

Mental Welfare Commission for Scotland

Report on announced visit to:

Community Learning Disability Team, Newton St Boswells,
Scottish Borders, TD6 0SA

Date: 1 and 2 November 2023

Where we visited

The Commission visits people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their home, a care home or in a local community setting. People are increasingly receiving their care and treatment in the community, rather than in inpatient services and the Commission's visiting programme has changed to ensure that we continue to hear individual's views about this in these settings.

The Borders Community Learning Disability Team (CLDT) is divided into East and West sectors. It is a rural service with a large geographical area and a catchment population of approximately 110,000.

The CLDT provides access to health and social care for people with a diagnosis of learning disability (LD) and who require a specialist LD service. In addition to the CLDT, there was a forensic community LD team, an autism spectrum disorder (ASD) assessment and diagnosis team, dementia screening programme and liaison nurse team.

Who we met with

We met with and reviewed the care of 20 individuals, who were all supported by either by relatives or carers.

We spoke with the general manager, social work team lead, nurse team lead, nurses, consultant psychiatrist, psychologist, local area coordinator, speech and language therapist (who was also representing occupational therapy (OT) and physio) and the planning and development manager.

Commission visitors

Susan Tait, nursing officer

Kathleen Taylor, engagement and participation officer (carers)

Tracey Ferguson, social work officer

Dr Sheena Jones, consultant psychiatrist

What people told us and what we found

We heard a range of views from people we spoke with about the input they had from the team. Some were extremely positive about their experience, telling us that they “felt listened to” and were “well supported” when they needed it.

One person told us that the care and treatment received by their family member had been “excellent” in the short time that they had been with the team. They spoke about their family member having been assessed and diagnosed with autism, which had never previously been picked up and how helpful this had been. The same family member also spoke about the difficulties that they had experienced with the transition from child to adult services. They had frequently sought planning meetings with the child learning disability social work team to prepare for transition, but these had not happened and at the age of 16 years their family member had been left without any support.

Another family we spoke with said they felt the transition support was “almost non-existent” and described feeling that they “had landed” in adult services, which caused significant issues for their needs as a family. We followed up this instance with the service on the day of the visit.

Care, treatment, support and participation

There have been no specialist inpatient services in the Borders for individuals with LD since 2006. Individuals with mild learning disability and mental ill health access general adult psychiatry inpatient services and we were told that some people with complex needs had been managed very well in the general psychiatry ward with support from the learning disability team.

Individuals with more significant learning disability and complex presentations with significant behaviours that challenge are not considered to be appropriately placed in the general adult settings. This has presented challenges in providing care and support for individuals with significant, complex needs whose care and treatment could not be provided in the community. This has meant that some people have been placed in out of area services in both Scotland and England.

Dynamic Support Register and *Coming Home*

The Scottish Government report [*Coming Home*](#) was published in February 2022, with a focus on highlighting the importance of enabling individuals who were placed out with Scotland to return to their home area, where this was appropriate. We were told there was a long-term piece of work that is currently ongoing, to bring people home, undertaken with the establishment of a Coming Home programme board, and processes to review the needs of individuals placed out with the Borders. The Board are proactive at considering the needs of both children and adults and at the time of our visit there were 19 people identified through this process. Information gathered through these processes has also been helpful in reporting data about the care and treatment of adults with learning disability via the Scottish Government’s Dynamic Support Register.

As part of this programme, two bungalows had been built and a community support organisation has been identified to provide specialist supported accommodation to four individuals with complex needs. It is expected that these individuals will be able to move in in early autumn 2024.

There have been additional commissioning processes with a specialist third sector organisation, to develop three bespoke supported tenancies, with extensive work with housing and supported organisations to involve them in this process. This work is ongoing. It was positive to hear of the work that had gone into these processes, and we look forward to hearing how these plans develop.

Recommendation 1:

Senior managers must ensure repatriation of those individuals who have been placed out of area in specialist LD provision progresses, as appropriate.

Delayed discharges

We were told that occasionally people can become delayed in the general hospital whilst they await a package of care. We reviewed care records for one individual in this situation and we will continue to monitor progress towards discharge.

Transitions

We were advised that the CLDT took over the care of individuals from the age of 18 (or from 16 if they had left school). The service told us that they had undertaken a multi-partner transitions project prior to the Covid-19 pandemic. This included consultation with education, CAMHS, primary care, social work young people's services, and their families/carers. There was also a multi-agency meeting held twice a year for information-sharing across agencies, where transition planning could be commenced. We were told there was a full-time transitions worker who started working with young people and their families/carers from the age of 14; this was dependent on individual circumstances and priority of need. An adult social work assessment and support plan was then formulated when the individual reached adult status.

At present, there is less than one whole time equivalent LD nurse, and no specialist LD psychologist in the CAMHS. We heard that for the CLDT, this could result in a transition to the adult team without a comprehensive LD assessment. The adult LD team have no dedicated service for transitioning, although we were told that they try to be as flexible as possible when an under-18 was referred.

The transition from child to adult services are challenging and this was echoed by the families we spoke with.

Recommendation 2:

Senior managers should establish a seamless pathway for transition from child to adult learning disability services ensuring that it is a co-ordinated, planned and person-centred process that supports continuity of care.

Care plans

We heard about and saw evidence that the community learning disability team were providing a wide range of care and treatment to individuals in their service. We saw good evidence of

regular face-to-face contact between people, the community learning disability team, primary care and support organisations.

The care plans we reviewed that had been completed by social workers on the MOSAIC electronic recording system were person-centred, had an outcome-based focus and were detailed.

The nursing care plans we reviewed were not as detailed and in one care plan the individual was referred to as “the patient”, and not referred to by name. Several of the care plans we reviewed demonstrated a task orientated approach, with a list of actions rather than detailing what the nursing intervention was.

We asked to review the notes of an individual who the team considered had complex needs. The latest care plan we could locate was ‘to monitor physical health needs’, which was dated January 2022 and had not been reviewed since. There were, however, detailed notes of contacts with the individual.

There was some very positive work on care pathways, including dementia pathways, autism assessments, positive behaviour support strategies and contributions to Adult Support & Protection (ASP), Adults with Incapacity (AWI) and Care Programme Approach (CPA). CPA is a structured multidisciplinary, multiagency process which keeps the individual at the centre. We saw evidence in case records of positive behaviour support plans, person-centred positive behaviour support training to support organisations and detailed care programme approach care plans.

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, and can be found at:

<https://www.mwcscot.org.uk/node/1203>

Recommendation 3:

Senior managers should review care plan documentation to ensure that it supports effective care planning with clearly defined person-centred outcomes, information on how these will be implemented and the monitoring and review of progress.

Annual health checks

The Scottish Government have issued directions for annual health checks for people with learning disabilities that came into effect in May 2022. The service told us that an implementation planning team was established early in 2023. It had been agreed that the health checks will be provided by primary care, supported by a Band 6 nurse. It was positive to hear of the work that had been done to date. We saw evidence of recent health assessments in the care records that we reviewed.

Electronic care records

The health team used the electronic system EMIS, and social work staff used MOSAIC. Information was not transferable between the two systems, which posed risks to effective communication. However, there was access to both systems by all professionals. We were told that systems often ‘went down’ and in particular, the wi-fi availability was very patchy,

which again presented risks when professionals were unable to access systems either to gain information or to record it.

Recommendation 4:

Senior managers should investigate and attempt to ensure consistent access to the electronic system for all disciplines.

Participation

We heard from the service that some people were involved in health and social care meetings, including multidisciplinary health and social care meetings, CPA meetings and Adults with Incapacity Act meetings.

We were also told that there had been a recent review of advocacy services, and an advocacy plan was in development. We look forward to seeing this when it is completed.

We did not see any reference to the involvement of advocacy services for the people that we reviewed.

Multidisciplinary team (MDT)

The Borders CLDT MDT had one consultant psychiatrist, one associate specialist doctor, 15 nurses including a team lead, an advanced nurse practitioner, charge nurses and staff nurses. There was also speech and language therapy, physiotherapy, OT, social workers, local area coordinator, dietician and music therapists. We heard that the psychology team had recently been expanded and was supported by the psychology trainee programme.

There was a weekly MDT meeting, which allowed for the discussion of complex clinical situations. As the teams were co-located, there were natural opportunities for multidisciplinary working, as well as coming together at the weekly MDT meeting.

There was clear evidence of a multidisciplinary approach to care, and we heard that the team valued this, however, we found it difficult to identify if the individual had an opportunity to participate in their care and treatment at these meetings.

Use of mental health and incapacity legislation

Where people were receiving their care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act), we found that the relevant documents relating to the Mental Health Act were easily located in the electronic care records. We also saw robust and up-to-date risk assessments, where required and detailed CPA care plans were in place.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given, to individuals who are receiving their care and treatment under the Mental Health Act. Certificates authorising treatment (T3) were in place, where required, and corresponded to the medication being given.

In some cases, the EMIS alert system included information about the person's legal status and specifically whether they were receiving care and treatment under the Mental Health Act, which was helpful.

Where people were receiving care and treatment under the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) we saw that in some cases, this was referred to on the alert system, and the relevant certificates were kept in the care record. However, unfortunately for a number of individuals, this was not the case.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We did not have sight of any section 47 certificates and associated treatment plans in the case records we reviewed; we have recommended that these are completed and stored on the EMIS system.

There were a significant number of individuals with LD who were subject to welfare and/or financial guardianship orders. On reviewing the care records, we were unable to locate information where supervision had been carried out for private guardianships. We were aware that there was a resource issue but have since been advised that there was a plan in place to address this.

Recommendation 5:

Senior managers should ensure consistent recording on EMIS of every individual's legal status, and where relevant, the completion and detail required for all relevant Mental Health Act/ Adults with Incapacity Act documentation.

Rights and restrictions

When we are reviewing patient files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements, however, we did not find any. We appreciate that there are very low numbers of individuals subject to the Mental Health Act, however we were unable to identify in notes where this was considered in cases where it may have been appropriate. We would encourage the service to review how they promote and record discussions and the uptake of advance statements.

The Commission has developed [Rights in Mind](https://www.mwcscot.org.uk/law-and-rights/rights-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. This can be found at:

<https://www.mwcscot.org.uk/law-and-rights/rights-mind>

Activity and occupation

Several of the individuals we spoke with said that they found the local area coordinator very helpful. Their role included supporting people to access community services, providing a link with the learning disability health and social care team, and making referrals to the community learning disability team.

One issue that was highlighted by the team was the difficulty in accessing suitable transport and transport links to allow people to attend activity resources. We will remain in contact with the service to hear how work to address this is progressing.

We heard from people and their families about a range of vocational and occupational activities that they were engaging with. We heard from a number of people about their disappointment that a local community enterprise that had provided meaningful occupation for people with learning disability had closed due to funding issues.

One person told us that she wanted to be able to access a range of services for her family member and this was proving difficult due to funding arrangements. However, a referral to the social work service had been made to address this.

We heard from members of the community learning disability team that there had been changes in how day services functioned in the area. In one day service, local authority staff were no longer in place and this had reduced access to experienced staff.

One service in the area was reported to have lost their premises and there was a lack of clarity as to what would happen – one family member told us that this had been expected for a number of years and it was disappointing that no progress had been made.

We heard from the community learning disability team that since the Covid-19 pandemic, some people had become very isolated. They had lost contact with their peers during the lockdown and some people had been worried about returning because of Covid-19.

We also heard that the community learning disability team had established regular meetings with some of the day services involving all the multidisciplinary team to support the day service staff and promote early intervention where there were concerns about people's mental health or behaviour.

We heard about a very positive local initiative called Project Search that involved a local college, Scottish Borders Council and the NHS. The project involved an initial college-based learning programme followed by supported employment placements in NHS and council services. This had led on to ongoing employment for some people. We heard from service managers that there had been a recent review and re-commissioning of daytime activities including an external consultancy process. We look forward to hearing more about this review, on completion.

The physical environment

The CLDT base was primarily for the health, social work and administration staff. Individuals open to the team could attend the base for some of their meetings with the team, but most of the team's activity happened in the community.

Summary of recommendations

Recommendation 1:

Senior managers must ensure repatriation of those individuals who have been placed out of area in specialist LD provision progresses, as appropriate.

Recommendation 2:

Senior managers should establish a seamless pathway for transition from child to adult learning disability services ensuring that it is a co-ordinated, planned and person-centred process that supports continuity of care.

Recommendation 3:

Senior managers should review care plan documentation to ensure that it supports effective care planning with clearly defined person-centred outcomes, information on how these will be implemented and the monitoring and review of progress.

Recommendation 4:

Senior managers should investigate and attempt to ensure consistent access to electronic system for all disciplines.

Recommendation 5:

Senior managers should ensure consistent recording on EMIS of every individual's legal status, and where relevant, the completion and detail required for all relevant Mental Health Act/ Adults with Incapacity Act documentation.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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