mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Aberdeen City Community Learning Disability Team, Len Ironside Centre, Mastrick Drive, Aberdeen, AB16 6UE

Date of visit: 11 and 12 March 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

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, 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.

Aberdeen City Community Learning Disability Team (CLDT) is one of five CLDTs operating in the Grampian area and is run by Aberdeen City Health and Social Care Partnership (ACHSCP). Aberdeen is the third largest city in Scotland and has a population of approximately 232,000.

The CLDT provides access to health and social care services for people with a diagnosis of learning disability (LD) and who require a specialist LD service. The team is located in a purpose-built resource centre, which provides office space and also houses a day service, offering meaningful and therapeutic activities for individuals.

We also visited Stoneywood, a new purpose-built complex care project for eight people who had previously been placed out with Aberdeen. Care is delivered in partnership between Aberdeen City Council and ACHSCP, with Richmond Fellowship contracted as the support provider. The project was developed in response to the Scottish Government's Coming Home report of February 2022.

Who we met with

We met with 10 individuals in person and reviewed the care records of 14 people. We also had discussions with five relatives, either on the phone or in person.

We met with three groups of social work/care management staff, nurses and speech and language therapy staff. On an individual basis, we met with the lead psychologist for learning disability and specialist services, an occupational therapist (OT), a nurse, a physiotherapist, a speech and language therapist and a social worker/mental health officer (MHO).

We had a pre-visit meeting and discussions throughout the course of the two-day visit with the service manager for learning disability, the nurse consultant and the lead speech and language therapist. We also had pre-visit meetings with the clinical director for learning disability and the lead officer for community learning disability, mental health and drug and alcohol services.

Commission visitors

Audrey Graham, social work officer

Susan Hynes, nursing officer

Susan Tait, nursing officer

Gordon McNellis, nursing officer

Dr Juliet Brock, medical officer

What people told us and what we found

Care, treatment, support, and participation

We heard a range of views from the people we met about input from the team. A theme that came through strongly was of staff taking a person-centred approach. One person told us, “It’s been really good, they think about all of me”. A relative told us, “they’re aware our situation is unique”.

Most individuals and relatives that we spoke to felt listened to and understood; one told us, “I’ve felt involved and listened to. He understands our anxieties”. Another said, “He listens and he’s very approachable”. A relative told us of the kindness and empathy they had received from a team member.

One person told us that they had not felt involved all the time. Their care manager was aware that this was an issue and offered assurance that they were doing all that they could to address it.

We heard about staff taking a holistic view and seeing the individual in their immediate environment and as part of a family and a community. A staff member told us, “you go in for one thing, and you begin to see all the needs”. We heard about the positive impact for all of the family when receiving support from the team. A relative told us, “We’ve been close to burnout. The team have been such a help; they’ve helped us see there’s a lot more out there that’s accessible”.

The skilful linking of individuals to resources in their community was another theme that was repeatedly identified. We heard about liaison taking place to progress individual outcomes, with a range of resources and services such as housing providers and various charities. One family member told us, “They go out of their way to find solutions”.

We heard about team members valuing the views of individuals and families as experts in their own lives. An example given was where one member of staff talked about what was important for the person to communicate; “If I suggest something and you know it’s not going to work, please tell me, you’re the one living the life”.

We were interested to hear about efforts made to enable one person to optimise communication using PCEye technology, (eye gaze software to access a communication aid). We were told that there were indications the individual would be able to express a lot more than had been thought. We found this to be an excellent example of empowerment and person-centred practice.

Staff talked about how they valued the relationships built with individuals and families over time and the importance of that relational approach to their work. We heard about the importance of continuity of care in the team and of taking a flexible approach, for example in continuing to link and support individuals when they were

admitted to hospital. One person told us, “My community nurse looks after me when I go into hospital too”. We heard from several staff about positive links with the staff in the two learning disability wards, Loirston and Strathbeg, in the Royal Cornhill Hospital in Aberdeen.

Some concerns that were raised with us were when we heard a relative’s concerns about financial pressures that had driven decision-making about the choice of care home by social work managers for their family member. The placement had broken down, and the experience was described as traumatic for the individual and family.

We also heard from staff about the challenges of working in a public service that faced significant budget constraints. Funding for support was only being authorised for emergency and critical level needs, with no option to fund needs not meeting this threshold. There were concerns expressed about the longer-term impact of significant cuts in individual support packages of social support hours, including increasing experiences of loneliness, social isolation and associated mental health issues. Concerns were expressed about the wellbeing of staff having to implement cuts in support packages.

While we heard about significant challenges faced by the team, we also heard of a commitment to quality improvement work. We were interested to hear about work to improve pathways relating to the assessment of capacity and in transitions from child to adult services. We heard about the development of the complex risk assessment group (CRAG) and about a potential project to support care homes to accommodate older people with learning disability.

We heard about future planning around the care and accommodation needs for an aging and increasingly complex group of individuals with learning disabilities in the context of a commitment to the ‘Coming Home’ agenda. We were pleased to hear about the broad range of improvement work that was being undertaken.

Care records

There were two different electronic record management systems used in the CLDT. Health professionals used TRAKCare but completed most of their recording on word documents and uploaded these to C-Cube which was linked to TRAKCare. The care management professionals used the D-365 system which we found was relatively straightforward to use.

We found it difficult to navigate C-Cube and to locate the information we wanted to review. We were concerned about possible delays in staff uploading information to C-Cube and the inherent risk with the challenge in finding pertinent information quickly, for example, in a crisis where someone needed to be admitted to hospital. We were given assurance about arrangements in any such crisis.

We were told that TRAKCare had only been rolled out to learning disability services in March 2025 and that work to improve the functionality of the system for individual services was active. We would support efforts to achieve this.

We found that language in the care records that we reviewed was person-centred and non-judgemental. Care records and assessments were well articulated and of a high standard.

In most of the records reviewed, care plans were of a good standard and evidenced involvement of the individual and their relatives or guardian.

Risk assessments and positive behaviour support plans reviewed with the Stoneywood service were robust.

Care programming approach (CPA) is a multidisciplinary framework used to provide structured care for individuals with complex mental health issues, particularly those requiring multiple services. The framework enables co-ordinated and robust assessment, planning, care management and review. We heard that CPA worked well as an approach to reviewing individuals with more complex needs and risks, but that co-ordinating and documenting the meetings for CPA could be challenging as there was no administrative support; the CPA records we reviewed were detailed and of high quality.

Multidisciplinary team (MDT)
The CLDT consisted of around 50 health, social care and social work professionals including LD nurses, psychologists, OTs, speech and language therapists, physiotherapist, care management professionals, social workers/MHOs and support workers. One full time locum consultant psychiatrist was attached to the team but was generally based at the Royal Cornhill Hospital.

Day service staff were co-located and worked closely with CLDT staff and there were several business support staff on site.

We heard that there was one central point of referral into the team and that all referrals were discussed at a weekly MDT meeting. All professions were represented and discussion took place on what profession would be best to take the referral forward. We were advised that this meeting functioned well.

We heard about how the MDT had worked closely, with support staff at the Stoneywood complex care resource, on assessment and planning of transitions for the individuals who lived there. An enhanced review process had been put in place. All professions had contributed to supporting care staff to achieve the best outcomes for this small group of individuals with the most complex care needs.

Working together in this way had led to individuals being closer to their families, enhancing their right to family life. We heard about examples of greater inclusion in the local community and improved independent living skills in some individuals. We were pleased to hear about the intention of the MDT to continue to support Stoneywood.

Staff talked in overwhelmingly positive terms about MDT working. Comments included “this is the best MDT I’ve ever worked in”. We heard about good relationships across and within professional groups. We were told that staff were open and comfortable about seeking advice from colleagues and in sharing knowledge. Co-location of the various professions was felt to be very helpful.

We were advised that there were low levels of staff sickness, low staff turnover and that many staff had worked in the team for 8-10 years or more. Our impression was of a resilient staff group.

We saw managers who were present and available, working alongside colleagues in the main open plan office. We observed warm and supportive interactions between managers and staff. We heard about managers listening to challenges and the issues raised and who were actively trying to address these. Importantly, we were told about the priority given to one-to-one supervision for staff. We thought that this positive approach to leadership contributed to a healthy and supportive team culture.

We were advised that there had been long term issues recruiting permanent consultant psychiatrists across the Grampian learning disability service, despite regular efforts. On a positive note, there had been good stability with locums in the last number of years. Additionally, consultant monies had been used to beneficial effect to pay for advanced nurse practitioners (ANPs) and additional in-patient psychology time.

Psychiatry offered clinic based or virtual appointments rather than home visits to achieve a more effective use of limited clinical time. No one that we spoke to raised any issues about the accessibility of psychiatric reviews.

We were advised that there was no specialist learning disability forensic team and that these individuals were supported in the CLDT. We wanted to explore the impact of this further with managers and staff.

Overall, the view was that this was the right model of service provision. Individuals with forensic issues were at times allocated to staff with particular skills and experience but staff across the whole team had opportunity to develop knowledge and competency in the area. The clinical director for LD was a forensic specialist and there was a specialist forensic psychologist to support the team. Additionally, staff were supported in terms of complex risk management by the recently developed

CRAG. This was described as a supportive and well-used forum where staff would attend to present particular individuals.

We did hear from several members of staff and managers about a gap with a team leader post for health professionals which had existed for some time. This post had previously been in place and was not replaced due to budget constraints. We heard that while other managers had willingly covered some of the gaps left by the vacancy, there was some concern about the fatigue and stress that this may lead to.

In exploring the impact of this gap, which also included concerns from staff, we heard that there was a lack of parity with other Grampian CLDTs and a lack of representation for the city team at the Grampian-wide managers forum. There was some concern about lost opportunities to learn from others afforded by such forums and a lack of capacity to take developments forward. We thought that senior managers should review their position and consider recruiting to a health team leader post.

Recommendation 1:
Senior managers should consider appointing a health team leader to the team, commensurate with other Grampian CLDTs to provide additional leadership and managerial support to the team.

Use of mental health and incapacity legislation

Team managers and the clinical director confirmed that no-one supported by the team was subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003 (Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act) at the time of our visit; we wanted to explore this further.

We were advised that treatment related to mental health was in general, a small part of what individuals needed and that the Adults with Incapacity (Scotland) Act, 2000 (AWI Act) provided the more appropriate legal framework for delivery of health, care and support services.

We discussed the issue with the clinical director and one of the MHOs in the team. We were reassured that regular discussions took place, on whether use of the Mental Health Act was necessary in specific individual situations, to safeguard rights and provide lawful authority for treatment.

We were told that 442 individuals supported by the team had a private guardian or a local authority guardianship under the AWI Act was in place. Discussion with the care management team evidenced that they were clear on their supervisory responsibilities in respect of private guardians and their delegated officer responsibilities relating to local authority guardianships. Staff advised that current

guardianship numbers and the year-on-year increase was posing significant challenges in terms of fulfilling statutory duties.

We heard from senior managers that there was a waiting list in Aberdeen City for the allocation of an MHO to complete guardianship suitability reports and that 40 out of the 55 people on the waiting list were individuals with learning disability. Service managers were actively considering options for managing demand on the CLDT with an example given of looking at capacity in other social work teams to assist and by using winter monies to commission additional MHO hours.

We were pleased to see a practice of recording delegation of guardianship powers, evidenced in the records reviewed. We did note that two out of the eight people living at Stoneywood did not have a record of which powers were delegated to staff in their care records and this was addressed on the day.

We noted that two individuals had restrictive care plans in place which were appropriate to their needs and risks. However, we were concerned to note that these restrictions were not fully authorised by the guardianship powers in place. We acknowledged that this had been discussed with the respective private guardians and that the team would offer support to ensure applications to vary powers were progressed.

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 heard from the clinical director that GPs prescribe all medication and have responsibility for completing section 47 certificates. We could not locate copies in the care management or health recording systems. We thought that it would be important for these to be available for staff given their involvement in assessing, managing and reviewing complex care packages.

In addition, we could not locate copies of guardianship paperwork in the health records system and would recommend that this is rectified. It is important that health professionals are aware of the specific powers held by proxy decision makers in respect of the individuals they support, to assure them that care and treatment plans are lawfully authorised.

Recommendation 2:
Managers should ensure that copies of all relevant AWI Act paperwork are held in health and care management recording systems to support informed, person-centred and lawful care and treatment.

We heard that there was a relatively new centralised adult protection social work team and that all concerns potentially requiring investigation under the Adult (Support and Protection) (Scotland) Act, 2007 (ASP Act) went to this team for initial screening, which was working well. All care managers were trained as council officers and there were seven active ASP cases being managed by the team when we visited. We heard that there was a positive culture of peer support and discussion of situations requiring potential investigation and intervention under the ASP Act.

Rights and restrictions

We heard from most that we spoke with, and in the records we reviewed, about the involvement of advocacy in people's lives in different ways, past and present.

In the guardianship review documentation that we saw, there was evidence of adherence to the AWI Act principles. Reviews were thorough and included consideration of the continued necessity of each power.

In the care records reviewed at Stoneywood, we identified good use of social stories and positive behaviour support plans, with interventions which often reduced the need for restrictive interventions.

For the two care plans that included restrictive practice but needed additional powers, we were satisfied that the service was actively working to address the gaps with the guardians involved, and we will follow up on progress and outcomes.

Activity and occupation

We heard about close links between the CLDT and the day service in the Len Ironside Centre. Many individuals supported by the team attended regular activities there. We heard from managers about a "one team identity", which included joint celebrations of 'learning disability awareness week' "right in the heart of the city", with all staff coming together for staff well-being events, celebrations of seasonal events, as well as joint review of individuals' support and activity provision.

We heard about a full, diverse and imaginative range of activities in the day centre. These included a Makaton choir and a drama group, gardening, sports days, computing, inclusive cycling, arts and crafts, relaxation therapies and pampering groups, a tuck shop run by individuals, visits from a therapet and from various local entertainers.

Individuals enjoyed trips to the local swimming pool, library, pub, shops and the community centre as well as outings further afield, for example, to see the Tall Ships and to do the maritime mini trail.

It was good to hear accounts of people having fun, learning new skills and building confidence through meaningful activity.

We were pleased to hear about efforts to open the centre up to community groups and to connect individuals to their local community. We thought the team was making a valuable contribution towards enhancing inclusion and addressing the stigma and discrimination experienced by individuals with learning disability.

On the visit to individuals living at the Stoneywood service, we were pleased to see excellent emphasis on developing skills though meaningful activity and a focus on supporting people to access resources in the community.

The physical environment

The centre was purpose built in 2017 and consisted of a business centre accommodating the CLDT and the day service. There was an enclosed garden which was very pleasant and had good quality seating, swings, a summerhouse, birdhouses and planters. The wide paths were designed to accommodate different kinds of accessible bikes and were used by the cycling group. We heard that the garden was valued and used regularly.

Staff advised that they had been consulted through the design process. Many had worked in day centres previously and had valuable views on what had worked there. We heard that the staff group were happy with the design and felt that it was accessible for the individuals they supported, many of whom had complex physical disabilities as well as learning disabilities.

Corridors were wide, with seating at intervals to allow individuals to rest. There was ample storage for the equipment and specific rooms were fitted with tracking to allow for equipment needed for complex personal care.

We heard that the kitchen was designed to be accessible for individuals who were independently mobile as well as those with a range of mobility issues. There was a pleasant café area and lots of artwork and photo galleries from various outings on display.

The business centre area accommodating the CLDT staff consisted of a large, open plan office, with a spacious meeting room and three smaller meeting rooms. There were ample toilet and kitchen facilities. The room was well lit and was a comfortable temperature.

We were pleased to see a staff well-being board and a study room. The centre was clean, bright and spacious and offered a good quality environment for individuals and staff.

Summary of recommendations

Recommendation 1:

Senior managers should consider appointing a health team leader to the team, commensurate with other Grampian CLDTs to provide additional leadership and managerial support to the team.

Recommendation 2:

Managers should ensure that copies of all relevant AWI Act paperwork are held in health and care management recording systems to support informed, person-centred and lawful care and treatment.

Good practice

We were pleased to find out more about the work of the Stoneywood project and to see the partnership working that was taking place between the CLDT and the Richmond Fellowship which ensured successful transitions and good outcomes for a group of people with the most complex of care needs.

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 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 careers, 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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