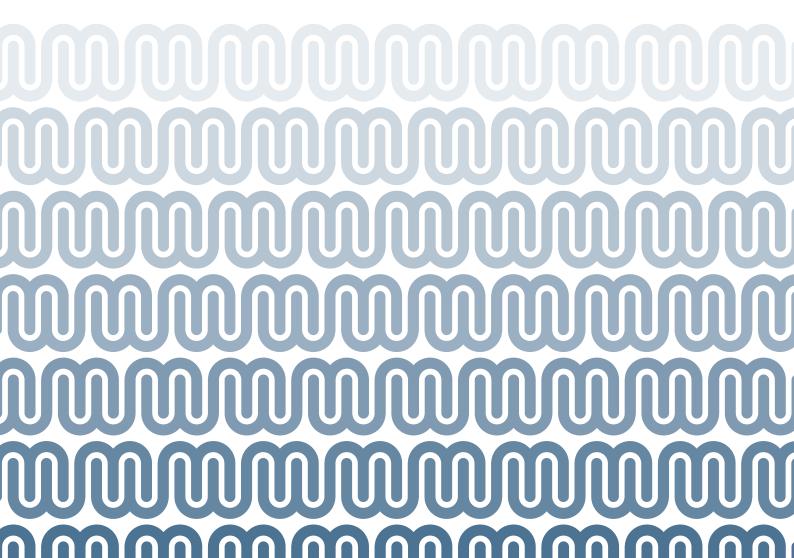**mental welfare**
commission for scotland

Older people's functional mental health wards in hospitals: themed visit report

Visiting and monitoring reports

16 April 2020

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Report on a series of visits carried out by the Mental Welfare Commission for Scotland to people admitted to wards for older people with functional mental illness in Scotland 2019.

Contents

Executive summary

The Commission visited all NHS wards across Scotland that provide assessment and treatment for older people with a functional mental illness. We last carried out a visit of this type in 2015 and we wanted to find out if improvements had been made since then.

On deciding who constitutes an 'older person', of the wards we visited, most (17) reported that the age criteria for admission was over 65 years but in practice they operated a flexible admission policy and those under 65 would be admitted where appropriate. Five wards described the criteria as strictly over 65 years.

We came across positive developments since our 2015 visits including improved physical environments, often in new purpose built facilities. Where we found there had been an investment in the provision of therapeutic and recreational activities, this was hugely beneficial and appreciated by patients.

We also came across some areas where we found that improvements were still required. These include attention to physical health and wellbeing and the provision of psychology.

We also found that many wards provide assessment and treatment for older people with dementia alongside those with a functional mental illness and this often presented challenges.

Comments we received from psychiatrists and other identified that for patients moving from adult to old age services, the process was not always understood and decision making often did not involve the patient.

There was also a view that mental health services designated specifically for older people (usually over the age of 65) were less comprehensive and able to react in a crisis than those for adults generally.

The Scottish Recovery Network emphasise that anyone can have mental health problems but with the right support people can and do recover. Recovery means being able to live a good life, as defined by the person, with or without symptoms. That must include those that are older adults.

This report will be shared widely across Scotland and we want this report to be used to improve the care of older people with functional mental illness. We make some specific recommendations below and we will follow these up with the appropriate people.

Summary of recommendations

An Integration Authority can be a Local Authority, a Health Board or an Integration Joint Board, according to the model of integration adopted locally.

In relation to services for older people with functional mental illness, Integration Authorities should:

- Review and increase where necessary the provision of psychological intervention for older people with mental illness.
- Ensure people with dementia are not admitted inappropriately to wards for older people with functional mental illness.
- Where wards are mixed (admit people with dementia alongside those with a functional mental illness), the physical environment should provide privacy and dignity for both patient groups and staff should be suitably trained and resourced to meet the complex and diverse needs of both groups.
- Review the skill mix in wards for older people with functional mental illness to ensure there is adequate availability of staff to recognise and manage physical health needs.
- Invest in the provision of staff who are trained and resourced to provide a range of therapeutic and recreational activities.
- Ensure clear protocols, that include social work, are in place for patient transition from adult to old age services and decisions to transition are based on individual need and not on arbitrary age limits or the needs of the service.
- Provide a range of community services to support older people with mental illness, particularly in relation to crisis and preventing unnecessary admission to hospital.

Introduction

This report details what we found when we visited 23 NHS wards providing assessment and treatment for older people with functional mental illness in Scotland. It contains recommendations we have made to improve patient care.

Functional mental illness in older people

Functional mental illness includes common conditions such as depression and anxiety and rarer conditions such as schizophrenia, delusional disorder, bipolar affective disorder and obsessive and compulsive disorders.

They are considered distinct from dementia, although people may have both. While most functional mental illness will be successfully treated in the community, some older people will need in-patient treatment as they can be severely unwell and may have existing physical health problems that complicate their care and treatment. They may spend several months in hospital.

A lack of data and evidence on older people with mental health issues has been a concern for some time. People aged sixty and over are identified as being less likely to seek medical help for their mental health as well as being less likely to receive treatment if they do, in comparison to younger adults. Depression in older people is under-diagnosed and under-treated[1].

Support in Mind Scotland have asked for support to increase spending for older adults experiencing mental illness and conditions other than dementia as well as an increase in the number of residential/nursing care beds suitable for older adults with co-existing mental and physical health conditions.[2]

The 10-year *Mental Health Strategy 2017–2027* [3]has a strong focus on equalities, recognising the enormous impact mental health can have on health, wellbeing and quality of life in older age.

A Fairer Scotland for Older People: Framework for action states that older people in Scotland want action to ensure they have access to the health and social care services they require, including mental health.

The span of older age as defined in this framework – from age 50 – emphasises the breadth of diversity in this population. The population is ageing at a faster rate in Scotland than the rest of the UK. There is also considerable geographical variation in the ageing of the population within Scotland. In general, it is lowest in the cities and higher in more rural areas.[2]

Why we carried out these visits

For older people with functional mental illness, the care and treatment they receive in hospital is crucial to their ability to return to independent living as soon as possible.

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[1] Allan, Charlotte E.; Valkanova, Vyara; Ebmeier, Klaus P. Depression in older people is underdiagnosed. Practitioner 2014;258(1771):19-22 2014
[2] Voluntary Health Scotland, VHS Briefing: Mental health in later life
[3] https://www.gov.scot/publications/mental-health-strategy-2017-2027

We last carried out this kind of themed visit in 2015.[4] We made recommendations that included making improvements to:

- person-centred care planning,
- the level of activity provision,
- the provision of clinical psychology,
- ensuring that any restrictions placed on patients respect the right of the individual,
- the provision of information for patients, their right of access to advocacy, respect for privacy, dignity and family life, and
- the physical environment and access to pleasant, safe and secure outside areas.

We wanted to repeat this themed visit to see if improvements had been made since our last report and to meet with patients, relatives and staff to hear their views and experiences of care, treatment and support.

Prior to carrying out the visits we consulted with people with lived experience, their family/carers, and professionals involved in care, treatment and support to help ascertain specific areas to focus on.

Support in Mind[5] are increasingly concerned about those aged 65 years and over, in regard to access to services and rights. We have heard from people with mental illness and their family/carers that the transition between general adult psychiatry services that treat younger adults to old age psychiatry services can be difficult. There is often a perception that older adult services are not as well-resourced as general adult services.

We also heard that people over the age of 65 years with poor mental health can face a wide range of barriers, particularly in accessing appropriate care and other services. The attention paid to dementia, through the dementia strategies and other initiatives, is positive but there was a view that it could push other mental health issues that affect older people into the background.[6]

Since the 2015 themed visit, the Commission has continued to visit people in wards of this type as part of its local visit programme. [7]During these visits we have heard about patients' and staff experiences of difficulties if admitted for assessment and treatment to a ward that also cares for people with dementia.

This information informed the focus of the 2019 themed visit. The main areas we focused on were:

- care and treatment (including physical health),
- provision of activity,
- the physical environment, and
- involving family/carers.

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[4]https://www.mwcscot.org.uk/sites/default/files/2019-06/making_progress_older_adult_functional_assessment_wards.pdf
[5]Reference from Falling off a Cliff
[6]National dementia strategy 2017-20 https://www.gov.scot/publications/scotlands-national-dementia-strategy-2017-2020/
[7] https://www.mwcscot.org.uk/visits-investigations/local-visit-reports

How we carried out these visits

We identified all psychiatric wards in Scotland with designated beds for older people with functional mental illness. There were a total of 425 beds in 23 wards over 21 sites (see Appendix 2). We advertised our visits in advance and invited patients and their visitors to either make an appointment, ask to meet with us on the day or request a telephone interview. We carried out a formal interview with the senior nurse on duty and, collected information about the ward. We also carried out a review of the care file for all patients we met with to collect further information and completed an environment assessment tool.

We wanted to meet patients who had been admitted for assessment and treatment of functional illness rather than for dementia. We therefore did not include patients who had been admitted primarily for the assessment and treatment of dementia. However, if the patient was admitted for assessment of functional illness concurrent with pre-existing dementia or dementia was diagnosed during admission for assessment of functional illness, they were included.

Where we had concerns about care and treatment being provided, we raised any issues with the nurse in charge on the day and where necessary we followed this up. After the visit, we sent a feedback letter to the ward manager for each ward providing some ward specific feedback.

Where we visited

The visits were carried out between May and September 2019, across all mainland NHS Health Board areas. This included visits to a total of 23 wards of which all but two admitted both male and female patients. Wards varied in size from six to 25 patients.

We noted that many of the wards visited in 2015 have now closed and been relocated to new accommodation though overall bed numbers had increased from 404 to 425.

Patient characteristics

We recorded visits to 145 patients and carried out file reviews for all those patients. Of those, 95 were also able to engage in an interview with us to discuss their care and treatment. We met with 23 family/carers.

Of patients visited, 66% were female and 44% male, broadly similar to the visits in 2015 (63% and 37%, respectively).

Of patients visited, most had a diagnosis of mental illness (85%) or mental health illness and other diagnoses (7%). A small proportion of patients had no recorded diagnosis (3%), 'other diagnosis' (2%), alcohol-related brain damage (ARBD) (1%), drug assessment (1%), or diagnosis data was missing (1%).

The majority of patients were informal with 36% detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).[8] This was similar to the 2015 visits, where 35% of patients were detained under the Mental Health Act.

Of the 52 patients who were detained, the majority had a Compulsory Treatment Order (CTO; 62%), followed by Short-Term Detention Certificate (STDC; 30%). A small number were detained under an Emergency Detention Order (6%) or a combined STDC/CTO (2%). The distribution was similar to 2015.

Age distribution was similar in the 2015 and 2019 visits; the majority of patients were aged 65–84 years with a minority aged 85 years of older and less than 1% under 65 years.

As an alternative to age as a criterion for old age services, the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists has developed criteria based on need. The Royal College of Psychiatry[9] defines old age psychiatry as:

- People of any age with a primary dementia.
- People with mental disorder and physical illness or frailty that contributes to or complicates, the management of their mental illness. This may include people under sixty-five years of age.
- People with psychological or social difficulties related to the aging process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over seventy years of age.

Some services use age, usually 65 years, as the criteria for determining when someone is transferred to old age psychiatry services.

Of the wards we visited, most (17) reported that the age criteria for admission was over 65 years but in practice they operated a flexible admission policy and those under 65 would be admitted where appropriate. Five wards described the criteria as strictly over 65 years.

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[8] Mental Health (Care and Treatment) (Scotland) Act 2003
[9] Royal college of Psychiatrists, Criteria for Old Age Psychiatry Services in UK, October 2015
https://www.rcpsych.ac.uk/docs/default-source/members/faculties/old-age/old-age-challenging-ageless-services-criteria-for-old-age.pdf?sfvrsn=1e602061_2

Details of admissions

Table 1 shows the length of admission for patients who were visited. About half (46%) had been admitted between one and six months prior to our visit and 34% less than one month.

Table 1. Length of admission

Admission length	n	%
<1 month	48	34
1−6 months	67	46
7−12 months	15	10
13−24 months	5	3
>2 years	3	2
unknown	6	3
Total	**145**	**100**

To be admitted to a ward more than two years previously is very concerning and we followed up on those cases. Two patients had a complex, severe and enduring mental illness, both were detained under the MHA. For both a suitable community placement had been found and they were due to move shortly. The third patient had only recently had a suitable care home identified and was awaiting confirmation of a date to move. Due to the patient's age (68 years), finding a suitable care home had proven difficult as most local care homes had a much older age group of residents.

Of the five patients who had been waiting to move between 13 and 24 months, all were women over 70 years of age.

The majority of patients had been admitted from their own home (74%) and there was no delay in discharge for the majority of patients (86%).

Table 2. Place for admission and discharge delay

Admission and discharge		n	%
Place admitted from	Own home	107	74%
	Care home	5	3%
	General hospital	12	8%
	Other	17	12%
	Unknown	4	3%
	Total	**145**	**100%**
Delayed discharge	Yes	11	8%
	No	124	86%
	Unclear	1	1%
	Unknown	9	5%
	Total	**145**	**100%**

Ward characteristics

Mixed wards

When we say in this report that a ward is mixed, we are referring to a ward that admits people with dementia alongside those with a functional mental illness.

There will be times when someone with dementia is admitted to a ward for patients with functional mental illness, this is appropriate when patients with dementia require assessment and treatment for a concurrent functional mental illness, or are early in the process of diagnosis, when it is not clear if the patient has a functional illness or dementia.

Nine wards were described by the senior charge nurse as mixed wards. Four were described as functional only and the remainder (10) described as being designated as functional only but regularly admitting patients with dementia, usually due to pressure on beds in dementia care wards.

This is in contrast to our visits in 2015 when only four wards were described as being mixed. On this visit we asked the senior charge nurse to describe and record the ward function whereas in our 2015 visit the MWC visitor recorded this information.

Where wards were mixed, nurses often described difficulties. On one ward we were told by staff that the mix of patients, including those with dementia and other patients "boarding in" from an acute adult ward, had a negative effect on older individuals, in particular those with a functional illness.

In wards where there was flexible and adequate space it was reported as easier to maintain privacy and dignity for patients.

> *We are a functional ward but have a number of patients admitted for assessment who have a dementia diagnosis and several patients with dementia admitted due to vacant beds.*
> Staff comment.

> *Challenge of meeting all individual needs for functional patients and dementia patients as needs can be complex.*
> Staff comment.

> *When there is a higher percentage of patients with dementia this has a negative impact on patients with a functional illness.*
> Staff comment.

> *The forthcoming restructuring of old age services across the area will address some of the issues around the mix of patients, and will allow staff to spend more time with patients who have a functional illness. We are looking at models of care and discussing ways that improve the patients' journey throughout our services.*
> Staff comment.

Locked door

In only three wards was the ward door open to exit. All other wards described a variety of methods to exit including swipe cards, key pads and slow closing doors. In all wards where the door was locked, staff said there was a locked door policy in place which detailed that patients who were able to leave should be allowed to exit upon request.

Although staff were aware of these policies, patients were not always aware and these were not always evident on the ward. Some staff noted that it was a balance between patients' freedom to enter or exit the ward and to keep the ward safe and secure

> *Balance between freedom of entry/exit and safety and security.*
> Staff comment.

> *Patients/relatives turn the handle to gain entry to the ward. To leave the ward there is a key pad with the code displayed directly under the key pad.*
> Staff comment.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. [10]

Advocacy

The Mental Health Act puts a duty on local authorities and the NHS to ensure independent advocacy is available to people with mental illness whether in hospital or the community. Independent advocacy is important to ensure the individual's views are heard and understood and that they receive support to ensure their rights are not infringed.

Twenty two of the 23 wards visited had access to independent advocacy and most described a mixture of referral and drop-in systems that worked well.

In one ward, advocacy was only available to patients subject to compulsion under the Mental Health Act and we are following this up with managers.

Visiting

All wards said they operated a flexible visiting policy and we did not hear any concerns from patients or staff about visiting. Family/carers we met with said they could visit whenever they liked and all were able to access a private space to be with their relative.

> *Visiting is encouraged within designated times to promote protected therapeutic engagement and assessment of needs but we are fully flexible based upon needs of patients and their friends/family/carers especially given the geographical difficulties within the region.*
> Staff comment

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[10] https://www.mwcscot.org.uk/law-and-rights/rights-mind

Family/carers

We were keen to speak to relatives and carers of older people to get their opinion on services and hear of their experiences. We had contact with 23 family/carers during our visit over six health boards and 12 hospitals. Most family/carers were spouses.

Most of the family/carers who gave an opinion were happy with the situation and some were very complimentary about the care.

> *Cannot praise staff highly enough and always welcomed on the ward.*
> Tay Kingsway. Family/carer comment

> *All staff are excellent, from domestics to doctors. Communication and support is excellent. Staff take the time to speak to you, e.g. in a quiet room if you're upset.*
> C-GGC IRH 4. Family/carer comment

We asked family/carers about the impact the illness had on them and the rest of the family. The family/carers who commented described their experiences as being difficult, upsetting, traumatic, demanding and time consuming. They described themselves as tired, worried, and stressed and one was "at the end of their tether".

> *Enormous impact - through generations - from son down to great grandson. Also need to acknowledge people have other problems in their lives also... often wider caring responsibilities.*
> Family/carer comment

> *Hugely. My daughter is closely involved in, supporting me and my husband, my son and my grandchildren have all been affected.*
> Family/carer comment

The Carers (Scotland) Act 2016 introduces the Adult Carer Support Plan, which puts a duty on the local authority to assess the needs of a family/carer. This can be around emergency planning, ability of a family/carer to provide this role, support available locally and whether a break from caring is necessary.

Seven family/carers felt they had been given signposting to support for themselves, the rest did not.

Comments from family/carers are incorporated across this report.

Workforce

The workforce planning tool (ISD/SG)[11] is a core measure that NHS Boards are required to run on an annual basis. We expect to find wards that having used the tool, are resourced with the correct level of registered nurses and health care support workers, to the ratio that is needed.

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[11] https://www.isdscotland.org/Health-Topics/Workforce/Nursing-and-Midwifery/NMWWP/Tools/

We asked the senior charge nurse on all wards to identify any issues that they had in retaining and recruiting staff to work in older adult services. The majority did not report any difficulties in recruiting and retaining nurses who were motivated and committed to working in this setting.

Increased staffing levels, providing activity coordinators and investment in the environment were reported to increase staff morale and benefits for patients.
Where issues with recruiting and retaining nurses were identified by the senior charge nurse, they identified issues including more newly qualified staff in posts, who had less experience of working with this patient group. Where there were vacancies, recruitment was often a slow process and in some Board areas another challenge in retaining staff was the range of opportunities that were available for nurses in other clinical areas.

Four out of the six services that did comment on staff shortages felt this was having an impact on patient care.

> *Staff vacancies are an ongoing issue. This means that we are not able to give patients who have functional mental illness as much time on the ward.*
> Staff comment

> *The ward went through organisational change last year… staff sickness increased due to stress – it has been a challenging time for us all.*
> Staff comment

The Royal College of Psychiatrists in their 2019 Census[12]identified that around a third of all substantive whole and part time consultant posts in old age psychiatry in Scotland were vacant or unfilled compared to around a fifth across the UK.

We asked the senior charge nurse about the opportunities for nursing staff to develop their skills and knowledge when working with older people.

There was a range of training options available across Boards but little that was specific to older peoples mental health ; some was done as e-learning, such as LearnPro, while others offered an opportunity for staff to be out with the clinical setting. However, we heard that this created a challenge with having the resources to support staff going off ward. Some of the educational training options that focused specifically on mental health were:

- Stress and Distress
- The Decider Skills
- Safe Talk/ASSIST
- Psychological Formulation
- Low Intensity Psychological Therapies
- Wellness and Recovery Action Planning

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[12] The Royal College of Psychiatrists Census 2019,Workforce figures for consultant psychiatrists, speciality doctor psychiatrists and physician associates in mental heath

Care and Treatment

We expect that care and treatment is provided by a multi-disciplinary team as in any other mental health service. As recommended in the CCQI Standards, Standard 3.3.1 that should include:

- therapies and activities;
- medication;
- physical healthcare; and
- risk and safeguarding.[13]

We expect that treatment options are discussed and agreed with the patient, and their family/carers.

Medication

We found that the main treatment offered to patients was medication (95%). We assessed whether the patient's medication had been reviewed since admission and found that was the case for 90% of patients. For those we recorded as not having a medication review, it was due to either no record of a review being found or the patient having been admitted to the ward very recently.

> *The combination of medication, staff encouragement and meeting with the psychiatrist have helped me do things differently. Medication has helped; I was reluctant to take it at first, but I'm able to see how it's helped.*
> Patient comment

> *Restarting medication has helped – I'd been off it for 19 months as I was stable but my mental state got worse at Christmas due to stress. I'm now on different medication, as well as one that I was on before. They suit me well.*
> Patient comment

For patients detained under the Mental Health Act, we expect that a T2 form (where a patient is consenting to medical treatment) or a T3 form (where the patient is not consenting) is in place where required. For those that required certificates, there were concerns in four cases that the certificate was either unavailable or incomplete to cover all prescribed medications. These issues were addressed with the senior charge nurse on the day of the visit.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under Section 47 of the Adults with Incapacity (Scotland) 2000 legislation must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act.

At our previous visit in 2015 and on subsequent local visits we have come across a generally high completion rate for these and therefore chose not to look routinely at these on this visit.

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[13] https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/older-adult-wards-qn/qnoamhs-5th-edition-standards.pdf?sfvrsn=ac2002d4_2

Psychology

A major part of mental health services in Scotland is enabling access to psychological therapies, a range of interventions designed to help people understand and make changes to their thinking, behaviour and relationships to relieve distress and improve functioning.

The mental health strategy[14] commits the Scottish Government to offer national support to NHS boards to ensure no unwarranted variation across the country to mental health and psychological therapy services, and no lower levels of access to psychological therapies for people over the age of 65.

Psychology can have an important role in the treatment of functional mental illness in older people, both directly, with the patient, and by supporting nursing staff to deliver therapy. We would expect that all assessment wards have timely access to psychology input.

Only seven wards reported regular input from psychology, two said they had no service and the remaining wards said it was on a referral only basis. Only a few (12%) of patients we reviewed were in contact with psychology. This is in contrast to a recent themed visit carried out by the Commission to adult NHS inpatient rehabilitation wards [15]where 41% of patients were receiving input from a psychologist.

> *Long waiting list for the service. RMO would need to refer.*
> Staff comment

> *I think I would benefit from psychology to help me deal with my feelings. I hope to follow this up after I've been discharged, as there is a feeling that I wasn't in a good place to begin this work.*
> Patient comment

Where it was available it was described as helpful.

> *Psychologist very involved in 1:1 work with patients, providing support to staff re managing behaviours, and formulisation.*
> MWC visitor comment, Tayside Kingsway

> *I see a psychologist once a week – that is the best help I get. I complete worksheets with them.*
> Patient comment

> *I've had a psychologist since admission – I met her for the first time when I was admitted and I'll hopefully be able to see her when I go home.*
> Patient comment

NHS Education for Scotland has developed a matrix to support improving access to psychological therapies for the oldest and most vulnerable members of society.[16]

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[14] https://www.gov.scot/publications/mental-health-strategy-2017-2027
[15] https://www.mwcscot.org.uk/publications?type=42
[16] NHS Education for Scotland. (2015). *The Matrix Evidence Tables – Older Adult Mental Health.* Edinburgh: NHS Education for Scotland. Retrieved from: https://www.nes.scot.nhs.uk/media/3325333/matrix_-_olderadults.pdf

Multi-disciplinary input

Where there is an identified need, there should be input from clinicians in psychiatry, mental health nursing, activity coordinators, occupational therapy, psychology, pharmacy, dietetics, physiotherapy, speech and language to support the patient and their family/carer.

We wanted to hear about the patient and family/carer experience of meeting with these professional disciplines; we wanted to find clinical records that identified what had been agreed, what actions were planned, and who would be involved in helping the patient achieve their goals.

Standard 2.3.8 of the CCQI standards for inpatient older adults' mental health services recommend that "a comprehensive assessment is started. This involves the multi-disciplinary team".

What we found

For those patient's we reviewed, all had nursing staff and a psychiatrist involved in their care and half had input from occupational therapy. Other professionals and family were involved in a smaller proportion of cases Social Work involvement:

In only a small number of patients that we reviewed (n=6) did we find that there was active involvement with a social worker. In some cases, a mental health officer was involved; in others, we found that input was from a social worker.

Where there was involvement, the reasons for contact varied. For some it was in relation to an assessment of services that would be required to support the patient where a home discharge was planned. Other reasons were where a guardianship application was being made, or where a referral to a care home was being considered. In most instances, social work input was proactive and helpful, however it was noted that on occasion, clinical staff in the in-patient setting had to pursue input from this service to prevent the patient being delayed in hospital.
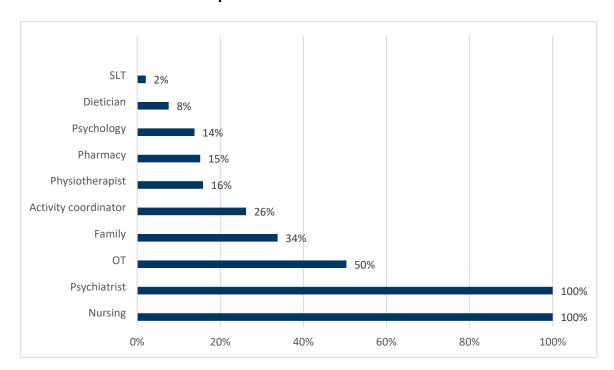
Table 3. Those involved in the patient's care

We found a broad range of clinicians involved, although their contact with patients varied.

Occupational therapy

We discuss the value of occupational therapy in the chapter on activities. However the role of the OT goes beyond that of providing recreational activity and occupational therapy uses occupation to establish or re-establish functioning.The majority of patients were receiving input from occupational therapy (61%).

> *I have plenty of hobbies but I lost all interest in them and everything. Here on this ward, I am doing things I've never done before and enjoying it. My confidence is slowly building up. The nurses and the OT are very attentive and come and see me throughout the day to check how I am doing.*
> Patient comment

One-to-one sessions

Standard 3.3.8. recommends that there should be a weekly meeting to discuss progress, care plans and concerns. We found that in the majority of records we reviewed there was evidence of one-to-one interactions with a member of nursing staff that met this standard. Most commonly one-to-one meetings occurred daily or three to four times per week. In a quarter of records it was unclear how often a one-to-one session took place.

> *I have a named nurse who has been really good and has read about and understands my problems. Now that my named nurse understands my illness, she is educating the other staff, so that is helpful.*
> Patient comment

There are one-to-one sessions which are detailed giving evidence of the patient's growing insight into his situation and care needs.
MWC visitor comment

Multi-disciplinary team meetings

We wanted to see how often the multi-disciplinary team (MDT) met to review each patient's care, in line with standard 3.2.1 of the CCQI Standards.

The standard recommends that a review should be at least every week. We found that most records had evidence of MDT review while a very few had no record of MDT review (5%) or had very recently been admitted (4%).

Most records had evidence of review of care plan goals (70%). The majority of MDT reviews were weekly.

We found some positive examples of the frequency and the quality of the care plan goals that were reviewed at the MDT:

I have attended the MDT meeting. It was good to hear staff's thoughts about my presentation and allowed me to offer my views which are an alternative, and not necessarily as a result of my mental illness.
Patient comment

A new goal was set last month that related to activities in the care plan, where it was identified that he wished to play the guitar. When I met the patient, he was playing the guitar in the garden.
MWC visitor comment

However, some were less positive:

Two reviews since admission six weeks ago. No evidence that the patient was involved in this.
MWC visitor comment

Reviewed in January 2019, then again in May 2019. Care plan does not identify when reviews take place, or how often.
MWC visitor comment

For about half of those patients (=70) at the time of our visit, there were discharge plans in place. Of those, around half were returning to their own home with a few moving on to a care home or other NHS facility.There were various reasons why the remaining patients were not at the point where discharge had been discussed.

Mr X is due to be discharged home tomorrow. He has community psychiatric nurse support, and has also been helped with structuring his time, continuing his voluntary work and applying for full time paid employment, which he was keen to do.
MWC visitor comment

Physical health care

We expect that a comprehensive physical review be completed within the first week of the patient's admission to the ward.

In most case, we found that this had been done while a small proportion of records did not give an indication of whether a physical review had been conducted and a very few patients who had very recently been admitted were yet to have a review done.

ECG was not recorded in about half of cases. Similarly, around a third of patients had no record of lifestyle, respiratory rate or heart rate recorded (see table 4).
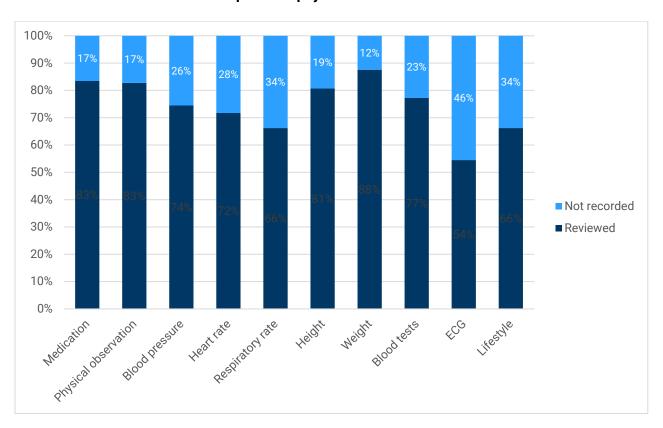
Table 4. Records of review of the patient's physical health.

We looked at whether any physical health issues identified since the time of admission, had been addressed in the patient's care plan.

In a third of the total number of patients there were no physical health care issues. For the remaining patients we found the issues had been addressed in the majority of care plans.

> *Excellent screening and detail in care plan. Links to outcomes in the MDT and investigations into the patient's physical health.*
> MWC visitor comment.

> *Care plan lists physical co-morbidities but provides no detail on how these are to be managed.*
> MWC visitor comment.

We wanted to know if patients were assessed for any difficulties in relation to alcohol, smoking, weight management and physical activity. Only a third had been assessed for these risk factors.

We found that support offered was mainly provided by dieticians and physiotherapists. Exercise groups and attending a gym session were available for a few (=8), and less than half of those that smoked either had access to, or were willing to engage in smoking cessation programmes. For those that identified alcohol misuse, there were only two who had been involved in educational programmes in relation to this need.

> *I know I need to stop drinking. I now realise why my family didn't visit me, because I was drunk all the time. I really don't want to do that when I go back home but, I don't have transport, so getting out to go to social groups or alcohol support groups is going to be difficult.*
> Patient comment.

Family/carer Views

We asked family/carers what they thought would improve patient care and treatment. They said access to appropriate, timely care when the patient deteriorated physically and better access to psychological services.

Improved interaction between mental health and physical health care was highlighted. One family/carer said that training for nurses in "silos" was causing distress to patients, as expertise in mental health situations was lacking around physical care environments and vice versa.

In an older, and inevitably frailer population, lack of training around medical care on mental health wards could lead to delays and indecision at critical times.

Care planning

Care plans provide a written record that describes the care, treatment and interventions that a person should receive, to ensure that they get the right care at the right time. Care plans are a crucial part of supporting and helping the recovery process.

Care planning should enable patients to take more control of their lives whilst they are receiving care and treatment and ensure that their needs and aspirations have been taken into account. Standard 3.2.8 of the College Centre for Quality Improvement (CCQI) *Standards for Inpatient Older Adults Mental Health* services states that every patient has a written care plan reflecting their individual needs. The care plan should clearly outline agreed interventions for physical, mental and psychological wellbeing.

We were interested to find out if every patient had an individual care plan and if they or their family/carer had a copy. By reviewing the care plans we could see if the identified goals covered mental health, physical health, psychological interventions and what these were.

The Carers (Scotland) Act 2016 notes that an assessment must take the family/carer's views and opinions into account as far as is reasonable and practical. In reviewing care plans and in speaking to both patients and their families and carers, we wanted to find out when, where and how they were encouraged to engage with the care planning process.

We would expect that carers and relatives would be fully involved, as appropriate, in decisions around a patient's care and treatment. The unique knowledge they have of the individual should be used to help shape a care plan and support given to maintain their relationship with the individual. If a power of attorney or welfare guardianship is in place this should be respected and any named persons should be involved accordingly.

We found that most patients had a care plan. The majority of patients though did not have a copy of their care plan or there was no indication that a copy had been provided, only a very few had a copy of their care plan (n=8).

The goals in the care plans that we found related to the mental health symptoms of the patient, their physical health needs and the use of psychological interventions and, where used, what psychological therapy had been provided. While the majority of care plans had mental health symptoms recorded, few had recorded psychological interventions. (See table 6).

Most had an individualised risk assessment (n=139).

Recording of goals in care plans

We considered whether the care plan was relevant to the patient's care needs and recorded this. There were some care plans where this had not been recorded but in nearly half that we reviewed (n=75), we thought that the care plan either met the care needs, or was well defined. In our findings from these we noted that plans were detailed, personalised and relevant – covering mental health and wellbeing, dietary intake, social inclusion and wellbeing.

In a third of the goals we thought could be improved upon; we found that the care goals were vague and general.

The care plans brought the patient to life. They are highly personalised and identify all their particular difficulties.
MWC visitor comment.

From the review of the records, we noted some good practice relating to the care plans. In more than half of the notes we looked at (n=88), we found positive qualities in the standard of recording:

"Interventions are detailed in the formulation care plan, focusing on stressed/distressed behaviours that are specific and person-centred and highlight the de-escalation techniques and particular activities he enjoys, and that can reduce stressed behaviour".
MWC visitor comment

"Excellent care plans. Patient A has highly individualised, unusual and complex needs. Care plans are detailed and goals are very clear. Complex physical health needs are also fully addressed and all updated regularly".
MWC visitor comment

"Care plans regularly reviewed and involves patient and her husband. They include the need for physical health care, associated with mental illness".
MWC visitor comment

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability.[17]

Family/carer involvement and engagement in the care plan

More than half of the care plans that we reviewed noted that family/carers were involved. For the remaining plans, there were either no family/carers involved or it was not recorded at the time of the visit.

We asked when a carer or family member was encouraged to become engaged in the care plan process; the main times that this took place was at the point of assessment or when the patient's care was being reviewed. We found that family/carer engagement happened less frequently on a day to day basis, and was not recorded in the care plan (n=126) with very little information about any other options where carers and family members were encouraged to be more involved (n=119).

In a few care plans, we noted some positive examples of this; opportunities to meet with hospital care workers or participation in a family inclusion group, although these were only available in a few services. For the small number of family/carers who were actively involved

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[17] https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf)

(n=22), geographical distances reduced the opportunity to be more engaged, while for others, the main focus of their involvement was at the time when a review of care was taking place.

Just under half of the family/carers we met with had welfare guardianship orders in place, although not all were using their powers. One family/carer felt decisions had been made about medication against their wishes leading to "catastrophic problems with their [the patient's] mental health". Everyone felt they could speak to nurses fairly frequently with the majority saying they could easily access a doctor. Not all were as clear about attending reviews; some were very satisfied whereas others were not so positive.

> *Found MDT to be quite daunting. Had not been prepared for the number of people attending and some he didn't know.*
> MWC visitor comment

One family member felt they would benefit from some time at the review without the patient as they felt "put on the spot" to go along with care decisions and not able to express their views. Three families had concerns about decisions being made against their wishes or without adequate consultation.

Activities

Engagement in meaningful activity is essential to an individual's health, wellbeing and self-worth.

NICE define meaningful activity as including any:

"… Physical, social and leisure activities that are tailored to the person's needs and preferences. Activity can range from activities of daily living such as dressing, eating and washing, to leisure activities such as reading, gardening, arts and crafts, conversation, and singing. It can be structured or spontaneous, for groups or for individuals, and may involve family, friends and carers, or the wider community. Activity may provide emotional, creative, intellectual and spiritual stimulation. It should take place in an environment that is appropriate to the person's needs and preferences, which may include using outdoor spaces or making adaptations to the person's environment." [18]

Activity has the potential to restore, maintain and improve physical and mental health. Staff with relevant knowledge, skills and confidence providing a range of activities can enrich the quality of life for an individual, build up confidence and enhance relationships within the ward. There should be adequate space and opportunity to engage in recreational and therapeutic activity within and out with normal working hours.

We would expect to see a person-centred activity programme that is based on a multi-disciplinary assessment of an individual's needs and strengths. Such a programme should include options both on and off the ward for therapeutic and recreational activity and reflect social, cultural and religious preferences.

Range of activities

Opportunities for physical activity are important. A number of patients we met had been leading isolated lives prior to admission and we know that for this group, going out of their home can be difficult for a variety of reasons. The majority of patients we met told us that physical exercise on the ward including armchair yoga, tai chi, music and movement, and dancing was highly valued by them.

> *I like physical activity and find this is a good way for me to remain well, it also gets me off the ward. If I did not participate in these activities, I would have found this admission much more difficult and would have been unlikely to have improved so quickly.*
> Patient comment

Other activities that were most appreciated by patients were activities such as music groups, arts and crafts (including mindfulness colouring in), quizzes and board games. These activities were highly valued and the social aspect of these activities was as important as the activity itself. Many of the patients we met had not participated in group activities for a long time and managing to do this gave them a sense of achievement. Patients we met with were

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[18]https://www.nice.org.uk/guidance/qs50/chapter/Quality-statement-1-Participation-in-meaningful-activity

mainly positive about activities as they provided purpose to the day and helped them make a connection with others.

In wards where there was an investment in activities, we saw patients participating in a wide range of activities that matched their level of ability and it promoted a sense of engagement in their own recovery.

> *There is huge range of things to do. The OT is really great, she's here Monday to Friday and nurses do things at weekends. I am doing things I wouldn't normally do but I am prompted to do them and I love them. Ward 3 St John's.*
> Patient comment

For those who found it hard to participate in group activities, we saw examples of good practice by nursing staff who had one-to-one sessions instead and recorded these and the outcome of these sessions.

> *I am finding it difficult to ask for help and support at the moment but staff encourage me to come out of my room and do things. I can be quite self-isolating.*
> Patient comment

In a small number of wards, where we saw little evidence of a variety of activities, patients told us about their dissatisfaction with the level of activity.

> *There are no activities here. There isn't enough to do. I would like more structured things, like a quiz, to get us actively involved.*
> Patient comment

Activity care plans

We looked for evidence of activity planning in care files and to see that activities were linked to individual goals, recorded and evaluated. Although we found reference to activities, these varied greatly. We found some highly individualised care plans relating to activities which set out, in small incremental steps, the goals for the next week.

In preparation for discharge, one patient who preferred his own company and enjoyed listening to the radio and watching television, had access to both in his room. The care plan referred to "graded introduction to the outside world". The primary goal was to offer opportunities to go out to the hospital café. Something he had done on several occasions since admission and where participation and therapeutic effect was recorded.

Some other examples lacked specificity and included statements such as "learn to fill gaps that alcohol used to fill". We observed, and the patient confirmed, that the only activities on the ward on offer were jigsaws and board games. Their interest was in walking and there was no evidence of this interest being incorporated into the care plan or that staff had tried to facilitate this.

Some care plans had no clear examples of individual goals in relation to activity nor clear recording of activities engaged in. On one ward there was an activity planner for staff to refer to but it was not visible to patients on the ward.

Activity rooms

It is important that there is a suitable space for activities. On some wards there were specialist areas or rooms dedicated to activities, which was helpful to staff as the resources were at hand and the room was clearly defined for the exclusive use for activities. The majority of wards we visited had either activity rooms or designated activity areas, many using dining or lounge area for activities. The Leven Ward, Murray Royal Hospital, had two spacious activity rooms. They were bright, filled with equipment, beautiful wall murals, and patient's artwork was displayed there and in corridors on the ward.

If dedicated space was not available, wards used the dining area/room or lounge area for activities. We observed that this could also be useful, particularly for individuals who were reluctant to engage but could sit and watch what was happening without having to commit themselves to participating before they felt able to.

Dining rooms and lounge areas can be useful places to start activities. Dining rooms in particular were seen as quieter and did not have the distraction of a television. Having activities in an area where other people are sitting and can watch, might encourage people to walk over and join in.

On one ward, we saw an occupational therapist (OT) holding a mindfulness colouring session with seven patients around the dining table, whilst also talking to someone who was on the periphery, reluctant to join in, but wanting to talk about their experiences of art at school. The OT encouraged this conversation and with some persuasion encouraged the individual to join the group, which she did for a short period of time. Her skill at engaging at all levels of abilities and levels of confidence meant that she could encourage participation and extend patients' comfort zone whilst building up their confidence and creating a small social grouping.

Staffing

In most wards, activities were provided mainly by nursing staff only. One nurse told us of the range of activities that were potentially on offer every week day, but noted that activities were dependent on nursing staffing levels and it was difficult to prioritise activities when there were pressing clinical needs of patients who required enhanced levels of observation or high physical health care needs. We also heard from nursing staff that when fully staffed, staff were often taken away to other wards resulting in being unable to provide the activities they intended to offer.

On most wards, structured activities usually took place 9–5, Monday to Friday. Weekend activities were often reliant on nursing staff and were described as *ad hoc*. This was not only dependent on the clinical needs of individuals and staffing ratios, but also the confidence and training of staff to be able to offer activities in a consistent and structured way.

One nurse told us that their ward had a quiz every Saturday night. Others told us of timetabled activities at weekends but it was hard to gauge if these activities were happening, as recording

of activities on these wards was often poor. However, provision in most wards, even with excellent OT input, fell short of the recommended standard of the Royal College of Psychiatrists that activities are provided seven days a week and out of hours'.[19]

Good practice

An OT told us that she met every patient within one week of admission, explained the role of the OT and asked about their interests prior to coming into hospital. With their involvement, she then built an activity plan to suit their needs, she recorded every activity the individual was involved in on daily basis and reviewed their participation and the value of the activities for that person on a weekly basis. She also held a fortnightly review of the activity planner with all patients on the ward, to gauge what they would like to see on the timetable for the next fortnight. She also left suggestions and resources regarding activities the individuals could do for themselves at weekends and passed this information on to nursing staff to encourage their involvement in activities. In addition to one-to-ones with the most unwell patients and those who were reluctant to participate in group activities, she also ran group events. As this is a mixed ward, some of the groups she ran were for mixed abilities, when she would encourage participation gauged on level of ability but some were exclusive and were perhaps more intellectually or physically demanding.

Commission visitor comments, Ward 3 St Johns

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[19] Standard 3.3.5 the College Centre for Quality Improvement (CCQI) *Standards for Inpatient Older Adults Mental Health*

Environment

We expect all wards to provide a therapeutic environment including sufficient living space, adequate lighting, a satisfactory state of repair, and a stimulating and enabling indoor and outdoor environment. There should be adequate space to uphold the privacy and dignity of the patient.

Access to an outside place is essential because of the therapeutic benefit for patients and is particularly important for those who are not able to leave the ward. It gives patients a private and stimulating space in which to meet visitors and allows those with limited mobility a safe place to venture out to.

Welcome and orientation to the ward

Admission to hospital can be a daunting, frightening and confusing experience. Friends and family/carers who are visiting can feel similarly disorientated. We asked our MWC visitors to consider the welcome they received on entering the ward, to reflect the welcome patients and their friends and family/carers may experience.

Our visitors described a variety of environmental factors which contributed to that welcome. These included; clear signage, a pleasant area with comfortable seating at the entrance, information boards including visiting times, a written explanation of a locked door policy if there was one, and easy access to written information on various mental health diagnoses. One ward was described as unwelcoming, due to the lack of an obvious welcome sign on entering the ward and a number of old filing cabinets, books and bookcases just inside the door.

About half of the family/carers we met with described some form of introduction to the ward, but only five described having been shown round and receiving written information. No one described feeling unwelcome on the ward. Those who commented said they could visit whenever they liked and all were able to access a private space to be with their relative. Only one family/carer highlighted a concern over a lack of security.

> *People are able to come in without the staff always noticing that they are in.*
> Family/carer comment

We found a locked door policy sometimes assisted with the welcome to the ward, as visitors were greeted at the door by a member of staff who confirmed they were in the correct ward and taken to the patient or member of staff they needed to speak to.

With the exception of one ward, all staff members were easy to identify as they were wearing national uniforms and name badges.

Around half of the wards had a highly visible board in the corridor with the names of staff on duty, as recommended by NICE guidelines [20]

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[20] https://www.nice.org.uk/guidance/qs50/chapter/Quality-statement-1-Participation-in-meaningful-activity

One ward had a photo board included on the board that explained who the staff were and their job title, which family/carers found very helpful.

> *Visitors meet with patients in privacy of patients bedrooms. Members of nursing staff at ward entrance to meet/greet visitors. Nursing office adjacent to ward entrance should visitors wish to speak to staff. Ward 5 FVH.*
> MWC visitor comment.

Gardens

Getting away from a busy ward environment, taking in fresh air in peace and quiet is important for maintaining good physical and mental health.

Getting off the ward, initially to the ward garden (or later a walk in the grounds) was mentioned throughout our interviews as being highly valued. These opportunities were viewed by patients as a very important part of their journey to recovery, particularly for those who weren't yet well enough to leave the ward. It was also seen as a more private place to meet with visitors.

Patients mentioned that visiting a local café or the hospital hub was very important to them, particularly if in the early stages of recovery. A café or hub based within the hospital campus was seen as beneficial and gave a slow introduction to re-engagement with social activities in a safe, protected space.

Of the wards we visited, all had access to a garden but four wards were on an upper level with no direct easy access, so a member of staff often needed to accompany the patient.

For all but one ward, the garden was well maintained with different places to sit, pot plants and landscaped gardens which added to the environment. One ward in particular (Rossbank, Midlothian) had a beautiful, well-maintained garden which the Cyrenians charity supported the patients and staff to maintain. Their garden had a circular safe path, raised beds, a variety of seating, fragrant planting and a gazebo all of which added value to the experience of being there. This was also an excellent example of community services supporting the ward and introducing patients to volunteers.

We found that when there was a good garden area directly accessible from the ward, there was evidence of regular use. For six wards, a member of staff with a key to the garden needed to take a patient and/or their visitors to the garden and depending on risk, might have to stay with them the whole time, taking them away from duties on the ward. Unsurprisingly, these gardens were not used as often.

> *Access to two gardens that wrap around the ward. Patients are encouraged to become involved in gardening with volunteers".*
> GRH Timbury. MWC visitor comment.

Lounge layout

We asked our visitors if the environment promoted a relaxing experience where interaction was encouraged. We found that activities taking place within lounge areas kept people occupied. In general if staff were highly visible and there were patients who were unwell or

becoming distressed, staff were able to recognise this quickly and provide reassurance before the patient's distress worsened. Positive interaction between staff and patients was observed to contribute to a calm and quiet atmosphere on most wards.

For the majority of lounge areas, we found some good examples of layout, including bright and spacious seating areas with a variety of seating options (couches and single seats at different heights) to suit different people. Having seating around a coffee table or in small groups encouraged interaction and promoted staff and patient interaction.

In wards where a television was on we found that they were at acceptable noise level. In ward 4, Woodland View, the television was only on for an hour in the morning to encourage participation in activities.

> *Staff have worked hard to create a warm and comfortable environment for the individual.*
> Ward 4, Woodland View. MWC visitor comment

Most wards we visited had a variety of soft furnishings e.g. pictures, decorative objects, items of interest and good colour choice which helped create a homely atmosphere. In a small number of wards (3) we found an environment which was unwelcoming, one was described as 'bleak' and another as 'clinical'. We raised this on our visit and will be visiting again to see if improvements have been made.

> *Neglected lounge, large dormitory of six beds, each of them sparse and not personalised.*
> MWC visitor comment

Quiet room

We asked if there was a quiet room where patients could go with their visitors. Eighteen of the wards had quiet rooms and the quiet room was often multi-functional and used for activities for some part of the day. On most wards the quiet room was used as a place to meet visitors or just a quiet space for those who chose not to be in the main area of the lounge. Most were described as welcoming, only one of these was described as not very cosy or welcoming.

If the patient had a single bedroom then this was often used as a quiet place to meet. Dining rooms and other communal areas are often not ideal as conversations can be overheard. Ward gardens, where privacy can be respected in a calm and pleasant environment were a great asset for meeting visitors.

On one ward that also admitted patients with dementia, the quiet room was a room that many patients with a functional illness preferred to use as it was a quiet space in which to engage in conversation and build supportive relationships with other patients with similar difficulties.

Dining areas

The dining area should encourage a person's interest in their meals and help meet social needs. We hoped to find a dining-area where attempts had been made to minimise noise and

make the environment a pleasant and relaxing place to eat. The majority of wards had dining areas which were described as spacious and adaptable, patients could choose where they wanted to sit and who they wanted to sit with.

Bedroom areas

Bedroom areas should be a quiet, personal and private space; an easily identified personalised area which affords privacy and allows space for personal belongings and pictures. We visited fifteen wards where patients were encouraged to personalise their bedrooms and had brought in bed covers and pictures helping orientating them to their own room.

One ward did not allow personalisation and bed areas were described as "clinical". Another ward was mostly dormitory style with very little privacy and another ward was dated with little evidence of personalisation.

Bathrooms and accessible toilets

Eighteen of the 23 wards had accessible toilet facilities which were well signposted, on the remaining five wards we thought that signposting could have been improved.

In the more modern wards, all those who had single rooms had en-suite facilities in their bedroom. Of those that had en-suites we found that most of those places were spacious, comfortable and easy to move around in. However, in one ward there was only one shower and two bathrooms for 24 people and in another there were two showers and one bathroom for 23 people.

Wards should maintain privacy and dignity. We did not think that the bathroom arrangements in some wards met this standard. A number of wards were in old buildings and the structure and layout of outdated facilities brought its particular challenges.

Keeping belongings safe

We expect patients to be able to have personal possessions while in hospital and a means of keeping their belongings' safe. Most wards had places to put personal possessions, either in bedside cabinets or cupboards, particularly in single rooms. In other wards all valuables would not be expected to be brought into the ward but if they were brought in they were often held within the ward safe.

Other comments and impressions

On the majority of the wards we visited, we did not identify issues with the overall cleanliness, odour, noise, maintenance or decoration, although a few were described as needing attention.

The newer, more modern hospitals we visited were bright, with airy rooms full of natural light, supplemented with a variety of artificial lighting in dining areas.

High noise levels can adversely affect people who are feeling unwell. Twenty two wards were described by the Commission visitors as being free from adverse noise on the day of our visit. On the one occasion when the noise levels were high, it was on a mixed ward where a patient was unwell and closely monitored by nurses who were supporting them appropriately.

One ward had invested a significant amount of time in reducing noise levels wherever possible to create a calm atmosphere on the ward (ward 3, St Johns). We were told this had led to a reduced numbers of incidents where patients were distressed.

Transition from adult to old age mental health services

The earlier chapters in this report refer to inpatient wards. As part of this themed visit, a survey was distributed to psychiatrists across Scotland to gather their views on the transition of patients from adult to old age mental health services. This includes access to community support and care, not just to inpatient wards.

We did this because practice around this was raised as a concern during our consultation process. A link to an online survey was distributed through the Royal College of Psychiatrists. In total, 44 psychiatrists responded [21]. The findings should therefore be interpreted with caution, as they may not be representative of Scottish psychiatrists more broadly.

However, the survey was designed to complement the visits undertaken to add to the experiences of patients, family/carers and clinicians. A few family/carers we met with commented that communication between services at times of transition was a problem. Inconsistencies in staffing and change in personnel were also felt to have caused delays in admissions and medication management.

The main findings from the survey were:

- Not all NHS Board areas had a protocol in place for transition between services
- Most consultants were not aware of the transition arrangements with their local social work teams
- Some consultants expressed concern about services where a decision was based on age alone
- Just under half of patients were not involved in the decision about moving to another service
- The majority of consultants reported a difference in the provision and range of mental health services between adult and old age, some of which could prevent admission to hospital

Psychiatrist survey

Survey participants

Table 5 provides an overview respondent characteristics. Psychiatrists who took part in the survey worked in nine of the 14 Scottish NHS Health Boards. The highest representation was from Greater Glasgow and Clyde, Grampian, Ayrshire and Arran and Lanarkshire. The majority were consultants, worked in permanent position, with speciality in general adult or old age psychiatry. Most psychiatrists worked across in-patient and out-patient/community services.

Table 5. Characteristics of responding psychiatrists (N=44).

		n (%)
Health board	Ayrshire and Arran	6 (14)
	Dumfries and Galloway	2 (5)
	Fife	4 (9)
	Grampian	8 (18)
	Greater Glasgow and Clyde	14 (32)
	Highland	1 (2)
	Lanarkshire	6 (14)
	Lothian	2 (5)
	Tayside	1 (2)
Grade	Consultant	34 (77)
	Trainee	6 (14)
	Specialist Doctors and Associate Specialists, correct	4 (9)
Position	Permanent	37 (84)
	Locum	6 (16)
Specialty	General adult	21 (48)
	Old age	16 (36)
	Rehabilitation	3 (7)
	Liaison	1 (2)
	Medical Psychotherapy	1 (2)
	Forensics	1 (2)
	Intellectual Disability	1 (2)
Setting	In-patient and out-patient/community	33
	Out-patient/community	7 (16)
	In-patient	4 (9)

SAS: Specialist and Associate Specialist

Provision of old age psychiatry services

All respondents reported that there is a dedicated old age psychiatry service in their area. A third of psychiatrists reported that when a patient turns 65 years, a discussion about transfer to old age psychiatry services takes place. Seven percent of respondents reported that transfer takes place automatically once the patient turns 65, while 16% reported that nothing happens and the patient remains permanently in general adult services (Table 6). Two fifths of psychiatrists noted other processes regarding transfer, most commonly that transfer is only considered once a patient develops further mental or physical health problems as perceived

as needed for the patient. Only two psychiatrists mentioned other age cut-offs; in one case transfer was considered at age 75 years unless cognitive decline occurs and in another the psychiatrist noted that age cut-off varied, with 65 years in one area and 70 in another, in one case automatic transfer took if the patient is in general adult services, whereas if a patient is in specialist services a discussion takes place with greater likelihood of rejection.

Table 6. Processes for transfer to old age psychiatrist services (N=44)

		n (%)
Process at 65 years	Other	17 (39)
	Old age psychiatry transfer discussion	14 (32)
	Nothing[1]	7 (16)
	Automatic transfer to old age psychiatry	3 (7)
	Don't know	2 (5)
	Missing	1 (2)
Transfer protocol	Yes	22 (50)
	Not sure	13 (30)
	No	9 (20)

[1]*Patient remains with general adult services permanently;*

Half of responding psychiatrists reported that their area has a protocol for transferring patients to old age psychiatrist services (Table 2). However, despite a protocol being reported as in place, there were differences in how these were followed:

> *Generally for an MDT (multidisciplinary team) to be called but this doesn't happen locally even if referred for consideration.*

> *Unfortunately GAP services not always engaged in following the agreed protocol.*

A third of psychiatrists were unsure if their area has a protocol, including one where a comment was left that a protocol is currently being developed. Another response suggested that there are variations to the use of protocols between local areas; "I have seen a protocol for our health board but I understand that individual hospitals, especially in outlying parts of the board work in slightly different ways.

The remaining 20% reported that protocol is available and among those responding no protocol is available comments included the following:

> *It is very vague and everything is decided on a case by case basis.*

> *There is a policy but cases are discussed with old age service for suitability.*

In most cases, the transfer process includes a letter with about half involving a doctor-to-doctor discussion and a fifth includes a MDT discussion (Figure 1), with several respondents ticking more than one option. Some difficulties with the process were noted:

> *This is very difficult and most of my colleagues do not bother trying to transfer patients to Old Age given the difficulty.*

Tends to be a mixture, but unless referred through doctors it almost always gets into an impasse or "lost".

Comments relating to other arrangements included two 'Don't know' responses, two that noted that a mix of all processes take place, two noted it depends on relating to involvement of Community Psychiatric Nurse (CPN) and as noted above, respondents noted that the process may vary depending on the patient's situation. One respondent did not provide any response, noting that they are not involved in the transferring the patient and therefore unaware of the process.

Formal referral to Old Age service - patient has to meet criteria for increased physical needs, these are not formalised beyond "frailty" and "significant co-morbidity". These terms do not have specific meanings, referrals are decided case-by-case by Old Age service.
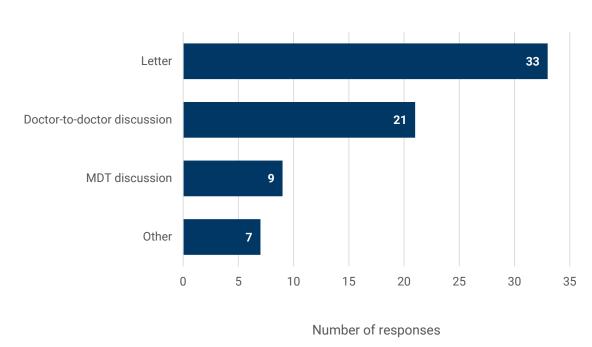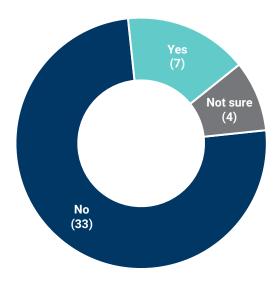
Figure 1. Process for transfer to old age psychiatry services (N=43)

Number of responses

As shown in Figure 2, most of psychiatrists reported that they were not aware of transition arrangements with the local social work department – only 16% said they were aware about transfer arrangements with local social work services. Only one comments was provided in relation to being unsure about the arrangement, highlighting issues with getting social work involved with patient's in general adult services:

If a patient remains in a general adult team after 65 then it becomes very difficult to get social services involvement. They tend to be the strictest with their inclusion criteria.

Figure 2. Awareness of transfer arrangements with local social work department (N=44)
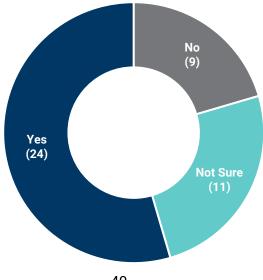

Patient involvement

Psychiatrists were asked whether the patient is involved in making a decision regarding transfer from general adult to old age psychiatry services. Just over half (55%) of respondents reported that the patient is involved in the decision about transfer, while a quarter were unsure and a fifth said the patient is not involved in the decision (Figure 3).

Comments regarding patient involvement included that while it is meant to happen, in practice that is not always the case and that often it is rather that the patient has been informed rather than involved in the decision. One respondent noted difficulties with patients who do not wish to be transferred from general adult services:

> *In general adult, sometimes a consultant will keep on a patient who doesn't want to transfer but it becomes very complicated because they then can't access the other members of the MDT, all of whom have tight age cut-offs. Specialities (addictions/rehab etc.) are different.*

Figure 3. Patient involved in transfer decision (N=44)

Differences in services for acutely unwell adults and older adults community services

A particular question of interest in the survey was whether there are differences in you services offered to acutely unwell general adults compared to old age patients in the community. Most respondent left comments indicating that there are differences between general adult acute services and community services for old adults. In general, comments related to different access to services where there in general was a perception that some services are not available to older people, including a smaller range of social work services compared to general adults. One psychiatrist noted that third sector services tend not to include people over the age of 65 years, noting that it is an "artificial and unlawful age barrier". One psychiatrist noted that they felt that wider MDT services have longer waiting times for older adults compared to general adult acute services. One reason mentioned for differences related to the large number of people with dementia, which puts strain on resources.

A common theme within the comments was around crisis teams and their response to older adults. There was a sense that CAST teams are less experienced in working with older people and also that crisis services in general are not available to older people, though one psychiatrist noted that in their area general adults do not have a crisis team while older adults do. One psychiatrist, who reported that no crisis team is available for older adults in their area, felt that if an older adult is suicidal and needs quick access to support in the home there is not the same sort of "safety net" as there is for general adults.

> *Old age service have no extended hours equivalent and will generally "refer in" patients transiently (e.g. over weekends and public holidays) for support until usual CPN is available again*

Another psychiatrist noted that the differences in services relates to lack of staff in community settings and, as a result, older patients are not used to their conditions being possible to manage within community settings:

> *There are less community staff in older adult service. We tend to support more in the community and despite having less staff will manage ill people more out with hospital. This has been illustrated to me by recent cases. The graduate (from GAP) patient is so used to being admitted to hospital when ill that it does take time for them to realise that we can manage their symptoms just as effectively in the community.*

Other services that are not available for older patients in the areas where psychiatrists work that were mentioned included eating disorder services for people over 65 years, liaison services for functional neurological disorder, and brain injury. One psychiatrist also noted that thresholds for admission may vary:

> *I'm not familiar with old age psychiatry but for patients with severe psychosis with associated behavioural issues there appears to be a lower threshold for admission in OA psychiatry.*

Services to prevent admission and good practice

Psychiatrists were asked about what services they find helpful in preventing admission to hospital. Comments included:

- Intensive home treatment team (available for old age psychiatry but not general adult)
- Support team for care home patients
- Hospital liaison service
- Supported accommodation
- Urgent referrals team
- Crisis Assessment and Support Team (CAST)
- Community Mental Health Team (CMHT)
- Extended hours CPN service
- Acute psychiatric liaison teams
- Early identification of delirium

While there were several services that were seen as helpful to prevent admission, there were some comments about issues with crisis teams and availability for this patient group:

> *Crisis team, but this is not available to old age in working hours and crisis team will not facilitate passes home from hospital for functional patients in order to facilitate discharge.*

> *"Crisis" services have been very <65 focussed in the past. As bed numbers have been drastically cut, we have tried to involve them in the support of >65s in the community but they seem to do little more than curate an admission.*

Along with helpful services, psychiatrists were asked to describe good practices in their area in relation to 'graduate arrangements for patients'. Responses included:

- Involvement in Care Programme Approach (CPA) meetings before transfer (particularly for rehab patients).
- Transfer only carried out only when in a stable condition.
- Not always a 'birthday referral'.
- Decision is based on which service is best placed to serve the patient's needs.
- The use of a pilot transfer protocol.
- Discussion between consultants before review of case notes and tests.
- Deciding what service best suits the patients and whether they require the skills of an old age psychiatrist and specialist Older Adult Community Mental Health Team (OACMHT).

Other comments on the transfer process related to assessment based on the patient's condition and individual circumstances, patient involvement, and work across older age psychiatry and specialist services:

> *Patients who are open to GAP services are not automatically transferred when they turn 65, which I consider is good for the patients.*

Very occasionally there is discussion. Too often there is just a letter. Often the letters are incomplete. Sometimes the patient is unhappy re transfer. Very occasionally transfer is attempted before 65. Very occasionally patients are thought to have dementia before 65 and this appears to influence decision to transfer or attempt transfer.

It's appropriate that people are able to remain in speciality care (for example, for intellectual disabilities, addictions, rehabilitation) where they need those specialist skills and staff. It would be great if we were able to cross-work with older age psychiatry, including their MDT rather than simply asking a consultant for a second opinion.

Perceptions about old age psychiatry services

Psychiatrists were also asked to reflect on anything else they considered important relating to old age psychiatry services. Key issues raised included:

- Transfer arrangements differ from Health Board to Health Board.
- Not many patients live to transfer age (75 years in the area).
- Similar issues exist in the transfer from general adult to older age as with Child and Adolescent Mental Health Services (CAMHS) to adult mental health services.
- No dedicated old age service for people with intellectual disability, meaning they are managed within the same services general adult intellectual disability.
- Premature discharge due to lack of beds results in services managing more people who are unwell in their own home.
- Age should not be the determining factor, transfer should be determined following assessment of the individual patient's circumstances.
- More patient involvement in the transfer process.

One issue raised by a few psychiatrists was that the transfer process or referrals depend on which clinician is dealing with the patient, leading to inconsistencies in the process. One psychiatrist specifically reported that in their area the link between general adult and old age psychiatry does not work well. Another psychiatrist suggested that building good relationships between clinicians help benefits the transfer process, services and patients:

Having come from working in a different health board area where transition arrangements felt much better, I think that developing relationships between clinicians in both services is key to improvement. Mutual trust and flexibility on both sides makes a positive difference to patient care. This only tends to happen when there has been a focus on developing good working relationships.

Throughout the survey there was, however, a sense that automatic transfer should not take place as several psychiatrists expressed that existing age limits are arbitrary.

I disagree with automatic transfer and believe transfer should be needs led and with full involvement of patient and relatives and in accordance with college guidance/policy.

Finally, one psychiatrist noted that specifically in certain areas, such as the overlap between substance use and cognitive function there is a need for better collaboration and assessment of the patient's needs, rather than using age as an indicator for transfer.

In the alcohol service it's particularly difficult to get older adult input into patients who continue to drink. The reason is often that it can't be proven that they have illness (cognitive problems or functional illness) because they haven't maintained sobriety for long enough (you need at least 6/52). However, input and cross working from the older adult team would be extremely valuable, particularly where there is a functional cognitive impairment and their social problems are more typical of older adults. Simply transferring patients to older adult wouldn't work, either, they need both sets of skills and resources.

With thanks to Dr Adam Daly, Associate Medical Director (MH and LD), Consultant in old age psychiatry, NHS Lanarkshire

Conclusion

In our 2015 report we made several recommendations, in particular about ensuring the physical environment maintained the privacy and dignity of the individual patient. We have seen improvements across many of the wards we visited but a small number are still not conducive to providing a therapeutic environment that helps recovery.

We have seen an investment in some areas in the provision of therapeutic activity and the comments received by patients about how helpful this is to them speaks volumes.

However, the number of patients accessing psychological therapy remains low compared to what we would expect to find in wards for younger people and further work is required to make sure that older people are not being disadvantaged.

We were told that pressure on admission beds across the country is resulting in more wards regularly admitting people with dementia and this often presents challenges. In general we do not think that mixed wards meet the needs of either patient groups.

Where wards are mixed, there needs to be considerable thought and effort to ensure the environment, staff training and skill mix is able to meet the differing needs of both groups.

We heard from psychiatrists and others about a difference in the provision and range of mental health services between adult and old age and of improvements that are required if people are transitioning between adult and old age services.

The Mental Welfare Commission will continue to visit patients in wards of this type on a regular basis as part of our local visits programme and this report will help inform those visits.

Appendix – Visited wards

Ward	Number of beds	Number of patients visited
Ayrshire & Arran, Woodland View, Ward 4	15	5
Borders General Hospital, Lindean Ward	6	4
Dumfries & Galloway, Midpark Hospital, Nithsdale Ward	15	6
Fife Queen Margaret hospital, Ward 1	24	5
Fife, Stratheden, Muirview Ward	24	6
FV, Forth Valley Hospital, Ward 5	20	6
GGC, Gartnavel Royal Hospital, Timbury Ward	25	6
GC, Inverclyde Royal, Ward 4	20	3
GGC, Leverndale, Banff ward	20	7
GGC, Royal Alexandra Hospital, Ward 39	20	7
GGC, Stobhill, Isla Ward	24	7
Grampian, RC, Muick Ward	24	6
Grampian, RC, Skene Ward*	23	13
Highland, New Craigs, Ruthven	12	5
Lanarkshire, Udston Hospital, Clyde Ward	23	6
Lanarkshire, Wishaw General, Ward 3	23	8
Lothian, Midlothian CH, Rossbank	24	5
Lothian, REH, Eden ward	15	6
Lothian, REH, Harlaw	15	5
Lothian, St John's, Ward 3	12	8
Tayside Kingsway Care Centre, Ward 4	14	7
Tayside, Murray Royal, Leven Ward	14	7
Tayside, Stracathro, Rowan Ward	13	8
Total	425	145

Ward was visited on two occasions due to demand for interviews but counted as one visit for purposes of this report.

Key

Most more than 80%	Majority 56-80%	About half 45-55%	A minority 20-44%	A few less than 20%	A very few less than 10%

national
preventive
mechanism