Mental Welfare Commission for Scotland

Report on announced visit to:
East Dunbartonshire Older Adult Community Mental Health Team

Date of visit: 30 January 2025

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 own home, or a care home or local community setting. As the balance of care shifts from mental health inpatient wards and units to delivery of mental healthcare in the community, the Commission's visiting programme has been adapted to reflect this change so that we can continue to find out about an individual's views of their care and treatment in the setting it is provided.

This was the first time the Commission has visited an older adult community mental health team (CMHT); this visit was to the service provided by East Dunbartonshire Health and Social Care Partnership/NHS Greater Glasgow and Clyde (NHS GGC). The CMHT is a multi-disciplinary mental health service which provides assessment and community-based care and treatment to older adults with a functional or organic mental illness, living in the East Dunbartonshire local authority area and an area of north Lanarkshire consisting of Auchinloch, Chryston and Muirhead, which were historically part of Strathkelvin district.

We had the opportunity to hear from individuals and their families/relatives about the input they received from the CMHT, as well as the staff themselves, who gave us a detailed overview of the types of care and treatment that was available.

Who we met with

We met with and reviewed the care of twelve people, three of whom we spoke with and nine who we reviewed the care notes of. We also spoke with the family members/carers of two people.

We spoke with the senior nurse operational manager, the team leader, the service manager, the consultant psychiatrist, members of the medical team, the advanced nurse practitioner, members of the community psychiatric nurse (CPN) team including the care home liaison team nurses and the community rehabilitation CPN, the occupational therapist, the psychologist, the social work team managers, members of the post diagnostic service and a member of Ceartas advocacy service.

Commission visitors

Mary Hattie, nursing officer

Claire Lamza, executive director (nursing)

Anne Craig, social work officer

Jenn MacIntosh, student nurse

What people told us and what we found

The individuals and relatives we spoke with were very positive about the service they received. Several staff from across the service were highlighted as being particularly helpful and having a positive impact, from reception staff to specific doctors, nurses, and health care support workers.

We were told by carers that “everything was tailored to meet my parent’s needs”; “they explained the expected journey; they were very patient, calm and understanding”; “I get someone who helps me once a week - I didn’t realise how important this was” and “I’ve never felt more cared for”. We also heard “the team have been a “godsend”; “they treat us with kindness and are very professional, from reception to the doctors”. We were advised by one carer that “there was no follow up meeting after the diagnosis – nobody phoned to check we were okay”. We asked about the delay between receiving the diagnosis and the commencement of their post diagnostic support and heard that the carer had found this to be frustrating. We were advised by the team that there is currently an eight to 10 week wait for post diagnostic support (PDS) although with vacancies in the team having been recently filled, this waiting time should reduce in the near future.

From those receiving input from the CMHT, they told us “my referral was acted on the next day”; “two staff visited and we felt linked in”. We heard that CPNs visited frequently and all that we spoke to told us they could telephone anytime and speak to their CPN or another member of the team. We heard how reassuring this was. “she is excellent; I can phone her at any time and get reassurance” and” they are a good listener, very pleasant”. We heard that staff provided additional practical support such as collecting prescriptions when this was difficult for someone.

Individuals and carers spoke about physical health needs also being monitored by CPNs and medical staff. We heard that the group programme provided by the service is valued, hearing that “I attended the eight-week course on building resilience and one on medications. This helped to cope with emotions”.

Care, treatment, support, and participation

The CMHT takes referrals of older adults with either functional or organic mental health issues. We heard that the number of referrals has increased significantly in the last decade and team currently receive between 20 to 30 referrals a week.

GP and specialist health care teams referrals are accepted by the CMHT; these are made via the electronic system, SCI Gateway and there is a phone duty rota supported by nursing and occupational therapy staff from the CMHT. This approach to referrals ensures that they are dealt with promptly; helpfully, where early indications from a referral identified that further information could be required, the staff rostered on phone duty screened this and gathered additional information from

more complex referrals, ensuring that delays from the referral were reduced to a minimum. Referrals are discussed and allocated at the weekly multidisciplinary team (MDT) meeting.

Urgent referrals are screened and dealt with on the same day. Routine referrals are currently seen at the memory clinics, or when appropriate, in the individual's own home, within four weeks of the referral being made. There has been a considerable reduction in the waiting list for psychology, which has improved from a wait of over a year to now being below the 18-week target. Where it is appropriate, individuals on the waiting list are offered input from nursing staff who can provide low level psychological interventions while they await psychology input.

Social workers are not embedded in the team, however they attend all MDT meetings. Social work staff cannot refer directly to the team although there are mechanisms in place to ensure that any individuals highlighted by social work and who require input can be referred into the service without any undue delay.

Care pathways for individuals accessing the service were clearly person-centred, based on a holistic assessment of the needs and preferences of the individual, and this was adapted as any changes occurred during the course of the person's journey through the service. CPNs and Community Home Liaison (CHL) nurses attend discharge planning meetings in the admission wards and the senior staff from Jura and Isla wards, the older adult's mental health assessment inpatient units, have regular meetings with the community team leads.

There are close links between physical health services, such as the acute care home liaison team and the community rehabilitation team, where there is a part time CPN embedded in the rehab team that creates a positive and efficient link to the CMHT. All of these links help to facilitate seamless transitions between services and enhance joint working when this is indicated to meet an individual's needs.

Care records

Information about a person's care and treatment was held on EMIS, the electronic record system which was available to all team members.

In the care records we reviewed, we found meaningful and relevant chronological notes that provided a clear picture of the individual's needs and clinical involvement. There was excellent carer family communication which we heard about from those that we spoke with and we found that this was reflected in the notes we reviewed. We found up-to-date CRAFT risk assessments and, where appropriate, Newcastle formulations, a framework and a process developed to help nursing and care staff understand and improve their care for people who may present with behaviors that challenge. In a number of the records we reviewed, individuals had physical

co-morbidities; we found that physical health needs were documented and considered fully in the care records.

We heard that the CMHT had been a test site for the new electronic care plan system which had recently gone live. We found that the new system allowed for care plan reviews to be added, and the care plans had been updated to reflect changes; this new system can now support meaningful evolving care planning.

We could see that the introduction of the care plan template has already made a significant improvement to the quality of the care plans that we found in the files we reviewed. However, the level of detail in care plans remained variable, although we found some excellent examples of meaningful reviews and care plans that had been revised and updated to reflect the care and treatment provided. We found some examples where relevant information had been identified in the very comprehensive chronological notes that had not then been added to the individual's care plan.

Recommendation 1:
Managers should ensure that there is an ongoing process of auditing the qualitative information in the care plans that then supports improvement in care planning and ensures that these reflect the high quality of care being delivered.

The Commission has published a good practice guide on care plans[1]. 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.

Multidisciplinary team (MDT)
We were impressed with the cohesiveness of the comprehensive multidisciplinary team that provides the CMHT's model of care and on the day of the visit, had the opportunity to meet with the various staff teams that provide joined up care for older adults in the East Dunbartonshire area.

The CMHT has multidisciplinary input from two consultant psychiatrists, one speciality doctor and a medical clinical fellow. All individuals who received input from the team are seen by a doctor as part of the assessment process and are under the care of a consultant psychiatrist. Occupational therapy and psychology are also an integral component of the team, with input from psychology providing both input for individuals in the CMHT and via training and group supervision for staff.

There is a nursing team that includes a team leader and 10 community psychiatric nurses (CPNs) from nurses at Band 3 to Band 7. There is also an advance nurse practitioner (ANP) who focuses on the physical health of those individuals referred to and engages with the service.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

The team have four care home liaison staff who provide input to individuals with complex needs and support to care home staff in the 16 care homes in the local authority area. We heard how this increases the capacity of the care homes to manage individuals complex care needs.

There are four staff for the post diagnostic team who deliver one year of post diagnostic support to individuals diagnosed with dementia. We heard that the CPN whose post sits in community rehab team provides early intervention for individuals referred to the rehab team and who require additional mental health support. Where appropriate, this provides a direct, well-informed and timely referral for the individual into the CMHT.

Use of mental health and incapacity legislation

On the day of the visit, there were no patients subject to treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

The team has a total caseload of approximately 1400 individuals, several of whom will be under the auspices of the Adults with Incapacity (Scotland) Act, 2000 (AWI Act).

Where individuals lack capacity to make decisions in relation to their own welfare a proxy decision maker may be in place, either in the form of a Power of Attorney, which the individual granted before they lost capacity, or as a welfare guardian, appointed via the court after their loss of capacity. For the individuals we reviewed and who had a proxy decision maker under the AWI Act, a copy of the powers was held on file.

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. Where this was indicated, we found completed section 47 certificates and treatment plans in the records of the patients we reviewed.

Rights and restrictions

When we are reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. While there are currently no individuals on the caseload who are under the Mental Health Act, we did find one advance statement in the records we reviewed.

From our discussions with staff, it was clear that the team works collaboratively with individuals and their families to ensure that their views are taken account of with the care planning process and that care pathways reflect their needs and their wishes.

We heard that there had been ongoing work to increase the uptake of anticipatory care plans, referred to by the service as future care plans, in the local authority and as a result of this, over 120 individuals on the caseload now had these in place. There are held on EMIS and the clinical portal, so are available to all NHS and ambulance services who may encounter the individual. These provide a record of the individuals wishes and preferences should their care needs increase in the future.

The Commission has developed *Rights in Mind.*[2] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

On the day of our visit, we heard about a range of additional resources and activities that individuals and their carers were signposted to and could utilise. These included access to interventions such as the emotional coping skills group, which was provided by psychology, dementia cafes provided by Ceartas, carers support groups, football memories groups and a variety of activities provided by Alzheimer's Scotland.

We heard that there are only two day services operating in East Dunbartonshire and as a result, the threshold for accessing places is high, however the post dementia support group work with families to ensure benefits are maximised and to support them to use resources creatively to maximise their quality of life.

The physical environment

The CMHT base is located in Kirkintilloch, Glasgow. The building is spacious and comprised of a staffed reception, consultation rooms, CPN, psychology and occupational therapy office space and access to group rooms and a kitchen.

We were advised that the team does encourage other services to use these facilities on a bookable basis, and that the team also has access to clinic space in Milngavie which they can use to see individuals.

Any other comments

We were told about the ongoing difficulties which occur with the North Lanarkshire corridor which consists of Auchinloch, Chryston, Moodiesburn, and Muirhead and currently sits in the CMHT catchment area.

[2] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

This area was historically part of Strathkelvin locality and health input for this area was provided by Greater Glasgow health board. Health board and local authority boundaries have evolved and changed over time resulting in the health care provision for this area currently remaining with NHS GGC, and therefore the mental health care being provided by the East Dunbartonshire CMHT. However, the challenges arise more specifically with the provision of social care and other local authority functions which sits with North Lanarkshire local authority.

We heard that the current mismatch between boundaries has a significantly detrimental impact on the quality of service experienced by individuals in this area. We were told that there are challenges in communication with North Lanarkshire social work and homecare and lengthy delays in the provision of home care services and equipment that has a negative impact on the experience of individuals being discharged from hospital.

The older adult CMHT in East Dunbartonshire are having to fill gaps in services which should be provided by North Lanarkshire, resulting in care at home leading to failed discharges and re-admissions. This results in a disproportionate and inappropriate use of nursing time, which then has an impact on the resource availability for the East Dunbartonshire proportion of the catchment area.

We are advised that there have previously been discussions to formulate a plan to address this issue and hand responsibility for health care with this area, and the associated funding, to Lanarkshire health board. However, these plans have never come to fruition. We heard that discussions are currently ongoing as part of a wider repatriation conversation, but that there are no firm proposals agreed or date set.

Recommendation 2:
NHS GGC and NHS Lanarkshire along with relevant HSCP partners need to agree a plan and set a date for the handover of the North Lanarkshire corridor to NHS Lanarkshire as a priority.

Summary of recommendations

Recommendation 1:
Managers should ensure that there is an ongoing process of auditing the qualitative information in the care plans that then supports improvement in care planning and ensures that these reflect the high quality of care being delivered.

Recommendation 2:
NHS GGC and NHS Lanarkshire along with relevant HSCP partners need to agree a plan and set a date for the handover of the North Lanarkshire corridor to NHS Lanarkshire as a priority.

Service response to recommendations

The Commission requires a response to the recommendation 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 an individual's care, treatment, and support are 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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