Mental Welfare Commission for Scotland

Report on announced visit to:
Shetland Islands Community Mental Health and Learning Disability Services

Date of visit: 18-21 August 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

Shetland, also called the Shetland Islands, has a population of 22,870 (estimated in 2023).

The local authority is Shetland Islands Council and NHS Shetland's current hospital and healthcare facility is Gilbert Bain Hospital (the Gilbert Bain), which opened in 1961. In 2021, NHS Shetland published proposals to construct a new hospital within five years. While there was no mental health unit in the Gilbert Bain, there was the facility to admit individuals who experience mental ill health and who may require transfer to a mental health inpatient bed. For adults, this was usually to the Royal Cornhill Hospital (RCH), NHS Grampian or to Dudhope Young People's Inpatient Unit, NHS Tayside. Individuals would remain in the Gilbert Bain until transfer off-island could be facilitated.

The Shetland health and social care partnership (HSCP) had been formed as part of the integration of services provided by Shetland Islands Council and NHS Shetland health board. The HSCP aimed to improve, develop and manage community health and care services, providing a closer partnership between health care, social care and hospital-based services. Shetland Islands Council and NHS Shetland agreed to formally delegate community health and social care services for adults to a third body, which is the Shetland integration joint board (IJB). The IJB is responsible for the operational management and main decision making for Shetland HSCP. Most of our visits and contacts were with mental health and learning disability services and individuals who were based in Lerwick, which is the main town.

We last visited this service in September 2024 on an announced visit and made recommendations that managers should review the psychiatric emergency plan in line with Commission guidance and produce an effective document which should guide services. We also recommended that managers review the current approach to risk assessment and ensure that any tool which is rolled out is consistently used throughout the service. We suggested consideration be given to the development of a risk policy. We made a recommendation around streamlining the electronic records systems to reduce the risks associated with several systems which not all staff could access. Lastly, we recommended that a robust risk assessment of both the low stimulus room and Ward 3 was undertaken with a view to providing a safe and comfortable space that promoted privacy and dignity and minimised the potential risk posed to individuals and staff.

The response we received from the service was that the psychiatric emergency plan was still to be approved by the clinical governance department, but that Commission guidance had been included in the policy. We were told that the review of the risk assessment process was in progress and was due to be implemented and that while streamlining electronic record systems was out with the control of the mental health

service, this had been passed to IT services. Lastly, we heard that a risk assessment had been carried out of the low stimulus room but not for Ward 3 and that there had been little progress in progressing this recommendation.

Who we met with

We met with six individuals and spoke with another via the telephone, all of whom were receiving input from the community mental health team (CMHT). Some of these individuals were accompanied by a relative.

We also met with six adults who were subject to welfare guardianship orders, and where possible, their guardians.

We met with the team leader for mental health community support services, the clinical nurse manager, consultant psychiatrists, the executive manager for adult services (learning disability and autism), executive manager of adult social work and acting chief social work officer, the head of mental health services, the team leader for mental health adult social work and the mental health officer (MHO) lead, the MHO team, a group of psychiatric community nurses (CPNs), the learning disability (LD) nurse consultant, some of the primary care and counselling team, the chief executive officer (CEO) for NHS Shetland, some nurses from the child and adolescent mental health service (CAMHS) and support staff who worked in social care. All the staff we met with were committed and positive about providing the best care they could.

Commission visitors

Susan Tait, nursing officer

Tracey Ferguson, social work officer

Margo Fyfe, senior manager, Team A (West)

What people told us and what we found

The mental health team arranged for us to meet with six people who were receiving input from the team. All said that they were happy with the service they received and that they valued the contact they had. We heard comments, such as, “I feel cared for”, “the reception staff are wonderful; nothing is ever a bother” and “the staff overall are all good, I’ve no complaints”.

On the last visit we heard about housing shortages affecting the availability of supported accommodation. This has continued to be an issue, along with difficulty in recruiting and retaining support staff. We noted that this is an issue not only specific to Shetland, but also reflects the housing crisis across Scotland. One individual we met had been in temporary accommodation, living in a static caravan for over two years and they were not hopeful of moving to somewhere permanent that would meet their needs.

When we met with the nursing team, they were almost at full staffing complement. They were pleased that some of those who had joined the team had knowledge of Shetland, and we heard of the positive impact that the addition of the clinical nurse manager had brought to the team. We heard that although the medical input comprised of locum psychiatrists, they had been in post for a significant amount of time which contributed to the stability of the team. On the last visit there was only one LD nurse consultant on Shetland, which has double the national average population of people with a learning disability. With a caseload of over 240, it was difficult to see how needs could be met. However, we heard that another LD nurse was due to start in September, with a significant part of their remit being to carry out the mandatory physical health care checks, as directed by the Scottish Government.

We were told that there had been a significant investment in training and increasing skills for nursing staff which had resulted in them feeling more valued. This was evidenced by the results from a recent staff feedback tool. When we met with the MHO team, we were pleased to hear that they had a full complement of staff. There was nearly always an MHO available to consent to emergency detention certificate (EDCs) and out of hours short term detention certificates (STDCs) under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). We commented again on the consistently high quality of welfare guardianship applications.

The communication between the MHO team and CMHT had not been as effective as hoped and while the use of communication technology (MS Teams) had been helpful in some respects, a suggestion of in-person meetings, whenever possible, would improve the situation. We agreed this seemed a reasonable solution to promote and support more effective communication. Shetland local authority employed MHOs who were based in RCH to review STDCs and complete social circumstances reports

(SCRs) for individuals who were from the island but who were receiving care in RCH. We heard that this arrangement continued to be satisfactory.

We noted that mental health, CAMHS and learning disability services seemed quite disparate as they sat under different areas of governance. CAMHS gave an example where they were unable to access a person's mental health history and current treatment. Overall, the system appeared to work in silos and there was a general agreement between the services that this was the case. In order to provide a more cohesive and responsive mental health and learning disability service we would recommend that consideration is given to how these could be brought together and operate more cohesively. We look forward to hearing how this might be achieved.

Recommendation 1:
Managers should review the current governance of all mental health and learning disability services with a view to bringing them together under one directorate.

We noted that the transition from CAMHS to adult services would benefit from a policy, with clear procedures to ease understanding for all staff, allowing for a smoother pathway for individuals and a more robust transfer of care.

Recommendation 2:
Managers should develop a transition policy from CAMHS to adult mental health services.

Care, treatment, support, and participation

There are some difficulties unique to an island community that has no immediate access to inpatient mental health services. To support this, there should be a psychiatric emergency plan (PEP), which is agreed and understood by all services who may be called upon to provide input at these times. The PEP would require to take account of the uniqueness of the outer isles communities, who all had different levels of service and as already noted, at the time of the visit, the PEP was still to be submitted to the local governance committee for final ratification.

On the last visit, we also noted that there was not an agreed mental health service operational framework, which could lead to inappropriate referrals and a lack of clarity for both individuals using the service and for staff. Again, we were shown a draft document for this and look forward to seeing the finalised one. On the last visit we were surprised to hear that there was no agreed risk assessment tool in use across services. On this visit we were told that the Ayrshire risk assessment tool was now the agreed measure being used and we were able to see this in the care records we reviewed. We noted however that the risk assessments had not always been updated, and we saw risks were also identified on a separate assessment document on the electronic system, Care Partner. We were concerned that this inconsistency in information could lead to inappropriate or ineffective risk management.

Recommendation 3:
Managers should ensure that all individuals have comprehensive risk assessments and risk management plans which are regularly reviewed.

There were also inconsistencies in care plans in relation to detailed interventions and recovery outcomes for individuals. In one file we reviewed, we found that the risk assessment and care plan had not been updated following discharge from RCH, which had been over a month ago.

When we reviewed the care records of some people who were receiving learning disability day services from the Eric Gray Centre, we noted very person-centred, outcome focused support plans which incorporated people's views, and were reviewed regularly.

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.

Recommendation 4:
Managers should review and audit nursing care plans to ensure that they are person-centred care goals are SMART (specific, measurable, achievable, relevant and timely) and reflect individual participation, where possible.

Care records
There continued to be multiple care record systems in operation which included Care Partner, Trak Care, SCI Store and the local authority were just embarking on using the EMIS system. There were difficulties with the interface between the Gilbert Bain and the mental health department, which used the Care Partner system. There had been measures taken to ensure that staff at the Gilbert Bain could access Care Partner care records, continuation notes and summaries. However, there was an acknowledgement that the interface was not working well. We were advised that this issued had been escalated to the head of NHS Shetland IT department, but the service had not had any feedback. We appreciate that this may not be an easily resolved issue, but we would hope to hear of progress over the coming year.

Multidisciplinary team (MDT)
The CMHT MDT meeting took place weekly to discuss individuals care and progress. It was difficult to see where individuals were involved in the process. We saw where decisions about care, treatment and medication changes were made and where these decisions were relayed to the individual, but in most records we reviewed there was no record of the person's views. However, we did see one example of where this was done well for one individual in the records we reviewed. We felt that MDT

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

meetings would benefit from a template that recorded attendees, the discussion and decisions, the views of the person and if appropriate their family/carer. These discussions and decisions should link to and effect changes in the care plans. We did see one instance of a detailed follow up letter from an MDT discussion between the CPN, the psychiatrist and GP, but this was not reflected in all files reviewed.

Recommendation 5:
Managers should ensure that individuals are routinely consulted prior to the MDT meeting, and their views are recorded on an MDT meeting proforma.

Use of mental health and incapacity legislation

At the time of the visit there were four people from the CMHT service who were detained under the Mental Health Act on a community compulsory treatment order (CCTO). 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, for all but one individual, who we found was being treated without the relevant T2 certificate in place. This was referred to the responsible medical officer (RMO) on the day and rectified.

We noted that on the detention forms that Shetland community mental health team was cited as the hospital where the person was detained/under the care/management of. It is not possible for an individual to be detained to a community base, and a hospital must be named, which in this case would be the Gilbert Bain. This was raised with the consultant psychiatrist at the time of the visit.

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.

For those people that were under the AWI Act we found that all had section 47 certificates in place and the welfare guardians had been consulted.

Activity and occupation

Although the CMHT did not provide any activities directly, they helped and signposted individuals to projects such as the ‘survive and thrive’ group and the ‘bog squad’ which was a restoration project for peatland. Individuals told us that they valued these initiatives. There was also the Eric Gray resource centre which provided a wide range of activities and support for people with a learning disability. This was

described by the LD nurse as the best resource centre they had encountered throughout Scotland.

The physical environment

There were no mental health inpatient facilities in Shetland. The only hospital, the Gilbert Bain Hospital was situated in Lerwick. On the last visit we viewed the 'low stimulus room' which was originally designed to be used as a short-term place of safety while an MDT treatment plan was agreed to support someone who presented with acute mental health crisis and/or distress who was not suitable for admission to the medical unit.

We reviewed this environment on the last visit and considered it not fit for purpose in its current state. It was bleak with no windows, and only contained a bed and a chair, with no access to outside space or fresh air. The room was situated at the end of a corridor. There would be no ability for nursing staff to remove themselves safely and still observe an individual in the event of aggression resulting from stress and distress. There was no alarm system to summon help. We were told that there was a team of senior staff who were trained in the management of aggression, who could be called upon in this event. However, we were also told that they could live up to an hour or more away and be unable to provide immediate assistance.

We reviewed this room again and were given a copy of the comprehensive environmental risk assessment that had been completed following a recommendation from the last visit. We were disappointed and concerned to see that none of the risk assessment recommendations had been implemented, which would effectively make the room a more feasible option for individuals to be safely cared for while awaiting transfer to the mainland. However, the risk assessment did not extend to the room opposite (the forensic suite) which would be used by staff to carry out one-to-one observation. If this was done and all identified risks were managed, this would provide a safer space than the side room in Ward 3 where individuals could be placed while awaiting transfer.

Recommendation 6:
Managers should arrange for a risk assessment of the room adjacent to the low stimulus room and implement the recommendations from this and the previous recommendations for the low stimulus room to ensure the provision of a safe and comfortable space that promotes privacy and dignity and minimises the potential risk posed to individuals and staff.

Summary of recommendations

Recommendation 1:
Managers should review the current governance of all mental health and learning disability services with a view to bringing them together under one directorate

Recommendation 2:
Managers should develop a transition policy from CAMHS to adult mental health services.

Recommendation 3:
Managers should ensure that all individuals have comprehensive risk assessments and risk management plans which are regularly reviewed.

Recommendation 4:
Managers should review and audit nursing care plans to ensure that they are person centred and SMART (specific, measurable, achievable, reviewed and timely) and reflect individual participation, where possible.

Recommendation 5:
Managers should ensure that individuals are routinely consulted prior to the MDT meeting, and their views are recorded on an MDT meeting proforma.

Recommendation 6:
Managers should arrange for a risk assessment of the room adjacent to the low stimulus room and implement the recommendations from this and the previous recommendations for the low stimulus room to ensure the provision of a safe and comfortable space that promotes privacy and dignity and minimises the potential risk posed to individuals and staff.

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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