mentalwelfare
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Mental Welfare Commission for Scotland

Report on announced visit to: Netherton Unit**,** 19 Blackwood Street**,** Glasgow G13 1AL

Date of visit: 6 February 2017

Where we visited

Netherton is an 8-bedded unit situated in a residential area near Anniesland, Glasgow. It is a two storey building accommodating four patients in the downstairs unit and four upstairs. It provides for men with learning disabilities and additional mental illness and complex behaviour issues who require or required a longer period of rehabilitation or treatment.

The 'Strategy for the Future' NHS GGC 2014, made a recommendation that the NHS should not be a long term provider, and that people should be supported to live independent lives outwith hospital settings where possible. This aspiration was reinforced when guidance on hospital based complex clinical care was issued in May 2015, replacing guidance on NHS continuing healthcare contained in CEL26 (2008). NHS Greater Glasgow and Clyde strategic direction is in keeping with national policy for people with learning disabilities. This strategy applies to the two long stay units in NHS Greater Glasgow and Clyde, Netherton and Waterloo Close, which have hospital status, although neither are located on a hospital sites.

Netherton and Waterloo Close, both with longer stay patients, are in the process of a resettlement and re-provisioning process which will lead to the closure of these two units. The relevant council social work services have been coordinating the assessment of each person’s needs and their suitability for placement in social care services. To date, two people have moved on from Netherton, though one of these beds has been used for a patient from Waterloo Close. Another patient is about to move on to a community placement. On the day of our visit there were seven patients in the unit.

We last visited this service in September 2015, as part of a national visit to all learning disability hospital services in Scotland (excluding forensic services). At that time we were very positive about the care and treatment people were receiving. We made some recommendations on the level of activities for patients, including the need for clearer documentation of the individual’s participation in activities and the reasons for any cancellation of activities.

We visited on this occasion to see if there had been improvement in this area. We also wanted to give patients and carers an opportunity to raise any issues with us, particularly as we have been contacted by several families from Netherton and Waterloo Close who are unhappy about the re-provisioning plans and are very concerned about the future for their relatives.

We also looked at:

- Care and treatment and service user participation
- Therapeutic activity
- Use of legislation
- Physical environment

Who we met with

We met with four patients and looked at the records of all the patients. We also met with two sets of relatives.

We spoke with the senior staff nurse, the staff nurse and the consultant psychiatrist. We spoke prior to the visit with the General Manager of the Learning Disability Service to get an update on the current position with regard to re-provisioning the service.

Commission visitors

Alison Goodwin, Social Work Officer

Jamie Aarons, Social Work Officer

What people told us and what we found

Care, treatment, support and participation

The nursing staff told us of the challenges with patients' care and treatment in recent months. All the patients in the unit have complex needs, including autistic spectrum disorder and mental illness. As some of the patients are aware that they may be moving elsewhere and have seen two people move out, they have become anxious and there has been an increase in incidents. This has meant that a number of activities, particularly outwith the unit, have had to be cancelled due to safety issues for both patients and staff. This in turn can add to the patients' distress, particularly those who do not like any disruption of their routine. An extra member of staff has been brought in on the day shift and on the night shift. The recent increase in staff, who are all familiar with the patients, is a risk management strategy to support both staff and patients, with a view to maintaining a predictable environment. The purpose was to both to address behaviour issues and attempt to re-establish activities both in and out of the unit which have been disrupted due to the increased level of input connected to the assessment process and discharges.

The relatives and the patients we spoke to were very positive about the care and treatment provided by the nursing staff. However, they were unhappy and concerned about the plans to re-provision the service and did not want the unit closed. They told us that patients concerned had a long history, over decades, of community and other hospital placements which had been unable to meet their needs and cope with their behaviour problems.

They told us that the Netherton staff had been able to manage the complexity of these needs and improve the quality of life for those individuals. They did not accept the rationale of potentially disrupting this and expressed the view "if it's not broken, why fix it".

Additionally they have concerns about the time it may take to find appropriately robust placements for those assessed as being able to move to a community resource and the impact on both patients and relatives if this takes some considerable time.

There are very full nursing assessments for each patient, including risk management plans. Care plans are person-centred and detailed in terms of physical and mental health and there were 'Positive Behaviour Support Plans' in place with regular input from psychology. It was clear that staff knew the patients well and their care and treatment was appropriate to the patients' current needs. We were able to see regular reviews of care and treatment recorded in both the review paperwork and in the chronological notes. There are good occupational therapy (OT) and speech and language therapy (SALT) assessments and reviews for all the patients, though we understand the OT service has been more limited in the unit in recent months due to illness. There were learning disability specific health checks carried out by the GP-Learning Disability Liaison Service and good follow up of any physical health issues.

It was evident from the chronological notes and from talking to nursing staff and relatives that they actively promote and support family involvement in the patient's life and, where appropriate, in discussion of the patient's care and treatment.

There are 'easy read' care plans for discussion with the patients. We thought it would be useful to date when these were reviewed with the patient. There is a good record of people's likes and dislikes and we saw the use of Talking Mats with some patients to elicit their views. We also saw social stories and scripts prepared by SALT to prepare people for events or explain what was happening.

Questionnaires for getting feedback from patients are completed every six months. These are sent to the psychologist and go to a governance meeting. An action plan has been developed to include People First in assisting the service to establish a process of feeding back to patients on "Your Views", using an accessible format.

The tendering process for advocacy has led to a change in the provider for Netherton. This has led to a new advocate for many of the patients who had long-standing relationships with the previous advocate. All patients, however, have an advocate who can reflect their views, as far as possible, in the assessments for the re-provisioning process.

Recommendation 1:

The service should keep the recent increase in staffing levels under review to ensure it is sufficient to maintain risk management plans and daily activity programmes.

Use of mental health and incapacity legislation

We were pleased to find all consent to treatment (T2) and forms authorising treatment (T3) under the Mental Health Act (MHA) and s47 incapacity certificates and treatment plans under the Adults with Incapacity Act (AWI) were in place.

There are good personal spending plans for those patients whose funds are managed under Part 4 of the AWI Act. We saw efforts to encourage spending on appropriate items and think of ways patients could benefit from their money.

All documentation related to Specified Person restrictions were in order with reasoned opinions in the files.

Activity and occupation

As mentioned above, the OT service in Netherton has been limited in recent months and has relied on input from the OT technician who is shared with another unit. Additionally, the increase in behaviour issues and incidents in the unit has meant nursing staff have at times had to prioritise patient safety over the programme of therapeutic, social and recreational activities. Staff have, as far as possible, been trying to maintain individual programmes where the person is able to participate. There is now a full OT complement and with the additional nursing staff this will hopefully be sufficient to reinstate activity programmes fully. Prior to these difficulties, there were plans to look proactively at expanding opportunities for some of the patients but this has not happened. One set of relatives we spoke to were keen to access art and music therapy and other activities for their relative and were happy that he should fund this himself but would benefit from assistance to put this in place.

Recommendation 2:

Nursing and OT staff need to update all the individual activity programmes with a view to reinstating and expanding the range of activities.

The physical environment

We were pleased to see the ward is clean, bright and reasonably well maintained. The sitting rooms are comfortable and well furnished. Bedrooms are personalised with photos and belongings and efforts have been made to make them as homely as possible.

The garden area is pleasant and well maintained. It is a useful facility for patients in the summer for gardening and leisure.

Summary of recommendations

1. The service should keep the recent increase in staffing levels under review to ensure it is sufficient to maintain risk management plans and daily activity programmes.
2. Nursing and OT staff need to update all the individual activity programmes with a view to reinstating and expanding the range of activities.

Alison Thomson

Executive Director (Nursing)

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

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 MWC 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 individual care, treatment and support is 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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