Mental Welfare Commission for Scotland

Report on unannounced visit to:
Tryst Park, Bellsdyke Hospital, Bellsdyke Road, Larbert FK5 4SF.

Date of visit: 25 February 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Tryst Park is a 12-bedded, low secure, forensic ward providing care and treatment for adult males in NHS Forth Valley. It is located on the site of Bellsdyke Hospital in Larbert, Falkirk. The wards on the Bellsdyke site share access to four self-contained bungalows and a hospital owned flat in the local community. This additional resource is used to increase skills and independence for people progressing in their rehabilitation.

On the day of our visit, there were eight people on the ward, two in the onsite bungalows and one living in the off-site flat.

We last visited this service in February 2024 on an announced visit and made one recommendation in relation to specified person restrictions. The response we received was that everyone's status would be reviewed at multidisciplinary team (MDT) meetings and renewed or revoked according to their individual requirement.

Who we met with

During the visit, five people agreed to meet us and we arranged to visit another individual who was living off-site a few days later, in accordance with their preference; we were able to speak with one carer who was visiting the ward on the day.

We reviewed the care records of four of the people we spoke with and an additional two people. We also met with team members, including a forensic consultant psychiatrist, nursing staff and a clinical support worker (CSW).

Commission visitors

Denise McLellan, nursing officer

Sandra Rae, social work officer

Graham Morgan, engagement and participation officer (lived experience)

What people told us and what we found

Overall, we heard positive feedback from the range of people we spoke with, and we observed mutually respectful interactions throughout the course of the day.

Individuals were complimentary about the support given by the whole team, describing all staff as approachable and telling us that support was always available when needed. We heard descriptions such as “brilliant”, “friendly” and “by far the best”. One person told us that “staff should talk to patients more” while another noted positive relationships, saying that staff were key to this, telling us “I like everything about here.”

One individual told us the multidisciplinary team (MDT) meeting occurred on a three-weekly basis and although they didn’t always attend, they told us “I do have a say in what happens to me.”

One person we met with was unhappy they were subject to compulsory treatment and as such, felt they had no choice or involvement, with staff lacking understanding. Although voicing their unhappiness with being given a diagnosis and detention in accordance with legislation, they told us that they enjoyed some aspects of the activity programme and had an awareness of their specific restrictions and rights.

Generally, the ward environment was described as “peaceful” and “safe”. People enjoyed having access to the hospital grounds for walking. There is a small shop in the grounds as well as some local shops nearby. We also heard that there was a large onsite gym that was popular. Most spoke enthusiastically about the range of activities available, but one person said they would like activities to be more nature oriented, including hill walking and similar outings away from the hospital; we were aware that they could raise this at the ward community meeting. They also felt increased opportunities for swimming, football and other sports would be beneficial.

We were able to speak to an individual who was living in one of the onsite bungalows. They told us that they enjoyed living there and regarded it as a positive move in preparation for discharge to their own accommodation. Although still living onsite and having contact with staff, their independence and confidence had increased.

Observations and feedback from the carer who also fulfilled the role of named person, included “the atmosphere is very calm and quiet here and not as intense as other places.” A comparison was made to their experience of another inpatient ward where they were concerned that there had been greater exposure to illicit substances and they considered their experience of staff communication with families as poor. They spoke of feeling that their opinion was irrelevant and of being “brushed off”. “Here is so much better, it’s like a breath of fresh air” adding that staff involved them as much as possible and were “approachable, easy to talk to and they felt listened

to." They expressed their gratitude for this and spoke positively about the support with activities and specifically how these were matched to an individual's interest rather than by any coercion. They told us that the activity coordinator would involve the individual at the planning stage to encourage participation as otherwise they would not be motivated. They spoke positively about how nursing staff had made efforts to adapt the care to the individual's needs, given the complexities of the illness and condition.

They highlighted that the consultant psychiatrist had recognised a risk of carer stress associated with trying to maintain frequent visiting. Support and discussion around this with them had been helpful to manage this and provided a sense of relief. They spoke of attending meetings, being able to ask questions, contribute and felt that the care was good and staff were supportive.

Some staff described the team as "healthy" where opinions and ideas were both welcome and encouraged. The changes that had been made to the shift pattern that we had heard about on our last visit were considered to have been beneficial and had promoted a positive work/life balance. There were however continued shortages in the nursing team and there was ongoing action to address this. It was considered that although able to recruit to vacancies, retention of staff was more challenging.

We heard about team cohesion and the level of commitment from all disciplines and that "we all really work well together." Those from the staff team that we spoke with added "it's a really supportive environment here, unlike other places and this is one of the reasons I work here" and that Trystpark was "a nice, contented environment with motivated staff and opportunities".

The Royal College of Psychiatrists (RCPsych) offers accreditation programmes for inpatient mental health services to help improve the quality of care delivered. This is achieved by using a structured framework to assess against a set of core standards with the aim of overall quality improvement. When services are awarded this status, staff often become more invested and inclined to remain with the service in the knowledge they are providing safe, effective and compassionate care. We were pleased to hear that the MDT had volunteered to pursue accreditation and although a significant undertaking, they were committed to attaining this.

Care, treatment, support, and participation

Given the more restrictive nature of a forensic setting, building therapeutic relationships to provide non-judgemental care and treatment in tandem with effectively managing risk can be challenging. We were able to see a culture that was supportive, engaged and inclusive with continued efforts to keep people informed. We were also pleased to hear that the School of Forensic Mental Health (SoFMH) teaching programme 'New to Forensic' (NTF) was still being delivered despite the staffing challenges.

Numerous display boards with information including activities, local information and the day's menu were well presented and kept up to date. We also saw information about ward rules clearly displayed, which included a reference to respecting others. We saw the 'positive messages for the team' board which was a new addition since our last visit.

There was an emphasis of promoting physical health, which was being pursued through regular health monitoring, a healthy dietary intake and a range of different physical activities. It was acknowledged that the shop located in hospital grounds did sell some less healthy options and consideration was being given to how change with this could be influenced without force.

The electronic record of physical health initiative (EHIP) was a quality improvement project introduced to look at the physical health of individuals to ensure they had access to screening which would be equitable to those living in the community.

Care records
Individual records were held on Care Partner, the electronic health record management system in place across NHS Forth Valley.

Risk assessments using the structured clinical tool assessing historical, clinical and risk management factors (HCR-20) were available and up to date. The risk management traffic light plan (RMTLP) was further discussed at MDT meetings. The structured meeting template documented a summary of discussion, outcomes and actions being taken forward from meetings. It also captured which professionals, individuals and carers attended. We found information relating to professionals-only meetings and representation from other services where relevant, such as the forensic community mental health team (FCMHT).

Individuals were managed under enhanced care programme approach arrangements (CPA) with relevant documentation available. Where individuals were subject to multi agency public protection arrangements (MAPPA) scrutiny, this was also recorded.

There was evidence of regular and detailed one-to-one contacts and continuation notes that described individuals' mental health presentations and their participation in various activities. Where an individual had refused to engage in physical health monitoring, this was documented.

Care plans covered various aspects of physical and mental health needs. Overall, they were person-centred, used accessible and easy-to-read language, were detailed and informative, with regular reviews. Where someone had not agreed with aspects of their care and treatment planning, this was made clear. We found one recording that an individual had been consulted but this was not clearly evidenced. We were unable to see that their views had been captured or evidence of a summative review in the record. We highlighted this example during our feedback meeting and the

senior charge nurse (SCN) and deputy senior charge nurse (DSCN), who assured us that this would be followed up.

Multidisciplinary team (MDT)
The team consisted of forensic consultant psychiatry, psychology, nursing, clinical support workers, OT, activity coordinators, pharmacy and physiotherapy. Other professionals such as mental health officers (MHOs) and social workers attended relevant meetings at specific points in the care journey.

Occupational therapy (OT) provided sessions, including assessments for individuals living in the bungalows or off site. Some individuals were completing substance misuse work with psychology assistants. Behavioural family therapy (BFT) was also available for individuals and families.

We were pleased to hear that family were welcome to participate in the MDT meetings, along with the individual who was receiving treatment. Where individuals chose not to attend, we found records detailing that discussion had been offered through face-to-face contact after the meeting.

The ward did not have a carer group, and we were told that people were signposted to Falkirk & District Association for Mental Health (FDAMH) for further information. Forth Valley Advocacy provided independent advocacy for individuals requiring this service.

The ward had access to a community GP for medical issues during clinical hours and were supported by Forth Valley Royal Hospital medical staff for any issues arising out of hours.

Use of mental health and incapacity legislation

On the day of the visit, all individuals were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act). Detention paperwork was available for everyone, along with information on individuals' suspension of detention (SUS). People told us that they were aware of and understood their rights in accordance with the legislation.

Any individual receiving treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where individuals had nominated a named person, we found details recorded and copies of the nomination on Care Partner.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to 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 were in date and available in hard copy format as well as being on Care Partner.

T2 certificates included a clear plan of treatment and were signed by the individual. T3 certificates corresponded to medication being prescribed apart from one. In this instance the prescription included one medication which was not authorised on the corresponding T3. We spoke with the SCN to clarify the purpose of the medication, and it was confirmed it was being prescribed to manage symptoms associated with mental disorder rather than a physical health problem. They agreed to follow this up with medical staff so this could be rectified.

Recommendation 1:
Managers should ensure that all psychotropic medication given under Part 16 of the Mental Health Act is legally authorised and an audit system is put in place to monitor this.

We found that three people were being supported to manage their funds by the hospital in accordance with the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act). One person was also subject to an intervention order and an AWI case conference had been arranged to discuss future management. All corresponding documentation was in date and available on Care Partner.

Rights and restrictions

Tryst Park operated a locked door policy commensurate with the requirements of a forensic unit in managing risk.

Sections 281 to 286 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act) provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is designated a specified person and where restrictions are introduced, it is important that the principle of least restriction is applied. Through our visit programme we had become aware of instances where services had designated individuals as specified persons for safety and security in hospitals as a 'blanket measure'.

When we visited last year, we found that all individuals had been designated as specified persons, regardless of their individual needs. On this visit we were pleased to find that only three individuals were subject to additional restrictions, and that this was reviewed at MDT meetings. Two of these individuals had additional restrictions on their use of phones and we found detailed reasoned opinions for this.

When reviewing individuals' files, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 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. Where written, we found copies of advance statements. One individual told us that they had been asked about this however, had decided not to make one and were not interested in doing so. They spoke of previously accessing independent advocacy but not currently needing them, however they were aware they could seek re-referral in the future.

Amendments to the Mental Health Act in 2015 extended the right of appeal to be transferred from the State Hospital or a medium secure hospital to conditions of lower security, however there is no right of appeal against conditions of excessive security for people in a low secure environment. The MDT continued to look for placement opportunities in the local area, where the individual would be discharged to, so that they are not disadvantaged further by this situation. We learned about one individual being considered for housing in their own health board area.

Activity and occupation

There was a broad range of activity available both in the ward and across the wider site, encouraging increased socialisation. Individuals discussed preferences with the coordinators and activity plans were devised that met with the individual's range of interests.

Activities were offered over the entire week, and the timetable was up to date. The carer we spoke with praised the benefits of activity and told us of the improvements they had noticed.

Details of activities were printed off each week and prominently displayed on the notice board directly across from the nursing office. It was printed on larger A3 paper and brightly coloured in an easy-to-read format, making it more accessible and appealing.

We heard from individuals who valued this variety which included karaoke, a walking group, bingo, relaxation, cold baking, circuits class, gym sessions, horticultural therapy, art therapy, freedom and mind choir, litter picking and indoor bowls. Other themed visits included trips to the cinema, ten pin bowling and swimming. Some individuals had vocational placements in the community.

The physical environment

The ward layout consists of three specific areas created in a Y shaped formation.

Although bedrooms were single occupancy, they did not have en-suite facilities. Instead, individuals shared two bathrooms, two showers and toilet facilities.

Bedrooms were positioned along two separate corridors, with each corridor having its own lounge.

We asked about the longer-term improvement project, including addressing the identified ligature risks. We were told that capital funding had been allocated, and a ten-year programme was being developed. It was hoped that the Bellsdyke Hospital refurbishment would be commenced within two years.

The MDT meeting room and offices were located separately. The nursing office, clinical areas and main reception were centrally located. The ward benefitted from two separate lounges, a wellbeing room and a quiet room with access to a public phone. There was also supervised access to a pool table. The dining area was shared, and we were told there were two sittings but if the ward was quieter there could be opportunities for peers to mix. All areas were clean and tidy and well organised. The environment was quiet, calm and felt relaxed.

The garden was private, well used and was enhanced by a multi-sport court and adequate seating. It was not overlooked by other buildings. On the day of our visit the estates department were carrying out routine maintenance as part of the rolling programme. There had been a lot of leaves and associated debris from a recent storm, and they cleared this quickly. We were told that estates were responsive to any repair requests.

Any other comments

We were pleased to be told that regular clinical supervision and reflective practice were still prioritised despite frequent staff shortages.

NTF, venepuncture, and ECG training was also available along with development opportunities, including role playing scenarios. Other encouraging news was the team's ambition to work towards RCP accreditation, and the commitment to improving staff retention.

Summary of recommendations

Recommendation 1:
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Service response to recommendations

The Commission requires a response to this recommendation 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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