Mental Welfare Commission for Scotland

Report on announced visit to:

Community Mental Health Team, Three Towns Resource Centre, Nelson Road, Saltcoats, KA21 5RF

Date of visit: 12 October 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 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 North Ayrshire Adult Community Mental Health Team (CMHT) covers the area of North Ayrshire and the islands of Arran and Cumbrae; it is part of North Ayrshire Health and Social Care Partnership with delegated responsibility from NHS Ayrshire & Arran Mental Health Services. Individuals between the age 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.

Currently there are 2255 individuals who are open to the team. Most of these are open to psychiatry, most are supported through a multi-disciplinary and multi-agency approach (including psychology, allied health professionals, social work, and mental health officers), although there were several individuals open only to nursing and a smaller number open only to the group programme.

Who we met with

On the day of our visit, we met with seven people who were attending for support from the service. We also joined the deciders skills group, which had two attendees and a cognitive behaviour therapy (CBT) group that had four attendees. We reviewed the care notes of twelve people.

We spoke with the nursing team manager, senior and service managers, and other members of the nursing team. We met with the pharmacist, one of the consultant psychiatrists and two members of the brief intervention team (identifiable as previous primary care mental health team).

Commission visitors

Margo Fyfe, senior manager

Anne Craig, social work officer

Susan Hynes, nursing officer

What people told us and what we found

Care, treatment, support and participation

Those that we met with on the day were very positive about the staff they worked with, and about the care they received. Individuals spoke of helpful interventions that supported their recovery and felt that they were involved in their care and treated with respect. People attending the group programme spoke highly of the skills they learned and support they received from peers and the group leaders. They did feel there was a lack of individual support linked to the group programme and some were using private or commissioned third sector therapists for support. The individuals who were open to the team spoke highly of all the professionals available to them, finding the advice and treatment provided helpful. One person described how dietetic involvement had helped them regain a healthy weight and others spoke very positively about the occupational therapists and recovery workers who supported them to access community groups and courses.

We heard from one individual, who commented "without the folk here, I wouldn't be here." We were impressed with the holistic approach to the care provided for people using this service and were pleased to hear about innovative approaches to supporting access to health screening. The work we heard about during our visit and from the people we met with wasn't always fully reflected in the patient records, we look forward to seeing this improved in future visits.

The service is keen to receive feedback from people who use their service, and they currently use Care Opinion (where there tends to be 1-2 comments made each month), as well as the letters and cards received from those individuals who have accessed these services. There were more formal questionnaires from those who attend the decider skills and CBT groups. It is hoped that in future, electronic tablets will be used to collect more standardised feedback from all who access the services. While the tablets had been ordered, there was a delay receiving these, but they were expected in the very near future. We would hope to see this in place and the feedback used to plan further quality improvement projects.

Care plans/care notes

We reviewed individual care plans on the electronic system, Care Partner. We were able to review care plans, but we were unable to locate any reviews that detailed an individual's progress throughout their contact with the service. We found that some care plans were generic and did not provide the level of person-centred information that we would have expected to see.

Each time a care plan was updated, a new care plan was created; this meant it was difficult for us to review progress. We discussed care plan writing, evaluation, and reviews. We were advised that, generally, this is done as a paper copy with the individual, and this is then transferred to create an electronic copy that acts as a summary. The individual keeps the paper copy. The information we reviewed on the system may not fully reflect all aspects discussed and we feel the service needs to consider a system that allows the same

information to be in both plans. We recognised there was information about interventions and evaluations in the care notes that was not reflected in the care plan.

Recommendation 1:
Managers should ensure that the quality of the care plan is reviewed and audited on a regular basis, is reflective of the care delivered and includes a summative evaluation.

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 found the care records that were recorded on Care Partner easy to navigate and legal paperwork was clearly documented. We saw recordings of regular one-to-one meetings, but the level of detail varied. We discussed this with managers and suggested that a more consistent approach to these records should be developed.

Review meetings were detailed, and the medical reviews were person-centred and contained a plan of treatment.

We saw some meaningful and detailed risk assessments. These included a risk management plan that was updated regularly. We were told the team would create 'staying well plans' with individuals, detailing strategies that they wanted to achieve and that would help maintain recovery and what actions could be taken at times of crisis. We were not able to locate these in care records and the people we spoke to were not aware of these plans. They were confident that if they needed support urgently, they could contact the team and would receive a response but were unsure what to do if this support was required out of hours.

Recommendation 2:
Managers should ensure that 'staying well plans' are completed and available in the care record, and that the individual has a copy and is aware of out of hours support.

Multidisciplinary team (MDT)

The multidisciplinary team consisted of four consultant psychiatrists, nurses, occupational therapy (OT), psychology, pharmacy, and dietetics. The wider community mental health and social care service included social work, mental health officers, social work assistants and mental health support workers. The inpatient mental health ward for people from North Ayrshire is Ward 9 at Woodland View Hospital. The team have links with both the ward and the intensive support team. The intensive support team provides support for individuals for up to twenty-one days following discharge from hospital if required, and then they transfer care to the CMHT. If the person was already open to the CMHT it would be negotiated who was best placed to provide optimum support for the person.

We were informed that if an individual's mental health was concerning to the MDT, further discussion about care options took place at the care pathway meetings that are held weekly. These involve medical, nursing, psychology, social work, and OT staff. Staff had the opportunity to discuss individuals' care at these meetings, or more regularly at daily nursing meetings if there were urgent concerns or there were changes in their presentation.

Additionally, there were three North Ayrshire MDT locality meetings each week that the consultants and nurses attended.

We found evidence of MDT meetings taking place, with a record of those who attended. Individuals' views and next treatment steps were recorded along with a review of how well the current treatment was working. These reviews took place at least annually, but the frequency was increased depending on the requirements of the individual. There were three, weekly MDT meetings where staff told us they could discuss any concerns they had about someone on their caseload and where medical staff were available. Staff felt confident that if the individual required a medical review, this could be arranged promptly.

The nursing team consisted of a nurse team lead, nine charge nurses (one lived and worked on the Isle of Arran), 12 staff nurses and one health care support worker (HCSW). Newly qualified registered nurses 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 for between six and twelve weeks. This had positively resulted in the recruitment of permanent posts for newly qualified nurses; the team had recently recruited five newly qualified nurses.

The CMHT is a Monday to Friday service operating between 9am and 5pm. There was a crisis team, named locally as intensive CPN team, available at evenings and weekends that could be contacted if required via unscheduled care mental health pathways.

Workload/supervision

We found the referral processes to the team robust. There was an electronic referral form, and these were triaged each day by a dedicated triage nurse. If necessary, contact was made to arrange a same day or next day appointment. The duty worker would then send any urgent or routine referrals to the appropriate team lead (nursing, psychology or social work) for allocation. The team explained this system avoided unnecessary delays.

Care pathway meetings were held weekly. These involved medical, nursing, psychology, social work, and OT staff. Complex cases could be discussed at this meeting, and there were regular daily meetings if there were urgent concerns. There was also an allocation meeting every week.

The caseloads for each team member varied between 20 and 40 individuals. Depending on the mental health of individuals, contact could range from single appointments to two or three contacts per week, where this was required. The team provided care and support for individuals with a range of mental health diagnoses, and they also supported those who have a co-existing mental health and problem substance use.

The service had seen an increase in people with a diagnosis of attention deficit and hyperactivity disorder (ADHD). The pharmacist explained how there had been work undertaken to manage this demand and provide a prescribing service for people with a diagnosis of ADHD.

We asked about people who did not attend (DNA) 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 were sent an alternative appointment via post, but where there were concerns or risks that had been raised, another appointment could be hand delivered by a member of the team. There was MDT discussions about all people who do not attend, where a plan was agreed, and referrers were updated on the person's non-attendance. There was a standard operating procedure to guide management of non-attendance.

The team also provided information on those who attended a clinic for clozapine or lithium blood monitoring and for depot medication. There were individuals in the community who required to be visited at home for depot medications. High dose monitoring was in place for those individuals who required this. We were impressed to hear about a project to improve physical health monitoring and where access to routine health screening was being provided by the CMHT, in collaboration with General Practitioners and community health teams. This service offered individuals a more holistic health monitoring option that included dietetic advice, blood sugar screening, testing for blood borne viruses, bowel screening, cervical screening and breast screening. This had started as a quality improvement project and had become now been embedded in the clinic.

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 and discussions between the CMHT, social work and mental health officer (MHO) team. We were advised that in addition to formal supervision, there were regular peer supervision and staff wellbeing sessions in place.

Leadership

The nursing team leader provided visible and compassionate leadership for the team, it was evident during our visit there was a strong focus on staff development and wellbeing. There was a recognition of the need for supervision and support for staff working in the team and this was provided both formally and informally, with a clear induction process in place for new staff. The management team appeared to recognise the need to provide this to support recruitment and retention and staff we spoke to welcomed the opportunities for development in the team.

The leads for each professional team appeared to work well together and there was good communication between them. There was a joint governance group that allowed discussion of any issues or developments, and this facilitated the planning of actions and responsibilities to be agreed. The team described the senior managers as supportive and accessible.

Use of mental health and incapacity legislation

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

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 T3's that were stored electronically on Care Partner. The medication prescription forms were held in paper form, and we noted that was where the person's legal status was highlighted. There was also documentation highlighting that the person had a T2 or T3 form, authorising treatment and the date that authorisation was due to expire. A copy of the form was not available in paper form for nursing staff administering the medication and though this was available electronically, staff could not easily access this system at the point of administration of medication. The T2 and T3s we reviewed were found to be in order.

Recommendation 3:
Managers should ensure copies of the T2s and T3s which authorise medication are kept with the medication prescription sheets.

Care Programme Approach (CPA) is a framework used to plan and co-ordinate mental health care and treatment. Staff were aware of those individuals who were subject to CPA and we were advised of the exact numbers.

Staff were also aware of those individuals who were subject to MAPPA (Multi Agency Public Protection Arrangements) or MARAC (Multi Agency Risk Assessment Conferences) restrictions and those where there was ongoing actions from Adult Support and Protection procedures. There was a training programme in place to ensure that all staff had knowledge of these processes and how it might impact on care requirements. There were staff in the nursing team who had more in-depth training in these areas, and they were used as a resource for the team.

Right and restrictions

In discussion with the team, we found staff were able to identify those on caseloads who were under the Mental Health Act and those individuals whose care and treatment was voluntary. All the individuals we met with were informal, but one had previously been subject to a community compulsory treatment order (CCTO). They discussed how this had supported them to engage with treatment and how their rights had been explained to them both verbally and in writing. They felt they had been included in decisions about their care and felt the support had been beneficial in their recovery; we heard that this had been the longest period, for a number of years, where they had not required hospitalisation.

When we reviewed the available records, we looked for evidence 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. 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 something they hoped to focus more on, and we were pleased to find some examples in notes. We also saw that advance statements were reviewed at each annual review, to ensure they

were still relevant. There had recently been training for staff in supporting individuals to write advanced statements and it was hoped that this would be repeated.

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

Activity and occupation

We were pleased to hear about various activity, occupational and therapeutic groups facilitated by the team. There were two recovery workers who supported individuals to engage in community groups and to link with the recovery college. We heard from one individual how this had supported their recovery, increased their confidence and they are now attending a mainstream college placement.

We had the opportunity to meet people who attended the deciders skills group and the CBT group; they all gave very positive feedback about the skills they learned in the group and how these could be used ''in real life situations''.

The physical environment

The CMHT work within an integrated Mental Health and Social Care Service and are co-located with the social work and mental health officer team, primary care team, known locally as brief intervention team, and intensive CPN team, known nationally as crisis team. There was recognition that sharing the accommodation with other disciplines and agencies led to closer working relationships, improved communication, and a sharing of knowledge.

The building was bright and welcoming and there were several individual clinic rooms and group rooms. There was a large staff room where staff could have meals. There appeared to be adequate desks and IT equipment for all staff. Clinics were also held in Woodland View Hospital.

Summary of recommendations

Recommendation 1:
Managers should ensure that the quality of care plans is reviewed and audited on a regular basis, is reflective of the care delivered and include a summative evaluation.

Recommendation 2:
Managers should ensure that 'staying well plans' are completed and available in the care record, and that the individual has a copy and is aware of out of hours support.

Recommendation 3:
Managers should ensure copies of the T2s and T3s which authorise medication are kept with the medication prescription sheets.

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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