Mental Welfare Commission for Scotland

Report on announced visit to:
Arran, Iona, Lewis and Mull Hubs, The State Hospital
110 Lampits Road, Carstairs, Lanark, ML11 8RP

Dates of visits: 20 September 2022 and 14 October 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.

The State Hospital is the national high secure forensic hospital for patients from Scotland and Northern Ireland. The State Hospital provides a service to patients admitted under The Mental Health (Care and Treatment) (Scotland) Act 2003 and Criminal Procedure (Scotland) Act 1995. Patients in the State Hospital are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings.

The Commission visits the State Hospital a minimum of once per year to give patients, their relatives and staff an opportunity to speak with us. The hospital comprises of four units (hubs) with either two or three wards in each. We last visited Iona and Lewis hubs on 18 August 2020 and Arran and Mull hubs on 21 November 2021.

On the day of these visits we wanted to give patients an opportunity to speak with us regarding their care and treatment. We also wanted to follow up on the issues identified from previous visits, on matters that had been brought to our attention since the last visits. We wanted to ensure that care and treatment was being provided in line with mental health legislation and within a human rights compliant model.

On our last visit to Iona and Lewis Hubs we made no recommendations and on our last visit to Arran and Mull Hubs we made recommendations regarding the difficulties recruiting and retaining staff and the importance of reviewing the ongoing need for the additional Covid-19 pandemic restrictions that had been put in place.

The hubs at the State hospital previously consisted of three wards each with 12 single en-suite bedrooms. At the time of these visits one ward on each of Arran and Mull hubs was closed, pending a review of the clinical care model. On the day of our first visit we met with patients in wards Arran 1 and 2, Mull 1 and 2, Lewis 1, 2 and 3 and Iona 1 and 3. These wards comprised of an admission ward, rehabilitation, transition and continuing care wards. Iona 2 is the identified intellectual disability (ID) ward, however these patients were transferred into Arran 3 and there were also some patients from the ID service based in some of the other wards. The ID service was being redesigned to best meet the needs of this complex patient group. We therefore decided to visit this service (Iona 2) separately on 14 October.

At the time of our visits there were 111 patients in the hospital. All patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) or the Criminal Procedures (Scotland) Act 1995 (Criminal Procedures Act), as would be expected in a high secure facility.

Who we met with

Prior to the visit, we held virtual meetings with the director of nursing and operations, the senior charge nurses, charge nurses, professional nurse advisor, lead nurses, the person centred improvement lead, and the advocacy manager.

On the day of the visits we met with most of the above again and also with the social work manager, with nursing staff on each of the wards we visited and with the person centred improvement advisor.

Over the two visits we met with and reviewed the care of 36 patients who had requested to meet with us and we spoke with three sets of relatives.

Commission visitors

Lesley Paterson, senior manager (practitioners)
Claire Lamza, executive director (nursing)
Margo Fyfe, senior manager (practitioners)
Douglas Seath, nursing officer
Anne Buchanan, nursing officer
Gillian Gibson, nursing officer
Justin McNicholl, social work officer
Paula John, social work officer
Graham Morgan, engagement and participation officer (lived experience)
Kathleen Taylor, engagement and participation officer (carers)

What people told us and what we found

Care, treatment, support and participation

We heard from those that we spoke with that they found that staff attitudes have improved over the years, and that where historically, they had been more negative, many patients told us that they found staff to be much more approachable and praised them for their interactions with patients. Many patients told us that they felt safe in the hospital. Some patients spoke of the 'power imbalance' between patients and staff and in particular the fact that staff could decide if patients were to be locked in their rooms, however patients could not make this decision, if they did indeed wish to remain in their rooms on a particular day.

Feedback from relatives

The feedback we received from relatives varied. We heard positive feedback from one set of relatives who were very complimentary about the care and treatment their family member had received whilst in the State Hospital. However, we did hear of other concerns from another set of relatives who highlighted their dissatisfaction with the engagement and communication from the clinical team, along with numerous concerns about their family member's care and treatment, and an overall concern that their family member remained in the hospital. The Commission will follow up on these concerns and liaise with all relevant parties as appropriate.

We were told that the issue of maintaining contact between patients and their families had been a hospital priority throughout the pandemic. Most patients had been able to maintain telephone contact, where appropriate. Early in the pandemic, the Scottish Government Connecting Scotland scheme donated 50 iPads for families to use for virtual video visiting. We heard that most patients and many families had embraced the video visiting option, especially those who lived a significant distance from the hospital. Most in-person visits took place in the family centre. This environment had been commented on favourably by both patients and relatives as being more conducive than visiting in the wards, however visits could still take place on the wards, if required. There were plans to restart the carer support group, which had been paused during the Covid-19 pandemic.

Care records

Information on patients' care and treatment was held on the fully integrated electronic patient record system, Rio. We found this to be responsive, easy to navigate and allowed all professionals to record their clinical contact in one place. Care records were detailed and comprehensive. The Hospital Electronic Prescribing Medicines Administration (HEPMA) system was in place across all wards.

Care plans

When we last visited the service we found examples of detailed and person-centred care plans which addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual. We found the same on this occasion, with comprehensive, person-centred care plans that evidenced patient involvement; we were pleased to find easy read versions of the care plans which were used in patient discussions, where required. Patients we spoke with told us they felt involved in their care and treatment and it was positive to see discharge care plans in place, where appropriate, and there was

evidence of regular review. We also found detailed information contained in patient's one-to-one discussions with their named nurse.

Patients at the State Hospital have their care and progress managed using the enhanced Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment, with a particular focus on planning the provision of care and treatment by involvement of a range of different people and by keeping the individual and their recovery at the centre. CPA documentation was detailed and available for each patient we reviewed

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

We saw that physical health care needs were being addressed and followed up appropriately and relevant physical health monitoring was in place. We heard about a small cohort of patients who had an increased level of physical health needs and these were being provided with enhanced dementia and palliative care. We were told that nursing staff continued to receive all training required to meet the complex physical health needs of their patients.

Risk assessment

Risk assessment and risk management is an essential component of patient care and treatment within the State Hospital. We were pleased to find detailed risk assessments and robust risk management plans in place for all patients whom we reviewed. All professionals involved with the patient contributed to the risk assessment and risk management process and there was evidence of regular review.

Multidisciplinary team (MDT)

Each ward had access to a multidisciplinary team (MDT) of nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology and pharmacy staff. It was clear from the thorough MDT meeting notes that all professionals involved in an individual's care and treatment were invited to attend the meetings and provide comprehensive updates on their involvement.

MDT meeting records were detailed and it was clear to see who attended each meeting, as well as the recorded discussions, outcomes and actions. Patients were not always invited to attend their MDT meetings and some told us did not always receive feedback from MDT meetings, which they found frustrating. In some cases we could see no record of the patient's views, or limited evidence of relative or carer involvement at these meetings. Some patients told us that they only saw their consultant psychiatrist on a monthly basis, and they felt this was not frequent enough. However, other patients told us that although they were not always invited to attend, their views were gathered before the meeting and they received feedback afterwards.

Recommendation 1:
Managers should ensure patients and carers have the opportunity to attend or participate in MDT meetings and contribute to discussions and decisions in relation to their ongoing care and treatment. All participation should be recorded in the clinical notes.

There was an acknowledgment that the Covid-19 pandemic had been very challenging, not only for patients, but also for staff. We heard that there had been considerable pressures on staffing. Patients told us of ongoing and frequent situations where reduced levels of staffing (particularly nursing) resulted in some wards regularly being fully or partially 'closed,' resulting in them being locked in their rooms for hours at a time. This also impacted on the availability of therapeutic interactions, ward and therapeutic activities, with patients reporting feelings of uncertainty regarding staffing levels and not knowing how this would impact on a day-to-day basis. We heard from staff that for some of them, staff shortages and high levels of sickness absence were negatively impacting on staff morale. Despite these difficulties, patients generally spoke positively about the hospital staff and acknowledged the fact they were stretched and working extra shifts to help.

We were told of initiatives and strategies which had been put in place during the pandemic, to monitor the frequency and impact of patients spending increased amount of times in their rooms and also to record the activity levels of all patients. This information was shared with clinical teams, meaning that they could respond appropriately and ensure all patients were supported to engage in activity as far as possible. A new recruitment strategy and action plan was approved in June 2022 that intended to meet the organisational objectives of recruiting and retaining staff. Daily workforce meetings were taking place to assess real time staffing for that day and the following one, ensuring all areas had adequate cover and staffing resource could be distributed as required. Further resource meetings were taking place twice per week to plan ahead for the following week. Recruitment drives had taken place and a staff bank had recently been established, comprising of existing and recently retired staff.

Recommendation 2:
Managers should continue with their efforts and initiatives to address the significant staffing difficulties in the hospital to minimise the impact on patient care. The Commission requires to be kept updated on progress and any situations of serious concern.

Participation

We heard about the Patient Participation Group (PPG). This was a patient-lead initiative where a group of patients met weekly to consider any issues, concerns or suggestions they had. There was a patient representative from each ward and the PPG chair was elected by their peers. The PPG group had recognised that some patients arrived with very little in the way of clothing, so had started a charity shop in the family centre that had many donations and was due to open in late 2022. Patients will be able to volunteer for various roles in this enterprise, which will provide an opportunity to develop valuable skills for them to use in their ongoing rehabilitation. The PPG also set up a television hire purchase system for those who for whatever reason, did not have their own television. Over the past three years, 41 patients have benefited from this, being able to hire a television for £2 per week. All profits from any PPG venture remained with the group, for them to decide how best to spend it, to provide maximum benefit for patients. The PPG also regularly liaise with hotel services to discuss menu planning, and with senior management to escalate concerns as necessary. They also arranged weekly themed nights, which have proven to be popular.

Regular community meetings took place on each ward. These were minuted and allowed all patients to discuss issues and make suggestions that related to their particular clinical area. There were also suggestion boxes for patients to leave comments.

Use of mental health and incapacity legislation

Patients we saw were all detained under either the Criminal Procedure Act or the Mental Health Act. All legal documentation pertaining to these Acts was accessible in the patient records.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required, and in almost all cases, corresponded to the medication being prescribed. We did pick up on a couple of minor issues with these certificates, however this was fed back to staff on the day and we were given assurances these would be immediately rectified.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) 2000 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 required, section 47 consent to treatment certificates were in order along with accompanying care plans.

Rights and restrictions

At the time of our visit all patients we reviewed were legally detained, had access to legal representation and to an on-site advocacy service. Patients reported to us that they found the advocacy service to be very helpful, responsive to their needs and described it as "great", "fantastic" and "brilliant".

We met with the advocacy service and heard that it was a well-used and valued service and of the 111 patients in the State Hospital, 108 of them have regular input from the advocacy service, with the other three only having contact at the time of case reviews. We heard that some of the common themes patients raised with advocacy were around lack of activities, too few staff and concerns regarding the attitudes of some staff. We were told that all of the issues patients raised were discussed with and escalated to senior managers as appropriate, with advocacy commenting that managers have seemed receptive to addressing these issues. We were also told that the complaints procedure had been reviewed, meaning that patients were able to submit complaints anonymously, which had been welcomed by the patient cohort. Advocacy continued to work closely with the complaints officer, liaise with senior members of staff and also input into the induction programme for new staff.

One particular area of concern were issues around accessing translators for patients whose first language was not English. If translators were not readily available, this could be a barrier to safe, effective patient care and result in an inequality of care. Under s261 of the mental

health act, health boards have a duty to provide assistance with communication difficulties and managers should ensure that where a patient has particular communication needs these are addressed within a care plan to ensure there is consistency of approach and adequate input from an interpreter. This matter will be further explored and followed up with senior managers.

When we are reviewing patient files we looked for copies of advance statements. The term 'advance statement' refers to written statements made under ss274 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. Where patients had opted to make advance statements, we were able to view copies in the care records.

As patients in the State Hospital are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings, the Commission has frequently highlighted the significant difficulties with regard to 'patient flow' across the forensic estate. The recent Covid-19 pandemic exacerbated an already problematic situation and attempts to manage Covid-19 risks between hospitals had resulted in some patients who should be moving to lower levels of security having their moves delayed. This issue had been the focus of high level discussion in the forensic services, along with the Commission and Scottish Government. However, it would appear that as restrictions have eased, patient flow across the estate had improved from what it was earlier in the Covid-19 pandemic.

That said, the situation of patients in the hospital awaiting moves to lower levels of security remains an issue which continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission continue to highlight the legal challenge these patients face and produced *Appeals against detentions in conditions of excessive security* good practice guidance which can be found here: https://www.mwcscot.org.uk/node/1674

At the time of our visit, the Commission was aware of thirteen patients at the hospital who had had successful excessive security appeals and were awaiting moves to medium secure hospitals; seven of these to Rowanbank Clinic in Glasgow, four of these to the Orchard Clinic in Edinburgh and two who had no medium secure provision yet identified. There were six patients who had been accepted for transfer to lower conditions of security and had been placed on waiting lists (four for Rowanbank, one for the Orchard Clinic and one for Rohallion Clinic in Perth). There was also a patient who had been identified as suitable for transfer back to prison and a further two who had been referred to medium secure facilities some time previously, however were awaiting assessment. Lastly, there were two patients who were being held in The State Hospital under the 'exceptional circumstances' clause, meaning that they had been admitted to the State Hospital only as there were no lower security option available at the time of their admission. Some of the patients we met with during our visit voiced their frustrations regarding this, especially the ones who had 'won their appeal', but they were still in the State Hospital a number of months later. The Commission is concerned that the rights of these patients to move to lower levels of security are not being met. The Commission is involved in national discussion to address these concerns as well as receiving regular updates on their progress and plans to transfer to medium secure and other services. We continue to follow up on individual patient cases, as appropriate.

The paucity of beds in medium and low security forensic services across Scotland has been the focus of the Scottish Government for some time. To this end, they commissioned an *Independent Review into the Delivery of Forensic Mental Health Services in Scotland*; the *What people told us* report, which was published in August 2020. The recommendations of this report are still under consideration and the Commission will continue to monitor and contribute to this ongoing work.

The Commission has developed *Rights in Mind*. This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Prior to the Covid-19 pandemic, patients at the State Hospital generally had access to a good range of recreational and therapeutic activities, particularly through the Skye Centre. However activity provision at the hospital was severely impacted during the Covid-19 pandemic. This was initially primarily due to the need to prevent patients from mixing and more latterly due to the continuing depleted staffing levels. Despite the Skye Centre being open, ongoing staffing pressures had meant that some activities have continued to be cancelled, as staff were required to cover the wards. Ongoing efforts however had been made to engage patients in a range of both on and off ward activities as much as possible. Some patients told us that although activities were available, there was not always the staff to facilitate, although most acknowledged that the majority of staff always tried to go the extra mile to facilitate activity as far as was possible.

While patients appreciated the importance of physical activity, some were unhappy as they felt that this was promoted above all else, meaning that this had an impact on open university sessions, learning and education and arts and crafts, with some patients reporting that if you were not interested in attending the gym, then you can end up spending the majority of each day engaging in no activity at all.

Despite hearing that some activities continued to be cancelled, most of the patients we saw were still engaged in a range of off-ward activities and interventions which were clearly documented in their records. Some of the documented activities included literacy and numeracy classes, couch to 5K fitness event, table tennis, arts and crafts, jigsaws, bingo and board games.

The physical environment

The physical environment of the four hubs was unchanged from our previous visits. These purpose built units were fit for purpose with single en suite rooms, access to secure garden areas and appropriate areas to nurse patients safely and securely. Each hub had an activity area which allowed wards to share a range of facilities including day spaces, group treatment/therapy facilities and multi-function spaces. All wards had domestic kitchens and laundry areas that supported patients in maintaining and developing activities of daily living skills. On a previous visit we heard that some patients were frustrated of only having one Sky TV box per hub, which meant each ward in that hub had to watch the same channel at any particular time. We were pleased to hear that a resolution to this had now been found.

The family centre

The family centre was situated in the grounds of the hospital and almost all visiting had taken place here since it was restarted after lockdown. Some visiting took place on the wards, if clinical reasons or strong patient preference dictated. The family centre was bright, welcoming and pleasantly decorated. The atmosphere was calm and relaxed. It had a large spacious lounge area where families could have privacy, as although there was always a member of staff present in the lounge, this felt unobtrusive. There were also board games and jigsaws to provide entertainment and promote engagement for visiting families.

Families and carers reported that they much prefer this to the previous arrangement of visiting taking place primarily on the ward, reporting that the family centre felt more homely, relaxed and provided more privacy for visits. Staff also felt it was beneficial to have this close contact with relatives and felt it enhanced their engagement with relatives and carers.

Any other comments

We heard from senior managers that the current clinical care model was under review. The term 'clinical care model' refers to the way in which the hospital delivers care to its patients. The rationale to develop a new clinical model initially came from a survey carried out with staff in 2018 that identified that staff felt less safe, and would welcome a change in how patient care was organised. There was an acceptance of the need to promote recovery for patients whilst managing risk factors more effectively. The new model of care proposes to be person-centred, and will enable patients to feel a sense of progress through the clinical stages of their treatment journey. The proposed model will takes cognisance of their needs, risk, physical and mental health factors and comprises of four clinical sub-specialty areas:

- Admission and Assessment Wards
- Treatment and Recovery Wards
- Transitions Wards
- Intellectual Disabilities Wards

This work commenced prior to the Covid-19 pandemic, however had to be paused in March 2020, but had now resumed. We have received information regarding proposals for the new model and we look forward to hearing more about this as it progresses.

Summary of recommendations

Recommendation 1:
Managers should ensure patients and carers have the opportunity to attend or participate in MDT meetings and contribute to discussions and decisions in relation to their ongoing care and treatment. All participation should be recorded in the clinical notes.

Recommendation 2:
Managers should continue with their efforts and initiatives to address the significant staffing difficulties in the hospital to minimise the impact on patient care. The Commission requires to be kept updated on progress and any situations of serious concern.

Good practice

We heard about the recent initiatives to promote staff support and wellbeing, as well as a push to reinstate formal clinical supervision and also a focus on ward specific multidisciplinary reflective practice, which would be supported by a psychodynamic psychotherapist. We were told that Peer Support training was to be delivered to State Hospital staff in conjunction with NHS Lanarkshire. Trained peer supporters come from a range of disciplines and provide a confidential and non-judgemental service to colleagues. Peer support is an early support for staff with access to early intervention, additional support and signposting and provides a safe space for staff to share and reflect on experiences, identify sources of strength, and build resilience.

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.

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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