Mental Welfare Commission for Scotland

Report on announced visit to:

Community Mental Health Team, North Carbrain Road, Cumbernauld, G67 1BJ

Date of visit: 22 August 2023

Where we visited

The Commission visits people wherever they are receiving care and treatment. Often this is in hospital, but it might be in their own home, or a care home or local community setting. With the shift in the balance of care, that is, delivery of mental healthcare in the community, rather than in mental health inpatient wards and units, the Commission's visiting programme has 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.

The Community Mental Health Team (CMHT) that covers the area of Cumbernauld and the surrounding district is part of NHS Lanarkshire Mental Health Service. Individuals between the ages of 18 and 65 can access the CMHT, although there can be some exceptions to this age range, dependent on which service is best placed to provide support.

There is a plan to take over the community support of individuals from the northern corridor in the near future. The northern corridor is the area on the boundary between Lanarkshire and Glasgow covering Stepps, Chryston, Muirhead, Gartcosh, Glenboig, and Moodiesburn. These areas, along with Rutherglen, Cambuslang and areas near Carmunnock will transfer to NHS Lanarkshire from NHS Greater Glasgow and Clyde to link with the local authority areas. Currently this area sits within the NHS Greater Glasgow and Clyde (NHS GGC) catchment area. The plan is for the responsible medical officer (RMO) responsibility to remain in NHS GGC, but the community psychiatric nurse (CPN) provision will be from the Cumbernauld team. We are very concerned about how this will be managed between the two health boards.

Currently there are 1075 individuals who have open access to the team. Most of these are open to psychiatry, although there were a number of individuals open only to nursing and a smaller number open only to occupational therapy. There were also a number of individuals that the CPNs supported on a "duty" basis. We noted that some people did not appear to have active involvement and some persons had died but were still noted as active on the system.

Who we met with

On the day of our visit, we met with two people who were attending for support from the service, and we joined the arts and crafts group, which had five attendees. We reviewed the care notes of nine people.

We spoke with the charge nurse and other members of the team. We spoke for a short time with the nurse team leader who was unable to attend until later in the afternoon.

In addition, we met with one of the occupational therapists.

Commission visitors

Anne Craig, social work officer

Susan Hynes, nursing officer

Lesley Paterson, senior manager

What people told us and what we found

Care, treatment, support, and participation

Care notes

We reviewed individual care plans on the electronic system, Morse. We saw care plans, some of which were created at the point of initial contact with the service, but we were unable to locate any reviews that detailed an individual's progress throughout their contact with the service. We found that care plans were generic and did not show individual or person-centred information that we would have expected to see, especially for those who were receiving treatments such as depot and clozapine medication.

The care plans were not evaluated or updated. There was little evidence of individual involvement in them. We asked about care plan evaluation and reviews; we were advised that, with few exceptions, these were not generally completed. As there was no evidence of ongoing care plan reviews for people we would recommend urgent implementation of care planning, reviews, and regular audit of those care plans and reviews.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should ensure that the quality of care plans is urgently reviewed and audited on a regular basis.

Recommendation 2:
Managers should ensure that nursing staff include summative evaluations in individual care plans that clearly indicate the effectiveness of the interventions being carried out and any required changes to meet care goals.

On some occasions we could not tell from Morse whether the person was receiving any active support from the team. Continuation notes were empty, and no activity had been recorded. This led to the Commission visitors querying whether individuals were active cases on the caseload of the team. It was unclear what the procedure was for closure of an individual's care from the workload, and when cases would no longer be deemed as active.

We saw good recording in relation to signposting to other agencies, even when the input from the team continued.

We saw some meaningful and detailed risk assessments. However, two of the risk assessments did not include self-neglect but this was clearly present in the descriptions of the individual's histories and living conditions. We did not see any evidence of crisis plans on Morse, or on any of the other paper notes we reviewed.

We asked about a policy for regular assessment of an individual's physical health care, with regards to psychotropic monitoring. We were told that there was nothing "hard and fast" in relation to assessing physical health care but the standard for this is an annual check that should be undertaken. We were told that the GPs held the budget for annual health reviews

but if there are concerns from the team around physical health care, they would refer to the GP for a review. We saw no evidence to confirm that physical health care needs were being addressed and followed up appropriately with an ongoing referral to other agencies that were more appropriate to caring for an individual's physical symptomology. We were unable to locate a physical healthcare policy.

It was positive to see that in many of the notes, where there was a concern around acquired brain injury, a fast alcohol screening test had been undertaken at an early stage of the contact with the team.

Multi-disciplinary team (MDT)

The MDT consisted of three consultant psychiatrists, nurses, occupational therapy, psychology, and a dedicated social worker. A link nurse from the GP service also attended the MDT on a monthly basis. The inpatient mental health ward for people from Cumbernauld and this district is Ward 2 at Wishaw General Hospital, and we saw robust links between the team and the ward in respect of inpatient activity. Due to the number of people linked with the team, a full multi-disciplinary team meeting for each person could not be undertaken on a regular basis but the consultant psychiatrist who undertook the role of responsible medical officer (RMO) met with them on a one-to-one basis and uploaded details of the appointment on Morse. On occasion, if the consultant psychiatrist/RMO thought that it would be more beneficial for an individual to have support from the nursing team, a CPN would join the one-to-one meeting. If an individual's mental health was concerning to the MDT, further discussion about support options took place. We found no evidence of the MDT template being used to record the MDT meeting and no minimum standard to ensure that all individuals were discussed at an MDT meeting and no minimum frequency defined.

Recommendation 3:
Managers should ensure that there is robust recording of one-to-one meetings with the individual and the RMO, in the clinical notes to inform multi-disciplinary decision making.

The nursing team consisted of a senior charge nurse, 5 charge nurses, 6 staff nurses and one health care support worker. The team complement was 19, however at the time of our visit, there were seven vacant posts (5 staff nurses and 2 health care support workers). There was acknowledgment that staff who were newly qualified could choose their preferred area of work and the team made every effort to make working in the community an attractive option. The team also supported student nurse placements of between six and 12 weeks, which has positively resulted in permanent posts for newly qualified nurses.

Nursing staff provide an extended hours service. This runs until 6.30pm from Monday to Friday and from 8.30am to 4.30pm on a Saturday and Sunday. The team also provided staff to cover the crisis service in Lanarkshire that operates out of hours from 4.30pm until 8.30am every evening and weekend. If an individual had contact with the crisis team out of hours, the information on any activity would be passed on to the CMHT the morning after the contact.

Workload and supervision

We found the referral processes to the team robust. There was a referral form that was electronically sent to the team. Each day there was a dedicated duty practitioner who screened and triaged all new referrals and where necessary, contact was made with the referrer to advise them of any actions that were required, e.g. downgrade an urgent referral to routine, or

signposting to another service. There was a multi-disciplinary meeting on a Thursday every week where new referrals to the team were discussed and allocated. Response time was noted to be around two to three weeks. On the day of our visit, the allocations folder had 15 new referrals for discussion at the MDT next day. A significant number were for support with low mood and anxiety, or seeking ongoing referral to psychological services. We were advised that waiting times for psychological services was currently around 10 months.

The caseloads for each team member varied between 20 and 40 individuals. Depending on acuity levels, contact could range from single appointments to more regular contacts for those individuals who had severe and enduring mental disorder. The team provided care and support for individuals with a range of mental health diagnoses, and they also supported those who had co-occurring mental health condition and problem substance use. These individuals were also supported by the Alcohol and Drug Recovery Service and this service is co-located with the mental health team. On the day of our visit, a definitive number of individuals with co-occurring mental health condition and problem substance use could not be provided, although we were later advised of the exact number.

We asked about people who did not attend appointments and how the team responded. We were told that response to individuals who did not attend was considered on a case-by-case basis. Some are sent an alternative appointment that was posted to them, but where there were concerns or risk had been raised, another appointment could be hand delivered by a member of the team.

The team also provided information in relation to activity for those who were required to attend a clinic for the administration of clozapine and for lithium blood monitoring. We felt that the clozapine clinic was well established and well organised, with paperwork that had been developed specifically for use in this clinic. The clozapine clinic had a robust monitoring system in place for physical health checks, in relation to the prescription of, and side effects of this medication. There were also individuals in the community who required to be visited at home for depot medications.

Formal staff supervision was on a four-to-six-week basis by the line manager. On our visit, we saw evidence of informal support being provided on an ad-hoc basis by the charge nurse. We were advised that in addition to formal supervision, there were regular peer supervision and staff wellbeing sessions in place.

Leadership

On the day of our visit the nurse team leader (NTL) was not able to be present for much of the visit, as they had been called to an admission ward at Wishaw General Hospital. It was unfortunate that the NTL was only able to spend a very short time with the Commission visitors and post-visit follow up had to be undertaken by email contact. We would also have expected to have some contact with the service manager, however, they too were unavailable. The Commission undertakes preparatory meetings, prior to a visit, with the nurse in charge of a service. It may be that, had the nurse team leader been able to attend these, they would have known what the Commission's expectations were.

Whilst the NTLs absence was unexpected, it was clear that no prior preparation for the Commission visit had taken place between the NTL and the charge nurse who met with Commission visitors on the day. On some occasions, it was evident that the responses we would have hoped to gather at the time of the visit, and that would have informed and reassured the Commission visitors about the care and treatment that was being provided, were not able to be provided.

Use of mental health and incapacity legislation

For individuals who are on the CMHT caseload, and who have their care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, we would expect that all documentation relating to the Mental Health Act, including certificates around capacity to consent to treatment, were in place in an individual's records and that any documentation around their legal status was kept up-to-date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given, to individuals 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 should be in place, where required, and correspond to the medication being prescribed.

We reviewed the authority to treat forms, T2 and T3s, and were concerned that there appeared to be confusion around the legal status for some patients. We found no record of the authority to provide medications, or that individuals had consented to medication administration. We found one T3 that had expired.

We asked about the administration of medication and how this was recorded; we were told that the CMHT was not connected to HEPMA, the electronic medication prescribing system and what was used was an "old-school drug kardex". We saw the Prescription and Administration Records (PAR) for individuals and noted that on the PAR, there was nowhere to identify the person's legal status. We were later advised that the paperwork relating to medications for those under the Mental Health Act was on Morse. We could not see evidence of this, but an action has been taken forward by the NTL to ensure this is uploaded.

In discussion with the team, we did not feel that they were able to identify those on their caseloads who were under the Mental Health Act easily and those individuals whose care and treatment was voluntary. We were concerned by the uncertainty around legal status. We were later advised by email from the senior charge nurse (SCN) of the exact numbers that were open to the team, both in hospital and in the community.

Care Programme Approach (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. We asked about individuals who were subject to CPA and were advised that the team were unsure of exact numbers. We would have hoped that each CPN would know who on their caseload were on CPA, as the CPN is central to the CPA meeting, and almost always noted as the defined CPA care coordinator.

On the day we asked about people who were subject to Multi Agency Public Protection Arrangements (MAPPA), or Multi Agency Risk Assessment Conferences (MARAC) restrictions and which individuals had ongoing activity from adult support and protection procedures. There seemed to be a lack of awareness of those individuals who were subject to these highly restrictive measures. We were concerned that the lack of awareness as to how those on caseloads who were subject to legislative frameworks could impact on the work of the team, and how these individuals required adequate support in conjunction with additional legislation requirements. After the visit had taken place, we were also given details of the number of people who were known to the team and subject to these restrictions.

We found that where there were concerns about a person's living conditions, and/or increased alcohol use and/or poor self-care that had been recorded in their records, there were no actions noted. When asking about the role of the team in making referrals to social work in these circumstances, it was not clear if the team were aware of their responsibility to refer for an Adult Support and Protection inquiry. The response that we received was that the team would try to improve the person's motivation and use the Triangle of Care to effect change in the individual's circumstances. The Triangle of Care is "a national initiative adopted by the NHS that promotes a therapeutic alliance between service users, staff and carers to optimise safety, opportunity and recovery for the service user and support carers". We noted on the day of the visit that the main focus of the CPN's role was in relation to medication administration and that other professionals, such as a mental health officer (MHO) or social worker would support an individual to manage living conditions.

We also found that in some of the notes that we reviewed, there was, what we consider to be the use of negative language in some instances, which appeared to reflect negative value judgements. We found this language to be unhelpful and disrespectful.

Recommendation 4:
Managers should ensure that copies of the T2s and T3s which authorise medications are kept with the prescription medication administration sheets.

Recommendation 5:
Managers should ensure that staff have a framework to identify people who are subject to additional oversight, such as MAPPA or MARAC.

Recommendation 6:
Managers should ensure that staff have a framework to identify the legal status of all people who are open to their service, so that staff are able to provide individuals with the necessary information and access to the appropriate safeguards.

Recommendation 7:
Managers should ensure that when staff are referring to the personal circumstances of a person that the language used is non-judgemental and respectful.

Recommendation 8:
Managers should ensure that all staff are aware of when and how to make a referral to social work where people may require protection under Adult Support and Protection (Scotland) Act 2007.

Right and restrictions

When we reviewed the available records, we looked for evidence 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. We consider that CMHTs are well placed to support people to complete advance statements. We heard from the team that the promotion of advance statements was "not great".

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

Recommendation 9:
Managers should ensure that staff promote the positive aspects of individuals completing an advance statement when they are well, to ensure that their wishes for future periods of mental illness are taken into account.

Activity and occupation

We were pleased to hear about various activity and occupational groups facilitated by the team and were told these include walking groups, pool, and snooker activities. We had the opportunity to join an arts and crafts group. People were notified what groups were on each day and were invited to attend, however, they were not compelled to do so.

There were five people enjoying arts and crafts, using "diamond art" and colouring in on the day of our visit, and we saw some of the other activities the arts and crafts group can undertake such as stone painting and painting on canvas. There was a selection of refreshments on offer to the participants, which was donated by the staff and attendees. We were informed that there used to be a carers support group prior to the pandemic, but to date this has not restarted.

The physical environment

The team are co-located with two GP practices in the local health centre; they occupy rooms on the upper floor of the building. Other disciplines are also co-located. There were some meeting rooms on the ground floor that had to be booked in advance if the CHMT wished to meet with individuals. We noted that availability of these rooms was extremely limited, and we heard that on occasion, those who were attending an appointment had been sent away as there was no private space for discussion. Working conditions in the office areas appeared cramped and did not offer any opportunity to make sensitive calls to individuals or carers. We also noted that, without exception, all staff had their lunch at their desks.

Any other comments

We saw a dedicated staff team who clearly prioritised the needs of those on their caseload. We heard and noted on the day of our visit that staff regularly go to the foodbank and get provisions for the people on their caseloads and deliver them in person. They also picked up and delivered prescriptions for some individuals where needed. When asking about the need for registered staff to do this as part of their role, we were told that all staff undertake these tasks but it was mainly the health care support workers who made visits to those who required provisions and medication to be delivered.

Nearly all the people we spoke to were very positive about the staff in the team and there was particular mention of how valuable the support of the occupational therapy team was from one of the individuals that we spoke to.

We asked if assessment of the individual included discussion about their financial situation and if there was a pathway for the team to refer to a particular agency for support. We were advised that the team can refer to the financial inclusion team in the local Health and Social Care Partnerships for advice and support. We saw a list of useful community groups where staff could refer people on to, and this included money advice and welfare rights services.

Summary of recommendations

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Recommendation 2:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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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