Mental Health Board

Gibraltar

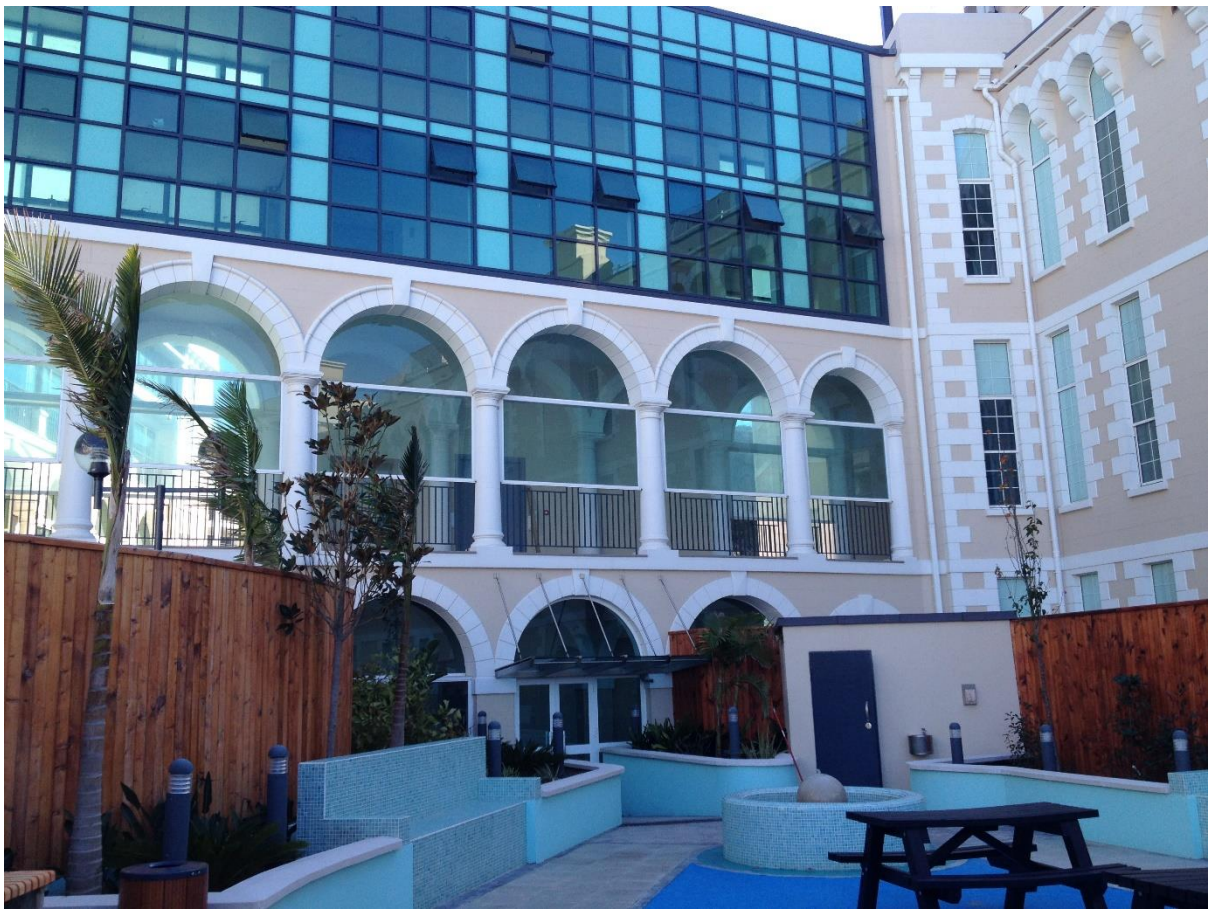
Annual Inspection Report

2022

Week beginning 26th September 2022

Ocean Views Mental Health Facility (OV)

Community Mental Health Team (CMHT)



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1. General introduction

The Mental Health Act 2016 (MHA) requires the establishing of a Mental Health Board (MHB) under part 9, Sect. 113 (1) of the Act. Such a board was established on the 23rd April 1018, under Government Notice No.674 (Appendix A)

In April 2021, Mr Julio Alcantara M.B.E, the chair of the MHB, stepped down after completing his three-year cycle. The Chair was taken up by Mr George Parody the previous Vice Chair. Ms Emily Adamberry M.B.E., took over as Vice Chair. The MHB would like to extend their collective thanks to Mr Alcantara, who has worked tirelessly to kick start the MHB from its inception.

The board currently consists of six members, one of whom is a registered medical practitioner, one barrister, one retired SRN, and three lay members with extensive community experience. The seventh member resigned in January 2022 on health grounds. In March 2022, the board's eighth member resigned.

The current situation also has two board members, who are also members of the Mental Health Review Tribunal, which reduces their availability in covering the extensive field it is charged to inspect.

The board has consistently asked for an increase in the number of board members and it is urging the Ministry to do so as a matter of urgency.

Under Section 115 (1) of the MHA, the functions of the MHB are to satisfy itself as to the state of the Ocean Views Facility (OV) at Europa Road and the Community Mental Health Facility (CMHT) at Coaling Island, their administration and treatment of patients.

It may enquire into any case, where it appears there may be ill treatment, deficiency in care and treatment or improper detention or reception into guardianship.

As often as it may think appropriate, the MHB may visit and interview, in private, patients who are liable to be detained under the MHA.

Further, the MHB shall bring to the attention of the Minister any matter concerning the welfare of any individual, which the MHB considers ought to be brought to the Minister's attention.

In furtherance to the exercise of its functions under subsection (1), the MHB may, under subsection (2), refer cases to the Mental Health Review Tribunal (MHRT); interview and medically examine in private, patients held under the

Act; and may require the production of and inspect any records relating to the detention or treatment of any person, who is, or has been subject to the Act.

Under Section 116 (1) of the MHA, the MHB is required to make an annual report to the Minister at the end of each year, concerning its activities, and such report shall be laid before Parliament. In the past the MHB has defined its year as concurrent with the Government's financial year, however this year this has not been possible for the following reasons.

Since the first meeting of the MHB in April 2018, it was put forward by the members that it was prudent for the board to sign some form of confidentiality agreement. This was broached on a number of occasions, but was never followed through.

In October 2021, after a change in approach, the new board decided to write up an internal interim report for the GHA in order to iron out any issues before the annual inspection.

This Interim inspection was carried out in October 2021 and presented to the GHA in December 2021. However, it was during the course of that inspection and the subsequent changes in the GHA hierarchy, that the question of confidentiality came to the fore.

The Board entered into an agreement with the GHA in relation to certain aspects of the patient data shared with the board for the purposes of the audit. Once this was agreed the annual inspection began on the 26th September 2022.

It could have been carried out sooner, however, after significant managerial re-structuring in the service it was decided by the board to allow the new team time to settle in to ensure a fairer inspection.

In July 2021 the MHB finally took ownership of its own fully equipped office and a boardroom at OV to service the needs it provides to patients, families and staff. It further hopes that it will function as a focus point, where issues and problems can be discussed, solved and be open to all interested parties. The boardroom is also to be used by OV staff if not programmed for MHB business. The MHB is very grateful to the GHA and the previous Minister for Health and Care, the Hon. Samantha Sacramento for making this possible.

Once the office was up and running the board sent out some information and contact posters for individuals to voice any issue which concerned them. It has, however, been quite disappointed with the lack of uptake and will encourage

the GHA to include this information in their website as well as other departments.

The MHB's 2020 and 2021 reports were tabled simultaneously in Parliament in July 2021.

From now on the annual audit will be carried out in October, with mini inspections taking place at intervals to be determined.

The MHB has met formally on fifteen occasions since the new board was formed in May 2021.

2. The 2021 Interim Report

This report was carried out at a time of great challenge and change to the service. The publication of the Gibraltar National Mental Health Strategy 2021 – 2026, paved the way for a new, open and more positive approach to mental health delivery with clear pathways and timelines. This document, the MHB believes, is a crucial development in the way that mental health services will operate and be more responsive to the needs of the patients under their care. We cannot underestimate the substantial sea change that this document brings to the table and the shift it proposes.

The board hopes that this blue print for action is implemented and fully supported by staff and senior management, as their support is crucial to its success.

The report was based on a two-week period, where staff and patients were allowed to speak freely about what they found positive about the system and what they felt was lacking. At the end the board produced a number of recommendations for improvement in each area reviewed.

Throughout this report there will be reference to the Interim report and how things might have or might not have moved since last year.

3. Change of Managerial Responsibilities (2022)

The senior managerial system for Mental Health Services has been re-structured. The Senior Management Team is comprised of:

(i) The Clinical Director

(ii) The Divisional Nurse Manager

(iii) The Divisional Site and Services Manager

Each deals specifically with their area, and they consult and support each other in taking decisions.

Having seen the system in action the board is encouraged by this division of labour, while still retaining cooperation and teamwork as its core.

4. Staff Complement Throughout the Service

Community Mental Health Team (CMHT)

Charge Nurse – (1)

Registered Mental Health Nurses – (3)

Enrolled Nurses – (3)

Approved Mental Health Practitioners (AMHP) – (4)

BELLA VISTA

Enrolled Nurse – (1)

Auxiliary Nurse – (1)

MENTAL HEALTH LIAISON TEAM

Registered Mental Health Nurses – (5)

Enrolled Nurses – (2)

Auxiliary Nurse – (1)

Nursing Assistant – (1)

HORIZON/SKY WARDS

Charge Nurses – (3)

Registered Mental Health Nurses – (12) + BANK (2)

Enrolled Nurses – (5)

Nursing Assistants – (6) + BANK (2)

DAWN WARD

Sisters – (2)

Registered Mental Health Nurses – (8) + BANK (1)

Enrolled Nurses – (5)

Nursing Assistants – (13)

There are currently 6 RMN vacancies

5. Who the MHB has talked to and its approach

Members of the MHB spent three-days in Ocean Views, returning on many other occasions to talk to specific members of staff and patients, who they were not able to talk to on those specific days.

On another day some members of the board visited patient housing in the community. The equivalent of another three days were spent at CMHT.

Members of the board also shadowed the CMHT Outreach Team on three home visits.

The Board also visited Gibraltar Young Minds (GYM).

On our visits the board spoke to the following:

111 Lead
Administrative assistants
CMHT Lead
Community Outreach Nurses
Community Psychiatric Nurses
Enrolled nurses (EN)
GYM (RMN)
GYM Multidisciplinary Team (MDT)
Nursing Assistants (NA)
Occupational Therapists (OT)
Patients in OV, Coaling Island and 3 Supported Accommodation houses/flats
Carers.
Psychiatrists
Registered Mental Health Nurses (RMNs)
The Chief Pharmacist and Pharmacist
The Clinical Director
The Divisional Nurse Manager
The Divisional Site and Services Manager

This does not include incidental conversations held with other staff, patients and other ancillary workers, which have also added to the overall picture.

6. Ocean Views

Please note that these observations are general in nature and they might not apply to all wards or staff, but is a snapshot of our time listening and observing

6(a) Staff interviews

Throughout our visits at OV all staff members were aware of our presence and cooperated fully with our requests. The board was pleased with the professional way the staff dealt with the patients under their care. They do a difficult job in demanding circumstances.

It was clear when they spoke about their patients that they knew them and their individual needs well. There seemed to be a level of mutual respect and there was a relaxed atmosphere in the wards visited. This very much mirrored the last time we visited in October 2021.

However, this was as far as the similarities went. Whereas last October there reigned a feeling of low morale and a genuine concern that their views were not being heard and taken on board, this time round there was a much more positive outlook, where suggestions are well received in a constructive atmosphere.

Staff members were confident and enthusiastic about recent developments and felt supported by Senior staff. Issues that crop up are dealt with swiftly and effectively and as such staff morale is much higher as there is more open dialogue. This is consequently empowering staff and contributing to a more positive atmosphere pervading the wards.

Teamwork was particularly valued and unlike in the last report, there was a genuine feeling of everyone pulling together. Everyone was mentioned at some point. From the psychiatrists, to the OTs, the social worker, nurse and nursing assistants. All received praise for their collaborative efforts in improving the situation of their patients.

The regular availability of two psychiatrists based in OV has had a positive impact on the care provided to the patients as issues can be dealt with almost immediately. Added to that, MDT meetings are held twice a week. It also makes sense to have the psychiatrists on hand when the MHRT meets.

Dawn Ward staff were particularly pleased with the support they were receiving from the different agencies, namely the Care Agency, Housing and OTs in

discharging long term patients and organising their care packages and home situations.

They commented that the addition of a social worker to the mental health services, even for two days a week, had been crucial in the improvements seen. This view has been echoed by the CMHT, who have all commented on the difference that the social worker has made to the work of getting patients back into the community. The majority interviewed expressed a feeling of hope that what they were doing was now paying dividends.

They continued that there were now more activities organised for the patients and more home visits to prepare them for discharge.

6(b) Staff areas of concern

It is fair to comment that the staff areas of concern are very different in tone and substance from the October 2021 report. The most important contrast is that although they feel issues still need to be tackled, the overriding feeling is of a greater belief and confidence that they can do the job, knowing that senior management is on their side.

One of the most important concerns that recurred in the interviews was the recruitment of RMNs to the profession at a time when some are being lost back to the UK or retirement.

The problem is world-wide, however it is exacerbated by Gibraltar's political situation (Brexit), the high cost of local accommodation and the lucrative contracts offered to RMNs in UK, which far outweighs any local advantage Gibraltar might have had in the past.

Many felt that there was a great need to have locally trained RMNs (Gibraltar University) to maintain a stable service.

Another issue of concern to one of the staff was the need to formalise and establish a protocol for admittance to OV, when the patient does not come through A&E.

This is a clearly a professional concern that needs to be clarified, but the fact that this is aired openly and confidently regardless of the outcome, is refreshing.

The situation with the ARC and the role it plays in OV is something that has been highlighted in other reports. There still seems to be a lack of understanding of the role that OTs play and comments made by ward staff leads the board to the

conclusion that there is still plenty of work that needs to be done to clarify their respective roles. They also talked of the attempt to have an Activities Coordinator appointed, which had not materialised. (*There will be a whole section dedicated to this later on*).

At the time of the inspection, there was a patient, who required a 1 to 1 and this had restricted the activities that the staff were able to carry out with the rest of the patients.

Although an agency worker was covering this patient, it was not always the same one and every time a new carer joined the ward, it was necessary to convey the same information about the patient. Clearly some carers were more suitable than others and it often hampered what they could do with other patients.

They were quite willing to work with the agency to train some carers so this situation could improve for all concerned.

Some staff members were concerned that there was lack of physical and medical staff available to cater for patients' everyday medical needs. They had Consultants come in, but what was needed, they believed, was a Junior doctor assigned to the facility to assess patients' overall needs.

Nursing Assistants had been promised meal allowances when out on Outreach, many months ago, but this had not been forthcoming. This was causing frustration and is something that clearly could be solved quickly to the benefit of all.

They also raised the issue of "petty cash", which had been highlighted in the previous reports and which had still not been dealt with – namely having no access to cash and members of staff having to use their own money and then wait for reimbursement.

The lack of transport for OV was also highlighted as a negative factor. They could not understand how GHA, Bella Vista and ERS have transportation for their patients, while OV had to rely on the bus or resort to taxis.

It was reported to the board that some staff had limited access to EMIS and there was no document scanner in their ward.

The speed at which Sunshine Ward had been decanted, the removal of the staff and the use it was going to be put to in the future were common concerns voiced by staff members.

6(c) Observations and Recommendations

It is evident that there have been many positive changes since last year, with a greater emphasis on listening to the workforce and having a greater level of transparency. This was apparent from the way that staff opened up to the board and how they felt relaxed and comfortable in talking about their situation and how this had positively benefitted their patients.

- ✓ The recruitment of locally trained RMNs in the situation Gibraltar finds itself, is crucial to the continuing development and improvement of our mental health services. It would be prudent for the GHA to take up the challenge and seek to discuss this issue with the Gibraltar University to see if a solution can be found.
- ✓ Dawn Ward has discharged into the community many of its long term patients and there is a programme of activities for the ward as well as individual programmes for patients. This is certainly a step in the right direction and the board feels very strongly that it is crucial for the rehabilitation of patients for this to continue and new activities added.
- ✓ There was a concern raised about the role of the ARC, which we will address later on in a specific section, but it is important to stress the necessity to define roles and improve liaison between some wards and the ARC.
- ✓ The need for a Junior doctor at the hospital is a topic that keeps recurring in our discussions with staff and patients. Many patients also have medical conditions, which need constant monitoring. The board recommends that the GHA takes these comments on board and appoints a doctor to oversee patients' medical needs at OV and possibly CMHT.
- ✓ The files for each patient are very comprehensive and contain care and discharge plans as well as risk assessments and medical notes. Although every attempt is made to keep them tidy and in order, this is not always possible. The board wonders if this paper work could be significantly reduced by digitising systems. This would also help when transferring files to CMHT, which is now done by scanning the relevant paperwork. All in all, there seemed to be too much reliance placed on paper work to the detriment of time spent with patients on the ward. Some of the notes were also difficult to read.
- ✓ When asked about the "Recovery Star" programme, which two board members had taken part in, there was little evidence that this was taking

place. The board was under the impression that this scheme was being rolled out in OV, but this did not seem to be the case. The following day when the board visited the ward again, there had been a flurry of activity to activate it. This needs to be followed up. If the programme is to be followed, it needs to be carried out properly and all staff should be trained to deliver it.

- ✓ Long gone are the days that at quarter to the hour there would be long queues of patients waiting at the sister's office to get their cigarettes and go for a smoke in the garden. That thankfully has stopped, however there is still a smoking culture, which persists and more of an attempt should be made to encourage patients to give up as part of a healthier lifestyle choice. The main problem is that this must also be driven by example from the staff, together with positive support. The board would like to see further progress in this area and have the GHA declare all mental health facilities smoke free areas, like the rest of all GHA and Government Departments. It recommends that the Smoking Cessation committee be resurrected to ensure that help is given to those who need it.
- ✓ What is going to happen to Sunshine Ward is a question which the board has asked on a number of occasions, but up to now there is only speculation and the ward is an asset that is not been fully taken advantage of. The board urges the GHA to do its utmost to ensure that the ward is fully utilised as soon as possible.
- ✓ Last October 2021, there was a lot of anxiety and stress caused by the uncertainty surrounding the renewal of contracts at the 4-year mark. This was not so this time round as the majority of those have now become permanent, though there may still be a few more in the pipeline.
- ✓ Why is EMIS not available to all wards?
- ✓ The question of "petty cash" and "meal allowances" are issues which are longstanding and are easy to solve, with the benefits far outweighing the costs.

6(d) Patient audit

These interviews took place over a period of two days. The first impression going round the ward was how spotless everything was. There was also a very relaxed atmosphere; a huge difference to the previous October, where the tension was palpable. Conversations were held on the ward and in the Rock Flats, mostly on a one to one basis. Please note that not all patients wished to engage with us and some of them, because of the nature of their illness were not able to.

Relationship with Staff

- Patients interviewed seemed to be suitably engaged with staff and well informed on their own care. Some were preparing for discharge.
- All patients had care plans and everyone had some level of understanding of their situation and felt included.
- All the patients the board interacted with, felt comfortable talking to the staff about everything and anything.
- Patients and staff agreed that the agency carers supporting patients on the ward on a one to one basis needed to be consistently the same personnel as constant change defeated the objective of supporting ward staff and was a difficulty to patients, who needed stability in these relationships.

Care Plans & Physical Health & Concerns

- The patients' conditions appeared to be known to staff and in the main, from their file notes, these were being monitored.
- A concern was voiced about the need to have greater medical input at OV.
- One patient was refusing daily diabetic testing. This patient had already suffered heart attacks, which are due to increased vascular disease, a complication of diabetes. Blood tests were carried out regularly and results did not reveal any concerns, but they were going to flag the board's concern to the patient's team.
- Another patient appeared to present with symptoms of Parkinson's disease, but appeared confused as to whether this was in fact the case.
- There were two patients with Alzheimer's, who were waiting to be moved to a better suited care facility. We were informed that the move was imminent.

- Some patients were worried about their physical health and would like to have theirs checked more often. On one occasion the ECG machine had not been working properly.
- There was talk of vaccines and the board enquired whether a vaccination programme for Covid and Flu was being organised for those in OV and those under the umbrella of CMHT.
- Patients seemed to enjoy mealtimes. The food looked and smelled good. There was plenty of choice and the board was informed that the breakfast was equally good, though you cannot please everyone all the time and one person wanted to have more orange juice.
- This same patient had trouble swallowing and mentioned that soft food and the Multifood complement she took was not always available. This really should not be the case and needs looking into.
- Some asked why the cafeteria had been closed and the vending machine taken away. Sometimes they wished to buy something and not being able to do so was very disappointing.
- A couple of patients were worried about their housing situation and that was causing them anxiety.
- One wanted to do more exercises and use the ARC.
- Another was upset because his disability benefits had not been sorted out.
- There was one who wanted to see a psychologist. He had been promised he would see one some time ago, but that had not happened.
- Some enjoy going out for a coffee as a group, while others like doing some exercise. However, some do not seem that enthused and just preferred going down to smoke in the garden. Perhaps a more robust and enthusiastic programme, built in conjunction with the preferences of the patients, might be more successful.
- In tandem to this, a smoking cessation clinic, open to both patients and staff, might go a long way to change the age-old culture prevalent in mental health facilities worldwide.

6(e) Mental Health Social Worker(MHSW)

During our visit to OV, one of the board members spoke to the MHSW, who was doing her rounds.

This development of having a social worker attached to the mental health services is relatively recent, but it has already make a substantial difference, according to everyone the board has spoken to, whether in OV or CMHT.

The social worker concerned only works for two days of the week in mental health services, but even this has made its mark and as a result the board would recommend an increase in the time this social worker spends dealing with mental health patients.

It also points to an even closer integrated working relationship between the Care Agency, the Housing Department and the Mental Health Services. A very welcome development.

The board witnessed her dealing with two patients. One, who is waiting to be relocated to an Alzheimer facility and another who is being helped to transition to an elderly care residence.

6(f) Patient admission papers, medication and consent to treatment.

All sectioned patients at Dawn Ward and Rock Flats on 19 October 2022 were reviewed.

One Patient who had been recalled to Dawn Ward from a Community Treatment Order was also reviewed.

Horizon Ward patients and their documentation were not available due to a Covid 19 outbreak that day.

A total of 7 patients were therefore reviewed.

Patient A was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and appropriate. On interview, this Patient had no insight into their condition or the original/continuing reason for their admission. They were unable to explain what medication they were taking. This Patient did not have the benefit of a T3 Certificate by a Second Opinion Appointed Doctor (SOAD), which in the Board's view was required under the Act given their inability to consent to treatment.

Patient B was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and appropriate. On interview, this Patient had no insight into their condition or the original/continuing reason for their admission. They were unable to explain what medication they were taking. This Patient did not have the benefit of a T3 Certificate by a Second Opinion Appointed Doctor (SOAD), which in the Board's view was required under the Act given their inability to consent to treatment.

Patient C was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate, with the exception of a beta-blocker which is not recommended in patients with bronchitis such as this. The Patient was not subject to a T2 or a T3 due to the length of their admission. However, this Patient is well known to the service and the Board and would generally be treated with a T2 Certificate given their insight into their condition and awareness of the medication prescribed. This Patient was not available for

interview, but the Board members carrying out the visit are very familiar with the patient and did not require it.

Patient D was subject to a Section 3 admission. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. On interview, the patient appeared not to have sufficient insight into their condition or the original/continuing reason for their admission. The Patient was not subject to a T2 or a T3 due to the length of their admission. They appeared unable to explain what medication they were taking. This Patient would likely require a T3 Certificate by a Second Opinion Appointed Doctor (SOAD) in due course, in view of their apparent inability to consent to treatment.

Patient E had been recalled from a Community Treatment Order and was at Ocean Views as an informal patient. The combination of daily and as required medication prescribed was within BNF limits and generally appropriate. This Patient was not available for interview, but the Board members carrying out the visit are very familiar with Patient E and did not require it.

Patient F was subject to a Hospital Order. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits, appropriate and consistent with their T2 Certificate. This Patient had the benefit of a T2 Certificate, on the basis that the Hospital deemed them able to consent to their treatment. This Patient could not be interviewed by the Board as they were not at the Hospital. However, the Board members carrying out the visit are very familiar with the patient and agree that a T2 is adequate given their insight into their condition and awareness of the medication prescribed.

Patient G was subject to a Hospital Order. Admission papers were in good order. The combination of daily and as required medication prescribed was within BNF limits, appropriate and consistent with their T3 Certificate. This Patient had the benefit of a T3 Certificate, on the basis that the Hospital deemed them unable to consent to their treatment. However, the T3 Certificate had not been reviewed for a significant period of time. This Patient could not be interviewed by the Board as they were not at the Hospital. However, the Board members carrying out the visit are very familiar with Patient G and agree that a T3 is adequate given their lack of insight into their condition and their general unawareness of the medication prescribed.

6(g) Observations and recommendations

- ✓ Admission papers are completed well and subject to the required timely scrutiny by the facility.

- ✓ The combination of daily and as required medication prescribed was generally within BNF limits, appropriate and consistent with their T2 and T3 Certificates.

- ✓ The absence of T3 Certificates in relation to some patients admitted under Section 3 of the Act was of concern. The Board is aware that the GHA is actively trying to address the unavailability of a Second Opinion Appointed Doctor, but in the meantime this essential safeguard is not in place in respect of those patients unable to consent to treatment.

- ✓ Dementia patients are now generally being correctly treated as temporary admissions pending a return or transfer to an appropriate ERS setting.

- ✓ Patients subject to Hospital Orders are being actively managed to ensure their progress from a hospital setting to a community setting with controlled attempts at increased levels of independence via escorted and unescorted leave and transfers to the community flats.

6(h) The Activity and Rehabilitation Centre (ARC)

The ARC and its role has been a controversial area which has been highlighted many times in our reports. The Interim report was no exception.

The ARC should be a place, where patients learn skills for life and do so in a fun, educational and social setting. It should be a hub, where the needs of the patient are assessed and then acted upon, giving that patient the skills and experience necessary for their integration back into the community.

The role of the OTs is to carry out detailed psychological, neurological and physical assessments and to provide group and individual treatment to address assessment needs and rehabilitate patients.

In order to do this, they undertake preparatory home visits, plan adaptations and equipment for independent living and liaise with the different departments including the Care Agency and Housing.

All activities carried out and recommended by OTs are designed to assist in their main goal of achieving independence at home.

The board has found, through talking to the different stakeholders, that this role is not clearly understood and therein lie many of the issues encountered when talking to staff in the wards.

There is clearly a difference when we talk about random activities carried out for recreational purposes, to the kind of activities proposed by OTs for a specific purpose after an initial assessment.

And therein lies the problem.

Staff comments

There was a general perception by the OTs that their role was not particularly well understood within the mental health services.

They explained that their work differed in scope and intention from activities for the sake of activities.

They argued that there were expectations from the wards, which clearly did not match the reality of their role.

After the last interim report there was a flurry of initial meetings as Activity Coordinators were appointed, but these soon fizzled out as the new initiative lost impetus.

They were concerned and demotivated by the cancellation of bed management meetings through omissions or otherwise. They believed that their presence at these meetings would be crucial in highlighting who might require help. As it was, it was left up to them to seek patients, through files and generally walking around. This was happening in one particular ward.

They did see some positives moving forward: two new psychiatrists were interested in the "holistic" approach to mental health and pointed out to a better understanding of the OT element in the ARC.

The other was the assignment of a Mental Health Social Worker and a better relationship with the rehabilitation ward, where they attended MDT meetings on Tuesdays and Thursdays.

The ARC is open to activities all the time and they are willing to assist staff in whatever way they can.

There are plans to re-introduce the post of Activity Coordinator as a full time option and they welcomed the opportunity to work closely with the selected individual.

6(i) Observations and Recommendations

- ✓ It was very clear from the board's meetings with the OTs and staff ward members that there is a lack of real understanding of the OTs role in mental health and that this lack of communication between the parties concerned lead to poorer outcomes for patients.
- ✓ It is of the utmost importance for the lines of communication to be opened and for clarity to be brought to the table as to the role of the OTs and the ARC in OV. Only then can real progress take place.
- ✓ There is a need for professionals to work together to maximise opportunities for activities aligned to patients' needs on the wards, in the ARC and in the community.
- ✓ It does not help that the OTs' line manager is based in SBH and not OV.

7. Coaling Island (CMHT)

7(a) Introduction to last year's interim report for this section (October 2021)

"It is very evident when we visit Coaling Island that the building is clearly not up to the standard of other GHA facilities.

It is not up to the board to document the history or delve in the politics of this. It is simply that if we are to make progress in the way that we deal with mental health patients and place the emphasis on the community, then Coaling Island needs to have premises, which are worthy of the great challenge it faces.

Whether it is a new build or a recycled premise, it could be the perfect opportunity to try and integrate the other agencies that feed into it and vice versa.

Lack of communication and cohesion between the different agencies, often lead to issues, which impedes progress and consequently affects the patient.

With the re-siting of the new CMHT, the board suggests that consideration should be given to house the different entities in one building and thus have service users benefit from the teamwork engineered by the close proximity of the different agencies: CMHT, Care Agency and Drugs and Alcohol

A new build would be ideal, but a more realistic solution might be the re-cycling of an existing building.

A site which might be considered could be the "old" Primary Care Centre, which has parking facilities, wheelchair access, different entrances and is in the centre of town."

In our visit, a year later, the physical situation remains exactly the same. Places and plans have been suggested and the board has been told that this move is in the process of being finalised, but as yet there is nothing concrete.

The board strongly recommends that this be taken up as a matter of urgency and the CMHT is given a new base which is in consonance with the new approach of greater emphasis of community care for those in need of support.

In our interim visit we also saw how the new Mental Health Strategy was changing the way CMHT worked.

The board was taken through the changes taking place. It was explained how the AMHPs and the MHL teams now came under the remit of CMHT and how that worked following the publication of the new Mental Health Strategy and the 111 Crisis Pathway.

Generally, it was felt that the system was working well and they were able to channel help quickly and effectively much sooner and thus avoid a crisis.

This was echoed by the majority of the staff, who after initial reservations, agreed that the new reforms had indeed improved working practices.

There were, however, concerns about the way the changes had taken place and the manner in which events were happening and it was clear that a lot of work needed to be done in order to restore confidence and morale in the workplace.

There were also concerns expressed by the board as to the frequency of cancellations of clinics and the subsequent fall out from this.

7(b) CMHT (October 2022)

Many of the changes which had taken place before the interim visit had now been clearly established and there was a much more focussed and confident approach observed in the staff.

There are still issues to be dealt with, but at least the staff felt that their opinions and ideas were being valued and taken into consideration.

They commented on the positive changes they had seen in the past year and it was clear to the board that the new managerial team had made an important impact on staff dynamics. They talked of the greater presence in CMHT of senior management and their quick response and support in sometimes difficult situations.

They talked of a greater level of transparency and willingness to listen to the workforce. There was the example of the “Depot Clinic”, which had been proposed by a staff member, which had not been acted upon at the time, but had now become a regular monitoring service. As a result, several medical issues had been identified and patients referred to the appropriate medical practitioners. In these sessions nurses are able to observe and interact with their patients and issues like non-attendance can flag up deeper problems.

Another issue which had caused controversy at the time was the “off duty” list, which was now open for everyone to see.

Like OV, they spoke of the game changing introduction of a Mental Health social worker, who only worked two days in CMHT, but was making a huge difference. This has created a seamless transfer of information between departments and is developing a much greater rapport between the Care Agency and the Mental Health Services.

They welcomed the now regular established meetings between CMHT and Dawn Ward, working towards a smooth transition between ward care to being discharged into the community.

All CMHT staff are now documenting on EMIS to allow clear communication between all professionals involved in the patients' care. Daily case notes are still handwritten and there is possibly a need to see if these could be written into a particular system. There was a suggestion that a more comprehensive system like "RiO" or similar, that caters specifically for mental health services, could be introduced, especially as more and more patients are being treated in the community. This view was echoed by a number of staff members.

One staff member, who previously worked in OV was happy that CMHT were using EMIS, but although OV had access they were unable to write in it themselves.

It seems to the board that there needs to be consistency in electronic reporting and it pays to have everyone on the same system.

A new counsellor has also been appointed to work from CMHT, to join the other two psychiatrists already based there. A very welcome move.

During our last visit in October 2021, the board found a chaotic situation with regards to the psychiatrists available at CMHT. On the one day we visited there was only one psychiatrist providing emergency cover and as a result, all clinics were cancelled with the exception of the emergency one. When the board enquired they were told that one psychiatrist was on sick leave, one on annual leave, one on compassionate leave and one on extended sick leave since mid-September 2021.

The board was informed that this did indeed happen frequently and that when it occurred the admin staff would have to re-schedule all appointments usually a month from the date of cancellation and reassure the patients, some of whom, found this situation very stressful. This same point was brought up by a member

of the Outreach team, who found that some patients needed support when this happened.

Fortunately, the board is able to report that the situation a year on is much improved. Having two psychiatrists based at OV and two at CMHT has made all the difference. When asked about cancellations this time round, it was found not to be an issue, except on the odd unavoidable occasion.

The board is very pleased that this has been reversed and hopes it continues to work well. It urges senior management to monitor the situation regularly so situations like October 2021 be avoided at all cost.

There was concern that the drive to treat patients in the community, although laudable, was fraught with problems and needed better resourcing in order to be effective.

They knew the plans to remove patients from the responsibility of CMHT to the PCC was on the cards, but they had doubts about the practicalities of this and whether the patients themselves would be amenable to this change.

The board was informed by senior management that the process had already begun and that the CMHT would cater for those with long and enduring mental health issues. However, it was stated that if an ex CMHT patient needed support they would be able to access it.

In our previous report, the board had highlighted the need for a review of the filing system and a need to digitise its contents in line with the rest of the GHA.

There was, in fact, an attempt to do this using overtime, but this has stopped and it has reverted to carrying this out during working hours. In reality this has slowed down to a trickle and it seems that a seemingly modest cost reduction has put paid to something that is badly needed.

7(c) Shadowing The Outreach Team

In order to facilitate our understanding of the problems and issues experienced by both patients and outreach staff, the board proposed a series of home visits, accompanying staff on three home visits at different times of the day. One visit was early in the morning, one at lunchtime and the other in the evening.

The visits gave members of the board a good insight as to what happens once a patient moves back into the community.

In all three visits the members of the board were able to observe how patients are supported and the difficulties and complexities that ensues with this kind of support.

This support varies from a phone call, a visit and a chat to two visits a day to ensure that medication is being taken and if they have any other personal, emotional or social issues.

The latter identified in these visits varied from rent relief, benefits, unemployment, and in one particular situation loneliness and boredom.

In one case the individual concerned received help with daily living twice a day. In another there was an overnight carer to support a patient sharing a flat. Unfortunately, one of the individuals was still awaiting the appointment of a carer.

One member of the board also observed an individual who said he felt alone and stated that he had nothing to do all day. This case was particularly poignant as it was late in the evening. He also had issues with his sight and it was somewhat distressing to see him struggle with the TV remote. The nurse said that his problem had been highlighted and that he had been encouraged to visit an ophthalmologist, but that this offer of help had been refused.

The Outreach Nurse explained that it was not always easy to get help to the different individuals as they objected to the help offered and it then became a question of convincing them that it was in their own best interests. They continued that on some occasions some would not even allow them in.

Regardless of any of this, the board member was sufficiently concerned about the individual's eyesight that he asked the nurse to report the matter in his notes once again.

Two flats were in really good condition and they were properly maintained and suitably furnished, however, one flat had damp patches in different rooms and there was a need to brighten up the place, hang some curtains and make it homelier and less impersonal.

Flats such as these need to be given priority for repairs and they should be furnished to a degree that you can call it home. The board urges the relevant authority responsible to ensure that these flats set aside for vulnerable people be kept to a good standard of repair and made personable to the people residing there.

7(d) Observations and Recommendations

- ✓ The board acknowledges that CMHT will eventually move from its present unsuitable site, however, it urges the GHA and Government to do their utmost to make this move a reality as soon as possible. The building is clearly not fit for purpose and with the drive to treat patients in the community, the service desperately requires a purpose built facility that will be a suitable focus for patients.
- ✓ The board notes the much more positive atmosphere pervading the community team on the whole and praises the sterling work undertaken by Senior Management to achieve this.
- ✓ The "Depot Clinic", with its health checks has already paid dividends and some patients have benefitted from the extra medical vigilance. The board commends this. They would, however, prefer to see a better system of appointments, so that it is not so protracted during the day. A board member attended one of these clinics and only two individuals were seen in the space of 2 hours.
- ✓ There was general consensus that the introduction of a Mental Health Social Worker has made an important impact in CMHT and there are now much better levels of communication between them, Dawn Ward and the Care Agency. The board has seen this move as crucial in the improvement it has observed. Elsewhere it has already recommended that there should be an increase in the time spent in CMHT, especially as more and more patients will be treated in the community.
- ✓ The board was encouraged to see all CMHT documenting on Emis, though there was a feeling that there needed to be a more specific system, which catered exclusively for the Mental Health Services. The board also asks, why it is not possible to record notes remotely, especially when patients are visited late in the evening.
- ✓ The board welcomes the appointment of a new Counsellor to work in addition to the two psychiatrists based at CMHT and notes the improvement in the number of clinic cancellations, which at this time last year, was unacceptably high.
- ✓ The attempt at digitising the records at CMHT has slowed to a trickle, with the removal of the overtime that was making inroads into the mountain of files waiting to be inputted. Clearly, doing this during the working day is going to take considerably longer. This work is time consuming, but

needs to be carried out. The board recommends that this is tackled as soon as possible, with the return far out-weighing its cost.

- ✓ The board found the shadowing visits very interesting and informative, getting a taste of what patients and staff experience on a daily basis. It was able to see first-hand the interaction with patients and the difficulties that some individuals have living in the community.
- ✓ Talking with the staff the board were able to gauge their views on the current changes taking place in the service. Without exception, they believed in what they were doing, but felt that an increase in treating people in the community needed to come with a subsequent increase in the number of staff required to service such numbers. The board echoes those thoughts and it asks the question, whether extra human resources are indeed needed, in order to have a better service? Whether this comes from within or with extra staff is the question for the GHA. Clearly a change of direction merits a serious look as to how resources are deployed, and where they can make the greatest impact.

8. Supported Accommodation

For the first time in our interim report we visited flats and houses, where former OV patients were slowly being introduced back into the community. We talked to staff and those living there to get a picture of what was happening and how well this was working.

For it is abundantly clear to the board that the road to recovery actually begins when a patient is discharged and everything should be in place to ensure that they have the best opportunity of succeeding in re-joining the community. And with the much greater emphasis on individuals being treated in the community in the new Mental Health Strategy, it is vital that we get this right so we break the vicious circle of "crisis-sectioning-discharge-crisis" situation that many individuals go through.

We have already written about one of these flats in the section above. This is the first time that the board has visited. Clearly it was felt that maintenance and furnishing needed to be a priority. Only when you have a suitable environment can you begin to feel that there is a way forward.

The second flat was visited in October last year and the board were not at all impressed. Here is an extract from the interim report:

"Some members of the board visited the flat and spoke to one resident and one carer.

First of all, it must be commented that the board found the physical conditions of the flat below standard. After all, if "we" are trying to re-insert vulnerable individuals into society then "we" should be able to provide an environment as close to home as possible.

The entrance to the flat is dim and dingy. To the right, at head level, there is a visible high voltage cable feeding two electricity meters. Someone clearly has done a very poor job of this. Whether this is dangerous or not is not for the board to say, but this is something no one should have at the entrance to their house and neither should they!

One side of the flat is in a very reasonable condition. The kitchen, bathroom and patio are of a standard, which anyone would find hard to fault, although there is a fairly large damp patch near the entrance to the patio.

The living and bedrooms are another matter altogether. None of the two bedrooms have curtains or wardrobes and consequently the two residents have to keep their clothes and belongings wherever they can.

One bedroom in particular has damp and crumbling patches at the corner of the wall and ceiling. Being at ground level the windows and shutters seem to be permanently closed and this does not help the condition of this room.

The living room furniture has seen better days and one sofa was brought in from the street, as it was in better condition than the one they had. Similarly, this room has no curtains and like the rest of the flat cannot be considered at all homely. There are no pictures or anything that might give this flat a different feel.

Notwithstanding this, it is clean and there are no issues in that respect.

The board voiced their concerns with the Nursing Clinical Manager and she assured the board that everything was on hand to improve the situation and that this year's estimates would reflect this. The board's concerns were also based on personal experience when it depended on other departments carrying out essential works."

When we visited a year later, the situation was exactly the same, with the flat housing only one resident.

Fortunately, over the last few weeks, essential works are being carried out in order to correct all the issues identified in our interim report.

The board would have preferred that action would have been taken sooner, but at least there is movement in the right direction. It has not yet seen the finished product, but hopes that the recommendations have been taken fully on board.

The board reiterates the point that if “we” are trying to re-insert vulnerable individuals into society then “we should be able to provide an environment as close to home as possible.”

The board also visited a privately run facility, which can house up to five individuals and was full at the time. When we visited last it was a mixed sex set up, with only one bathroom available in the main part of the house. The staff mentioned that this did not cause any issues with the mix of individuals then, but could prove problematic at some stage.

Regardless of this, the board believes, that there should be separate bathroom facilities, or make the main part of the house a single sex unit.

At the time of this visit there were three same sex residents in the house.

On both our visits we found the house to be reasonably clean, neat and tidy, with the staff being helpful, positive and enthusiastic about what they do. They do however, voice concerns, but also point out that communication pathways are now much clearer

They argue that the high turnover of psychiatrists affects the progress of patients and that patients do not have therapy sessions.

They feel exposed with little recourse in the event of violence shown by anyone. That they have not had training to manage patient expectations or boundaries, or what to do when lines are crossed.

They would appreciate defined roles for the patients and boundaries for the care of patients, safeguarding both parties.

Sometimes they do not feel supported by OV or CMHT.

They are not privy to patient diagnosis or even the most basic paperwork when a new patient is brought in. Therefore, they have no background and do not know what to expect.

Care plans are not always shared with staff, when it is they who are supposed to implement them while the patient is in their care, which is 24/7.

They would like more ideas and input from OTs.

8(a) Observations and Recommendations

- ✓ When talking with CMHT, the concerns roughly align with theirs, however, there is a different emphasis, which is further complicated, since the facility is privately run.
- ✓ CMHT are aware that the staff are caring and wish to do their best, but lack of training is apparent in their regular daily calls to CMHT in order to sort out the simplest of tasks.
- ✓ The perception is that there is a lack of clarity as to their role, with the facility, acting as a holding bay, with little or no therapeutic value for the patient.
- ✓ Furthermore, they are unclear as to how much they are able to place boundaries on their patients and how to deal with emergencies.
- ✓ They propose that the facility be run by an RMN, who would use their medical and local knowledge to run it effectively.
- ✓ There is clear divergence of opinion on how this facility is working, but what is abundantly clear to the board is that there is enough discrepancy to warrant a complete re-assessment of its functions and take whatever steps are necessary to sort out the problems highlighted by both sides and develop a clear and transparent pathway, through which this facility can provide a better service to its users.

9. Senior Management Team

9(a) Divisional Nurse Manager & Divisional Sites and Services Manager

The board met with the Senior Management team on various occasions to discuss the way they saw the service moving and to clarify certain issues, which had come up during the course of the audit.

It is clear from our meetings that the service is clearly in a state of flux and there are many strands, which are undergoing fundamental change. As always, change can bring about its own issues, but there is a much clearer vision of where the service is going, with a definite plan to improve the services to its users.

In the wards at OV, the board has seen a great improvement in the levels of communication, and as a result, a better understanding of the issues that staff face. This has resulted in better outcomes for patients and improved pathways for treatment and discharge.

This has also been mirrored at CMHT, where a much better working atmosphere is apparent and there is a much more positive outlook among the staff. The allocation of a Mental Health Social Worker for two days a week has been fundamental in facilitating communication and patient care in the community. There is still much to be done to provide those patients in the community the best possible care and support, but what the board has seen is clearly pointing in the right direction. The board also commends the closer working relationship between the Mental Health Services and the Care Agency as this is crucial to the success of treating patients in the community.

Management have re-established open meetings, which is a forum where discussions can take place tackling changes or concerns within the service.

Also as from December 2022, one-to-one meetings are being scheduled. It is through these personal meetings that managers can communicate with their staff any issues or concerns which they might have. This forum will also be used to commend good practices and set objectives for the upcoming year. Training and development will also be discussed.

There was a concern, both at staff and senior level that recruitment of Registered Mental Nurses (RMNs) was becoming more difficult (See page 8), especially after the COVID 19 pandemic.

The service currently has six RMN vacancies, which will be advertised soon, to other countries, including Wales and Northern Ireland. However, this is a short term solution and there are discussions taking place to train RMNs locally, through the University of Gibraltar, with placements locally and abroad. The opportunity will be offered to persons with a degree, who would wish to pursue a career within mental health. It will be run as a part-time 3-year course with guaranteed employment if successful.

The board agrees wholeheartedly with this proposal and would hope that it would be taken forward, as the future of our mental health services depends on forward thinking planning such as this.

Management agreed that there were historical issues with the ARC and that it was scheduling a meeting with the senior OT to establish the year's strategy for the OT service

Although the board welcomes this, it has heard enough from both sides in this area for there to be a definite move by management to tackle the misconceptions that exists and to ensure that everyone in the service is aware of their own roles and responsibilities. Only then can there be progress in this area, with everyone working towards the same goal.

The appointment of a specific Activities Coordinator is a step in the right direction as it will be their sole role to establish and coordinate activities. The last attempt to recruit Activity Coordinators did not work out as they were expected to carry out their own duties on top of having that responsibility. Hopefully now this will be a stand-alone post which, will work closely with the wards as well as with the OTs.

Management were also very pleased to announce that all employees reaching the 4-year mark had been offered an indefinite contract, thus ending their stress and worry, which was evident in our last report. This now provides both employees and the service the required stability to press on with the challenges ahead.

The question of Sunshine Ward was brought up, as it is an asset, which is not being utilised and rumours are rife as to its future use. As we have mentioned before, there are many speculative options doing the rounds, but as yet, management says that the final decision has not been taken at Senior Executive level. Again the board urges the GHA to make a decision as to its future use, as soon as possible for the benefit of the mental health service.

As to the issues relating to the 1:1 supervision in Dawn Ward, management agreed that it was causing an impact on the activities on the ward, but that supervision was necessary taking into consideration the nature and environment of the building. This situation is a temporary one and two patients from Dawn Ward are awaiting to be transferred to ERS.

The board realises the issues involved, but also recognises that transfer to ERS is dependent on factors outside anyone's control. In lieu of an immediate solution the board recommends that some of the suggestions given by staff members be considered as temporary measures.

The last interim report had commented on the fact that smoking cessation help was being made available to patients and that long queues witnessed at quarter to the hour had now stopped. If a patient wanted to smoke, they would simply ask and if the risk assessment allowed, to go down to the garden. This was an improvement from previous reports and after the latest report a Smoking Cessation committee was established. One of the board members was asked to join, but unfortunately it met only on one occasion and the initiative lost all its momentum.

The new management has pledged to re-convene this committee and push for a smoke free hospital, promoting a good health drive for both patients and staff. The board looks forward to see OV follow the lead that the GHA has implemented in all their other facilities.

Many patients and staff were questioning when the canteen was to re-open as there are no catering facilities or shops nearby and how it acted as a focus point, adding some cheer to the waiting area at OV. Management were quick to respond that the re-opening of the canteen was imminent and OV would be offering sheltered employment to some of the patients. The board clearly welcomed this move, which will prove popular with the patients and staff and hopes that "imminent" means precisely that.

When discussing "Assisted/Sheltered accommodation" members of the board were informed that this was a topic that had been thoroughly explored since the new Mental Health Management team came into being. That nothing was set in stone and that they were exploring different models that would best suit the patients and the community. Everything was thus under review and details would eventually emerge as to how the service would proceed.

The board hoped that this would happen soon and the new strategy would be able to help those who find it difficult to live independently in the community.

The Senior Management team is also responsible for monitoring the living conditions of patients within the community and helping whenever possible. At the moment there is no set budget for this, so the impact it can have is minimal. The board would like to see a set budget for this and perhaps a small crew to tackle minor jobs that would make life so much easier and would not be the cause of more serious issues later on. It also welcomed the recent interventions, when the living conditions of individuals living in the community have caused grave concerns.

9(b) Observations and Recommendations

- ✓ The board recognises the improvements carried out in the last six months and urges the team to sustain this progression.
- ✓ It notes the closer working relationship with staff at both OV and CMHT and the subsequent benefit for patients. It welcomes the continuation of "open" meetings and the introduction of performance related goals.
- ✓ The deployment of a Mental Health Social worker has made a huge difference in helping discharging patients into the community and has brought a much closer relationship between the Mental Health Services and the Care Agency. The board recommends an increase in this service.
- ✓ Recruitment and retention has been an issue which has been highlighted by senior and upper grades in the service. The board realises the challenges facing the sector and urges the GHA to continue to develop links with the University of Gibraltar so the service can have stability in the long term.
- ✓ The relationship between the ARC and OV requires an overhaul. It is essential that there is clarity as to the different roles that each have to play in the rehabilitation of the patient and to clear any misconceptions as to the roles ward staff and OTs play.
- ✓ It welcomes the appointment of a stand-alone "Activity Coordinator" to involve patients in activities in and out of the ward and liaise with the OTs in the ARC.
- ✓ The announcement that all 4-year contracts has been extended to an indefinite period has been well received by the staff and equally so by the board, who see this as a necessary step forward to ensure the long term stability of staff in the service.

- ✓ “What is going to happen to Sunshine Ward,” is a question on everyone’s lips. The board urges the GHA to come up with a clear use for this ward that benefits the service.
- ✓ Issues like the 1:1 and meal vouchers for Nursing Assistants are in the process of being sorted out, but these issues are in the hands of executive management for approval. The board believes that taking care of issues such as these promptly, go a long way in raising staff motivation and consequently patient care.
- ✓ Smoking is the perennial issue which needs to be tackled, like it has been done in other GHA premises. Patients and staff need help in dealing with this and a smoking cessation committee, together with greater direction from the GHA, should make the transition to a smoke free hospital easier. It is difficult, though by no means impossible!
- ✓ OV is crying out for a cafeteria. It should not be beyond the realms of possibility to re-open it, especially as all the equipment is in “situ.”
- ✓ The question of “Assisted/Sheltered” accommodation issue needs to have a decision in place very soon and a “model” decided which would benefit the individuals concerned.
- ✓ Many individuals living in the community, do so in conditions which are far from ideal. If the system advocates treating patients in the community, then it must deal with the poor living conditions which some of these individuals live in. Apart from developing a very close relationship with the Housing Ministry, the board recommends that a small budget be set aside for the Mental Health Services themselves to have the flexibility to deal with minor repair issues in a prompt manner. Whether, this is done in-house or outsourced, it must be borne in mind that these vulnerable individuals need quick resolutions to their problems.

  The board, in the course of its interviews with staff and patients, has been told that many of the problems faced by these individuals are practical in nature; be it housing, non-payment of benefits, rent arrears etc. If you add this stress to the issues they already suffer from, then we see how it can become a vicious circle, which is very difficult to break away from.

- ✓ The board therefore recommends much closer liaison between all the departments dealing with vulnerable individuals, who find it very difficult to navigate the bureaucracy they are expected to follow.

9(c) The Clinical Director

The board met with the recently appointed Clinical Director, who spoke candidly about the new initiatives taking place and how the new mental health strategy had impacted on the mental health services.

He echoed others when he praised the work being done through the 111 mental crisis line, which had contributed significantly to the reduction in the number of admissions to OV and had triaged many callers to the relevant medical team, depending on the severity of the crisis.

The situation at OV with the deployment of two full time psychiatrists on site and two based at CMHT had greatly improved the efficacy of the system, by providing continuity and support where and when required.

He was aware of the need for psychological support and commented on the continuous efforts by the GHA to add to the present contingent. At the moment there were three psychologists working for the GHA (OV, PCC and GYM), with vacancies for two more. He continued that they were continuing with their recruiting campaign, but it was not easy in the present climate to attract prospective “good” candidates to Gibraltar.

The Clinical Director was particularly pleased with the work being carried out in GYM. Whereas previously the facility was offering a service of one day every two weeks by a visiting psychiatrist it had recently been totally re-structured and upgraded.

There were now two psychiatrists servicing the department, with one clinic held in the late afternoon to avoid children missing out on school activities. There was now one RMN and two enrolled nurses dealing with patients on a daily basis and one psychologist and one more hopefully joining the team soon.

MDT meetings were held twice a week and these meetings were now being attended by social workers assigned to the young people involved.

He believed that it was essential that there was total cooperation with all agencies involved. That included the Care Agency, the Housing Department, the Education Department, the Police etc. He stressed that “Inter-Agency” cooperation was essential in delivering a better service. More so, this could be done successfully, especially as Gibraltar was small enough to achieve this.

He continued that on that note there were meetings planned with the Education Department to liaise with their educational psychologists in order to develop

closer links and address the issue of the backlog of ADHD referrals amongst other issues.

As a temporary and practical solution to the lack of psychological support and the positive cooperation beginning to be witnessed, there was a proposed solution to those who need psychological support.

The College of Further Education is running courses for Counsellors and these trainees need extensive practical experience in order to achieve their qualifications, so it has been mooted that these trainees work, under the supervision of psychiatrists, in the mental health services, where there are temporary shortages of psychological support in some areas. As an example he commented on the prison service, which he currently visits, but which does not have any psychological support since the person assigned to carry out this task retired. There are moves afoot to remedy this, however, the use of trainee counsellors would help in an area which is so sorely needed to break the cycle of repeat offenders.

When talking about CMHT he commented on the on-going programme to use CMHT as a team to deal with patients with severe and enduring mental illnesses. He calculated that this was estimated at between two hundred and fifty to three hundred individuals. There were many patients attending CMHT, whose care was being transferred to the PCC. In all, approximately one hundred and fifty had already been moved to the PCC and the process was on-going. He did add a caveat, that if any of those patients required the attention of CMHT then they would be able to access this service without going through any referral system. Many of those patients being transferred were being seen at six or twelve month intervals, so it made sense to remove them from their books, so CMHT could concentrate on the more complex cases.

When asked about the situation reference the CMHT building itself, the Clinical Director informed the board that this would soon be re-located to SBH. He could not give an exact time frame, but it needed to be fairly soon, especially with the new building works taking place at Coaling Island.

The members of the board were aware that there was an issue with the recruitment of a second opinion doctor (SOAD), who is an essential element in the protection of patients held under the Mental Health Act 2016. He agreed that this was so and there was a stop gap measure in place at a local level to cover this, however, this was not entirely satisfactory and there was a possibility

of combining this with the recruitment of suitably qualified professionals in the UK, via video conferencing to enhance the service.

When the board met with the Chief Pharmacist, it had been suggested that the synchronisation of the Clozapine Clinic with the blood tests required could be improved if the bloods were actually taken at CMHT when the patient had their appointment as opposed to trying to find a suitable appointment in the main GHA system.

The Clinical Director replied that he would look at this to try and improve the service and proposed that extra training would need to be given to staff at CMHT in order for them to be sufficiently capable to take bloods from all patients.

Likewise, when asked about the Lithium Clinic and how it was not as tightly controlled as the Clozapine one, he agreed to look into this.

When questioned about the plans for Sunshine Ward, there was the often repeated answer that this was still in the hands of the GHA executive and that he hoped it would soon be resolved.

He went on to explain that the service needed to know where it was going in the long term as well as solving immediate issues. He saw the possible transfer of the acute ward to SBH and the deployment of the rehabilitation ward into a community hub, close to where the majority of patients lived and the possibility of much closer supervision, as alternatives to the present system. These comments he reiterated were his own vision going forward and were not policy statements.

9(d) Observations and Recommendations

- ✓ The board wholeheartedly agrees with the Clinical Director in his comments about the 111 Crisis hotline. This has clearly proved to be a turning point in the way the service deals with individuals in a crisis. Since its inception the service has responded to the challenges met and has dealt proactively with issues that have arisen.
- ✓ It welcomes the re-structuring of the psychiatrists in OV and CMHT, which allows the latter to take ownership and for them to be more accountable to management and patients.
- ✓ Having visited GYM, the board was not surprised by the comments made by the Clinical Director and reiterated the views expressed earlier on in this report in that particular section. It does, however, recommend, that

every effort is made to ensure that another psychologist is recruited as soon as possible. Likewise, it encourages that the service continues to involve as many stakeholders as possible so that a “holistic” approach can make a difference to those in need of support.

- ✓ The use of trainee counsellors in the short term, even under the supervision of a senior psychiatrist, is something that needs to be tackled with caution. There is much to be gained from it, both professionally from the point of view of the student and also from the patient, however, it needs to be very well managed so it does not simply become a substitute and a cheaper option for suitably qualified personnel.
- ✓ The re-siting of CMHT is long overdue and has been commented on extensively before. The move to SBH, if this is the case, should be carried out as a matter of urgency.
- ✓ The SOAD is an important element of the MHA 2016, which ensures protection to all individuals detained under it, particularly those unable to consent to treatment. Everything possible should be done to enable the SOAD, whether in person or remotely, to continue to protect the rights and oversee the treatment of our most vulnerable patients.
- ✓ The board is pleased that the Clinical Director has reacted positively to the suggestions reference the Clozapine and Lithium Clinics. The latter is long overdue the kind of scrutiny that the former enjoys. The board looks forward to positive developments in this area very soon.
- ✓ The question of what is happening to Sunshine Ward has been asked from Nursing Assistants right up to Senior Management level. Clearly it is an issue that requires clarity form the GHA. It is now nearly six months since the ward was vacated and patients transferred to ERS facilities.
- ✓ The board notes the personal comments made by the Clinical Director and hopes that this vision and others, equally valid, are discussed openly so that the best possible outcome is experienced by those, who at the end of the day, are the ones most affected.

10. Chief Pharmacist and Clozapine and Lithium Clinics

The board spoke to the Chief Pharmacist and the Pharmacist about the Clozapine and Lithium Clinics and also about their interaction with OV and CMHT. It asked about safety controls and the required blood tests necessary to ensure that a patient is taking the correct dosage.

They felt that they had a good handle on the Clozapine Clinic and would not dispense any medication unless a blood test had been carried out beforehand. They felt that the hospital had a good control of the process and whenever they were satisfied with the blood results the patient was marked “green” to go and the prescription issued.

They did, however, state that there is sometimes a lack of synchronisation between the need for a blood test and when the next prescription is due. This is due to the fact that the GHA blood appointments do not necessarily coincide with the next prescription.

In cases like these, patients are not placed in danger, as the Pharmacy will only dispense the necessary number of tablets until the blood test results are received. It is, however, a clumsy system and could be vastly improved by having patients’ bloods taken at CMHT when patients go for their appointments. In this way, there is a certainty that the blood results will be ready before the next prescription is due and stops the uncertainty of appointments after the due date or the chance that the patient might forget to go. This new protocol would ensure that there would be even tighter controls in place.

When asked about the Lithium Clinic, they informed the board members present that this was not under the control of the hospital. That many on the list were not even known to the Mental Health Services and were in the Primary Care System.

They surmised that they might have once been, and at some point they had been passed on-to a GP. These patients, however, do not have the supervision of a psychiatrist and so are not fully within the Mental Health system or subject to its comprehensive oversight. Because of the nature of the drug they are taking, they should be seen by a psychiatrist at regular intervals, even if only to allow them to continue treatment.

They suggested that there should be a specific Care Pathway for roles and responsibilities to be explicitly laid out so that everyone was aware of the part

they played and that “someone” needed to have an overview of where everyone was in the system and when bloods were due, very much the same as the Clozapine Clinic.

They continued that there are many such models already available in the NHS and it should not be difficult to adapt one of them to fit in with the local situation.

The board asked about their role in OV and they replied that they go to OV two mornings a week, whenever possible and there is a possibility of video conferencing in some cases.

The board reminded them that it had been promised as far back as 2019, that the visits would be increased to five a week, but that that had not materialised.

The argument put forward why this could not be done at the moment was because by law there needed to be two people manning the hospital pharmacy at any one time, so it was particularly difficult to be able to release a pharmacist to go up to OV.

The Chief Pharmacist, continued that he had made submissions to increase the number of pharmacy assistants, which if approved, would allow extra time to be allocated to OV.

This was also necessary as it was a legal requirement in the UK, that a new patient entering the service would need to be clerked in by a pharmacist within a 24-hour period.

10(a) Observations and Recommendations.

- ✓ The board was very pleased that the Clozapine Clinic continues to be well regulated and there are robust safeguards to ensure that no patient is dispensed this medication without the required monthly or more frequent haematology screen for possible neutropenia. It would seem, however, that the lack of synchronisation between the timing of the prescription and blood tests could be better managed and lead to a much smoother service, with a lesser chance of errors creeping in. The board therefore recommends that the idea of taking bloods at CMHT be further explored. It makes perfect sense to do this at the time the patient has their appointment and will not cause any delays further along.
- ✓ The Clozapine list presented to the board was deemed to be correct by our medical member and all the patients there had their “green” traffic

light on. Clozapine serum levels need to be checked regularly also, though not so frequently, and the BNF is recommending increasing regular serum levels of other anti-psychotic and other psychiatric medication with a limited therapeutic range.

- ✓ The question of the Lithium Clinic is a worrying one for the board and there is a need for someone to take control and organise it in the same way as the Clozapine one. The board proposes that the pharmacy plays an important part as a safety net to ensure that no patient escapes scrutiny and is under the supervision of a psychiatrist. The board has been reiterating this point since the 2019 report and feels that it is high time that a particular Care Pathway is agreed upon and those charged with its oversight, given clear guidelines and protocols to follow.
- ✓ In the list presented to the board, one particular individual had high creatinine levels, however, these were coming down and there were no concerns raised, either by the pharmacists or the board's medical representative. The rest of the patients were being regularly tested.
- ✓ Again since 2019, the board has been advocating the need to increase pharmacy cover to OV. It was promised five mornings a week and it has been disappointed year in year out that this has not happened. The board hopes that the Chief Pharmacist gets his Pharmacy Assistants so we can see a greater pharmaceutical participation in OV. The board sees this increase as a relatively small price to pay in order to ensure that effective, but "potent" medication is delivered safely to vulnerable patients.
- ✓ GHA must also look to deliver the clerking of patients within a 24-hour period. With the new assistants this might be possible.

11. The Code of Practice

The Code of Practice, required under Section 106 of the MHA 2016, is still undergoing an update, which as yet has not been finalised. This is indeed a crucial document for everyone involved in the delivery of Mental Health Services. It is the manual which unlocks the MHA 2016 and should be made available to everyone who works in the mental health services.

This practical guidance is crucial to ensure that staff follow agreed protocols when confronted with particular situations in the wards or in the community.

The board was informed in 2021 that the Ministry for Health had instructed counsel to completely re-write the Code as the previous code was based on a UK version which did not take into account a major revision that subsequently took place.

11(a) Recommendation

- ✓ The board understands the complexities involved and the desire to ensure that everything is accurate, however it urges the GHA to do everything possible to get the Code published so that the process of disseminating to the staff can begin.

12. A Psychiatrist's Perspective

Some members of the board met with a psychiatrist and sought his views on his role in Gibraltar. Below are excerpts from that conversation.

He has a high regard for the dedication and professionalism shown by the staff, however, "archaic practices", which are labour intensive and thus inefficient need to be changed.

He affirmed that his role is unsustainable in the long run, where," ... even lunch had to be compromised at times"

This needed to be sorted, as it could very well be a deciding factor in attracting the right sort of qualified personnel to the service.

He explained that certain processes were not enabling psychiatrists to do the job they were paid to do. He was being paid handsomely to carry out time-consuming jobs that could be carried out by a junior doctor and a medical secretary.

He used the phrase "… in a constant state of exhaustion…", especially if he was on call and was expected to be at work the following morning. In fact, this was the kind of work he was doing as a junior doctor fifteen years ago.

He continued that changes like he proposed did not necessarily involve more money, but a better use of the human resources already in place.

He believed that the number of psychiatrists employed by the GHA, was above the norm in UK and the money saved could be used to employ junior doctors and medical secretaries in OV and CMHT.

With these measures in place, consultants would be able to provide the services, which they were being paid to do; looking after a person's care and moving forward.

He was certain that the use of electronic record keeping was also going to be a game changer.

He favours a "Care Programme Approach", which is patient centred and involves including everyone associated with the patient.

He stated that a "Patient forum" is the way forward, because the concerns of the patient have to be at the forefront of policy making decisions. It was not an easy task, but it was worth pursuing.

He recognised the work that Clubhouse does in Gibraltar and how essential it was to empower individuals to integrate back into the community.

Finally, he expressed the view that it was important to have a canteen in OV, so that patients, family and staff can meet informally.

13. Gibraltar Young Minds (GYM)

This is the board's first visit to the Gibraltar Young Minds and they spoke to the RMN in charge of the daily running of the centre, which caters for all youngsters up to the age of eighteen.

It has recently been re-organised and the staff complement is as follows:

- 1 RMN
- 2 Enrolled nurses
- 2 Psychiatrists, who have clinics twice a week and can be contacted in an emergency.
- 2 Psychologists (one in post and one vacancy to be filled)
- The Behaviour Team, who come from UK every six to eight weeks, and stay for two weeks

The centre is now open seven days a week, with Saturday and Sunday closing at 13.00.

Members of the board were informed that, because of the nature of the referrals and the inability of some children to attend during the week, it was felt that weekend opening was necessary to cater for those children in order not to impact on their other activities.

The team also carried out school and home visits as well as seeing the children in the Centre. Every Tuesday the staff would meet to discuss any new referrals and on-going cases.

There are approximately 150 minors on their books, with anxiety and behaviour issues being the major causes of referrals. Many of them are also waiting ADHD diagnosis. Whereas the majority of cases are in the higher age bracket, the age of children attending the Centre ranges from four to eighteen.

GYM takes referrals from GPs, paediatricians, schools, the Liaison Team, Social Workers etc.

The plan is to work together with schools and school counsellors in order to pre-empt issues before they become entrenched problems and work for a way forward. These meetings are scheduled to begin in the new year.

The board enquired if they had any dealings with the Primary School sector, seeing that some children were in that age bracket. This they answered that this would happen as the service developed.

Likewise, the team is planning to begin a Group Therapy group in conjunction with Childline and the Care Agency.

Finally, she did mention that they were working through a backlog of cases, but that anyone on the books could call at any time if there were any problems and they would be seen.

13(a) Observations and Recommendations

- ✓ The board were very pleased to have had the chance to visit the Centre and have a baseline on which to base future visits.
- ✓ It welcomed their plans to work together with different agencies and looked forward to seeing their plans turn into action.
- ✓ The staff complement was minus a psychologist, which the board hoped would soon be filled. This in turn would help reduce the current backlog, especially those ADHD referrals.
- ✓ When talking about schools, the board stressed the need to include the Primary sector as well as both Comprehensives, the College of Further Education as well as the local Youth Clubs.
- ✓ A member of the board also attended an MDT meeting at the Centre. This meeting is held every Tuesday and brings together as many of the team as possible to consider current cases and new referrals. It also allows them to follow up any cases or "no shows". The MDT includes two psychiatrists, a Paediatrician, a Psychologist, as well as representatives from the Care Agency and GYM staff. There was also a video consultation with a UK based psychiatrist.
- ✓ The board member found the experience very positive; one which demonstrated the internal workings of the system, rarely seen from the outside. It praises the level of Inter-Agency input and encourages this to also include the Education Department at some future date as many of the cases referred were already under the radar of the latter.
- ✓ It notes the difficulties that staff at GYM sometimes have to contact patients and proposes that a clear pathway is followed so that contact details are routinely updated.
- ✓ The UK psychiatrist made reference to a case, where the patient was seventeen and would be receiving treatment beyond the eighteenth birthday threshold for GYM, so he asked about the transition from adolescent to adult services. The reply was that there was, at present, no

formal pathway, but the service would be provided by the same psychiatrists at adult level.

- ✓ Rather than leave it to chance, the board recommends that a specific protocol is designed so that there is particular emphasis on this transition, which in any situation is where many problems are exacerbated.

14. 111 Call Centre.

As a lynchpin of the Mental Health Strategy, the board felt that a visit to the Centre was warranted. It first went to the facility in October 2021 urged on by many across the service who had commented on the difference it was making.

The team was motivated, confident and had clear protocols to follow. The system was still developing and it was very clear that they had a handle on everything that came their way.

The lines of communication and the network established between all stakeholders was allowing a fast, efficient service in dealing with mental health issues.

Up to the 21st October 2021, 111 had dealt with one hundred and one mental health calls, and triaged them using the criteria set out.

In November 2022, this had risen to three hundred and forty-nine for the eighteen-month period since it began. (See Appendix 1)

Since its inception the Centre has encouraged and established much better links with the Police and the Care Agency. This improved coordination has made a significant impact on the service provided to those who call in a crisis. Thus for example when they receive a call from the police, 111 is able to respond with the right clinician and take them to a place of safety, either in A&E or New Mole House.

The board was informed that there were proposals to use OV as a place of safety, rather than A&E or New Mole House to carry out a full assessment, but this was still under review.

The introduction of the service has led to the reduction of acute cases being admitted to OV and individuals presenting with a crisis have been triaged to other medical personnel according to their needs.

What was made very clear to the board, was that those who call in a crisis need very careful handling and the operator, because of the very complex situations presented, needs much more time to deal with the person's situation, as opposed to a medical emergency.

As a result of this, the Centre requires extra personnel to deal with other "medical matters" if one operator is handling a mental health call.

14(a) Observations and Recommendations

- ✓ Undoubtedly the introduction of the 111 Crisis Pathway for Mental Health is one of the most important steps taken in recent times to enable the GHA to tackle mental health issues swiftly and effectively.
- ✓ It has developed a highly trained, motivated body of professionals dedicated to provide a service that continues to develop and improve.
- ✓ As a pivotal player it is able to coordinate and triage cases that before would have probably ended in an admission to OV. It has also eased the work load in A & E.
- ✓ The board commends the work done by the 111 Call Centre and urges the GHA to look at the possibility of increasing the office space necessary to carry out this crucial service. As it continues to develop the space required to carry out these duties should expand accordingly.

Appendix (I)

	Category					
Date	A calls and RGP/GAS was dispatched	B Mental Health Liaison responded to A&E	C AMHP (Approved Mental Health Practitioner) same day appointment	D AMHP next day appointment	E AMPH appointment within a week	Grand Total
2021	**28**	**20**	**14**	**49**	**55**	**166**
Jul	2	2		5	7	16
Aug	8	4	3	19	13	47
Sep	4	3	2	9	7	25
Oct	4	3	4	5	10	26
Nov	6	5	4	6	8	29
Dec	4	3	1	5	10	23
2022	**20**	**19**	**29**	**60**	**55**	**184**
Jan	2	3	3	7	5	20
Feb		3	7	10	6	26
Mar	3	1		6	8	18
Apr	4	4	4	2	5	19
May	1	2		6	3	12
Jun			1	3	4	8
Jul	2	2	3	1	3	11
Aug	1	2	1	6	1	11
Sep	1		3	6	6	16
Oct	4	2	6	8	5	25
Nov	2		1	5	9	17
Grand Total	**48**	**39**	**43**	**109**	**110**	**349**

(Breakdown of 111 Mental Health calls since inception. GHA sources)