Mental Welfare Commission for Scotland

Report on enhanced visit to: Rannoch Ward, Murray Royal Hospital, Muirhall Road, Perth, PH2 7BH

Date of visit: 7 and 8 September 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.

Introduction

The Mental Welfare Commission routinely visits hospitals which provide support, care and treatment to people with learning disability in Scotland. We have various sources of intelligence and based on feedback received, we decided to undertake unannounced, enhanced visits to inpatient learning disability settings in 2026.

It is in this context that reference to the Muckamore Abbey Hospital Inquiry report[1] published in June 2026 is also important.

The report details the suffering of some of the most vulnerable people in Northern Ireland, people with a learning disability who were admitted to Muckamore Abbey Hospital.

The Commission's methodology routinely aims to maximise involvement of those receiving care, their families, staff and other staff visiting hospitals as recommended by the Muckamore Inquiry. That is, we do not simply rely on documentation review. That said, our visits to all learning disability hospitals in Scotland over a four-month period, in 2026, as part of a 'themed' piece of work is timely. Our intention is to complete individual reports for each setting and a final thematic summary report.

This report relates to Rannoch Ward, Murray Hospital in Perth.

[1] Muckamore Inquiry Report June 2026 (Electronic Version_).pdf

Rannoch Ward, Murray Royal Hospital, Perth

Staff and patients moved from the former Learning Disability Assessment Unit (LDAU) at Carseview Centre, Dundee to the newly refurbished Rannoch Ward at Murray Royal Hospital in Perth on Tuesday 24 March 2026.

Rannoch Ward is an LDAU which has 10 beds for both male and female adult patients. There are eight single bedrooms and two double bedrooms, all with ensuite shower and toilet facilities.

While the Commission's usual approach involves visiting a ward on one day, on this occasion we visited Rannoch Ward across two days with a team of three staff in September 2026 (our staff are all qualified mental health or learning disability nurses, social workers and psychiatrists). There were five people receiving care and treatment in the 10-bedded unit throughout our visit. The length of stay of the people in Rannoch Ward ranged from approximately two months to over five years. All were noted to have a learning disability and additional mental health related diagnoses and were receiving care and treatment on a compulsory basis according to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Mental Health Act).

- All five patient health records were reviewed by Commission staff.
- We engaged with four of the five people in receipt of care and treatment and with five nursing staff who described themselves as their key workers/named nurses.
- We engaged with the relatives/carers of two people on the ward.
- Four of the multidisciplinary staff working directly on the unit provided us with additional information.
- We also received feedback from five mental health officers (MHOs), and one response was received from the independent advocacy service working with the people on the ward at the time of our visit.

What the Commission heard

Adults with learning disabilities

What we expect:

We would expect people receiving services in wards which specialise in supporting people with learning disabilities, to receive holistic, person-centred care delivered by an experienced, specialist, multidisciplinary team which is inclusive and recognises the person as a unique individual. We would expect the person to have a key worker/named nurse with whom they have built or can build a therapeutic and trusting relationship. We would expect communication to be tailored to individual needs to support people to be aware of their rights, to be treated with dignity and respect and for all interventions to be lawful.

What we heard:

There were five people on Rannoch Ward when we visited; four of whom (aged in their 20s to 40 years+) chose to engage with us.

All were receiving care on a compulsory basis (according to the Mental Health Act 2003. Some also had guardians in place according to the Adults with Incapacity (Scotland) Act 2000 (the AWI Act).

Care plans evidenced that three people had been actively involved in their development and four care plans included the wishes and views of the person. It was good to see commitment to ensuring the recording of the views of individuals. The care plans themselves were not all 'easy read' or accessible, however.

Two of the people we spoke to said they knew why they were in hospital whilst the other two were not sure. We heard that help in hospital included getting meals, getting washing done, going to the shops and help with physical health. One person talked about feeling "claustrophobic" however and just wanted to get home. Most of the people we engaged with spoke about wanting to go home.

All five named nurses told us that they spoke regularly to the person and asked how they were feeling and they had enough privacy to do so.

Three people mentioned having advocacy support and when asked whether staying in hospital was 'not very good', 'okay' or 'really good', three people answered "okay" or "really good".

Carers/relatives

What we expect:

We expect that families should always be allowed and encouraged to offer information to professionals involved in a person's care and treatment. In all

situations, and regardless of the person's consent or capacity, families can give information to the professionals involved and staff should listen to them. Families and carers know the person best and can provide valuable information that does not breach the confidentiality of the relationship between the individual and the professional team. The Commission's good practice guide *Carers, consent and confidentiality*[2] explains this in more detail but an inclusive approach to carers, relatives, and people important to the person cannot be understated.

What we heard:

Care records confirmed that four of the people on Rannoch Ward had carers/relatives involved in their care.

Two carers/relatives of the people in Rannoch Ward engaged with us during our visit.

They spoke positively about their involvement in care planning, decision making and being given enough information to contribute meaningfully.

"They're good in here. If there's any changes, they tell you"

This carer/relative carried on to tell us that they were then invited to meet with the doctor and the team if they wanted to discuss changes further.

We heard that where seclusion took place, this was explained to the carer/relative and both relatives/carers reported that they have confidence and trust in the staff and felt able to raise concerns if there were any.

The relatives/carers said there were enough things for the person to do in the ward throughout the week and weekends/evenings and were overall satisfied/very satisfied with the care provided.

An adult carer support plan had not been discussed with either of those who engaged with us and this was a missed opportunity to ensure the rights of the carers were prioritised.

Staff working directly on the ward

What we expect:

We expect commitment to the delivery of annual health checks[3] recognising stark statistics that adults with learning disabilities are twice as likely to die from preventable illnesses[4].

[2] Carers, consent and confidentiality: https://www.mwcscot.org.uk/node/223

[3] National Directions

[4] Scottish Learning Disabilities Observatory

We expect multiprofessional shared decision making and formulation which aims to secure the rights of people with learning disabilities to live in their own homes and communities[5]. A multidisciplinary approach to care and treatment, underpinned by respect for individual roles and contributions and characterised by positive collaboration between professionals to meet the needs of individuals is therefore expected to form the basis of the work of Rannoch Ward.

What we heard:

All care records confirmed annual physical health checks were undertaken. There was evidence provided that the nursing staff have been trained by podiatry to cut toenails, but podiatry was accessible for any other issues. Likewise other specialist advice (e.g. speech and language therapy and dietetics) was sought where other physical health conditions required this, for example, risk of choking, obesity, seizure risk and chronic obstructive pulmonary disease (COPD). There was one example where the person's dental check-up and eye test were overdue and this was highlighted.

We heard that Rannoch Ward was "top heavy" with nursing staff at Band 5 level and not enough skill mix with Band 3s for example. We were told of a review that is currently progressing, including work force modelling, which is due for completion in November 2026.

Allied health provision was said to be generally delivered thanks to "goodwill" rather than dedicated resource (particularly psychology and speech and language therapy) and there was frustration regarding links with social work which could be improved to support more timely discharges. No longer having pharmacy around the multidisciplinary team (MDT) table was also noted to be a gap.

The activities support worker was available for three extended days leaving four days with no activity support workers in place.

Three of the four staff who engaged with us said that the skill mix on the ward was not appropriate.

All staff confirmed that they had received child and adult protection training and felt confident and competent in their reporting duties in relation to adult/child protection. They reported feeling able to speak up if they witnessed practice which was not the best it could be.

[5] The keys to life - Improving Quality of Life for People with Learning Disabilities - gov.scot

Staff spoke positively about the team working and change management on the ward "this ward has come a long way" and said that working and interacting with patients was what they enjoyed most. It was explained that:

"The key in this area of work is not just about medication but developing strategies to help deliver positive outcomes".

The lack of core dedicated multidisciplinary professional support was a challenge, however.

"…potentially patients are getting less services in hospital than community".

Advocacy

What we expect:

The Mental Health Act is clear about the vital importance of independent advocacy to ensure people's own voices are heard. Young people and adults have a legal right to independent advocacy whether they are subject to compulsory measures under the Act or not. This right applies to everyone with a mental illness, personality disorder, learning disability, dementia or related condition, and to all types of independent advocacy. Section 259 of the Act enshrines this in law. We therefore expect that all patients are offered independent advocacy support. We would expect commissioned advocacy services to include specific advocacy expertise to enable people with a learning disability to have as much control and influence on their care and treatment as possible.

What we heard:

We spoke with one representative from Independent Advocacy, Perth and Kinross, the service responsible for supporting people in Rannoch Ward (care records confirmed that two people were in receipt of advocacy support at the time of our visit). Independent Advocacy, Perth and Kinross are not a specialist advocacy service for people with learning disabilities.

It was explained that the level of advocacy contact is partner led so will depend on the wishes of the person receiving care on the ward. For example, some individuals will have received only one or two visits, whereas others may have received four or five visits and been supported at a mental health tribunal.

We were told that "the understanding that they [those receiving care and treatment] have can be quite variable".

The advocacy representative said that they were not aware of any restrictive practices, such as restraint or seclusion and spoke positively about relationships with ward staff who were said to value the contribution of advocacy.

Mental health officers

What we expect:

Mental health officers (MHOs) have statutory powers under the Mental Health Act to support the care and treatment of people whose mental health condition may require the protection afforded by legislation.

As social workers, MHO's responsibilities include care planning, assessing mental health need and whether compulsory intervention may be required as well as ensuring the rights and welfare of individuals is protected. It is a critically important role and we would expect active involvement by MHOs in the care of people whose liberty has been impacted by detention in hospital against their wishes.

We would also expect that each person has a current and relevant social circumstances report (SCR) on file which has been sent to the key recipient, the responsible medical officer and copied to the Commission (section 231 Mental Health Act).

The content of an SCR is clearly set out in the Mental Health (Social Circumstances Reports) (Scotland) Regulations 2005 and their purpose in the Code of Practice (Volume 1 Chapter 11). The Commission has published good practice guidance in relation to SCR provision[6] and also monitors the provision of these statutory reports. These reports are key to planning exit strategies from detention and indeed hospital.

What we heard:

Five MHOs provided their views as part of this visit process. All were involved in working in partnership with all of the people currently on the ward. Most MHOs had relatively recently started working with the person (in recent months) with one longer term relationship over a few years.

MHO visits to the ward were based on the needs of the individual person but were generally regular. Two of the MHOs met with people in the visitors' room rather than actually on the ward. It was explained that it was necessary to adapt communication for three people, for example, ensure verbal communication rather than reliance on the written word and to be able to interpret body language and behaviours.

Three people were noted to have had advocacy support (one non-instructed) and attempts were made to maximise information provision through the use of easy reads and talking mats. The responsible medical officer (RMO), in particular, was said to be skilled in ensuring understanding and inclusion: "his RMO takes his time to explain information so that he can understand his treatment".

[6] SocialCircumstancesReports_GoodPracticeGuide_2022_1.pdf

Four out of the five MHOs said they were routinely invited to the multidisciplinary ward meetings and had no concerns regarding any restrictions in place.

Four MHOs confirmed that discharge planning was underway (for one person, they were not yet well enough to return home):

“The MDT [multidisciplinary team] is committed to ensuring that the discharge destination is appropriate and will be a home for life”.

“Further discussions will be required as discharge planning progresses to ensure that appropriate supports are in place and to minimise the risk of readmission”.

MHOs noted no concerns in the course of their work but felt able to raise matters either with the nursing staff, the responsible medical officer, their line manager, the Commission or via adult support and protection procedures as appropriate. All five MHOs confirmed that they felt confident and competent in relation to their child protection/adult support and protection responsibilities.

SCRs were reportedly prepared for three people on the ward with one MHO stating the view that: “An SCR will serve no purpose as [the patient] has been looked after by his RMO [responsible medical officer] for some time and he is aware of his circumstances”.

We were not able to locate any SCRs within case records where we would expect them to be.

MHOs spoke positively about their experience of the ward: “The RMO knows his patients well and staff are approachable and not defensive when asked questions”.

What else did we hear and learn?

What we expect:

We expect a culture of openness and respect for the Commission’s duty in law to seek and receive a wide range of information including access to patient records. We also expect leaders to facilitate this process and to support their staff during the time the Commission is both on and off site.

What we found:

The staff we met with spoke openly about what works well on Rannoch Ward and what the barriers are. The move from Carseview Centre in Dundee to Rannoch Ward in Perth this year was no doubt a significant challenge for all involved but there was commitment to make it work.

We found the staff to be visible and approachable at all times throughout our visit. All interactions between individuals and staff were observed to be respectful and compassionate.

Key findings

Adult protection

The Commission asked all staff (those on the ward and those visiting) whether they have been trained in recognising and reporting harm (child and adult related). All staff on the ward that we spoke with, MHOs and advocacy confirmed this to be the case and said they felt able to speak up if necessary. This is important because adult and child protection is everyone's business. It is also important because the Muckamore Abbey Hospital Inquiry report, June 2026[7] raised concerns about a culture where abuse is witnessed by others but not prevented or reported by them.

Mental Health Act legislation / authority to treat

The Mental Health Act provides the authority for compulsory treatment of individuals under strict circumstances and describes important safeguards for individuals as to how medical treatment, such as medication, NGT feeding and ECT may be lawfully authorised. Part 16 of the Mental Health Act describes these requirements which seek to ensure that the rights of patients are sufficiently upheld and protected at a time when they are unwell and may be unwilling to receive treatment or be admitted to hospital on a voluntary basis.

All T2/T3 (Mental Health Act) paperwork was in place (pharmacy audited these) and section 47 certificates (AWI Act) were in place for two people, recognising that while some people may not be able to make decisions about their mental health treatment, they were still able to make decisions about their physical health. It is, however, important to ensure that section 47 certificates do not simply comprise of the front sheet but have an appropriate treatment plan attached too.

None of the people on the ward had completed an advance statement (despite three people being well enough for discharge and this being delayed). There appeared to be no consideration or discussion of advance statements.

Physical health

We found firm commitment to physical health checks and screening for those receiving care and treatment on Rannoch Ward. A general practitioner visited the ward weekly.

This is important as evidence shows that annual physical health checks are clinically effective in detecting unmet clinical conditions, and in improving the management of long-term conditions. This helps to deliver a preventative pathway towards better

[7] Muckamore Inquiry Report June 2026 | Muckamore Abbey Hospital Inquiry

health for people with learning disability who are more likely to die from preventable illness as highlighted previously.

We noted that families advised the Muckamore Inquiry of concerns in relation to the lack of attention paid to the physical health needs of those receiving care at Muckamore Abbey Hospital in Northern Ireland. This was not the case on Rannoch Ward.

Multidisciplinary team working

The core ward team comprises, medical (part time) nursing (skill mix to be addressed) and occupational therapy (part time). There is no dedicated ward psychologist, physiotherapist, pharmacist or speech and language therapist. Not having other professionals as integrated members of the team means that "favours" have to be asked to ensure the range of multidisciplinary input required. We did not think this was good enough. We also thought that invitations to family members would enhance partnership working.

There remains a lack of community provision to prevent admission and we heard that there is the need to create learning disability informed intensive community support to facilitate people returning home more quickly. As noted previously, three people in the ward were said to be in delay (delayed discharges).

The commitment to the right of individuals not to live in hospital but to live in their own communities was evident from the team's approach, however, discharge planning is more systemic and not necessarily under the control of the hospital team.

Care planning and recording of information

Care planning and recording are fundamental to safe, effective, person-centred care.

We found that plans were generally inclusive but could be written in more accessible formats. The quality was generally good although recording was inconsistent at times and locating relevant paperwork was difficult as it was not clear where this could be found; whether on the electronic system or elsewhere in separate folders. We assumed that it is therefore difficult for staff on a day-to-day basis to be fully informed by all the information available.

While risk assessments were completed, we could not find risk management plans or formulations flowing from this assessment (although named nurses told us they were done).

Records of multidisciplinary team meetings were not always fully completed and these meetings did not consider risk assessments/risk management plans routinely.

Where there were records of use of restraint, emergency medication or seclusion, the information provided evidenced this was not a first line response, was necessary and lawful and families had been advised. Named nurses confirmed that reassurance was given throughout these interventions and individuals were supported afterwards. Despite the lack of ward dedicated psychology resource, psychology had assisted with the completion of positive behaviour support plans for two people. Psychology had also provided staff training which was said to have built confidence in reducing risk aversion.

There were matters relating to the finances of a couple of people on the ward, one of which the Commission will follow up with the health and social care partnership involved.

Activities

The provision of meaningful activity on a ward such as Rannoch Ward cannot be underestimated. We heard about jigsaws, board games, interactive games, Xbox (motor mobility), making sensory items with sands and play dough, access to a walled garden and football pitches, community duck pond and bus trips (to cafes, shops, cinema).

Activities build social relationships, independence, wellbeing and helps people to manage their cognitive and emotional needs. The activities co-ordinator is only available for three days of the week at Rannoch Ward, however. There is concern about the lack of activity provision throughout the whole week which has the potential to lead to boredom and dysregulated behaviour and indeed a loss of life skills.

The soft furnishings within Rannoch Ward require to be replaced. A Snoezelen multi-sensory room (which had already been planned for) requires to be completed together with the provision of additional garden space so that the new environment at least matches the environment at Carseview Centre (particularly in the absence of the noise abatement measures yet to be completed).

Whilst some people are unfortunately in delay because of a lack of community provision, failure to invest in meaningful activities and resources within the ward makes it less likely that people will be ready and able to effectively take up opportunities in the community when they do arise.

Recommendations

Recommendation 1:

It is recommended that work is done to ensure more accessible formats are in place to support people to actively contribute to their care plans and understand their rights e.g. easy read leaflets.

Recommendation 2:

Everyone has a right to make an advance statement, and we recommend that Rannoch Ward build the offer of an advance statement into practice when the person is well, as part of discharge planning. This is not the sole responsibility of MHOs and advocacy staff.

Recommendation 3:

There is a need to strengthen audits of care plans and risk assessment/risk management plans to ensure consistent quality and full completion to support effective care delivery.

Recommendation 4:

Investment is required in dedicated integrated allied health professional multidisciplinary support.

Recommendation 5:

Meaningful activities require to be available throughout the week and evening; investment is required to secure this.

Recommendation 6:

The multisensory room should be completed as a matter of urgency. An update on this particular action and the noise abatement work is required by end December 2026.

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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