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 25 July 2024

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 services that were available 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 mental health inpatient beds here, there is a mental health patient transfer room. 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), NHS Grampian or for children/young people, this would be to Dudhope Young Persons Unit, NHS Tayside - would remain in this room until transfer off the island could be facilitated.

We last visited the mainland services on 30 May 2023, until 1 June 2023. This visit was announced as it was the first time that we had met with a range of staff and services. The recommendations that we had made included: exploring the interface between primary and secondary care to develop mental health care being delivered in primary care settings; reviewing the discharge pathway with NHS Grampian so that discharge processes could be audited and any gaps identified; in communication and improve patient outcomes; agreement by all agencies of psychiatric emergency plans (PEPs) that would assist the safe and timely transfer of patients; consider the feasibility of alternative approaches to increasing AMP input; revisit the service level agreement that was in place with NHS Grampian for the provision of inpatient beds and the transfer process; staff supporting those who access the mental health patient transfer room should have a key so that outdoor access for the patient is possible and any enhanced level of intervention that occurs in the mental health transfer room is proportionate to need.

We received a response from the service in August 2023 where we heard about plans to develop primary care mental health nurses if funding was made available; an audit tool had been devised for discharges from NHS Grampian, along with monthly meetings between managers; PEPs were due to be approved by all partners and disseminated; an option appraisal on developing a sustainable provision of approved medical practitioners (AMPs); the mental health service level agreement (SLA) had been prioritised by NHS Orkney; the access key for the outside space attached to the transfer room was now readily accessible and the risk assessment process had been reviewed and strengthened. There would be a supporting observation policy devised to ensure a proportionate level of observation was put in place at the times the transfer room was in use.

During this visit, we wanted to follow up on the previous recommendations and gather further information about the delivery of care for individuals, their

families/carers, and how the professionals working with them were meeting their care and treatment needs.

Who we met with

We carried out 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.

We met with a range of staff from the community health and social care teams, including child and mental health services, older people's services and the learning disability/autism spectrum service. We had meetings with senior managers from the health and social care partnership, GPs who covered both the day and out of hours services, the mental health officer (MHO) team and the consultant psychiatrist who was on the island at the time. We also met with the chief executive of NHS Orkney and the board chair.

Commission visitors

Susan Tait, nursing officer

Tracey Ferguson, social work officer

Claire Lamza, executive director (nursing**)**

What people told us and what we found

Of the individuals and families/carers that we spoke with, we heard differing views about their experiences of the support they had received. From those individuals who were able to engage with us, we heard that they were “happy” with their current environment. For others we visited who were unable to verbally communicate with us, we were able to see the environments they stayed in, review the records that were available about their care, and get a clear understanding of the support that was in place.

Where we were able to speak to families/carers, we heard that for most, they found that the quality of care provided for their family member was positive; we were told that it was “the care from the team that made a difference” and that there was a “good team in place that knew how best to support them”. We were advised that input from the local authority supervising officers (SO) of the guardianship orders varied. We heard that reviews were not always timely, although families could contact the SO if they had any queries.

We noted that for some access to personalised activity programmes were tailored to their specific needs and heard that they enjoyed attending a broad range of activities that were provided either in their own environment, or with local community services. We also heard from those individuals that we met with that for some, access to meaningful activities was problematic and that the duration of respite care options that had previously been available had reduced.

On speaking with the community health and social care staff, and the manager for mental health services, we heard of occasions when transferring a patient off the island for ongoing mental health care and treatment which was provided by NHS Grampian could prove difficult. Staff from Orkney escorted the individual and this was usually done through a combination of community mental health staff or mental health officers. However, the unpredictable nature of this happening has, for some time now, created additional pressures for staff that can significantly disrupt their working week, meaning that scheduled work and planned appointments have to be cancelled, rearranged or other members of the team have to provide any additional support required. We were also told of occasions when there had been differing views between various partners regarding the requirement for patient sedation, prior to the transfer taking place. This was noted in the last report and remains an ongoing issue overall for the service.

We heard that there were discussions around developing a liaison service which may take pressure away from the CMHT to provide the care of individuals awaiting transfer. We also discussed a model of intensive home treatment service which could provide crisis and increased input to enable individuals to remain on the island.

Recommendation 1:
Managers should consider the development of a resourced model of care that can support individuals who require intensive support for their needs at a time of crisis.

We were pleased to hear that with a recent investment in the child and adolescent mental health services (CAMHS) that there were additional staff now in post and this had had a positive effect and outcomes for the young people on the island who required support and intervention.

The code of practice for the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) recommends that comprehensively developed and locally relevant psychiatric emergency plans (PEP's) are a means to help manage the detention of a patient and aspects of multi-agency working. They are also referred to in the Police Scotland standard operating procedure (SOP) for dealing with patients who present in mental health crisis. We had been made aware that Orkney's PEP had been in draft form for a number of years and required some work for it to be reinvigorated and ratified. There had been significant review since the last visit and the Commission's recommendation for further work on this, however it had not yet been fully implemented. We repeat the recommendation made on our last visit.

Recommendation 2:
Managers should make arrangements for the PEP to be finalised by all agencies and implemented to assist in the safe and timely transfer of patients.

We met with the nurse who is the learning disability service on Orkney. We were told that they have 63 active individuals on their case load and at least 20 on a waiting list. We were advised that there were plans for a second nurse for this service, and that recruitment for this post was planned. There are no other clinical staff on the Mainland who can make a diagnosis of learning disability, so individuals who should be able to benefit from this input were unable to access it; we were told that there was flexibility when there were clear indications that an individual has a learning disability.

When we met with staff from the community teams we were told that they had raised formal concerns about the service as a whole. They informed us that they found there to be disparity and variation from other teams who were required to work alongside mental health staff. We heard that support from accident and emergency staff, other mental health and health colleagues could, at times create additional difficulties for those working in community and social care for individuals with mental health needs. Staff raised their concerns that attitudes and culture from staff working in other areas were of concern.

The community and social care staff advised us that this can lead to them trying to provide care and treatment beyond the capacity that they have to do so. In the

Commission's report of 2023, we highlighted the willingness and goodwill of these teams to do their best, but on this visit, we heard that they had reached a point whereas a team, they considered the current way of working was no longer tenable and that the risks posed to individuals in their care was significant.

We did hear that there had been a development day where the whole team working in CAMHS, mental health and learning disabilities had had an opportunity planned to discuss and try to address these issues; overall, they were hopeful that this would have a positive outcome. We look forward to hearing about the progress of the outputs of the development day at our visit in 2025.

We also had an opportunity to meet with the chief executive (CE) and board chair. They provided us with an overview of some of the strategic plans that were in the process of being developed. We heard from the CE that there have been opportunities for staff to make contact and discuss any concerns they had with the CE on a one-to-one basis; the CE advised us that this work would continue but be led by another senior member of staff in NHS Orkney.

We also heard that NHS Orkney's strategic plan for mental health services had been shared with staff, and that further work was being progressed. The CE and chair did acknowledge that there were areas where a greater focus may be required, specifically around the quality, assurance and managing risks where the challenge of resources and staff could have a direct impact on care and treatment. The Commission will keep in contact with Orkney as the development of core mental health standards and Scottish Government's framework for assurance of mental health and learning disability services progresses.

Care, treatment, support, and participation

Of the care and treatment recorded in an individual's records that we were able to review, which was with a number of adults who subject to welfare guardianship orders, we had no significant concerns in relation to the care and support they received from services. We heard from some of the relatives, welfare guardians and staff that there were issues in relation to housing and future planning.

The care records we reviewed in relation to their care were of a reasonable standard. We did note that the quality of some of the guardianship reports that had been completed by the MHO lacked detail in the applications and in the completed guardianship supervision records and guardianship reviews. We followed up one of the issues for an individual in relation to risk assessment and future access to community facilities. We found that the quality of some of the guardianship reports that we reviewed lacked detail in the applications and supervision records.

In the report of our last visit, we heard how there was no real time mechanism for information to be shared between professionals and the risk this carries. We were

told that this in part could be addressed with the implementation of the electronic system, MORSE which was expected to be available towards the end of the year. We were advised that training for staff would be provided.

We look forward to hearing about the impact of this when we next visit.

Multidisciplinary team (MDT)
During our visit to the Mainland, we had planned to meet with as many of the social (SW) mental health officers (MHO) as possible, although only the lead MHO and an MHO trainee were available on the day. The local authority has four MHOs, this includes two full time officers and two who are part time; as social workers/MHOs they can be based in CMHT, CAMHS, older adult and home first team services.

Currently there is one trainee on placement who was due to qualify in September 2024. All MHOs do statutory work associated with their duties under the Mental Health Act, AWI and the Adult Support and Protection (Scotland) Act, 2007 (ASP) in addition to their duties as social work officers employed by the local authority/Orkney council. The MHOs in Orkney have a social work duty rota system and all members of the team participate in this; the MHO team were required to respond to out of hours MHO statutory work.

Of those that we spoke with, some of the issues they raised concerns about were that there was no specific lead for the Mental Health Act or ASP or for the operational or strategic work across the HSCP, although we have been advised that there is a service manager in post who has the lead for ASP. We heard that the model for a lead MHO/MHA is currently under development.

Planning in relation to the workforce appeared to be challenging, although we heard that there were now five MHOs which we anticipate will help with contingency plans and the sustainability of the service. MHOs were required to respond to all calls and that meant that some workers were working continually working long days, in the evening and at weekends without a break.

We were provided with data that had been collected by the service on the type of orders and intervention across the Acts, although there was limited information that provided evidence of MHO standards and the amount of MHO time, or hours, that the service requires. During the visit, we were advised that no established governance processes of performance management frameworks had been put in place although have subsequently heard that the joint Clinical and Care Governance committee receives a bi-annual report on mental health. This information is also included in the annual report.

Aberdeenshire has previously supported Orkney with mental health act statutory work during daytime and out of hours although this has since ceased as of December 2023. This has added additional pressures to the existing MHOs and their

statutory work. We were advised that MHOs do not complete other statutory work tasks such as social circumstances reports (SCRs) unless a person's care and treatment progresses to a compulsory treatment order (CTO); we heard that this is due to lack of capacity.

In our last report, we found that restrictive powers had been requested for some chief social work officer (CSWO) guardianships with no evidence that these are required. We were concerned that this continues to appear to be a practice that happens in Orkney, where powers are applied for just in case they are needed. We also found that guardianship orders were not being supervised or reviewed within statutory requirements. We discussed this with the service and heard that there were some local constraints that had an impact on this, although the service committed to keep this under review.

We were advised that there had been a recent appointment of a CSWO in Orkney and that they had met with staff who have raised concerns about the impact on their practice in trying to meet the statutory duties and responsibilities of MHO work and on their well-being.

We were concerned that as a local authority, Orkney is not fulfilling their statutory obligations, with a lack of available MHOs to do statutory work and/or meet MHO standards. We heard that MHOs were feeling compromised that due to a lack of capacity, they could not meet their own professional standards. We were advised that the Chief Officer/Head of health and community care had engaged an external MHO consultant to provide supervision and to determine a proposed leadership model for our consideration. We will look forward to hearing the findings from the review.

Recommendation 3:
The Commission should receive a copy of the independent review into MHO services in Orkney.

We met with the current psychiatrist who was visiting the Mainland at the same time as the Commission visit was taking place. We heard from the psychiatrist that they tried to ensure they visited on a monthly basis for several concurrent days, but sometimes, depending on annual leave or other circumstances, this timescale could be longer. We were advised that there is input from another psychiatrist in relation to CAMHS, but this is only done virtually. We were also made aware that one of psychiatrists did not have a job plan that they worked to, although there were plans to rectify this.

We were pleased to hear from the community health and social care staff that even though there was no permanent psychiatrist available on a day-to-day/week-to-week basis, they found that if they needed input from the psychiatrist, or in relation to

responsible medical officer (RMO) duties, the current psychiatrist was responsive and helpful.

While we recognise that the RMO who does visit the island is as involved as they possibly can, the current psychiatrist/RMO provision does not lend itself to giving regular and consistent treatment on a face-to-face basis for the people who are in need of input from the mental health service.

We also met with the GPs who covered both the Mainland and the smaller islands that are more remote. Some were able to meet with us in person, others joined the meeting virtually. They raised concerns about their frustration for someone who lacked capacity but needed to go to hospital via ambulance, and that air ambulance service staff would not support them.

The issue that created this difficulty was where consideration of restraint/restrictions may be required if an individual had stressed or distressed behaviours - this was described as “laying on hands” - and if they refused to be transferred. For the GPs, this left people who had significant medical risks, and who were unable to make capacitious decisions about travelling in an ambulance, unable to get the care they needed.

We had a discussion as to when the Mental Health Act might be used, such as if the medical condition requiring assessment was being refused as a result of mental illness and the individual met the criteria for detention under the Mental Health Act.

We also heard from the GPs that there could be difficulties when they had used the Mental Health Act. We were told that staff were not always available to support the individual who required immediate care and treatment, or that the risks assessed by the GP were not always supported fully by staff who were there to manage the identified risks.

We previously made a recommendation about consulting with primary and secondary care professionals to see if there was a way forward that might allow for mental health care to be provided in primary care settings. We also recommended that the feasibility of alternative approaches to increasing AMP input should be considered. With the implementation of safe staffing legislation and support for health boards being provided by Healthcare Improvement Scotland (HIS) we would suggest that further work should be undertaken to look at the workforce needed to support medical treatment across Orkney.

Recommendation 4:
Managers should consider undertaking a multidisciplinary workforce review to develop a strategic plan for the short- and medium-term needs for those requiring care and treatment for their mental health/learning disability needs.

Use of mental health and incapacity legislation

There are significant issues for individuals who require compulsory treatment. It is not possible to have someone on a community compulsory treatment order as there is no approved medical practitioner (AMP) to act as the RMO who is based on the island.

For most individuals who require urgent treatment under the Mental Health Act, this is nearly always done with an emergency detention certificate (EDC), which is applied by one of the island GPs, although we were pleased to note that this is always authorised after MHO consent.

However, for the majority of the time, it is unlikely that the AMP will be on the Mainland island, so the individual must be transferred to Royal Cornill Hospital (RCH) to have the EDC reviewed and consideration given to whether the EDC should be revoked or progressed to a short-term detention certificate (STDC). For the Commission, this raises concerns regarding the principals of the least restrictive alternative, benefit and reciprocity.

Positively, we were not made aware of any specific instances where a person was moved to RCH when this was not clinically indicated but when it is procedurally required to revoke an EDC/STDC, there is potential for this to be an issue. We have been advised that a review of adult psychiatry is planned to commence in the incoming financial year and may provide recommendations in relation to having an AMP available on the Mainland.

The physical environment

During our visit, we again visited the mental health transfer bedroom in the Balfour Hospital. We noted efforts had been made to soften the environment and make this more inviting for people who required to be in the room. There was a very small area outside of the room, which was fully enclosed on all four sides and open above to the elements with no shelter from sun or rain.

On the last visit staff were unable to locate the key to open the door to this small courtyard and there was a recommendation around this, however on the day of this visit, the room was not being used and the room door to the courtyard was open. The member of staff who showed us the room demonstrated where the key could be found.

There was a second room, off the bedroom, which was essentially an observation area, where staff were able to be separate and secure so that they could observe the bedroom and anyone admitted there through a large perspex window. We asked for information on how long the room had been used throughout the period of January to July 2024; this varied from five hours to 119 hours. We were told that the duration

that someone could be in the room depended on weather and transport arrangements, and previously it could have been longer than five days.

We would support the ongoing monitoring and usage of the room to ensure that whenever possible, it is used infrequently and for the shortest time.

Summary of recommendations

Recommendation 1:
Managers should consider the development of a resourced model of care that can support individuals who require intensive support for their needs at a time of crisis.

Recommendation 2:
Managers should make arrangements for the PEP to be finalised by all agencies and implemented to assist in the safe and timely transfer of patients.

Recommendation 3:
The Commission should receive a copy of the independent review into MHO services in Orkney.

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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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