Healthcare Improvement Scotland

Scottish Patient Safety Programme

Core Mental Health Standards - Local Assessment Findings

July 2025

NHS SCOTLAND

Published July 2025

www.healthcareimprovementscotland.org

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Foreword

It has been a true privilege for us to support the work of the Scottish Patient Safety Programme for Mental Health (SPSPMH), Expert Reference Group (ERG) throughout the development of the Core Mental Health Standards. This work marks a significant milestone in our collective efforts to enhance mental health care across Scotland, and to improve our measurement and reporting of care quality.

The Core Mental Health Standards have provided each health board with a valuable opportunity to self-assess their clinical practices and service delivery, celebrate areas of excellence, and identify priorities for improvement. Importantly, they also create a platform for sharing good practice nationally, enabling us to learn from one another and strengthen our services collaboratively.

With the development and measurement of the standards it feels like a particularly positive and progressive time for mental health practice, as we now have a national benchmark to guide and inspire continuous improvement against shared priorities. Importantly, we also have data for local improvement, and a greater understanding of the local improvement skills and capacity which can help drive this work.

We would like to extend our heartfelt thanks to all members of the SPSPMH ERG for their dedication and contributions to this important work. We also wish to acknowledge the invaluable input from our external agencies and partners. Finally, a sincere thank you to all fourteen health boards for completing their assessments and identifying their improvement priorities, your commitment is deeply appreciated.

Dr Julia Wells - Chief Nurse Mental Health and Learning Disabilities, Aberdeen City, Moray and Aberdeenshire Health and Social Care Partnership (HSCP)

Mark Richards - Associate Chief Nursing Officer, Scottish Government

Introduction

The Core Mental Health Standards were published in September 2023. The standards were developed by Scottish Government with a wide range of partners including people who use services and people who work within services. They were developed to support individuals, their families and carers to understand what they can expect from mental health services and ensure a person-centered approach is central to the provision of care and treatment. Informed by the principles set out in the Mental Health and Wellbeing Strategy, the standards define what support should look like for people accessing mental health services across five themes:

- Access
- Assessment, Care Planning, Treatment and Support
- Moving between and out of services
- Workforce, and
- Governance and accountability.

The aim of the quality standards is to support services to improve the quality and safety of mental health services for people in Scotland, reduce unnecessary variation in the quality of care, and to reduce inequalities in experiences and outcomes. They provide the basis for continual improvement in the quality and safety of services, including the experiences and outcomes for people who use them.

The SPSPMH is supporting the implementation of the Core Mental Health Standards through the development of a local assessment tool, and the provision of quality improvement support and guidance.

Local assessment

The purpose of the local assessments is to support board areas to consider how well they currently implement each area of the standards within working age adult mainstream secondary mental health services. This forms a picture of current implementation of the standards across Scotland, identifying shared challenges and strengths, and the variance within and between regions and services. This information can then be used to inform priorities for local and national improvement initiatives and support. Within the quality improvement journey, the gathering of local assessment data can be considered as part of 'understanding the system' prior to agreeing aims for improvement.

To develop the local assessment tool, a user testing phase was undertaken with participation from three boards to refine the tool. The finalised local assessment and guidance document was then circulated to nominated leads in every board area with a request to assess current implementation of the standards within each area, including inpatient/hospital site, Community Mental Health Team (CMHT)/HSCP area, and Home-based treatment/Crisis teams (where these existed as separate to CMHT). Microsoft Teams calls were undertaken with the nominated board leads to consider how the work might best be supported and progressed within their area.

The local assessment requested that the completing team:

- discuss the assessment with the multidisciplinary team (MDT),
- decide on a current implementation status score for each item within the assessment (1= not implemented to 5= fully implemented), and
- detail current activity and sources of evidence for the score, including areas of strength and future areas for development.

Guidance and examples were provided to indicate possible sources of evidence. An organisational readiness tool was also circulated, to clarify the resource available within each board area to support the local assessment and improvement work.

Limitations of the assessment

It is of note that a definition for each status score was not given within the local assessment guidance to identify necessary variance and to allow individual areas to consider what implementation would look like within their local context. Scores for the implementation status are therefore subjective and reflect the judgement of clinicians and managers when evaluating their own services and assigning scores within their different settings. The scores do not reflect a standardised, objective statement regarding the amount or quality of evidence identified within the assessment that can be compared directly with other boards. The scoring system offers a baseline from which each board can locally reflect on and build an improvement plan.

This report presents the key findings from the local assessments and recommendations based on these findings. It does not attempt to triangulate information with other existing sources of intelligence, such as NHS benchmarking data or quality indicators for mental health and is not reflective of the challenges within the system in totality.

Summary of findings and recommendations

There has been positive engagement from NHS boards in response to the local assessment work. All 14 boards completed local assessments to give a representative overview of how well they consider the Core Standards to be currently implemented across Scotland.

The following findings represent data from a total of 63 returned local assessments from inpatient sites (n=16), Community Mental Health Teams (CMHT) (n=37), Home-based treatment (HBTT)/ Intensive home treatment (IHTT)/ Crisis teams (CRHTT) and Assessment and Treatment Team (MHAATS) (n=6), and other* (Forensics service and rehab service) (n=3) (*Not included within findings due to being beyond the agreed remit of this work). Organisational readiness assessments were submitted by 13 NHS boards. The data can therefore be deemed representative of the extent to which local health boards consider themselves to be currently implementing the Core Standards across Scotland.

In keeping with the structure of the standards, findings are presented for each of the five themes contained within the Core Standards. This includes a graph of implementation status for each item, alongside some of the types of evidence provided that illustrate current practice, development work and shared challenges. Data included within this report are of individual local assessments, with most boards submitting more than one assessment. The most common score for each item (mode) is circled in each chart for comparison between items.

The evidence cited within the findings considers all available evidence submitted. This included reference to policies and processes used within boards, alongside other documents to demonstrate implementation of the standards. Local assessments also referred to current improvement work being undertaken.

Summary of findings

All 14 NHS boards completed local assessments of the Core Mental Health Standards. Based on the average implementation status given within all assessments, the themes considered to be best implemented were **Access** and **Workforce**. The areas with the highest average implementation scores were:

1.1 – Provision of information to people who use services
1.5 – Criteria for accepting referrals
2.2 – Effective assessment and care planning
4.1 – Identification of statutory and mandatory training needs

4.3 – Availability of well-being support services
5.4 – Internal governance and assurance structures to support service safety, quality and improvement

The theme that was least well implemented - based on the mode for all assessment returns - was **Governance and accountability**. The individual items with the lowest average implementation scores were:

2.4 – Use patient outcome data and experiences to inform service planning and delivery
5.1 – Involving people with lived experience to co-design services and how they are delivered
5.6 – Collection and use of equalities data to inform the planning and delivery of services

The key areas of challenge that were seen across different themes within the standards were:

- absence of agreed and reported measures,
- challenges presented by electronic record systems for MDT working and evidencing involvement of service users and carers,
- access to data for efficient quality control and improvement, and
- design of services around people's needs (for example, working with people who use services, identification of inequalities).

Summary of recommendations

Synthesising the results of local assessments, collation of findings across each health board, identified priorities and stakeholder feedback, six key recommendations are outlined as follows:

At a national level:

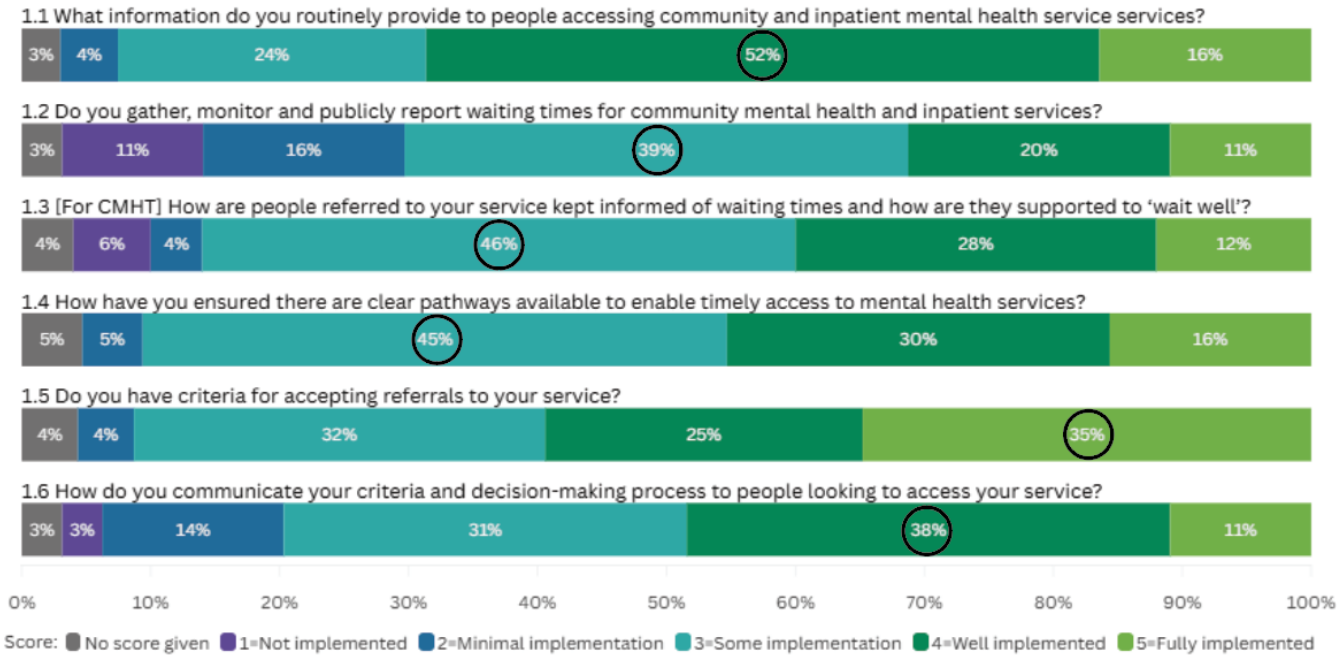
- **promote sharing of learning across health boards** by facilitating the sharing of successes and learning opportunities to expedite improvement across Scotland
- **utilise the findings of local assessments to inform SPSPMH redesign** with a focus on safety at points of transition between services
- **refine scoring criteria to improve standardisation** which will in turn improve reliability and repeatability of future local assessments against the standards, and
- **development of key national measures** to improve monitoring, measurement and understanding of variation.

At a local level:

- **bring together the findings of core standards and existing local intelligence** to inform improvement initiatives and make best use of quality improvement capacity, and
- **identify improvement priorities and develop improvement plans** to ensure accountability and responsibility for improvement against the standards.

Findings of local assessment by theme

Core standards theme 1: Access



The **provision of information to people accessing services (1.1)** was considered to be well to fully implemented in 68% of assessments, and an active area of development in services. Current improvement work being undertaken in services included expanding re-engagement options across all localities, ensuring consistent access to duty workers and out-of-hours crisis teams, the co-design of information sources with people with lived experience, evaluating the reliability of the provision of information, and the development of webpages for people to access information prior to accessing services (for example, ***'Virtual walk arounds' for wards in NHS Borders and NHS Fife***).

A quarter of all local assessments reported that the **gathering, monitoring and public reporting of waiting times (1.2)** was minimally or not at all implemented. This response was

from a range of boards and services (across nine boards including 11 CMHT). Where local data was gathered and reported this was done in a variety of ways such as demand, capacity, activity, queue (DCAQ), data packs, local databases or performance score card. Some services reported externally via the NHS benchmarking dataset 2025.

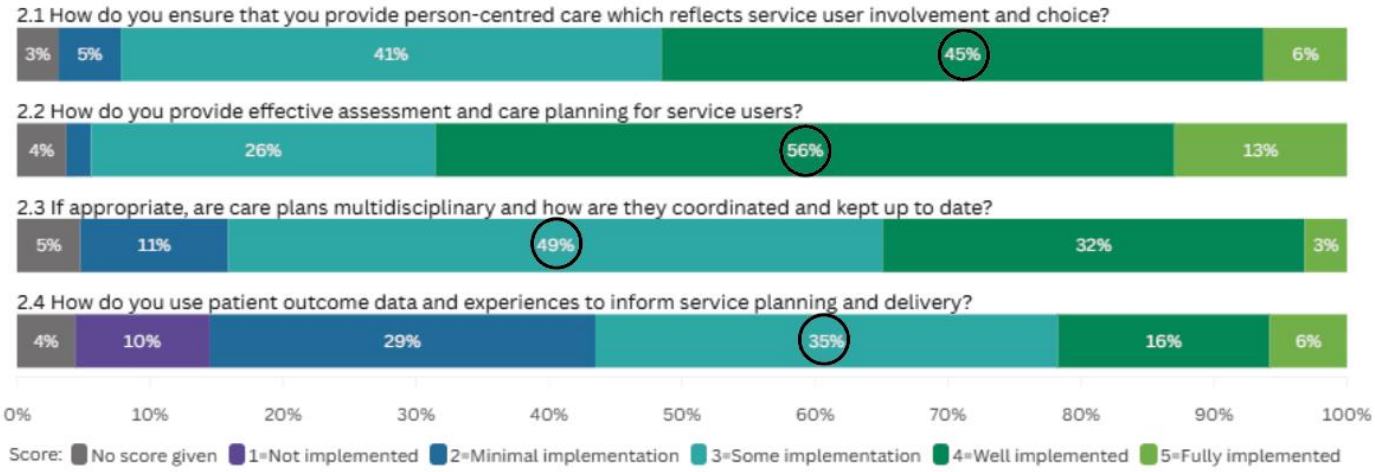
Several services had developed resources for **keeping people informed of wait times and supporting people to 'wait well' (1.3)**. For example, the ***'recovery road map' (Dundee HSCP), 'Connect Me' digital directory (South Ayrshire HSCP), and the 'Are you ok?' campaign (Angus-wide integrated mental health service)***. However, there are still notable gaps in practice. Some areas currently do not communicate with individuals on waiting lists or provide access to additional resources while waiting to access services.

Most services gave evidence of protocols to **ensure clear pathways** to guide admission, discharge and transfer between services, including Child and Adolescent Mental Health Services (CAMHS), adult mental health, and substance use services (1.4). However, this was most often self-assessed as having 'some implementation' and commonly identified as an area for review and further development by services. For example, formalising approaches to joint working with substance use, addictions services and the development of pathways such as the ***Model of Care work and Crisis re-design at NHS Tayside***.

Almost all local assessments (92%) gave evidence of **criteria for accepting referrals to the service (1.5)**. Sometimes this was embedded within referral or assessment documentation or policy. These were made available to referrers and not always available externally.

Local assessments most commonly indicated that the **communication of criteria and decision-making processes (1.6)** were well implemented. In the areas where this was 'not implemented' improvement work was underway to address this. For example, the development of clearer operational frameworks, or publication of criteria for external referrers via the Right Decision Service website.

Core standards theme 2: Assessment, Care Planning, Treatment and Support



The provision of **person-centred care which reflects service user involvement and choice (2.1)** was often embedded in day-to-day practice, but there are challenges in evidencing this within the electronic documentation. For example, it is common practice for service users to 'sign' care plans on an electronic system, via the named nurse. Similarly, there is no easy way of identifying or auditing whether an electronic copy has been printed and issued to the patient.

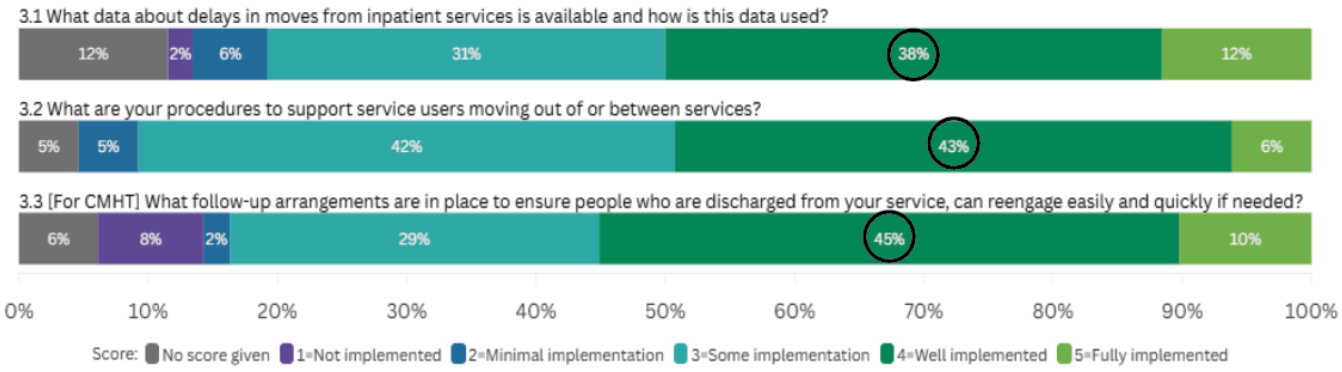
The **provision of effective assessment and care planning for service users (2.2)** was indicated as well to fully implemented in 69% of assessments and one of the best areas of implementation within the local assessment overall. However, challenges were noted within remote and rural areas when responding to urgent referrals.

The **involvement of the multidisciplinary team in care planning and the co-ordination and updating of care plans (2.3)** was rarely 'well implemented,' and increasing the multidisciplinary input into care planning and review was identified by a number of boards as an area for improvement. Workforce constraints, particularly in rural and remote areas, can limit consistent access to a full range of professionals such as psychologists, allied health professionals and psychiatrists. While urban boards often benefit from dedicated multidisciplinary team presence on wards, many areas are working to improve the inclusivity and documentation of multidisciplinary team contributions. Identified improvement initiatives included development of electronic patient record systems, development of standardised documentation, virtual attendance within MDT and reviewing the provision of psychiatry.

The **use of patient outcome data and experiences to inform service planning and delivery (2.4)** was one of the least well implemented across all items, with 39% of assessments

indicating no or minimal implementation. Patient reported outcomes were not evidenced within local assessments, although patient feedback was often gathered via questionnaires.

Core standards theme 3: Moving between and out of services



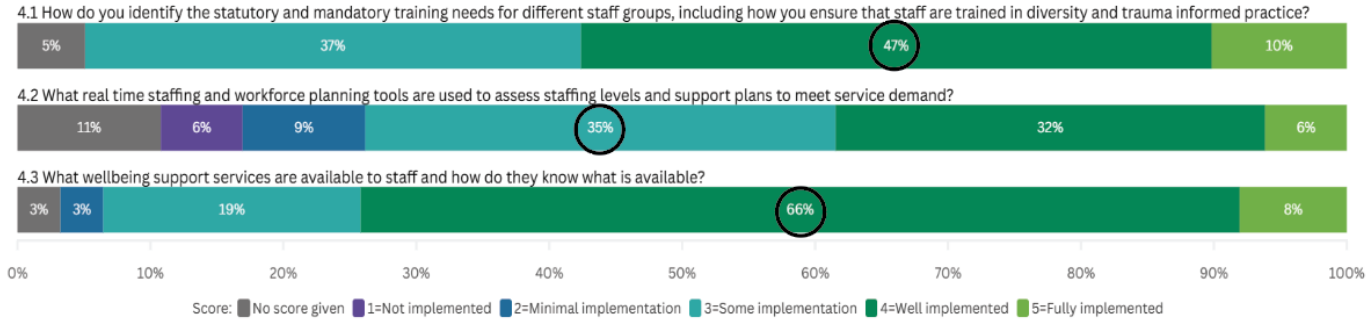
Moving between and out of services was most often rated as well implemented, yet this theme was also identified as a priority for around half of all health boards. **Data about delays in moves from inpatient services (3.1)** are often regularly gathered and discussed. In community settings, CMHT face challenges when discharges are communicated at short notice, limiting their ability to provide timely follow up, particularly when external factors like housing or guardianship orders contribute to delays. The ***'Discharge without Delay' group (NHS Grampian)*** have been working with Healthcare Improvement Scotland to make improvements to communication and patient flow processes, resulting in a 46% reduction in delayed discharges within the Royal Cornhill Hospital.

There were many examples of **procedures to support service users moving out of or between services (3.2)** and improvement activity identified around transitions out of inpatient care. While most boards aim to follow up within seven days - some within 72 hours - variation remains, for example when discharges occur at short notice or across health boards. Efforts are underway in some boards to standardise discharge protocols, improve communication between inpatient and community services, and ensure patients are informed of their next steps. ***Hospital based social workers (NHS Fife)*** are supporting discharge planning and management to improve patient flow. NHS Highland are looking to implement a ***'discharge app'*** to 'pull' people out of inpatient services instead of waiting for the 'push' from inpatient services.

Some areas indicated no implementation of **follow up arrangements to ensure people who are discharged can re-engage easily and quickly if needed (3.3)**. There were many examples of different approaches to this, from providing information to the GP on how to re-engage, ***involvement of third sector organisations to support a person after discharge (Aberdeenshire central HSCP), being able to contact the CMHT directly if deteriorate within 4 weeks (Dundee)***, fast track where person deteriorates within 12

months, and ***'opt in' letters to patients who do not accept appointments (NHS Lothian)***.

Core standards theme 4: Workforce

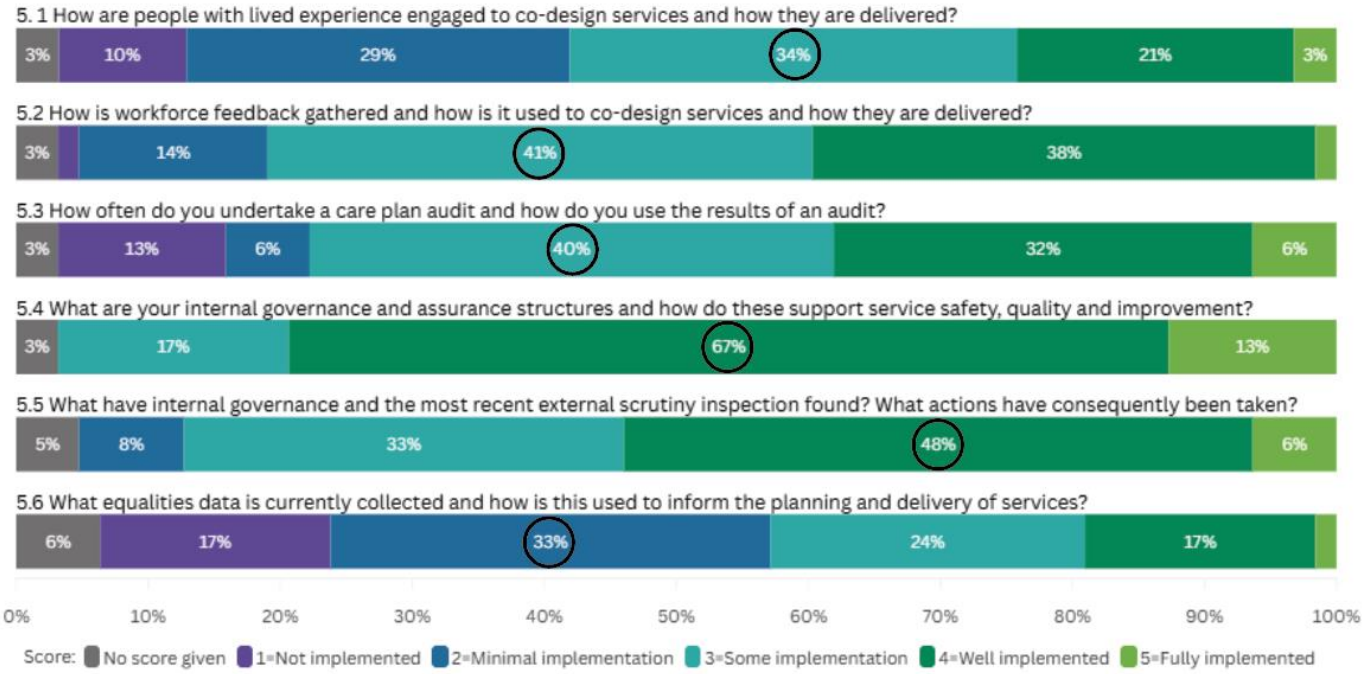


Workforce was the strongest implemented theme. Data was regularly collected on the completion as well as **the identification of statutory and mandatory training needs (4.1)** including suicide prevention, safety and stabilisation, equality and diversity, trauma-informed care and risk assessment. Within Angus wide mental health services, there is an agreed training plan for all staff which includes health and local authority specific training and joint training including substance use.

The **availability and use of real time staffing and workforce planning tools (4.2)** was minimally implemented in CMHTs and identified as an area for improvement. The Clinical Nurse Specialist Tool was not seen to be fully aligned with the roles of CMHT nurses, and Scottish Standards Time System and e-roster do not fully support community services.

Well-being support services available to staff (4.3) were well implemented with a range of resources available to staff, such as dedicated areas for staff to relax and recharge, reflective practice sessions and well-being champions. More formalised support was available such as counselling.

Core standards theme 5: Governance and accountability



More than a third of local assessments reported that **engagement with people with lived experience to co-design services (5.1)** was not implemented or minimally implemented and identified this as an area for improvement. Many areas have forums, networks or engagement days for ongoing engagement with people with lived experience which could be further developed, for example to build more diverse engagement. There were examples of engagement of people with lived experience in specific projects, such as the development of apps, community well-being centres and educational sessions. ***NHS Ayrshire & Arran undertook widespread engagement which led to the development of the South Ayrshire Living Well: Adult Mental Health and Well-being Strategy (NHS Ayrshire & Arran)***.

The gathering of workforce feedback and use of this to co-design and deliver services (5.2) is done via various mechanisms, including through established weekly meetings, partnership forums and development days, utilising iMatter Staff Survey to gather feedback and create action plans for improvement, and professional working groups / forums to facilitate ongoing dialogue and collaboration among staff. Identified improvements included reviewing feedback processes to ensure they remain relevant and effective, improving the transparency around how feedback is used, and clear communication about changes made based on staff input.

Local assessments cited a range of **frequency of care plan audits and use of the results (5.3)**. Challenges such as staffing resources due to sickness and increased service demands inevitably impact the frequency and effectiveness of audits. It was identified within

assessments that improvements could be made to identify themes and trends across teams and the entire service to inform improvement. A further area identified for improvement is the design of electronic systems to support audit. An example where this worked well was the care plan section on care partner tools, which was seen as user-friendly and efficient.

Internal governance and assurance structures to support service safety, quality and improvement (5.4) were well to fully implemented in 80% of assessments, the highest implementation score for an individual item.

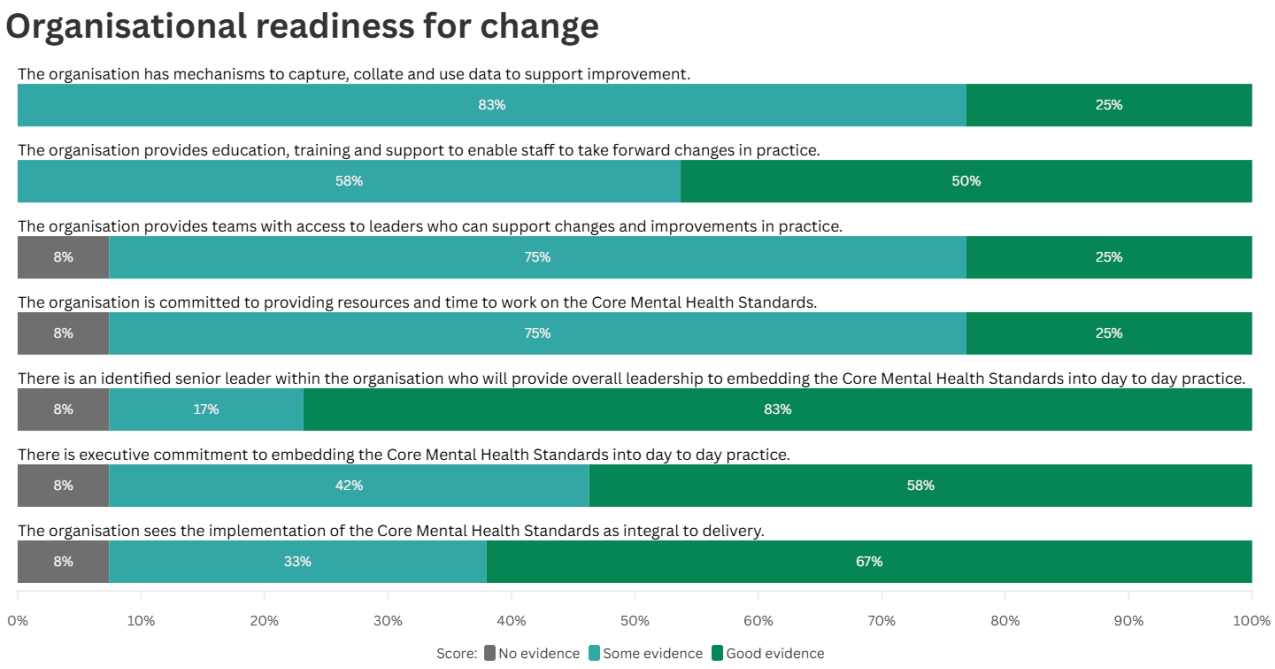
All assessments gave evidence of **findings and actions taken from internal governance and external scrutiny (5.5).** Internal audits are conducted regularly, with some areas performing them monthly, with improvements such as reduced waiting times for assessments and enhanced care assurance standards. Serious Adverse Event Reviews (SAER) have resulted in the implementation of action plans to mitigate future risks, with findings shared at senior meetings and feedback provided to staff. Recommendations from the Mental Welfare Commission and Healthcare Improvement Scotland have been addressed through the development and implementation of action plans, quality improvement initiatives and regular meetings to discuss and share good practices. NHS Fife have developed a newsletter to share learnings from audits and SAER to promote continuous learning and improvement. Advanced statements and care planning were mentioned in several assessments, for example the development of ***person-centred care planning and nursing care assurance standards based on findings from the Mental Welfare Commission and Healthcare Improvement Scotland inspections (NHS Lanarkshire)***.

The **collection and use of equalities data to inform planning and delivery of services (5.6)** had the lowest levels of implementation of any item in the assessment, with over half of assessments scoring this as having not been implemented or having minimal implementation. This was an area identified for improvement.

Organisational readiness for change

To support the implementation of the standards, boards were also asked to complete a readiness for change assessment to better understand their readiness to initiate and support improvements identified from the local assessments and to ensure that they are effectively prepared for change. The aim of the assessment was to identify local and national challenges and opportunities faced when trying to make any improvements - as well as aid understanding of strengths and gaps - to better understand the support needed to ensure changes are a success. The assessment also gave a baseline understanding of resources allocated locally to mental health improvement, particularly in relation to the Core Mental Health Standards.

All mainland board-retained mental health services have access to staff whose role is specifically to support quality improvement (QI). Dedicated QI support solely for mental health was evident in some boards. However, where mental health QI support was not ring fenced in some way (for example 0.4 WTE QI support for mental health, or 'analyst for mental health'), support for QI and data for mental health was allocated for dedicated pieces of work (for example performance times). QI support was also described as 'small' or 'ad hoc' pieces. Registers of trained QI staff are often kept locally in various ways, however staff trained in QI are not easily identifiable and it is not known if they are actively involved in QI work. Some boards have dedicated mental health data analysts, while others rely on broader data services or limited resources. Sometimes data support was via the QI team, for example collation of quality control data at NHS Lothian. Several boards either had or were looking to develop electronic data systems that enabled the access and use of data at a local ward/team level. Engagement of people with lived experience was varied across all boards.



Identification of local priorities

All board areas were asked to identify up to three priority areas that they would like to focus on and which standards these aimed to address. Leads were asked to consider the findings of the local assessments alongside other available data such as recommendations from inspections, NHS benchmarking data and mental health quality indicators, along with local intelligence. All NHS boards have now submitted these as part of the local assessments. Priority areas of the standards were wide-ranging and are summarised below, with a full list of local priorities by board area provided in Annex A.

Theme 1 - Access was identified as a priority theme by seven boards, with several boards currently looking at timely and appropriate access to community mental health teams, including joint working with substance use services. This was linked to other priorities regarding development of IT infrastructure and sustainability. Other priority improvements were the gathering, monitoring and public reporting of wait times and clarity and transparency regarding out-of-hour provision.

Almost all boards identified aspects of **Theme 2 - Assessment, Care planning, Treatment and Support** as a priority theme, including improving MDT care planning; person-centred care planning; understanding of confidentiality and consent when involving patients, family and carers; and the use of patient outcome and experience data in service planning and delivery.

Six boards identified **Theme 3 - Moving between and out of services** as a priority theme to focus on for the coming year, aimed at reducing fragmented care, unnecessary reassessments and improving communication. Priorities included implementing a structured approach to transitions with standard operating procedures, early identification of a predicted discharge date, and MDT involvement (for example, social workers) throughout admission. Several health boards also identified patient flow as a priority, particularly the collection and use of data to reduce delayed discharge from inpatient units.

Two boards identified priorities relating to **Theme 4 - Workforce**, including the provision of staff well-being support; working alongside practice development to optimise completion and recording of training; and rollout of real time staffing tools.

Theme 5 - Governance and accountability was identified as a priority theme by half of boards. Priority areas were:

- improving governance and reporting structures that more effectively connect services and HSCP

- review and standardisation of care plan audits including how these are seen and actioned within services and governance groups to inform service delivery
- development of electronic patient record systems to streamline record keeping and data extraction, and
- strengthening of engagement with people with lived experience and families in the design and delivery of services (for example, readily available information on compliments, feedback and complaints) and improving the collection, reporting and use of equalities data.

Recommendations

Following on from completion of Core Standards local assessment and collation of responses, Healthcare Improvement Scotland were asked to consider over-arching themes and recommendations for improvement. National improvement support and local considerations based on the local assessment findings are provided below.

At a national level for Healthcare Improvement Scotland and Scottish Government:

Utilise the findings of local assessments to inform SPSPMH redesign
The SPSPMH Programme team will take forward the findings from the local assessments, priorities identified and organisational readiness assessments to inform the programme redesign and support offer. This will focus on moving between and out of services as a priority area, with safety at points of transition recognised to be a key issue.

Promote sharing of learning across health boards
For each item within the local assessments, there are services who have identified parts of the standards that are well implemented. There is an opportunity to share the learning from boards who have implemented aspects of the standards, with boards who have not yet fully implemented certain areas and are looking to develop maturity. Healthcare Improvement Scotland can facilitate the sharing of successes and learning via hosting learning events, workshops to develop improvement plans and the provision of coaching support. This learning could include topics such as:

- Improving engagement with people who use services, including the identification of protected characteristics and inequalities to the co-design and evaluation of services and having diverse representation in existing engagement. This links to the Scottish Approach to Change being developed by Healthcare Improvement Scotland.

- Review and development of digital and IT resources. Local assessments referred to digital technology both supporting and hindering practice in relation to the Core Mental Health Standards. There is learning to be shared from boards who have electronic systems that allow teams to locally extract data in a way that reduces the data burden on staff and informs local improvements.
- There is potential for Healthcare Improvement Scotland to connect with NHS Education for Scotland to consider the suitability of existing workforce planning tools and real-time staffing resource tools for use within CMHT. Similarly, the identification and support for staff trained in QI such as Scottish Improvement Leader Programme ScIL.

Refine scoring criteria to improve standardisation

Reflecting on the questions asked via the local assessment, the subsequent scoring criteria and variation in both the quality of responses and volume of supporting evidence received, it may be beneficial to review the definitions and scoring criteria. This will enable repeatability for future completion of local assessments relating to Core Standards.

Development of key national measures

As described previously in the Core Standards publication 2023, the development of key national measures will enable geographic comparison. This may include measures relating to the Core Mental Health Standards, drawing on existing Public Health Scotland (PHS) mental health quality indicators, including patient and clinician reported outcome measures for mental health services. This may aid the allocation of appropriate QI and data support for mental health that is proportionate to the requirements of mental health services.

At a local health board/HSCP level:

Bring together the findings of core standards and existing local intelligence

The above findings and identified priorities should be supported via integration into appropriate local governance structures. This would aid the consideration of various data sources alongside the local assessment findings to provide additional context, informing improvement activity and organisational priorities (for example delays to accessing treatment including bed pressures).

Identify improvement priorities and develop improvement plans

All boards are to identify items within the standards, as areas of focus for improvement throughout 2025-26. Associated unified improvement plans across health board areas should be developed to ensure clear accountability for delivery.

Annex A: Locally identified priorities for 2025-26

Board	Priority area 1	Priority area 2	Priority area 3
NHS Ayrshire & Arran	**Core Standard 2.4** - Improving use of use patient outcome data and experiences to inform service planning and delivery.	**Core Standard 5.3** - Work on improving care plan audit activity and using these results to inform service delivery development.	**Core Standard Theme 2: Assessment, Care Planning, Treatment and Support** - Ensuring we provide person-centred care that reflects service user involvement and choice through co-production.
NHS Borders	**Core standard 1.14** - Gather, monitor and publicly report waiting times for community mental health and inpatient services.	**Core standards 2.1 and 2.13** - Provide person-centred care which reflects service user involvement and choice.	**Core standard theme 5: Governance and accountability -** Improve internal governance and assurance structures to support service safety, quality and improvement.
NHS Dumfries & Galloway	**Core standard 2.3** - Improve care planning in line with Mental Welfare Commission best practice standards. Improving risk assessment completion/formulation for suicide prevention as part of national response to National Confidential Inquiry into Suicide and Safety in Mental Health report.	**Core Standard 5.1** - Spread of good practice when working with people with lived experience to review and co-design of services, across the whole of secondary mental healthcare.	**Core standard 3.1 -** Communication at transition between hospital-home and vice versa considering any delays and communications to support this.
NHS Fife	**Core Standard Theme 1: Access** - Implementing clear pathways and protocols within all areas of the service to enable timely access to Mental Health Service and improved transitions between services where this is appropriate.	**Core Standard Theme 2: Assessment, Care Planning, Treatment and Support** - Improving our use of patient outcome data and experiences to help inform service planning and delivery.	**Core Standard Theme 2: Assessment, Care Planning, Treatment and Support** - Improving the range of well-being support options available to staff and ensuring they are accessible to all.
NHS Forth Valley	**Core standard theme 2** – Improve the collection, collation, reporting and use of patient outcome and experience data.	**Core standard theme 5** – Improve our engagement with people with lived experience, their families and carers in the design and delivery of services.	**Core standard theme 5/Local assessment 5.6** – Improve our collection, reporting and use of equalities data.

Board	Priority area 1	Priority area 2	Priority area 3
NHS Grampian	**Core standard 1.9** - develop Adult mental health criteria for CMHT.	**Core standard theme 5 Assurance and Governance** - Undertake a piece of work with staff team in Adult Mental Health and other areas about governance, what governance is and encourage and improve reporting.	**Core standards theme 2 Assessment, care planning, treatment and care** - undertake work around confidentiality and consent, considering the service users and significant others.
NHS Greater Glasgow and Clyde	**Core Standard 2.1** - Embedding person-centred care plans which reflect service user involvement and choice.	**Core standard 4.2 -** Develop Real time staffing assessment and Escalation local standard operating procedures. Developing and roll out local process across NHS Greater Glasgow and Clyde Mental Health services in line with the developing Service Stratification Document for both Inpatient and community services.	**Core standard 5.3** - Audit of practice on use of template and care planning content.
NHS Highland	**Core standard theme 1 Access** - Publicly reporting and monitoring waiting time disparities in access across different partnerships and districts, to ensure equitable access to mental health services for all.	**Core standard theme 2 -** improve MDT care planning and collaboration to reduce fragmented care and ensure that all aspects of a person's mental health and well-being are addressed, leading to more comprehensive and person-centred care.	**Core standards theme 3 Moving between and out of services** - Improving structured transitions to reduce duplication of effort, such as unnecessary reassessments and ensures that service users experience uninterrupted care when moving between and out of secondary care services.

Board	Priority area 1	Priority area 2	Priority area 3
NHS Lanarkshire	**Core standards theme: 3 Moving between and out of services** – Improvement work relating to delayed discharges, transfer of care. CMHT also looking at **Core standard theme 1** - protocols for joint working for example mental health and substance misuse.	**Core Standard Theme 2: Assessment, Care Planning, Treatment and Support** - Family and carer involvement in care planning, as appropriate. Triangle of Care (March 2025) QI overview. Nursing Care Assurance Audit. Person-centred care plan and risk assessment.	**Core standard 4.1** - Improvement work relating to staff training needs.
NHS Lothian	**Core standards theme: 3 Moving between and out of services** - Ensuring smooth transitions, improving patient flow and addressing delayed discharges.	**Core standards theme: 2 Assessment, care planning, and treatment and support** – Enhancing standardisation, ensuring compliance with Mental Welfare Commission recommendations.	**Core standards theme: 5 Governance and accountability (including patient feedback mechanisms)** – Improving reporting structures, standardising audits and strengthening engagement.
NHS Orkney	**Core standards theme 1: Access** - Improve collation, monitoring and public reporting of data on waiting times for the community mental health services.	**Core standard 3.2 -** Improving data gathered on moving between and out of services, and the implementation of the All-Age Nurse-Led Psychiatric Liaison Team (who will be involved in the first point of contact on return to Orkney).	**Core Standard 5.3** - Implementation of MORSE to support data extraction to inform service development and external reporting. Development of an audit schedule for completion and reporting to provide assurance of person-centred care treatment delivery and recording.
NHS Shetland	**Core standard 1.8** - Ongoing work on the out of hours (OOH) role within Mental Health for NHS Shetland to ensure safe and effective OOH care is delivered and patients and services have access to this.	**Core standard 2.15/5.4** - Ensure that information on compliments, feedback and complaints processes is easily available and in a clear, easy to understand format. Plan to look at implementing Care Opinion within Mental Health services.	**Core standard 2.7 and 2.8** - Work on Care plan and risk assessment training for staff. Ensure consistency across teams. Care Plan and Risk assessment standards to be developed, with regular audits to ensure standards are continually being met.

Board	Priority area 1	Priority area 2	Priority area 3
NHS Tayside	**Core standard 2.7** - I will have one written care and treatment plan which is jointly created by me and the professionals supporting me.	**Core standard 2.15** - Routinely measure and report care and treatment outcomes, including service users and carer experience, and use this data to ensure inclusion in service planning and delivery.	(None noted)
NHS Western Isles	**Core Standard 5.1** - Improving community Engagement and feedback via Care Opinion and patient experience surveys, with support of the patient panel / peer support groups.	**Core standards theme 2: Assessment, Care Planning, Treatment and Support** - develop a standard proforma guide to ensure staff across all islands are following the assessment process in a uniformed way, also on MORSE.	

Published July 2025

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Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

Healthcare Improvement Scotland

Edinburgh Office	Glasgow Office
Gyle Square	Delta House
1 South Gyle Crescent	50 West Nile Street
Edinburgh	Glasgow
EH12 9EB	G1 2NP
0131 623 4300	0141 225 6999

www.healthcareimprovementscotland.scot