Mental Welfare Commission for Scotland

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

Date of visit: 27 September 2023

Where we visited

The State Hospital is the national high secure forensic hospital for patients from Scotland and Northern Ireland. All patients are under the Mental Health (Care and Treatment) (Scotland) Act 2003 or the Criminal Procedure (Scotland) Act 1995; they 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 at 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 Arran, Iona, Lewis and Mull hubs on the 20 September 2022 and we carried out a separate visit to Iona 2 Ward on 14 October 2022. On this occasion we decided to visit Lewis and Mull hubs with a plan to visit Arran and Iona at a later date.

We wanted to follow up on the issues identified from previous visits, and on matters that have been brought to our attention since then. We also wanted to give patients an opportunity to speak with us regarding their care and treatment, and 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 we made a recommendation regarding patients' attendance at MDT meetings to ensure they are supplied the opportunity to discuss their care. We further noted the difficulties with recruiting and retaining staff and recommended that steps should be taken to address these matters which were impacting on patient care.

The hubs since our last visit have adopted a new clinical care model which has reduced Mull hub from three to two wards with Mull 3 closing. On the day of our visit, we met with patients in Mull 1 and 2, Lewis 1, 2 and 3. Hubs now comprise of an admission, a transition and a recovery wards.

At the time of our visits there were 104 patients in the hospital; there were 56 patients in the wards in the Mull and Lewis hubs.

Who we met with

Prior to the visit, we held virtual meetings with the director of nursing and operations, the associate medical director, the professional nurse advisor, one of the lead nurses for the hospital, the social work manager and the advocacy manager.

On the day of the visit we met with most of the above managers as well as the charge nurses and the nursing staff on each of the wards we visited. We met with and undertook file reviews into the care and treatment of 10 individuals. We carried out a further 11 file reviews into individuals' care and treatment.

Commission visitors

Justin McNicholl, social work officer
Gemma Maguire, social work officer
Lesley Paterson, senior manager (practitioners)

Anne Buchanan, nursing officer
Arun Chopra, medical director
Sheena Jones, consultant psychiatrist
Gordon McNelis, nursing officer

What people told us and what we found

Care, treatment, support and participation

As this visit was announced, patients and staff were prepared to meet with the Commission staff. During our meetings with individual patients, we discussed a range of topics that included contact with staff, patients' participation in their care and treatment, activities available to them and their views about the environment. We were also keen to hear from patients who had been in the State Hospital for a number of years and those who were subject to excessive security appeals.

Since our last visits in 2021 and 2022, the staffing pressures throughout the hospital remains one of the key factors that has had an impact on the care and treatment of some individuals we spoke with. In 2021, we were aware of the lack of staffing and ward closures resulting in more confinement for patients during the day. Confinement overnight remains in place in the hospital however the increasing use of daytime confinement has had a further impact upon the recovery journey of patients. We commented briefly on the use of daytime confinement during our visit in 2022, however since then, the hospital managers have set up a new process mapping tool that Commission staff had sight of on the day. This new tool was found on the electronic patient information system, RIO which provides direct daily oversight of the frequency of confinement on all patients. This relies on staff inputting in relation to when confinement is used.

On this visit, we noted that across a seven-day period, some patients were being forced to spend unrequested time in their bedrooms for up to five days per week. The frequency of confinement varied across wards, however it was a cause for concern as individuals told us directly that this interrupts their therapeutic interactions on the ward, their activities and the therapeutic interventions they access out of the ward area. We heard from some individuals that they were accepting of the use of daytime confinement, while others spoke of using grounds access, if they had this level of freedom; this was as a means to working around the staff shortages in the ward. We heard from a few individuals that the use of daytime confinement has resulted in the postponement of family visits which was distressing for them and their families. We heard from staff that confinement has had a direct impact upon the delivery of therapeutic care, including psychological work that improves a patients' recovery.

Following on from our visit, we met with the hospital managers to discuss the impact that daytime confinement is having on staff and patients. The Commission noted that managers have agreed to update us on the reduction and planned eradication of this practice.

We heard from those that we spoke with, that when provided with consistent staffing to their wards the care was "second to none" and that "you can't fault the staff, they are doing their best". Similar to our visits in 2021 and 2022, many individuals told us that they felt safe in the hospital, commenting on feeling of "relaxing" and "calm". Some individuals who had been in

prison prior to their admission spoke of their relief of being in the hospital, “I am so glad to be here compared to prison”. We heard further comments that staff were “approachable” and that “regular keyworker meetings” took place to ensure that individuals could be supported with any issues that may arise.

All of the staff members we spoke with knew the patients well and were able to comment on risk and their associated management plans. This was further reflected in the interactions we observed and the daily notes we read. Staff spoke of being “readily available” to support individuals who presented in crisis. We heard from a variety of professionals across all disciplines of the positive impact that the new clinical model was having for patients, and staff acknowledged that this was working well and benefiting all whom we spoke with.

Since our last visit a new psychologist had joined the staff team at the hospital. During our visit, we heard from staff and patients that psychology were regularly providing input to individuals’ care and treatment. We met with two psychologists during the visit, who discussed with us their role and oversight of the individuals who they are working with. This was echoed by the senior management team who advised us that the majority of the Historical, Clinical and Risk Management 20 **(**HCR -20) reports into the risk of violence were completed by psychology. We found that these were completed to a high standard and the use of HCR-20’s has assisted the hospital to support patients moving to a lower level of security, with clarity on the risks associated with all individuals. Individuals told the Commission staff of the positive impact that psychology had on their well-being, with one individual stating, “I started engaging with psychology, one-to-one and group work which was something I tried to avoid, due to not coping with sharing information about myself. They have really helped me”.

We heard of the ongoing positive support the allied health professionals (AHP) have provided to the hospital and there was considerable praise from patients; we heard that AHP input was valuable to their recovery. One patient commented on the therapeutic relationship with an occupational therapist which was “a great motivator” in supporting him to improve his quality of life. The senior managers advised us that since our last visit, a permanent lead AHP clinician had been appointed. We noted that there continues to be a turnover of occupational therapy staffing, however recruitment of these staff has been maintained. We were advised that input from speech and language therapists and physiotherapy staff to the hubs remains consistent.

We heard from staff and patients that a common occurrence across Mull and Lewis hubs was for staff to be called to other wards to manage incidents, to support observations for those patients subject to these additional measures, and to support wards that are short staffed. We heard of the frustrations for staff who told us that previous mechanisms that were in place to manage staff shortages, and that had worked in the past were not being adopted by the hospital managers. It was pointed out that wards managers previously had autonomy to work flexibly with staff to ensure cover, but these arrangements had ceased and instead a “longitudinal” approach had been adopted by the senior manager of the hospital so that shift patterns were planned weeks in advance, which then had an impact on ward staffing.

We heard from senior managers that there was a gap of 21 full time equivalent nursing post vacancies across the hospital that is directly affecting the workforce. However, this was due to reduce to three vacancies once the latest round of recruitment has been completed by the middle of October 2023. We heard from senior managers that a continuous recruitment drive has been requested by the board, to address the retention and vacancy challenges across all the hubs.

Recommendation 1:
Managers should continue to address the ongoing staffing challenges in the hospital to minimise any impact upon patient care, access to their relatives and activities. Managers should keep the Commission informed of progress.

Care records

Information on patients' care and treatment continues to be held on the fully integrated system, Rio. We found this to be responsive, easy to navigate, and it 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

In 2021 and 2022, we found care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the individual patients. For this visit, we again found comprehensive, person-centred care plans that evidenced patient involvement. Patients we spoke with told us they felt involved in their care and treatment. It was positive to see discharge care plans in place, where appropriate, and there was evidence of regular review. We also found detailed information of one-to-one discussions between patients and their named nurse.

Patients at the State Hospital have their care and progress reviewed using the enhanced Care Programme Approach (CPA). CPA is a framework used to plan and co-ordinate mental health care and treatment. CPA was used for all patients in the State Hospital; of the records we reviewed, the documentation was detailed, and we found evidence relating to individual patient rights and the recording of advance statements.

We saw that physical health care needs were being addressed and followed up appropriately, and relevant physical health monitoring was in place. The point of access for individuals requiring urgent health care is through a contracted General Practitioner, who visits the hospital twice per week. We visited the health centre to observe where this care is delivered and were impressed by the facilities available. There is an ageing population in the hospital, and there are currently long waiting periods for outpatient appointments that have occurred as a result of the Covid-19 pandemic. We were pleased to note that, as a result of the GP triaging health care, this has meant that there have been improvements for the treatment of minor ailments that have reduced the number of times patients have to leave the hospital to access secondary care.

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. These meetings took place either in person or on Microsoft teams.

The MDT records that we reviewed were detailed, with a clear rational of all recorded discussions, outcomes and actions. During our last visit in 2022, we recommended that patients should attend MDT discussions, so that they could contribute to the decisions about their ongoing care and treatment. We were advised this recommendation has not been met and that no patients were invited to attend their MDT meetings. We were informed that patients were met with before and after each meeting by their keyworker to ensure their views and requests could be discussed at the MDT.

We saw some improvement on the recording of patients' views but continued to see limited evidence of relative or carer involvement pre or post MDT meetings. The senior managers advised us that they ensure relatives are provided with the opportunity to express their views at CPA meetings, with most of these meetings taking place on a six-monthly basis. We believe that views of the named person or nearest relative should be reviewed more frequently than this. The clinical director advised us that all psychiatrists are required to meet with individuals at least once per month to ensure clear, consistent, and communicated oversight of plans for individuals' futures.

Recommendation 2:

Managers should ensure named persons and relatives have the opportunity to contribute their views to the MDT and this should be recorded in the clinical notes.

Participation

As noted in the report in 2022, we heard about the patient participation group (PPG). This is a patient-lead initiative, where a group of patients meet weekly to consider any issues, concerns, or suggestions they have; we were pleased to see this group continues to take place. This meeting aims to have a patient representative from each ward and the PPG chair is elected by their peers. This appears to be working well and ensures participation.

There were regular community meetings that took place on each ward. These were minuted and allowed all individuals to discuss issues and make suggestions that related to their particular ward. We heard from senior managers that the Skye Centre provided a space out with the hubs for individuals to link in with the advocacy service; this supports those who may wish to raise complaints or matters that have not been dealt with at ward level. We found the ease of access to advocacy and the PPG were positive measures and ensured that participation was being promoted by the hospital.

During our routine visits to the State Hospital, we usually meet with the person-centred improvement lead for the Hospital. Since our last visit the previous post holder has retired and a new lead has recently been appointed; we plan to meet with the new lead officer on our

next visit. We were advised that the person-centred improvement team were working on creating a new online support group specifically for new relatives or carers to the hospital. At a future date, the Commission would also plan to attend this group, so that we can gather views or identify themes that are impacting upon their relatives' experience in the hospital.

Use of mental health and incapacity legislation

Patients at the State hospital are subject to restrictions of high security; all patients require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act 1995 (CPSA). The patients we met with during our visit had a clear understanding of their detained status. All patients that we met with reported that they had advocacy support and legal representation.

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act 200 (the AWI Act), including certificates around capacity to consent to treatment, were in place and were up-to-date. 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, where required, should correspond to the medication that is prescribed. We found a number of issues with both T2 and T3 forms that needed updating and amended to reflect the current treatment that was being delivered. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) to record non-consent, and they were up-to-date.

Any patient who receives treatment under the Mental Health Act or Criminal Procedure 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 on the patient's record.

Where we found that where patients were subject to a guardianship order under the AWI Act, staff had a clear understanding of these orders.

Recommendation 3:

Managers and medical staff should ensure that all treatment under the Mental Health Act is legally authorised and recorded on T2 and T3 forms.

Rights and restrictions

Patients reported to us that they found the advocacy service to be very helpful, responsive to their needs and described it as "supportive" and "easy to access".

We met with the advocacy service and heard that it was a well-used and valued service. It was noted that of the 104 patients in the State Hospital, all of them have regular input from the advocacy service. We heard that some of the common themes that patients raised with advocacy were around lack of activities, staffing levels, closure of the wards, and the use of daytime confinement that has had an impact on individual experiences in the hospital. 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 found that the advocacy service continues to work closely

with the complaints officer. The service liaised with senior members of staff and also had input into the induction programme for new staff. We were advised of the introduction of a new protocol that ensures that there is consistent advocacy cover for those individuals who are boarding out in a general hospital.

The visit report in 2022 commented upon the challenges for the hospital to access translators for patients whose first language was not English; for this visit, there were no issues or concerns raised by staff, advocacy services, or the individuals that we met with.

When we are reviewing patient records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 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. On this visit we were surprised to find a large number of patients, who were deemed as preparing for discharge in the transition service, to have no advance statement in place or no recording that these had been offered to the patients on a consistent basis. When we discussed this with staff we were informed, "it is not our job to complete advance statements". We saw no evidence that advance statements were promoted on the ward noticeboards or via any other mechanism. During our meeting with the advocacy service manager, it was confirmed that they would be willing to assist staff on supporting patients with advance statements.

Recommendation 4:
Managers should ensure that staff have training to understand their role in promotion and assistance for individuals in making advance statements, as well as the recording of advance statements for individuals who are well enough to complete one.

The Commission has regularly highlighted the significant difficulties with regard to 'patient flow' across the forensic estate. The situation of patients in the hospital awaiting moves to lower levels of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced *Appeals against detentions in conditions of excessive security* good practice guidance which can be found here:
https://www.mwcscot.org.uk/node/1674

There continues to be a lack of beds in medium and low security forensic services across Scotland, which has been raised with Scottish Government. As previously reported, the recommendations from the commissioned *Independent Review into the Delivery of Forensic Mental Health Services in Scotland*; the *What people told us* report, which was published in August 2020, are still under consideration by Scottish Government; the Commission will continue to monitor and contribute to this work.

The exact number of patients awaiting moves to lower security changes regularly. During our visit there were seven individuals who were found to be in conditions of excessive security. Due to the wait for a lower level of security, two individuals had appealed to the Supreme Court, the appropriate legal route to escalate these matters. The Commission remains

concerned that the rights of these patients to move to lower levels of security are not being met, and we continue to follow up on individual cases, as appropriate.

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

Since our last visit, it was positive to note that patients appear to have increased access to a range of recreational and therapeutic activities, particularly through the Skye Centre which is adjacent to the hubs.

During this visit, we undertook a tour of the Skye Centre to explore the environment and liaise with staff around the services that were available. The Skye Centre has a welcoming atrium area that provides individuals with the opportunity to be in an environment where they can meet for a chat with staff and have a refreshment. The centre has a shop, greenhouse, IT room, gym, recreational hall, hairdresser suite, animal care centre, and a spiritual room where various religious services are held for all faiths.

We observed patients undertaking a variety of activities including football, SVQ training, and work in the Skye Centre library. We heard from patients who praised the staff who work in the Skye Centre, including the occupational therapy staff. We did note however that staffing for these activities can be affected when staff numbers vary across the hospital site. We noted that staff were aware that the importance of physical activity could appear to have a higher focus than other activities, and that could mean that educational and arts and crafts sessions could be cancelled, with patients being supported in the hubs with these activities, instead of attending the centre. We observed a number of other activities that included a campaign to complete the North West 500, a cycling event that was held in the hall and that helped to raise money for charity.

In many of the wards, it was busy with staff and patients moving throughout the hospital for various activities and meetings. Despite how busy the wards seemed, many of the patients presented as relaxed and comfortable with the staff on shift. In Mull 2, one of the transition wards, we found that the patient group was focused on preparing to move towards medium security.

The physical environment

The physical environment of Lewis and Mull hubs was largely unchanged from previous recent visits to these hubs. The wards have single en-suite rooms, access to a secure garden area, and areas that support safe and secure care.

However, we did hear the frustration of some patients, who advised us about the notice board in Lewis 3 has been broken for nearly two years and that this has not been fixed despite repeated attempts to have this addressed. We observed that some of the patio areas were slippery in the cold weather and staff advised patients not to use the space. It would appear that the patio requires cleaning to ensure moss and other slippery substances are cleaned

off the paved area. This is particularly important during the winter months for those patients who do not have grounds access, as this can be the only space where they have access to fresh air.

In Lewis 3 there was a modified strong room (MSR); this required maintenance as there was a broken blind that had been reported and the room required painting to make it more hospitable for patients. The MSR in Mull 2 had recently been updated although we were advised by staff that this room has not been used for a significant period of time. We heard from a number of patients that they preferred spending time in their bedrooms, away from the communal dayroom of the wards, as they reported that it felt, "like a goldfish bowl", that it was "boring", "dull" and "uncomfortable".

We were pleased to note that many of the bedroom across the wards were personalised and provided a comfortable and relaxing environment for the individuals with whom we met.

The hospital continues to have extensive grounds with walking trails; it remains a smoke-free environment. CCTV is currently in operation in the grounds of the hospital. There is no CCTV in the communal areas of the ward, however there is consideration of cameras being introduced into these areas in the future. The Commission would wish to be kept informed of any developments in this area.

Any other comments

We met with social work managers who told us of the positive working relationships that exist with various professions in the hospital. We heard how there is a service level agreement between South Lanarkshire and the hospital to ensure social workers and mental health officers are available to support patients.

We noted the positive joint training that has enabled the delivery of Adult Support and Protection (Scotland) 2007 legislation, to ensure staff are aware of their duties and to report any adults who may be at risk of harm in the hospital. We were pleased to see that 85% of staff had had their training updated and there is ongoing work to ensure all staff, including new members of the hospital, are aware of their duties. There are regular monthly meetings with the director of nursing which ensures that any matters of concern from a social work perspective are swiftly addressed.

We heard about a small number of patients who were subject to transfer for treatment directives (TTDs) and the impact that this has had on their finances, compared to other patients across the hubs. We understand that these individuals are not entitled to the same level of benefits as those who are subject to civil orders in the hospital, however we hope that work can be undertaken to ensure that this group of patients are not discriminated against and are provided with financial support, to ensure that they are not denied equitable provision of items as other patients in the hospital. We will check on this again during future visits.

Summary of recommendations

Recommendation 1:
Managers should continue to address the ongoing staffing challenges in the hospital to minimise any impact upon patient care, access to their relatives and activities. Managers should keep the Commission informed of progress.

Recommendation 2:
Managers should ensure named persons and relatives have the opportunity to contribute their views to the MDT and this should be recorded in the clinical notes.

Recommendation 3:
Managers need to ensure that all treatment under the Mental Health Act is legally authorised and recorded on T2 and T3 forms.

Recommendation 4:
Managers should ensure that staff have training to understand their role in promotion and assistance for individuals in making advance statements, as well as the recording of advance statements for individuals who are well enough to complete one.

Service response to recommendations

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