

Mental Welfare Commission for Scotland

Report on unannounced visit to:

Lynebank Hospital, Daleview Ward, Halbeath Road, Dunfermline
KY11 8JH

Date of visit: 29 July 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

Daleview Ward is a 10-bedded regional low secure forensic unit situated in the grounds of Lynebank Hospital in Fife. The ward provides assessment and treatment for adult males with a learning disability diagnosis, who present with behaviour that may be harmful to themselves or others, and who require close supervision in a secure setting. On the day of our visit, there were eight people on the ward.

Some individuals who had been admitted to this ward had come via the forensic pathway and had been assessed as requiring a lower level of security. The ward covers the East area of Scotland but also admits individuals from other health boards.

We last visited this service in June 2024 as an announced visit and made recommendations about care planning, section 47 of the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) treatment plans, staff daily recordings and activities. In response to these recommendations, we received a detailed action plan from the service. On the day of this visit, we wanted to follow up on the previous recommendations, find out how the service had implemented the actions and hear about people's progress around their discharge planning.

The Commission published 'Hospital is not Home' in January 2025. This reported on the circumstances of people with a learning disability and complex needs who have been in hospital for 10 years or more. This report can be accessed [here](#).

We were aware that several people in this ward had been delayed for a lengthy period and wanted to find out about individual's progress with regards to discharge planning. Since our last visit, it was positive to hear about individuals who had moved on from the ward to the community and we were told that the ward had good links with other regional services to aid these transitions.

Who we met with

We met with six people and reviewed the care notes of four of those individuals and reviewed the care notes of a further person. As this visit was unannounced, relatives and carers were not aware that the Commission was visiting the ward and we asked that the senior charge nurse (SCN) contact all relatives/carers and let them know of the visit and if they wished to be contacted.

On the day of the visit, we spoke with the SCN, other nursing and ward-based staff, the occupational therapist (OT), the clinical psychologist and art therapist.

At the end of the visit, we had a further meeting with the senior leadership team of NHS Fife.

Commission visitors

Tracey Ferguson, social work officer

Anne Buchanan, nursing officer

What people told us and what we found

From the individuals we spoke with, we gained a sense that activities were important to them, as was being discharged from the ward. People told us that they liked routine and structure and were able to tell us about their structured timetables, and of the activities that they participated in, both on and off the ward.

The majority of people we spoke with were able to tell us about their involvement in their care and treatment, about how they regularly met with the consultant psychiatrist and were able to tell us about the other professionals involved in their holistic care.

Individuals told us that they felt safe in the ward and that staff were available if they needed to talk or raise any issues or concerns. A few people told us that staff supported them with their family relationships and how this was important to them, along with maintaining social connections. Most concerns raised with us were around discharge planning and although people seemed to know what stage they were at in this journey, individuals expressed their frustration around the timeframe for this.

Most individuals were able to tell us about their rights, including their involvement from advocacy and legal services, as well as their involvement at meetings, their discharge pathway and care planning processes.

All individuals told us that the staff were nice, approachable and supported them as much as possible with independence.

Care, treatment, support, and participation

On the day of our visit, we saw individuals and staff engaging in activities, either in small groups or with one-to-one therapy. We saw warm interactions between staff and individuals and observed a person who required support; the staff attended to this promptly in a supportive manner. From speaking to staff, we gained the sense that the staff team knew the individuals well and had knowledge and experience of the people in their care.

Similar to our visit last year, people were keen to show us their individualised discharge pathway illustrations also known as the 'road to freedom'. With support from allied health professionals, including OT, speech and language therapy and also psychology, individuals had a diagram of their pathway to discharge on their bedroom wall. In these personal diagrams, there were illustrations to recognise their strengths, what needed to be in place to enable recovery, and who would be needed to support them to achieve this. People we spoke with felt involved in making decisions around their discharge planning.

From reviewing the care records, we found these to be detailed documentation and they provided a sense of the staff's investment in getting to know the individual and what was required to meet individual outcomes, from admission and throughout their stay in hospital. We found comprehensive nursing assessments and where a person had been in the ward for a longer period, these had been updated. Detailed risk assessments and risk management plans were in place, and we saw that those documents had been regularly reviewed and updated. We recognised from the way that the multidisciplinary team (MDT) approached and reviewed the risk, that individual's well-being in accessing community facilities was a priority, in tandem with managing risk.

We wanted to follow up on the recommendation regarding care planning and see how the service had implemented the actions that were identified to meet this. We found evidence of detailed, holistic care plans, with identified interventions to support the person to meet their goals. There were regular reviews taking place that included individual participation. We found care plans that had been devised as 'easy read' or were in a pictorial format to support individual involvement and understanding.

We also wanted to follow up on our recommendation last year with regards to the daily recordings in the care records. We were pleased to see that there was significantly less perfunctory language used to describe an individual's presentation. We found detailed daily recordings by nursing staff that provided an overview of how each person presented on that day. The recorded discussions between the staff member and the individual also incorporated the individual's view about their day and of their care and treatment.

We were told that the SCN provided a monthly care assurance report to managers and that the charge nurses were involved in the audit processes. This has enabled the senior leadership team to identify any specific issues and address any performance management, while highlighting good practice with the ward team. We were satisfied with the measures that were in place to monitor the standard of the documentation of the care records, and we will continue to review progress on our next visit.

Care records

Individuals' care records were held on electronic record system 'MORSE'. We heard from staff last year that there continued to be some issues with the system's capacity, with documentation having to be stored electronically on other areas of the platform. Staff were keen to highlight areas that required improvement in relation to storing significant documents and the need for easy access to ensure communication was not compromised.

We were provided with an update that there had been improvements made and that where staff had highlighted areas for improvement to support them in their role; these continued to be taken forward in the wider system.

In May 2022, the Scottish Government committed £2 million every year to NHS Boards to implement annual health checks for people with learning disabilities across Scotland. Annual health checks have been evidenced to be clinically effective in detecting unmet clinical conditions, and in improving the management of long-term conditions. NHS Boards require to report to Scottish Government on an annual basis with data on implementation and delivery of health checks. We were told that the ward-based nursing staff continued to carry out the annual health checks of all the individuals. We found detailed recordings in relation to physical healthcare monitoring and intervention. The importance of physical healthcare was evident through the assessments, care planning and daily observations.

Multidisciplinary team (MDT)

This ward continued to have comprehensive input from a range of multidisciplinary professionals into people's care and treatment, working effectively in addressing the holistic needs of individuals while managing identified risks.

The MDT meetings took place every week where the various professionals including nursing staff, the consultant psychiatrist, the OT, psychologist, art therapist and pharmacist; all came together to discuss each person's care but could meet more frequently, depending on the stage of the individual's journey.

Each member of the MDT delivered care and treatment specific to their area of expertise and provided weekly feedback to the clinical team, outlining individuals' progress, which we saw recorded in the minute of the meeting. There were detailed assessments available from allied health professionals. This helped individuals to consider their strengths and focus on the areas that required additional skills and support. Each individual met with their consultant psychiatrist regularly and this was reflected in what he heard from individuals.

For people who required additional support from other allied health professionals, we were told that referrals were made to specific services, such as physiotherapy, the dietician or speech and language therapy.

The MDT meeting record provided an update regarding progress from each professional involved, along with individuals views on whether they wished to attend or not. We found that the outcome/action section of the minute was often left blank or had little information recorded, although the actions were often recorded in other sections. We suggest to managers that they record the specific actions following the meeting in the appropriate section.

All people in the ward continued to be managed using the care programme approach (CPA). CPA provides a robust framework for planning and managing mental health care, particularly in relation to the management of risk. We reviewed the minutes of the CPA meeting and found them to be comprehensive. The minute recorded attendees, and we saw 'easy read' documentation that the individuals used to ensure they were fully included in their CPA, which is what we heard from individuals.

For the individuals who had been identified as ready for discharge, we found some minutes that lacked detail as to what progress was being made around this. We were told that mental health officers (MHOs) and the social workers would attend these meetings, but at times came with little information about progress that had been made.

Six individuals in the ward had been identified as ready for discharge and we discussed each individual's progress and plans for discharge. While it was positive to hear of progress for some, we were concerned to hear about the little progress for others. We will continue to follow up on these individuals and request an update in three months from the clinical service manager.

We heard that there had been good links developed with the senior managers in the health and social care partnership (HSCP), and that there was a recognition that a joined-up approach was required to ensure effective and successful discharges for the individuals.

Use of mental health and incapacity legislation

On the day of our visit all individuals were subject to either Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or Criminal Procedure (Scotland) Act 1995 (Criminal Procedure Act) legislation. All documentation relating to the Mental Health Act and CPSA was available in the electronic files.

The individuals we met with during our visit had a good understanding of their detained status and had access to advocacy and legal representation to support and assist them with their rights.

Individuals were also provided with accessible information to support their understanding of legislation and their rights where this was required.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to people who are detained, who are either capable or incapable of consenting to specific treatments. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were all in place and corresponded with the prescribed psychotropic medication.

We wanted to follow up about a recommendation we made last year about the section 47 AWI Act certificates and treatment plans. Where an individual lacks

capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. Section 47 AWI certificates were in place, easy to locate and we were pleased to find were accompanied by treatment plans which had been completed in accordance with the AWI Act code of practice for medical practitioners.

For individuals who were subject to a welfare guardianship order, we found copies of the order in the file, except for one individual, where we could not find the most up to date order that had been granted at the sheriff court. The SCN agreed to request a copy of this order.

There was an information board on the wall of the SCN's office that at a quick glance, provided a very detailed overview of important information about all individuals legal status, treatment authority, risk management, etc. There was no information on this board around AWI Act legal framework, so we suggested to the SCN that this information be added to the board.

Any individual who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in their file.

Rights and restrictions

All individuals in the ward were subject to detention under the Mental Health Act or Criminal Procedure Act. This ward was locked and there was a locked door policy in place that was balanced with the level of risk managed.

Each individual had their own detailed time off the ward plans, where the documentation clearly recorded where individuals required to be supervised in the community and others where there was a mixture of independent time and other time with staff. We saw detailed suspension plans that were approved by Scottish ministers about time off the ward and how this was risk managed. We saw where these plans were being reviewed regularly by the MDT. Ward nursing staff, MHO's and advocacy continued to support people with their rights and we saw where information had been provided to individuals in accessible and pictorial format.

Some individuals we spoke with would have preferred additional time away from the ward and told us that they struggled with the restrictions placed upon them, as is required in a low secure setting.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are detained in hospital. Where an

individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found that all of the authorising paperwork, including reasoned opinions, were in place and stored electronically. However, we found that the small paper file that the ward also kept did not have the most up to date documentation in it with regards to specified person status. We advised the SCN where there were two systems in place, it was imperative that both systems contained up-to-date information. The SCN agreed to carry out an audit as soon as possible to address this matter.

When we are reviewing individual's files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We could see evidence of where individuals had been supported to document their views in relation to the care and treatment they wished to receive. With input from advocacy and nursing staff it was evident that individuals had shared their views, and an advance statement was recorded and filed in their electronic records.

Activity and occupation

People we spoke with, were able to tell us about their activities on and off the ward, and how these activities were important to them. Everyone that we met with had a weekly planner in place.

The ward had dedicated OT input who provided assessment-focused activities. The OT continued to be involved in the functional assessments that were pertinent to individuals' discharge planning and which supported their re-integration back to the community. The OT told us that they were involved in setting goals with individuals and working towards achieving these goals.

There was a breakfast group held in the activities of daily living (ADL) kitchen which enabled people to develop and learn new skills. The OT also carried out other assessments in this kitchen to assess and prepare individual for discharge. The OT was involved in the environmental risk assessment once accommodation had been sourced for an individual, and made recommendations to the HSCP about the suitability of the placement or adaptations that may be required.

We saw that there had been planned events throughout the year and were told that some of these were planned with another ward based on the same site. People told us they really enjoyed the ward staff's commitment to offer these themed activities throughout the year, and we saw pictures of these events displayed on the wall in the ward.

Regular community meetings continued to take place where individuals were provided an opportunity to raise any issues, and we saw that people had raised issues about the garden and activities. We reviewed the minutes of those meetings and saw where individuals took the lead with fundraising events and putting forward ideas.

Where an individual was preparing for discharge and had an identified commissioned provider from the HSCP, we were told that the social care staff would begin to support the individual on activities in the community and that this support would be built on as part of their transition plans for discharge.

We wanted to follow up on the recommendation from last year about a daily programme of activities for people on the ward. We made a recommendation on our visits in 2023 and 2024 for the service to consider appointing an activity co-ordinator. Senior managers told us that the plan was still to recruit an activity co-ordinator and that current budgets along with staffing vacancies were being reviewed in order to progress with this appointment.

We were also told that the provision of activities was an area of focus for not only across this ward, but other services. We gained the sense that staff and the MDT were committed to and valued the importance of therapeutic activities, and we saw detailed recordings of activities in the care records. People spoke positively about their activities, and in particular activities off the ward. We will therefore continue to request an update from senior managers about the appointment of an activity co-ordinator.

The physical environment

Daleview Ward is a purpose-built facility that opened in 2010.

The ward offered a large reception area, with several communal areas and all 10 bedrooms had ensuite facilities. The ward was spacious, bright, well-maintained, and welcoming. The corridor walls displayed information about individual rights and discharge pathways. Individuals had personalised their rooms, had their activity planner displayed and some individuals had their discharge pathway illustrations on their walls and pictorial strategies to help reduce anxiety, stress, and distress.

The dining room benefitted from bespoke furniture, and the ward had utilised some rooms that offered quieter space for individuals. There were ample rooms for individuals to meet with professionals, whether this was for one-to one sessions with the psychologist or meeting their MHO. There was a therapeutic kitchen where the OT worked with individual as per their care plans. There was an activity room where we saw individuals participating in various activities.

We saw that a fence had been erected in one of the gardens, to offer privacy, however, were told that not long after it was built, due to the storms, the fence fell down. We were pleased to see that this had been fixed. The ward also had another accessible large garden that was also available for people to use that had space for sports, socialising, seating, and offered privacy.

Service response to recommendations

No recommendations have been made. We would however like information about how the service has shared the visit report with the individuals in the service, their relatives/carers and with the staff who work in the service. We will follow this up with them.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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