Mental Welfare Commission for Scotland

Report on announced visit to:

Integrated Community Mental Health Team, Woodlands Resource Centre, Falkirk Community Hospital, Westburn Avenue, Falkirk, FK1 5SU

Date of visit: 5 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 adult Integrated Community Mental Health Team (ICMHT) is located in Woodlands Resource Centre at Falkirk Community Hospital. It comprises of two teams, (East and West) providing mental health assessment and care and treatment for adults with mental illness living in the community in the Falkirk area. Referrals to the team can be made by GP services, other specialities in the secondary care system and between disciplines in the team. There were two multidisciplinary teams (MDTs) on site consisting of mental health nursing, psychiatry, occupational therapy, music and arts therapy, psychology, social work, and mental health officers. We were told that there were some nursing vacancies, including two band 5 registered nurses, one health care support worker, and a recent band 7 vacancy. Recruitment was ongoing to fill these posts and newly registered staff can be employed directly into the band 5 role.

Bank staff had been used to cover existing gaps including maternity cover. Managers liaise with and attend a fortnightly general adult psychiatry huddle via Teams, along with the two other Forth Valley Community Mental Health Teams (CMHTs) as well as the Inpatient Service and Crisis Service, to share information and ideas.

Who we met with

We were able to interview nine individuals who were working with the CMHT, and one relative. On the morning of our visit, we conducted telephone interviews with four patients. We had been made aware that they had expressed a preference for phone contact rather than a visit to their home. Another had chosen to use the 'near me' facility and one other attended the centre. We were also able to get collective feedback from three participants of the 'Decider Skills' group facilitated in the resource centre that morning. There was some confusion from one patient's relatives about whether we were visiting at home. However, following discussion with the CPN, the relatives agreed to travel to the resource centre for interview. During our visit we were therefore able to speak with eight individuals and reviewed the clinical notes of nine.

Prior to the visit, we had a video conference with the service manager and nurse team leader. On the day, we had further opportunity to speak with the occupational therapist (OT), community psychiatric nurses (CPN), a psychologist, a mental health officer (MHO), and a principal art therapist.

Commission visitors

Denise McLellan, nursing officer

Anne Buchanan, nursing officer

Margo Fyfe, senior manager (practitioners)

What people told us and what we found:

Care, treatment, support and participation

The feedback offered from the individuals we spoke with was overwhelmingly positive. They were particularly enthusiastic about the service they received from their CPNs, commending them as "incredible in their support". They spoke about learning new skills and feeling supported by them, including being offered advice on housing and benefits, and signposting to resources. One family did raise concerns about their relative's diagnosis and treatment plan. This was discussed with managers on the day and we followed this up separately with the patient's consultant.

Some individuals felt that there was frequent change in medical provision with someone commenting that they were "unsure who my doctor is". They spoke of seeing a different one at each medical review, although another said that their consultant was "brilliant, and really listens". The clinical director advised that there had been some changes in consultants due to vacancies which is a national issue, but now the medical staffing was much more stable, and all senior medical posts were filled by substantive appointments except for one, which had a fixed term contract to avoid agency locum with frequent changes of personnel. We were told that some did not feel supported by the GP service and felt medication could be managed better, adding that they had found the mental health nurses in the practice more helpful. Comments from those we spoke with from the decider skills group included staff being "very, very patient and approachable". They were clear that the goal of the group was to "help, not cure". All agreed that the staff approach was "helpful and reflective". Individuals were vocal in their commendation of the CPN service and they praised them for support they had received: "I don't know what I will do without them" and referred to one as "a diamond".

Care notes

Information relating to patients' care and treatment was held on the electronic patient recording system, Care Partner, which we found relatively easy to navigate. We were able to review care plans, however, could not find information in relation to numbers on caseloads, who they were allocated to, how many had co-existing conditions, or were managed under the Care Programme Approach (CPA). We were told that the current recording system used does not lend itself to easily generating this data, but managers would liaise with IT and administrative services to look at this further. We were subsequently provided with this information following the visit.

We noted there were some inconsistencies in the frequency of care plan reviews, and for one individual, the last review had last been completed in June 2023; there was no evidence of this individual's participation in relation to aims, goals or interventions of their care. Other care plans were collaborative and we could see that individuals knew what they were working towards.

Assessments were comprehensive, however some of the care plans were not linked to what had been found in the assessment. There was also variation in the level of detail in documentation of some of the one-to-one contacts and with the group work. We suggested that an audit tool be developed to improve this, however, were informed that there was already

a process in place to address this. We look forward to seeing how this develops at future visits.

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 create and regularly maintain a record of information relating to caseload numbers and disciplines involved. Information should also be available in relation to referral stage, waiting lists and legal status.

Recommendation 2:
Managers should undertake regular audits of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are detailed, person centred and consistent across all care plans.

The team use the Functional Analysis of Care Environments (FACE) risk profile to assess and manage risk; this was easily accessed on the electronic system. We were told that risk updates were completed six-monthly or sooner if there were any significant events. Most of the updates were completed in this timeframe.

We were pleased to see good evidence of physical health care needs being addressed and followed up appropriately. For patients who were administered medication by long-acting depot injection at home, a National Early Warning Score (NEWS) was kept along with their prescription and administration sheet. This tool improves detection and response to clinical deterioration and is a key element of patient safety and improving patient outcomes. By keeping this with the medication kardex it provided a prompt to monitor physical health for those who were not regularly attending the resource centre.

Multidisciplinary team (MDT)

The East and West teams have their own separate weekly multidisciplinary team (MDT) meetings. The East team consultant psychiatrists practice across both community and inpatient settings, while the West team consultant psychiatrist holds only a community caseload. Meetings remain on Teams but there are plans to resume on a face-to-face basis since the easing of Covid-19 restrictions. There was representation from all disciplines and we were pleased to hear this included the music and arts therapist. The MDT meeting was viewed as the "centre of care", where referrals and assessments were logged and managed. New referrals, clinical concerns, case reviews, formulation, discharge planning, reviews of inpatient discharges for community follow up, as well as feedback from the previous week's assessments, were all discussed in this forum.

Workload/Supervision

Referrals

Referral screening was always completed by clinical staff, usually by a band 6 nurse or a more senior nurse. Clinical staff were allocated to this role on a rostered daily basis, with any new referrals being reviewed within four hours of receipt. The duty practitioner offered signposting

to other services where required. Although the ICMHT operates a two-team system based on geographical locality, assessments were carried out by both teams. The referral form itself was clear and comprehensive with space for patient demographics, prioritisation of need, such as routine or urgent assessment required, and to whom the referral was being forwarded for follow up. There was additional space to gather information regarding attempts to engage the patient for assessment, with space for outcome notes. The process offered flexibility and choice, and the initial appointment could either be in the resource centre, at home, or using the 'near me' facility. This allowed for assertive outreach, helping to reduce the number of people not attending appointments.

We found that all discussions and decisions were then documented on the Care Partner system. Where an assessment was indicated, it was considered best practice for this to be undertaken jointly by two clinicians, however assessments could be carried out alone by an experienced band 6 nurse or a more senior nurse. It had been recognised by managers that there was a need to develop the assessment skills of staff. We were informed that this was an area where competency-based training would be delivered. We were told about a full team meeting called a huddle that took place each Friday to discuss any urgent referrals, individuals who may be at risk of crisis and who might require follow up over the weekend. The intensive home treatment team (IHTT) undertook intensive treatment at home with medical responsibility and also responded to crisis referrals seven days per week, but medical responsibility still sat with the ICMHT for crisis referrals. We were told of good links with the homeless CPN, housing CPN, forensic CMHT and with the community addictions team. There was a shared care agreement that patients could be discharged back to GP services when their mental health was stable.

Therapeutic group programme

In addition to one-to-one therapy, group sessions delivered in the resource centre included safety and stabilisation, anxiety and depression management, emotionally unstable personality disorder (EUPD) pathway, dialectical behavioural therapy (DBT), decider skills group, which included mindfulness and managing emotions in relationships and behavioural family therapy (BFT). Progress for those in one-to-one or group therapy were discussed at allocation meetings and during caseload supervision to determine whether an alternative group was indicated or if discharge from the service was appropriate. Those on the EUPD pathway were allocated a key worker in preparation for group work. Health care support workers (HCSW) actively engaged and supported patients to attend appointments until they felt ready to progress independently.

Health maintenance clinics

Patients attended the clinic for physical health monitoring including venepuncture, blood pressure, body mass index (BMI) checks and psychotropic side effect screening. Electrocardiogram testing (ECG) was also undertaken on site. We were told that medication (including Clozapine) was delivered directly to community pharmacies as this was generally the individuals' choice and an established pharmacy arrangement within NHS Forth Valley, however a minority did still collect it from the resource centre. High dose monitoring was undertaken every three months, and it was the key worker's responsibility to ensure annual reviews were completed in the appropriate timeframe. Long-acting antipsychotic medication (depot) was mainly administered at the resource centre at a specialised depot clinic but also

at home by the CPNs, and a buddy system was in operation to manage any risks associated with lone worker visits.

Use of mental health and incapacity legislation

Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (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. We reviewed a number of medicine prescription sheets and found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place and corresponded with prescribed medication.

T2s had been completed to record consent with details attached, and in the case of T3s, a designated medical practitioner (DMP) had authorised them. All certificates were up to date. We also noted that the nurse team leader (NTL) had a nurse prescriber qualification. We were told that a diary system was used to highlight the date of the next depot injection. Team CPNs had access to others' diaries to mitigate the risk of this getting missed if a colleague was absent.

During our individual interviews, one person said they were unclear of their detention status and whether they were still detained under the Mental Health Act. We discussed this with managers and were reassured that this was routinely reviewed. It was acknowledged that insight may fluctuate over the course of illness and consensus was reached that this was perhaps something that could be evaluated.

Rights and restrictions

When we review individual records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections274 and 276 of the Mental Health Act and are 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 did not find any advance statements in the files reviewed but were told that there were information leaflets in a carousel in the waiting area. The MDT should be able to evidence how they have made efforts to enable patients to complete an advance statement. CMHT staff are ideally placed to promote and support the writing of advance statements given that people's mental health could be more stable while under their care. Staff should understand their role in promoting advance statements and encourage all patients wishing to complete these an opportunity to do so. It was acknowledged by managers that this does require further promotion. We did note that there was information and contact details for the local independent advocacy service displayed on one of the notice boards and there were copies of the Mental Welfare Commission's publication 'Rights in Mind'.

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

Recommendation 3:
Managers should ensure that staff are trained to support the promotion and recording of advance statements for individuals who wish to complete one.

Activity and occupation

We met with the OT who informed us that although activity focussed groups were not delivered in the centre, patients were signposted to a variety of groups in the local community. In particular, they spoke about the enthusiasm patients had for the football group. We also met with the art therapist and were pleased to learn that therapy had continued online to support participation, and that this had been well received.

The physical environment

The building was previously a mental health inpatient facility. On entering the building, the reception area was welcoming and relaxed. There was seating to one side with a vending machine adjacent and there was some fresh fruit available on the table. An accessible toilet was also nearby. Walking around the facility, we observed several eye-catching notice boards and carousels with details of helpful local resources and information leaflets. The area was clean and brightly lit, with corridor windows overlooking the internal courtyard. The lower floor was split between two wings with one side accessible to the patient group. On this side we found a variety of rooms including a treatment room, several interview rooms, and larger rooms for group work.

Offices for both CPN teams, OT and MHOs were in the other wing, and could only be accessed by security code. Social work personnel were accommodated on the same floor of the building. We were told that despite it being a busy resource used by many, there was good access to rooms. The MHO told us that being located with other disciplines made multidisciplinary working much easier.

During our discussion with the MHO, we heard that the nursing leadership was very good, and that the MDT worked well. We were also told that staff were motivated and enthusiastic because of this. We were pleased to hear that there was never a waiting list to get a CPN, adding that the service manager was skilled at working in a very collaborative way.

Any other comments

We were made to feel welcome by the NTL and other managers who were generous with their time. They spoke of seeing this initial visit as a way to establish a baseline, with the aim of improving future service provision. We heard that one of the senior charge nurses (SCNs) had recently returned from a fifteen-month secondment with the drug-related deaths team and that there were plans to develop pilot meetings for higher risk polysubstance misuse groups. It was also hoped that Naloxone training could be delivered to other staff in the near future. We were also pleased to learn that competency-based training in assessment and risk assessment was to be delivered to band 5 nurses.

Summary of recommendations

Recommendation 1:
Managers should create and regularly maintain a record of information relating to caseload numbers and disciplines involved. Information should also be available in relation to referral stage, waiting lists and legal status.

Recommendation 2:
Managers should undertake regular audits of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are detailed, person centred and consistent across all care plans.

Recommendation3:
Managers should ensure that staff are trained to support the promotion and recording of advance statements for individuals who wish 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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