



Healthcare
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Scotland

Inspections
and reviews
To drive improvement

Review of Adult Community Mental Health Services, Tayside

January – March 2020





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About us

Healthcare Improvement Scotland (HIS) supports healthcare providers to improve the quality of care they deliver through promoting self-evaluation for improvement and delivering external quality assurance.

Our quality of care approach (QoCA) is how we design our inspection and review methodologies and tools and provide external assurance of the quality of healthcare provided in Scotland.

We have included only the elements of the quality of care (QoC) framework/domains that are specific to addressing the focus for this review. Domains included for this review were:

Domain 2:	Impact on people experiencing care, carers and families
Domain 5:	Delivery of safe, effective, compassionate and person-centred care
Domain 6:	Policies, planning and governance
Domain 7:	Workforce management and support
Domain 9:	Quality improvement-focused leadership

This in turn, formed the basis for our key lines of enquiry (KLOE) for the review. More information about the quality framework (QF) and QoCA can be found in Appendix 1 and on our [website](#).



Adult Mental Health Services in Tayside

Background and review focus

HIS carried out a focused review visit to mental health services in Tayside from Thursday 7 to Saturday 9 December 2017. A review report was published in February 2018. (*Review of Adult Mental Health Services in Tayside: February, 2018*)¹

The report set out the key findings from the visit, which had a specific focus on:

- General Adult Psychiatry (GAP) services within the Carseview Centre, Dundee, and
- Community Mental Health Services (CMHS) and crisis support for residents in the local council areas and localities of Angus, Dundee City and Perth & Kinross.

During the review, HIS highlighted five key areas of strength and six areas for improvement.

At the time of the review, NHS Tayside and Perth & Kinross Health and Social Care Partnership (HSCP), which hosts inpatient mental health and learning disability services across Tayside, were redesigning the adult mental health and learning disability inpatient services as part of its mental health and learning disability services redesign transformation programme.

On Monday, 4 June 2018, HIS met with senior management from mental health and learning disability services in Tayside. The focus of the meeting was:

- for Tayside to provide an update on the consultation of adult mental health and learning disability inpatient services, and the decision on the preferred option that was announced on 26 January 2018, and
- to discuss progress against the six areas for improvement.

Ahead of the meeting, Tayside shared its improvement action plan that had been created to track its actions and progress against the six areas for improvement.

Following this meeting, HIS published a report on the progress and continued areas of improvement required. NHS Tayside announced that an independent inquiry would be carried out by David Strang to examine the accessibility, safety, quality and standards of care provided by mental health services. In view of the work to be undertaken by this independent inquiry, HIS stated it would give NHS Tayside and the partnerships the time to focus on this inquiry and that HIS would request an update, and plan future quality assurance activity, once the independent inquiry published its findings.

¹ http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/programme_resources/tayside_mental_health_review.aspx

The final report of the inquiry was published in February 2020, *Trust and Respect, Final Report of the Independent Inquiry into Mental Health Services in Tayside, February 2020*. For full details of the report, please click [here](#).

The Sharing Intelligence for Health & Care Group (SIHCG) provides a mechanism enabling seven national agencies to share, consider, and respond to intelligence about care systems across Scotland. The organisations which represent this group are:

- Audit Scotland
- Care Inspectorate
- HIS
- Mental Welfare Commission for Scotland (MWC)
- NHS Education for Scotland (NES)
- Public Health & Intelligence (part of NHS National Services Scotland), and
- Scottish Public Services Ombudsman.

In June 2019, the group raised concerns regarding the continued and ongoing shortages of consultant psychiatrists with a particular shortfall in general adult psychiatry. Only 50% of psychiatry posts were filled with permanent consultants. Locum psychiatrists, if available, would be employed to reduce the gap in vacant posts to support and manage the service.

The group also identified issues regarding the strategic planning and direction of Tayside's CMHS and the efficiency of how they provide a range of mental health interventions across communities.

Concerns regarding the partnerships' governance, leadership structures and decision-making capabilities were also raised, as they are responsible for the commissioning of mental health services.

In September 2019, HIS asked the chief executive of NHS Tayside to provide a response on the progress against the recommendations made following HIS's previous review of adult mental health services. A decision was made to undertake further quality assurance activity around the quality and governance performance of NHS Tayside and the partnerships for GAP Services, particularly for those accessing Community Mental Health Teams (CMHTs) and the Crisis Resolution and Home Treatment Team(s), which sit within GAP Services.

HIS carried out a review on the quality of care in Tayside with a specific focus on adult community mental health services between January – March 2020. For a list of review team members, please see Appendix 2.

Profile of service

In 2016, HSCPs were established in Tayside. The HSCP is responsible for the delivery of social care and community-based health services for all adults in Angus; Dundee; and Perth & Kinross localities. The Integration Joint Board (IJB) – the partnership’s board of governance, strategy and scrutiny – became responsible for its delegated health and social care functions at the same time and its purpose is to ensure people receive integrated seamless support and care throughout these localities in Tayside. (*Demographics, see figures 1-3*)

The three HSCPs are responsible for ensuring that mental health services are planned and delivered in Tayside. Services should also be available, accessible, appropriate, and of the same high quality.²

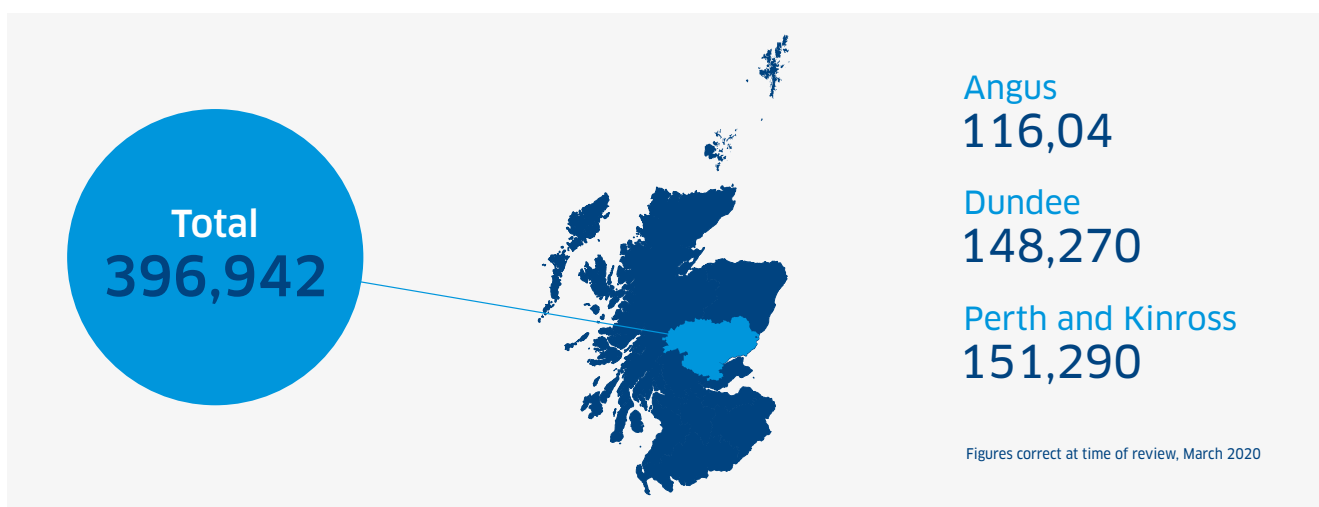
CMHTs were set up to provide care for those people who present with severe, complex and enduring mental health problems in the community. The CMHTs also work with more specialist services such as learning disability, substance misuse, and adult psychological therapies services.

Around 94% of patients who require specialist secondary care intervention for their mental health receive this support in their own communities via community mental health services, with only a small proportion of people (6%) requiring admission to hospital.

Crisis Resolution and Home Treatment Teams (CRHTTs) provide an alternative to hospital admissions by offering emergency assessment and intensive interventions within the community. They act as a single point of access for all inpatient mental health admissions. Where hospital admission does occur, Home Treatment teams will also assist in providing intensive home treatment to support early discharge back into the community.

The HSCP has the hosting responsibilities for the following:

Figure 1: Population of NHS Tayside



² <https://www.gov.scot/publications/mental-health-strategy-2017-2027/pages/3/>

Figure 2: Community Mental Health Services delivered by locality

	Hosted	Angus	Dundee	Perth & Kinross	Tayside
GAP CMHT		Yes	Yes	Yes	
Forensic CMHT	Tayside				Yes
CAMHS Outpatient	Tayside				Yes
Learning disability CMHT		Yes	Yes	Yes	
Psychiatry of old age CMHT		Yes	Yes	Yes	
Substance misuse Outpatient		Yes	Yes	Yes	
Liaison Psychiatry				Yes	
Eating disorder Service	Dundee		Yes		
Psychotherapy	Dundee		Yes		
Psychology	Dundee		Yes		

Figure 3: In patient services delivered by locality (Please note CRHTTs are a community based service however they are managed as part of inpatient services)

	Hosted	Angus	Dundee	Perth & Kinross	Tayside
CRHTTs	Perth & Kinross			Yes	
GAP Inpatient	Perth & Kinross			Yes	
Rehabilitation				Yes	
Psychiatry of old age Inpatient		Yes	Yes	Yes	
Substance misuse Inpatient	Perth & Kinross			Yes	
Forensic Inpatient	Tayside				Yes
Learning disability Inpatient	Perth & Kinross			Yes	
Young Persons unit	Tayside				Yes
CAMHS Inpatient	Tayside				Yes

GAP General Adult Psychiatry
 CMHT Community Mental Health Team
 CRHTTs Crisis Resolution and Home Treatment Teams
 CAMHS Children and Adolescent Mental Health Services

About this review

For this review, we concentrated on community services with a particular focus on CMHTs the Crisis Resolution and Home Treatment Team (CRHTT), based in Dundee and the Home Treatment Team (HTT) in Perth & Kinross. This involved looking at how services are planned, how teams communicate and interface with other services and most importantly, peoples' experience of care from accessing and using the service.

Before our visit, NHS Tayside and the three partnerships provided us with self-evaluations and supporting evidence. The review team considered this information to form the key lines of enquiry (KLOE) for the review visit.

The review was carried out over a 3 week period: week 1 commencing 27 January 2020; followed by week 2 commencing 17 February 2020, and week 3 commencing 2 March 2020. On-site visits took place involving a range of staff and service providers across NHS Tayside and the three partnership areas (Perth & Kinross, Dundee and Angus).

During week 1 we undertook a review of case records to look at how people access and receive care across Tayside. We also looked at the record keeping and assessed how well the case files were consistent and reflected best practice guidelines. The lived experience of people experiencing care was elicited from the case record review and the follow up interviews with patients identified from the case files.

During weeks 2 and 3 we were on site in various locations throughout NHS Tayside. For the complete list of clinical and non-clinical areas visited, please see Appendix 3.

We spoke with the following staff groups during the review.

- CMHTs, CRHTTs and HTT staff.
- Consultant psychiatrists: locum and substantive.
- Psychological therapies staff.
- Strategic planning groups.
- Mental Health Officers (MHOs).
- Heads of services.
- Egton Medical Information System (EMIS) leads.
- People experiencing care.
- Third sector organisations.
- Chief officers and locality managers of each of the three partnerships.
- NHS Tayside's medical director and associate medical director for mental health.

This report is intended to:

- provide NHS Tayside and the partnerships with the findings of our review to support them in their efforts to identify and address areas of concern, and
- take forward the immediate actions and recommendations to improve the provision of its adult community mental health (ACMH) service to avoid further crises and a downward spiral of deterioration in service provision.

On Wednesday 11 March 2020, The Minister for Mental Health, Clare Haughey, announced that the management of GAP in-patient services must be led by NHS Tayside rather than an integration authority. The following statement was made:



'I am clear that operational management of general adult psychiatry services must now be led by NHS Tayside, rather than an integration authority. NHS Tayside will now implement this change, and will work closely with its integration partners in doing so.'

www.gov.scot/publications/update-independent-inquiry-mental-health-services-tayside

Executive summary

Our main focus of this review from the outset was to provide assurance as to whether:

6 *'People referred to Community Mental Health Services in Tayside have access to mental health care where and when they need it and are they able to move through the system easily so that those people who need intensive input receive it in the appropriate place and at the right time?'*

We conclude from our findings that this is not always the case for everyone using services across Tayside. We identified areas of significant concern but we also saw examples of good practice and encouraging initiatives throughout the area. These were confined to individual areas and pockets of the service rather than being consistent pan Tayside initiatives. This was a recurring theme across the three partnership areas.

We saw that the Crisis Resolution and Home Treatment service continued to face many challenges, difficulties and complexities and as highlighted in previous HIS reports, there is still a lack of equity in relation to geographical location, speedy access and timely interventions for people to access care. We considered this inequity of service provision across Tayside to be a concern. NHS Tayside and the partnerships have highlighted to us in the self-evaluation documentation those areas of the service that they plan to address and take forward for improvement.

We acknowledge that since we commenced this review, the Scottish Government has announced that responsibility for the provision of General Adult Psychiatry in-patient services (which includes the medical workforce and Crisis Resolution and Home Treatment Teams) will be the operational responsibility of NHS Tayside. This is an encouraging development, however we would expect to see NHS Tayside and the partnerships work together to achieve a clear pan Tayside approach to strategic planning to ensure equity of access and treatment across all community mental health services.

Locum doctors provide valued input and complement the permanent workforce. However, too many ever-changing locum consultants, alongside a large number of vacancies tips the balance with regard to the provision of care into a significant risk for the service. Staff told us that they need to spend considerable time and energy supporting new locum psychiatrists and are obliged to accommodate the changes in working practices and patient care which a new consultant inevitably brings.

This has had a negative impact on the multi-disciplinary teams which has compromised staff working in this environment. This is not sustainable and we are concerned about the negative longer-term impact and risks this has on staff wellbeing and patient care. We were told by staff how this makes daily working life even more difficult while trying to deliver a service where demand far exceeds capacity; the need to constantly adapt to and monitor the work of a new doctor creates its own risks due to the distraction it causes.

We acknowledge that Tayside is the first area we have reviewed in respect to its adult community mental health service. In the interests of fairness, demands and challenges in the provision and delivery of adult community mental health services is a situation we recognise affects all NHS boards and partnerships providing this service. In particular, there are challenges with a national shortage of consultant psychiatrists and the difficulty to recruit permanently to these posts. However, how this is managed and the lack of leadership and management of this situation is an area of significant concern which NHS Tayside and the partnerships need to address as a priority.

NHS Tayside and the partnerships must:

- Implement formal senior mentoring and supervision to ensure locum psychiatrists are monitored and supported to deliver safe and high-quality clinical practice. In particular, more formal processes and checks need to be in place for changes in medication and/or diagnosis.
- Put job plans in place for locum psychiatrists to support this group of doctors in order to give clear guidance of what is expected in the role and to outline the minimum standard of practice expected.
- Take steps to reduce the current inequity of service provision across all three partnership areas.

Recommendations

In addition to implementing the above actions, NHS Tayside and the partnerships must also:

- Review its referral and acceptance standards for primary and secondary community adult mental health services, to ensure that there are clear pathways for people to access care and to support equity of access to care across Tayside.
- Ensure that it has clear governance and oversight of all of the cases currently open to the CMHT's enabling systematic monitoring and review of all open cases to the teams.
- Ensure that there are robust audit processes in place for clinical records to ensure that all clinical documentation meets standards for Nursing and Midwifery Council (NMC)/NHS record keeping guidance.
- Review its use of Egton Medical Information System (EMIS) to make sure it is used to its full capability. EMIS web is an electronic clinical record in which clinical and some social care staff record their assessments and update their contacts with people who use the service.
- Review waiting times for routine initial assessment into CMHTs and monitor, adopt and share learning and good practice from teams across the partnership to inform service improvement.
- Ensure that effective governance systems and processes are embedded across all mental health services and that policies and procedures are up-to-date consistent and support staff to provide high quality care and treatment.
- Ensure that clear clinical and corporate risks are identified and effectively managed at every level in the organisation including a clear risk escalation process and recording on the risk register.
- Ensure that there is a clear systematic and standardised approach to improve communications between the CRHTT, HTT, inpatient wards and CMHTs. Technology such as video conference or other IT communication platforms should be considered.
- Review the remit and scope of the CRHTT and HTT teams to ensure they can effectively provide a timely and accessible service. This should include:
 - the operational role of the co-ordinator within the CRHTT including reviewing the bed management role
 - the accessibility to services and location of assessments for people in crisis within Tayside, reviewing where and when people can receive assessments, and
 - the actual capacity for the CRHTT team to effectively provide the home treatment aspect of care for people in Dundee.

- More collaborative working between partnerships to ensure all key performance indicators for ACMH are reviewed, updated and consistently applied across all partnership areas.
- Ensure the provision of specialist data support from the NHS board's business intelligence unit to support staff to use data to monitor service provision and help drive improvement across all areas of ACMH. In particular, there needs to be a greater focus on outcome data to drive improvement.
- There needs to be a systematic approach for measuring and monitoring the quality of community mental health services in Tayside. The main purposes of this are to learn about, and improve, the quality of care delivered.
- Essential components of this are:
 - collecting quantitative data about important aspects of the delivery and outcomes of care
 - collecting information about the experience of people using and also those delivering mental health services and
 - drawing together this data/information to learn about the quality of care, for example what aspects of care are reliably delivered to a high standard and, what elements of care need to be improved?

During our time on-site, we observed a very committed workforce from all specialties across the service. We very much appreciate the excellent levels of engagement and openness from all staff we met who gave us an insight into the work they do to deliver the service on a daily basis. We wish to acknowledge their professionalism and honesty throughout the review.

Good practice

We identified the following areas of good practice which had a positive impact on patient care and services:

- In the commissioning of services, the Dundee partnership sought mental health nurse clinical knowledge to best suit the needs of the people using the services.
- The HTT team based in Perth & Kinross had care plans which were strength-based and recovery-focused and there was evidence both of the person receiving the service and their carer being involved in their care. Copies of the care plan and safety plans were given to both the patient and their carer, and we saw that consent to share information was documented.
- Teams used outcomes from significant adverse events to drive improvement.
- There was evidence of effective multidisciplinary team (MDT) collaboration in CMHTs which supported patient care and the ongoing management of their condition.
- Community teams we met with were committed to providing high quality care to people using their service under difficult circumstances.
- Positive working relationships and good communications were observed at a local level. There was evidence of teams having a positive and supportive culture despite the challenges they faced daily.
- Teams were committed to reducing waiting times by running additional services on Saturdays in Dundee.
- CMHTs in Angus HSCP were fully integrated with local social care services and we saw good examples of effective collaboration with third sector providers to develop an inclusive primary care mental health services for the provision of “low level” interventions.

Community Mental Health Teams

In Tayside, adult CMHTs provide a single point of access for people who present with severe, complex and enduring mental health problems. To achieve this, the teams work closely with other services such as, acute inpatient wards, more specialist services, primary care, local community networks and other agencies.

It is important to highlight that the community teams we met with were committed to providing high quality care to people using their service under difficult circumstances.

Positive working relationships and good communications were observed at a local level. There was evidence of teams having a positive and supportive culture despite the challenges they faced daily.

CMHTs had local operating policies and procedures in place which included a service specification – a descriptor of the remit of the service. However, we consistently heard how the nature of referrals had changed in recent years. In particular, all CMHTs' remit seems to have widened from “severe, complex and enduring mental health problems” to include “moderate” level of needs, with many more referrals for people with mild/moderate distress and emotionally unstable personality disorders.

The teams also received a very broad range of referrals including requests for:

- the assessment and diagnosis for people with suspected autism spectrum disorder (ASD)
- attention deficit hyperactivity disorder (ADHD), and
- for general support and medication review.

Most referrals are received from GPs via SCI Gateway (a national system that integrates primary and secondary care systems). Like most teams nationally, the CMHTs do not accept self-referrals.

CMHTs catchment areas were commonly attached to GP practices, however, we were told this was changing to locality areas based on an individual's postcode. For adult CMHTs in Tayside, the response time for referrals accepted for assessment would be categorised as follows:

- emergency – within 4 hours
- urgent – within 72 hours, and
- routine – within 12 weeks.

Once received, an initial screening was undertaken by a duty worker, and the level of priority would be decided at a CMHT referral and allocation meeting. Normally this group consists of senior clinicians and practitioners from a range of disciplines. The referrer did not have to complete a risk assessment when referring which meant there could be limited information on risk factors and history to base their decisions when considering the priority of referrals.

There were examples of CMHTs accepting referrals where vague suicidal thoughts or superficial self-harm in reaction to life events or social stressors. This was happening regularly, however the more appropriate option may be to consider third sector organisations or primary care services who can provide support for these specific referrals.

It was acknowledged by some teams that they were risk averse and believed it was simpler to see the person for an assessment and to signpost to more appropriate services afterwards. Lack of consistent medical leadership to support decision making about referrals were highlighted as a contributing factor and raised as a concern with the review team.

The review team was concerned that these current working practices may be detrimental to the person receiving care due to the delay in receiving the most appropriate intervention at the time of greatest need.

It is important to highlight that the nursing workforce was the most consistent element of the CMHTs. We saw that nurse team managers were the core element in supporting staff, making decisions and providing steady and resilient leadership to their teams. Staff we spoke with told us that they provided stability and resilience.

On reviewing waiting times for routine assessments, we observed considerable disparity between teams in different areas. Some CMHTs in the partnerships manage to see people for routine assessment in as little as two weeks, whilst in other partnerships, it might be as long as 12 weeks. There were many complex and varying reasons for this, for example:

- staff retention and allocation of resource
- ongoing vacancies
- the composition and availability of clinical staff, and
- the planned scheduling of referrals, with some teams allocating more weekly referral assessment slots than others.

However, we also saw examples of teams committed to reducing waiting times by running additional services on Saturdays in Dundee, which entailed locum psychiatrists supported by nursing staff arranging clinics to reduce the backlog of referrals. Staff supporting this initiative should be commended. However, providing this additional locum work resource at weekends may not be the most efficient or cost effective way to manage the service.

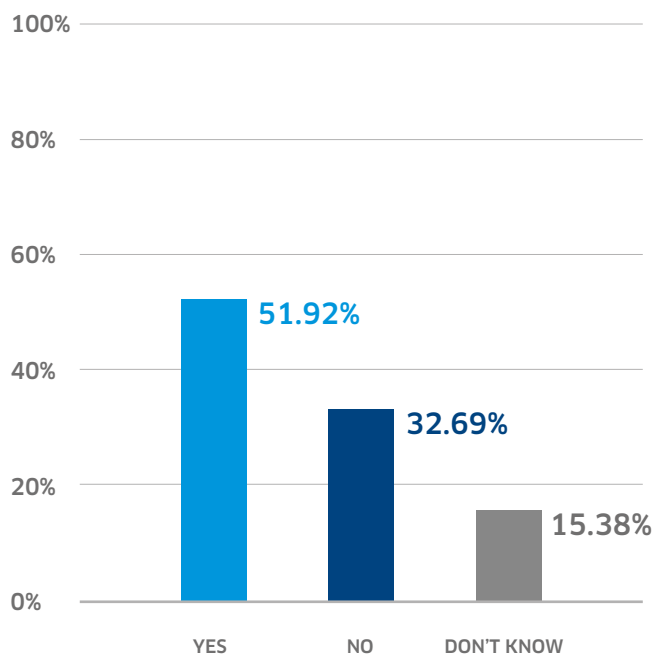
Our discussion with senior managers highlighted that there did not seem to be an opportunity to capture, monitor and discuss actual waiting times for initial assessment across the three partnerships, or to discuss the breadth and nature of referrals coming into the teams. As mentioned earlier in the report, the needs of the population have changed with the expectation of the service fundamentally changing in response to this. For example, people seeking help with diagnoses, such as ADHD, and an increase in referrals for mild/moderate distress and emotionally unstable personality disorders.

The review team was concerned that waiting times for access to assessment were dependent on the geographical area. Depending on where someone lived, they could be seen as much as 10 weeks earlier than others, which is clearly inequitable.

As part of the review, we asked 69 GPs seven questions to obtain their views on the referral process to CMHTs and how the service communicates and responds. Eighty-three per cent of GPs responded, of which 48% reported that they were not aware of the referral criteria for the CMHT (Figure 4). Comments included that guidelines on referral had been received many years ago however it would be beneficial if these could be updated and re-issued to GPs and primary care mental health nurses.

Forty percent of GPs reported that they received information on the progress of referrals with 56% saying they did not receive any such information (Figure 5). Seventy-four percent reported that they were given a reason if a referral is rejected. Some 12% reported that they do not have a clear understanding of waiting times for initial assessment. GPs are however aware of the shortage of psychiatrists.

Figure 4: Do you know the referral criteria for Community Mental Health Teams?



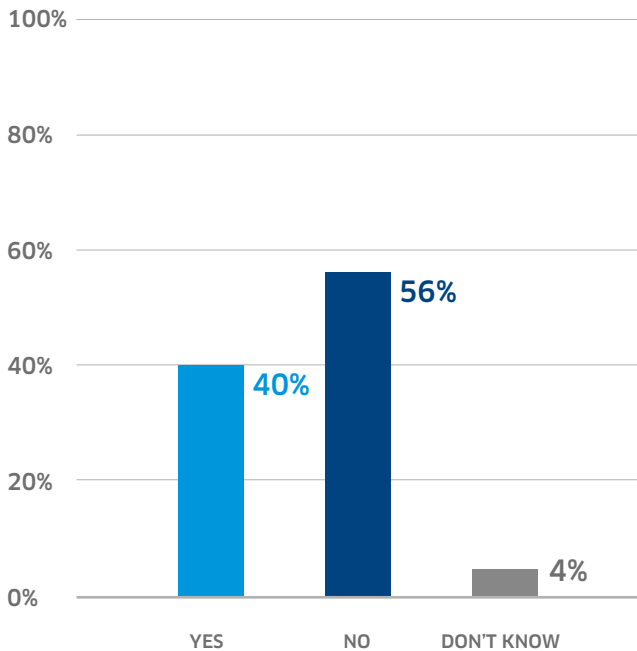
Referral Criteria to CMHTs

“Previously sent guidelines but many years ago now. Updated referral pathways would be useful to new GP’s locums and primary care mental health nurses”

“From my experience of working in Tayside, I have knowledge of what our local CMHTs will accept and which mental health needs are met within other services”



Figure 5: Are you given information on the progress of referrals you have made?



Information on Referral Progress

“Feedback often slow and incomplete”

“Through discharge letters once discharged from hospital if admitted. Details are given of any plans for visiting in the community by crisis team etc. However no progress information is given if the patient remains in hospital”



The CMHTs were not fully integrated, or managed as a single entity, with clinical psychology and occupational therapy (OT) services operating as centralised services. Common themes, particularly in Perth & Kinross and Dundee, were that each professional group worked in silos, with MHOs, social workers, OTs and psychologists operating from and being line-managed in different bases.

Although some teams had a psychologist co-located with the CMHT for part of the working week, they were unable to accept direct referrals. Referrals to the team for psychology would have to be discussed with more senior colleagues in the centralised psychology department prior to approval and allocation. This resulted in delays to referrals being allocated.

However, on a positive note, CMHTs in Angus HSCP were fully integrated with local social care services; this was established prior to the formation of the HSCP. This has enabled access to and use of the same electronic record systems, which has in turn enhanced and supported clear communication between professionals.

Once people had undergone the initial assessment and were identified as potentially benefiting from intervention and treatment, they were then placed on an internal waiting list, dependent on which clinical specialty was required.

The longest internal waiting times – up to a year in some instances – were for OT, clinical psychology and psychiatry. Some community teams had internal waiting lists for mental health nursing input, one for assessment and one for treatment. There was no robust process to capture, monitor, analyse or discuss waiting times for the commencement of treatment or intervention.

Review and care planning

For people referred to CMHTs, planning their care and support should be a collaborative process at all levels of intervention, including the identification and management of risk, whether to self or others.

For most CMHTs, there was no scheduled routine process to review patients accepted onto the CMHT's caseload. Cases of concerns could be brought to the team meeting (if one existed) and while processes for monitoring and review appeared better in some teams than in others, overall, there was no clear robust, systematic and consistent process across all teams.

We were concerned that for some teams there was a lack of clear governance and oversight of all of the cases currently open to the CMHT. There was no systematic monitoring or review of open cases. We saw examples where people were waiting for an appointment to see a psychiatrist but if one was not available, they were not offered a follow-up appointment or alternative support.

LOCAL INITIATIVE

The Penumbra mental health charity in Arbroath supports around 1,800 adults and young people every year and works to promote mental health and wellbeing for all, prevent mental ill health for people who are 'at risk', and to support people with a range of mental health problems. It provides a wide range of services which offer hope and practical steps towards recovery throughout the Angus area.

Clinical records and EMIS web

Following consultation with other NHS boards, NHS Tayside introduced EMIS web to its mental health service in June 2018. EMIS web is an electronic clinical record in which clinical and some social care staff record their assessments and update their contacts with people who use the service. On the introduction of EMIS across Tayside, two or three 'super users' were trained in each area to support staff in using the new system. However, due to staff changes, it was not clear whether the staff in those roles were still in post. There is a generic email address to support staff with any issues or concerns, but the lack of clarity about dedicated staff to support EMIS raised concerns around the coordination and monitoring of challenges in using the system to its full potential.

Areas for improvements included the following:

- Designations of staff completing the written record were not being included on the system – this was a concern as it meant that it was not clear which professional member of staff has actually seen the person.
- Appointments were not forward-planned using EMIS – another system 'Trak Care' is used for scheduling appointments. This meant that staff had to navigate between two electronic systems to arrange appointments. We also asked why a single system was not used in the community and were advised that this was primarily to allow alignment with the 'Trak Care' system used in acute care.
- We observed inconsistencies and difficulties in being able to follow care plans; evidence patient involvement; or confirm whether consent had been sought or obtained from the person receiving care. We also noted that care plans were not always person-centred. The quality and consistency of documented risk assessments were also variable. There was a lack of clarity as to who had completed or been involved in the completion of the risk assessments.
- NHS Tayside acknowledged that there was considerable work required to ensure a consistent approach to clinical record-keeping for people receiving mental health services. To support this, in May 2019 it established person-centered care planning standards. The aim of the standards is to provide an auditable framework to support a quality approach to care planning for nurses working in all mental health and learning disability settings in NHS Tayside.
- For the CRHTT and HTT it had been identified that there was duplication and lack of consistency in the approach to records management.

We concluded that EMIS web is not currently being used to its full potential and we recommend that it is used to its full capability. This would better support staff in their work, using their time more efficiently and allowing appointments to be arranged quickly and simply. Using two systems simultaneously incurs additional costs; staff time; duplication of effort and creates more risk of error by the very nature of having to enter the same information twice.

Service user, carer engagement and support

On meeting with community teams we heard that people using the service would be given information on the service at the point of contact. There was a clear process for ensuring that people were informed of their appointment, which consisted of letters and phone calls. However, the information provided on the service was not available in different formats or “easy-read” versions.

There is no strategic or consistent approach to capture the patient experience. However, there were examples of evaluations, a patient story and recognition of the importance of patient stories in the recent independent review. Material on advice, support and information on how to raise concerns was displayed in various areas visited, although patient and carer feedback has been highlighted by the partnerships themselves as an area for further improvement. The teams were using significant adverse event reviews to drive improvement which is good practice. However other sources of feedback such as information from patient surveys should be accessible to staff to enable greater focus on learning from feedback received to help drive improvement. At the time of the review staff in the partnerships did not feel they had the support, skills or the capacity to do this.

As discussed previously, on reviewing individual records we saw that there was no consistent approach to capturing and recording informed consent, carer involvement and information supplied.

Person-centred care planning was also variable and inconsistent. People using services did not systematically receive copies of their care plans and evidence that a discussion had taken place between the individual and the clinician was not consistently recorded.

The review team met with patients identified from file reading activity. One patient we spoke with told us about the good experience they had received from the CMHT in their area. Through effective MDT collaboration, we saw how a number of services had been utilised to monitor and promote recovery for the patient. This included liaising with their family to help identify early changes in the patient’s behavior. This has provided a positive outcome for the patient to regain confidence and manage their condition successfully.

Crisis Resolution and Home Treatment Teams

Crisis Resolution and Home Treatment Teams are now an established part of mental health services across Scotland. In general, their purpose is:

- to provide short-term, intensive home treatment for people experiencing an acute mental health crisis.

Tayside provides 24 hour crisis service where people can receive an urgent mental health assessment. For some people requiring short term intervention, this is provided by a home treatment team which supports them through their crisis.

The Crisis Resolution and Home Treatment service has faced many challenges, difficulties and complexities and as highlighted in previous HIS reports, there is still a lack of equity in relation to geographical location, speedy access and timely interventions. We also acknowledge the difficulty for substantive staff across all disciplines working to deliver a service despite the daily challenges, and we would like to highlight their dedication and motivation to deliver a service in these circumstances.

Our findings from this review confirm that there were clear variations in the help, care and support available to people in crisis in Tayside and although we did find examples of good crisis care, we saw that many people had poor experiences due to challenges accessing the service when they needed a response.

It is important to acknowledge that the partnerships and NHS Tayside recognise that they were struggling to provide the appropriate levels and quality of crisis response. Steps are being taken to address this.

LOCAL INITIATIVE

Refugee support has been developing peer support for refugees with mental health issues and is modelled on the mental health foundation work in Glasgow.

Access and availability

The CRHTT based at the Carseview Centre in Dundee provides a 24 hour, 365 day service for people to access an urgent mental health assessment across Tayside. We found the pathway and criteria for a person to access the CRHTT was complex and variable depending on the partnership area. People who used CRHTT services, CMHTs, and third sector providers told us that the access process and pathways for crisis assessments were not easy to navigate or understand.

The assessment service is hosted in the Carseview Centre in Dundee. However, people living in Dundee could also be visited at home if they could not attend their appointment due to mitigating circumstances, for example a physical disability. We found inequality for the provision of the home visit service for people in Perth & Kinross and in the Angus partnership areas, despite living geographically further away from the Carseview Centre.

We consistently heard concerns that travel time could exceed an hour for people attending the Carseview Centre in Dundee. Due to demands upon the service, some people were being offered times for assessment late at night. This then meant that it might be difficult or impossible, depending on the person's address, to attend the centre and return home on the same day.

Across Tayside, there was a maximum response time of 4 hours for a crisis assessment. We were told that this would often be breached due to the demands of the service. The CRHTT has a very broad remit, including the assessment of child and adolescent mental health service patients; older adults; liaison psychiatry patients, NHS24 referrals and police referrals. The CRHTT also provides home treatment team intensive intervention and undertakes all emergency referrals for the people living in Dundee.

Across Tayside, there are inequities in the ability to access the home treatment team. People in Angus do not have a 7 day home treatment team service. This was first highlighted in a HIS report in December 2017 and it is concerning to see that improvement has not been progressed. There were several reasons offered for this delay: initially, the funding was unavailable and more recently lack of available and qualified staff to fill posts.

Planning and delivering support

On reviewing peoples' record for the CRHTT across the partnership, similarly to the CMHTs we saw that there was not a consistent approach to clinical record-keeping and care planning.

The HTT based in Perth & Kinross creates care plans which are strengths-based and recovery-focused and there was evidence of the person receiving the service and their carer being involved in their care. Copies of the overall care plan and safety care plans (for people at risk of deliberate self-harm or suicide) were given to the patient and their carer, and we saw that consent to share information was also documented.

Disengagement plans were also in place for how services should act if the person does not attend or otherwise tries to disengage from the service and there was a process to review care plans and risk assessments in collaboration with the person receiving care.

The CRHTT team in Dundee was not able to evidence a collaborative approach between the person receiving care and the team providing the care. Care plans, in general, were not focused on an individual's strengths or recovery and we were concerned to see that some care plans were apparently generated before the clinical team had actually met with the person. Crisis plans were not widely available to people using the service.

Similarly, issues identified with consultant psychiatrist leadership within CMHTs were echoed in the CRHTT and the HTT in Perth & Kinross. Concerns were raised about the impact of inconsistent availability of psychiatrists on people using the service. Lack of senior medical support for locum psychiatrist and staff grade doctors in the HTT was also an area of concern.



LOCAL
INITIATIVE

The Haven is a service for people hearing voices. The service provides a free café and there are plans to open on Saturdays.

Service user involvement and supporting carers

Information on the service was given to the person receiving care at the point of contact and there was a clear process for ensuring that people were informed of their appointments, which consisted of letters and phone calls. Information on the service was not available in different formats or languages or easy read versions. Procedures were in place to record and feedback the outcome of a referral to service users, carers and referring agencies.



LOCAL
INITIATIVE

The Wellbeing Works is funded by Dundee HSCP and promotes better wellbeing for those who face mental health challenges, by building confidence, teaching new skills and connecting with others and having a positive impact on the community.

Interface with other services

Communication between the CRHTT, HTT, CMHTs and the inpatient units was not consistent and at times there was a failure to communicate effectively, which led to confusion and conflict between teams. There was no formal scheduled and systematic mechanism to facilitate contact between teams to discuss people in their care with all communication being ad-hoc and unscheduled, relying on emails and telephone calls.

Effective communication protects people using the service from potential harm arising from misunderstandings between clinical staff. To reduce clinical risk NHS Tayside must ensure that there is a clear systematic and standardised approach to communication between all community teams and inpatient wards.

The role of co-ordinating and arranging admission to an inpatient bed is the responsibility of the CRHTT team daily co-ordinator. This meant that if a person requires admission to hospital, and required an escort, this would be arranged by the co-ordinator within the CRHTT team. Both community staff and CRHTT staff told us that could be challenging and extremely time consuming, leading to delays in getting people to hospital. It was also perceived as an ineffective and inefficient way of managing escorts as it impacted and detracted on the time available for the co-ordinator to manage the CRHTT team.

Staff in the CMHTs and the CRHTT and HTT did not participate in ward meetings. This meant that they did not contribute to the care planning and support for early discharge or make arrangements for people planning to return home. This was a concern as it meant that there was a limited contribution to planning and evaluation of people's care in preparation for discharge. There was no structured mechanism in place for discussion between the CMHT and the inpatient team. When meeting with staff we were told that time constraints were a factor in attending meetings.

NHS Tayside and the partnerships must consider ways to improve communication between inpatient settings and the community teams, making sure that resources are used effectively for example, IT support, such as video conference or other IT communication platforms. This will help provide a better mechanism to facilitate discussions in supporting arrangements for peoples care and discharge.

Communication with inpatient services was via members of the team attending 'daily huddles' which discussed operational issues such as bed status and staffing pressures. We saw that this enabled pressure points in the service to be discussed and managed and there was representation from senior managers at this meeting.

Psychological therapies

In 2017, when HIS visited Tayside, we were informed that psychology services were hosted by the Dundee IJB. We were concerned that this could lead to challenges in understanding and agreeing priorities across all parts of the service.

Psychological therapies (sometimes called ‘talking therapies’) are interventions for problems related to a person’s mental health or wellbeing. Psychologists, psychiatrists, some GPs, social workers, mental health nurses, counsellors and others may be able to offer different psychological therapies provided they have been appropriately trained and possess the necessary skills.

On the most recent review visit, we saw that psychology services continued to be hosted within the Dundee partnership but provided services across the 3 partnerships. Psychologists were co-located in each CMHT for at least part of the working week and people could be referred to the service via their GP or by another mental health professional within the CMHTs.

There are nationally established criteria within each partnership’s local delivery plan which aims to improve access to mental health services by delivering a maximum wait of 18 weeks referral-to-treatment for psychological therapies.³

Access to psychological therapies in community adult mental health services can vary depending on the partnership area in which the person resides. Certain areas do not meet the national waiting time standards of 18 weeks from referral-to-treatment. There were lengthy waits for people to access diagnosis and treatment within subspecialist teams, in particular for ADHD and ASD.

On a positive note, a number of measures had been put in place to improve access to psychological therapies and supporting services across the three partnerships. This has had a positive impact on waiting times overall. However, challenges remain concerning the strategic vision and systematic planning for the provision of psychological therapies and how this fits in as an essential part of an integrated mental health service.

We did not see evidence of robust processes in place which enable the effective measurement of the quality of care provided by psychological services. For interventions provided within CMHTs, we saw that data relating to waiting times, referrals, reasons for rejections and complaints in relation to psychological therapies were reviewed. However, analysis of data is very limited and as a result, no significant learning or improvements have been made from the data collected.

³ <https://www.webarchive.org.uk/wayback/archive/20170701074158/http://www.gov.scot/Publications/2011/12/15095906/0>

The Patient Assessment and Liaison Mental Health Service (PALMS) is a new pilot service run by Dundee HSCP. It aims to improve access to community mental health assessment for adults within primary care settings and provide direct, timely clinical advice to GPs.

However, we note that despite the good practice displayed in this partnership, it is not replicated in the other partnerships. We recognise that there are local variables to consider regarding demographics and workforce resource disparities, however, there is significant concern that the current pilot and an uncoordinated approach to roll-out will result in a continued lack of a fair, equitable and sustainable service for people across Tayside.



LOCAL
INITIATIVE

Dundee Independent Advocacy offers a service to people aged over 21 years with learning disabilities, mental health issues, dementia and physical ill health.

Primary care services

Over recent years, the partnerships have developed a community-orientated model of primary care mental health services. Primary care mental health services support people with mild to moderate levels of mental health problems. The intention is to ensure that people can access the right support and treatment at the right time. We found that there was wide variation in how primary care services were being delivered and monitored.

In the partnerships of Dundee and Perth & Kinross, the review team did not see clear strategic planning or pathways to ensure alignment between primary care mental health services and secondary care provision by CMHTs. However, we found that the Angus CMHTs had a much better model in place with systems and processes which enable good collaboration with primary care mental health services for the provision of “low level” interventions. This is a marked contrast to the other partnerships. The review team saw evidence of local initiatives which have had a positive impact on people using the service and we considered it important to acknowledge these and recommend them to other HSCPs.



LOCAL
INITIATIVE

Building Bridges of Hope was started for homeless people and is a forum to enable a range of third sector agencies to meet and discuss available resources across Dundee.

Recruitment and retention of staff

Recruitment was regarded as an extremely lengthy and problematic process which requires simplification and streamlining throughout all services. There were long waits to interview and recruit successful applicants for vacant posts. Some staff highlighted a 9 month gap for vacancies to be filled and for a new staff member to come into post. Managers we spoke with agreed that the processes are multi-layered, which causes delays and hinders the recruitment process.

Despite an ongoing recruitment campaign by NHS Tayside to employ psychiatrists, which included incentives to encourage staff to apply, it was recognised by the NHS board that given the very high number of vacancies in adult psychiatry posts nationally, it was unlikely that all posts would be filled in the near future.

A new model for working was being developed, with a programme of training Advanced Nurse Practitioners (ANPs) in mental health over the next year who will work across mental health services, including the community. ANPs will function at an advanced clinical level with considerable autonomy and are often non-medical prescribers. NHS Tayside has developed a competency framework to support ANPs which includes regular supervision and support from a substantive consultant psychiatrist. At the time of the review, we were unable to say what impact this initiative will have on people receiving care, however, we recognise this as a positive development which is likely to enhance the skill mix and resilience of CMHTs.



LOCAL
INITIATIVE

Recovery@Dundonald works closely with local partners to support people on their recovery and empower those with lived experience of mental illness to flourish.

Training and education

We did not see a NHS Tayside board-wide policy for staff training and development. However, we were informed that within each locality there is a local Clinical and Care Governance Forum which monitors all governance arrangements. Additionally, there is a mental health Quality and Review Group which meets on a monthly basis to review key performance indicators (KPIs) across NHS Tayside. However, we saw that some KPIs, such as, the quality of care in psychological therapies, were not monitored and reviewed on a regular basis. NHS Tayside must review all KPIs for adult CMHS.

Each partnership spoke about a range of training provisions from local to national mandatory training for various staff groups. We were told that training requirements are managed at various levels for mandatory requirements, including ongoing professional development and clinical competency which addresses the requirements of NHS Tayside as well as those of professional regulatory bodies.

On speaking with the teams, we were told that access to training was generally good, with some team members having been trained in Behavioural Family Therapy, Dialectical Behavior Therapy (DBT) and low-level psychological therapies. Most nursing staff have had training in safety and stabilisation.



LOCAL INITIATIVE

The Wellbeing Team in Perth & Kinross offers short term support and intervention to people aged 16 years or over, who have mental health needs such as depression and anxiety, or other mental health issues which interfere with the individuals cognitive, social or emotional abilities.

Vision and leadership

Planning within each of the three partnerships in Tayside has led to a perceived imbalance in the provision of adult CMHS with individual local approaches to services delivery not being replicated across Tayside.

Staff groups told us they were supported by their immediate locality managers. However, they also described a disconnect between senior leadership and frontline staff delivering the current service model throughout the localities and within the CMHTs. This has contributed to low morale, with staff not feeling listened to. Staff told us that they felt that services were better integrated before the formation of the three partnerships. Most staff were not aware of the partnership or its strategic direction for mental health services and felt that the strategic intentions and frontline service risks did not match up.

Medical staffing and the inability to recruit substantive consultant psychiatrists has been a significant concern for a considerable period in Tayside. During this review, we consistently heard from community teams that the short-fall of substantive psychiatrists and the high turnover of short-term locums had a direct impact on the team's ability to deliver comprehensive and consistent mental health care.

The shortage of senior permanent medical staffing and leadership had not only significantly impacted on staff morale and relationships with colleagues, but has also led to gaps in key organisational learning and continuity of care for individual patients. Teams told us that people receiving services were unhappy at the regular changes in locum doctors. We were also told that decisions with regard to medications, diagnosis and care planning could change frequently and had at times been unhelpful and had a detrimental impact on the person receiving care.

As highlighted in previous HIS reviews, we continue to have concerns that the lack of medical leadership also affects the quality and consistency of training, support and supervision available to trainee psychiatrists. Medical students are the consultants of the future and are most likely to join a service if they have had a good educational or training experience there. While there is a lead clinician who provides a level of oversight and support to locum psychiatrists in Dundee, the continued absence of a lead psychiatrist remains a significant concern.

Lines of accountability and medical line management were neither clear nor effective for locum psychiatrists. There was not a clear escalation process in place for responding to concerns raised regarding a locum's performance. There was also a lack of clarity as to who is responsible and accountable for managing such concern – NHS Tayside or the individual HSCP.

During the review, we heard from staff that there was no clear guidance or process to follow to raise concerns, and worryingly when they did raise a concern, that they were not listened to.

Tayside highlighted that the use of data is an area for improvement throughout the service and described it as being 'in development'. We saw some good examples of using data and intelligence for inpatient services but these need to be extended to community mental health. For example, NHS Tayside previously applied The Health Foundation's framework for measuring and monitoring safety in an inpatient setting and also as part of its performance reviews. There may be some good learning from this experience.

Mental health performance reviews were established over 5 years ago to assure consistency of approach and measurement of outcomes for services users. A Tayside group meets every two months to examine available data and provide positive, supportive challenge across the whole system to understand how this process works, the data being considered, and what conclusions are being drawn about the quality of care.

Overall, we saw a limited focus on outcome data across all groups and any future approach should ensure quantitative data is collected about the important aspects of service delivery and outcomes of care. Tayside must use other sources of information in conjunction with quantitative data, such as feedback from people using services and staff for the purpose of learning about and improving the quality of care throughout CMHS. The data and intelligence considered by higher governance groups were very much focused on central government targets, such as waiting times, and because there is no waiting time target for the community, they reviewed relatively little or no data about community mental health services.

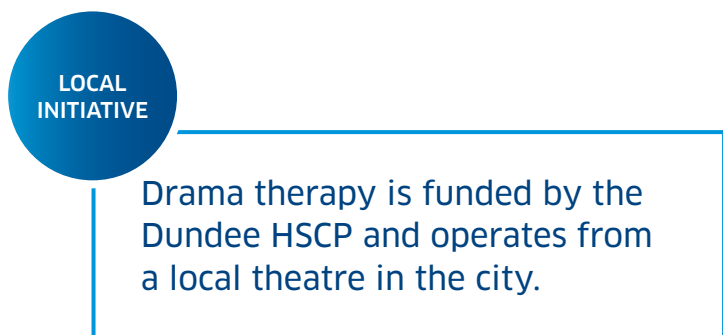
In relation to community mental health services, we saw that partnerships and NHS Tayside made limited use of data to manage quality. We did see some recent efforts to enrich governance meetings with new sources of data about community mental health services. This was often undertaken by medical staff who have the valuable subject knowledge, but who were not supported to analyse data in a way that helps them recognise important variation or patterns in the data.

In general there was no demonstrable understanding of how to use data to inform quality management, both locally and at a strategic level. Staff we spoke with felt there was a need for a consistent approach for enhanced data gathering, sharing and its systematic use to drive improvement, describing services as 'data-rich but analysis light'.

As noted in the Perth & Kinross joint inspection with the Care Inspectorate (the Effectiveness of Strategic Planning in Perth & Kinross HSCP, September 2019) concerns were raised that the partnership did not take a coordinated approach to involving CMHS in the early plans for mental health and learning disability inpatient redesign resulting in a mismatch of service provision.

Tayside was aware of the lack of joined up planning and we heard of a co-production approach to the development of a strategic single mental health and wellbeing strategy. The strategy sets out the responsibilities for action and governance for the Tayside Mental Health and Wellbeing Strategy Board which will replace the Tayside Mental Health Alliance (TMHA). It identifies priorities and initiatives from each partnership both locally and Tayside-wide. It also examined the format of the Lanarkshire model⁴ and what could be tailored to apply to the Tayside landscape.

Initially the TMHA was designed to strengthen an integrated approach between the health board and HSCPs in the delivery of all aspects of mental health services. Membership consists of representatives of the 3 partnerships across Tayside as well as third sector partners. Each partnership in Tayside has its own set of priorities for financial planning, governance and strategic planning arrangements as well as leadership capacity. We therefore express concern at this group's ability to effectively make decisions and prompt change. We acknowledge that since we commenced this review, the Scottish Government has announced that responsibility for the provision of General Adult Psychiatry (GAP) in-patient services (which include the medical workforce and Crisis Response & Home Treatment Team(s), will be the operational responsibility of NHS Tayside. This together with the new Tayside Mental Health and Wellbeing Strategy Board is an encouraging development, however we would expect to see NHS Tayside and the 3 HSCPs work together to identify and implement shared strategic priorities for mental health to ensure equity of access and treatment across all adult community mental health services.



LOCAL INITIATIVE

Drama therapy is funded by the Dundee HSCP and operates from a local theatre in the city.

⁴ <https://www.nhs.uk/lanarkshire-scotland/strategies/mental-health-wellbeing-2019-24/>



Further information

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Appendix 1: Quality of care review process

Listed below are the key stages in the quality of care review process.

Stage 1 – schedule planning and notification

We notify the organisation of the review several weeks in advance of a self-evaluation submission being required. Initial discussions and planning takes place regarding the requirements of the review.

Stage 2 – pre-work and self-evaluation

The organisation uses the Quality Framework, self-evaluation tool and the detailed guidance to ‘tell its story’. This involves reflecting on how well it makes an impact and delivers improved outcomes for people who experience care, plus the challenges and ‘bright spots’ of good and innovative practice.

Stage 3 – analysis phase

The HIS team analyses the package of data, with input from service-based or topic specialists as required. This analysis includes publicly available information, the SIHCG information and the completed self-evaluation and any additional evidence. Based on this analysis, the team develops Key Lines of Enquiry (KLOE) to shape the discussions with the NHS board representatives during the visit.

Stage 4 –visit

The review team visits the NHS board and meets with a range of staff and people who experience care to discuss the KLOE. This process provides an overview of what the team has seen and heard, and discussion around good and innovative local practice and any areas for potential further work.

Stage 5 – output and agreement on next steps

HIS will write up a report for publication following the review identifying key findings, areas of good practice, challenges and any areas for improvement. A draft version of the report will be shared with the NHS board before publication to check for factual accuracy. Once factual accuracy has been confirmed the report will be published on the HIS website.

Appendix 2: Review team

Name	Title	Organisation
Caroline Arnott	Senior Reviewer	Healthcare Improvement Scotland
Sharon Baillie	Programme Manager	Healthcare Improvement Scotland
Aileen Bradford	Administrative Officer	Healthcare Improvement Scotland
Ross Cheape	Service Development Manager/Interim Clinical Director	NHS Forth Valley
Jane Cheeseman	Consultant Psychiatrist	NHS Lothian
Margaret Doherty	Public Partner	Healthcare Improvement Scotland
Jo Elliot	Project Officer	Healthcare Improvement Scotland
Cath Haley	Senior Inspector	Healthcare Improvement Scotland
Cat Hutcheson	Senior Inspector	Healthcare Improvement Scotland
Maureen Johnston	Strategic Inspector	Care Inspectorate
Taf Madziva	Inspector	Healthcare Improvement Scotland
Tim Norwood	Data and Measurement Advisor	Healthcare Improvement Scotland
Mark Richards	Director of Nursing and AHPs	The State Hospital
Jennifer Russell	Mental Health Integration Manager	NHS Lanarkshire
Helen Samborek	Senior Inspector	Healthcare Improvement Scotland
Cliff Sharp	Medical Director	NHS Borders
Ian Smith	Head of Quality of Care	Healthcare Improvement Scotland
Emma Vaughan	Senior Charge Nurse	NHS Greater Glasgow & Clyde

We would also like to acknowledge the contribution provided from our colleagues in Community Engagement.

Appendix 3: List of clinical and non-clinical areas visited

- Action 15 Funding Panel, Perth
- Angus Care and Professional Governance, Angus House, Forfar
- Assertive Rehab Team Meeting Recovery Centre and wider team, Dundonald Centre, Dundee
- Clinical & Professional Team Managers, Murray Royal Hospital, Perth
- Clinical Team Manager & Senior Occupational Therapist, Arbroath
- CMHT (Access Team) meet and shadow, Perth
- CMHT (East), Dundee
- CMHT (North Angus), Stracathro Hospital, Brechin
- CMHT (North Perthshire), Blairgowrie Community Hospital
- CMHT (Perth City), Perth Royal Infirmary, Perth
- CMHT (South Angus), Arbroath
- CMHT (South) Staff team meeting, Arbroath
- CMHT (South Perthshire), Crieff
- CMHT (South) Allocation Meeting, Arbroath
- CMHT (South) follow up, Arbroath
- CMHT (West), Dundee
- CRHTT Huddle, Dundee
- CRHTT (shadow), Dundee
- Daily Triage Meeting, Perth Royal Infirmary
- DBT Staff Consultant, Perth Royal Infirmary
- Dundee Mental Health & Wellbeing SPG – Employment Support Service, Dundee
- EMIS meeting, Dundee
- Head of Health & Head of Service (Social Care), Perth and Kinross – Teleconference
- In-Patient Therapeutic Governance Committee (telecom), Murray Royal Hospital, Perth - Teleconference
- Inspector, Murray Royal Hospital, Perth
- Integrated Manager and Clinical Lead (telecom), Murray Royal Hospital, Perth
- LAER meeting (observing), Whitehills Hospital, Forfar
- Learning Event, Gannocy Learning Theatre, Ninewells
- Locality Manager and Clinical lead, Dundee
- Medical Director and Associate Medical Director, Dundee
- Mental Health Nursing Interface Meeting, Carseview

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