Mental Welfare Commission for Scotland

Report on unannounced visit to:
The Priory, Coll and Tiree Wards, 38-20 Mansionhouse Road, Glasgow, G41 3DW

Date of visit: 4 June 2026

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

The Priory Hospital, Glasgow is a 35-bedded independent psychiatric hospital that provides care and treatment for individuals with eating disorders and mental health or addiction needs. The service comprises of three wards, Coll, Barra and Tiree. At the time of our visit, Barra Ward was temporarily closed.

Coll and Barra wards provide a specialist eating disorder service. Historically, this service has received a high number of referrals from the National Health Service (NHS), predominantly from NHS England. On the day of our visit, we were informed that there had been a significant reduction in referrals, which had resulted in the temporary closure of Barra Ward. Senior managers advised that this position remains under review and that the Commission will be kept informed.

At the time of our previous visit, Coll Ward had 14 beds, plus one separate bedroom located in Tiree Ward. We were advised that the separate bedroom room may be used as a 'step-down' facility in the future, to support individuals in preparing to move on from the eating disorder service. On the day of our visit, Coll Ward was fully occupied, with 15 individuals admitted.

Tiree Ward provides care for individuals with mental health or addiction needs, with placements funded on a private basis. Since our last visit, the number of beds on Tiree Ward has increased from nine to 12. On the day of this visit, 11 individuals were admitted, with one vacant bed. We were advised that the additional bedrooms had previously been used as recreational spaces. Tiree Ward does not accept admissions for individuals with severe mental illness, such as those experiencing psychosis. Staff advised that should an individual become severely unwell, care and treatment will continue to be provided until the individual is transferred to an appropriate NHS acute mental health facility, including where the use of the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) is required.

We last visited this service in October 2023 on an announced basis and made recommendations in relation to person-centred care planning, communication with individuals on Tiree Ward about their rights, and the progression of remedial work to improve accessibility for people with mobility needs or physical disabilities. In response, the service advised that person-centred care planning guidance and auditing processes had been implemented, written rights information was now provided to that individuals on Tiree Ward and an accessible wet room had been installed to meet the needs of individuals with mobility issues or physical disabilities.

Since our last visit, we have made several enquiries to the service and provided advice in relation to legal safeguards for individuals subject to pass or discharge arrangements and who reside in England, as well as communication with family members and unpaid carers.

During this visit, we followed up on the issues above and those recommendations from the previous visit to understand how the changes implemented by the service had impacted on individuals' experiences of care and treatment.

Who we met with

We met with and reviewed the care of 11 people. We did not meet with any relatives during this visit but left our details for people to call us, although we did not hear from any relatives after the visit.

We spoke with the director of clinical services, the therapy service manager, the senior charge nurses (SCNs), the medical director, staff nurses and a consultant psychiatrist.

Commission visitors

Gemma Maguire, social work officer

Kathleen Liddell, social work officer

Lesley Paterson, senior manager for practitioners (East and West team)

Alison Thomson, nursing officer

Justin McNicholl, social work officer

Graham Morgan, engagement and participation officer

What people told us and what we found

Everyone we met during our visit spoke positively about staff and the care they were receiving. Individuals in the eating disorder service told us that admission to Coll Ward, had given them “hope” and, in some cases, had helped to “save” their lives.

Some individuals who had experience of other mental health or eating disorder services across the United Kingdom (UK) told us that Coll Ward provided the “best” treatment.

Individuals we met on Tiree Ward described staff as “irreplaceable” and “amazing”. We were also pleased to hear that the service was supporting individuals who had children to maintain regular and consistent contact with them, both in and out with the hospital.

We heard that people valued the strong recovery focus and access to a wide range of therapeutic interventions across Coll and Tiree Wards. This feedback was consistent with our previous visits to the service.

Since our last visit, the Commission has received information via our advice line, where concerns were raised about communication with families and unpaid carers, including named persons. We made enquiries with the service and provided advice, including sharing our guidance on carers, consent and confidentiality.

As this visit was unannounced, no family members were available to speak with us, however individuals told us they were satisfied with how the service communicates with their loved ones. We also heard that the family and unpaid carer support group has developed since our last visit and now meets monthly to provide information, support and an opportunity to gather feedback. Care records evidenced engagement and communication with families and unpaid carers.

The Commission recognises that, for some individuals who were admitted informally, remaining on the ward as part of recommended treatment may be appropriate and lawful, provided they understand their rights and can give fully informed consent. On our last visit, some individuals in Tiree Ward believed they were not permitted to leave the hospital when asked to remain on hospital grounds as part of a ‘pass plan’. We recommended that the service ensure individuals admitted informally understood their rights and provided consent to their care and treatment, including pass plans.

During this visit, we were pleased to find that individuals we met with in Tiree and Coll Wards understood their rights, whether they were admitted informally or detained under the Mental Health Act. Admission information packs contained clear and up-to-date information about rights. Care records demonstrated that consent to pass plans had been obtained where appropriate and this clearly documented the individuals’ rights, including access to advocacy, named persons, advance

statements and legal representation. Information on rights, including advocacy and advance statements, was also displayed throughout the hospital.

Some individuals subject to the Mental Health Act and who were receiving care and treatment on Coll Ward had transferred from other UK jurisdictions. Where discharge planning was progressing for these individuals, we found that appropriate legal safeguards, in line with the Commission's cross-border guidance, was being considered.

We heard that the temporary closure of Barra Ward resulted in the loss of approximately seven whole-time equivalent registered nurse posts. This included voluntary redundancies, with some staff redeployed to Tiree Ward and others leaving the service. We also heard that nursing salaries in the eating disorder service were significantly lower than those in an NHS equivalent type service.

Staff, managers and individuals described the impact of these changes as unsettling, with concerns about the potential loss of experienced staff to better-paid roles elsewhere.

Individuals described their relationships with staff as 'invaluable' and the knowledge and skills of staff in Coll Ward as 'exemplary'. Throughout the visit, we observed staff to be compassionate, warm and kind. The relational approach to care at the Priory Hospital, Glasgow was evident in the support provided to individuals to ensure they felt safe and engaged with their treatment.

The Commission recognises that changes to staffing can adversely affect the quality and consistency of care. While the standard of care that we observed was high, we strongly encourage Priory managers to take steps to support and retain staff. These issues were discussed with the director for clinical services and the ward manager, who advised that pay scales were under review. We were also informed that a business case would be developed to increase registered nurse posts should Barra Ward reopen. The service has agreed to keep the Commission informed of developments.

Care, treatment, support, and participation

Care Records

All care records were held electronically and were accessible. Care plans were structured across four key areas: keeping healthy, keeping connected, keeping safe and keeping well.

In Coll Ward, several care plans were person-centred, with the views of individuals and, where appropriate, their families recorded, however identified needs tended to focus primarily on medical interventions and physical health monitoring associated with eating disorders. Wider therapeutic, psychological and recovery-focused interventions were not consistently reflected in the care plans, despite evidence elsewhere in the care records that these formed part of care and treatment.

From discussions with staff and individuals in Coll Ward, there was evidence that care plan reviews were being undertaken. However, documentation of these reviews was often repetitive and contained limited detail regarding the progress that individuals were making in their recovery.

Risk documentation was in place in all the care records that we reviewed on the day of our visit. Risk assessments included helpful chronologies detailing historical risks, however it was more difficult to identify current risks.

In Coll Ward, information on how individuals should be supported to manage risk was not always clear, and in some cases, details of the management of risks was missing.

In contrast, care plans in Tiree Ward were consistently person-centred, appropriately reviewed, and clearly recorded the views of individuals. Identified needs were broader in scope, reflecting a more comprehensive and individualised approach to care, including therapeutic and recovery-focused interventions.

We discussed our findings regarding care plans in Coll Ward with the service on the day of our visit. We were advised that training and auditing in relation to person-centred care planning was being rolled out to support and improve practice. We look forward to reviewing the progress with this.

The Commission has published a good practice guide on care plans[1]. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia, or learning disability.

Recommendation 1:
Managers responsible for Coll Ward should ensure that care plans are person-centred, address all identified needs, including therapeutic and recovery-focused interventions, and clearly evidence regular review and progress towards agreed recovery goals. Compliance should be monitored through a programme of quality assurance and audit.

Recommendation 2:
Managers responsible for Coll Ward should ensure that all identified risks are clearly documented and supported by up-to-date risk management plans that describe how risks are to be monitored, managed and reviewed. Systems of oversight should be implemented to ensure consistency and quality of risk recording.

Multidisciplinary team (MDT)
Tiree and Coll Wards continue to hold weekly multidisciplinary team (MDT) meetings, with case conference meetings taking place every four weeks. Individuals meet with their named nurse twice weekly and with the consultant psychiatrist on a weekly basis.

[1] *Person-centred care plans good practice guide*: https://www.mwcscot.org.uk/node/1203

The MDT comprises of three consultant psychiatrists, a resident hospital doctor who undertakes physical health reviews, blood tests, day-to-day reviews and prescribing, and professionals from psychology, occupational therapy, dietetics and pharmacy.

The views of individuals, families, unpaid carers, and other agencies, including social work and Mental Health Officers, were also available.

We reviewed records from both MDT meetings and case conferences. Case conference records provided more detailed information on individuals' recovery, including clear discussions, the views of attendees, and agreed actions. While MDT meetings involved individuals and a range of professionals, the recorded notes often lacked detail on how decisions and actions were reached.

We fed this back to the service on the day of our visit and were advised that work is underway to improve MDT formulation and the quality of meeting records. We look forward to seeing progress in this area of practice when we next visit the service.

Use of mental health and incapacity legislation

On the day of the visit, 11 people were detained under the Mental Health Act. All individuals detained under the Mental Health Act were aware of their rights. Several individuals were receiving independent legal advice and accessing advocacy services.

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. Consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act were in place; we noted one discrepancy and raised this with the service on the day and were assured that the service would rectify the discrepancy.

Any person who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found documentation to be accessible and the named person had been appropriately consulted.

No one that we met with or reviewed the care records for had experienced any issues in relation to their capacity with either welfare or financial decision making and there was no one who was subject to the Adults with Incapacity (Scotland) Act, 2000.

Rights and restrictions

Some individuals we met with on Coll Ward raised concerns about access to en-suite bathrooms in their bedrooms, which were used to support those who require higher levels of observations.

Where an individual occupying these rooms was assessed as being at significant risk, the bathroom could be locked when not in use as part of risk management

measures. We heard that the ward only had one key to open these bathrooms and individuals experienced delays in accessing their toilet and shower if the staff member who had the key was dealing with other incidents on the ward.

We also heard that on one occasion, the key was misplaced by a staff member. In line with ward policy, this resulted in searches of individuals' rooms and a delay of several days while the lock was replaced.

We discussed this with the service during our visit. The ward manager explained that maintaining a single key is intended to reduce the risk of multiple keys being lost. They also advised that, on the occasion, when the key was misplaced, individuals were able to access alternative bathroom facilities elsewhere in the hospital.

Recommendation 3:
Managers responsible for Coll Ward should review and revise arrangements governing access to en-suite bathroom facilities and the management of associated keys to ensure that individuals have safe, timely and dignified access to toileting and showering facilities at all times.

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 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. At the time of our visit, no individuals were subject to specified person provisions under the Mental Health Act.

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, should they become unwell in the future. Health boards have a responsibility for promoting advance statements. We were pleased to find that where an individual had an advance statement in place, this was clearly highlighted in their care records.

We also found that meaningful discussions were taking place with individuals about the benefits in completing a statement or reviewing the current documents. We found that one individual's advance statement had not been uploaded to the system. This was fed back to the service on the day of our visit, and we were advised this would be rectified.

One individual we met shared concerns about being treated differently from others by some staff members. They believed this was related to their sexuality and differing cultural and religious views. On reviewing care records, we noted that the individual had raised concerns with members of the multidisciplinary team, however it was not clear what action or investigation had been taken by the service in response to the person's concerns. We discussed this with the ward manager on the

day of our visit, who was not aware of any such incidents but agreed to speak with the individual to clarify their concerns and to investigate further. The Commission will continue to follow up on this matter.

The Commission is aware that the Priory has a service-wide policy on 'banned and restricted' items, which includes restrictions on the use of smartphones to protect individuals' privacy. We were advised that individuals may use and keep their mobile phones in their own bedrooms but are asked not to use them in communal areas, such as the dining room.

On our previous visit, individuals we spoke with did not raise any concerns about this policy. During this visit, some individuals on Coll Ward advised us that they had an understanding of the mobile phone restrictions during mealtimes and how they were part of the agreed care and treatment. We were also informed that phone use was restricted after mealtimes although the reasons for this were not clear to individuals.

We discussed this with the ward manager on the day of our visit. We were advised that any restriction on phone use after mealtimes should be based on individual risk assessment. It was also stated that, where an individual did not consent, their phone should not be removed unless this was supported by an individual risk assessment and authorised under the Mental Health Act.

We advised the service to ensure that this information was clearly communicated to individuals and appropriately recorded in care records.

Recommendation 4:
Managers responsible for Coll Ward should ensure that any restrictions on telephone use, implemented as part of an individual's risk management plan, are clearly communicated to the individual concerned. Appropriate consent, or the legal authority and safeguards underpinning such restrictions, should be clearly documented within the person's care record.

During our previous two visits to the service, we found that individuals had access to advocacy services although this was mainly provided on a remote basis. During this visit, we were pleased to see that, following input from a local Glasgow-based advocacy provider, the Advocacy Project, in person meetings were now taking place. Some individuals we spoke with felt that advocacy services had been less visible recently, although they knew how to contact the service if required.

The Commission has developed *Rights in Mind.*[2] 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.

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

Activity and occupation

Individuals on Coll Ward told us they enjoyed a range of leisure activities supported by an activity coordinator.

Both one-to-one and group-based activities are available seven days a week, including trips to the local cinema and coffee shops.

Individuals on Tiree Ward were also regularly accessing the local community, including local support groups. We were pleased to see that access to psychological and recreational therapies continued to be provided across the service.

The physical environment

The Commission has previously recommended that the service ensure Tiree Ward was accessible to individuals with mobility issues or physical disabilities. We are pleased to report that an accessible wet room has now been installed, addressing this issue.

Some individuals on Tiree Ward reported concerns regarding laundry arrangements, in particular that bed sheets were not always changed regularly.

Individuals on Coll Ward raised concerns about the availability and quality of some food and drink items, including the provision of oat milk. People told us that these issues are raised both at ward community meetings and directly with staff. We shared this feedback with the service on the day of our visit and were advised that these matters would be explored further with individuals.

At our previous visit, we noted the tired appearance of both Tiree and Coll Wards, including chipped furniture and stained carpets. We found that these issues persisted, with some carpets requiring repair due to wear and tear.

We were informed that managers have escalated these concerns through Priory's internal processes, however limited resources have been made available to address them.

Recommendation 5:

Senior managers responsible for environmental matters in Priory should develop and implement a time-bound improvement plan to address the identified environmental concerns within Coll and Tiree Wards, including the repair and replacement of worn fixtures, furnishings and décor, to ensure that the physical environment supports individuals' comfort, dignity and recovery.

Summary of recommendations

Recommendation 1:
Managers responsible for Coll Ward should ensure that care plans are person-centred, address all identified needs, including therapeutic and recovery-focused interventions, and clearly evidence regular review and progress towards agreed recovery goals. Compliance should be monitored through a programme of quality assurance and audit.

Recommendation 2:
Managers responsible for Coll Ward should ensure that all identified risks are clearly documented and supported by up-to-date risk management plans that describe how risks are to be monitored, managed and reviewed. Systems of oversight should be implemented to ensure consistency and quality of risk recording.

Recommendation 3:
Managers responsible for Coll Ward should review and revise arrangements governing access to en-suite bathroom facilities and the management of associated keys to ensure that individuals have safe, timely and dignified access to toileting and showering facilities at all times.

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Recommendation 5:
Senior managers responsible for environmental matters within Priory should develop and implement a time-bound improvement plan to address the identified environmental concerns within Coll and Tiree Wards, including the repair and replacement of worn fixtures, furnishings and décor, to ensure that the physical environment supports individuals' comfort, dignity and recovery.

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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