mental welfare
commission for scotland

Recommendations and outcomes from our local visits
1 April 2021 to 31 March 2022

August 2022

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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1. Our local visits

The Mental Welfare Commission for Scotland has a statutory responsibility to carry out visits to places of detention, care and support to ensure that individuals under the Mental Health Act and the Adults with Incapacity Act are being treated appropriately and their human rights respected.

The Commission undertakes this work through visits categorised and organised as follows:

- Local visits
- Themed visits
- Guardianship visits

One way of achieving our mission and purpose is to meet with people in particular services or facilities when we are interested in the individuals' experience of their care and treatment. We undertake local visits for various reasons; some facilities, for example secure units, are more restrictive on individuals' freedom and we visit them more often as a consequence.

However, as a result of the national lockdown, in response to the Covid-19 pandemic, our visit programme to local services was affected throughout 2020 and 2021. The Commission adapted its visits to a virtual format, where we were still able to hear about an individual's care. We were also able to speak with carers wherever possible, and use technology to virtually visit the ward environment and access clinical records. Where it was safe and viable to undertake a face-to-face visit, this was the preferred option.

Throughout the pandemic, we have continued to publish our findings from each individual visit on our website. The recommendations we make reflect on established good practice as appropriate (such as national health and social care standards, dementia standards for Scotland etc) but also include the observations we make on the day of the visit, the professional expertise and judgement of our Commission visitors and, most importantly, what people we met with told us.

We share information with key scrutiny bodies, e.g. Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS). We meet regularly with them through the Sharing Intelligence for Health & Care Group. This is a mechanism that enables seven national agencies to share, consider and respond to intelligence about health and care systems across Scotland (in particular NHS Boards) and the information shared helps us to decide where we should prioritise our visits.

In addition to our website publications, copies of all our local visit reports are sent to the CI for visits to care homes, to HIS for NHS services and independent hospitals. Copies of our reports to prisons are sent to HIS and Her Majesty's Inspectorate of Prisons (HMIP).

We want to make sure that these organisations are aware of any concerns that we have raised as they may choose to look further at these.

2. How often we visit

The frequency of visits to people in a particular service is based on information from a variety of sources and can be increased or decreased depending on the intelligence we receive. Our focus on the visit will depend on the type of facility and the information we have.

As a result of restrictions to our visiting programme throughout 2020, we gathered intelligence on health and social care services through virtual meetings. The information we gathered, was collated and shared with the services, and where possible, a local visit report was published. When restrictions eased, and we could again visit services in person, our visits were all planned in advance to ensure that Covid-19 procedures were fully considered. There were no unannounced visits from the start of the formal lockdown until early 2022. For the year commencing 2022 to 2023, we will again aim for a percentage of our local visits to be unannounced.

Services we visit are:

- Adult acute admission wards on an annual basis
- Child and adolescent mental health (CAMHS) inpatient wards on an annual basis
- Other specialties e.g. perinatal inpatient, eating disorder units, every two years
- Dementia assessment wards on an annual basis
- Dementia continuing care wards every two years
- Learning Disability (LD) assessment wards on an annual basis
- Learning Disability (LD) continuing care wards every two years
- Adult rehabilitation wards every two years
- High secure wards (State Hospital) twice a year
- Medium secure hospitals on an annual basis
- Low secure hospital, not less than every 18 months
- Prisons every two to three years

We visit independent hospitals after discussion with HIS. We have not visited care homes as part of our local visiting programme but will do so if it is appropriate and after discussion with the CI.

Between 1 April 2021 and 31 March 2022, we carried out **95** local visits; we made **229** recommendations and **10** services had no recommendations relating to these visits.

3. About our recommendations

When we make recommendations, we allow the senior manager in the service three months to formally write to us with their response. If the recommendation is particularly serious and urgent we will reduce the response time accordingly.

Once we receive the response it is allocated to the Commission officer who co-ordinated the visit to decide if the response is adequate or if we need any further information. We will check on any future visits to see that the recommendations were implemented as planned.

We expected an acceptable response to at least 90% of the recommendations we made. We were satisfied that services had responded appropriately to 97.5% of our recommendations in 2021-22.

Looking closely at the recommendations we make to particular services helps us to determine our future visiting priorities and what we need to focus on during our visits. It also helps us to determine if we need to carry out a particular themed visit or develop good practice guidance.

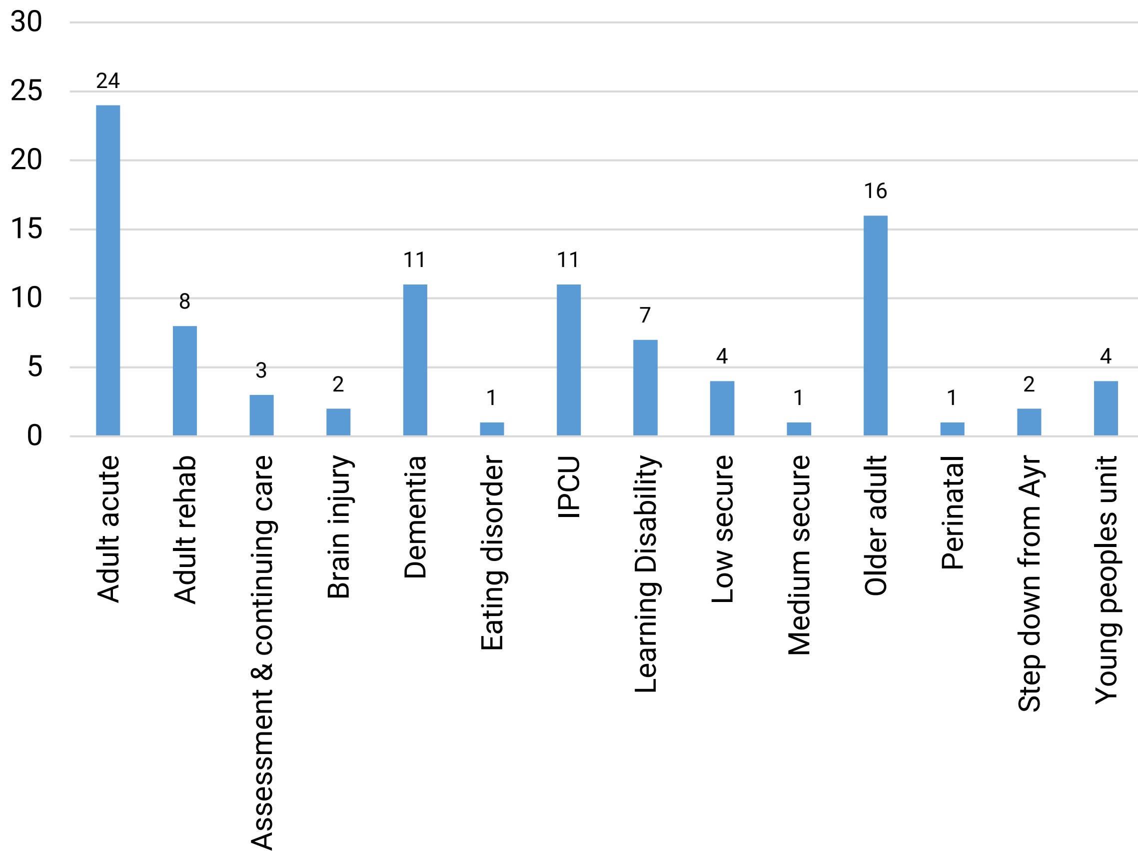
This report looks at where we were most likely to make recommendations and what they were about. We also give some examples of where improvements have been made and which may be of interest to other services across Scotland.

To make sure our recommendations are being acted upon, we provide managers of services with guidance about what they need to include in their response to us. The Commission now has a standard action plan template to assist.

We then consider when the next visit is required dependent on the nature of the recommendation and the service's response.

4. Where we visited

Chart 1: Number of services visited (1 April 2021 to 31 March 2022)



The 10 wards where there were no recommendations made included:

- two intensive psychiatric care units (IPCUs);
- two adult acute wards;
- one older adult long-stay dementia ward;
- one forensic rehabilitation ward;
- one low secure unit (private sector);
- one child and adolescent unit;
- one forensic learning disability unit;
- one step-down facility.

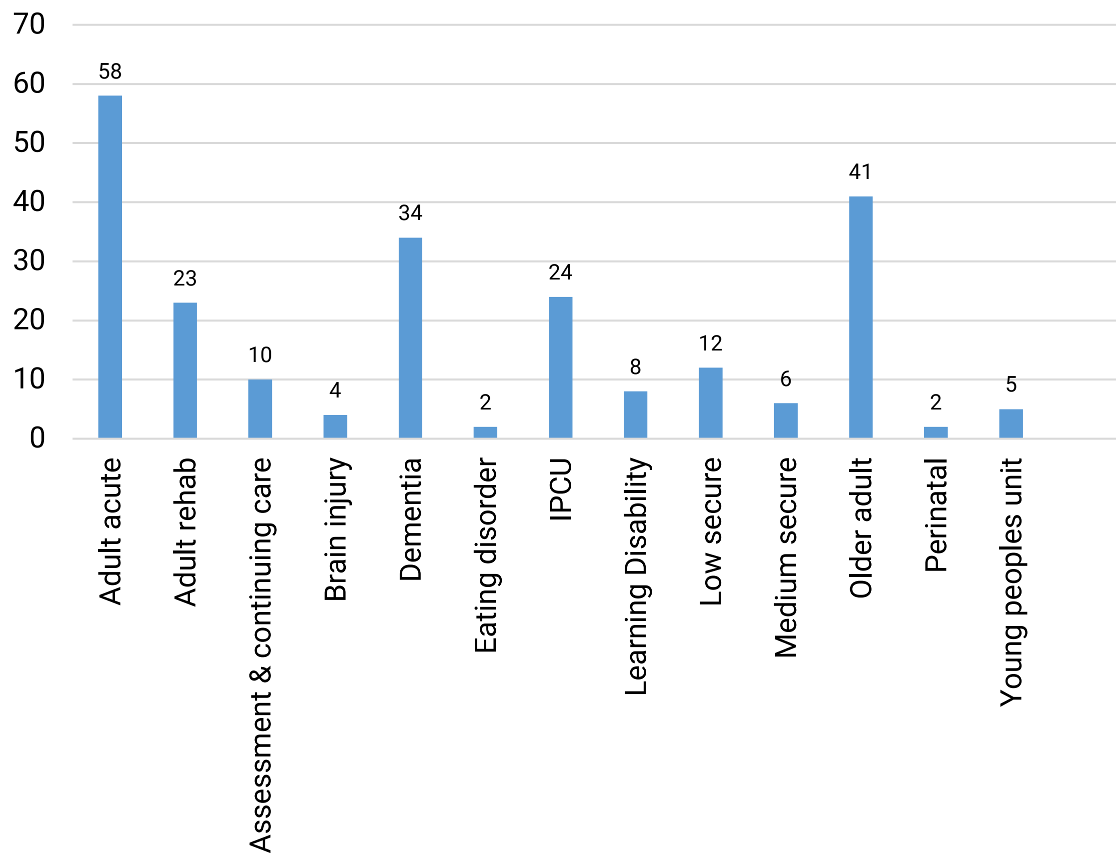
For those services where recommendations were made, these ranged from one recommendation to nine recommendations. On average, the number of recommendations made to most services was three.

5. Recommendation category

Table 1: Number and percentages of recommendations by category (1 April 2021 to 31 March 2022)

Recommendation category	(n)	%
Care plans, multidisciplinary team (MDT) notes, documentation	71	31.00%
MH Act/ AWI Act/ legislation	47	20.52%
Accommodation/ environment/ facilities	44	19.21%
Activities	15	6.55%
Communication with patient, families, carers	12	5.24%
Staffing	11	4.80%
Medication	9	3.93%
MHO/ social work provision	5	2.18%
Service provision	5	2.18%
Advocacy	4	1.75%
Delayed discharge	3	1.31%
Covid-19	2	0.87%
Confidentiality	1	0.44%
	229	**100%**

Chart 2: Types of services with the number of recommendations (1 April 2021 to 31 March 2022)



6. Some examples of our recommendations and responses

6.1 Care plans, MDT Notes, documentation

Table 2: Number of care plans, MDT Notes, documentation recommendations by service type (1 April 2021 to 31 March 2022)

Type of service	Number of recommendations	%
Adult acute (NHS)	11	15
Dementia (NHS)	11	15
Older people (NHS)	21	30
Other	28	40

6.2 Mental Health Act/ Adults with Incapacity Act/ legislation

Table 3: Number of Mental Health Act, Adults with Incapacity Act, legislation recommendations by service type (1 April 2021 to 31 March 2022)

Type of service	Number of recommendations	%
Adult acute (NHS)	10	21
Dementia (NHS)	8	17
Older people (NHS)	10	21
Other	19	41

6.3 Accommodation/ environment/ facilities

Table 4: Number of accommodation, environment, facilities recommendations by service type (1 April 2021 to 31 March 2022)

Type of service	Number of recommendations	%
Adult acute (NHS)	12	27
Dementia (NHS)	7	16
Adult rehab (NHS)	7	16
Other	18	41

7. Some examples of our recommendations and outcomes

<table>
<tr><th>Some examples of our recommendations and outcomes we recommended</th><th>The service response</th></tr>
<tr><td>Managers should ensure nursing care plans identify clear interventions and care goals to support discharge planning, and set out review timescales, and this should be audited on a regular basis.

*Recommendation made to an adult acute ward</td><td>SCN and Practice Development Nurse (PDN) have met to explore solutions. The PDN will undertake a comprehensive audit of care plans and identify areas of development. SCN/PDN and Hospital Management Team will meet to review outcome of audit and construct an improvement plan.

Monthly (routine audit) of care plans will be undertaken by Charge Nurses and nurse line management supervision will focus on the need for person centred care plans</td></tr>
<tr><td colspan="2">Our local visit reports signpost to our published good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/node/1203</td></tr>
<tr><td>Managers should ensure specified persons procedures are implemented for patients where this is required to authorise room searches or other restrictions and all staff are clear on these processes and legislation.

*Recommendation made to a rehabilitation ward</td><td>All nursing staff to include in their PDP a review of the local Specified Person Policy and guidance which links to audit of its use and increased understanding of the range of interventions covered.

The Specified Person Procedure was discussed at the MHS Clinical Governance Group. As such, the group discussed and agreed that they will use this learning to produce a seven-minute briefing to share learning across the system about the procedure. This will be the first seven-minute briefing we have developed.</td></tr>
<tr><td colspan="2">If this recommendation is made, our report would signpost to our specified persons good practice guidance that is available on our website:

https://www.mwcscot.org.uk/node/512</td></tr>
<tr><td>Senior managers should urgently carry out an environmental risk review of patient bedrooms and en-suite facilities. As a matter of priority, an appropriate solution must be</td><td>A review of the built-in shelving has been carried out. GTFM, our facilities management are requesting that the installers review and provide costings to fit a lockable door to part or all of the shelving.</td></tr>
</table>

found to enable patients on the ward to access their clothing in their room. The Commission expects to receive details of this solution. **Recommendation made to an older adult dementia assessment unit*	This will provide protection and ease of access. Once a practical solution and costs are obtained a better timescale can be predicted for carrying out work. I am keen that our responses to this results in a robust solution that is not easily broken and is both aesthetically pleasing and does not introduce any unintended risk.
All our local visit reports can be found at www.mwcscot.org.uk	

Mental Welfare Commission 2022