Mental Welfare Commission for Scotland

Report on announced visit to:
Bellsdyke Hospital, Hope House, Bellsdyke Road, Falkirk, FK5 4WS

Date of visit: 1 December 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

Hope House is a six-bedded unit in Falkirk that provides care and treatment for women experiencing more complex mental health care needs, requiring greater levels of support and supervision.

When we visited, there were three women in the unit with another living in one of the self-contained bungalows on site. The bungalows provide an additional resource for transition to more independent living in the community, for individuals from wards in the wider site. There were no delayed discharges in the unit at the time.

We last visited the service in December 2024 on an announced basis and recommended that medication consent forms should record specific details of medication rather than list by classification only. We were pleased to see that this recommendation had been actioned. We were also aware of concerns about a reduction in psychology provision on our last visit and wanted to follow up on this.

Who we met with

We were provided with a general update from the senior charge nurse (SCN) and clinical nurse manager (CNM) in an online meeting the week before our visit.

On the day of the visit, we reviewed the care records of four people, three of whom we met in person. One relative was happy to provide feedback and arranged to meet us in the unit.

During the visit we met with the service manager, the SCN, the CNM, the consultant psychiatrist, health care support workers (HCSW) and the activity co-ordinator. An online meeting was arranged with psychology following the visit.

Commission visitors

Denise McLellan, nursing officer

Tracey Ferguson, social work officer

Alison Thomson, nursing officer

What people told us and what we found

Feedback was positive, with one individual telling us she felt respected, listened to and involved in her care and treatment. She described the environment as feeling safer than her experience of other wards and there were lots of groups adding structure to her day and that encouraged her to be more independent. Another individual described the staff as “great”, identifying the SCN and consultant psychiatrist as particularly supportive and “believing in me.” The opportunity to move into the bungalow had allowed another person to complete tasks independently, simultaneously increasing her confidence. She was knowledgeable about future planning and had an awareness of her rights and support.

Another individual told us she had felt a positive difference since transferring from a previous ward. She felt “less restricted” having been moved off continuous observation and was now able to have supported time at activities that were out with the ward, as well as visits to the family home. She spoke of the environment feeling” homely” and that she had been able to personalise her bedroom. She found the structured days helpful and personalised to her choice which encouraged integration with others at a manageable pace. She added that she found all staff to be non-judgemental, seeing her as a person which was helping her mental health.

One other individual we met told us that they had been in the service for several years and described their experience of “ups and downs”, which was predominantly linked to their mental health. She felt there was a focus on her recovery, with opportunities to learn new skills and integrate with the local community. She told us of a recent benefit from a therapeutic intervention that not only helped her but also improved the relationship with her family, resulting in their participation in meetings. The only issue raised related to a restriction in the number of parcels that could be delivered each week. With it being close to Christmas this was considered limiting when trying to arrange shopping for gifts. We enquired with nursing staff about this and were told this was ward policy due to constraints on storage and not related to specific restrictions on individuals.

The relative we met offered positive feedback about the staff in an environment that was new to them. They highlighted the focus of the expertise with personality disorder and a lack of stigma. They made positive comparisons about increased involvement and felt their daughter was in a safer environment. They commented that despite levels of intervention being reduced through robust risk management and effective planning, this had had a positive impact, leading to reduction in other risks. They spoke of there being a structured goal for this admission to support their daughter achieve a safe discharge to independent living in the future. They also felt their own role as named person was considered and they were informed of decisions.

Care, treatment, support, and participation
Individuals confirmed participation in fortnightly multidisciplinary team (MDT) meetings as well as care programme approach (CPA) meetings. CPA is the framework used to provide structured care for individuals with complex care needs requiring multiagency involvement, and everyone on the ward was subject to CPA. We heard that families could attend MDT meetings, but few did, largely due to other commitments, however most attended CPA meetings. One family were currently engaged in behavioural family therapy (BFT), and the team was looking to offer this to another individual and her family.

We were told themes, such as common unit practices, e.g. access to the kitchen and accessing mobile phone devices at set times, were regularly discussed at community meetings, along with the general functioning of the unit. We were told everyone was supported to make their opinions known. Regular twice-weekly one-to-one contact between individuals and nursing staff/HCSWs were offered and additional input could be facilitated if requested.

Routine monitoring of physical health observations was carried out by ward staff in line with the psychotropic medication policy. There was access to a local GP surgery for any physical health needs and the advanced nurse practitioners aligned to the GP surgery continued to visit the ward weekly. We were told there had been some lack of continuity noted, an example of which related to analgesia, which was being pursued. We saw input from dietetics, physiotherapy and that individuals were being encouraged to attend local clinics for dental treatment.

Care records
Individual records were located on the electronic health record management system, Care Partner. This held information about assessment, fortnightly MDT meeting record, CPA meeting minutes, risk assessments, continuation notes, recording of one-to-one contacts and mental health care plans.

Care plan goals promoted recovery and rehabilitation, addressed needs including social isolation, promoting physical health and maintaining mental health and support. The care plans were detailed, strengths-based and person-centred. They were reviewed monthly and evidenced individual involvement, which included individuals' signatures as well as documenting their views.

Risk assessments and risk management plans were completed using the functional analysis of care environments (FACE) document. We found risk profiles in place that focussed on strengths, protective factors and provided an historical context. Families' views were incorporated into risk assessments, with descriptive summaries of the main risks identified; they were reviewed regularly and updated following MDT meetings.

The MDT documentation provided prompts for discussion, including time away from the ward, legal status, medication, and discharge planning. There was also information on individuals' and families' views on the goals of admission and progress.

We noted that one individual was awaiting psychology input for completion of an 'Historical, Clinical and Risk Management-20' (HCR-20) risk assessment. The HCR-20 is a structured tool used to assess the risk of violence. Each professional was responsible for recording their own involvement and entries were comprehensive and detailed.

The language used in the records was non-judgemental, gave a sense of who the individuals were and evidenced that their views had been sought. We had been told by individuals that they were regularly approached to be involved in care plans reviews and one-to-one contacts.

We found section 76 care plans detailing treatment plans for those who were subject to compulsory treatment orders under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act).

Multidisciplinary team (MDT)

The MDT consisted of a consultant psychiatrist, medical staff, mental health nurses, HCSWs, an occupational therapist (OT) and activity co-ordinators. Except for some recent spikes in continuous intervention, the use of bank nursing had reduced over the past year, and we were pleased to hear that when the nurse recruitment process was complete there would be a full complement of staff.

We were informed at the last visit of a reduced psychology provision and were told that the team had noted a further reduction since then. Funding for a Band 8 psychology post was lost as part of the board's financial saving measures. Historically, wards had access to regular sessions from an allocated psychologist, but the service had now changed to a referrals-based system across the site. Where specific work was needed, sessions would be allocated ad hoc. Additionally, a psychology assistant would be allocated to the ward to attend MDT meetings and feedback about any need or issues arising.

We heard from staff though that the psychology assistant designated to attend these meetings had not always been available due to other clinical activity coinciding. There was also a concern expressed that therapeutic intervention could be delayed due to reduced availability. We were told that nursing staff were unable to deliver some low intensity therapies as this required ongoing supervision by a clinical psychologist. The impact on scheduling completion of risk assessments and formulations was also raised as a potential concern. An example that was given was

of a delay completing a formulation which would have helped identify and manage an individual's risk.

We also heard concerns that reduced capacity would impact on the provision of reflective practice and for the proposal for a pastoral care service to deliver this going forward. We noted uncertainty from nursing staff about the robustness of this because staff were working with people with complex histories and significant relational challenges. It was felt that professionals with specialist training should continue to deliver this as they were best placed to understand and support staff as necessary.

Recommendation 1:
Managers should ensure ongoing review of service changes to measure any impact on care and treatment and that a satisfactory solution is agreed to deliver support to all personnel working in this clinical area.

Use of mental health and incapacity legislation

On the day of the visit, three people were detained under the Mental Health Act, with the other individual being subject the Criminal Procedures (Scotland) Act, 1995. All legal documentation was accessible on Care Partner.

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 consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all available and corresponded to the prescribed medication.

Any person receiving treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found the completed nominations on Care Partner.

Rights and restrictions

The unit operated a locked door policy commensurate with the requirements of managing the presenting risk. When we are 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. NHS Forth Valley mental health administrators notify individuals about making advance statements by letter and this was promoted by staff. Advance statements were in place for individuals who wished to complete one and there were copies of a template in the records with details of when this was completed or declined. We could see evidence of the decision being revisited for those who chose not to write one.

We reviewed the records of one individual on continuous intervention and saw the need for this was kept under review.

Pass plans were detailed, including safety plans in place for those with time off the unit. Individuals had restricted access to their phone while they were in the unit and limited to access for tea and coffee making facilities in the kitchen up to four times daily. There was also a restriction in place regarding the number of parcels that could be delivered weekly. We were told everyone had agreed to these local protocols, that it was explained on admission and discussed at community meetings. We were unable to find individuals' views on these restrictions documented, but one individual told us this could be difficult when trying to organise the purchase of gifts, particularly at this time of year, as the current situation was too restrictive. Staff spoke to aspects of risk and limited storage, but we considered that other solutions could be explored.

Recommendation 2:
Managers should ensure that that individuals' views regarding any restrictive protocols are fully explored and documented. These protocols should also be supported by written policy.

Individuals were familiar with their detention status and order and had an awareness of their rights including access to independent advocacy, the complaints procedure and contact with the Mental Welfare Commission. All that we spoke with told us that staff were helpful in providing information.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. One person we met was unaware that she remained subject to specified person legislation. We noted another person had been listed as a specified person on the whiteboard in the office however, there was no paperwork in place authorising this, which was confusing. We sought clarification from the SCN and consultant psychiatrist who confirmed that this had been an error as she was not specified, and they agreed to revisit the legislation with the other individual to ensure she had a clearer understanding of this.

The Commission has produced good practice guidance on specified persons[1].

[1] *Specified persons good practice guide*: https://www.mwcscot.org.uk/node/512

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

Activity and occupation

There was a broad range of activity offered to individuals throughout the day which extended into evenings and weekends, giving individuals opportunities to socialise with peers from other wards. The weekly community meeting provided a forum for discussing activities, how the unit functioned and to explore future plans.

A structured timetable for the week was displayed in the day area and decisions about activities were reviewed daily to allow these to be tailored to individual preferences. In addition to ward-based activity such as arts, crafts and games, staff delivered decider skills training that helped teach individuals to recognise their own thoughts, feelings and behaviours which would help them manage their emotions. There was also a cycling group, onsite gym, walking in the grounds, and tennis available to promote physical activity.

We were told by individuals that they enjoyed the variety and regularity of activity which they found to be therapeutic and was built into their care and treatment; it was "not just for the sake of filling the day."

Activities were purposeful and linked to recovery goals providing structure and promoting independence. As well as activity on site we saw engagement with community-based charities, such as volunteering at a local dog behavioural centre and a foodbank. We also saw evidence of participation in cooking sessions, face/hand massage, lunch group, and bus trips. The addition of dedicated activity co-ordinators had helped to ensure a variety of activity was available.

We did hear that on occasion, activity co-ordinators could be included in staffing numbers when clinical activity was high. We met with one individual supported by continuous intervention and were pleased to hear that therapeutic activities continued to be supported, including time away from the ward, in cases where the MDT considered this beneficial.

The physical environment

Although the layout was largely unchanged from our last visit when we had been told about a lack of facilities, there were plans to repurpose some space gained from the closure of the Tryst View Ward in summer 2025. The plans included creating additional therapeutic space, office space for allied health professionals (AHPs), a

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

meeting room for CPA and MDT meetings to allow individuals with limited grounds access to attend more easily.

Anti-ligature work remained outstanding, and a plan of work had commenced in inpatient areas in NHS Forth Valley to address the ligature risk. It is hoped that this work will be completed across all sites in the anticipated timeframe.

The layout of the ward consisted of a communal day and dining area, a therapeutic kitchen, sensory room, visitor room, individual bedrooms and shared toilet, showering and bathing facilities. Rooms were designated for nursing and the SCN office was nearby. There was storage for individuals' belongings and a large cupboard to store a variety of activity resources.

There was direct access from the ward to a pleasant, secure garden area. There was sufficient seating and outdoor equipment storage. Although we visited in the winter, we could see that the garden would be a welcoming and relaxing area and this was maintained and accessible all year round. Although the environment was dated, the décor was clean and bright and overall, the unit was calm and relaxed. We were told it could be noisy at times from safety alarms going off.

Wall art was positive and inclusive, and we saw several notice boards with helpful information about community resources. We had been given positive feedback about the bedrooms, and we saw that people were able to personalise them to make them more homely and individualised. One person described her room as looking like a ski chalet and how nice this was.

There was a small shop on the hospital site that was popular and well utilised by individuals; this sold snacks and also included a cafe area. There were also a variety of local shops within a relatively short walking distance. Where needed, there was access to the on-site bungalows and these continued to be utilised to help increase skills and independence for people moving towards discharge.

Smoking was not permitted, in keeping with smoke free legislation.

Any other comments

Since our last visit where we learned of changes made to psychology provision and given the complexities associated with this group of individuals, it is imperative that effective collaboration in the service is maintained to ensure timeous treatment delivery.

We listened to concerns from staff about how the changes could impact on this and wider MDT support. This was discussed with senior managers who acknowledged there had been a further reduction in staffing, including personnel changes, however recruitment was planned to fill a vacancy.

Regarding the absence of psychology representation at the MDT meeting, this was considered to have been a temporary situation due to short term issues but would be addressed. We consider it to be essential that there is involvement from psychology as part of the wider MDT functioning.

Summary of recommendations

Recommendation 1:
Managers should ensure ongoing review of service changes to measure any impact on care and treatment and that a satisfactory solution is agreed to deliver support to all personnel working in this clinical area.

Recommendation 2:
Managers should ensure that that individuals' views regarding any restrictive protocols are fully explored and documented. These protocols should also be supported by written policy.

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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