mental welfare
commission for scotland

Mental Welfare Commission for Scotland

Report on announced visit to: Bellsdyke Hospital, Trystpark, Larbert, FK5 4WS

Date of visit: 24 February 2026

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

Trystpark is a 12-bedded, low secure, forensic ward in Bellsdyke Hospital in Falkirk. It provides care and treatment for adult males.

The wards on the Bellsdyke site share access to three self-contained bungalows and four hospital owned flats nearby in the community. The additional resource promotes increasing skills and independence for people progressing towards discharge. When we visited, the flats were vacant to allow scheduled refurbishment.

Seven people were in Trystpark, with another housed in one of the onsite bungalows. This individual had been decanted from a hospital flat during the maintenance period.

There was one individual whose discharge from hospital was delayed as supported accommodation was being sought. Another individual was expected to transfer from a medium secure unit (MSU) in March 2026 and had visited on a day basis as part of the transition.

We last visited this service in February 2025 on an unannounced visit and made one recommendation in relation to the authorisation of medication given under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act). The service developed an audit checklist, and monthly audits were ongoing to ensure medication is legally authorised.

Who we met with

Staff told us that individuals had been informed about the visit and asked whether they wished to meet Commission visitors. We also saw the visit notification poster displayed in the lounge. Most had declined, choosing to leave the unit for work placements and other activity.

We managed to speak with four individuals at various points during the day, one of whom had provided written feedback in case they missed us but met us along with independent advocacy on return to the ward.

We reviewed the care records of four of the people we spoke with and an additional two people.

We met with team members, including a forensic consultant psychiatrist, nursing staff, a psychology assistant and the service manager. We also met with an independent advocacy representative from Forth Valley Advocacy.

Prior to the visit we had a Microsoft Teams’ meeting with the senior charge nurse (SCN) and clinical nurse manager (CNM).

Commission visitors

Denise McLellan, nursing officer

Justin McNicholl, social work officer

What people told us and what we found

One individual told us they had been in mental health services for a significant period and was of the view that things were better in the past, telling us; “it’s got worse.” He did not identify any specific issue other than feeling there had not been enough progress during his lengthy admission. He described the consultant psychiatrist as “okay” but felt staff were less friendly than experienced historically. “They don’t treat you well. There is just a different standard of staff. Now I don't know the staff in the same way." He did not describe any concerns regarding aspects about the care and treatment and appeared to be reminiscing back to earlier periods where they considered there to have been less restrictions and reflecting on the length of time detained in hospital. He was unhappy with his detention in hospital but was aware of his rights and had access to independent advocacy. He told us that he did like his bedroom which had a television and an iPad. He said the exercises and stretches given by the physiotherapist were helpful and that it was “very good and they see you regularly”. He spoke positively of the activity co-ordinator “they are very good, as they get me out and would do this seven days a week if they could”. He described regular outings in the surrounding areas and participation in several activities, including walking groups, karaoke and using the bus to get out and about.

Another person spoke of hospital being “a hard life” and there being “not much room for things to go wrong in hospital.” He felt the service was “holding people too long” but had exercised his legal right of appeal. He described the general atmosphere in the ward as “good” and told us about groups and social activities he engaged in. He indicated that protected mealtimes should be reduced from one hour to 30 minutes as this was “too restrictive.”

We briefly spoke to another individual who had declined to meet us when offered but agreed to let us see inside his bedroom. He told us he liked spending time there and we saw that it was filled with numerous books and other personal effects. Although unwilling to speak at length he commented that he was content with his current care and treatment.

We had been given a written statement from one individual that documented:

“I am enjoying my care and attention at Trystpark. I don’t want to move on. I am enjoying my activities like HTV, the walking group, bowling, bingo, quiz night, games night etc. The staff in Trystpark are nice and friendly and treat me well. I am doing good. I am also enjoying my time off ward like going to Falkirk, going to church, going to the shops etc.”

When we met him later in the day, he described the food as “okay” but there was “a lot of mince on offer.” He reiterated that staff were nice and friendly compared to experiences across various other hospitals, saying that “people make Trystpark” and that there were variety and regularity in activities offered. He spoke of attending various meetings and having one-to-one contact with staff including his consultant psychiatrist whom he met “at least once a month, she is a good doctor.” Regarding care plans he said, “I don’t think I’ve seen a care plan, but I know it exists.”

We spoke with various members of staff during the visit and were pleased to hear that overall staff retention had improved and it was a friendly environment to work in, hearing that there were “no cliques”, “friendly, like working here.” There was ongoing access to supervision, but nursing staff told us that redeployment to cover shortfalls in the learning disability service at Lochview had caused anxiety.

We heard concerns about the potential for being the sole registered staff nurse in charge of this unfamiliar environment. We discussed this with managers who acknowledged their awareness from consultation with staff. They advised of union involvement and steps being taken to address changes being made, including training and induction, the shadowing of shifts where the individuals would not be included in numbers and of virtual meetings to familiarise new colleagues and learn about the environment before moves took place. A ‘welcome to Lochview’ leaflet was also being prepared to help provide information for staff.

We heard about changes to psychology provision across the Bellsdyke site and the impact it could have for individuals and staff. This had already been highlighted to us during our visit to Hope House when we listened to similar concerns regarding reductions in therapeutic work as well as implications for multidisciplinary team (MDT) working. We were told that this was still under review and the team were meeting later in the month to discuss further.

Care, treatment, support, and participation

The holistic approach taken was evident in all aspects of care and treatment delivery. As well as treatment with psychotropic medication for mental disorder, there continued to be a clear emphasis on physical health promotion, monitoring and meaningful activity.

There was access to a local GP, and we were told there was no difficulty arranging appointments with them. We also heard that when individuals could not attend the clinic, GPs would attend the ward after surgery hours and could also prescribe over the phone.

For people who had not registered with local dentists, treatment was available from the dental service in the community hospital. Individuals with a diabetes diagnosis,

had access to the community podiatry service and diabetic nurse team. We saw that people were encouraged to access other community resources, such as opticians.

We heard that most individuals participated in MDT meetings. Where requests were made about treatment this was considered, and we saw consultation with pharmacy for this. Referrals to other services for specialist input were made. The responsible medical officer (RMO) for one individual had approached the National Psychosis Service for input regarding treatment and this was being progressed. We could see that this individual had been sent information about the service and was awaiting assessment.

Strengths, preferences, protective factors and sensitivity to help maintain privacy and dignity were evident in the care and treatment being delivered.

The team told us they had had a positive year with two people successfully moving on to other areas, one of whom had been in the ward for nine years and had several failed discharge attempts. The individual living in one of the bungalows had been living off site in one of the hospital flats and a previously identified tenancy had fallen through. Due to the refurbishment of the flats, he was temporarily moved to one of the bungalows on an informal basis until other permanent accommodation was found.

We heard about difficulties experienced when people transferred to the ward from different health board areas. One person had been referred to the relevant forensic community team for conditional discharge, but this was rejected. The individual had expressed disappointment and spoke to the clinical team about feeling demotivated by this decision. He had spent considerable time commuting to his original area attending work placements as part of the rehabilitation plan and did not know what else needed to be done to achieve transfer given his own clinical team felt he was ready.

Unlike in high and medium secure facilities, individuals in low secure settings are unable to appeal against levels of excessive security. Having already been in a medium secure environment, they found this lack of progress very frustrating.

Another individual from out of area whose discharge was delayed due to a lack of options in their own health board area, had now expressed thoughts about wishing to remain in the ward. This was a concern, as the person did not require this level of security and could be at risk of becoming institutionalised. The SCN agreed to alert the Commission if this situation continued without resolution.

Care records

Records were stored on ‘Care Partner’ the electronic health record management system in place across NHS Forth Valley, which was relatively easy to navigate. The filter function made it easier to locate documents such as detention paperwork,

advance statement and named person information. When opening individuals' records, alerts specific to them were immediately highlighted.

Risk assessments were detailed, providing a descriptive summary of the main risks identified. Current and historical risks were captured along with professionals involved in managing them. It was clear the team knew the individuals in the ward well and there was evidence of positive risk taking.

Comprehensive daily records were found to be informative and specific, with a summary of presentation, associated risks and recent events. The language used was descriptive and positive with evidence of reassurance and other support being given and was written in plain English making it easy to understand the broader context, such as what people's days looked like.

Care plans identified various goals across a spectrum of needs focussing on outcomes and how they were to be achieved. These included monitoring mental state with clear reference to stress/distress and anxiety management, physical health, medication, activities and discharge planning.

Regular reviews evidenced progress. We could see individuals' views recorded and that they participated in one-to-one contacts and MDT meetings or were given feedback where they chose not to. However, when we asked people about their care plans, they spoke more of an awareness of having them which appeared to indicate a more passive role. It could be that individuals not accessing their care plans may be associated with being "a forensic patient" and them becoming accustomed to being directed by legislation, sometimes requiring Scottish Government approval for decisions.

There was evidence of physical health and psychotropic medication monitoring such as venepuncture, men's health checks, smoking status, exercise and electrocardiograms. Diabetic management was also apparent and there were records documenting alcohol and illicit substance testing. Suspension of detention information, therapeutic activity, input from occupational therapy (OT) and physiotherapy was recorded with clear communication about mobility aids, other equipment, exercises and level of support needed.

Individuals were managed under enhanced care programme approach arrangements (CPA) with meeting minutes available. Where individuals were subject to multi agency public protection arrangements (MAPPA) scrutiny, this was documented. The MDT meeting template was structured demonstrating participation, summaries of discussion including decision making and who was responsible for actioning.

Multidisciplinary team (MDT)
The team consisted of a forensic consultant psychiatrist, registered mental health nursing, health care support workers (HCSWs), OT and activity co-ordinators. Up until four months prior to the visit, there was a designated clinical psychologist for each ward.

Following the reduction in psychology provision across the site, meetings were now attended by psychology assistants who would then give feedback to the psychologist responsible for provision to the Bellsdyke site and forensic community mental health team (FCMHT). Assistants delivered silver cloud and low intensity interventions under supervision and supported with risk assessment and management. The assistant we spoke to felt they had enough supervision from psychology colleagues. We heard that two of three assistants were absent due to sickness, and a psychologist was resigning that same week to take up a post elsewhere. Managers confirmed this vacancy would be recruited to.

Pharmacy, physiotherapy and mental health officers (MHOs) attended meetings where their specific input was required.

There was some long-term absence in nursing, but a recent over recruitment of nursing staff had helped to alleviate this. With one Band 3 healthcare support worker (HCSW) due to commence employment in the coming weeks, we were told staffing was improving. The SCN was supported by two deputy SCNs, ensuring managerial support across the week.

The involvement of an activity co-ordinator maintained a variety of regular therapeutic activity. We were pleased to hear of plans to make the activity programme more substantial going forward. Individuals told us about valuing this input and how activities provided opportunities to leave the ward in the evening as well as during the day.

We learned of a change of consultant psychiatrist planned for August resulting from recruitment to a vacancy elsewhere in the service.

From reviewing the care records, we found that MDT meetings were held monthly and individuals had opportunity to participate and provide their views. We also found that independent advocacy had an active role where individuals wished this support.

Use of mental health and incapacity legislation
On the day of the visit, seven individuals were detained under the Criminal Procedure (Scotland) Act, 1995 (the Criminal Procedure Act) as amended by the Mental Health Act. Another person who was subject to a community compulsory treatment order was living in one of the bungalows. He was living there on an informal basis and accommodation in the local community was being pursued.

Detention paperwork and details of reviews were available and current. Where subject to Scottish Government monitoring, information on suspension of detention (SUS) was accessed easily.

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. We found four consent to treatment certificates (T2) and four certificates authorising treatment (T3). They were all in date and corresponded with treatment given.

T2 certificates included a clear plan of treatment and were all signed by the individual. A short life working group involving all inpatient units and pharmacy had been established with a focus on making the auditing process more robust in response to repeat Commission recommendations about authorisation. Audits were completed monthly and we were pleased to note no discrepancies on this visit.

Anybody who receives 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. There was evidence in the records of this being discussed with individuals. The people we spoke with understood their detention status and had awareness of their associated rights.

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 (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. No one was receiving medical treatment in accordance with the AWI Act, but one individual had their finances managed under section 39 of the AWI Act and there was a care plan available detailing a daily spending plan and of the need for MDT agreement for larger purchases.

Rights and restrictions

Trystpark operates a locked door policy commensurate with the requirements of a forensic unit in managing risk. People told us that they were aware of and understood their rights in accordance with the legislation.

They knew their detention status including what being a 'restricted patient' meant and had access to solicitors. Three people had active involvement with advocacy, and a representative attended the ward to support one individual who agreed to meet us. They did not describe any difficulties with the referral system or maintaining contact with individuals.

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 a person is designated a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Two people were subject to additional restrictions with reasoned opinions in place. We could see this was kept under review and changes made where appropriate.

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 of the individuals we spoke with had previously declined to nominate a named person or write an advance statement, as is their right, but said they would give this some further thought. Advocacy agreed to support them with this if they changed their mind. The NHS Forth Valley mental health administration office notified individuals about making advance statements by letter annually and this is promoted by the clinical team.

The Commission has developed *Rights in Mind.*[1] 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 evidence of a range of activity available on site and in the wider community. Individuals told us they enjoyed the variety offered.

Care plans and continuation notes captured the activities that were offered and what people participated in. These were a mix of psychoeducational, social, physical, therapeutic, community and outings providing a range of positive outlets. Activities were provided during the day, evenings and weekends. Interests were discussed with individuals at monthly meetings, and timetables displayed so that people were reminded of the full range of activity available each week. Spiritual care was also available in the local community.

The onsite gym floor had recently been repaired and was back in use. We heard it was popular with individuals and that staff could also use this during their breaks. It was well equipped and a large, bright space with a variety of equipment.

Physiotherapy provided physical exercise for those who wished this. As well as gym sessions, other exercise offered was chair exercise, walking groups and circuits

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

class. There was a boxing punch bag in the gym and two individuals were supported to attend a local community boxing group. Although the focus was fitness it also taught discipline and control.

Other community activities included swimming, ten pin bowling and cinema visits. The OT was also considering the potential to use community badminton courts. Some individuals had vocational placements in the community as part of their individualised plans.

The onsite horticulture therapy unit (HTU) provided gardening opportunities. Karaoke, bingo, relaxation, quizzes, cold baking, freedom and mind choir and art therapy was also available. Skills such as cooking sessions with OT were also promoted. We were told about a charity event that had helped to raise funds across the site 'Bellsdyke Bake Off' which was enjoyed by individuals and staff alike.

The physical environment

When we visited, the ward environment was relaxed and calm. We had been told that people liked their rooms and found them "comfortable and personalised". No major changes had been made to the layout and although bedrooms were single occupancy they did not have ensuite facilities and communal bathrooms and toilets were still in use.

Bedrooms and living spaces, including quiet rooms and separate day areas, were allocated in each side of the ward. The dining area was shared, and mealtimes were split into two sittings to facilitate this. The ward benefitted from a private garden which included a sports court at the rear of the building. These areas were well maintained.

Meeting rooms and offices were in a separate area of the ward. There was an abundance of information displayed, and all areas looked tidy and clean.

Although there had been some improvements made in recent years including new windows, the decor was dated. Ligature reduction and ensuite improvements had been costed but we were told that the service was not in a financial position to undertake this work.

The CNMs from Bellsdyke and the mental health unit at Larbert were part of the estates oversight group and funding work would not commence before 2027/2028, but Trystpark would be the first ward on the site to be improved when finances permitted. We asked about how these risks were being mitigated in the meantime and were told of certain rooms being locked off when not in use, enhanced levels of observations being used, were appropriate and monthly environmental audit reports were being completed.

Any other comments

Changes had been made to the psychology provision across the site, and we became aware of some tension between professional groups about resourcing. There were concerns about the impact this may have going forward which had been exacerbated by a psychology vacancy arising soon. We were told this post would be filled but were aware the recruitment process could be lengthy. There was apprehension about a reduced capacity for clinical work, and we were told that nursing staff would not have opportunity to participate in psychology led reflective practice until a new psychologist had been recruited.

The impression we got from those we spoke with was that their preference would be to have designated psychology for the ward; reasons given included continuity and consistency. Under the new model, psychology was allocated as required to focus on CPA and risk assessment meetings. This had previously been discussed with managers following our visit to Hope House.

We also heard there was some long-term absence in the team and that there was to be a meeting the following month to reach a general agreement on what was working and what was not. We will remain in contact with senior managers for regular updates on this matter.

Recommendation 1:

Managers should ensure ongoing review of service changes to the psychology services 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.

Summary of recommendations

Recommendation 1:

Managers should ensure ongoing review of service changes to the psychology services 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.

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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