mental welfare commission for scotland

Recommendations and outcomes from our local visits 1 April 2023 to 31 March 2024

August 2024

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

Contents

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 subject to powers 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 undertake local visits to meet with people in particular services or facilities to learn about their experience of care and treatment. We undertake these local visits for various reasons; some facilities, for example secure units, are more restrictive on individuals' freedom and therefore, we visit them more often.

For the year 2023 to 2024, there were still times when visits had to be cancelled or re-arranged due to the ongoing impact of the Covid-19 pandemic, although the majority of our visits took place as planned.

We increased not only the number of visits in the year, but also where we visited. We visited all of the island communities, finding that services varied significantly between the Western Isles, Orkney and Shetland. We extended our visit programme to include community teams, visiting community mental health (CMHTs) services and community learning disability teams (CLDTs) across Scotland.

A percentage of our visits are unannounced and this year we achieved 28% (against a target of 25%); some of these unannounced visits were to more rural adult acute inpatient services, where we wanted to see how care was provided in the early evening, and first thing in the morning.

We have continued to publish our findings from each individual visit on our website. We also promote the publication of these via Twitter/X, where we note the forthcoming visit reports that are about to be published one week prior to being posted on Twitter/X, and on the week of publication, provide a brief quote about the key findings of all the visits that are published.

The recommendations we make after we have visited reflect on established good practice and also include the observations we make on the day of the visit, gathered by the professional expertise and judgement of our Commission visitors and, most importantly, what people, and often their families and carers, have told us.

We share information with key scrutiny bodies, such as Healthcare Improvement Scotland (HIS) and the Care Inspectorate (CI). This enables the agencies that we directly share the outcomes of our visiting programme with to consider and respond to intelligence about health and social care systems across Scotland. This joint sharing of information with key scrutiny partners helps us to decide where we should prioritise our visits and also in the coordination of visits; this aims to reduce the likelihood of the Commission and organisation such as HIS attending the same service at the same time.

In addition to our website publications, copies of our local visit reports are sent to HIS for NHS services and independent hospitals and to the CI for visits to care homes. Copies of our visit reports to prisons are sent to HIS and His 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 based on their remits as regulators.

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.

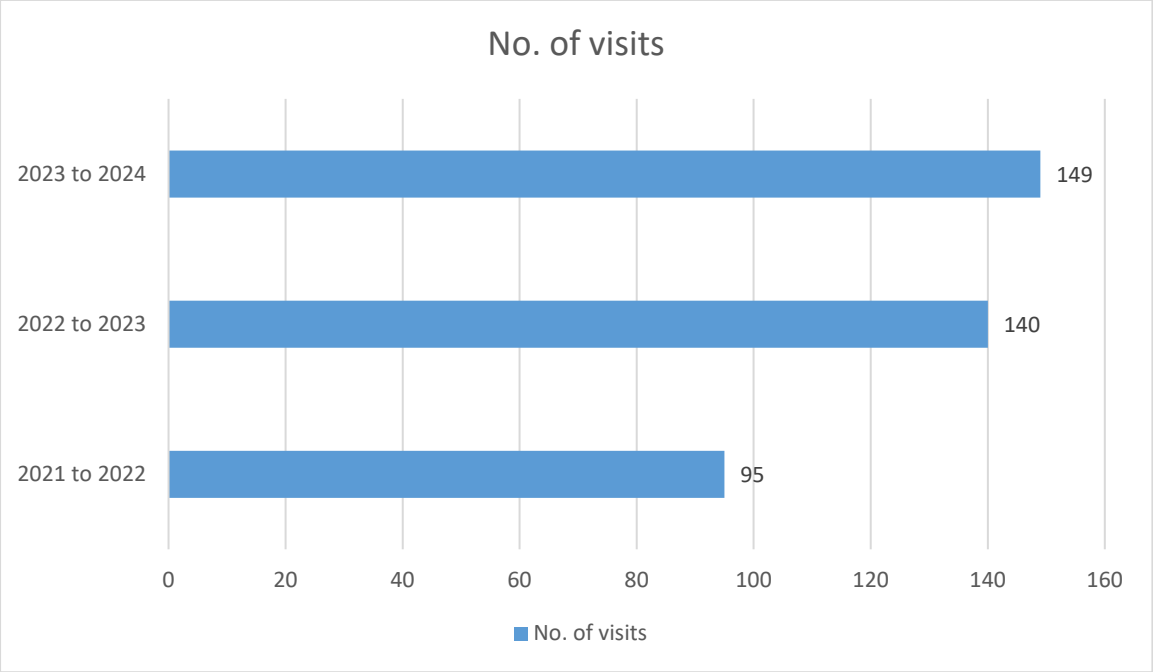
Services we visit are:

- Adult acute admission wards visited annually.
- Intensive Psychiatric Care Units (IPCUs) visited annually
- Child and adolescent mental health (CAMHS) inpatient wards visited annually
- Other specialties e.g. perinatal inpatient, eating disorder units, every two years
- Older adult and Dementia assessment wards visited annually
- Older adult and Dementia continuing care wards every two years
- Learning Disability (LD) assessment wards annually
- 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 visited annually
- Low secure hospital, not less than every 18 months
- Prisons every two to three years

We will also visit independent hospitals and care homes and will advise HIS and the CI respectively of our intention to do so and to consult with them in advance, to share intelligence.

Between 1 April 2023 and 31 March 2024 we carried out **149** local visits, an increase of nine on the previous year; we made **448** recommendations, a decrease since our visits in 2022 to 2023.

Year on year, we have increased the number and types of services we visit.



3. About our recommendations

When we make recommendations, we provide the senior managers 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.

To support the delivery and implementation of our recommendations, we provide managers with guidance about what they need to include in their response to us. The Commission now provides a suggested standard SMART action plan template for this.

We ask services to provide feedback as to how they have shared the findings and recommendation(s) that are detailed in the visit report. From March 2024, the ward/unit/service has been asked to provide additional information relating to this. Responses are now beginning to be collated, with an example from one of the services in Greater, Glasgow and Clyde:

"The MWC report was discussed at several community meetings with copies made available for patients to read.

Copies of the report are available for patients to read, a notice is displayed advising patients of the availability of the report and to ask staff for a copy.

Copies of the report are displayed and available in the ward airlock for relatives/carers.

The MWC report has been emailed to all staff and a copy has been displayed in the staff room for staff to read" (DT, 5/6/24)

We will be able to report on this more fully in this report for 2024 to 2025.

Once we receive the SMART action plan, we assesses the quality of the response; if we need any further information we will ask for this. Prior to any future visits to the service, we will check to ensure that the previous recommendations were implemented as planned.

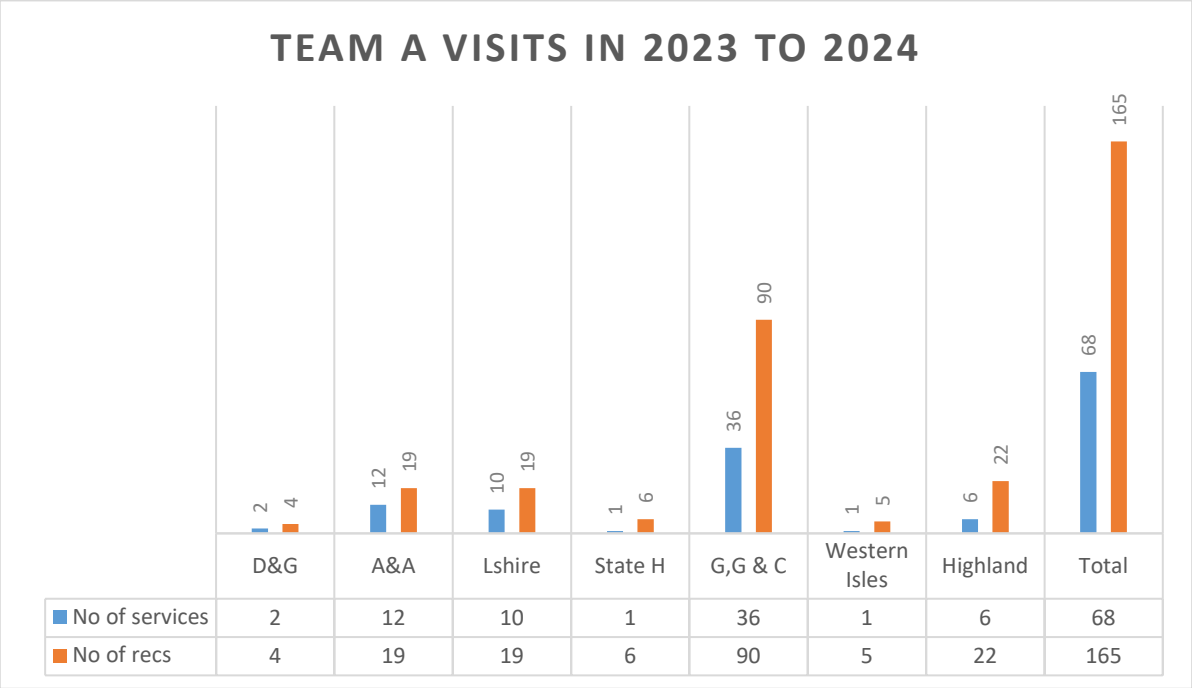
We expect a satisfactory response to at least 95% of the recommendations we make within the stated three-month period. Of the recommendations we made in 2023-24, 96% of the responses we received were satisfactory and returned in the three-month timescale. For those out with the timescale, all services were either in contact with the Commission to advise us of the reason for delay or were followed up by the Commission officer covering the particular service.

Scrutiny of the responses to the recommendations 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.

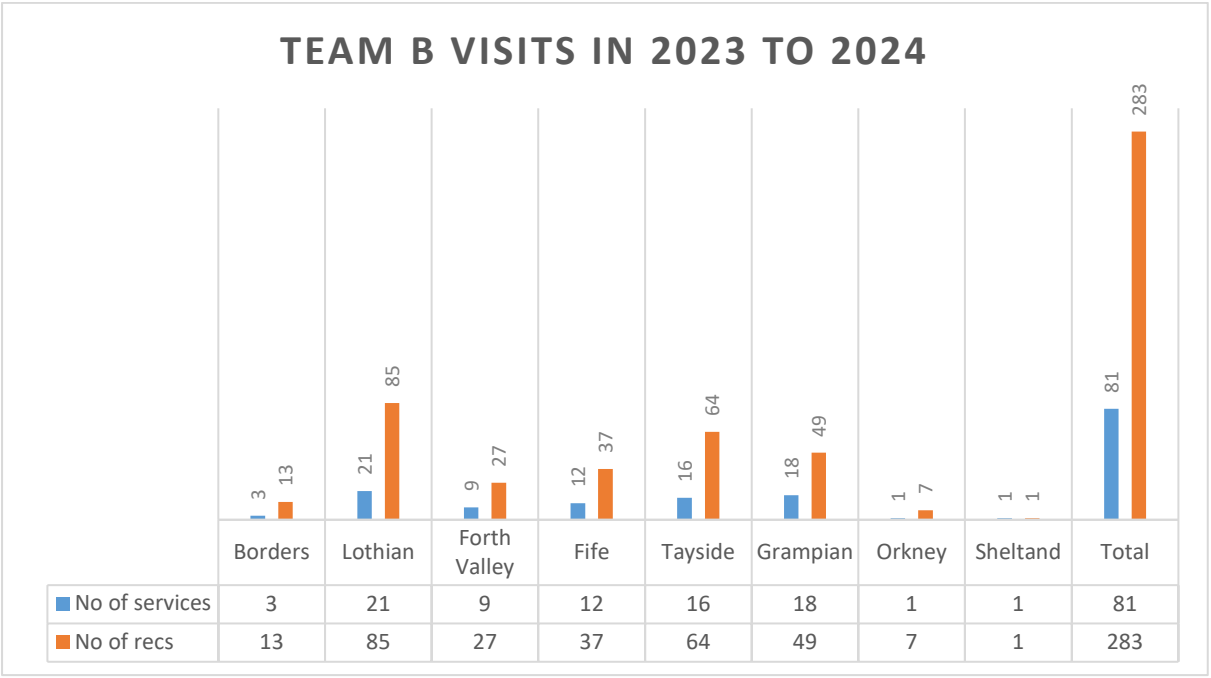
4. Where we visited

Our visits are organised and undertaken by two Commission teams. Team A visits services on the west side of the country, from Highland to Dumfries and Galloway. Team A comprises of nursing, social work and medical officers/Consultant Psychiatrist; Team B visits the services on the east, again, there is a multiprofessional team of nurses, social workers and doctors visiting services from Shetland to the Scottish Borders. Visits can also include our engagement and participation officers, either from a carer or lived experience background.

Chart 1 & 2: Team A and B visits



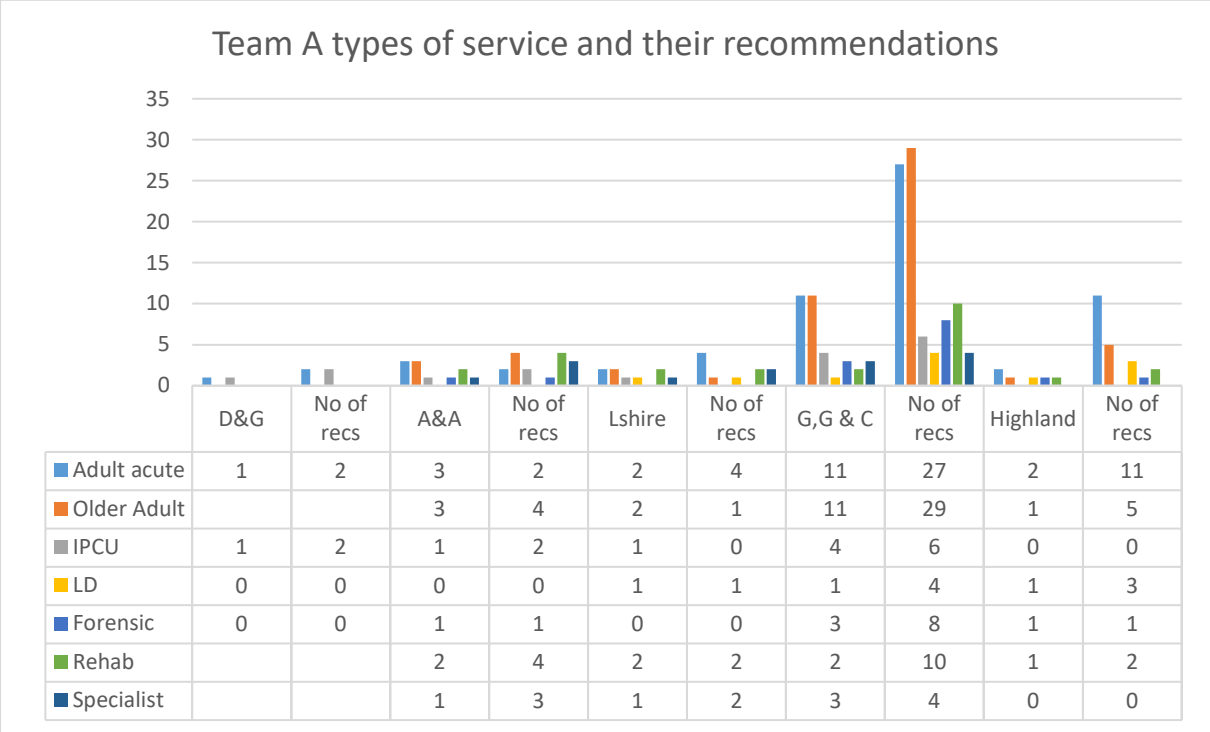
	D&G	A&A	Lshire	State H	G,G & C	Western Isles	Highland	Total
No of services	2	12	10	1	36	1	6	68
No of recs	4	19	19	6	90	5	22	165



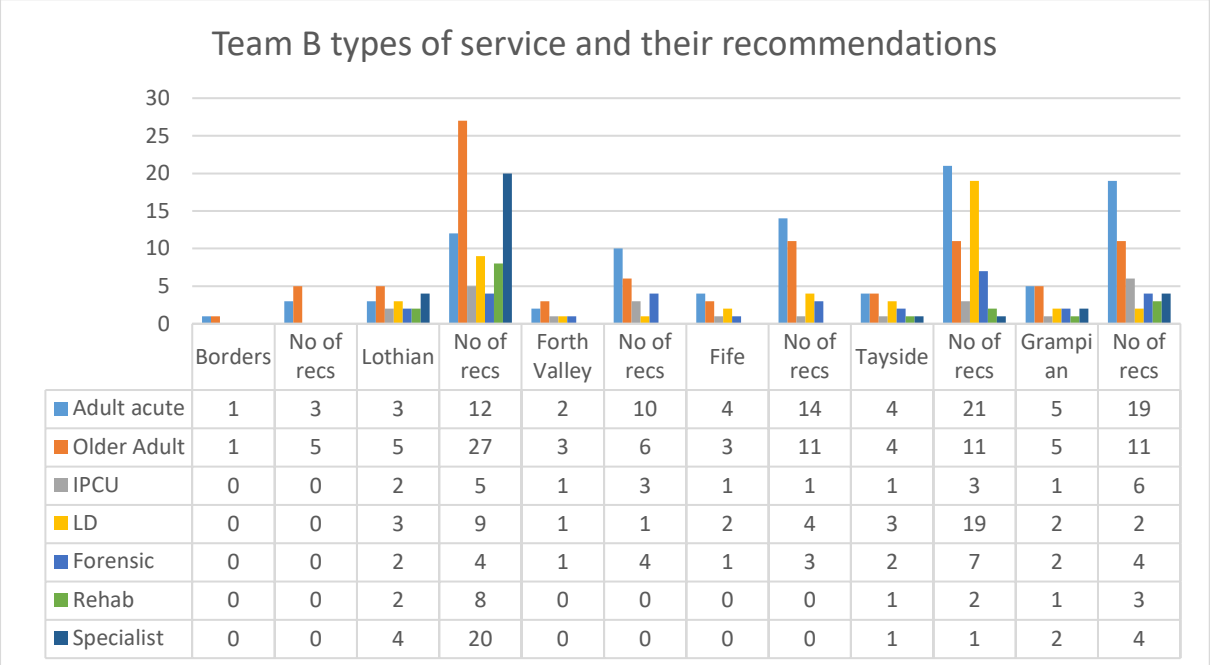
	Borders	Lothian	Forth Valley	Fife	Tayside	Grampian	Orkney	Sheltand	Total
No of services	3	21	9	12	16	18	1	1	81
No of recs	13	85	27	37	64	49	7	1	283

Not all of the areas we visit have the same range of inpatient service. While all of the mainland areas have adult acute admission services and older adult wards, some health board areas have wards for those with needs associated with a learning disability, or for individuals who require either dedicated rehabilitation or forensic care. Across the country there are a number of specialist units for children and young people, for those who have an acquired brain injury, for individuals who require specialist care for an eating disorder and there are a small number of units for those who have complex care needs.

Chart 3 & 4: Team A and B range of services



	D&G	No of recs	A&A	No of recs	Lshire	No of recs	G,G & C	No of recs	Highland	No of recs
Adult acute	1	2	3	2	2	4	11	27	2	11
Older Adult			3	4	2	1	11	29	1	5
IPCU	1	2	1	2	1	0	4	6	0	0
LD	0	0	0	0	1	1	1	4	1	3
Forensic	0	0	1	1	0	0	3	8	1	1
Rehab			2	4	2	2	2	10	1	2
Specialist			1	3	1	2	3	4	0	0



	Borders	No of recs	Lothian	No of recs	Forth Valley	No of recs	Fife	No of recs	Tayside	No of recs	Grampian	No of recs
Adult acute	1	3	3	12	2	10	4	14	4	21	5	19
Older Adult	1	5	5	27	3	6	3	11	4	11	5	11
IPCU	0	0	2	5	1	3	1	1	1	3	1	6
LD	0	0	3	9	1	1	2	4	3	19	2	2
Forensic	0	0	2	4	1	4	1	3	2	7	2	4
Rehab	0	0	2	8	0	0	0	0	1	2	1	3
Specialist	0	0	4	20	0	0	0	0	1	1	2	4

5. Recommendation category

The theme/category below reflect the key areas the Commission focuses on when we visit. Our reports always focus firstly on what we have heard from the individuals who are receiving care and treatment in the service on the day of our visit, including wherever possible the views of families and carers. Following on from this, our discussions with staff working in the service, our review of records and our assessment of the environment helps to provide a better understanding of the quality of care and treatment being provided. When recommendations are made, it is intended that these will lead to improvement.

The categories we use for our local visits include care, treatment, support and participation, use of mental health and incapacity legislation, rights and restrictions, activity and occupation and the physical environment.

The Commission staff have to shape their recommendations in a way that reflects their findings. For example, a recommendation on care plans could include the need for them to be more person-centred, or for the evaluation of the care plan to reflect changes in care and treatment, or both. Similarly, this could be the same for recommendations about the multidisciplinary team, in that the record of the meeting could have more detail about those in attendance, or that the discussion at the multidisciplinary team meeting should reflect the care plan goals.

Below, the condensed recommendations provide an overview of all of the recommendations we have published in our local visit reports (LVRs) throughout 2023 to 2024. It also provides a comparison to those we made in the previous year.

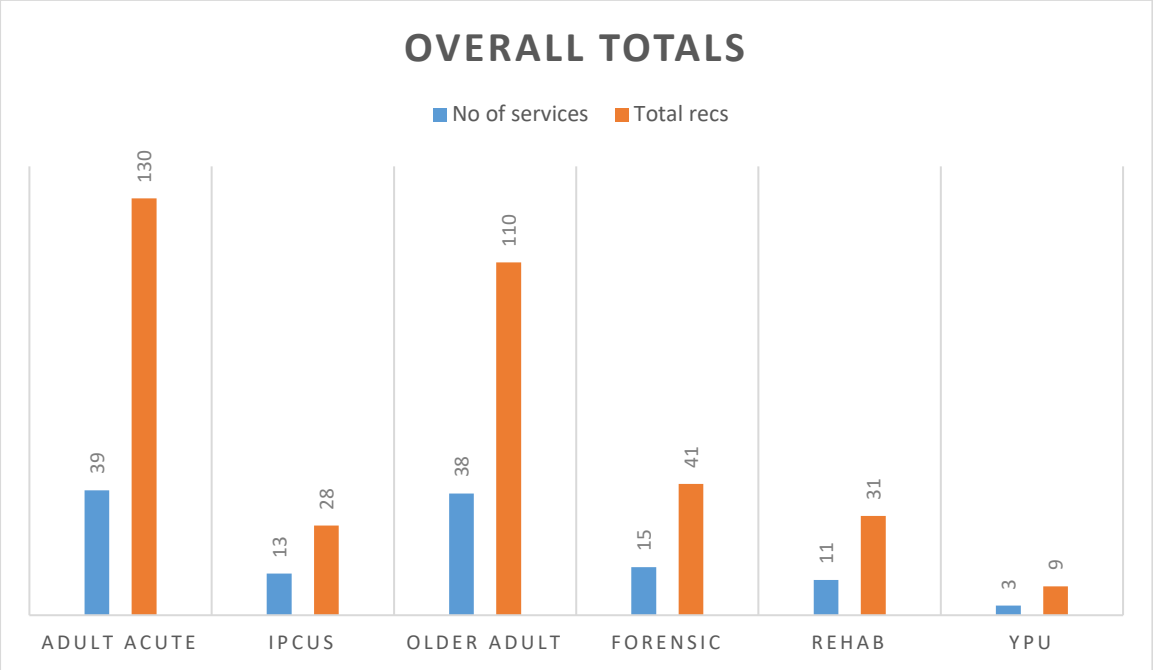
Table 1: Number and percentages of recommendations by category/theme

Recommendation category/theme	(n/%) in 2022-2023	(n/%) in 2023-2024
Care plans, multidisciplinary team (MDT) notes, documentation	152/30%	125/28%
MH Act/ AWI Act/ legislation	107/21%	103/23%
Accommodation/ environment/ facilities	81/16%	53/12%
Activities	36/7%	38/9%
Communication with patient, families, carers	29/6%	14/3%
Staffing concerns	11/2%	17/4%
Medication/access to treatment	19/4%	4/1%
Advocacy	6/1%	1/0.2%
Recommendations relating to people and their rights	21/4%	18/4%
Risk related issues	4/1%	25/6%

Table 1 highlights some of the changes we have found in this visiting year, compared to the last one. There were positive improvements, specifically in relation to the environments and facilities of some of the services that we visited. There were more frequent recommendations made about staffing concerns, not only the number of nursing staff available to support individuals, but also to a full multiprofessional team including psychiatry, psychology and occupational therapy. Recommendations increased this year in relation to issues around the assessment and management of risk documentation, the legal authority when restrictions were placed on people in relation to their environment, their safety and security, access to their mobile phones and in having the freedom to leave the ward environment.

This year, there were seven services that had no recommendations relating to a visit, two less than in 2022-23. The types of services where no recommendations needed to be made varied; there was one rehabilitation, one forensic, an adult acute admission, an intensive psychiatric unit and three older adult wards.

For those services where recommendations were made, these ranged from one to 10 recommendations. On average, the number of recommendations made to most services was three.



6. The main focus of recommendation themes across the different service types

6.1: Adult acute assessment wards (n = 39) - total of 130 recommendations

Focus of recommendations made	Number of recommendations
Care plans/MDT/audit	22
Use of MHA/AWI and associated legislation	18
Accommodation	9
Activities	7

6.2: Older Adult wards (n = 38) – total of 110 recommendations

Focus of recommendations made	Number of recommendations
Care plans/MDT/audit	26
Use of MHA/AWI and associated legislation	21
Accommodation	11
Activities	8

6.3 Forensic services (n=15) – total of 41 recommendations

Focus of recommendations made	Number of recommendations
Care plans/MDT/audit	10
Use of MHA/AWI and associated legislation	8
Accommodation	6
Activities	5

6.4 Learning Disability wards (n= 14) – total of 43 recommendations

Focus of recommendations made	Number of recommendations
Care plans/MDT/audit	13
Use of MHA/AWI and associated legislation	10
Accommodation	4
Activities	6

7. Some examples of our recommendations and outcomes

<table>
<tr><th>Examples of our recommendations and outcomes</th><th>The service response</th></tr>
<tr><td>Managers should ensure named persons and relatives have the opportunity to contribute their views to the MDT and this should be recorded in the clinical notes.

*Recommendation made to a forensic service</td><td>Short-Term: Initial meeting with senior clinicians to discuss current systems and processes in place for patient, relative and carer contributions to weekly Clinical Team meetings.

Medium-Term: Associate Director of Nursing and Associate Medical Director to consider ways to increase patient, named persons/relatives at weekly meetings. This work will be taken forward by members of the CMOG.

Medium/Longer Term: Development of a carer's strategy which will explore what meaningful engagement opportunities for relatives/carers/named person.</td></tr>
<tr><td colspan="2">The Commission has recently published a good practice guide on carers, consent and confidentiality; it also includes a link to named persons. By involving family members wherever possible means it is less likely that important information will be missed and helps families to maintain a supportive relationship with the individual.

The guide can be found at:

Carers, consent, and confidentiality (mwcscot.org.uk)</td></tr>
<tr><td>Managers should ensure that Specified Person status has in place the required paperwork. This should be competently completed at the time thus affording the patient their legal rights. Paperwork should be sent to the MWC timeously.

*Recommendation made to an adult acute ward</td><td>Self evaluation: Registered Medical Officer (RMO) is required to record the reasoned opinion detailing the rationale for why specified status is required and what measures/restrictions are being put in place in the patients notes after informing the patient.

They then notify the medical records department who process the required paperwork and inform the MWC.

There is no current formal process for when this is revoked apart from the recording process in patients' notes and informing the patient.</td></tr>
</table>

	Activity: Requirement for the RMO to notify medical records as soon as the decision is reached to allow the process to be followed. Need to improve the communication process between RMO and medical records – Mental Health Medical records will develop a flow chart to support the process, this along with the MWC guidance will be added to the agenda for the consultants meeting and ask the interim medical director to share. **Audit:** Medical records will keep a log of the timeliness in which they are notified for specified persons over the next 3 months. **Timescale:** Flow chart by end of May – Then circulate early June
The MWC guidance on specified persons can be found at: specified_persons_guidance_2015.pdf (mwcscot.org.uk)	
Managers must ensure there is a structured, scheduled, meaningful activity programme available to patients that is person-centred, offering a variety of activities specific to individual care needs and reflecting patients' preferences. Activity participation should be recorded and evaluated in the individual care, **Recommendation made to an IPCU*	**Action planned**: QI Huddle weekly commenced – aim for 100% of patients in Ward 1 to be offered therapeutic activity by ward staff, on the early or late shift every day by mid March 24. This will be audited by evidence through nursing notes. Nursing staff – Offer a community meeting 3 times per week where patients are asked to suggest activity. Minuted and documented in nursing notes. There is not a timetable for this as is identified in real time. Provision of therapeutic material – Patients have provided a shopping/wish list of what should be available on the ward for therapeutic activity. Ward also to keep endowment money to spend weekly on activity. **Timescale:** Baseline data collected; huddle started week beginning 29 Jan 24.
All our local visit reports can be found at www.mwcscot.org.uk	

Concluding Remarks

During 2023-24, we visited more services than previously and included visits to community mental health and learning disability services. We are grateful to all the people who spoke with us during our visits.

We found commitment to improvement where indicated and heard about genuine and respectful engagement in person centred care planning in the context of significant demand and pressure on resources. We look forward to continuing to work in partnership to visit, monitor and promote the rights of people with mental illness, learning disabilities, dementia and related conditions across Scotland.