NHS Tayside Consultation Feedback December 2017

Rebuttal Report

19th January 2018

Background

NHS Tayside conducted a public consultation between 3rd July 2017 and the 4th October 2017. The purpose of this consultation was to seek public feedback on a preferred option for future general Adult Psychiatry Acute admission and Learning Disability in-patient services which had been identified following a process of option appraisal and modelling.

In December 2017 NHS Tayside published their consultation feedback report which included their interpretation of the results and the supporting documentation.

PLUS Perth members expressed an overwhelming lack of confidence in the NHS consultation exercise as many members were concerned. They were concerned that their views would be ignored or lost in the static as many had experienced previous feedback session disappointments. Many also expressed the feeling that the decision had already been made. However they did wish to express their views on a forum that they could trust and as a result PLUS Perth decided to conduct their own consultation but expand the survey questions beyond the NHS consultation. PLUS Perth consultation ran for two months and the completed Final Report has now been published on the PLUS Perth website.

In order to complete the circle of both consultations it was felt that an analysis of the NHS Consultation Feedback Report was required.

Aim

The aim of this report is to challenge, with evidence and reasoned argument, the NHS Feedback Report and present the findings to all stakeholders and IJB Voting Members so as they have a complete perspective of the opposing arguments prior to any decisions being made on the 26th January 2018.

General Outline

The NHS Consultation Feedback Report is attached at **Annex A** and the points we will challenge have been annotated with a corresponding number which is referred to in the main body of this report. This report will end with a couple of topics that have come to light since the publication of the PLUS Perth Final Report before summarising the main arguments.

The Rebuttal Report complements the PLUS Perth Final Report and we would strongly recommend reading that in its entirety first. However, this report will stand alone.

Rebuttal Points

1. This is an inaccurate statement and throughout the course of this report we will provide evidence to support this claim.

2. Participants views have been listened to and recorded. However, we would contend that there is no evidence that it has helped shape the decision-making process nor is there evidence that future participation by the public would have a different outcome.

3. This consultation did not reflect upon participants views. The NHS has manipulated its arguments to suit its narrative. This decision had already been made before the consultation began and can be traced back to March 2016. PLUS Perth Final Report Chapter II Section 5.

4. 6 Themes identified. The veracity of each theme will be reviewed later in this report.

5. Stakeholders views will no doubt be listened to, but the NHS has no track record of implementing any suggestions that run contrary to theirs. They will justify this under the guise of patient safety, as they are doing with this very consultation.

6. As stated in point 5 the NHS does not collaborate with stakeholder views that are contrary to their own "professional" opinions/plans. In addition, they have misrepresented "the wide range of care and support arrangements that enable people to live well in the community. Mental Health resources are being centralised at Carseview in Dundee contrary to the Scottish Government 10 Year Mental Health Strategy 2017 – 2027 and the 2014 Scottish Government legislation for the Integration of Health and Social Care.

   6a). The NHS used the title "Mental Health and Learning Disability Service Redesign Transformation Programme" (MHLDSRT). Now compare that with the PLUS Perth Title "NHS Tayside Adult (16-65) Acute Mental Health Beds Centralisation. The NHS title would indicate that mental health and learning disability services were to be completely "redesigned and transformed". This could not be further from the truth. In fact, the PLUS Perth title more accurately reflects the NHS consultation aims. This is simply "bed centralisation," saving money and implementing, in the future after the 26 January 2018, a number of contingency plans to mitigate public concern.

7. PLUS Perth Final Report, Chapter I and II highlight significant failings in the Option Appraisal process and modelling.

8. How many concerns need to be raised by the public and stakeholders during the consultation before the NHS recognise that there was no acknowledgement of issues raised during the Option Appraisal process.

9. The number of "affected parties" that have expressed a view clearly demonstrates that the NHS has not engaged meaningfully. This is highlighted by the Scottish Health Council letter dated 15th November 2017 and attached at **Annex B.**

10. If the Mental Health Review of 2005-06 started the shift of care to the community, why then in 2009 was NHS Tayside in negotiations to sign a PFI contract which would concentrate resources at in-patient facilities across Tayside. See **Annex C**.

11. The NHS decision to concentrate resources at in-patient facilities was against reasoned arguments as demonstrated at **Annex C.** In addition, the memo also confirms that the escalating costs of this project and the financial implications over the 40-year contract were NOT presented to the full NHS Board for them to review and approve. The overall cost is £440m @ £11m/year and is an expensive example of "poor decision making" and governance by NHS Tayside.

12. This is completely inaccurate. For Learning Disability there is a potential 28.43% deficit and for GAP they have not deducted the Crisis Response Home Treatment Teams which were relocated from Angus in 2016 and Perth & Kinross February 2017. In addition, PLUS Perth has since learnt that 9 Mental Health Support Workers are to be made redundant before the end of this financial year. Whilst this saving will not be part of the NHS budget it will nevertheless impact on the overall community mental health spend. PLUS Perth Final Report Chapter I, Community Services.

13. There has been NO evidence presented that confirms the balance of care has already moved to predominantly community based services.

14. There is no indication of what the changes to the current model are to be except to centralise all services and resources in one location contrary to the Integration philosophy stipulated in the Scottish Government legislation 2014.

15. This has been known for many years and despite that the NHS has failed to address the issue with a credible action plan. Any future proposals do lack credibility when one considers that the preferred option workforce model will require 15.4 fte locums. PLUS Perth Final Report Chapter I Manpower Sustainability.

16. This has been known for years and further reinforces the NHS inability to prioritise and forward plan.

17. The PLUS Perth Final Report highlights many points in Chapters I and II that would indicate the preferred option is NOT "safe, high quality healthcare" which is "sustainable and affordable now and into the future." This is a very misleading statement which will be explored further in this report.

18. The NHS fails completely with this aspiration as evidenced by the PLUS Perth consultation feedback analysed in Chapter III of the Final Report.

19. Where does this 6% figure come from? It would indicate that this was established at a particular point in time or the average admittance to an in-patient facility over a given period of time. There is no indication from the evidence presented to the IJB by the NHS that this figure includes patients continually readmitted.

20. This runs contrary to evidence gathered by PLUS Perth survey and available at Chapter III of the Final Report. "Fit for purpose environment" will be explored further in this report.

21. This clearly raises the workforce sustainability issue for the long term but does NOT acknowledge that the preferred option will also require as a minimum 15.4 fte locums thus negating the predicted financial savings. PLUS Perth Final Report, Chapter I Manpower Sustainability.

22. This paragraph confirms that crisis services are to be centralised in Carseview. Whilst the Crisis Response Home Treatment Teams no longer have a presence in Perth as was stipulated in the contingency plan agreed by the IJB in November 2016. This service has been amended without informing service users and other stakeholders nor was this agreed by the IJB. The agreed service provision was that crisis assessment was to remain in Murray Royal Hospital (Mon-Fri 0900-1500hrs). Out of hours cover was from Carseview in Dundee. We have confirmed this change to the contingency plan.

23. The workforce model is NOT sustainable as demonstrated in the PLUS Final Report, Chapter I Manpower Sustainability.

24. "The option allows for remodelling and enhancement of community services". This is factually incorrect according to the IJB Chair, 30th June 2017 she stated quite clearly for the whole Board to hear that "savings made will NOT be retained within the mental health budget". This was noted in PLUS Perth Final Report Chapter II, Section 4 p31. In addition, "provide ease of acute care pathways" could potentially indicate EVERYTHING moving to Dundee.

25. PLUS Perth Final Report **Annex S** authored by the UN Special Rapporteur has stated quite clearly that mental health services in developed countries "must" develop models of care that move away from the excessively large "Centres of Excellence." These models of care must be based on patient need NOT the needs of mental health staff.

26. The impact on service users and carers has been outsourced and pushed beyond the decision date. Any assurances given on the 26th January 2018 can be quietly forgotten during the implementation phase.

27. This report was NEVER presented to the IJB for approval or even for information. NO opportunity for Board members to question or challenge the findings or even to understand the direction of travel of the Option Appraisal Team. This can be confirmed on the P&K IJB website, Agenda Items for the 26th August 2016. Neither was it on the agenda for any subsequent meeting until the 30th June 2017, 10 months after submission to the Scottish Government.

28. The involvement of the Scottish Health Council (SHC) is problematic and embarrassing for NHS Tayside. On the 30th June 2017 the Chair of P&K IJB stated quite clearly that the SHC would be producing a consultation mid-point report in order to placate concerns regarding the approval of the NHS consultation. At the IJB meeting on the 18th August 2017 no mid-point report was produced. There was a consultation report produced on the 3rd November 2017 but was authored by the Chief Officer with "input" from the SHC (P&K IJB website meeting papers of the same date). The language and tone in that report compared with the letter at **Annex B** is noticeably different thus reinforcing the perception that the NHS wrote the report. See also PLUS Final Report, Chapter II, Section 2 Agreed Action Points and Language Accuracy.

29. There was not a programme of information sharing. All that was circulated was non-descript posters across an unknown number of sites in Tayside an example of which is at **Annex D**. If there was any other activity it was certainly not effective nor were the public or relevant stakeholders aware of it.

30. PLUS Final Report **Annex A** challenges this point.

31. The reference from point 30 also applies to this highlighted section. However, we wish to raise a few further issues that will summarise the inaccuracies of this paragraph.

    - The consultation documentation was only circulated at the beginning of the meeting. There was insufficient time to review the material and make constructive comments.
    - The team running the meeting were more interested in "numbers" attending this meeting and displayed deep unsatisfaction that less than half of those invited chose to invest their valuable time.
    - "seek suggestions and feedback." Not at all. The NHS circulated at the meeting a list of known stakeholders and wanted the attendees to supply names of individuals/organisations that the NHS should contact as part of the consultation.
    - Suggestions/ideas to aid the NHS with the consultation would have been better served if the documentation had been circulated prior to the meeting. As it was, those in attendance were not in a position to add meaningful contributions and what ideas were discussed appeared to be acknowledged but NOT taken on board.
    - Furthermore, there was no follow-up part-way through the consultation to review progress thus further reinforcing the belief that this was nothing more than "a meeting to tick a box."

32. If the NHS had really wanted to engage meaningfully with stakeholders, they would have timed public events for after normal working hours. Instead it was timed to benefit members of staff with the least inconvenience to them. The result of this deliberate policy was reflected in the poor feedback numbers from the NHS survey and public engagement figures reported by the SHC at **Annex B**. This begs the rhetorical question "does the NHS want to formalise what it already knows is the public/stakeholder's views of this consultation proposal?" The answer is "no" and the consultation was an exercise in damage limitation whilst at the same time manipulating some very clever linguistic gymnastics and "ticking all appropriate boxes."

33. PLUS Perth Final Report **Annex A** argues emphatically that there was absolutely no excuse for not providing the consultation materials prior to the meeting of 4th July 2017. The paragraph also implies that the consultation team could not produce the documentation until after P&K IJB had authorised the NHS to proceed to the consultation. This is misleading as the Option Appraisal process was always headed towards a consultation. This is an example of withholding important information from the public and stakeholders in order to limit their opportunities of challenging the NHS.

34. As stated by the SHC at **Annex B** the publication of the NHS supporting material was very confusing to the public.

35. This statement implies that over 100,000 members of the public have engaged with this consultation process. This is not the case and to demonstrate we will use one of the authors Twitter Accounts. During the month of December 2017, not 3 months like the consultation time-period, the author tweeted 14 times. The account has 13 followers, all military charities, but twitter analytics established that the account made 2,926 impressions. This does not mean it made a meaningful impact with these individual organisations. The same can be said for Facebook. Anyone visiting the NHS page may end up "scrolling through" the article and register as having seen but did not actively engage with said post. What would indicate a meaningful engagement would be the total number of "likes" and "shares" but the NHS deliberately avoids stating those figures.

    Finally, on this subject of internet/social media engagement, "reaching" over 100,000 is not borne out by the number of completed NHS consultation surveys – 363. We would argue that the NHS social media strategy was not meaningful, and the Facebook and Twitter figures quoted are nothing more than a smoke screen masking their lack of engagement with the public.

36. These update bulletins were NOT published on the NHS website.

37. Completely inaccurate, see point 31 and **Annex A** of PLUS Final Report.

38. Interesting use of the word "supported." One of these focus groups was held at the Royal George Hotel in Perth. The primary purpose of that meeting was not to gain an understanding from stakeholders about their concerns regarding the consultation. Instead, the NHS team dictated their way onto the agenda at the end of a very long day already. The unsatisfactory responses from the NHS team in their inability to provide answers to service users was brought up by a Councillor at the 3rd November 2017 meeting of the IJB. The Councillors' concerns appeared not to be allayed at the IJB meeting.

39. This reinforces the lack of engagement plus the poor planning and preparation by the NHS for the consultation period. We would also hypothesise that, possibly, one of the reasons why so few NHS questionnaires were completed was that the public and stakeholders believed the decision had already been made and there was little point wasting their time. This point is reinforced in the SHC letter at **Annex B**.

40. This is interesting using a graded response – Fully/Partly Support. It is either one site or it is not! It would be interesting to analyse members of staff responses – 69 across NHS Tayside. A small number but we suspect would have had a significant impact on the stats stated in the survey results. Compare that with the emphatic 90% response against the preferred option from the much clearer question in the PLUS Perth survey. PLUS Perth Final Report Chapter III details the survey response stats and analysis.

41. So, 60-70% of respondents feel that mental health services are not meeting their needs. In addition, 60% do not agree with a one site option for GAP or LD services. This is very telling. The NHS is being told that their current mental health services and their preferred option is and will not meet the needs of the public and, yet they are still pushing forward regardless of the feedback. This is not patient-centric neither is this a collaboration between the stakeholders and the NHS.

42. One could argue that these six themes could have been identified during the option appraisal feedback. Thus giving the NHS a "head start" in planning potential contingencies to allay public concern but instead they adopted a very cynical approach declaring throughout the "whole" process that no decision had been made and that they were awaiting the analysis of the consultation feedback before making a formal decision.

    This leads us onto the obvious question. Why? The areas highlighted are fundamental questions about the future delivery of mental health services in its entirety but by pushing potential solutions into the Implementation Phase it allows the NHS to outsource or ignore the problems prior to the 26th January 2018.

43. NHS Tayside recognise that they are not transport providers which is accurate, but they fail to recognise that out of hours transportation is of the greatest concern to stakeholders. At the same time they appear to be laying the groundwork to outsource the problem to other statutory service providers and the 3rd Sector which will place a drain on their resources.

    43a) People experiencing a mental health crisis are going to have great difficulty using public transport.

44. This has been a goal for over 10 years + but with the commissioning of "purpose-built" in-patient facilities at the turn of the decade resources have moved away from the community. With centralisation and a concentration of in-patient services there will be no expanding community services as there will be no further resources as stated by the IJB Chair 30th June 2017.

45. The NHS does not have the credibility to make this statement and I would draw the readers attention to PLUS Perth Final Report Chapter II Section 6. This paragraph pushes the concerns of Voting Members of the IJB Board beyond the 26th January 2018. There is no guarantee or firm commitment by the NHS to address these issues highlighted and we suspect a casualty of this will be P&K and Angus patients not have the same opportunities to re-socialise, in stages, in preparation for a return to their community due to the distance from their home.

46. This is not the minority of the population of Tayside but the majority. This paragraph alleviates Voting Members concerns with an assurance it will be looked at after the 26th January 2018.

47. This is providing further confirmation that the NHS is looking to outsource the problem to predominantly the local Councils, other statutory bodies and the third sector.

48. This is outsourcing the problem and the cost.

49. These are voluntary organisations and statutory service providers with their own budgets to contend with. Will they be reimbursed?

50. This is a completely misleading paragraph based on "current" in-patient services and is NOT going to translate neatly to a single site model. Particularly as most of the community resources will also be centralised in this "Centre of Excellence." There appears to be no attempt to think beyond the current medical model and look at how people presenting early signs of an issue could be assisted in the community. Instead, what you will have is people not being able to access mental health services until they are at an acute stage and must be admitted to the in-patient facility.

51. This is a generic statement and gives absolutely zero commitment for the future. However, it does get the NHS beyond the 26th January 2018 without having to address the solution.

52. More vague language with no firm commitment but again it does get the NHS beyond the 26th January 2018.

53. There are two issues raised in this paragraph. Firstly, where would the funding come from? Secondly, we come back to the issue of an acutely unwell individual getting on a bus.

54. This is a misleading statement as it is based on the current two sites being open and not just one which is being proposed. It should be noted that the Angus site has already closed, and patients are being sent to Carseview right now.

55. Is the NHS going to train bus/taxi drivers to deal with people that are suffering a mental health issue? In addition, is the NHS making a commitment to provide in-patient IT facilities or are they just making a generic IT statement because in their existing GAP wards there is not these facilities.

56. These organisations and teams are predominantly voluntary. Does the NHS expect them to restructure their propositions/service provision which would require additional resources? Will the NHS fund these changes to the service delivery and if so from which budget?

57. This is a very random comment and appears only to have appeared in the report to tick a box.

58. A factually correct statement. However, with resources being centralised this will be at the detriment of primary mental health services.

59. With NO indication that resources will be allocated to primary care this is a meaningless paragraph without any firm commitments from the NHS, but it does get them beyond the 26th January 2018. One example is the P&K Wellbeing Fair was not held in 2017 because of a lack of funding.

60. Not only does the NHS need to think differently about how they plan services but they also need to act differently.

61. The NHS has a clear track record of ignoring stakeholder feedback that they disagree with, why would the inclusion of this paragraph indicate a change of policy? In addition, this whole policy proposal runs contrary to this point. NHS Option Appraisal Report August 2016, Option Feedback.

62. This consultation and the Option Appraisal process has done precisely the opposite of what this paragraph is stating. Stakeholder feedback is ignored, resources are being centralised and the model of care for both primary and secondary care is remaining exactly the same. No redesign of the mental health care service. See PLUS Perth Final Report Chapter IV.

63. Growing evidence shows that the poor physical health of people with mental health issues is caused by long term use of psychotropic medication. See PLUS Perth Final Report Chapter IV.

64. This misleading paragraph would suggest that the majority of the mental health resources is being allocated to community services. Not the case. Workforce, finance and infrastructure are all massively weighted in favour of in-patient services. In addition, as the stagnation of resources into the community continues in the coming years the demand for in-patient services will increase as individuals will only be able to access mental health services when they are acutely unwell. In order to compensate for this lack of community service there will be a significant increase in the use of psychotropic medications in order to "manage" patients that have been "discharged" back into the community. Over the last 10 years there has been approximately a 40% increase in the use of these medications as community services have declined. The Freedom of Information request at **Annex E** confirms this statistic. Compulsory Treatment Orders for 2015/16 in Tayside was 36/100k head of population against a Scottish national average of 25/100k. This statistic was presented to the IJB in meeting papers 30th June 2017.

65. Theoretically, these are all important statements/points but most of these core principles are unlikely to happen in reality, according to feedback from PLUS Perth members.

66. There is no model because the NHS is unwilling to divert resources away from in-patient care into the community in line with Integration legislation. PLUS Perth Final Report Chapter IV.

67. The Chair P&K IJB at the meeting 30th June 2017 stated very clearly that the preferred option savings, £2m, would not be retained within the mental health budget. PLUS Perth Final Report, Chapter II, Section 4, p31 1st bullet point.

68. Each of the 3 Partnerships have produced their own "Detailed Community Information." Angus and Dundee have produced "wish lists" with some aspirations in their lists. In both cases these lists could have been produced 20 years ago. In fact, they have probably been a "work in progress" for that time-period. We would be inclined to ask why these have not been implemented already? The answer I am sure is the excessive spend on in-patient facilities.

    Perth & Kinross has taken the Scottish Government 10-year Mental Health Strategy and put Perth & Kinross in the title.

    All three lack any detail and the required resources to implement these "aspirations." This can possibly be explained by the existence of a parallel NHS group which is also working on a community mental health model and until very recently unbeknown to the P&K Mental Health and Wellbeing Group. It is not known at this stage who this NHS group is answerable to. Plus Perth Final Report, Chapter II Section 3.

69. The appetite for feedback and involvement after this consultation is a moot point now as the views given have been ignored. In addition, the exceptionally unremarkable number of NHS surveys completed, we would argue, indicates that the public feel the NHS will not listen to any feedback. This consultation and the numbers involved make the argument admirably.

70. "Feedback highlighted current perceptions of reduced quality service provision." This is NOT a perception, this is a reality. The Courier wrote an article dated 17th October 2017 which highlighted failures at Carseview from 2015 which resulted in the death of a young man. In addition, there was a death at Murray Royal, Perth also in 2015, plus two further deaths in each of the preceding years in this location. Four deaths in three years and each one either in the care of or because of failings in NHS Tayside mental health services.

    There is something fundamentally wrong with mental health services in Tayside. Rather than take a concerned professional approach to these tragedies the NHS has tried to ignore, divert attention or quote customer satisfaction surveys as they did at the NHS Tayside Annual Review 2017.

71. The only comments coming from the public at the NHS Tayside Annual Review were negative and the positive comments were coming from the NHS Board members.

72. The phrase that springs to mind is "actions speak louder than words." The NHS has a credibility deficit with the public that they refuse to recognise. This statement goes nowhere near reducing that deficit. I would go further and say that engagement and partnership is a two-way street and the NHS has got to do more than just demand

stakeholder involvement with no ability to influence what has already been decided by them and justified by "clinical imperatives."

73. Until the Psychiatric profession recognise the damage to physical health from psychotropic medication this point will NEVER be addressed. PLUS Perth Final Report Chapter IV

74. This is not a valid argument for mental health services. The United Nations has recognised the necessity to move away from "Centres of Excellence" which dominate the developed western democracies. The UN Special Rapporteur makes his arguments in a report dated 28th March 2017 which is at **Annex S** of PLUS Perth Final Report.

    NHS Tayside is proposing going back 10 years and does not consider emergent and new thinking on best practise.

    W would like to explore an alternative view which may explain their stagnant, critical thinking approach to alternatives and an idea that may explain why the NHS is so insistent about centralising mental health resources. At **Annex C** I introduced an NHS Tayside internal memo dated 27th February 2009 which expresses concerns regarding the capital project being proposed at that time as well as the governance of said project. It is clear from this one memo that the cost to NHS Tayside is £11m/ year for 40 years. I have 5 further memos and one e-mail that provide further evidence to this fact.

    To be clear the capital project refers to the PFI builds in Tayside. This financial burden of £440m over a 40-year period will have an impact on any future design of mental health services. NHS Tayside's dire financial situation would not be able to withstand any reduction in the in-patient budget in preference to community services. Hence the manufacturing of arguments to ensure that resources remain within in-patient services. So, the real reason for centralising resources in Dundee, we would argue, is financial. The next logical question we would ask is with the changes to the PFI building in Dundee what will be the impact on this contract? I suspect the NHS do not want to explore this until after the 26th January 2018 and even then, the financial cost will not be available for some time as they will claim that it is "Commercial-In-Confidence."

    Finally, on this point there is no desire on the part of the NHS to remodel in-patient services. If there was this would have happened back in 2012 when Tayside had brand new, purpose built GAP wards across the region. Instead they maintained exactly the same model of care and as highlighted in point 70 this model of care resulted in 4 deaths in a three-year period which questions their ability to provide a "safe" service. It is worth pointing out that there has been no public enquiry and the NHS has not released the findings of their internal enquiry, if they ever did one.

75. Point 70 dismisses the argument of providing a safe environment or at the very least calls it into question until a full public enquiry has been undertaken.

    PLUS Perth Final Report, Chapter I, Section 8 Manpower Sustainability clearly demonstrates the unlikelihood of the NHS being able to sustain the workforce levels

for the preferred option over the coming 5 years. The NHS has known about this recruitment problem for the last 10 years and have not been able to resolve it. There is no indication that they will in the coming 5 years.

The tragic deaths detailed in point 70 should raise concerns regarding the models of care at Carseview and Murray Royal. We would expect that with the public interest in this case and in the interest of transparency, the NHS should make available a "public" version of their internal enquiry.

76. As explained in previous points the NHS is only prepared to listen and act on views and feedback that match their own. It is fair to say that stakeholders recognise this and feel alienated from any meaningful engagement. This consultation, we feel will result in a further decline in stakeholder engagement.

77. With the exception of Brexit, these recruitment issues have been known for years, potentially decades as retirement dates don't change. The simple fact is the NHS has not deemed it a priority until recently when it has now become a crisis. This further demonstrates their inability to forward plan in a meaningful way. Even now with this dire workforce problem they fail to address it with realistic solutions. There should have been as part of the Option Appraisal process a realistic forward projection of workforce levels for the next 5-10 years. From those predictions there should have been a realistic workforce model of care designed that was robust and had in-built redundancies. Instead the preferred option workforce model and the reality right now is that 15.4 full time equivalents (fte) locums will be required to fill the manpower shortfall. PLUS Perth Final Report, Chapter II Section 4 Manpower Sustainability.

78. There appears to be a lot of activity but where are the measures of success and who is accountable for these initiatives? All this is well and good, and we are sure that it has been tried before but there appears not to be a good track record that NHS Tayside can point towards. However, it does get them beyond the 26th January 2018.

79. If the Royal College of Psychiatrists is stating that there is a year on year rise in Consultant vacancies, why is NHS Tayside proposing a workforce model that is reliant from the outset on locums? If the number of Consultants is reducing, then it stands to reason that the number available for Tayside is also going to reduce. Not recognising this is negligent and not implementing realistic plans is beyond negligent.

80. This point at least acknowledges the workforce reality. However, I suspect that it is preparing the groundwork to only opening 3 wards in the summer of 2020 and if the workforce and financial crisis escalates possibly only 2 wards will open.

81. This is further repetition to enable the NHS to tick appropriate boxes. They have shown zero inclination to engage meaningfully throughout this whole process. Their over-riding aim has been to save money as per point 74. There is no indication that this will change in the future and we would go further and say that the NHS has no credibility with regard to this point.

82. There is no evidence that people wish and need to be involved in planning of future GAP and LD services.

83. The NHS has no credibility in the area of stakeholder participation and co-design of services

84. There is no "beyond" if the NHS cannot acknowledge and action previous attempts to collaborate.

85. The NHS needs to acknowledge these benefits and engage meaningfully with stakeholders.

86. As per point 85.

87. Reading this paragraph, we cannot help but feel the target audience is one. The Scottish Government. Feedback from the public and stakeholders is completely at odds with the preferred option recommended. To continue this unbalanced equation is going to be problematic for the relationship between NHS, stakeholders and the public. However, we really do not think that the NHS is particularly concerned provided the decision goes their way.

88. The balancing of the three service measures in this paragraph and the arguments pertaining to each one has not been made.

    - 4 deaths in 3 years.
    - High quality. The death of the young male raises questions regarding the quality of service at Carseview. Quoting satisfaction surveys will not be an acceptable response.
    - Value for money. The preferred option projected savings does not include locum costs neither does it include the overall cost in the variation to the existing PFI contract. As such this calls into question the whole predicted savings figure.

89. We have no doubt that the report the Scottish Government receives will reflect every statutory point required, twice over. However, it runs contrary to the PLUS Perth Final Report and this Rebuttal Report which we will highlight to Geoff Huggins, Director of Health and Social Care Integration.

90. As per point 89.

91. The NHS still fail to recognise that the preferred option workforce model is still going to be short Consultants, Doctors and Nurses. The only way to square this circle is to reduce the number of wards opening at Carseview ie from 4 wards to 3 or possibly even 2 by the summer of 2020. See point 80.

92. Another misleading statement as per point 44.

93. As per point 92.

94. Unlikely as indicated in many previous points.

95. Further evidence of the NHS trying to manipulate other statutory and voluntary organisations to bear the financial burden and take responsibility away from the NHS and provide appropriate solutions.

96. This statement lacks credibility, but it does get the NHS beyond the 26th January 2018.

Community Mental Health Services

We wanted to analyse in a little detail what is being undertaken by the P&K Mental Health & Well-Being Group. We have referred to this group in Chapters I and II of PLUS Perth Final Report and it is apparent that they are still at the "concept" stage of the planning process. This is not a criticism and we understand that they are in the process of finalising their Terms of Reference.

A short paper authored by this group has been placed on the agenda of the IJB meeting 26th January 2018 and there are a couple of items that caught our attention.

Priorities For Mental Health Services. The following paragraph taken from the paper at para 1.4 clearly demonstrates the NHS priority when it comes to community Vs in-patient:

1.4 Ask the Chief Officer to bring a draft plan in 6 months with commissioning priorities for community-based services that will complement the redesign of inpatient mental health inpatient services across Tayside.

The purpose of integration is to turn the current model upside down and the priority then becomes community services and "in-patient facilities" complement this changed priority.

Direction of Travel. This working group has been given 6 months to produce a Commissioning Plan. Perhaps what they meant to say was provide the IJB with a detailed analysis as follows:

- Overview of existing community based services and where they operate.
- A detailed analysis of resources allocated to each organisation.
- Historical funding trends for each organisation.
- A detailed analysis of each organisations workforce structure.
- Measures of success and historical outcomes.

It is important to understand what the existing services and supports are and where they operate. From this we can establish geographical gaps and what services are not being undertaken from the P&K MH&WG "wish list" of community services. That will then give the "Direction of Travel."

Finance. The short paper makes it quite clear that the financing of 3rd Sector Organisations is value for money. However, the Council and NHS need to be extremely careful if they start to change the Service Level Agreements (SLA) of these organisations. If these SLAs have responsibilities added to them this will require additional funding or existing services will have

to be stopped to accommodate different priorities. Alternatively, if services must be provided within current budgets, then there will be a corresponding loss of services to accommodate the new priorities.

We would suggest the following approach:

- The P&K MH&WG establish a "wish list" to be implemented within P&K.
- Having established each organisations expertise and geographical location they can allocate services from the wish list to the relevant organisation.
- Each organisation would then be asked to provide a detailed plan, including costings, of how they would implement that service.
- From these individual plans the group can formulate a consolidated plan which would be presented to the IJB in 6 months.

NHS and Council Resources. Whilst the above activity is being undertaken a similar exercise needs to be undertaken for NHS and Council resources and their current geographical deployment.

This is where I think the planning will fail. The NHS have a parallel grouping that is undertaking a similar exercise. There is no meaningful contact between either group and if past is prologue, the NHS has a track record of this, the NHS group will assume priority for their resources and leave non-medical services to the Council. No integration.

If there is no "integration" of these two working groups inevitably there will be gaps for people to fall through. As a result there needs to be very clear Terms of Reference for the MH&WG and they need to integrate the NHS working group within their organisation thus ensuring a comprehensive proposal is completed.

Repeating History

At **Annex C** to this report a major financial commitment was undertaken in 2009. This resulted in a staggering £440m price tag over 40 years and we are currently only in the fifth year of that contract. This financial burden was NOT agreed by the full NHS Tayside Board and the likelihood is that with additional works required at Carseview will only add to this financial burden.

As can be seen from this NHS Tayside internal memo, there was concern regarding this project. Not only the cost but also the governance behind the process. Having analysed in detail this "bed centralisation exercise" there are similar "echoes" to the 2009 exercise.

Firstly, the outcome of the preferred option stems from a decision in March 2016 by NHS Tayside Board to include a one-site consideration in the Option Appraisal process. Secondly, the behind closed doors elimination of Option 8, which was the participants preferred option, in favour of the one-site proposal. Finally, despite all the negative feedback from the public and stakeholders the NHS is proceeding regardless.

The 2009 decision was a financial catastrophe and this project will result in an expensive in-patient resource in Angus, still costing the NHS, needing to be re-tasked and probably refurbished at further expense. It appears that the primary reason behind this preferred option is to save money, but we would anticipate that in the future as pressure mounts to relocate resources into the community another restructure will have to take place at further expense.

Summary

Shortly after the January 2018 NHS Tayside Board meeting a programme update, Issue 9, was published. In it Professor Connell commended the project team for the excellent work carried out in the consultation. We take great exception to this and we anticipate that the reader of this report will at the very least have significant concerns if not a complete loss of confidence in NHS Tayside being able to manage a complex project through to a reliable and logical conclusion.

The PLUS Perth Final Report does analyse the complete process in more detail and provides a very logical conclusion and recommendations when compared with the NHS. In addition, the Final Report provides an alternative backed by detailed research and evidence which would provide NHS Tayside with a comprehensive model of care that ultimately would be of less expense than the current NHS proposal. It is realistic and considers the realities of workforce predictions as well as emerging best practises being promoted by respected International organisations like the UN and WHO.

Recommendations

We would draw the reader's attention to PLUS Perth Final Report Chapter V Summary and Recommendations.

Annexes

A. NHS Consultation Feedback Report.
B. Scottish Health Council letter dated 15th November 2017.
C. Internal NHS Tayside Memo dated 27th February 2009.
D. NHS Consultation Poster.
E. Freedom Of Information Request dated 7th November 2017.