Mental Welfare Commission for Scotland

Report on announced visit to: Services in NHS Shetland, Shetland HSPC, and the Shetland community

Date of visit: 30 August – 1 September 2023

Where we visited

Shetland, also called the Shetland Islands, have a total area of 566 square miles, with a population of 22,870 (estimated in 2023). The local authority, the Shetland Islands Council, is one of the 32 council areas of Scotland.

NHS Shetland's current hospital and healthcare facility, Gilbert Bain Hospital (the Gilbert Bain), opened in 1961. Due to concerns about the large amount of maintenance required and limited room for expansion, 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 was facility to admit individuals who were experiencing 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.

Who we met with

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 professionals who delivered mental health and learning disability services across Shetland, including those from the community mental health, substance misuse, child and adolescent mental health, dementia, and psychological services and with the team of social work mental health officers (MHOs).

We carried out six welfare guardianship visits and either met with or spoke with some of the welfare guardians for these adults, and social workers who were allocated to each case.

We visited the Gilbert Bain, where we met with members of the multidisciplinary team (MDT) and were shown the areas where individuals may receive mental health care and treatment on a short-term basis.

We visited Annsbrae House which was a supported accommodation and mental health community support service.

We reached out to 'Shetland Carers' and left our contact details with them, should any carer wish to contact us.

Lastly, we met with a group of executives and senior managers, including:

- IJB chief officer
- NHS chief executive
- chief social work officer
- chief nurse
- head of mental health
- clinical lead nurse for child and adolescent mental health services (CAMHS)
- executive manager for adult social work
- executive manager for community care resources
- chief midwife / women's and child lead
- learning disability nurse specialist
- team leader for mental health and adult social work
- senior team leader for adult services
- senior team leader for community care resources

Commission visitors

Lesley Paterson, senior manager (practitioners)

Claire Lamza, executive director (nursing)

Kathleen Liddell, social work officer

What people told us and what we found

Care, treatment, support and participation

Most of the adults subject to welfare guardianship orders whom we met with and were able to speak with us, were happy with the 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. We heard that due to the nature of island living, there was a shortage of housing stock, resulting in limited housing options for people to move on to. Most welfare guardians spoke positively of the respite and day care services on offer, but one raised an issue about accessing day services for their young adult, which we have raised with the relevant social worker. We found the guardianship applications to be of a very high standard. Guardianship supervisors were routinely allocated for private guardians, in line with the Adults with incapacity: code of practice for local authorities. Guardianship reviews were taking place in a timely way and decisions, outcomes and actions were robustly recorded.

The main themes we took from discussion with the array of professionals we met with were around: service provision, mental health specific service provision, off-island mental health care, and developing future services that meet the needs of those with more complex and co-existing conditions.

Service provision

We heard that most services delivered across Shetland were delivered 'in-house' by the local authority and less so by the third sector, meaning that the local authority has more control of what is delivered and to whom. We were told that the learning disability provision across the islands was to be reviewed, and there was an acknowledgement that the provision of supported tenancies and robust support packages was an area which required some development. We heard that there was intensive support when caring for adults with dementia, predominantly in residential homes, as opposed to nursing homes.

We were also told that there was a distinct lack of specialist services on the islands, such as forensic services, perinatal services, or acquired brain injury input.

We heard that for the Eric Gray Resource Centre at Seafield, a new build replacing the old centre, there were discussions taking place regarding optimal use for this, including facilitating individuals being able to use it in the evenings and weekends.

We heard about Newcraigielea, which was a dedicated short break and respite unit for adults with learning difficulties in Shetland, but due to the longer-term nature of some of the placements, there was less opportunity to provide respite care than originally planned. There was an acknowledgement that the area of supported tenancies required to be reviewed. As part of the learning disability review, we were told of discussions about moving to more core and cluster type supported accommodation, as a more cost-effective approach to care delivery.

When we visited Annsbrae House, we were told that it provided eight supported tenancies and one respite place for people with mental health difficulties. They also provided an outreach service which could be accessed through the mental health and adult social work services. The outreach service was provided by a small pool of staff who knew the individuals they

visited well, helping them with their daily living skills and providing ongoing support and monitoring of their mental health. Annsbrae House worked collaboratively with many health and social care professionals, housing services and even environmental health, when required. We heard that this was a responsive service which promoted a "no wrong door" approach, meaning that the service was inclusive, reduced barriers, and if they were not best placed to meet the particular needs of an individual, then they would signpost and support that individual to access the service that would best suit their needs. We heard that following the introduction of an overnight support service, there had been a 27% reduction in the admissions to residential units. We were really interested to hear about this service, which appeared to be engaged and motivated to explore new and innovative ways of working to best meet the needs of those who used it.

Mental health inpatient provision

There were no mental health inpatient facilities, however, during our visit to the Gilbert Bain, we were advised that Ward 3 was deemed to be a 'place of safety' and there was also a quiet room on the ground floor of the hospital. Both these areas were used to hold and care for individuals who required to be transferred off the islands in order to receive specialist mental health care and treatment. We had asked about the arrangements for caring for these individuals, especially in times of stress and distress. We were told that if an individual was required to be nursed under continuous intervention, then this registered nursing resource could come from the CMHT, and if required, a healthcare support worker from the medical or surgical ward in the Gilbert Bain could also be made available. We were also told that there was always an on-call psychiatrist available for consultation.

Community mental health and learning disability services

When we met with the large group of community mental health staff, we heard about their day-to-day workload, and in particular, of the challenges they faced when delivering high quality community mental health care and treatment. We heard that some felt they were "everything to everybody" and that there was a definite need to realign and redefine the parameters of the service after the Covid-19 pandemic. We heard that due to the lack of specialist services, CMHT staff were delivering care which would be considered under the specialities of perinatal, autism, attention deficit hyperactive disorder (ADHD), forensic; however, some of them were concerned as they felt there was not enough investment in staff and training provided to ensure they were competent in all these areas. We were told that community psychiatric nurses have no access to administrative support, meaning they have to type their own letters, which can significantly impact on the time to deliver clinical care.

We heard that the learning disability service currently employed one learning disability nurse specialist, who had a very large caseload of 220 individuals. We were pleased to hear that there had recently been funding secured to employ a second learning disability nurse. We also heard that physical health checks for adults with a diagnosis of learning disability were being introduced and there were discussions happening to decide on the best way to meet the physical healthcare needs of this group across the geographical spread of the islands.

Recommendation 1:
Managers should consider carrying out a learning needs analysis for staff working in the community mental health and learning disability services to identify any learning or development needs and deliver any target training as indicated.

Off-island provision

NHS Shetland had a service level agreement in place with NHS Grampian, meaning that Shetland residents who required inpatient mental health care and treatment were transferred to NHS Grampian. We were told that there was also some regional work happening with NHS Western Isles, which would hopefully support and enhance the arrangements which were already in place. We were interested to hear about a relief MHO model, which employed three relief MHOs who were based off-island and became involved with individuals who are admitted to inpatient services on the Scottish mainland. We heard that this model worked well and supported a more integrated model of care delivery, discharge arrangements, and transfer back to the islands, which was really positive.

Care records

We found that across the islands, information on care and treatment was held in different ways. We heard that all individuals accessing mental health services were registered on the electronic system 'TrakCare' and that the CMHT predominantly used 'Care Partner', however because this was a relatively basic package, they were unable to easily quantify the numbers, demographics, and diagnoses of individuals accessing their service. CAMHS used paper notes and the local authority used the electronic system 'Swift'.

Although MHOs told us that they were able to access most health records, the current situation could still lead to issues as there was no clear 'real time' mechanism for notes to be shared between professionals. We also heard from mental health staff that there was sometimes a lack of contemporaneous recording done after individual contact due to the constraints of the electronic system. We heard of the 'North of Scotland Care Portal', which was a proposed health and social care portal that will support information shared from providers in NHS Highland, NHS Grampian, NHS Orkney and NHS Shetland. We were advised that the while the portal has been implemented, at present it is of limited use. When we discussed our concerns about the development of shared access for health and social care staff, we heard from managers that discussions are underway with the NHS ICT service, in order to expand usage locally.

We look forward to hearing more about this at our next visit.

Use of mental health and incapacity legislation

We heard that individuals who required to be detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) were most commonly detained under short term detention certificates (STDCs), instead of emergency detention certificates (EDCs). This is in line with best practice, as the Mental Health Act intended that STDCs be used in preference to an EDCs, whenever possible due to the additional safeguards which are afforded. We were also told that social circumstances reports (SCR) completion rates were high. The Commission produced a good practice guidance on SCRs, which can be found at:

SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf (mwcscot.org.uk)

Rights and restrictions

The MHO team raised a query with us regarding a potential reluctance to look for 24/7 care packages for adults, as there as there was sometimes a feeling that applying for more significant powers was not aligned with the principles of the Adults with Incapacity (Scotland) Act 2000 (AWI Act). We explore this with them and feel that when a robust assessment of need has been undertaken, which had identified that a 24/7 care package would be in the best interests of the adult and be what was required, the identified level of care and support, care packages should be sourced to meet this.

We were aware that advocacy provision on the islands was being provided by the Advocacy People, although we did not have any direct contact with the service during our visit.

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.

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 challenges these services sometimes face when providing robust, effective, person-centred, rights-based care, commensurate with care delivery across the country. We noted and were aware that the integrated management team have a close working relationship and these working relationships generated the level of compassion, commitment, and professionalism 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

Recommendation 1:
Managers should consider carrying out a learning needs analysis for staff working within the community mental health and learning disability services to identify any learning or development needs and deliver any target training as indicated.

Service response to recommendations

The Commission requires a response to the recommendation within three months of the publication 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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