Mental Welfare Commission for Scotland

Report on unannounced visit to:
Leverndale Hospital, Wards 5, 6, Boulevard, Bute and Campsie House, 510 Crookston Road, Glasgow G53 7TU

Date of visit: 18 March 2025

Where we visited

Wards 5, 6, Boulevard, Bute, and Campsie House make up the low-secure forensic service for the Greater Glasgow and Clyde Health Board (NHSGGC). The wards are based at Leverndale Hospital, which is located in the Crookston area of Glasgow.

- **Ward 5** provide low secure facilities for 15 men.
- **Ward 6** provide low secure facilities for 15 men.
- **Boulevard Ward** is a nine-bedded male 'pre-discharge' ward.
- **Bute Ward** provides a low-secure female provision for five women.
- **Campsie House** is a nine-bedded, male, low-security ward for forensic patients with a learning disability.

On the day of our visit, there were 50 people in the service with three vacant beds across all of the wards.

We last visited this service in February 2024 on an announced visit and made four recommendations. These included the need for care plan reviews to be person-centred and that individuals were given the opportunity to engage in their reviews. We recommended that treatment plans were attached to section 47 certificates and that specified person procedures were implemented with reasoned opinions attached. We recommended that repairs were undertaken at Campise House, with a review of suitability of the ward due to the concerns found on the day.

The response we received from the service was that the audits were set up to address care plan reviews. The consultant psychiatrists for the hospital were completing treatment plans and that the rational for the use of specified persons would be recorded on EMIS. The service supplied a summary of the various steps taken to improve the environment of Campsie House.

On the day of the visit, we wanted to give individuals and their relatives an opportunity to speak with us regarding the care and treatment on offer. We wanted to ensure that care and treatment was being provided in line with mental health legislation and in a human rights compliant model and that the forensic services were delivering care in line with their local service standards.

Who we met with

We met with 20 individuals and reviewed the care records of 14 individuals. We spoke with two relatives.

We spoke with the acting service manager for the day, the senior charge nurses (SCNs), the lead nurse, the lead for the allied health professionals (AHPs), two consultant psychiatrists and various nursing staff for the hospital.

We had the opportunity to observe individuals taking part in group activities in the wards and our engagement and participation officer was able to attend lunch with individuals in Boulevard ward.

Commission visitors

Justin McNicholl, senior manager (projects)

Kirsty MacLeod, engagement and participation officer

Catriona Neil, ST6 learning disability psychiatrist, on placement at the Commission

Mary Leroy, nursing officer

Paul Macquire, nursing officer

Audrey Graham, social work officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, restrictions, participation in their care and treatment, activities that were available to them and their views of the environment.

We were also keen to review the care plans for individuals who had been in the hospital for several years, individuals who were subject to oversight by the Scottish Government ministers and the plans to prepare them for discharge.

Individuals told us that “the care is brilliant here”, “staff are lovely”, and “they treat you with respect, they want to help you”. We heard a variety of positive statements about the support they received from nursing, medical and AHP staff including “the doctor is good”, “I feel listened to by her”, “they make sure I have things to do” and “I have a really good relationship with them all”.

We received several comments on the issue about staff numbers in the wards, such as “I’ve not been able to get out due to lack of staff in Campsie”, “my outings were prevented due to lack of staff”, “we need more staff on the ward to accommodate our wellbeing”, “there’s times I can’t get out when I’m supposed to out for walks for 4-5 hours per day” and “there are times they are light on staff”. Despite these shortages individuals commented, “I feel listened to”, “I feel safe” and “there are always opportunities for me and my mum to be spoken with”, although one individual said that staff “should be more bubbly and cheery”.

The majority of the individuals we spoke with were clear that there were opportunities to meet with the multidisciplinary team (MDT) to ask questions. Several individuals stated “I see my doctor at least once every week” and “I’m able to get answers to any questions or worries I have”. The individuals we spoke with were relatively happy with their care and treatment across the wards, despite being subject to significant restrictions on their liberty. The majority spoke positively of contact with their family members. We did hear from individuals in Boulevard Ward who reported that there was a lack of consultation with their family members and this was reflected in the notes we read.

We heard several frustrating comments from individuals in Campsie House. We were told “I hate it here”, “the place is bogging”, “the showers are bogging”, “its noisy at night and my sleep is disrupted due to how thin the walls are”, “there are eight of us in here and they expect us to share two showers; it’s horrible”. Another individual commented “why can’t we be like everywhere else that has their own toilet and showers?”. We raised these concerns with managers on the day of the visit to stress the need that these matters required addressing to improve the quality of life for individuals living in Campsie House.

All the individuals in Boulevard, Campsie and Bute were pleased with the food on offer as they were able to prepare food choices. One stated, “as we make it ourselves…it’s not like that factory stuff other wards have”, while individuals in Ward 5 and 6 commented, “the food is not great”. We met with seven individuals in Ward 6 and only one of them stated that the food was “good”; the rest of the individuals expressed their disappointment at the menu options and the poor quality of food supplied. This matter was raised with managers of the hospital on the day of the visit and they stressed that this feedback would be shared with the catering staff.

We had several positive comments about ease of access to advocacy services and individual solicitors who helped to represent people’s views at mental health tribunals, care programme approach (CPA) meetings and multi-agency public protection arrangements (MAPPA) meetings.

In relation to family contact, we consistently heard evidence that families had the opportunity to attend CPA meetings. Individuals told us “my mum can catch up what’s going on” and “my named person can ask questions - they have at the CPA”.

There was evidence from nursing and relatives that good rapport was in place across the various wards with families where supervised contact was in place, as and when required, depending upon the individual’s risks. We heard positive comments about individuals having visits home to their accommodation or to that of their families.

The Commission was aware of the significant challenges both individuals and the service face with supporting those who are fit for discharge to return to the community. We reviewed all those who were subject to delayed discharge proceedings and were given information about the various barriers and the extensive steps taken to move these matters on. We found evidence across all of the wards that individuals were facing delays in their discharges. We found that the service was prioritising efforts between responsible medical officers (RMOs), mental health officers (MHOs), social workers, advocacy workers and the delayed discharge team to address individual cases.

Care, treatment, support, and participation

Care plans

Care plans are a tool that detail how care and interventions will be delivered; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed to provide a record of progress being made.

During our last visit we made a recommendation regarding the need for care plans reviews to be audited to ensure they are completed on a regular basis. We found that individuals in the hospital had care and treatment plans in place to support outcomes that had been identified. These were stored in paper files, held in each of

the wards. Care plan reviews were stored on the NHSGGC system called EMIS. There is a plan for the service to roll out the recording of all care plans and reviews on EMIS in the future.

Similar to our previous visits, we had no concerns with the quality of the care plans; we found them to be comprehensive, meaningful, with a clear focus on risks and with regular reviews in place.

We found that individuals had multiple plans to support their care and treatment in the hospital. Individuals were aware of their care plans and participated in the review of these, as and when required. The information in the plans detailed the care, treatment and support the individual required, provided a clear understanding to staff as to what interventions were necessary to provide the support that was required.

There was clear evidence of involvement and progress in the care plans. Similar to our last visit, we noted that there were some delays in care plan reviews being completed. On this occasion, it was in Bute Ward where the monthly review targets were not being met, due to staff sickness and absence.

Recommendation 1:
Managers should ensure care plan reviews are completed on a consistent basis in Bute Ward.

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 care plans for people with mental ill health, dementia, or learning disability.

Care records
Individuals records are held mainly on EMIS, the electronic health record system used by NHSGGC. Additional documents continue to be collated in paper files, including care plans. There is a long-term plan in NHSGGC for all individuals' records to be held on EMIS but as noted in our previous visits there is no exact date confirmed for the transition to a paperless system.

Similar to our last visit, we found individuals' records easy to navigate, and there was a clear focus upon their mental and physical wellbeing, with comprehensive annual physical health reviews in place.

We found clear, consistent recording of daily notes, with a clear summary of events for each individual. We found a more detailed, descriptive narrative that helped in understanding how an individual had been encouraged to engage with the ward-based team, that described their emotional and physical wellbeing and when the

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

individual presented with stress, how staff had supported them to reach a position of relaxation again.

The records included evidence of a comprehensive model by used by psychology staff. We found details of the range of activities and therapies provided by occupational therapy and technical assistant staff; the ward and community-based activities were detailed in the records.

We were pleased to see evidence of one-to-one discussions between individuals and their nurses recorded in the care plans. We reviewed minutes of the care programme approach (CPA) meetings which were detailed, regularly reviewed, and included clear individual risk management plans. The plans were robust, comprehensive and what we would expect to see when managing restricted patients.

There was also clear evidence of MAPPA meetings and input ,where applicable, with the Principle Medical Officer (PMO) who holds a key role in the management of forensic patients.

We found evidence that some HCR-20 risk assessments that had not been reviewed in line with the service targets. Those who are subject to civil orders have their HCR-20 assessments reviewed every two years while restricted patients have these reviewed annually. From the files we read, this target was not being met in a number of cases due to psychology staff shortages.

Recommendation 2:
Managers should ensure HCR-20 review reports are completed on a consistent basis in all wards.

Multidisciplinary team (MDT)
We were pleased to note that the wards all have a full, multidisciplinary team (MDT) that included psychiatry, nursing, occupational therapy, psychology, pharmacy and other professions as and when required.

The recording of the MDT meetings were detailed, with a rational for decisions made and the required actions. The MDT took an active role with all individuals and we were pleased to see evidence of how staff regularly engaged with individuals and when applicable, with their relatives, to discuss what was important to them and how the MDT could support their decisions and views.

When individuals receive care and treatment in forensic services, we would expect a focus on rehabilitation. This was available to those in the wards who had a clear focus on discharge planning it was particularly well documented in Boulevard Ward.

We found evidence of physical health care monitoring being provided throughout each individual's journey. We found annual physical health reviews and screenings

of individuals' blood pressure and weight. Where some individuals required input from other specialities, such as dietetics, speech and language therapy and physiotherapy, this had been identified and discussed at the MDT and those services were accessed as part of an individual's care and treatment.

The weekly MDT meeting was recorded on EMIS, and the records that we reviewed provided a comprehensive overview and update. Details of who was present at the meeting, along with outcomes, actions and any requests from individual were recorded.

There was clear evidence of input from advocacy services at all key meetings where there was an impact upon their recovery and journey through the low secure service.

Use of mental health and incapacity legislation

On the day of our visit, all of the individuals in the wards were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 ('CPSA') as would be expected in the restrictive environment of a low secure setting.

The appropriate detention paperwork was easily accessible for all individuals. 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 found that consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health were held both on EMIS and in a separate paper file.

We found some evidence that not all prescribed medication had been included in the T2 and T3 forms by the allocated responsible medical officer (RMO). Our view is that the forms should be completed with all appropriate medication prescribed under the Acts.

Recommendation 3:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised. Regular audits should be undertaken to ensure correct authorisation is in place.

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 a patient had nominated a named person, we found these recorded on EMIS.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of 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 found section

47 certificates in place for all individuals records that we reviewed and where a proxy decision maker was appointed, they had been consulted.

When an individual is subject to a section 47 we would expect to see a treatment plan recorded on an Annex 5 form. This is completed by the clinician with overall responsibility for the patient. The treatment plan should be written to include all of the healthcare interventions that may be required during the time specified in the certificate. The treatment plan should be clear on whether the patient has capacity to make decisions regarding nutrition, hygiene, skin care, vaccinations, eyesight, hearing, and oral hygiene. We found treatment plans attached to the section 47 certificates that we reviewed.

Rights and restrictions

All individuals on the wards continue to be individually designated as 'specified persons' in relation to safety and security provisions, under section 250 of the Mental Health Act. This has been raised with managers on previous visits and we have been assured that each individuals' specification is reviewed on a three-monthly basis in line with their management plans.

Despite this assurance, during our visit we continue to find no evidence of any reasoned opinions on file for those subject to safety and security restrictions. RMOs are required to notify the Commission of the use of all specified persons measures.

Managers and psychiatry staff that we met during our visit were clear that all individuals required to be individually designated as specified persons for the protection of patients and staff in these wards. We had a further discussion with managers about the lack of recording. They confirmed that at present, NHSGGC do not have a template in place to address the gap in the recording of a reasoned opinion, however we signposted them to a template which is used in other inpatient services on the Leverndale site which could address this gap. We have also repeated the previous recommendation.

Recommendation 4:
Managers should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

The Commission has published a good practice guide in relation to specified person which nursing and medical staff may find helpful when considering restrictions: specified_persons_guidance_2015.pdf

When we are reviewing individuals' care records, we look for advance statements. The term 'advance statement refers to written statements 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. Most individuals in the wards had their own advance statement. We were pleased to see evidence on how the services have linked with advocacy to support individuals to do this and that the rights of each person are safeguarded. We were pleased to see that the advance statements linked with the care programme approach (CPA) to ensure that all views were captured.

The individuals we reviewed all had access to advocacy and the wards had regular input from Circles Advocacy, a specialist forensic advocacy service. As well as individual work, they ran meetings on the wards to help individuals with collective issues. We did not hear from advocacy during this visit, however we look forward to linking in with them during our next visit regarding the input they provide to ensure individuals are supported with their rights while in the low secure setting.

The Commission has developed Rights in Mind. This pathway is designed to help staff in mental health services ensure that individuals have their human rights respected at key points in their treatment. This can be found at https://www.mwcscot.org.uk/rights-in-mind/

Activity and occupation

Similar to our last visit, many of the individuals reported opportunities to have time out in the grounds of the hospital, as well as in the wider community. We heard from those that we met with that they had regular access to on-site and off-site community groups and activities. The activities included a guitar group, singing groups, stop-motion animation classes, gardening, budgeting skills, attendance at college courses and gym access. While we heard from individuals of their enjoyment in being able to attend local shopping centres, the circus, the pantomime and trips to various significant locations.

We noted that there were activity timetables on display in the wards that provided a weekly structure. The Boulevard, Campsie and Bute Wards have a 'home-style' model in place which is focused on preparing individuals for returning to the community. The home-style model of care works with a recovery-based framework; staff and individuals work together to ensure that each person is equipped with the practical skills necessary to allow them the optimal chance of successful rehabilitation from the long-term inpatient forensic setting to an identified community setting. Most of the individuals we spoke with were positive about this model of care; they told us that they felt in control of different aspects of their life, including their diet and as such, were developing or maintaining cooking skills.

The wards were focused on providing a holistic model of activities and occupational outlets that would benefit the individuals in the service. We were pleased to note that while the needs of this group of individuals can be complex, the service appeared to

be working well with their model of care which was delivering successful rehabilitation and discharges to the community.

We heard from staff of the new continuous intervention strategy that was being introduced to assist those who require enhanced observation. To aid with this occupational therapy staff were providing activity boxes to aid those individuals who were confined to their bedrooms but continued to require activities and stimulation. We look forward to hearing more of this strategy at future visits to see whether it was making a difference to those who were restricted by continuous interventions.

The physical environment

The physical environment of the wards was unchanged from our last visit.

We once again heard a significant number of concerns from individuals regarding the poor conditions in Campsie House. Since 2019, the Commission has been raising issues, commenting upon and making recommendations about the overall conditions in Campsie House. There has been little change.

During our last visit we heard concerns regarding the flooring in the ward, holes in walls of individual bedrooms, issues with sofas and furnishings and the shower rooms. For this visit, individuals stated they did not believe Campsie House was a suitable environment for them.

While we found that the holes in the ward walls had been repaired and there was a patch to the floor in the maintain corridor, we found chairs and soft furnishing in the ward in a poor condition. These items had been picked at and ripped with visible scratches. The sitting room door did not close properly and was in need of repair. The shower room was foul-smelling, ceilings were covered in damp and the floor seals were damaged.

We found the overall décor of the ward was tired and required repainting to address the various marks and poor state of repair.

Following our visit to the ward we met with managers who informed us of the ongoing limited success they experienced in trying to improve the ward due to the lack of budget. As we have noted since 2019, this matter should be prioritised as it is directly impacting upon the individuals in the ward, many of whom have been in the ward for several years and are annoyed and frustrated that their views on the conditions of the ward are being ignored. Given that this us a repeated recommendation from previous years, we will escalate this to the senior management team (SMT) for the health and social care partnership (HSCP).

Recommendation 5:
The SMT of the HSCP should prioritise repairs to Campsie House and review the suitability of the ward due to the patient and staff concerns.

On this visit the individuals in Boulevard, Bute and Ward 5 and 6 noted that they found the wards to be comfortable despite the fact that some of these wards have no en-suite facilities available. In particular the individuals in Bute ward praised the environment and reported it to be “lovely”, “clean” and “calming”.

All wards have access to a number of lounges and rooms. Some of the wards have an education room, a therapeutic kitchen, a quiet room, a laundry room and a TV room. All of the wards have a garden area.

We observed some issues with the state of the garden in Ward 5 which was unkempt and in need of tidying. We were advised by managers that this resource was maintained by those individuals in the ward and not the estate staff. We believe more work could be done to improve this area to make it more therapeutic for individuals.

Any other comments

We were informed by nursing staff that there were positive opportunities to have reflective practice sessions for staff which helped to manage the complexity of the individuals in the service.

We were informed that a new practice development nurse (PDN) post had been established to focus on risk management, behaviour family therapy and venepuncture.

We were advised that psychology staff are providing training for staff with a focus on the psychological safety model which was supporting the practice of staff.

Summary of recommendations

Recommendation 1:
Managers should ensure care plan reviews are completed on a consistent basis in Bute ward.

Recommendation 2:
Managers should ensure HCR-20 review reports are completed on a consistent basis in all wards.

Recommendation 3:
Managers and the responsible medical officers must ensure that all psychotropic medication is legally authorised. Regular audits should be undertaken to ensure correct authorisation is in place.

Recommendation 4:
Managers should ensure a reasoned opinion is provided for all restrictions applied to individuals specified under the Mental Health Act.

Recommendation 5:
The SMT of the HSCP should prioritise repairs to Campsie House and review the suitability of the ward due to the patient and staff concerns.

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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