Mental Welfare Commission for Scotland

Report on visit to: Wards 5, 6, Boulevard, Bute and Campsie House, Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

Dates of visits: 23 and 24 February 2022

Where we visited

Due to the Covid-19 pandemic, the Commission has had to adapt their local visit programme in accordance with Scottish Government guidance. There have been periods where we have carried out face-to-face visits or virtual visits during the pandemic. We continually review Covid-19 guidance and carry out our visits in a way which is safest for the people we are visiting and our visiting staff. This local visit was carried out face-to-face.

Wards 5, 6, Boulevard, Bute and Campsie House together make up the low secure forensic service for the Greater Glasgow and Clyde Health Board. The wards are based at Leverndale Hospital which is located in the Crookston area of Glasgow. Our visit took place over two days with visits to Wards 5 and 6 on the first day, and Boulevard, Bute and Campsie Wards on the second day.

Ward 5 provide low secure facilities for 15 men. All rooms in Ward 5 are single rooms with en-suite facilities available for all patients.

Ward 6 provide low secure facilities for 15 men. All rooms in Ward 5 are single rooms with en-suite facilities available for all patients.

Boulevard Ward is a nine-bedded male 'pre-discharge' ward. This ward provides en-suite facilities for all patients.

Bute Ward provides a low security female provision for five women. This ward has no en-suite facilities and all patients are required to share toilets and showers.

Campsie Ward is a nine-bedded, male low security ward for forensic patients with a learning disability. This ward has no en-suite facilities and all patients are required to share toilets and showers.

We last visited these wards on 12 and 13 August 2019; we made recommendations for managers to address patient concerns about the location of patient pay phones on Ward 5 and Ward 6 due to lack of privacy. We also highlighted the need to improve aspects of the environment and repairs within Bute and Campsie Ward.

This visit was as part of our regular visits to adult forensic wards where patients are subject to restrictions on their liberty. We wanted to follow up on our previous visit recommendations and to look at general issues important for patient care; treatment, support and participation. Furthermore we aimed to supply patients and their relatives with the opportunity to speak with Commission on the impact of Covid-19 on the provision of care and treatment in the low secure setting.

Who we met with

We met with and reviewed the care and treatment of 22 patients across all the wards that we visited. A number of patients had advocacy support during our discussions. We met with

senior managers of the service, psychiatrists, senior charge nurses for the wards, allied health professionals (AHP) and several nursing staff for each of the wards. There were no approaches from carers for interview in relation to this visit; however from time to time carers for patients at the clinic do contact the Commission for advice. We also met with several workers from the Circles Network advocacy project who provide direct advocacy services to the Leverndale wards.

Commission visitors

Justin McNicholl, Social Work Officer
Yvonne Bennett, Social Work Officer
Kathleen Taylor, Engagement and Participation Officer
Douglas Seath, Nursing Officer
Dr Gordon Skilling, Consultant Psychiatrist

What people told us and what we found

Care, treatment, support and participation

At the time of our visit all the wards were at full capacity with 52 patients admitted across the low secure estate. Since our last visit in 2019, the Covid-19 pandemic remains one of the key factors in terms of impact on the care and treatment for all patients. We heard that the pandemic directly impacted on patient life at the Leverndale Hospital site affecting patients' ability to mix with each other and as well as with their families. This resulted in the reduction of time out of the wards, activities in the wards and the delivery of rehabilitation activities in the community. We were also told that the pandemic had a negative impact on staffing levels. Despite the pandemic however, the wards appear to have managed well in minimising the numbers of those who contracted the virus and the subsequent spread within the wards.

While managing the impact of Covid-19, all wards have been running at full capacity with a waiting list due to the continuing demand for low secure forensic beds. We are aware of a high level of clinical demands from some of the unwell patients on the site, which we observed during our visit. This high level of demand has placed additional pressures on the staffing provision within the hospital, which has resulted in the requirement to employ bank staff to cover shift patterns and maintain safe staffing numbers across the wards. The enduring nature of the pandemic has made life particularly difficult for patients as many of the onsite activities available at Leverndale have stopped.

We were able to speak to patients on the forensic wards, who all reported frustration at the reduction in off-site activities. We heard from some patients that they previously had full days away from the ward reduced to 2-3 hour visits to local community provisions. We heard directly from allied health professional (AHP) staff (occupational therapists and physiotherapists) that a number of in-ward opportunities were developed as a result of Covid-19 and delivered to patients to mitigate the impact on the reduction of community activities. This included a budgeting group, cycling group, digital healthy literacy group and an art group. The hospital café, Acorn project and recreational therapy (RT) unit based in the hospital grounds, which previously provided important rehabilitation opportunities, all remain closed with no expected date of re-opening identified by the service managers. Despite this, patients with unescorted leave spoke positively about not having their time out reduced to access their families and the ability to visit alternative local shops, which has helped to maintain their independence.

Recommendation 1:

Mangers should identify a timescale for the re-opening of previous on-site facilities to aid with patient rehabilitation as a matter of priority.

Patients and staff in all visited wards raised concerns about the difficulties in accessing support workers in the community to enable progression of timely discharges from hospital. We also noted the difficulties in timely access to community supported accommodation, which remains a barrier for individuals who are ready to move into the community. Two examples were supplied of patients waiting over a year for their new supported accommodation properties to be identified or built. Much of the delays in accommodation

have been the result of Covid-19 delays. We heard that as the building work is being completed by a third sector provider, delays are outwith the remit of Glasgow City Council or the Health and Social Care Partnership. However, we were told that the work is almost complete with plans for the patients to move in July/August 2022. We look forward to hearing how this progresses when we next visit.

Generally patients spoke favourably about all staff and the ability to approach them when they need support and guidance. We witnessed in many of the wards clear activity time-tables, which detailed a weekly structure for most patients through the home-style model. The home style model of care works within a recovery based framework; staff and patients work together to ensure that each individual is equipped with the practical skills necessary to allow them the optimal chance of successful rehabilitation - from the long term in-patient forensic setting to an identified community setting. This provides a detailed structure for those patients subject to the programme in Campsie, Bute and Boulevard wards.

Patients on Bute Ward were generally very positive about their care, with the women advising that they felt well supported by ward staff. We heard of the positive aspects of the home-style model in place within this ward, which ensures that patients and staff share responsibilities around cooking, cleaning, ironing, household chores and healthy eating.

A number of patients in all wards highlighted that they were not clear in relation to their progress on the ward or when they could be expected to be discharged from the hospital. They highlighted the lack of a “clear 12 week plan” so they would know what needed to be achieved to enable them to be ready for discharge. These patients also indicated that they felt they were “plodding along” awaiting an indication from their ward team about “when, if ever” they could be discharged from the hospital.

Recommendation 2:

Medical staff should ensure all patients are clear on their in-patient journey and discharge plans.

We heard of a number issues in relation to suitability, layout, noise levels and environment of Campsie House. The issues highlighted related to environmental hazards within the ward due to the cramped conditions which were causing a number of falls experienced by some patients due in part to the ward layout and close proximity that patients find themselves in. It was further noted that there was a lack of quiet space for patients to avoid the levels of noise within the house. We heard there were plans to convert one of the ward bedrooms into a quiet space to support the patients. We heard of one situation where a patient with a series of complex needs who could perhaps be better supported in the community via a 24-hour supported accommodation model. We followed this up separately with the consultant psychiatrist.

Recommendation 3:

Managers and medical staff should regularly review the suitability of all patients placed in Campsie House to ensure that the ward continues to the meet their needs.

Other issues raised by patients were in relation to their personal issues and appropriate advice and signposting was provided to individuals by the Commission during our visit.

All patients in the wards continue to be managed using the care programme approach (CPA) with the risk assessment forming an essential component of all care plans. We were pleased to see detailed CPA meetings had taken place for patients and we saw evidence of the meetings in patient records. Since Covid-19, CPA meetings are taking place online and not in person. Some patients reported that this format was not helpful for them to express their views and engage with the meeting. The care plans we examined were comprehensive and focused on individual patients, reflecting positive evidence of communication between patients and their relatives as well as with ward staff. The care plans were regularly updated.

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/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

We were pleased to see notes of regular multidisciplinary team meetings (MDT) in the patient records on all of the wards we visited. In general, we noted good multidisciplinary input into patient care. We observed that patients had good support from occupational therapists, physiotherapists and in some cases, psychology input. However, we also saw gaps in the completion of the MDT forms, where several lacked clarity of whether the patient was present for the meetings or if the patient had any views which could be recorded on the forms. We found many of the MDT forms were left blank in relation to patient views. The Commission recommends a review of this process to ensure that patients are included and their views are recorded, including a record of the patients' preference not to provide a view. A consistent approach by all staff is required to ensure that all patients are supplied with access of opportunity to express their views and that this is recorded fully throughout their journey in the wards.

Recommendation 4:

Managers should review recording of MDT meetings to improve consistency and ensure patient participation and views are evident on the forms.

The wards are currently in a transition phase in relation to recording of patient information. We observed that most patient records are now on the electronic EMIS records system, although some records remain in paper from. We found the current record systems to be inconsistent. We were pleased however to find good recording and evidence of advanced statements recorded and highlighted on the EMIS system. In relation to those who had nominated a named person, we found limited evidence of the nomination acceptance for the named person in the patient records.

Recommendation 5:

Mangers should review the records system to improve functionality and ensure that all named person paperwork is consistently recorded across all wards.

We noted weekly GP ward visits for physical health check-ups and regular monitoring for antipsychotic side effects and found good attention being given to patients' physical health care.

Use of mental health and incapacity legislation

All wards, except Boulevard, are locked wards where patients have high levels of restrictions imposed on them. We would expect that all patients on the locked wards should be detained under the Mental Health (Care and Treatment) Scotland Act 2003 or the Criminal Procedures Scotland Act 1995, which was the case for all the patients at the time of our visit.

We found the appropriate legal paperwork in place for the patients we reviewed and the patients we interviewed were clear about their status, as were the staff. We found patients had consent to treatment certificates (T2) and certificate authorising treatment (T3) forms where required, under the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Mental Health Act'). Patients we spoke to have a good knowledge of their legal status and rights; they also had advocacy support and legal representation. We found no issues regarding the required legal paperwork.

Many patients across the wards are subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act'). In relation to the patients' welfare benefits, this means that the NHS has applied for the department of work and pensions (DWP) appointeeship role to manage patients' welfare benefits. We found a small number of patients records where the recording in the ward folders were out of date for those currently subject to appointeeship. From further discussions with staff during our visit, we noted that staff used terms such as "they are on AWI", with a lack of understanding from a variety of nursing staff and managers around what this means in practice and whether this was in reference to a Guardianship Order or Part 4 of the AWI Act. We heard from some staff that they assumed appointeeship/"on AWI' means the NHS are permitted to manage all aspects of the patient monies not just their welfare benefits. This assumption is incorrect we met with managers to discuss this further and will follow up on this issue on future visits.

However, there were also examples of patients who retained capacity but their finances were managed via the AWI process and detailed in the AWI ward folder. Due to this lack of a consistent approach deployed in the wards, we are recommending that training for staff around Part 4 of the AWI Act is considered and the current process is reviewed to ensure that the terminology is improved so that staff and patients are clear and consistent about what powers and provisions are being deployed for patients across all wards who are requiring support under the appointeeship process.

Recommendation 6:

Mangers should review staff training around the use of the different areas of the Adults with Incapacity (Scotland) Act 2000.

Recommendation 7:

Managers should ensure all staff understand and appropriately manage patient funds ensuring consistency for those subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000.

Rights and restrictions

All patients on the wards continue to be individually designated as 'specified persons' in relation to safety and security provisions, under s250 of the Mental Health Act. This has been raised with managers on previous visits and we have been assured that each patient's specification is reviewed on a three monthly basis in line with their individual management plans. Staff are very clear that patients require to be individually designated as specified persons for the protection of patients and staff in these wards.

The patients all have access to advocacy and the wards have consistent input from Circles Advocacy, a specialist forensic advocacy service. As well as individual work they run meetings on the wards to help patients with collective issues. We heard from advocacy that there is a joint project planned to work together with patients to review their advanced statements in the coming months which would ensure that all patients' latest views are recorded and taken into account for their future care and treatment. The Commission advance statement guidance can be located here:

An ongoing issue was noted around the availability of community resources to move on from Leverndale which as highlighted previously in the report is linked with the provision of care providers and supported accommodation.

Activity and occupation

Activity provision initially for patients had been significantly impacted during the pandemic due to restrictions on patients being able to mix, social distancing and staffing pressures. Patients, prior to Covid-19, had many opportunities to attend a wide variety of activities either on the wards, in the grounds and/or in community settings. The reduction in access to activities has not yet returned to pre-pandemic levels. However, we observed that activity provision within wards is now gradually improving, with an increase in projects being supplied directly in the wards by AHP staff. Activities that are currently available appear to be very much based on personal choice and are recovery focused.

The situation in relation to community placements and activities have already been highlighted in this report. This is of significant concern to patients and needs to be kept under review in accordance with the function of the wards and the reciprocity principles of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Recommendation 8:

Mangers should hold regular discussions with commissioners and social work managers in the local Health and Social Care Partnership to improve the provision of community activities for patients.

The physical environment

The physical environment of Ward 5 was found to be generally in good condition and we noted improvements since our last visit. The steps taken to replace flooring in Ward 5 since our last visit continue to help make the ward environment feel comfortable for patients. We heard from the ward management that there are further plans to make repairs to some of the en-suite shower facilities due to general wear and tear. Managers reported plans to secure funding to replace aspects of Ward 5 furnishings during 2022 due to the age of the items. One notable change for Ward 5 since the pandemic is that patients are being permitted more access to their rooms during the day which we noted they appreciated

The physical environment of Ward 6 was found to be generally in good condition. We heard from the ward management that there are plans to repurpose some of the storage rooms in the ward.

However some patients in Wards 5 and 6 highlighted their frustration at being made to sit in the communal lunch room throughout the serving of lunch even if they are not eating the hospital food.

Recommendation 9:

Mangers should address the concerns raised by patients regarding the current restrictions relating to the serving of lunch in Ward 5 and 6.

The physical environment of Boulevard ward was found to be in very good condition with no amendments required.

The physical environment of Bute ward requires noted improvements. In particular each patient has access to single rooms with no en-suite facilities available. Each patient is required to access shared showers and toilets. This was highlighted as an issue for the patients within Bute Ward who in particular reported that their dignity and privacy was being affected by the lack of en-suite provision. We heard there are issues on Bute Ward regarding the location and noise from the ward washing machine and laundry room which are close to patient bedrooms. The ward managers advised that staff always ensure that the laundry room have set times when they can be used to minimise the noise for patients close to these room.

The physical environment of Campsie ward requires noted improvements. The ward has only single rooms available with patients having no access to en-suite facilities. This was highlighted as an issue for the patients who reported that they were required to live in close proximity with fellow patients which resulted in excessive noise levels. They further reported that was not a comfortable ward to reside in. There were further concerns raised by staff regarding the safety of Campsie ward. In particular staff highlighted concerns regarding the safety of patients who were prone to falling in this environment. As the corridors of the ward are narrow the mobility of both patients and staff can be compromised when undertaking activities of daily living. Due to this finding we are recommending that the Campsie ward is reviewed to consider all reasonable adjustments for the safety of patients and staff.

We were able to observe the family visiting facilities at the Boulevard ward which is utilised for any patient having contact with their children. This was a warm and comfortable room

which was patient centred and provides privacy for those using the facility. Some visitors to Ward 5 and 6 tend to utilise the communal dining area for contact, which on occasion has been shared with fellow patients which we believe can have an impact on their privacy. We would expect managers to consider alternative arrangements for visits to Ward 5 and 6 to minimise any breaches of confidentiality for patients.

Any other comments

Food. The issue of food was raised by patients in Ward 5 and 6 on this visit. We heard the menu is too static and there is not enough variation in the options if you are in the hospital for many years. For those patients with significant restrictions they have little in the way of alternative to what the hospital provides.

Recommendation 10:

Managers should continue address patient concerns with regard to the food on offer in Wards 5 and 6.

Summary of recommendations

1. Mangers should identify a timescale for the re-opening of previous on-site facilities to aid with patient rehabilitation.

2. Medical staff should ensure all patients are clear on their in-patient journey and discharge plans.

3. Managers and medical staff should regularly review the suitability of all patients placed in Campsie House to ensure that the ward continues to the meet their needs.

4. Managers should review recording of MDT meetings to improve consistency and ensure patient participation and views are evident on the forms.

5. Mangers should review the records system to improve functionality and ensure that all Named Person paperwork is consistently recorded across all wards.

6. Mangers should review staff training around the use of the different areas of the Adults with Incapacity (Scotland) Act 2000.

7. Managers should ensure all staff understand and appropriately manage patient funds ensuring consistency for those subject to Part 4 of the Adults with Incapacity (Scotland) Act 2000.

8. Mangers should hold regular discussions with commissioners and Social Work Managers in the local Health and Social Care Partnership to improve the provision of community activities for patients.

9. Mangers should address the concerns raised by patients regarding the current restrictions relating to the serving of lunch in Ward 5 and 6.

10. Managers should continue address patient concerns with regard to the food on offer in Wards 5 and 6.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

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

Suzanne McGuinness
Executive Director (Social Work)

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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