

Mental Welfare Commission for Scotland

Report on announced visit to:

Surehaven, 3 Drumchapel Place, Glasgow, G15 6BN

Date of visit: 5 August 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

Surehaven is a low secure, independent, psychiatric hospital located in Drumchapel, on the outskirts of Glasgow. The hospital is managed by the Shaw Healthcare group, and Surehaven is their only Scottish-based hospital; the company headquarters are in Cardiff.

The hospital has 21 inpatient beds across two wards. Campsie Ward accommodates six females, and Kelvin Ward accommodates 15 males. While the layout of the hospital, and facilities that were in use were largely unchanged since our previous visit in January 2025, a new extension has recently been completed which will add another 12 male beds to Munro Ward.

The service reported that they were waiting on final building control approvals from Glasgow City Council to allow Munro Ward to open. On the day of our visit, there were no vacant beds, and we heard that there were nine patients who had been identified for transfer to Surehaven once the new ward opens.

Low secure forensic wards generally have a higher ratio of staff and a locked door. It would be expected that staff working in this setting have specific skills and experience in caring for acutely ill and often distressed patients.

Our last visit to the service was unannounced and we made recommendations related to record keeping, the need to ensure that section 47 certificates were completed in line with the Adults with Incapacity (Scotland) Act, 2000 (the AWI Act) and staff training to support this, and the training and application of specified persons procedures.

Who we met with

We met with, and reviewed the care of six individuals, who we met with in person and who we reviewed the care notes of. There were no relatives who requested to meet with us during this visit.

We spoke with the service manager, senior charge nurse, the clinical nurse lead, the occupational therapist and the consultant psychiatrist.

Commission visitors

Mark Richards, nursing officer

Karen Beattie, nursing officer

What people told us and what we found

During our meetings with individuals, we discussed a range of topics that included contact with staff, participation in their care and treatment, activities that were available to them in the unit and in the local community, and their views of the care environment.

We also looked at the plans that were in place for individuals who had been in the hospital for several years and what was in place that would help support them to prepare for discharge.

Individuals told us that they had good relations with staff. Not everyone we spoke with was happy about the pace of their rehabilitation, nor their placement in Surehaven but they were able to share their understanding of the different factors which influenced this, such as restrictions associated with their legal status.

People that we met with spoke positively about access to activities and the role of staff in facilitating these. We heard feedback such as “the staff are good and work hard to help us get out of the unit” and “I feel I have lots to do”. There were several positive comments offered from individuals who felt that they had a helpful relationship with their named nurse and that they were able to meet with them regularly. We also heard comments that “my doctor is very good, and I get to see him regularly”.

Individuals who had specific dietary needs could explain in detail the work they had been doing with staff such as the Speech and Language Therapist to minimise choking risk. All the individuals we met with commented positively about the range of activities they were involved in.

We wanted to hear the views of those who met with us about their care and rehabilitation journey. We were informed individuals were routinely invited, and welcomed into the multidisciplinary team (MDT) meeting and where their views were actively sought. We saw good evidence of participation through the MDT meeting notes, including pre-meeting planning and post-meeting discussion/feedback.

We heard from individuals how they were regularly supported to maintain contact with their family members. Although we did not speak directly with any relatives, we heard positive feedback from individuals about staff actively supporting and maintaining individuals’ contact, in person and by telephone.

It was clear that staff members we spoke with knew the individuals on the ward very well. They were able to answer any questions we had regarding the care of individuals and were knowledgeable about their care needs, the management of risks and management plans. We observed caring and professional interactions

throughout the day of the visit and staff were positive and hopeful when discussing individuals.

Similar to our 2025 visit, we noted that many of the individuals in Campsie Ward had been in the hospital for several years due to their illness; despite this, it was evident that staff were continuing to seek ways to promote independence and provide care in a person-centred manner. We felt the use of services in the local community was very positive in supporting access to activities that encouraged independence, promoted wellbeing and met the personal interests of those individuals who were accessing these.

The construction of Munro Ward has created opportunities to improve the outdoor space for all the wards. We were pleased to hear that people had had the opportunity to contribute to the design of the new enclosed space. We visited this and were impressed with the accessibility and size of area, and with the creation of a very pleasant, safe and secure space for recreation and relaxation.

All of the individuals we spoke with said that they had regular access to the community to undertake activities that they enjoyed. There was a wide range of activities available to people and we were told about the 'Adopted Station' initiative with Network Rail where the service maintained planters at the station. We heard of visits to the local shops, larger retail outlets, attendance at local churches, visit to local gyms, the golf range, swimming pool and regular walks in the community, all of which individuals found to be beneficial. Individuals were able to practice accessing travel options, which was part of the skills development programme.

The occupational therapy team maintained links with other secure services through the forensic network.

In planning for the opening of Munro Ward, we heard from managers that recruitment of new staff had been very positive, and that staff from across all disciplines were in post for its opening. This has increased overall staffing for the hospital by 25%.

Managers confirmed that no agency staff were utilised by the hospital, and supplementary staffing was provided through their own internal nurse bank.

Care, treatment, support, and participation

Care plans

Care plans are a tool that identify detailed treatment and interventions that are to be delivered; effective care planning helps ensure consistency and continuity of the care and treatment. They should be regularly reviewed to provide a comprehensive record of progress being made. These were stored in paper files, held in each of the wards.

As in our previous visits, we had no concerns with the quality of the care plans; we found them to be comprehensive, with a clear focus on mental health and physical health needs. We saw evidence of the involvement of individuals in the planning and review of their care, with their views being actively sought and recorded. A personal story was included from each individual which helped inform the planning of care. This was written either directly by the individual or narrated by the individual and written by staff and then signed off.

We found that all individuals had multiple plans to support their care and treatment in the hospital. The information in these plans detailed the care, interventions and support the individual required. We found up-to-date care plan reviews providing information on individuals' progress towards agreed goals, including discharge planning. We did note that some care plan reviews lacked adequate detail of the individual's progress, with this lacking in detail.

Recommendation 1:

Managers should ensure that all care plan evaluation/reviews provide clear detail of progress towards agreed care goals.

The Commission has published a [good practice guide on care plans¹](https://www.mwscot.org.uk/node/1203). 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.

Care records

All care records, including care plans, MDT records and risk assessments, were accessible in paper files. The paper files were all in good order and divided into sections; they were easy to navigate.

We found daily continuation notes to be of a good standard, and we found evidence of regular one-to-one interactions. We saw several examples of 'observation' plans in the care records. We would have preferred to see this framed in a more purposeful and contemporary way, using continuous intervention rather than observation; we thought that this should change to ensure there is a focus on therapeutic engagement and intervention. This was brought to the attention of managers on the day of the visit.

There was clear and consistent recorded evidence of risk assessment and risk management plans in place across all the care records we reviewed. The risk assessments in the wards were completed to a consistently high standard, which included detailed HCR-20 reports, as well as use of the care programme approach (CPA) which informed decision-making for individuals moving out of the low secure care when it was assessed as appropriate to do so. CPA is the structured

¹ *Person-centred care plans good practice guide*: <https://www.mwscot.org.uk/node/1203>

multidisciplinary process for the care and treatment planning of individuals and the management of risk.

We found occupational therapy assessments and reports that were comprehensive. We noted the use of assessment of motor and process skills (AMPS) the model of human occupation screening tool (MOHOST) and other functional assessments. These reports were clear and provided detailed evidence of engagement and participation. We were pleased to see the use of interest checklists to identify personal preferences and motivations, and which helped with the design and delivery of meaningful and person-centred treatment plans. The occupational therapist told us they hoped to further their skills through the completion of the AMPS training course.

Multidisciplinary team (MDT)

We were pleased to note that both wards continued to have a full MDT that met in person on a weekly basis and included psychiatry, nursing, occupational therapy, psychology and other staff as and when required. We noted that a local GP visited every Tuesday and we heard that this contract was being revisited to reflect the increase in numbers and activity when Munro Ward opens.

We also heard about the important role the Speech and Language Therapist (SaLT) has played in ensuring safe care delivery for individuals with dysphagia. This has extended to include the development and delivery of training sessions for nursing staff and has been well received. Individuals we met with were also able to tell us about the role SaLT played in their care.

Staff talked very positively about the input of clinical psychology, with this enhancing the focus on clinical risk assessment, formulation and management. We also heard about the psychology role in delivering reflective practice sessions for staff and this was seen as an important part of staff support and development. Psychiatry provision has increased by 20 hours per week in advance of Munro Ward opening.

The recording of the MDT meetings was found to be consistent, with evidence of engagement and participation by individuals, and where appropriate, their named person and their relatives. We found evidence of steps taken before the MDT meeting to ensure views are gathered, considered and if required, actioned at the meeting. Of the records we reviewed, there was a note of the attendance by social workers, mental health officers and other external professionals, where required.

When we reviewed the MDT meeting records in our January 2025 visit, we found that only the initials of the staff present were recorded, meaning it was not clear who these staff members were or their job titles. We were pleased to see that this gap was addressed in all the records we reviewed.

Use of mental health and incapacity legislation

On the day of our visit, all 21 of the individuals in Surehaven were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (CPSA). This is what we would expect in a low secure setting. Most of the orders in place were under the Mental Health Act.

All of the documentation relating to the Mental Health Act, the CPSA and the AWI Act were in place in the paper files.

Anyone 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 this was clearly recorded in each individual's care records.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, 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 where required and matched to the medicines prescribed.

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 were three individuals who had section 47 certificates in place with treatment plans attached.

Rights and restrictions

Surehaven operates a locked door, commensurate with the level of risk identified with the individuals in the hospital. The restrictions that were in place were understood by those that we spoke with. Almost all the individuals in the hospital had agreed plans allowing for the suspension of their detention, for periods of escorted or unescorted time out of the ward to help with their recovery and rehabilitation. The time out was clearly planned and recorded. One individual was subject to continuous interventions on the day of our visit.

All the individuals that we spoke to could describe their legal status and their rights. They knew how to access legal representation or had access to support from advocacy. Advocacy provision is provided by Circles Advocacy Network who hold a specific contract with Surehaven.

When we are reviewing individuals' files, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has

capacity to make decisions on the treatments they want or do not want. We found copies of advance statements in the records we reviewed. Similar to our last visit, we found evidence of when individuals had opted not to complete an advance statement, and that this was revisited monthly, along with the named person nomination forms.

Sections 281 to 286 of the Mental Health Act provides a framework in which restrictions can be placed on people who are subject to detention in hospital. Where someone is made a specified person in relation to these sections of the Mental Health Act and where restrictions are introduced, it is important that the principle of least restriction is applied. The Commission would therefore expect restrictions to be legally authorised, and that the need for specific restrictions to be regularly reviewed.

There were nine people on the day of our visit who were subject to restrictions. We were told that these arrangements were reviewed regularly to determine whether restrictions were still required. On our last visit we recommended that the relevant forms (RES1) should have reasoned opinions attached. We were pleased to see that these were completed for all specified persons and heard from service managers that training has been developed and delivered to support the improvements we saw.

As noted on previous visits, closed-circuit TV (CCTV) is in place across all the communal areas of the wards. There were no cameras in the bedrooms, toilets, showers or bathrooms. We heard no concerns from staff or individuals on the use of CCTV throughout the hospital. We did note that individuals were asked to consent to CCTV being used. We questioned this with managers on the day as it was not clear what would happen if someone did not consent. We suggested that it would be more appropriate to inform individuals that CCTV was being used, and to explain what limits and legal safeguards were in place to govern the use of this.

Recommendation 2:

Managers should revisit their current practice of seeking consent for the use of CCTV and replace this with written information for individuals and their families/carers about the use of CCTV. This should cover the scope of its use and the safe handling of digital CCTV data/footage aligned to the General Data and Protection Regulation (GDPR).

Activity and occupation

We heard from individuals and staff in the hospital regarding the wide variety of activities available. This included art, singing, baking, games, yoga, movie nights, walking, exercise and various other recreational activities. Much of this work was led by occupational therapy staff who had access a therapy kitchen which promoted healthy eating. We also heard about significant amount of activity that took place off

the unit, which were very well received by individuals. We were told about how impactful the recreational activity coordinator roles were in ensuring activity design and delivery.

As with our last visit, it was positive to see that there were a wide variety of meaningful activities arranged in partnership between individuals and staff. During our review of the care records, we could see evidence of the recording of these activities.

During our last visit to Surehaven, unlike some other low secure facilities, most individuals had access to their own phones or tablets for internet usage, subject to individual risk assessments. This access was noted to be of benefit, as people could maintain regular communication with their families and access online entertainment.

We heard about weekly community meetings between individuals in the unit and staff, and we received copies of the Surehaven Magazine which is jointly produced.

The physical environment

The layout of the hospital has changed since our last visit due to the construction of Munro Ward. This has provided an opportunity to create a substantial, fully enclosed central garden area. The work on this had been recently completed, and this new facility looked well-thought through in terms of providing safe and secure access to recreational and green space. We also noted that one-way reflective film had been added to the ground floor windows of ward areas that faced into the garden to ensure that individual's privacy was protected.

The older part of the unit was clean, bright and in a good state of repair. The new ward was bright, spacious and had facilities such as a therapy kitchen and a fully equipped gymnasium. It also has its own separate garden space, over and above the shared central courtyard. We were shown facilities for staff which appeared to be well-thought through in providing enough space for work tasks and restorative activities. We heard that the construction of the new ward had been as minimally disruptive as possible and we had no concerns raised by individuals about this.

Individuals continued to have access to their own individual en-suite bedroom which they were encouraged to personalise with their own belongings.

Summary of recommendations

Recommendation 1:

Managers should ensure that all care plan evaluation/reviews provide clear detail of progress towards agreed care goals.

Recommendation 2:

Managers should revisit their current practice of seeking consent for the use of CCTV and replace this with written information for individuals and their families/carers about the use of CCTV. This should cover the scope of its use and the safe handling of digital CCTV data/footage aligned to the General Data and Protection Regulation (GDPR).

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.

Contact details

The Mental Welfare Commission for Scotland

Thistle House

91 Haymarket Terrace

Edinburgh

EH12 5HE

Tel: 0131 313 8777

Fax: 0131 313 8778

Freephone: 0800 389 6809

mwc.enquiries@nhs.scot

www.mwcscot.org.uk

