Mental Welfare Commission for Scotland

Report on announced visit to:
Inverness Community Mental Health Team, RFM Building, New Craig's Hospital, Leachkin Road, Inverness, IV3 8NP

Date of visit: 17 September 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 intends 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 Inverness Community Mental Health Team (CMHT). The CMHT is a multi-disciplinary mental health service which provides assessment and evidence-based treatment for individuals with suspected or diagnosed moderate to severe mental illness/mental disorder, who for reasons of complexity, severity or lack of treatment response require specialist secondary care input. The CMHT covers the Inverness area, and areas south to Drumnadrochit and Foyers.

We had the opportunity to meet with individuals receiving input from the CMHT, as well as the staff themselves, to find out the types of care and treatment that was available. Wherever possible, we invite individuals receiving care from the service to meet with us on the day of our visit. On this occasion, we met with people in their own homes, along with the CMHT practitioner and also in rooms at the CMHT resource on the site of New Craigs Hospital. We also had the opportunity to meet with the senior leadership team.

Who we met with

We met with, and reviewed the care of eight people, whom we met with in person.

We spoke with the service manager, the team leader, social work manager and senior social worker, community psychiatric nurses (CPNs), occupational therapist, social workers, clinical director and consultant psychiatrist.

Commission visitors

Dougie Seath, nursing officer

Margo Fyfe, senior manager

Justin McNichol, social work officer

What people told us and what we found

During our visit we heard mostly positive feedback about the CMHT service from those that we spoke with. For people who received support from the CMHT, we were told the team worked with them on their mental health and physical well-being, checking they were receiving all benefits they were due and organising additional support where needed.

One individual told us about their positive experience in getting help to secure accommodation and the support they had received in moving to a new area. We heard from another individual "they have all helped me a lot; social work, the CPN and my support workers…they have all been great". However, we did hear other views. In one case, we heard that the turnover of nursing staff had caused issues with the continuity of care and a lack of follow through on actions detailed in care plans.

Care, treatment, support, and participation

Treatment offered by the CMHT included a range of psychosocial and psychoeducational interventions and therapies; we heard that 'Survive and Thrive' is due to begin next year.

Nursing care plans were written together with the patient and in most cases included the treatment and intervention being provided and the aim of the treatment, however we found inconsistency here. Care plans included risk assessment and risk management plans, identifying sources of support if in crisis and if support was needed outside of office hours. The aim of the interventions, in the main, was to work towards the individual's eventual discharge from the service. A number of individuals have required long term support and treatment; this has been provided in line with ongoing clinical review and need. The service has adopted a recovery approach where there was no assumption of life-long intervention from the secondary care mental health services.

Where required, the Care Programme Approach (CPA) was used to ensure robust multidisciplinary and / or multi-agency care planning. CPA is a framework used to plan and co-ordinate mental health care and treatment that involves a range of different people and keeps the individual and their recovery at the centre of this.

There were a number of individuals involved with the CMHT subject to CPA, with the care co-ordinator role undertaken by an individual's community nurse or social worker. However, it was the responsibility of the multidisciplinary team to ensure an individual was provided with the appropriate care, treatment and support to meet their needs. Minutes from CPA reviews were held in an individual's care records and we saw evidence of detailed discussions and individuals' participation, as well as involvement of their relatives and other key people in their lives.

Care records

During our visit, we met with people who had a wide range of health and social care needs; each person had input from different members of the team depending on their specific needs. We found good evidence of multidisciplinary team working, with a weekly meeting to discuss individuals' progress, which was attended by representatives from all professions and there was regular input to these meetings from the inpatient service.

Referrals to the service was made through various routes. Typically, referrals were received from GPs, inpatient services and health and social care partners. Each referral was reviewed or triaged; this process was done weekly by the multidisciplinary team and the person would be seen within five days if urgent, or 28 days if the referral was noted as non-urgent. Those in crisis that needed a response within 24 hours were referred through the clinical pathway established for the locality. We were subsequently advised that there is a rapid discharge pathway that has been established with the social workers in the team who provide in-reach assessment and support to inpatient wards to facilitate safe discharge planning (including those individuals who have no fixed abode). If a referral had been identified as requiring an immediate response, this would be discussed on the day the referral was received.

Any individual who had been referred to the service and had been identified as requiring an assessment would be invited to attend for a mental health assessment. It was agreed between the individual and professionals undertaking the assessment where the assessment would take place. Assessments could be completed by the consultant psychiatrist, psychology, occupational therapy and nursing staff. The CMHT's intention is to have a fully integrated service with social work staff embedded in the team.

All referrals that did not meet the criteria for the service would have a written response sent to referring agencies, with alternative suggestions for further care and support where indicated.

On the day of the visit, we reviewed several care records for individuals who were receiving input from community mental health nurses or social workers.

We looked at care plans where individuals had been invited to participate in their content. Unfortunately, this was not evident with all care plans we reviewed. 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, staff should be able to evidence how they have made efforts to do this, and that actions that are part of the care plan are clear and attainable.

Where people were being reviewed through the CPA, we saw detailed and comprehensive CPA care plans that were reviewed and updated, usually at six monthly intervals. When people had appointments with their psychiatrist, we saw copies of clinic letters sent to their GPs and relevant others; these detailed the care and treatment, regular reviews, and subsequent changes to treatment. However, in some records, the CPA care plan was the only record of care planning and this was reviewed at six-monthly intervals. There was no working care plan with more regular reviews, or clarity around changes made to care plans prior to the six-monthly CPA review.

Recommendation 1:
Managers should ensure that all individuals have working care plans, which are person-centred, and evidence individuals' participation in the care planning process. These can be part of CPA process where this is in place and should be regularly discussed with individuals and adjusted as necessary between CPA reviews.

We found in social work records that where support services had been commissioned, there was not always evidence of social work assessments and reviews held on the electronic information system.

Recommendation 2:
Managers should undertake an audit to ensure that all individuals receiving a social work service have an assessment and review on file.

Where people had an allocated nurse, there was evidence of the use of a nursing support plan. This tended to identify different health needs and how care goals would be achieved. While there was a clear person-centred focus in most of these plans, there was little detail as to how the specific outcomes could be achieved or how progress towards these would be reviewed over time.

Recommendation 3:
Managers should carry out an audit of the 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[1]. It is designed to help nurses and other clinical staff create person-centred ca re plans for people with mental ill health, dementia, or learning disability.

Multidisciplinary team (MDT)
The multi-disciplinary team consists of three consultant psychiatrists, one community mental health team leader, 14 community psychiatric nurses, a psychologist, three occupational therapists, support workers, and a small team of

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

social workers lead by a social work manager with a senior social worker, social workers and a social work assistant. Currently, caseloads of between 26-34 individuals are allocated to a key worker with a further 84 individuals on anticipatory care plans; these individuals are provided with occasional or crisis support. 28 individuals attend for groupwork.

We were late advised that NHS Highland mental health services are working towards being one division (North Highland) and that this would ensure equitable service across areas.

Currently, there is a weekly team meeting between areas, used to facilitate improved communication. The weekly team meeting is on Microsoft Teams which allows everyone to attend from their current location and includes a session to discuss inpatients preparing for discharge to decide on follow up required.

The use of anticipatory care plans supports goal-centred care plans with a view to eventual discharge from the CMHT to other supports, where necessary. There is a plan in progress to encourage nursing staff to undergo psychological therapies training, who will then receive supervision, provided by clinical psychology staff.

There is a weekly multidisciplinary team meeting that all staff can attend. There are regular discussions about complex clinical situations and about those identified to be at risk of relapse. Staff members told us how they have seen people with increasingly complex needs e.g. autistic spectrum disorder and attention deficit hyperactivity disorder being referred to the service. In addition to the complex case discussions, the team can also raise specific concerns with colleagues via an established review system.

We heard that although the service covers the city of Inverness, there is also a large rural component, and that in response to the Covid-19 pandemic, the number of admission beds had been reduced as this had added pressure on the CMHT, both in terms of accessing beds and in the need for earlier discharge.

Use of mental health and incapacity legislation

Where people were receiving their care and treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) we found that the relevant documents relating to the Mental Health Act were easily found in the care records.

On the day of the visit, 50 people were subject to compulsory treatment under the Mental Health.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, 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 for individuals who required this. Although none of the people we interviewed on the day required these to be in place, we saw them in care records for other individuals.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We did not have sight of any section 47 certificates and their associated treatment plans in the care records we reviewed.

Rights and restrictions

When we met with people who had received treatment under the Mental Health Act, it was clear that they had had support to understand their rights, access advocacy and could seek legal advice.

When we reviewed the available records, we looked for evidence of advance statements. These are written statements made under sections 275 and 276 of the Mental Health Act and are written when a person has capacity to make decisions on what future treatments they may or may not want. Health Boards have a responsibility for promoting advance statements. We did not find reference to an Advance Statement in the care records we reviewed.

The Commission has developed the *Rights in Mind*[2] pathway, which is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to hear about the therapeutic interventions and groups provided by the CMHT; these included Decider Skills, You Matter, Early Intervention in Psychosis, graded exposure, Dialectical Behaviour Therapy, and Psychosocial Interventions in Psychosis. We heard about these activities from individuals that we spoke with and saw evidence of them being provided in the individual's electronic care records.

Community mental health nurses could also refer individuals to non-statutory or third sector services who provided recreational and therapeutic recreational activities. Some individuals were encouraged to apply for further education courses. Others had taken up positions in employment and in voluntary work.

[2] Rights in Mind: https://www.mwcscot.org.uk/law-and-rights/rights-mind

We visited the Centred recovery centre, based in Inverness. Many individuals supported by the CMHT reside there before taking up their own tenancies in the community. We found good evidence that those who are in Centred had ease of access to all professionals from the CMHT and were appreciative of the range of community activities and supports on offer.

The physical environment

The community mental health team were based on the site of New Craigs Hospital and 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 and social workers 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.

Any other comments

We were very grateful to the team for their commitment to transparency in setting up opportunities to see the wide and varied work of the CMHT as well as meeting with individuals in a number of settings. This was our first venture in visiting CMHTs in NHS Highland and our visit provided the Commission with a good foundation on which to build for future visits.

We recognised the benefit of the weekly MDT meeting on Microsoft Teams that allowed a good attendance from all professions and provided discussion about potential referrals from the inpatient ward and individuals at risk of relapse. There was also good discussion about complex cases, with alternatives to admission always considered before admission to hospital being considered as a last resort.

Summary of recommendations

Recommendation 1:
Managers should ensure that all individuals have working care plans that are person-centred, and evidence individuals' participation in the care planning process. These can be part of CPA process where this is in place and should be regularly discussed with individuals and adjusted as necessary between CPA reviews.

Recommendation 2:
Managers should undertake an audit to ensure that all individuals receiving a social work service have an assessment and review on file.

Recommendation 3:
Managers should carry out an audit of the 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.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication 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 an individual's care, treatment, and support are 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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