



NHS Governance – Clinical Governance

The Royal College of Psychiatrists in Scotland (with specific input from the Child and Adolescent Faculty)

The Royal College of Psychiatrists in Scotland has received input on this consultation from its members. The College has also received specific input from the Child and Adolescent Faculty. In the interest of clarity, this Child and Adolescent Mental Health Service specific response is provided as a separate attachment.

It should be noted that mental health professionals are increasingly working in integrated services which do not simply consist of health services. This integration agenda challenges health views of what is “effective” and “efficient” and the governance of psychiatric staff is increasingly dependent on the performance of staff from outside of health.

Responses to Health and Sport Committee’s Questions

1. Are services safe, effective, and evidence-based?

We believe all working in the NHS should support safe, effective and evidence-based services. These ideals mirror the work of Healthcare Improvement Scotland whose three priorities are to promote evidence based practice, service improvement and scrutiny of performance. Whilst clinical governance allows examination of services, safe, effective and evidence-based services should not be a destination to be arrived at. They should be the result of a constant engagement between clinicians, patients, academics, managers, third sector organisations and political leaders. We also have concerns about Integrated Joint Boards creating variance in what patients might expect across the country, and question how this could be improved.

An essential tool to ensure safe, effective and evidence-based services must be accessible, reliable data about demand on services, clinical activity and spending. For example, a dashboard of information with comparisons to the national average. Without reliable data, we can do no benchmarking to consider the quality of performance and rely on anecdote.

2. Are patient and service users’ perspectives taken into account in the planning and delivery of services?

Mental Health offers an example to the rest of health about what service user involvement can achieve. We can also learn more from our third sector partners

about involving patient and service users. Lived patient experience is essential, but must be complemented by practitioner experience. We would encourage third sector and practitioner involvement in decision-making, including representation on Integrated Joint Boards. We are pleased Realistic Medicine is championing the quality of clinician/patient interaction in the clinical encounter.

3. Do services treat people with dignity and respect?

Dignity and respect are fundamental to the NHS. However, treating everyone the same way does not create dignity and respect – one size does not fit all. There is no place for blaming a patient for not attending at a convenient time, speaking a convenient language or having complex needs. This leads us to question why those threatening to take their own lives are still being detained in police cells. We believe patients and service users have a right to be treated with dignity and respect in our health centres and hospitals but this is not always the case.

For there to be dignity and respect in our health and social services, there must be parity between physical and mental healthcare. This also means parity of access. We have concerns about certain treatments not being open to patients with mental health problems, such as solutions to obesity. Whilst we understand some patients are excluded from certain treatments, this should only occur when such a decision is backed up by firm clinical evidence.

4. Are staff and the public confident about the safety and quality of NHS services?

We believe confidence regarding the safety and quality of NHS services could be improved via practitioner and user organisations working in partnership to review the results of internal reviews. Concerns have been raised regarding occasions where an independent report reviewing a failure in healthcare shows problems were raised by staff at an earlier stage and not acted upon. We worry that sometimes internal reviews overemphasise individual shortcomings and underemphasise those organisational arrangements which have contributed to a failing. Here is an opportunity for practitioner and user organisations working in partnership to review the results from internal reviews and ensure recommendations are acted upon. These 'local partnership groups' would bring patient and practitioner experience which is independent from organisational line management. Staff could also be encouraged to go to such local partnership groups if they identify management structures have failed to respond to concerns, which may assist in boosting the public's confidence.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?

Healthcare Improvement Scotland (HIS) has a critical role in quality improvement, however, there is a tendency to turn to more generic management solutions to solve the challenges of the health service. We are concerned that local clinical leadership is being replaced by clinical managers whose primary role is to manage their professional group and not champion a service. Finance officers, once embedded in a service, are often isolated from clinical realities and have no engagement with the human face of the work they do. We are also concerned with the amount being spent on external consultants, where the advice of local practitioners/service users and the

support of HIS has not yet been exhausted. Here, again, local partnership groups could have a key role in planning and resource allocation.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

There is currently scrutiny from several bodies, many of which will have different agendas and policies: for example, the Health and Safety Executive, the Mental Welfare Commission and Royal Colleges. The current system could be improved by introducing measures which re-establish the practitioner role in scrutinising quality of care and involve working alongside carer/user organisations. Local partnership groups could also be established to scrutinise Governance reports, the results of incident reporting, and hold managers to account for implementation of recommendations from local and national strategies.



RESPONSE OF: Faculty of Child and Adolescent Psychiatry, The Royal College of Psychiatrists in Scotland

RESPONSE TO: Scottish Parliament Health and Sport Committee Call for Views on Clinical Governance

Comments with respect to Child and Adolescent Mental Health Services (CAMHS) community, subspecialty and inpatient services.

Overarching care principles:

- Over the past three decades, CAMHS culture has been strongly influenced by relevant legislation relating to education, welfare and medical treatment for under 18s. These include GIRFEC (Getting It Right for Every Child) principles.
- All public services for under 18s in Scotland are governed by legislation which is based on the United Nations Convention on the Rights of the Child 1989. Core principles include placing the welfare of the child as paramount, taking account of views of children and parents, and ensuring least restrictive alternatives.
- Notably, the Mental Health (Care and Treatment) (Scotland) Act 2003 and Mental Health (Scotland) Act 2015 provide clear guidance about how children should be treated by services in order to safeguard their welfare and access to education.
- As CAMHS has increased its age range to include all 16 and 17 year olds, attention has also been paid to legislation for vulnerable and/or dependent young adults.

1. Are services safe, effective, and evidence-based?

It is a challenge for CAMHS in Scotland to respond quickly and effectively to the number of referrals which have increased significantly over the past 5 years. Given their developmental profile, children and adolescents require a timely response to prevent further deterioration in their functioning, as well as support to meet the developmental challenges of growing up, learning and developing into healthy adults. Access to CAMHS has been a particular focus for some time. Initially, this ensured services included children who were at risk of social exclusion. Over the past few years, waiting times have greatly reduced.

The evidence base for specialist mental health care for children and adolescents is growing. We have SIGN, NICE and College guidelines to inform treatment for important common conditions and presentations (ADHD, Autism, psychosis, depression, self-harm, and low-weight eating disorders). Examples of this include CAMHS working closely with Health Improvement Scotland to ensure adherence to evidence-based practice in ADHD, and the recent focus on family/community based treatment for Anorexia Nervosa across Scotland contributing to a growing evidence base.

Further work is needed on prescribing and monitoring of psychotropic medication in children and young people, e.g., having access for physical monitoring in CAMHS clinics.

This is even more important since GPs have asked secondary care services to provide this monitoring. Although there is good evidence for CAMHS interventions, there is a need for further research into mental health disorders in children and young people and into related interventions. Improved access to evidence-based treatment, especially for vulnerable children, would be expected to improve outcomes. Safety also remains an important area of development, and CAMHS is engaging with the Scottish Safety Programme to focus on particular aspects of delivering safe care.

For years across Scotland, CAMHS have tried to collect data on outcomes. This has involved linking with services in other parts of the UK by using systems such as "CORC." More attention will be given to this when implementing the new Mental Health Strategy. Due to the relatively small size of CAMHS, inpatient services are provided on a national/regional basis. This means that clinicians naturally connect across the country with opportunities to compare and improve practice.

2. Are patient and service users' perspectives taken into account in the planning and delivery of services?

This is a key area of development. For some time, CAMHS have routinely sought patient/carer views on experience of care as part of routine clinical outcomes. Recent major inpatient developments have actively involved users to fulfil requirements of planning processes. However, involvement of service and parent user input into CAMHS in Scotland is patchy and should be mainstreamed as part of day-to-day clinical practice, as well as service planning. The Royal College of Psychiatrists in Scotland Child and Adolescent Faculty Executive has benefitted greatly from having service user representatives as part of its committee. A recent important focus has been work with the Children and Young People's Commissioner Scotland around "7 Golden Rules for Participation."

3. Do services treat people with dignity and respect?

This is of paramount importance, in children's best interests, and central to clinical practice. The Mental Health Act and involvement of the Mental Welfare Commission have highlighted the need for dignity and respect, particularly when children and young people require detention and compulsory treatment. CAMHS have worked to ensure dignity and respect for patients, carers and staff, with policies around inclusion and diversity facilitating this. We would note there is further scope for obtaining views of all service users on their experience of using CAMHS. CAMHS have also participated in the NHS Scotland staff survey to assess the experience of our workforce. Although the zero tolerance towards violence against NHS staff is welcome, this must be understood within the context of severe mental illness, if relevant.

4. Are staff and the public confident about the safety and quality of NHS services?

There has been much attention in the media on children and young people's mental health, such as the recent focus on "rejected referrals." Unfortunately, there has often been a focus on services not responding adequately to children and young people's needs without a full exploration of the relevant factors. The impact of this on staff and public confidence needs to be considered when responding to complaints and concerns. The Royal College of Psychiatrists has played a positive role in communicating with media, and directly, to build confidence.

5. Do quality of care, effectiveness and efficiency drive decision making in the NHS?

CAMHS staff work hard to provide an excellent service, however, we note changes in the financing and organisation of other statutory services, e.g., social work and education, have made an impact. More public debate and transparency of what NHS Scotland

CAMHS can provide in the current financial climate could be helpful, and would flag up discrepancies between funding of mental health versus physical health services and between children versus adult services. In recent years, CAMHS have been very focussed on delivering strategic commitments. Compliance with HEAT targets was a clear driver in recent decision making, and has been an important improvement in efficiency and quality of care. At present, improving clinical effectiveness is the current focus.

6. Are the correct systems in place to detect unacceptable quality of care and act appropriately when things go wrong?

Child protection is core to CAMHS practice to ensure that patients are safe and free from harm. Many systems to address unacceptable quality of care are managed within services and can support improvement in services. CAMHS use "DATIX" systems to record negative incidents. Adverse events are taken seriously in CAMHS. Services routinely contribute to multi-agency and NHS adverse event reviews. The Mental Welfare Commission also play a key role in "scrutiny" for inpatients and, increasingly, users of community services.

As part of local processes, CAMHS pay attention to complaints from families and make use of clinical networks to provide second opinion where there is conflict around diagnosis and treatment. Involvement of patients/carers, service users and those who refer into CAMHS should be supported, so that useful feedback can help drive service improvement.

This response was prepared by the Chair and Vice Chair of the RCPsych in Scotland Faculty of Child and Adolescent Psychiatry.