Mental Welfare Commission for Scotland

Report on announced visit to:

Services in NHS Orkney, Orkney HSCP and the Orkney community

Date of visit: 23 to 26 June 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

Known as the Orkney Islands, which are situated off the north coast of Scotland, there are about 70 islands, of which 20 are inhabited. The largest island is called the Mainland, where we spent several days visiting a range of mental health and learning disability services for individuals, carers and their families across the island.

NHS Orkney's hospital and healthcare facility, The Balfour, opened in 2019. While there are no dedicated mental health inpatient beds, there is a room available for mental health transfers. Adults or children who have been assessed as requiring transfer to a mental health inpatient bed – for adults this would routinely be to the Royal Cornhill Hospital (RCH) in NHS Grampian or for children/young people, this would be to Dudhope Young Persons Unit in NHS Tayside - would remain in this room until transfer off the island could be facilitated.

Who we met with

We carried out six visits across the mainland island and met with individuals who were subject to guardianship orders under the Adults with Incapacity (Scotland) Act, 2000 (the AWIA) and in some instances, met with the families/carers and the paid staff involved in their care, guardians and supervising officers.

We had contact with and reviewed the care of six people who were receiving input from the community mental health team (CMHT); this was either in person or we spoke to the person by phone. We reviewed the care notes of another four people. We also met with/spoke with three relatives.

We met with members of the improvement team of a care home where there was a large-scale investigation taking place under the Adult Support and Protection (Scotland) Act, 2007 (the ASP Act).

We met with a range of staff from the community health and social care teams, including child and mental health services, older adult services and the learning disability/autism spectrum service. We had meetings with senior managers from the health and social care partnership (HSCP), GPs who covered both the day and out of hours services and the mental health officer (MHO) team. After the visit had been completed, we had a virtual meeting with the two consultant psychiatrists. We also met with the chief executive (CE) of NHS Orkney and the chair of the NHS Orkney Board.

Commission visitors

Claire Lamza, executive director (nursing)
Lesley Paterson, senior team leader (East team)
Tracey Ferguson, social work officer
Susan Tait, nursing officer

What people told us and what we found

When we met with the HSCP senior managers, we heard that there was to be a review of the current psychiatry model with recommendations for future provision throughout Orkney. Funding had been secured for a year and one of the consultant psychiatrists who had previously been part-time had been recruited to this post. We look forward to hearing the outcome of this at our next visit.

We had a discussion with the team who lead on alcohol and substance misuse. Having heard that there were concerns with a possible change to elective detox admissions to the Balfour Hospital, we raised this when we met with the CE and the chair, as well as with senior managers. We were advised that this was not the case and that people who required detox would be admitted if a bed was available. We fed this back to the team and heard that a report with the formal arrangements would be taken to the Joint Clinical and Care Governance Committee.

We heard mostly positive views from individuals who were receiving input from the mental health team and praise was forthcoming for the community psychiatric nurses (CPN). They were described as' going above and beyond' and we were told 'I really trust my CPN to help me' and 'for the first time I feel listened to'.

We were told that a private practitioner had been commissioned to carry out assessments for Attention Deficit Hyperactivity Disorder (ADHD) and autism. As a result of this, many people had received a diagnosis. We heard from one individual that this had made a significant improvement in their life, and they received appropriate medication to alleviate the symptoms of ADHD. However, this was not the case for a significant number of the individuals; they had been assessed as requiring medication by the psychiatrist, but the GPs felt unable to prescribe this as there was no 'shared care pathway' between mental health and GP services. This has created inequity for treatment, which was available but not prescribed.

Recommendation 1:
Managers should review how a shared care pathway can be developed to ensure equity of treatment for those with a diagnosis of ADHD and/or autism.

Previously we had made a recommendation about a model of care to support individuals in times of crisis. The funding for the has been secured for two years and a psychiatric liaison team will be developed with recruitment underway at the time of our visit. Although it was recognised that there could be a challenge in recruiting to posts for the team in the island community, it will be a welcome addition to the CMHT. A dedicated liaison team will hopefully ease some of the current pressure on the CMHT who have been providing this within existing resources.

We spoke with a group of GPs, similar to what we did on the 2024 visit. They told us that nothing much had changed for the people they were providing care for. In

particular, they said that the people who live on the outer isles on Orkney only receive crisis intervention for mental health issues and we heard from the GPs that there was a reliance on the use of video appointments (near me) which were not always appropriate. An example was given of a near me appointment that was offered to an individual with significant hearing difficulties, with no support with sign language.

The GPs said that they were aware of the work being done to complete the psychiatric emergency plan (PEP) that includes bespoke actions for those living on the outer isles and they were hopeful that this would help with crisis interventions. The GPs were aware of the plans to create a psychiatric liaison team.

In the last report we commented on morale in the CMHT; we had been advised that there had been a whistleblowing report that spoke of the impact that the workload was having on staff. We were pleased to hear that overall, morale was better. Waiting times for adult mental health service from the CPNs had been up to one. Staff had initially set up some weekend clinic appointments to tackle the initial backlog and then the CMHT established regular weekly assessment clinics staff by the CPN group, and this has significantly reduced the waiting list. There has now been a reduction in this for both adult and older adult mental health service, with adult waiting times for CPN care and support now reduced to between four and six weeks.

There was discussion about the culture and interface with general adult colleagues. We were told that medical staff working in accident and emergency (A&E) do not appear to have much mental health training and support the role in safety planning. As a result of this, work was being done to complete an induction pack for junior doctors.

Recommendation 2:
Managers should ensure that appropriate training in mental health is provided for junior doctors to ensure that a rights-based approach is provided.

We heard from the CAHMS team that the service continues to operate well due to the increased funding.

The psychologists we met with spoke of the challenge in providing a service where there was a reliance on much of their work being delivered remotely via video links. The meeting discussed how the shortage of accommodation in Orkney can hinder recruitment efforts, but a flexible and remote model of service delivery mitigates this challenge effectively. The psychologists advised us Orkney to maintain a full staffing complement, which has been essential to ensure compliance with the Scottish Government's waiting list standards. Neuro-psychological assessments may present challenges when conducted remotely; however, these can be addressed through regular visits of psychology staff to the island and by utilising trainees based locally.

Some recent research indicated that trauma focused interventions can be delivered very effectively through remote methods. This is not always the best option for everyone, particularly for those individuals who have experienced trauma and need in person support. We advised that cases should be assessed on an individual basis. The psychologists we spoke with also commented on the importance of having a job plan in line with those from across Scotland and which was supported by regular appraisals.

We heard of the plan to develop the psychological model for the older adult service, which will be welcome for this group of people.

We met with the mental health officer (MHO) team and heard of some of the developments they had undertaken. This included a hoarding and self-neglect protocol, which had been undertaken regarding Adult Support and Protection (ASP) and there had been a local media focus. The MHO team had also completed work on raising awareness about adult support and protection, by providing training for carers and care home staff. While this had resulted in an increase of referrals, it had also helped to developed stability with the process of trying to support people to remain at home for as long as possible.

During our meeting with the MHO team, they spoke of the significant case load that they manage, as all of them perform duties in the wider SW team as well as the MHO work that is required of them. Since our last visit, an MHO is now available to carry out reviews of emergency detentions when individuals are admitted to Royal Cornhill Hospital in Aberdeen; this has been very successful.

The local MHO team continues to have an overview of detentions made out with Orkney but there is not the same requirement to travel to Aberdeen as was previously necessary. We had previously made comment on the quality of the guardianship applications and were informed that the team has since reviewed this. The MHOs had found that many of the historical applications were not of a standard they would want but more recent ones were thorough and detailed. As part of local authority (LA) duties, MHOs may have a responsibility to supervise private guardianships as well as managing the LA ones which are delegated by the chief social work officer. We heard from the team that the last 12 months had been challenging for this small, generic team, with increased work-related activities and competing demands. Unfortunately, supervision of private welfare guardianships has not been taking place as often as it should. There were 1,054 referrals to social work services last year, not including MHO or ASP referrals, MHOs who work as social workers tend to have individual caseloads of 25–35 individuals.

In our last report, a recommendation was made to provide us with a copy of the proposed leadership model for the MHO's. This had been recently completed and a paper provided to the service in draft form. We were advised that the paper required

to be reviewed before the final version was approved. We look forward to receiving the final version.

Recommendation 3:
The Chief Social Work Officer for Orkney should review how private guardianships are supervised whilst considering the proposed leadership model which may have an impact on the MHO workload.

As part of the objectives from the 'Coming Home' report by the Scottish Government, a dynamic support register has been developed to enable individuals with a learning disability to return to their home communities. We heard of the continued challenge that there are several people on the Scottish mainland that are in supported accommodation and should be repatriated. Due to a lack of available supported accommodation across Orkney, this was not possible.

In the last report we commented on the sizable case load of the learning disability (LD) nurse. This has improved slightly since last year. Since our last report, an additional LD nurse has been recruited to augment the team, one duty will be to carry out the annual health checks for people with a learning disability and as a result of this, they have a smaller case load as a focus of the role is undertaking the physical health assessments.

Care, treatment, support, and participation

When we visited the care home, we accessed the care records and reviewed the relevant documents in order to find out how the guardianship orders were working for the individuals. Where individuals had a care provider in place, we checked whether the service had a copy of the welfare guardianship order in place and where relevant, we found copies of orders, with powers that had been delegated from the welfare guardian to the care staff.

Staff working in the improvement and monitoring team at the care home told us that they were looking to improve some of this documentation and were happy to share this with us. We viewed all care plans, risk assessments and where appropriate, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. Where individuals had a DNACPR in place, we found that all relatives had been consulted. We found that the relevant private guardians were involved in the care planning process and had attended care reviews. There was no link to the care plan when a guardianship order was in place; we fed this back to staff.

We also found that there was lack of care planning and formulation for individuals with dementia around stress and distress strategies. We were told by the improvement and monitoring team that this issue had already been identified and that there was action plan in place to address this.

Care records

For this visit, we reviewed several of the care records held by the CMHT. We also spoke with an individual who had regular input from a CPN. They spoke about the difficulties when appointments were cancelled, as there seemed to be no formal process where they could make another appointment. They were told that it would be a case that 'we will catch up sometime'. In our discussion, we heard of the distress that the person faced on an ongoing basis; they said that their CPN knew about as it had happened more than once. In reviewing this individual's record, we noted that there was no risk assessment, or risk management/safety plan and no care plans. The only documentation was an entry on file of the visit by the CPN.

Another file that we reviewed had a care plan with a heading of 'recovery plan', however the individual was referred to as 'the patient' with nothing to indicate this being person-centred, or any evidence of attempts to involve the individual in their recovery.

We reviewed one care plan that had more detail and evidenced discussion with the individual about the option to prepare an advance statement. We were concerned to find that there was limited or no information recorded as to how to support the individual with their mental health.

We were advised and provided with a copy of a planned audit tool although this had not yet been implemented.

Recommendation 4:

Managers should arrange, as a matter of importance, training for staff on person-centred plans and undertake a qualitative audit to ensure risks are managed.

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. We have also passed on good practice from another area in Scotland.

At our last visit, we were advised that a new electronic system (MORSE) was due to be in place by the end of 2024. This had not yet happened, but those that we spoke with were hopeful that this would be implemented this year.

In the meantime, records continue to be fragmented and this can pose a significant risk for individuals, particularly when communication about care and treatment is not documented systematically or shared across the records. We heard that when MORSE is in place, it will not be used by the social care sector, who use a different

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

system PARIS and there may continue to be challenges for staff with access to the most up-to-date and relevant information.

Multidisciplinary team (MDT)
There are two part time consultant general adult psychiatrists who come to the island on approximately every four to six weeks. Previously, only one of the psychiatrists attended in person and the other provided their input remotely. We were pleased to find that now both attend in person.

Along with the CPNs, who are the main group of clinical staff who attend the multidisciplinary team (MDT) meetings, there is input from psychology and social work where and when this is appropriate.

Use of mental health and incapacity legislation

In our last report, we noted that there were significant issues for individuals who required compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). It was not possible to have someone on a community compulsory treatment order (CCTO) as there was no approved medical practitioner (AMP) to act as the responsible medical officer who was based on the island. This situation has now changed with increased on island presence of the two RMOs.

On the day of the visit three people were subject to the Mental Health Act. We were unable to meet with them but reviewed the consent to treatment certificates that were in place. Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place where required and corresponded to the medication being prescribed.

We found that there was appropriate authority for care and treatment under the Mental Health Act, although the paperwork for this was not easily located. We discussed our concerns in relation to good practice with record keeping with the service manager at the end of the visit.

Recommendation 5:
Managers should ensure that the Mental Health Act documentation is readily available on the electronic system to ensure that individuals are being treated within the law.

We did find that all individuals in the care home had a section 47 certificates in place and that the proxy had been consulted with. We did not find any treatment plans in place that should have accompanied the s47.

In our other visits to the community services, we found one person did not have a section 47 certificate in place and we requested that the staff to follow this up.

Rights and restrictions

In the care home we visited, individuals had support from advocacy, and we were told that others would be able to access this if required. For Commission staff, as part of the guardianship visits, we look to see what restrictions may be in place and whether these are authorised by the guardianship order.

We found that a few of the guardianship orders that had been granted at court had the authorisation to use restraint, however we spoke to care staff and were told that this had never been used or applied. We feedback to managers and advised them that it would be relevant for the supervising officers to monitor this and where powers were no longer required, a discussion with the guardian would be appropriate to consider recall of those power(s).

We also advised that it would be relevant for the MHO to comment specifically on whether and what restrictive powers should be set out in a guardianship application, when the reports are being completed for the court process. We were pleased to hear that there had been ongoing discussions with MHOs and the LA's legal representative about the necessity of powers; we were pleased to hear that this has led to a change in practice.

We had continued to follow up on one case from our visit in 2024, where there were powers in place for an individual that were not being exercised and pleased to find that these have now been removed from the order.

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.

The physical environment

The CMHT use a room in the Balfour general hospital called the Emergency Mental Health Transfer Room (EMHTR), where individuals await if they are transferring to hospital on the Scottish mainland.

This room continues to be far from ideal as it has only limited outside space and is at the end of a corridor in the general hospital. We note that the room is only used in urgent situations and for the least time possible, dependant on travel conditions. We realise that there are no other options currently available but suggest that continued efforts be made to make this space as safe and comfortable as possible.

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

Summary of recommendations

Recommendation 1:
Managers should review how a shared care pathway can be developed to ensure equity of treatment for those with a diagnosis of ADHD and/or autism.

Recommendation 2:
Managers should ensure that appropriate training in mental health is provided for junior doctors to ensure that a rights-based approach is provided.

Recommendation 3:
The Chief Social Work Officer for Orkney should review how private guardianships are supervised while considering the proposed leadership model.

Recommendation 4:
Managers should arrange, as a matter of importance, training for staff on person-centred plans and undertake a qualitative audit to ensure risks are managed.

Recommendation 5:
Managers should ensure that the Mental Health Act documentation is readily available on the electronic system to ensure that individuals are being treated within the law.

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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