Mental Welfare Commission for Scotland

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

Date of visit: 10-12 September 2024

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), opened in 1961. In 2021, NHS Shetland published proposals to construct a new hospital within five years.

Whilst there was no mental health unit in the Gilbert Bain, there is 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 routinely to the Royal Cornhill Hospital, NHS Grampian or to Dudhope Young Peoples 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 also carried out a visit to one of the outer isles.

Who we met with

We met with eight individuals who were receiving input from the community mental health team (CMHT), some of whom were accompanied by a relative. We also met with three adults who were subject to welfare guardianship orders.

We also met with the director of community health and social care, the IJB chief officer, the chief nurse, the team leader for mental health community support services, consultant psychiatrists, the medical director, the interim deputy director of acute services, the executive manager for adult services and acting chief social work officer, the head of mental health services, a clinical pharmacist for mental health, the team leader for mental health adult social work and mental health officer (MHO) lead, the MHO team, a group of psychiatric community nurses (CPN), the learning disability (LD) nurse consultant and some of the primary care and counselling team.

Commission visitors

Susan Tait, nursing officer

Dr Arun Chopra, executive director (medical)

What people told us and what we found

We heard mixed views from the people who were receiving input from the CMHT. Some individuals said they were extremely happy with the input they had, saying “I wouldn’t be here without the help I get from my community psychiatric nurse CPN” Others said they highly valued the service.

Some individuals said that the service was unable to meet their needs in a timely manner and described the serviced as “reactive, rather than proactive with good intentions, but inadequate outcomes”. One individual said they and their family felt very let down by the service and were unaware of any crisis plan to support them in times of distress. We raised these issues with the mental health lead.

Following our visits to people on welfare guardianship orders, we contacted services regarding aspects that came up to ensure that the principles of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) were being upheld and raised a request for specific professional input.

On the last visit we heard about housing shortages for supported accommodation. This remained 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 reflected throughout Scotland.

When we met with the nursing team, they acknowledged that there had recently been an improvement in the staffing complement. This had been a significant issue in the past, but they were almost at full complement. They were pleased that some of those who were joining had knowledge of Shetland.

We heard there was more positivity about the stability of the medical team following a succession of locum medics.

We noted that at the time of the visit there was only one LD nurse on the island, which has double the national average population of people with a learning disability. With a case load of over 240, it was difficult to see how needs could be met. However, since the visit, we have been made aware that there was another LD nurse in post and look forward to hearing the impact this has for individuals and their families.

When we met with the MHO team, we were pleased to hear that they had a full complement of staff, with only one agency social worker covering whilst a trainee completed their training. There was nearly always an MHO available to consent to emergency detention certificate (EDCs) and out of hours short term detention certificates (STDCs). We commented on the high quality of welfare guardianship applications that we reviewed.

The main issue raised with us was that since the Covid-19 pandemic, the communication between the MHO team and CMHT has not been as effective and whilst 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 employs MHOs who are based in Royal Cornhill Hospital to review short term detention certificates (STDCs) and complete social circumstances reports (SCRs) for individuals who are from the island but who receive care in Royal Cornhill Hospital, Aberdeen; we heard that this arrangement works well.

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 with and understood by all the services who may be called upon to provide input at these times. We were given a copy of a draft one which had been completed in August 2024. This contained many of the required elements, but did not have a clear plan of execution. The Commission has produced a template of what we would expect to be included in a PEP, which can be found here.

Recommendation 1:

Managers should review the psychiatric emergency plan in line with Commission guidance and produce a document that can be applied by services.

We also noted that there was not an agreed mental health service specification document, which could lead to inappropriate referrals and a lack of clarity for both individuals using the service and for staff. Again, we were given a draft document for this and look forward to receiving the finalised one.

We heard of an attention deficit hyperactive disorder (ADHD) pathway which had made a significant impact in the approach to treatment for people with this diagnosis and we heard from a family of the positive impact this had made for their relative. We heard from professionals of their intention to develop a similar pathway for individuals with a diagnosis of personality disorder and would hope to see this during our next visit to the island.

We were surprised to hear that there was no agreed risk assessment tool in use across services. We heard that some staff were using the Ayrshire risk assessment tool, but there was not a clear sense that all were aware of this. It would appear that individual staff have developed their own systems however, this approach carries inherent risks for individuals using the service and for staff.

Recommendation 2:

Managers must review the current approach to risk assessment and ensure that any tool which is rolled out is consistently used throughout the service. The development of a risk policy should be considered.

Care records

There continued to be multiple care record systems in operation. There were particular difficulties with the interface between the Gilbert Bain Hospital (GBH) and the mental health department, which used the Care Partner (care pathway) system. There was discussion that staff at the GBH could access Care Partner to ensure staff across the service were able to access notes and summaries. However, there was an acknowledgement that the interface was not working well.

On the last visit we heard that there was a possibility of a 'north of Scotland portal' which is an NHS Scotland North programme that would aid communication, but this had not yet been implemented.

The concerns extended to how appointments were being organised. Apparently, these were organised through an MS Outlook calendar, rather than through an electronic notes system. It was unclear what the rationale for this was.

We remain concerned about the risks to individuals using mental health services when a number of systems are in place that some staff are unable to access.

Recommendation 3:

Managers must consider how the electronic systems can be streamlined to reduce the risks associated with several systems which some staff cannot access when required.

Use of mental health and incapacity legislation

At the time of the visit there were four people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (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 in place. This was referred to the responsible medical officer (RMO) on the day and rectified.

When we are reviewing individual's 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. We saw one advance statement on file, but the care plan in that file belonged to another individual. We raised this with the team on the day of the visit and advised that an audit of the care records would be useful to ensure that care records contain accurate information and that all documentation pertains to the correct individual.

The physical environment

There are no mental health inpatient facilities in Shetland. The only hospital, the GBH is situated in Lerwick.

The GBH had a 'low stimulus room' which was originally designed for anyone who required a short-term place of safety whilst an MDT treatment plan is agreed to support someone who presents with acute crisis and distress who is not suitable for admission to the medical unit. We reviewed this environment 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.

If an individual required to be detained on an STDC, prior to transfer to the Royal Cornhill Hospital in Aberdeen, there was usually a side room made available in Ward 3, which is a medical ward. The individual would be supported by CPNs mostly on a one-to-one basis. We reviewed this facility and whilst it was a better option than the 'low stimulus room', there were still some obvious concerns, including lots of medical equipment around which could pose a risk should an individual be in a stressed and distressed state. We do however acknowledge the challenge posed to provide care and treatment in the confines of what is available.

Recommendation 4:
Managers should carry out a robust risk assessment of both the low stimulus room and Ward 3 with a view to providing 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 psychiatric emergency plan in line with Commission guidance and produce an effective document which can be applied by services.

Recommendation 2:
Managers must review the current approach to risk assessment and ensure that any tool which is rolled out is consistently used throughout the service. The development of a risk policy should be considered.

Recommendation 3:
Managers must consider how the electronic systems can be streamlined to reduce the risks associated with several systems which some staff cannot access when required.

Recommendation 4:
Managers should carry out a robust risk assessment of both the low stimulus room and Ward 3 with a view to providing 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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