mental welfare commission for scotland

Recommendations and outcomes from our local visits 1 April 2024 to 31 March 2025

August 2025

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 (Care and Treatment) (Scotland) Act, 2003 and the Adults with Incapacity (Scotland) Act, 2000 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 2024 to 2025, while most of our visits continued to be to NHS inpatient units, we have broadened our visits to community-based services, which included both adult and older adult community mental health teams. In this visit year, we also included registered community care settings and although the focus was on our guardianship visits, we used recommendations to effect improvement and change where required.

We visited all of the island communities, finding that services varied significantly between the Western, Orkney and the Shetland islands.

A percentage of our visits are unannounced; this year we achieved 23% (against a target of 25%).

We have continued to publish our findings from each individual visit on our website. We have used social media platforms such as "X" and BlueSky to highlight forthcoming visit reports that are about to be published one week prior to them being posted.

The Commission can make recommendations after we have visited a service. These reflect 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 organisations 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 registered community care settings. 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 or inspectors.

2. Where we visit

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 B visits the services on the east side, from the Shetland Islands to the Scottish Borders. There is a multiprofessional team of mental health nurses, social workers (mental health officers) and psychiatrists who undertake each of the visits.

Visits can also include our engagement and participation officers, either from a carer or lived experience background.

Table 1 below sets out a comparison of the number of visits to the different health boards that we completed in the visit years 2023 to 2024 and 2024 to 2025, along with the total number of recommendations.

Area visited	Number of local visit reports - 2023 to 2024	No of recs	Number of local visit reports- 2024 to 2025	No of recs
NHS Ayrshire & Arran	12	19	6+	12
NHS Borders	3	13	3	12
NHS Dumfries & Galloway	2	4	4	8
NHS Western Isles	1	5	*	*
NHS Fife	12	37	10	33
NHS Forth Valley	9	27	11	36
NHS Grampian	18	49	12+	49
NHS Greater Glasgow & Clyde	36	90	34	120
NHS Highland	6	22	6	20
NHS Lanarkshire	10	19	5	18
NHS Lothian	21	85	21+	85
Orkney Islands	1	7	1	4
Shetland Islands	1	1	1	4
NHS Tayside	16	64	14	76
State Hospital	2	6	2	8
HM Prisons	8	32	6	24

+ non-NHS services for guardianship visits;
* visit took place in April 2025

3. How often we visit

The frequency of Commission 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) annually
- 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 2024 and 31 March 2025 from our local visit reports, we made a total of **509** recommendations. This is an increase of 11.6% and increasingly, some recommendations are being repeated from our previous visit due to a lack of progress.

It should be noted that a local visit report may include a visit to more than one service in a particular health board, and this can vary on a year-by-year basis. Examples of this for our visit year in 2024 to 2025 would be our visit to Woodland View Hospital in NHS Ayrshire and Arran, with a visit to all three admission services. Similarly, we visited all four adult acute wards in NHS Grampian over two days and Rowanbank Clinic in NHS Greater Glasgow and Clyde, where all eight wards were visited on the same day but only one report is produced.

4. 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.

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.

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 further visits, announced or unannounced or consider an extended visit.

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 2024-25, 54% of the responses we received were satisfactory and returned to us within the three-month timescale. For those action plans that we received after three months, 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 to enquire about the progress of the action plan.

We did achieve a 100% response rate for all local visit reports that required a completed action plan and we follow up every recommendation that has been made at our next scheduled visit to the service.

We now routinely ask services to provide feedback as to how they have shared the findings and recommendation(s) that are detailed in the visit report. Since March 2024, the ward/unit/service has been asked to provide additional information relating to this. Feedback is now collated and in response to the reports that were sent out, 35 (25%) services provided feedback. We look forward to these responses growing.

One of the most comprehensive examples that we received from a service in NHS Grampian was:

“"Upon receiving the MWC visit report, an initial meeting was held with the senior charge nurse, nurse manager and service manager to review the findings and recommendations. The report was then shared with the wider staff team through a dedicated staff meeting, where we discussed the key points, recommendations, and actions to be implemented.

To ensure transparency with families, patients, and carers, the report was shared in the following ways:

- *Summary of report and SMART action plan will be shared with patients at next residents meeting 30/11/24, copies to be provided on request*
- *The report will be shared with family upon request*
- *The report will be displayed on the patient and visitors notice board.*

The report and related actions were also reviewed during our monthly clinical governance meeting with the senior leadership team to ensure accountability and alignment with organisational standards. This structured approach allowed us to integrate feedback from all stakeholders into our action plan, reinforcing a commitment to continuous improvement and quality care."

We have shared the final visit report with patients during our community meetings, patients were happy to discuss the report during the meeting and declined having a paper copy when asked. Patients were happy with the findings from the report and no disputes were raised. Family/Carers were given a paper copy who were happy to take this home to read.

Staff were sent an email copy and this was discussed during staff meetings and line management supervision. This was also shared with all senior charge nurses on site during our monthly senior charge nurse meeting."

Chart 1 below provides an overview of the way that services told us they were sharing the Commission's report of their service

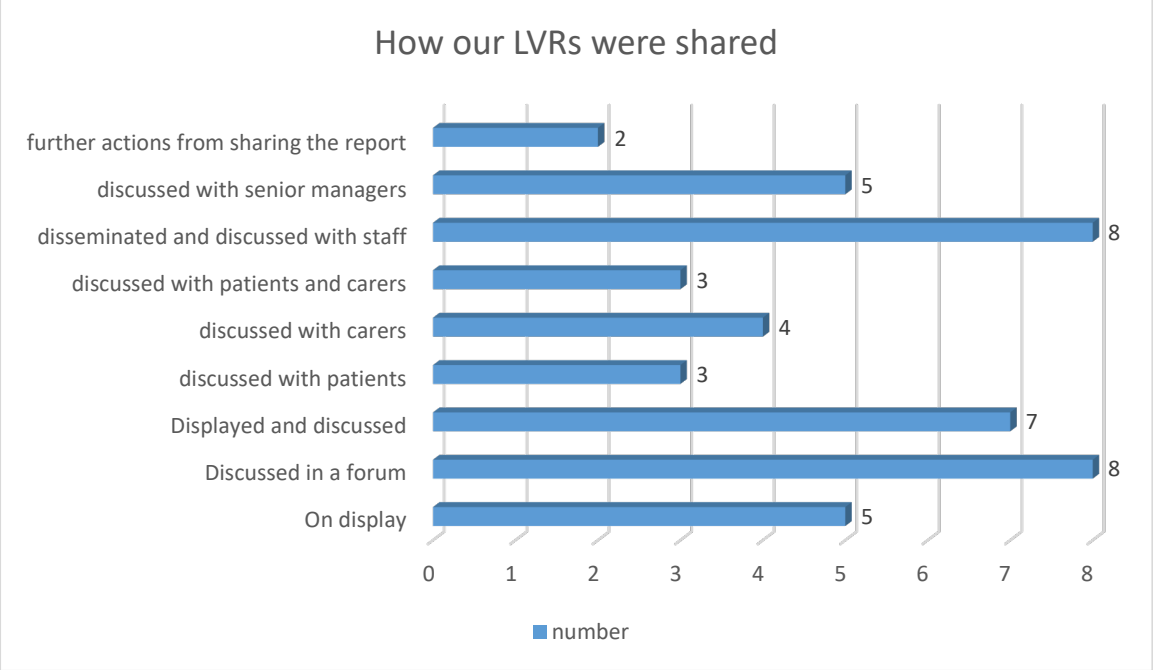

Chart 1

5. Recommendation categories

The theme/categories 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 and how this compares to our good practice guidance.

When recommendations are made, it is intended that these will lead to improvement.

The six categories we use for our local visits include:

- care, treatment, support and participation,
- the multidisciplinary team (MDT)
- use of mental health and incapacity legislation,
- rights and restrictions,
- activity and occupation,
- 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.

Chart 2 below provides an overview of categories of recommendations for each of these areas as set out in our local visit reports (LVRs) throughout 2024 to 2025.

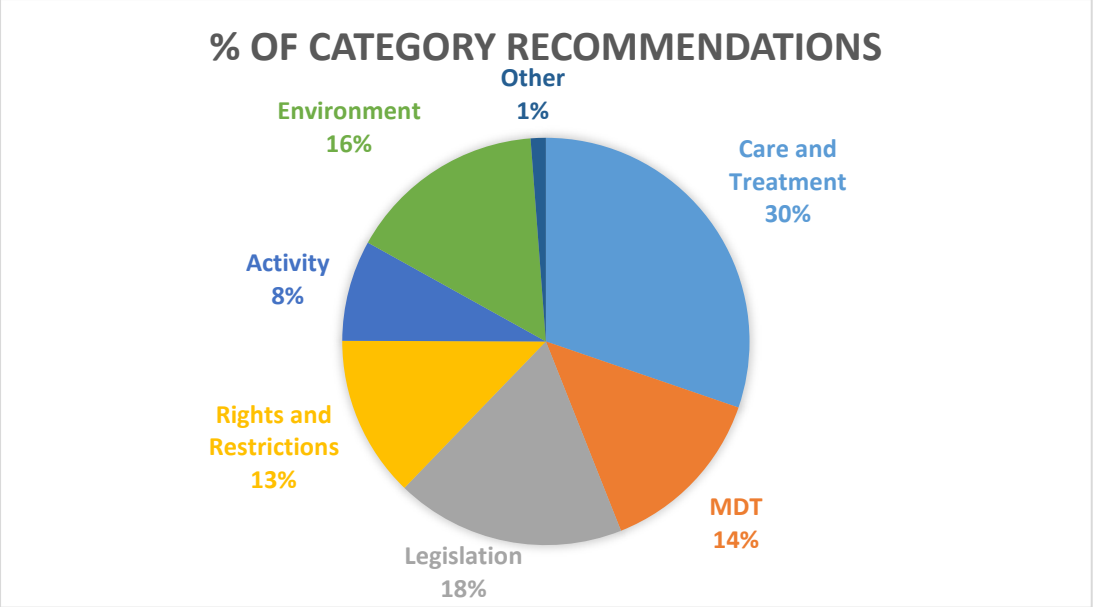

Chart 2

This year, there were 10 services where no recommendations had been made following on from our visit; in 2023 to 2024, there were only seven services with no recommendations. The types of services varied and included:

- one slow-stream rehabilitation service,
- one low secure forensic unit,
- an acute assessment ward,
- two intensive psychiatric care units and
- three older adult wards.

Both of the mother and baby units, one in the west and one in the east of Scotland had no recommendations made.

For those services where recommendations were made, these ranged from one to 13 recommendations. On average, the number of recommendations made to most services was between three and four.

6. Recommendations across the different services

With the six main categories for our local visit reports (on a few occasions there have been 'other' recommendations that do not easily fit with the main ones), chart 3 below provides a visual reference on the number for each category across all of the areas that we visit.

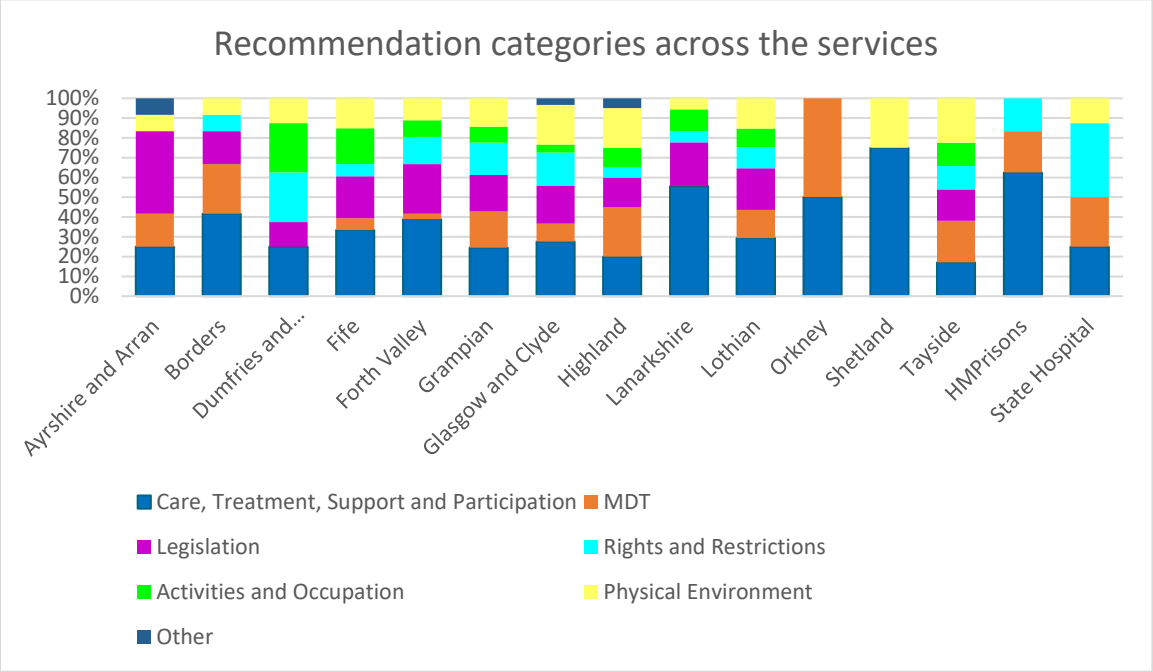

Chart 3

As noted in Chart 2, if we consider that the average number of recommendations are as follows:

- 30% of recommendations are in relation to care, treatment, support and participation,
- 14% about MDTs,
- 18% with concerns about the use of legislation,
- 13% to make improvement with rights and restrictions,
- 8% in relation to better activity and occupation and
- 16% on the actual physical environment,

There are a number of health board area that, proportionately, depending on the number of services we have visited, have a higher number of recommendations in these categories. Where this is the case, we have highlighted this in amber on the table below.

Service	No. of visit reports	Total no of recs	Care, Treatment, Support and Participation (30%)	MDT (14%)	Legislation (18%)	Rights and Restrictions (13%)	Activity and Occupation (8%)	Physical environment (16%)	Other
Ayrshire & Arran	6	12	3	2	5	0	0	1	0
Borders	3	12	5	3	2	1	0	1	0
Dumfries &Galloway	4	8	2	0	1	2	2	1	0
Fife	10	33	11	2	7	2	6	5	0
Forth Valley	11	36	14	1	9	5	3	4	0
Grampian	12	49	12	9	9	8	4	7	0
Glasgow & Clyde	34	120	33	11	23	20	5	24	4
Highland	6	20	4	5	3	1	2	4	1
Lanarkshire	5	18	10	0	4	1	2	1	0
Lothian	21	85	25	12	18	9	8	13	0
Orkney	1	4	2	2	0	0	0	0	0
Shetland	1	4	3	0	0	0	0	1	0
Tayside	14	76	13	16	12	9	9	17	0
HMPrisons	7	24	15	5	0	4	0	0	0
State Hospital	2	8	2	2	0	3	0	1	0

Table 2

6.1. Some examples of our recommendations and detailed actions proposed by the service

Examples of our recommendations and outcomes	The service response
Managers should ensure all staff who document in individual's care records are provided with guidance to ensure all documentation is appropriate and professional Recommendation under Care, Treatment, Support and Participation to an NHS Fife service	Record keeping is an essential aspect of health care delivery and as such, is explicit within the Nursing & Midwifery Council (NMC) Code of Conduct, section 10 (2018) and within the Code of Conduct for Healthcare Support Workers 2009 (section 4, sub section 4.1.6). NMC record keeping guidelines to be adhered to and copies and access to relevant policies for record keeping are available in main ward area in particular nursing station, main office, student learning room for staff to review and they can access these online with details outlined at these points. We have issued and held staff short sessions regarding overall documentation to ensure it is appropriate and professional utilising all guidelines available as above. These will continue moving forward and nominated 'champions' being allocated from the team. Following the visit an email sent to all trained staff with attached NMC guidance on record keeping with a view to reflect on and improve documentation and a reflective piece has been requested for their own CPD. A request has been sent to Practice and Development about a structured learning activity for the whole service in

	relation to ensuring professional and appropriate language in all official communications and documentation. Documentation audit has always been maintained however recognised that this is a priority even more so during high acuity as this can result in shorter or potential inaccurate documentation being submitted. Staff documentation audit was already undertaken monthly with results reported.
In addition to the guidance developed by the Commission on person centred care plans (link below) the Commission has produced a webinar on care plans PersonCentredCarePlans_GoodPracticeGuide_August2019.pdf https://youtu.be/RjPu0Yisa4Q	
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 under Rights and Restrictions to an NHS Greater Glasgow and Clyde service	We have identified that nursing staff have gaps in their knowledge, specifically in relation to specified persons processes and documentation. Medical staff have recognised that there are some inconsistencies in how reasoned opinions are recorded. We have not had robust monitoring or assurance processes in place for specified persons We have developed a nursing checklist for specified persons that will support nurses to ensure that all correct paperwork is in place. This includes both legal documentation and nursing care plans/risk assessments. Medical staff and medical records have developed a form for recording the reasoned opinion that should ensure consistency and accurate recording.

	This will be taken to the consultant group for approval. We have updated the weekly nursing team lead audit to include a check that the specified checklist has been completed. This will enable monitoring and provide assurance to the SCN. We have re-circulated the current MWC guidance on specified persons with the nursing team.
The MWC guidance on specified persons has been updated to include a reasoned opinion now to help clinical staff: Specified persons good practice guide	
Senior managers must ensure there is a programme of work, with identified timescales, to address the environmental issues and outstanding repair and refurbishment work. Recommendation under the physical environment to an NHS Grampian service	We are engaged with NHSG Estates and Maintenance to progress backlog maintenance. Longer term improvement to be included in Phase 3 of Forensic Improvement Works. Backlog maintenance and calls logged with estates, followed up by ward/service including areas identified for painting, resealing within bathrooms and vent cleaning. Replacement flooring is being costed. Phase 1 commenced May 2025 in Forensic Acute, Phase 2 to follow later in 2025 scheduled to take 52 weeks to complete. Phase 3 scope and planning for completion of Business Case to NHSG Asset Management Group for approval will commence shortly. If approved likely work would be planned within financial year 2026-2027.
Scottish Government has developed a specific tool for the rollout of the Mental Health Built Environment (mHBE) Assessment across NHS Scotland.	

7. Key findings

This report has seen an increase in the number of recommendations made by the Commission, across the six categories, reflective of the organisation's statutory responsibilities under both Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity (Scotland) Act 2000.

Over the last few years, there has been little change or improvement in the percentage of some of the recommendation categories. Since 2022, approximately 30% of the recommendations we have made related to care and treatment, specifically around care planning. There has also been minimal improvement with recommendations relating to activities and the physical environment. What has been positive to note is that there has been a year-on-year reduction in the overall percentage of our recommendations relating to the use of the legislation, which is at its lowest this year at 18%; last year's recommendations for this category were 23%.

Consequently, more of the recommendations in these (and other) categories - care, treatment, support and participation, legislation, rights and restrictions and the physical environment - are being repeated year after year. We will be increasing our follow up where recommendations have been repeated despite actions in place to effect change.

The Commission acknowledges and accepts that there are a number of challenges that can impact on actions being progressed. However, as recognised by the Scottish Mental Health Law Review, should the Commission have more specific powers to address a lack of progress, then the rights-based care that individuals, their families and carers deserve to have from services could be achieved more readily.

All of our local visit reports can be found at www.mwcscot.org.uk

8. Charts and Tables