**Mental Welfare Commission for Scotland**

**Report on announced visit to:**

Services in NHS Orkney, Orkney HSPC and the Orkney community

**Date of visit:** 30 May 2023 – 1 June 2023

## Where we visited

Orkney, also known as the Orkney Islands is an archipelago situated off the north coast of Scotland. Orkney is 10 miles north of the coast of Caithness and has about 70 islands, of which 20 are inhabited. The largest island, the Mainland, has an area of 202 square miles, making it the sixth-largest Scottish island and the tenth-largest island in the British Isles. Orkney's largest settlement, and also its administrative centre, is Kirkwall.

NHS Orkney's hospital and healthcare facility, The Balfour, opened in 2019. Whilst there were no mental health inpatient beds here, there was a 'mental health patient transfer bedroom'. Adults or children who had been assessed as requiring transfer to a mental health inpatient bed – for adults this was routinely to the Royal Cornhill Hospital (RCH), NHS Grampian or to Dudhope Young Persons Unit, NHS Tayside - would remain in this room until transfer off the island could be facilitated.

We heard that between April 2022 and March 2023, there were 32 patients transferred from Orkney to mental health inpatient services on mainland Scotland. We heard that this was a significant rise from pre-Covid-19 pandemic times, as between April 2018 and March 2019 there were 16 transfers. We heard that, as was the case in many other parts of Scotland, it would appear that the Covid-19 pandemic had had impact on mental health in the Orkney Islands.

Orkney Health and Social Care Partnership, (Orkney HSCP) was a partnership between Orkney Islands Council and NHS Orkney. The Partnership aimed to improve and develop social care, community health and wellbeing. Orkney HSCP had been responsible for the delivery of the full range of the Council's social work and social services, for all age groups and service user groups, and NHS Orkney's community based health services since 2011, under joint management arrangements.

This was a different type of visit for the Commission to conduct. Instead of visiting an individual ward or service, we met with a range of people who have had contact with mental health and learning disability services. We also met with professionals who delivered the majority of these mental health and learning disability services, senior managers who worked in NHS Orkney and the HSPC, Age Scotland and a number of adults who were subject to a welfare guardianship order under the Adults with Incapacity (Scotland) Act (2000) and their welfare guardians.

## Who we met with

We were invited to attend the Orkney Blide Trust, a charity that provides support for those who have, or have had, lived experience of mental ill health and their family or carers. They offered a range of activities and supportive services, which included a daily drop-in service. We attended the drop-in and met with ten people. We also met with a group of ten women from Age Scotland Orkney. We carried out eight welfare guardianship visits and either met with or spoke with the welfare guardians for these adults, and in most cases the social worker who was allocated to each case. We arranged visits to and meetings with a range of health care professionals from the community mental health team (CMHT), the child and adolescent mental health team, the learning disability and autism spectrum disorder service, and met with the mental health officer team.

In addition, we also met with a group of senior managers, including the chief officer, the medical director, the head of health and community care, the adult and learning disability social work service manager and also with one of the solicitors who was involved in guardianship applications in the area.

## Commission visitors

Lesley Paterson, senior manager (practitioners)

Dr Arun Chopra, executive director (medical)

Kathleen Liddell, social work officer

# What people told us and what we found

## Care, treatment, support and participation

We met with people through the Blide Trust and most of the people we met had experience of mental health services on the islands; mostly from primary and secondary care, although two people had experience of the mental health inpatient services in NHS Grampian.

From those individuals, they described a mixed picture of their experience of mental health services in Orkney. Many spoke highly of their general practitioners and of the care that they had received from the community mental health team (CMHT). Some people spoke of particular community psychiatric nurses, (CPN's) some who had since retired and described them as caring and supportive. A few people described difficulties with seeing psychiatrists and we heard about issues concerning staffing. One person spoke encouragingly of the new consultant psychiatrist who worked on the island.

However, some people we spoke to described that there was often a difficulty in receiving support when they were most unwell. At those times they described a varied and uncertain picture of whether support would be available and there was a feeling that these difficulties appeared to have increased for them in recent years.

We also heard about the experiences of another person who described a lack-of joined up care between the admission ward at RCH and the CMHT in Orkney. We heard about the experience of one patient who had no planned follow up on discharge on their return to the island and came to harm. This patient had been due to meet us, but unfortunately we were unable to find a suitable time. We therefore made arrangements to follow up on this case.

One person who had co-occurring mental health and problem substance use spoke about the difficulties they had experienced in getting help around their addictions. They described a high level of substance use issues on the island. They reported that they often felt in a spiral however, they spoke highly of the programme of support they were receiving from the Blide Trust for addiction difficulties.

Most of the adults subject to welfare guardianship orders whom we met with were happy with their care and support they received from services. Some of the issues raised by relatives, welfare guardians and staff were in relation to housing and future planning. Two of the adults we met were living in a respite unit that was not a permanent arrangement. Neither of these individuals had any indication of future housing options and we were advised that there was a problem with housing stock on the island, resulting in limited housing options for people to move on to. One welfare guardian raised an issue that community-based support was not always consistent, adding that this had become more difficult since the Covid-19 pandemic. The welfare guardian added that their relative used to have a consistent team of carers however, there were now greater staff shortages, which they believe has had a negative impact on the quality of the care their relative received. Another guardian felt powerless regarding best supporting their family member in accessing future vocational activities and support services and did not feel that social work had been helpful with this.

We heard from professionals of some interface issues between primary care and secondary care. Some concerns were raised that primary care was not welcoming of a suggestion of

mental health professionals using primary care facilities to see their patients however, we also heard from other sources that the primary care services were supportive and wished to work closely with mental health services. We were made aware of a document that had been commissioned by NHS Orkney some years ago, to look at closer working / other ways of working across this interface, however noted that this was no longer available on the NHS Orkney website. We also heard that primary care practices had recently stopped undertaking any type of psychotropic monitoring blood tests for CMHT patients, which had impacted on the workload and availability of CMHT staff.

When we met with the community mental health team, we heard about their day-to-day workload, and in particular the impact of staffing the mental health patient transfer bedroom at Balfour Hospital. This room was designed for use for short periods of time, however, we were made aware that the room was being used for extended periods of time beyond what it was expected to be used for. For the duration of time that a person is cared from in this room, there is a requirement that they are placed under enhanced observation by a minimum of two staff members. Due to the unscheduled and unpredictable nature of when this room will be in use, there was no dedicated staff, so staffing resource came from the existing community mental health team. It would appear that this created a situation where there were risks to the delivery of the service, and to its longer term sustainability. The idea that staff had a constant expectation that they may be required to staff the patient transfer room, with little notice was not in keeping with the 'right to switch off' and the need for breaks from caring work. Also, there have been times that the day-to-day work of the CMHT has had to be cancelled, as staff were involved in providing input to the patient transfer room, where a person has been placed on an emergency detention certificate (EDC). Staff did raise questions about what this might mean to individuals that they supported in the community and the potential impact of cancelling appointments and not being available to carry out their scheduled work.

Whilst the transfer room remains in use at the levels that we observed, we consider that there ought to be timely consideration of the staffing levels required to safely support its use and / or the safe running of the CMHT when the room is in use and that these are maintained. The potential development of a rota to ensure that staff were able to check whether they were required to staff the room may be of benefit.

We also heard of occasions when transferring a patient off the island, to NHS Grampian for ongoing mental health care and treatment, could prove difficult. Staff from Orkney provide the patient escort, usually a combination of community mental health staff or mental health officers and the unpredictability of this requirement again put pressure on staff and disrupted their working week, meaning that scheduled work and planned appointments had to be cancelled. We were also told of occasions when there had been dissent between various partners regarding the requirement for patient sedation, prior to the transfer taking place.

The Mental Health Act (2003) Code of Practice 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 Procedures 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.

In 2020, the Commission undertook a review of psychiatric emergency plans across Scotland, which can be found here:

A review of Psychiatric Emergency Plans in Scotland 2020_0.pdf (mwcscot.org.uk)

We were particularly concerned from what we heard from social workers, CMHT staff and people who had experience of services at the Blide Trust, about the discharge pathway and the extent to which discharges from the Royal Cornhill Hospital (RCH) were planned, coordinated and communicated with Orkney mental health services. We heard of at least two cases that concerned us of people being discharged with minimal planning or collaboration; this had led to little or nothing in the way of follow up and we heard of poor outcomes post-discharge because of the communication issues around this. We are following up on some of these cases in more detail with the relevant services.

### Care records

We heard that across the island, information on patients care and treatment was held in different ways, meaning that the community mental health services notes were not searchable across the health and care service. The CMHT manager showed us how notes were recorded in a folder structure at the CMHT, however we understood that these notes were not accessible out of hours to the CMHT team and were not accessible to clinicians working at the Balfour Hospital or at the RCH, where patients may be admitted to. There was no clear real-time mechanism for notes to be shared between professionals involved. We were concerned by this situation, as these barriers appeared to be a potential impediment to the provision of safe care and adequate information sharing. We did however understand that proposals were in place for a shared electronic health care notes system and look forward to hearing how this progresses in the near future.

**Recommendation 1:**
Senior managers should give consideration to consulting with primary and secondary care professionals to explore the interface to see if there is a way forward that might allow for more mental health care to be delivered in primary care settings.

**Recommendation 2:**
Senior managers should give urgent attention to the discharge pathway they have with NHS Grampian and ensure that discharge processes are audited to identify and reduce any further gaps in communication and improve patient outcomes.

**Recommendation 3:**
Senior managers should make arrangements for the PEP to be agreed by all agencies and implemented to assist in the safe and timely transfer of patients.

## Use of mental health and incapacity legislation

We were aware that there was no Approved Medical Practitioner (AMP) present for much of the time on Orkney, who would have been suitably qualified to be able to revoke an EDC once this had been granted by any qualified medical practitioner. This may mean that some people are kept in the patient transfer room for longer than necessary. Although we were not made aware of any specific instance where a person was moved to RCH when this was not clinically indicated, but was procedurally required in order to revoke the EDC, the potential for this issue

to arise was noted. We would suggest that revisiting the service level agreement with NHS Grampian that governs the bed transfer process would be beneficial, and in particular looking at whether this needs to be reviewed, extended or a new approach developed with a more extensive range of partner boards. Whilst we could not immediately recognise a mechanism for review of EDCs, we did consider that an economic case could possibly be made for review by an on-call AMP, potentially via a shared resource across island boards. This would provide particular benefit in cases when there is an expectation that continued detention was not necessary. We also note that across Scotland, most EDCs do not progress to short term detention certificates (STDCs), so the fact that most EDCs granted on Orkney appear to be progressing to STDCs requires further exploration. This may reflect threshold or procedural factors, or it may also be related to the high level of MHO presence for EDCs in Orkney, which is of course a positive feature that is not always replicated across other parts of Scotland.

**Recommendation 4:**
Senior managers should consider the feasibility of alternative approaches to increasing AMP input, especially where there is an expectation that continued detention is not necessary and criteria for detention are not met.

## Rights and restrictions

The mental health patient transfer bedroom in the Balfour Hospital was designed for use for short periods of time, however, we were made aware that the room was being used for extended periods of time beyond what it was expected to be used for. We understand that some of the use for longer than expected was due to downstream bed pressures on the admitting ward(s) at the RCH in NHS Grampian. There was little personalisation or an individualised approach to the way in which the room could operate. There was a requirement that anyone in the room was observed continuously (except when in the toilet). We were concerned that this approach was not person-centred and could be considered as intrusive in some cases.

When we reviewed the welfare guardianship orders, we noted that in some cases, a significant numbers of powers had been granted, that did not appear to be proportionate to the assessment of care needs and risk. We discussed this with the local authority solicitor and the adult and learning disability social work service manager and were advised that given the difficulties of securing two capacity assessments, the applications tend to request more powers in the event that these will be needed. We therefore discussed the importance of timely reviews of the powers during guardianship reviews, to ensure that there were not unnecessary restrictive powers in place and that all powers were required and proportionate to the assessed needs and risk.

We heard that there was currently limited advocacy provision on the island, which was a concern that senior managers were fully aware of and were exploring alternative options.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

**Recommendation 5:**
Senior managers should give consideration to revisiting the service level agreement currently in place with NHS Grampian around provision of inpatient beds and the transfer process, to review if this is meeting current needs.

## The physical environment – the mental health patient transfer room

During our visit we had asked to be shown the mental health transfer bedroom in the Balfour Hospital. There was a small area outside of the room, which was fully enclosed by metal fencing, however on the day of our visit, staff were unable to locate the key to unlock the door and we were told that this was very common. In addition, there was a television encased in a wooden and perspex fronted box on the wall, but the remote control was missing and again, we heard that this happened regularly. There was a second room, off the bedroom which was essentially an observation area, where staff could choose to lock themselves in and observe the bedroom and its occupant through a large perspex window. The décor was drab and the bedroom felt bleak, oppressive and lacked sunlight, fresh air and ventilation.

**Recommendation 6:**
Senior managers should ensure that all staff who are required to provide enhanced observation and escort duties in the mental health patient transfer room are furnished with a key to facilitate outdoor access for the patient, should they so wish.

**Recommendation 7:**
Senior managers should review the current situation where anyone detained in the mental health patient transfer room is nursed under continuous intervention (constant observations) to ensure the use of this enhanced level of intervention is proportionate to need.

## Any other comments

This was an unusual visit model for the Commission to undertake, however it was a worthwhile visit and positive to have the opportunity to meet with and develop relationships with those whom we generally have less contact with. Only by visiting these more rural parts of the country, can we hear about and begin to appreciate the particular set of challenges these services face when providing robust, effective, patient-centred, rights-based care, commensurate with care delivery across the country. We noted the great deal of compassion, commitment, and good will that existed in all the teams and services we visited. It was clear that there were many people who were engaged and committed to do their very best to benefit their patients, service users and colleagues.

# Summary of recommendations

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## 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.

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 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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