integration

Implementation Plans for 2015/16 to Support Delivery of Everyone Matters *outlines local implementation plans for 2015-16 to deliver the five priorities contained within Everyone Matters: 2020 Vision Implementation Plan – Healthy Organisational Culture; Sustainable Workforce; Capable Workforce; Integrated Workforce; and Effective Leadership and Management.*

NHS Board's Contribution to Community Planning Partnerships sets out how Boards will continue to strengthen their approach to community planning during 2015/16.

LDP Standards 2015/16

There will be no HEAT targets contained within the 2015/16 LDP due to the delivery of the existing HEAT targets in March 2015. The LDP will now contain nineteen Standards. Performance trajectories will not be required for these Standards, with the exception of the 12 weeks outpatient waiting times standard.

The LDP Standards for 2015/16 are outlined within Appendix 1.

The Scottish Government will continue to review the LDP Standards to ensure that their definitions are consistent with changes in service delivery through the 2020 Vision.

STRATEGY DEVELOPMENT IN 2015

This LDP for 2015/16 comes at a time when NHS Tayside is reviewing its future approach to strategy. The **NHS Tayside Strategic Health Plan 2012 – 2015** was approved by NHS Tayside Board in March 2012. Consideration has already been given about how best to replace that strategy in a new and changing environment. In the context of the 2020 Vision and the parallel vision for health promotion and public health, the strategic direction is largely fixed but there is a need to consider further the pace and reach of strategic change and how best to make it sustainable.

NHS Tayside has already made considerable progress in the direction of the 2020 Vision and continues to deliver against the HEAT Targets/Standards, but the Board increasingly recognises that to realise fully the ambitions of the 2020 Vision for care and those for promoting better health and reducing health inequalities, it is necessary to take much more of an integrated, 'whole systems' approach to strategy. This means considering **together** the various services in Tayside for health, care and support that, through different ways of being organised and connected, can make significant improvements to people's health and well-being.

The intention is to have a high-level Integrated Health Strategy for Tayside that will run in the first instance to 2020. Many of the components of the strategy have already been developed, but further work is required to pull these elements together into a single, integrated package, develop the workstreams further, and to communicate and affirm the strategy internally and externally.

There will be six themes underpinning the new strategy:

1. **Prevention.** Concentrating increasingly on services that help both staff and public to identify and respond rapidly to emerging risks and signs of deterioration.

2. **Engagement.** Offering people more opportunities to engage in managing their own care and support and in tackling risks to their health.

3. **Responsiveness.** Providing everyone with services that are not just effective, but which respond to their wider personal needs and preferences.

4. **Community-Focused**. Encouraging and supporting local communities to build up and mobilise their resources to create accessible opportunities for people to improve their health and well-being.

5. **Collaborative.** Working with a range of local statutory, third sector and commercial organisations to maximise the improvements possible to people's health and well-being.

6. **Strengths.** Building and developing the strengths of NHS Tayside, including its role as a tertiary centre and its links to Dundee University, to maximise the contribution the organisation can make to Tayside and Scotland in terms of its employment, economic and social impact alongside benefits for health and care.

These six themes reflect what is needed to make faster and wider progress towards the 2020 Vision **and** towards national priorities regarding health inequalities and health improvement. Underpinning the six themes will be the requirement to maintain the quality – effectiveness, safety and value for money – of current services. The themes emphasise

that many of the most significant improvements to the quality of services will come in the future from building a wider set of connections outside NHS Tayside. However good the services provided by NHS Tayside are on their own terms, it is increasingly accepted that the overall outcomes and benefits that can be achieved are dependent upon what the recipient of NHS services, other local services and organisations, and communities also choose to do. Reinforcing the best of what is already done along with building new ways of working with others is to be an essential platform for effective changes to health, care and support, and to changes that people locally can support.

This platform will offer an opportunity to remodel and redesign services in a way that is driven by improving quality in ways that those using services will recognise, and more importantly to which they have contributed. The changes from remodelling services that will be most important in the future are those that create:

1. Increased engagement of people in communities – especially the poorest ones – to address more effectively the risks associated with poor health – economic, environmental and behavioural risks.

2. A locality focus along with other agencies on the provision of services that can be continuous, responsive and joined up around the overlapping and reinforcing problems faced by individuals and families with the greatest needs.

3. Less dependence upon hospital – especially inpatient – care for those with complex, ongoing needs through more prevention and more effective community interventions.

4. Improved opportunities for people with ongoing conditions to manage their own conditions effectively through improved monitoring systems and better access to information and support.

5. Greater flexibility about how, where and when services are delivered to match better the needs and wishes of service users.

6. Reduced reliance on spend on property and buildings to release more money for direct patient services.

7. Improved research & development, education and innovation capacity, which builds upon the work of the Academic Health Science Partnership, to enable NHS Tayside along with its partners to give the people of Tayside access to the latest types of care and to contribute to the wider economy and society.

The kind of redesign and remodelling of services outlined above which will lie at the heart of this Integrated Health Strategy for Tayside are put forward on the basis of achieving significant improvements to health, care and support for people in Tayside. Taking forward the changes that will produce these benefits will not be without challenges:

1. These changes have to be introduced while continuing to provide current services 24/7 and transitions will not always be easy especially those staff roles which will develop and transform to provide care and support in different ways.

2. New models of service provision – especially the community based emphasis – will have implications for the organisation of existing – especially hospital – services that will have to be addressed.

3. A shift to community engagement and locality planning requires different approaches to the planning and delivery of services compared to those with which staff and public are familiar.

4. The funding pressures faced by NHS Tayside and other partner organisations make it difficult to focus on - and to identify resources for - significant change even where there are significant benefits.

In the light of the above, before moving to develop the Integrated Health Strategy for Tayside, the following actions will be undertaken:

1. Engagement within NHS Tayside regarding how far the six themes represent the principal areas for change over the next five years.

2. A review of the financial, workforce and property contexts within which the Integrated Health Strategy for Tayside will be launched and how specific issues might be anticipated and addressed proactively.

3. (Following internal and external consultation) determining the most appropriate 'strategic workstreams' through which the Integrated Health Strategy will be undertaken. [1]

4. Engagement with Integrated Joint Boards and partner organisations on how best to develop further both a strategically integrated and a locality focused approach to care and health.

5. Establishment of a Multi Partner Advisory Group to support partnership contributions to the Strategy and its development and implementation.

6. Confirmation of the validity of existing arrangements for patient/public engagement in decision making.

These actions are to be complete by **June 2015** with a view to having the first iteration of the Integrated Health Strategy for Tayside produced by the **end of 2015.**

1. At this stage, it is proposed that there are 6-8 workstreams covering the five year period. The workstreams would be based on 'areas of challenge' (e.g. extending self-management of care). These would represent the 6-8 big things NHS Tayside need to do. There would still be planning of individual services.

RESPONSE TO NHSSCOTLAND

IMPROVEMENT PRIORITIES

FOR 2015/16

Health Inequalities and Prevention

The LDP should set out local priorities for addressing health inequalities and improving prevention work based on the needs of the local population, with a focus upon those communities where deprivation is greatest. Outlining Improvement aims, levels of activity and demonstration of how activity is embedded in to routine practice, along with information on prioritisation of action and progress monitoring.

OVERVIEW

Tackling health inequalities is central to the public health agenda. Four years ago, on behalf of NHS Tayside and its partners, we published The Health Equity Strategy - Communities in Control - whose objective was to eliminate health inequalities in Tayside within a generation.

An audit/stock-take of where we had got to in Tayside in moving towards health equity shows numerous examples of encouraging progress; however, progress was greater and more rapid in some areas than in others. In the areas where progress has not been so substantial, the organisational culture around targeting of services and programmes towards those most in need has not been as receptive as it needs to be to deliver on what is a very radical Strategy.

Our job in the NHS (and with other colleagues, Integrated Joint Boards and across the local Partnerships), is to re-energise our equity-focused work so that it becomes a core part of how all public sector organisations, including hospitals, work on a day-to-day basis.

Underlining that approach, CEL 01 (2012), Health Promoting Health Service (HPHS) promotes that '*every healthcare contact is a health improvement opportunity'.* Given the proportionately greater use of acute services by patients from deprived communities, health improvement in acute settings offers an opportunity to reduce health inequalities. A revised CEL to be issued in 2015 will reflect the health improvement topics highlighted for the 2015/16 Local Delivery Plan: smoking, alcohol, food and health, breastfeeding, staff health (Healthy Working Lives), physical activity and active travel. There is an underpinning health behaviour change training programme to support frontline staff.

SMOKING

The Scottish policy on tobacco, *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland* sets out plans to make Scotland a smoke-free nation. The Scottish Government has previously recognised the importance of a comprehensive approach to tobacco control and has published a series of strategies and policies to support increased legislative control and investment in smoking prevention and cessation programmes.

PRIORITY ACTIONS

Delivering on the prevalence targets set out in *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland* requires that we decrease the numbers of new smokers taking up smoking. A change in investment has therefore been delivered that diverts substantial amounts of resource away from smoking cessation and into evidence-based interventions that decrease the numbers of young people who take up smoking. These interventions are focussed on communities classified as SIMD quintile 1 and 2. This change in direction is much more likely to deliver on the policy objective of a smoke-free nation than the previous approach.

Strengthen the Delivery of the Smoking Prevention Work Streams

In 2015/16, the Early Years and Young People Team will continue to deliver their current smoking prevention programme to primary and secondary schools and young people across Tayside.

In addition, NHS Tayside has successfully bid to become one of the Scottish Government's pilot sites for the ASSIST intervention, which is to be offered to the 27 local authority managed secondary schools across Tayside. The planning of this work has been taken forward in partnership with local authority partners. ASSIST is a licensed intervention and requires a prescribed series of quality assurance mechanisms for the training of staff and delivery to schools. Implementation of the programme began in January 2015 and the pilot will run until June 2017.

The team will also work with cessation colleagues and multi-agency partners to design and implement an intervention that protects looked after-children and young offenders from exposure to tobacco and second hand smoke.

Engaging with all schools across the three localities presents the main challenge to the delivery of the smoking prevention work.

Measure to demonstrate improvement

The smoking prevalence estimates published by SALSUS give an indication of the relative progress made in preventing children from taking up smoking tobacco at 13 and 15 years old.

Implement Smoke-Free Premises and Grounds

In 2015/16 work will be taken forward on competent implementation of the revised smoking policy and effective communication to staff, patients and visitors. Work will be undertaken to review the revised nursing documentation and make a judgement around whether all the measures required to support patients and staff in achieving a smoke-free hospital stay are in place. Communication with our communities is a key part in this process and we will set out our vision for partnership with local people, so that we can harness the assets of local people in making Tayside a healthier place. Through local Tobacco Alliances we will work to engage with local authorities and partners to enable them to use their remits to further this agenda so for example, we see the first smoke-free play parks and public areas. The revised Tobacco Control Policy requires to be in place by March 2015. However, consolidation and effective implementation including working to communicate with the public, is likely to be an ongoing process. The major challenge presented in this area is in encouraging a change in behaviour from smokers and to enlist the support of the majority of the public who are non-smokers.

Measures to demonstrate improvement

- CEL (1) 2012 Annual Report Submission.
- Monitoring progress in implementation can be achieved through point prevalence surveys.
- New e-pharmacy system to record activity.

Maximise the Effectiveness of the Community Pharmacy Smoking Cessation Scheme

The implementation of the new specification has taken several months to bed in and this has been complicated by issues with the new e-pharmacy service that has been implemented simultaneously. During 2015/16 we will continue to work with community pharmacists to support them in starting to perform under the new system. Nationally, work is ongoing to adapt the e-pharmacy system to get around the glitches in the current IT. We will continue to publicise the smoking cessation service and promote the help that is available for patients wishing to stop smoking. The timescale for these actions are ongoing. A larger challenge is likely to be around how smoking cessation services are redesigned to effectively compete with more widespread use

of e-cigarettes. A programme of work will be described and undertaken in 2015/2016 to understand how smoker's requirements for support has changed and how we can support the group of e-cigarette users who are still addicted to nicotine and wish to move their lives on.

Measure to demonstrate improvement

The LDP standard challenges smoking cessation services to consolidate activity and maximise the number of 3 month quits achieved.

FOCUS FOR 2015/16

- Successful implementation of the ASSIST programme with community linkage.
- Effective communication that describes a different narrative of our expectations for patients, visitors and staff to be partners in making Tayside a healthier place. A tangible element of this refreshed approach will be the revised Smoking Policy; we will work with local authorities and other partners to investigate how the approach taken by this policy can be spread.
- Consolidation of the community pharmacy smoking cessation service and re-positioning of the service to compete with e-cigarettes: a programme of work will be undertaken to provide evidence for us to redesign and re-position services to make them more relevant to the needs of patients.

KEY DELIVERABLES BEYOND 2015/2016

- Creating a Tobacco-Free Generation creates an aspiration for Scotland to become a healthier place where almost nobody smokes. There are smoking prevalence trajectories to meet to ensure that this ambition for the population of Tayside can be met. We are conscious of the 46 priorities within the strategy and the wide range of actions that will be undertaken with partners to deliver this ambitious plan.

SUBSTANCE MISUSE

Substance misuse disproportionately affects the most vulnerable and socio-economically deprived in our community. *Changing Scotland's Relationship with Alcohol: Framework for Action* focuses upon reducing alcohol consumption. *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* highlights the importance of a recovery focused approach.

There is strong research evidence that reducing alcohol consumption reduces alcohol-related health and social harm. Alcohol consumption can be reduced by restricting affordability, availability and accessibility.

Restriction on density of outlets through licensing is a way of reducing harm from alcohol. Other evidence-based measures include minimum unit price and drink driving measures. Alcohol brief interventions are key to reducing harm from alcohol too.

PRIORITY ACTIONS

NHS Tayside will have a direct involvement in the redesign of substance misuse services to create a greater focus on "whole families" and support for recovery in the Angus local communities and to address new ways of working to deliver the 'Support and Connect' Project - a recovery directed system - within the Dundee communities.

Work has already been initiated across agencies in Perth & Kinross to support the development of a recovery focussed model of care. NHS Tayside will actively support the future development of mutual aid groups within this locality.

Alcohol Licensing

NHS Tayside will continue to work with ADPs to make available and accessible the information on health and social harms from alcohol intake with a view to influencing licensing decisions to restrict availability of alcohol. NHS Tayside is a statutory consultee for licensing applications and as such has the opportunity to influence licensing applications.

In all three localities, work is progressing:

In the Angus locality, early work to describe the extent of alcohol provision and alcohol related social harm is being built on by the collaboration of an NHS Tayside Information Analyst with ADP colleagues so that data from Local Authority, Police and Health can be used to scope out the extent of alcohol related harm to health and to society. The information within the scoping paper can then be used to inform decisions on licensing of premises for sale of alcohol.

In the Dundee locality, NHS Tayside in collaboration with community planning partners, completed a comprehensive assessment of alcohol related harm in the city and a statement on licensing overprovision. The locality Licensing Board has since made a statement to the effect that the city is overprovided for in terms of licensed premises and so there is an onus on applicants to show that the granting of a new licence would not contribute to over provision.

In the Perth & Kinross locality, NHS Tayside has participated in the ADP initiated and chaired Alcohol Scoping Meetings over recent months and has, with the input of community planning partners, completed a report outlining the health and social harms and describing the alcohol provision within that locality.

Overall, it is encouraging that community planning partners in each of the three local authority areas are keen to address the issues of health and social harms related to alcohol. NHS Tayside remains committed to working with the Licensing Forum within each area and building on the work already ongoing.

Alcohol Brief Interventions (ABIs)

Continue work in community pharmacies to deliver ABIs to those people who are less likely to attend their GP e.g. young men from deprived areas. There is an enhanced service contract with community pharmacies for the delivery of screening and brief interventions. Funding to continue this is in the plan for 2015/16. Analysis of the data recorded at community pharmacies will be undertaken to ensure ABI delivery best fits need, especially in communities less likely to engage with Primary Care, by February 2016.

<u>Measure to demonstrate improvement</u>

Ongoing measurement of LDP Standard to embed ABIs in the three priority settings and broaden delivery in wider settings.

Access to Services

Extra clinic time (which was established in January 2013) will continue. NHS Tayside is meeting the LDP access standard and we will continue to work towards maintaining this.

<u>Measure to demonstrate improvement</u>

Ongoing measurement of the LDP Standard to ensure that no clients wait more than 3 weeks to appropriate drug or alcohol treatment.

FOCUS FOR 2015/16

- Continue delivery of ABIs in the priority areas of Primary Care, Accident & Emergency and Antenatal Services and embed training to deliver ABIs.
- Apply learning from community pharmacy delivery of ABIs so that provision for people in deprived areas is tailored to need and effectiveness of delivery.
- Work with each Licensing Forum to provide relevant data to assist Licensing Boards in recognising the health and social harms from alcohol in their locality.
- Contribute to the Alcohol and Drug Partnership implementation of the recommendations from recent needs assessment, firstly around children affected by parental substance misuse and secondly on new psychoactive substance use.

KEY DELIVERABLES BEYOND 2015/2016

- To focus on a recovery approach, looking ahead to a life that is no longer defined by substance misuse and in which change initiated and driven by the individual is supported by family and community.

- The risk of death from drugs is increased when people use combinations of drugs, both prescribed and illicit. There are a number of actions planned to reduce polypharmacy, including a pilot in a deprived area. Actions from an audit of drugs prescribed to people who misuse substance are being and will be taken forward.

- Alcohol and Drug Partnerships have incorporated the learning from two needs assessments, 1) around the needs of children affected by parental substance misuse and 2) around new psychoactive substances into their workplans for the upcoming year.

- The Drug Death Review Group continues as an expert group to share learning from review of drug deaths which ADP partners apply within their locality to reduce risk of death from substance misuse.

PREVENTION OF OBESITY AND PROMOTING HEALTHY EATING

The Scottish Government policy (*Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight)* sets out four preventative actions - control exposure to, demand for and consumption of excessive amounts of highly calorific foods and drinks; increase opportunities for physical activity in daily lives and minimising sedentary behaviour; establish life-long habits for positive health behaviour; and increase the responsibility of organisations for the health and wellbeing of employees.

National policy also calls for assurance that cost effective and appropriate weight management services are provided.

PRIORITY ACTIONS

Multi-agency partnership working is necessary to make 'sustainable changes to our living environment in order to shift from one that promotes weight gain to one that supports healthy choices and healthy weight for all'. NHS Tayside is working with local authorities and external partners such as local employers and voluntary agencies to integrate support and, provide sustainable preventative and treatment services. Health improvement programmes for obesity prevention and treatment are in place (Maternal and Infant Nutrition, Child Healthy Weight, Adult Weight Management and Workforce):

Maternal & Infant Nutrition (MIN)

The MIN programme is improving the capability and capacity of those working with nutritionally vulnerable women of childbearing age and infants, by increasing access to training opportunities that are based on the principles of health behaviour change, asset based approaches and early intervention. It is also improving and increasing the workforce contribution to: obesity management in pre-pregnant, ante-natal (optiMum) and post-natal women (Weight Watchers); promotion of *Healthy Start* (including retailers) and; in supporting women with infant feeding choices and their experience of infant feeding.

Measures to demonstrate improvement

- Number of courses delivered and attendance; pre and post knowledge and skills evaluation; post course application assessment (planned).
- Number of obese women receiving optiMum; number of women attending postnatal weight management (Weight Watchers) and % achieving ≥5% reduction in body weight.
- Uptake of Healthy Start scheme and vitamin supplements; feedback from families.
- Achievement of UNICEF UK Baby Friendly accreditation.
- Breastfeeding rates.

Child Healthy Weight (CHW)

The CHW programme continues to deliver a high quality healthy weight service to children, young people and their families. This includes developing and implementing a childhood weight management pathway which includes referral in to and out of the Paediatric Overweight Service Tayside (POST) (clinical service). It is also improving the Fun Fit Tayside (FFT) programme (child healthy weight whole class approach) with the three local authority education departments. POST continues to deliver a comprehensive training programme for healthcare professionals and others, and collects and analyses outcome and patient experience and performance data to support continuous quality improvement and service redesign.

Measures to demonstrate improvement

- Clinical service - change in BMI SD; qualitative feedback.
- Prevention – number of teachers trained to deliver FFT; number of schools and classes undertaking FFT; qualitative feedback.

Adult Weight Management (AWM)

The AWM programme continues to develop and implement an evidence-based, high quality and best value weight management pathway for overweight/obese adults. Work is focusing on the surgical patient pathway (Tier 4) and the non surgical specialist weight management pathway (Tier 3), but Tier 2 also requires attention. There are inequalities in the level of services provided at Tier 2 across each of the three CHPs. The population needs assessment also identified that within the current financial envelope the service can only support <2% of the obese population in Tayside. A lack of integrated weight management data collection results in the inability to target improvement in services and look at clinical outcomes. In response to this, the AWM Service was re-designed and an improvement plan is being implemented to reduce the inequalities in all tiers of the pathway. A shift in resource from Orlistat spend to help bridge some of the funding gap is proposed and an integrated weight management data collection system is being developed.

Measures to demonstrate improvement

- Numbers of patients achieving ≥5% weight loss in Tier 2.
- Demographics and number of patients commencing and completing Tier 2.
- Numbers of patients achieving ≥5% weight loss in Tier 3.

- Demographics and number of patients commencing and completing Tier 3.
- Reduce spend on Orlistat by at ≥50%
- Number and percentage of patients undergoing bariatric surgery who meet agreed criteria for Tier 4.
- Numbers of hits on Tayside Nutrition MCN (weight management) internet site.

Workforce

Improving access to healthier food and drink options on NHS sites and beyond and, increasing the knowledge, skills, confidence and attitudes of NHS staff and others towards healthier eating and obesity prevention is a priority. This includes attainment of Healthy Working Lives awards for all acute and community hospitals, achievement of the Healthyliving Award plus on NHS sites, removal all soft drinks with added sugar content greater than 0.5g per 100ml from vending machines in hospitals and, including health promoting health service criteria in the specification for the combined vending contract for drinks, confectionery and snacks.

Measures to demonstrate improvement

- Number of NHS sites registered with Healthy Working Lives.
- Number of 'Winning Weigh' programmes in workplaces.
- Number of NHS Tayside dining areas (serving to staff and the public) holding the national *Healthyliving Award plus*.

FOCUS FOR 2015/16

- Target healthy weight interventions at women of child bearing age from low income families.
- Achieve UK Baby Friendly accreditation as a minimum standard by NHS Tayside and Children's Centres.
- Implement the child healthy weight pathway and undertake a robust analysis of the necessary steps for healthy eating and physical activity for children, young people and families that address obesity prevention.
- Continue to assist vulnerable families to develop fundamental food skills and access affordable healthy food.
- Enable NHS Tayside's Nutrition & Dietetic services to support partners in activities that prevent and control obesity.
- Increase capacity and capability of the adult weight management service and address the specific needs of priority groups.
- Undertake a system wide risk assessment of NHS Tayside's seating provision for severely obese individuals.
- Develop and implement obesity prevention and control strategies in the workplace.
- Devise a standardised framework supporting high-quality, consistent evaluation of obesity prevention and treatment.
- Apply the principles of co-production and asset based approaches to the design and delivery of all obesity prevention and treatment approaches.

KEY DELIVERABLES BEYOND 2015/2016

To help achieve the Scottish Government aims of having a higher proportion of people in a normal weight range, NHS Tayside will work to make the region an environment where healthy life choices become easier. Beyond 2015/16, the priority will be to take forward implementation of weight management pathways for children, young people and adults in target populations and a comprehensive multi-agency prevention programme.

PHYSICAL ACTIVITY

Physical Activity is driven by a number of Scottish Government policies formulated to get Scotland active:

CEL 01 (2012) Health Promoting Health Service;
The Physical Activity Implementation Plan- a More Active Scotland – Building a Legacy from the Common Wealth Games 2014;
Active and Healthy Ageing - An Action Plan for Scotland 2014.

PRIORITY ACTIONS

Promotion of the benefits of physical activity for staff is taken forward through the Healthy Working Lives (HWL) programme. There has been information provided on the benefits of physical activity on NHS Tayside Staffnet and though notice board displays. There have been opportunities provided for staff to be active during the working day including promotion of walking outdoors at break times, use of stairs for health benefits as well as annual pedometer or stair climbing challenges. Active travel has also been promoted through a variety of routes including HWL and corporate routes.

Information highlighting the benefits of physical activity and active travel has also been targeted at patients and visitors through notice board displays in patient waiting areas and the NHS Tayside internet pages. The national physical activity pathway has been implemented with associated training in the pre-assessment service across Tayside. There has also been a pilot of the use of improvement tools to evaluate progress in one area. Engagement has been held with various agencies in order to progress actions around physical activity and active travel e.g. TACTRAN, local authorities and NHS Tayside staff from various Directorates.

<u>Measures to demonstrate improvement</u>

Progress is continually measured by achieving/maintaining HWL Awards and providing satisfactory evidence of meeting the requirements of CEL 01.

FOCUS FOR 2015/16

- Through the HWL award programme there will be promotion of the benefits of physical activity and active travel for staff as well as physical activity /active travel initiatives.
    - Carry out a travel survey of staff in conjunction with TACTRAN and Operations Directorate to inform the development of an overarching NHS Tayside Travel Plan.
    - Provide an NHS Tayside annual physical activity challenge, information and opportunities for staff to be physically active at work / commuting to work.
- CEL 01 reporting requirements will direct the focus on the promotion of physical activity for patients, visitors and staff. This information is not yet available for the 2015/16 reporting period.

KEY DELIVERABLES BEYOND 2015/2016

- Develop key deliverables to demonstrate improvement, measurement and reporting on the national targets set out within *'Lets Make Scotland More Active'* for recommended physical activity levels and future CEL 01 reporting requirements.

LEARNING DISABILITIES

The Keys to Life ten-year strategy document sets out the stark health inequalities faced by people with learning disabilities (LD) –

- significantly shorter life expectancy,
- increased risk of accompanying sensory and physical impairments,
- poorer physical and mental health than the general population. For example, the average number of health co-morbidities in the population of people with LD at aged 20 is the same as for the general population at age 50.

The health inequalities faced by people with LD make a significant contribution to overall health inequalities. In order to address the health inequalities, there is a need to identify people who have LD and ensure that their additional needs are met. However, people with LD remain "invisible" on routine administrative health care data sets. The Scottish Government has issued guidance to redress this.

PRIORITY ACTIONS

NHS Tayside has acted on the Scottish Government guidance relating to the establishment of a database which would allow the ascertainment of health inequalities at locality level and the development of a SMART action plan to reduce health inequalities for people with LD.

The overall purpose of the work is to improve wellbeing and to reduce health inequalities in order to promote health equity for people with LD and to protect their human rights.

In keeping with Scottish Government guidance, a named public health lead has been identified, collaborative work between Public Health, Primary Care and Specialist Learning Disability Services is ongoing. NHS Tayside recognises that there is a need to strengthen the improvement in care of people with Learning Disability when they are accessing general hospital based services for physical healthcare reasons. Working with colleagues in partner agencies, for example social care, education, housing and third sector is essential within the Health and Social Care Integration agenda.

A high level risk is around the difficulties in identifying people on routine data since data sources tend to underestimate the number of people who have a Learning Disability and who may need services. It is essential to record the additional needs of people with LD so that reasonable adjustments are made so that they can equitably access care.

Several strands of work are underway and will be developed further to address this risk:

Firstly, using the Read codes issued by Scottish Government in October 2014, a pilot identification of people with LD has successfully been undertaken in one practice. Discussions have begun around the roll-out of this to all practices so that when the national database, SPIRE is established, the data extracted from each individual practice will be as complete as possible. By February 2016, we will measure progress by the number of GP practices in which this Read code search has been undertaken in preparation for SPIRE.

Secondly, a locality based pilot, in Dundee, has evidenced the feasibility of describing needs of people with LD through recording the additional needs of people being seen in the community by the community LD teams on a database. The aim is to replicate this in other localities.

Thirdly, NHS Tayside will explore, within appropriate information sharing governance arrangements, how recent data extracts may contribute to identifying those people who have LD and ensuring that health services are ready to meet their needs. A system which can "flag" the additional health care needs of people with LD, for example on eKIS, is required and fits with the wider work within the Improving Interpretation and Translation Strategy that NHS Tayside is undertaking to fulfil Equality Act responsibilities.

A further high level risk is around the redistribution of resources that would enable the Specialist Learning Disability Services to support other services, including primary and secondary care to deliver high quality care where reasonable adjustments are made for LD service users, as described in keys to Life recommendations.

By applying the "Triple Aim Framework" (Institute of Healthcare Improvement), NHS Tayside will be able to simultaneously pursue:

1. The health of the population who have LD.
2. The good health care experience of people in the LD population.
3. The cost per capita for providing care of this population so that health is maximised for a given expenditure.

FOCUS FOR 2015/16

- Making people with LD visible on routine health data by completing the Primary Care Read code search, developing and extending the locality LD database and exploring how best to use data extracts in order to meet individual health and population health needs, especially ensuring that additional needs are recorded and reasonable adjustments to healthcare provision made.
- Committing to a dedicated primary care liaison resource to support General Practice and Primary Care, especially support for delivery of annual health checks *(recommendation 21 from Keys to Life).*
- Working in partnership to ensure that people with learning disabilities receive the appropriate level of support in general hospitals, including appropriately funded support from familiar carers as well as from specialist learning disability acute care liaison nurses *(recommendation 24 from Keys to Life).*
- Working with partner agencies within The Tayside Public Health Information Network (TAYPHIN) to identify the information required to support delivery of care within health and social care integration.
- Completing a focused needs assessment for people with Learning Disability in Tayside, including discussions with people from the LD community, family and carers, analysing factors that contribute to person centred care and development of a Health Improvement and Co-production plan.
- Ensuring that people with a particularly high level of need e.g. older people, those with autism and young people transitioning into adult systems have their needs identified and met.
- Assess patient pathways and redesign where necessary to support timely interventions and provide opportunities to improve quality of life and health across acute care, community based care, rehabilitation and enablement and to encourage social inclusion.

KEY DELIVERABLES BEYOND 2015/2016

- Identification of the majority of people with LD in Tayside; the ability to describe their health needs and how to meet them.
- Availability of accessible data to measure a proportion of the health inequality indicators specified by Scottish Government.
- Development of a SMART Action Plan to reduce health inequalities for people who have a learning disability.

Antenatal and Early Years

The LDP should set out the local actions to be taken to ensure that the relevant parts of the workforce will have the capacity, training and relevant protocols to carry out the duties under the Children and Young People (Scotland) Act 2014: action – named person service for every child up to aged five and a single statutory Child's Plan for every child aged under five who requires one – by August 2016.

The Scottish Government's vision is for Scotland to be the best place in the world to grow up. GIRFEC (Getting It Right For Every Child) is the national approach for improving outcomes and life chances for children and young people. Parts 4 and 5 of the Children and Young People (Scotland) Act 2014 address two key elements of the GIRFEC approach, namely the Named Person Service and the Child's Plan. The Act places a duty on Health Boards to provide a Named Person Service for every child from birth until they commence school. The Children and Young People (Scotland) Act 2014 has a phased implementation, with the parts addressing GIRFEC being introduced in August 2016.

PRIORITY ACTIONS

The framework to ensure NHS Tayside is prepared for implementation by August 2016 consists of a number of multi-agency and single agency groups as follows:

- The Tayside GIRFEC Group is a multi-agency group with representation from senior officers from the three Tayside Local Authorities (Perth & Kinross, Angus and Dundee), NHS Tayside, Police Scotland, the third sector and the Scottish Government. The Group is currently chaired by the Chief Executive of Dundee City Council and NHS Tayside is represented by the Child Health Commissioner.
- Each of the three Tayside Local Authorities has a multi-agency GIRFEC Implementation Group with representation from the relevant CHP Children's Services.
- The NHS Tayside GIRFEC Group is a single agency group chaired by the Child Health Commissioner, who is also the CEL 29 Change Manager.

The NHS Tayside GIRFEC Group has created and oversees the Implementation Plan which addresses eight key areas as follows:

1. Vision, values and principles
2. Consent and Information Sharing
3. Role of the Named Person
4. Lead Professional
5. Electronic Sharing of Information
6. GIRFEC Assessment
7. Child's Plan
8. Self Evaluation

In addition to the GIRFEC Implementation Plan, work is also being undertaken to cross reference the plan against the recently created "Touchpoint Programme" document circulated by the National Implementation Support Group.

Inextricably linked to the issue of ensuring staff capacity and training is the work being taken forward under the Transforming Health Visiting and School Nursing Service. In NHS Tayside, this agenda is being taken forward by the Chief Nurse for Children and Families and an Implementation Plan exists for this work too. With regard to the Family Nurse Partnership, this

has reached small scale permanence throughout Tayside with all eligible young mums being offered the programme.

The challenge arises from NHS Tayside, as one health system, working with three separate local authorities, each of whom has their own pace of progress, priorities and ideas. To mitigate this challenge, the overarching Tayside GIRFEC Group supports, where possible, undertaking work on a Tayside-wide bases. Examples of this are the production of a basic GIRFEC e-learning module and Lead Professional Training tool which are available for all agencies. In addition, several short-life multi-agency working groups with membership from across Tayside are meeting to agree a consistent Tayside-wide approach to aspects of the Child's Plan, sharing information and assessment. Future discussion will also focus on delivering a consistent, multi-agency, pan Tayside message to the public, particularly parents and carers.

To address the area of IT capability and compatibility in respect to information sharing, the Tayside Data Sharing Group, in considering the information sharing requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, will ensure a framework which can also address the requirements of the Children and Young People (Scotland) Act 2014.

The close working relationship between the Child Health Commissioner, Chief Nurse, Children & Families, and Local Authority colleagues, will ensure that the GIRFEC Implementation Plan and Transforming Health Visiting and School Nursing Implementation Plan complement each other effectively and efficiently.

FOCUS FOR 2015/16

The NHS Tayside GIRFEC Implementation Plan sets out the actions required to ensure readiness on the part of NHS Tayside, and all these actions require to be completed. These actions underpin delivery on the eight key areas which were outlined on the previous page. As mentioned, this Plan will be augmented with reference to the Touchpoint Document and will also focus on ensuring communication with the public is robustly addressed. The Plan will also sit alongside the Transforming Health Visiting and School Nursing Implementation Plan.

In addition, however, there are other areas which will require focus in 2015/16 and these include:

- Other elements of the Children and Young People (Scotland) Act 2014 (Children's Planning; Children's Rights; Corporate Parenting).
- The Early Years Collaborative - ensuring continued commitment and progress with the three Tayside EYCs.
- The work of the Chief Nursing Office focussing on transforming the School Nursing Service.

KEY DELIVERABLES BEYOND 2015/2016

- Progress beyond 2015/16 will be measured against the developed suite of primary and supporting measures focussed on Early Years. These consist of the three high level stretch aims of the Early Years Collaborative focussing on stillbirth, infant death and developmental concerns at 27 – 30 months.

Person Centred Care

The LDP should set out how services will support a positive care experience delivered in accordance with the "five must do's with me". Outlining the key local action being taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback; widely publicise the information people need to give feedback and make complaints, and the support available for them to do so; and with a focus on learning from feedback, implementing the changes; and telling people what improvements were made as a result of their feedback. The plan will include information on how progress will be measured locally.

There are a range of national drivers in relation to person centred care including:

- The Patients Rights (Scotland) Act 2011.
- The Healthcare Quality Strategy (2010).
- 2020 Vision.
- Listening and Learning Report: how feedback, comments, concerns and complaints can improve NHS services in Scotland. Scottish Health Council (2014).

PRIORITY ACTIONS

Within NHS Tayside, person centred care is a key strategic priority with a broad definition that includes family, carers and staff. The ambition of NHS Tayside's Clinical Governance Strategy is that "every day every one of us delivers, sees and experiences standards of care that we would want for our own loved ones. This can only happen by putting the patient at the centre of everything we do, working as a team and making sure we have the information and data we need to deliver excellent treatment".

Creating the right conditions for staff to provide safe, effective person-centred care is vital, therefore NHS Tayside has developed in partnership with staff, patients, carers and the public the Vision, Aim, Values and Behaviours to express what they believe to be the best environment to deliver person-centred, safe and effective clinical care.

Underpinning the Clinical Governance Strategy is NHS Tayside's Care Governance Measurement & Monitoring Framework which details eight specific ambitions and key actions to improve quality. One ambition focuses on improving patient experience 'Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others.'

In order to achieve this, the following programmes of activity have been progressed:

Feedback

We understand that feedback about the experiences of our patients is an important gauge of the service we provide. Feedback can be used as a measure of the quality of our service and allows patients to be more involved in their own care and contribute to improving care.

NHS Tayside has identified three key priority areas for progression during 2015/16 in relation to feedback, these priorities are as follows:

1. Identification and implementation of accessible feedback mechanisms.
2. Undertake and act on whole systems review of the complaints procedure, ensuring the implementation of quality assurance mechanisms and objectivity of investigations, and the implementation of all key elements of 'Can I Help You?
3. Building capability (through strong leadership, role modelling and professional supervision) in frontline staff to optimise patient and carers' experiences and to act appropriately when individuals raise dissatisfaction or make suggestions.

FOCUS FOR 2015/16

- Raising public awareness of how to provide feedback.
- Ensuring feedback mechanisms are accessible to our diverse population.
- Implementing the use of validated tools for gathering feedback through the use of volunteers.
- Developing our systems to support timely provision of information to both the public and staff on actions or improvements made in response to feedback received.
- Improving and gaining assurance regarding the quality of our complaints handling.
- Agreeing and implementing standards for complaint handling that ensure objectivity and transparency of the process and outcome.
- Development of a culture that values all forms of feedback, including the empowerment of all staff to resolve things early – with apologies given freely and action taken where things go wrong – and a strong leadership focus on complaints handling and governance arrangements.

Improving Care Experience

NHS Tayside has engaged with the Person-Centred Health and Care Collaborative since its inception and has made progress with implementing aspects of person centred care principally through its improving care experience programme which incorporates four existing improvement programmes - Releasing Time to Care plus (RTC plus); Caring Behaviours Assurance System (CBAS), Leading Better Care (LBC) development programme and Dementia and Delirium care. Progress with actions that support the 'five must do's with me' includes:

- implementing person-centred visiting and person centred handovers;
- investing in values based reflective practice facilitator training;
- routine use of patient feedback in quality improvement activity;
- public involvement in service evaluation and design;
- introducing "teach back";
- testing the use of volunteers to conduct telephone patient experience surveys and patient interviews;
- training and protocol implementation to support early detection and treatment of delirium in all settings;
- improving the reliability of the use "All About Me" for all patients with cognitive impairment, learning disability or specific communication needs;
- implantation of SAGE and THYME® communication training to support all staff in health and social care to effectively support people who are in emotional distress;
- training of staff in the use of health behaviour change techniques, evidence based interventions that support person centred care and enhance patient experience, and anticipatory care plans;
- customer care training;
- development and use of Team Vitality & Care Questionnaire, supporting individual clinical teams to use results to improve team working and person centred approach to care.

NHS Tayside recognises the value of volunteers and volunteering particularly the contribution volunteers make to health across all sectors. NHS Tayside's plan for volunteering in 2015/16 mirrors the three national outcomes -

1. Volunteering contributes to Scotland's Health.
2. The infrastructure that supports volunteering is developed, is sustainable and inclusive.
3. Volunteering, and the positive contribution it makes, is widely recognised, with a culture which demonstrates its value across partners involved.

There are currently 754 active, formally recruited volunteers providing services to enhance patient care across NHS Tayside.

FOCUS FOR 2015/16

- Volunteering will continue to be provided as a single Volunteering Service across Tayside.
- Review the Volunteering Policy to incorporate changes associated with Health & Social Care Integration.
- In order to recognise the contribution volunteering makes to health, a celebration of volunteering is planned as part of the National Volunteer Week and long service awards will be presented to volunteers by NHS Tayside Board members.

The objective for NHS Tayside in 2015/16 is to build on the work detailed above which focussed on developing capacity and capability within the workforce to drive changes in practice that are aligned to the person centred programme particularly to support the implementation of the '5 must do' elements.

KEY DELIVERABLES BEYOND 2015/2016

- The aim within NHS Tayside is to test a model that brings together a multidimensional approach to improving care and care experience by supporting the Nursing/Midwifery, Medical and AHP leads within individual teams to use a range of quality improvement methodologies including values based reflective practice, improvement methodology and critical companionship to deliver sustainable improvements in person centred care.
- Outcomes will be routinely reported through existing governance arrangements within the Board, the metrics will be reassessed every 6 months alongside routine, real time data which will be used to support teams and facilitators to refine their improvement efforts.

Safe Care	*The LDP should set out the priority actions the NHS Board is taking across the Scottish Patient Safety programmes of work, the plans for spread and sustainability and the impact they are having on patient care, including examples from each programme of how safety of care has improved in the last 12 months. This should include plans to ensure that governance and leadership across managerial and clinical staff is in place for each programme and that robust data collection methods are in place to demonstrate improvement. Boards will work towards implementing the recommendations set out in the Vale of Leven Inquiry Report.*

The overarching aim of the Scottish Patient Safety Programme (SPSP) is to reduce avoidable harm to patients by improving the safety of patient care at all points of care delivery with a goal to reduce HSMR by 20% by December 2015.

PRIORITY ACTIONS

The multiple and increasing programmes attached to SPSP has led NHS Tayside to focus on a more systematic approach to improving patient safety where it is seen as more than a national programme, with improvements that address local safety priorities identified by frontline clinicians and the voice of patients and carers.

Following consultation with frontline clinical teams and data from patient feedback, mortality reviews, and Significant Clinical Events Analysis, the following three areas have been identified as NHS Tayside priorities for patient safety; multidisciplinary team working, deteriorating patients and medicines safety.

In August 2014, NHS Tayside launched a new Patient Safety Network to support the patient safety agenda for the next two years and will collectively support the individual aims of each national patient safety programme, more details of which can be found at;
http://www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes

The Patient Safety Network will bring together and support multidisciplinary team members from across organisational and professional boundaries to improve the safety of care across the whole patient pathway. It will create the conditions for improvement by providing a forum to; develop staff, create knowledge, exchange information and spread good practice. It will also provide the opportunity for staff to develop their Quality Improvement Skills and to move forward Patient Safety activities within their service with a curriculum of topics delivered to support this.

NHS Tayside has delivered considerable improvements in patient safety across all the programmes.

Examples of this include:

- A sustained reduction in cardiac arrests within Ninewells Hospital, with the most recent 15 data points below the centreline. Our Intensive Care Unit in Ninewells Hospital has had a 0% central venous infection rate since June 2013.
- Intensive Care Unit in Perth Royal Infirmary has gone 11 months without a ventilator acquired pneumonia.

- Within the primary care setting, 100% of our GP practices have undertaken the Safety Climate Survey and 96% of practices have completed two trigger tools (structured case note reviews), both of which aim to improve patient safety.
- Our maternity unit continues to demonstrate improvement with each of the elements of the sepsis six bundle. The median time to first antibiotic is currently 35 minutes (recommendation within 60 minutes).
- Within the mental health setting there is a sustained reduction in patients experiencing restraint.

FOCUS FOR 2015/16

- A robust and clearly defined measurement framework (ROI) has been developed, aligned to the measurement plans which already exist through the national programmes. This framework will support the three workstreams and will be used to coordinate and monitor progress across the organisation. Reporting against this framework will be embedded within the existing clinical governance reporting structures.

- Locally defined patient safety priorities, CEL 19 published in August 2013, sets out a set of ten patient safety essentials to be implemented everywhere in NHS Scotland. Work is now being led by the Patient Safety Team, the Nursing and Midwifery Directorate and the Infection Control Team to develop local mechanisms and tools to support directorates and teams to provide assurance that the ten essentials of patient safety have been reliably implemented and comprehensively spread in all relevant clinical areas.

- Early testing of a 'patient safety toolkit' to self assess or peer review reliable implementation of the ten essentials is underway to provide assurance including; direct observations, soft intelligence, conversations with patients and staff and dashboards. They will also support directorates and teams to ensure that any recording or monitoring of these measures is proportionate and does not detract from the provision of high quality, compassionate patient care by generating an excessive data burden as a step down approach to process measurement will be incorporated.

KEY DELIVERABLES BEYOND 2015/2016

- Continue to develop and deliver the Scottish Patient Safety Programmes, striving to reduce mortality, harm and avoidable injury in a variety of care settings including Acute Adult Care, Maternity, Neonatal, Paediatrics, Mental Health and Primary Care settings including:

    - The development of the Patient Safety Network aimed at ensuring sufficient Board level capacity and capability to deliver, report and learn from the safety programmes within the context of a broader whole system approach to quality improvement capacity and capability.

    - Supporting effective implementation of the Scottish Patient Safety Indicator (SPSI).

    - NHS Tayside is working in partnership with Health Improvement Scotland and NHS Borders to develop and test the Health Foundation prototype work focused on the measuring and monitoring of safety www.health.org.uk/publications/the-measurement-and-monitoring-of-safety

Vale of Leven Inquiry Report

A mapping exercise against the recommendations from the Vale of Leven Inquiry Report was undertaken by NHS Tayside. This focused upon the position of NHS Tayside against the recommendations and identification of key themes which required further work to address any adverse findings and shortcomings. As a result of the mapping exercise, an overarching NHS Tayside Improvement Action Plan was developed.

To drive continuous improvement and demonstrate clinical and professional leadership, the Improvement Action Plan will be delivered by establishing a small number of multidisciplinary workstreams under the auspices of a Core Steering Group chaired by the Board Nurse & Midfwife Director and Medical Director.

The local reporting structure for the overarching NHS Tayside Improvement Action Plan will be conducted through NHS Tayside Improvement and Quality Committee.

NHS Tayside will work with the national Implementation Group and Reference Group to take forward the recommendations from the Inquiry Report. A linkage both nationally and locally to demonstrate the monitoring and implementation of the recommendations is forming part of the work of both national Groups.

Primary Care

The LDP should set out the prioritised local actions that are being pursued to increase capacity in primary care and the resources identified to achieve this. The plan should also identify where national actions would help local delivery.

The key strategic areas and high level plans for Primary Care services in Tayside take into account the available national, international and professional body of literature and evidence. These plans are being set out with a view to developing over the next five years towards 2020.

Although there is a heavy emphasis on general practice within this section, these issues apply equally to the other contractor bodies within pharmacy, dentistry and optometry and the wider primary care team.

The objectives set out within the five areas of **service planning, interfaces, infrastructure, workforce** and **leadership** have been benchmarked against the national Route Map to the 2020 Vision for Health and Social Care and connect closely with the work ongoing across the whole Tayside system, including Transforming Outpatients, Shaping Surgical Services, the Older People's Board, Integrated Partnerships and the Health Equity Strategy. Our Strategic Work Plan (summarised in the driver diagram below) also takes cognisance of the need to consider emerging agendas within areas such as pharmacy (Prescription for Excellence), optometry and community dentistry. In addition to this, our strategic narrative has been set against the emerging health and social care integration agenda.

PRIORITY ACTIONS

The following strategic areas must be considered as a "whole" in order to effect the transformational change in culture and practice which will be required to meet our challenges:

Throughout this all runs our "golden thread" of" **Prepared Patient - Prepared Process - Prepared Professional."**

Leadership and Workforce
"The Prepared Professional"

The importance of clinical leadership is now recognised at all levels, and is well supported in Tayside. As the importance of primary care involvement in service planning and development becomes increasingly recognised and valued, so has the involvement of primary care leaders in diverse forums from locality to national level. The Associate Director of Primary care role (7 sessions per week) is supported by primary care clinical leads in dentistry, optometry, pharmacy and each of the three Community Health Partnerships as well as out of hours services and Managed Clinical Networks. A Leadership Framework has been developed, and there is active and ongoing participation within a number of leadership activities at national regional and local level. Tayside is a pilot Board for paired learning, and is exploring how this can be done at both a primary/secondary care level, and between health and social care.

FOCUS FOR 2015/16

- *Work with Primary Care providers and our partners in Public Health and Local Authorities to consider existing patterns of demand and workload and to aspire to improving quality in primary care in reviewing models of consultation.*

We will look to explore different kinds of consultation with practices and patients, using the best evidence and improvement methodology to support tests of change. This will include use of IT including e-consultation (NHS Tayside has offered to be a pilot Board for the work being developed with NHS 24), patient access to records, and learning from access surveys. Our optometrists and dentists already have close links with acute services with shared learning across a number of areas. Our locality pharmacist model is well placed to fit the strategic priorities within Prescription for Excellence. We are working with our Local Medical Committee to undertake a local workforce survey review to feed in to the Board's Workforce Plan.

- *Continue to support and test new ways of working, building on successes to date* including health inequalities and rural fellows, working with NHS Education for Scotland supporting research and personal development for newly qualified GPs, helping to retain skills and support succession planning. New proposals include integrated primary care roles, working across areas of interface such as medicine for the elderly, unscheduled care and paediatrics as well as supporting practices. We have successfully tested this approach as part of our unscheduled care / winter planning work, bringing a salaried GP and locality pharmacist into an integrated team working across a locality and helping to enable patients to stay at home and reduce length of stay and admissions. Our optometrists and dentists already have close links with acute services with shared learning across a number of areas. Our locality pharmacist model is well placed to fit the strategic priorities within Prescription for Excellence.

- *Ensure a clear career structure and leadership development opportunities*, with nationally agreed training and pay scales appropriate to the role. We will look to develop this further, working in collaboration with national and local partners to test models. Examples of this include the leadership and development structure we are implementing around out of hours care, with a substantive Clinical Director post supported by Locality Leads to help shape the future development of a whole system 7-day working across both primary and secondary care.

  We are building good links with the newly established Tayside Academic Health Sciences Network, with shared learning opportunities around leadership developments for both undergraduate and postgraduate students in partnership with the Deanery.

<u>National Action That Would Support Local Delivery</u>

- Clear strategic direction around national workforce planning for GPs, based around risk stratified population per whole time equivalent GP.
- National funding to support leadership development and expansion of programmes to further include more of the primary care team.
- Career development pathways for clinical managers.
- Explicit support for organised Protected Learning Time with cover provided via NHS 24. Resource (finance and expertise) to support leadership development.
- Endorsement for the leadership development proposals developed by the Royal College of General Practitioners.
- Explore contractual opportunities to allow more accurate workforce assessment.
- Develop shared outcome measures across priorities such as Prescription for Excellence and the new GMS Contract.
- Networking support for developments such as optometric prescribing and dental inspections.

<u>Resource Shift Identified</u>

- Allocation of a proportion of winter plan monies enabled the successful enhanced care at home pilot, supporting MDTs to proactively manage patients in their own home, and

promote earlier discharge. Change Fund and Integration Fund monies continue to support the application of the model at scale.

- Leadership development and funding support has been identified from Board allocations, as well as Integration Fund monies this financial year.
- Support from our Organisational Development Team is provided in Primary Care across a number of different levels.

Planning and Interfaces
"Prepared Process"
"Prepared Patient"

As healthcare policy and delivery adapt to meet the changing and growing demand for services, so too must the traditional interfaces. The ability to move seamlessly across interfaces at all levels is an essential requirement if we are to deliver safe and effective care. We need to have a reliable and consistent "Prepared Process".

The advent of a more "Scottish" GP contract in 2013 has resulted in some changes designed to reflect national planning priorities, most notable this year being patient safety and the introduction of anticipatory care planning within a contractual context. It is anticipated that this contract will not change significantly over the next year or two, and its complexities and history mean that, at best, it will be a useful piece in what will require to be a much bigger toolkit. The GMS contract, as yet does not formally align with the integration agenda, other than in broad terms, most notably the use of Anticipatory Care Plans.

Growing demand and complexity continues to drive increasing referral rates and unscheduled care, and any attempts to tackle waiting times and national "targets" must start at the beginning of the patient's journey in the community, and service planning needs to be considered in this context, starting with the "Prepared Patient".

FOCUS FOR 2015/16

- ***Work to develop patient focussed, evidence based end to end pathways of care needs to be strengthened and will be an NHS Tayside priority***. Initial pathways will focus on areas such as frail elderly, dementia, assess to admit and complex care. The role and input of all parts of the primary care system, including social care, must be considered as part of any pathway proposal, and should be done as part of a single system approach. These pathway developments will take account of the national strategic drivers such as Prescription for Excellence, Review of Nursing in the Community and the New Role for Health Visitors.

- ***Existing mechanisms, such as the GP Contract will be used to support the embedding of pathways –*** examples to date include colorectal referrals, use of digital photography on dermatology referrals, falls, and DVT. This will be further developed and new options investigated.

- ***New ways of sharing data and information will be explored.*** We will look to produce primary care data reports utilising individual clinician data and agreed data sets. We will facilitate practices sharing and learning from data (including from Local Authorities) in local clusters which will help inform the local population needs and service requirements. We are developing a primary care data set encompassing care governance and quality standards across all four independent contractors, and reported to NHS Tayside Board (and in due course, to the Integrated Joint Boards). These will be developed to take account of the proposed integration measures.

- ***Seek to engage with practices willing to consider new and innovative models of care, with a focus on reducing unscheduled care, outpatient attendances, and more integrated working.*** A number of opportunities are beginning to emerge around tests of change – most notably in Dundee with Whitfield and Menzieshill / Maxweltown Local Care Centre models, the work around Enhanced Community Support in Broughty Ferry, Monifieth and Carnoustie, using the Integrated Resource Framework to drive service delivery discussions in Perth & Kinross, and options for new kinds of service delivery across practices in Tayside, which include exploring the "Nuka" model and implementing the "year of care" model across the most deprived practices in Dundee to improve pathways of care for diabetic patients, and in rural areas such as Letham, Angus.

  Primary care will be a key component of the developing NHS Tayside Clinical Services Strategy, with development having the active engagement of the Local Medical Committee.

- ***Support the establishment of Health and Social Care Partnerships in Tayside to create the conditions for the meaningful engagement of primary care in this important agenda.*** This should be conducted by clear job planning, support for leadership and development, and accountability. BMA research has shown that the most important enablers to supporting integration are a collaborative culture, good professional relationships and effective leadership. Work requires to be taken forward with new partnerships to agree what this needs to look like in each area.

- ***In promoting the primary/secondary care interface, we will continue to develop the positive culture of collaborative working*** through building on the work of Joint Clinical Boards, Older People's Board, local interface groups, clinical pathways, sharing of significant events, electronic communication and messaging systems. As demand continues to grow, both in primary and secondary care, we will create opportunities for joint working for integrated pathways of care, service planning and shared learning.

National Action That Would Support Local Delivery

- Consideration of national pathways and national purchase of systems such as "Map of Medicine" would allow implementation of local pathways of care at a national scale.
- More "joined up thinking" at national level to consider how national strategy could be more aligned to support pathways of care which both begin and end in primary care.

Resource Shift Identified

- By working in collaboration with local partners, Tayside's property strategy developments are now starting to provide community infrastructure to support multidisciplinary models of care in buildings that are both fit for purpose and value for money. Site rationalisation allows a percentage of funding to be reinvested in service development. Continued dialogue will be held between primary and secondary care around the resource shift required to deliver increased activity.

Technology and Data

FOCUS FOR 2015/16

- ***Support joint working to ensure that the information that is shared is timely, complete and accurate to support patient journeys.*** We will further develop the single electronic patient record, the Key Information Summary (KIS) and electronic referral and discharge documentation to enhance sharing of information across patient pathways. This will also be considered as part of NHS Tayside's refreshed eHealth Strategy**.**

- ***Continue to test the sharing of learning from significant events through incident recording using the DATIX system*** and extend this to all practices during 2015, allowing electronic sharing of incidents, complaints and events. This will be further rolled out to the remaining three independent contractor streams.

  We will seek to implement full roll out of electronic referral between primary and secondary care optometry, and facilitate access to NHS Net and the Clinical Portal for all independent contractors.

National Action That Would Support Local Delivery

- Agreed target dates for developments such as e-pharmacy, optometry referral.
- A national eHealth Strategy which enables delivery at Board level.
- Support to enable patient access to records, booking, e-consultation and decision support and sign posting.
- An agreed primary care IT provider to allow for the development of a system which can interface with other existing systems.

Contracts and Resources

Within Tayside the majority (63/65) of general practices have a 17C Contract. There is currently no appetite to consider other contractual models such as 17J. However, locality models are now well established across all three Integrated Joint Boards, and through leadership development, support groups of contractors are now starting to consider the total community resource available and what service delivery models may need to be in place for the future. There is a growing awareness of the need to consider how all four independent contractor models can work better together, and how these models can support the integration agenda.

If post 2017, the new GP Contract is predicated on the role of the "expert generalist" providing co-ordination and management of complex care in the community then there will be a significant need for other resources in the community to consider taking on roles traditionally undertaken in practice. These could include large elements of prescribing, public health (including immunisations) and mental health. Supporting people to self direct their own care with direct access to specialties such as physiotherapy, occupational therapy, social care and employability will free up more GP time and resource. Direct access to other community specialists such as optometrists, dentists, midwives has already demonstrated a successful shift in how people access services.

FOCUS FOR 2015/16

- ***Support investment in primary care estate and infrastructure, which recognises the wider context of what we are trying to deliver in the future, using new and innovative models of commissioning***. Some good examples include working with communities to identify land and fundraising (Edzell), and the collaboration with Dundee City Council which saw the new Whitfield Local Care Centre open in April 2014, followed by plans for Menzieshill and Maxwelltown in 2015/16 (which includes the potential to explore new service models for primary care, taking on management and delivery of services currently being delivered in secondary care such as family planning, dermatology/leg ulcers, continence services).

- ***Prioritise investment in services and facilities in places which match the growing demographic changes***, and which should be planned and designed in partnership wherever possible. The Carse of Gowrie should be considered in this context.

- ***Utilise the roles and contractual frameworks of other independent contractors alongside general practice***. For example, the new Pharmacy Contract and the "Prescription for Excellence" agenda will be explored, ensuring the patient accesses the right professional at the right time and in the right place. Direct referral between primary and secondary care optometry and dentistry is well established, and the advent of improved IT systems will help to further strengthen this.

- ***Further strengthen the roles and skills of community nursing*** including district nursing, health visiting, school nursing, public health, mental health and minor injury and illness nursing teams. We will look to develop locality "hubs" enabling provision of a wide range of services including minor illness and injury, phlebotomy, long term condition monitoring, pre-op assessment, wound management and community clinics.

- ***Work with patients and local communities to understand together the difficulties and challenges they face accessing care*** ensuring that feedback, stories, learning from significant events, formal engagement and self management support are all embedded within the primary care culture. We will however consider more radical reviews around access and demand across the system, patient held records, the use of telehealth and fully utilising the opportunities offered by new infrastructure. NHS Tayside will look towards our partners in the third and independent sectors to play a much bigger role and above all we will develop the principles of the "Prepared Patient" in partnership utilising the principles of co-production.

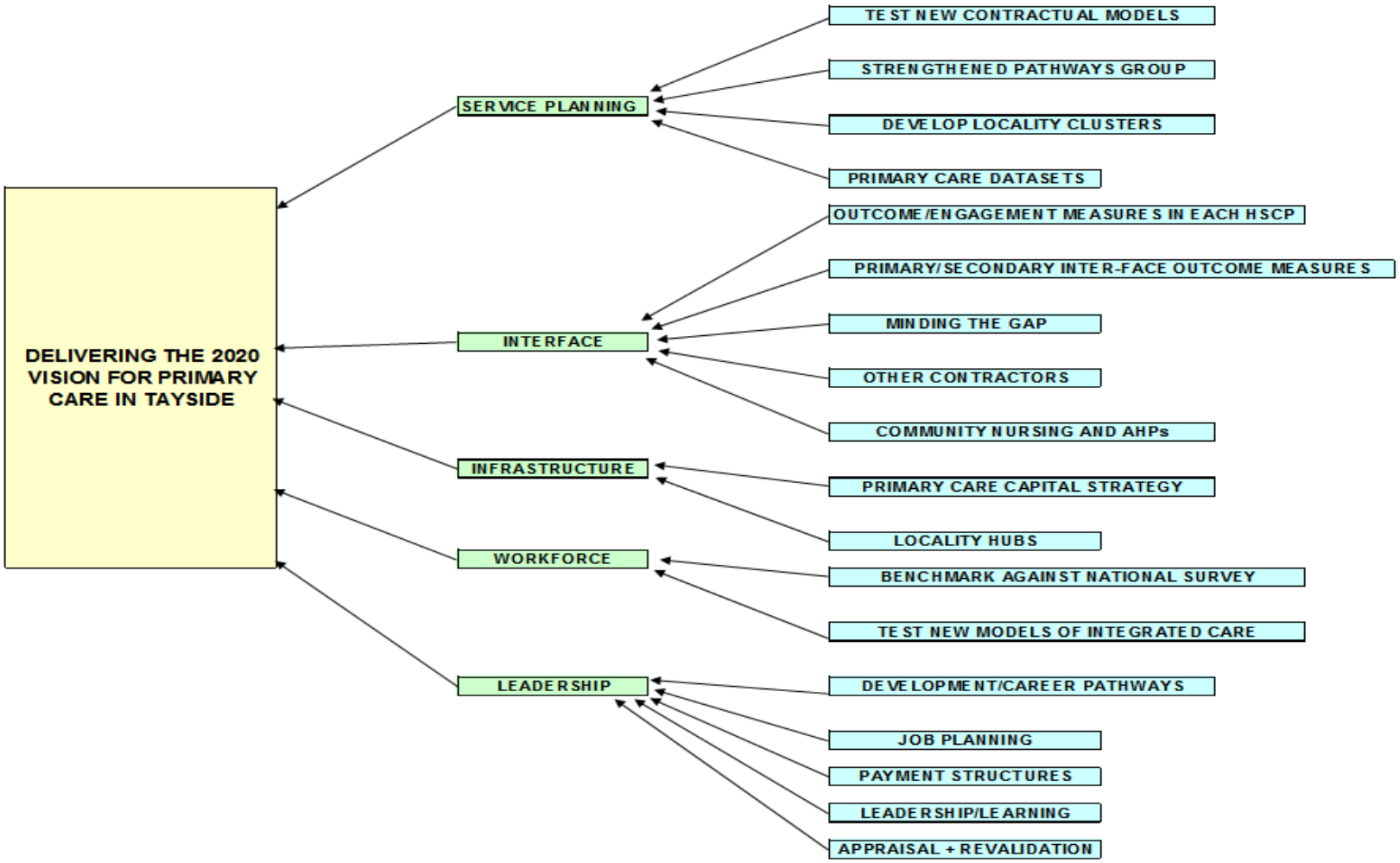
National Action That Would Support Local Delivery

- National dialogue around how people can self direct and access health care advice.
- Helping to disseminate and facilitate learning.
- Support acute targets which match primary care priorities.
- Consider the public health agenda alongside contracts and national targets.
- Commission research to support evidence based outcome measures.

KEY DELIVERABLES BEYOND 2015/2016

The narrative above sets out the key strategic priority areas which will be taken forward to achieve our Vision for Primary Care services in 2020. The "golden thread" of the Prepared Patient – Patient Process – Prepared Professional will continue to run through all our work, and help bind us to the work of others at individual, local, regional national (and international) level. The driver diagram below sets out the main high level strategic objectives which we will look to develop over 2015/16 as part of NHS Tayside's Clinical Services Strategy and which will support our developing integration agenda.

This will be articulated within the NHS Tayside Clinical Services Strategy with measurable outcomes and timeframes set within a Strategic Work Plan and Financial Framework reporting to Health and Social Care Integrated Boards.


DELIVERING THE 2020 VISION FOR PRIMARY CARE IN TAYSIDE
SERVICE PLANNING
INTERFACE
INFRASTRUCTURE
WORKFORCE
LEADERSHIP
TEST NEW CONTRACTUAL MODELS
STRENGTHENED PATHWAYS GROUP
DEVELOP LOCALITY CLUSTERS
PRIMARY CARE DATASETS
OUTCOME/ENGAGEMENT MEASURES IN EACH HSCP
PRIMARY/SECONDARY INTER-FACE OUTCOME MEASURES
MINDING THE GAP
OTHER CONTRACTORS
COMMUNITY NURSING AND AHPs
PRIMARY CARE CAPITAL STRATEGY
LOCALITY HUBS
BENCHMARK AGAINST NATIONAL SURVEY
TEST NEW MODELS OF INTEGRATED CARE
DEVELOPMENT/CAREER PATHWAYS
JOB PLANNING
PAYMENT STRUCTURES
LEADERSHIP/LEARNING
APPRAISAL + REVALIDATION

Integration

Integrated partnerships will be required to establish a Strategic Planning Group to prepare the Strategic Plan – this group will include representation of the key stakeholders. The LDP should set out the key local actions that are being pursued to ensure effective involvement of clinical and care professionals in the Strategic Planning Group. The plan should also set out the redesign priorities emerging for the integrated care pathways delivered in the community.

NHS Tayside is working with the three constituent local authorities, Angus, Dundee City and Perth & Kinross to establish health and social care partnerships in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014 and associated Statutory Guidance and Regulations. The partners in each area are building models of care consistent with the Government's 2020 Vision for Health and Social Care. The focus of the partnerships will initially be on adults and older people and the intention is to establish the partnerships in accordance with the "body corporate" model and the partners have prepared Draft Integration Schemes for the creation of Integration Joint Boards (IJBs) in each area in accordance with the regulations. Work has also commenced on the preparation of Joint Strategic Commissioning Plans so that once the Ministerial approval of the schemes is secured, the plans can be agreed, enabling the formal establishment of the IJBs and the transfer of functions and responsibilities before or on 1 April 2016.

This work will reflect the strategic direction set out in the NHS Tayside 'Rich Picture Vision' and the development of the NHS Tayside Clinical Services Strategy and will connect with the Community Plans and Single Outcome Agreements for each partnership area.

PRIORITY ACTIONS

There are in place regular steering groups to progress integration at a Tayside wide level in each area, we have worked with our local authority partners to put in place shadow board arrangements and the appointment of Interim Chief Officers, progressing to establish the IJBs and appoint the Chief Officers on a designate basis. It is anticipated that the draft schemes will have been submitted prior to 31 March 2015 and that these will be approved within the scheduled 12 week period set out by Scottish Government for the Ministerial Approval and Order.

The planned schedule is for the Joint Strategic Commissioning Plans to be completed and agreed by September 2015, enabling the formal establishment of the IJBs in autumn 2015. The transfer of functions and responsibilities to the IJBs is anticipated on or before 1 April 2016.

The partners are also agreeing a range of governance frameworks to strengthen the assurance in support of the move towards integration, including:

- Clinical, Care and Professional Governance Framework (including feedback)
- Financial and Audit Governance Framework
- Workforce and Staff Governance Framework
- Joint Risk Management Strategy / Framework

There is also in development integrated workforce planning, information sharing and data handling, corporate and support services and participation and engagement arrangements.

We will agree the range of services that are within scope that will be directly managed or hosted and those that will be included within the "Large Hospitals" definition and will detail the functions, services and responsibilities that will devolve and the associated budgets and set aside amounts. These will be the subject of scrutiny through the due diligence process to ensure that there is openness and transparency around the proper transfer of the functions and responsibilities to the IJBs.

Although the specific proposals are focussed on health and social care integration involving principally NHS Tayside and the local authorities, it is the clear intention in each partnership to develop a fully inclusive partnership to include the third and independent sectors as well as patients, service users, carers, communities and individuals.

The partners have agreed and submitted plans and proposals for the Integrated Care Fund to support the implementation of new models of care.

Importantly, at the heart of the integration work will be the development of integrated locality service delivery (on a multi-disciplinary team basis) and locality planning. This will involve considerable workforce development and workforce planning and organisational development. We have already agreed planning and delivery localities within each partnership area, built around natural communities, neighbourhoods and clusters of GP practice populations, on which to focus the locality development work.

We acknowledge the challenge of engaging clinicians, professional and practitioners within localities and will work to build on the existing strengths of joint working at the very local level, particularly around the best practice from our work on reshaping care for older people supported through the Change Fund. A particular challenge will be the engagement of primary care practitioners, particularly General Practitioners in the localities, clusters and MDTs. We will identify GP practice leads, GP Locality / Cluster Leads and will build and strengthen locality team working as well as connecting acute and primary care integrated working through a clinical engagement and development process.

The aim will be to ensure that the vision of supporting people to keep well at home and within the community with planned and scheduled care, reducing crisis admission to care and to hospital through unscheduled care will be a key aim, and this will be based around making community the right place.

The development of the support networks in localities will be supported by work with acute care and large hospitals with the aim of these becoming more community facing and the development of an Integrated Care Collaborative that will ensure cohesion between the Strategic Hospital Plan (to be developed in partnership) and the Joint Strategic Commissioning Plans for each area, ensuring a joint investment strategy for the "set aside" amounts for the unscheduled care pathways.

While NHS Tayside will continue to meet the challenging targets for unscheduled care, particularly through Accident and Emergency, we are increasingly challenged to meet targets for reducing hospital admissions for over 75 year olds and to manage capacity and flow through acute care due to unscheduled care admissions and increasing complexity and frailty. This is impacting upon the ability to manage care through hospital, to maintain emergency and elective pathways of care and to ensure safe, effective and timely discharge home or to an appropriate care setting.

While we have worked in partnership to consistently meet the target for discharge of patient within 28 days during 2014/2015, this is proving increasingly challenging and we will develop improvement plans in each area to meet the new target for the discharge of patients within 14 days of being medically fit. A particular concern has been the increasing trend in the overall numbers of people whose discharge from hospital has been delayed, particularly those patients delayed in acute hospitals.

We will work within each partnership to use the additional delayed discharge funding allocation over the next three years to create capacity to reduce demand pressures, reducing unscheduled care admissions, further improving discharge planning and moving towards immediate discharge or transfer of patients from acute care.

We will build on the success of the Enhanced Community Support model in moving from the positively evaluated pilots to scaling this up and testing within whole localities, starting within the South Locality in Angus and rolling out to other areas.

We will also build on the effectiveness of our work on the development of community based teams for dementia care across Perthshire and test similar models within Angus and Dundee. This will strengthen our capability to further deliver on the targets for identification of people with dementia and provision of post diagnostic care and support.

As part of the Clinical Services Strategy, we will seek to release capacity and resources to strengthen our community teams through more efficient use of our property and estate and through operating from fewer sites. This will include the re-provision of community hospital care and a re-focus towards planned and step-up care. We will seek to re-provide care from Royal Victoria Hospital, Dundee and to develop a new sub-acute care facility for the city.

FOCUS FOR 2015/16

We will continue to build the health and social care partnerships in conjunction with partners by:

- Securing Ministerial approval for the Integration Schemes.
- Supporting the implementation of the plans and proposals within the Integrated Care Fund Plans.
- Completing and agreeing the Joint Strategic Commissioning Plans for each partnership area.
- Establishing the Integration Joint Boards and appointing Chief Officers.
- Completing all governance and supporting frameworks to underpin the partnership arrangements.
- Transferring functions, responsibilities and budgets to the Integration Joint Boards on or before 1 April 2015.

We will also;

- Develop and complete an Integrated Workforce Plan.
- Develop an integrated clinical and professional engagement programme to support integration.
- Establish an Integrated Care Collaborative for the planning and coordination of Unscheduled Care Pathways, development of a Strategic Hospital Plan and agree the direction of set aside resources.
- Agree with partners a Delayed Discharge Improvement Plan for Tayside and for each partnership area, including deployment of national delayed discharge funding to deliver the 14 day target and to move towards 72 hour discharge from an acute hospital setting.
- Scale up the Enhanced Community Support Model within one locality area and seek to progressively roll out across Tayside.

- Spread the delivery of a community based dementia model of care to additional localities and scale up to locality.
- Implement new models of care to replace facilities-based care with integrated community team working.
- Develop sub-acute care within retained community hospitals and commence development of a new sub-acute centre for Dundee.

KEY DELIVERABLES BEYOND 2015/2016

In future years we will support the Integrated Joint Boards to:

- Enhance the Joint Strategic Commissioning Plans and develop Locality Plans.
- Implement the Integrated Workforce Plan to create integrated locality teams across all areas.
- Fully roll out the Enhanced Community Support Model.
- Deliver improvement across the national outcomes and indicators.
- Continue the implementation of the Delayed Discharge Improvement Plans.
- Complete the integration of Occupational Therapies.

Everyone Matters

Implementation Plans 2015/16

In the context of delivery of the highest quality of safe, effective and person-centred care, our workforce is the critical enabler. It is the commitment and skill of workforce that provides our services, builds our capacity, maintains our efficiency, and delivers our quality agenda. That is why in 2014 our Board published its 'People Matter' Strategy, which set out its commitment to the delivery of the "Everyone Matters - 2020 Workforce Vision", and the actions it would progress in 2014/15 to do so.

Against the key areas required under CEL 20 (2014) to deliver "Everyone Matters", in 2015-16 the following priorities will therefore be actioned in NHS Tayside:

HEALTHY ORGANISATIONAL CULTURE

2015/16 Commitment: We will promote and recognise the behaviours of individuals and teams at all levels which reflect our values.

Values and Behaviours - Since the Board launch of the NHS Tayside core value set in December 2013, which mirror the NHS Scotland value set, staff across NHS Tayside have been part of line-led discussions on these values, their meaning, and individual responsibilities. This has been supported by information packs and toolkits distributed to all line managers to support this exercise. Implementation is subject to regular audit, with reporting to the Board's Staff Governance Committee.

The most recent audit report (February 2015) demonstrates that 74% of staff who completed the audit felt that their team were aware of the NHS Tayside values. This correlates with the results of the 2014 National Staff Survey, in which 76% of staff reported that they were aware of the NHS Tayside values. Importantly, recognition by staff of our prioritisation of the care of patients and those who use our services increased to 70%.

In 2015/16, work building on that platform will be implemented, including the use of values and behaviours across staff appraisals and objectives; further development sessions on values and behaviours; a reintroduction of visible leadership walk-rounds to reinforce the Board's vision and core values; and line manager feedback to individuals on behaviours that are not consistent with the values.

Staff Experience - National Staff Survey and iMatter - The 2014 National Staff Survey results, published in December 2014, saw NHS Tayside achieve the highest percentage increase in overall response rates, and the Board aims to maintain this momentum across 2015/16.

Having been a pilot Board for the staff experience programme, NHS Tayside has been an early implementer of the national iMatter programme, with a comprehensive 3 year roll out plan agreed by the Board. For 2015/16, oversight of implementation of the iMatter toolkit has been delegated to our Local Directorate Partnership Foras, with formal quarterly progress reporting to the Board's Staff Governance Committee.

Engaging and Involving Staff - The 2014 National Staff Survey saw 84% of NHS Tayside staff stating they are clear on their duties and responsibilities, with some 76% confirming they understand how their work fits into the overall aims of NHS Tayside, and perceptions of NHS Tayside as a positive place to work continued to grow, with 61% of recommending us as an employer of choice.

Against this positive backcloth, NHS Tayside has embarked on a redesign of our partnership arrangements to ensure staff involvement in all decision making, and that staff remain active participants in our agenda.

To strengthen the Area Partnership Forum's (APF) strategic role, recent changes to our APF work plan ensure all clinical and financial strategic matters are considered at this table alongside the

existing Staff Governance issues, and Management attendees of the APF revised to include all Board Directors.

The priority for 2015/16 is the embedding of a revised Local Partnership Fora structure. This structure, developed with and agreed by Staff Partners, ensures the consideration by key decision makers and staff partners across all local services of their clinical strategy, financial plans, and co-production of workforce plans. Progress reviews of this work programme are regularly reported to the APF, and will continue throughout the year.

SUSTAINABLE WORKFORCE

2015/16 Commitment: We will use high quality workforce data and contextual information to inform local workforce plans

2015/16 Commitment: We will ensure that recommendations from the Working Longer Review around occupational health, safety and wellbeing are fully implemented and that flexible approaches are taken.

Strengthening Workforce Planning - Against a Scottish Government priority of boosting the economy and job creation, NHS Tayside has taken a tactical position of maintaining and growing our workforce. Across the last two financial years to date (March 2012 to January 2015) we have grown staffing numbers by 400 WTE.

Vacancy Areas - The skills challenge that faces the wider health community also impacts in Tayside across medical, nursing and some other specialist staff, with vacancy management issues arising across a range of disciplines including:

> ***Medical***: Anaesthetics, Addiction Psychiatry, Clinical Oncology, Dermatology, Emergency Medicine, ENT, General Adult Psychiatry, Immunology, Medicine for the Elderly, Neurosurgery, Paediatrics, Neurophysiology, Neonatology, Child & Adolescent Psychiatry, Old Age Psychiatry, Oral Max Surgery, Orthodontics, Obstetrics & Gynaecology, Ophthalmology, Histo and Cyto Pathology, Palliative Medicine, Radiology, and Trauma & Orthopaedics.
>
> ***Nursing***: Particularly Community Nursing, Health Visiting, Public Health, Theatres.
>
> **Other Staff groups**:- Physiotherapy, Radiology, eHealth, and Healthcare Science.

With the Scottish economy requiring further inward migration to help address some of these challenges, opportunity to engage alongside colleagues in Scottish Government around UK migration policy needs therefore to be viewed by as a critical tactical enabler.

Despite these challenges, NHS Tayside continues to be successful in positioning itself as an employer of choice, securing, for example, recruitment of an additional 32 medical and dental staff over the last 12 months.

Nursing Workload Tools - As an early adopter Board, we have already begun the comprehensive roll out of the national Nursing Workload Tools, which are informing an ongoing recruitment programme for nursing staff across all specialties. In line with emerging requirements, in November 2014 alone, we recruited 180 new graduate nurses from universities throughout Scotland.

Modern Apprenticeships - At the same time, and in support of Scottish Government commitment to tackling inequalities and youth employment, we have invested heavily in the development of skills across the Tayside population. Alongside our established Health and Social Care Academy model, supporting individuals from across our community to be work-ready, we

have moved to significantly expand our Modern Apprenticeship Programme, which will see an additional recurring 25 places (34 in total) across a range of specialities.

Board Workforce Plan - The scale of workforce growth described above brings with it challenges however, and 2015/16 sees a commitment around reshaping our workforce. Led by our Clinical Services Strategy, this will see us taking a robust position on some staff working in different roles, delivering services in different ways, and in different places. This in turn offers opportunities for staff retraining and career development.

This agenda will be reflected in our Workforce Plan to be submitted to Scottish Government in June 2015, built in partnership, and which will support our Clinical and Financial Strategies, securing the principle of the right people in the right place to ensure the safety and quality of care.

Workforce Optimisation - Enabling effective staff deployment is a key 2015/16 Board strategic priority. Alongside challenges of reducing protection costs, the Board has prioritised the use of eRostering to ensure the best use of staff and skills across shifts.

Following successful piloting, procurement of a full eRostering system was completed in 2014, and NHS Tayside is now leading NHS Scotland in the implementation of eRostering. Initially focussing on nursing rosters across 2015/16, this tool will be rolled out throughout the period 2015-17 across Junior Medical, AHP, and some other non-clinical services. The use of eRostering tools compliments existing work implementing other systems which support data-driven management.

This targeting of effective staff deployment to meet clinical need underpins the Board's target of significant reduction of supplementary staff expenditure throughout 2015/16.

CAPABLE WORKFORCE

2015/16 Commitment: We will ensure that everyone has a meaningful conversation about their performance, their development and career aspirations

2015/16 Commitment: We will develop the skills and behaviours required for working collaboratively and flexibly across primary and secondary care, and across health and social care.

Appraisal - In the context of NHS Tayside's work on values and behaviours, incorporation of behaviour as the primary focus of appraisal has already been agreed with the Board's Remuneration Committee for use within the Executive / Senior Manager cohort as a pilot group in 2015. This is based around the piloting of the nationally-recognised "VOICES" reflective tool developed by Cohort 8 of 'Delivering for the Future' national Strategic Clinical Leadership Development Programme 2014, to capture the contribution of leadership behaviours within the behavioural element of each objective.

In support of our appraisal programme, in-house development will continue to be delivered by the Learning & Development and Organisational Development Teams to ensure both the ongoing development of appraisal skills, and, following piloting and evaluation, supporting the embedding of behavioural factors in appraisal for all staff groups.

eKSF - Alongside this, while continuing to promote the effective use of eKSF for all Agenda for Change staff, work is being led by the Employee Director, Director of HR and Nurse and Midwife Director throughout 2015 supporting the senior Operations management team in improving their use of appraisal and promoting access to development for Support Services staff.

This focus in ensuring effective appraisal is a key enabler to ensuring all staff have equitable access to personal development opportunities, as monitored by our Area Partnership Forum and Staff Governance Committee.

INTEGRATED WORKFORCE

2015/16 Commitment: We will work with partners toward the Health and Wellbeing Outcomes [4] developing a shared culture, values and ways of working through effective teams and local partnerships

2015/16 Commitment: We will provide leadership to continue to support the integration of primary and secondary care, recognising the role of GPs, dentists, pharmacists and others as part of the workforce.

Supporting Integration - The system-wide impact of the Health and Social Care Integration (HSCI) agenda will continue to be a primary focus at all levels of the organisation. A Chief Officer has already been appointed for the Angus partnership, while both Dundee and Perth & Kinross partnerships begin to move toward similar early appointments. NHS Tayside established an NHS HSCI Partnership Board in 2014/15 to help support delivery of a positive staff experience moving in to the new integrated arrangements and this will continue to be met across 2015/16. A network of functional joint forums have also been established, including Human Resources and Finance, to promote early joint planning, across the range of Council geographies.

Meetings will continue throughout 2015/16 with the new HSCI Chief Officers and staff partners from all partner organisations to ensure a focus on effective staff working and maximising the positive impact of integration through shared understanding and shared values.

Supporting Primary and Secondary Care - NHS Tayside recognises that Primary Care and Community Services provide both the first and ongoing point of contact between an individual and healthcare professionals in the majority of cases, and therefore the importance of Primary and Community Services care as the gateway to secondary care.

The appointment by NHS Tayside in early 2015 of a Director of Community Services and Primary Care, working alongside a Director of Acute Services, will help ensure our services work more closely together, and with GPs, Dentists and other partners to develop a sustainable workforce model. In the context of HSCI, 2015/16 will see the emergence of early sharing and integration of workforce information, and through that, development of more effective integrated workforce plans which better reflect the needs of our local population.

EFFECTIVE LEADERSHIP AND MANAGEMENT

2015/16 Commitment: We will build leadership skills to lead/drive Quality Improvement

2015/16 Commitment: We will ensure leaders at all levels and in all professions have the skills to support the workforce through change.

Building Capability - 2014/15 saw Learning and Development and Organisational Development expert teams refresh NHS Tayside's Leadership Strategy and introduce initiatives which support the skills, behaviours and capabilities required by those we see leading delivery of our clinical, financial and people strategies in the coming years. This work will continue across 2015/16, including extending expert development programmes on improvement techniques to underpin our values around quality of care.

This includes in 2015/16, delivery of a comprehensive suite of development interventions that focus on people management and change management skills. This will ensure leaders at all levels are enabled to demonstrate the values and behaviours promoted by NHS Tayside and NHS Scotland, while supporting service changes that may emerge from local and national clinical strategies. At the same time, this work will begin to build the platform for the enhanced line management requirements around performance, policy, engagement, and equality likely to arise from the move to a national HR shared services model.

LDP SICKNESS ABSENCE STANDARD

NHS Tayside has made significant strides in relation to reducing sickness absence. Our performance at December (most recent available) across the rolling year, offers a local NHS Tayside average of 4.83% against a national position of 4.97%.

While we have consistently remained below the Scottish average across 2014/15, and achieved one of the largest sustained reduction in overall rates, we clearly still have more to do to achieve the 4% standard. That is why we have adopted a focus around staff well being, and ensuring effective staff support; this includes the recent high profile Board launch of the "Live Positive" training and support materials, designed in partnership to help staff cope with stress and anxiety, and build awareness and self reliance, and progress in this area will remain the central tenant of our approach across 2015/16.

Contributions to Community Planning Partnerships

NHS Tayside is a key member of the **ANGUS** Community Planning Partnership (CPP) which works towards improving the area's economy, improving community learning, making Angus a healthier and safer community in which to live, and protecting and enhancing the quality of the Angus environment.

NHS Tayside is represented by the Chairman of NHS Tayside and the Director of Primary & Community Services on the CPP Board. Additionally the CHP Interim Lead Officer, Director of Public Health, and other local officers are members of the full Partnership. The CHP has been fully engaged in its strategic development and actively supports and promotes the set of core values of CPP planning for place: through actively engaging with its communities, promoting sustainable growth, promoting fairness and equality, and providing excellent public services that are value for money.

Work is currently taking place to reinvigorate the Partnership and plans are well advanced to replace the current system of Thematic Partnerships reporting into the Community Planning Partnership. The CPP has the responsibility for overseeing the delivery of the Single Outcome Agreement.

The full Community Planning Partnership meets four times per year and agenda items for future discussions during 2015/16 will include: Locality Approach & Community Empowerment; Sustainable Economy & Employment; Poverty & Disadvantage; and Shifting the Balance of Care. These cross cutting issues will also inform the new Single Outcome Agreement from 2016 onwards.

A formal full year and mid year report are provided to the Partnership which highlights progress in the performance of the Angus Community Plan and Single Outcome Agreement 2013/16.

The new strategic emphasis will see planning for place at a locality level on a holistic basis. In order to take this forward an event will be held in each of the four localities during 2015 for communities to determine their 3-5 priorities. It is envisaged these will be held thereafter on an annual basis. All partners will contribute to the leadership and commit to actions determined within the localities.

The importance of the third sector to the work of the Partnership and the locality approach has been underlined by the development of a Third Sector Compact which has set out the broad principles which will govern the relationship between the Angus Community Planning Partnership and the local third sector in future years.

NHS Tayside is a key member of the **DUNDEE** Community Planning Partnership, and is represented on the Partnership Management Group and Co-ordinating Group. NHS Tayside leads Healthy Dundee (the Health and Care Partnership) and is a fully engaged partner in the ongoing implementation of the Single Outcome Agreement for 2013-2017 and the associated Delivery Plan, with its emphasis on reducing inequalities, and on implementing prevention and early intervention approaches.

Healthy Dundee has been responsible for overseeing the implementation of the Dundee Action Plan for the Health Equity Strategy and driving forward the top priority Physical and Mental Wellbeing outcomes and deliverables first agreed in the 2012 SOA i.e.

- Reducing harm from substance misuse
- Introducing city-wide social prescribing, and
- Rolling out Equally Well approach to mental wellbeing.

A Health Inequalities Sub Group of Healthy Dundee has been established and is working across the Partnership to ensure that our core health inequalities work is targeted at the most deprived communities in Dundee in an efficient and effective evidence based way. Health Inequalities has been included within the Dundee bid for Integrated Care Funding for 2015/16 and we aim to use this resource to:

i. Review and consolidate existing health inequalities work by merging existing health inequalities programmes to provide multi disciplinary locality teams.
ii. Build the capacity of public and voluntary organisations to adopt health inequalities sensitive practice.

In Dundee, we have had a particular focus on employability and mitigating the impact of welfare reform. NHS Tayside is represented on the Dundee Partnership Employability Group and Dundee CHP hosts the newly established NHS Tayside Employability and Welfare Reform Forum on behalf of the Director of Public Health. This Forum has overseen the development and implementation of NHS Tayside's Outcomes Focussed Plan and has included a number of key pieces of work such as the development of a Welfare Reform "App", the development of an online repository of information for NHS Staff and the development of an on-line training resource.

NHS Tayside is a key member of the **PERTH & KINROSS** Community Planning Partnership. It is an active contributor on the Community Planning Partnership Board, Community Planning Partnership Executive Officer Group (CPPEOG), the four Outcome Delivery Groups and Community Empowerment Working Group

Following the agreement of the Single Outcome Agreement in June 2014, four Outcome Delivery Groups were established from existing thematic groups:

1. Health and Social Care integration Pathfinder Board
2. Children and Young People
3. Community Safety and Environment
4. Economy and Lifelong Learning

These Groups lead and are responsible for actions which support the delivery of the Community Plan and Single Outcome Agreement across Perth and Kinross. They plan, oversee and are accountable for delivery by Community Planning Partners of key actions which support the relevant Community Plan objectives.

The Health and Social Care Integration Pathfinder Board is the Outcome Delivery Group committed to providing the support structures that allow people to lead health, independent and active lives. Linked to these aims are tackling inequalities and prevention. The Vice Chair of this Group is a Tayside NHS Non Executive Board member. During 2015, its chief focus is on ensuring the effective implementation of the Public Bodies (Joint Working) (Scotland) Act and the creation of the Integration Joint Board for Perth & Kinross, and as a result embedding new locality based ways of working.

NHS Tayside representatives are active in the Community Empowerment Working Group, which the Non Executive Board member chairs. This group advises the Community Planning Partnership on involving and engaging with communities, aims to share best practice as to "what works" in community development, as well as advising on the effective use of community research and intelligence. During 2015, the Group will take forward its recommendations relating to community empowerment and participation into a comprehensive plan for action.

LDP STANDARDS

There will be no HEAT targets contained within the 2015/16 LDP. The LDP will now contain nineteen Standards as below – the content of the first nine of which remain unchanged from 2014/15 and the remaining ten consist of previous HEAT targets due for delivery within 2014/15 which now apply as **LDP Standards** within the 2015/16 Local Delivery Plan.

1. Cancer waiting times: 31 days from decision to treat (95% performance); 62 days from urgent referral with a suspicion of cancer (95% performance).
2. 12 weeks treatment time guarantee (TTG) for inpatient and day cases (100% performance).
3. 90% of patients seen and treated within 18 weeks from initial referral (RTT).
4. 95% of patients waiting no more than 12 weeks from referral (all sources) to a first outpatient appointment.
5. 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment.
6. Sustain and embed alcohol brief interventions in the priority settings of Primary Care, A&E, Antental Care, and broaden delivery in wider settings.
7. 48 hour access or advance booking to an appropriate member of the GP team (90% performance).
8. Sickness absence rate of 4%.
9. 95% of patients attending Emergency Departments to wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment.
10. 25% increase in patients diagnosed and treated in the first stage of breast, colorectal and lung cancer.
11. People newly diagnosed with dementia will have a minimum of one years post-diagnostic support.
12. At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation.
13. 90% of eligible patients commence IVF treatment within 12 months.
14. 90% of patients referred for Child & Adolescent Mental Health Services (CAMHS) are to start treatment within 18 weeks of referral.
15. 90% of patients referred for Psychological Therapies are to start treatment within 18 weeks of referral.
16. Obtain a maximum rate of 0.32 cases of Clostridium difficile infections in patients aged 15 and over per 1,000 total occupied bed days.
17. Obtain a maximum rate of 0.24 cases of *staphylococcus aureus* bacteriamia (including MRSA) per 1,000 acute occupied bed days.
18. Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% most-deprived datazones in the NHS Board area.
19. Operate within agreed revenue resource limit; capital resource limit; and meet cash requirement.

The nineteen standards will be formally performance and risk managed through monthly update at the NHS Tayside Senior Leadership Team, and quarterly reporting to NHS Tayside Board on progress with the Local Delivery Plan standards. If necessary, the Board will also receive exception reports. The performance report provides a validated data position against each standard, with supplementary information where standards have or are at risk of not meeting expected performance, detailing issues affecting performance and the actions being taken to address these. Board Meetings are held in public and reports are available via NHS Tayside Internet. The Local Delivery Plan Corporate Risk is also presented to the Board on an annual basis and the Strategic Risk Management Group on a quarterly basis.

Executive Leads responsible for overseeing the delivery of each LDP standard are responsible for making sure that the appropriate mechanisms are in place to review and manage performance, and to implement the necessary actions through the respective service improvement/action plans.

Key Plans to Support Delivery of Strategic Priority Areas

HEALTH INEQUALITIES AND PREVENTION

- NHS Tayside Health Equity Strategy – Communities in Control
- Tayside Partnership Tobacco Control Plan
- Tayside Alcohol & Drug Partnerships Work Plans
- NHS Tayside Healthy Weight Strategy
- NHS Tayside Maternal and Infant Nutrition Improvement Plan
- NHS Tayside Healthy Working Lives Action Plan
- Tayside Partnership Single Outcome Agreements

ANTENATAL AND EARLY YEARS

- Tayside Partnership GIRFEC Implementation Plan
- NHS Tayside Transforming Health Visiting & School Nursing Implementation Plan
- Tayside Partnership Children and Young People Improvement Plan
- Tayside Partnership Single Outcome Agreements

PERSON CENTRED CARE

- NHS Tayside Clinical Governance Strategy
- NHS Tayside Care Governance Measurement & Monitoring Framework

SAFE CARE

- NHS Tayside Clinical Governance Strategy
- NHS Tayside Care Governance Measurement & Monitoring Framework

PRIMARY CARE

- Primary Care Strategic Work Plan
- Primary Care Financial Framework

INTEGRATION

- Partnership Clinical Care & Professional Governance Framework
- Partnership Financial and Audit Governance Framework
- Partnership Workforce and Staff Governance Framework
- Partnership Joint Risk Management Strategy/Framework

NHS SCOTLAND

Your health, your rights

The Charter of Patient Rights and Responsibilities

Everyone who uses the NHS in Scotland has rights and responsibilities

The Scottish Government

Your health, your rights

The Charter of Patient Rights and Responsibilities

Everyone who uses the NHS in Scotland has rights and responsibilities

The Scottish Government, Edinburgh 2012

Laid before the Scottish Parliament [by the Scottish Ministers]
under Section 1(7)(b) of the Patient Rights (Scotland) Act 2011

September 2012

SG/2012/171

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Contents

The NHS in Scotland

Throughout the Charter the terms ‘NHS services’ and ‘NHS staff’ refer to those services provided and staff employed by your local Health Board, Special Health Boards, the Common Services Agency (known as National Services Scotland), and Healthcare Improvement Scotland where appropriate. This will normally include independent contractors and their staff (for example GPs, dentists, opticians and pharmacists) who are contracted to deliver NHS Services.

Introduction

The Patient Rights (Scotland) Act 2011 was passed by the Scottish Parliament on 24 February 2011, and received Royal Assent on 31 March 2011.

The Act gives all patients the right that the health care they receive will:

- consider their needs
- consider what would most benefit their health and wellbeing
- encourage them to take part in decisions about their health and wellbeing, and provide them with the information and support to do so.

It also gives patients a right to give feedback, comments, raise concerns or complaints about the care they have received.

The Act requires Scottish Ministers to publish a Charter of Patient Rights and Responsibilities which summarises the existing rights and responsibilities of patients using the NHS in Scotland and of people with a personal interest in such patients' health care.

What the Charter does

This **Charter of Patient Rights and Responsibilities** (the 'Charter') summarises your rights and responsibilities as well as what you can expect when you use NHS services and receive NHS care in Scotland.

Some of your responsibilities when using the NHS in Scotland are set out in law. Others are what everyone is expected to do to help the NHS work effectively in Scotland and to help make sure its resources are used responsibly.

The Charter also tells you what you can do if you feel that your rights have not been respected.

The series of seven **Your health, your rights** factsheets listed on page 24, available at the Scottish Government website (www.scotland.gov.uk) and the Health Rights Information Scotland website (www.hris.org.uk), will tell you more about what the rights and responsibilities in this Charter mean for you.

Part 1: Patient rights and responsibilities

This part provides an explanation of your rights and responsibilities when using the NHS.

It also explains what the NHS expects from you.

The information in this part is presented under the following headings:

Access: your rights when using NHS health services in Scotland

Communication and participation: the right to be informed, and involved in decisions, about health care and services

Confidentiality: the right for your personal health information to be kept secure and confidential

Respect: the right to be treated with dignity and respect

Safety: the right to safe and effective care

Feedback and complaints: the right to have a say about your care and have any concerns and complaints dealt with

Access:

your rights when using NHS services in Scotland

What does this mean for me?

- **NHS services are provided free of charge.** This includes NHS services provided by GP practices, local pharmacies, hospitals or clinics and emergency services. There is also a right to free NHS eye examinations and free NHS dental examinations.
  - There are some exceptions to this. For example, you may have to pay for some services and appliances, like dental treatments (in most cases) and glasses.
  - Some people can get help with these costs. To find out more about what you have to pay, and whether you are entitled to help with travel costs for attending a hospital for treatment see the leaflet **A quick guide to help with health costs** (HCS2). You can get this from your GP practice, local pharmacy, optician, dental practice, the Patient Advice and Support Service (see page 25 for contact details) or on the internet (go to www.scotland.gov.uk). The Highlands and Islands Travel Scheme (HITS) provides non-means-tested reimbursement of travel expenses for people living in the Highlands and Islands NHS Board areas.
  - If you are visiting Scotland from overseas and need treatment during your stay you may have to pay for certain NHS services. You can find more about this at www.nhsinform.co.uk or by phoning the NHS inform Helpline on **0800 22 44 88**.
- **You have the right to have your needs taken into account when receiving NHS services.**
  - Your Health Board must take account of your needs when providing health services.
  - However, your Health Board must also consider the rights of other patients, clinical judgement and the most efficient way to use NHS resources.
  - You must never be refused access to NHS services on the basis of unlawful discrimination against you because of your age, disability, sex, or sexual orientation, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief.
- **You have the right that your local Health Board will assess the local community's health needs and provide the services it considers necessary to meet them.**
  - Your Health Board must make informed decisions about how best to use the resources it has to meet its area's needs.

- **Under European Union (EU) arrangements you have the right to go to other European Economic Area (EEA) countries for treatment in a state hospital or, in certain circumstances, an independent hospital, although a number of conditions apply. Therefore, if you are thinking of travelling to an EEA country for treatment you should first of all discuss your options with your local NHS Board to find out, amongst other things:**
    - if the treatment is covered by EU arrangements
    - the best option for your particular circumstances
    - if your local NHS Board will arrange funding or reimburse the cost of the treatment (including the level of reimbursement where applicable)
    - the treatment that the NHS can provide at home.
- **You have the right to request support to access NHS services.**
    - You can have someone else present at an appointment. If you want this please let staff know. This could be a carer, family member, partner, friend, advocate or another health care worker.
    - If you need an interpreter or a sign-language interpreter, or other communication support, ask a member of staff to arrange this for you in advance.
    - If you have a mental health disorder you have a right to support from an independent advocate. NHS staff will arrange this for you.
    - If you want to speak to a hospital chaplain you can ask a member of staff to arrange this for you.
    - If you have a clinical need for transport to get to a hospital or clinic appointment, ask a member of NHS staff or your Health Board about the Patient Transport Service.
    - The independent Patient Advice and Support Service (PASS) can provide advice and tell you about support services available to you. See page 25 for information on how to contact them.
- **You have the right to be registered with a GP practice.**
    - Your GP is usually your first and main point of contact for access to general medical services and referrals for hospital treatment. If you cannot register with your chosen GP practice, your Health Board can help you find another.
    - You can indicate a preference for a particular doctor within your GP practice. The GP practice will try to meet any reasonable preference.
    - A GP may be able to take steps to have you removed from the practice register in some situations, for example if you move out of the practice area or you are physically or verbally abusive to people at the practice.

- **You have the right to start to receive agreed inpatient or day case treatment within 12 weeks of agreeing to it. This is called the Treatment Time Guarantee.**
  - Patients who are due to receive planned treatment provided on an inpatient or day case basis have a right to start to receive the treatment within 12 weeks from the date they agree to the treatment. Some examples of treatments include hip or knee replacements or hernia surgery.
  - If your agreed treatment has not started within 12 weeks, your Health Board **must** explain the reasons for this, and give you information about how to make a complaint if you wish to do so. Your Health Board **must** also take steps to ensure you start your treatment at the next available opportunity, taking account of other patients' clinical needs.
  - There are a small number of treatments excluded from the Treatment Time Guarantee. Further information is given in the **Your health, your rights: Hospital Waiting Times** factsheet. See page 24 on how to get your copy.

What does the NHS expect from me?

- **You should register with a GP practice.**
  - Your GP is usually your first and main point of contact for access to general medical services and referrals for hospital treatment. If you are unable to register with your preferred GP practice, your Health Board can help you find another.
- **You should register with a dental practice.**
  - If you are unable to register with your preferred NHS dental practice, your Health Board can provide details of other dental practices that accept NHS patients. If you are unable to register with your preferred NHS dental practice, NHS inform can help you find another. See page 24 for information on contacting NHS inform.
- **You should attend any GP, dental, optical, hospital or clinic appointments that have been arranged.**
  - If you cannot keep an appointment, let the GP practice, dental practice, optician, hospital or clinic know as soon as possible. This will allow them to offer it to someone else.
  - Be on time for appointments. If you are going to be late, let a member of staff know.
  - If a member of NHS staff (for example a Health Visitor or Community Psychiatric nurse) is coming to visit you at home, make sure you are in at the agreed time or let them know in advance if you are unable to keep the appointment.
  - Make sure your GP practice, dental practice, optician and any hospital or clinic you are attending has up-to-date information about how to contact you.

- **You should use health services responsibly.**
  - Always try to order repeat prescriptions in plenty of time. This will ensure your prescription is processed in time for you.
  - Use your GP practice or local pharmacy for routine treatment and medical advice.
  - **Only go to your local Accident and Emergency department (A&E) in an emergency**.
  - If you are ill when your doctor's surgery is closed and you feel you can't wait until it reopens, phone NHS 24 on **08454 24 24 24** for advice.
  - **If you or someone else is ill and you think your/their life is in danger, always phone 999 and ask for an ambulance.**

Communication and participation: the right to be informed, and involved, in decisions about health care and services

What does this mean for me?

- **You have the right to be involved in decisions about your care and treatment.**
  - NHS staff must not make decisions about your care and treatment without involving you in that decision as appropriate.
  - You can ask for a second opinion before you make a decision about your care and treatment, if you think you need it. Where possible, your request will be met.
  - You can ask any question if you do not understand something.
  - You should be given enough reasonable time to make up your mind about any proposed examination or treatment, without pressure from staff.
  - If you are unable to make a decision for yourself, you must still be supported and encouraged to be involved in decisions about your care and treatment.
  - If you are unable to make a decision for yourself, staff who have to make decisions about your care and treatment may also consider:
    - what is the best clinical option for you
    - what you have said in the past about how you want to be treated
    - the views of others who are close to you
    - the views of a parent, guardian or other person who has responsibility for you if you are a child
    - the views of anyone who has legal authority to make a decision on your behalf
- **You have the right to be given the information you need to make informed choices about your health care and treatment options.**
  - You have the right to be told about the care and treatment options available to you.
  - You have the right to be told what the care or treatment will involve, including the risks and benefits, and what may happen if you do not have the treatment.
  - You can ask for more information if you want to know more.
  - You have the right to be given information in a way you can understand.

- **You have the right to request support when making decisions about your health care.**
  - If you need an interpreter or a sign-language interpreter, or other communication support, you can ask in advance for a member of staff to arrange this for you.
  - Please let staff know if you want someone else present at an appointment. This could be a carer, family member, partner, friend, or another health care worker.
  - You may ask (and if you have a mental health disorder you have a right) to have an independent advocate to help you give your views. NHS staff can arrange this for you.
- **You have the right to clear communication about your care and treatment from NHS staff.**
  - Staff must communicate clearly and openly with you about your care and treatment.
  - Staff must check whether you have understood the information you have been given and whether you would like more information before making a decision.
  - You have the right to be given all the information you need about your medicines, and their possible side effects, in a way you can understand.
  - If you have a long-term condition, staff must make sure you have clear information about your condition in a way you can understand.
  - You have the right to get support to manage your condition. For example, you can expect staff to tell you how and when to take your medication, how to control pain and how to access other services that could help you.
  - You have the right to be given information about support that is available from the NHS and other relevant agencies for example local authorities, the Patient Advice and Support Service and the voluntary sector, and any follow-on care that is available to you.
  - You have the right to be given information about your care and treatment in a format or language that meets your needs (for example in audio format, British Sign Language or in a language other than English).
  - If you have to go to hospital for treatment you should be told how long you are likely to have to wait.
  - You should be told the names of the staff responsible for your care and how to contact them.
  - You are entitled to get a copy of any letters, faxes or emails written by NHS staff about your care and treatment if you ask for them (in line with the Data Protection Act 1998), although you may have to pay for them. See page 25 on how to find out more about your rights under the Data Protection Act.

- You can access information and advice on how to give feedback, make comments and raise concerns or complaints about the care you have received and the services you have used. The independent Patient Advice and Support Service can help you with this. See page 25 for contact details.

- **You have the right to accept or refuse any treatment, examination, test or screening procedure that is offered to you.**
  - If you can understand the information you are given and are capable of making a decision for yourself about the care or treatment you are offered and appropriate available alternatives, then you have the right to accept or refuse any treatment, examination, test or screening procedure, or to take part in research.
  - If you are the carer of an adult who is unable to make decisions about their health care and treatment without help, you can expect to be involved in the decision making process under the terms of the Adults with Incapacity (Scotland) Act 2000.
- **If a person is under 16, and the health professional looking after them believes they can make decisions for themselves, then the person under 16 can make a decision about their own health care and treatment.**
  - But if you are the parent of a person under 16 who is unable to make decisions for themselves, you can decide about their health care and treatment. The same applies if you have legal responsibility for a person under 16.
- **You have the right to have your wishes about organ and tissue donation respected after your death.**
  - If you join the NHS Organ Donor Register, you can expect staff to take account of your wishes. See page 26 on how to learn more about Organ Donation.
- **You have the right to be involved, directly or through representatives, in the planning, design and provision of services in your area.**
  - You can expect Health Boards to make decisions about changes to NHS services in an open and honest way.
  - Health Boards must involve the people who live in their board area in the planning and development of services, and in decisions that significantly affect the operation of those services.

What does the NHS expect from me?

- **That you take some personal responsibility for your own health.**
  - Ask your GP or any member of staff involved in your care for support to help you manage your condition and to lead a healthy lifestyle.

- **That you take an active part in discussions and decisions about your health care and treatment.**
  - If you want or need more information to help you make decisions about the care and treatment that is available to you, ask a member of staff.
  - Discuss your care and treatment with staff in an open and honest way.
- **That if there is anything you do not understand, you ask questions.**
  - If there is anything you do not understand about your condition or treatment, ask NHS staff to explain it. And please make sure you understand how to take any medicines you have been given. The leaflet **It's okay to ask** offers handy tips and advice on asking questions and is available from Health Rights Information Scotland (HRIS). See page 24 on how to contact HRIS.
  - Ask staff to explain any words you do not understand.
  - Tell a member of staff if you need information in a particular way to meet your needs (for example, in audio format, British Sign Language or a language other than English).
- **That you let staff know about any changes in your health condition.**
  - Share information about anything that may be relevant to your care and treatment.
- **That you tell your GP practice, dental surgery, optician and any hospital or clinic you go to if you change your address, phone number or email.**
  - This is to make sure staff involved in your care can easily contact you about your treatment, check-ups or appointments.
- **If you want to become an organ or tissue donor after you die, put your name on the NHS Organ Donor Register.**
  - You should also carry a donor card and discuss your wishes with the people close to you. See page 26 for how to contact the NHS Organ Donor Register.

Confidentiality:

the right for your personal health information to be kept secure and confidential

What does this mean for me?

- **You have the right for your personal health information to be kept secure and confidential.**
  - NHS staff must keep your personal health information confidential in accordance with confidentiality laws, the Data Protection Act 1998 and professional standards. See page 25 on how to find out more about your rights under the Data Protection Act.
  - Staff must not discuss confidential information about you in public without your consent. There may be some circumstances however where your consent is not required (e.g. where there is a legal requirement for staff to share information, it is necessary in order to protect you, or it is in the public interest).
- **You have the right to know how your personal health information is stored, shared and used by the NHS.**
  - Staff use your information to give you the care and treatment you need. They will share relevant information about you with other staff involved in your care where this is necessary.
  - Some of your personal health information may be given to other people who need information about your health in order to contribute to your care - for example, a carer, a home help or a social worker. Subject to certain exceptions (for example a medical emergency or legal requirement), your personal health information will only be given to them and to other NHS staff if you have agreed to this.
  - Sometimes the NHS also uses relevant information about your health to help improve NHS services and public health in Scotland - for example to find out how many people have a particular illness or disease. If so, information that identifies you is removed if possible. If the NHS uses information that does identify you (for example to include it in a disease register), they must explain how and why your information will be used.
  - You may give consent to your information being used or shared in different ways, for example, depending on the circumstances:
    - by saying that you agree or signing a form, or
    - by not objecting when it is clear that the information will be shared.

- **NHS staff must not give information about you to organisations such as employers or the media without getting your permission.**
  - Sometimes the law allows the NHS to share your information without your permission where disclosure can be justified in the public interest to protect individuals and communities from serious harm (for example to prevent the spread of a communicable disease or to investigate a serious crime).
- **You have a right to say if you do not want your personal health information to be shared in particular ways, and to expect that the NHS will not normally pass on your personal health information without your permission.**
  - If you do not want your personal health information to be used or shared, tell a member of staff providing your care. If you do this, the NHS has to limit how it uses your information where possible. The NHS may, however, be required to share information in an emergency or if the law says it must, even if you do not consent.
  - You should tell staff if you want your information to be shared with family members or a carer.
- **You have the right to access your own health records.**
  - If you want to see or get a copy of your health records, you should contact the practice manager at your GP practice or the records manager at the hospital or other NHS service provider that holds your health records. Some information on your records may be kept from you. For example, you won't be able to see information that could cause serious harm to your physical or mental health, or might identify another person (except staff who have treated you), unless that person gives permission or it is reasonable in all the circumstances to disclose the information without such consent.
  - You may have to pay (in line with the Data Protection Act 1998), to see your records and/or get a copy but you do not need to give a reason for wanting to see them.
  - After you give staff enough information to identify you and your health records and pay any fee, you will normally receive the information within 40 days.
  - Staff should explain any words you do not understand. Let staff know if you need your records to be given to you in another format. This will be done wherever possible.
- **If you care for an adult who cannot make decisions for themselves, or who cannot tell others their decisions, the law allows you to see their records, only if:**
  - they have granted you a welfare power of attorney, or
  - a court has appointed you Guardian with welfare powers or given you power to do so under an Intervention Order.

What does the NHS expect from me?

- **That you help to keep your health records accurate and up-to-date.**
  - Tell your GP practice, dental practice, optician, and any hospital or clinic you go to if you change your name, address, phone number or email address.
  - Let staff know if any information in your health records is wrong.
  - Tell your GP practice, dental practice, optician, and any hospital or clinic you go to if you do not want your personal health information shared in a particular way.
  - That you protect the privacy of the personal health information which you hold, for example letters you have been sent by the NHS in Scotland.

Respect:
the right to be treated with dignity and respect

What does this mean for me?

- **You have the right to be treated as an individual and with dignity and respect.**
  - When using NHS services and receiving NHS care, you can expect to be treated with dignity and respect and in a way which takes your needs, understanding and culture into account.
  - You have the right to ask for your needs and preferences to be taken into account. Health Boards must take such matters into account and are committed to doing so. However, your Health Board must also consider the rights of other patients, clinical judgement and the most efficient way to use NHS resources.
  - In emergencies, decisions need to be made quickly. However, in other cases, you can expect to be given enough time to make up your mind about any examination or treatment, without pressure from staff.
  - You have the right to expect staff to respect your right to confidentiality, except where the law requires or authorises them to disclose information. See the Confidentiality section on page 13 for more information.
- **You have the right not to be unlawfully discriminated against because of your age, disability, sex, or sexual orientation, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief.**
- **You can expect your right to privacy to be respected when receiving health care.**
  - When staff examine you, you can expect this to be done in a private place that is appropriate to the circumstances. This may not always be possible (for example, in an emergency).
  - You can say if you do not want students to be present while you are examined or treated.
  - If you have to stay overnight in a hospital, you can usually expect to be in a single-sex room or ward. However, this may not be possible if you need intensive care or in an emergency.

What does the NHS expect from me?

- **That you treat staff, other patients, their carers and family members with consideration, dignity and respect.**
  - You must not be abusive, violent or aggressive towards staff or other patients, their carers and family members. Violence includes verbal or written abuse and threats, as well as physical assaults.
  - You must not be involved in any racial, sexual or any other kind of harassment or abuse towards staff or other patients, their carers and family members.

Safety:
the right to safe and effective care

What does this mean for me?

- **You have the right to expect that any care and treatment you receive is provided with reasonable care and ordinary skill by properly qualified and experienced staff.**
  - You can expect that everyone working in the NHS has the appropriate skills and training for their job.
  - Any person treating you must act with reasonable care.
  - Any health care professional treating you must act with the ordinary skill of a person in that profession.
  - The care and treatment you receive must be suitable for you, carried out lawfully and based on recognised clinical guidance and standards where these exist.
  - You can expect that any medicines your doctor or other qualified health care professional prescribes are appropriate for you.
- **You have the right to expect that the treatment you receive is provided in an appropriate, safe and clean environment.**
  - You can expect that the care you receive will be provided as safely as possible**.**
  - You can expect health care premises to meet standards of hygiene agreed by the NHS and monitored by the Healthcare Environment Inspectorate (HEI). See page 26 for further information on the HEI.
  - Staff should always wash their hands before they examine you.
- **You have the right to expect that your personal health information is kept accurate and up-to-date.**
  - The NHS will keep accurate and up-to-date records of the care you receive.
  - If you need to move from one care provider to another (for example, from hospital to care at home), information about the care you need will be shared with any relevant care providers if you have given your permission for this. This means there should be no interruption to the care you need. See the Confidentiality section on page 13 for more information.

What does the NHS expect from me?

- **You should follow any advice you are given on medication and treatment.**
  - Ask staff to explain anything you do not understand. You can use the leaflet **It's okay to ask** to note your questions. The leaflet **It's okay to ask** offers handy tips and advice on asking questions and is available from Health Rights Information Scotland (HRIS). See page 24 on how to contact HRIS.
  - Tell staff if you are allergic to any medicines or if you have experienced any side effects after taking a particular medicine.
  - Finish any course of agreed treatment. If you want to change or stop your treatment, you should discuss this with your doctor, dentist or pharmacist first.
  - Do not take any medicine that is out of date or prescribed for someone else. Give any out-of-date or unused medicines to your pharmacist to get rid of safely.
  - Store medicines safely and out of children's reach.
  - If you go into hospital or attend a dentist, tell staff about any medicines you are taking.
- **You should help to prevent the spread of infection in places where you or someone you are visiting receive NHS care.**
  - Always wash and dry your hands before entering a hospital ward, particularly after using the toilet. Use the hand gel provided at the ward door or at the bedside.
  - You should avoid visiting a patient in hospital or a resident in a care home if you are feeling unwell, or if you or anyone in your household is suffering from vomiting or diarrhoea. You should wait 48 hours after the vomiting or diarrhoea has stopped before visiting. If you are unwell you may be able to phone the ward or care home and speak to the person instead.
  - If you visit someone in hospital, do not sit on their bed. Keep the number of visitors as low as possible at any time. Never touch dressings, drips or other equipment around the bed.
  - Ask ward staff for advice before you bring food, drink or flowers for someone you are visiting in hospital.

- **You should raise any concerns you have about the safety, effectiveness or cleanliness of services that may affect your care.**
  - If you think a member of staff has forgotten to wash their hands before examining you, ask them to do this.
  - If you think NHS premises are not as clean as they should be, let a member of staff know. If you are in hospital, you can ask to speak to the ward sister or charge nurse about this.
  - You can report your concerns to the Healthcare Environment Inspectorate. See page 26 for how to contact them.
- **That you consider your health care needs when travelling abroad.**
  - If you are planning to visit a country in the European Economic Area or Switzerland, on holiday or on a business trip, you should get a European Health Insurance Card (EHIC). This card lets you get state health care at a reduced cost or sometimes for free. It will cover you for medical treatment you may need during your visit if you're ill or have an accident, or for the treatment of pre-existing medical conditions. The EHIC is free of charge. See page 26 on where to find out more.
  - Different countries have different health care systems. Many countries expect patients to pay towards the cost of their treatment. Before you go, find out about the country you're visiting. You should also take out travel insurance to ensure that you're fully covered. You should do this even if you have an EHIC, as the card won't cover you for costs such as rescue services in ski resorts, or being flown back to the UK.

Feedback and complaints:
the right to have a say about your care and have any concerns and complaints dealt with

What does this mean for me?

- **You have the right to give feedback, make comments, or raise concerns or complaints about the health care you receive.** This includes NHS services provided by GP practices, local pharmacies, dentist or opticians or NHS services commissioned and provided through a private health care provider. Further information about giving feedback and about the NHS Complaints Procedure can be found in the leaflet **Your health, your rights**: **Feedback and Complaints**. See page 24 for information on how to get a copy.
  - Your relatives or carers may also give feedback or comments, or raise concerns or complaints.
  - You have the right to be given information and advice on how to give feedback, provide comments, raise concerns, or make a complaint about the care you have received and the services you have used. And you have the right to be given information about how any feedback, comments, concerns and complaints you make will be handled.
  - You may ask (and if you have a mental health disorder you have a right) to have an independent advocate to help you give your views. Staff can arrange this for you.
  - In some cases it may be appropriate for your complaint to be resolved through the provision of alternative dispute resolution services (mediation). This is a service where independent mediators help the relevant parties to reach an agreement. You can request, or Health Boards may offer, to provide this service although both parties must agree to take part in the mediation. The Feedback and Complaints Officer at your local Health Board can provide further information about mediation.
- **You have the right to be told the outcome of any investigation into your concerns or complaints.**
  - You can expect any concern or complaint you raise about NHS services to be dealt with efficiently and to have it properly and appropriately investigated.
  - You can expect to receive a full explanation and to be told what action has been or will be taken as a result of any complaint you make. Where a mistake has occurred you should receive an apology.
  - You have the right to expect the NHS to take your feedback into account in order to improve services.

- **You have the right to independent advice and support to provide feedback, make comments, raise concerns or make a complaint.**
  - The independent Patient Advice and Support Service (PASS) can help you with this. See page 25 for how to contact them.
- **You have the right to take your complaint to the Scottish Public Services Ombudsman (SPSO).**
  - If the NHS has fully investigated your complaint and you are still not satisfied, you can ask the SPSO to consider your complaint further. See page 26 for how to contact them.

Claims for compensation for injury or harm caused by clinical negligence are not dealt with under the NHS Complaints procedure. See Part 2: What if my rights have not been respected on page 23.

What does the NHS expect from me?

- **That you give feedback positive or negative about the care and treatment you have received or about the NHS generally. This helps to improve services for everyone.**
  - If you have feedback, comments or concerns about your health care, you can:
    - speak to a member of staff
    - take part in NHS surveys
    - put your comments in a suggestion box (if available)
    - use the feedback forms on Health Board websites
    - use the Better Together website to share your experiences with the NHS and people across Scotland (go to www.bettertogetherscotland.com). Some Health Boards do not use the Better Together website but have their own ways of making it possible for people to share experiences.
  - If you have a complaint about the service provided, you can contact the Feedback and Complaints Officer at your local Health Board or primary care service provider.

Part 2: What if my rights have not been respected?

If you think any of your rights have not been respected or that the NHS is not meeting its commitments, **you can raise a concern or make a complaint.**

- In the first instance, you should talk to a member of staff involved in your care to see if your concern or complaint can be sorted out immediately.
- If you do not want to do this, you can speak to the Feedback and Complaints Officer, the person in charge at the NHS organisation involved, or follow the NHS complaints procedure. The leaflet **Your health, your rights**: **Feedback and Complaints** tells you how to do this. See page 24 for information on how to get a copy.

If the NHS in Scotland has not respected your rights and you have been harmed by negligent treatment you have the right to take legal action and make a claim for compensation.

- Negligent treatment is when care provided falls below the reasonable standard to be expected in the circumstances and causes physical or mental injury or death.
- Depending on the individual circumstances, you may be entitled to compensation if you can prove through legal action that you have been harmed by a negligent act of the NHS in Scotland.
- If you think you may be entitled to compensation you are strongly advised to seek legal advice. To make a claim you or your solicitor should write directly to NHS National Services Scotland's Central Legal Office (CLO) who will then investigate the claim. See page 26 for contact details. Details of solicitors who specialise in handling negligence claims can be found on the Law Society of Scotland website (www.lawscot.org.uk) or by phoning 0131 226 7411.

You have the right to seek judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body.

- Judicial review is a court process that allows you to challenge a decision made by or action of an NHS body because you think it is unlawful. It looks primarily at how the decision was made rather than what was decided.
- As a general rule, you have the right to seek judicial review if your personal interests are affected by the action or decision you wish to challenge.

If you want a decision to be judicially reviewed, you should seek independent legal advice.

You may be subject to legal action if:

- you are abusive, violent or aggressive towards staff or other patients, their carers and family members.

Part 3: How can I find out more?

You can get the following leaflets and factsheets about health rights from:

- GP surgeries, hospitals and other places where you receive NHS services
- www.hris.org.uk (alternative formats are also available here) or at www.nhsinform.co.uk
- the NHS inform Helpline on **0800 22 44 88** (lines are open every day from 8am to 10pm).

For information about health rights

See the following leaflets and factsheets:

- The series of **Your health, your rights** factsheets tell you more about what the rights and responsibilities in this Charter mean for you. There are seven factsheets in the series: Access, Communication and participation, Confidentiality, Respect, Safety, Hospital Waiting Times, and Feedback and complaints.
- **Consent – it's your decision** explains how you should be involved in decisions about your health care and treatment.
- **How to see your health records** explains your right to see or have a copy of your health record.
- **Health care for overseas visitors** is a set of factsheets explaining what NHS services overseas visitors can expect to receive when they are in Scotland.

Information for young people

- **Consent – your rights** explains how you should be involved in decisions about your health care and treatment.
- **Confidentiality – your rights** tells you how the health service keeps information about you private.
- **Have your say! Your right to be heard** tells you how to give feedback or make a complaint about the NHS.

Information for carers

Caring and consent explains the rights of people who **cannot** consent to medical treatment and the rights of their carers.

For information about NHS services in Scotland:

- for details of all pharmacies, GP practices and dental practices in Scotland, visit www.nhs24.com
- for information about illnesses and conditions, treatments, NHS services and other support services, visit www.nhsinform.co.uk
- phone the NHS inform Helpline on **0800 22 44 88** (textphone 18001 0800 22 44 88; the helpline also provides an interpreting service). Lines are open every day from 8am to 10pm.
- see the leaflet **eHealth – using computers to improve your** health care for more about how eHealth will affect the service you receive from the NHS, how your information will be stored and shared safely and legally and what may happen in the future. It is available on the internet (go to www.hris.org.uk).

For information, help and advice

- **For independent help and advice** you can speak to someone at the independent Patient Advice and Support Service (PASS). The service provides free, accessible and confidential information to patients, their carers and families to raise awareness of their rights and responsibilities when using NHS services. It can also support you to provide feedback, comments, concerns or complaints about the NHS to help improve health care provision. The service is provided through the network of Citizen's Advice Bureau (CAB). You can visit www.cas.org.uk or use the phone book to find your local CAB.

- For more about the rights of people with mental illness, learning disability, dementia or other mental disorder, contact:

  Mental Welfare Commission for Scotland
  Thistle House, 91 Haymarket Terrace, Edinburgh EH12 5HE
  Phone **0800 389 6809** (freephone number for service users and carers)
  Email enquiries@mwcscot.org.uk
  Website www.mwcscot.org.uk

- For more about how your rights under the Data Protection Act, contact:

  Information Commissioner's Office (Scotland)
  45 Melville Street, Edinburgh EH3 7HL
  Phone **0131 244 9001**
  Email scotland@ico.gsi.gov.uk
  Website www.ico.gov.uk

- If the NHS in Scotland has fully investigated a complaint and you are still not happy, you can contact:

  Scottish Public Services Ombudsman (SPSO)
  Freepost EH641, Edinburgh EH3 0BR or
  4 Melville Street
  Edinburgh EH3 7NS
  Adviceline freephone **0800 377 7330**
  Text **0790 049 4372**
  Email ask@spso.org.uk
  Website www.spso.org.uk
  Online contact form www.spso.org.uk/contact-us

- If you think you may be entitled to compensation and you wish to make a claim, you should write directly to:

  Central Legal Office
  Anderson House
  Breadalbane Street
  Bonnington Road
  Edinburgh EH6 5JR
  Phone **0131 275 7800**
  Website www.clo.scot.nhs.uk

- **To join the NHS Organ Donor Register:**

  Phone - **0300 123 23 23**
  Text - SAVE to 61611
  Visit www.organdonationscotland.org and complete the online form

- **To apply for an EHIC card:**
  For further information on the European Health Insurance Card, and also how to apply for yours free of charge, visit www.nhsinform.co.uk/travel-health or telephone **0800 22 44 88**.

For information about standards

- To find out about the **Healthcare Environment Inspectorate** and how to contact them, visit the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org.
- To find out about how decisions are made before medicines can be routinely prescribed by NHS doctors in Scotland, see the leaflet: **New medicines in Scotland – who decides what the NHS can provide?** It is available from the Scottish Government website (go to www.scotland.gov.uk).

(The Scottish Government is not responsible for the content of the external links. They are provided for information only, and are not part of the Charter.)

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This document is also available on the Scottish Government website:
www.scotland.gov.uk

APS Group Scotland
DPPAS13379 (09/12)

United Nations Convention on the Rights of Persons with Disabilities

Preamble

The States Parties to the present Convention,

(a) *Recalling* the principles proclaimed in the Charter of the United Nations which recognize the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world,

(b) *Recognizing* that the United Nations, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, has proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind,

(c) *Reaffirming* the universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination,

(d) *Recalling* the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Rights of the Child, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families,

(e) *Recognizing* that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others,

(f) *Recognizing* the importance of the principles and policy guidelines contained in the World Programme of Action concerning Disabled Persons and in the Standard Rules on the Equalization of Opportunities for Persons with Disabilities in influencing the promotion, formulation and evaluation of the policies, plans, programmes and actions at the national, regional and international levels to further equalize opportunities for persons with disabilities,

(g) *Emphasizing* the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development,

(h) *Recognizing also* that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person,

(i) *Recognizing further* the diversity of persons with disabilities,

(j) *Recognizing* the need to promote and protect the human rights of all persons with disabilities, including those who require more intensive support,

(k) *Concerned* that, despite these various instruments and undertakings, persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world,

(l) *Recognizing* the importance of international cooperation for improving the living conditions of persons with disabilities in every country, particularly in developing countries,

(m) *Recognizing* the valued existing and potential contributions made by persons with disabilities to the overall well-being and diversity of their communities, and that the promotion of the full enjoyment by persons with disabilities of their human rights and fundamental freedoms and of full participation by persons with disabilities will result in their enhanced sense of belonging and in significant advances in the human, social and economic development of society and the eradication of poverty,

(n) *Recognizing* the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,

(o) *Considering* that persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them,

(p) *Concerned* about the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status,

(q) *Recognizing* that women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,

(r) *Recognizing* that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, and recalling obligations to that end undertaken by States Parties to the Convention on the Rights of the Child,

(s) *Emphasizing* the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities,

(t) *Highlighting* the fact that the majority of persons with disabilities live in conditions of poverty, and in this regard recognizing the critical need to address the negative impact of poverty on persons with disabilities,

(u) *Bearing in mind* that conditions of peace and security based on full respect for the purposes and principles contained in the Charter of the United Nations and observance of applicable human rights instruments are indispensable for the full protection of persons with disabilities, in particular during armed conflicts and foreign occupation,

(v) *Recognizing* the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms,

(w) *Realizing* that the individual, having duties to other individuals and to the community to which he or she belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the International Bill of Human Rights,

(x) *Convinced* that the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities,

(y) *Convinced* that a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries,

Have agreed as follows:

Article 1: Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2: Definitions

For the purposes of the present Convention:

“Communication” includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology;

“Language” includes spoken and signed languages and other forms of non spoken languages;

“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

“Reasonable accommodation” means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

“Universal design” means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. “Universal design” shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

Article 3: General principles

The principles of the present Convention shall be:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons;

(b) Non-discrimination;

(c) Full and effective participation and inclusion in society;

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women;

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 4: General obligations

1. States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:

(a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;

(b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;

(c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;

(d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;

(e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;

(f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;

(g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;

(h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;

(i) To promote the training of professionals and staff working with persons with disabilities in the rights recognized in this Convention so as to better provide the assistance and services guaranteed by those rights.

2. With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately

applicable according to international law.

3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.

4. Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent.

5. The provisions of the present Convention shall extend to all parts of federal states without any limitations or exceptions.

Article 5: Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.

2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.

3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.

4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 6: Women with disabilities

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of

guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Article 7: Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Article 8: Awareness-raising

1. States Parties undertake to adopt immediate, effective and appropriate measures:

(a) To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;

(b) To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;

(c) To promote awareness of the capabilities and contributions of persons with disabilities.

2. Measures to this end include:

(a) Initiating and maintaining effective public awareness campaigns designed:

(i) To nurture receptiveness to the rights of persons with disabilities;
(ii) To promote positive perceptions and greater social awareness towards persons with disabilities;
(iii) To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market;

(b) Fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;

(c) Encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;

(d) Promoting awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities.

Article 9: Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

(a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;

(b) Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures to:

(a) Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;

(b) Ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;

(c) Provide training for stakeholders on accessibility issues facing persons with disabilities;

(d) Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;

(e) Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;

(f) Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;

(g) Promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;

(h) Promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Article 10: Right to life

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 11: Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

Article 12: Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Article 13: Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their

effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 14: Liberty and security of the person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:

(a) Enjoy the right to liberty and security of person;

(b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.

2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.

Article 15: Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.

2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16: Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances

of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 17: Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 18: Liberty of movement and nationality

1. States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including by ensuring that persons with disabilities:

(a) Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;

(b) Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;

(c) Are free to leave any country, including their own;

(d) Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.

2. Children with disabilities shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by their parents.

Article 19: Living independently and being included in the community

States Parties to this Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Article 20: Personal mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

(a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;

(b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;

(c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;

(d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Article 21: Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

(a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;

(b) Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;

(c) Urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;

(d) Encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;

(e) Recognizing and promoting the use of sign languages.

Article 22: Respect for privacy

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

Article 23: Respect for home and the family

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;

(b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Article 24: Education

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and life long learning directed to:

(a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;

(b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;

(c) Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:

(a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;

(b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;

(c) Reasonable accommodation of the individual's requirements is provided;

(d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;

(e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:

(a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;

(b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;

(c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development.

4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

Article 25: Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-

sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26: Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Article 27: Work and employment

1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:

(a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;

(b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;

(c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;

(d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;

(e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;

(f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one’s own business;

(g) Employ persons with disabilities in the public sector;

(h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;

(i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;

(j) Promote the acquisition by persons with disabilities of work experience in the open labour market;

(k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.

2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

Article 28: Adequate standard of living and social protection

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.

2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:

(a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;

(b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;

(c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;

(d) To ensure access by persons with disabilities to public housing programmes;

(e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

Article 29: Participation in political and public life

States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake to:

(a) Ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:

(i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;
(ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;
(iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice;

b) Promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:
(i) Participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;
(ii) Forming and joining organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

Article 30: Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:

(a) Enjoy access to cultural materials in accessible formats;

(b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;

(c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.

2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.

3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.

4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.

5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:

(a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;

(b) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;

(c) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;

(d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;

(e) To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.

Article 31: Statistics and data collection

1. States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall:

(a) Comply with legally established safeguards, including legislation on data protection, to ensure confidentiality and respect for the privacy of persons with disabilities;

(b) Comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics.

2. The information collected in accordance with this article shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights.

3. States Parties shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others.

Article 32: International cooperation

1. States Parties recognize the importance of international cooperation and its promotion, in support of national efforts for the realization of the purpose and objectives of the present Convention, and will undertake appropriate and effective measures in this regard, between and among States and, as appropriate, in partnership with relevant international and regional organizations and civil society, in particular organizations of persons with disabilities. Such measures could include, inter alia:

(a) Ensuring that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities;

(b) Facilitating and supporting capacity-building, including through the exchange and sharing of information, experiences, training programmes and best practices;

(c) Facilitating cooperation in research and access to scientific and technical knowledge;

(d) Providing, as appropriate, technical and economic assistance, including by facilitating access to and sharing of accessible and assistive technologies, and through the transfer of technologies.

2. The provisions of this article are without prejudice to the obligations of each State Party to fulfil its obligations under the present Convention.

Article 33: National implementation and monitoring

1. States Parties, in accordance with their system of organization, shall designate one or more focal points within government for matters relating to the implementation of the present Convention, and shall give due consideration to the establishment or designation of a coordination mechanism within government to facilitate related action in different sectors and at different levels.

2. States Parties shall, in accordance with their legal and administrative systems, maintain, strengthen, designate or establish within the State Party, a framework, including one or more independent mechanisms, as appropriate, to promote, protect and monitor implementation of the present Convention. When designating or establishing such a mechanism, States Parties shall take into account the principles relating to the status and functioning of national institutions for protection and promotion of human rights.

3. Civil society, in particular persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process.

Article 34: Committee on the Rights of Persons with Disabilities

1. There shall be established a Committee on the Rights of Persons with Disabilities (hereafter referred to as “the Committee”), which shall carry out the functions hereinafter provided.

2. The Committee shall consist, at the time of entry into force of the present Convention, of twelve experts. After an additional sixty ratifications or accessions to the Convention, the membership of the Committee shall increase by six members, attaining a maximum number of eighteen members.

3. The members of the Committee shall serve in their personal capacity and shall be of high moral standing and recognized competence and experience in the field covered by the present Convention. When nominating their candidates, States Parties are invited to give due consideration to the provision set out in article 4.3 of the present Convention.

4. The members of the Committee shall be elected by States Parties, consideration being given to equitable geographical distribution, representation of the different forms of civilization and of the principal legal systems, balanced gender representation and participation of experts with disabilities.

5. The members of the Committee shall be elected by secret ballot from a list of persons nominated by the States Parties from among their nationals at meetings of the Conference of States Parties. At those meetings, for which two thirds of States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting.

6. The initial election shall be held no later than six months after the date of entry into force of the present Convention. At least four months before the date of each election, the Secretary-General of the United Nations shall address a letter to the States Parties inviting them to submit the nominations within two months. The Secretary-General shall subsequently prepare a list in alphabetical order of all persons thus nominated, indicating the State Parties which have nominated them, and shall submit it to the States Parties to the present Convention.

7. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election once. However, the term of six of the members elected at the first election shall expire at the end of two years; immediately after the first election, the names of these six members shall be

chosen by lot by the chairperson of the meeting referred to in paragraph 5 of this article.

8. The election of the six additional members of the Committee shall be held on the occasion of regular elections, in accordance with the relevant provisions of this article.

9. If a member of the Committee dies or resigns or declares that for any other cause she or he can no longer perform her or his duties, the State Party which nominated the member shall appoint another expert possessing the qualifications and meeting the requirements set out in the relevant provisions of this article, to serve for the remainder of the term.

10. The Committee shall establish its own rules of procedure.

11. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under the present Convention, and shall convene its initial meeting.

12. With the approval of the General Assembly, the members of the Committee established under the present Convention shall receive emoluments from United Nations resources on such terms and conditions as the Assembly may decide, having regard to the importance of the Committee's responsibilities.

13. The members of the Committee shall be entitled to the facilities, privileges and immunities of experts on mission for the United Nations as laid down in the relevant sections of the Convention on the Privileges and Immunities of the United Nations.

Article 35: Reports by States Parties

1. Each State Party shall submit to the Committee, through the Secretary-General of the United Nations, a comprehensive report on measures taken to give effect to its obligations under the present Convention and on the progress made in that regard, within two years after the entry into force of the present Convention for the State Party concerned.

2. Thereafter, States Parties shall submit subsequent reports at least every four years and further whenever the Committee so requests.

3. The Committee shall decide any guidelines applicable to the content of the reports.

4. A State Party which has submitted a comprehensive initial report to the Committee need not, in its subsequent reports, repeat information previously provided. When preparing reports to the Committee, States Parties are invited to consider doing so in an open and transparent process and to give

due consideration to the provision set out in article 4.3 of the present Convention.

5. Reports may indicate factors and difficulties affecting the degree of fulfilment of obligations under the present Convention.

Article 36: Consideration of reports

1. Each report shall be considered by the Committee, which shall make such suggestions and general recommendations on the report as it may consider appropriate and shall forward these to the State Party concerned. The State Party may respond with any information it chooses to the Committee. The Committee may request further information from States Parties relevant to the implementation of the present Convention.

2. If a State Party is significantly overdue in the submission of a report, the Committee may notify the State Party concerned of the need to examine the implementation of the present Convention in that State Party, on the basis of reliable information available to the Committee, if the relevant report is not submitted within three months following the notification. The Committee shall invite the State Party concerned to participate in such examination. Should the State Party respond by submitting the relevant report, the provisions of paragraph 1 of this article will apply.

3. The Secretary-General of the United Nations shall make available the reports to all States Parties.

4. States Parties shall make their reports widely available to the public in their own countries and facilitate access to the suggestions and general recommendations relating to these reports.

5. The Committee shall transmit, as it may consider appropriate, to the specialized agencies, funds and programmes of the United Nations, and other competent bodies, reports from States Parties in order to address a request or indication of a need for technical advice or assistance contained therein, along with the Committee's observations and recommendations, if any, on these requests or indications.

Article 37: Cooperation between States Parties and the Committee

1. Each State Party shall cooperate with the Committee and assist its members in the fulfilment of their mandate.

2. In its relationship with States Parties, the Committee shall give due consideration to ways and means of enhancing national capacities for the implementation of the present Convention, including through international cooperation.

Article 38: Relationship of the Committee with other bodies

In order to foster the effective implementation of the present Convention and to encourage international cooperation in the field covered by the present Convention:

(a) The specialized agencies and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite specialized agencies and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;

(b) The Committee, as it discharges its mandate, shall consult, as appropriate, other relevant bodies instituted by international human rights treaties, with a view to ensuring the consistency of their respective reporting guidelines, suggestions and general recommendations, and avoiding duplication and overlap in the performance of their functions.

Article 39: Report of the Committee

The Committee shall report every two years to the General Assembly and to the Economic and Social Council on its activities, and may make suggestions and general recommendations based on the examination of reports and information received from the States Parties. Such suggestions and general recommendations shall be included in the report of the Committee together with comments, if any, from States Parties.

Article 40: Conference of States Parties

1. The States Parties shall meet regularly in a Conference of States Parties in order to consider any matter with regard to the implementation of the present Convention.

2. No later than six months after the entry into force of the present Convention, the Conference of the States Parties shall be convened by the Secretary-General of the United Nations. The subsequent meetings shall be convened by the Secretary-General of the United Nations biennially or upon the decision of the Conference of States Parties.

Article 41: Depositary

The Secretary-General of the United Nations shall be the depositary of the present Convention.

Article 42: Signature

The present Convention shall be open for signature by all States and by regional integration organizations at United Nations Headquarters in New York as of 30 March 2007.

Article 43: Consent to be bound

The present Convention shall be subject to ratification by signatory States and to formal confirmation by signatory regional integration organizations. It shall be open for accession by any State or regional integration organization which has not signed the Convention.

Article 44: Regional integration organizations

1. “Regional integration organization” shall mean an organization constituted by sovereign States of a given region, to which its member States have transferred competence in respect of matters governed by this Convention. Such organizations shall declare, in their instruments of formal confirmation or accession, the extent of their competence with respect to matters governed by this Convention. Subsequently, they shall inform the depositary of any substantial modification in the extent of their competence.

2. References to “States Parties” in the present Convention shall apply to such organizations within the limits of their competence.

3. For the purposes of article 45, paragraph 1, and article 47, paragraphs 2 and 3, any instrument deposited by a regional integration organization shall not be counted.

4. Regional integration organizations, in matters within their competence, may exercise their right to vote in the Conference of States Parties, with a number of votes equal to the number of their member States that are Parties to this Convention. Such an organization shall not exercise its right to vote if any of its member States exercises its right, and vice versa.

Article 45: Entry into force

1. The present Convention shall enter into force on the thirtieth day after the deposit of the twentieth instrument of ratification or accession.

2. For each State or regional integration organization ratifying, formally confirming or acceding to the Convention after the deposit of the twentieth such instrument, the Convention shall enter into force on the thirtieth day after the deposit of its own such instrument.

Article 46: Reservations

1. Reservations incompatible with the object and purpose of the present Convention shall not be permitted.

2. Reservations may be withdrawn at any time.

Article 47: Amendments

1. Any State Party may propose an amendment to the present Convention and submit it to the Secretary-General of the United Nations. The Secretary-General shall communicate any proposed amendments to States Parties, with a request to be notified whether they favour a conference of States Parties for the purpose of considering and deciding upon the proposals. In the event that, within four months from the date of such communication, at least one third of the States Parties favour such a conference, the Secretary-General shall convene the conference under the auspices of the United Nations. Any amendment adopted by a majority of two thirds of the States Parties present and voting shall be submitted by the Secretary-General to the General Assembly for approval and thereafter to all States Parties for acceptance.

2. An amendment adopted and approved in accordance with paragraph 1 of this article shall enter into force on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the date of adoption of the amendment. Thereafter, the amendment shall enter into force for any State Party on the thirtieth day following the deposit of its own instrument of acceptance. An amendment shall be binding only on those States Parties which have accepted it.

3. If so decided by the Conference of States Parties by consensus, an amendment adopted and approved in accordance with paragraph 1 of this article which relates exclusively to articles 34, 38, 39 and 40 shall enter into force for all States Parties on the thirtieth day after the number of instruments of acceptance deposited reaches two thirds of the number of States Parties at the date of adoption of the amendment.

Article 48: Denunciation

A State Party may denounce the present Convention by written notification to the Secretary-General of the United Nations. The denunciation shall become effective one year after the date of receipt of the notification by the Secretary-General.

Article 49: Accessible format

The text of the present Convention shall be made available in accessible formats.

Article 50: Authentic texts

The Arabic, Chinese, English, French, Russian and Spanish texts of the present Convention shall be equally authentic.

In witness thereof the undersigned plenipotentiaries, being duly authorized thereto by their respective Governments, have signed the present Convention.

αβχδεφγηιφκλ
Health Department

NHS Management Executive
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Dear Colleague

HEALTH, SOCIAL WORK AND RELATED SERVICES FOR MENTALLY DISORDERED OFFENDERS IN SCOTLAND

Summary

1. With this letter we enclose copies of the Scottish Office policy governing health, social work and related services for mentally disordered offenders in Scotland which was launched by the Minister for Health and the Arts on 28 January 1999.

Background

2. The attachment to this letter was the subject of extensive consultations between 15 April and 31 August 1998 and now sets out the policy for the best organisation of care, services and support for mentally disordered offenders in Scotland.

3. The overall aim of the policy is to co-ordinate care and support for the benefit of the individual and to ensure public safety. The paper sets out steps that will involve multi agency and multi-disciplinary working to organise services which:

- provide care under conditions of appropriate security with due regard for public safety
- have regard to quality of care and proper attention to the needs of individuals
- where possible provide care in the community rather than institutional settings
- provide care that maximises rehabilitation and the individual's chance of an independent life.

Addressees

For action:
General Managers, Health Boards
General Manager, State Hospitals Board for Scotland
Chief Executives, NHS Trusts
Directors of Social Work/Chief Social Work Officers
Directors of Housing/Chief Housing Officers

For information:
Chief Executives, Local Authorities
Chief Executive, COSLA
Chief Executive, Scottish Homes
General Manager, Common Services Agency
Executive Director, SCPMDE
Mental Welfare Commission for Scotland
General Manager, HEBS

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Crown Office
Mrs C McDivitt

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Scottish Prison Service
Mr J McNeill

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Miss A Ross

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4. Agencies should be aware of 3 reviews which are in progress, or about to commence, and which may affect legislation and practice covering the detention, treatment and supervision of mentally disordered offenders. These are the review of the Mental Health (Scotland) Act 1984, under the chairmanship of the Right Hon Bruce Millan; the review of sentencing and treatment of serious violent and sexual offenders including those with personality disorders, under the chairmanship of the Hon Lord MacLean; and the Expert Panel on Sex Offending, under the chairmanship of the Hon Lady Cosgrove. The Millan and MacLean reviews are expected to report during the year 2000. The Expert Panel, which was announced in December 1997 to take forward key areas of 'A Commitment to Protect' (the 'Skinner Report'), will report annually to the Secretary of State on its past and planned work during its 3 year term.

Action

5. Health Boards, NHS Trusts, local authorities, the Scottish Prison Service, the Crown Office, the Police and other recipients are asked to ensure that this letter and attachment are distributed widely to all staff involved in the planning and delivering of services, care and accommodation for this care group (ie those who have committed an offence and also have a mental illness).

6. Each Agency is also requested to take the necessary steps to implement the recommendations within the attachment to this letter. Progress towards implementation will be monitored by The Scottish Office under established arrangements for these purposes. Where appropriate further guidance will issue in due course relevant to the action points identified in the attachment to this letter.

7. A copy of this letter and attachment are available on the internet (at www.scotland.gov.uk)

Yours sincerely

GEOFF SCAIFE
Chief Executive, NHS in Scotland

J HAMILL
Secretary, The Scottish Office Home Department

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HEALTH, SOCIAL WORK AND RELATED SERVICES FOR MENTALLY DISORDERED OFFENDERS IN SCOTLAND

The Scottish Office

1999

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PART I: REMIT AND GUIDING PRINCIPLES

1.1 This policy statement examines the provision of mental health and social work services for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work departments, the State Hospital and other psychiatric services in hospitals and in the community, and makes proposals for the organisation and development of these services throughout Scotland. This review does not in any respect change the role and responsibilities of Scottish Ministers in relation to State patients and is without prejudice to the work of the Millan Committee set up to review the provisions of the Mental Health (Scotland) Act 1984.

1.2 For the purposes of this paper 'mentally disordered offenders' covers those who are considered to suffer from a mental disorder as defined in the Mental Health (Scotland) Act 1984, whether or not they are, or may be, managed under its provisions and come to the attention of the criminal justice system. "Mental disorder" is used to cover those people with a mental illness or learning disability. The issues for people with a personality disorder, who do not commonly come under this heading, are also specifically considered. The term 'mentally disordered offender' covers wide variations in the state of mental health, in the severity of incidence in one individual over time and in the seriousness of actual or potential offending behaviour.

1.3 The overall objective is to promote the provision of a sufficient and effectively co-ordinated range of services (including health, criminal justice, social care, housing, education and employment and benefits advice) to meet the individual needs of mentally disordered offenders and the public interest. The public interest covers both the protection of the public and the most effective use of resources consistent with high standards of public safety.

1.4 In 1992 the Department of Health published the Review of Health and Social Services for Mentally Disordered Offenders and others requiring similar services (The Reed Report)(1) which related to England and Wales. This report has been widely accepted by clinicians and has become a part of the culture and working practice of forensic psychiatry in Scotland at a clinical level.

1.5 The Scottish Office policy on the delivery of these services is based on the same set of guiding principles and should be read with the Framework for Mental Health Services in Scotland (10). Mentally disordered offenders should be cared for:-

- with regard to quality of care and proper attention to the needs of individuals;
- as far as possible in the community rather than in institutional settings;

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- under conditions of no greater security than is justified by the degree of danger they present to themselves or to others;

- in such a way as to maximise rehabilitation and their chances of sustaining an independent life;

- as near as possible to their own homes or families if they have them.

Services for mentally disordered offenders should include careful assessment and management of risk in appropriate facilities. Where possible general health and social care services for the mentally ill should be used for treatment and support. The offenders' rights as citizens should be respected. Care should be provided with attention to the specific and sometimes different needs of those in a minority by virtue of ethnic group, gender, creed or religion.

1.6 This review paper covers the services provided for 'adults', that is those aged 18 or over. The services may however on occasion be expected to deal with those aged from 16 to 18. The needs of children and adolescents are very specific and every effort should be made so that they are dealt with separately. It is acknowledged that young mentally disordered offenders are particularly vulnerable. The transfer of responsibility from teams concerned with children's and young persons' services to teams providing adult services should allow some flexibility. The appropriate age for transfer will vary from case to case and depend on the nature and complexity of the individual's condition.

Background

1.7 Service provision for mentally disordered offenders is a complex and difficult field. It covers many different agencies and professional groupings throughout the public, private and voluntary sectors. The boundaries between some of the service areas and the responsibility for co-ordination of services may be only partially or not sufficiently defined. There is a need to consider the effectiveness of the system as a whole and this paper attempts to do this by bringing forward a series of proposals for each of the individual service areas. At the same time it identifies the tasks to be addressed by health and social care service providers and those who require access to these services, including decision makers in the criminal justice system, eg procurators fiscal, the courts and the Parole Board. Given the interdependence of health boards, social work departments and voluntary agencies who are responsible for the bulk of service provision, there are many opportunities to create new working partnerships and to strengthen key areas, such as joint planning for the future of the services.

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1.8 Although many mentally disordered offenders may be diagnosed as having more than one psychiatric condition, it is often the combination of medical and social factors which leads to their offending behaviour. The route to services for this group may be through social, criminal justice or health care agencies. The stated policy objectives should be effective joint responses for all, regardless of the severity of the presenting disorder, the seriousness of the offence, or the initial referral route.

1.9 Action will be taken forward by the relevant agencies which work together in this complex field. There are costs involved in providing the existing range of services and although additional costs may be associated with some of the key proposals there will be limited offsetting savings to be found elsewhere. The costs will have to be met within existing public expenditure totals.

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Co-ordination of Services and Public Safety

1.10 The co-ordination of services for mentally disordered offenders sets a special challenge. A large number of agencies is involved. From The Scottish Office point of view a range of financial and statutory relationships have to be accommodated within any overall plan. From the public point of view there is a need for reassurance that any dangerous behaviour by this group of offenders can be satisfactorily managed and contained at each level of service provision. Every stage of treatment should be preceded by a careful and detailed assessment of all the risks involved.

1.11 The mentally disordered offender is an individual who is entitled to treatment of his or her underlying condition and respect of their rights, as is any other individual. This is a matter which must take into account clinical and public protection issues. A variety of social and clinical facilities and treatments will be required within different settings and with varying levels of security so that the individual may be appropriately placed. Depending on the needs of the individual some of these facilities will be in hospital, some in prison and some in the community.

1.12 Providing the right services at the right time in the right place is particularly important for mentally disordered offenders. Thus, suitable psychiatric care or intervention may prevent or reduce offending behaviour. The right kind of secure hospital facilities will reduce pressure on the State Hospital. Good community support and related services will enable rehabilitation to take place in the community. The key to effective co-ordination is a clear overall framework with specific identification and acceptance of responsibilities. This paper sets out this framework.

The Framework

1.13 This paper examines the criminal justice process, the health and social care services and announces the policy for responding to the needs of the mentally disordered offender. A recurring issue in each section is that of sharing information between agencies. It is a basic principle that information about the health and welfare of a patient is confidential; that it must be safeguarded and that it should not be disclosed without the consent of the patient. Similar protections exist in relation to the information held by other agencies. There are, of course, circumstances where information can be disclosed without the patient's consent including where disclosure is in the public interest. For example where disclosure will prevent serious risk of harm to the individual or others and where it is necessary for the prevention, detection or prosecution of serious crime. The need for sharing or disclosure of information should be a consideration that is an integral part of clinical risk management.

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1.14 While it is clearly important to safeguard patient information it is also essential that this should not act as a barrier to the provision of an integrated service. The decision to share information where it is in the interests of the patient and where appropriate safeguards are in place must be taken locally by a senior health professional or appropriate senior professional within other Agencies. Ideally this should be done with the agreement of the patient. The Scottish Office, Department of Health recognises that there needs to be a consistency of approach in this area however. It is therefore the intention to take forward work with other Departmental interests to identify the key principles and practical issues relating to the sharing of information and to develop guidelines and protocols are required and which can be adopted locally. These will be developed taking account of professional guidelines including those of the GMC and UKCC.

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PART II: THE CRIMINAL JUSTICE PROCESS

This section addresses those aspects of the criminal justice system which relate to mentally disordered offenders and, in particular, police procedures, procurator fiscal decision-making, court disposal and transfers to and from prison. The roles of health boards and local authorities are also considered along with the requirement for joint planning and working.

2: INVESTIGATORY PROCEDURES

Background

2.1 When a person appearing to suffer from a mental disorder comes to the attention of the police, whether or not criminal proceedings are involved, a medical opinion should be sought immediately, either from the person's own doctor if the incident occurs within the person's own home, a police surgeon or a hospital doctor. This examination may take place within the person's own home, at a "place of safety" (normally a hospital), or in exceptional circumstances within a police station for instance when there is a continuing risk of violence.

2.2 When such a person is found in a public place, and not necessarily suspected of having committed an offence, but who is in "immediate need of care and control" may be removed by the police (under Section 118 of the Mental Health (Scotland) Act 1984 (the 1984 Act)) to "a place of safety". The Act defines this as a hospital or residential home for persons suffering from a mental disorder or any other suitable place which is willing temporarily to receive the patient; but does not include a police station unless in an emergency when there is no alternative place available for receiving the patient. Wherever possible, local arrangements based on an inter-agency approach should ensure that a mentally disordered person receives appropriate support and care. If a police station has to be used, then a police surgeon or other doctor should be readily available. The consultation paper which issued in July 1997 on 'The roles and responsibilities of general practitioners and police in dealing with potentially violent mentally disordered persons in the community' explains this process in more detail (2).

2.3 Where persons who might be suffering from a mental disorder are taken to a police station, for example, due to the seriousness of the suspected offence, they are often seen first by a doctor contracted to the police, namely the police surgeon, to assess the medical condition of people who are in police custody. The role of these police surgeons is to make an assessment of the individual's fitness for detention by the police. The police surgeon should obtain any necessary medical background from the person's own GP, if possible, before reaching a decision on his or her fitness. If the person is considered to be fit for detention, the police would deal with the suspected offender under the terms of the Criminal Procedure (Scotland) Act 1995 (the 1995 Act) as with any other suspected offender. If the

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mentally disordered person is considered to be unfit for detention, then they are considered for hospital placement under the relevant section of the 1984 Act. A report may still be submitted to the procurator fiscal for consideration of criminal proceedings. Some police surgeons may have little experience of dealing with mentally disordered people. In these cases assessment should be carried out preferably by an experienced psychiatrist who can then arrange appropriate mental health care, if necessary.

2.4 In some areas the operation of duty psychiatrist schemes, where experienced psychiatrists provide a prompt response to requests to examine people held in custody in police cells has demonstrated the value of the police being provided with an easily accessible psychiatric consultation service. In every case local arrangements between mental health services and the police should be in place.

2.5 The combined police, social work and health guidance "Interviewing People Who are Mentally Disordered: Appropriate Adults Scheme" (3) recommends that when the police interview an individual who is suspected of being mentally disordered, whether he or she is an accused, a witness or a victim, an "appropriate adult" should also be present. An appropriate adult should be someone who is completely independent of the police and, where possible, the interviewee and who has a sound understanding of and experience or training in dealing with mentally disordered persons or with the needs of a particular group. The guidance encourages the establishment of Appropriate Adult schemes throughout Scotland by June 1999, with police, social work and health interests locally nominating a lead agency.

Police Discretion

2.6 Where criminal behaviour is involved but only minor offences have been committed, the police may decide against charging and reporting the case to the procurator fiscal. In order to decide whether or not to report a case involving an alleged offender whose behaviour suggests that he or she may be suffering from a mental disorder, police need quick access to information and advice from health and social work services. Ideally local arrangements should provide for a single point of entry for referrals and for collaboration between health services (psychiatrists and community psychiatric nurses) and social welfare services (to include local authority criminal justice, community care and housing services as well as voluntary sector agencies). The police will particularly want to know whether the alleged offender is already under the care of the health or social services or whether to refer the person to one or both of these services before deciding whether charges should be brought. There should be hospital services available to accommodate mentally disordered offenders at short notice where they require containment for assessment or treatment in clinical facilities with an appropriate degree of security. This need may be independent of the severity of the alleged offence. Such individuals should not be left in custody while the process of law continues. In most cases a report will ensue and ultimately any decision to divert or remove

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the offender from the criminal justice process is a matter for the procurator fiscal, (see paragraph 5.18. While decisions about placement in the mental health system may need to take place urgently, decisions to drop charges should not. Discussion about this can take place with the psychiatric team involved in the patient's long term care. If a mentally disordered offender is considered to pose a severe risk to others, there should be careful consideration of the security requirements. Hasty decisions should be avoided.

Deciding about Prosecution

2.7 As with the provision of information and advice to the police, there needs to be good co-ordination between those responsible for providing information and advice to procurators fiscal. Local arrangements should provide a single point of entry for referrals as stated in the previous paragraph. (See also paragraph 5.18.)

2.8 Identifying those alleged offenders who may be suffering from a mental disorder is critical to this approach. Basic awareness training for police officers is already included in probationer, constable and detective training, and the Appropriate Adults guidance (3) recommends additional training in this area, covering how to identify mental disorder, basic techniques for dealing with mentally disordered individuals and appropriate forms of questioning. Police may also be able to make better use of information which is already available about repeat offenders previously identified as having a mental disorder and ensure that that is communicated to the procurator fiscal in the report. Procurators fiscal will also take account of such information and would welcome approaches by others with a knowledge of the accused and his circumstances.

2.9 As well as effective joint planning of the service to fiscals, each agency needs to be in a position to commit the necessary resources. Local arrangements for direct referral by the procurator fiscal for psychiatric assessment should be available. The correct identification of alleged offenders with mental disorder and the alerting of the procurator fiscal to the suspicion is a key trigger for accessing specialist services. It is also important for the police and the procurator fiscal to establish whether repeat offenders have been previously identified as suffering from a mental disorder, before deciding how best to proceed with cases.

The Health Board Role

2.10 Mentally disordered people who come into contact with the law should receive care and support from health or social work services. Health boards should ensure that this provision is covered by appropriate agencies. The service specification should ensure that mentally disordered individuals in police custody are examined by an experienced psychiatrist within 24 hours of the request being made. Health boards should ensure access to appropriate beds so that, if admission to hospital is appropriate this can be arranged quickly.

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The Local Authority Role

2.11 Local authorities contribute to services for mentally disordered offenders through their responsibility for planning and providing community care services in partnership with the NHS, through their responsibility for providing social work services in the criminal justice system and through their responsibility for housing services. They have statutory responsibility for providing mental health officers under the Mental Health (Scotland) Act 1984. In seeking to meet the needs of the mentally disordered offender, the role of criminal justice social work services is primarily concerned with providing information and advice for decision makers and with helping to access appropriate assessment, health and social care services. Their job is to complement the work of other local authority and health services in providing for those suffering from mental disorder who have offended. Housing services are a responsibility of the same unitary authority.

Joint Planning

2.12 Mentally disordered people have widely differing needs. Some require specialist services because of their offending behaviour but the majority can be looked after within the general mental illness or learning disability services. Multi-agency joint planning and resourcing of these services by health and social work agencies should be geared to meeting the needs of mentally disordered people who offend and, in particular, should provide, wherever possible, for their diversion from the criminal justice system at the earliest opportunity. Housing departments and other agencies will have an input where placement in the community is envisaged. Services for people with learning disabilities should be distinctively tailored to the health, education and social care needs of such persons.

2.13 A network of health and social care services, available to each police authority and procurator fiscal service, is required if the needs of mentally disordered people who come into conflict with the law are to be met and the right balance struck between meeting these needs and those of the public interest. Development of such networks should be an integral part of joint planning between the courts, police, criminal justice social work, community care and health services.

The Service Requirement

2.14 Health boards and social work departments should work together to develop services for mentally disordered people who come into contact with the criminal justice agencies through joint planning procedures which are already an integral part of the community care process. Health boards and local authorities should enter service level agreements with the criminal justice agencies to provide effective and flexible local arrangements for the initial

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assessment and treatment of people in their charge who appear to be mentally disordered. Procurators fiscal should be involved in discussions as to levels of service. These service agreements should cover:

- the use of Section 118 of the 1984 Act ("removal to a place of safety");

- the availability to the criminal justice agencies of "duty psychiatrists" and "appropriate adult" services;

- the facilities and services that can be used for mentally disordered people diverted from the criminal justice system;

- the provision of specialised accommodation for mentally disordered accused persons who might otherwise have to be remanded unnecessarily in custody; and

- the specification should address the 3 levels of service to be provided:

    (1) emergencies within 24 hours;

    (2) urgent cases to be covered within one week; and

    (3) routine cases to be completed within 3 weeks.

- the specification should also cover the training needs of those who will be required to operate these services on a day-to-day basis.

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3: COURT PROCEEDINGS

The criminal courts require assistance in the following areas:

- *in assessing the fitness of an accused to plead;*
- *in assessing the state of mind of an accused person at the time of the offence;*
- *the disposal of a case where an Examination of the Facts (EOF) makes a finding that the person did the act or made the omission constituting the offence; and*
- *the disposal of a case if a person has been found guilty of an offence.*

This section addresses these requirements and identifies proposals for the improvement of the services available including multi-disciplinary assessment in the larger courts and the development of an emergency psychiatric service.

The Health Service Role

3.1 When the prosecution service suspects that an accused is mentally disordered, they will ask for a report from the local psychiatric service. Expert witness reports from psychiatrists and clinical psychologists may be provided for the prosecution, or defence. An assessment of mental disorder may be made at an early stage, with a recommendation for remand to hospital under the Criminal Procedure (Scotland) Act 1995, if the psychiatrist considers the person to be mentally disordered and detainable under mental health legislation. This allows for the gathering of more information and a further period of assessment before any final recommendation is made on disposal.

The Local Authority Role

3.2 Following conviction, or a finding at an Examination Of the Facts (EOF) that the person did the act or made the omission constituting the offence, the court may ask for a social enquiry report (SER) to be provided by criminal justice social work staff in accord with national standards, or a psychiatric report, or both. The court must obtain an SER in certain circumstances and may request one in any case.

3.3 The SER will include information and analysis of those aspects of the offender's circumstances and personality which may have a bearing on the person's offending behaviour. One aspect involves an initial assessment/screening of the offender's apparent state of mental health. If concerns are identified, the author of the social enquiry report can suggest that the court obtains a formal psychiatric report. Alternatively, the author may

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establish that the offender is currently receiving or has received treatment and may seek information and advice from the relevant medical services to include in the SER. The SER will also review disposal options appropriate to the assessment which has been made of the offender. The content of the SER is disclosed to the offender.

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Bail Decision-making

3.4 Mentally disordered people have the same rights as others to be considered for bail and they should not be deprived of this right. However, the police or court may be inhibited from releasing a suspect or granting bail, if a suspect is homeless, or because there is doubt whether the individual can understand an obligation to attend court if released. Social work departments can provide information and advice relevant to the decision by the court about whether to grant bail. Two bail information/supervision schemes have been established in Scotland (see paragraph 5.17) which check information about an alleged offender, access resources and, when requested by the court, offer a supervision service. Where no such scheme is in place, it is still possible through the arrangements for planning local authority criminal justice and community care services to provide for assessment, supervision and accommodation to be made available to the court in suitable cases. (See paragraph 5.20 also.)

Multi-disciplinary Assessment

3.5 Good practice suggests that the principle of multi-disciplinary assessment should apply so that the offender's health and social care needs can be fully investigated and comprehensive advice can be provided to the court to assist in decision making.

3.6 There are cases where symptoms of a mental disorder are not recognised until an individual appears in court or is remanded to prison. In such cases the psychiatric service provided for each health board's residents should therefore specify that the courts and procurators fiscal in their area require a promptly delivered psychiatric assessment service to assist the transfer of an accused person to hospital as and when required. Development of a service involving a duty psychiatrist with access to community or hospital resources would be the preferred means. The psychiatric service needs to be complemented by a multi-agency network of services including clinical psychology, nursing, social work and housing.

3.7 The commitment of staff and resources to multi-disciplinary assessment arrangements at the post conviction stage should be an integral part of the same joint planning among court, social work, criminal justice community care, and health as discussed earlier in relation to formal diversion (paragraphs 2.12, 2.13). Normally an offender, considered by the Court to be mentally disordered and who has committed an imprisonable offence has sentence deferred for an SER and/or psychiatric reports to be obtained. The Criminal Procedure (Scotland) Act 1995 governs the time periods that apply to these procedures. Assessments of this kind are best carried out in the community (whether in hospital or an out-patient clinic). It should not be necessary to remand the offender in custody for the sole purpose of enabling assessment.

3.8 The court requires a properly co-ordinated multi-disciplinary assessment. To ensure a single entry system, arrangements for assessments of this kind should be the responsibility of

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the social work department (criminal justice social work services). The number of contributors to the assessment will depend on the circumstances of the case and on local court arrangements. Possible contributors should include psychiatry, social work community care or family services, clinical psychology, primary care and housing. Unless there are exceptional reasons, contact with the offender's family is an essential part of the assessment. Consideration, as known, of the issues relating to the victim, victim's family and the public are also an essential part of these assessments. The aim should be to develop, for the court, where appropriate, an individual service plan which identifies the potential range of services available to the offender in association with a suggested court disposal. If the court appearance results in custody, the plan should be sent to the prison by the Sheriff Clerk to inform work with the prisoner by prison-based medical and social work services.

3.9 To implement these proposals effectively, the authors of SERs need to have the skills and capacity to screen for mental health problems and to comment on the possible impact of a custodial sentence on someone with an identified mental health problem. This requires training which, subject to local agreement, should include other agencies involved to ensure all work from the same instruction base. See also paragraph 6.35.

3.10 A properly co-ordinated procedure for preparing multi-disciplinary assessment reports will be developed as a means of identifying the range of options available for mentally disordered offenders.

3.11 This approach requires more time for preparation of the reports and for consideration by the criminal justice agencies. Experience elsewhere has indicated that courts are prepared to provide longer adjournments (up to 8 weeks) to assist this procedure. The liaison required in preparing the reports will lead to increased collaboration in the provision of health and social care services for those who come before the courts.

3.12 Whatever local arrangements apply, supervised accommodation within the criminal justice network will not fully meet the needs of people with a range of mental disorders. Providing accommodation to ensure that accused persons who are mentally disturbed are not remanded unnecessarily in custody is largely a matter for community care service level agreements between health boards and local authority social work departments. Community arrangements will be inappropriate for the severely mentally disordered for whom local hospital care should be available. Local authorities and health boards should review the accommodation services provided for mentally disordered persons to ensure that they are not remanded unnecessarily in custody and that, wherever possible, they can be supported under existing community care arrangements.

Community-Based Disposals

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Deferred sentence

3.13 There are two main ways in which the court's powers to defer sentence may be used to deal with offenders with identified mental health problems. If the offender is receiving treatment, a deferred sentence provides a means for the court to allow the treatment to continue and to check its progress. A deferred sentence could also be used to motivate the offender to face up to the need for treatment. Voluntary support could be provided by the social work department or other social care agency to assist the individual in this respect.

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Supervision and treatment orders

3.14 The court can impose a supervision and treatment order on a person judged unfit to stand trial but who was found at an 'examination of the facts' to have done the act with which he was charged, or on a person who has been tried but acquitted on the ground of insanity at the time the act was committed. As the title of implies, this disposal involves both supervision and treatment in the community. It will be made only when the court considers it the most appropriate of the disposals available in these special circumstances, in respect of a person with a mental disorder who is considered able to live in the community with support and assistance from health and social care agencies. A joint circular of guidance has issued, (13).

Guardianship order

3.15 A guardianship order may be made by the court after consideration of an application by a Mental Health Officer made with the support of two doctors. As with supervision and treatment orders, the powers to enforce the order are limited and its use is best suited to mentally disordered offenders who may themselves require to be protected from abuse and who will adhere to the conditions laid down in the order. These may relate to arrangements for treatment/oversight and to where they should live. This order may be particularly suited to people with a learning disability.

Probation order with a condition of psychiatric treatment

3.16 The court may make a probation order of up to 3 years with a condition of psychiatric or psychological treatment of no longer than 12 months if it is assured that treatment is available either in an in-patient or an out-patient basis. The offender must give his/her informed consent. Orders of this kind require close co-operation between health and social work services. Primary responsibility for enforcing the order rests with the social work department (usually criminal justice social work services) but provision of individual care services remains with health/community care. The supervisory responsibility includes checking that the required treatment takes place and that a report is made to the court if, for whatever reason, it does not. Any recommendations to the court to make a probation order with a condition of psychiatric treatment should include an action plan setting out clearly the contribution of health, social work and any other social care agencies. This plan should be arrived at jointly and include the participation of offenders so that they can give their informed consent. The plan should set out clearly the commitment of the agencies involved. National standards for the supervision of probation orders require that progress is reviewed at regular intervals. These reviews should, wherever possible, involve the participation of all the agencies contributing to the action plan. A circular of guidance by the Home Department and the Department of Health is in preparation (1998).

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Hospital-based disposal options available to the Courts

3.17 For the purposes of this section references to "hospital orders" and "restriction orders" include references to orders that have the same effect as hospital orders and restriction orders. Before a person can be committed to hospital certain statutory conditions must be met, including that the grounds for admission to hospital set out in section 17(1) of the 1984 Act apply in relation to the person. The Mental Welfare Commission's protective duties (under the 1984 Act) towards people with mental disorder apply equally to mentally disordered offenders.

Remand for inquiry into physical or mental condition/Interim hospital orders

3.18 Under the Criminal Procedure (Scotland) Act 1995 courts have the power to remand an alleged offender in custody or on bail or commit him to hospital for up to 3 weeks at a time so that a medical examination and report may be made before deciding how to proceed. In certain circumstances the courts may impose an interim hospital order (maximum length 12 months) before proceeding to deal with the offender either by making a hospital order or in some other way (eg passing a sentence of imprisonment, with or without a hospital direction). The order is to allow sufficient time for a thorough assessment to be made of the person's mental condition where there would otherwise be difficulty in making such an assessment in the time available.

Hospital orders

3.19 Hospital orders can be made by the courts in the following circumstances:-

(i) where a person is convicted of offences punishable with imprisonment (other than offences for which the sentence is fixed by law);

(ii) where a person is acquitted on the ground of insanity at the time of the act or omission charged, either by a court or at an EOF; or

(iii) where an EOF makes a finding that the person did the act or made the omission constituting the offence.

Offences not punishable with imprisonment are excluded on the basis that it would be more appropriate to proceed under the 1984 Act in such cases. Hospital orders may be made only by the High Court or a sheriff court. These courts may not, in addition to making a hospital order, pass sentence of imprisonment or detention or impose a fine or make a probation order or a community service order. District courts have the power, in terms of the Criminal

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Procedures (Scotland) Act 1995, to remit a case to a sheriff court, if mental disorder is suspected.

Restriction orders

3.20 Where a hospital order is made in respect of a patient the court may also make a restriction order. The test for making such an order is that the court must be of the opinion that it is necessary 'for the protection of the public from serious harm' to make the order 'having regard to the nature of the offence with which the person is charged, the antecedents of the person and the risk that as a result of his mental disorder he would commit offences if set at large'. The majority of prisoners transferred to hospital are also subject to a restriction direction. Any transfer of such patients within the hospital system to an area of lesser security requires the approval of the designated Scottish Minister.

Hospital directions

3.21 The courts may, when passing a sentence of imprisonment after conviction on indictment, direct that the offender be admitted and detained in hospital for continuing care. Once recovered he would transfer to prison if any balance of the prison sentence remained to be served. Otherwise, when the sentence expired he would be released direct from hospital into the community, unless he was still ill, in which case he may be subject to detention in hospital under civil procedures.

Leaflet for Victims of Mentally Disordered Offenders

3.22 A leaflet will be available from The Scottish Office for victims of mentally disordered offenders which includes factual information about the processes that apply to offenders who are ordered to be detained in mental illness hospitals under the Criminal Procedure (Scotland) Act 1995 and who are as a result subject to the Mental Health (Scotland) Act 1984.

4: SCOTTISH PRISON SERVICE

The Scottish Prison Service is committed to commissioning health services, including mental health services comparable within the constraints of imprisonment, to those available to other citizens.

Provision in Relation to Prisoners

4.1 In the light of the guiding principles outlined in paragraph 1.5 problems of mental illness among prisoners require a coherent response from the Scottish Prison Service, the health service and local authorities. This should take the form of a care management

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approach to the extent that the problems of individual prisoners warrant it and the constraints imposed by imprisonment allow. This could be facilitated by service level agreements between prison managers and health providers and between prison managers and the relevant social work departments. The aim should be the provision of a continuous, integrated throughcare package which maximises access to community based services at each stage: health, community care services and specialist voluntary sector services. So far as possible within the constraints of resources and of imprisonment, the Scottish Prison Service aims to provide or commission services for prisoners with mental health problems in line with best practice in the wider community. The number of registered mental nurses within Scottish prisons continues to rise, and they should be involved in the assessment of those suspected of suffering from a mental disorder.

The Nature and Scale of the Problem

4.2 The Prison Service will deal both with prisoners whose mental disorder may be appropriate for medical intervention and those whose disturbed behaviour is not the result of mental disorder as defined earlier. While the number of prisoners with psychotic illness who might be accepted for transfer to hospital is quite small, research suggests that the rate of psychological disturbance in Scottish prisons could be at least twice that in the general population and perhaps even higher among female prisoners. Experience suggests that prisoners are most at risk of developing, or suffering exacerbation of, mental health problems in the period immediately following reception, whether on remand or after sentencing. The loss of social acceptance, of material possessions, general medical conditions and separation from family, friends and other social supports can be expected to have a detrimental effect on mental health.

Identifying and Responding to the Problem

4.3 Those entering prison with a current mental illness problem pose particular difficulties. For others, a period in prison may expose an underlying condition, while some prisoners may develop a mental illness for the first time during custody. All such individuals need accurate diagnosis and appropriate health and social care. Local authorities will have an important contribution to make towards identifying and helping these vulnerable prisoners. For prisoners with mental illness, prison managers in preparing such agreements will consider what contribution might be made by relevant social work services available within the community, eg community care teams, mental health teams, hospital social work, specialist voluntary sector programmes, befriending schemes etc.

The Mental Health Needs of Prisoners

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4.4 The following groups of prisoners, whether sentenced or on remand, may seek health service intervention for problems related to mental disorder, or be referred to medical staff by concerned staff:

(1) Those who have a mental disorder which falls within the categories set out in section 1 of the 1984 Act. Prisoners in this group should transfer to hospital if they meet the statutory transfer criteria of the 1984 Act.

(2) Those who have a mental disorder but who do not meet the criteria for transfer to hospital.

(3) Those who ask for the help of the caring agencies within the prison system, although they may not specifically fall within categories (1) and (2) above.

Psychiatric Assessment and Treatment, including Transfer to Hospital

4.5 Mentally disordered prisoners need access to psychiatric care in prison and, if their condition merits it, admission to hospital services which offer an appropriate level of security. Prisoners who do not meet the criteria for hospital admission need to be treated in prison under a suitable regime agreed with the psychiatric services or on an "out-patient" basis. Specialist forensic psychiatric care should be provided to all prisons with links to local forensic and general psychiatric services. Just as many in the wider community will receive psychiatric care from a general practitioner, so many prisoners will receive psychiatric care from the medical officer (generally a visiting general practitioner). As some offenders will develop a mental disorder while in prison, The Prison Service must be able to identify those who need psychiatric care and, where appropriate, to arrange a transfer under the 1984 Act.

4.6 A person who develops a mental disorder while in prison on remand may not meet the statutory criteria for transfer to hospital under the 1984 Act. In such cases access to health and social work services in the community can be arranged if the court agrees. The proposed system for co-ordinating court reports (see paragraph 3.11) will enable the courts to make full use of alternatives to imprisonment. In order to ensure that those within the Scottish Prison Service responsible for looking after the needs of those who may be mentally unwell are able to do so, it is proposed that copies of the psychiatric court report accompanies the prisoner from court to prison. This should be the responsibility of the Sheriff Clerk. Reports should be marked "Confidential" and to be opened only by health care professionals within the prison. It is also essential that the prison medical officer is able to access essential information about a prisoner's psychiatric history. Links should therefore be formalised between prison medical officers and psychiatrists who previously have been responsible for a prisoner to ensure that relevant information is made available to the prison medical officer.

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4.7 Prison managers should make suitable arrangements with health boards for the rapid assessment and transfer of prisoners suspected of suffering from a mental disorder. It is proposed that prison managers should arrange appropriate accommodation within the prison for psychiatric assessment and prison medical officers should ensure that full medical information on the prisoners being assessed is available to visiting psychiatrists.

Return to prison

4.8 Prisoners transferred to hospital who recover from their mental disorder within the period of their sentence are required to return to prison. Similarly patients, to whom the new hospital direction applies, will, when hospital treatment is no longer needed, be required to transfer to prison to complete their sentences. Effective liaison should therefore exist between the responsible medical officer and The Prison Service. It is proposed that service commissioners should require treating responsible medical officers to submit regular progress reports on prisoner patients to the prison medical officer, visiting psychiatrist and The Scottish Office, Department of Health forensic psychiatric adviser. These reports should provide an early warning for both the visiting psychiatrist and the prison medical officer of any intention to return the patient to prison so that the necessary care and support can be allocated on the prisoner's return. At the point of return the responsible medical officer should provide the prison medical officer and visiting psychiatrist with an updated report. The majority of such prisoners will be subject to a restriction order and therefore cannot be returned to prison without the approval of the designated Scottish Minister. A warrant for this purpose should be requested from The Scottish Office.

Social Work Services

4.9 National standards require prison-based social workers to give a high priority to those prisoners identified as being vulnerable, including those at risk of self-injury or with other mental health problems. However, not all prisoners falling within categories (2) and (3) of paragraph 4.4 make use of social work services either from choice or because of the priority that can be afforded to the large number of prisoners received on remand or for short sentences.

4.10 Prison-based social workers must be alert to the possibility of mental health problems and possess the skills to identify and assess the needs of such prisoners, or have access to someone who can so advise. They need to be able to recognise those factors which have been identified as associated with increased vulnerability amongst prisoners, eg isolation, lack of contact with family and community supports, previous contact with psychiatric and community-based mental health services, previous self-harm, erratic behaviour etc. It should be standard practice for those preparing social enquiry reports to alert the social work unit in prison to any concerns they may have about the mental health needs of remand prisoners.

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This will allow prison-based social work staff to respond accordingly. They already have the obligation to alert prison management where they consider a prisoner may be at risk of self-harm. Equally, where prison social workers have concerns about the mental health of a remand prisoner, this information should be available to those preparing social enquiry reports. Information about mental health problems of prisoners, whether on remand or sentenced should be shared between prison social work staff, prison staff and health professionals on a need to know basis: arrangements will need to be in place to ensure that this happens.

4.11 Once community-based multi-disciplinary assessment procedures are established as proposed in section 3 (paragraph 3.11), these could be used to assess offenders remanded in custody who have mental health problems, to put together individual care plans and increase the disposal options available to the courts.

Aftercare on release

4.12 Local authority criminal justice social work staff have lead responsibility for pre-release planning and assistance with resettlement in the community for those prisoners who will be subject to statutory supervision on release. Where prisoners with mental health problems and those not subject to supervision on release seek assistance with resettlement in the community, decisions about whether the lead responsibility for an individual care plan should rest with health or community care social work staff will be determined by the severity and complexity of the prisoner's mental health problem. In either event, local authority and health personnel will require to work together to ensure that the health and social care needs are adequately met. Consultation with other agencies which might have a contribution to make towards the care plan is an essential part of joint work involving housing, education, employment, social security and specialist mental health organisations.

4.13 Where prisoners are released on statutory licence, including extended sentences, it is the responsibility of the supervising officer to ensure that the conditions of supervision are met, including any conditions which require medical or psychological treatment and that any such medical treatment is taking place. If it is not, whether through non-compliance by the supervised person or for some other reason, the supervising officer has to decide what action to take, wherever possible in consultation with the relevant health professional. Where the supervisor considers there is a risk of self-harm or harm to others as a consequence of failure to comply with any of the conditions, this should normally result in a report to the Parole and Miscarriages Review Division, of the The Scottish Office Home Department along with a recommendation on what action might be appropriate. In the case of supervised release orders the supervising social worker will report back to the court in every case where treatment is not being provided, irrespective of the degree of risk arising from the absence of such treatment.

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Serving prisoners

4.14 The Scottish Prison Service is aware of the benefits of developing multi-disciplinary supportive interventions for prisoners with mental health problems. This involves clinical psychologists, psychiatrists, mental health nurses, occupational therapists, social work, residential and education staff. The experience of the Barlinnie Mental Health Project ("Open Doors") suggests that this approach may offer a useful model for improving the quality of mental health services in penal establishments and may provide useful lessons for wider application - both in terms of preventing the inappropriate use of custody for remand prisoners and improving access to community-based services following sentence.

4.15 In terms of regime development, under the sentence management scheme the Scottish Prison Service is developing further opportunities for group work programmes and cognitive/behavioural learning. Assistance with social support networks in the community and the development of pre-release planning (as noted above, para 4.12) will also be important.

The Service Requirement

4.16 The Scottish Prison Service is developing service level agreements with local authority social work departments for the provision of all social work in prison, including that in respect of prisoners with mental health problems. Prison governors will enter service agreements with local health service providers for a forensic psychiatric service which will match the operational requirements of penal establishments. The service level agreements will cover the purchase of appropriate services from health and social work. These agreements will specify the identification and assessment of mental disorders, crisis intervention and continuing treatment on the basis of individual care plans, for those for whom transfer from hospital is either not possible or delayed, and effective programmes of aftercare. There should also be a specified requirement to have local NHS beds available for admission if required. The service specification should also require a response within 24 hours for emergencies, with urgent cases being dealt with within a week and routine cases within 4 weeks of referral.

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PART III: PROVISION OF HEALTH AND SOCIAL CARE SERVICES

This section describes the health and social care services for people defined as mentally disordered and who need assessment, treatment, rehabilitation and after care because they have come into conflict with the law. It includes an element of taking stock and illustrates both the complexities and interdependence of the various strands of service provision.

5: CURRENT HEALTH AND SOCIAL WORK SERVICES

HEALTH SERVICES

The General Practitioner

5.1 General Practitioners have an important role to play in early diagnosis and, by intervention and treatment of mentally disordered people, they may reduce the potential for anti-social behaviour and help to avoid offences against the law. GPs are also responsible for the general medical care of offenders who have been discharged from a long-stay mental hospital and consequently can support their rehabilitation programmes. Good practice guidance on the implementation of Care in the Community emphasises the need for effective inter-professional collaboration between the local psychiatric team, GPs and all members of the primary care team. The Care Programme Approach (4) in particular requires the key worker to keep the GP fully informed of adjustments and changes to individual programmes. Guidance to GPs and practice staff on the management of potentially violent patients is being prepared (1998). Effective communication between GPs and specialist forensic and general community mental health teams is essential at all times and especially when the care of the patient transfers from one team to another, ie from a young persons' team to a team caring for adults.

Local General and Forensic Psychiatric Services

5.2 The general psychiatric service, supported by forensic psychiatrists, provides most of the care for mentally disordered people including those who offend. This service is multi-disciplinary and involves doctors, nurses, clinical psychologists, occupational therapists and social workers at its core. It covers the assessment of mentally disordered offenders; the preparation of reports for the procurator fiscal and for the courts; the acceptance into local hospitals of people diverted from, or sentenced by the criminal justice system, and of State Hospital patients who no longer require such a high level of security; and the supervision of patients, including those subject to restriction orders who are in hospital or who are conditionally discharged into the community. A circular of guidance by the Scottish Office Home Department and the Department of Health will issue in 1999.

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Out-Patient and Community Services

5.3 Multidisciplinary teams and out-patient clinics provide support and follow-up for patients in the community. A proportion of these patients will be offenders. A wide range of input is possible, including continuing assessment by the psychiatric team, occupational therapy, psychological intervention and support for the patient and their family. The Care Programme Approach may be formally used to co-ordinate services.

In-Patient Care

5.4 The open door policy in psychiatric hospitals has a long history. However, not all psychiatric patients can be managed in this way. A number of groups have special needs in their psychiatric treatment. These include:

- the acutely disturbed who can cause disruption and discomfort to other patients, or may harm themselves seriously and who require short periods of intensive psychiatric care;

- forensic admissions for assessment and treatment remitted from courts and prisons to the State Hospital. They require a well-structured programme usually in conditions that provide some security.

- a group of patients with a serious, enduring mental illness with associated behavioural problems. Some of these patients may have had no contact with the criminal justice system.

Many of these patients have been managed locally throughout their illness while some may have spent a period of time at the State Hospital. The clinical teams make carefully considered and planned judgments for individuals undergoing rehabilitation to establish how and when patients are ready and able to assume greater responsibility for their own treatment and behaviour.

Intensive Psychiatric Care Units

5.5 Intensive Psychiatric Care Units (IPCUs) have not been generally regarded as secure but have been used jointly to provide intensive care for acutely disturbed patients and as forensic facilities for offender patients due to the lack of specific alternative accommodation. The units provide modest physical security, for example, lockable reinforced doors and windows, but largely depend for their security on higher than average staffing levels and a skilled nursing input. An IPCU may be a mixed or single sex unit and each nursing charge is usually not larger than 12 patients. They aim to provide adequate space and offer scope for

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meaningful day and evening activities for the patients. There is increasing tension between the needs of mentally disordered offenders accommodated in this way and those patients requiring acute and intensive care. Referrals and refusals of admission require close monitoring by the service manager responsible for the IPCU in order to ensure that the unit can rapidly accommodate those patients who cannot be managed in more open wards.

Forensic Psychiatric Services

5.6 Forensic psychiatry, which developed as a sub-speciality of psychiatry is the area for inter-action between psychiatry and the law in all its aspects. Forensic psychiatrists are concerned with the assessment, treatment, rehabilitation and after care of patients suffering from a mental disorder including those who offend or who are considered likely to offend. The service also covers some non-offending patients including those who are difficult to manage but whose behaviour is responsive to control and treatment. They provide a tertiary service and can give specialist advice to general psychiatrists and take over the treatment of some of the more difficult patients with behavioural problems.

Secure Provision

5.7 A small proportion of mentally disordered people present sufficient risk to themselves or others to need more secure care. Beyond the IPCUs there have been some attempts to provide low secure care for patients with enduring mental illness. However the only designated secure provision currently in Scotland is that of high security care at the State Hospital, Carstairs Junction. The State Hospital provides for persons who require treatment under conditions of special security on account of their dangerous, violent or criminal propensities, as detailed in the 1984 Act. In Scotland some patients who may only require medium secure care are treated together with those who require high secure care at the State Hospital. (Security at the State Hospital is of a higher level than obtains in the medium secure hospitals in England and Wales and is equivalent to that of the Special Hospitals.)

The State Hospitals Board for Scotland

5.8 The State Hospital, is a high security hospital administered for Scottish Ministers as a Special Health Board. It serves as the Special Hospital for Scotland and for Northern Ireland and accommodates patients admitted under the Mental Health (Scotland) Act 1984 or Criminal Procedure (Scotland) Act 1995 and equivalent legislation in Northern Ireland. The State Hospital can accommodate up to 240 patients. Its ability to accept new referrals is dependent on Health Boards ensuring local facilities and support services are available for the transfer back of those patients who no longer require its special facilities.

SOCIAL CARE SERVICES

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Local Authority Services

5.9 The Social Work (Scotland) Act 1968 places a general duty on local authorities to provide for those with social welfare needs, including persons suffering from mental illness, in their areas. Further to this Section 8 of the 1984 Act requires local authorities to provide after care services for "any persons who are or have been suffering from mental disorder". The National Health Service and Community Care Act 1990 (the 1990 Act) gave local authorities the lead responsibility to develop community care plans and assess the individual needs of people for community-based social work services. The Act also introduced a specific grant for the development of mental illness services.

Mental Health Social Work

5.10 Social work authorities have a general duty of assessment and care management of vulnerable people including those who have mental health problems. Social workers play a number of roles in discharging this duty. They may be care managers in community care, criminal justice or children and family social work teams; they may be members of a multi-disciplinary community mental health teams; or they may be in out-of-hours teams or they may work in hospital settings.

5.11 Social work services are available in most general and psychiatric hospitals. Hospital social workers contribute as members of a multi-disciplinary team to patient assessment, treatment and rehabilitation, and work with families or carers. They also play a key part in mobilising community resources and in the rehabilitation process for patients who are being prepared for their return to the community. In addition hospital social workers prepare reports, prior to the removal of special restrictions applied to a patient under the 1995 Act, and may be appointed to act as the supervisor for restricted patients conditionally discharged from hospital.

5.12 A small number of social workers are based in the NHS primary health care service working in health centres dealing with social problems caused by mental illness or learning disability. In these locations they can also provide social care for people when they leave hospital.

Mental Health Officers

5.13 The social work departments of local authorities are required under the 1984 Act to employ Mental Health Officers (MHOs) who are experienced social workers with specific professional qualifications and who have completed an approved training programme. MHOs have a range of statutory duties and responsibilities including contributing to the social work

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department assessments of mentally disordered people; involvement of relatives in short term detention procedures; applications for long-term detention; consideration of guardianship; and after care.

5.14 MHOs may be placed in any of the settings identified in paragraph 5.10. They must work closely with health professionals and can make an important contribution to work with mentally disordered offenders. MHOs are sometimes involved at an early stage with people suspected of having committed an offence, for example, in assessing people for possible detention under the 1984 Act or in the assessment of someone detained in a place of safety by the police.

5.15 Under the procedures of the 1984 Act, MHOs prepare social circumstance reports for the Responsible Medical Officer (RMO) for persons on a 28 day order to allow RMOs to make judgments about future disposal. They also prepare these reports for the Mental Welfare Commission for Scotland and provide information to the relatives of patients about their rights. They may be involved in the care of a number of mentally disordered offenders who have been placed under guardianship.

Social Work Services in the Criminal Justice System

5.16 Local authority social work departments are responsible for providing social work services in the criminal justice system under the Social Work (Scotland) Act 1968. Since 1991, the main services have been wholly funded by central government. National objectives and standards specify the detailed service requirements. Criminal justice social work services can contribute to the identification, management and treatment of mentally disordered offenders at the following stages of the criminal justice process.

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Bail Decision-Making

5.17 There are bail information and supervision schemes currently (1998) available in 2 Scottish courts (Edinburgh and Glasgow). The schemes obtain and check information which can assist the court to decide whether alleged offenders, including those with mental health problems, can be released on bail, with or without supervision.

Diversion from Prosecution

5.18 In some areas, criminal justice social work services have developed diversion schemes in collaboration with local procurators fiscal. A number of these schemes are being funded and evaluated as pilot initiatives. The aim is to divert cases from prosecution where there is sufficient evidence to prosecute but where, on the basis of information provided by the police, the criminal justice social work service, other social work services or health agencies, the procurator fiscal decides that prosecution is not in the public interest and that the alleged offender could benefit from an identified service which would assist him or her to deal with problems which may have led to criminal involvement. Most of these schemes defer prosecution pending the outcome of the diversion initiative. The service which the alleged offender receives may be provided by the social work department or other health and social care agencies. The criminal justice social work service takes the lead responsibility for dealing with referrals, although it does not itself necessarily carry out all aspects of the assessment or provide the full range of services which may be regarded as part of a diversion package. The police report to the procurator fiscal may identify mental health problems as a possible reason for the alleged offending. Such problems are unlikely to be sufficiently severe to warrant action under the relevant mental health legislation but may be amenable to help from both health and social care professionals, eg minor depressive illness, alcohol and other substance misuse, learning difficulties.

Reports for the Court

5.19 Social workers working for the criminal justice social work service prepare any social enquiry report required for the courts. These reports investigate the personal and social circumstances of the offender and examine his/her offending and possible reasons for it. (They are described more fully in paragraphs 3.2-3.11).

Court-based Services

5.20 Criminal justice social work services provide services to the courts. In the busier courts staff may be present in the court and be in a position to provide immediate assistance where necessary, eg checking information, contacting relatives, or alerting a hospital if the

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situation requires it. (See also paragraph 3.4.). In other courts a service may be accessed on request.

Probation Orders

5.21 Criminal justice social work staff supervise offenders placed on probation by the court. Such orders range in length from 6 months to 3 years. The aim of the order is to prevent or reduce further offending by a combination of control and, where necessary, assistance to deal with problems associated with offending. Additional requirements may be included by the court to help meet these objectives. A significant number of those placed on probation may be experiencing or have experienced mental health problems and, depending on the severity of these problems, the probationer may have received, be receiving or require psychiatric treatment.

5.22 The court can make a probation order with a condition of psychiatric treatment. In these cases the probationer is required to submit to treatment for not longer than 12 months as a resident or non-resident patient. The court has to be satisfied on the evidence of a doctor that the mental condition requires and is susceptible to treatment and that treatment and supervision are available. In certain circumstances, the condition may be varied. The offender must consent to the proposals.

5.23 Criminal justice social work staff are normally responsible for supervising this type of order. They have a particular responsibility to ensure, as far as they can, that the offender attends for treatment and they must provide assistance, support and oversight. Orders of this kind require very close collaboration between the doctor responsible for medical treatment, the supervising social worker and the court. They are usually made where the court and the other professionals concerned consider that the offender does not require to be dealt with under the Mental Health (Scotland) Act 1984 but needs treatment and is unlikely to avail him/herself of it without a degree of oversight and ongoing support. The court may also consider that oversight and support of this kind reduces the risk of harm to others which the offender may constitute if dealt with in the community.

Social Work in Prison

5.24 Criminal justice social work staff based in prisons are required by national standards to give a high priority in their work with prisoners (whether on remand or following sentence) to those identified as being vulnerable, including those at risk of self-injury or with other mental health problems. They may work directly with these prisoners, assist prison staff to develop sentence plans and co-ordinate plans for discharge with the appropriate community-based health and social care agencies including, where appropriate, criminal justice social work services.

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Post Prison Supervision

5.25 Criminal justice social work staff supervise offenders who are released on parole or non-parole licence, extended sentence or supervised release order and also offer a voluntary service to offenders discharged from prison. In the case of offenders discharged on licence who have a continuing mental health problem, criminal justice social work staff should be involved in pre-release planning and where necessary negotiating access to appropriate community-based health and social work services.

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6: FUTURE HEALTH SERVICE PROVISION

The overall policy and guiding principles set out in Part I provide the framework for proposals on the future provision of health services for mentally disordered offenders. The section deals first with the national level and then examines the provision of locally-based services as a key factor in the strategy. This section should be read in conjunction with the provisions of the Framework for Mental Health Services in Scotland (9).

6.1 Application of the guiding principles necessarily leads to a patient-centred service which delivers care at the lowest appropriate level of security as close to the patient's home as their medical condition and personal circumstances allow. They also require that the service should develop on a sound local basis and should be readily accessible to patients from mainstream psychiatric hospitals if required.

6.2 Alongside the question of resource constraints, two factors need to be taken into account:

(a) the geography of Scotland is such that for some patients from widely dispersed rural communities the appropriate specialist treatment has to be provided at a distance from their homes; and

(b) for all mentally disordered offenders, treatment considerations must be viewed in tandem with the need to protect the public.

NATIONAL LEVEL - HIGH SECURITY CARE

The State Hospital

6.3 In considering the role of the State Hospital, successive Governments have chosen not to establish medium secure facilities in Scotland but have instead concentrated investment on facilities at the State Hospital which have provided suitable economies of scale. The State Hospital has become a centre of expertise in forensic psychiatry offering a comprehensive range of treatment facilities. The Government is satisfied that the case for a single high security establishment remains valid.

6.4 The concentration of services of any degree of security on one site does limit the range of treatment options for patients who need a decreasing level of security as they recover from the acute phase of their illness. Local forensic services have developed to a varying extent in different parts of Scotland from within existing budgets for mental health services.

6.5 The present arrangements also mean that:

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- the State Hospital regularly comes under pressure to take referrals for which there appears to be no alternative local provision; and

- when State Hospital patients are ready for transfer, there can be a reluctance on the part of some local services to accept them because of a perceived lack of appropriate local services, leading to lengthy delays in their transfer which may cause distress to patients who may have worked very hard at their own rehabilitation.

6.6 The State Hospital will continue to act as the national centre providing high security services for patients with mental disorders (including learning disabilities) who are likely seriously to threaten others on account of their dangerous, violent or criminal propensities, and whose condition is characterised by actions outside the normal range of aggressive or irresponsible behaviour and which can cause actual damage, injury or real distress to others.

The Demand For High Security Care

6.7 Applying the Glancy (5) and Butler (6) "norms" to the aggregate population of Scotland and Northern Ireland leads empirically to a requirement of some 200 beds at the State Hospital. More recently, evidence from the needs assessment carried out in England (1) indicates an overall level of demand of between 150 and 200 beds for Scotland and Northern Ireland. Other assessments are underway (1998).

6.8 A national needs assessment will be conducted involving representatives of all relevant agencies including the State Hospital, health boards and Trusts, the Scottish Prison Service, the criminal justice agencies and local authorities. As the State Hospital provides a high security care service for Northern Ireland, the Northern Ireland Office will also be involved to establish that country's continuing need.

6.9 Co-ordinated assessment is necessary to inform decisions on capital and other financial allocations. The NHS Management Executive will be responsible for co-ordinating and maintaining this assessment of the need for national high security services. However, pending the results of the proposed national needs assessment, and the full operation of a complementary local service, it is assumed that the State Hospital services should continue to aim to meet demand for around 200 patients.

6.10 Services to carers, prisons and other hospitals should be such that local forensic psychiatric opinion is sought as soon as it is considered that a referral to specialist care may be appropriate. The need for a State Hospital opinion or referral will be decided where appropriate. This allows knowledge of local facilities and services to be involved in the

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decision and has been shown to lead to improved patient care and continuity of care in the long term, and to prevent unnecessary admissions.

Health Board Monitoring of their High Security Patients

6.11 The State Hospital Medical Sub-Committee regularly reviews each patient's case to confirm that their circumstances require their continued treatment at the State Hospital. Indications are that around 50 of the existing group of patients may not need such a high level of security if adequate alternative facilities and local support service networks were available in their home areas.

6.12 Health boards should become more closely involved in monitoring the progress of patients from their area accepted into the State Hospital from the Courts or the prisons or referred to the State Hospital from local hospitals and should develop suitable continuing and after care local services to allow these patients to return to their home area as soon as their condition warrants it.

6.13 By entering service agreements with health boards, the State Hospital will ensure that the boards retain interest in these patients while they are being treated in the State Hospital. The agreements will include a specification that no patient should remain in the State Hospital for more than 3 months after clinical agreement between the State Hospital and local services that the patient's needs no longer justify high security care. Health boards and local authorities will therefore include a matching requirement in their overall service specification.

6.14 The NHS Management Executive will monitor the effectiveness of these service agreements and take action with any health board where patient transfers out of the State Hospital appear unreasonably delayed.

LOCALLY-PROVIDED SERVICES

Local Forensic Psychiatric Services

6.15 In line with the Framework for Mental Health Services in Scotland (9) The Scottish Office believes that health boards should organise a range of in-patient facilities from general psychiatric to more specifically forensic, short and longer term and a range of community options with general psychiatric provision with more specialist forensic care in terms of both staffing and buildings. Each board's response will be appropriate to local needs and may involve for other responses to local health needs, joint arrangements with other boards. The concept of the "managed clinical network" (as described in the Acute Services Review Report (12)) is relevant; it implies a formal relationship between components of a service, based on standards of service, quality assurance and a seamless provision of care. Some NHS Trusts

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in Scotland are developing alternative lockable facilities, separate from their IPCU accommodation, designed to deal with patients who either need a decreasing level of security on their return from the State Hospital, or who need longer-term care and treatment but not in a unit where there is a high level of noise and disturbance. Experience in Scotland and elsewhere has shown that the security of patients is partly governed by the availability of well-trained and highly motivated staff and by access to facilities which engage patients in structured day time activities. The development of supporting local forensic psychiatric services should meet the demand in Scotland for suitable placements for returning State Hospital patients, and also provide, where appropriate, services to local courts, prisons and psychiatric services. It is proposed that health boards should investigate the need for a structured development of local facilities and services to provide for mentally disordered offenders from courts, prisons and returning from the State Hospital, who require assessment and treatment in conditions of lesser security than is provided at the State Hospital.

6.16 Small units suitably located throughout Scotland have the benefit of being locally-based and also integrated with local services including prisons. However, the more "medium secure" end of the spectrum of low to medium security requires a larger unit with its associated range of clinical staff and should be better able to provide the required range of services to patients by drawing upon a substantial pool of expertise and experience. In turn this would facilitate treatment at varying security levels and allow the specific needs of all patients within the group to be addressed. A larger staff grouping also helps to promote effective peer group review and clinical audit; it also generates more effective multi-disciplinary teamwork with resulting benefits for both patients and staff. An important feature of the management of care in such forensic psychiatric units will be the gradual calculated reintroduction of patients to taking responsibility for their own decisions. While this process will inevitably mean giving more choice and freedom to patients and some associated risk-taking by both patients and their therapists, it will be done against a higher basic level of security and staffing than is currently available locally.

6.17 The requirement to balance optimum unit size against the need for local services is recognised. In Scotland there needs to be a geographical distribution of these units to provide a reasonably accessible service involving close links with local services and bearing in mind also that different security requirements may apply in different areas. The staff-intensive treatment regimes required by the target group of patients indicate that units should be commissioned for multiples of around 12 patients. Good space standards and therapeutic facilities in such units are also essential to generate satisfactory performance. The staffing provision of all forensic psychiatric units should include occupational therapist, clinical psychologist and social work complements, the latter to assess the social care needs of patients and to play a key role in the co-ordination of plans for their resettlement in the community. The Scottish Office view is that 4 or 5 such units will be required, including in that number those already established in Perth and Aberdeen.

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6.18 A small number of providers will deliver this forensic in-patient psychiatric service on an area or supra-board basis. The new facilities when available should reduce or remove the current requirement for forensic and other difficult patients having to mix with and live alongside more acutely ill and disturbed individuals and create a more stable and secure environment for patients, staff and the public. They will only be successful in conjunction with a range of local forensic general and community services as described. Such local general forensic and community services will be required to support the local position in all health board areas, and not only those in which the new units are established. (See paragraphs 6.30-6.34, and 7.16.) The NHS locally should determine appropriate staffing levels in the light of local needs. The Royal College of Psychiatrists recommends that in-patient forensic units of this type should have a consultant to patient ratio of 1 to 12-15 patients. The National Health Service Management Executive will ensure that proposals for area or supra-board forensic psychiatric units are developed by the health boards to be served by them along with a full range of local forensic services.

6.19 The contribution of experienced staff will be crucial to the development of these new facilities and should be utilised wherever possible. Supra-board forensic psychiatric units should be associated with existing forensic mental health services, bearing in mind the locality of prisons, especially remand prisons. The availability of this type of unit will improve the treatment options available to certain non-offender patients, for example, violent or difficult to place patients, whose needs are different from those of the more acutely ill patients normally considered appropriate for an IPCU. Local and supra-Board forensic services are tertiary services and should be accessed only via the responsible consultant forensic psychiatrist. Services should include in-patient facilities for medium and long-stay care, in conditions similar to those specified for IPCUs or dedicated learning disability units, for patients returning from the State Hospital, remanded and transferred from court and transferred from prison plus some general psychiatric patients requiring similar care. The local forensic psychiatric services should be resourced to provide high standards of multi-disciplinary in-patient and out-patient follow up care; to enable off-site assessment of patients and to facilitate liaison with the general psychiatric services. The consultant forensic psychiatrist in each case will ultimately be responsible for the admission decisions on individual patients.

People With Personality Disorders

6.20 The management and care of persons with a personality disorder can present particular problems alongside the care of other mentally disordered patients. People with a personality or psychopathic disorder are not a homogeneous group for whom established social, penal or medical treatment techniques have proved successful. People with personality disorder who

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offend are usually dealt with by the criminal justice system. Disposal, whether to prison or hospital or in any other way, will depend on the circumstances of the individual case.

6.21 Where there is doubt about diagnosis of a patient convicted of a serious offence, an interim hospital order, under the Criminal Procedure (Scotland) Act 1995, may be made to allow for further assessment or treatment for a period of up to 12 months. A recommendation may then be made for a hospital order if a treatable mental illness is considered to be present. Increased use of the interim hospital order procedure will give scope for psychiatric reports to be compiled which contain, for the benefit of the court, specific recommendations on the appropriateness of a hospital disposal. For those offenders who are convicted and sentenced on indictment but who are also mentally disordered, a hospital direction is now available so that when it is considered by the responsible medical officer the patient no longer needs to be detained in hospital for treatment, the patient may be transferred to prison.

6.22 Consideration of the disposal and wider management of personality disordered offenders will be taken forward separately by the Committee set up under Lord Maclean to examine the sentencing and treatment of, serious sexual and violent offenders, including those with personality disorders.

Operation of Intensive Psychiatric Care Units

6.23 Experience within the National Health Service in Scotland has demonstrated that the IPCU model works well for the client group for which it was designed ie short term acutely disturbed patients with behavioural problems directly related to psychiatric disturbance. Mainland health boards should continue to ensure appropriate local IPCU provision for the acutely mentally ill. There should be local needs assessment to determine the size of the service - a 12 bedded unit (or multiples of 12 or less) with generous space provision and levels of nurse staffing is the recommended IPCU model for acutely mentally ill patients.

General and Community Psychiatric Services

6.24 The needs of the mentally disordered offender should be met on clinical grounds bearing in mind the protection of the public. It will often be appropriate for general psychiatry services to be involved either right from the start or after a period in forensic care. The forensic services need to work in tandem with general psychiatry services, in a parallel and interlinking way. This will ensure that the mentally disordered offender is cared for by the right person in the right place and also that there is no inappropriate blockage of the forensic service. Service planning arrangements should bear in mind that general psychiatry services and community support will continue to be required to meet the needs of some of these patients.

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6.25 The principles of good mental health care, including access to care in the community, should apply to mentally disordered offenders cared for by the general and forensic psychiatric services. At some suitable point in their treatment, many of these patients will either return to the community or, if they are forensic patients, be transferred back to the care of the general psychiatric service or other specialists, although a small number may need to remain under long term forensic care. Health boards should specify the close liaison required between the general and forensic psychiatric services and the State Hospital to allow patients to be integrated into the provision of out-patient and outreach services.

6.26 A number of patients in local hospitals and the State Hospital recover sufficiently to leave hospital. These patients are offered a placement under their home area's community care arrangements as close to their home as appropriate in the individual circumstances of each case. It is the joint responsibility of the patient's health board and local authority social work department to commission this form of care and to ensure that sufficient specialist residential provision is available to accommodate those ready to leave local hospitals. A key issue to be addressed in making this provision is that of public safety. Well-resourced after-care teams will be required for intensive follow-up of patients previously assessed to be high risk in the community.

Community Psychiatric Nurses

6.27 The management and support of many patients in the community has been shown to improve with the support of community psychiatric nurses or community learning disability nurses and wherever possible plans should be made to incorporate their contribution into the care of mentally disordered offenders. These nurses may assist in training police officers to identify and interview mentally disordered people; they may visit offenders in their home, be involved directly in group therapy sessions and may also take part in assessment visits to offenders in prison and courts. These nurses may also become key workers for some mentally disordered offenders.

The General Practitioner

6.28 The general practitioner may reduce the likelihood of delinquent or offending behaviour by the early identification, intervention and treatment of an underlying mental disorder. GPs also play a vital role in maintaining the rehabilitation of offenders released from prison or discharged from hospital and consequently they should have ready access to appropriate advice. The role of the general practitioner in relation to the multidisciplinary psychiatric team may be very specific to the needs of the patient, for instance, in focusing primarily on the patient's general health requirements. In this regard, health boards should specify the level of inter-professional collaboration necessary to meet the needs of GPs and

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primary care teams. Advice should be readily available to GPs on the management of potentially violent patients.

Health Board Responsibilities For Service Development

6.29 Just as the need to maintain an effective national facility at the State Hospital is recognised, there is also a need for health boards to develop a database recording the appropriate services for people with a mental disorder whose normal place of residence is within their catchment area, and taking into account those in prisons and elsewhere in NHS care. There will also be occasions where a Board must accept responsibility for a non-resident patient, for example, because the onset of the problem behaviour took place in their area or because the caring relative is resident there.

6.30 Plans for treating mentally disordered offenders should be prepared in the context of the Framework for Mental Health Services in Scotland (9). Where a health board's plan is judged unsuitable, the National Health Service Management Executive will require that board to submit within 6 months of being requested to do so, their proposals for the care of people suffering from a mental disorder and who have offended or are considered likely to offend. These proposals will also cover some non-offenders detained in the State Hospital, IPCU or dedicated disability unit, and those patients who have had to remain in intensive care units longer than 3 months. Patients who are unmanageable in local wards because of aggressive, disorderly, irresponsible or anti-social behaviour beyond the ordinary level of resources and skills of the mental health service and who can be expected to be a hazard or danger to themselves or others, should also be included.

6.31 The detailed specification for this local service will cover integrated multi-disciplinary assessment, treatment, rehabilitation and after-care service for mentally disordered offenders, and those non-offender patients with similar needs. It will ensure that patients have the same liberty, rights, autonomy and choice as any other member of the community within the constraints of the law and their potential danger towards others or themselves.

6.32 The broad principles on which local services will be based are as follows:

(1) all arrangements should seek at all times to reduce the risk of offending behaviour consequent upon mental disorder and thereby to afford protection to the public;

(2) service provision and delivery should be designed to meet the individual needs of patients, and patients who are clinically judged to require the high security of the State Hospital should continue to be located there;

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(3) the service should be delivered flexibly and comprehensively to respond to the individual needs of patients, and should be specialised in order to attain the level of expertise required to implement individual treatment programmes effectively, providing out-patient, day-patient and community care where appropriate in addition to in-patient treatment;

(4) multi-disciplinary working methods should be adopted to ensure the most effective management, assessment and treatment of patients and support to other agencies;

(5) as continuity and consistency of care and treatment are essential, as far as possible the same team of local professionals should be responsible for the service to an individual throughout their care as an in-patient and subsequently in the community;

(6) close liaison should be maintained with the State Hospital on the care required to facilitate the earliest appropriate return of patients from each Board's catchment area.

(7) close liaison should also be maintained with prison services to ensure prisoners with mental illnesses requiring in-patient care are transferred to hospital.

6.33 Within an agreed framework, health boards and Trusts should work towards a number of specific objectives:

- at local level a specialist service which works in tandem with the general mental health service and works closely with the criminal justice system; and management of the system so that the needs of patients and the requirement to protect the public are given equal consideration;

- suitably secure local and area forensic psychiatry accommodation for patients who have severe and enduring forms of mental illness associated with difficult and dangerous behaviour and for offender patients who require specialist services;

- specialist forensic community services for those who require such services, and onward referral to other agencies for those who do not;

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- the earliest return of appropriate patients from the State Hospital to local services and the transfer of mentally disordered offenders in prison to hospital facilities where this is required;

- regular evaluation and review of service delivery in the context of changing needs and developments.

6.34 The psychiatric service planned by health boards should also require the development of a comprehensive service involving good working relationships with the State Hospital.

From a managerial and clinical point of view there is a need to ensure:

- that no patient is admitted to the State Hospital without prior assessment by, or discussion with, and agreement of the local forensic psychiatric team;

- that local clinicians and managers are involved in monitoring the progress of patients in the State Hospital;

- that periodic multi-disciplinary case conferences are instituted for each patient;

- that reports for the State Hospital on patients eligible for outward transfer are produced in good time;

- that the assessment of patients in the State Hospital should be carried out within 3 weeks of the request to the local psychiatric team and transfers, if agreed clinically, should be accomplished within 3 months;

- that trial leave provisions should be made in appropriate cases; and

- that a range of facilities are made available as appropriate to patients on transfer from the State Hospital, including general and forensic facilities, in hospital and the community.

The health boards' specification of these objectives should be in measurable terms. Performance indicators and outcome measures should be incorporated into the commissioning, provision and delivery of the service.

Staff Training

6.35 Clearly specified training levels agreed between health board and NHS Trusts enable staff to feel more confident in managing their duties and responsibilities. It can also lead to a

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reduction in day to day incidents and in the need for crisis measures, including the isolation of patients. In terms of training, teaching and research, collaboration between the State Hospital and local forensic services provides broad development of expertise, for example, through mutual exchange of consultant sessions. Professionally accredited nurse training schemes and exchange visits should be designed and developed by a joint working group involving senior staff from forensic psychiatric nursing in the local services, the State Hospital and university institutions.

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7: FUTURE SOCIAL CARE PROVISION

This section deals with the interlocking role of community-based social care services for mentally disordered offenders that complement the health service proposals set out in the preceding section. The emphasis is on joint working between Health Boards and social work authorities to plan and develop their services throughout Scotland.

The Framework of Community Care

7.1 Under the Government's policy on community care, mental health services are increasingly provided by multi-disciplinary community teams or by other specialised community services. Primary care services also link with the care provided by local authority community care services, which in turn are supported by a range of partners including housing, education and voluntary and independent sector organisations. Most mentally disordered people who have, or are alleged to have, offended are not in hospital but are in the care of health professionals and social work staff in the community.

7.2 Care has to be taken to recognise the distinctive statutory supervision and accountability procedures of criminal justice social work services where the offender is subject to a court order or is on licence from the Parole Board. However, it is for health and community care services to make and fund the provision which would normally be made to a non-offending person with similar mental health needs, for the duration of the supervision, and thereafter. The assessment of the extent of this provision should be carried out by health and community care staff working closely with criminal justice social workers. It follows that there is a need for comprehensive, well-integrated community services which operate in a variety of settings, with sufficient flexibility to respond to individual needs, whether or not the offender is under any form of statutory supervision.

7.3 The Government has taken several initiatives to develop services for mentally disordered people. For example, the Care Programme Approach was introduced in the 1992 Departmental circular "Community Care: Guidance on Care Programmes for people with a mental illness including dementia" (4). A further circular on the Care Programme Approach was issued in 1996. A Mental Illness Specific Grant was also introduced in 1991 to assist local authorities in the provision of social care and has been used to fund projects for this care group. These developments complement local authorities' general duties under Section 8 of the 1984 Act to provide after care services for any persons who are or have been suffering from mental disorders, and Section 55 of the NHS and Community Care Act 1990 to provide assessment and care management of vulnerable people including those with mental disorder. The Framework for Mental Health Services in Scotland (9) is also relevant.

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7.4 Health boards and social work authorities will therefore already be including mentally disordered offenders in their local assessment and care management procedures. The available services and possible development proposals should be identified in a section in their community care plans devoted to this client group and in annual and strategic plans for 100% funded criminal justice social work services. Monitoring of these plans by The Scottish Office will seek to ensure that proper account is being taken of the need to develop these services.

7.5 NHS staff play an important role in contributing to community-based assessments and in the development of programmes of community care. Community care planning teams in developing their joint links between social work departments, housing agencies and health boards should ensure that local psychiatric and psychological services have an opportunity to contribute to the planning process. These links will also assist in the development of a joint approach to assessment and service delivery. Planning for social work services in the criminal justice system should be aligned as far as practicable with planning for community care services to ensure that appropriate access to social care services is available.

7.6 While housing bodies will not be responsible for the provision or management of most accommodation for mentally disordered offenders, they may require to provide or secure the provision of mainstream housing in some cases and manage such housing. Health boards and social work department community care services should collaborate in advance with housing departments and agencies for this purpose.

Public Safety

7.7 According to the guiding principles in paragraph 1.5, mentally disordered offenders should be held at no greater (and no less) security than is necessary. This also applies to the programme of community care for those who do not need to be in hospital. In particular this approach requires:

(a) effective systems to identify and manage individual and changing needs and risks; and

(b) a range of accommodation and other appropriate support, eg day care, home care, respite care, employment training and advocacy/befriending.

7.8 It is essential that the care and treatment of mentally disordered offenders in the community meet the requirements of the criminal justice system and of public safety. This will result in constraints on individual care plans. Some mentally disordered offenders, for example patients on restriction orders on conditional discharge and former prisoners on statutory supervision or licence, are subject to special supervision and will require specific

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follow-up monitoring. However, their health and social needs are likely to be similar to those of non-offenders with mental disorders and consequently, they need access to a similar range of services. Health and social work services for mentally disordered offenders should be planned and developed parallel to and linked with the general community-based mental health service with special attention to supervision and monitoring where this is needed for public safety reasons.

7.9 Each case must be jointly assessed with criminal justice and community care interests closely involved to determine an outcome which meets the following aims:

(a) safeguards public safety;

(b) delivers any statutory requirements (such as probation, etc);

(c) meets the needs of the offender in a way that is likely to reduce offending behaviour.

In the majority of cases there are no special forensic needs arising from the offending behaviour. Decisions about the provision of local services must therefore take account of the need to cater for mentally disordered offenders, and for ensuring that they gain access to them. All mentally disordered offenders, especially those who require services that take account of their "special needs", should be provided with a properly co-ordinated programme of specialised care, treatment or supervision and effective multi-disciplinary pre-release planning undertaken before discharge from hospital or release from custody. In all cases service provision is tailored to meet individual needs while ensuring that public protection is a key consideration.

7.10 Criminal justice social work has a statutory responsibility to supervise orders made by the courts and by the Parole Board on offenders, who may suffer from mental disorder, in accord with national standards on throughcare. Depending on the assessment of needs and risks and the agencies involved, day-to-day case management may be undertaken by a community care specialist, but the criminal justice social worker must retain oversight of the order and responsibility for enforcing it. In effect, the supervision requirement may be seen as a means of securing satisfactory local co-ordination of service plans between criminal justice, health and social care agencies. The main contribution of the criminal justice social worker may be in managing the interface with the criminal justice system and ensuring that any licence conditions are met.

Individual Care Plans

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7.11 The Care Programme Approach (4) specifies arrangements for ensuring that people in the community who have severe and enduring mental illness and complex health and social service needs are provided with individual care plans which set out the support and care they will receive. All severely mentally ill people whether in the community or in hospital prior to discharge should be assessed for the Care Programme Approach (4). This applies to patients in all hospitals including the State Hospital.

7.12 Given the need to focus the Care Programme Approach on people with severe and enduring mental illness and complex needs, including some who also have learning disabilities, the approach should not be applied to all mentally disordered offenders. Those who do not meet these criteria would, however, benefit from care management. The principles of a co-ordinated approach and an identified key worker as set out in the guidance on the Care Programme Approach (4) for people with severe and enduring mental illness should also be applied to people with a learning disability who, on discharge into the community, are considered to be at risk of breakdown or re-offending while living in the community. Essentially the approach provides continuity between hospital and community support services. Consideration should always be given in the assessment to whether the patient will require support and supervision by a social worker with specialist mental health training. In all cases where the Care Programme Approach (4) is being followed, consideration should be given to the allocated social worker being a mental health officer.

7.13 Unless detained, a person may discharge himself or herself from the Care Programme at any time. It is therefore important that the key worker named in the Programme should take all reasonable steps to make contact with the person whatever the circumstances, so that the health and community care authorities are fulfilling their requirements to monitor and if necessary act on the person's behaviour. It is also essential that GPs are kept informed of progress and of any decision on the part of an individual patient to withdraw from the programme.

A Local Model

7.14 Local government re-organisation provided opportunities for building fresh links between the new councils and health boards. Services for mentally disordered offenders require multi-agency working as recommended in the Framework for Mental Health Services in Scotland (9). The health board could act as the base for a local forum to consider the needs of this group. This would provide a source of co-ordinated expertise and guidance for local developments; it would also be able to identify service needs and gaps in provision. The local forum should include nominees from the health board, social work, criminal justice and community care services and housing departments; appropriate voluntary organisations should also be included as well as the police, procurators fiscal and the courts. The forum should communicate directly with both general and forensic psychiatric services in the health

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board area and also with the services provided for people with learning disabilities. Modernising Community Care – An Action Plan (11) sets out ways in which agencies can work on an integrated basis to secure better results for those who use community care services.

7.15 A senior group should be established to focus on agreeing shared objectives and on setting agreed strategic targets and priorities at a local level; these officers should where possible have the authority to commit their own agencies to action on services for mentally disordered offenders and to resource contributions. Further an operational group should be set up in each area with a mandate to deliver the committed action, to devise practical arrangements for securing collaborative assessments and to develop both service provision and monitoring requirements.

7.16 Some smaller health board areas will not be able to support a viable multi-agency approach to the provision of the more specialised services for mentally disordered offenders. When this is the case, a joint approach with social and health care agencies in adjacent health board areas should be pursued. A minimum scale for such a grouping might relate to a population base of around 600,000. It is of course only a guideline figure and other factors including geography, demographic distribution and the location of prisons will be relevant to the establishment of this type of liaison group.

7.17 As with other examples of community care, the local financing and commissioning implications of joint service provision will play an important part in developing local collaborative effort. Contracting-out and other arrangements must operate in the interests of enhanced patient care and add value to the contributions of individual agencies. A model for these joint arrangements is set out in the paper "Community Care: Joint Purchasing etc for Inter-Agency Working, MEL (1992) 55" (10). Similar working arrangements should be applied for services for mentally disordered offenders.

7.18 Attendance at meetings of the operational group may vary according to the task being undertaken. However, well-defined and agreed arrangements for ensuring that specialised professional contributions will be sought as part of the co-ordinated approach to service provision are essential to the success of this proposed local model.

Day Services

7.19 Access to structured day activities is central to the successful habilitation or rehabilitation of many mentally disordered offenders. These individuals have difficulty in obtaining employment and the day services should enable retraining to take place alongside any continuing rehabilitation or educational initiatives which were begun in hospital. Multi-agency centres, providing "drop in" and timetabled access to psychiatric, general medical,

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nursing, and social work support, will be particularly valuable. As voluntary bodies will contribute significantly to these day services, both through their own provision and through support to statutory services, their representatives should be involved at the earliest possible stage in the planning process. The Social Work Services Inspectorate has reported on day services for people with mental illness (7). This includes much valuable information on good practice.

Advice and Referral

7.20 While the pattern of services is for local assessment and determination, some level of demand for advice and referral can be anticipated on a "round the clock" basis. This means that in all areas there should be 24 hour access to advice and help.

7.21 It follows that what is needed is an effective local emergency out-of-hours network operated by someone with a list of duty contacts or a standing arrangement. The development of such a service and how it might be organised and financed is clearly a matter for local consideration. Suitable referral points can now be introduced with the aid of modern telecommunications systems and a managed rotation of on-call staff who are trained to deal with these enquiries.

Involvement of Families and Carers

7.22 Another of the guiding principles in good comprehensive service provision is that mentally disordered offenders should be cared for as near as possible to their own homes or families if they have them. Continuing care for offenders following their discharge from hospital or prison can be provided in their own homes if this is in the interests of the individual patient and their carers. This is of course subject to considerations of public safety and victim concerns.

7.23 Consequently there is an important role for patients, their families and other informal carers in the organisation and planning of these services. The Patient's Charter requires that this should include, where possible, involvement in:

(a) care and treatment decisions;

(b) the running of particular services or facilities;

(c) service planning.

7.24 It follows that patients should become involved in planning their care as should families and carers whenever this is consistent with the patients' wishes. When a care plan

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depends on a major contribution from family or other carers, this should be agreed with them in advance. Families and carers will often need to be supported in order to cope with particular stresses and with the practical effects of a family member being subject to a hospital order eg, involving possible lengthy travel to visit the State Hospital. Support for families in the early stages of psychological distress can help to prevent deterioration in personal relationships and reduce the pressures on the offender. Special attention may need to be given to the welfare of any children in the family. In terms of the Children (Scotland) Act 1995, such children will be regarded as children affected by the disability of a family member. As such they will, at the request of their parent or guardian, be entitled to an assessment of their needs in their own right by the local authority.

Voluntary Agencies

7.25 Voluntary agencies are involved in the care of mentally disordered offenders through their activities in the general field of mental health. This ranges from individual support involving advocacy on behalf of patients through to the provision of accommodation by negotiation with housing providers. Community care planning arrangements offer the basis for involvement of social work authorities and health boards along with the voluntary organisations in their area and the opportunity to create links between voluntary bodies, social work authorities and the local psychiatric services. Volunteers can act as appropriate adults in cases where police are questioning persons suspected of having committed an offence or who may have been the victim of an offence and who are thought by the police to be mentally disordered.

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8: SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

This section is about the services provided for people with a learning disability who offend. It illustrates the need for a variety of services to be provided by health, social services and the criminal justice system, after an individual assessment of the offender has been carried out. The majority of these services should be community-based, but there is a need for some semi-secure and secure facilities. Similar services may also be necessary for people who are at risk of losing their residential or daytime placement through behaviour which causes physical harm to others, and will be covered separately under the learning disability review (1998-99).

Introduction

8.1 For the purposes of this document people with learning disability are those who, by reason of their developmental intellectual impairment, need additional specialist services to lead a normal life or as normal a life as possible. The range of competence is very wide. Many have difficulties in addition to their learning disability that present them, their families and service providers with further challenges.

8.2 People with a learning disability may need assistance in coping with police interviews and court procedures. Following the Departmental Circular 2/1990, updated by the joint Police, SWSG and Health guidance (Interviewing People who are Mentally Disordered: "Appropriate Adult" Schemes) (3), "appropriate adult" schemes have been established in Scotland to facilitate police interviews with mentally disordered adults. People with a learning disability can be particularly vulnerable in prison. The criminal justice system should be aware of their special needs. Diversion schemes should be available for use when appropriate. It is, however, helpful for some people with a learning disability to see the consequences of their behaviour in a similar way to other citizens.

Current services for offenders with a learning disability

8.4 Some people with learning disability who offend are treated in hospital or in the community under the Mental Health (Scotland) Act 1984. A guardianship order may be used on the grounds of learning disability (mental handicap is the term used in the Act). Hospital treatment may be appropriate if the person suffers from mental impairment (or a severe impairment) of intelligence and social functioning associated with abnormally aggressive or seriously irresponsible conduct.

8.5 The health service provides facilities for specialised assessment and treatment of offenders. Assessment is carried out by appropriate professionals (eg nurses, psychiatrists, clinical psychologists and speech therapists) and may take place in the community, in hospital

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or in prison. Subsequent treatment may be provided in the community by multidisciplinary community teams, at a day hospital, in local in-patient facilities (many of which are in large learning disability hospitals) or within the secure facilities of the State Hospital.

8.6 Social work services have the lead responsibility for care in the community, both as providers of criminal justice services and as planners of social work services. The point at which social services may become involved with someone with a learning disability who may have offended will vary dependent on individual circumstances. Some will have been diverted whilst others may have been admonished. In other instances, people with learning disabilities may not always be recognised as needing additional assessment/support. When Social Enquiry Reports are requested prior to disposal, criminal justice services are involved. They may decide to consult with both social work colleagues in learning disability teams and with health professionals. (Paragraphs 3.2-3.17 and 5.9-5.25 also apply to people with learning disabilities.)

Future services

8.7 The Scottish Office view is that there should be a joint assessment of learning disability need by health boards and local authorities. Service providers should cater for the majority of offenders with a learning disability who require a comprehensive range of health, education and social work services to meet their needs. Serious offenders with learning disabilities should be separated from others where possible.

8.8 A range of services will be necessary including:

- support from social work services, criminal justice social workers, primary health care teams, specialist learning disability teams and voluntary organisations;
- community accommodation with resident staff who may receive support from the agencies described above;
- potentially lockable well-staffed NHS accommodation for the purposes of assessment and treatment which should be in the form of small units;
- secure accommodation for the very small number of people who require such provision.

There should be linked access between the dedicated secure settings and less secure forms of accommodation in the community. There also should be adequate and properly planned aftercare including access to the necessary range of rehabilitation and training facilities and

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opportunities. Community care assessment as part of the discharge planning process should be included in the aftercare arrangements.

The respective roles of agencies

8.9 There should be liaison between all the relevant agencies: criminal justice services, National Health Service, police, prison and social work services and appropriate multi-agency agreements should be made.

8.10 Health boards and local authorities should ensure that an individual care plan is prepared for each person receiving a service, which takes a risk assessment into consideration. Services should be provided in the least restrictive environment consistent with public safety. An appropriate adult service should be established, with a register of identified individuals who should receive regular training. Independent advocates should be available for the service users.

8.11 Carers' needs should also be taken into account. The Carers (Recognition and Services) Act 1995 is concerned with carers who are either providing or intending to provide substantial amounts of care on a regular basis. A carer meeting these requirements is entitled, on request, to an assessment of their own needs. Adequate day and respite care services should be provided.

8.12 There should be evidence of training strategies for all staff involved with the service. Monitoring systems should be in place to ensure that appropriate treatment/care plans are in place and are reviewed regularly.

The role of service providers

8.13 Appropriate services should be provided for offenders with a learning disability through multi-agency liaison and an assessment of the local need. There should be a range of treatment facilities (eg community, residential and specialised semi-secure or secure, which may be local or national). There should be a recognition that while the majority of offenders with a learning disability will need relatively short-term support, there is a small group who have severe enduring difficulties and will require long-term supervision.

Care for learning disabled offenders in the community

8.14 At a local level there should be comprehensive community plans and individual treatment packages, ensuring that care and supervision are provided in the least restrictive environment. A framework should be established to ensure multi-agency involvement and

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information sharing systems. Health service staff should be involved in all relevant points in assessment and treatment.

8.15 As indicated in paragraphs 8.10 and 8.11, appropriate adult schemes should be in place, advocacy services should be available and the needs of the carers should be considered. There should be a support service for victims with a learning disability. Procedures for dealing with abuse should be in place. Suitable accommodation should be available in the community, with opportunities for work, leisure and educational placements. Training should be available for staff of all agencies working within the offenders service. Monitoring systems should be established.

Semi-secure accommodation

8.16 This should be provided in small units dedicated to the needs of this client group. There should be facilities for comprehensive assessment and treatment, with close links to community resources. These units may also be used in the rehabilitation of people from secure units.

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Secure accommodation

8.17 Although only a small number of learning disabled offenders will require such a facility, their stay may be prolonged and it is important that there is multi-professional input and treatment plans which are regularly reviewed. The environment should be congenial and adequate educational and recreational activities should be provided. It is likely that such units will be regional or national and it is important that links with the area of origin be maintained.

Aftercare

8.18 Services should be available for learning disabled offenders following discharge from prison or specialised semi-secure or secure facilities to offer support and reduce risk of re-offending.

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PART IV: THE WAY FORWARD

9: PROPOSALS

The specific proposals linked to each of the preceding sections of this report are drawn together in sequence in this part under the associated section headings and sub-headings. The form and content of each proposal is as stated earlier.

PART II: CRIMINAL JUSTICE PROCESS

2. POLICE PROCEDURES

The Service Requirement

Paragraph 2.14 Health boards and local authorities should enter service level agreements with the criminal justice agencies to provide effective and flexible local arrangements for the initial assessment and treatment of people in their charge who appear to be mentally disordered. Procurators fiscal should be involved in discussions as to levels of service. These service agreements should cover:

- the use of Section 118 of the 1984 Act ("removal to a place of safety");
- the availability to the criminal justice agencies of "duty psychiatrists" and "appropriate adult" services;
- the facilities and services that can be used for mentally disordered people diverted from the criminal justice system;
- the provision of specialised accommodation for mentally disordered accused persons who might otherwise have to be remanded unnecessarily in custody; and
- the specification should address the 3 levels of service to be provided:
    - (1) emergencies within 24 hours;
    - (2) urgent cases to be covered within one week; and
    - (3) routine cases to be completed within 3 weeks.

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- the specification should also cover the training needs of those who will be required to operate these services on a day-to-day basis.

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3. COURT PROCEEDINGS

Multi-disciplinary Assessment

Paragraph 3.6 The psychiatric service provided for each health board's residents should specify that the courts and procurators fiscal in their area require a promptly delivered psychiatric assessment service to assist the transfer of an accused person to hospital as and when required. Development of a service involving a duty psychiatrist with access to community and hospital resources would be the preferred means. The psychiatrist needs multidisciplinary support from social work, psychology, nursing and housing. The psychiatric service needs to be complemented by a multi-agency network of services.

Paragraph 3.10 A properly co-ordinated procedure for preparing multi-disciplinary assessment reports should be developed in the larger courts as a means of identifying the range of options available for mentally disordered offenders.

Bail Decision-making

Paragraph 3.12 Local authorities and health boards should review the accommodation services provided for mentally disordered persons to ensure that they are not remanded unnecessarily in custody, and that, wherever possible, they can be supported under existing community care arrangements.

4. SCOTTISH PRISON SERVICE

Psychiatric Assessment and Transfer to Hospital

Paragraph 4.7 Prison managers should arrange appropriate accommodation within the prison for psychiatric assessment and prison medical officers should ensure that full medical information on the prisoners being assessed is available to visiting psychiatrists.

Return to Prison

Paragraph 4.8 Service commissioners should require treating responsible medical officers to submit regular progress reports on prisoner patients to the forensic psychiatrist of the Prison and the Scottish Office Department of Health's forensic psychiatric adviser. These reports should provide an early warning for both the Trust and the prison service of any intention to return the patient to prison so that the necessary care and support can be allocated on the prisoner's return. At the point of return the responsible medical officer should provide the prison and the visiting psychiatrist with an updated report.

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The Service Requirement

Paragraph 4.16 The Scottish Prison Service is developing service level agreements with local authority social work departments for the provision of all social work in prison, including that in respect of prisoners with mental health problems. Prison governors will enter service agreements with local health service providers for a psychiatric service which will match the operational requirements of penal establishments. The service level agreements will cover the purchase of appropriate services from health and social work. These agreements will specify the identification and assessment of mental disorders, crisis intervention and continuing treatment on the basis of individual care plans, for those for whom transfer from hospital is either not possible or delayed, and effective programmes of after-care. The service specification should also require a same-day service for emergencies, with urgent cases being dealt with within a week and routine cases within 4 weeks of referral.

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PART III: PROVISION OF HEALTH AND SOCIAL CARE SERVICES

6. FUTURE HEALTH SERVICE PROVISION

The State Hospital

Paragraph 6.6 The State Hospital will continue to act as the national centre providing high security services for patients with mental disorders (including learning disabilities) who are likely seriously to threaten others on account of their dangerous, violent or criminal propensities, and whose condition is characterised by actions outside the normal range of aggressive and irresponsible behaviour which can cause actual damage, injury or real distress to themselves or others.

The Demand for High Security Care

Paragraph 6.8 A national needs assessment will be conducted. This will involve representatives of all relevant agencies including the State Hospital, health boards and Trusts, the Scottish Prison Service, the criminal justice agencies and local authorities. As the State Hospital provides a high security care service for Northern Ireland, the Northern Ireland Office will also be involved to establish that country's continuing need.

Health Board Monitoring of their High Security Patients

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Paragraph 6.12 Health boards should become more closely involved in monitoring the progress of patients from their area accepted into the State Hospital from the courts or the prisons or referred to the State Hospital from local hospitals and in developing suitable continuing and after care local services to allow these patients to return to their home area as soon as their condition warrants it.

Local Forensic Psychiatric Units

Paragraph 6.15 Health boards should investigate the need for a structured development of local facilities and services to provide for mentally disordered offenders from courts, prisons and returning from the State Hospital, who require treatment in conditions of lesser security than is provided at the State Hospital.

Paragraph 6.18 The National Health Service Management Executive will lead in ensuring proposals for area or supra-board local forensic psychiatry units are developed by the health boards to be served by them.

Paragraph 6.19 The services should include in-patient facilities for medium and long-stay care, in conditions similar to those specified for IPCUs or dedicated learning disability units, for patients returning from the State Hospital, remanded and transferred from court and transferred from prison plus some general psychiatric patients requiring similar care. The local forensic psychiatry unit should be resourced to provide high standards of in-patient and out-patient follow up care; to enable off-site assessment of patients and to facilitate liaison with the general psychiatric services.

Operation of Intensive Psychiatric Care Units

Paragraph 6.23 Mainland health boards should continue to ensure appropriate local IPCU provision for the acutely mentally ill. There should be local needs assessment to determine the size of the service - a 12 bedded unit (or multiples of 12 or less) with generous space provision and levels of nurse staffing is the recommended IPCU model for acutely mentally ill patients.

The General Psychiatric Service

Paragraph 6.24 Service planning arrangements should bear in mind that general psychiatric services and community support will continue to be required to meet the needs of some of these patients.

Community Services

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Paragraph 6.25 Health boards should specify the close liaison required between the general and forensic psychiatric services and the State Hospital to allow patients to be integrated into the provision of out-patient and outreach services.

The General Practitioner

Paragraph 6.28 Health boards should specify the level of inter-professional collaboration necessary to meet the needs of GPs and primary care teams. Advice should be readily available to GPs on the management of potentially violent patients.

Health Board Responsibilities for Service Development

Paragraph 6.30 Plans for treating mentally disordered offenders should be prepared in the context of the Framework for Mental Health Services in Scotland (9). Where a health board's plan is judged unsuitable, the National Health Service Management Executive will require that board to submit within 6 months of being requested to do so, their proposals for the care of people suffering from a mental disorder and who have offended or are considered likely to offend. These proposals will also cover some non-offenders detained in the State Hospital, IPCU or dedicated learning disability unit, and those patients who have had to remain in intensive care units longer than 3 months. Patients who are unmanageable in local wards because of aggressive, disorderly, irresponsible or anti-social behaviour beyond the ordinary level of resources and skills of the mental health service and who can be expected to be a hazard or danger to themselves or others, should also be included.

Paragraph 6.33 Within an agreed framework, health boards and Trusts should work towards a number of specific objectives:

- at local level a specialist service which works in tandem with the general mental health service and works closely with the criminal justice system; and management of the system so that the needs of patients and the requirement to protect the public are given equal consideration;

- suitably secure local and area forensic psychiatry accommodation for patients who have severe and enduring forms of mental illness associated with difficult and dangerous behaviour and for offender patients who require specialist services;

- specialist forensic community services for those who require such services and onward referral to other agencies for those who do not;

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- the earliest return of appropriate patients from the State Hospital to local services and the transfer of mentally disordered offenders in prison to hospital facilities where this is required;

- regular evaluation and review of service delivery in the context of changing needs and developments.

Staff Training

Paragraph 6.35 Professionally accredited nurse training schemes and exchange visits should be designed and developed by a joint working group involving senior staff from forensic psychiatric nursing in the local services, the State Hospital and university institutions.

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7. FUTURE SOCIAL CARE PROVISION

Public Safety

Paragraph 7.8 Health and social work services for mentally disordered offenders should be planned and developed parallel to and linked with the general community-based mental health service with special attention to supervision and monitoring where this is needed for public safety reasons.

A Local Model

Paragraph 7.15 A senior group should be established to focus on agreeing shared objectives and on setting agreed strategic targets and priorities at a local level; these officers should, where possible, have the authority to commit their own agencies to action on services for mentally disordered offenders and to resource contributions. Further an operational group should be set up in each area with a mandate to deliver the committed action, to devise practical arrangements for securing collaborative assessments and to develop both service provision and monitoring requirements.

8. SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

Future services

Paragraph 8.7 There should be a joint assessment of learning disability need by health boards and local authorities. Service providers should cater for the majority of offenders with a learning disability who require a comprehensive range of health, education and social work services to meet their needs.

The respective roles of agencies

Paragraph 8.10 Health boards and local authorities should ensure that an individual care plan is prepared for each person receiving a service, which takes a risk assessment into consideration. Services should be provided in the least restrictive environment consistent with public safety. An appropriate adult service should be established, with a register of identified individuals who should receive regular training. Independent advocates should be available for the service users.

The role of service providers

Paragraph 8.13 Appropriate services should be provided for offenders with a learning disability through multi-agency liaison and an assessment of the local need. There should be

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a range of treatment facilities (eg community, residential and specialised semi-secure or secure, which may be local or national). There should be a recognition that while the majority of offenders with a learning disability will need relatively short-term support, there is a small group who have severe enduring difficulties and will require long-term supervision.

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4. SOHHD DGM 1992/9 and SWI 1992/1 'Community Care: Guidance on Care Programmes for People with a Mental Illness including Dementia'.

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Mental Health Strategy for Scotland: 2012-2015

The Scottish Government

MENTAL HEALTH STRATEGY: 2012-15

Ministerial Foreword

Improving mental health and treating mental illness are two of our major challenges. We are not unique in facing these challenges and in Scotland we have had much success in promoting rights and recovery, addressing stigma and improving service outcomes. More people are receiving effective treatment and they receive it more quickly than ever before. Increasingly, people have a good understanding of their own mental health and are prepared to talk about things when things are not good. People come from around the world to learn from us.

We are rightly proud of what we have collectively achieved. But though Scotland does well, there is more work to do. This Strategy sets out our objectives for the period to 2015.

Key challenges are to continue the good work that has already been started to deliver on our commitments to offer faster access to specialist mental health services for young people and faster access to psychological therapies. These targets are world leading in setting expectations for access to mental health services. They demonstrate how in Scotland we truly give mental health parity with other health services in what we do as well as in what we say. We have also made good progress on reducing suicide in challenging conditions and must build on that success.

In the coming period, we are making key commitments that demonstrate our desire to increase the pace of change. We will focus on reducing variation in the availability of good quality mental health services such as intensive home treatment and first episode psychosis services. We will build on the prevention agenda, with a greater focus on the first years of life. We will target key connections between mental health and other policy areas such as employment, justice and early years services, where mental health has a large contribution to make.

While these commitments are valuable and necessary, our ambition is greater. We must take a step into the future and think beyond how services are currently structured and delivered.

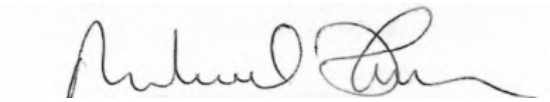
People are already taking greater responsibility for their own health through lifestyle changes designed to produce better health outcomes. They are more likely to seek information for themselves to understand their own mental health and wellbeing and

have a greater desire to control how they access help and support. Self-help, self-referral, self-directed, self management and peer to peer are all concepts that will only grow in importance and which demand a different mindset and approach to service design. The system of the future must develop to embrace and adopt these approaches alongside the more traditional approaches to service delivery, which will also continue to be necessary.

We have learnt how to make improvement by developing a shared understanding of the goal that is to be achieved, using data to understand what is happening at national and local level, identifying early gains to create momentum and confidence, building in improvement support to share and develop learning and putting in place a clear performance and accountability framework. We are able to say when things are working well, but also have the confidence to say when things must be improved.

We have confidence that these are changes that we can make and that when we review progress in 2015 we will evidence a further step forward. Though circumstances are challenging we are ambitious for improvement. We already have a strong consensus in place about the mental health outcomes that we want to achieve and a firm partnership in place between national and local government, other national organisations, the voluntary sector and most importantly with service users and carers. This Strategy is focused on key changes and improvements, but it will be adapted to respond to new challenges as they emerge between now and 2015.

I commend this Strategy to you and ask that you work with us to take forward the commitments set out in it.



Michael Matheson MSP
Minister for Public Health

The Challenge

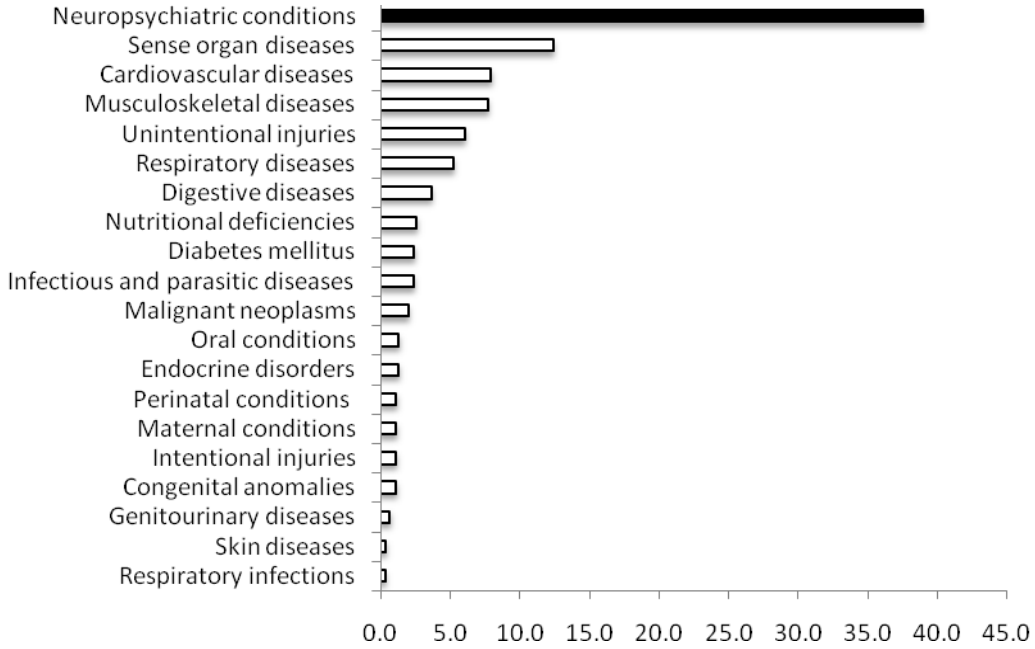
Mental illness[1] is one of the top public health challenges in Europe as measured by prevalence, burden of disease and disability. It is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. About 1-2% of the population have psychotic disorders, and across Europe 5.6% of men and 1.3% of women have substance misuse disorders. The ageing population is leading to an increase in the number of people with dementia, 5% of people over 65 and 20% of those over 80 years of age. In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing[2].

Across Europe, neuropsychiatric disorders are the second largest contributor to the burden of disease (DALYs), accounting for 19% of the total. There is considerable variation across Europe, with mental disorders already ranked highest in many high income Western European countries, but only fourth or fifth in some low income countries due, in part, to the continuing high prevalence of perinatal and cardio-vascular diseases. An important indicator of the disease burden on society and health systems is the contribution of specific groups to all chronic conditions.

Mental disorders are by far the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40% of all years lived with disability.

[1] Terminology is important but difficult. In this document we use the term 'mental illness' where there is or may be a diagnosis of a particular and defined condition within a document such as "The ICD-10 Classification of Mental and Behavioural Disorders" published by the WHO; 'mental disorder' to refer to the broader category of mental illness, personality disorder and mental illness (which follows the definition in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as well as substance misuse disorders); and "mental health problems" to refer to the more ambiguous territory which includes those with illness, but also people who may be experiencing challenges to their psychological wellbeing, but who do not have a persisting mental illness or disorder.

[2] "Paying the Price – The cost of mental health care in England to 2026" – King's Fund, 2008 available at http://www.kingsfund.org.uk/publications/paying_the_price.html



Years lived with disability in the WHO European Region

Depression alone is responsible for 13.7% of the disability burden, making it the leading chronic condition in Europe. This is followed by alcohol-related disorders (6.2%) in second place, Alzheimer's and other dementias in seventh (3.8%), and schizophrenia and bipolar disorders in eleventh and twelfth position, each responsible for 2.3% of all Years Lived with Disability[3].

A high percentage of people who receive social welfare benefits or pensions because of disability have, as their primary condition, mental disorders. Data from countries where information is available show that people with mental disorders account for as much as 44% of social welfare benefits or disability pensions in Denmark, 43% in Finland and in Scotland and 37% in Romania. Rates of employment for people with mental health problems in Europe vary between 18%-30%. Higher figures for social welfare benefits do not necessarily indicate higher levels of illness, but reflect a combination of reporting arrangements, levels of stigma and discrimination and the different scope of welfare systems across Europe.

Mental disorders are strongly related to suicide. Suicide rates in Europe are high compared to other parts of the world. The average annual suicide rate in Europe is 13.9 per 100,000, but there is a wide variation. In Scotland the most recent figure is for 2010 and was 14.7 per 100,000 (which gives a three year rolling average for 2008-10 of 15 per 100,000[4]) placing Scotland a little above that average, but in the middle group of European countries. There are reports that suicide rates have been rising in Europe since 2008, with the greatest increases in those countries most

[3] Figures and graph from The European Mental Health Strategy, WHO Europe (forthcoming).
[4] Figures from the General Register Office for Scotland (GROS) at http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/

affected by the economic recession, but in Scotland figures for suicide have continued to fall[5].

People with mental disorders have a much higher mortality than the general population, dying on average more than 10 years earlier. That gap is widening as health gains have been made more quickly in the general population than for those with mental illness. A reason for this widening gap is the high prevalence of chronic diseases such as cardiovascular disease, cancer and diabetes, and the often poor access and quality of treatment across Europe for such conditions for people with mental illness. Similarly, across Europe people diagnosed with chronic physical health conditions suffer from high rates of depression, often remaining undiagnosed, and this is also associated with higher mortality.

There are now good treatments for many mental disorders and co-morbidities. Suicide can be reduced. However, across Europe the majority of people with mental health problems do not receive treatment, the so-called treatment gap, or experience long delays. It is estimated that even in countries with the most developed mental health systems many people are not diagnosed and do not receive treatment. That is not the case in Scotland and closing this treatment gap has been a key objective of the Scottish Government's work on depression and alcohol misuse – the two conditions least likely to be diagnosed and treated in other countries.

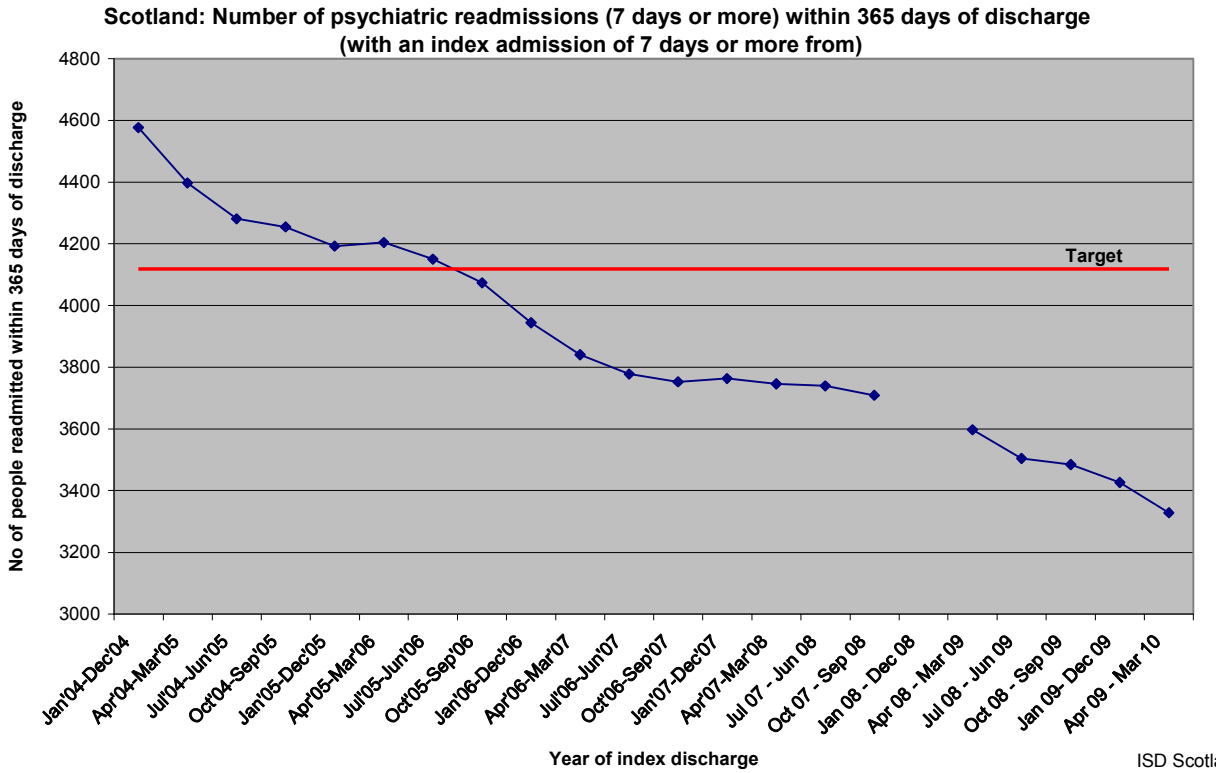
[5] The figures for 2011 are published by GROS in August 2011 and will have become available after this document has been sent for printing. The data is published at http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/suicides/

Achievements

The Challenge set out above is sobering and intentionally stark in setting out the scale and range of mental illness and its impact on both individuals and on society as a whole. It is a challenge to which the Scottish Government, working with the NHS, local government, the voluntary sector and service users and carers has responded effectively over time. There is more to do and the challenge remains great, but the Scottish Government has prioritised mental health and worked to give it parity with other health conditions.

Some high level examples of the improvements that have been made include:

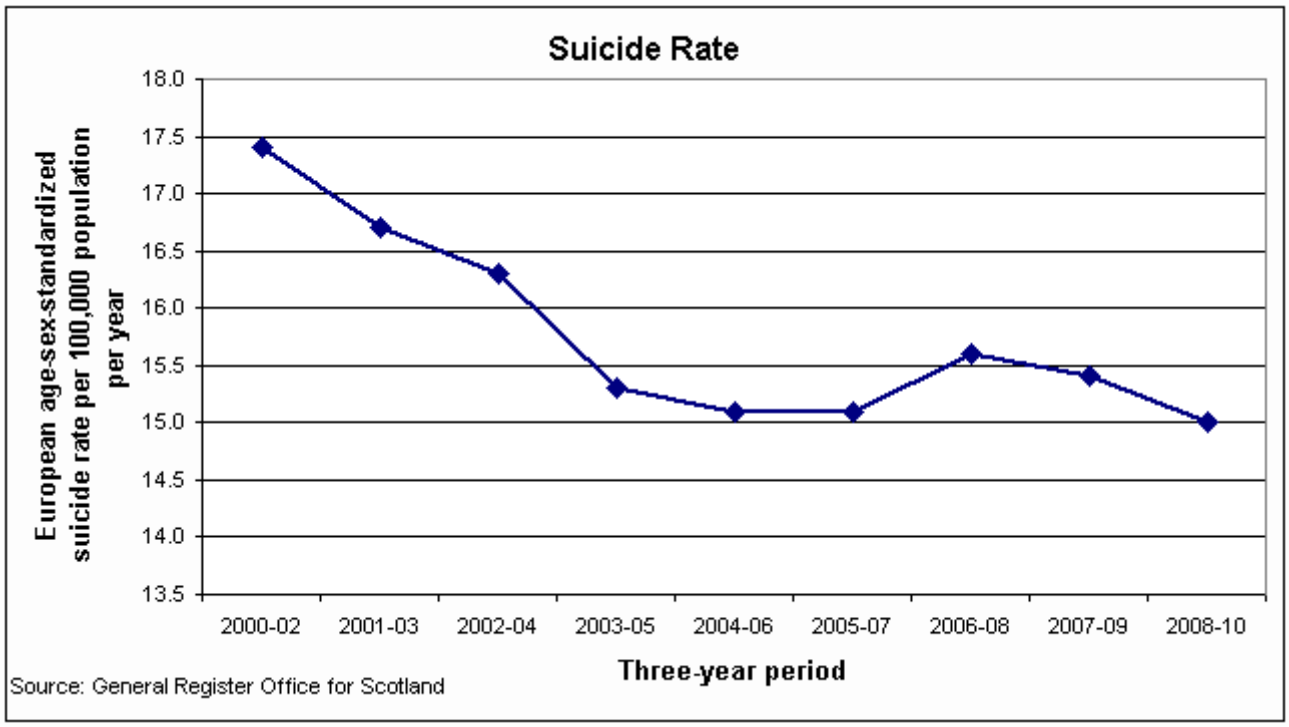
Readmissions – We have seen a steady reduction in the number of people being discharged and then readmitted to services, following work on inpatient and community settings and better discharge planning. Being admitted to an inpatient service has economic and social implications and so reducing readmissions is a necessary quality target. The number of patients who had a psychiatric readmission within one year of a previous psychiatric admission decreased steadily from 4,576 for the year ending 31 December 2004 to 3,426 for the year ending 31 December 2009. The reduction from the baseline figure at December 2004 was 25.1% for those discharged up to December 2009[6].



ISD Scotland SMR04

[6] The period of readmission was for readmissions up to December 2010 and more information is available at http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2011-12-20/2011-12-20-MentalHealth-Report.pdf The numbers of individuals readmitted within 365 days of discharge for Jan 08 – Dec 08 is not available due to data completeness issues during that period.

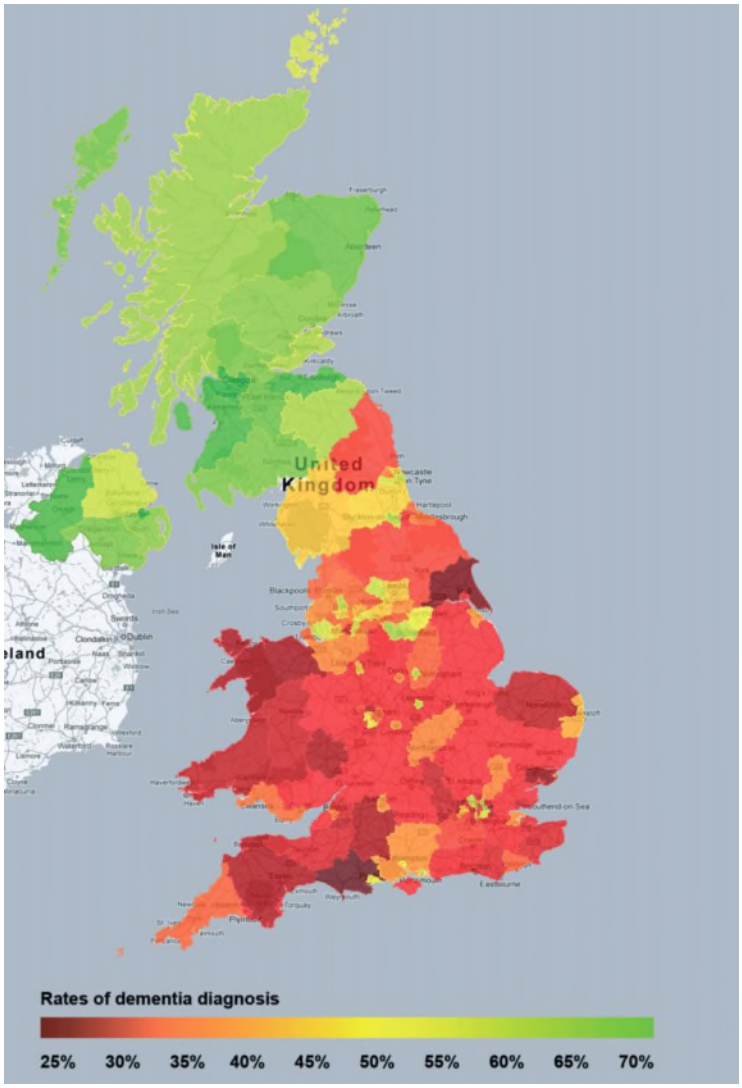
Suicide – the number of suicides reduced by 13.8% between 2000-02 and 2008-10. We have also delivered the HEAT target to train at least 50% of all frontline staff in understanding suicide and being able to work safely with people at risk of suicide. The number of suicides in 2009 was the lowest since 1991 and the number for 2010 also one of the lowest. The graph below shows the change over time using three year rolling averages[7].



Dementia – based on work taken forward from 2008, NHS Boards in Scotland now have the highest level of diagnosis in the UK and are the most improved. The Alzheimer Society report 'Mapping the Dementia Gap: Progress on improving diagnosis of dementia 2010-2011' showed that NHS Scotland has nine of the top twelve performing health areas across the UK for dementia diagnosis[8]. Faster diagnosis of dementia continues to be a HEAT standard and work to increase diagnosis is continuing. Diagnosis allows access to treatment and support, including for carers. We will say more about our work on dementia later in 2012 when we launch the consultation on the next dementia strategy. The map illustrates the rates of dementia diagnosis across the UK.

[7] More information about delivery against the suicide target is available on the Scotland Performs website at http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance/suicideprevention

[8] The report is available at http://alzheimers.org.uk/dementiamap with information at NHS Board or Trust level across the United Kingdom.



Map data ©2012 GeoBasics-DE/BKG (©2009), Google, Tele Atlas

Access to Psychological Therapies – we have introduced a HEAT target to deliver faster access to mental health services by ensuring access to a psychological therapy within 18 weeks by December 2014. Work with NHS Boards on antidepressant prescribing demonstrates that GPs in Scotland are more likely to be working to clinical practice and guidelines than elsewhere[9]. The gap in prescribing rates between Scotland and England appears to be reducing.

Child and Adolescent Mental Health Services – we are on target to deliver the HEAT target to ensure access to specialist Child and Adolescent Mental Health Services (CAMHS) treatment within 26 weeks by March 2013 and by 18 weeks by December 2014, reflecting a significant service improvement and reduction in waiting times. Data suggests a reduction from over 1200 waits of over 26 weeks when we began this work to around 300 currently. We have further work in hand that will

[9] "Factors associated with duration of new antidepressant treatment: analysis of a large primary care database" British Journal of General Practice 2012; DOI: 10.3399/bjgp12X625166

assure delivery of the target. There has been a 34% increase in the size of the specialist CAMHS workforce between the end of 2008 and March 2012.

What these achievements tell us is that it is possible to make significant improvements in the quality and availability of mental health services and that those improvements produce better outcomes for people with mental illness, their families and our communities. These improvements have been delivered through service improvement, redesign, strong leadership and the hard work of NHS, local government and voluntary sector clinicians and staff. That approach is sustainable even as we face economic challenges and we will commit to a similar or greater rate of improvement over the period of this strategy.

The position we are in 2012 is very different to the challenge we faced in 2003 when the new mental health legislation was agreed by the Scottish Parliament. At that time Dr Sandra Grant was invited by the then Minister for Health and Community Care to undertake a review of services within Scotland to assess their readiness for implementation of both the terms of the legislation and the expectations that were placed upon it. Her report identified deficiencies in services across Scotland and made a range of recommendations for improvement[10]. We have acted on the basis of what that report found and we continue to seek further improvement.

Commitment 1: The Scottish Government will commission a 10 year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014.

[10] National Mental Health Service Assessment: Towards Implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003 Final Report. Available at http://www.scotland.gov.uk/Publications/2004/03/19084/34431

POLICY CONTEXT

National Performance Framework

This Mental Health Strategy supports the Purpose of the Scottish Government which "is to focus Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth."[11] This Purpose applies across all the activities and responsibilities of the Scottish Government and creates the overall context for our work on mental health. It is supported by the Strategic Objective for Health which is "Helping people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care"[12] and by 16 National Outcomes, a number of which are directly applicable to the objectives set out in this Strategy, notably[13]:

> We live longer, healthier lives.
>
> We have tackled the significant inequalities in Scottish society.
>
> We have improved the life chances for children, young people and families at risk.
>
> Our people are able to maintain their independence as they get older and are able to access appropriate support when they need it.
>
> Our public services are high quality, continually improving, efficient and responsive to local people's needs.

The National Outcomes also mark out the territory for the work of local Community Planning Partnerships in developing and taking forward their Single Outcome Agreements which connect the high level national objectives with local priorities. This approach was reaffirmed in the Statement of Ambition earlier this year which reinforced the commitment to delivering demonstrable improvements to people's lives, promoting preventative approaches and to strengthening community engagement and participation in delivering better outcomes[14].

Delivering for Mental Health and Towards a Mentally Flourishing Scotland

Scotland's Mental Health Strategy is the successor document to Delivering for Mental Health[15] and Towards a Mentally Flourishing Scotland[16]. It builds on that work as well as on policy and service improvements taken forward alongside those main policy documents. It reflects the mature development of mental health policy in Scotland in the context of a population that increasingly understands mental health

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[11] Available at http://www.scotland.gov.uk/About/Performance/scotPerforms/purpose
[12] Available at http://www.scotland.gov.uk/About/Performance/Strategic-Objectives
[13] Information about each of the National Outcomes can be found at http://www.scotland.gov.uk/About/Performance/scotPerforms/outcome
[14] Available at http://www.scotland.gov.uk/News/Releases/2012/03/statementofambition15032012
[15] Available at http://www.scotland.gov.uk/Publications/2006/11/30164829/0
[16] Available at http://www.scotland.gov.uk/Publications/2009/05/06154655/0

and mental illness, service user and voluntary sector engagement and leadership in taking forward improvement and change, and a Scottish Parliament that recognises the importance of the issue and regularly debates and considers mental health.

Mental health was established as a priority on the global agenda by the World Health Report of 2001 Mental Health: New Understanding, New Hope[17], which was endorsed by the World Health Assembly of the World Health Organisation (WHO) in 2002. In Europe, in 2005, the Regional Office of the WHO adopted the Helsinki Declaration and Action Plan at a special Ministerial Conference held in Helsinki[18]. These Reports and Declarations set an agenda for action to support rights for people with mental health problems and develop community based services. The European Commission launched its European Pact on Mental Health and Wellbeing in 2008[19] and the European Union has now established a Joint Action on Mental Health and Wellbeing starting in 2012[20]. The Scottish Government collaborates with both the European Commission and the WHO Europe office in developing and taking forward mental health policy and improvement.

A Health Promoting and Preventative Approach

The Mental Health Strategy is fully consistent with the 2020 Vision:

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The focus on "prevention, anticipation and supported self management" is central to taking forward mental health policy in Scotland. As indicated above, services in Scotland have already reduced the number of mental health readmissions by around 25%. In this strategy we have a focus on a range of improvements and interventions that are in accordance with the best evidence for return against investment over time, including:

Early intervention for conduct disorder in children through evidence based parenting programmes;

Treating depression in those with long term conditions such as diabetes;

[17] Available at http://www.who.int/whr/2001/en/index.html
[18] Available at http://www.euro.who.int/__data/assets/pdf_file/0008/88595/E85445.pdf
[19] Available at http://www.ec-mental-health-process.net/index.html
[20] Available at http://register.consilium.europa.eu/pdf/en/11/st10/st10384.en11.pdf

Early diagnosis and treatment of depression; and

Early detection and treatment of psychosis.[21]

In addition there is a strong focus throughout this strategy on actions that people can take for themselves and with their communities to maintain and improve their own health. There is a good evidence base for such approaches, in particular for physical activity.

[21] "Mental health promotion and mental illness prevention: The economic case", Martin Knapp, David McDaid and Michael Parsonage (editors) Department of Health January 2011. http://www.centreformentalhealth.org.uk/publications/mental_health_promotion_economic_case.aspx?ID=630

WAYS OF WORKING – KEY THEMES

The Quality Strategy

In addition to specific commitments to particular action, we will also be working on a range of themes in respect of the improvement of mental health services and mental health improvement. These are set in the context of the Quality Strategy[22] and focus on working with people and communities to produce better outcomes.

This Mental Health Strategy fully supports and adopts the **3 Quality Ambitions** for Scotland that health and care must be:

Person centred – which is;

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe – which is;

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective – which is;

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

These are not new ideas to mental health, but inform the continuous improvement approach, which aims at delivery of and for consistent and reliable services everywhere. Much of the work that has already taken place in mental health in Scotland exemplifies the objectives and ambition of the Quality Strategy, notably the work in support of the Person Centred ambition. A key element of that work is in enabling people to become more involved and active in their own health and wellbeing – which is a key theme of our work on mental health.

Using a person centred approach to partnership working requires change in how the NHS and its partners develop and deliver services, and approaches to do more to give people greater control and engagement. Similarly, the work to understand how people experience and understand their health and are actively involved in their healthcare experience and decision making, directly links to the work that has begun with service users and their carers in mental health.

[22] NHSScotland Quality Strategy - putting people at the heart of our NHS http://www.scotland.gov.uk/Publications/2010/05/10102307/0

We will continue to develop a person-centred approach in mental health and ensure that the learning that has taken place in mental health at a local and national level is fed into the Quality Strategy Person Centred strand of work, and learn from how it develops in other areas of health and care. There are particular references to work on patient safety in mental health and to clinical effectiveness in the sections below, notably in respect of the access target for specialist CAMHS services and psychological therapies.

Seven Themes for Mental Health

Seven key themes emerged from the consultation on the mental health strategy. None of these ideas are new, but they will have increased emphasis across the mental health and mental health improvement agenda and some have explicit linkages with particular parts of the work programme. The themes are fully consistent with and exemplify the Quality Ambitions and have general application across the mental health work programme for promotion, prevention, treatment, care and recovery.

The themes are:

1. Working more effectively with families and carers

Families and carers can have an important role in providing support to those with mental illness, but can often feel excluded from making the contribution they would like to because of how services are structured or delivered:

> The work from Healthcare Improvement Scotland on learning from suicides shows that better work with families can contribute both to safety and to better outcomes[23];
>
> Caring Together: The Carers Strategy for Scotland 2010-2015[24] sets out the action that is being taken with partners to provide better support to family members and carers to enable them to offer care and support without coming to harm themselves.

Commitment 2: We will increase the involvement of families and carers in policy development and service delivery. We will discuss how best to do that with VOX and other organisations that involve and represent service users, families and carers.

2. Embedding more peer to peer work and support

The work that was taken forward under Delivering for Mental Health to establish the first paid peer support workers was successful in creating the role within Scotland. There is a demand to make greater use of the approach, but people need to understand the role and benefits better:

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[23] Suicide Reporting System: Learning and Improving Review
http://www.healthcareimprovementscotland.org/programmes/mental_health/programme_resources/suicide_reporting_system/learning__improvement_review.aspx

[24] http://www.scotland.gov.uk/Publications/2010/07/23153304/0

The Scottish Recovery Network (SRN), working with the Scottish Qualifications Authority, have developed a nationally accredited Professional Development Award to assure that the role is of an appropriate quality to add value based on lived experience[25];

SRN are developing a values framework with peer workers to help define and assure the role and have additionally developed the Experts by Experience Implementation Guidelines to help ensure considered role development[26];

There is a broader demand for greater use of formal and informal peer support approaches, in addition to the peer support worker role within care teams, and we will seek to build this in to our work more generally.

Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.

3. Increasing the support for self management and self help approaches

The evidence base for people taking a leading role in managing their own illness over time and the wider benefits to them that this approach offers is well established. As outlined earlier, mental illnesses are amongst the most severe long term conditions:

NHS 24 has developed, piloted and now delivers the Living Life Guided Self Help Service, under which self-help coaches guide individuals over the phone through a series of self-help workbooks to help them understand some of the reasons why they are feeling low, depressed or anxious[27];

NHS Health Scotland managed the Steps for Stress[28] resources which contain practical ways for people to start to deal with stress. This complements Well Scotland[29], the national health improvement website;

NHS Boards continue to develop and deliver self-help services locally, generally for people with common mental health problems, with many of these services being available through primary care, including the provision of self-help materials, access to computerised cognitive behavioural therapy and guided self-help.

This work links directly to the action and commitments on social prescribing which are set out later.

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[25] Information about the award is available on the SQA website at http://www.sqa.org.uk/sqa/47021.html
[26] A copy of the Guidelines can be requested from http://www.scottishrecovery.net/Resources/experts-by-experience-implementation-guidelines.html
[27] Information about the services can be found at http://www.nhs24.com/UsefulResources/LivingLife
[28] The website which offers support is at http://www.stepsforstress.org. There is more information about how we intend to develop the use of Steps for Stress below.
[29] http://www.wellscotland.info

4. Extending the anti-stigma agenda forward to include further work on discrimination

The work that has been taken forward in Scotland through *see me*[30] is internationally recognised as establishing best practice and has been learnt from and adopted throughout the world[31];

There is a need to build on this success by developing the work further to focus on the experience of discrimination and exclusion that many people with mental illness experience;

There is also the need to focus attention more directly on stigma and discrimination in health and social care services, which is where service users often tell us they feel the most discriminated against.

Commitment 4: We will work with the management group for *see me* and the Scottish Association for Mental Health, who host *see me*, and other partners to develop the strategic direction for *see me* for the period from 2013 onwards.

5. Focusing on the rights of those with mental illness

The Mental Health (Care and Treatment) (Scotland) Act 2003[32], established core principles to apply to mental health services in Scotland and that approach has firmly embedded rights at the heart of practice within services:

The principles of the Act underpin many of the values of inclusion, reciprocity and dignity which are key to effective, person centred mental health services;

The Dementia Standards[33] built on this approach to establish a framework for care and treatment standards for those with dementia and their carers; the standards apply irrespective of who delivers care or treatment, or where care or treatment are delivered and create a common understanding of how the quality of care and treatment should be assessed.

The Scottish Human Rights Commission has established a framework for embedding rights within care and treatment settings and services.

Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care in Scotland.

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[30] Available at http://www.seemescotland.org/
[31] "Stigma: An International Briefing Paper", WHO Europe, 2008 http://ec.europa.eu/health/mental_health/eu_compass/reports_studies/stigma_paper.pdf
[32] The Mental Health (Care and Treatment) (Scotland) Act 2003 can be found at http://www.legislation.gov.uk
[33] Available at http://www.scotland.gov.uk/Publications/2011/05/31085414/0

6. Developing the outcomes approach to include, personal, social and clinical outcomes

The Scottish Recovery Network[34] was established in 2004 to take forward the recovery model in Scotland; recovery is the idea that individuals and services should look beyond purely clinical outcomes to see the whole person and their social and personal outcomes as equally valid:

> In Delivering for Mental Health we set out plans to establish the Scottish Recovery Indicator as an approach to refocus services on the wider range of outcome and objectives; the SRI was launched and used, and has now been refined and re-launched in a more usable format as SRI 2[35];
>
> In the work on access to psychological therapies we are working with NHS Boards to embed the capacity, not just to collect clinical outcomes but to be able to report on them, and do so in a way which encourages monitoring and improvement from the level of individual patients right through to how clinical teams are performing;
>
> Our adult mental health benchmarking indicators and toolkit[36] provide a platform from which service activity and outcomes can be compared between NHS Boards. As further indicators, including outcomes indicators, are developed they will be added to the benchmarking toolkit;
>
> To promote outcomes-focused planning for mental health we have developed the Mental Health Improvement Outcomes Framework[37];
>
> Scotland is one of several nations engaged with the International Initiative in Mental Health Leadership[38] in developing a set of mental health outcome indicators which are considered to be of importance, valid, and feasible, in today's mental health systems. This work will ensure that Scotland remains at the forefront of outcomes measurement in mental health.

7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services

Many people already look to the internet and other new media approaches for help when they are in distress and this trend is likely to increase over time. The NHS in Scotland already offers a range of services through new technologies:

> Since 2008 NHS 24 has offered telephone based Cognitive Behavioural Therapy and Guided Self-Help as a response to depression[39];

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[34] Available at http://www.scottishrecovery.net/
[35] Available at http://www.sri2.net/
[36] More information is available in the final section of this document and at http://www.isdscotland.org/Health-Topics/Finance/National-Benchmarking-Project/mental-health.asp
[37] Available at http://www.healthscotland.com/understanding/evaluation/planning/mental-health.aspx
[38] Available at http://www.iimhl.com/
[39] Available at http://www.nhs24.com/UsefulResources/LivingLife

Other NHS Boards provide services such as Living Life to the Full Online, Beating the Blues and Moodgym;

NHS 24 hosts the NHS Inform service which includes information on mental health and wellbeing.[40]

Commitment 6: During the period of the Mental Health Strategy we will develop a Scotland-wide approach to improving mental health through new technology in collaboration with NHS 24.

[40] The website is at http://www.nhsinform.co.uk/mentalhealth

KEY CHANGE AREA 1: CHILD AND ADOLESCENT MENTAL HEALTH

Infant and Early Years Mental Health

"The period between pregnancy and 3 years is increasingly seen as a critical period in shaping children's life chances, based on evidence of brain formation, communication and language development, and the impact of relationships formed during this period on mental health. It is therefore also a critical opportunity to intervene to break cycles of poor outcomes."[41]

The Scottish Government is already committed to publishing a Parenting Strategy later in 2012 with a focus on work to support parents to be competent and confident in their efforts to build strong attachments with babies and young children. This will build on existing policy and on the day to day activities of midwives, public health nurses, nursery teachers and others. The Scottish Government is also committed to an expansion of the Family Nurse Partnership[42] – a model of delivering intensive support to vulnerable young first time mothers which has been shown to significantly improve a range of outcomes for children. We are already working through the Early Years Taskforce to prioritise and invest in interventions for which there is sound evidence of effectiveness.

However, we know that there is more that could be done for those who are most vulnerable. Secure attachment and competent, confident parenting are known to be significant protective factors, conferring confidence, resilience and adaptability. Disorganised attachment in infancy has been linked by both longitudinal and retrospective studies to a number of severe mental health problems manifesting in later life[43]. The importance of early experience in creating the conditions for good or poor mental health cannot be overstated.

Those most in need of help can be either easy or hard to identify depending upon whether the manifesting problems are visible (e.g. young children with very challenging behaviour) or hidden (e.g. babies who may be quietly suffering and anxious because their needs for social interaction through secure attachments are not being met).

Responding Better to Conduct Disorders

It is normal for young children to display challenging behaviour by being non-co-operative, highly emotional and aggressive, at times. Generally, these behaviours peak in the early pre-school years and start to reduce by the time children start school. However, approximately 10% of young children show a different

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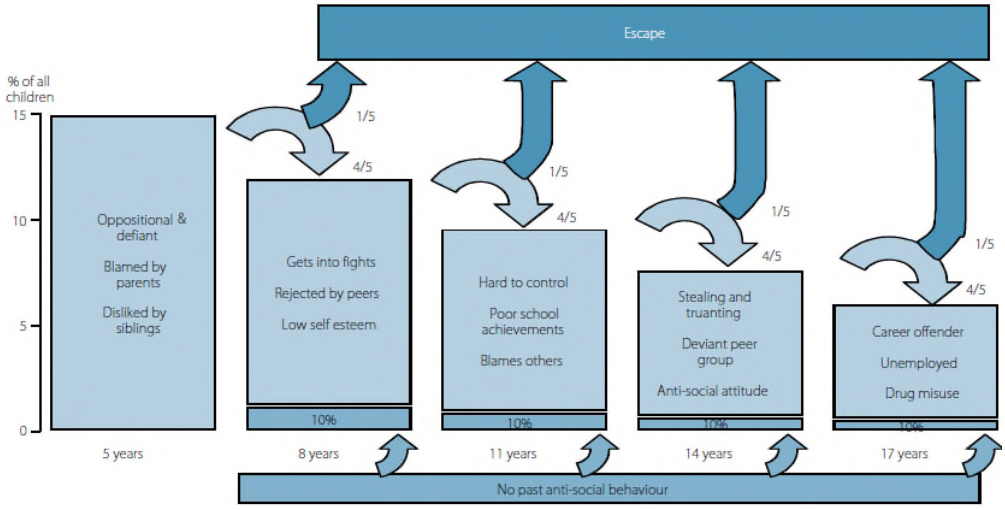
[41] The Early Years Framework, Scottish Government 2008 available at http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf

[42] More information about the Family Nurse partnership work is available at http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership

[43] "Attachment, the reflective self, and borderline states", Fonagy P., Steele M., Steele, H., Leigh T., Kennedy R., Mattoon G., & Target M. (1995) Pp 233-278 in Goldberg, S., Muir, R., & Kerr, J., (Eds) (1995) Attachment Theory: Social Development and Clinical Perspectives. Hillsdale, N. J.,: The Analytic Press.

developmental pattern[44]. For these children, their already elevated levels of aggression, non-compliance and emotional distress persist throughout childhood. As the diagram below shows, for many, the pattern endures into, and throughout, adulthood[45].



Source: Scott 2002

Research conducted by Stephen Scott for Home Office, 2002 (unpublished).

The reasons for these behaviours are complex, but we know that this pattern of behaviour problems is a powerful indicator of risk of long-term negative personal and social outcomes, including school disruption, family stress and dysfunction, mental health problems, loss of employment productivity, social isolation, drug and alcohol problems, as well as crime and antisocial behaviour[46]. A longitudinal study showed that antisocial behaviour at age 13 was predicted by externalising behaviour at age three[47]. Another study showed that by age 28 those with conduct disorder in childhood were 3 times more likely to have been convicted of a crime than those with no problems (and 12 times more likely to have spent time in prison)[48].

Evidence-based parenting programmes, such as Triple P and Incredible Years, offer a powerful way of addressing and responding to these early-onset behaviour problems. They are relatively inexpensive and produce long term benefits to the individual and society. The programmes take a positive and assets based approach to strengthening parental competencies. For those with early onset disruptive

[44] "The mental health of children and adolescents in Great Britain" Office for National Statistics, 1999; "Growing Up in Scotland: Children's social, emotional and behavioural characteristics at entry to primary school" Paul Bradshaw and Sarah Tipping, Scottish Centre for Social Research. http://spoxy4.insipio.com/generator/en/www.scotland.gov.uk/Publications/2010/04/26102809/0

[45] The diagram is sourced from "What Works in Parenting Support? A Review of the International Literature" , Moran P, Ghate D, van der Werwe A: Research Report 574. London: Department for Education and Skills, 2004.

[46] "The development of offending and antisocial behaviour from childhood: key findings from the Cambridge study in delinquent development", Farrington DP, J Child Psychol Psychiatry 1995 36:929-64, 1995.

[47] "Very early predictors of conduct problems and crime: results from a national cohort study", Murray J, Irving B, Farrington DP, Colman I, Bloxson AJ, J Child Psychol Psychiatry 2010, 51:1198–1207

[48] "Financial cost of social exclusion: follow up study of anti-social children into adulthood", Scott S, Knapp M, Henderson J, Maughen B., British Medical Journal 2001;323:191.

behaviour problems there is over 30 years worth of top quality research demonstrating the effectiveness of parenting programmes based on social learning theory. The research shows that, after their parents had participated in one of these group-based parenting programmes, roughly two-thirds of the children (with early onset disruptive behaviour) were behaving at a level comparable to that of their peers[49]. Research results have been replicated in randomised control trials by independent research teams in various countries worldwide as well as in Britain[50].

A partnership between the NHS and Glasgow City Council is in the process of making Triple P available to all parents in the city of Glasgow. Hundreds of practitioners, including health visitors, social workers and nurses, have already been trained to deliver the programmes. We believe that we should build on this approach and that a nationally coordinated approach is the best way of maximizing efficiencies and ensuring the quality of training and supervision, thereby ensuring that the programmes are delivered in accordance with the research evidence.

Commitment 7: In 2012 we will begin the process of a national roll out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour. We will include more information about the delivery of this commitment in our Parenting Strategy which will be published in October 2012.

Responding Better to Attachment Issues

Secure attachment is a basic human need of all infants but not one which is always met. An infant whose attachment becomes disorganised can experience high levels of stress and anxiety without necessarily showing outward displays of distress which would signify to their caregiver or the other adults in their support system that something is wrong.

We know about the importance of attachment and we also know a bit about what interventions are effective to address attachment issues in individual cases. Where the key challenge lies is in designing and developing good systems which combine raised levels of general awareness, a capacity to identify enhanced need and a capacity to respond appropriately and effectively when enhanced need has been identified. In order to address this 'hidden' health need of the present and improve the mental health and wellbeing of our future population we need to do three things. We need to do more to improve the general understanding of the issue of attachment, we need to improve the skills and awareness of those who come into contact with infants so that attachment problems or potential problems are recognised and where possible addressed, and we need to improve access to specialist support such as parent infant psychotherapy where this is indicated as necessary.

[49] "Treating Children With Early-Onset Conduct Problems: Intervention Outcomes for Parent, Child, and Teacher Training", Webster-Stratton, C., Reid, J.M., and Hammond, M. 2004. Journal of Clinical Child and Adolescent Psychology.

[50] "Randomised Controlled Trial of a Parenting Intervention in the Voluntary Sector for Reducing Conduct Problems in Children: Outcomes and Mechanisms of Change", Gardner, F. and Burton, J., Journal of Child Psychology and Psychiatry 2006 47:11. 1123-1132.

We are committed to gaining a better understanding of how the range of elements, outlined above, fit together to make up a good infant mental health service system. To do this we intend to examine the range of services and models of delivery currently in operation in Scotland and elsewhere and to learn from the latest available evidence about what systems are effective. We shall also focus attention on specific areas of innovative practice – for example following, with interest, the progress of the New Orleans Intervention model – being delivered and evaluated in Glasgow by NSPCC in partnership with Glasgow City Council and NHS Greater Glasgow and Clyde. The New Orleans Intervention Model was developed in the USA and is a cutting edge way of intervening with abused and neglected pre-school children[51]. This is a potential prototype for a new way of working nationally.

Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children's services workforce. We shall also improve access to child psychotherapy (a profession which specialises in parent infant therapeutic work) by investing in a new cohort of trainees to start in 2013.

Looked after Children

Research carried out in the UK and elsewhere consistently shows that looked after children have significantly poorer mental health than the rest of the population[52]. Work with this particular group is often made more complex by the strong feelings which can be evoked in care-givers and professionals by children who are struggling to cope with and come to terms with a personal history of trauma including abuse and neglect.

In recent years there have been many positive developments, both in relation to an increase in direct therapeutic services for this population and an increase in the indirect mental health support available. An example of the indirect support is the basic mental health training which has been made available to all those working with or caring for looked after children and young people[53]. In addition, NHS Boards are required to assess the mental health needs of all looked after children for whom they have a responsibility[54].

There is still work to do to improve the way in which Child and Adolescent Mental Health (CAMH) services, local authorities and third sector providers work together to address the mental health needs of this population. Services work best for children where NHS Boards are able to deliver training and also opportunities for professionals to discuss particular concerns about an individual child or young person in care, where work has been done to develop a shared understanding of thresholds (the signs and symptoms of distress and/or mental illness which make a

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[51] More information about the work the NSPCC is taking forward is available at http://www.nspcc.org.uk/what-we-do/the-work-we-do/priorities-and-programmes/physical-abuse/new-orleans-intervention-committee/new-orleans_wda86270.html

[52] "Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households", Ford, T., Vostanis, P., Meltzer, H. and Goodman, R., British Journal of Psychiatry 2007, 190, pp. 319-325.

[53] Delivering for Mental Health, Scottish Executive, 2006 available at http://www.scotland.gov.uk/Publications/2006/11/30164829/0

[54] Looked After Children and Young People; We Can and Must do Better, Scottish Executive, 2007 available at http://scotland.gov.uk/Publications/2007/01/15084446/0

specialist CAMHS assessment or intervention necessary), where good professional relationships between individuals from different agencies have been allowed to build up over time, and where there is confidence that new referrals for assessment will be given appropriate priority. In accordance with Getting it Right for Every Child principles we shall continue to encourage high quality, individually tailored, multi agency approaches for this vulnerable group[55].

Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.

Learning Disability and CAMHS

We know that access to mental health services for children with a learning disability is better in some parts of Scotland than in others. This work is complex and challenging, with combinations of learning and developmental disorders as well as mental illnesses giving rise to a wide range of presentations, uncertainties about diagnosis and difficulties in identifying effective treatment regimes which are sustainable over time. Different approaches to service delivery are also taken in different parts of Scotland. We have recently produced a report to support service development which will be made available and issued to NHS Boards and we will work with clinicians to take forward key actions identified from the report.

We are collecting data, through the CAMHS Balanced Scorecard, on the numbers of children with learning disability gaining access to mental health services in different parts of the country. This will help us towards a better understanding of the variance and help NHS Boards to take appropriate action, where necessary, to improve access in the short term.

Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become or lead to prototypes for future testing and evaluation.

Access to Specialist Child and Adolescent Mental Health Services

Much work has been undertaken nationally over the past 3 years to improve access to specialist CAMHS by reducing the time patients wait between referral and treatment. This followed the setting of a HEAT target which states “no patient shall wait longer than 26 weeks between referral and treatment for specialist CAMHS by March 2013”. An additional target of 18 weeks by December 2014 has now been set to bring the target into line with other access time targets and the access to psychological therapies target.

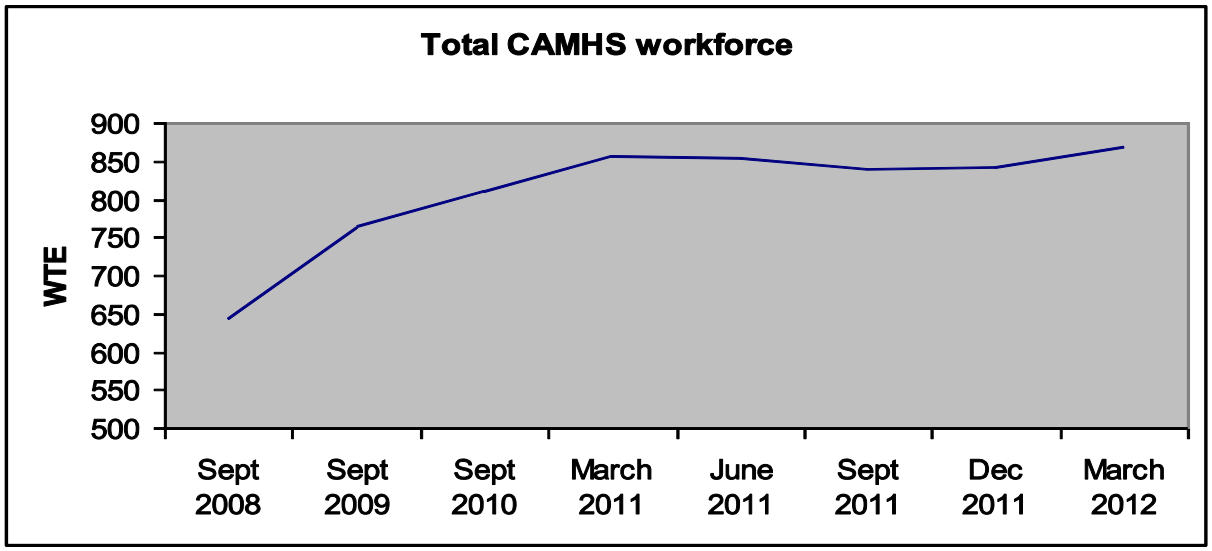
We are on track to deliver the HEAT target, reflecting a significant service improvement and reduction in waiting times. Data suggests a reduction from over 1200 waits of over 26 weeks when we began this work to around 300 currently and

[55] More information about the GIRFEC approach is available at http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

with further work in hand that will assure delivery of the target. The target is intended to reduce waiting times and improve access to CAMH services overall, but it does not remove the role of clinicians in deciding when a child needs to access a service more quickly. Where a child or young person is assessed as needing to access a service urgently, they will be seen more quickly, sometimes the same day.

Changes have been achieved in a number of ways. Firstly there has been a focus on growing the specialist CAMHS workforce which has increased by over 34% in less than four years from 645.3 whole time equivalents (WTE) in September 2008 to 868.9 WTE in March 2012 (see graph below). We have worked on capturing data to measure CAMHS waits which is due to be published for the first time in August 2012 by ISD. There has also been a significant amount of service and patient pathway redesign work undertaken which has ensured a more efficient and effective use of resources.

The growth in the total whole time equivalent (WTE) for the CAMHS workforce, September 2008 through to March 2012 is shown in the graph below.



Note: Numbers exclude trainees
Source: Child and Adolescent Mental Health Service Workforce Database.

Commitment 11: We will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets.

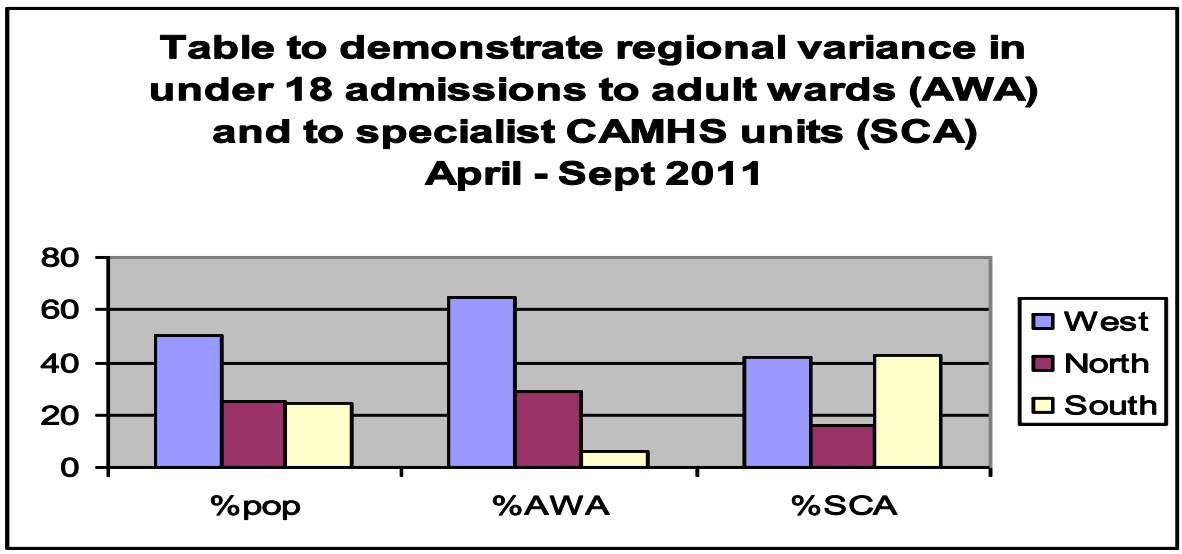
CAMHS Admissions to Adult Beds

A decision to admit a young person to an adolescent unit will be made only if admission is deemed the only safe and appropriate option available for the patient. It is important therefore that beds are available when required. In order to ensure that this is the case two approaches are being taken nationally. Firstly a decision of the North of Scotland NHS Boards to build a new 12 bedded unit in Dundee to replace the current 6 bedded unit will increase the bed base from 42 to 48 beds and improve the quality of the estate. Secondly a new model of care and treatment has been introduced. This new approach to addressing the issue of capacity has seen the

development of CAMHS intensive 'hospital at home' type service delivery in a number of NHS Board areas.

The new approach used emphasises the child's strengths and uses the expertise within the family and the local community to maximise the support available - the theory being that a small change in a child's familiar environment will be more significant in their recovery than a larger change in a setting alien to them. When provided in conjunction with practices such as proactive discharge (planning discharges from the date of decision to admit) and flexible approaches to in-reach and out-reach work, a number of benefits have been demonstrated. Some admissions are avoided altogether. Many are significantly shortened. Where evaluation and research has been undertaken, good patient outcomes have been demonstrated[56].

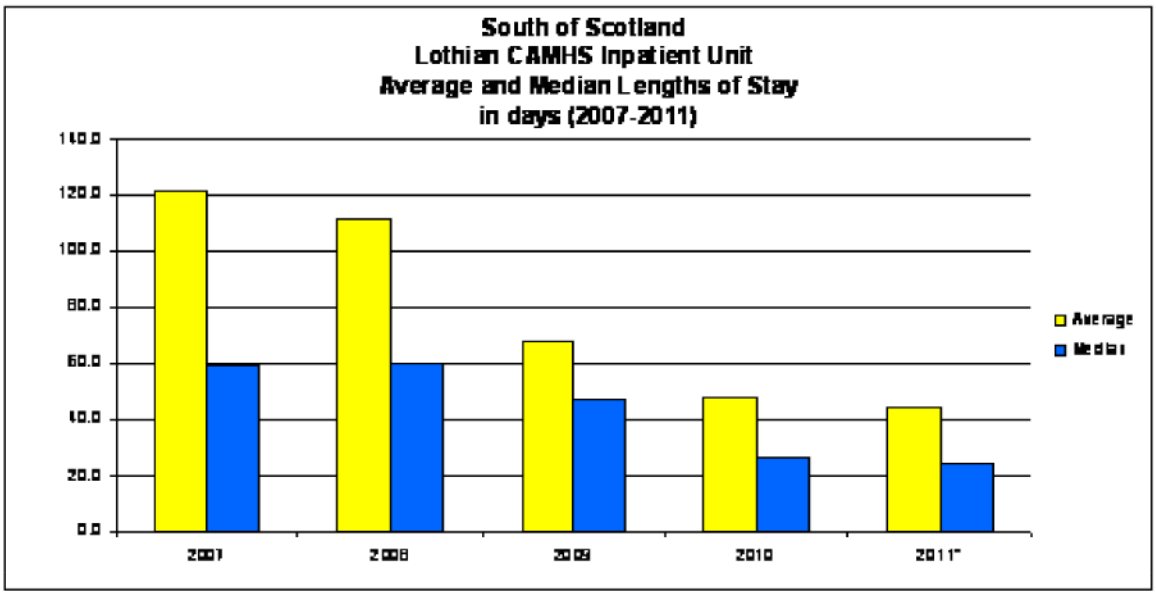
The benefit to the system as a whole is that new capacity is created. In the areas where the new approaches are most advanced this has been demonstrated to have had the effect of significantly reducing the need for unscheduled and temporary admissions of under 18s to adult psychiatric hospital beds.



Source ISD SMR04 returns

Focusing on the South of Scotland demonstrates the variance and the potential benefits of newly created capacity, arising from the new model. In a recent 6 month period it was shown that the South of Scotland had 25% of the population but only 5% of admissions to adult wards. During the same period almost half of all admissions to CAMHS specialist units occurred in the South, though this is also the product of shorter admissions, increasing the number of young people accessing the service as is shown in the following graph.

[56] "The Effectiveness of a Community Intensive Therapy Team on Young People's Mental Health Outcomes", Simpson, W., Cowie, L., Wilkinson, L., Lock N., & Monteith, G., 2009, Child and Adolescent Mental Health available at http://www.playfieldinstitute.co.uk/research/reports/effectiveness_of_community_intensive_therapy_team_camh_2010.pdf



Source NHS Lothian PIMS

This graph shows a dramatic reduction in lengths of stay during the five year period 2007- 2011. While there have been changes elsewhere in Scotland, they have been less dramatic and we will be undertaking further work focused on variance, with the objective of delivering similar benefits to those which have been delivered in the South and East of Scotland Regional Planning Area.

A small number of young people in Scotland with very complex needs are admitted to adult forensic services or specialist services in England. As use of the CAMHS inpatient estate continues to developed, we will consider how the varied and complex needs of this group of young people can best be met.

Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.

Child and Adolescent Mental Health Indicators

A set of national mental health indicators for children and young people in Scotland has been established. This complements the mental health indicator set for adults. It was launched formally by NHS Health Scotland in November 2011, with a follow up web publication[57]. The children and young people's mental health indicators cover both the state of mental health (mental wellbeing and mental health problems) and the associated contextual factors.

The indicators provide for the first time a means of assessing and monitoring the mental health of Scotland's children and young people over time and will enable the development of the first national mental health profile for children and young people (aged from pre-birth to 17 years). Updated every four years, the profile will result in a

[57] The publication and further information can be found at www.healthscotland.com/scotlands-health/population/mental-health-indicators/children.aspx

greater understanding of the current and changing picture of mental health within this population and the factors that influence it.

KEY CHANGE AREA 2: RETHINKING HOW WE RESPOND TO COMMON MENTAL HEALTH PROBLEMS

Common mental health problems such as depression and anxiety can be both severe and enduring, but the response they will generally require is different from that for illnesses such as schizophrenia. However, in many ways the systems for providing care and treatment can look very similar. We need to examine and challenge that model.

The themes above and commitments set out throughout this Strategy promise a system where therapies are more readily available, but also where there is a wider range of responses, including social prescribing, self help and peer to peer work. People already have access to more information themselves and are increasingly able to self refer to services or to seek support for themselves. These approaches build capability and make choices, and that degree of control and mastery is itself health producing.

This marks a move away from the model where, uniformly, the doctor diagnoses and treats illness, to a wider range of responses which includes that approach, but also includes approaches where people will be identifying problems for themselves and seeking help or taking action, and where families and friends are more likely to say something or offer support. Information and support will be more widely available, whether from health care professionals or from the web.

This is not a utopian vision and these new ways of working will not be for everyone, whether because of personal choice or for reasons linked to illness. Services as we know them will continue to be necessary as part of a mental health system.

This is a change which will accelerate over the next period of time and services and approaches need to adapt quickly.

Faster Access to Psychological Therapies

The Scottish Government is already committed to delivering faster access to psychological therapies for those with mental illness or disorder. We have already seen improvements in service performance across Scotland since the HEAT target was set. Patients and clinicians have long identified access to therapies as a key service improvement that would better meet their needs and expectations in getting access to world class clinical care, both for those with severe and enduring mental illness and for those with more common illnesses such as depression and alcohol addiction.

Delivering faster access is a significant and complex challenge. The objective is that by 2014 the standard for referral to the commencement of treatment will be 18 weeks, irrespective of age, illness or therapy. No other country in the world has set such a wide ranging and comprehensive target within a publicly funded healthcare system.

The programme to take forward this work is delivered locally, but supported nationally. To deliver the target we have had to undertake the following work:

- we are developing national and local information systems and data to record performance and progress against the target; this has required us to specify and define the target and what should be recorded, as well as creating the capability to record data to a high standard over time;

- we have offered guidance through the Matrix[58] on what treatments are effective for which illnesses and conditions; the HEAT target covers all types of evidence-based therapy for all types of mental illness or disorder, as well as allowing for work where the evidence base is underdeveloped or not available at this time;

- the Matrix also stresses that services must provide adequate psychological therapies supervision for staff delivering psychological interventions, to ensure patient safety and the delivery of evidence-based care; the evidence also shows that supervision improves the quality of outcomes and the efficiency of service delivery;

- with NHS Education Scotland, we are working to assess and develop workforce capacity; this is not just about psychology staff, but ensuring that a range of staff including psychologists, nurses, allied health professionals and doctors are equipped to deliver therapies, at a range of levels, as part of their clinical practice;

- we are working to ensure that systems are designed to make the most effective use of current resources by removing duplication, unwarranted variation and waste;

- we are building processes into the work to gather information on clinical outcomes; while it is important that we are able to offer faster access to services, it is equally important that what we offer produces clinical benefit.

While data systems are still developing and we are continuing to resolve issues with recording and reporting systems, good progress is being made across NHS Boards in Scotland which gives us confidence that the target will be achieved on time. More information on the target and the work to support its implementation is on the NHS ISD website[59].

Local service redesign informed by evidence is central to delivery of the target. For example, mental health services historically have tended to have high rates of people not attending appointments. One service reduced its Did Not Attend rate from 21% to 7.5% by making changes which gave patients more choice over appointment times. Another service reduced the amount of time spent in allocation meetings by 312 hours, giving an extra 312 hours to see patients just by changing its processes for allocating patients to staff. Work being taken forward by NHS 24 to deliver therapies and guided self-help by telephone is increasingly being accessed by

[58] The Matrix is available at http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix/the-psychological-therapies-matrix.aspx
[59] http://www.isdscotland.org/Health-Topics/Mental-Health/Psychological-Therapies.asp

people who self refer to the service. In each case these improvements contribute to the objective that people in distress get to see the right person as quickly as possible.

Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014 the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.

Equality of Access to Services

Some people can experience more difficulty than others in accessing mental health services to meet their needs. This can be because some groups are less likely to try to access services, for example due to stigma, or because there are gaps or lack of capacity in some services.

We need to understand who is accessing services to identify where there might be unmet need or where additional preventative action could be taken. Consistent recording of data about ethnic background and other information, for example, gender, sexuality and disability provides us with information about whether services are delivered in a way that meets people's specific needs.

Commitment 14: We will work with NHS Boards and partners to improve monitoring information about who is accessing services, such as ethnicity, is consistently available to inform decisions about service design and to remove barriers to services.

Social Prescribing and Self Help

The work on access to psychological therapies is just one part of creating the well functioning mental health system. In parallel with this, NHS Boards and their partners offer access to information and advice, self-help approaches, some of which may be online or through NHS 24, bibliotherapy, counselling and other accessible low-intensity treatments, including exercise, to meet the needs of people experiencing psychological distress.

The evidence base for a wider range of approaches to tackle common mental health problems like depression is already established. Many people would prefer to 'do something' to improve their mental health than to receive a treatment. We also know that the recovery of people with more severe mental illnesses also benefits from access to services that support physical activity and social integration. The poor life expectancy of those with mental illness is as much or more driven by poor physical health and health behaviours as it is by their mental illness.

A standardised assessment tool and a pathway for brief advice and brief intervention have been developed for use by primary care teams, to assess and improve levels of physical activity in the community. Though we know activity has physical and mental health benefits, currently only 39% of the adult population in Scotland achieve the minimum guidelines of 30 minutes five times per week of physical activity. NICE describe Brief Intervention for Physical Activity as highly cost effective, at £20-£440 per quality adjusted life year (QALY)[60] . These tools and pathways are being

[60] For commonly used methods to increase physical activity, http://www.nice.org.uk/PH2

integrated into existing Keep Well pathways. eLearning modules on Health Behaviour Change including "Raising the Issue of Physical Activity" have been developed and can be used by any health professional.

We do not think the challenge here is primarily about the range of local services and facilities. The challenge is more about connecting people to such opportunities and addressing the reasons why they might not access them. Our focus is on things that people and communities can do for themselves which are particularly valuable given the additional benefits that people derive from taking control of their own health and wellbeing. However, people may not access services for the following reasons: they may not know about them; they may not think they are for them; or they may be uncomfortable or nervous about going for the first time.

Primary care and particularly General Practitioners have a key role to play in this work. Often they are the best placed to signpost a person successfully to such a service. They have a good understanding already of their patients and what might work for them. Toolkits and reviews have been produced previously to show the benefits and give guidance on social prescribing approaches. We will ensure that this information is easily available. One example is Developing Social Prescribing and Community Referrals for Mental Health in Scotland[61]. Similarly the Links Project Report[62], based on work in Glasgow and Fife, showed how General Practices can make better use of community resources to help and support the people they are working with. It was notable that in many cases, up to 50% in Glasgow, the resources being referred to were for addiction or mental health. In some cases it is necessary for practitioners to connect people to local community and voluntary sector services to assist people to access activities for the first time and to develop confidence and skills to do so on an ongoing basis.

Commitment 15: We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find[63]. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.

One of the 22 commitments delivered under Towards a Mentally Flourishing Scotland was the development and publication of Steps for Stress[64]. Steps for Stress is a short booklet which provides an easy guide to understanding common mental health problems and providing advice on things that people can do for themselves or services such as debt advice that they can access to gain support.

[61] Available at http://www.scotland.gov.uk/Resource/Doc/924/0054752.pdf
[62] "Links Project Report: developing the connections between General Practices and their Communities" http://www.scotland.gov.uk/Publications/2012/05/1043/0
[63] Available at http://www.aliss.org/
[64] Available at http://www.scotland.gov.uk/Publications/2009/05/06154655/0

The booklet is supported by a website that has additional content and links[65] and a relaxation CD is also available. Since 2009 more than 420,000 copies of the booklet and almost 970,000 CDs have been handed out. We have recently agreed to allow the Northern Ireland Assembly to produce their own local version of the resource.

We intend to take this approach forward in a number of ways to make best use of the existing resources and materials. One component of this will be to provide and share learning for local health improvement and voluntary sector staff in how they can use the materials in their locality and how they can work with people who are using the materials. A second element will be to link the resource more directly to the ALISS project so that people can easily identify local opportunities to access help and support.

Commitment 16: NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use Steps for Stress as an early intervention approach to address common mental health problems.

Mental Health and Alcohol

There are strong links between depression and drinking above recommended guidelines. The SIGN Guideline – 'The management of harmful drinking and alcohol dependence in primary care'[66] – explains how hazardous drinking and alcohol dependence present in many ways, one of which may be through depression.

Alcohol Brief Interventions (ABIs) are part of the Scottish Government's wider strategic approach to tackling alcohol[67]. In 2008, an NHS health improvement HEAT target was introduced, based on the SIGN Guideline, requiring NHS Boards to deliver ABIs within the following 3 priority settings – primary care, A&E and antenatal. To date, over 272,000 ABIs have been delivered. Many of these interventions have been delivered in primary care settings. We believe there is value in clearly aligning the work in place to diagnose and respond to depression with the delivery of brief interventions to reduce people's alcohol consumption.

[65] Available at http://www.stepsforstress.org
[66] SIGN 74 is available at http://www.sign.ac.uk/guidelines/fulltext/74/index.html
[67] Alcohol Framework for Action (2009) http://www.scotland.gov.uk/Publications/2009/03/04144703/0

For 2012-13 ABI delivery has become a HEAT standard. NHS Boards and Alcohol and Drug Partnerships (ADPs) will sustain and embed ABIs in the 3 priority settings. In addition, they will continue to develop delivery of ABIs in wider settings, which may include specific mental health settings.

NHS NES is supporting the development of a standardised training and certification programme in Motivational Interviewing which will be of relevance across all tiers of service in relation to alcohol misuse and wider health behavioural change issues. Training is also being delivered in core behavioural and cognitive behavioural therapy skills for relapse prevention and recovery management.

Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care.

Mental Health and Debt

In 2010/2011 Citizens Advice Scotland (CAS) received over 90,000 new debt enquiries and over 15,800 new debt cases. There is evidence of a link between debt and mental health problems, and research shows that suicide risk is raised for virtually all mental health problems and substance abuse. Bureaux advisers reported that some clients experiencing debt were also indicating signs of stress and anxiety. CAS identified a need for further training on mental health awareness and suicide awareness for advisers, and training for supervisors to enable better support of client advisers following a distressing contact.

Earlier this year, the Scottish Government funded Samaritans to undertake joint work with Citizens Advice Bureau Scotland to produce two e-learning modules to develop the service which clients with mental health problems receive from Citizens Advice Bureaux (CAB). The first module covers suicide risk awareness, recognising signs of suicidal intent and providing first level response and support to clients and is aimed at paid staff and bureaux volunteer advisers across Scotland. The second module is for use by CAB line managers and supervisors to support advisers after they have handled a distressing contact.

Trauma

The relation between trauma and mental illness is complex. Across the lifespan trauma is a relatively common phenomenon and many people have experience of single life-threatening events, or longer-term traumatic circumstances, without suffering significant psychological harm. However, some do suffer harm and that harm, while rooted in the psychological trauma, may manifest in a variety of mental health problems including depression, addiction or physical symptoms. There are clear linkages to the work on distress set out later, as well as to the work to improve access to psychological therapies.

While there is a growing recognition of the significance of trauma, clinicians and others may be reluctant to engage with it because of the concern of causing further harm, or of not being able to offer an appropriate response which meets the needs of

the person. We need to address that deficit and improve the general service response to trauma.

The Rivers Centre in NHS Lothian has been commissioned to investigate the issue of staff awareness of trauma-related mental health disorders in primary care. The work will begin with engagement with a number of GP practices in NHS Lothian with different experience and circumstances. A consultation process will follow with the Royal College of General Practitioners and with representatives of NHS Education for Scotland.

The objective of this work is to develop an approach designed to raise the awareness of primary care practitioners of post traumatic disorders, facilitate best practice management of post traumatic disorders and improve identification of available local resources and services for onward referral. This approach will be piloted in the same GP practices as are involved in the first stage study. The pilot data will be analysed, modifications to the training package will be made in consultation with the Royal College and with NES, and, if appropriate, a wider roll-out plan will be designed.

NHS NES will continue to develop and deliver a range of training courses to support staff working across the tiers of the stepped care system, including psychoeducation for complex trauma, trauma-focussed cognitive behavioural therapy and Working with Dissociation in Survivors of Trauma.

The Scottish Government is also supporting the UK Psychological Trauma Society to develop and support a national learning network for trauma practitioners and services working in Scotland.

Commitment 18: We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network.

Distress

Over recent years there has been a greater recognition of a group of disorders, illnesses and behaviours which present particular challenges to services and to families. Particular examples are eating disorders and self harm. The common characteristics are that they are behaviours that involve risk to the individual and which others find frightening or upsetting; they are associated with self-stigmatisation and guilt leading to avoidance and disengagement; generally individuals are regarded as having capacity, and so there is an element of voluntariness which produces confusion about interventions; they present in primary care and A&E and other non-specialist settings; and they tend to begin early in life, but can be fatal or have a continuing impact.

The current model of service delivery is treatment approaches that tend to focus on the behaviours, not the underlying cause (except in some cases where trauma or personality disorder is identified), alongside treatment of co-occurring illness issues, notably depression, anxiety and addictions. In some cases these treatment approaches are effective and successful, but often that is not the case and the

behaviours are chronic. There is a preference in primary care to refer to secondary care for 'specialist' mental health treatment, but also often a recognition by primary care practitioners that this is unsatisfactory. Families and carers are able to act as advocates, but often feel disempowered to help.

People within this group may have frequent contact with crisis and healthcare services and a subset have regular attendances at A&E. Some will also have regular contact with the police or with social work services, but the challenges they present are very similar. At times they may seek or request help, but they are likely to disengage or to fail to take up appointments. There is no single treatment or intervention which is appropriate and referrals to specialist mental health or addiction services are often unsuccessful. There is an interaction with the work on Adult Support and Protection which may also offer new opportunities for different ways of approaching the challenge and co-ordinating the statutory sector response.

The Scottish Government has been undertaking recent work with NHS Tayside and partners, including families, focusing on this group following on from a group of suicides in 2010. Developing ideas from that work include moving the focus from the behaviours to focus more on the underlying distress. The thinking is that doing so would offer a more human, caring response that acknowledges what is going on with the person and which is less likely to produce a stigmatizing and excluding response, with the effect that more people will come forward for treatment or engage with services. It could also give family members and others a better basis for offering care and support and enable us to mobilise a wider range of treatment and community supports. Initial discussions with service users and others suggest that further work to develop the approach would be welcomed.

Commitment 19: We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.

Mental Health of Older People

There has been a significant focus on the mental health of older people through the work on dementia. The next stage of work on dementia will be consulted on later this year and there is a commitment to produce an updated strategy in 2013. However, more older people experience illnesses such as depression and anxiety than experience dementia and there is a need to better respond to their needs. More than any other group, older people are less likely to have illness diagnosed and less likely to receive treatment, though prescribing data since 2000 would suggest that this is improving and the mental health needs of older people are increasingly recognised.

In 2010, as part of the work on better access to psychological therapies, the Scottish Government established a working group to focus on the mental health needs of

older people. That working group reported in December 2011 and made recommendations for service development based on seven key principles[68]:

Seven Principles of Good Psychological Care for Older People

1. A psychologically and age-aware workforce for all services.
2. Specialist older people's psychological services are based on need not age.
3. Access for older people to general non-age related services where appropriate.
4. A matched care approach is used that meets the needs of older people.
5. Sufficient numbers of highly trained staff are available to undertake low and high intensive therapy, plus training, research and service development.
6. Trained staff will have reserved and protected time to undertake such work.
7. There will be ongoing clinical support, clinical supervision and reflective practice opportunities.

The report identified the need to make improvement across the system, from highly specialist therapeutic approaches to better community and self help approaches that support and maintain people's wellbeing in later life. This is consistent with the recommendations that were produced by the reference group for Mentally Healthy Later Life[69], flowing from the commitments in Towards a Mentally Flourishing Scotland to explore what is needed to support wellbeing in later life. The indications are that in a number of local authority areas preventative approaches have been prioritised under service redesign initiatives being taken forward under the Change Fund[70]. As with the adult population, we know that addressing common mental health problems such as anxiety and depression alongside co-occurring long-term conditions improves clinical outcomes and reduces the likelihood of admission to hospital or institutional care.

Commitment 20: We will take forward the recommendations of the psychological therapies for older people report with NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population.

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[68] The Challenge of Delivering Psychological Therapies for Older People in Scotland Report of Older People's Psychological Therapies Working Group, December, 2011.

[69] Mentally Healthy Later Life Reference Group - Recommendations to inform Scottish Government's action plan to promote mentally healthy later life in Scotland (2010) NHS Health Scotland available at http://www.wellscotland.info/guidance/tamfspolicy/laterlife/index.aspx

[70] More information about the Change Fund is available at http://www.scotland.gov.uk/Topics/Health/care/reshaping/changefund

In addition, the Scottish Government is currently consulting on the integration of adult health and social care, with a particular focus in the first instance on improvements in services and support for older people[71].

Commitment 21: We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people's mental health as part of the work to take forward the integration process.

Mental Health of those with Physical Illness

In "Improving the Quality of Health Care for Mental and Substance-Use Conditions", the Institute of Medicine identified as its first overarching recommendation that: "health care for general, mental and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body."[72] In "Long-term conditions and mental health: the cost of co-morbidities", the Kings Fund found that people with long-term conditions who also had co-morbid mental health problems such as depression and anxiety had increased health care costs and poorer clinical and other outcomes[73]. Recent research in Scotland supports these conclusions and argues for new approaches to care and treatment to enable clinicians to offer better support to those with co-morbidities, particularly in deprived areas[74].

This academic and clinical research evidence is in accord with what patients often tell us, that they feel that their treatment is fragmented. There is an ongoing need to address co-morbidities with a particular focus on identifying and responding effectively to depression. The indications are that clinicians in primary care in Scotland have been very effective in closing the treatment gap for patients with depression, but further work is needed in all settings to tackle this challenge.

The Living Better Project – a learning collaboration between a number of partners including the Royal College of General Practitioners in Scotland – identified key lessons for staff working with people with long term conditions who also had common mental health problems[75]. It developed training interventions both for professionals and for patients and addressed issues to do with stigma by promoting activity in a way that plays down the connection to mental illness and focused on positive wellbeing and people's potential strengths as individuals and as a group. Similarly, work with the Thistle Foundation in Craigmillar in Edinburgh gave us insight into how local community services can engage with General Practitioners. GPs became more confident about referring to services if they got feedback from those services about how patients benefitted. As part of that programme the Thistle Foundation provided GPs with data on improvements on depression scores over

[71] More information about health and social care integration is available at http://www.scotland.gov.uk/Topics/Health/care/IntegrationAdultHealthSocialCare
[72] Improving the Quality of Health Care for Mental and Substance-Use Conditions, IOM, page 11.
[73] Available at http://www.kingsfund.org.uk/publications/mental_health_ltcs.html
[74] "Multimorbidity: redesigning health care for people who use it" available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60482-6/fulltext
[75] The final report is available at http://www.ltcas.org.uk/news-and-events/news/2012/03/final-report-of-the-living-better-project-is-now-available/

time. Seeing benefits in clinical terms encouraged GPs to make greater use of the service and also kept it at the front of their mind.

NHS NES will continue to support work to produce learning resources for staff working with patients with physical health problems, particularly long-term conditions, which will help them to understand the link between physical and emotional issues and deliver more holistic and effective care.

Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.

KEY CHANGE AREA 3: COMMUNITY, INPATIENT AND CRISIS SERVICES

A well functioning mental health system has a range of community, inpatient and crisis mental health services that support people with severe and enduring mental illness. There has been considerable redesign of mental health services across Scotland, continuing the long-term trend of moving from largely inpatient services to services where care and treatment is delivered mostly in the community. Within the broad direction of change towards developing more services based in the community, we know that there are wide variations in pace of change, delivery, and models of services.

As information about mental health services has been developed over the past few years, there is increasing scope to use data – across teams, services, local areas and internationally – to understand variation and use the information to plan and implement change. There are examples across Scotland of NHS Boards using such data to improve the quality of care and treatment, improve the efficiency and effectiveness of services, and to make strategic decisions about how services should be configured. We intend to develop our understanding of how service structure and design produce better outcomes.

Intensive Home Treatment Services and Crisis Prevention Approaches

Some mental health problems can be episodic in nature, with people experiencing stable periods with few symptoms, and periods of crisis with intense symptoms. A number of NHS Boards have developed home treatment services to care for people in their own homes during the acute phases of severe mental illness. Two reports, The Scottish Crisis Resolution/Home Treatment Network Service Mapping Report[76] and A Review of Crisis Resolution Home Treatment Services in Scotland[77], highlight the range of models that have been developed in Scotland but also indicate the difficulty in making comparisons across the models to understand which deliver the best outcomes.

Intensive Home Treatment Teams – Edinburgh CHP

Available 24/7, these multi-professional teams provide a rapid response, intensive specialist assessment, treatment and risk management in a community setting. They focus on people who might otherwise require hospital admission. They have had a significant impact in quality terms:

- A 32% decrease in admissions and readmissions allowing closure of 25 beds in December 2008 and 12 beds in the Summer of 2009. NHS Lothian now has the lowest number of acute beds per capita in Scotland: 13 per 100,000 population.

[76] The report is available at http://www.evidenceintopractice.scot.nhs.uk/media/147569/scrhtt%20network%20service%20mapping%20report.pdf

[77] The report is available at http://www.qihub.scot.nhs.uk/media/264761/crisis_resolution_home_treatment_report%20final%20november.pdf

- Average length of stay reduced by 6 days.
- Average occupied bed days reduced from 89% to 77%.
- Service user feedback is routinely positive, with 87% of respondents reporting clinical improvement, 43% feeling recovered at discharge and 96% feeling safe during their episode of treatment. People value the level and quality of support, avoidance of hospital admission and improved recovery facilitated by home treatment.[78]

The Mental Welfare Commission in their report Intensive Not Intrusive[79], into intensive home treatment services in Scotland found that individuals who had received a service, and also carers, valued the service highly. They found that most mental health services were able to demonstrate how intensive home treatment had reduced the use of inpatient beds, with many demonstrating fewer admissions and shorter spells in hospital where admission had been necessary. However, they also noted that intensive home treatment is not equally available across Scotland and made the recommendation that NHS Boards should monitor the uptake of intensive home treatment to ensure equality of access and to continue to evaluate services.

The Mental Health Pathway Efficiency and Productivity Report[80] also considered the role of crisis resolution and intensive home treatment teams. It concluded that while the overall evidence for the cost-effectiveness of the approach was mixed there were also likely to be significant quality and efficiency savings attached to preventing crisis occurring in the first place. As there is evidence that psychiatric crisis is often preceded by a social crisis, integrated, responsive health and social care services are vital.

Further work is needed to identify the key components of crisis prevention services, but the likely elements include:

Routine use of relapse and crisis contingency planning for individuals who have experienced more than one acute episode;

Integrated (cross heath and social care) and person-centred care planning;

Effective involvement of families, friends and carers; and

Timely responses by specialist services when an individual or their carers highlight the occurrence of early warning signs.

[78] More information is available at http://www.qihub.scot.nhs.uk/media/264764/ihtt%20mhas%20review%202010%20amended%20final.pdf

[79] Copies of all Mental Welfare Commission reports are available at http://www.mwcscot.org.uk/

[80] The Report is available at http://www.qihub.scot.nhs.uk/media/266122/mh%20pathway%20efficiency%20and%20productivity%20report%20(2).pdf

A further idea that is creating interest in Scotland is of a crisis safe house, safe haven or sanctuary. Crisis houses offer intensive short-term support to help resolve a crisis in a residential rather than hospital setting. There is no single model for a crisis house, but they are often run by third sector organisations and can provide a key location for undertaking peer to peer support. They also have a clear function and linkages to statutory services. We will be interested to see how this idea develops over the coming period and will take forward discussions with interested parties.

Commitment 23: We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHS Scotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services.

First Episode Psychosis

Early detection of psychosis and intervention for first episode psychosis provides better outcomes for individuals and financial savings for the NHS and wider public sector. Early intervention teams provide intensive support and treatment for people who have had a first episode of psychosis, and aim to reduce relapse and readmission rates, and improve clinical and social outcomes such as returning to employment, education and training. The Mental Health Pathway Efficiency and Productivity Report[81] also identified potential savings from early intervention teams, and used benchmarking data on psychiatric bed usage by individuals aged 18-24 years in Scotland to illustrate where there might be scope for improvement in service delivery.

Commitment 24: We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option.

Quality of Community Services

To underpin the work to understand variation across services and particular models of service provision, we need to further develop indicators of quality across community services. Information on reducing readmissions to inpatient services provides part of the picture as it is dependent on having effective community services and discharge planning in place.

Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services.

[81] See note 80

Inpatient Services

As community services have developed, the number of psychiatric beds has reduced across Scotland. There is considerable variation in how beds are used across Scotland, in terms of the primary diagnosis of patients, the numbers of admissions and the average length of stay. There has also been recent development of specialist services e.g. significant investment in the forensic inpatient estate.

We want to better understand the use of acute, Intensive Psychiatric Inpatient Units and crisis services. We also want to consider the balance of services between the overall general inpatient provision and specialist provision, including where there is pressure to develop additional specialist provision. In undertaking this work we are clear that it is intended to support future local and regional decisions on redesign to improve outcomes and efficiency and that any decisions on local restructuring will be made by NHS Boards.

The National Forensic Network is supported by the Scottish Government with the aim of developing protocols to assist in patient movement throughout the secure estate, maximising the use of the forensic estate and creating sustainable services for specific patient populations with specialist needs. The Forensic Network has developed standards for low security and community services and will work with other local services to continue to improve standards and equity of access to specialist interventions.

Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland.

Patient Safety

As well as understanding the balance between community and inpatient services and how they can deliver the best outcomes, we want to ensure that services are safe. We have introduced the Scottish Patient Safety Programme in Mental Health (SPSP-MH) The SPSP-MH will be a four year programme with an overall aim of reducing the harm experienced by individuals in receipt of care from mental health services. It will start with a focus on adult psychiatric inpatient units and forensic inpatient units, including admission and discharge processes.

Whilst there is clear evidence that harm is experienced by people using mental health services, there is currently no method in place within Scotland, other than for suicide, for reliably measuring the levels of that harm occurring. Therefore work will progress as part of the first phase to develop an approach to reliably measuring levels of harm in mental health services. Similarly, initial scoping into the subject area revealed limited evidence about what interventions will reduce harm in mental health. Therefore the programme will start with an initial one year phase of testing interventions and development of a future approach.

Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health.

Health Improvement for People with Severe and Enduring Mental Illness

As explained above, people with mental disorders have a much higher mortality than the general population, dying on average more than 10 years earlier. The Scottish Government made a commitment to take forward work on the physical health of people with mental illness in Delivering for Mental Health. We said:

> Commitment 5: We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient where possible and appropriate has a physical health assessment at least once every 15 months.[82]

We produced guidance on how NHS Boards could ensure good work between primary and secondary care in providing good quality physical health services to people with severe and enduring mental illness, to build on the QOF (Quality and Outcomes Framework used by GP practices) points, and to ensure that we got full value from them[83]. The guidance made seven main recommendations with the key themes focusing on awareness raising, removal of barriers to accessing services, and the requirement to evidence improvement over time. It created a framework for local services to develop their local approaches.

NHS Greater Glasgow and Clyde works with primary care through the Primary Care Interface Group. The Interface Group took forward work to ensure that there was good recording of diagnosis in GP mental health registers and the matching process increased the percentage of people recorded on GP registers with a secondary care diagnosis of psychosis from 68% to 90%. GPs welcomed having access to better information which continues to be updated regularly. This increased the number of physical health reviews being taken forward, and we tracked performance on this across Scotland as one of the areas we focused on in twice yearly NHS Board area visits in 2008 and 2009.

This work to improve physical health is also supported by work in secondary care settings. Physical health improvement is built into the Scottish Recovery Indicator, ensuring practice in mental health services relates to the factors which can help recovery[84]. Service providers are asked how they support people's physical health care. Service users are asked how the service takes account of their physical health needs. Similarly, the Releasing Time to Care inpatient programme, which is designed to increase the amount of time that professional nursing staff spend in therapeutic activity with patients, encourages a focus on physical health[85]. Early work from the Releasing Time to Care work is showing increases in some areas in activity such as walking groups, exercise induction and preparation for sleep.

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[82] See note 53 for reference to Delivering for Mental Health.
[83] A copy of the report "Mapping and review of physical health improvement activities for adults (16-65) experiencing severe and enduring mental illness" is available at http://www.healthscotland.com/documents/4806.aspx
[84] See note 35 for reference to Scottish Recovery Indicator.
[85] More information about Releasing Time to Care can be found at http://www.evidenceintopractice.scot.nhs.uk/leading-better-care.aspx and an early evaluation of impact at http://www.evidenceintopractice.scot.nhs.uk/media/126433/lbc%20and%20rtc%20briefing%20paper%20sept%202010.pdf

Various health improvement activities that are effective in the general population can be appropriate for those with severe and enduring mental health issues. We do know there are real barriers and challenges for this work but surveys and feedback show that it is important to service users. To gain maximum benefit, individuals are likely to require additional education and support to participate, sustain involvement in, and benefit from, health improvement activities. A combination of motivational and behaviour change interventions, alongside appropriate pharmacological treatments, appear to provide the best results in terms of both health gain and adherence to health improving activities.

Commitment 21 of Towards a Mentally Flourishing Scotland was that NHS Health Scotland would review the evidence base for health improvement activities for those with severe and enduring mental illness and work with NHS Education for Scotland to build knowledge and skills in the workforce[86]. The review demonstrated that those with severe and enduring mental health problems can gain health improvement benefits from participation in health improvement activities (smoking cessation, weight management and physical activity)[87]. These are evidenced to be successful as long as the activity is tailored to the individual, and the professionals involved have increased knowledge and awareness of issues surrounding the individual's mental and physical health, are aware of the benefit and impact of combination therapies, and ensure the most appropriate support mechanisms are in place.

Clozapine is the 'gold standard' antipsychotic for the patients with treatment resistant schizophrenia. Unfortunately it is associated with a range of side-effects, some of which can have a profound effect on a patient's on-going physical health. Work has been undertaken to develop NHS Scotland Clozapine Physical Health Monitoring Standards and these Standards will be taken forward through awareness raising, the development of appropriate prompts and the use of local clinical audits.

Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine.

Employability

We know that being in the right work is good for a person's health and improves their quality of life and wellbeing. This is also true for people with a mental or physical health condition. Remaining in, or returning to work quickly, aids recovery and more people gain health benefits from being in work than are negatively affected by it[88]. However, people with mental illness are less likely to be engaged in work than the general population or those with other health conditions with one review identifying that 79% of people with serious, long-term mental health problems are not in

[86] See note 16 for reference for Towards a Mentally Flourishing Scotland.
[87] See note 83 for reference to the review report.
[88] "Vocational Rehabilitation What works, for whom and when?", Waddell G., Burton A.K., Kendall N.A.S., 2008, London available at http://www.dwp.gov.uk/docs/hwwb-vocational-rehabilitation.pdf

employment[89]. Improving and increasing access to employment for those with mental illness is challenging, but necessary and achievable.

We have already seen success in the use of recovery-orientated practice and person centred practice in services with the development of the Scottish Recovery Indicator[90]. This approach has been well supported by Rights, Relationships and Recovery focused on nursing practice[91]. Employability is also embedded and integrated into the work that enables service users to develop personalised wellness recovery action plans[92]. These approaches demonstrate how services, service users and those who support them can orientate themselves towards work.

A key component of this change process is to reinforce this message of the importance of employment in promoting and maintaining health and for community mental health teams to more effectively incorporate vocational information and activity into care plans. This is a cultural as well as a technical challenge. NHS Lothian and NHS Lanarkshire are training occupational therapists to be aligned with community mental health teams to lead this role. In other places this role may be taken on by a dedicated support worker. NHS Tayside and NHS Fife are developing an electronic resource in partnership with work agencies to help staff signpost to resources. A community of practice has also already been established[93] and employability training made available to health professionals through NHS NES[94]. AHPs in mental health are being encouraged to lead the way in promoting timely access to effective vocational support for service users through informed signposting and implementation of evidence-based models of practice.

There is an evidence base that shows that, with the right kind of help, people with serious mental health problems can successfully get and keep work. This applies irrespective of individual characteristics such as clinical history or previous employment. A Cochrane systematic review found that those with severe mental illness who received supported employment were two or three times more likely to be in competitive employment at 12 months[95]. The evidence demonstrates that 'place then train' models are much more effective than traditional approaches such

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[89] "Disability and employment in Scotland: a review of the evidence base" Riddell S., Banks P. and Tinklin T. Scottish Executive, 2005, available at http://www.scotland.gov.uk/Publications/2005/01/20511/49760

[90] Information about the SRI 2 is available at http://www.sri2.net/

[91] The most recent information about Rights, Relationships and Recovery together with a link to the original document is available at http://www.scotland.gov.uk/Topics/Health/health/mental-health/RRRmentalhealth/

[92] More information about Wellness Recovery Actions Plans is available at http://www.scottishrecovery.net/WRAP/wellness-recovery-actions-planning.html

[93] Materials which support this community of practice are available at http://www.knowledge.scot.nhs.uk/work/groups-and-projects/mental-health-and-forensic-ahp-network.aspx)

[94] The materials are available at http://www.employabilityinscotland.com/toolkits/capacity-building/employability-training-for-health-professionals

[95] "Vocational rehabilitation for people with severe mental illness", Crowther R., Marshall M., Bond G.R., Huxley P., the Cochrane Library, 2010, available at http://summaries.cochrane.org/CD003080/vocational-rehabilitation-for-people-with-severe-mental-illness

as vocational training and sheltered work in successfully getting people into work[96]. A 12 month study on the impact of supported employment for those with mental health issues also found that those who entered work used significantly less mental health services[97].

"Place then train" focuses on competitive employment as a primary goal and is open to all those who want to work. It has demonstrated strong employment-related outcomes for individuals with long term mental health problems and has an evidence base that extends outside the US where it originated, across to Europe and the UK. The most well-established method of 'place then train' in mental health is Individual Placement and Support (IPS). IPS has been shown to be more effective the more closely it follows these eight principles:

1. It aims to get people into competitive employment
2. It is open to all those who want to work
3. It tries to find jobs consistent with people's preferences
4. It works quickly
5. It brings employment specialists into clinical teams
6. Employment specialists develop relationships with employers based upon a person's work preferences
7. It provides time unlimited, individualised support for the person and their employer
8. Benefits counselling is included.[98]

There are already good examples of the "place then train" model being implemented in Scotland[99]. The WORKS is an NHS Lothian vocational rehabilitation service for people living in Edinburgh that supports people with mental health conditions to stay in work, return to work, or gain work for the first time. It provides ongoing practical and emotional support that can include on-the-job support to manage a mental health condition, advice about informing employers about a mental health condition and other tailored support for as long is required. It also offers employers advice around good working practices, including disability discrimination legislation and reasonable adjustment.

Commitment 29: We will promote the evidence base for what works in employability for those with mental illness by publishing a guidance document which sets out the evidence base, identifies practice that is already in place and working, and develops data and monitoring systems. Change will require redesign both within health

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[96] "The effectiveness of supported employment for people with severe mental illness: a randomized controlled trial", Burns T., Catty J., Becker T., Drake R., Fioritti A., Knapp M., Lauber C., Tomov T., van Busschbach J., White S., Wiersma D., The Lancet, 2007, 370 1146-1152 available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61516-5/fulltext

[97] "Impact of supported employment on service cost and income of people with mental health needs" Schneider J., Boyce M., Johnson R., Secker J., Slade J., Grove B., Floyd M., Journal of Mental Health 2009 18(6) 533 available at http://informahealthcare.com/doi/abs/10.3109/09638230903111098

[98] More information is available at http://www.centreformentalhealth.org.uk/employment/ips.aspx

[99] "Realising work potential. Defining the contribution of allied health professionals to vocational rehabilitation in mental health services", 2011, Scottish Government, available at http://www.scotland.gov.uk/Publications/2011/12/16110149/0; "Towards Work in Forensic Mental Health National Guidance for Allied Health Professionals" available at http://www.forensicnetwork.scot.nhs.uk/alliedhealth.html

systems and the wider employability system to refocus practice on more effective approaches and to realise mental health care savings.

KEY CHANGE AREA 4: OTHER SERVICES AND POPULATIONS

Mental Health and Offending

Within forensic services the Care Programme Approach (CPA) is used to manage the risks posed by restricted patients (patients who are subject to special restrictions applied by the court, because of the risk posed because of a mental disorder). The School of Forensic Mental Health has created a number of training modules focusing on risk assessment and delivered training to create capacity to deliver psychological therapies for mentally disordered offenders.

The Report of the Commission on Women Offenders[100] identified mental illness and personality disorder as a key contributor to women's offending and to the likelihood of prison as a disposal. The report identified the need to improve the treatment and support offered to women with borderline personality disorder, the need to develop better approaches for short term prisoners to allow for interventions to start in prison and continue into the community, faster access to psychological therapies and a better capability within police, health care, prison and social work staff to understand the interaction between mental disorder and offending.

In its response, the Scottish Government made a series of commitments to continue to work to improve mental health services to address these challenges[101].

Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a 'mentalisation' approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh.

Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.

As indicated above, over the period of this Strategy we will also build on existing work to improve access to mental health services, including the HEAT target to reduce waiting times for access to psychological therapies. The focus on people who experience distress, and the complex connections with eating disorders, depression, self harm, domestic violence, substance misuse, personality disorder and depression is particularly relevant to the work with women offenders.

In addition to this work, which has a particular focus on women offenders, we will also take forward other work focused on offenders. We have already committed to extending the current forensic work in NHS Lothian which supports justice staff working with sex offenders who have personality disorders, to include work with serious violent offenders.

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[100] The Report is available at http://www.scotland.gov.uk/About/Review/commissiononwomenoffenders/finalreport-2012

[101] The response is available at http://www.scotland.gov.uk/Resource/0039/00395486.pdf

We are also aware that there has been relatively limited use made of Community Payback Orders with a mental health condition. These orders were introduced under the Criminal Justice and Licensing (Scotland) Act 2010 with the intention of allowing for treatment in particular cases, to accompany a non-custodial sentence[102]. They are likely to be particularly appropriate for some people with personality disorders or developmental disorders, where treatment within the legal framework could potentially give quite different long term outcomes.

Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.

Neurodevelopmental Disorders

In the consultation on this Strategy we set out our view that the provision of specialist mental health services and associated supports for people with a range of neurodevelopmental disorders could be improved. The term "neurodevelopmental disorders" encompasses a range of conditions with features specific to each diagnosis but in common they can impact on social functioning and behaviour, sometimes quite severely, irrespective of the level of intelligence of the individual. Autism spectrum disorder (ASD) and Aspergers syndrome, attention deficit hyperactivity disorder (ADHD), and Tourettes syndrome and chronic severe tic disorders are among the neurodevelopmental disorders most frequently seen through childhood and into adulthood.

While developmental disorders are not uncommon – the prevalence of ASD in the general population is around 1% - there is a small number of people with ASD within Scotland who have particularly high levels of need, which makes providing their care that bit more complex. The response to the consultation confirmed that this view is shared and that there is a desire and need to deliver improvement which must start with addressing levels of awareness and skills amongst health and other professionals. This challenge crosses traditional boundaries between health and social care services and requires more work to make the linkages between this Strategy and the Scottish Strategy for Autism[103] work for individuals and their carers.

Similarly there is work needed to improve diagnosis of and response to Attention Deficit Hyperactivity Disorder (ADHD). Work within NHS Lothian has established that people with ADHD are increasingly presenting to adult mental health services, but there are inconsistencies within mental health services in how this is responded to. ADHD is also known to be linked to higher rates of offending and we will make the linkage with justice services.

Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.

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[102] More information about Community Payback Orders is available at http://www.scotland.gov.uk/Topics/Justice/public-safety/offender-management/offender/community/examples/payback/CPO

[103] The Strategy is available at http://www.scotland.gov.uk/Publications/2011/11/01120340/0

Veterans

The Scottish Government has supported development and provision of specialist mental health and community outreach services for veterans. The Scottish Government funds the NHS-commissioned service delivered by Combat Stress at Hollybush House, which offers a wide range of specialist services to meet the needs of veterans with a mental health problem. Combat Stress is redesigning its service to provide 32 places for veterans resident in Scotland on a 6 week intensive Post Traumatic Stress Disorder course, in addition to delivering treatment to veterans as either an inpatient, outpatient or, where appropriate, in the community. Community outreach services run by Combat Stress have been developed to respond quicker and better to veterans' mental health needs and to improve access to NHS services. Two regional teams operate across the East and West of Scotland, with the Scottish Government funding the East Team.

Veterans First Point is a "drop-in" service for veterans based in the Lothians, providing support and advice covering a range of areas such as health, social, employment and education, with signposting where appropriate to other relevant agencies for further help and support. The service was evaluated positively by Sheffield University as one of 6 UK community mental health pilots and was the overall winner at the Military and Civilian Health Partnership Awards 2011.

Commitment 34: We will continue to fund the Veterans First Point service and explore roll out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer to peer activity for veterans with mental health problems.

SUPPORT ACTIVITY

The Scottish Government's Quality Strategy aims to put NHS Scotland at the forefront of world healthcare through delivery of the highest quality, person centred, clinically effective and safe care. This strategy describes how we aim to take that vision forward in mental health. Our aspirations are high, but the progress we've achieved to date shows we are well placed to make further improvement. However, to deliver world class mental health services, it is not enough just to set aspirational visions and aims. We also need to create the right conditions for change and to support services and individuals to make the specific improvements.

We set out above the seven key themes which will underpin how we deliver services. This section looks at how we will support the work of improving services.

We will:

> **Ensure staff have the skills to deliver effective and person centred interventions**. This work is primarily led nationally by NES and includes the current programme of work to increase the number of people trained and supervised to deliver evidence-based psychological therapies;
>
> **Ensure staff treat everyone with dignity and respect, supporting them on their unique journey to recovery**. This has been a key focus of the Scottish Recovery Network and is a key aspect of an integrated approach to improvement work in mental health;
>
> **Ensure our processes are designed to deliver effective, evidence-based interventions**. Current programmes designed to support this change work include the Integrated Care Pathways programme, the work currently in place across NHS Boards to align the delivery of psychological therapies against The Matrix and the work of the Scottish Patient Safety Programme in Mental Health;
>
> **Ensure our processes are designed to do the right thing reliably and efficiently**. Reliably delivering interventions which reduce harm is a key aim of the Scottish Patient Safety Programme. Both the efficiency and productivity work and the systems redesign work attached to the mental health 18 weeks access targets have a focus on doing things more efficiently through reducing unwarranted variation, duplication and waste;

To meet the current financial challenges, whilst maintaining and improving the quality of care delivered, we need to make progress in all 4 domains at the same time. Just focusing on one issue will not be enough and central to this will be the work to redesign pathways of care, making sure that we reliably do the right thing at the right time in the most efficient way.

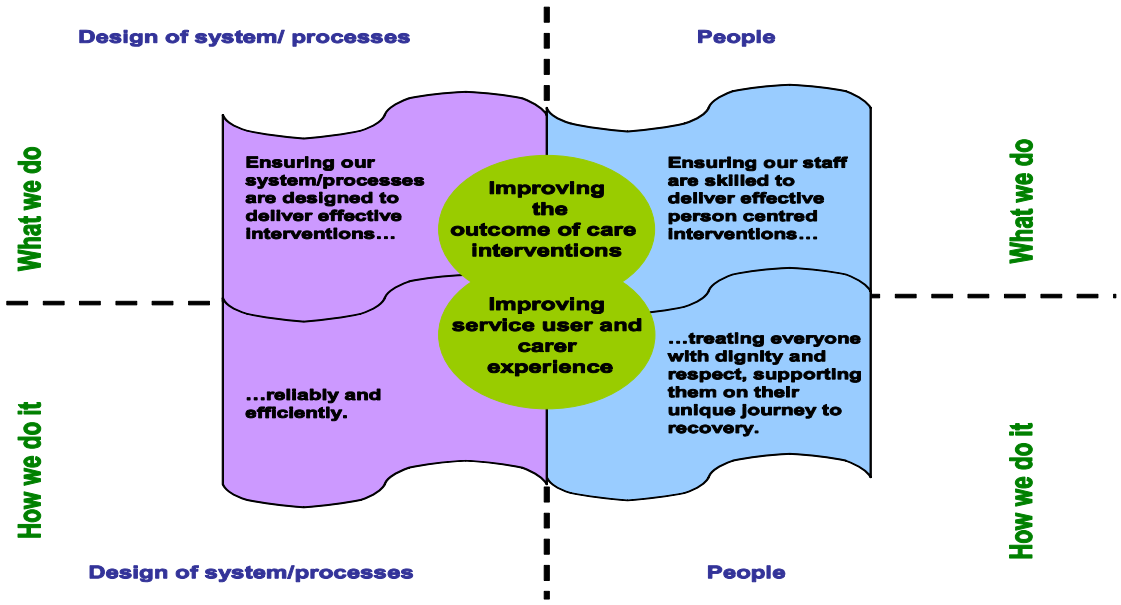
Further, underpinning all of this work needs to be a focus on information, both quantitative and qualitative. We need information to tell us how well our system currently works and where the opportunities are for improvement. We also need

information to tell us whether the changes we are making are actually delivering improvements.

Finally, none of this will happen without effective leadership at all levels creating the right conditions for change and supporting services to make the specific improvements.

The following diagram shows how these link together to ultimately deliver improvements in clinical/care outcomes and improvements in the experience of individuals using our services.

The Improvement Jigsaw – an overall framework for improving the quality of mental health services in Scotland



Using information to review all of the above and ensuring effective leadership that creates the conditions for change and supports the work of improvement

Delivering the above is not the responsibility of just one part of the system, it will require all parts to work together in partnership to create and sustain a context that enables ongoing improvement in care to be a day to day reality. The Scottish Government, NHS Boards, local authorities, the third sector, academics, service users and carers all have their part to play in supporting the delivery of world class mental health services.

Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.

Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to co-ordinate, monitor and performance manage progress on the national commitments outlined in this strategy. In doing this we will build on the successful experience of managing the implementation of the Dementia Strategy.

In support of this commitment we will:

Continue to conduct twice yearly mental health performance reviews with each NHS Board, where local progress on delivering improvements is reviewed;

Provide ongoing support for the use of continuous quality improvement approaches across mental health services by:

Funding and supporting Healthcare Improvement Scotland to deliver the Scottish Patient Safety Programme for Mental Health.

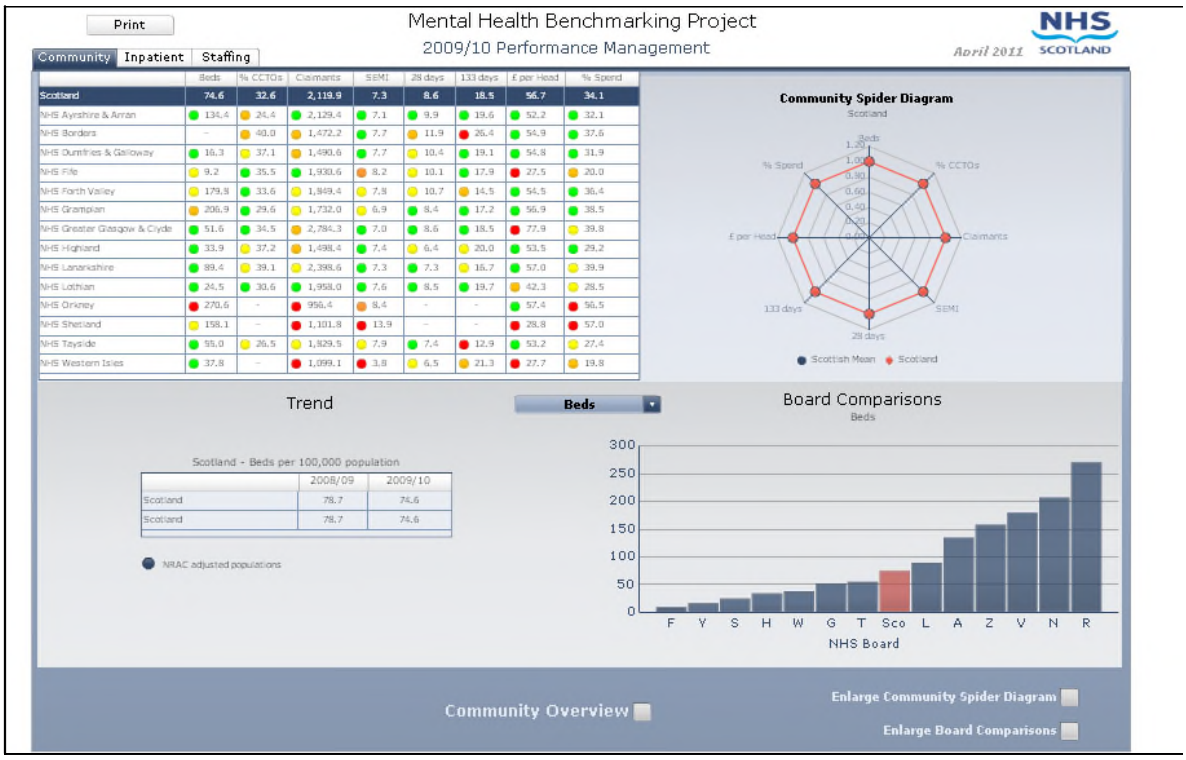
Producing a toolkit to support services and clinical teams to diagnose and deliver productivity and quality improvements across community mental health teams.

Putting in place a learning support network for individuals involved in using quality improvement methods to deliver faster access to mental health services whilst maintaining or improving quality of care.

Ensuring clarity on how any new improvement programmes nationally interface with the existing work.

Continue to develop the Adult Mental Health Benchmarking project to provide a tool to aid in the improvement of mental health services in Scotland by using a range of comparative information to compare key aspects of performance, identify gaps, identify opportunities for improvement and monitor progress. The Mental Health Benchmarking Toolkit has been created to facilitate this aim[104].

[104] More information about mental health benchmarking and the mental health benchmarking toolkit is available at http://www.isdscotland.org/Health-Topics/Finance/National-Benchmarking-Project/Mental-Health.asp



The toolkit is structured to provide a balanced view across the Quality Strategy domains of Efficient, Effective, Person Centred, Safe, Equitable and Timely. The first release of the toolkit contains information on nineteen indicators across the first five Quality Strategy domains. Future releases of the toolkit will contain additional indicators and will populate the remaining Timely domain.

SUMMARY OF COMMITMENTS	Person Centred	Safe	Effective
Commitment 1: The Scottish Government will commission a 10 year on follow up to the Sandra Grant Report to review the state of mental health services in Scotland in 2013. The review report will be published in 2014.			
Commitment 2: We will increase the involvement of families and carers in policy development and service delivery. We will discuss how best to do that with VOX and other organisations that involve and represent service users, families and carers.			
Commitment 3: We will commission a short review of work to date in Scotland on peer support as a basis for learning lessons and extending the use of the model more widely.			
Commitment 4: We will work with the management group for see me and the Scottish Association for Mental Health, who host *see me*, and other partners to develop the strategic direction for *see me* for the period from 2013 onwards.			
Commitment 5: We will work with the Scottish Human Rights Commission and the Mental Welfare Commission to develop and increase the focus on rights as a key component of mental health care in Scotland.			
Commitment 6: During the period of the Mental Health Strategy we will develop a Scotland-wide approach to improving mental health through new technology in collaboration with NHS 24.			
Commitment 7: In 2012 we will begin the process of a national roll out of Triple P and Incredible Years Parenting programmes to the parents of all 3-4 year olds with severely disruptive behaviour. We will include more information about the delivery of this commitment in our Parenting Strategy which will be published in October 2012.			
Commitment 8: We shall make basic infant mental health training more widely available to professionals in the children's services workforce. We shall also improve access to child psychotherapy (a profession which specialises in parent infant therapeutic work) by investing in a new cohort of trainees to start in 2013.			
Commitment 9: We will work with a range of stakeholders to develop the current specialist CAMHS balanced scorecard to pick up all specialist mental health consultation and referral activity relating to looked after children.			

Commitment 10: We will work with clinicians in Scotland to identify good models of Learning Disability CAMH service delivery in use in different areas of Scotland or other parts of the UK which could become or lead to prototypes for future testing and evaluation.			
Commitment 11: We will work with NHS Boards to ensure that progress is maintained to ensure that we achieve both the 2013 (26 week) and the 2014 (18 week) access to CAMHS targets.			
Commitment 12: In addition to tracking variance and shorter lengths of stay, we will focus on reducing admissions of under 18s to adult wards, with a new commitment to reduce figures across Scotland to a figure linked to current performance in the South of Scotland area.			
Commitment 13: We will continue our work to deliver faster access to psychological therapies. By December 2014 the standard for referral to the commencement of treatment will be a maximum of 18 weeks, irrespective of age, illness or therapy.			
Commitment 14: We will work with NHS Boards and partners to improve monitoring information about who is accessing services, such as ethnicity, is consistently available to inform decisions about service design and to remove barriers to services.			
Commitment 15: We will work with partners, including the Royal College of General Practitioners and Long Term Conditions Alliance Scotland, to increase local knowledge of social prescribing opportunities, including through new technologies which support resources such as the ALISS system which connects existing sources of support and makes local information easy to find[105]. We will also raise awareness, through local health improvement networks, of the benefits of such approaches.			
Commitment 16: NHS Health Scotland will work with the NHS, local authorities and the voluntary sector to ensure staff are confident to use Steps for Stress as an early intervention approach to address common mental health problems.			
Commitment 17: We will work with NHS Boards and partners to more effectively link the work on alcohol and depression and other common mental health problems to improve identification and treatment, with a particular focus on primary care.			
Commitment 18: We will develop an approach to support the better identification and response to trauma in primary care settings and support the creation of a national learning network.			

[105] Available at http://www.aliss.org/

Commitment 19: We will take forward work, initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time.			
Commitment 20: We will take forward the recommendations of the psychological therapies for older people report with NHS Boards and their statutory and voluntary sector partners and in the context of the integration agenda. Access to psychological therapies by older people will be tracked as part of the monitoring of the general psychological therapies access target, which applies to older people in the same way that it applies to the adult population.			
Commitment 21: We will identify particular challenges and opportunities linked to the mental health of older people and will develop outcome measures related to older people's mental health as part of the work to take forward the integration process.			
Commitment 22: We will work with the Royal College of GPs and other partners to increase the number of people with long term conditions with a co-morbidity of depression or anxiety who are receiving appropriate care and treatment for their mental illness.			
Commitment 23: We will identify a core data set that will allow effective comparison of the effectiveness of different models of crisis resolution/home treatment services across NHS Scotland. We will use this work to identify the key components of crisis prevention approaches and as a basis for a review of the standards for crisis services.			
Commitment 24: We will identify the key components that need to be in place within every mental health service to enable early intervention services to respond to first episode psychosis and encourage adoption of first episode psychosis teams where that is a sensible option.			
Commitment 25: As part of the work to understand the balance between community and inpatient services, and the wider work on developing mental health benchmarking information, we will develop an indicator or indicators of quality in community services.			
Commitment 26: We will undertake an audit of who is in hospital on a given day and for what reason to give a better understanding of how the inpatient estate is being used and the degree to which that differs across Scotland.			

Commitment 27: Healthcare Improvement Scotland will work with NHS Boards to deliver the Scottish Patient Safety Programme – Mental Health.			
Commitment 28: We will continue to work with NHS Boards and other partners to support a range of health improvement approaches for people with severe and enduring mental illness, and we will work with the Royal College of Psychiatrists in Scotland and other partners to develop a national standard for monitoring the physical health of people being treated with clozapine.			
Commitment 29: We will promote the evidence base for what works in employability for those with mental illness by publishing a guidance document which sets out the evidence base, identifies practice that is already in place and working, and develops data and monitoring systems. Change will require redesign both within health systems and the wider employability system to refocus practice on more effective approaches and to realise mental health care savings.			
Commitment 30: We will build on the work underway at HMP Cornton Vale testing the effectiveness of training prison staff in a 'mentalisation' approach to working with women with borderline personality disorder and women who have experienced trauma. The pilot will be extended in that prison and also introduced in HMP Edinburgh.			
Commitment 31: We will also work with NHS Lothian to test an approach to working with women with borderline personality disorder in the community by extending the Willow Project in Edinburgh. We will use the learning from the test to inform service development more widely across Scotland.			
Commitment 32: We will promote work between health and justice services to increase the effective use of Community Payback Orders with a mental health condition in appropriate cases.			
Commitment 33: We will undertake work to develop appropriate specialist capability in respect of developmental disorders as well as improving awareness in general settings. As part of this work we will review the need for specialist inpatient services within Scotland.			
Commitment 34: We will continue to fund the Veterans First Point service and explore roll out of a hub and spoke model on a regional basis, recognising that other services are already in place in some areas. We will collaborate with the NHS and Veterans Scotland in taking this work forward and will also explore with Veterans Scotland how we can encourage more support groups and peer to peer activity for veterans with mental health problems.			

Commitment 35: We will work with COSLA to establish a local government mental health forum to focus on those areas of work where local government has a key role, including employability, community assets and support and services for older people, and make effective linkages with the work to integrate health and social care.			
Commitment 36: To support progress on this agenda the Scottish Government will put in place arrangements to co-ordinate, monitor and performance manage progress on the national commitments outlined in this strategy. In doing this we will build on the successful experience of managing the implementation of the Dementia Strategy.			

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Marketing			
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Date	Version	Change	Owner
04.07.16	1.1	Review of alternative formats languages	Laura Fergus

Introduction

1. This document details guidance and actions to be taken in order to comply with the NHS Health Scotland's Accessible Information policy 2015.

2. It is aimed specifically at NHS Health Scotland (NHS HS) staff in teams with key responsibilities as laid out in the policy (i.e. Marketing, and Events and Sponsorship).

3. This guidance relates to the production and development of all NHS HS information outputs, whether produced in-house or commissioned externally. These are defined as:

    a. **digital products** (includes websites, applications, content and social media)

b. **audiovisual content** (includes online films and audio, DVDs)

c. **publications** (includes both print and online publications)

d. **events and sponsorship information**

4. NHS HS's information outputs can be categorised into three groups:

   a. Professional-facing information intended to inform and support professionals to deliver health improvement (e.g. Smokefree NHS Scotland Implementation Guidance, www.maternal-and-early-years.org.uk)

   b. Public-facing information intended directly for members of the public (e.g. *Ready Steady Baby!*, *Living Well with Dementia* DVD, www.readysteadytoddler.org.uk)

   c. Information intended for members of the public to give informed consent* to a medical intervention (e.g. screening and immunisation leaflets, Childsmile consent forms)

* Throughout this document, 'informed consent' refers to the formal process for giving permission or agreeing to medical tests, treatment or investigations. Before a doctor, nurse or any other health professional can begin certain examinations or treatment, the patient must be given enough information about it, and should be allowed to make up their own mind without pressure from other people. The patient will usually be asked to sign a form to give their consent, but consent may also be assumed if they have read the information provided and agree to proceed.

Quality

5. The following quality standards should be used in the production of any NHS HS information outputs:

   a. **Targeted** – content should be relevant, targeted to the needs of the intended audience. The involvement of the Marketing team at the outset of the development of any new communication or information output should help ensure this. A Health Inequalities Impact Assessment (HIIA) should be carried out so that potential impacts on groups of people are considered up front.

   b. **Reach audience** – information should be delivered through the right channel for the audience – this might include print, online, face to face, or hard copy DVD. The Marketing team can help advise the most appropriate way to reach your target audience. An HIIA should also help ensure you are not having a negative effect on any particular group of people, or not reaching them. You also need to let your audience know that a new information output has been developed. Involving health professionals may be a key way of reaching the target audience. Professional briefings can be used to make sure professionals are aware of the new information output and how it should be

used with the target audience. This should include additional support such translations and patients' rights. The Marketing team can help advise on how best to do this.

c. **Engage users** – users, whether they are public or professionals, should be involved in the development of content to make sure it is fit for purpose and meets their needs. This may involve commissioned pretesting or user testing through a specialist agency, or advisory or working groups made up of end users and stakeholders, or it may be as part of your Health Inequalities Impact Assessment or a combination of all of these. Third-sector organisations often have strong links to end users so it is worth considering how to engage with them. The Strategy andCommunications team can help provide advice on this. Please note that involving users takes time so please make sure you allow sufficient time to do this meaningfully.

d. **Accurate** – content should be evidence-based, accurate and reliable; it should be consistent with current policy, and supported by expert individuals and organisations. It is important that you record who was involved in this process and what the relevant sources of evidence were. The factual assurance procedure and sign-off form can be found on NHS HS's intranet, The Source. External copies are available on request (nhs.HealthScotland-Publications@nhs.net).

e. **Current** – content should be current, up-to-date and regularly reviewed. The minimum requirement is that all NHS HS information outputs are reviewed every two years but they may be reviewed more frequently. The process for reviewing resources can be found on NHS HS's intranet, The Source. External copies are available on request (nhs.HealthScotland-Publications@nhs.net).

f. **Clear** – content should be clear, understandable and straightforward; it should be written in Plain English and easy to read. It should be written with the relevant audience in mind. It should also be transparent who has produced the information, with clear branding and copyright information. The principles of Plain English can be found at the end of this document. NHS HS's visual style guidelines can be found here.

g. **Accessible** – content should be produced in as accessible a way as possible so that it is as easy for anyone to obtain and use. Alternative formats and languages should be made available on request. More information can be found at this weblink: www.healthscotland.com/resources/publications/publications.aspx See below for details of the accessibility standards for each of the four types of information output.

h. **Supported** – information should be supported by health professionals who help to deliver information to end users – we can't do this alone!

i. **Evaluated** – information outputs should be evaluated to assess their impact and regularly reviewed to ensure they are still relevant and required. Involve end users and key intermediaries in the evaluation of any information output.

The above is adapted with permission from *Making the Case for Information* © Patient Information Forum, 2013 www.pifonline.org.uk

Health Inequalities Impact Assessment

6. In accordance with the Equality Act 2010, the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and the Human Rights Act 1998, NHS HS takes every proportionate effort to ensure our products and services:

    a. eliminate unlawful discrimination, harassment and victimisation and other prohibited conduct

    b. promote equality of opportunity between people who share a relevant protected characteristic* and those who do not

    c. foster good relations between people who share a protected characteristic and those who do not.

7. In addition to these legislative requirements, NHS HS commits to understanding and addressing how our products and services will have an effect on the fundamental causes of health inequalities, wider environmental influences and individual experiences of health inequalities.This will be through carrying out Health Inequality Impact Assessments (HIIAs)

8. Through business planning protocols, all our programmes of work are reviewed annually for their impact on health inequalities. We seek to identify products and services that are most likely to have an impact on equality/health inequality issues and carry out proportionate impact assessments to mitigate, prevent or undo health inequalities. If we discover that one of our products or services has a negative impact on protected characteristics or vulnerable groups. we will strive to address this.

9. Prior to publishing, all our information products are further subject to proportionate HIIAs according to the potential impact, reach and nature of the work (i.e. guidance, information or training). For guidance on how to carry out an HIIA, see the following documents on The Source:

    a. HIIA guidance for workshop facilitators

    b. HIIA workbook for workshop participants

    c. HIIA workbook summary

* Protected characteristics:
- age
- disability
- gender reassignment
- pregnancy and maternity
- marriage and civil partnership
- race
- religion or belief
- sex
- sexual orientation

Digital content

Digital products

10. The term ‘digital products’ includes websites, mobile apps, eLearning systems, online business tools and other online platforms.

Defining and scoping a digital project

11. Before engaging in developing any new digital product, a Health Inequalities Impact Assessment (HIIA) is carried out. This should include carrying out research and gathering insights into the needs of the intended users, right at the start of the project.

12. This should take into account not only the audience’s information needs and the messages we need to reach them with, but also how their attitudes and behaviours affect the way they access information, their level of technological ability, the availability access to technology, their accessibility needs, and so on.

13. If formal user research cannot feasibly be carried out, any developments should proceed based on previously gathered insight and evidence around user needs and behaviours, and supplemented by evidence from web analytics.

Web design and build

14. For all newly developed and redeveloped websites NHS HS will ensure the following:

    a) We adhere to the W3C’s Web Content Accessibility Guidelines (WCAG 2.0), which is an internationally recognised set of standards. We will always comply to double-A standard, and where possible and appropriate will aim for triple-A (the highest standard).

    b) We comply with hypertext mark-up language XHTML1.0 strict or equivalent, as defined by W3C.

    c) Our HTML is validated using the W3C Validation Mark-up Service or equivalent.

    d) We use Cascading Style Sheets to CSS 2.1 or equivalent specifications, as defined by W3C.

    e) All our web products have an accessibility help page, available from anywhere in the site. It states our accessibility policy and contains user help guides.

    f) The overall design of any web product is clean, simple, and free from moving text.

    g) Navigation uses simple, brief terms and is structured with the user’s most commonly used known tasks in mind.

    h) All our websites have a breadcrumb trail or equivalent so that users can easily find where they are in the site.

    i) Interactive elements (buttons, links, multimedia controls, etc.) have reasonably large sizes and that these are labelled with HTML text to aid accessibility.

j) We use images appropriately to ensure quality but do not exceed recommended overall page download size.

k) We avoid the use of background images. This avoids detracting from the content and reducing accessibility.

l) All our web products are internally User Acceptance Tested (UAT) prior to launch.

m) We use fonts that can be re-sized using keyboard commands or browser settings. Fonts will have relative size, rather than absolute size, and will be no smaller than 1em or 100%. We use a sans-serif font to promote readability (Arial or Verdana preferred). We avoid the use of italics and keep the use of bold to a minimum. Coloured fonts are checked for readability in a suitable colour contrast checker and colour alone is not relied upon to convey information.

Digital content

15. NHS HS will ensure the following:

a) Our content is precisely aimed at the target audience as well as appropriate to the medium.

b) It is written in Plain English and easy to digest, using lists and bullet points where applicable to the audience.

c) Content is encoded to allow a logical progression through the content for those using tabbed browsing.

d) Content which is essential to the user experience is not presented as an image.

e) Tables are only used for data, not words, and have a metadata label for users with screen readers.

f) Link text is styled so as to clearly indicate the text which is a link (using different styling on rollover). Links must not open a new window or new tab without informing the user. Only external links should open in new tabs or windows.

g) We optimise the use of metadata to promote accessibility. We will follow the Office of the e-Envoy's e-GMS standards for writing metadata.

h) We optimise the use of alternative text tags to promote accessibility; we follow the Worldwide Web Consortium's guidance.

i) We optimise accessibility by user agents (e.g. web browsers, mobile phones and any programmes that can access web pages)

j) We optimise accessibility by assistive technologies (hardware or software devices designed to meet specific requirements of users with disabilities).

k) Downloadable document resources (PDF, Word etc) are accompanied by a link to the correct viewer/ plug-in for those who do not have it, or as a minimum, available on the accessibility page. File sizes for downloadable documents must be no more than 4 MB – any exceptions to this must be discussed with the Web and Digital

Team and alternatives explored. Every downloadable document should have page numbers added.

l) Summaries for downloadable documents should be included at point of download, together with document type and file size. We will aim to ensure that documents are provided in PDF format wherever possible and are checked for accessibility.

Social media

16. Social media falls under the same guidance as digital products, as detailed above. Social media platforms include:

a) social networking sites; for example, Facebook, MySpace and LinkedIn

b) blogs; for example, Wordpress, Posterous and Blogger

c) microblog; for example, Twitter and Tumblr

d) audiovisual content-sharing websites; for example, YouTube and Vimeo

e) audio content-sharing websites; for example, Soundcloud and Audioboo

f) social bookmarking websites; for example, Reddit, Digg and Delicious

g) RSS feeds.

17. In addition to this, NHS HS will:

a) be transparent and open with all social media communications. This includes not using password-protected areas nor sites which force the user to register.

b) not require users to pay for content

c) respond to all requests in a timely manner

d) work under the guidance of the Freedom of Information (Scotland) Act 2002

e) publish material that is sensitive, respectful and inclusive

f) be accurate and factual

g) monitor contributions from the public and act quickly if they are abusive or offensive.

h) only use social media for organisational purposes

18. Digital outputs: standards of accessibility summary

	Professional	**Public**	**Informed Consent***
Accessibility	WCAG 2.0 AA minimum	WCAG 2.0 AA minimum	WCAG 2.0 AA minimum
Plain English	√	√	√

Audio and audiovisual content

Audiovisual content

19. Audiovisual content includes online films and hard copy DVDs.

20. NHS HS will ensure the following:

    a) All online audiovisual content WCAG 2.0 standards at level AA are met.

    b) All audiovisual content English language subtitles are always provided with an option to switch them on and off. For all subtitles we follow Ofcom guidance: http://stakeholders.ofcom.org.uk/broadcasting/guidance/other-guidance/tv_access_serv/archive/subtitling_stnds

    c) All audiovisual content audio description will be provided as standard. This will follow the guidelines of the Office for Disability Issues ODI: www.odi.govt.nz/resources/publications/bridging-digital-divide/appendix3.html and Ofcom www.ofcom.org.uk/static/archive/itc/itc_publications/codes_guidance/audio_description/introduction.asp.html

    d) All audiovisual content is accompanied by a text-only transcript in English, available alongside the original content.

    e) For public audiences, we will produce a BSL version as part of the production of audiovisual content. For professional audiences, we will automatically produce a BSL version on request.

    f) Where BSL versions are produced, these will be available as an option to switch on.

    g) BSL presenters should normally be a minimum of one on the screen and must follow the guidance from Ofcom: www.ofcom.org.uk/static/archive/itc/itc_publications/codes_guidance/sign_language_dtt/signing_1.asp.html

    h) For audiovisual content relating to informed consent, translated transcripts of the material will be made in the core languages (Chinese, Urdu and Polish) and will always be provided available alongside the original content.

    i) For any materials where a specific need is identified through an HIIA, we will produce audiovisual content in the required languages. These translations will be in the form of an oral soundtrack over the original DVD. Where written content is required (DVD menus, title screens, graphics etc.), these will also be translated.

    j) There is sufficient contrast between text and any background to ensure text is sufficiently legible.

    k) Foreground and background colour combinations provide sufficient contrast www.snook.ca/technical/colour_contrast/colour.html

l) Background audio (backing music, background noise, etc.) for online content is kept to a minimum wherever possible, and there is an option to turn it off. Aural style sheets should be used for audio tracks to enable the user to control audio content.

m) We will avoid relying solely on colour/text to convey information.

n) We will avoid blinking or constantly moving content.

o) We will ensure that film, audio elements and objects embedded in websites do not 'autoplay' or timeout unreasonably.

p) Use of symbols to indicate other formats and languages available where appropriate.

q) DVDs should be produced with enough flexibility to enable new translations or subtitles to be added, as needed.

r) The target audience's access to audiovisual content is considered and the most appropriate route/s to reach the widest audience is used. (for example, hard copy DVD, online video).

21. Audiovisual: standards of accessibility summary

	Professional	**Public**	**Informed consent**
Plain English	√	√	√
Subtitles	√	√	√
Audio description	√	√	√
English language transcript	√	√	√
BSL	Automatically on request	√	√
Alternative language transcripts	Not automatic, only as result of an HIIA	Not automatic, only as result of an HIIA	√□– core languages
Alternative language dubbing	Not automatic, only as result of an HIIA	Not automatic, only as result of an HIIA	Not automatic, only as result of an HIIA

Audio content

22. Audio content includes any audio files either online or on CD.

23. NHS HS will ensure that:

a) we automatically produce audio MP3 files of 'informed consent' publications. They will be available online at www.healthscotland.com and via audio CD if required.

b) we will automatically produce audio MP3 versions of other publications on request via Alternative Format Request Form.

c) For all online audio MP3 files WCAG 2.0 standards at level AA are met.

d) Large publications will be broken down into chapters with an audio playback on no more than 45 minutes per chapter.

24. Audio content: standards of accessibility summary

	Professional	**Public**	**Informed consent**
English audio versions	Automatically on request	Automatically on request	√

Publications

Publications

25. NHS HS will ensure that:

a) all our publications are designed and produced to meet our agreed accessibility standards as laid out in this policy, whether they are printed or online publications.

b) all our publications carry a clear, prominent message to let users know that alternative languages/formats are available on request. The majority of publications are published in English, with translations and alternative formats available on request.

c) publications intended to help people to make decisions where they are being asked to consent to a medical intervention will be automatically published in our core languages and formats, to coincide with publication of the English language edition.

d) we will endeavour to explain complex or technical terminology in our public-facing publications and will include a glossary where appropriate, and where space permits. We are developing an organisation-wide glossary of regularly used terms which we will make available internally via The Source.

e) most of our 'live' publications are available on www.healthscotland.com along with any alternative languages/formats in which the publication is currently available.(Some training materials are not available without the relevant training.)

f) we will make use of icons to clearly indicate which publications are available in which alternative formats and languages.

g) we use a clear sans serif font and ensure there is sufficient leading, to allow the text to be read easily. All new publications are produced in 12 point as standard. Some translations, for example Urdu, may need to use a special font.

h) there is sufficient contrast between text and any background tints. This ensures that publications will print legibly in black and white when printed on an office/home printer.

i) images are inclusive and reflect the diversity of the Scottish population, depicting a range of ethnicity, age and disability (without appearing tokenistic).

j) content which is essential to user experience is not presented as an image. We will ensure alt text is provided for all other images.

k) all publications are put through our rigorous in-house quality assurance (QA) processes and accessibility check. They are regularly reviewed following our content review procedures. This ensures that content remains factual and up to date and as accessible as possible.

l) online PDFs are produced meeting WCAG 2.0 accessibility guidelines to a minimum standard of AA compliance, which makes sure they are accessible by screen readers. Our quality assurance guidance is available on NHS HS's intranet (The

Source). External copies are available on request (nhs.HealthScotland-Publications@nhs.net).

m) full publishing accessibility standards can be found on NHS HS's intranet. External copies are available on request (nhs.HealthScotland-Publications@nhs.net).

Alternative languages and formats

26. To help us have the biggest impact and reach as much of our target audiences as possible, NHS HS has developed a primary and secondary list of languages and formats, drawing on our own statistics and information from other Health Boards about the most frequently requested formats and languages. These lists will help us be focused in our reach, while allowing us to operate within the context of best value for money.

27. NHS HS's list of **core** formats and languages includes the following:

    a) Braille

    b) Large Print

    c) BSL

    d) Audio MP3

    We will automatically produce these formats on request for any materials.

28. NHS HS's **primary** list of languages and formats is as follows:

    a) Polish

    b) Chinese (Mandarin/Simplified or Traditional, dependent on target audience)

    c) Urdu

    d) Easy Read

    We will automatically produce public-facing information relating to 'informed consent' in these languages and formats.

29. NHS HS's **secondary** list of languages and formats is as follows:

    a) Russian

    b) Latvian

    c) Lithuanian

    d) Punjabi

    e) Hungarian

    f) Slovakian

g) Romanian

h) Arabic

We will automatically translate public-facing information relating to informed consent into our secondary list of languages on request.

30. We will consider requests for any other languages and formats using the Alternative Format Request Form and will respond to all requests within three working days of receipt. We will aim to produce alternative versions within a reasonable time period, although these will vary depending on the size of original materials.

31. The core, primary and secondary languages and formats list was last updated in July 2016 and is based on the following:

    a) Requests received by NHS HS for additional languages. See appendix (i)

    b) We have also taken into consideration feedback from Health Boards in terms of languages requested for translation and for interpretation. See appendices (ii) and (iii).

    c) We will review this list every 12 months to ensure we are providing materials as appropriate for our dynamic population. Where there is a continual request for a language not on our lists, we will consider it for our primary or secondary lists.

32. NHS HS will carry out the following:

    a) Make explicit which materials are available in which formats/ languages and will use graphical icons to help us do this.

    b) Make translations/alternative formats available electronically through www.healthscotland.com/publications or via CD/DVD.

    c) Print out individual copies of translations on request (maximum of five per request).

    d) Aim to publish the English language versions at the same time as translations, even if this means delaying the publication of the English language translation. Remove all out of date translations in a timely manner.

    e) As at August 2013, NHS HS currently have a framework of ranked suppliers for translation services in place. This is divided into four lots, and lasts until August 2015 with a year's extension option.

        Lot 1 – Language translations
        Lot 2 – BSL
        Lot 3 – Easy Read
        Lot 4 – Large Print, Braille and Audio

    This framework is available to other Health Boards at their request.

33. Publications: standards of accessibility summary

	Professional	**Public**	**Informed consent**
Plain English	√	√	√
Core formats	Automatically on request	Automatically on request	Automatically on request
Primary formats and languages	Considered on request	Considered on request	√
Secondary languages	Considered on request	Considered on request	Automatically on request
Other languages/formats	Considered on request	Considered on request	Considered on request

Events and sponsorship

Information for NHS Health Scotland events and conferences

34. NHS HS will ensure that:

a) event information will be supplied in a range of formats via a range of media and comply with our accessibility standards for all publications

b) we comply with legislation to ensure that 'reasonable' adjustments are taken. This means that all our events are accessible for any delegates who make us aware of special requirements or disabilities

c) we ask attendees whether they have any special requirements and provide related support requirements, meeting any costs associated with this

d) delegates are given all relevant information before attending any NHS HS event. This ensures that venue information including directions, transport options, access details plus event timings, format and contact information are provided a minimum of one week before the event

e) speakers, chairs and facilitators are fully informed about event delivery methods and possible needs of participants

f) guidance will be provided to speakers on presentation and handout materials, in order that they comply with accessibility standards

g) delegates participating via video conference or webcast will be properly informed about joining the event ensuring that log-in information, troubleshooting guidance, event timings, format and contact information are provided a minimum of one week before the event

h) printed outputs for events (e.g. name badges, signage) comply with our accessibility standards for all publications

For more detailed information, please see Accessibility Guidance. External copies are available on request (nhs.HealthScotland-Publications@nhs.net)

Sponsorship

35. NHS HS will ensure that:

a) all sponsorship agreements are in line with corporate brand guidelines, accessibility guidelines and support the accessible information policy.

b) where possible, the principles of NHS HS policies and guidance are shared and adopted with the host organiser.

NHS Health Scotland participation in external events

36. NHS HS will ensure that:

a) speakers who are making presentations adhere to corporate brand guidelines, accessibility guidelines and support accessible information policy.

b) printed outputs for exhibitions comply with accessibility standards for all publications and delegates have ability to request alternative formats.

Principles of Plain English

37. NHS HS will apply the following principles of Plain English:

    a. Stop and think before you start writing. Make a note of the points you want to make in a logical order.

    b. Prefer short words. Long words will not impress your customers or help your writing style.

    c. Use everyday English whenever possible. Avoid jargon and legalistic words, and always explain any technical terms you have to use.

    d. Keep your sentence length down to an average of 15 to 20 words. Try to stick to one main idea in a sentence.

    e. Use active verbs as much as possible. Say ‘we will do it’ rather than ‘it will be done by us’.

    f. Be concise.

    g. Imagine you are talking to your reader. Write sincerely, personally, in a style that is suitable and with the right tone of voice.

    h. And always check that your writing is clear, helpful, human and polite.

    www.plainenglish.co.uk/files/how

Communications

38. This supporting guidance will be communicated to staff via:

    a. The Source

    b. Metacompliance

Review

39. The supporting guidance documents can be updated at any time as required.

Further guidance

10 Steps to LGB&T Inclusive Communications © Stonewall Scotland (www.stonewall.org.uk/scotland/at_home/9288.asp)
A Fairer Healthier Scotland: our strategy 2012–2017 - © NHS Health Scotland 2012 (www.healthscotland.com/documents/5792.aspx)
Everyone Matters: 2020 Workforce Vision © Scottish Government 2013 9 www.scotland.gov.uk/Publications/2013/06/5943)
Health inequalities impact assessment: answers to frequently asked questions © NHS Health Scotland 2014 (www.healthscotland.com/documents/23116.aspx)
Health Literacy: report from an RSCP-led health literacy workshop © Royal College of General Practitioners June 2014 (www.rcgp.org.uk/clinical-and-research/clinical-resources/health-literacy-report.aspx)
Health literacy and health information producers: Report of the findings of a UK wide survey of information producers and providers © Patient Information Forum 2013 (www.pifonline.org.uk/topics-index/producing/health-literacy/)
Health promotion glossary © World Health Organization 1998 (www.who.int/healthpromotion/about/HPG/en/)
Health Rights Information Scotland (www.hris.org.uk/)
Making health and social care information accessible – NHS England (www.england.nhs.uk/ourwork/patients/accessibleinfo-2/)
Making it Easy: a health literacy action plan © Scottish Government 2014 (www.scotland.gov.uk/Publications/2014/06/9850)
Making the Case for Information: The evidence for investing in high quality health information for patients and the public © Patient Information Forum 2013 (www.pifonline.org.uk/topics-index/planning/business-case-for-informationlevers/)
Principles of Inclusive Communication: An information and self-assessment tool for public authorities - © Scottish Government 2011 (www.gov.scot/Publications/2011/09/14082209/0)
Scotland's Digital Future: Delivery of Public Services © Scottish Government 2012 (www.scotland.gov.uk/Publications/2012/09/6272)
Scottish Survey of Adult Literacies 2009: Report of findings © Scottish Government 2010 (www.scotland.gov.uk/Publications/2010/07/22091814/0)
Statistical bulletin: Internet Access – Households and Individuals 2014 © Office for National Statistics 2014 (www.ons.gov.uk/ons/rel/rdit2/internet-access---households-and-individuals/2014/stb-ia-2014.html)
The Healthcare Quality Strategy for NHSScotland © Scottish Government 2010 (www.scotland.gov.uk/Publications/2010/05/10102307/0)
The Information Standard (www.england.nhs.uk/tis/)
Your health, your rights: The Charter of Patient Rights & Responsibilities © Scottish Government 2012 (www.gov.scot/Publications/2012/09/2252)

Appendix (i)
NHS Health Scotland Statistics for Alternative Languages/ Formats

Subject	No of times publications requested via inbox															
Language	Polish	Chinese	Urdu	Arabic	Russian	Portuguese	Slovakian	Latvian	Bengali	French	Hindi	Hungarian	Lithuanian	Punjabi	Romanian	Spanish
Screening	99	83	92													
Immunisation	77	23	25													
Early Years	152	32	20	28	7		2									
Tobacco	3	1														
Sexual Health																
Mental Health	4	1	1													
Better Health	1	2														
Oral Health	3	2	1													
Corporate																
Total	**339**	**144**	**139**	**28**	**7**	**0**	**2**	**0**								
Downloads for 2013-2014	**1768**	**904**	**500**	**6**	**99**	**56**	**72**	**2**	**56**	**16**	**274**	**9**	**18**	**11**	**45**	**22**

Subject	No of times publications requested via inbox			
Format	Large Print	Braille	Audio	Easy Read
Screening	2	2	1	8
Immunisation	2		1	6
Early Years	2		5	
Tobacco	3	3	3	
Sexual Health				
Mental Health	5		5	1
Better Health				
Oral Health				
Total	**14**	**5**	**15**	**15**
Downloads for 2013-2014	**n/a**	**n/a**	**n/a**	**928**

Total No. Of DF Requests 2013-2014	**90**

Appendix (ii) – Requests for alternative formats and languages made to other NHS Health Boards

03.03.14

Number of requests received for information published in alternative formats and languages other than English from 2011/12-2013/14

	Audio		**Video**								**Print**					
	Audio Disc e.g. CD, MP3, Daisy Disc	Electronic downloadable audio file, e.g. 'text to speech file', MP3	DVD video with audio description option	DVD video with BSL option	DVD video transcripts	DVD in alternative language	On-line video	On-line video with audio description	On-line video with BSL	On-line video transcripts	Easy Read	Large print	Braille	Accessible Adobe PDF file	SMS messaging	Email
NHS Dumfries and Galloway																
2011-2012																
2012-2013																
2013-2014																
Total for 2011-2014																
NHS Fife																
2011-2012	5											15	5			
2012-2013	80											1000	22			11
2013-2014	315										*6	3005	52			33
Total for 2011-2014	400											4020	79			44
NHS Grampian																
2011-2012											1	12				
2012-2013												74				
2013-2014												11	1			
Total for 2011-2014											1	97	1			
NHS Tayside *1																
2011-2012																
2012-2013																
2013-2014																
Total for 2011-2014				1							4	1	2			
Scottish Ambulance Service																
2011-2012											2	4	2		1	
2012-2013	1	1									3	4	2		1	
2013-2014	1	1	1		1		1	1		1	2	4	2	1	1	
Total for 2011-2014	2	2	1		1		1	1		1	7	12	6	1	3	
NHS GGC *2																
2011-2012																
2012-2013																
2013-2014									6		4		5	*3		
Total for 2011-2014									6		4		5	*3		
NHS Lanarkshire *4																
2011-2012																
2012-2013																
2013-2014																
Total for 2011-2014	1															
NHS Lothian																
2011-2012	1											1				
2012-2013													1			
2013-2014												1				
Total for 2011-2014	1											2	1			
Total for all Boards																
2011-2014	404	2	1	1	1	0	1	1	6	1	16	4132	94	1	3	44

03.03.14

Number of requests received for information published in alternative formats and languages other than English from 2011/12-2013/14

	Language																				
	Arabic	Amharic	Bengali	Bosnian	British Sign Language	Bulgarian	Chinese Cantonese	Catalan	Chinese Mandarin	Czech	Dutch	English *5	Farsi	Finnish	French	Gaelic	German	Greek	Hindi	Hungarian	Italian	Kurdish
NHS Dumfries and Galloway																						
2011-2012																						
2012-2013																						
2013-2014																						
Total for 2011-2014																						
NHS Fife																						
2011-2012							11		3			25										
2012-2013							12		6			36									1	
2013-2014	1						7		6			48										
Total for 2011-2014	1						30		15			109									1	
NHS Grampian																						
2011-2012	9					1	2		12	1					1						1	
2012-2013	14		5			3	15			2										1		
2013-2014	21		19			9	21		17										15	3		1
Total for 2011-2014	44		24			13	38		29	3					1				15	4	1	1
NHS Tayside *1																						
2011-2012																						
2012-2013																						
2013-2014																						
Total for 2011-2014							3		2													
Scottish Ambulance Service																						
2011-2012							1		1													
2012-2013							1		1										1			
2013-2014																						
Total for 2011-2014							2		2										1			
NHS GGC *2																						
2011-2012																						
2012-2013																						
2013-2014	17				6				16		1	6	4		8		1	1				1
Total for 2011-2014	17				6				16		1	6	4		8		1	1				1
NHS Lanarkshire *4																						
2011-2012																						
2012-2013																						
2013-2014																						
Total for 2011-2014																						
NHS Lothian																						
2011-2012	11		1	1	721	2	5		43	2	1		1	1	13		7			1	8	
2012-2013	10		3		925	2	9	1	15		3			2	7		10				6	1
2013-2014	13		5		740		9		13	2				6	5		6	4		2	10	1
Total for 2011-2014	34		9	1	2386	4	23	1	71	4	4		1	9	25		23	4		3	24	2
Total for all Boards																						
2011-2014	96		33	1	2392	17	96	1	135	7	5	115	5	9	34	0	24	5	16	7	26	4

03.03.14

Number of requests received for information published in alternative formats and languages other than English from 2011/12-2013/14

	Korean	Latvian	Lithuanian	Malayalam	Norwegian	Nepales	Portuguese	Punjabi	Romanian	Russian	Serbian	Slovakian	Spanish	Sweedis	Tagalog/ Filipino	Tamil	Thai	Tigrinian	Turkish	Urdu	Vietnamese
NHS Dumfries and Galloway																					
2011-2012																					
2012-2013																					
2013-2014																					
Total for 2011-2014																					
NHS Fife																					
2011-2012				1					19				2							16	
2012-2013		1							12	1			3							6	
2013-2014			41						17	1			2						1	27	
Total for 2011-2014		1	41	1					48	2			7						1	49	
NHS Grampian																					
2011-2012		65	38			1			8	72		1								2	1
2012-2013		18	57			1			1	35			3				1		1	1	
2013-2014		47	80			1	15		5	57			1				3		1	16	
Total for 2011-2014		130	175			3	15		14	164		1	4				4		2	19	1
NHS Tayside *1																					
2011-2012																					
2012-2013																					
2013-2014																					
Total for 2011-2014			1					2	1											4	
Scottish Ambulance Service																					
2011-2012																					
2012-2013							1													1	
2013-2014																					
Total for 2011-2014							1													1	
NHS GGC *2																					
2011-2012																					
2012-2013																					
2013-2014								15		1		4	2					1	1	18	
Total for 2011-2014								15		1		4	2					1	1	18	
NHS Lanarkshire *4																					
2011-2012																					
2012-2013																					
2013-2014																					
Total for 2011-2014																					
NHS Lothian																					
2011-2012	1	1	3		1		5	1	2	2			29				2		9	6	
2012-2013			2	1			13		4	1	1		29						13	3	1
2013-2014		9	5			1	13	1	2	2			25	1					8	11	1
Total for 2011-2014	1	10	10	1	1	1	31	2	8	5	1		83	1			2		30	20	2
Total for all Boards																					
2011-2014	1	141	227	2	1	4	47	19	71	172	1	5	94	1	0	0	6	1	33	93	3

Notes
*1 NHS Tayside could only provide cumilative totals for all requests from 2011-2014 so this couldn't be broken down by year.
robust data for years prior to 2013-2014 so only figures for this year are provided. GGC
*3 NHS GGC advise that all team docs presumably Corporate Inequalities Team are produced in accessible PDF.
*4 NHS Lanarkshire only cited 1 request which is undated. They provided a spread sheet with types of info translated but this doesn't capture the number of requests and it appears that requests have been made by staff so the number of patient
*5 Translations from other languages into English. See separate NHS Fife spread sheet which provides a breakdown for the range of languages that have been translated into English.
spread sheet for number of Easy Read leaflets accessed in 2013, i.e. the number of clicks on a publication via the following web site which

1325

Appendix (iii) – Requests received by NHS Health Boards for interpretations

24.06.14

Top five languages interpreted for.

Top five languages	NHS Ayrshire and Arran		NHS Fife		NHS Forth Valley		NHS Grampian		NHS GGC and NHS Lanarkshire		NHS Highland		NHS Shetland		Scottish Ambulance Service	
	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations	Language	No of interpretations
1	Polish	No figures	Polish	527	Polish	1124	Polish	2748	Mandarin	7758	Polish	1993	Hungarian	27	Polish	129
2	Mandarin	No figures	Russian	121	Punjabi	173	Lithuanian	694	Polish	7385	Cantonese	128	Mandarin	11	Russian	25
3	Bengali	No figures	Mandarin	102	Hungarian	172	Russian	637	Arabic	3766	Latvian	123	Cantonese	5	LITHUANIAN	22
4	Latvian	No figures	Cantonese	90	Mandarin	156	Mandarin	266	Urdu	2864	Mandarin	107	Polish	4	Arabic	18
5	Cantonese	No figures	Punjabi	67	Russian	93	Latvian	159	Slovak	2549	Russian	100	Russian	4	Mandarin	15

Notes

NHS Ayrshire and Arran data is for Jan 13-Dec 13. No individual figures were obtainable.

NHS Fife provided separate data for telephone interpreting and face to face interpreting both from Oct 13-Mar 14. Figures for telephone and face to face interpreting were added to generate the totals presented.

NHS Forth Valley provided separate data for telephone interpreting and face to face interpreting for Jun 13-Dec 13. Figures for telephone and face to face interpreting were added to generate the totals presented.

NHS Grampian data is for Jan 13-Dec 13.

NHS GGC data is for Oct 13-Mar 14. It includes face to face and telephone interpreting for NHS GGC plus telephone interpreting only for NHS Lanarkshire. Totals for each month were added generating the totals presented.

NHS Highland data is for July 13-Dec 13.

NHS Shetland provided data for each individual telephone interpreting call from 02 May 13-28 Mar 14. Individual calls for each language were added to generate the totals for NHS Shetland presented.

SAS data is from Nov 13-Apr 14

A sixth language is presented for SAS as both Mandarin and Romanian had an identical number of interpretations.

NHS Tayside

Steps to Better Healthcare

Electronic Patient Record Programme

ELECTRONIC WHITEBOARDS

Business Case

Version: 1.0

Contents

Version and Configuration Management

Configuration History Sheet			
Version No.	**Date**	**Details of Changes included in Update**	**By**
0.1 – 0.5	11/07/13	Initial Drafts	LB
0.6	25/09/13	Autosave	LB
0.7	27/09/13	Comments from Lorna Wiggin, Jenny Bodie, Grant Wilson	LB
0.8	02/10/13	Comments from Carol Goodman and Lorna Wiggin. Inclusion of additional costs	LB
0.9	11/10/13	Inclusion of ROI objectives results	LB
0.10	14/10/13	Inclusion of ROI objectives results, comments from Jenny Bodie and creation of Executive Summary	LB
0.11	22/10/13	Comments from Lorna Wiggin, Jenny Bodie. Inclusion of Executive Summary.	LB
0.12	30/10/13	Corrections to finance figures by Stewart Hunter, Grant Wilson & Jenny Bodie with further explanation on figures	SH
1.0	30/10/13	Comments from , Grant Wilson, Carol Goodman, Lorna Wiggin & Jenny Bodie.	SH

The issue of this document requires the approval of the signatories below on behalf of the respective governance Board/Groups.

Name	Title	Signature	Date
Lesley McLay	Programme Board Chair		
Lorna Wiggin	EPR Executive Sponsor		
Jenny Bodie	EPR Executive Sponsor		
Carol Goodman	EWhiteboard Project Group Chair		

Distribution		
Version No.	**Date**	
0.5		Stewart Hunter
0.6	26/09/13	Lorna Wiggin, Jenny Bodie, Grant Wilson
0.7	01/10/13	Lorna Wiggin, Carol Goodman, Grant Wilson, Nikki McColgan
0.8	10/10/13	Lorna Wiggin, Carol Goodman
0.9	11/10/13	Jenny Bodie, Stewart Hunter
0.10	21/10/13	Lorna Wiggin, Carol Goodman, Jenny Bodie, Grant Wilson

0.11	25/10/13	Lorna Wiggin, Carol Goodman, Jenny Bodie, Stewart Hunter, Paul Tovey, Grant Wilson
0.12	30/10/13	Lorna Wiggin, Carol Goodman, Jenny Bodie, Stewart Hunter, Paul Tovey, Grant Wilson
1.0	01/11/13	Submitted for consideration for EMT on 5th November 2013

1. Document Purpose

This document provides a current view on the progress towards implementing Electronic Whiteboard technology across NHS Tayside. Decisions have been made prior to the compiling of this document around the options involved for software and a subsequent test of change to trial the effectiveness of the solution in a small number of ward areas.

This document provides an up-to-date position on the progress and findings of the test of change, whilst providing a potential scope and cost for the further roll out of the technology beyond the test of change wards.

2. EXECUTIVE SUMMARY

2.1 THE STRATEGIC CASE

The roll out of Electronic Whiteboards across NHS Tayside is aligned to a range of national and local strategic aims, in particular the NHS Scotland eHealth Strategy.

In August 2013 the Scottish Government identified significant benefit could be realised from the use of Electronic Whiteboard technologies in the wards. Funding has been made available to NHS Boards to accelerate the implementation of this technology. The short term delivery requirements are that every NHS Board that receives an allocation will have implemented the capability in one or more wards in an acute hospital, evaluated the impact, and produced a rollout plan by 31st March 2014. This demonstrates progress against the Government's commitment to: "improve patient care in hospitals by increasing flow through the system by March 2014."

Within NHS Tayside it is anticipated that the rise in emergency admissions will continue over the coming years. It has been identified that management of patient flow through the use of electronic data of an improved quality will help to alleviate these pressures. It is known that ward write-on whiteboards are the most up to date source of this information. TOPAS and admission books have varying accuracy but amalgamation of these processes into one single electronic solution can improve real-time bed management and ultimately patient care on a 24 hour/7 day basis. NHS Tayside's response to this has been the trialling of Electronic Whiteboard solutions.

2.2 THE ECONOMIC CASE

2.2.1 Options Appraisal

In 2012 an Initial Agreement was initiated to examine the use of electronic whiteboard capability in NHS Tayside. From a number of available options, two possible options were identified:

- **Option 2 –** Purchase Nugensis *Ward View* solution as eWhiteboard software
- **Option 3** – Purchase Cambric *Cortix* solution as eWhiteboard software

These options were appraised further against Critical Success Factors with other key benefits and considerations taken into account. The preferred option was to purchase the *Ward View* solution from Nugensis.

2.2.2 Preferred Option Test of Change

During the course of this decision it was agreed to run the initial implementation of the preferred option as a test of change. This would then inform the writing of the Business Case prior to a decision being made on further roll out of the solution across the organisation.

Objectives for this test of change project include:

- Improve real-time electronic patient flow data to give a more accurate bed occupancy position statement on a 24 hour/7 day basis
- Replacement, enhancement and standardisation of the current ward whiteboards and the surrounding processes with an electronic solution
- Reduction in duplication of information recording particularly in relation to admission, transfer and discharge

2.2.3 Test of Change Investment

The following table outlines the total cost to the organisation of the Test of Change project spanning the financial years 2012/13 and 2013/14. Other than the additional Endowments funds, these costs have been absorbed into existing budgets. These are the total costs and include projected spend to complete the test of change project by 31st January 2014.

Budget	Amount (incl VAT)
Various eHealth Funds (incl SEHD allocation)	£402,600
eHealth Annual Application Maintenance	£33,000
EPR Endowments (Equipment)	£90,000
Other (Directorate Resources)	£12,000
Total	**£537,600**

Table 1: Test of Change Investment

2.3 THE COMMERCIAL CASE

Based on the findings of the test of change project, there is an organisational desire to roll the solution out across other wards in order to receive maximum benefit. The following paragraphs outline the proposed approach to this roll out to allow an informed decision to be made on approval to proceed

2.3.1 Potential Scope of Roll Out

In line with the national directive to roll the solution out across acute hospitals in the first instance, wards have been segregated into cohorts to allow the roll out in grouped wards across the acute setting. Further tests of change have been suggested where requirements are unknown due to lack of inclusion in the original test of change project.

- **Original Test of Change** – 7 wards across Medical, Surgical and Mental Health wards including the acute receiving units in Ninewells Hospital
- **Cohort A – Medicine wards (including Renal) in Ninewells Hospital**
- **Cohort B – General Surgical wards in Ninewells Hospital**
- **Cohort C – Specialist Services wards in Ninewells Hospital**
- **Cohort D – Receiving unit and downstream medicine and surgical wards in Perth Royal Infirmary**
- **Whole System Test of Change – Including Capacity and Flow processes and management overviews**
- **High Dependency/Intensive Care Test of Change**
- **Women and Child Health Test of Change**
- **Women & Child Health Roll Out**
- **Mental Health Test of Change**
- **Mental Health Roll Out**
- **Community Hospital wards across NHS Tayside**

  At the time of writing, community hospital wards across NHS Tayside have not been considered but remain on the agenda for future roll out. Feedback is sought as to the appropriateness of addressing the roll out across Community Wards in the short term.

2.3.2 Potential Risks

The following table outlines the key high level risks and the associated mitigation relating to the proposed roll out:

Description of Risk	Risk Category	Mitigation
Lack of additional resources to undertake the roll out and further tests of change will significantly impact eHealth resulting in elongated timescales and other initiatives/projects not taking place	High	Fully loaded costs for additional required resources included within the content of the Business Case

Winter pressures will impact ward staff ability to consider/undertake implementation/switch on	High	Planning rules have taken into account increased pressures on ward staff during winter months.
Lack of 24/7 technical support for TOPAS resulting in absolute contingency planning being resorted to when TOPAS is unavailable out of hours	High	NHS Tayside have 24/7 helpdesk support for TOPAS. Dependent on nature of outage this may be resolved by this but it may be an issue that requires escalation to the supplier. The supplier only currently operates a 9-5 5-day week support. If problem occurs then cost for 24/7 support will be sought.

2.3.3 Potential Benefits

The benefits appraisal of the product during the test of change period has followed a Return on Investment format involving extensive consultation with the project team, test of change wards and the Tayside Centre for Organisational Effectiveness (TCOE).

The key Return On Investment Objectives at Level 3: Application and Implementation, are detailed below:

Ref.	Objective	Benefit Category	Measurement Format	Target Met?
1.	1 hour a day time released within ward teams previously spent compiling/providing information displayed on whiteboard within 1 month of removing the write on whiteboard in the first four test of change wards	Resource Release	Process mapping/time measurement via shadowing/ questionnaires	To be measured following removal of write on whiteboard in each ward
2.	95% of ward discharges/transfers are entered in TOPAS real-time (within 15 minutes) at 2 weeks following the implementation of the TOPAS integration	Quality	Comparison of actual discharge/ transfer time against audit log in TOPAS	To be measured when TOPAS integration available – November 13
3.	100% of patients have all information on the eWhiteboard correct at 1 month following the removal of the write on whiteboard (within 15 mins of a change)	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward
4.	50% of Senior Charge Nurses/Heads of Nursing related to the test of change wards using electronic data as primary source of bed management information at 2 weeks following removal of the write on whiteboard	Quality	Survey Monkey questionnaire	To be measured following removal of write on whiteboard in each ward

At the time of writing it has not yet been possible to define Level 4: Business Impact targets and objectives. Following workshop sessions with Heads of Nursing the following benefits were identified at an organisational level:

- Reduction in time spent compiling Capacity and Flow information – whole system
- Improved information/status at a glance on patients out with the ward

Whilst it is indisputable that the Electronic Whiteboard project will provide benefits and positive impact on these two areas, it has not been possible to identify and isolate the level of impact solely attributable to Electronic Whiteboards. The clinical environment around this project is dynamic and constantly changing with other related and non-related tests of change and improvement exercises ongoing. Work will continue to try and isolate Electronic Whiteboard impact at this level throughout the remainder of the Test of Change project.

The calculation of an actual Level 5 return on investment is still ongoing due to the challenges encountered during the Level 4 objective setting.

Whilst the key benefits have been focussed on during the test of change there is recognition that there are a wide range of additional benefits to which the Electronic Whiteboard roll out will contribute. There is also significant potential to develop the solution further to realise further benefits.

2.3.4 Potential Personnel Implications

The following table outlines the personnel implications of the cohort roll outs and further test of change projects:

Overall Personnel Implications:

- Business Ownership – at budgetary and clinical level
- Supplier Support – service level agreements to be maintained between NHS Tayside and suppliers
- eHealth Support – including resources from Infrastructure, Application Management and System Administration/Support
- Improvement Resource – to support the ongoing evaluation of the return on investment objectives

Roll Out Personnel Implications:

Each cohort roll out will require:

- Clinical Leadership – in each ward
- Cohort Roll Out Team – including Improvement/OD Coordination and Improvement/Training Facilitation
- Estates – to support the installation of the ward equipment

Test of Change Personnel Implications:

Each test of change project will require:

- Clinical Leadership – in each ward
- Test of change project team – including Project Manager, Business Analyst, IT Training Facilitator
- Software “view” Development – to undertaken internal and external (supplier) development to meet the test of change requirements

2.3.5 Potential Implementation Timescales

High level timescales are detailed in the Gantt Chart below:

Task	Start Date	Finish Date
Cohort A – Medicine, NW	Nov-13	Jun-14
Cohort B – General Surgery, NW	April-14	Aug-14
Cohort C – Specialist Services, NW	Jun-14	Nov-14
Cohort D – Medicine/& General Surgery, PRI	Aug-14	Feb-15
Whole System Test of Change	Feb-14	Jun-14
HDU/ICU, NW Test of Change	Mar-14	Oct-14
Woman & Child Health Test of Change	Jul-14	May-15
Women & Child Health Roll Out	May-15	Oct-15
Mental Health Test of Change	Feb-15	Jan-16
Mental Health Roll Out	Jan-16	Aug-16

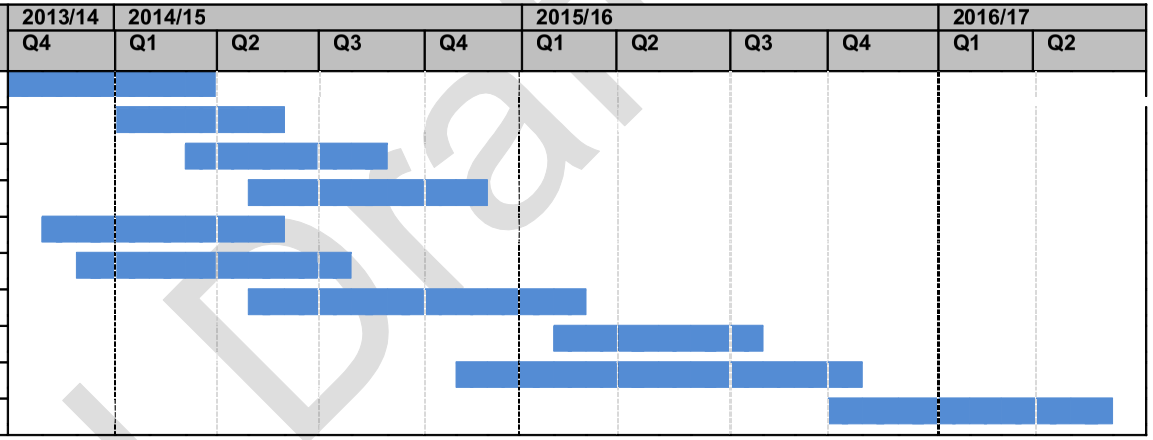

Figure 1: Potential Implementation Timescales Gantt Chart

2.3.6 Key Dependencies/Constraints

There are a number of key dependencies and constraints associated with the delivery of this project including:

- Appointment of an Improvement/Organisational Development Resource to coordinate the implementations must be in place in order to commence preparation with the wards.
- The existing Test of Change wards must sign off the product on behalf of the specific directorate before the relevant cohort roll outs can commence

2.4 THE FINANCIAL CASE

2.4.1 Potential Revenue 2013/14 to 2017/18

The following table details the breakdown of the total revenue costs to the organisation to run the project from initial test of change to full roll out of the potential scope detailed above (See Appendix 3 – Fund/Budget Detailed Descriptions for more information on individual funds):

Purpose/Budget	Initial Test of Change	2013/14	2014/15	2015/16	2016/17	2017/18	Total
SEHD Funding (Equipment)	£0	£98,500	£0	£0	£0	£0	**£98,500**
Endowments (Equipment)	£90,000	£12,000	£38,500	£19,500	£0	£0	**£160,000**
Various eHealth Funds	£402,600	£91,000	£585,000	£385,000	£164,000	£96,000	**£1,723,600**
eHealth Annual Application Maintenance	£33,000	£0	£22,500	£32,500	£32,500	£32,500	**£153,000**
Estates (Equipment Installation)	eHealth budget	£30,000	£32,500	£42,000	£7,500	£8,500	**£120,500**
Other (Directorate Resources)	£12,000	£7,200	£59,500	£38,000	£16,000	£0	**£132,700**
Unfunded Equipment	£0	£0	£103,500	£158,500	£60,000	£60,000	**£382,000**
Total	**£537,600**	**£238,700**	**£841,500**	**£675,500**	**£280,000**	**£197,000**	**£2,770,300**
Cumulative total by financial year		£776,300	£1,617,800	£2,293,300	£2,573,300	£2,770,300	

Table 2: Potential Capital and Revenue

The above table outlines the full costs to the Organisation for the roll out of the Wardview programme

2.4.2 Potential Unfunded Costs 2013/14 to 2017/18

The following table details the breakdown of the costs of the projects that cannot be absorbed into current budgets. In the circumstance of the *Various eHealth Funds*, if additional funds are not made available, other projects and support of some existing services will be compromised. Funding of the undernoted will be provided from the eHealth Strategic funding from Scottish Executive up to financial year 2014/15 after which the Scottish Government funding will be dependent on the outcome of their three year funding cycle for 2015/18.

Additional funds required	Initial Test of Change	2013/14	2014/15	2015/16	2016/17	2017/18	Total
Unfunded Equipment	£0	£0	£103,500	£158,500	£60,000	£60,000	£382,000
Unfunded eHealth Resources	£0	£0	£204,000	£145,200	£64,800	£84,000	£517,200
Unfunded Estates installation	£0	£30,000	£32,500	£42,000	£7,500	£8,500	£120,500
Total	**£0**	**£30,000**	**£340,000**	**£345,700**	**£151,500**	**£152,500**	**£1,019,700**

Table 3: Potential Unfunded Costs

2.4.3 Potential Annual Recurring Costs Beyond 2017/18

Once full roll out and the series of additional test of change projects are complete, there will be a recurring cost to the organisation as detailed in the table below:

Purpose/Budget	Going forward per annum
SEHD Funding (Equipment)	£0
Endowments (Equipment)	£0
Various eHealth Funds (£84,000 unfunded)	£96,000
eHealth Annual Application Maintenance	£32,500
Estates (Equipment Installation)	£7,500
Other (Directorate Resources)	£0
Unfunded Equipment (screen replacements)	£60,000
Total	**£186,000**

Table 4: Potential Annual Recurring Costs From 2017/18

2.4.4 Potential Unfunded Annual Recurring Costs Beyond 2017/18

The table below details the currently unfunded aspects for going forward beyond 2017/18. This money is not currently included in any budgets and should therefore be considered as cost pressure at the relevant time.

Additional funds required	Going forward per annum
Unfunded Equipment (screen replacements)	£60,000
Unfunded eHealth Resources	£84,000
Unfunded Estates (equipment installation)	£7,500
Total	**£151,500**

Table 5: Potential Unfunded Annual Recurring Costs

2.5 THE MANAGEMENT CASE

The project will be managed by eHealth as part of the Electronic Patient Record Programme. The Project Board governing the Electronic Whiteboard Test of Change will take on the governance of the roll out project co-opting relevant staff on to the Board as the project moves through cohorts. Regular reports will be submitted to the Programme Board.

Project Teams will be established within each ward to coordinate and drive the implementation of the product. These will consist of multidisciplinary staff affected by the Electronic Whiteboard and will be facilitated by the relevant eHealth Trainer.

The following diagram outlines the project organisational structure:

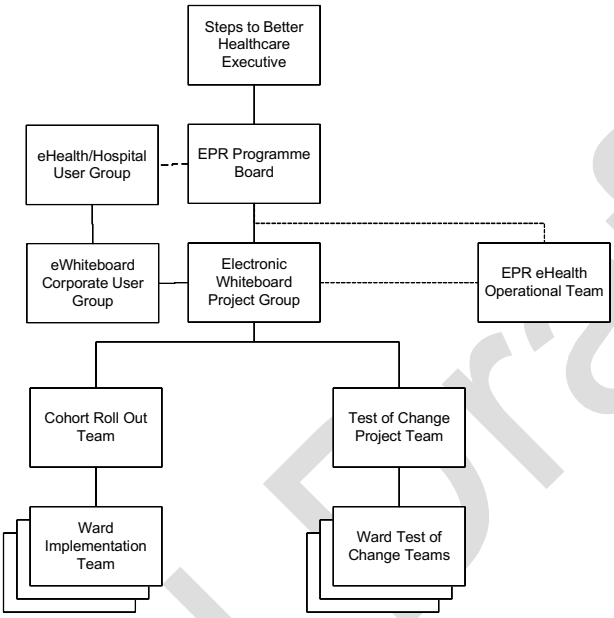

Figure 2: Project Governance Structure

3. THE STRATEGIC CASE

The Electronic Whiteboard Project is linked to Scottish Governments Quality Strategy and the eHealth Strategy:

3.1 Strategic Context

3.1.1 Healthcare Quality Strategy for Scotland

The Healthcare Quality Strategy for Scotland[1] sets out three Quality Ambitions which provide the focus for all activity to support the aim of delivering the best quality healthcare in the most efficient way to the people of Scotland:

- Person-centred – mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- Safe – there will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times
- Effective – the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

3.1.2 NHS Scotland National Unscheduled Care Action Plan

In early 2013, the Scottish Government announced the launch of an Unscheduled Care Action Plan. A new task force is in the process of leading the delivery of a programme of improvements worth over £50m for patients arriving at hospital for unscheduled, emergency care. This examines the whole system and details how to improve access to the right care and treatment for patient in hospital, along with who treats them to support timely discharge home.

The Unscheduled Care Action Plan will:

- Change the way that people are seen when they are admitted to hospital to make sure that they are treated as effectively and efficiently as possible
- Look at how staff work so that people can leave hospital as soon as they are ready
- Improve links with other areas of healthcare so that support is in place for people to be treated in the community where possible

The Capacity & Flow initiative in NHS Tayside is aligned with the National Unscheduled Care Action Plan in making more efficient use of current resources within the hospital setting, getting the patient into the right clinical setting for appropriate diagnosis and care as quickly and efficiently as possible.

3.1.3 NHS Scotland eHealth Strategy

Specific aims within the NHS Scotland eHealth Strategy[2] have been identified in relation to this project. The aims are to use information and technology in a coordinated way to:

- Aim 1: Maximise efficient working practices, minimise wasteful variation, bring about measurable savings and ensure value for money
- Aim 4: Enhancing the availability of appropriate information for healthcare workers and the tools to use and communicate that information effectively to improve quality
- Aim 6: Providing clinical and other local managers with the management information they need to inform their decisions

The project can also be aligned with the additional aims of the eHealth Strategy:

[1] The Healthcare Quality Strategy for Scotland; The Scottish Government, May 2010

[2] NHS Scotland eHealth Strategy 2011 – 2017; The Scottish Government, Edinburgh 2011

- Continue to promote, encourage and facilitate collaboration between Boards and to drive the convergence and standardisation of IT systems
- Build evaluation into eHealth developments and share the evidence from these experiences
- Ensure that Equality Impact Assessments are undertaken prior to the information of new eHealth systems and processes
- Capitalise on our existing eHealth investments
- Support innovative applications of eHealth which enable the delivery of the NHSS's Three Quality Ambitions

During 2013, discussions have been ongoing at the national eHealth Leads Meeting regarding the use of Electronic Whiteboard technology as achieving significant emerging benefits in patient safety, quality of service and efficiency. The Cabinet Secretary for Health and Wellbeing has viewed examples of this technology in action, including the first live eWhiteboard in NHS Tayside in early August 2013, and noted the patient safety and efficiency benefits.

It was agreed in August 2013 that Scottish Government Funding will support the acceleration of the implementation of this technology. £2.2 million is to be allocated in 2013 to NHS Boards, proportioned on the basis of the number of acute hospitals in that area. The expectation is that this will cover product license and supplier installation/integration charges for all acute hospitals.

The commitment to NHS Boards recognises that a number have already invested in this area and that the allocation will be used to enhance the current capability or to offset previous investment and allow accelerated progress within their eHealth Delivery plans against other objectives. The understanding is that NHS Boards will use their eHealth strategic funds or alternative local funding to meet other one off and recurring costs.

Delivery of this will be reviewed at each NHS Board's annual eHealth Plan review meeting for 2013-14.

In tandem with the planned review of eHealth Delivery Plan Common Measures, NHS Boards will work with Scottish Government to create a common measure that reflects this objective:-

"Improving patient safety and effectiveness of acute hospital wards through dynamic monitoring of patients and management of patient flow, supported by technology."

In the medium term, each NHS Board is expected to reflect accelerated delivery of this specific objective in their eHealth Delivery Plans allowing progress to be measured in subsequent years.

3.1.4 NHS Tayside Strategies

The strategic aims of NHST Board are detailed below:

- Contribute to closing the health inequalities gap within a generation
- Improve health life expectancy by supporting people to look after themselves
- Ensure that services meet agreed quality standards, especially patient experience
- Be cost effective in all decisions, actions and services

2.1.4.1 Steps to Better Healthcare

The Electronic Patient Record Programme and the Electronic Whiteboard Test of Change Project are aligned with NHS Tayside's Steps to Better Healthcare initiative.

SBH projects are about improvement: improving health, improving patients' experience, and improving cost efficiency. They include work as diverse as Releasing Time to Care, e-Rostering, Procurement, Medicines Leadership, Optimising Capacity, Electronic Patient Records, Travel Bureau, Chronic Pain & MSK Pathways, Discharge Pathway, Leading Better Care, HR and the Transport Review.

2.1.4.2 eHealth Delivery Plan

As stated in section 2.1.2 above, Boards are expected to incorporate the early implementation and evaluation of Electronic Whiteboard technology, and the further rollout of this into local eHealth Delivery Plans.

3.1.5 Electronic Patient Record Programme Overview

The Electronic Patient Record Programme was established in July 2013 as a Steps to Better Healthcare initiative. The aim of the programme is to apply technology to mobilise information and knowledge as a catalyst and enabler for transformational change to the way we deliver healthcare. The programme was initiated to address the increasing risks associated with a mixed paper/electronic record economy and move the organisation towards paperless working in clinical areas.

Following consultation the programmes vision statement was agreed as:

One patient → One record → One system → One log in

Simple, quick, available

The objectives are:

- Patient Centred/focused – the patient should lie at the heart of the EPR with a single record of care
- Fit For Purpose – complete information should be available in the right place at the right time
- Switching Off Paper Production – to reduce inefficiencies, risks to patient safety and duplication created by paper
- Communication – improved communication of patient care information between professions/disciplines

The programme comprises of a series of test of change projects that will guide best approach for full organisation roll out. The projects are: clinically-led; improvement orientated where good practice is automated and variation is reduced; organisational development orientated where clinical areas are prepared in advance of technical implementations. The whole system approach is driven by benefits realisation and is fully integrated with the business rather than being solely eHealth led.

The scope of the programme includes addressing the technical gaps that exist in the Inpatient and Outpatient environments in the Acute, Mental Health and Community Hospital settings.

3.2 Organisational Overview

NHS Tayside is responsible for delivering healthcare to more than 400,000 people living in Tayside, employing around 14,000 staff across a range of primary, community-based and acute hospital services for the populations of Dundee City, Angus and Perth & Kinross. Our annual budget is now over £750 million of public money which works out at around £2million spent by NHS Tayside for every day of the year.

Through strong links with local Universities, NHS Tayside is committed to teaching, education and research of the highest standard, enjoying an enviable reputation for both undergraduate and postgraduate medical, dental and nurse education. Training is also promoted within the paramedical and technical specialties as well as amongst professional and operational staff.

NHS Tayside is fully committed, with its partners, to achieving a step change in the health of the people of Tayside and modernising the care that they receive. This will be achieved through investment in staff to support improved ways of working, implementing new solutions and redesigning services to maximise the effectiveness of all existing resources. In recognition of this, longer term planning will increasingly be based on integrated programmes of change.

The overall strategic direction for the development of healthcare in Tayside is built around the 'Hierarchy of Care Model'. This promotes the delivery of services as close to people's homes as possible, capitalising on new ways of working and developments in e-health, whilst fostering a culture in which people take greater ownership and responsibility for their own life and health as well as that of their natural communities.

NHS Tayside incorporates three distinct localities within Tayside; Angus, Dundee City and Perth & Kinross, with North East Fife currently representing approximately 60,000 of the total patients treated by NHS Tayside.

Tayside covers a geographical area in excess of 7,000 square kilometres. This mix of rural and urban areas and the distances between them pose particular challenges for Tayside in providing an equitable service across the whole region and achieving this is a major driver for change to ensure that all individuals can access services regardless of geographic area.

3.3 Business Needs

3.3.1 Current Business Needs

The following table outlines the inpatient services within NHS Tayside and the associated throughput and capacity:

Hospital	Number of wards	Number of beds	No of admissions 2011/12
Acute			
Ninewells Hospital, Dundee	52	992	63,117
Perth Royal Infirmary	17	321	16,211
Stracathro Hospital, Brechin	7	120	5,212
Community			
Aberfeldy Cottage Hospital	1	12	103
Arbroath Infirmary	3	39	602
Blairgowrie & Rattray Cottage Hospital	1	22	136
Brechin Infirmary	1	16	164
Crieff Community Hospital	2	28	220
Dudhope House (Young Persons Unit)	1	6	19
Kings Cross Hospital, Dundee	1	6	439
Little Cairnie Hospital, Arbroath	1	12	42
Montrose Royal Infirmary	2	13	356
Pitkerro Intermediate Care Centre	1	23	0
Pitlochry Community Hospital	2	16	104
Royal Victoria Hospital, Dundee	10	158	572
St Margaret's Hospital, Auchterarder	1	13	136
Strathmartine Hospital	3	26	18
Whitehills Hospital, Forfar	3	51	251
Mental Health			
Carseview Centre, Dundee	5	66	414
Murray Royal Hospital, Perth	12	168	462
Royal Dundee Liff Hospital	6	72	102
Totals	**131**	**3,731**	**88,680**

Table 6: Current Business Needs – Organisation's Inpatient Capacity

On an annual basis winter pressures induce significant capacity and flow issues within NHS Tayside. Particular challenges are faced with a continually changing bed position statement that relies on manual updating of spreadsheets via phone-calls, ward visits and bed meetings at operational and strategic levels. During the winter of 2012/13 these pressures were unprecedented across NHS Scotland with a significant increase in emergency admissions to the acute setting.

Write-on Whiteboards and a variety of hand written notes are used by staff in all ward areas to record patient information, bed availability, patient placement on ward, Consultant responsible for care and estimated discharge date as a minimum. They may also include

information relating to outstanding investigations and staff task lists; however there is significant variation across different wards with no standard format.

Whiteboards are primarily a ward communication tool. When replaced with an electronic solution they provide an opportunity to capture patient flow information in real time. These boards are widely used by staff and visitors to the ward areas as a reference point; however there are known confidentiality/governance aspects involved in displaying this information in public areas.

3.3.2 Future Business Needs

It is anticipated that the rise in emergency admissions will continue over the coming years. The NHS is under increasing pressure to make efficiencies whilst maintaining the current quality and capacity. There is a need for the organisation to be working more efficiently particularly around patient flow.

It has been identified that management of patient flow through the use of electronic data of an improved quality will alleviate these pressures. It is known that ward write-on whiteboards are the most up to date source of this information. TOPAS and Admission Books have varying accuracy but amalgamation of these processes into one single electronic solution can improve real-time bed management and ultimately patient care on a 24 hour/7day basis.

3.4 Benefits

It is anticipated that electronic whiteboard technology will provide the following benefits:

Benefit Statement	Who will receive the benefit?	What will it improve?
Improved patient safety	Patient Staff Organisation	Quality
Improved communication	Patient Staff Organisation	Quality
Reduction in time spent compiling information	Patient Staff	Resource Release
Improved patient confidentiality	Patient Organisation	Quality
Improved accuracy of realtime patient status and bed management information	Staff Organisation	Quality Resource Release
Reduction in average length of stay for boarded patients	Patient Staff Organisation	Quality

Table 7: Strategic Benefits Statements

3.5 Benefits Criteria

The high level benefits criteria for electronic whiteboard technology are as follows:

Benefits Criteria	Description
Service Effectiveness	The degree to which the solution improves/enhances the organisation's clinical service effectiveness in the context of accurate bed management information and patient status at a glance
Resource Release	The degree to which the solution can release resource within the ward and the capacity and flow context.
Confidentiality	The degree to which the confidentiality of patient identifiable information on the wards can be improved

Table 8: Strategic Benefits Criteria

4. THE ECONOMIC CASE

4.1 Main Business Options

During the Initial Agreement stage consideration was given to a number of electronic whiteboard solutions based on their ability to meet NHS Tayside's electronic whiteboard requirements.

The table below shows the options that were considered during the initial agreement stage:

Service option	Reason for inclusion/exclusion at IA stage
Option 1 – Do Nothing	This option was excluded as the current status was not sustainable.
Option 2 – Purchase Nugensis *Ward View* solution as eWhiteboard software	This option would provide benefit as the solution had demonstrated proven benefits to clinical services in Trafford General Hospital. The proposal included additional software to allow configuration with single sign on. Supplier resources to develop/configure the software were included in the proposal.
Option 3 – Purchase Cambric *Cortix* solution as eWhiteboard software	The solution was unproven and was not fully integrated with TOPAS. This option would, however, provide benefit as integration with TOPAS would have been easier due to the suppliers knowledge of the system.
Option 4 – Develop in-house eWhiteboard software	This option was not possible due to a lack of development resource in-house that were already dedicated to developing and maintaining other high priority systems/services.

Table 9: Main Business Options

4.2 Critical Success Factors

In addition to the key investment objectives and benefits criteria there were a number of critical success factors to be considered.

Key CSFs	Broad Description
Strategic Fit and business needs	The preferred option must address all of the project objectives including: • The identified legislative and clinical needs • The project objectives as outlined in section 3.6.2 • The benefits criteria as detailed in section 2.4 and 2.5 above • Local and national technical development and infrastructure strategy
Potential achievability	The preferred option must be able to: • Respond to future changes in requirements • Respond to future support and maintenance requirements
Potential affordability	The preferred option must be able to : • Be affordable in terms of preparatory, development and implementation costs • Be affordable in terms of ongoing requests for change and configuration • Be affordable in terms of ongoing maintenance and support within a business as usual context • Be affordable in terms of staff use, equipment, general ongoing

	revenue

Table 10: Critical Success Factors

Each option was evaluated against the critical success factors and the results are shown below. This evaluation showed that options 2 and 3 met all of the identified critical success factors.

Key CSFs	Option 1	Option 2	Option 3	Option 4
Strategic fit and business needs	N	Y	Y	Y
Potential achievability	N	Y	Y	N
Potential affordability	N	Y	Y	Y

Table 11: Critical Success Factors Options Appraisal

4.3 Short-listed Options/Preferred Way Forward

The process undertaken as detailed within the previous section measured each of the options against the objectives, benefits and critical success factors, and identified the options to be taken forward for further appraisal.

It was agreed that the "Do Nothing" option could not be taken forward as a realistic option as it did not satisfy the criteria of the project.

The result was a short list of 2 options:

- **Option 2 –** Purchase Nugensis *Ward View* solution as eWhiteboard software
- **Option 3** – Purchase Cambric *Cortix* solution as eWhiteboard software

4.3.1 Option 2 – Purchase Nugensis *Ward View* solution as eWhiteboard software

There were obvious benefits to choosing this solution. The key considerations included:

- Minimised impact on internal development resources
- Utilisation of suppliers previous knowledge and expertise from successful implementations in other Health Boards/Trusts
- Proven clinical benefits during implementations in other Health Boards/Trusts
- Provision of a proven integration solution to work with Imprivata Single Sign On restrictions
- An independent solution with the flexibility in design to meet NHS Tayside's exact requirements allowing integration with a range of existing eHealth products
- An independent product that would allow future flexibility in terms of changing eHealth system feeds e.g. if a system is replaced the interface could be re-used and wouldn't affect the Ward View front end
- Other products available from the company e.g. Task Management software with integration potential for the future

4.3.2 Option 3 - Purchase Cambric *Cortix* solution as eWhiteboard software

There were obvious benefits to choosing this solution. The key considerations included:

- Integration with the Patient Administration System would be simplified as the two products were provided by the same supplier
- Predefined product with little flexibility for changes in design in accordance with NHS Tayside's requirements
- This was an unproven product that had not yet been implemented in other Health Boards/Trusts.

- Other products available from the company e.g. mobile working software with integration potential for the future

4.4 Costs

This section outlines the methodology for costing the short-listed options.

	Option 2: Ward View	***Option 3: Cortix***
Total Software Licence Cost	£73,500 (incl VAT)	£24,000 (incl VAT)
Total Recurring Maintenance Cost	£16,475	£3,000

Table 12: Option Appraisal Costs

4.5 Preferred Option

Following consideration of the short listed options, the preferred option was for *Ward View* as supplied by Nugensis (Option 2).

During the course of this decision it was agreed to run the initial implementation of the preferred option as a test of change. This would include:

- initial design and development of the software and associated integrations (see Appendix 1 – Ward View Screen Shot)
- purchase and evaluation of the most appropriate hardware/equipment including location of the equipment on the wards
- implementation in a small number of wards (see Appendix 2 – Test of Change Wards) as early adopters
- evaluation of the benefits to the wards and organisation/business of running this solution

This would then inform the writing of the Business Case prior to a decision being made on further roll out of the solution across the organisation.

These test of change wards would represent a variety of directorates to ensure that the solution was fit for purpose beyond the early adopter wards.

The project would be amalgamated within the Electronic Patient Record Programme and appropriate governance established under the chairmanship of Carol Goodman, General Manager – Medicine.

4.6 Electronic Whiteboard Test of Change Project Overview

The Electronic Whiteboard project was initiated as a development and implementation "test of change" project within the EPR Programme structure to allow access to the relevant resources across the organisation to allow it to progress.

4.6.1 Test of Change Project Objectives

The following objectives were defined at the beginning of the test of change project:

- Improve real-time electronic patient flow data to give a more accurate bed occupancy position statement on a 24 hour/7 day basis, including improving the quality of electronic recording of admission/discharge information
- Replacement, enhancement and standardisation of the current ward whiteboards and the surrounding processes with an electronic solution
- Reduction in duplication of information recording particularly in relation to admission, transfer and discharge
- Streamline the use of ward whiteboards and improve communication and patient management within ward areas
- Stream-lined recording of ward and medical records data
- Improved means of accessing electronic information through appropriate integration of eHealth products
- Improvement of admission, transfer and discharge processes involving ward and medical records staff to achieve this
- Identification of appropriate, cost effective electronic devices to support the solution

- Achieve first steps in the move towards paperless acute ward environments, and as such, integration with the wider Electronic Patient Record programme of work
- Develop more robust procedures on handover, eliminating the need for the use of paper handover documentation/handwritten notes

4.6.2 Test of Change Investment

The following table outlines the total cost to the organisation of the Test of Change project spanning the financial years 2012/13 and 2013/14. Other than the additional Endowments funds, these costs have been absorbed into existing budgets. These are the total costs and include projected spend to complete the test of change project by 31st January 2014.

Budget	Amount
Various eHealth Funds (incl SEHD allocation)	*£402,600*
eHealth Annual Application Maintenance	£33,000
EPR Endowments (Equipment)	£90,000
Other (Directorate Resources)	£12,000
Total	**£537,600**

Table 13: Test of Change Investment

The following table outlines the details the breakdown of the Various eHealth Funds. It should be noted that £68,000 of the SEHD Funding allocation was used under Product Development:

Various eHealth Funds Breakdown	Amount	Amount incl VAT
Product Development	£122,500.00	£147,000
Infrastructure	£17,000.00	£20,400
Resources/Personnel	£166,500.00	£199,800
Equipment/Installation	£11,500.00	£13,800
Product Support	£18,000.00	£21,600
	Total	**£402,600**

Table 14: Test of Change Investment – eHealth Strategic Fund Breakdown

For a detailed description of the individual funds see Appendix 3 – Fund/Budget Detailed Descriptions

5. THE COMMERCIAL CASE

Based on the findings of the test of change project, there is an organisational desire to roll the solution out across other wards in order to receive maximum benefit. The following paragraphs outline the proposed approach to this roll out to allow an informed decision to be made on approval to move to the next stage.

5.1 Potential Scope

In line with the national directive to roll the solution out across acute hospitals in the first instance, wards have been segregated into cohorts to allow the roll out in grouped wards across the acute setting. Further tests of change have been suggested where requirements are unknown due to not being included in the original test of change project. The following sections detail the proposed cohorts and further tests of change (see Appendix 3 – Fund/Budget Detailed Descriptions

The following paragraphs provide a more detailed description of the individual funds/budgets that are mentioned in this Business Case:

- **Scottish Executive Health Department (SEHD) Funding:** In August 2013 the SEHD attributed an allocation of funding to each NHS Board to roll out Electronic Whiteboard technologies. This amounted to £168,000 for NHS Tayside for the financial year 2013/14.
- Various eHealth Funds: A variety of eHealth funds have been used to fund various aspects of this project e.g. national strategic monies, existing eHealth resources, additional funding locally and nationally for eHealth initiatives
- **Annual Application Maintenance** Fund: NHS Tayside maintenance budget for all software applications.
- Electronic Patient Record (EPR) Endowments: A bid was submitted to the Endowments Committee in September 2012, which successfully secured £200,000 for the purchasing of innovative equipment to support the Electronic Patient Record programme. The purpose of this fund is to purchase and test new equipment within test of change projects that will inform the equipment requirements for organisational roll outs.
- **Other (Directorate Resources):** During the test of change resources have been used that are currently provided/funded through Directorate budgets. These resources dedicate time to the projects at no extra cost. The amount attributed to this fund description is to take account of the time involved from these resources.

Appendix 4 – Implementation Cohorts/Test of Change Breakdown for full breakdown of wards per cohort/tests of change including high level costs and timescales):

- **Original Test of Change** – 7 wards across Medical, Surgical and Mental Health wards including the acute receiving units in Ninewells Hospital (see Appendix 2 – Test of Change Wards)
- **Cohort A – Medical Floor (including Renal), Ninewells Hospital**

  A number of medicine wards were included in the eWhiteboard Test of Change project and are in the process of going live with the solution.

  The remaining wards across the medicine floor require to be implemented as well as Ward 31 (Renal decant ward) to allow the Task View project to progress (NOTE: Women and Child Health wards will be dealt with as a separate test of change and roll out.)
- **Cohort B – General Surgical wards in Ninewells Hospital**

  The Acute Surgical Receiving Unit was included within the eWhiteboard Test of Change project and is in the process of preparing for switch on.

  The remaining general surgical and orthopaedics wards in Ninewells Hospital require to be implemented.
- **Cohort C – Specialist Services wards in Ninewells Hospital**

  The remaining specialist services wards (excluding Renal – see Cohort A) in Ninewells Hospital require to be implemented.
- **Cohort D – Receiving unit and downstream medicine and surgical wards in Perth Royal Infirmary**

  Ward 8, (Orthopaedics) in Perth Royal Infirmary was included within the eWhiteboard Test of Change project and is in the process of going live.

  The admission unit and the remaining medicine, general surgical and orthopaedics wards in Perth Royal Infirmary require to be implemented.

  Specialist high dependency/intensive care wards will be dependent on the completion of the High Dependency/Intensive Care Test of Change – see below.
- **Whole System Test of Change**

  The original test of change has focused on the implementation of the Electronic Whiteboards at individual ward level. There has been limited consideration given during the initial Test of Change to the larger picture/whole system view of patient flow throughout the organisation. A further test of change will be planned to look at the requirements across the Capacity & Flow/Patient Flow processes including management and senior nursing gathering/display of information. It is anticipated that there may be further use of other software including a previously created Bed Management Qlikview App. Consideration will also be given to the use of Electronic Whiteboards outside the ward setting e.g. management offices, Capacity & Flow meeting room, and that mobile devices could be trialled by senior nurses moving around the organisation whilst on Patient Flow duties.
- **High Dependency/Intensive Care Test of Change**

  There has been no high dependency/intensive care ward included in the original test of change project. A further test of change will be planned to look at the requirements across all specialist care wards of this nature in the acute setting. The build and configuration will then be rolled out across medical and surgical high dependency unit, the Intensive Care Unit and Coronary Care Unit in Ninewells Hospital. This will allow complete coverage of one site prior to winter 2014/15 whilst addressing the requirements of all specialist units across the acute setting.
- **Women and Child Health Test of Change**

  There has been no ward relating to gynaecology, paediatrics, obstetrics or neo-natal included in the scope of the investigative work for the original test of change. Some wards within this Directorate have specific governance/confidentiality issues that will have to be examined. It is known that there are flow issues within maternity across NHS Tayside. A separate project requires to be initiated to look at the specific

requirement, capacity and flow, and potential benefits and risks of implementing eWhiteboards in these wards. Requirements will be agreed across the directorate and three test of change wards will be identified to trial the solution prior to a decision being made on the roll out of the Electronic Whiteboards across the other wards.

- **Women & Child Health Roll Out**

  It is recommended that a further Business Case is produced based on the findings of the Women & Child Health Test of Change prior to a decision being made on the further roll out of Electronic Whiteboards across Women & Child Health wards.

- **Mental Health Test of Change**

  Leven Ward, Murray Royal Hospital has been included within the scope of the original test of change. It has been identified that this ward has different requirements and benefits/risks from acute wards, and may not represent the full Mental Health requirements across NHS Tayside. It has therefore been recommended that a dedicated test of change be initiated to allow agreement of an organisation-wide Mental Health configuration/requirement. This would then be trialled in three mental health wards across NHS Tayside prior to a further decision being made on the further roll out of the solution.

- **Mental Health Roll Out**

  It is recommended that a further Business Case is produced based on the findings of the Mental Health Test of Change prior to a decision being made on the further roll out of Electronic Whiteboards across Mental Health wards.

- **Community Hospital wards across NHS Tayside**

  At the time of writing, community hospital wards across NHS Tayside have not been considered but remain on the agenda for future roll out. Feedback is sought as to the appropriateness of addressing the roll out across Community Wards in the short term.

5.2 Potential Risks

During the test of change a Risk Register has been maintained with escalation of appropriate risks through the project and EPR Programme governance structure. The full Risk Log is available on request. These risks have informed the potential risks for the organisational roll out, whilst further workshops have undertaken risk assessment.

Below is a summary of the key risks associated with the organisational roll out:

Description of Risk	Risk Category	Mitigation
Lack of additional resources to undertake the roll out and further tests of change will significantly impact eHealth resulting in elongated timescales and other initiatives/projects not taking place	High	Fully loaded costs for additional required resources included within the content of the Business Case
Winter pressures will impact ward staff ability to consider/undertake implementation/switch on	High	Planning rules have taken into account increased pressures on ward staff during winter months.
Lack of 24/7 technical support for TOPAS resulting in absolute contingency planning being resorted to when TOPAS is down out of hours	High	NHS Tayside have 24/7 helpdesk support for TOPAS. Dependent on nature of outage this may be resolved by this but it may be an issue that requires escalation to the supplier. The supplier only currently operates a 9-5 5-day week support. If problem occurs then cost for 24/7 support will be sought.
Lack of ward staff capacity to undertake additional data entry tasks with Ward View/TOPAS particularly in	Medium High	Collaboration with other tests of change to improve capacity and flow.

admitting ward, resulting in ROI objectives not being met		
User account maintenance overhead not sustainable due to staff rotations resulting in staff not having access to update product in a timely fashion	Medium High	Planning to set up all user accounts at outset
Further development/integration required within further test of change projects resulting in additional resource requirement and negatively impacting delivery dates	Medium High	Cost and timescales include development time to take this into account
Timely installation of equipment/estates work affecting roll out schedule	Medium High	Up front agreement/collaboration with Estates taking place to agree timescales/costs in advance
Lack of Business Ownership following Test of Change, resulting in product not evolving to realise future benefits	Medium High	Work underway to address setting up of appropriate Business Ownership model
Product will not realise a significant improvement in real-time bed management position statement without other improvement/change exercises being implemented, resulting in ROI objectives not being realised	Medium High	Continuing to monitor ROI objectives results and collaborate with other improvement/change exercises where appropriate
Lack of adequate levels of clinical engagement and buy-in to the new electronic solution, affecting roll out schedule	Medium	Project governance structure will contain senior professional individuals to allow escalation if issues encountered
Inability to change culture in clinical professional activity, resulting in Return On Investment objectives not being realised	Medium	Implementation packs to be used in wards based on improvement aspects of test of change. Clinical Business Owner(s) to take on responsibility for implementing standard operating procedures around use of the eWhiteboard where appropriate
Lack of 24/7 technical support for solution, resulting in unscheduled downtime out of hours not being addressed in a timely fashion	Medium	Contingency planning to be put in place during ward preparations. Amalgamated with overall ward contingency.
Lack of improvement/OD resource for organisational roll out to support coordination and improvement measurements, affecting roll out schedule	Medium	Appointment of resource was unsuccessful. Currently investigating appointment of senior nurse.
Resistance in relation to clinical staff being required to undertake some of the functions required to implement the solution, affecting roll out schedule	Medium	Implementation packs to be used in wards based on lessons learned from test of change. Collaborate with management structures where appropriate and provide full training where applicable
Ward Users not aware of AD accounts and ability to use functionality within the product(s) resulting in ROI objectives not being met	Medium	Implementation packs to include training and awareness of this from outset of preparations
Lack of Information Governance sign	Low	Information Governance paper to

off of information displayed, affecting roll out schedule		be submitted to IG Committee Quarter 3 2014
TOPAS screen integration not available before organisational roll out commences	Low	Currently in testing. Scheduled for release November 2014
ICNet/EDISON feeds/integration will not be available before organisational roll out comments affecting realisation of ROI objectives	Low	Currently in testing. Scheduled for release November 2014

Table 15: Potential High Level Risks

5.3 Potential Benefits

The benefits appraisal of the product during the test of change period has followed a Return on Investment format involving extensive consultation with the project team, test of change wards and the Tayside Centre for Organisational Effectiveness (TCOE).

Benefits were identified prior to and during the initial switch on of the eWhiteboard in Ward 5, Ninewells. These benefits were graded/plotted to ascertain the level of impact (See Appendix 4 – Return On Investment Objectives Development). The most significant positive benefits were identified and translated into objectives within a Return on Investment format. Achievable targets and timings were calculated within the project team prior to gaining agreement within the Project Group.

NOTE: The test of change project is not yet complete so targets are still being measured. See Appendix 5 – Return on Investment Objectives Data for available baselines and data.

5.3.1 Level 1: Engagement, Satisfaction, Reaction and Planned Actions

At this level of evaluation, satisfaction of the project participants with the overall product are measured, along with their understanding of has been learned/acquired during the technical development phase and initial implementation/test of change.

The following table outlines the objectives that have been devised during the test of change project with the associated status:

Ref.	Objective	Benefit Category	Measurement Format	Status
1.	90% of ward staff see the benefit of the electronic whiteboard at 1 month following the removal of the write on whiteboard	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward
2.	50% of ward staff report that the Electronic Whiteboard has improved the availability of patient status information at a glance on the ward at 1 month following the removal of the write on whiteboard	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward
3.	50% or more of Senior Charge Nurses and Heads of Nursing want the Electronic Whiteboard solution in their own ward at 2 weeks following the removal of the write on whiteboard	Quality	Survey monkey questionnaire	To be measured following removal of write on whiteboard in each ward

Table 16: Return On Investment Level 1 Objectives

5.3.2 Level 2: Learning & Capacity-building

This level of evaluation focused on what participants learned during the project, providing evidence that participants absorbed the knowledge, skills and attitudes that are necessary for the implementation of the Electronic Whiteboard to be a positive exercise, with the potential of realising the expected benefits to the patient, ward and organisation.

The following table outlines the Level 2 objectives with the associated status:

Ref.	Objective	Benefit Category	Measurement Format	Status
1.	80% of ward staff understand the importance of having TOPAS up-to-date for the benefit of the patient at 1 month following the removal of the write on whiteboard	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward
2.	50% of ward staff know how to update TOPAS if patients details are incorrect at 2 weeks following the implementation	Quality	Semi-structured interviews on wards	To be measured when TOPAS integration

	of the TOPAS integration			available – November 13
3.	80% of ward staff know how Ward View is updated when patient details change at 1 month following the removal of the write on whiteboard	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward

Table 17: Return On Investment Level 2 Objectives

5.3.3 Level 3: Application and Implementation

This level of evaluation focuses on proving whether the learned knowledge and skills have been applied appropriately by ward staff during the implementation of the Electronic Whiteboard. This measures on-the-job behaviour and progress against the planned actions and objectives of the test of change project.

The following table outlines the Level 3 objectives with the associated status:

Ref.	Objective	Benefit Category	Measurement Format	Target Met?
1.	1 hour a day time released within ward teams previously spent compiling/providing information displayed on whiteboard within 1 month of removing the write on whiteboard in the first four test of change wards	Resource Release	Process mapping/time measurement via shadowing/ questionnaires	To be measured following removal of write on whiteboard in each ward
2.	95% of ward discharges/transfers are entered in TOPAS real-time (within 15 minutes) at 2 weeks following the implementation of the TOPAS integration	Quality	Comparison of actual discharge/ transfer time against audit log in TOPAS	To be measured when TOPAS integration available – November 13
3.	100% of patients have all information on the eWhiteboard correct at 1 month following the removal of the write on whiteboard (within 15 mins of a change)	Quality	Semi-structured interviews on wards	To be measured following removal of write on whiteboard in each ward
4.	50% of Senior Charge Nurses/Heads of Nursing related to the test of change wards using electronic data as primary source of bed management information at 2 weeks following removal of the write on whiteboard	Quality	Survey Monkey questionnaire	To be measured following removal of write on whiteboard in each ward

Table 18: Return On Investment Level 3 Objectives

5.3.4 Level 4: Business Impact

This level of evaluation focuses on the actual results achieved at the organisational level as application of the solution takes place.

At the time of writing it has not yet been possible to define Level 4 targets and objectives. Following workshop sessions with Heads of Nursing the following benefits were identified at an organisational level:

- Reduction in time spent compiling Capacity and Flow information – whole system
- Improved information/status at a glance on patients out with the ward

Whilst it is indisputable that the Electronic Whiteboard project will provide benefits and positive impact on these two areas, it has not been possible to identify and isolate the level of impact solely attributable to Electronic Whiteboards. The clinical environment around this project is dynamic and constantly changing with individual tests of change and improvement exercises. Work will continue on this level throughout the remainder of the Test of Change project.

5.3.5 Level 5: Return on Investment

This level of evaluation compares the major organisational benefits from the project (Level 4 objectives above) with the total costs and presents this as a percentage return on investment.

The calculation of the Return on Investment value for this project is still ongoing due to the challenges encountered during the Level 4 objective setting.

5.3.6 Benefits Appraisal During Further Roll Out

Using the predefined targets/objectives detailed above the continued evaluation of the potential further roll out and tests of change is planned to continue. Whilst all wards were included in the measurements within the initial test of change, it is intended to measure a proportion of wards in each cohort to minimise impact on resources. It should also be noted that Level 3: Objective 1 will not be measured during the further roll out due to the impact this has on resources. (i.e. 1 hour a day time released within ward teams previously spent compiling/providing information displayed on whiteboard within 1 month of removing the write on whiteboard in the first four test of change wards)

It is also anticipated that the further tests of change will develop further, but similar, objectives relevant to the clinical setting e.g. Women & Child Health, Mental Health.

5.3.7 Other Strategic Benefits

Other strategic benefits have been identified that will be positively impacted by the roll out of the Electronic Whiteboard across the organisation. Whilst the project will contribute to these benefits, improvements are not envisaged to be significant and any change in trend cannot be truly isolated to this project alone. These organisational benefits include:

- Reduction in average length of stay
- Safer care with less errors and harm
- Improved ability to achieve waiting times targets allowing the organisation to maintain the current capacity even with increasing admissions
- Improved patient outcomes and mortality rates

5.3.8 Further Opportunities and Potential Benefits

There are significant potential benefits to the organisation of developing and implementing the Electronic Whiteboard further. Whilst there is potential for benefits these are viewed as indirect to the current Electronic Whiteboard project and as such have not been included as key objectives in the Level 4/5 return on investment analysis. These potential benefits include:

- Potential benefits through further integration of accurate ADT data with other eHealth systems. Whilst these integrations are currently technically possible, there is a reliance on the accuracy of the ADT data. These include:
    - Integration of ADT data with ICE to allow results to follow the patient rather than clinicians having to search for the results
    - Integration of ADT with Electronic Discharge to allow the discharge letter to be automatically sent to the GP when discharge is completed in TOPAS. This would reduce the known issue whereby letters are being sent electronically to GPs when the patient has not yet left the hospital.
    - Integration of ADT with potential mobile electronic task management.
- Potential benefits through further development of the Ward View product. In order to reach a testable initial version of the product, the requirements of Ward View were kept to a minimum. On initial switch on of the solution there were obvious further requirements that would increase the potential of resource release and improve patient safety across the organisation. The criticality of appropriate business ownership to coordinate and prioritise these changes is imperative. The following suggested changes to the current functionality are included as illustrative of the potential for the future:
    - Appointments column – this column currently presents any Outpatient appointments as recorded in TOPAS that may be pending for each patient.

The suggestion has been raised that Radiology appointments could also be included in this column to alert ward staff of approaching appointments at a glance.

- Indirect savings on other departments. It has been identified that other Health Boards/Trusts have seen savings attached to the implementation of Electronic Whiteboard functionality in relation to:
    - Reduction in Porters waste visits to wards
    - Reduction in wasted meals due to patients whereabouts being unknown

5.4 Potential Personnel Implications

The organisational roll out of the product has the following personnel implications. Cost implications have been included in the financial trajectories included in Section 5:

Overall Personnel Implications:

- **Business Ownership** – Ward View is considered a Corporate System and as such will be amalgamated into eHealth Application Management. Funding has been identified on a yearly basis to cover future maintenance and changes/enhancements to the software from eHealth funds. This will ensure that the product remains at an optimum performance and functional level.

  A Corporate Clinical Group is to be established to take on the prioritisation and agreement of any future enhancements to the solution. This group will exist as a sub-group of an overall eHealth/EPR User Group that is yet to be established. The remit of the group will include agreement on "view" configurations and will cover risk and information governance aspects to ensure a standard agreed version is rolled out across the organisation. The Group will be co-chaired by a representative from the Nursing Directorate and from the Medical Directorate.
- **Supplier Support – Service Level Agreements are being put in place as part of the initial test of change with Cambric and Nugensis to ensure that adequate support of the aspects of the technical solution are supported. This has been set up on 9-5/5** days a week basis.
- **eHealth Support – the following personnel implications exist within eHealth to ensure adequate collaboration with the relevant suppliers and support of the product itself:**
  - ***Infrastructure* – including contribution to roll out and test of change projects in relation to equipment installation/configuration as well as technical hardware (servers etc) support for the software solution. This also includes Service Desk implications. For the purposes of the Business Case this has been calculated as 1WTE (Band 5).**
  - ***Application Management*** – business as usual and ongoing office hours support of the technical aspects of the solution that are the responsibility of NHS Tayside to maintain. An additional annual cost has been attributed to this support (see section 5).
  - ***System Admin/Support*** – to deal with ongoing triaging of second line support calls and systems administration. For the purposes of the Business Case this has been calculated as 1WTE (Band 4) going forward.
- **Improvement Resource** – to support the evaluation by measuring improvements against the Return On Investment objectives throughout the roll out and tests of change. For the purposes of the Business Case this has been calculated as 0.25 WTE (Band 5) per Test of Change and 0.1 WTE (Band 5) per cohort roll outs.

Roll Out Personnel Implications:

The following paragraphs detail the resources that will be required to support each of the roll out cohorts:

- **Clinical Leadership** –Time will be required from the Senior Charge Nurse/Clinical Lead in each ward during the preparation and initial switch on of the solution until it is embedded in day-to-day practice. Whilst the intention is to facilitate the implementation process this must be led by clinical staff in a position to enforce change within the ward. The amount of time required to implement this solution will be dependent on the levels of engagement in each ward but for the purposes of the Business Case this has been calculated as 0.5 days per week.
- **Cohort Roll Out Team** – A Roll Out/Implementation Team will be required with the following personnel implications for each cohort/roll out:

Role	WTE per cohort	Band	Responsibility
*Improvement/ Organisational Development	0.3	7	Coordination/project management of roll out across all

Coordinator			cohorts. Initial communication with wards prior to preparations commencing Improvement/OD support during roll out
IT Training Facilitators	2.5/3.0	5/6	Facilitate/coordinate preparations and switch on within individual wards Provide improvement/OD support for wards during preparations IT training

* eHealth money has been allocated to appoint this role but as yet the vacancy has not been filled. It is currently being investigated whether clinical resource can be used to fill this position e.g. Senior Nurse, working within eHealth for a period of time to help support the clinical areas implementing this and other solutions.

- **Estates** – there is a requirement from Estates to support the installation of Electronic Whiteboards during the roll out, tests of change and replacement of these going forward. This includes electrical wiring, joinery work etc. An additional cost has been attributed to this support (see section 5).

  NOTE: There will be an implication for planned maintenance of the touch-screens and PCs with the Estates department. This will be absorbed into the current resources supporting the ward environments.

Test of Change Personnel Implications:

The following paragraphs detail the resources that will be required to support each of the roll out cohorts:

- **Clinical Leadership** –Time will be required from the Senior Charge Nurse/Clinical Lead in each ward during the test of change. This role will be involved in process mapping, requirements gathering, user acceptance testing and general support and leadership throughout the whole project. The amount of time required to implement this solution will be dependent on the levels of engagement in each ward but for the purposes of the Business Case this has been calculated as 1 days per week for the first ward in each test of change, falling to 0.5 days per week for subsequent wards.
- **Test of Change Project Team** – A Test of Change Project Team will be required with the following personnel implications for each test of change:

Role	WTE per cohort	Band	Responsibility
eHealth Project Manager	0.75	7	Project management of test of change Early life support following switch on Coordination of service transition to business as usual
Business Analyst	0.75	6	Current/desired process mapping Requirements gathering and specification Testing and support for project manager/wards during User Acceptance Testing
IT Training Facilitators	0.25	5/6	Testing and support for project manager/Business analyst during project IT training

			User account coordination Early life support following switch on

- **Software "View" Development** – Dependent on the outcome of the analysis phase of each Test of Change there will be a requirement for further development to realise these requirements. This may take the form of development from each of the suppliers or from internal NHS Tayside Development Services. Allocation to allow for a cost of this has been included in the potential cost of each test of change.

5.5 Potential Implementation Timescales

Based on learning throughout the test of change the following rules have been used when planning the implementation timescales:

- The emphasis is on getting at least one hospital site fully implemented before winter 2014/15
- Implementation Preparation has been estimated at 5 weeks on average per ward. This is entirely dependent on ward engagement to undertake the implementation.
- Cohort A will be planned with one ward going live per fortnight until March 2014 with longer preparation time. This will allow bedding in of the implementation process and technical support of the product. This will also minimise the impact on the wards during the winter pressures. During March 2014 the switch on rate will be increased to 1 ward per week.
- Contingency which is relative to the number of wards has been included per cohort to account for annual/sick leave and slippage during preparations with the wards
- Cohort B will be planned to commence ward switch on following completion of cohort A with two wards going live per week.
- Once a technical decision has been made that the solution and infrastructure can cope, the implementation will be increased to three wards per week for Cohorts C and D to be implemented simultaneously.

High level timescales are detailed in the Gantt Chart below:

Task	Start Date	Finish Date
Cohort A – Medicine, NW	Nov-13	Jun-14
Cohort B – General Surgery, NW	April-14	Aug-14
Cohort C – Specialist Services, NW	Jun-14	Nov-14
Cohort D – Medicine/& General Surgery, PRI	Aug-14	Feb-15
Whole System Test of Change	Feb-14	Jun-14
HDU/ICU, NW Test of Change	Mar-14	Oct-14
Woman & Child Health Test of Change	Jul-14	May-15
Women & Child Health Roll Out	May-15	Oct-15
Mental Health Test of Change	Feb-15	Jan-16
Mental Health Roll Out	Jan-16	Aug-16

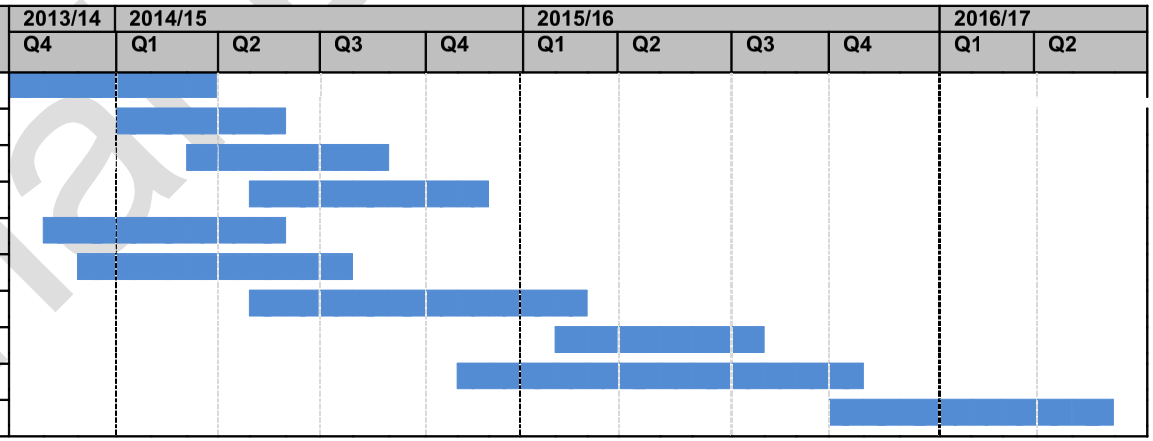

Figure 3: Potential Implementation Timescales Gantt Chart

See Appendix 4 – Implementation Cohorts/Test of Change Breakdown for more detailed timescales per cohort.

5.6 Dependencies/Constraints

There are a number of key dependencies and constraints associated with the delivery of this project:

- Appointment of an Improvement/Organisational Development Resource to coordinate the implementations must be in place in order to commence preparation with the wards.
- Organisational roll out cannot commence until formal sign off has been achieved by the Information Governance Committee on the content of the Ward View product and the location of the Electronic Whiteboards in the wards
- Organisational roll out cannot commence until the TOPAS screen integration (allows updating of TOPAS direct from the eWhiteboard) has been released to live. This is currently scheduled for live release in November 2013
- The implementation of Cohort A – Medicine wards in Ninewells Hospital is dependent on Ward 5 and 2 having signed off the solution as fit for purpose as part of the original Test of Change project.
- The implementation of Cohort B – General Surgical and Orthopaedics wards in Ninewells Hospital is dependent on Ward 10 (Stracathro) and Ward 8 (PRI) signing off the solution as fit for purpose as part of the Test of Change project
- The implementation of Ward 23, Ninewells (Cohort C) and the high dependency/intensive care units in PRI (Cohort D) are dependent on the successful completion of the High Dependency/Intensive Care Test of Change
- The implementation of Cohort G – Mental Health is dependent on an extended requirements gathering phase and test of change in additional mental health wards.
- The implementation of Cohort H – Women and Child Health is dependent on further scoping work being undertaken to identify those wards that can be implemented without further change to the current views/configurations.
- The implementation of Cohort D – High Dependency/Specialist Units is dependent on further scoping working being undertaken to identify the requirements of each of these wards.

6. THE FINANCIAL CASE

6.1 Potential Capital and Revenue 2013/14 to 2017/18

The following table details the breakdown of the total capital and revenue costs to the organisation to run the project from initial test of change to full roll out of the potential scope detailed above (See Appendix 3 – Fund/Budget Detailed Descriptions for more information on individual funds):

Purpose/Budget	Initial Test of Change	2013/14	2014/15	2015/16	2016/17	2017/18	Total
SEHD Funding (Equipment)	£0	£98,500	£0	£0	£0	£0	**£98,500**
Endowments (Equipment)	£90,000	£12,000	£38,500	£19,500	£0	£0	**£160,000**
Various eHealth Funds	£402,600	£91,000	£585,000	£385,000	£164,000	£96,000	**£1,757,000**
eHealth Annual Application Maintenance	£33,000	£0	£22,500	£32,500	£32,500	£32,500	**£135,000**
Estates (Equipment Installation)	eHealth budget	£30,000	£32,500	£42,000	£7,500	£8,500	**£120,500**
Other (Directorate Resources)	£12,000	£7,200	£59,500	£38,000	£16,000	£0	**£132,700**
Unfunded Equipment	£0	£0	£103,500	£158,500	£60,000	£60,000	**£382,000**
Total	**£537,600**	**£238,700**	**£841,500**	**£675,500**	**£280,000**	**£197,000**	**£2,770,300**
Running total by financial year		£776,300	£1,617,200	£2,293,300	£2,573,300	£2,770,300	

Table 19: Potential Capital and Revenue

The above table outlines the full costs to the Organisation for the roll out of the Wardview programme

6.2 Potential Unfunded Costs 2013/14 to 2017/18

The following table details the breakdown of the costs of the projects that cannot be absorbed into current budgets. In the circumstance of the *Various eHealth Funds*, if additional funds are not made available, other projects and support of some existing services will be compromised. Funding of the undernoted will be provided from the eHealth Strategic funding from Scottish Executive up to financial year 2014/15 after which the Scottish Government funding will be dependent on the outcome of their three year funding cycle for 2015/18.

Additional funds required	Initial Test of Change	2013/14	2014/15	2015/16	2016/17	2017/18	Total
Unfunded Equipment	£0	£0	£103,500	£158,500	£60,000	£60,000	£382,000
Unfunded eHealth Resources	£0	£0	£204,000	£145,200	£64,800	£84,000	£517,200
Unfunded Estates installation	£0	£30,000	£32,500	£42,000	£7,500	£8,500	£120,500
Total	**£0**	**£30,000**	**£340,000**	**£345,700**	**£151,500**	**£152,500**	**£1,019,700**

Table 20: Potential Unfunded Costs

The detail of the Unfunded eHealth Resources required within these costs includes:

- 1WTE Project Manager to run the Test of Change projects over 2014/15
- 1WTE Business Analyst to gather and specify requirements within the Test of Change projects over 2014/15
- 1WTE permanent System Support/Administration
- Infrastructure and Application Management internal Product Support costs

6.3 Potential Annual Recurring Costs Beyond 2017/18

Once full roll out and the series of additional test of change projects are complete, there will be a recurring cost to the organisation as detailed in the table below:

Purpose/Budget	Going forward per annum
SEHD Funding (Equipment)	£0
Endowments (Equipment)	£0
Various eHealth Funds (£84,000 unfunded)	£96,000
eHealth Annual Application Maintenance	£32,500
Estates (Equipment Installation)	£7,500
Other (Directorate Resources)	£0
Unfunded Equipment (screen replacements)	£60,000
Total	**£186,000**

Table 21: Potential Annual Recurring Costs From 2017/18

6.4 Potential Unfunded Annual Recurring Costs Beyond 2017/18

The table below details the currently unfunded aspects for going forward beyond 2017/18. This money is not currently included in any budgets and should therefore be considered as cost pressure at the relevant time.

Additional funds required	Going forward per annum
Unfunded Equipment (screen replacements)	£60,000
Unfunded eHealth Resources	£84,000
Unfunded Estates (equipment installation)	£7,500
Total	**£151,500**

Table 22: Potential Unfunded Annual Recurring Costs

7. THE MANAGEMENT CASE

7.1 Project Management Arrangement

Project management structures will be put in place in line with current NHS Tayside practice.

The project will be managed by eHealth as part of the Electronic Patient Record Programme. The Project Board governing the Electronic Whiteboard Test of Change will take on the governance of the roll out project co-opting relevant staff on to the Board as the project moves through cohorts. Regular reports will be submitted to the Programme Board.

Project Teams will be established within each ward to coordinate and drive the implementation of the product. These will consist of multidisciplinary staff affected by the Electronic Whiteboard and will be facilitated by the relevant eHealth Trainer.

The Project Manager will report to the Project Board with exception reports, change control notifications, risk and issue logs and requests for conflict resolution. The project also has public representation through the Patient Public Involvement team via the EPR Programme.

Competencies and skills of project leads are appropriate to the delivery of this proposal:

The following diagram outlines the project organisational structure:

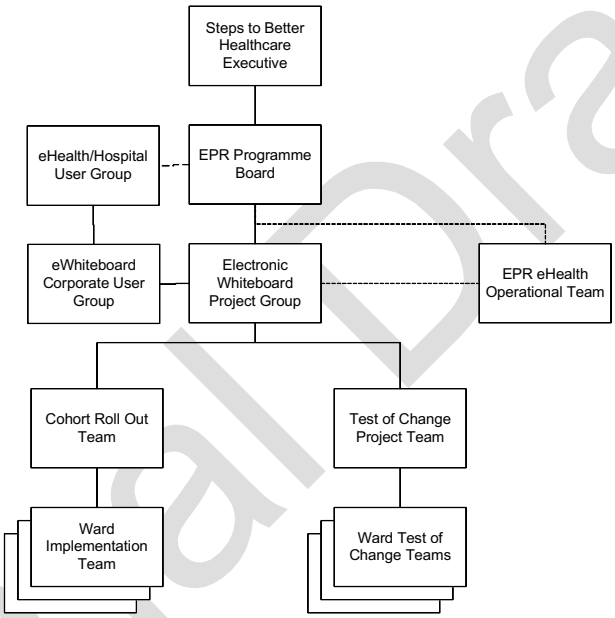

Figure 4: Project Governance Structure

7.1.1 Electronic Whiteboard Project Group

This group currently exists to drive forward the initial test of change and is chaired by Carol Goodman. This group will expand its remit to include the cohort roll outs. Membership of this group will expand to include representation from the Test of Change areas at the relevant time. This group will govern the progress of each of the roll outs and provide a decision making/escalation forum for the project teams.

7.1.2 Cohort Roll Out Team

This group will provide an operational team to govern the detailed approach to the cohort roll outs and will be chaired by the Improvement/Organisational Development Coordinator. Relevant clinical and managerial individuals from each of the cohorts will be represented on this team along with the Implementation resources. The membership of this group(s) will change according to the specific cohort being implemented at the time.

7.1.3 Ward Implementation Teams

These groups will provide an operational team to govern the detailed implementation of the solution in the actual wards. This will be chaired by the clinical lead in the specific ward and supported by the Training/Implementation Resource.

7.1.4 Test of Change Project Team

This group will provide an operational team to govern the detailed approach to the specific test of change and will be chaired by a clinical lead and supported by the test of change Project Manager. The chair will represent the group on the Electronic Whiteboard Project Group.

7.1.5 Ward Test of Change Teams

These groups will provide operational teams to govern the detailed implementation of the test of change solution in the actual wards. This will be chaired by the clinical lead in the specific ward and supported by the test of change project manager.

7.2 Change Management

Changes will be managed using the standard eHealth change management process. This will be managed on two levels:

- Changes to the project will be identified and the person requesting the change will complete a change request form. Changes will be reviewed frequently and escalated rapidly where necessary. All changes must be approved by the eWhiteboard Project Group or the EPR Programme Board as appropriate, and a management summary detailing accumulative costs to date will be included within the Project Managers update report. All change control forms are held within the project library for audit purposes.
- Changes to the product itself will be identified and the person requesting the change will complete a change request form. Changes to the project will then be reviewed frequently by the Corporate eWhiteboard User Group and prioritised against all other changes. These will then be passed to the standard eHealth change management process for actioning against the allocated product budget.

All changes will be reviewed frequently and escalated rapidly where necessary. All changes must be approved by the Project Group and a management summary detailing accumulative costs to date included within the Project Managers update report for review by the Project Group. All change control forms are held within the project library and within the standard eHealth change management library as necessary.

7.3 Risk Management

Risks will be managed using the standard eHealth risk management process and the EPR Programme Risk Management Strategy. Through using this structured approach, risks which may cause future delay or cost implications to the project will be identified, assessed and controlled.

Risks will be identified, logged, severity/impact assigned and categorised. Risk owners and managers will be assigned to manage the appropriate mitigation and set acceptable tolerance levels. Risks will be categorised and escalated within eHealth and to the Project Board and EPR Programme Board as necessary.

Risk assessment has taken place during the Test of Change project and through development of the Return on Investment objectives. Risk management will progress throughout the organisational roll out of the product.

7.4 Issue Management

Issues will be managed using the standard eHealth issue management process and the EPR Programme Issue Management Strategy. Once an issue is identified, the issue will be captured electronically on the project issue log.

This log will be reviewed regularly and issues resolved, progressed or escalated as necessary. The Electronic Whiteboard Project Group and the EPR Programme Board will receive management summaries of outstanding issues for review, as appropriate.

7.5 Contract/Supplier Management

The Contract/Supplier Management will be handled via individual Service level Agreements with the relevant suppliers. These will detail the nature of the Service Level and include

response times and other expectations of the support provided. These will be mutually agreed between eHealth and the supplier.

7.6 Benefits Realisation

The Return on Investment objectives as detailed above will continue to be evaluated throughout the course of the organisational roll out. This will be reported regularly to the Project Board and the EPR Programme Board to demonstrate the realisation of the benefits.

7.7 Post Project Evaluation

eHealth will carry out a Post Project Evaluation (PPE) of the development and implementation of the solution at intervals. These will take place following completion of the development project and then again following completion of the implementation of a pre-defined number of cohorts. This work will include development of questionnaires and surveys for completion by all stakeholder groups involved in the Test of Change and organisational roll out projects. This will concentrate on the operational, functional and strategic performance of the eHealth during these projects.

The Return on Investment objectives will continue to be evaluated to ensure that realisation of the project objectives is achieved.

7.8 Contingency Plans

Contingency (relative to the number of wards in each) has been planned into the schedule of the cohort implementations. Tolerance levels will be set within each ward implementation project. If the tolerance is exceeded an exception report will be submitted to the EPR Programme Board for further action. It is anticipated that any exceptions will be due to engagement of ward staff to implement the solution.

Contingency planning in the wards in the event of product failure has been included as part of the Test of Change project. During the implementation of the product in each ward, contingency planning will be amalgamated into the overall ward contingency planning.

It is likely that this will involve resorting to the use of TOPAS and the use of “Magic Whiteboards” to provide a portable, temporary Whiteboard function until the system/product can be re-stored.

8. Informing, Engaging and Consulting

All major stakeholders have been identified during the test of change project and involved in the project as necessary. This has informed the organisational roll out by dictating the stakeholders who require to be involved at project and individual ward implementation level.

Communication/Consultation Plans will be developed in line with the EPR Programmes Stakeholder Engagement Strategy. Communication with direct project stakeholders will be undertaken by the Project Team. Communication with the rest of the organisation will be undertaken by the Programme Team.

Consultation with patients and the public has taken place as part of the measurement of the Return on Investment objectives. Further consultation is planned at the Public Partnership Group Conference.

Appendix 1 – Ward View Screen Shot

The following screen shots provide a representation of the Ward View software as run on the Electronic Whiteboard during the test of change in the Medicine wards (Ward 5 (Medicine for the Elderly), Ninewells and Ward 2 (Gastroenterology), Ninewells)

8.1 Ward View Geographical View

The following screen shot illustrates the Ward Geographical View. This view is defaulted to be displayed on the board during periods of inactivity. This provides a level of security on the display of patient details and also provides a geographical layout of the ward floor at a glance.

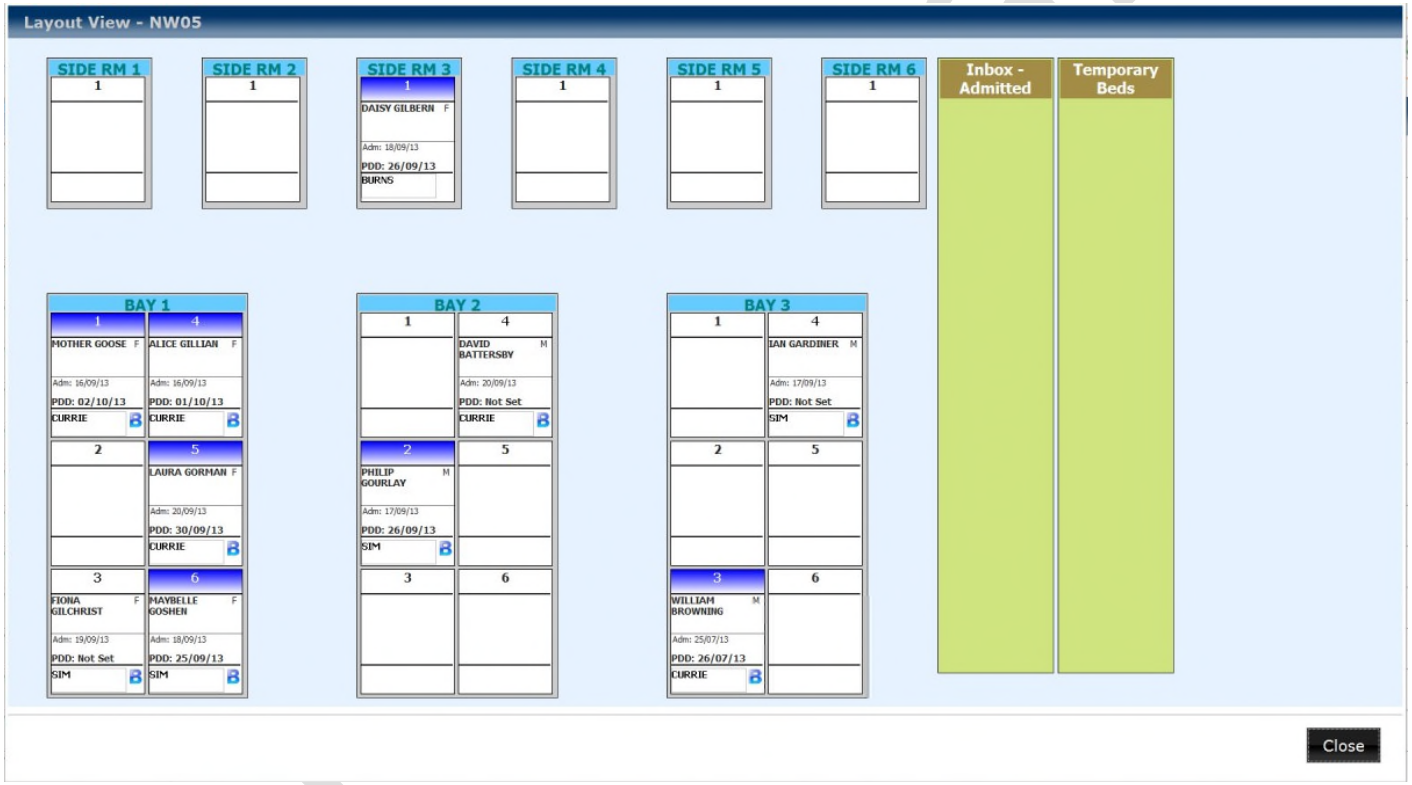

Figure 5: Ward View Geographical View

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8.2 Ward View – Columns

The following screen shot illustrates the Ward Column View. This view is used during Board Rounds and general use of the eWhtiebaord to provide an at a glance status of the ward including information on patients.

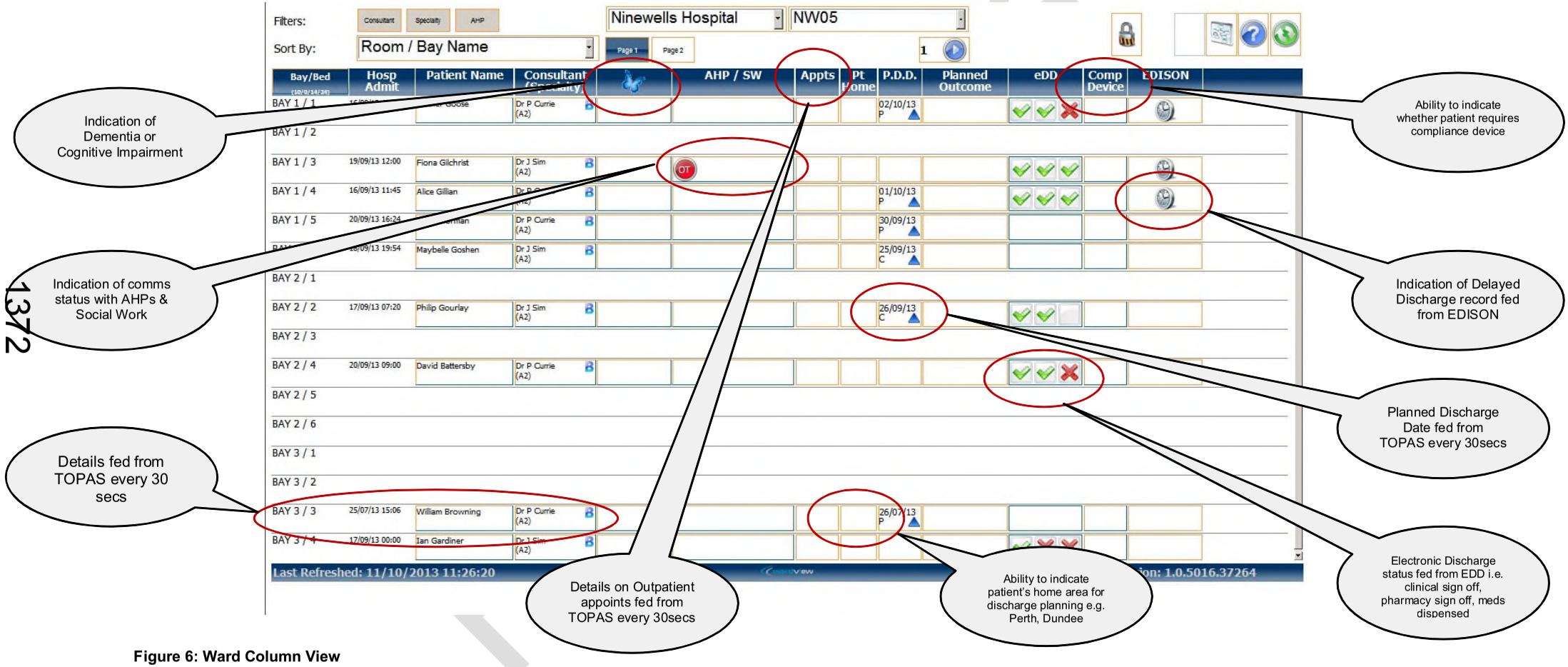


Figure 6: Ward Column View

TOPAS integration allows updating of discharge, transfer, Consultant directly from Electronic Whiteboard without separate need to access/update TOPAS.

Appendix 2 – Test of Change Wards

The following wards were identified to participate in the Electronic Whiteboard Test of Change project:

- Ward 5 – Medicine for the Elderly, Ninewells Hospital
- Ward 2 – Gastroenterology, Ninewells Hospital
- Acute Medical Unit, Ninewells Hospital
- Acute Surgical receiving Unit, Ninewells Hospital
- Ward 8 – Orthopaedics, Perth Royal Infirmary
- Ward 10 – Day Surgery, Stracathro Hospital
- Leven Ward – Mental Health, Murray Royal Hospital

Appendix 3 – Fund/Budget Detailed Descriptions

The following paragraphs provide a more detailed description of the individual funds/budgets that are mentioned in this Business Case:

- **Scottish Executive Health Department (SEHD) Funding**: In August 2013 the SEHD attributed an allocation of funding to each NHS Board to roll out Electronic Whiteboard technologies. This amounted to £168,000 for NHS Tayside for the financial year 2013/14.
- **Various eHealth Funds**: A variety of eHealth funds have been used to fund various aspects of this project e.g. national strategic monies, existing eHealth resources, additional funding locally and nationally for eHealth initiatives
- **Annual Application Maintenance Fund**: NHS Tayside maintenance budget for all software applications.
- **Electronic Patient Record (EPR) Endowments**: A bid was submitted to the Endowments Committee in September 2012, which successfully secured £200,000 for the purchasing of innovative equipment to support the Electronic Patient Record programme. The purpose of this fund is to purchase and test new equipment within test of change projects that will inform the equipment requirements for organisational roll outs.
- **Other (Directorate Resources)**: During the test of change resources have been used that are currently provided/funded through Directorate budgets. These resources dedicate time to the projects at no extra cost. The amount attributed to this fund description is to take account of the time involved from these resources.

Appendix 4 – Implementation Cohorts/Test of Change Breakdown

The following sections outline the breakdown of wards into cohorts:

8.2.1 Cohort A – Medical Wards, Ninewells Hospital

- Ward 1 (Cardiology)
- Ward 3 (Respiratory Medicine)
- Ward 4 (General Medicine)
- Ward 6 (Medicine for the Elderly)
- Clinical Investigation Unit, Ninewells
- Ward 31 (Renal – decant ward) – installation in Ward 22 to coincide with refurbishment
- Ward 33 (Stroke – General Medicine)
- Ward 42 (Infectious Diseases)
- A&E Short Stay Ward

NOTE: The Acute Medical Receiving Unit, Ward 2 (Gastro) and Ward 5 (Medicine for the Elderly) are original test of change wards and will be live in advance of this cohort.

The following table outlines an approximate cost for the implementation of this cohort:

Description	Approximate Cost
Project Team Resources and Clinical Leadership	£100,000
Equipment (9x£4,000)	£36,000
Total excl VAT	**£136,000**

Potential Timescales:

Start Date: 18th November 2013
First ward live: 13th January 2014
All wards live: 12th June 2014

8.2.2 Cohort B – General surgical wards, Ninewells Hospital

- Ward 7 (General Surgery)
- Ward 9 (Urology)
- Ward 10 (General Surgery)
- Ward 11 (General Surgery)
- Ward 12 (Vascular Surgery)
- Ward 16 (Orthopaedics)
- Ward 17 (Orthopaedics)
- Ward 18 (Orthopaedics)
- Ward 19 (Orthopaedics)
- Day Surgery Unit

Note: The Acute Surgical Receiving Unit is an original test of change ward. This ward is scheduled to be live prior to the implementation of this cohort.

The following table outlines an approximate cost for the implementation of this cohort:

Description	Approximate Cost
Project Team Resources and Clinical Leadership	£62,000
Equipment (10x£4,000)	£40,000
Total excl VAT	**£102,000**

Potential Timescales:

Start Date: 21st April 2014
First ward live: 26th May 2014

All wards live: 22nd August 2014

8.2.3 Cohort C – Specialist Services wards, Ninewells Hospital

The following Specialist Services wards require to be implemented:

- Ward 22 (Renal) – installation only required to coincide with ward refurbishment
- Ward 23 (Neurosurgery High Dependency Unit), Ninewells – including Neurology and Neurosurgery inpatient beds
- Ward 24 (Dermatology)
- Ward 25 (Ophthalmology)
- Ward 26 (ENT)
- Ward 27 (Plastics and Palliative)
- Ward 32 (Oncology)
- Ward 34 (Haematology)

The following table outlines an approximate cost for the implementation of this cohort:

Description	Approximate Cost
Project Team Resources and Clinical Leadership	£62,000
Equipment (8x£4,000)	£32,000
Total excl VAT	**£94,000**

Potential Timescales:

Start Date: 30th June 2014
First ward live: 4th August 2014
All wards live: 13th November 2014

8.2.4 Cohort D – Receiving unit and downstream medical and surgical wards, Perth Royal Infirmary

- Ward 1 (General Surgery)
- Ward 2 (Day of Surgery Assessment)
- Ward 3 (General Medicine)
- Ward 4 (Acute Receiving Unit)
- Ward 6 (General Medicine)
- Ward 7 (Orthopaedics)
- Stroke Unit (Perth CHP)
- Tay Ward (Medicine for the Elderly)
- Day Surgery Unit
- Coronary Care Unit/High Dependency Unit, PRI
- Intensive Therapy Unit, PRI

Note: Ward 8 (orthopaedics) is an original test of change ward and will be live prior to the implementation of this cohort.

The following table outlines an approximate cost for the implementation of this cohort:

Description	Approximate Cost
Project Team Resources and Clinical Leadership	£82,500
Equipment (11x£4,000)	£44,000
Total	**£126,500**

Potential Timescales:

Start Date: 25th August 2014
First ward live: 29th September 2014
All wards live: 20th February 2015

8.2.5 Whole Systems Test of Change

- General/Service Managers Office
- Heads of Nursing/Senior Charge Nurses on Capacity & Flow responsibilities

The following table outlines an approximate cost for the implementation of this cohort:

Description	Approximate Cost
Project Team Resources and Clinical Leadership	£41,000
Equipment	£10,000
Total	**£51,000**

Potential Timescales:

Start Date:	28th February 2014
Test of Change Start Date:	9th May 2014
All wards live:	19th June 2014
Decision to proceed to further roll out:	July 2014

8.2.6 High Dependency/Intensive Care, Ninewells Hospital – Test of Change

- Ward 10 (Surgical High Dependency Unit) Ninewells
- Ward 20 Intensive Care Unit (Anaesthetics), Ninewells
- Coronary Care Unit (Cardiology), Ninewells
- Medical High Dependency Unit, Ninewells

The following table outlines an approximate cost for the implementation of this cohort:

Description	Cost
Project Team Resources and Clinical Leadership	£78,000
Equipment (4x£4,000)	£16,000
New software "view"	£5,000
Total	**£99,000**

Potential Timescales:

Requirements signed off:	14th March 2014
Build/UAT complete:	13th June 2014
First ward live:	16th June 2014
All (4) wards live:	12th September 2014

8.2.7 Women & Child Health Test of Change

Three wards to be identified to act as test of change wards across Gynaecology, Paediatrics, Obstetrics and Neo-natal.

The following table outlines an approximate cost for the implementation of this cohort:

Description	Cost
Project Team Resources and Clinical Leadership	£95,000
Equipment (4x£4,000)	£16,000
New software "view"	£5,000
Total	**£116,000**

Potential Timescales

Requirements signed off:	September 2014
Build/UAT complete:	January 2015
First test of change ward live:	January 2015
All (4) wards live:	April 2015
Decision to proceed to full roll out:	May 2015

8.2.8 Women & Child Health Roll Out

The following wards are included in this cohort:

- Ward 29 (Paediatrics, GP Receiving, High Dependency Unit) Ninewells
- Ward 30 (Paediatric Surgery) Ninewells
- Ward 35 (Assisted Conception Unit) Ninewells
- Ward 36 (Gynaecology)
- Ward 37 (Obstetrics) Ninewells
- Ward 38 (Obstetrics) Ninewells
- SCBU/NICU, Ninewells
- Labour Suite, Ninewells
- Ward 40 – NICU (Paediatrics) & Transitional Care (Obstetrics) Ninewells
- Gynaecology Assessment Unit, Ninewells
- Community Midwifery Unit, Dundee
- Community Midwifery Unit, Perth
- Community Midwifery Unit, Montrose
- Community Midwifery Unit, Arbroath
- Ward 10 (Paediatrics) PRI
- Gynaecology Unit, PRI

The following table outlines an approximate cost for the implementation of this cohort:

Description	Cost
Project Team Resources and Clinical Leadership	£77,000
Equipment (12x£4,000)	£48,000
Total	£125,000

Potential Timescales:

Start Date:	4th May 2015
First ward live:	8th June 2015
All wards live:	18th September 2014

8.2.9 Mental Health Test of Change

Leven Ward, Murray Royal was an original Test of Change ward. It is proposed that another two wards are identified across NHS Tayside to trial a new Mental Health view.

Original Test of Change Ward:

- Leven Ward, Murray Royal

A further three wards are to be identified to act as test of change wards.

The following table outlines an approximate cost for the implementation of this cohort:

Description	Cost
Project Team Resources and Clinical Leadership	£124,500
Equipment (4x£4,000)	£16,000
New software "view"	£31,000
Total	**£171,500**

Potential Timescales

Requirements signed off:	April 2015
Build/UAT complete:	July 2015
First test of change ward live:	August 2015
All (4) wards live:	November 2015
Decision to proceed to full roll out:	January 2015

8.2.10 Mental Health Roll Out

The following wards are included in this cohort:

- Mulberry (Acute Admissions Unit) Stracathro
- Rowan (Psychiatry of Old Age) Stracathro
- Willow (Psychiatry of Old Age) Stracathro
- Amulree Unit (Long Stay Rehab) Murray Royal
- Garry Ward (Dementia) Murray Royal
- Kinclaven Ward (Long Stay Rehab) Murray Royal
- Leven Ward (Elderly) Murray Royal
- Moredun Ward (Acute Admissions Unit) Murray Royal
- Rannoch Unit (Substance Misuse Service – NHST & Grampian) Murray Royal
- Rohallion (Medium, Secure/Forensic – NHST & Grampian) Murray Royal
    - Esk Ward
    - Faskally Ward
    - Lyon Ward
    - Spey Ward
    - Ythan Ward
- Tummell, Murray Royal
- Ward 1/2 (Acute Admissions Unit), Carseview
- AIS (Neurology – Specialist Services), Carseview
- Intensive Psychiatric Care Unit (pan NHST), Carseview
- Learning Disability Assessment Unit, Carseview
- Young Persons Unit (CAHMS), Dudhope

The following table outlines an approximate cost for the implementation of this cohort:

Description	Cost
Project Team Resources and Clinical Leadership	£115,000
Equipment (16x£4,000)	£64,000
Total	**£179,000**

Potential Timescales:

Start Date: December 2015
First ward live: February 2016
All wards live: July 2016

Appendix 4 – Return On Investment Objectives Development

The following diagram outlines the plotting of the potential benefits that were identified prior to and during the switch on of the Electronic Whiteboard in Ward 5, Ninewells. This plotting of benefits allowed the significant positive benefits to be identified to allow creation of objectives within the Return on Investment format:

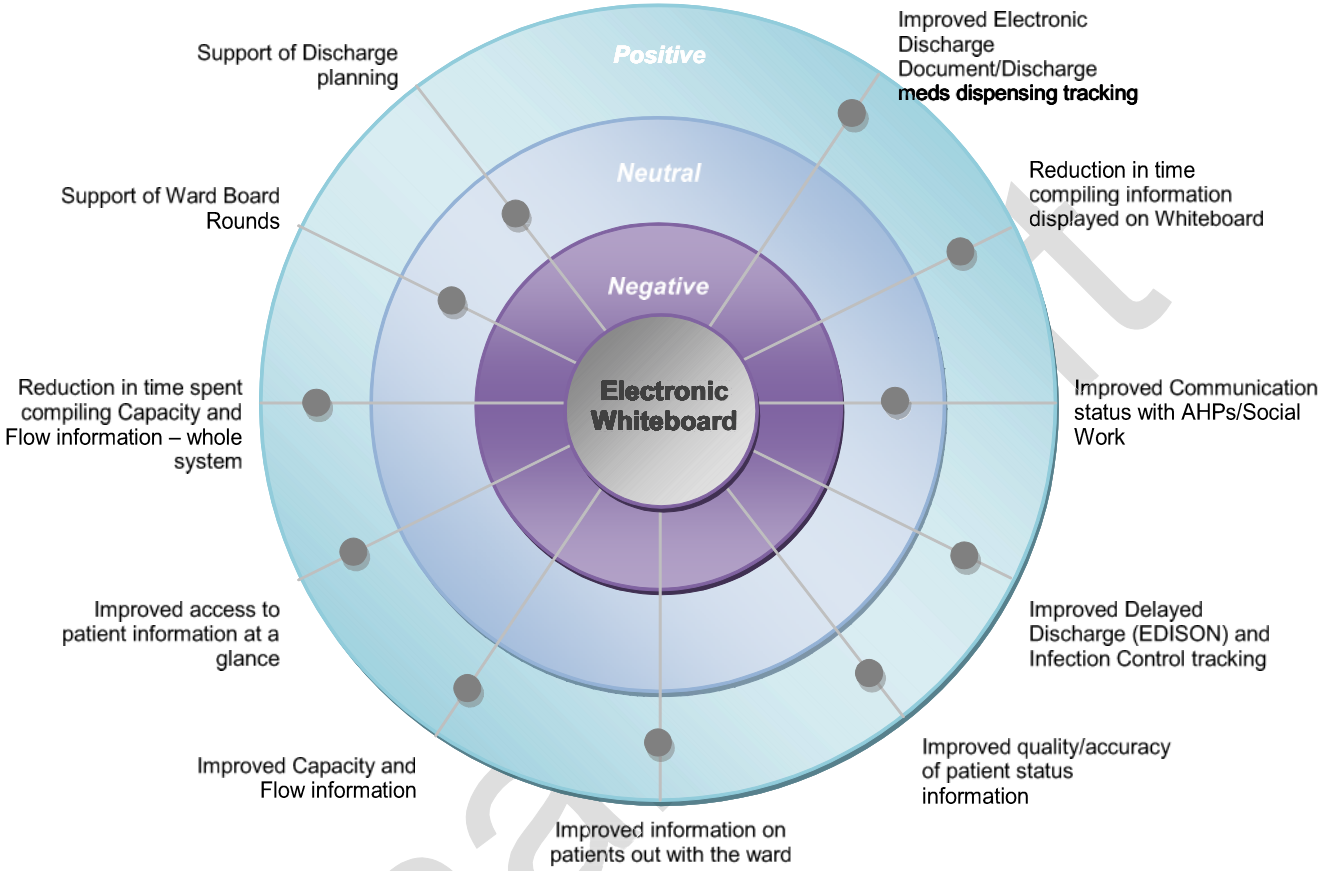


Figure 7: Benefits Plotting

The following table outlines the positive benefits from the diagram above and the agreed Return on Investment objectives that were developed:

Benefits Statement	ROI Level	ROI Objective
• Improved access to patient information at a glance • Electronic Discharge Document/Discharge medications dispensing tracking • Improved Delayed Discharge (EDISON) and Infection Control tracking	1	50% of ward staff report that the Electronic Whiteboard has improved the availability of patient status information at a glance on the ward at 1 month following the removal of the write on whiteboard
• Reduction in time compiling information displayed on whiteboard	3	1 hour a day time released within ward teams previously spent compiling/providing information displayed on whiteboard within 1 month of removing the write on whiteboard in the first four test of change wards

• Improved Capacity and Flow information	3	95% of ward discharges/transfers are entered in TOPAS realtime (within 15 mins) at 2 weeks following the implementation of the TOPAS integration
• Improved quality/accuracy of patients status information	3	100% of patients have all information on the eWhiteboard correct at 1 month following the removal of the write on whiteboard (within 15 mins of a change)
• Improved Capacity and Flow information	3	50% of Senior Charge Nurses/Heads of Nursing related to the test of change wards using electronic data as primary source of bed management information at 2 weeks following removal of the write on whiteboard
• Reduction in time spent compiling Capacity and Flow Information – whole system	4	*Cannot isolate Electronic Whiteboard project to being solely responsible for any improvement in quality of capacity and flow information due to improvement exercises being undertaken in conjunction/separately*
• Improved information on patients out with the ward	4	*Cannot isolate Electronic Whiteboard project to being solely responsible for any improvement to the risk to patients outwith the ward due to other influencing factors and improvement exercise being undertaken*

Appendix 5 – Return on Investment Objectives Data

8.3 Level 1: Engagement, Satisfaction, Reaction and Planned Actions Results

8.3.1 Objective 1 - 90% of ward staff see the benefit of the electronic whiteboard at 1 month following the removal of the write on whiteboard

To be measured following removal of the write on whiteboard. No baseline data required.

8.3.2 Objective 2 - 50% of ward staff report that the Electronic Whiteboard has improved the availability of patient status information at a glance on the ward at 1 month following the removal of the write on whiteboard

The following sections detail the baseline data for each ward where data has been gathered to date:

- ***Ward 5 (Medicine for the Elderly), Ninewells***

The following data was captured in relation to the write on whiteboard prior to the Electronic Whiteboard being switched on in Ward 5:

Question	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree	N/A	Q not asked
Easy to access info about boarding patients		5	1	2			
Easy to access info about EDD		2		1	3	2	
Easy to access info about AHP process stages	3	4		1			
Easy to access info about SW/Discharge Teams stages	1	1			1		5
Easy to identify info about consultant review				1	7		
Easy to access info about patient safety	1	2	1	2	2		
Easy to access info about compliance aid				2	3		3

- ***Ward 2 (Gastroenterology), Ninewells***

The following data was captured in relation to the write on whiteboard prior to the Electronic Whiteboard being switched on in Ward 2:

Question	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree
Easy to access info about boarding patients	1	2		6	2
Easy to access info about EDD		1		1	9
Easy to access info about AHP process stages		1	2	7	1

Easy to access info about SW/Discharge Teams stages				2	9
Easy to identify info about consultant review			1	2	8
Easy to access info about patient safety		1	2		8
Easy to access info about compliance aid		1	1	4	5

- ***Surgical Unit, Stracathro (Elective Day Surgery)***

Semi-structured interview is to be designed following agreement on the Surgical Ward View configuration. Baseline data is to be measured in relation to the write on whiteboard, prior to Electronic Whiteboard being switched on.

8.3.3 Objective 3 - 50% or more of Senior Charge Nurses and Heads of Nursing want the Electronic Whiteboard solution in their own ward at 2 weeks following the removal of the write on whiteboard

To be measured following removal of write-on whiteboard. No baseline required.

1383

8.4 Level 2 - Learning & Capacity-building Results

8.4.1 Objective 1 - 80% of ward staff understand the importance of having TOPAS up-to-date for the benefit of the patient at 1 month following the removal of the write on whiteboard

To be measured following removal of the write on whiteboard. No baseline required.

8.4.2 Objective 2 - 50% of ward staff know how to update TOPAS if patients details are incorrect at 2 weeks following the implementation of the TOPAS integration

To be measured following removal of the write on whiteboard. No baseline required.

8.4.3 Objective 3 - 80% of ward staff know how Ward View is updated when patient details change at 1 month following the removal of the write on whiteboard

To be measured following removal of the write on whiteboard. No baseline required.

1384

8.5 Level 3 – Application and Implementation Results

8.5.1 Objective 1 - 1 hour a day time released within ward teams previously spent compiling/providing information displayed on whiteboard within 1 month of removing the write on whiteboard in the first four test of change wards

The following sections detail the results corresponding to this objective, where data has been gathered to date:

- **Ward 5 (Medicine for the Elderly), Ninewells**

Due to the definition of the objective ongoing during the initial switch on of the Electronic Whiteboard it was not possible to obtain an accurate baseline of time spent updating details on the Board. Based on experience the following staff have saved the following time:

Staff	Task	Time saved per day
Senior Charge Nurse	Interrogating EDD against planned discharges and updating Write on Whiteboard with patients who require an electronic discharge to be completed. Chasing up status of discharge medicines from dispensary.	30 mins
Ward Clerk	Cross referencing admission books/ward with TOPAS and updating TOPAS to reflect current position statement	30 mins

- **Ward 2 (Gastroenterology), Ninewells**

The following table details the baseline (prior to Electronic Whiteboard switch on) average time spent for each activity that was identified within Ward 2 as contributing to this objective:

Activity	Staff	Avg time spent before eWB switched on (mins)	Avg time spent 1 month after write on removed (mins)	Total time difference (mins)
Bed position statement initial checks against TOPAS	Ward Clerk	19	To be measured after write on removed	
Updating TOPAS to reflect bed position statement	Ward Clerk	15	To be measured after write on removed	
EDD check (cross	Senior Charge	30	To be measured	

referencing planned discharges with status of discharge document)	Nurse/Charge Nurse		after write on removed	
			Total time saved	

- **Surgical Unit, Stracathro**

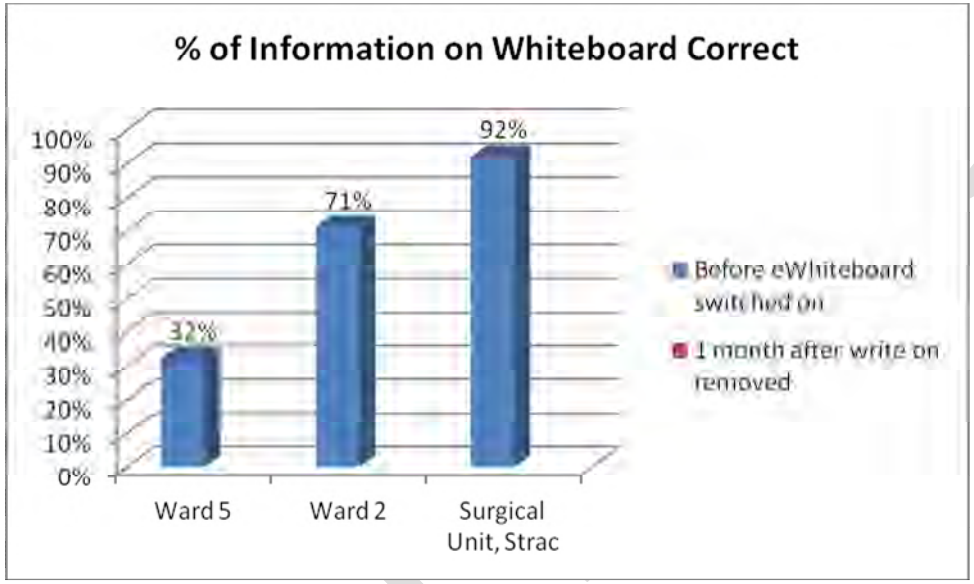
In the process of defining the measurement plan.

8.5.2 Objective 2 - 95% of ward discharges/transfers are entered in TOPAS realtime (within 15 minutes) at 2 weeks following the implementation of the TOPAS integration

Work is still in progress to define an appropriate reporting format for the baseline and subsequently measured data corresponding to this objective.

8.5.3 Objective 3 - 100% of patients have all information on the eWhiteboard correct at 1 month following the removal of the write on whiteboard (within 15 mins of a change)

The following chart details the results of spot checks on the test of change wards where data has been gathered to date:



1387

8.5.4 Objective 4 - 50% of Senior Charge Nurses/Heads of Nursing related to the test of change wards using electronic data as primary source of bed management information at 2 weeks following removal of the write on whiteboard

To be measured following removal of the write on whiteboard.

Appendix Two

Community Services

ANGUS	DUNDEE	PERTH & KINROSS
LEVEL 4	**LEVEL 4**	**LEVEL 4**
Cliffview Court - Supported Accommodation provided by Angus HSCP	Supported accommodation 8 block of flats run by 3rd sector for CMHT clients commissioned by local authority Carr Gomm Richmond Transform Seagate Gowrie Care – Martingale Gardens	Simpson Square
Chapel Bond- Supported Accommodation provided by Angus HSCP		CIC
		Scone Project-Supported Accommodation
LEVEL 3	**LEVEL 3**	**LEVEL 3**
Montrose/Brechin, Forfar/Kirriemuir and Arbroath/Carnoustie/Monifieth Community MH Teams	Wedderburn CMHT Alloway CMHT	North Perthshire CMHT, Perth City CMHT, South Perthshire CMHT
Substance Misuse Team.	MAPS	Move Ahead Day Opportunities Team,
MAPS	Addiction services	Wellbeing Team
	Eating Disorder Services Tayside wide	Therapeutics/ECT Team,
	Tayside Adult Autism Consultancy Team	Substance Misuse Team
		MAPS.
LEVEL 2	**LEVEL 2**	**LEVEL 2**
Angus Adult Psychological Therapies Service.	Psychological Therapies Service	P&K Adult Psychological Therapies Service.
Contract with Penumbra to provide Employment, Education and Leisure.	Dundee Independent Advocacy Support Partners in Advocacy	Perth Independent Advocacy
LEVEL 1	**LEVEL 1**	**LEVEL 1**
Tayside Carer Support,	DAMH Outcome focussed interventions for Dundee citizens. Funding from various sources.	Support in Mind/Tayside Carers support (Carers)
Angus Voice (Service user Group)	The Haven Main funding big lottery Budget	PLUS (Service user Group)
Insight Counselling	Art Angel	Mind Space Counselling.
Angus Independent Advocacy	SAMH outreach and carers respite budget	The Walled Garden.
PAMIS	Penumbra Enabling and Carers Support	PKAVS
	Drama-therapy	PAMIS
	Chrysalis gardening project run by SAMH	Minority Ethnic Communities
	Insight counselling	Tayside Forensic Voices
	Service User Network and Voluntary co-ordinator, DVA	PUSH
	Gowrie Outreach	
	Dundee Carers service	
	Turning Point	
	PAMIS	
Additional Info	**Additional Info**	**Additional Info**
Self Directed Support- Richmond, SAMH, Penumbra, Turning Point -	DAMH:- outcome focussed mental health interventions commissioned mainly by local authority. Some other external funding The Haven run by hearing voices network lottery funded Art Angel for people with mental health issues some statutory funding SAMH outreach service commissioned by local authority Penumbra Enabling service commissioned by local authority Drama-therapy commissioned by local authority Chrysalis gardening project run by SAMH some funding from health Insight counselling Service User Network drop in 2 times per week Penumbra carers support	Self Directed Support- Richmond, SAMH, Penumbra, Turning Point, The Bield. Choose Life Scottish Care
General services people with mental health services use for their mental health needs but not funded directly for this purpose - Angus Carers Voluntary Action Angus	Some supported accommodation no longer fit for purpose, but is being reviewed.	Crisis Response and Home Treatment (CRHTT) deliver in the community and also Learning Disability community and day treatments and Tayside Eating Disorder Services
ANGUS	DUNDEE	PERTH & KINROSS

LEVEL 4	LEVEL 4	LEVEL 4
Residential Care **The Gables – Local authority care home registered for 17 people** **Cairnie Lodge (HC-One) – 6 contracted beds** **Other Residential / Nursing home placements – 60 spot purchase agreements** **Supported Accommodation – contracted by block purchase** **Sense – Lentlands Court, Forfar** **Gowrie – Silverway, Montrose** **Doocot Park, Arbroath** **Lousen Park, Carnoustie** **River Street, Brechin** **River View, Brechin** **ARK – Burnside Drive, Arbroath** **Windmill Brae, Forfar** **RLO – Broomfield, Montrose** **Lilywynd, Forfar** **Turning Point – Walton Mill, Dundee**	White Top Day Support Service (PMLD) White Top Respite (PMLD) Weavers Burn – Care at Home/Housing Support Service (Complex needs/challenging behaviour) Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music) LD Clinical Psychologists Community LD Nurses LD Acute Liaison Nurse Weavers Burn Nursing Staff PMLD Nurse – White Top Centre Fleuchar St Respite – Sense Scotland Day Opportunities–Hillview–Sense Scotland Day Opportunities/Enabling–Sense Scotland Care at Home / Housing Support Services • Rose Lodge • Dudhope Villa • Westlands • Cornerstone • Turning Point Scotland • Scottish Autism • Sense Scotland	Residential Care The Grange Dalguise Court / Orchard Court Ericht View (Muirton House) Corbenic Upper Springlands (LD / PD) Supported Accommodation – contracted by block purchase Gowrie Burnside Court (4 people) An Cala (4 people) Airlie View (4 people) Milnabstreet(7 people) Ark Housing Ark Brae (9 people) and outreach Ark Blairgowrie Outreach (11) Turning Point Tulloch road (6 people) Springlands (4 people) Richmond St.Madoes (2 people &1 funded by Edinburgh)) Mungo Foundation (5 people) Sense (4 people) Autism Initiative Earn project (10 people)
LEVEL 3	LEVEL 3	
Adult Resource Centres – **Lilybank Forfar** **Rosehill Montrose** **Lochlands Arbroath** **Angus Integrated Community Learning Disability Teams –** **Inland & Coastal, Social Work, LD Nursing and AHPs**	Wellgate Day Support Service LD Care Management Team – Social Workers / Mental Health Officers/Social Care Workers Dundee Community Living - Care at Home/Housing Support Service Supported Living Team - Care at Home/Housing Support Service Weavers Burn – Care at Home / Housing Support Service Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music) LD Clinical Psychologists OT Employment Support Worker – Forensic bridge Community LD Nurses Weavers Burn Nursing Staff Hawkhill Nursing Staff PMLD Nurse – White Top Centre LD Nurse Seconded into LD Care Management Leisure & Recreation Team - including Autism specific post. Day Opportunities/ Enabling • City Quay– Capability Scotland • CLS/FSS - Capability Scotland • Cornerstone • The Inclusion Group • Jean Drummond Centre • North Lindsay St - Scottish Autism Care at Home / Housing Support Services • Carr Gomm – Rosefield Street • Cornerstone • Gowrie Care Care Home Placements	Adult Resource/Day Opportunity (PKC Gleneagles Blairgowrie Kinnoull Supported Living team PKC
LEVEL 2	LEVEL 2	
Community Opportunities Team –	Employment Support Service (generic	Employment and Further Education

Enablement, Health & Wellbeing and College Support **Care and Support –** **self directed support individual agreements provided by; Abbey care, Camphill, Care About Angus, Cornerstone, Enable, Margaret Blackwood,** **My Care, Quarriers, Real Life Options, Richmond, SAMH, Sue Ryder, Turning Point, Tus Nua, Voluntary Service Aberdeen**	Community Care service hosted within LD cost centre) Through Care and After Care Adult Placement (usually follows on from Foster Care) Community LD Nurses – Health Shop ,Sexual Health Clinics, Mental Health support, Parenting Network, Down`s Screening Clinics, LD Epilepsy Clinic, Links to GP Practices Leisure/ Recreation Team Specialist LD AHPs (Dundee only - OT, PT and Tayside wide SLT, Dietetics, Art, Music) • Student Support Service – Gowrie Care • Dundee Independent Advocacy Support • Advocating Together • Partners in Advocacy • PAMIS • Dundee & Angus College • Dundee REP Theatre • Tayberry Social Enterprise Organisation • Barnardos - transition caseload and Growing Up Project	Check In (Giraffe) Stepping Stones S.R.U.C. (Elmwood) Day Care Camphill Blair Drummond Camphill Newton Dee Camphill Village Trust Corbenic camphill Hayfield Individual packages Ashdene Avenue Care C-Change Cornerstone Elite Care (Scotland) Enable Gowrie Care Hansel Kibble education & Care Mears care Richmond fellowship RIGIFA Autism Initiative Scottish Autism Sense Scotland Judith and Tim Smith Turning Point Capability Scotland Care Services
LEVEL 1	LEVEL 1	
PAMIS – **Service level agreement to provide information & support to people with profound and multiple disability and their carers**	Assistance, training and guidance from any element of the specialist LD Health team can be provided on a case by case basis to assist universal services to provide care and intervention to LD Individuals.	Independence Advocacy PUSH social inclusion PAMIS advice and support
HOPE – **Service level agreement to Hospitalfield Organic Project Enterprise for horticultural training & work experience**		
Additional Info		
General services **Angus Carers** **Voluntary Action Angus** **Angus Independent Advocacy**		

DUNDEE INTEGRATED COMMUNITY LEARNING DISABILITY SERVICE –for TRANSFORMATIONAL CHANGE PROGRAMME

Arlene Mitchell, Locality Manager Dundee Health & Social Care Partnership. 4/4/17

Health Services

Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)
Community LD Nurses
Weavers Burn Nursing Staff
PMLD Nurse – White Top Centre
LD Acute Liaison Nurse

Area Wide In-Patient LD Services (including Nursing & AHPs)
- *LD Assessment Unit Carseview*
- *Behavioural Support & Intervention Unit and BSI Outreach Team*
- *Craigowl Unit*
- *Autism Unit*

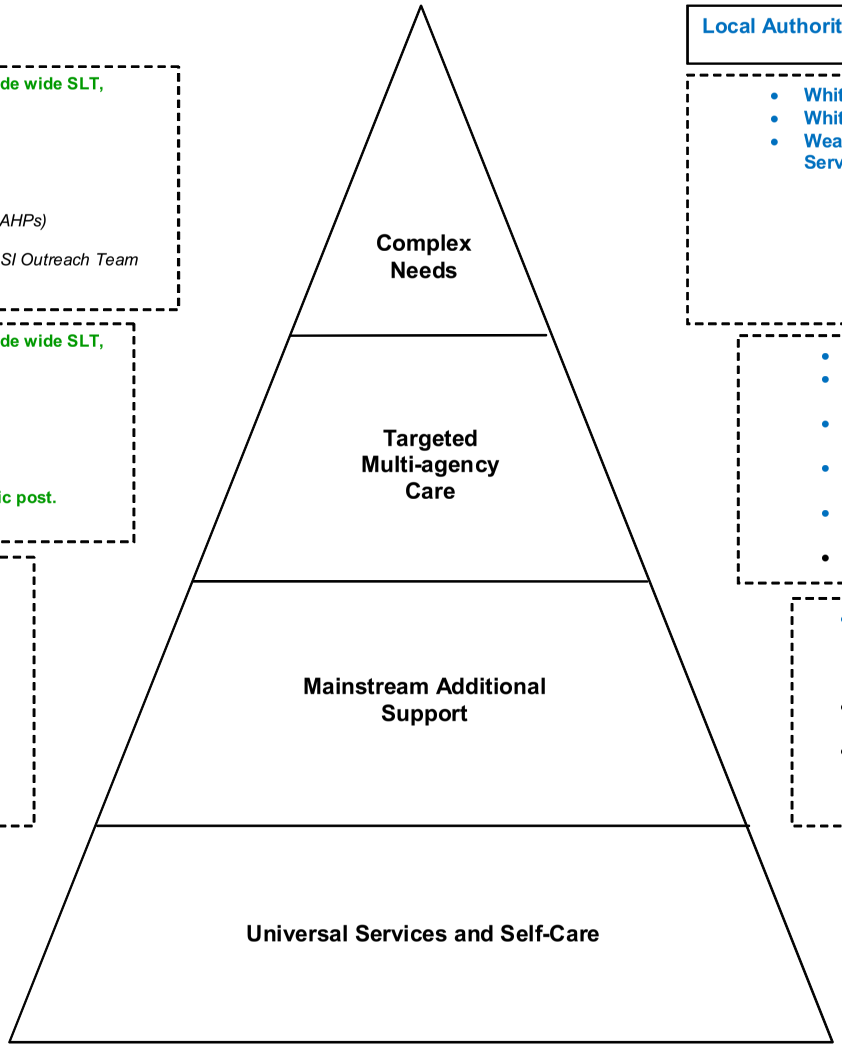
Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)
OT Employment Support Worker – Forensic bridge
Community LD Nurses
Weavers Burn Nursing Staff
Hawkhill Nursing Staff
PMLD Nurse – White Top Centre
LD Nurse Seconded into LD Care Management
Leisure/ Recreation Team - including Autism specific post.
LD Psychiatrists and Clinical Psychologists

Community LD Nurses – Health Shop
- Sexual Health Clinics
- Mental Health support
- Parenting Network
- Down`s Screening Clinics
- Links to GP Practices
Leisure & Recreation Team
Specialist LD AHPs (Dundee only OT, PT and Tayside wide SLT, Dietetics, Art, Music)

RNIB – Bridge to Vision Project
RNID
Epilepsy Specialist Nurse

Assistance from any element of the specialist LD Health team can be provided on a case by case basis to assist universal services to provide care and intervention to LD Individuals.

Public Health Initiatives



Local Authority Services

- **White Top Day Support Service (PMLD)**
- **White Top Respite (PMLD)**
- **Weavers Burn – Care at Home / Housing Support Service (Complex needs/ challenging behaviour)**

- **Wellgate Day Support Service**
- **SW Care Management Team (LD) – Social Workers/ Mental Health Officers /Social Care Workers**
- **Dundee Community Living - Care at Home/Housing Support Service**
- **Supported Living Team - Care at Home/Housing Support Service**
- **Weavers Burn – Care at Home / Housing Support Service**
- *Mental Health Officer Team*

- **Employment Support Service (generic Community Care service hosted within LD cost centre)**
- *Through Care and After Care*
- *Adult Placement (usually follows on from Foster Care)*

- *Community Alarm*
- *Leisure & Culture Services (including leisure centres, parks, community centres, libraries, theatres)*
- *Welfare Rights*

Procured Services (Voluntary/Independent Sector)

Fleuchar St Respite – Sense Scotland
Day Opportunities–Hillview–Sense Scotland
Day Opportunities/Enabling–Sense Scotland
Care at Home / Housing Support Services
- **Rose Lodge**
- **Dudhope Villa**
- **Westlands**
- **Cornerstone**
- **Turning Point Scotland**
- **Scottish Autism**
- **Sense Scotland**

Day Opportunities/ Enabling
- **Anton/Ogilvie– Capability Scotland**
- **CLS/FSS - Capability Scotland**
- **Cornerstone**
- **The Inclusion Group**
- **Jean Drummond Centre**
- **North Lindsay St - Scottish Autism**

Care at Home / Housing Support Services
- **Carr Gomm – Rosefield Street**
- **Cornerstone**
- **Gowrie Care**

Care Home Placements

- **Student Support Service – Gowrie Care**
- **Dundee Independent Advocacy Support**
- **Advocating Together**
- **Partners in Advocacy**
- **PAMIS**
- *Dundee & Angus College*
- *Dundee REP Theatre*
- *Tayberry Social Enterprise Organisation*
- *Barnardos - transition caseload - Growing Up Project*

TRANSITION

PATHWAYS

Additional Support Needs | Autism | Mental Health & Wellbeing | Complex Care & Anticipatory Planning | Challenging Behaviour including Forensic | Dementia | Palliative

Underpinned by Equitable Access to community based Health Promotion & Health Screening Initiatives

TRANSITION

KEY : areas in black *Italics* are either not `owned` by the Dundee LD Service but are accessed by LD service users **or** depict Co-Production Partner Agencies

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Appendix Three

Communication and Engagement Plan

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

COMMUNICATION AND ENGAGEMENT PLAN

Index

1. DESCRIPTION AND BACKGROUND OF PROJECT / SERVICE CHANGE

The Mental Health Service Redesign Transformation Programme formerly known as the Steps to Better Health Care Mental Health Improvement Programme commenced in 2013. Initial work established by the newly formed Mental Health Leadership team looked primarily at clinical pathways and areas to improve these and a review of the accommodation from where these services are currently provided to ensure that services are safe; of a high quality; meet clinical governance standards; are sustainable; and that all resources are being optimised and used as efficiently as possible.

The work of the programme progressed initially in two phases

Phase 1 of the Programme looked to address areas highlighted within General Adult Psychiatry (GAP) services of immediate clinical concern. Several work streams were established in 2013 to 2015 to progress the work of Phase 1. These work streams were –

Moredun Work stream – which reviewed the Moredun GAP acute admission ward at Murray Royal Hospital environment, workforce and service model. This work stream progressed the required refurbishment of the Moredun ward at Murray Royal to split the environment into two separate male/female areas and reduce the size of the ward from 30 beds to 24 beds. This refurbishment addressed concerns re size and safety of large ward environment and allowed separation of patients in the ward. Workforce shift patterns, workforce plans and working patterns were also reviewed and consistent approach applied and a revised service model was updated and agreed.

Rehabilitation Workstream - which implemented changes to environments in Rannoch, Kinclaven and Amulree wards at Murray Royal Hospital to increase capacity for GAP rehabilitation, improved environments and provided a dedicated ward with an increase in beds for female patients with complex needs

Property Workstream – which looked at all Mental health accommodation and supported the relocation of day services for Learning Disabilities from Birch Avenue to brand new day hospital accommodation at Murray Royal.

Phase 1 has also included a review of clinical pathways across GAP and Learning Disabilities, the initial implementation of Tayside wide Crisis Response and Home Treatment teams and assisted workforce planning for the opening of the third medium secure ward at Rohallion

Secure Care Clinic at Murray Royal.

Phase 2 of the Programme began in 2014 and initially commenced with a review of our Intensive Psychiatric Care Unit (IPCU) pathways which quickly highlighted a requirement to undertake a wider review of all Mental Health Services pathways across Tayside to look at the clinical models of how we deliver care and the current facilities from where we deliver that care.

Work commenced in 2014 through a series of workshops undertaken with Capita (external Health Care Planners appointed to support process) which looked at reviewing a wide range of options for future GAP and Learning Disability services identified by key clinical stakeholders. As this initial work was part of a proposed HUB initiative the option appraisal work progressed with Capita also included review of Psychiatry of Old Age, Medicine for Elderly and Centre for Brain Injury services in Dundee only.

Initial scoping work was presented to NHS Tayside Board in March and highlighted significant concerns with maintaining current GAP services across three sites in Tayside. NHS Tayside Board agreed in March 2016 that future GAP acute admissions services could no longer be sustained from three sites and the Programme should undertake a further review of options providing GAP acute admissions from either two sites or from a single site.

During 2014/2015 work progressed around the current IPCU service pathway review and improvements have been made to service delivery, enhanced environment (now able to accept female admissions previously sent outwith Tayside) and has improved patient experience, lengths of stay and function of IPCU

2. AIM / PURPOSE OF ENGAGEMENT

The aim of the programme is ensure as wide engagement as possible with all stakeholders identified below to assist and inform the review of current service models, planning of future service models, workforce requirements and a review of accommodation from where services are to be provided.

3. PROJECT / SERVICE LEAD

Executive Lead – Neil Prentice
Operational Lead – Robert Packham
Programme Lead – Lynne Hamilton

4. TIMETABLE

- **PROJECT**
- **ENGAGEMENT / CONSULTATION**

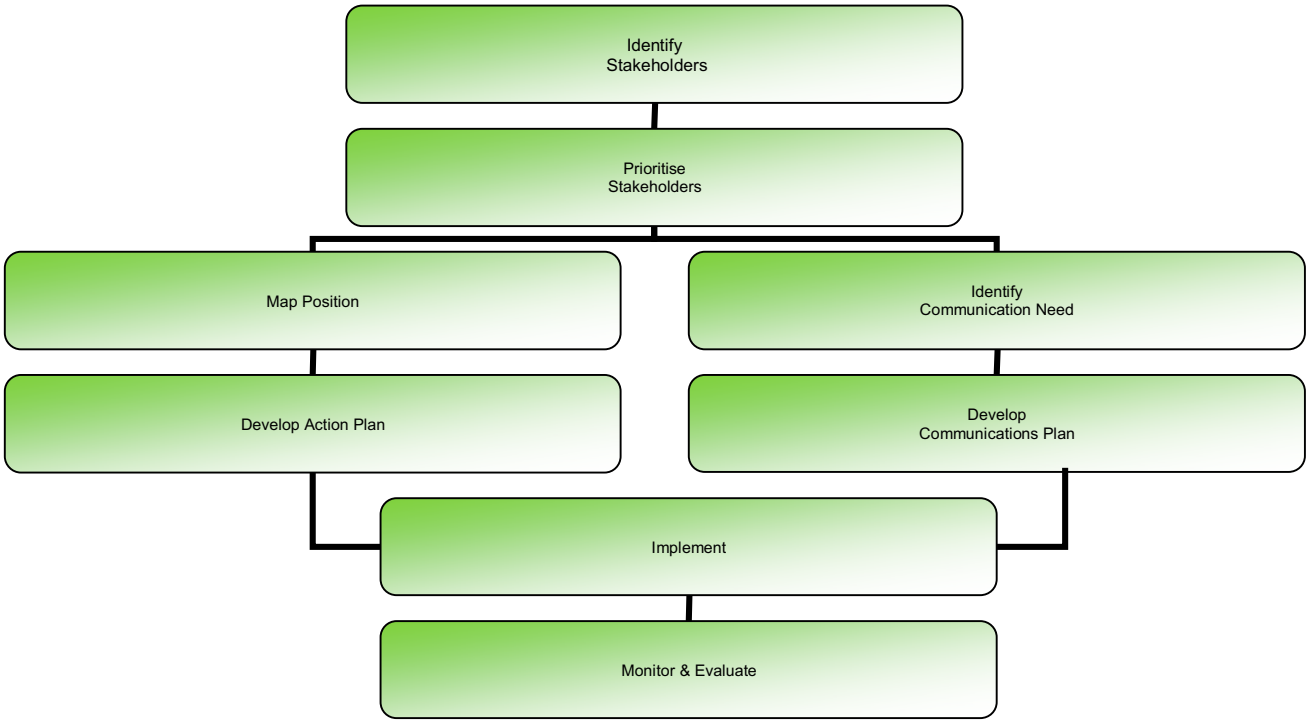
Programme– Draft Outline Programme

Task	Date
Capita Report received	July 2015
Complete financial option appraisal	August/ September 2015
Presentation of Capita work and option appraisal to stakeholders involved in original workshops	October 2015
Option appraisal paper presented to NHST Board for information to inform of progress with programme and wider engagement of service options	October 2015
Commence wider engagement regarding options	January to March 16
Paper presented to NHS Tayside for consideration of proposed service models	March 2016
Paper presented to NHS Tayside Board for approval of proposed engagement and Option Appraisal Process to be followed	April 2016
Option Appraisal Training session – Kings Cross	June 2016
Option Appraisal Workshops – Invercarse and The Steeple, Dundee	June 2016
Option Appraisal Paper presented to NHS Tayside Transformation Board, NHS Tayside Board, IJBS, ACF,CCGC, APF	August 2016
Option Modelling event – General Adult Psychiatry – Improvement Academy Ninewells	September 2016
Option Modelling event – Learning Disabilities – Improvement Academy, Ninewells	December 2016

Option review report submitted for approval	February 2017
Consultation plan presented to Boards for approval	March 2017
Formal Consultation Period on Preferred Option with all stakeholders	April to July 2017
Initial Agreement Report submitted for approval	August/Sept 2017
Outline Business Case submitted for approval	Nov/Dec 2017
Detailed design work /wider engagement	August 2017 to December 2017
Financial Close	January 2017
Construction commence	January 2018
Full Business Case submitted for approval	February 2018
Construction complete (assumes 18mth Build/Decant - to be reviewed)	July 2019

Throughout the development of the programme there will be various key stages where engagement/ consultation will take place in line with the above programme.

5. ENGAGEMENT PLAN



6. METHODS OF ENGAGEMENT TO DATE (OUTLINED IN DETAIL IN SECTION 8 & 9)

- Focus Groups
- Workshops
- Reference Forums for users/carers/voluntary organisations
- Staff sessions in each locality
- Briefing sessions for staff
- Information sharing events
- SBAR reports and briefings
- Presentations to various groups/meetings/committees
- Newsletters
- Media releases
- Steps to Better Healthcare Staffnet site
- Steps to Better Healthcare Display
- Steps to Better Healthcare Road shows and events
- SPECTRA
- Website for Programme

7. STAKEHOLDER IDENTIFICATION BY PROGRAMME TEAM AND THROUGH PARTNERSHIP WORKING WITH INTEGRATED JOINT BOARDS

STAKEHOLDERS

- Current General Adult Psychiatry, Forensic and Learning Disability inpatients
- Past patients/ service users of General Adult Psychiatry, Forensic and Learning Disabilities that are now living in the community that currently attend outpatient appointments/ day services.
- Past patients/ service users of General Adult Psychiatry, Forensic and Learning Disabilities that are now living in the community who attend third sector organisations
- Relatives
- Carers
- Current General Adult Psychiatry, Forensic and Learning Disability inpatient staff (NHS Tayside) – Senior and Junior Medical staff, Service Management, Nurses, Clinical Psychologists, Occupational Therapists, Physiotherapists, Speech & Language Therapists, Dieticians, Pharmacist, Art therapist, Administration and Clerical Staff and support staff/FM contract staff.
- Local Authority (Angus, Dundee and Perth & Kinross) – Service managers and Social Work Leads

- Community Mental Health Teams
- Community Learning Disability Teams
- Community Forensic Teams
- Crisis Response and Home Treatment Teams
- Learning Disability Day service staff
- Forensic Day service staff
- Community Mental Health Allied Health Professionals
- Community Learning Disability Allied Health Professionals
- Ancillary staff
- General public
- Steps to Better Healthcare (SBH) Project Team/Board, Executive Leads and Project Leads
- Neighbouring NHST services/ staff on any proposed site
- Other services - Psychiatry of Old Age, centre for Brain Injury and Medicine for the Elderly services
- Scottish Health Council
- NHST Transformation Programme Board and Perth & Kinross IJB Transformation Board
- Voluntary organisations such as:

  - Hearing Voices
  - Angus In Advocacy
  - PAMH
  - Dundee Outreach and Carers Service
  - Penumbra
  - Advocating Together
  - Forensic Voices
  - Richmond Fellowship
  - Art Angel
  - Nova Service
  - Dundee Voluntary Action
  - SAMH
  - Support in Mind
  - Voluntary Action Angus
  - Forensic Voices
  - DAMH
  - Hot Chocolate
  - Carr Gomm
  - Angus Voice
  - Mindspace
  - PLUS Perth
  - PKAVS
  - PAMIS
  - PLUS Perth
  - MEAD project Perth

- Local politicians/MSPs
- Scottish Government and Scottish Futures Trust

- Neighbouring properties located in close proximity to site (once a site has been identified)
- Bell rock (SPV for Carseview)
- Taycare (SPV for Murray Royal and Stracathro)
- Steps to Better Healthcare Ambassadors & Champions
- GPs and GP Sub Committee
- Media Partners
- Partner Agencies – i.e Police, Fire Brigade, Scottish Ambulance Services etc
- Joint Clinical Improvement Board for Mental Health
- Area Partnership Forum
- Integration Joint Boards

8. EARLY RELEVANT ENGAGEMENT ACTIVITY

DETAILS OF ANY EARLIER RELATED ENGAGEMENT/CONSULTATION ACTIVITY

The original SBH MHI Programme began in June 2013 following appointment of the Programme Director. However, an earlier review of Mental Health services commenced in 2001/02, and work progressed under the Tayside Adult Mental Health Review Programme until approval of an Outline Business Case in 2005/06. The Adult Mental Health Review programme identified a five year plan for future service model delivery and the accommodation required to support it. The Programme included a significant amount of consultation work which was undertaken across Tayside and assisted in the delivery of the new builds at Murray Royal and Susan Carnegie Unit, at Stracathro, which were completed in 2011/12. Amendments required to the Carseview site were part of the original Outline Business Case in 2005/06; however, these were subsequently delayed when the PFI contractor for the site went into administration. Further engagement/ consultation work has taken place with new site owners regarding alternative refurbishment options for Carseview however a further review of service models was required and refurbishment project was placed on hold.

In 2013 the SBH Mental Health Improvement Programme commenced a further review of service model options which will include a review of utilisation of Carseview site and any refurbishment/extension work which may be required.

The original Adult Mental Health Review Engagement and Consultation work undertaken was as shown below -

Date	Service	Activity
21 October 2003	GAP	Dundee City Council – Presentation
16 September 2003	GAP	Dundee Carers, Carseview, Dundee
25 September 2003	GAP	Staff Consultation, Carseview, Dundee

14 October 2003	GAP	Staff Consultation, Carseview, Dundee
1 September 2003	GAP	Staff Consultation Event, Carseview, Dundee
21 October 2003	GAP	Dundee City Council – Presentation
31 October 2003	GAP	Little Wing, Users Group, Dundee
4 November 2003	GAP	Locality Focus Group, Dundee
26 November 2003	GAP	Dundee Carers
4 December 2003	GAP	Benefit Criteria Event, Carseview
12 December 2003	GAP	Consultation Event, West Park Centre, Dundee
January 2004	GAP	Two Open Meetings with Staff
20 January 2004	GAP	Benefit Criteria Event, West Park Centre
May – September 2004	GAP	AMHSR Report sent to various stakeholders (list available)
May 2005	SCC	Information Briefing Number 1 issued
31 July 2006	GAP/POA/SCC	Approved Outline Business Cases sent to: Angus Council and Main Library Dundee City Council and Main Library Perth and Kinross Council and Main Library Scottish Health Council SEHD Main Library NHS Tayside Staff Partnership Representative Grampian NHS Board office Highland NHS Board office Orkney NHS Board office Shetland NHS Board office Tayside NHS Board office
9 January 2007	GAP/POA/SCC	Tayside Area Partnership Forum
15 January 2007	GAP/POA/SCC	Tayside Carers Support Group Briefing
22 January 2007	GAP/POA/SCC	Scottish Health Council
7 May 2007	GAP/POA/SCC	Meeting with NHST Partnership Representatives

9. STEPS TO BETTER HEALTHCARE PROGRAMME / MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME – RECORDED ENGAGEMENT ACTIVITY

Ongoing - from June 2013	Face to Face meeting – Monthly Programme Team meetings
Ongoing – from June 2013	Face to Face meetings – Six weekly Programme Board meetings
Ongoing – from November 2013	Monthly face to face Communication and Engagement Group Meetings – Board Secretary, Public Involvement Manager, Diversity & Inclusion Manager, Communications Manager, Staffside and programme representatives in attendance.
Ongoing from – July 2013	Face to face meetings – monthly Work stream meetings held for – Phase 1 – Moredun, Rehabilitation, Property, TSMS/Rannoch
22 August 2013	Initial SBH MHI Programme paper presented to NHST Board to request move forward to engagement on Phase 1 work and plan Phase 2.
4 September 2013 and as and when required	Face-to-Face meetings – Presentation of Phase 1 of programme to Area Partnership Forum. Updates to Area Partnership Forum
11 September 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
31 October 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Murray Royal Hospital, Perth
13 November 2013	SBH MHIP Presentation slides and question/answer session undertaken with SBH Ambassadors and Champions. Positive Feedback received
November 2013	Communications and Engagement plan developed
November 2013 to present	Provision of monthly, bi monthly and adhoc update papers requested for SBH PET and SBH Board
November 2013	Branding developed
14 November 2013	SBH Ambassadors/ Champions workshop – Presentation giving overview of programme
11 December 2013	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Ninewells Ian Lowe Centre
December 2013 to present	Impact Assessments – Ongoing – Phase 1 Moredun Impact Assessment completed Phase 2 in progress
December 2013	Staffnet – Staffnet micro site to be developed – Part of SBH website

December 2013	Vital Signs, Staffnet, inbox – General information about Mental Health Improvement Programme to all staff
December 2013	Newsletter – 1st Moredun Newsletter circulated to all staff and users/carers re Phase 1 works
January 2014	Spectra - Article on MHIP and MH Leadership team
January 2014	4pp A5 booklet developed Information booklet developed for patients and their families and carers to share information about the Mental Health Improvement Programme re Moredun Phase One improvements
4 February 2014	Face to face meeting – Paper presented to NHST Endowment Committee to request progress of Phase 1 Moredun environmental changes.
February 2014	Newsletter – 2nd Moredun ward update newsletter released to all staff and patients/carers
February 2014	Newsletter – 1st MHIP newsletter giving overview of Programme and MH Leadership Team
6 March 2014	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
12 March 2014	Presentation of MHIP Programme update to Staff side Area Partnership Forum.
16 April 2014	Presentation of MHIP Programme update to SBH PET (Programme Executive Team)
15 May 2014	Face-to-Face meeting – Reference Group meeting held with key Stakeholders, Carers, Service Users/Representatives
6 June 2014	Presentation of Programme Poster and attendance at SBH Roadshow event to staff at Susan Carnegie Clinic
May to August 2014	Face to face meetings – Series of work shops run by Capita with key stakeholders from Mental Health, LD, POA, MfE and CBIR present to undertake review of current service models, look at future model requirements and then agree criteria and conduction option appraisals – work ceased in August due to early maternity leave of Programme Director
Jan to March 2015	Face to face meetings – Work shops with Capita restarted under James Henderson SBH Programme Director and completed work with Capita to review criteria and consider options. Option appraisals undertaken with key staff present from each service.
July 2015 and ongoing quarterly meetings	Face to Face meetings – Provision of SBH MHIP progress update to Mental Health and Learning Disability Joint Clinical Improvement Board (JCIB)
August 2015	Face to Face meetings – Provision of Patient Benefits report to SBH PET and SBH Programme Board.

Commenced August 2015 to present	Face to face meetings – Work Streams – Phase 2 – Learning Disability
24 September 2015	Face to face meeting – Presentation of SBH MHIP Programme update by Karen Ozden to NHS Tayside Board Development event.
30 September 2015	Completion of SBH Programme Health check for SBH Programme Board
30 September 2015	Updates for staff via SBH Newsletter updating progress of programme
30 October 2015	Paper presented to NHST Board to update on programme and request approval to progress to engagement of options considered
25 November 2015	Face-to-Face meetings – Presentation of Phase 2 of programme to Area Partnership Forum. Updates to Area Partnership Forum
9 December 2015	SBH Roadshow
12 January 2016	Face to face – 3 x Staff engagement sessions at Stracathro (10am, 2pm and 8pm)
13 January 2016	Face to face – 3 x Staff engagement sessions at Carseview (10am, 2pm and 8pm)
14 January 2016	Face to face – 3 x Staff engagement sessions at Strathmartine (10am, 2pm and 8pm)
20 January 2016	Face to face – 3 x Staff engagement sessions at Rohallion Unit at Murray Royal Hospital (10am, 2pm and 8pm)
26 January 2016	Face-to-Face meetings – Presentation and update of programme provided to Area Partnership Forum meeting
28 January 2016	Face to face – Users and carers reference forum – Kings Cross Hospital (40 invited)
11 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Stracathro (10am and 2pm)
12 February 2016	Questions and Answers information pack distributed to Angus Reference Forum in advance of meeting.
15 February 2016	Face to face – 2nd Users and carers reference forum for Angus users/carers/vol orgs – held Stracathro (42 invited)
15 February 2016	SBAR Paper presented to GP Sub- Committee to provide update on programme for discussion and to request feedback regarding options
17 February	Face to face – 2nd events for Staff engagement – 2 x sessions at

2016	Rohallion Unit, Murray Royal (10am and 2pm)
19th February 2016	SBAR paper and presentation slides circulated to Local Authority representatives in each locality for General Adult Psychiatry, Learning Disabilities and Forensic services to request feedback regarding options being considered and to note any potential impact on services.
19th February 2016	SBAR paper and presentation slides circulated to Police and Scottish Ambulance Service representatives to request feedback regarding options being considered and to note any potential impact on services
22nd February 2016	Update report provided to Mental Health Leadership Team re Programme Progress and feedback re engagement undertaken to date.
23rd February 2016	Face to face – Presentation and update provided to Mental Health Joint Clinical Improvement Board to request feedback
24 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Strathmartine (10am and 2pm)
25 February 2016	Face to face – 2nd events for Staff engagement – 2 x sessions at Carseview (10am and 2pm)
26 February 2016	Face to face – 3rd Users and Carers reference forum for Learning Disability/Forensic user/carers and vol organisations at Strathmartine
1 March 2016	Letter of concern received from Angus resident. Prof J Connell responded 21 April 16
10 March 2016	Paper presented to NHST Board to update on programme, consider options and approve way forward.
15 March 2016	Face to Face – 4th Reference Forum for Forensic service – meeting arranged with Forensic Voices – preliminary discussions undertaken
24 March 2016	Letter of complaint received via A Angus from Jenny Laird. Response sent offering to meet face to face. . Meeting held 27 April 16
24 March 2016	Letter of complaint received from Angus Voice. Response sent 26 March from CE offering to meet. Meeting held 27 April 16
24 March 2016	Letter of complaint received from Angus Independent Advocacy. E-mail response sent 25 March 16 offering to meet to discuss. Meeting held 27 April 16
25 March 2016	Complaint received via The Courier to Comms Team. Response provided by Comms Team 25 March 16
5 April 2016	E-mail received via N Fraser from J Megoran SG re Angus Council Concerns. Dr K Ozden responded 22 April 2016 following discussion with Chief Executive/Chairman
12 April 2016	Facilitated session to agree way forward for Communication and Engagement

21 April 2016	Update report provided to NHS Tayside Board re communication and engagement plans to take programme forward
22 April 2016	Staff Bulletin circulated re outcome of Board meeting and impact on staff
26 April 2016	Face to Face with Perth & Kinross Chief Finance Officer to update on programme and discuss finance
27 April 2016	Face to Face – Angus Voice – Jenny Laird, Dennis Roark, Callum Whitelaw to discuss Mulberry Ward and GAP
27 April 2016	Face to Face – Angus Independent Advocacy – Suzanne Swinton plus 2 Directors to discuss programme consultation process.
28 April 2016	Face to Face – Friends of Stracathro reps. Meeting rearranged. Due to take place 5th May 16
29 April 2016	Letter of concern received from Angus Presbytery. Dr Karen Ozden responded May 16
5 May 2016	Face to Face – Meeting with Friends of Stracathro to discuss position re Mulberry Unit and GAP
25 May 2016	Letter received from Penumbra re OA events. Invitation to OA Events /training sent on 24 May 16
31 May 2016	Update on current position provided in response to e-mail received 24 May 2016 from Minister for Health re engagement process
9 June 2016	Telecon with Pennie Taylor Independent facilitator for OA events
10 June 2016	Face to face – Meeting with Perth & Kinross Chief Officer to discuss programme for OA/Scoring events
16 June 2016	Face to face – Option Appraisal training event – Kings Cross – facilitated by SHC and Tracey Williams (35 in attendance)
16 June 2016	Face to Face – Tayside Advocacy Forum to discuss ongoing work within MH Programme
17 June 2016	Face to Face – MSP Briefing –Overview provided of ongoing work within MH Improvement Programme
18 June 2016	Telecon – Susan Scott PLUS Perth re OA and Scoring process
20 June 2016	Option Appraisal workshop held at Invercarse Hotel, Dundee– Long list to Short list of options agreed (88 stakeholders attended of 110 confirmed)
29 June 2016	Face to Face – Susan Scott PLUS Perth to discuss OA – meeting held with Susan and two other colleagues from PLUS. Subsequent e-mail received to give apologies for event and further email to be sent to R Packham copied to L Hamilton explaining reasons for not participating in OA
30 June 2016	Option Appraisal workshop held at The Steeple, Dundee – Benefit Criteria agreed, ranked and weighted. Options scored against criteria and four top scoring options agreed (84 stakeholders attended of 105 confirmed) 74 attendees participated in scoring exercise

10 July 2016	Dr K Ozden provided update to Minister for Health following request for further information.
1 August 2016	Meeting with APF leads regarding outstanding action from previous APF requiring update
2 August 2016	Presentation of Draft Option Appraisal report to NHST pre Agenda Meeting.
4 August 2016	Communications and Engagement group met with Yvonne Summers regarding communication and engagement to date, advice regarding consultation, SCIM guidance re papers and associated timeframe
5 August 2016	Face to face with POA Manager to provide update on progress of programme
12 August 2016	Response to Press enquiry – Brechin Advertiser re Option Appraisal events
17 August 2016	Face to Face – Presentation of Option Appraisal update to staff side APF meeting
24 August 2016	Option Appraisal Report provided to NHS Tayside Transformation Programme Board
24 August 2016	Option Appraisal Report provided to Perth & Kinross Transformation Programme Board
25 August 2016	Option Appraisal Report provided to NHS Tayside Board
26 August 2016	Programme Bulletin circulated to all Stakeholders to update re outcome of Board meeting
26 August 2016	Option Appraisal Report and update provided to Perth & Kinross IJB re outcome of NHST Board meeting
30 August 2016	Option Appraisal Report and update provided to Dundee IJB re outcome of NHST Board meeting
31 August 2016	Option Appraisal Report and update provided to Angus IJB re outcome of NHST Board meeting
2 September 2016	Face to Face – Scottish Health Council –Overview provided of ongoing work within Programme
21 September 2016	Face to face – Option Appraisal Report and update provided to APF meeting
29 September 2016	Facilitated stakeholder GAP Option Modelling event held in Improvement Academy, Ninewells. (61 invited 55 attended)This information has now been used to produce the Option Review report which will propose a preferred option to go out to formal consultation.
27 October 2016	Update provided to NHS Tayside re revised timeline
4 November 2016	Update provided to Perth & Kinross Transformation Programme Board re revised timeline

8 November 2016	Face to face – Ann Gourlay /Maureen Summers Service User and Carer representatives P&K IJB to provide background and update re programme
18 November 2016	Progress update provided for MSP Briefing meeting
23 November 2016	Face to Face - Update provided to APF meeting
25 November 2016	Face to Face – Cabinet Secretary/Yvonne Summers visit to Carseview – Update provided re Programme background and progress
7 December 2016	Face to face - Update provided to Capital Scrutiny Group re timelines and progress
8 December 2016	Facilitated stakeholder Learning Disability Option Modelling event held in Improvement Academy, Ninewells (44 invited 29 attended). This information has now been used to produce the Option Review report which will propose a preferred option to go out to formal consultation.
12 December 2016	Face to Face – Meeting arranged with representatives from Perth & Kinross 3rd sector and voluntary organisations (Mindspace offices) to provide background, progress of Programme, highlight next steps and request their input into planning consultation process.
15 December 2016	Information provided to P&K service users and carers (PKAVS) regarding the Mental Health Service Redesign Transformation Programme work to date.
16 December 2016	Programme bulletin circulated to all stakeholders re revised timeline, progress update and next steps
17 January 2017	Meeting with P&K service users and carers (organised with PKAVS) to provide background, update and next steps. Press present
23 January 2017	Feedback received for P&K Public Partners meeting held on 17th January 17
23 January 2017	E-mail received from Support in Mind Carers Service with collated feedback and responses from Perth & Kinross Carers
23 January 2017	Media enquiry received re Adult Acute Admission Beds in Murray Royal Hospital.
24 January 2017	E-mail received from Positive Steps seeking further information regarding bed numbers in options being considered.
25 January 2017	E-mail received from Claire Forbes Support in Mind Carers Service with responses/feedback
26 January 2017	Email sent in response to Positive Steps e-mail of 24 January 17 providing further info. Thank you e-mail received from Positive Steps requesting any further information as it becomes available.

27 January 2017	Meeting with Yvonne Summers Scottish Government re draft Option review report and advice regarding consultation planning.
6th February 2017	Angus Public Event – City Hall Montrose
16th February 2017	Angus Public Event – YMCA, Montrose
24 April 2017	Angus press enquiry re delay in decision on the future of Mulberry Unit
25 April 2017	Response to Angus press enquiry sent
24 April 2017	Dundee Press enquiry re funding for mental health provision
24 April 2017	Response to Dundee Press enquiry sent
22 May 2017	Visit to Mental Health Services by Professor Sir Lewis Ritchie (GAP, POA, Rohallion atMRH, Carseview, CRHTT,CAMHS, Strathmartine) Background Information re Programme provided.

Attached Appendix provides all comment and option/feedback gathered to date

MENTAL HEALTH SERVICE REDESIGN TRANSFORMATION PROGRAMME

Engagement Feedback

Engagement Event	Attendees
1st Angus event	18
2nd Angus Event	12
1st Carseview event	24
2nd Carseview Event	12
1st Strathmartine event	36
2nd Strathmartine Event	28
1st Rohallion event	40
2nd Rohallion	8
Tayside Reference Forum	12
Angus Reference Forum	44
Learning Disability Reference Forum	29
Area Partnership Forum	32
General Practice Sub- Committee	
Police	1
Ambulance	2
Local Authority	6
Option Appraisal Training event 16th June 16	35
Option Appraisal Workshop 20th June 16	88
Option Appraisal Workshop 30th June 16	84
PLUS Perth	3
Advocacy Services	7
Staff Side APF	12
TOTAL	533

Engagement Feedback Section Index

25 January 17

1.25 E-mail from Positive Steps request information re options and response sent.

1.26 Angus press enquiry re delay in decision on the future of Mulberry Unit

1.27 Dundee press enquiry re mental health provision

1.1 COLLECTIVE FEEDBACK FORM RESPONSES

Main themes from feedback forms received.

1. Enough information was presented
2. Background to programme was understood
3. Opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Understood next steps

Comments from feedback forms received

1. Felt decision had already been made/lack of evidence
2. More information on costs/info that decision made are based on quality of care/more info to take away
3. Not enough time to process information given
4. Would have liked more information about POA.
5. What models would be used for CMHT/CRISIS Teams if went to 2 sites.
6. Sessions should have been done by end of 2015 this suggest that decision is already made.
7. Model of CMHT in relation to Integration.
8. Very informative.
9. This is the first introduction to SBH - not involved in consultation process.
10. Wasn't aware enough - didn’t know about this until today.

1.2 FEEDBACK FROM ANGUS STAFF EVENT – 12TH JANUARY 2016 -

18 Attendees

Comments/Questions noted on day

1. Impact on other services - POA services/Medical rotas/ECT
2. Low morale/rumours/impact on recruitment & retention/de-stabilise current services/risks around continuation of services
3. Will the accommodation proposed be of similar standard?
4. Need for robust timeline to reassure staff
5. Quality of care in Angus be recognised
6. Advanced Nurse Practitioner roles – could we consider?
7. Knock on effect to community – how will be mapped out
8. Travel for staff (other side of Dundee)? Accommodation for staff?
9. Review medical role – demand /capacity/ what should be priority?
10. Need to be realistic /open and honest re what we can do
11. Shifting values – Prevention rather than reaction.
12. Triage of patients at OOHs before secondary care

FEEDBACK FROM 2ND STAFF EVENT IN ANGUS – 11TH FEBRUARY 2016

12 Attendees

Comments/Questions noted on day

1. Equity of service – having to travel 30 miles at night.
2. OOH Services
3. Feeling of centralisation
4. Can't get into current service so many will be the same and can't get into beds when service is transferred.
5. Knock effect of other services in Angus – Brechin/Montrose/OOH
6. Difficult to feel valued because of what happened with OOHs and the way it was handled.
7. Communication and engagement timing too late.
8. 18 months of rumours in the community

9. Low staff morale
10. No input/influence
11. In 2 years 75% of staff will walk
12. Knock on effect on stability/staff morale
13. Has Ninewells and PRI been considered as alternative site?
14. Oil workers – re-training
15. Critical mass – what does that mean? – Contradicts equity of service
16. What is/was the psychology input to relocating beds?
17. How many patients are detained under the MH Act?
18. Availability of beds versus reduction in beds in a crisis situation
19. Stress re waiting for transfer.
20. What was the feedback/concerns from users/carers/patients
21. Mulberry ward is dangerous as no male staff on at night.
22. % of population nearer to Dundee
23. Isolated population have further to travel.
24. What will the impact be on recovery process by being further away.
25. How secure is Carseview
26. Will there be more cross cover on larger sites.
27. Impact on wider recruitment

COLLECTIVE FEEDBACK RESPONSE RECEIVED FROM MULBERRY STAFF AT SUSAN CARNEGIE IN ANGUS

Many of the staff did not have an opportunity to attend the staff consultation sessions so as a group of staff we have complied our feedback in relation to the Steps to Better Healthcare Programme proposal of 2 site model.

For ease of reading it has been spilt into sections but many of sections do overlap.

Inequality for patients and carers

- Angus has over 230 years of local mental health provision and this 2 site model would mean inconsistent service provision across Tayside resulting in inequality for Angus patients only. I.e. No in-patient ward in Angus when there is already no CHRTT locally in contrast to mental health patients in Dundee and Perth.
- From 2014/15 data, only around 26 - 30% of patients admitted to Mulberry actually live closer to Carseview than Mulberry. This means the majority will be disadvantaged.
- Disadvantaging patients – further to travel for admission and higher costs for travelling there. Patients have many practical issues that can be resolved much easier if the ward they are in is local. For example – tending to pets, collecting clothing from home.
- Disadvantaging family and carers – further to travel to visit relatives and of course higher costs incurred to do so.
- Patients will have further to travel and incur more costs to participate in the necessary treatment plans. For example, graded exposure programmes, passes. These patients are already on low income or unemployed so centralisation will create further inequalities.

Quality of care/patient experience

- Mulberry provides high quality person centred recovery focussed care. This is reflected in feedback from patients and other organisations such as Mental Welfare Commission. In the past year, feedback from patients have been that 95% state service provided was excellent or very good.
- In 2014, NHS Tayside recognised the good quality of care provided and the on-going improvement ethos within Mulberry. This was shown by them selecting Mulberry to undertake part of the Health Foundation work by undertaking several projects. NHS Tayside were awarded monies from the Health Foundation for this and then decided to use it in an area that they were considering closing.
- There is a low incidence of violence and self harm in Mulberry. The factors which attribute to this low numbers include staff attitude, ethos of ward, environment, and accessibility to activities on ward, recreational room and local community facilities. This will not be replicated in centralisation.
- Maintaining links with the voluntary sector and local authority services will be a real challenge for patients to access when they are being cared for out with their local area in terms of their early supported discharge and recovery.
- Maintaining contact with family and social networks will be a challenge for patients.

Staff

- The leadership team convey that Mulberry is isolated from other GAP services so therefore must be at more risk, however the evidence on violence and aggression does not support that. In practice being isolated has helped staff to be more adept to managing difficult complex situations with limited resources.
- Staff will incur additional costs to wear and tear of their vehicles.
- Up to 75% of Mulberry staff has stated they would be unwilling to travel to Dundee to work, this will result in a potential loss of experienced staff from GAP including AHP staff who know the patient group and the community services.
- There will be additional costs with protection of banding/unsocial hours payment/travel costs for these staff. Out of a staff group of 40+ only 5 staff live closer to Carseview. Thus affecting the work life balance for the majority of the staff group.
- Loss of multidisciplinary team who together have continued to work hard at providing excellent care and working through many challenges.
- Staff work closely in partnership with their POA colleagues on the Stracathro Hospital site for mutual support and management, this would be lost.
- A move to Dundee would incur additional costs to POA wards in Stracathro Hospital as they would need to look at increasing their staffing as no longer supported by GAP staff during violent emergency situations.
- Junior medical staff cover the whole Stracathro Hospital site during out of hours, by removing GAP junior doctors from Stracathro site will ensure additional costs and recruitment problems to other NHS Tayside services.
- Centralisation would have an impact on CMHT staffing and resources. There would be increased travel and time to visit their patients and/or attend case reviews/ward meetings. This would affect the CMHT's capacity and also affect the quality of care patients receive.

Environmental

- Mulberry was built just 4 years ago to remain in Angus, the new environment would need to provide equal environment to Mulberry if quality of care to be maintained.
- The unit was purpose built and compared to modifying a current ad hoc ward it would be impossible to replicate the same environment Angus patients already have.
- Also it seems like a waste of public money to spend money on something that already exists and is evidenced to be successful in terms of providing high quality care.
- The current environment supports recovery focussed care this would be difficult to replicate in a refurbishment.

Miscellaneous points

- Staff consultation has been poor – insufficient number of sessions to safely release staff to attend whilst meeting the clinical needs and safety of the ward. Insufficient time for staff to be made aware of first session in January with 24 hours' notice given to staff.
- There is no nursing or AHP recruitment issues in Mulberry.
- Our experience of centralisation in terms of accessing rehabilitation or IPCU beds has been fraught with challenges in the past. There is a strong believe Angus patients would soon have same difficulties in accessing GAP beds in a centralised unit in Dundee.
- The Mulberry team will be diluted across various services so the learning achieved through the Scottish Patient Safety Programme and The Health Foundation work will be lost. Also the culture and ethos of the ward will be lost in this process.

1.3 FEEDBACK FROM CARSEVIEW STAFF EVENT – 13TH JANUARY 2016 –

24 Attendees

Comments/Questions noted on day

1. Impact on other services – Learning Disability day services
2. Medical Rota issues / Two sites easier to cover
3. Impact on travel time – staff/users/carers
4. Proposed increase in community include home treatment?
5. Numbers of open Forensic and low secure Forensic Learning Disability patients?
6. Inpatient exit to community care – what are links and who will provide?
7. Look at skills elsewhere – Local Authority/Leisure
8. Resource for Rehabilitation – clarity re patient pathways?
9. Workforce planning – AHP skill mix
10. Money Tayside has invested in PFI schemes
11. Delayed discharges in Learning disability – Local authority and Vol Organisations
12. Learning disabilities forgotten service in MH

FEEDBACK FROM 2ND CARSEVIEW STAFF EVENT – 24TH FEBRUARY 2016-

12 Attendees

Comments/Questions noted on day

1. Can see more positives than negatives
2. Cross cover
3. Training/learning /development opportunities
4. Running course for junior positions
5. Running course for support staff to train for support posts for future
6. How do we influence recruitment
7. 2 sites would improve physio services as greater ability to share resources
8. What if Board says no?
9. Why have Board spent so much on PFI?
10. How do we continue to cover if Board say no?
11. Is NHS cost cutting to affect planning?
12. Do we review sickness rates as part of this?
13. Clinical nurse specialist as solution to Junior Doctor rota
14. OOH's operational issues – lid on it – CRISIS Team

15. Crisis team no longer existing – staff weren't consulted with no communication – this happened over night – operational
16. Importance of partnerships in each locality with Local Authority
17. How was this received in Angus
18. 30 miles outside Tayside not your home
19. Pharmacy input required – include in planning if more move to Community
20. How will rehab pathway be managed in each area if moved back into Community with partner agencies
21. Step down from people out of MRH but services aren't available

1.4 FEEDBACK FROM STRATHMARTINE EVENT – 14TH JANUARY 2016-

36 Attendees

Comments/Questions noted on day

1. Criteria 1 and 2 feel like the same thing?
2. Where will day care/day service and community models sit/access issues/impossible to cover across sites?
3. Finance focussed/capital receipts do we keep the money?/ rumours re sell site for housing as next door being developed?
4. Students need to be recruited at right time /right place – not done very well currently – how are retirements to be covered?
5. Will patients be involved in process?
6. Feel like getting leftovers – what about new build for LD? Scope to build on Strathmartine site?
7. Impact on patients/carers – support needs identified?
8. Travel issues for patients re Angus Forensic patients/visitors to Perth
9. Could training for MH and LD be combined so can cover both areas?
10. How long are NHS tied into PFIs?
11. Inclusion of support services
12. Local Authority input

FEEDBACK FROM 2ND STRATHMARTINE EVENT – 23RD FEBRUARY 2016-

28 Attendees

Comments/Questions noted on the day

1. Equity of access for Angus patients
2. % of patients from Angus
3. Impact on clients/travel component
4. Number of patients ending up in custody increasing due to lack of access to treatment
5. Support to travel to Perth/ staff time - waiting on access to treatment
6. Impact on ability of group therapy - high number of angus patients in current group
7. Impact on day service

8. Sex offender treatment group wouldn't be feasible
9. Communication on one site is good – separation would reduce ability to communicate effectively.
10. Cardiff/Swansea models – access on 1 site more effective/responsive –
11. Providing LDAU/BSI/Open Forensic together at Carseview would alleviate these concerns
12. Split of forensic could affect communication – quality needs to be received at same or higher level – if split then may lead to less communication re high risk patients.
13. Difficulties in accessing IPCU and LD in general with GAP
14. Environment – autism / retro fit
15. Delays in Pinel / need to make sure work completed
16. Car parking – impact on site/extensions
17. How will all this fit on site – Day care
18. Treatment facilities are as important as clinical facilities
19. More treatment facilities needed
20. "Quality of life" – whole integration of services which provide improvements
21. Outdoor space – football – team building
22. Carseview – risk re mix of patients with GAP
23. Group potentially going to MRH re treatment options – access to activity space if shared with forensic
24. Day services?
25. Loss of resources for services – workshops, gardens, out door space
26. Freedom of space – football space
27. Impact on Angus LD Community – currently unable to provide any services due to high demand
28. OT resource pulled into more generic work
29. Improvement in community services ?
30. Will LD services monies be retained for LD services or used for other services
31. Patients starting to return to Strathmartine
32. Security blanket/place of safety

33. Feedback received following event by email: -

Good to get feedback on the current position. Noted below is some of the issues raised from a Forensic LD Psychology perspective :

Concerns/issues raised regarding simply clients travel to Dundee from Angus as noted on slide, it is an issue regarding the 'equity of access' to Forensic Psychological intervention for community based clients. Forensic Psychology services are a considerable and significant part of the Psychological Forensic Service for offenders with intellectual disability at Strathmartine. There is a significant percentage of sexual offenders within the client group although anger management and social problem solving are also focuses of intervention for Psychological Group Therapies.

The groups on the whole are attended by males however occasionally females attend the group therapy setting. The individuals on the whole may have attended court and received a disposal to the service as a part of a direction of treatment on a Criminal Justice Order. This is achieved through working with the courts and Forensic Psychologists or Psychiatric Colleagues providing a report on possible rehabilitation disposals available to them when sentencing offenders with intellectual disability in general and sex offenders in particular due to the expertise on site. Equally some of the clients may have received no disposal from court e.g. due to capacity to stand trial etc. but are identified as being able to participate in Psychological intervention where assessment has indicated this is warranted.

The Psychological Treatment groups that are available for offenders (Social Problem Solving, Anger Management, Sex Offender Treatment) are evidenced as effective and are run weekly (each Monday, Wed and Thursday) within Strathmartine Centre. These groups can be attended separately or as an integrated pathway of intervention (decided clinically) and are based on many modules of treatment but are also based on peer support and peer challenge as an effective method of attitude change. Numbers within the groups are essential for effectiveness. Having looked in the past at the provision of such group therapies in the separate areas (Angus, Dundee, Perth) this is not feasible firstly due to numbers within each group setting required for effectiveness, cost of running three groups (one in each area) in time, travel costs, lack of capacity within the service to do so and also situational risk management in so far as finding sites where risk can be managed for a gathering of sex offenders and also sites where risk is manageable for staff and a response available if required.

All Psychological interventions are based on a 'Good Lives Model'. This model is evidenced as best practice for sex offender intervention in particular but is utilised in all Psychological Group Therapies with good effectiveness. Basically alongside the provision of a Cognitive Behavioural Therapy model of intervention, we look to improve the offenders everyday life to aid desistance from offending behaviour (the offender becomes protective of his quality of life achieved and the work he has carried out to achieve this, and in turn has too much to lose to want to offend) hence the title 'Good Lives Model'. Significant dynamic risk items for sexual offending are recognised as loneliness and poor self esteem. Loneliness may often occur through poor social problem solving within interpersonal relationships (Social Problem Solving group therapy) and poor Self Esteem (Occupational therapy to build skills, education self confidence and appropriate social interactions). Thus work as an integrated treatment model for offenders with intellectual disability on an evidenced based model of intervention. This underpins the reasoning for any change in service provision to

maintain the ability of disciplines to integrate seamlessly, as currently happens on the Strathmartine site, to provide effective therapeutic intervention as often directed by the courts to offenders with intellectual disability alongside risk management to prevent future offending behaviour.

There is also a body of research evidence which suggests that service effectiveness in challenging behaviour is most effective when those working within a team are housed in the same building and free communication can occur between and within staff teams. This is also important to effectiveness of the team of staff within the Strathmartine service. There are a number of occasions where staff will stop one another and pass on information, whether its regarding the complexity of Timetabling for OT services to match up with the days an offender may be accessing Psychological Group therapies, it may be to organise, within a risk managed framework, communication regarding an offenders actual attendance at outings with Community Nurses, it may be simple communication of issues that have been passed on by care staff in the private sector as they have some concerns regarding an offender due to come to the service that day (it may be a risk issue that requires additional vigilance of the staff team working with him on the day or additional risk management to be put in place) it may be to share communication from offender management officers in Tayside Police of CJSW workers within criminal justice social work. Whatever the reason having the staff teams of various disciplines housed in the same area facilitates excellent risk management within the area and facilitates communication. This is all important to effective intervention and dynamic risk management of this group of clients.

This is evidenced through a 20 year follow up study as having an effective service to date and clearly with 'Steps to Better Healthcare' are always looking to improve our service and the provision of better healthcare however this also has to be able to support the current methods of best practice on delivery of interventions and risk management of this at times, complex client group.

1.5 FEEDBACK FROM ROHALLION EVENT – 20TH JANUARY 2016

40 Attendees

Comments/Questions noted on day

1. Had assumed SBH was GAP only and not LD or Forensic
2. Implications for staff on Rohallion site from any potential ward closure?
3. Staff in Rohallion were unaware of any impact on their site
4. Levels of expertise/potential to lose expertise if reduce a ward/who will look after Learning Disabilities ward?
5. Impact on day services at Birnam?
6. What is national strategy re Low secure beds?
7. What is age profile of Learning Disability patients? Will be males and females?
8. Have considered Pharmacy cover?
9. What % of patients from other areas? Angus patients being moved to Perth?
10. Which ward in Rohallion is being considered – size, fit, function?
11. Will learning from building this building be used for refurbishments?
12. Rehabilitation and Complex Care – need for clearer pathways

FEEDBACK FROM 2nd ROHALLION EVENT – 17TH FEBRUARY 2016-

8 Attendees

Comments/Questions noted on day

1. Which ward would be low secure?
2. How would it be chosen?
3. How many patients and would staff be transferring to new facility?
4. What outdoor space is there?
5. Would there be training for rehab?
6. Lessons learned
7. Gardens/workshop facilities

1.6 FEEDBACK FROM USER, CARER AND VOLUNTARY ORGANISATIONS

TAYSIDE REFERENCE FORUM - Held 28th January 2016 at Kings Cross Hospital - -

12 Attendees

Main Themes from Feedback Forms received.

1. Enough information was presented
2. The purpose of the discussion group was partially understood
3. Opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Understood next steps

Comments from feedback forms received

1. What other criteria were considered
2. Very internal review
3. Smaller group discussions would have been helpful
4. Not enough time to process information given
5. Earlier involvement
6. Would have hope for more time for further discussion
7. Information issued prior to meeting to enable a better understanding

1.7 ANGUS REFERENCE FORUM – Held 15th Feb 16 Stracathro-

44 Attendees

Main Themes from Feedback Forms received

1. Not enough information was presented
2. Uncertainty around background, purpose and process
3. For the majority of time opportunity was given to ask questions
4. Felt had no influence over criteria, ranking, options and scoring process.
5. Uncertainty over next steps

Comments from feedback forms received

1. Too much irrelevant information
2. Session felt like a delivery of information not a consultation
3. How can insufficient beds equate with supposed lack of demand locally
4. Acoustics very poor
5. Felt decision had already been made/lack of evidence
6. Presenters did well considering the feeling in the room
7. Presenters didn't have the opportunity to fully explain the point they were trying to make due to constant noise and interruptions from floor.
8. Not enough time to process information given
9. Late notice of meeting raised suspicions as to the actual purpose of the meeting
10. No prior consultation
11. Why was the hospital closing?
12. Unsure of the funding streams
13. Language used was too technical and unfamiliar
14. Earlier involvement
15. Would have hope for more time for further discussion
16. Information issued prior to meeting to enable a better understanding
17. Provision of user friendly information

Comments/Questions noted on day

1. What would happen in terms of visiting Dundee/Perth?
2. Should the workforce not be more integrated with social care
3. Better links with community – preventative
4. Cinderella Service
5. How does A& E link in – self-harm, suicide attempts
6. Further trauma/distress due to being discharged with no follow up
7. Why cant money be put into peer support/3rd sector
8. Would a drop in safe place not be better use of resources for crisis care
9. Long term chronic issues not supported
10. Money before people seems to be what's happening
11. Why not ask inpatients their views?
12. Why is there such a push for short admissions?
13. Can we guarantee that these proposals will not result in more community treatment orders?
14. Will more resource go into Angus Community Services?
15. How can closure of local hospitals be called improvement?
16. What are the plans for Mulberry Unit?
17. OOH's must be re-implemented/improved - even a team on the phone can prevent crisis developing further.
18. Experience by experience

The following is a survey carried out by Angus Voice amongst some service users, carers and others in Angus. This survey was circulated on 9th February, prior to the Angus Reference Forum where information about the Mental Health Improvement Programme and the proposed options was presented to this group.

angus voice

It has been suggested that the Mulberry ward might close and patients would instead have to go to Murray Royal in Perth or Carseview in Dundee.

Use this scale to show what you think of this idea
1: Good
2: Unsure
3: Bad

Total responses 58

What is your general feeling about the suggestion?

1. Good 1.79%
2.Unsure 5.36%
3. Bad 92.86%

How would you feel if you or someone you care for was told they had to go to hospital in Perth or Dundee rather than Stracathro?

1. Good 1.75%
2.Unsure 5.26%
3. Bad 92.98%

How would family and friends feel about this proposal?

1. Good 1.75%
2.Unsure 7.02%
3. Bad 91.23%

How would going to Perth or Dundee impact on a persons recovery?

1. Good 1.82%
2.Unsure 10.91%
3. Bad 87.27%

How do you think a hospital stay in Perth or Dundee would affect contact with friends and family?

1. Good 1.75%
2.Unsure 1.75%
3. Bad 96.49%

How would the financial and time constraints affect friends and family travelling out-with Angus?

1. Good 1.75%
2.Unsure 1.75%
3. Bad 96.49%

Do you think there would be a difference in how passes could be used if a person is in hospital in Perth or Dundee rather than Stracathro?

1. **Yes 76.79%**
2. **No 23.21%**

What would you identify as significant issues for a person going to Perth or Dundee rather than Stracathro?

- I feel it would be detrimental to their recovery. The individual would be taken out of their community and this would make it difficult for them to then integrate back into the community. It would cause difficulties for CMHT and voluntary organisations within Angus to then support the person back into the community. What would this mean for information sharing between ward staff and Angus based CMHTs/third sector organisations (e.g.Penumbra)
- Strain on both patients and their visitors both physically and financially
- I feel this would add considerable stress for individuals who are already struggling and make the experience even more daunting for people. Community support to aid transition upon discharge would also be problematic due to the logistics of travel.
- Distance is big factor. Visitation and access to legal help vital
- Distance
- Being away from family/friends and familiar surroundings
- Distance from family & friends, unfamiliar area.
- Travel
- Lots of families struggle with transport and this would limit their visiting time which i feel is crucial to recovery of patients
- Too far from loved ones
- Persons overall recovery as they itch to get home
- Travel issues.
- Stress of long travel

- Further away from family
- Too stressful when you are already ill
- Lack of family support due to travelling
- Travel
- Family being further away for visits.
- Time, money, stress on family
- Even further away from family, bigger hospital which could make the patient feel even worse and cut off from the world.
- Too far for Family & friends to have to go
- Less visitors as it's too far to travel
- Having support in the immediate area.
- Separation from family.
- Place near home, comfort.
- If a patient was to be admitted to hospital and there was no mulberry unit it would affect the individuals recovery, they could be further away from home e,g if home is in Montrose. This would mean further for family to visit, and not everyone can drive! It's a stressful time anyway when a loved one is in hospital never mind them being even further away from you. It would also affect passes home as there was be more arrangements to be made for travel and it would take up time.
- Cut off from their local community and family
- I wouldn't be able to get visitors, I'd also be even more isolated then I already am, it would also cost the NHS more in the long run, with transport.
- One more less local facility that would mentally ill people needing to go further for treatment and possibly worsening family connections but also Dundee cant as it is.
- Well for one it would be too much travelling for people.
- Isolation, cost factors, lack of support by loved ones.
- Being so far away from home with the impact of family/friends not being able to visit as much due to travel times/costs. Also if on a pass this will be extremely difficult for them to go out and about and will not be able to go home for a visit as this is to far to travel for the day back home.
- Lack of family/friend support, no access to services they will use on discharge so less prepared, time in travel for vulnerable people, options for day release etc would be limited - it wouldn't be feasible to go home for the day due to distance, or to take part in local groups/facilities in that time, isolation.
- Isolation-difficult to have contact with family and friends
- No local support with services, even more feeling of isolation from family, expensive/difficult for family to visit, they might end up being admitted at crisis stage if they know they won't be in hospital locally, day passes won't work . . .
- Over-crowding and would have a negative impact on individuals well being
- Upset and lonely
- Getting into the hospital in the first place due to reduced number of beds; once, the person we care for had to go to Dundee because of a shortage in Sunnyside. How much worse would it be with Stracathro closed?
- Travel for the individual. Change for the individual. Safety for the individual. Options for the individual. Choice in an individual’s care.
- Access to the community is a huge part of the recovery process; it would be difficult to strengthen community relationships and ties when so far away from the local community.

- This would potentially be an unfamiliar environment which could affect the patient's recovery and the use of passes
- As someone who has been an inpatient in Stracathro it was important to me to be close to my home in Angus so that my family and friends could be a part of my recovery, if Stracathro was closed and was moved to Dundee my family and friends wouldn't be able to visit due to distance or time constraints because of other commitments. Family and friends are an important part of recovery. It also helps being in the angus area for going on day or over-night passes as it's closer to home and I don't go to Dundee or Perth as I find it too busy and stressful and I don't know them well so day passes and over-night passes would fail before they even started as I'd have to find my own way home from a town I don't know. Where as in Angus I know the area well. The Muller unit is also a much nicer open wars in peaceful surroundings which is of proven benefit to help people more than busy areas in busy surroundings.
- Loss of contact with friends and family and community due to distance and time taken to travel. Stracathro is a General hospital - less stigma involved. May know
  staff at Stracathro already also some other others receiving services - less fear about
  going to hospital if relationships are already
  established.
- Much busier units. Not enough activities.
- Better staffing levels and less access to dual carriageways
- People visiting, travelling
- Lonely, isolated from friends, fear of a strange place. travelling back and forth to home visitation
- Unfamiliar, too far away, family unable to visit as much, expenses for travelling home, feeling isolated from normal environment, negative impact on patient self esteem and recovery as a result of the distance
- Access to Angus services
- Travel and costs
- Less contact with friends, loved ones and a strange environment wound impact negatively on a person's recovery.
- Transport would be the main issue for Perth. However, I believe it is easier to travel to Dundee from Angus than it is to Stracathro.

How important do you think it is to keep the ward at Stracathro? Would you like to say in your own words what you think of the proposal?

- I think it is essential that a inpatient ward remains in Angus
- I think it is extremely important to keep services local and that the proposal is a very bad idea
- I understand that the NHS may have to make changes due to financial constraints and savings that need to be made, however surely patients/local people should have been consulted during this process?!
- Have poor opinion of MH services
- Very important, I think the proposal would be a very bad idea as it was

bad enough Sunnyside moving from hillside.

- I think it is shocking and more money should be spent on helping people recover and feel safe and close to home
- Very very worried about it closing, it's a lifeline for a lot of people, will have major impact on individual's mental health and recovery.
- Bad idea
- Very....a fantastic place which has helped a speedy recovery of a good friend of mine.

  Dundee and Perth are too far away.
- Extremely important, having loved ones close by in my opinion is the best way to recovery knowing they are not far
- Its very important I think the proposal is utter crap and would effect people's recovery
- Very important. Convenience for the mentally ill and her/his family is vital for recovery.
- It's a terrible idea, for some people even Stracathro is very difficult to get to
- Very
- I struggle with mental health and would hate to think help is going to be further away.
- Very important to keep local support
- Very important to keep the ward
- Bad idea
- think it would have a massive impact, closing another ward could mean a shortage of beds, patients having to travel further than needed and strain on family.
- Very important it's a lovely hospital in beautiful grounds
- Ridiculous. ! Make this emotional time easier not harder
- Very important. First Sunnyside closes forcing family and friends to travel to Stracathro. Moving patients further afield would be very detrimental to the recovery of patients.
- It will be the same as closing Sunnyside, I think it will put patients off of being admitted for treatment due to the possibility of relatives and friend not being able to visit as much.
- Not beneficial to recovery or the family unit
- I think it's very important that mulberry unit stays open to help give reassurance to those living in Angus that the unit is there to help them. You would be taking more care that is highly needed away from those who need it.
- Closing the ward is going to disadvantage Angus residents when it comes to mental health services. Recovery will be slower for them and less people will want to seek help when unwell for fear of having to go to Perth or Dundee for treatment.
- It's extremely important to keep Stracathro open, as a patient I would be more isolated from my friends, family and community. Also I've been transferred to an out of area hospital before due to lack of beds and the whole ordeal was very distressing. I couldn't get visitors because I was too far away, I was also told due to the shortage of beds in Scotland I could be sent to England which was even more distressing!

- We need beds not closures and I think it's just another cut in mental health services.
- Cause it's so close to town and isn't too far for people who don't drive
- Huge impact on local support services and partnership working moving away from locality working
- I think it is unfair to expect someone to be so far away from home, this also makes it harder to make connections with community when being discharged through other services.
- I think it would be a huge mistake and very short-sighted at a time when mental health services are already stretched, to leave Angus with no inpatient beds, when
  Carseview and Murray Royal are already stretched and have no room. This will result
  in more patients having to go even further to be admitted. Mulberry has close ties with
  local facilities and services in Angus which help the transition from hospital to home, this would not be in place.

  Add to that the fact that Murray Royal is Perthshire, Dundee is separate from Angus and you will have staff struggling to get in place support on discharge as they are dealing with different areas so don't have the same access - what happens in Angus is different from Perth or Dundee - I have firsthand experience of this with a relative being released from Murray Royal back to Angus and the strain it puts on staff having to organise follow ups and aftercare. Combine this with the lack of contact with family, friends, local support and people will be discharged unprepared, resulting in an increase in re-admissions.

  Looking also at the cost and time of transport and staff hours spent on transport and there will be a significant rise in unnecessary costs, that is before you even consider the impact on the patient who is already in a vulnerable state and may be in a state of distress, psychosis, or other. The potential for risk in this situation is already high without adding in what could be a 2 hour or more journey and delay in start of treatment in a safe and secure environment. This also has the potential to impact on a patient's recovery time again leading to an increased cost of longer stays, meaning less space for new patients.

  I would question if the implication on financial costs has been thoroughly investigated, as whatever saving has been suggested by closure of the ward will almost certainly have to go towards the extra costs incurred, not just through the inpatient stay, but also on discharge into the community. And I doubt very much that the full implications of the cost to patients health has been considered.
- Needs to be kept local- people are used to Stracathro; it means they can stay in their local authority area and can maintain relationships.
- It is shocking, particularly as there appears to be more and more people needing support with their mental health issues, and a stay in hospital can provide care, support and stabilisation of their illness. Angus residents are being discriminated against. Many people who end up in hospital feel isolated and disempowered. It will even more difficult to engage with their local services.

- Important, don't think its beneficial for anyone
- Stracathro has a much better outlook to help recovery
- Vitally important. Uncaring, unimaginative, crass, ignorant.
- Recent research in England shows many reasons why travelling significant distances is detrimental. Look into it before making a knee-jerk reaction! There are never beds available in Dundee anyway. Surely we should be increasing service provision to mental healthcare and making moves to reduce barriers and increase choices rather than give mental health patients the short straw as usual. Each person is an
  individual so ask them, they are human beings, ask them! I am very very disappointed to hear about these misguided bureaucratic decisions being made at a level with not enough consultation with those involved first hand.
- Extremely important to keep services including hospitals local. I am concerned that the proposal has not been thoroughly thought about. The impact on recovery for patients is huge. Not everyone can drive or access public transport easily. The most vulnerable people will be the ones to suffer should this proposal go ahead.
- Friends and family may not have access to transport and may be unfamiliar with the bigger cities of Dundee and Perth. There is also frequently a shortage of beds in Angus anyway and patients are sent even further afield than Dundee or Perth so oversubscription of beds may be an issue.
- I think it's very important to keep the ward at Stracathro open and I think that the proposal is awful.
- I have been a patient at Stracathro and it is a nice hospital in peaceful surroundings with access to bus routes for day passes. The ward is bright and welcoming and has a safe atmosphere to it. I have close friends who have been in the psychiatric wards in Perth and Dundee as patients whom I have visited while they were there and it's completely different. The wards don't feel safe or welcoming or peaceful or relaxing. It's the polar opposite of Stracathro. Most other wards are locked wards and there needs to be unlocked wards available too as a lot of people don't need to be on locked wards. I personally feel that if the ward at Stracathro closes it will be a huge loss to the mental health teams in Angus and I would be more stressed in any other hospital not only because they are not as good/nice as Stracathro but because my contact with my family and friends who are very important in my recovery would be very little compared with if I was in the ward in Angus where all my family and friends live.
- A betrayal of those requiring services and their families. A lack of vision in recruitment of staff to fill positions at Stracathro. These proposals are not in keeping with known factors instrumental to Recovery for both users of services and their families. The proposal should be scrapped.
- It's a lovely unit. Very tranquil and in a peaceful location. Staff very good and plenty of activities for patients.
- The ward at Stracathro is understaffed and dangerous. Travel to Dundee or Perth is probably easier to co-ordinate. It reduces the chance of "unwanted" visitors bringing in "contraband" it may also focus the individuals in getting better as will feel much less than a home from home
- I think it's wrong and immoral to expect people from Angus to travel all that way
- The proposal is a ridiculous one people with mental health issues and their families work and pay taxes and deserve a real alternative, How would

someone maintain a normal life when they are separated from their family. This feels like going back into the dark ages of psychiatry where we are separated from the normal population.
- Vital
- Very, it's a busy ward and needed
- it's a special built unit made for this care
- I think it is important to have an Adult ward in Angus
- It essential that people with mental ill health can be treated in their communities, the proposal is typically without consultation with patients and carers, arrogant.
- I think I need more information and understand all the risks of staying in Stracathro ot moving elsewhere. It is important we get all sides of the debate.

What would be the best or worst things about being in a Perth or Dundee hospital?

- The worst thing about the closure of Mulberry ward would be the negative impact this would have on vulnerable adults living in Angus. It would be distressing in itself for the person to travel that distance, being so far away from home (despite everything else that would be going on for them at that time). In terms of recovery, it would put barriers in place for people being able to integrate back into the community with the support of services like Penumbra ad CMHTs.
- Being further away from family and friends is definitely the worst thing. Time goes slow in hospital and having visits is what you look forward to
- Best can't see there would be anything good about this for people living in Angus.
  From a providers point of view staffing issues possible made easier. Bad= distance, visitors unable to make the trip, unfamiliar surroundings, purpose of day pass not fully met if people unfamiliar with local area and wouldn't be accessing upon discharge, less of a recovery focus evident in the care of inpatients in Dundee hospital
- Have very poor opinion of MH services
- To much money to travel and less visiting.
- Can't think of any good being away from family/friends overcrowding
- No good if you're from Angus, too far away, probably no visitors, detrimental to relationships and recovery.
- Travelling
- Too far a distance for vulnerable people to be from their families
- Best wider range of help, worst families strain and overall contact with person
- The travel and decline in quality of treatment.
- Worst thing being so far away from friends and family
- Travelling costs, time, feeling lonely as friends and family wouldn't be close by
- Its too far away for family to visit
- Further away from family support
- Distance
- Families being so far away it might impact on persons recovery.
- All bad, time, money & stress on family

- More central for different facilities
- Even further away from family and bigger could make the patient feel worse
- Too far to travel, meaning patients would get less visits from friends or family.
- Being in strange surroundings, far away from home with more limited contact to loved ones. Also many people who are in numerous times come to know staff and feel that these familiar faces help their recovery.
- Too far from family. Travelling. Expenses. Isolation from loved ones.
- travelling makes people visit less
- The worst thing about the thought of a loved one having to go to Perth or Dundee hospital would be knowing that the loved one is already in distress about going into hospital never mind one further away.
- People who are seriously ill should be in hospital in their local area. There is no argument apart from money, to send patients miles from home, it is not in the patient's best interest.
  Isolation
- There are no more beds there that's the reality so why are you giving them as options.
- Nothing good about it being in Dundee or Perth they have done so much work with people.
- Worst thing would be lack of contact from loved ones if travel was an issue
- Being so far away from their home town/family/friends and connections with their community e.g. other services.
- I can see no benefit except being out of the local area may occasionally be a preference of one or two patients, although with the proposal that would no longer be the case as there are likely to be other patients from the same area. The worst thing would bending so isolated. Potentially having no visitors, no link to your life, no chance to meet people who may be involved in your support, worrying about what support there will be on discharge which is already inadequate in some cases, staff telling you that they can't do much as it all has to be passed to the Angus CMHT to sort out. Add to the fact that the care in Carseview especially is not of the same quality as the care in Stracathro (based on patient experience) then there is an added concern. Dundee and Perth areas also do not have the same integration and high level of cooperation which exists in Angus between health, social care and third sector services who all work closely together.
- Worst- far away, difficulties with travel/contact with family/friends.
- Worst - see 8 above.
- Family visits and travel time
- lack of visitors change of environment
- Best: Dundee is a good hospital (but so is Stracathro). Worst: further for some people to visit.
- Out of comfort Zone so feeling unsafe. Family and friends at too big a distance away.
  Basic comforts. Lack of beds. Feeling so far from home, in a city, different.
- Too far from home. I dont know how anyone would manage visits to see friends or loved ones if they were in hospital in either Dundee or Perth.
- Not everyone is familiar with an urban environment, particularly those from rural Angus, and this could be a daunting prospect, both for the patient and visitors.
- I have no positives at all if this was to happen.. It would actually put a lot more

stress on me if I was to become ill again as I wouldn't want to go into hospital in Perth or dundee, which would lead to me either not being truthful about how bad I was feeling, or acting on an impulse out of feeling I had no other option because I have nowhere else to turn. The worst thing would be being so far away from my home, in a town I don't know and getting very little visits from family and friends if any visits at all

- The worst thing about being in hospital in Perth or Dundee is that you are a visitor to the hospital and have to move on another area eg Fife if the bed is needed for a Dundee user of services. This can mean even less contact with family and friends who are important is a person's recovery.
- Not as personal in busier units. Not good for mental health having on a few structured activities. Visiting easier if family live in Dundee.
- Everything bad
- No best things because this is a ridiculous proposal and just because it saves money is not enough reason condemn those with a mental health issue with
- Too far away for passes and visitors not conducive to recovery travel would be a big problem
- Being far away from home - not being able to recover in local environment
- I see no positives and the worst thing would be patients suffering isolation and loneliness as a result.
- The same as any hospital-poor care

Transcript of a letter Mr Bill Troup received from a service user dated 21st Feb 2016

Dear Bill

Re: Better Healthcare Consultation meeting Mon 15th February

Further to the meeting I feel obliged to write to you as a patient who is rather concerned by some of implications of this meeting.

Although I fully understand the need to develop pathways to ensure 'Best Practice' it rather worries me that a large community like Angus may be without vital in-patient care.

As a person with mental illness I had to spend a 2 week period in the Mulberry Unit at Stracathro, I had to restart medication and appreciate how the facilities and staff helped me to get back into the community.

It appears from the meeting that facilities for Adult Patient Care may be in Carseview Centre, Dundee or Murray Royal Hospital, Perth.

This would concern me in terms of visiting and also in terms of the quality of care being replicated like the Susan Carnegie Centre.

A large sum of money would have been spent on the Mulberry Unit and it would be sad to see it close. Therefore, I hope as a patient that opinions will be considered before change is occurring.

Further comments/feedback received:
Comments and concerns raised at the Angus Mental Health Officers Forum 26.2.16 in relation to negative outcomes for service users were there to be a closure of these units, specifically :

1. Patients subject to the Mental Health Care and Treatment Scotland Act 2003 and the implications for provision of statutory services to service user groups both in terms of care planning and for MHO service provision;

2. The ability to provide the reciprocal arrangements necessary under the Act in a locale outwith Angus

3. The implications for the right to have family relationships supported when patients are so far away;

4. The cost/time implications for visitors

5. The implications for the environment to be provided, especially for those who have been cared for at Strathmartine which provided skills centre in a protective environment which gives maximum freedom to those who can have some time alone within the grounds but who would usually need one to one supervision in more public areas

6. The implications for CMHT's / LD services in being able to undertake good discharge planning and links to inpatient services, which is essential for recovery and good patient care.

1.8 LEARNING DISABILITY REFERENCE FORUM – Held 26th Feb 16 - Strathmartine

29 Attendees

Comments/Questions noted on day

1. Knock down Strathmartine and move to Carseview
2. Time for change
3. What about my mum/niece/sister
4. What will happen to day care
5. What about the workshops
6. How will we get to workshops if it moves
7. What about the garden project
8. I like it here
9. Will the staff move with us
10. What if someone doesn't want to go
11. I lived at the old Strathmartine and this is old now as well
12. Why cant we stay here – its like coming home
13. Why cant we all go to Carseview
14. This has been coming for a long time – its an old hospital
15. Can we all go to MRH
16. How many people would go to MRH?
17. When will this start?
18. Concrete works/gardens where are you putting them
19. I like working hard at the workshops
20. We make things for the gardens
21. Would you bring my mum to MRH/Carseview – Minibus/provide transport

Consultation Feedback from LD Senior Team Meeting
Dudhope Castle, Tuesday 6th December 2016

Service User evaluation of choices

 This symbol means you like the choice,

 This symbol means you are not sure

 This symbol means you don't like the choice

Choice 1 Leave everything as it is

 **10**

 **10**

 **5**

Choice 2 Improve LDAU and Strathmartine

 **14**

 **9**

 **2**

Choice 3 Improve LDAU and move BSI and Flat 1 /Craigowl to MRH

 **5**

 **8**

 **12**

Choice 4 Improve LDAU and add BSI and move Flat 1 and Craigowl to MRH

 **7**

 **10**

 **14**

Choice 5 Move all of services from Strathmartine to MRH

 **5**

 **5**

 **15**

Mental Health Engagement Session Summary 12th April 2016

Session One – Claims, Concerns and Issues.

In summary the three key outcomes from this section of the session noted:

Claims

Engagement

1. Open and constructive Involvement of all stakeholders is vital
2. Previous engagement validated by SHC with good history of meaningful engagement at a local/smaller scale level.
3. EQI process commenced and consistent

Why change is necessary.

1. The programme is a solution to the current service challenges and will reduce risks – opportunity to help people/staff understand the difficulties.
2. The programme addresses longstanding issues to providing higher quality of care at an affordable able, sustainable cost.

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Process of change- OBC/OA

1. The OBC/ Options Appraisal process is consistent and in line agreed standards
2. Further opportunity to establish common baseline of where the improvement programme is with all stakeholders
3. Full business case required by Board for next paper where final decision is made

Concerns and Issues

Engagement

1. Not all stakeholders identified. Not all stakeholders involved i.e. those who use services, those who care for them, those who support – e.g. 3rd sector, those who provide the service.
2. Clinical voice needs to be seen and heard.
3. Heads service are engaged and involved. Included.
4. That we invest in a rigorous means of communicating to service users and their families who have barriers to communication and understanding and that we actually listen to their views.

Why change necessary

1. Looking at Acute Care in isolation may not lead to good solutions.
2. Reports to Board missing vital information, i.e. finance. Board does not get information it requires to make decision

3. Information vacuum will result in damaging rumour.
4. The Dundee IJB is not strategically sighted on the programme as a whole board and is therefore not fully sighted on implication for the population.

Process of change – OBC/OA

1. Engagement process to date may be viewed as a 'tick box' exercise with decisions already made
2. Not something we can do in a week/month. Unrealistic deadlines did not enable appropriate planning of comms and engagement events (6 weeks to undertake).
3. More delays, comms programme being rushed, not getting public/stakeholders on board.

4. People don't understand process and when decision made i.e. How do we dispel the current impression in Angus locality that a decision has been made.
5. NHST Board being inconsistent and hesitant with decision making.
6. Must incorporate and meet staff governance standard.
7. We could go through process and come out the same outcome

Session Two – SWOT analysis

Strengths	Weakness
CEL4 compliant: developing options, criteria, benefit weighting allows us the opportunity to review how we engage people.	Ability to follow the process fully with the resources and buy-in required.
Uses Staff governance strands.	Depended on those who engage/turn up.
Role IJB and hosting arrangements – built in partnership and collective all stakeholders.	Potentially too restrictive re options.
SCIM – capture investments process.	Engagement of stakeholders with different communication requirements, e.g. LD.
Clear process. Include EQIA	Time consuming and requires contingencies.

Have learnt from previous options appraisals. If we plan for a major service change we will be in a good position. Done well, enables communication tailored to different stakeholder groups who have differing interests.	Credibility? • Previous experience • Board decide differently – large group of staff, patients, public disenfranchised No guaranteed outcome. Must sit within a broader strategy and vision for mental health and LD services.
Opportunities Outlining benefits and criteria again so public and staff understand what is being proposed and why. IJB – stakeholders – gives opportunity to think of objectively of the model. To have conversation around the future Review an incorporate other best evidence Better communications, especially with groups i.e. LD Opportunity to do brand new sales pitch. Opportunity to improve skills and knowledge in staff around options	Threats If staff 'messed around' further – impact on morale. People may leave. Too wide an options appraisal that may be rejected by board; e.g. is it about GAP beds or 21st century mental health services. Need clarification. Forced timelines – concern that we will be reactive rather than reflective. Service pressures/operational challenges – may be forced to take decision to keep service safe on patient safety issues alone. No political buy in. Credibility of process given work done to date.

appraisal process. Making sure people who were involved know what the decision was/why it was taken. Close loop. To challenge the pace at which the service needs to change. Change the legacy of historical mental health estate.	

Discussion

In summary the key outcomes from this section of the session noted:

Communication & Engagement

1. Public and staff – using established Governance framework for communication and engagement.
2. Advice from Health Board re options and process. Need to know and work with parameters and decision making.
3. Strategic planning requirement communication and engagement for partnerships/IJBs (+/- hosting arrangements). Host board opportunity to scrutinise and discuss with other IJBs to reach informed understanding re shared responsibility.
4. Body corporate approach regarding who is decision maker.

Why Change is Necessary

1. Options appraisal process going forward needs to describe (1 or 2 site model):

- Finance: evidence robustly as part of financial plan and structure, i.e. could cost more
- Patient safety
- Quality services
- Sustainable over time
- Staffing

2. Create modern, effective mental health services (need to remember this more)

3. LD services – needs to be fully reflected -cost and environment

Process of change OBC/OA

1. Reflect changed or new scope
2. CEL4 must be followed
3. Recommendation re timescales should be revised to enable us to establish the impact and effect on other services.
4. Needs to reflect service redesign and BAU- i.e. need to risk manage current state whilst developing future state may mean temporary changes – i.e. clinical issues right now
5. New process needs to reflect the role of P&K IJB re service model change – hosting arrangements post 1 April.
6. Is it major service change or not? (Use template as to way to proceed.)
7. Political timelines, i.e. local elections, etc.

What is the options appraisal about?

What 'model' (operating definition – include community, inpatient and third sector) need to look at if inpatients on one site or two sites? Is it Reduction in GAP beds and/or Development 21st century mental health services?

Session Three – Identifying all stakeholders and best approaches for Engagement

In summary the six key outcomes from this section of the session noted:

1. The programme would recognise the work which had been undertaken and learn from previous engagement programme to ensure user and carer and third sector inclusion in future option appraisal exercises. The programme team must also ensure appropriate timescales are made available to undertake this.
2. The programme should look to the new IJB structures and their strategic planning groups to support identification of key stakeholder groups within each locality and build on established groups and local knowledge available. The group recognised the need to join with IJB partners to progress future engagement.
3. The programme would plan any future option appraisal events following Scottish Health Council advice regarding split of participants i.e 1/3 Clinical, 1/3 Service/Admin and 1/3 Service Users/Carers/Vol orgs.
4. Training sessions would require to be provided for the more technical aspects of the programme to ensure full participation i.e option appraisal process. These sessions would be offered to all participants.
5. All future engagement and information sharing had to ensure a clear, honest and consistent message was circulated which reached all staff and stakeholders and provided adequately detailed information wherever possible

6. The programme would provide a post option appraisal event in each locality to allow sharing of outcomes and preferred option from events. These sessions would be held prior to preferred option submission to NHST Board.

1.9 FEEDBACK FROM COMMITTEES

Area Partnership Forum 26TH Jan 16

Presentation and update of programme was provided.

The report was received favourably by members. .

Questions were asked regarding the ability to staff new models of care and whether NHS Tayside had any ability to make any savings through existing resources expended annually from PFI/NPD schemes. Staff side sought assurances that any changes for staff would be progressed inline with current organisational changes policies.

GP Sub Committee 15th Feb 16

Paper provided to update on programme for discussion and to request feedback from group.

Feedback received:

There were concerns raised by Angus GPs that the lack of inpatient beds in Angus may require all patients to travel to Carseview both for inpatient care and assessment. Given that urgent psychiatric problems often arise as emergencies and are more likely to seen by the GP in the afternoon the fact that OOH psychiatric assessment seems to be starting at 3 pm makes it difficult to get patients assessed by local teams. This was felt to be a particular risk given the increasing numbers of recent patient cases where communication between inpatient and local teams has been an issue.

Total capacity across Tayside was raised as a concern as even now Murray Royal seemed to be at capacity fairly regularly with patients shifted to Carseview.

It was noted that action was required as Tayside apparently has the highest spending on Mental Health in Scotland and that stronger community services could both improve care and save money, but it would be disastrous if inpatient care was reduced without concomitant support in the community.

The committee will be represented by Dr Humble at the upcoming Mental Health JCB where it was hoped there would be further discussion.

Mental Health Leadership Team 22nd Feb 16

Update report provided re Programme progress and feedback re engagement undertaken to date.

Progress noted by Mental Health Leadership Team

Mental Health Joint Clinical Improvement Board 23rd Feb 16

Presentation and update provided to request feedback.

Attendees noted the content of the presentation. The following were raised as queries/concerns:

Angus GPs had raised concerns via GP Sub-Group re potential impact on Angus patients if ward in Susan Carnegie relocated and the travel distance to Carseview.

By response, it was reported that data had been analysed showing that the majority of MH referrals in Angus were closer to Carseview due to their geographical location in Angus.

POA Lead Clinician raised a query re the impact on other services at Stracathro, i.e. effect on Psychiatry of Old Age who rely on input from junior doctors. This will be reviewed as part of further option appraisal work required regarding future utilisation of Mulberry accommodation following any decision by the Board.

Questions were raised on the impact of relocation of LD and GAP services on integration and IJBs. Attendees were advised that consultation would need to take place regarding this. It was noted that currently 95% of Mental Health Services are provided in the Community.

Presentation and update was accepted and supported by JCIB members present

1.10 FEEDBACK FROM SAS/POLICE

Response received from Scottish Ambulance Service reads:

Thank you for providing an opportunity to feedback on the proposed service delivery models.

The criteria applied to rank the options certainly seems reasonable and appropriate as does the application of a weighting to each criteria. From a Scottish Ambulance perspective, I don't feel we are in a position to offer any view on areas such as accommodation. The move from 3 adult acute admission locations across Tayside to 2 based at Perth and Dundee is probably the key area which has the potential to impact on the Ambulance Service however given the relatively small numbers of journeys, along with the fact that the only site being removed would be Stracathro, this is not a significant concern.

I would have been keen to attend a presentation to ensure we have had an opportunity to hear more details around the review process and the proposal being considered but regrettably, given the short notice, I am not in a position to attend any of the planned events. I hope this brief feedback is of some assistance. If you would like to discuss further, please do contact me.

1.11 Feedback received from Local Authorities

Response received from Dundee

Following attendance at 25th Feb 16 event a collective Dundee view on proposals would be provided. Feedback awaited

Dundee CHP Representative

We would support 3b in line with NHS Tayside reducing sites and resultant costs

Response from Angus and Perth Representatives

Response awaited.

All feedback to date included in March 2016 Board report.

Subsequent Feedback recorded from April 2016

1.12 Feedback received from PLUS - Perth

Response received 17 June 16 reads:

Apologies that we have not decided yet whether we feel it is in our best interests to be involved with this:

We are concerned about whether it is a token gesture as we have heard via an NHS meeting, discussions and the media that Mulberry Unit is to close and MRH will not. That is not to say that would stop us from attending if the event was about some other decisions that has not already been made. The explanation we have already received via yourself read like no decisions have been made at all including the one about which unit will close so we are in a bit of a quandary.

If we decide not to come it is for a good reason – because we really care about what our organisation does and how it influences better healthcare. We would rather have no participation at all than bad participation and be part of something we believe is against our values.

I realise this requires serious consideration and perhaps something you will be unable to answer fully, in that case I am hoping that you can send it on to a person that knows.

Response received following meeting on 29th June 2016 reads:

Thank you very much for coming to meet with us at PLUS yesterday and sharing the bigger picture. We really appreciated you giving us your time, even when you have so much to be getting on with.

Following a discussion later we decided that we would not take part. We want to stress this is in no way at all to do with the way you have been taking forward this part of the process, and have felt wholly listened to and respected by you.

We will send a separate e-m ail with why we are choosing not to be involved to Rob and copy you in to it.

1.13 Note of meeting with Angus Independent Advocacy 27 April 2016

It was explained that, after the 'NHS Tayside Board Meeting' in March, a further piece of 'engagement work' would take place between now and August (Option Appraisal Process). This would be across the three areas in Tayside. It was discussed that identifying those who would be invited to partake in the Option Appraisal would be decided at an Integrated Joint Board level across the three areas.

The Option Appraisal Process would consist of 60 people (20 clinical representatives, 20 service user/carers representatives and 20 management representatives). This would be equally weighted across the three areas.

The Option Appraisal Process would consist of looking at a one or two site option for adult inpatient psychiatric care and inpatient learning disabilities care.

Once the options have been identified there will be wider consultation.

The Scottish Health Council have offered to provide advice on the Option Appraisal Process for participants. They will also attend and offer advice at the two workshop sessions. You hope this will happen in June.

·Independent advocacy will be involved in the consultation with patients in Strathmartine and may include one to one consultations (their independent advocates could support them). You have agreed to meet with the managers from TAF to discuss this further.

I explained that we also support many of the people currently detained in adult care wards as well as many people in the community. AIA only provide one to one advocacy, but other independent advocacy projects across Tayside also provide other models of advocacy.

We also discussed the potential organisational impact on independent advocacy organisations – particularly in a climate where our referrals are increasing. It was agreed again that you would meet with TAF to discuss this potential impact. We also discussed 'Advocacy Planning' and where this sits within the IJB and the future of the Tayside Advocacy Plan.

You also mentioned that we could get access to the minutes of the NHS Board Meeting in March, which includes feedback from the consultation events. I have included the link for TAF members.
http://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&dDocName=PROD_249617&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1

It would be good to arrange a meeting with TAF to discuss the issues identified.

A further meeting was arranged for Thursday 16th June 2016

1.14 Feedback from Option Appraisal Training Event 16th June 16 – Evaluation Forms

Feedback from Option Appraisal trai

ATTACHED AT THE END OF THE APPENDIX

1.15 Feedback from tables at Option Appraisal Event 20th June 16

Feedback on tables from Option Appraisa

ATTACHED AT THE END OF APPENDIX

1.16 Feedback from tables at Option Appraisal Event 30th June 16

Feedback from tables recorded at Op

ATTACHED AT THE END OF THE APPENDIX

1.17 Feedback from Option Appraisal workshops 20th and 30th June 16 – Evaluation Forms

16.07.28 Option Appraisal Workshops

16.07.28 Option Appraisal Workshops

ATTACHED AT THE END OF THE APPENDIX

1.18 Feedback from Option Modelling Event 29th September 16 – Evaluation Form

Evaluation160929.doc

INCLUDED IN APPENDIX 4 – WORKSROP EVALUTATIONS

1.19 Feedback from Learning Disability Option Modelling Event 8th December 16 – Evaluation Form

161208 LD Evaluation.doc

INCLUDED IN APPENDIX 4 – WORKSROP EVALUTATIONS

1.20 Feedback received from Dundee LD Service 13th January17

Dundee LD Seniors LD Modelling Consulta

DUNDEE LD SERVICE MODELLING VIEWS.d

ATTACHED AT THE END OF APPENDIX

1.20 Feedback received form P&K Public Partners meeting 15th December 16

Notes from December 15th Mental Health Transformation

Has primary care been involved so far?

How will social care resources be managed to accommodate change in inpatient beds?

Option 8

- Communication/brevity of stay – Very short time in step down process for patients to get to know staff then a change – not conducive to treatment and recovery
- Potential yo yo problem
- Patients beyond crisis phase more able to get more local and family support.
- How is population growth being incorporated?
- What is position of retrospective responsibility? (From member I think this might be with Step down process?)

How are staffing levels being encouraged?

Collection of stories re peoples experience versus statistics?

What age do people convert to adult care, 16?

Need for better listening to 'specialist' family knowledge

Mental health conditions very variable in nature

Change escalates the problem

Transport of patients and carers big issue

Big challenges for carers compound carers own health problems

Consultation Feedback from LD Senior Team Meeting
Dudhope Castle, Tuesday 6th December 2016

If Blank Sheet what is best model of care?

Lighthouse project – in trouble if day services are not invested in as this becomes overloaded crisis point.

Manage prevention more locally

Drop in place – safe space, peer support

Prevention doesn't apply to genetic conditions

Needs good communications, avoid early discharge, need team able to deliver

Need free transport so people can support relatives

Succession of family carers is an issue (older family carers)

Is there a cost benefit in going to one site which can release money for other supports?

Models to include 'plan' for absence of carer(family)

Infrastructure to support any new model incorporating all appropriate services.

Issues with things appearing service provider centred.

Carers are still not valued despite their cost saving

Voice of carer MUST be listened to

Mutuality of respect

Lighthouse – place of safety through the night, not existing at moment, manned by volunteers, going through formalities.

Highlights need for time period required for creating other supports

Crisis help needed – crisis house in each area to prevent hospital admission

Manned by carers/peers less threatening than very medical staff

Need to take account of variation in mental health conditions.

Police are quite skilled in identifying where and what problems people are having.

What does service look like without buildings? Is money being invested in community supports?

How is longer term plan being thought about – recruitment, training?

Throwing money at it not the point.

Would it be easier to recruit if healing/treatment process was more person centred?

Engagement process needs to be more supportive and take into account

- difficulty in feeling heard
- Importance of carer support groups

Much earlier prevention with children

Better identification

GPs need guidelines to recognise mental health in children

1.21 Feedback received form P&K Public Partners meeting 17TH Jan 17

Notes from 17.1 17 Mental Health Transformation Information Event

A=Audience

NP=Neil Prentice

LH=Lynne Hamilton

A -Definition of 'Community support' as 'medical' or 'Third sector' voluntary is confusing. Needs to be clear in Reports and Engagement material.

NP -The Health & Social Care Partnership structure gives better potential for integration across sectors.

A - What is being set up to prevent crisis?

NP -Home Crisis treatment package is being worked on.

(Probably need good explanation of what that is.) SAB Note

A -What happens with people growing up with MH in household? Concerns about how this is handled. Can result in future mental health problems for those children.

NP - There is more willingness to speak about MH developing which make things easier but much more work needs done on discussing that.

A - How will Crisis Team work over wide geography?

NP - Crisis response treatment at home will continue.

NP -Need to work on ways of getting people to service if that is necessary.

NP - Crisis assessment available 9am -3pm.

NP - Crisis response occurs until 5pm

A - What is happening in Primary Care to prevent crisis?

A - Need to be more effective with co-occuring disorder?

NP -Large number of physical problem have spells which show themselves like mental health condition.

Consultation Feedback from LD Senior Team Meeting
Dudhope Castle, Tuesday 6th December 2016

A - What is the potential of mobile service?

A - There are reservations of people being dealt with in communities as there is feeling of need for much closer understanding of family support and sharing of good information between families and services.

A - Carers have a feeling of not being listened to and the need for more openness around patient support.

NP - Law presents problem if patients request autonomy, even with advance statement in place.

NP - Crisis home treatment would be boosted and prevent hospital treatment being necessary.

A -How do you transport people who are really ill?

LH - Need to look at transport issues at 3 month state of consultation.

A - Worry re expectation of solutions falling onto carers. Limits to neighbour/community support if very difficult circumstances.

A - Much more training needed for GPs in recognising of conditions. Problem with criteria means there is bounceback from Community Mental Health teams to GPs.

A - 20 minute crisis visit. Is that really enough for people? What adjuncts to that crisis support?

A - Need for less barriers from professionals reported.

Specific User /Carer Reports

Severe challenge of trying to drive ill person to hospital while they try and open car door.

Level of mental distress can mean help required 'right now'.

Notes from Service User Public Partner

Option modelling over 2 days based on collected information to be given to IJB and NHST to agree a preferred option in Feb

Consultation as a series of roadshows over 3 months of preferred option

Quality Impact Assessment of demographics, deprivation and ethnicity etc will inform the preferred option

Can access progress on NHST website- our services-mental health

http://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthServiceRedesignTransformationProgramme/index.htm

Integrated approach with Health and Local Authority to redesign new models of care

Therefore need to continue to engage at all levels

1.22 Feedback from Service Users and Carers in Perth received 23rd January 17

NHS Tayside - Mental Health Re-Design
Transformation Programme

Support in Mind Scotland
Perth and Kinross Response

Support in Mind Scotland Carers' Workers were invited to and attended the consultation event at Ninewells on 29th September and represented Carers' views. As the Mental Health Carers Support project in Perth and Kinross we have worked in conjunction with the Community facilitators and the Carers Representatives on the Integrated Joint Board and Carers Voice, PKAVS. As our project works solely with, and for mental health carers, we ensured all relevant information has been sent to all project carers, and with them, and for them, we have attended the open consultation events.

We have also been in consultation with the other Mental Health organisations in Perth and Kinross and support the Mental Health Community Services Providers Group responses.

Consultation with Carers
We have consulted and gained the views of carers involved within our project on the above paper.

The carers of Support in Mind Scotland are keen that their views are heard through our organisation. We have achieved this through open discussion within the 5 Carer Support groups which are held across Perth and Kinross, and through direct conversations carers have had with us.

For ease this response is arranged taking one point at a time. The issues relate to the options which put forward the closure of Moredun Ward at Murray Royal Hospital. The word "patient" is used throughout as this is concerning in-patient care, but recognising in the community they may be referred to as clients or service users.

1. All carers wanted safe and good in-patient care.

2. Carers expressed that they would prefer to have hospital /inpatient care for the person they care for, as close as possible, and preferably in the community in which the person lives. This they feel reduces stigma, helps

recovery, and keeps those they care for closer to their homes, closer to those who love and care for them, and to the staff who keep them well.

Carers feel that mental health patients do not require the large amounts of specialised hospital equipment, which other medical specialties do, and so the in-patient beds they need do not necessarily require to be on a large medical centralised hospital site.

Carers believe that mental health care benefits from consistency of staff, committed staff and staff who are given time to know the patient. Carers want person centred care. Carers see value in the staff, who know the patient when they are well, being able to recognise when the patient is starting to relapse, and so are able to re-act promptly to prevent further relapse and so crisis.

When staff know their patients, they also get to know their carers, and so carers feel, together, they can find ways of jointly of working to maintain the patient's wellbeing and stay included in their community. This centralised policy for beds is more medically driven they feel, than patient centred, although they acknowledge the financial pressures and the staffing issues faced by NHS Tayside.

3. It is felt by carers that increased resources are needed in the community to reduce and prevent admission to in-patient care. Community care resources, carers feel, should not only be increased but also extended to include supports at weekends and in the evening. Most crisis situations seem to come out of regular working hours.

   At present carers feel the community is and has been under resourced, and has had significant nurse and consultant shortages. There has been significant turnover of staff, with locums, all of which has not been of benefit to patients, slowing their recovery, and so putting extra stress on their families, and as a result may have resulted in more hospital admissions. The rurality of P+K can put extra demands on services, but still needs to be supported.

4. There are concerns surrounding the number of beds. The in-patient bed numbers have been reduced since many carers have been involved with the project. The old Moredun "A" and "B" had 22 beds, each with 4 intensive care beds. Once these Wards closed and moved to the new Murray Royal Hospital, 30 beds were deemed to the requisite number for P+K's population. When the ward was re-configured to allow separate male and female rooms the number of beds were reduced again. 24 beds.

Carers are unsure whether there are sufficient in-patient beds to serve the P+K population. Carers have experienced situations where the person they care for has been unable to be admitted to a bed, and they have had to manage to keep and care for them at home until a bed has become available; others have seen patients sent to other units sometimes in or out of Tayside. Some patients have been discharged early, to free beds, before the carer feels they are fully better, and have therefore had to provide significant supports and care for the patient. The project would like confirmation on the numbers of beds that are thought required for the current P+K population base, and the prediction of need in the future.

5. Carers are concerned that when Murray Royal Moredun was re-opened by the NHS in 2013 that it was thought to be the "Vision of the Future" and was going to enable "rehabilitation"; however within a short period time planners seem to have re-considered this. Now, 3/4 years later there are new plans, again thought to be the correct way

6. Are the consultants and junior doctors who will care for patients' not in P+K in-patient units, going to be required to provide medical care out in the community of Perth and Kinross? If there is a current shortage of medical cover with in-patient care, will this shortage still transfer into the community, despite where the beds are, which has had difficulties already in recruitment of consultants.

7. We are aware that out-patient medical, and psychology appointments can be held in the in-patient hospital and carers ask if this will remain at Murray Royal or would this stop, with patients then having to travel to Ninewells , which could entail significant increase in travel, which would affect the majority of P+K population.

8. Carers in highland Perthshire and the Aberfeldy area would have appreciated consultation events to have been brought out of Perth, closer to their community, as the implications of the service will have an impact particularly on them, and planners would there be aware of their community and the distances involved.

9. There remains a strong feeling amongst carers that there will be significant pressure on them to provide transport for admissions, discharge, weekend passes, and home rehabilitation time, all of which will put additional stress on carers, especially if they have had to drive a patient for their admission.

   If a long journey has needed to be made by a carer driving to reach the hospital, it could be an unpredictable and stressful time, as the patient could be anxious, agitated, and fearful/not wanting admission. Weekend and day passes also will put time and emotional stress onto carers, and could be

harder for them to achieve, due to the amount of time this will require of them to find, and perhaps not taking into account their home situation.

10. Carers would recommend and ask for setting aside a dedicated "Carer " area to support carers who perhaps have travelled far, have waited, and or are exhausted with stress of driving, supporting, waiting for assessments, etc

11. It is now accepted that carers are "Equal Partners in Care", and their role in the recovery of patients is significant. For working carers they may have significantly greater distances to travel and so may have to reduce their visits, and so less involved in the patients care and recovery. They also may be unable to attend all appointments, due to distances and the time needed away from work.

12. Non - working carers too will be faced with longer journeys, and will need to find more time to make visits, which may bring complications with their home lives, as they may care for another family member, and/or have child care responsibilities. There will also be cost implications with either buses fares or petrol and parking costs, which might have implications to those with limited finance.

13. Visiting mental health patients can bring challenges for carers/ family members, as often those they visit can be unresponsive, resent their admission, want discharge, and can be not grateful for their visit. As a result of this, and if the distance is great, families may opt to visit less, especially those family members less able to cope with handling this behaviour which can come out of the illness.

    Reduced carer visits prevents staff having beneficial discussions with families to help with treatment, and the patients loses the stimulus of families and friends interactions which helps with their recovery as they miss the interaction of their family, the news from home etc.

14. Carers were unsure if the in-patients wards were going to be single sex, as proved more beneficial at Murray Royal; and would like to request that consideration could be given to putting younger patients in the same ward as each other, as transitions from adolescent services and adult services can have difficulties; and also asked about wards being area-specific – ie. Perth and Kinross only.

15. It is important for patients that they have easy access to "green spaces "safe outside space and or the inside courtyards as in the current Murray Royal, all help with patient recovery.

16. There is a concern that families/carers will have pressure on them to drive those they care for to Ninewells for the in-patient assessment. If the patient is subsequently assessed to be not needing admission carers then have drive back home. It is felt that if an inpatient stay is being considered the patient must be un-well so this amount of travel could be extremely difficult for patients and carers, and their help acknowledged. If families/carers do not make the journey, who else would provide the transport?

17. There is also a fear that more detentions may happen if patients have become more agitated due to the distances and the time needed to reach the hospital. Carers are keen that detentions are only used for the right reasons. Has consideration been given to comparing transportation time/admission time and use of detentions?

18. Could there be a crisis assessment centre in P+K to prevent travel in the cases above, and if one was open this might prevent or be able to support patients to prevent admission.

Summary

Carers in Perth and Kinross feel very anxious that this change will have a significant negative impact on the patients and their carers due to:

- Lack of continuity of local staff who know the situation and can intervene early
- Less focus on local rehabilitation and recovery
- Reduction in the number of beds available
- Lack of experienced clinical staff
- Increased distance to travel with huge impact on carers' time, resources and stress - particularly those with other caring responsibilities including childcare
- The specific issues faced by Mental Health Carers such as patients being unwilling to attend, or unwilling to have visits; additional stress and also the issue of detentions.

Carers ask for consideration to be given to these important issues they will face due to losing local facilities.

Sarah Cox
Support in Mind Scotland
Perth and Kinross, Carers' Support Worker

1.23 E-mail received from Jillian Milne, Chief Executive, Mindspace 23 January 17

Thank you again for coming along and meeting with us in December 2016. Further to your request for feedback, please find below collated comments from the Perth

and Kinross Mental Health Community Services Providers Group regarding the Transformation and Redesign of Mental Health Services.

Additional Data: Unless this information is in the documents which cannot be opened on p99, there is no information available on the number of hospital admissions (both no' of admissions and no' of individuals). Given the importance of geography to this decision making process, it would also be a useful exercise if this data was further interrogated in terms of the home addresses of patients. This would then give a much more detailed overview of the situation. The 2 day consultation exercise that so many P&K people did not attend/were not invited to seems to consider the situation from a beds/workforce point of view. Ideally, any data analysis would then also tie this in with the community based services available to those patients, and how/where these are concentrated.

Community Based Care: Given the importance of Community Based Care to support this process which is cited throughout the Mental Health Service Redesign Transformation Programme Option Appraisal Report, could information be shared on the approach which is going to be taken to strengthen community based resources across the sectors? In the event that the number of hospital sites will be reduced, it would be helpful to find out more information about how existing resources may be used differently (such as Mental Health Officers, Community Mental Health Teams and voluntary organisations e.g. Mindspace, Support in Mind, Rasac, Women's Aid, Six Circle, PKAVS etc) and whether/how additional services will be commissioned? What opportunities will local service providers, service users and carers be afforded in terms of the planning and co-design of any new community service models? How will the Transformation process dovetail with local Health and Social Care Planning Partnerships to ensure there is an overall planning process focussed on the best outcomes for those who use services?

Admissions Process: There needs to be clarity on the admissions process, and how this will change if the number of sites are reduced. Given the recent changes within the Perth and Kinross Crisis Home Treatment Team (out-of-hours assessments will transfer to the Carseview Centre between 3pm and 9am weekdays and at weekends), it would be helpful to know whether there would be any localised assessment/admission process or whether this would also be hospital based?

Access Issues: In terms of access and public transport issues, if there were a breakdown of home addresses of patients, this would also make the analysis of travel by car/public transport more illuminating. Is it feasible for people living in these areas (and their carers) to get to their designated hospital and back again? What consideration will be given to their discharge and visiting times? What will happen to outpatient appointments/services? Is there an option for dedicated transport services to be set up? Is there any information on the impact on partners, in particular, the Scottish Ambulance Service and Police Scotland? Moving services out with the local area could significantly increase travel time and cost for the service

user, their family and other partner agencies such as the Police, Ambulance and Mental Health Officer services. Has there been any consultation with GPs who may need to support a more complex level of need in local communities if more specialist assessment facilities are less accessible due to transport and travel issues? Some of those who require access to crisis mental health assessments can be quite unwell, distressed or difficult to support and the use of public transport or car is either unmanageable or unsafe. There will need to be a clear policy/criteria on access to NHS transport.

- What formal impact assessment has been completed to date as part of the Transformation process, and have service users, carers and service providers had a genuine opportunity to contribute to these?

You will note that these points emphasise a high level of concern regarding the erosion of local service provision. We look forward to working with you to ensure that the people of Perth and Kinross receive quality mental health provision commensurate with our population, geography and level of need.

On behalf of the P&K Mental Health Community Service Providers Group

Jillian

Jillian Milne

Chief Executive

MINDSPACE

Mindspace Limited

1.24 Feedback from Service Users and Carers in Angus 25 January 17

NHS Tayside - Mental Health Re-Design
Transformation Programme

Support in Mind Scotland
Angus Response

Consultation with Carers
We have consulted and gained the views of carers involved within our project on the above programme. The Angus carers of Support in Mind Scotland are keen that their views are heard through our organisation.

We would echo the sentiments of our Perth & Kinross team, who have submitted the views of our Perth & Kinross carers in a recent response, collated by Sarah Cox, Carers Support Worker.

We have been asked by carers in Angus to raise the following points, in relation to the plans within the programme for the possible closure of the Mulberry Unit at the Susan Carnegie Centre, Stracathro Hospital, and its implications.

- Major concerns in relation to travel – significant pressure on carers, not only for visiting, but also in providing transport for admissions, discharge, weekend passes, and home rehabilitation time, all of which will put additional stress on carers. If a long journey has been made by a carer driving to reach hospital for an admission, it could be an unpredictable and stressful time, as the patient could be anxious, agitated, and fearful at the prospect of admission.

- Emotional and financial impact of additional travel involved - faced with longer journeys (especially if public transport required and limited services in some rural areas), leading to more time needed to make visits, bringing complications with home lives, balancing work, other caring responsibilities and commitments. There will also be cost implications for all carers, but in particular those with limited finance.

- Concerns over implications for strain on Community Mental Health Teams, and worries around what services will be available to provide additional

support needed in the absence of local inpatient care - increased resources needed in the community to reduce and prevent admission to inpatient care.

- Concerns over continuity of care within community mental health services, which would be increasingly impacted by these changes – Carers believe that mental health care benefits from consistency of staff. Angus carers have been concerned about their experiences of regular staff changes within teams.

- Concerns over a potentially increased number of unwell patients remaining in the local community, who would not wish to be treated via Perth or Dundee, due to difficulties for family members not being able to visit regularly and provide support to them.

- Angus carers have the same concerns as those in Perth & Kinross, in regards to the number of beds which will be available. This is already beginning to cause anxiety for carers loved ones', who are worrying about what might happen should an inpatient admission be required.

- Carers have expressed concern about the impact on a loved ones' recovery – family support is a significant factor in this, which may be greatly affected if extra time and distance are needed for visiting and giving support during inpatient admissions. Carer interaction with key members of staff involved in their loved ones' care would also be impacted if visits were reduced.

Summary

Angus carers feel very anxious that this change will have a significant negative impact on the patients and their carers due to:

- Lack of continuity of local staff
- Less focus on local rehabilitation and recovery
- Reduction in the number of beds available
- Increased distance to travel with huge impact on carers' time, resources and stress - particularly those with other caring responsibilities including childcare
- The specific issues faced by Mental Health Carers such as patients being unwilling to attend, or unwilling to have visits; additional stress

Carers ask for consideration to be given to these important issues they will face due to losing local facilities.

Georgie Evans
Support in Mind Scotland
Angus Carers' Support Worker

1.25 **E-mail from Positive Steps request information re options and response sent.**

I read the December Newsletter today updating the process to date. I went back to the indicated Board papers but neither there nor in the outline of each option could I find any information on the effect of the proposals on the number or availability of acute beds across the region. Could you please direct me to where I might find this information.

Many Thanks.

Kind Regards,

Richard

Richard Howat

positive steps
real people real solutions

DSEN Member

POSITIVE STEPS 1969 SILVER JUBILEE 2014

Dear Richard

I have summarised the acute bed numbers for you below.

Current General Adult Psychiatry Inpatient beds are provided as follows:

Angus - Mulberry ward 25 beds
Perth - Moredun ward 26 beds
Dundee - Carseview Ward one and Carseview Decant ward have 40 beds plus 4 Advanced intervention service beds
IPCU - 10 beds for Tayside in Carseview Dundee
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards

Option 3A

Tayside - Carseview Ward One and Carseview Decant ward have 40 beds plus 4 Advanced intervention service beds plus the new two x 22 bed wards = 88 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Option 4A

Perth and Dundee - Carseview Ward one and decant ward 40 beds plus 4 Advanced intervention service beds plus one new x 22 bed wards = 66 beds
Angus - Mulberry ward 25 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity

Option 5A

Angus and Dundee - Carseview Ward one and decant ward 40 beds plus 4 Advanced intervention service beds plus one new x 22 bed wards = 66 beds
Perth - Moredun ward 26 beds
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Option 8

Dundee - One acute admission ward 18 to 22 beds for Tayside plus 4 Advanced Intervention Service beds
Angus - Mulberry ward 20 to 25 beds for step down/treatment
Perth - Moredun ward 26 beds for step down/treatment
Dundee - Carseview 22 beds for step down/treatment
IPCU - 10 beds for Tayside in Carseview Dundee - remain
Rehabilitation and complex care for Tayside in Murray Royal - 26 beds currently across 2 wards - currently being reviewed with potential to increase rehabilitation capacity if required

Each option being considered will require reinvestment in community services to support the inpatient bed model and this is being captured as part of the examination and analysis of each option to allow identification of a preferred option.

Hope this is helpful and please let me know if have any further queries or require any further detail.

Kindest Regards

Lynne Hamilton

Mental Health Programme Director and Finance Manager

1.26 Angus press enquiry re delay in decision on the future of Mulberry Unit

From: Amanda Cameron [mailto:amanda.cameron@jpress.co.uk]
Sent: 24 April 2017 12:49
To: TAYSIDE, Communications (NHS TAYSIDE)
Subject: Mulberry Unit

Good afternoon,

We've have been contacted by Councillor David May from Angus and Mike Rumbles MSP with regard to the decision on the future of the Mulberry Unit.

In their correspondence they have said that they have "criticised the delay of a decision on the future of the Mulberry Unit".

Mr May has said: "It is appalling that this decision has been delayed yet again. I suspect that this is political judgement rather than being in the best interest of patients, their families and the units staff. It has long been suspected that the direction of travel is towards the closure of this unit and it's about time that local people were given some clarity."

Would it be possible to get a comment from the NHS with regard to this matter.

Thanks

Amanda

-- Amanda Cameron
Multimedia reporter
Angus South
Twitter: @acp_amanda
Direct Dial: 01241 435773
VOIP: 6025 5773

1.27 Dundee press enquiry re funding for mental health provision

From: Steven Rae [mailto:srae@dcthomson.co.uk]
Sent: 24 April 2017 13:37
To: TAYSIDE, Communications (NHS TAYSIDE)
Subject: Bi-Polar

Good afternoon,

The co-facilitator of the Dundee Bi-Polar Self Help Group, Eilidh Rankin, has been in touch with us about funding for mental health provisions.

She spoke on the back of the story we had in Friday's paper, about Grant Brady, who claims he was previously "turned away" from Carseview, despite being seriously mentally ill and suicidal.

She said: " "There are definitely issues with mental health provisions in Tayside – and across the UK.

Consultation Feedback from LD Senior Team Meeting
Dudhope Castle, Tuesday 6th December 2016

"The users of our group have essentially doubled since we started in September, and that's for bi-polar people. There are a whole range of mental health problems that people suffer from.

"The most we have had is 20 attend a session, and I wouldn't be surprised if that number continues to go up.

"As for people apparently being "turned away" from places like Carseview – I am quite shocked.

"Although I can't go into details, we have had people who come to our group and others across Scotland who have felt they are at a point in their lives where it could be them who are in the situation when they really need that kind of help, it could be a life or death situation, the awful mental state they can be in. But coming to our group and others can really help that.

"The NHS is under so much pressure and mental health service are always being cut. It's the "Cinderella of the NHS" – poor and underfunded.

"There have been cuts made so far and it will only worsen and already bad situation, I think.

"It's not surprising that facilities like Carseview and elsewhere are struggling.

"Services have been badly underfunded for a long time and there doesn't seem to be many people sticking up for increased funding.

"Mental health problems are often an unseen illness, so because you can't see it, it's easier to cut. But there is a funding crisis in the NHS."

- What does NHS Tayside make of Ms Rankin's claim that mental health provisions are "the Cinderella of the NHS"?
- Is there a funding crisis in NHS Tayside when it comes to mental health provisions, if so, how will that be remedied?
- Any other comment to make?

Could someone get back to me by the end of today?

Thanks

Steven

Steven Rae
Senior Reporter
Evening Telegraph

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Evening Telegraph
Dundee Born and Read

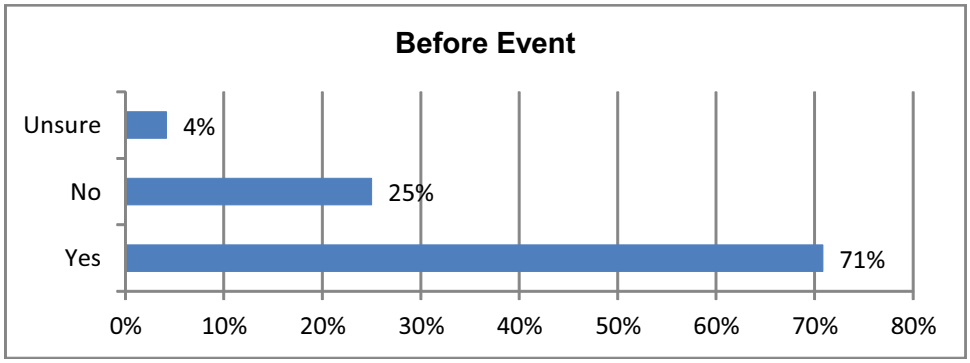
DRAFT

Mental Health Improvement Programme
Options Appraisal Training – 16 June 2016

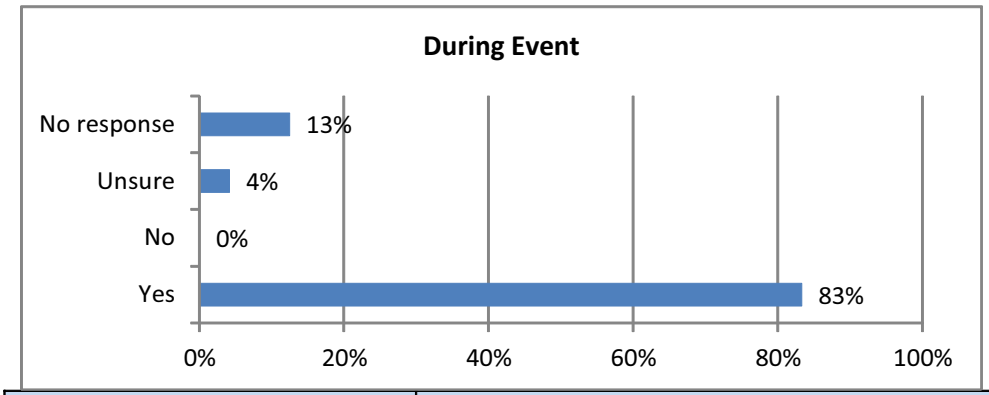
NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal training for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of twenty four questionnaires were completed.

EVALUATION - Analysis

1. Did you get enough information to help you prepare:

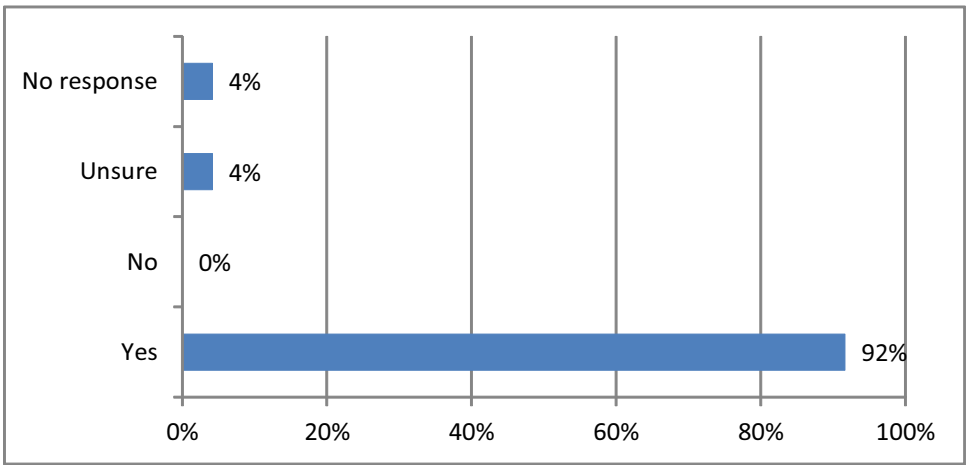


Answer Choices	Responses
Yes	17 (71%)
No	6 (25%)
Unsure	1 (4%)



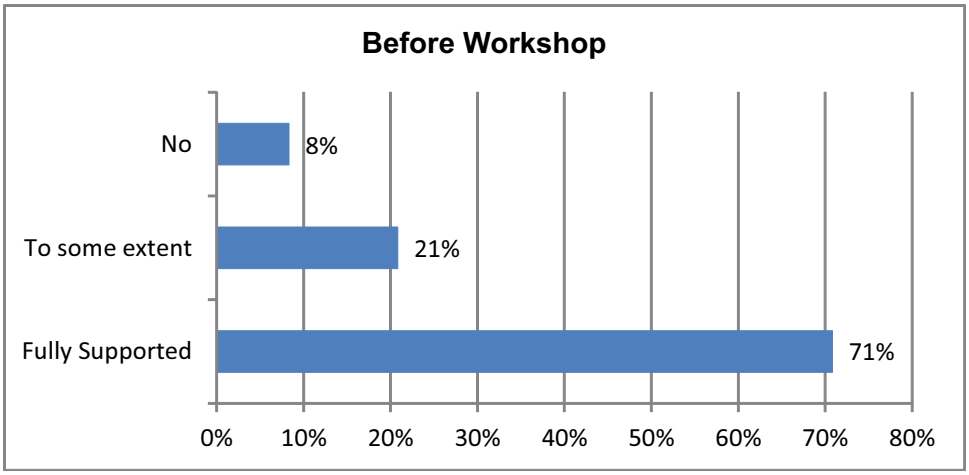
Answer Choices	Responses
Yes	20 (83%)
No	0
Unsure	1 (4%)
No response	3 (13%)

2. Was this information easy to understand?

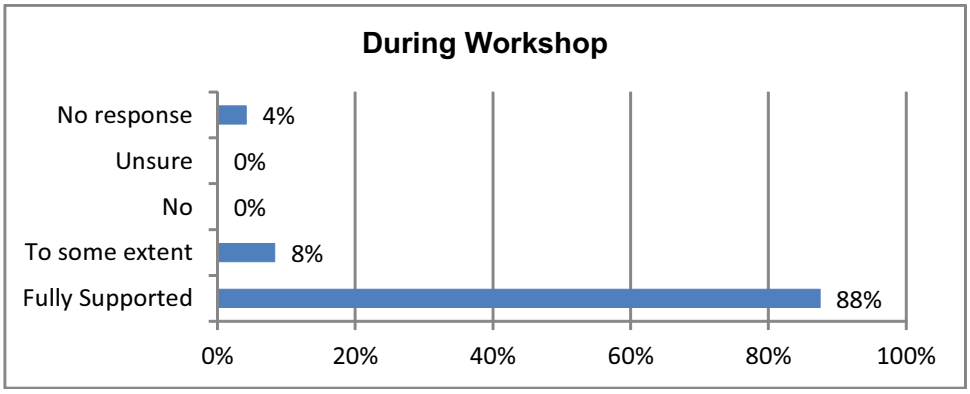


Answer Choices	Responses
Yes	22 (92%)
No	0
Unsure	1 (4%)
No response	1 (4%)

3. Were you provided with the support you needed to participate effectively?

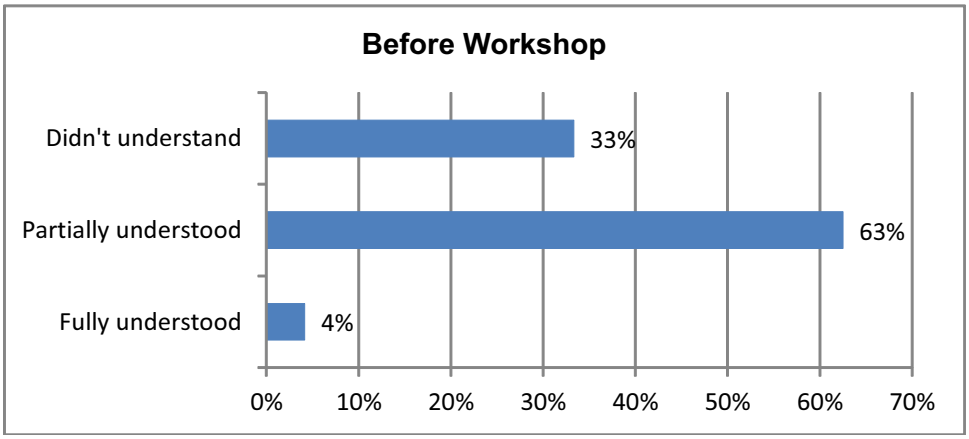


Answer Choices	Responses
Fully supported	17 (71%)
Supported to some extent	5 (21%)
No	2 (8%)

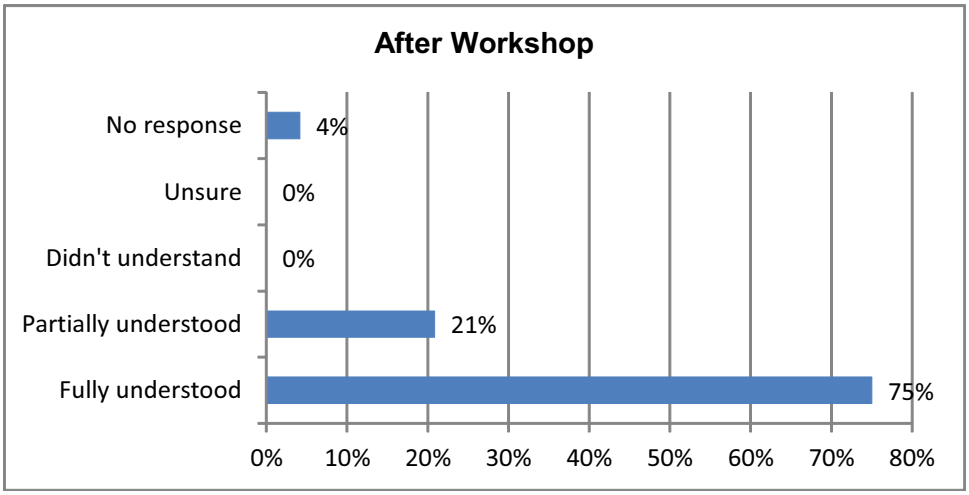


Answer Choices	Responses
Fully supported	22 (88%)
Supported to some extent	2 (8%)
No	0
No response	1 (4%)

4. How well did you understand the optional appraisal process before the training workshop and after?



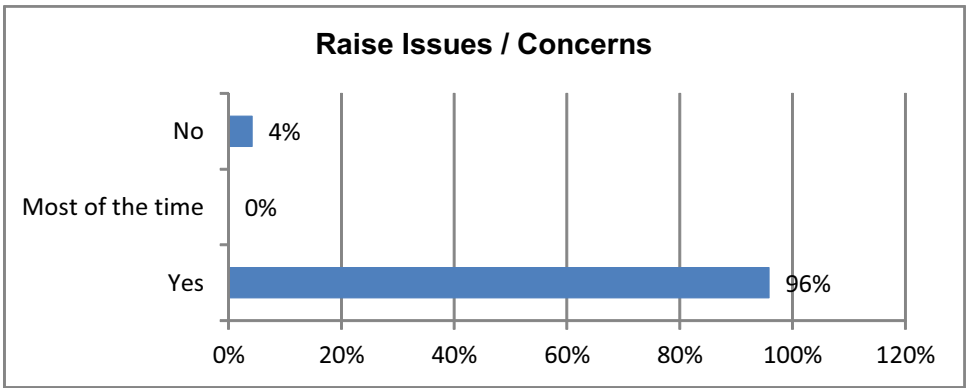
Answer Choices	Responses
Fully understood	1 (4%(
Partially understood	15 (63%)
Didn't understand	8 (33%)



Answer Choices	Responses
Fully understood	18 (75%)
Partially understood	5 (21%)
No response	1 (4%)

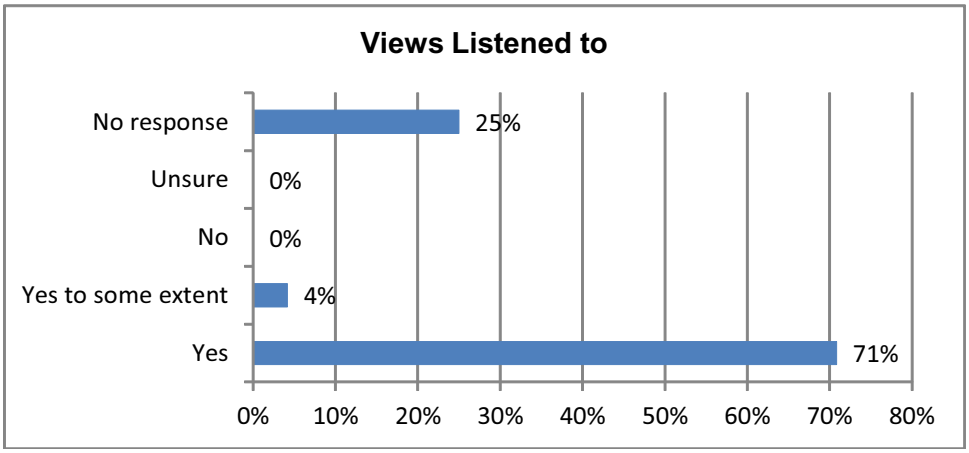
5. During the training workshop did you have the opportunity to ask questions or raise issues or concerns.

100% of attendees had the opportunity to ask questions.

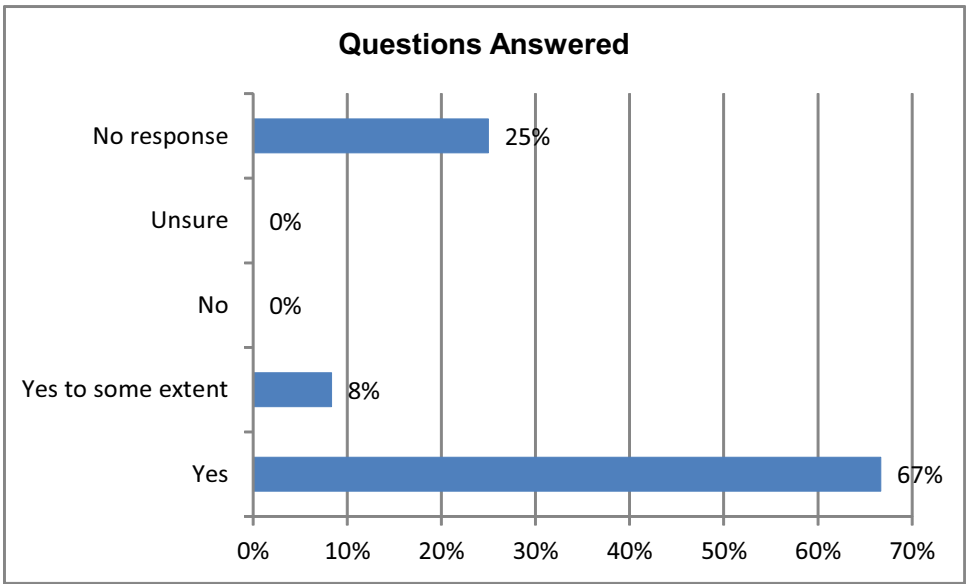


Answer Choices	Responses
Yes	23 (96%)
Most of the time	0
No	1 (4%)

6. Do you feel your views were listened and your questions answered during the workshop?



Answer Choices	Responses
Yes	17 (71%)
Yes to some extent	1 (4%)
No response	6 (25%)



Answer Choices	Responses
Yes	16 (67%)
Yes to some extent	2 (8%)
No response	6 (25%)

7. Were the next steps in the process explained to you?

All attendees said the next steps in the process were explained to them.

DRAFT

Mental Health Improvement Programme
Options Appraisal Training – 16 June 2016

NHS Tayside and the Scottish Health Council asked participants at the Mental Health Improvement Programme Option Appraisal training for feedback in their involvement in the process to identify and appraise options for the adult mental health and learning disability service model. A total of twenty four questionnaires were completed.

EVALUATION

Analysis

8. Did you get enough information to help you prepare:

There was a mixed response from participants in relation to getting enough information to help them prepare before the workshop. 17(71%) intimated they had enough information, 6(25%) considered they did not and 1(4%) was unsure if they received enough information. The responses demonstrated that they were given enough information during the workshop as indicated by 20 participants of the 21 whom responded to this question.

Participants were asked what additional information would you have found helpful?

The following comments were submitted:-

- *More information about workshop would have been helpful.*
- *Didn't receive email of last minute change of time*
- *Came in place of my manager at short notice. But workshop was informative*
- *An agenda and some bullet points beforehand might have helped to keep the discussion focussed*
- *A summary of what was going to be discussed. Also, change to timing of session should be notified in time to avoid me turning up forty five minutes early*
- *Did not get the email with attachments. Times were changed, no information that the venue had been changed on the 20th June*

9. Was this information easy to understand?

The majority of attendees 22(92%) found the information easy to understand.

Comments to support this:

- *Difficult to follow but understand process.*
- *Very well presented*

10. Were you provided with the support you needed to participate effectively?

17(71%) of the participants indicated they were provided with the support they needed to participate effectively before the workshop and the majority of attendees 21(88%) felt they were provided with the support they needed to participate effectively during the workshop.

11. How well did you understand the optional appraisal process before the training workshop and after?

Only 1 participant fully understood the option appraisal process before the training workshop but following the training workshop, this rose to 18(75%).

The following comments were submitted:-

- *Looking forward to the two days*
- *Very well presented*

12. During the training workshop did you have the opportunity to ask questions or raise issues or concerns.

All in attendance said they had the opportunity to ask questions during the workshop and the majority 23(96%) said they were given the opportunity to raise any issues or concerns.

13. Do you feel your views were listened and your questions answered during the workshop?

Of the18 participants whom responded to this question 17(94%) intimated that their views were listened to and 16(88%) intimated that their questions were answered.

Comments submitted to support this response are noted below:

- *I did not ask any questions but would have felt comfortable doing so*
- *Facilitators did an excellent job in trying to balance the need to answer queries and trying to attend to the larger group*
- *Didn't voice any but felt they would have been addressed*
- *I didn't express a view. The discussion was taken over disproportionally and diverted and I felt it curtailed participation,*

- *I had questions and they were satisfactorily answered*

14. Were the next steps in the process explained to you?

All attendees said the next steps in the process were explained to them.

15. Please let us know if you have any other comments or suggestions about the workshops.

- *Looking forward to the two days. A lot of work expected.*
- *I enjoyed the workshop and felt the information was very good. Thank you.*
- *The training was good, gave a good insight into the option appraisal.*
- *A physical example in the slides of the scoring against east options of the example given may have helped some people in the room. But explained very well. Thanks.*
- *Tracey deserves a medal*
- *Not enough room for all who attended.*

Findings

It was evident that more information could have been provided to help the participants prepare for the option appraisal training workshop. The information which was provided was considered easy to understand.

The results were positive in relation to the support provided to participants in order for them to participate effectively both before the workshop and also during the workshop.

All participants felt they were given the opportunity to ask questions. The majority of participants felt their views were listened to and their questions answered during the workshop.

It was apparent that the option appraisal training increased participants understanding of the process.

Recommendations

Based on the feedback received when planning similar events in the future, ensure sufficient information is provided to help participants prepare.

Feedback on tables from Option Appraisal Workshop 20th June 2016

TABLE ONE

Geography – equity of access to inpatient provision and equity of access from inpatient site to local community resources

- Access for carers/family/friends
- Ease of access re in reach/outreach services
- LD Patients travel
- Female LD patients
- Community Services models and provision including 3rd sector /vol sector
- Transport Links?
- Delayed discharges LD
- Specialist challenging behaviours & complex care – pathway
- LD community teams – community staff
- BSI
- Forensic LD nursing
- Forensic Psychology
- Consultant Psychiatry
- Helpful to have co located with beds but not essential

LD inpatient and community facilities together. Workshops & gardens on a big enough scale

- Community activities accessed by all LD with support work, leisure model to be duplicated in Perth Dundee and Angus, Joint with IJBs
- LD Nursing staff current daily model of care to incorporate the support needed for clients in the community eg travel & activities

Option Feedback

Option 1 A – NO

- LD model is unsafe in the configuration presented.
- Patient mix is not appropriate.
- GAP at MR would require new builds
- GAP equity of access for patients/staff/visitors

Option 1B – Possibility for LD

- GAP as above

Option 2A – NO

- LD as per 1A
- GAP – equity of access, IPCU split from acute admissions and in MR

Option 2B – Possibility for LD as per 1B

- GAP as 2A

Option 3A – NO

- LD patients – equity of access re Angus patients (majority of patients Dundee & Angus)
- Risk management re transporting day patients with forensic needs

Option 3B – YES

- Better equity of access for patients/families/visitors (would require major refurbishment)
- LD forensic to Rohallion
- LDAU to Strathmartine

Option 3C – NO

- LD as per 1A

Option 3D – YES

- Accessibility, central location
- LD new build would allow bespoke model of care
- Central workforce resource

Option 4A – NO

- LD model not safe in 1 ward

Option 4B - NO

- LD equity of access for Dundee & Angus patients
- GAP at Stracthro – difficult to provide workforce model required.

TABLE TWO

Option 1

- Not sure of land availability at MR and Finance
- Carseview – large empty parts?
- Travel issues for those furthest away
- Community services difficult to link in at distance
- B) refurbish less attractive

Option 2

- Similar issues to Option 1

Option 3

- A) moving Strathmartine services – MRH Day care community services need to be maintained.

- Issues with adjacencies regarding rehab GAP acute.
- B) centralising
- C) Geographical split in LD
- D) rebuild – ideal more important to be based together, Rehab not adjacent.

Option 4

- LD centralised in Perth - day service issues 4B and 4A, split services
- Rehab not co-adjacent
- Transport for GAP

Option 5

- Split LD service
- Acute service two sites
- B) Preferable

Option 6 – REJECT

Option 7 – REJECT

Option 8 – Status Quo and new build for LD on Strathmartine site

- ? Sustainable workforce
- Doesn't tackle issue at LD on multiple sites?
- ? viable model across three GAP sites
- Concentrate GAP on one site, LD on one site
- Need to have awareness of community
- Important to keep LD service together

Option 3B } site for GAP supported by enhanced community models across the board
Option 5B } particularly Angus. Two site for GAP. LD on one site preserves Strathmartine well accepted.

Caveats – Need to enhance community model, think beyond medical model. Keep LD on one site, Adjacencies between GAP and Rehab

TABLE THREE

Notes -

Option 1A -

- Concerns re viability – recruitment, pathways for patients, travel, links/outreach & community teams

Option 1B -

- As 1A above

Option 2A –

- Location creates accessibility issues ++ (as for 1A)

Option 2B –

- As 2A

Option 3A –

- Access better for Dundee but LD impact significant
- Low secure/LD beds – not bad!

Option 3B –

- Access to community modelling

Option 3C –

- LD Forensic/Low Secure Perth - Not Bad!
- LD SHX bed base - ?okay
- GAP Dundee – possible

Option 3D –

- Flat 1 better at MRH but services in Dundee & reasonable access??
- (would need better community)

Option 4A –

Option 4B –

- LD – Perth
- Angus ISQ

Option 5A –

- LD split
- GAP Dundee & Perth

Option 5B

Option 6A –

- Carseview
- LD Strathmartine

Option 6B –

- LD
- DD GAP and Angus, IPCU

Option 7 –

- DD GAP – Angus
- LD Strathmartine new build

Option 8 –

- Everything on MRH site
- GAP IP beds from SHX
- LD IP beds
- Community modelling

Option 9 –

- Everything on SHX site?
- GAP IP beds
- LD IP beds

Option 10 –

- Beds – as few as your community services can support and /or as many as you can afford.

Shortlisting –

Option 1A – NO

- Viability – recruitment, travel, patients/carers, not good use of estate, long term patients in place, in equity of access.
- Longer stay patients (rehab) in least accessible environment.
- Travel for families – onerous
- Recruitment of staff a challenge in Perth
-
- Community structure pivotal

Option 1B – NO

- Even less accessible
- Worse than 1A

Option 2A – NO

- Yes if locate IPCU close to low secure
- No increase Ambulance transfers for highest risk patients
- Fewest people live in Angus so inequity ++ All GAP beds in SHX

Option 2B – NO

- Worse than 2A
- Reasons above
- Access to Strathmartine now future proofed – isolated

Option 3A – YES

- LD & low Secure +ve
- Acute GAP facilities on one site +ve
- All LD on one site +ve
- Predicated on less beds and more community
- Not designed around local access –ve
- Needs community +++
- Acute crisis response needed for Angus & P&K (-ve)

Option 3B – YES

- As 3A above predicated on less beds and more community

Option 3C – NO

- LD located in 2 sites – diluting expertise
- Recruitment in Angus (-ve)

Option 3D – NO

- LD together (+ve)
- Currently isolated? (-ve) planning for housing?? i.e in 5 years will be better roads and infrastructure?
- Assessment unit on Strathmartine – less access to acute care

Option 3E – NO

- LD forensic in Low dependency in MRH (+ve)
- No better than 3D above re isolation so NO

Option 4A – YES

- Off Strathmartine and all LD together and Low Secure
- Predicated on less beds and increased community

Option 4B – YES

- LD in one site
- Predicated on less beds and increased community
- Access to own community challenging for angus (-ve)

Option 5A – YES

- As above

Option 5B – NO

- Strathmartine – LD NO

Option 6A – NO

- Strathmartine isolated

- Deprivation levels – inequalities ++

Option 6B – NO

- As above 6A

Option 7 – NO

- As above 6A

Option 8 – NO

- As above 6A

Option 9 – NO

- As above 6A

TABLE FOUR

Option 1A – NO (5 votes to 1)

- LD service all together (+ve)
- No as all acute at MR, hard for staff, carers visit – away from local community
- No resource for new build
- No inpatient beds at SHX
- Decreased staff cover, rehab wards at SHX not workable due to location
- Staffing concerns – rehab in isolation in Angus

Option 1B – NO (5 votes to 1)

- Possibly Yes refurb LD all on one site (+ve)
- No to rehab at SHX not using Carseview
- Again acute all at MRH no is=deal for family, services, rehab but LD all together
- Staffing concerns rehab in isolation
- Too rural for Rehab
- Doesn't utilise Carseview, future proofing of Strathmartine not possible due to site

Option 2A – NO (5 votes to 1)

- All services for LD in Carseview (+ve)
- Total split of all sites/services- under use of Carseview
- Splitting off service on all 3 sites, not good idea
- No acute admission in Perth
- Not ideal for Perth as travel for families and carers but LD altogether which would be ideal
- Not enough staff – too far for Perth patients

Option 2B – NO (5 votes to 1)

- LD services in one place if refurb good standard (+ve)
- Not utilising Carseview site
- Splitting of services not good
- Not using Carseview
- As above NO
- Again patients to travel but all LD together is good

Option 3A – YES (5 votes to 1)

- Maximises use of resources and sites
- Possible but not ideal, however issues around moves to MR for LD
- Possibly LD in one area, may be staff resource issue
- Concentration of services on 2 sites
- YES please
- Don't like all admissions to Dundee

Option 3B – YES (5 votes to 1)

- Yes good idea centralisation of services
- Good for LD and GAP
- Good to refurbish Strathmartine
- If refurb good standard for LD
- Possible option
- Doesn't provide best accommodation available for LD and Strathmartine site doesn't have ability to refurb to provide modern services

Option 3C – NO (4 votes to 2)

- Possible option
- Concern for LD staff resource getting to Strathmartine
- Poor Access and transport links for patients from Perth etc
- Isolation of facilities, local services
- NO
- Don't like LD at SHX

Option 4A – YES (5 votes to 1)

- Yes my favourite for LD services
- Possible option
- Yes centralisation of services, good for LD services
- YES
- Like new build for LD
- No capital available for new build (-ve)

Option 4B – NO (4 votes to 2)

- Acute admission in Dundee (+ve)
- Centralisation of LD good
- Yes for LD

- Could see this option working
- Preferred option
- No same as 1A
- NO
- Doesn't utilise all sites
- Not a feasible option – no crisis intervention in Angus
- No standalone
- No staff at Stracathro
- Not keen on all LD at MR

Option 5A – YES (4 votes to 1)

- Maximises estate and provides safe services
- YES LD split
- Think this would work
- Feasible option to consider
- NO

Option 5B – YES (4 votes to 2)

- Yes if good standard of LD refurb
- Feasible option to consider
- YES – better LD
- Like refurb for Strathmartine
- Not ideal option for Angus residents if detained in Perth
- Not best use of accommodation and no capital for refurb / ability to refurb to standard for modern healthcare

Option 6A – NO (5 votes to 1)

- Possible option
- No GAP in Dundee
- Doesn't maximise use of estate – no money for new build
- Not sure if feasible option – isolation of services
- NO money for new build
- Prefer to keep Carseview in some way

Option 6B – NO (5 votes to 1)

- Possible option
- No resource to build at Strathmartine, Carseview under utilised
- Not a feasible option
- NO on-call cover crisis team in Angus
- No GAP in Dundee
- Prefer better use to be made of Carseview

Option 7A – NO (5 votes to 1)

- Possible option

- No money for refurb or new build in capital plan not best for patients
- No GAP beds in Dundee
- New build for LD feasible but not the acute services option
- NO
- Like new build for LD but would like Carseview to be better utilised

TABLE FIVE

Notes –

- All GAP services in Perth
- All GAP services in Angus
- All GAP services in Dundee
- GAP services on 2 sites
- ALL LD services remain on Carseview & Strathmartine (refurbished)
- All LD services to Carseview and Low Secure Perth (2 sites)
- IPCU – Angus
- IPCU remain in Dundee
- Specialist services, rehab, IPCU, Complex care females on one site
- Change nothing status Quo
- All specialist services to Dundee

Option 1A – NO

- Build 2 units yet Carseview remains under utilised
- Day services required for LD
- Distance travel for acute care
- Refurb required for LD ward

Option 1B – NO

- Carseview underutilised
- Refurbishment required for Strathmartine
- New build required

Option 2A – NO

- New build for Stracathro
- Carseview empty
- Refurbishment required for LD
- Moredun empty

Option 2B – NO

- Carseview empty
- New build on Strathmartine
- Refurb required on Strathmartine

Option 3A – NO

- IPCU close to acute GAP
- No new build required
- Can shut Strathmartine
- Money available for Carseview
- LD and Acute GAP further from Angus
- Refurb LD ward required
- Empty purpose build unit at SHX
- Service user negative for Carseview
- Environment
- Not least restrictive option for LD due to mix of patients

Option 3B – NO

- IPCU close to Acute GAP
- Two purpose built wards empty
- Strathmartine needs refurbishment

Option 3C – NO

- IPCU close to GAP
- LD locked separate to rest of LD makes step down/up difficult
- Mulberry needs refurb for LD
- Empty purpose built Moredun
- Day services for LD?

Option 3D – NO

- New build at Strathmartine
- MRH and SHX have empty wards

Option 4A – YES PREFERRED OPTION

- IPCU close to GAP
- Acute GAP close to Dundee and SHX
- Recruitment benefits with GAP and LD (lose MR GAP)
- Good access for LD to acute GAP and medicine
- LD would need refurbish from Carseview money
- Moredun empty
- LD consultant cover for MR
- Day services for LD required

Option 4B – NO

- IPCU close to GAP
- Acute GAP close to Dundee and SHX
- LD ward needs refurbishment
- Day services for LD

- LD recruitment
- No LD services in Angus
- GAP far from MRH

Option 5A – NO

- IPCU and GAP close to each other
- GAP close to MRH and Carseview
- Mulberry new build empty
- Refurbish LD ward
- LD day services
- GAP far from Angus
- Recruitment issue for Gap MR

Option 5B – NO

- Refurb Strathartine
- No LD in Acute wards

Option 6A – NO

- Carseview empty
- New build on Strathmartine/refurb Strathmartine

Option 7 – NO

- Carseview empty
- Stracathro new build
- Strathmartine re build

Option 8 – NO

- GAP acute retained in Angus and Dundee
- Improve recruitment to GAP
- Better access for LD to GAP and general hospital
- LD ward need refurbishment – use Carseview monies
- LD day services

TABLE SIX

Notes

Develop & Implement a ROBUST community mental health service

Need more information as to what was agreed model 10 years ago.

A team will provide continuity of care

Consider Advanced Nurse Practitioner

Take pressure (demand) from inpatient service

A single GAP acute site ? LD Specialist ? Specialist ? Is one site big enough?

Why? Release funding for community – increase improve recruitment and retention of staff

Continuity of care is the community mental health team – they need to be informed of all services (Level one and two)

Where are the specialist staff based?

What needs to be centralised (regional or Tayside or Perth/Dundee/Angus)

Local knowledge is key

We do most of what we do in the community

What is the next step up e.g Regional

Initial Assessment important – what services proposed over 10 years ago? Level 1 and Level 3 and Inpatients

Who are the "experts"

Traige process with the "right people" including senior medical staff

What is safe when triage says no (experts)

How do we work with our referring partners to prevent hospital admissions

Crisis Teams need to work in community – "safe Place"

All this needs to be in place to assist early discharge

Manage delayed discharges

Make Tayside attractive place to work

If all of above in place, this will be answer to how many & where beds need to be.

Option 3A – Releases staffing resource to develop community services. Reduces number of Medical rotas. Supports bigger pool of trainee doctors working together. Best use of buildings.

Not clear how much resource this will release, addresses building needs but not patient needs e.g LD patients all to P&K

TABLE SEVEN

Option 1A – NO (5 votes to 1)

- Not feasible or practical on site
- Empty beds in Carseview, New Builds, IPCU in Forensic