Mental Welfare Commission for Scotland

Report on announced visit to:

West Fife Community Mental Health Team, Queen Margaret Hospital, Whitefield Road, Dunfermline, KY12 0SU

Date of visit: 8 February 2024

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.

On this occasion, we visited West Fife Community Mental Health Team (CMHT). We had the opportunity to meet with individuals who received care and treatment, as well as nursing and medical staff. We also had the opportunity to meet with the team who had responsibility for the physical wellbeing of individuals receiving care from the service.

Wherever possible we invite individuals receiving care from mental health services to meet with us on the day of our visit. On this occasion, we had limited opportunity to do this however, we took the opportunity to review the care records of several individuals and meet with their community mental health keyworkers. We were keen to speak with staff who provided care, particularly those who were responsible for the duty worker role. This role provides a point of contact for individuals, relatives and professionals who require information or support from the service.

We also had the opportunity to meet with the senior leadership team and advocacy services.

Commission visitors

Anne Buchanan, nursing officer

Lesley Paterson, senior manager (practitioners)

Tracey Ferguson, social work officer

Gordon McNelis, nursing officer

What people told us and what we found

We spoke with several mental health nurses including those who provided expertise in physical health and well-being. We heard consistent themes from individual staff that they valued the contribution they had made to the service; in turn, they had felt supported by the senior leadership team. A relatively new member of the service had felt this was an inclusive workplace, that their contribution had been welcomed and this had meant the support they could offer individuals on their caseload was valued.

We also spoke with advocacy services; we were told the CMHT is unwavering in their support for individuals to connect with advocacy services. Advocacy services continued to welcome referrals from keyworkers who had signposted individuals for support for a range of issues. Those included support with housing, financial concerns, appointments with professionals and attendance at mental health tribunal hearings. Advocacy services also received referrals from mental health officers, who are social workers with an additional qualification. Referrals for individuals subject to Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) legislation had increased and advocacy services recognised the importance of supporting individuals through this legal process.

For people who received support from the community mental health team, we were told the nursing team gave due consideration to their mental health and physical well-being. Individuals told us this was important to them and their families. Individuals valued having a nurse from the team they could speak to or contact if their mental well-being was a concern to them. One individual told us "everyone should have a community nurse to help them with their welfare". We also asked individuals that we spoke with about their experiences of being subject to the Mental Health Act, for example, a community compulsory treatment order. Some individuals told us they felt it was unnecessary, and that treatment should not need to be given by a legal framework and attending reviews with the Mental Health Tribunal for Scotland was not always a positive experience, even with support from relatives or advocacy services.

Care, treatment, support and participation

West Fife CMHT supported individuals who presented with a range of mental health difficulties and diagnosis. Where an individual had been assessed as requiring specialist care and treatment, there was a focus upon multidisciplinary engagement, psychosocial interventions and recovery. There was a recognition that for some individuals, their mental ill health required a robust structure of care that was without limit of time. However, for others, care and treatment could be for a shorter period and thereafter individuals should feel empowered to carry on with their day-to-day life. The CMHT considered their primary focus was to promote recovery, to enable individuals to remain well and to provide strategies to ensure this was achieved.

Referrals to the service could be made through various means. Typically, referrals were received from GPs, inpatient services and health/social care partners. Each referral was reviewed or triaged; this process was undertaken by the multidisciplinary team weekly. If a referral had been identified as requiring an immediate response, this would be discussed on the day the referral was received. An individual who had been referred into the service and had

been identified as requiring an assessment would be invited to attend for a mental health assessment. Where this assessment took place was agreed between the individual and professionals undertaking the assessment. Typically, the initial assessment would take place in a clinical space however, if this was not possible for an individual, the assessment could take place in their own home. The multidisciplinary team included senior mental health nurses and nursing staff who had recently completed their nurse training, so were supervised by more experienced staff. Furthermore, the CMHT also had consultant psychiatrists, psychology, occupational therapy and regular input from third sector/non-statutory services. The CMHT's intention was to have a fully integrated service with an allocated social worker embedded with the team.

On the day of the visit, we reviewed several care records for individuals currently receiving input from community mental health nurses. Information on individual's care and treatment was held in the 'MORSE' electronic record system. We found care records easy to navigate. We were told each community nurse had approximately 25-30 individuals on their caseload, and for nursing staff with less experience or newly qualified practitioners, their caseloads would be fewer in number. Each member of the nursing team had regular caseload supervision with the team leader. Support from the team leader was highly valued and enabled the nursing team to reflect on the work they were undertaking with individuals.

Of the care records we reviewed, we identified areas of good practice, for example, there was evidence of detailed initial assessments that included mental health, social, economic, housing, financial, family structure and physical well-being. The emphasis of physical well-being was clearly important to the service, with dedicated professionals supporting and engaging with individuals to reduce the risk of health inequalities associated with long term mental health conditions. The service also provided a separate clinic for individuals who received their medication by intramuscular injection. Nurses in this service were also able to undertake a variety of assessments that included regular mental health and physical well-being monitoring. Where concerns had been identified in relation to non-concordance with treatment, mental or physical well-being, the team took an assertive approach to ensure individuals received input that balanced managing risk and person-centered care.

We identified care plans where individuals had been invited to participate in their creation. Unfortunately, this was not evident with all care plans we had the opportunity to review. We could see where there were care plans that had been reviewed and amended as necessary. Again, not all care plans had regular reviews or were updated. To ensure participation and supported decision-making, nurses should be able to evidence how they have made efforts to do this and that actions which are part of the care plan are clear and attainable.

Recommendation 1
Managers should ensure nursing care plans are person-centred, contain individualised information, and evidence individual's participation in the care planning process.

Recommendation 2
Managers should carry out an audit of the nursing care plan reviews to ensure they fully reflect the patients' progress towards stated care goals and that recording of reviews are consistent across all care plans.

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

Further support for individuals could be accessed through third sector services, for example, opportunities to engage with the employment support service, Link for Life, a local provision for adults experiencing mental ill-health and a new initiative that included peer support workers. It was recognised having individuals with lived experience of mental ill health working alongside services had been beneficial and provided a degree of optimism for recovery.

Use of mental health and incapacity legislation

On the day of our visit, there were a significant number of individuals on caseloads who were detained under the Mental Health Act. Of the care records we reviewed, most individuals were subject to community compulsory treatment orders (CCTOs).

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We would expect to find consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act in place, where required. Unfortunately, we were unable to locate these on the day of the visit. We discussed this with the team and senior managers on the day and there was some confusion in ascertaining what psychotropic medication was prescribed by the CMHT, what was prescribed by the GP, whose responsibility it was to ensure all psychotropic treatment was authorised and we were therefore unable to view treatment certificates during the visit. It was of concern that in any case, CMHT nursing staff were administering intramuscular psychotropic medication without having sight of certificates that were required to legally authorise the treatment.

Recommendation 3
Managers and medical staff should locate and review all current T2 and T3 treatment certificates to ensure they are compatible with all psychotropic medication which is being prescribed and administered and medical staff should pursue DMP visits urgently, where required for T3 certificates.

Recommendation 4
Managers should introduce a robust audit system to ensure that all medication prescribed under the mental health act is appropriately and legally authorised.

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

The 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. There were 34 individuals from the CMHT subject to CPA, with the care coordinator role undertaken by an individual's community nurse. However, it was the

responsibility of the multidisciplinary team to ensure an individual was provided with care, treatment and support to meet their individual needs. Minutes from CPA reviews were held in an individual's care records and we saw evidence of detailed discussions and participation from individuals, their relatives and key people in their lives.

Rights and restrictions

When we are reviewing individuals' files, we looked 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.

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

Community mental health nurses could refer individuals to non-statutory or third sector services who provided recreational and therapeutic recreational activities. In the locality of West Fife, there were several initiatives to support individuals to improve their physical and mental well-being. Fife social care partnership also provided services to support individuals with a recent introduction of The Well. This was a community provision established in Fife that offered individuals information and advice in several areas including financial, social care, mental and physical well-being and accessing activities. Unfortunately, due to competing workforce demands the CMHT had not been able to restart their own activity programmes however, we were told there was an intention to commence a well-being programme once a full staffing establishment had been put in place. We were told individuals valued the input they had received previously from support staff, particularly the walking group, as it offered physical activity along with peer support.

The physical environment

The community mental health team were based in Queen Margaret Hospital, the service had direct links with the adult admission ward based in the hospital. The proximity of the service to the admission ward was helpful, as it allowed community nurses to actively engage with individuals on their caseloads who required an admission to hospital. Community nurses were invited to discharge planning meetings that were held on the ward and, if an individual was referred to the service having not had previous contact with mental health services, then fostering close links with the inpatient team was considered beneficial. In the CMHT, there were essentially two teams that shared the same space, due to the vastness of the locality there was a geographic separation however, the teams worked together to ensure a consistent model of care.

Any other comments

On the day of our visit to West Fife community mental health team, we had the opportunity to meet with the team who are working with individuals to improve access to physical health and

well-being. In this service, there was a dedicated team who had developed an inclusive service for all individuals who required physical health monitoring. To reduce the barriers for engagement with this service, the team worked alongside individuals to seek their understanding of their mental and physical health. The team also sought to understand how individuals who had experienced trauma might require a bespoke approach to their care to promote engagement. With a focus upon building trusting relationships and an inclusive model, the team had become an integral part of a holistic approach to supporting adults to achieve recovery and mental and physical well-being.

Summary of recommendations

Recommendation 1
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Recommendation 3
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Recommendation 4
Managers should introduce a robust audit system to ensure that all medication prescribed under the mental health act is appropriately and legally authorised.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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