Mental Welfare Commission for Scotland

Report on announced visit to:
Mid Argyll Community Hospital, Succoth Ward, Barbuie Road, Lochgilphead, PA31 8JZ

Date of visit: 25 November 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

Succoth Ward is a 16-bedded, adult acute admission ward in Mid Argyll Community Hospital. The ward covers the geographical areas of Mid Argyll, Kintyre and Islay, Oban, Lorn and Isles, and Cowal and Bute. Each area has their own consultant psychiatrist.

On the day of our visit, there were 12 people on the ward, and one person was being transferred to a specialist in-patient resource on that day.

We last visited this service in November 2024 on an unannounced basis and made recommendations on improving access to clinical psychology, the auditing of consent to treatment paperwork and enhancing activity provision. We received an action plan from the service addressing each recommendation and we wanted to follow up on progress, as well as exploring current issues.

Who we met with

We met with seven people, five who we reviewed the care records of, as well as two further sets of care records. We also met with one relative.

We spoke with the clinical service manager, the senior staff nurse on duty and one of the consultant psychiatrists. We met with the manager and the chairperson of the advocacy service and an advocacy worker.

Commission visitors

Audrey Graham, social work officer

Mary Hattie, nursing officer

Graham Morgan, engagement and participation officer

What people told us and what we found

It was important to us to hear the views of people receiving care and treatment in the ward. Themes that we identified through our discussions were of a sense of a warm and caring staff group. One person told us, “here is a warm, open place; the staff are approachable”. Another told us, “every time I pass a member of staff, they make eye contact and ask how I’m doing”. A family member told us, “communication is good, I get meaningful updates” and “staff are so nice, they’re genuinely interested”.

It seemed that overall, people felt able to have discussions with staff and to share their views and concerns. While at times, there was disagreement, there was a sense that this was respectful, “we butt heads sometimes…but staff are good”. Individuals reported having relatively regular one to one time with nursing staff.

There was some concern raised about inadequate time spent with medical staff; “having a 15-minute interview with the doctor once a week is not enough”. We heard that decisions around changes in care plans could be slowed due to medical staff only being in the ward one day a week.

Advocacy staff told us of themes that were raised with them when they provided support to individuals in the ward, including a lack of fresh fruit and vegetables in the meals provided, limited staff to accompany people out of the ward and a lack of regular, meaningful activity, including limited access to the gym. They also advised that the tribunal suite, set up for hearings to take place when individuals were subject to the Mental Health (Care and Treatment) (Scotland) Act, 2003, was poorly maintained. We were told that in-person hearings rarely occurred, including when this was the individual’s preference. We will raise these issues directly with senior managers in the health board and the Mental Health Tribunal Service.

Care, treatment, support, and participation

Care records

Care records were held in paper form and were straightforward to navigate. The care plans we reviewed were of a good standard and were person-centred. Needs and goals were set out clearly, with relevant interventions identified to meet goals.

Care plans could have been enhanced by focusing more on exploring the individual’s strengths and by taking a more holistic approach to include consideration of aspects of care and treatment such as meaningful therapeutic activity, relationships, educational, cultural, and spiritual needs.

Mental health care plans were of a good standard but would have further benefitted from being informed by psychological formulation. We heard about a continuing gap with the psychology provision for the ward. It was good to see regular reviews of care plans. While it was confirmed that there was a system in place for the audit of

care plans. Adherence to this had been challenging due to vacancies in the ward management team.

Care plans included reference to risk assessments that had been completed and we found that the risk assessment and management tool used was fully completed in the records we reviewed. We saw that risk assessments were regularly updated and it was noted that in most cases, the individual had contributed to the assessment.

It was good to see evidence of one-to-one sessions being recorded through the care records, which regularly included exploration of the individuals' views on their care and treatment.

We heard from staff that there were no clear pathways to access specialist beds for individuals requiring rehabilitation, intensive psychiatric care, learning disability or older age specialist care. Referrals were made to services outside of Argyll and Bute but still within NHS Highland and these were treated as if they were out of area referrals, making negotiations more complex.

We were made aware of an individual who was transferring that day to a specialist bed but who was having to be transported by two members of nursing staff from the local crisis team due to challenges in negotiating transport with the ambulance service. We asked on the day that managers escalate this to senior management in the ambulance service because of the potential impact this had for the delivery of services provided by the crisis team.

Recommendation 1:
Senior managers should ensure that clear pathways are put in place to enable straightforward access to specialist beds in areas including intensive psychiatric care, learning disability, rehabilitation and older age across NHS Highland.

We heard that there were significant issues in terms of accessing support for staff in the ward if there was an incident that involved violent or aggressive behaviour. While accident and emergency (A&E) staff in the hospital were able to assist with any emergency relating to physical health, they did not have the training to support any violent incidents. Ward staff were dependent on calling the police in if they needed extra support. While we were not informed about any recent challenging incidents, we did think that a more supportive and robust procedure was needed.

Recommendation 2:
Managers should look at options in addition to calling the police, to provide ward staff with supportive and robust assistance to deal with incidents of violent and aggressive behaviour. This should be detailed in a clear procedure.

Multidisciplinary team (MDT)
The multidisciplinary team providing care and treatment in the ward was made up of nursing, occupational therapy (OT), psychiatry and pharmacy. There was a significant gap in terms of leadership in the nursing team, with the senior charge nurse having recently left and only 1.8 of the 4.8 senior staff nurse posts for the ward filled. We were satisfied that managers were doing what they could to recruit to these posts.

The senior staff nurse posts had been vacant for a considerable period and challenges with recruitment and the rural setting were noted. The impact on capacity to support and supervise newly qualified staff and to orientate and support staff recruited from overseas was discussed. It was noted that international recruitment had made a positive impact. We thought that managers were aware of the importance of providing adequate support to staff and were being pro-active in their efforts to address the gap.

Professionals met weekly to review individuals' progress in terms of recovery. It was good to see from the records we reviewed and to hear that individuals and family/carers were involved in the MDT meetings, by attending or meeting with key staff before, or afterwards. The record of the meetings was of a high standard, providing a clear account of individuals' progress, actions required and who had responsibility for actions.

We heard that decision-making about changes to care plans could be delayed until the next scheduled MDT meeting, due to medical staff only being available on that day. We thought that medical staff should look at building in increased flexibility for consultation with ward staff to ensure care plans were dynamic, progressing at a rate commensurate with the individuals' progress.

Recommendation 3:
Medical staff should ensure that they are available for consultation with nursing staff at times in addition to the MDT review, to ensure individual care plans are dynamic and appropriate to progress and change in individual needs.

Other allied health professionals (AHPs) were accessed on a referral basis. We saw evidence of input to individuals' care and treatment from a range of professionals including dietetics, speech and language therapy, physiotherapy, podiatry and dentistry. We heard that demands on staff in terms of providing physical health care had increased, including the provision of palliative care. We were told that input from Macmillan nurses had recently been helpful.

We heard about the benefits of co-location in the hospital building with the mental health social work team, including mental health officers (MHOs) and the benefits this brought for more effective joint working.

Individuals were positive about input from the OT service, particularly around therapeutic activities on offer. We heard that there was a full complement of OT staff for the ward, who also provided the community-based services. We saw a comfortable, pleasant and well-equipped OT activity room.

It was good to hear that an OT assisted with delivery of a cognitive behavioural therapy (CBT) group, along with a specialist CBT nurse. This is the main source of psychological therapy provided to the ward. We heard that clinical psychology input was available on a referral basis and that this focussed on formulation, given that a key objective for the ward was on improving safety and stabilisation of individuals.

We thought that the provision of increased input from clinical psychology could also help with further development of a trauma-informed approach in the ward, would enhance the mental health care plans and risk assessments and support supervision and training for staff.

Recommendation 4:
Managers should consider how provision of increased clinical psychology input could be provided for the ward.

Use of mental health and incapacity legislation

On the day of the visit, three out of 12 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). Ward staff initially advised us that two people were detained, however we met with a third individual who was subject to a compulsory treatment order with community-based powers, but who had been admitted on an informal basis.

The individual was unsure of their legal status and there was a lack of clarity from ward staff on the person's legal status and whether Part 16 relating to treatment under the Act was applicable. We advised that Part 16 was applicable and that the individual would require a new T3 certificate to authorise treatment. The individual told us that they wished to go home and that they were being told that they could not. We requested that an urgent review of their mental health and legal status take place and managers agreed to progress this.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments. There were two certificates authorising treatment under the Mental Health Act (T3) in place. One corresponded exactly with the medication being prescribed and one required to be updated to reflect that a particular medication was being given regularly and not on an as-required basis. These issues were discussed with medical staff on the day of the visit.

It was good to note that all Mental Health Act paperwork was available and accessible in the care records.

There was one individual who ward staff advised had a power of attorney (POA) in place in terms of the Adults with Incapacity (Scotland) Act, 2000. The individual retained decision making capacity and we were unsure if there was understanding with the staff group that the POA was therefore not active. We discussed this with managers on the day.

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. There was no one who had been identified as requiring a s47 certificate on the day of the visit.

Rights and restrictions

The ward operated a locked door policy, which was commensurate with the level of risk identified with the patient group. The individuals we met with, who were being treated on an informal basis, did not raise any particular concern about this and overall seemed to understand the reasons for it. It appeared on the day of the visit that staff were able to be responsive when individuals wished to come and go from the ward.

Advocacy were active in the ward, and their contact details were on display on the notice board. They gave us feedback on themes coming through from individuals they were supporting, and these were fed back to managers on the day. Advocacy staff advised that funding to their organisation had been reduced, and they were only able to focus mainly on supporting individuals who were detained in hospital.

There was no one on the day of our visit who required continuous interventions due to distressed behaviours or because of the acuity of their illness.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. There were no individuals who were subject to specified persons restrictions on the day of our visit.

When we are reviewing individuals' files, we look 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 did not find any advance statements within the records reviewed.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

The lack of provision of meaningful recreational and therapeutic activity has been an issue noted by the Commission on previous visits and this remained an issue. While a few of the individuals we spoke to did refer to experiencing boredom, there was several references to working with the OT and the activities they offer.

It was good to hear that money had been identified for a dedicated activity co-ordinator to be employed for 20 hrs per week. There had been some issues with recruitment, and this process was continuing. We look forward to seeing the difference that this will make when we next visit.

It was also good to hear from managers and individuals that the hospital chaplain had been very active in organising outdoor activities, including working with small groups in one of the garden areas.

The physical environment

The layout of the ward consists of two small dormitories accommodating three people each, with the rest being single rooms with ensuites. There are shared sitting and dining areas, activity spaces and two smaller rooms where individuals can have time with family or meet with visiting professionals.

We noted that there was no curtain in place in one of the dormitory bedspaces to give the individual the option of some level of privacy. The charge nurse advised us that a new one had been requested but that it could take considerable time to progress repairs due to the building being owned by a private company under the PFI scheme. The managers we met with further advised us that they are charged excessively under the PFI arrangement for straightforward repairs or redecoration. It was not known when this arrangement was due to end.

All of the rooms were accessed from one long corridor. A theme coming through in discussions with both staff and individuals was that the layout of the ward did not encourage people to use the communal areas. Individuals largely chose to stay in their rooms. The ward was originally two separate wards and so was not designed with its current purpose in mind. This underlined the importance of efforts being

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

made to recruit to the activities co-ordinator role, so that this resource could focus on bringing people together, encouraging peer support and countering self-isolation.

There are two garden areas, one of which is secure and enclosed by a high fence, the other is larger and open to the hospital grounds with a low fence and hedge. The larger open garden is more pleasant but access to this was limited depending on staffing and the assessment of risk. The smaller secure garden was somewhat overgrown. We thought that the high metal fence made it an unpleasant space. Ready access to outside green space and fresh air is essential for mental well-being.

Recommendation 5:
Managers should identify resources to enhance the small secure garden to ensure access for all to a pleasant outdoor green space.

Summary of recommendations

Recommendation 1:
Managers should ensure clear pathways are put in place to enable straightforward access to specialist beds in areas including intensive psychiatric care, learning disability, rehabilitation and older age across NHS Highland.

Recommendation 2:
Managers should look at options in addition to calling the police, to provide ward staff with supportive and robust assistance to deal with incidents of violent and aggressive behaviour. This should be detailed in a clear procedure.

Recommendation 3:
Medical staff should ensure that they are available for consultation with nursing staff at times in addition to the MDT review, to ensure individual care plans are dynamic and appropriate to progress and change in individual needs.

Recommendation 4:
Managers should consider how provision of increased clinical psychology input could be provided for the ward.

Recommendation 5:
Managers should identify resources to enhance the small secure garden to ensure access for all to a pleasant outdoor green space.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

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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