mental welfare commission for scotland

Recommendations and outcomes from our local visits April 2025 to March 2026

November 2026



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

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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 (the Mental Health Act) and the Adults with Incapacity (Scotland) Act, 2000 (the AWI 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 2025 to 2026, while most of our visits continued to be to NHS inpatient units, we also continued to visit community-based services; this visit year they included teams working in adult and forensic mental health care, as well as learning disabilities. We again visited all of the island communities of the Western, Orkney and the Shetland islands.

In this visit year and for the first time, we completed a series of enhanced visits. These visits were developed in response to a request from the Minister for Social Care, Mental Wellbeing and Sport to undertake joint visits/inspections with Healthcare Improvement Scotland (HIS). This request followed serious concerns raised by the BBC documentary (aired in February 2025) regarding the experiences of young people in Skye House in Glasgow. The Minister therefore commissioned the visits/inspections across all three children and young people (CYP) units in Scotland and the separate children's in-patient psychiatric unit in Glasgow.

The enhanced visits involved our team spending up to five days on site (compared to one day) and having more time to speak with and engage with young people, their relatives, their mental health officers (social workers), their advocacy workers and staff working in the units. We also reviewed all case records for all young people. We completed reports for all four visits to Scotland's CYP units and a summary report during 2025-26. We subsequently tested this enhanced visit methodology in an adult ward setting, Ward 4 in Dr Gray's Hospital in Grampian, and intend to use this methodology going forward where our intelligence gathering suggests the value of this approach.

We completed 28% of our visits on an unannounced basis in 2025-26, thereby exceeding our target of 25%. Following feedback in relation to our strategic plan for 2026-29, we will now be aiming for up to 50% of our individual visits being undertaken on an unannounced basis.

We have continued to publish our findings from each individual visit on our website. We have used social media platforms such as YouTube, Instagram, LinkedIn, and Bluesky to highlight forthcoming visit reports that are about to be published one week prior to them being posted. We have also produced short, accessible videos on our enhanced visits to the CYP units, outlining key findings and the recommendations we made.

Recommendations made by the Commission are set out in our local visit reports 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 team and, most importantly, reflect what people, and often their families and carers, have told us.

We share information from our visit reports with key scrutiny bodies, such as Healthcare Improvement Scotland (HIS), the Care Inspectorate (CI), Audit Scotland and the team from the Patient Safety Commission office. The Mental Health and Learning Disability Collaborative chaired by the Commission was established in August 2025 and is a key forum for sharing information and linking in with our key stakeholders about mental health and learning disability services. This group aims to facilitate co-ordination of scrutiny and remove duplication and unnecessary burden on services.

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 and powers as regulators.

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 multi-professional team of mental health nurses, social workers (mental health officers) and doctors (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 2024-25 and 2025-26, along with the total number of recommendations. The table also notes the number of local visit reports (LVRs) produced for the number of wards visited.

Table 1

	2024/25			2025/26		
Area Visited	LVRs	Wards	No of recommendations	LVRs	Wards	No of recommendations
Ayrshire & Arran (A&A)	6	10	12	4	7	11
Borders	3	3	12	2	2	8
Dumfries & Galloway (D&G)	4	4	8	3	3	7
Fife	10	10	33	9	11	35
Forth Valley	12	14	38	6	7	14
Greater Glasgow & Clyde (GG&C)	34	49	120	23	27	114
Grampian	12	17	49	7	10	27
Highland	6	6	20	6	6	29
Lanarkshire	5	6	18	5	8	12
Lothian	22	27	87	18	24	75
Orkney	1	1	4	1	*	5
Shetland	1	1	4	1	*	6
Tayside	14	18	70	10	13	31
Western Isles	0	0	0	2	2	14
State Hospital	2	4	8	4	7	13
HM Prison	7	7	24	5	5	19
Totals	**139**	**177**	**507**	**106**	**132**	**420**

Table 1 now notes all of the wards we visited over the two-year period. This is to highlight that, although we may only produce one local visit report, this can be for

multiple wards/services. An example of this would be our visits to Rowanbank Clinic in Glasgow where there are eight wards but these are all included in one report.

It should also be noted that while we produced a local visit report for our visit to Orkney and Shetland, there are no mental health wards on these islands; these still count as a visit and have been categorised as *; they reflect our contact with the broad and diverse multidisciplinary teams that provide care and treatment for those with mental health and learning disabilities, as well as the individuals and their families and carers.

The five enhanced visits (four to CYP units and one to Dr Gray's) are not included in Table 1, so in total there were 139 visits.

3. 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) 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 registered care settings 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 April 2025 and March 2026 from our local visit reports, we made a total of **420** recommendations. While there have been fewer local visits and a decrease in the number of recommendations (17.5%), the average number of recommendations has slightly increased from 3.6 to 3.9. As was the situation in 2024-25, the Commission has continued to repeat some recommendations due to a lack of progress.

To analyse repeat recommendations further we reviewed recommendations made over the past three years for each setting. Future bespoke visits plans are now in place for those settings where a pattern has emerged that requires additional visit activity and focus by the Commission.

4. About our recommendations

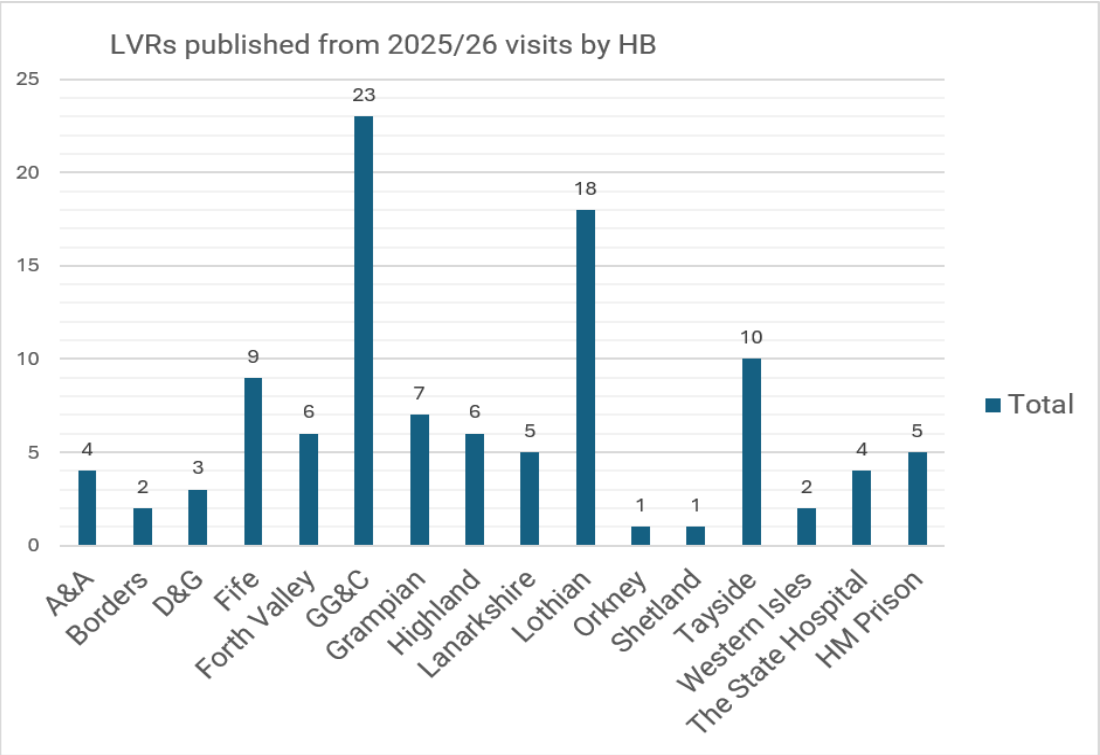
When we make recommendations, we provide the senior managers in the service three months to formally write to us with their response. If the recommendation is particularly serious and urgent, we will reduce the response time accordingly, revisit the action plan that the service has provided, escalate to senior leads for both the Commission and the service, and if we remain concerned, we escalate this to our sponsor department in Scottish Government.

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 assess 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 enhanced visit.

We expect a satisfactory response to at least 95% of the recommendations we make within the stated three-month period. Of the action plans for 2025-26, 76.4% (81) of the responses were 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.

Chart 1



We have now achieved a 100% response rate for all local visit reports that required a completed action plan.

Since 2024, we routinely ask services to provide feedback as to how they have shared the findings and recommendation(s) that are detailed in the visit report. 35 services told us how they were sharing our reports in 2024-25 and this has increased to 51 services in 2025-26. Where we have not received information about the sharing of the LVR, this is followed up by the Commission officer for the local area and we feedback on the data noted in Table 2 below at our end of year meetings with senior managers of the health and social care partnerships.

Table 2 below provides an overview of the responses relating to the sharing of the Commission's LVRs for their service.

Table 2

Health board	Shared	No sharing	Number of LVRs	% shared
A&A	3	1	4	75%
Borders	2	0	2	100%
D&G	3	0	3	100%
Fife	1	4	9	20%
Forth Valley	3	0	6	100%
GG&C	10	11	23	48%
Grampian	2	2	7	50%
Highland	5	1	6	83%
Lanarkshire	3	1	5	75%
Lothian	8	6	18	57%
Orkney	1	0	1	100%
Shetland	1	0	1	100%
Tayside	4	2	10	67%
Western Isles	1	1	2	50%
State Hospital	0	1	4	0%
HM Prison	4	0	5	100%
Total	51	30	106	63%

There are differences between the number of LVR numbers and the number of reports shared. Where there was no sharing this may relate to the visit cycle of April to March. For visits that took place in March 2026, for example, the action plan that is required three months after the visit has been published on the Commission's website will be due after the collation of the data above. It is also possible that some services have requested additional time for actions to be completed, which again may delay the sharing of the LVR. That said, we continue to seek information on how and where our reports are considered within health and social care partnerships.

An example of how we were told that the team in Glencairn Ward at Midpark Hospital in Dumfries and Galloway shared their report is noted below:

The Glencairn Ward team opted to celebrate the contents of the Commission's report with a variety of our stakeholders across the region. These included:

- Full circulation to all members of the multidisciplinary team within Glencairn Ward
- Electronic copy sent to the Carers Hub and NHS Dumfries and Galloway along with the local advocacy link
- Met with carers who supported the Commission's visit and shared feedback, they were pleased their comments had been included in the report.
- Senior Charges Nurses across Midpark both verbally and sent a copy of the report
- Paper copies made available at the entrance to the ward and in the visitors rooms
- UWS link lecturers as assurance of the service students are learning within
- Practice Education Facilitators who support the learning and development of the team.
- Electronic copy sent to staff side reps, occupational health and human resources to reflect how they work as a team for assurances.
- Copy sent to Senior Management Team within Mental Health.

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(s) 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 help 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.

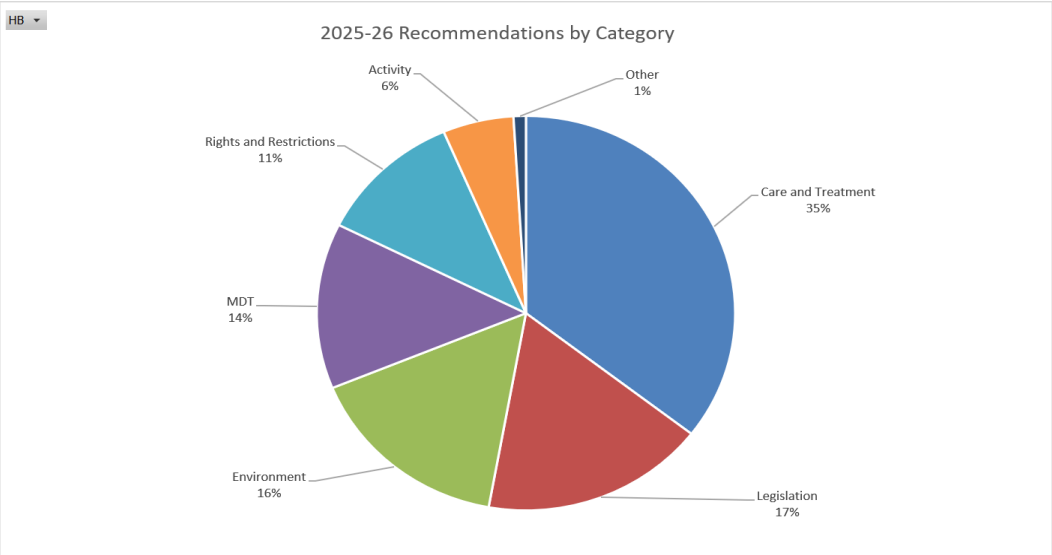
The six categories we use for our local visits include:

- 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 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 these meetings could have more detail about those in attendance, or that the discussion at the multidisciplinary team meeting should reflect the care plan goals more clearly.

Chart 2 below provides an overview of categories of recommendations for each of these areas as set out in our LVRs throughout 2025 to 2026.

Chart 2



This year, there were eight services where no recommendations required to be made following on from our visit; in 2024 -25, there had been 10 services with no recommendations. The types of services varied and included:

- one prison,
- one low secure forensic unit,
- one intensive psychiatric care unit
- one after a visit to the high secure hospital
- two learning disability services, one which was for both LD and mental health
- and two older adult wards – one for those with a functional mental illness and one for those with a diagnosis of dementia.

For some services, even though there may have been recommendations made, we acknowledge when good practice has been evident on our visit. For example, on a visit to a service in NHS Grampian in May 2025 we noted:

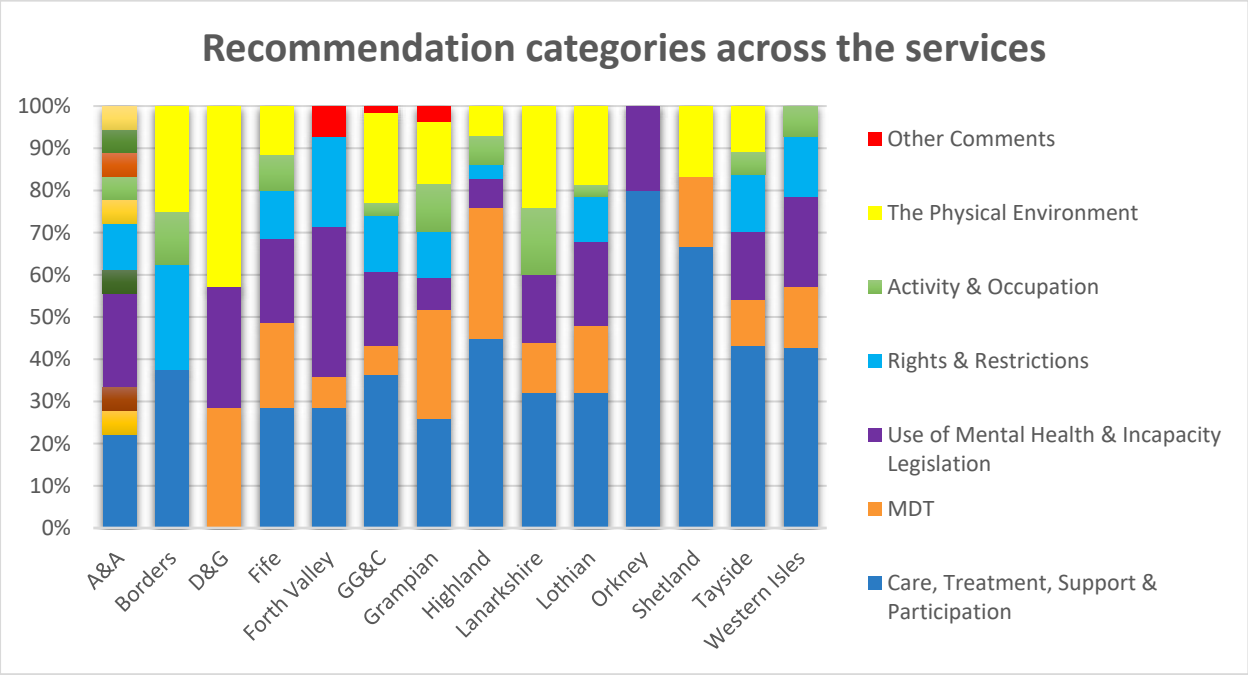
> We were told by the senior charge nurse that they were a pilot site for a delayed discharge project 'discharge without delay' with Health Improvement Scotland (HIS).
>
> This was showing encouraging results with an individual whose discharge was delayed on the day of our visit. We noted as part of this process there was proactive discharge planning from admission and consideration of use of AWI Act legislation at an early stage. We look forward to hearing how this work progresses and is rolled out to other wards at our next visit.

For those services where recommendations were made, these ranged from one to 10 recommendations. The average number of recommendations in a local visit report was 3.9.

6. Recommendations across the different services

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

Chart 3



The chart above shows the most frequent categories of recommendations made. At a glance, we can see that in the visits to Forth Valley, there were no recommendations made about the physical environment during 2025-26; Lanarkshire had no recommendations made on rights and restrictions.

Overall, the actual number of recommendations for each category was:

Category section in the LVR	**Total across all of the LVRs for 2025-26**
Care and treatment	149
Legislation	73
Environment	67
MDT	57
Rights and restrictions	47
Activity	23
Other	4
Total	**420**

The table below notes the total number of recommendations in the LVR categories for the particular health board area. As the Commission develops an intelligence-led approach to visits and using the red-amber-green (RAG) approach, the areas that have averaged between 3 and 4 recommendations for the services are noted, for the purposes of this report, as green, between 4 and 5 are amber and higher than that, red. There are two areas – Dumfries and Galloway and Forth Valley who in 2025-26 had an average of two recommendations.

Table 3

Health Board	Number of Visits	Care, Treatment, Support & Participation	MDT	Use of Mental Health & Incapacity Legislation	Rights & Restrictions	Activity & Occupation	The Physical Environment	Other Comments	Grand Total	Avg Number of Recs per Visit
A&A	4	4	0	4	2	1	0	0	11	3
Borders	2	3	0	0	2	1	2	0	8	4
D&G	3	0	2	2	0	0	3	0	7	2
Fife	9	10	7	7	4	3	4	0	35	4
Forth Valley	6	4	1	5	3	0	0	1	14	2
GG&C	26	46	9	22	17	4	27	2	127	5
Grampian	7	7	7	2	3	3	4	1	27	4
Highland	6	13	9	2	1	2	2	0	29	5
Lanarkshire	9	8	3	4	0	4	6	0	25	3
Lothian	19	24	12	15	8	2	14	0	75	4
Orkney	1	4	0	1	0	0	0	0	5	5
Shetland	1	4	1	0	0	0	1	0	6	6
Tayside	11	16	4	6	5	2	4	0	37	3
Western Isles	2	6	2	3	2	1	0	0	14	7
		149	57	73	47	23	67	4	420	

It is important to note that whilst the number of recommendations made following each visit is important, the types of recommendations and whether they are repeat recommendations also inform the overall (RAG) status for planning visits, planning how often we visit and planning whether the visits are unannounced, announced or indeed enhanced.

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 that information in relation to proxy decision makers is sought and recorded on admission. Recommendation under use of Mental Health and Incapacity legislation section in the local visit report to an NHS Greater Glasgow and Clyde service	In relation to this recommendation, we recognise that while staff routinely seek information regarding proxy decision makers as part of the admission process, this is not yet consistently or clearly recorded within EMIS. Local review and spot-check audit activity have identified that although proxy information is often known by the clinical team, there is variability in how this is documented, including the type of proxy decision maker (e.g. welfare guardian or power of attorney) and associated contact details. This has resulted in occasions where information is not immediately visible or easily accessible to the wider multidisciplinary team. We acknowledge that this presents a potential risk in ensuring timely and appropriate involvement of proxy decision makers, particularly where patients lack capacity. The management team have begun to address this by: • Reinforcing with staff the requirement to seek and record proxy decision maker information at the point of admission • Providing clarity on where and how this should be documented within EMIS to ensure visibility • Introducing regular spot-check audits to monitor compliance and identify gaps • Discussing this as a standing item within team meetings and safety huddles to improve awareness and consistency

	This is being monitored through local governance processes, with findings shared with the wider service to support consistency of practice. We will continue to review compliance through ongoing audit activity to ensure this requirement is embedded and sustained within ward practice.
Common concerns with Power of Attorney New TURAS Learn Zone – Adults with Incapacity | NHS Education for Scotland	
There was no promotion of advance statements. It is recommended that the unit builds the offer of an advance statement into practice when the person is well, as part of discharge planning. Recommendation under Rights and Restrictions that was made in one of our enhanced visits.	We will ensure that advance statements are promoted within the YPU to all patients, carers, families and guardians to inform the delivery of person-centred care and effective discharge planning. The following actions are in place: CPA checklist updated to ensure chair of the meeting is required to discuss advance statement at each meeting. Addition of advance statement section to CPA meeting report template (master template and all current CPA reports for Young People). Young Person's now explicitly recorded in the meeting note. Communication sent to all staff explaining requirement for promotion and discussion of advance statements at CPAs. Communication included MWC guidance links on advance statements. All staff now aware of requirements. Action taken to ensure that advanced statements are completed, when appropriate, during admission. Where advance statement is to be completed during admission, RMO, SLT and nursing team collaborate with Young Person to complete. If not, staff aware to ensure that action is passed to local board to take forward following discharge. Requirement in place for home team to take this forward included in the discharge letter. Letter template updated to include a section on advance statement status completed by RMO as part of their input to the discharge letter. Feedback received from young people and families in relation to advance statements solicited. Families did not feel that discussion of advance statement was appropriate during CPA meeting when their child is still unwell. Feedback provided to MWC that format of advance statement is not child or young person friendly and that further consideration needs to be given to approach for young people.

	The YPU MDT will continue to monitor feedback from young people and families and feed back to MWC.
AdvanceStatements-2024.pdf; AdvanceStatements-2024.pdf (easy read) The Commission is currently updating our good practice guide on Human Rights in mental health services which will be on our website in Autumn 2026.	
Managers must urgently review the environment, paying particular attention to anti-ligature work, appropriate bathing and kitchen facilities. Recommendation under the physical environment section of the local visit report with a response from the service in NHS Borders.	A review of the ward environment is underway, with particular focus on anti-ligature measures, bathing facilities, and kitchen areas. Initial assessments have identified several areas requiring improvement, and discussions with estates and facilities teams have begun to scope the required work. Some progress has been made in identifying priority actions; however, full completion is still pending. Further planning, funding allocation, and scheduling of works will be necessary to ensure the environment meets safety standards and supports high quality patient care.
Scottish Government has developed a specific tool for the rollout of the Mental Health Built Environment (mHBE) Assessment across NHS Scotland.	

7. Key findings

There have been fewer visits completed by the Commission in the 2025-26 period, and fewer recommendations made. This has been as a result, in part, of the need to develop and deliver an enhanced visit approach within the Commission's existing resources.

As noted in the report from 2024 to 2025, increasingly we are making repeat recommendations, mostly in the sections on care, treatment, support and participation, legislation and the physical environment. While the Commission recognises that in some areas, following through on a recommendation can take more time, for example, estates and new build plans, where care and treatment is not being delivered lawfully, the Commission considers such repeat recommendations as urgent areas of concern. In the absence of additional powers, as recommended by the Scottish Mental Health Law Review, in these circumstances, the Commission will consider an enhanced approach or escalation to the Minister.

People have a right to lawful care and treatment and recommendations need to be addressed and taken seriously, not repeated nor disregarded.

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



Mental Welfare Commission 2026