Health Services Safety Investigations Body

Investigation report

Keeping children and young people with mental health needs safe: the design of the paediatric ward

Date Published:
23/05/2024

Theme:
Mental health,Acute,Ward design

Contents

A note of acknowledgement

We would like to thank Leah, whose experience is documented in this report, and her family. We would also like to thank the healthcare staff who engaged with the investigation for their openness and willingness to support improvements in this area of care.

About this report

This report is intended for healthcare organisations, policymakers and the public to help improve patient safety in relation to children and young people with mental health needs while they stay on an acute paediatric ward. For readers less familiar with this area of healthcare, medical terms and the national landscape are explained in section 1 of this report.

This is a legacy investigation completed by the Health Services Safety Investigations Body (HSSIB) under the NHS England (Healthcare Safety Investigation Branch) Directions 2022.

Executive summary

Background

This investigation looks at the care of children and young people with mental health issues who are admitted to a paediatric ward in an acute hospital – that is, a ward for children and young people in a hospital that typically treats physical health conditions. Specifically, it focuses on the risk factors associated with the design of paediatric wards in acute hospitals caring for children and young people with mental health needs. The investigation recognises there are multiple factors that may come together to impact on the care of children and young people with mental health needs who may be admitted to an acute paediatric ward.

Children and young people with mental health needs may be admitted to an acute paediatric ward because they need treatment for a physical health condition, or because issues with their mental health have escalated. They may be required to stay on the paediatric ward as a place of safety while they await a mental health assessment, to receive mental health treatment and/or until a mental health and/or social care placement is found. However, acute paediatric wards are traditionally designed for the treatment of children and young people who need physical health care and are not typically designed to keep those with mental health issues safe. In 2023, 1 in 5 children and young people in England aged between 8 and 16 years showed signs of having a probable mental health disorder. Between 2021 and 2022, 39,926 (11.7%) of admissions to an acute inpatient ward, for children aged 5 to 18 years old, were due to mental health conditions. The percentage is higher for females aged 11 to 15, who account for 28.3% of all acute inpatient admissions for this age group. NHS England has recognised that there is a need to transform and improve children and young people’s mental health services. The NHS strategic

direction is that most children and young people with mental health needs will be supported in the community, avoiding hospital and mental health inpatient admissions where possible.

However, the high levels of children who present with both physical and mental health difficulties, as well as the high incidence of neurodivergence, means that there will remain a significant proportion of children and young people on the acute paediatric ward presenting with mental health, learning, cognitive, communication and/or behavioural difficulties. It is therefore essential that the design and delivery of care on paediatric wards is able to effectively meet the varied and often complex emotional, social and physical needs of the children and young people it serves. NHS England aims to build a culture where mental health is valued equally to physical health, in which the paediatric ward can be the right place of care for children and young people with mental health needs.

The investigation used a real patient safety incident, referred to as ‘the reference event’, as an example of care for children and young people with mental health needs admitted to an acute paediatric ward.

The reference event

The patient, Leah, was a young person who had a history of trauma. Leah was taken to her local hospital’s emergency department (ED) by her social worker because she was expressing suicidal thoughts.

Leah was admitted to a paediatric ward in the acute hospital while awaiting a mental health assessment under the provisions of the Mental Health Act (1983). After being assessed, Leah was detained on the paediatric ward under section 2 of the Act. During her stay she had episodes of violence and aggression where she attempted to self-harm and to harm staff. Staff attempted to keep her safe by removing most of the items (clinical and non-clinical) from her room and by using physical restraint techniques and sedation. Leah left the paediatric ward without permission (absconded) on several occasions; on two of these occasions, she took paracetamol tablets and needed medical treatment for an overdose.

The investigation

The incident was referred to the Healthcare Safety Investigation Branch (HSIB) by the Trust that runs the hospital where Leah was cared for, and the investigation sought to:

- understand the paediatric ward design factors that impact on the safety of children and young people with mental health needs in acute NHS hospitals
- identify opportunities to adapt the design of paediatric wards in acute hospitals to help support children and young people with mental health needs and those caring for them
- explore the management of risk associated with paediatric ward design in acute hospitals and adaptations that have been made locally.

The investigation produced an interim report which highlighted the significant risks associated with caring for children and young people who exhibit certain high-risk behaviours when staying in an acute paediatric ward. This could include instances of self-harm, suicide attempts or acts of physical aggression towards others. Such behaviours present risks to the safety and wellbeing of the individual, and of other patients, family members and staff on paediatric wards. The interim report suggested actions for integrated care boards and NHS organisations to help facilitate a system-wide response to these risks.

Findings

- Paediatric wards had features which were particularly challenging for children and young people with mental health needs, such as being noisy, busy, and brightly lit.
- There was limited national guidance about how paediatric wards should be adapted for children and young people with mental health needs.
- Paediatric wards in acute hospitals tended to focus on adapting their environments to improve the physical safety of a room for children and young people with a mental health need. Rooms would be stripped of items deemed to be a risk.
- Evidence indicated that removing items and creating a more restrictive environment can create more conflict situations including increased aggression, physical and verbal abuse, rule breaking, medication refusal, leaving the hospital without permission (absconding), and self-harm.

- There are opportunities to better support children and young people on acute paediatric wards by improving the environment to support therapeutic care and patient safety.
- Nationally, there was variability in the design of rooms that had been created on paediatric wards to support children and young people with mental health needs.
- Evaluating the learning from innovations and adaptations that individual hospitals around the country have made to their acute paediatric wards for children and young people with mental health needs can improve patient safety.
- There is a gap in the communication, escalation and management and oversight of risks associated with the acute paediatric ward environment for children and young people with mental health needs.
- There were differing views among paediatric ward staff, mental health experts and local, regional, and senior leaders in healthcare about whether children and young people with mental health needs should be cared for on an acute paediatric wards.

HSSIB makes the following safety recommendations

Safety recommendation R/2024/027:

HSSIB recommends that NHS England, in collaboration with key stakeholders, including young people with lived experience and their families, develops guidance on how acute paediatric wards could be adapted to support children and young people with mental health needs. This work should focus on improving the therapeutic environment.

Safety recommendation R/2024/028:

HSSIB recommends that NHS England, in collaboration with key stakeholders, updates ‘Health Building Note 23: Hospital accommodation for children and young people’ to include the therapeutic environment for supporting children and young people with mental health needs.

Safety recommendation R/2024/029:

HSSIB recommends that the Care Quality Commission uses the findings of this report to ensure healthcare providers and integrated care boards implement a robust way for risks associated with the adaptations made to acute paediatric wards to be escalated and managed.

HSSIB proposes the following safety response for integrated care boards and healthcare providers

Proposed safety response for ICB/2024/006:

HSSIB suggests that integrated care boards work in collaboration with healthcare providers to implement a robust way for risks associated with the adaptations made to acute paediatric wards to be understood, escalated and managed to ensure that adaptations enhance patient safety.

1. Background and context

1.1 Introduction

1.1.1 This investigation focuses on the care of children and young people with mental health needs who are treated in acute hospitals (hospitals that traditionally treat physical health conditions). In particular, it looks at the design of paediatric wards (specialist wards for children and young people) where children and young people with mental health needs may receive care. The investigation has wider applicability to children and young people who are neurodivergent and have other complex social needs.

1.1.2 The investigation looked at the care of children and young people up to the age of 18. The investigation recognises that there is variation in ages that paediatric wards in England will admit patients up to. For example, there are paediatric wards who do not admit young people over 16 years of age. In those circumstances they are either treated as adults or given a choice about whether they stay on a paediatric or adult ward. HSSIB's investigation into 'The provision of safe care during transition from children and young person to adult, inpatient mental health services' will explore variation in transition ages further

1.1.3 Children and young people with mental health needs may be admitted to an acute paediatric ward when they have a physical health need but can also be admitted when issues with their mental health have escalated. They may be required to stay on the paediatric ward as a place of safety while they wait for a mental health assessment to be carried out, and/or until a mental health and/or social care placement is found for them.

1.1.4 Paediatric wards are primarily designed for the care of children and young people who have physical health needs and are not typically designed to help keep those with mental health needs safe.

1.1.5 NHS England has recognised a need to transform and improve children and young people's mental health services (NHS, 2019). The NHS's strategic direction is that most children and young people with mental health needs will be supported in the community, avoiding hospital and mental health inpatient admissions where possible. Work at a national level aims to improve support for children and young people with mental health needs while they are staying in an acute paediatric ward, and for the staff caring for them.

1.1.6 The interim report published by this investigation (Healthcare Safety Investigation Branch, 2023) outlined some of the risks associated with caring for children and young people who exhibit certain high-risk behaviours when staying in an acute paediatric ward. This could include instances of self-harm, suicide attempts or act of physical aggression towards others. Such behaviours present risks to the safety and wellbeing of the individual, and of other patients, family members and staff on the paediatric ward.

1.1.7 The investigation recognises there are multiple factors that may come together to impact on the care of children and young people with mental health needs who may be admitted to an acute paediatric ward. Many important issues are raised in this report such as limitations in staff training, the use of restrictive practices, limitations in staffing, the use of the mental health act, the provision of mental health support to the paediatric ward, and the access to and provision of mental health services such as inpatient mental health beds and community support.

1.1.8 The investigation has focused on the design of paediatric wards as there was on-going national work (see 1.4) being conducted to improve many of the issues described above, and the design of paediatric wards was found to be a patient safety risk which was not being explored.

1.1.9 This investigation explores the adaptations being made to paediatric ward environments and how these changes relate to current national guidance, research, and expert advice.

1.1.10 The investigation highlights the importance of therapeutic care (see 1.2). The gap between providing safe and therapeutic care is explored as well as opportunities to adapt the paediatric ward environment to better support children and young people with mental health needs.

1.2 Therapeutic care

1.2.1 Providing therapeutic care is important in supporting children and young people with mental health needs. This investigation considers that therapeutic care includes both therapeutic engagement and the therapeutic environment.

1.2.2 Therapeutic engagement is the ‘partnership relationship between staff and patients, with shared decision-making and recovery-focused goals’ (Care Quality Commission, 2023a). The relationship between staff and patients is based on mutual trust and respect and enabling patients to solve problems and enhance their coping capacity.

1.2.3 The therapeutic environment is about creating an environment that reduces stress and anxiety and where the child or young person feels emotionally safe. Having a therapeutic environment can support therapeutic engagement and physical safety; an environment that is less stressful can reduce feelings of aggression and violence.

1.2.4 There are many factors that can affect a ward environment, including:

- physical layout (including privacy)
- lighting
- noise
- decoration
- age
- equipment
- staffing.

1.2.5 Each of these factors, in isolation or when taken together, can also help to improve care or may provide challenges for staff in delivering safe and therapeutic care to children and young people with mental health needs.

1.3 The Mental Health Act 1983

1.3.1 The Mental Health Act 1983 is the law relating to ‘mentally disordered persons’ (the term used in the Act for people with a mental health problem or certain learning disabilities). The sections of the act relevant to this investigation are ‘Part II compulsory admissions to hospital and guardianship’ which state the procedure for hospital admission.

Section 2

1.3.2 Under section 2 of the Mental Health Act 1983, a person may be detained for up to 28 days so that their mental health can be assessed.

Section 136

1.3.3 Section 136 of the Act allows a police officer to take a person to a place of safety, or if the person is already at a place of safety, to keep the person at that place or take them to another place of safety. According to the ‘Mental Health Act 1983 Code of Practice’ (Department of Health, 1983), police officers should not be expected to remain until a mental health assessment is completed. The police officer ‘should be able to leave when the situation is agreed to be safe for the patient and healthcare staff’.

1.3.4 A place of safety for a child includes an NHS hospital, an independent hospital or care home for mentally disordered people or any other suitable place. A police station may not be used as a place of safety for a child or young person. A section 136 suite may be used, which are safe and secure environments intended for people detained under Section 136 of the Act.

1.3.5 NHS England (2022a) recognises that children and young people who are identified as potentially requiring specialist children’s mental health care may need to be admitted to a paediatric ward while an assessment takes place. Children and young people may then remain in an acute paediatric setting as a place of safety for some time while a community pack of care across agencies is co-ordinated or because of complexities and pressures across the health and social care system, increased mental health needs or a social care placement falls through (NHS England, 2022a).

1.4 The national landscape

1.4.1 Over the past 10 years, there has been an increasing need for mental health services to support children and young people (NHS England, 2022b). The rates of ‘probable’ mental disorder in children and young people have remained stable between 2022 and 2023 with approximately 1 in 5 children and young people aged 8 to 16 years old having a probable mental health disorder (NHS England, 2023).

1.4.2 Data shows that 39,925 (11.7%) of acute inpatient admissions (i.e. to a paediatric ward) for children and young people aged 5 to 18 years old in 2021-2022 in England were due to mental health conditions. Increases in acute admissions were greatest in females aged 11-15, who accounted for 28.3% of all acute admissions for this age group (Ward et al., 2024).

1.4.3 Some children and young people with mental health needs are seen at acute hospitals because they need physical and/or mental health care. These children and young people can have complex needs, needing care and/or medical stabilisation within a paediatric or acute setting (NHS England, 2022a). For example, they may have neurodivergent needs, mental health needs and require treatment for an overdose or eating disorder that requires medical stabilisation.

1.4.4 Their complex needs, combined with pressures across the health and social care system (NHS England, 2022a), mean it can be difficult to find and arrange suitable follow-on care (Healthcare Safety Investigation Branch, 2023). For example, one regional review showed that 66% of children and young people with mental health needs on acute paediatric wards were, from a physical health perspective, clinically ready to be discharged.

The NHS Long Term Plan

1.4.5 The NHS Long Term Plan (NHS, 2019) sets the strategic direction of the NHS and will ensure that funding for children and young people’s mental health services will grow faster than both overall NHS funding and total mental health spending. The NHS website outlines the aims of the NHS Long Term Plan for children and young people’s mental health (NHS, n.d.a).

1.4.6 A key priority of the NHS Long Term Plan (NHS, 2019) is to achieve ‘parity of esteem’. This means ensuring that mental health care is valued equally with physical health care and that there is better integration of physical and mental health care for children and young people. For the NHS, delivering parity of esteem for mental health would mean equity of timely access, evidence-based and therapeutic care, and patient experience for people with mental health needs.

Care Quality Commission: ‘Assessment of mental health services in acute trusts’

1.4.7 Between September 2017 and March 2019, the Care Quality Commission (2020) reviewed how well the mental health needs of patients were met in acute hospitals, including children and young people’s services. The report identified challenges including:

- Limited availability of 24/7 community crisis services which meant patients were often left with no other option than to attend the emergency department
- Trust boards often lacked oversight of how people with mental health needs were cared for while in hospital
- People with mental health conditions that put them at high risk of harm were not always provided with a safe, therapeutic environment
- Staff were unclear about the mental health act and leg process of detaining someone in hospital
- Staff felt unsupported and unprepared to meet the mental health needs of their patients.

1.4.8 The report makes several recommendations to improve the planning and commission of services, to improve the care for patients with mental health needs while staying in an acute hospital and to better support for staff through training and wellbeing support.

NHS England: ‘Supporting children and young people with mental health needs in acute paediatric settings. A framework for systems’

1.4.9 NHS England (2022a) has published a framework for supporting children and young people with mental health needs who are admitted to an acute paediatric setting. The framework sets out six recommendations for how children and young people with mental health needs in acute paediatric settings will be supported.

1.4.10 One recommendation focuses on the need to ensure that five key principles underpin joint working to support children and young people in the acute paediatric setting, including:

- fostering a culture of collaborative working
- that a paediatric setting can be the right place for children and young people with mental health needs to receive care

- supporting the paediatric workforce with a multidisciplinary team both within the healthcare provider and by the wider health and social care system
- collaboration between health and social care systems across acute and mental health care to avoid long waits in emergency departments and delayed discharge
- personalising care for the needs of the children and young people.

1.4.11 Other recommendations include a need for partners within the health and care system to work together and develop joined-up care pathways, learning from ‘what good looks like’ and innovating practice, ensuring children and young people with mental health needs and a learning disability or autism are considered, and ensuring staff have the support and training needed to deliver high-quality care.

Mental Health Admissions to Paediatric Wards Study

1.4.12 The Mental Health Admissions to Paediatric Wards Study (MAPS) began in June 2022, hosted by University College London, and funded by the National Institute for Health and Care Research (NIHR). The study will continue until May 2025 and aims to positively impact the quality of care for children and young people in mental health crisis who are admitted to paediatric wards in acute hospitals.

1.4.13 The study will explore:

- national trends in admissions
- characteristics of admissions in terms of sociodemographic factors, diagnosis and reasons admitted
- factors influencing decisions to admit children and young people who primarily have a mental health need to paediatric wards
- views and experiences of children and young people, families and health professional during admissions to paediatric wards.

1.4.14 The NIHR research team is working with national health bodies and royal colleges as well as young people and parents with lived experience, and staff working on wards to co-design the research and to bring together their overall findings and recommendations...

Integrated care boards and integrated care systems

1.4.15 In July 2022 NHS England established 42 statutory integrated care boards (ICBs) in line with the Health and Care Act 2022. This was part of the Act's provision for creating integrated care systems (ICSs).

1.4.16 ICSs are partnerships of NHS bodies and local authorities, working with other relevant local organisations. Together they plan and deliver joined-up health and care services with an aim of improving the 'lives of people in their area' (NHS England, n.d.a). The purpose of ICSs is to bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development (NHS England, n.d.a).

1.4.17 Each ICS has an ICB, which is responsible for developing a plan, in collaboration with NHS trusts and other partners within the NHS, for meeting the health needs of the population. They also manage NHS budgets and arrange for the provision of health services within their defined regions.

1.4.18 A component of ICSs are NHS-led provider collaboratives. These are groups of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. They are responsible for the budget and pathway for their given population (NHS England, n.d.b).

1.5 Children and young people's mental health inpatient services

1.5.1 Children and young people's mental health services were divided into four tiers, each offering different levels of support and types of intervention (NHS England, 2014). For example, early intervention or milder mental health problems are supported by Tier 2 services, while more complex issues are supported by Tier 3 or Tier 4 services (children and young people's mental health inpatient services). Children and young people's mental health inpatient services, which are referred to in this report, are specialised children and young people's mental health services which include day and inpatient services. They provide treatment and care for a range of mental health problems, including eating disorders, obsessive compulsive

disorders, and high-risk behaviours such as risk of suicide, absconding with a significant threat to safety, aggression, or vulnerability due to agitation or sexual disinhibition (NHS England, 2018).

1.6 Health building notes

1.6.1 Health building notes (HBNs) give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities. They provide information to support the design processes for individual projects in the NHS building programme.

1.6.2 The responsibility for the production and management of health building notes transferred from the Department of Health and Social Care to NHS England and NHS Improvement in February 2017.

2. The reference event

The investigation used a patient safety incident, referred to as ‘the reference event’, to examine the safety risks associated with children and young people with mental health needs being admitted to an acute paediatric ward.

Leah’s background

2.1.1 At the time of the reference event, Leah was 17 years old and was a ‘looked-after child’ (a child in local authority care). She had a complex history of trauma, expressed suicidal thoughts and struggled to maintain her emotional responses to situations. Leah was receiving support for suspected post-natal depression from the specialist perinatal mental health (PMH) service, which offers mental health support during pregnancy and the first year after birth. Some more personal aspects of Leah’s story have been omitted.

First visit to the emergency department

2.1.2 Following a breakdown in her social situation, Leah expressed thoughts about taking her own life. Her social worker took her to the emergency department (ED) at her local hospital at 13:57 hours (day 1). At 14:40 hours she was referred to the children and young people’s mental health (CYPMH) psychiatric liaison team for an assessment of her mental health needs.

2.1.3 Leah was seen by the CYPMH psychiatric liaison team from 16:00 hours to 18:00 hours that day. Following their assessment, Leah was considered safe to be discharged from the ED. The plan was for her to stay with a foster carer that evening and for Leah's placement to be reviewed the following day. Arrangements were also made for a member of the PMH service to contact Leah, with a follow-up face-to-face appointment arranged for 2 days later.

Second visit to the emergency department

2.1.4 At her foster placement Leah continued to express suicidal thoughts. Leah was taken back to the ED at 20:58 hours (on the same day as her first ED visit) by her social worker. Shortly after arriving at the ED Leah's social worker left, and Leah then absconded (ran away) from the ED.

2.1.5 Leah was returned to the ED by police at 22:00 hours (not under arrest or under a section 136 of the Mental Health Act). She was assessed by the ED adult mental health liaison team at 00:20 hours and was referred for an assessment under the Mental Health Act. Leah was assessed by staff as being at minimal risk of hurting herself at that time. However, she was unable to go back to her overnight foster placement and no other social care placement was available. A decision was made by staff for Leah to remain in the ED overnight and for social services to review a placement the following day.

2.1.6 Between 03:30 hours and 04:00 hours (day 2), Leah absconded from the hospital. She was returned to the ED at 13:30 hours by the police under section 136 of the Mental Health Act. She was expressing suicidal thoughts and required a medical assessment for a head injury she had sustained.

Events on the acute paediatric ward

2.1.7 Leah was admitted to the hospital's paediatric ward. Arrangements were made for the CYPMH urgent help service (a service for young people who are at immediate risk of taking their own life or showing severe psychotic symptoms) to conduct a Mental Health Act assessment the following day. The police remained with Leah in the paediatric ward overnight.

2.1.8 At 07:40 hours the following morning (day 3), Leah became verbally abusive towards the police and attempted to leave. Leah was handcuffed by the police; however, the handcuffs were removed later, when Leah had calmed down.

2.1.9 At 12:00 hours Leah was assessed under the Mental Health Act by two approved mental health professionals and a decision was made to detain Leah under section 2 of the Act, ‘an application for admission for assessment’ (see 1.3).

2.1.10 The reason for admission was that Leah was not able to fully understand the need for, or consent to, being admitted to hospital voluntarily for a mental health assessment. Leah was not able to be cared for in the community with mental health support as she kept running away from the services designed to help and protect her. The urgent help service tried to find a specialist CYPMH inpatient placement for Leah (see 1.5.1).

2.1.11 The police then left... Leah absconded from the paediatric ward later that afternoon. Ward staff followed Leah but were unable to follow her beyond the hospital’s boundary; Leah was later returned to the ward by the police.

2.1.12 Once back on the ward, two police officers attempted to search Leah. Leah refused so she was handcuffed. Two more police officers arrived because Leah’s behaviour was difficult to manage and it was difficult to keep her safe. Leah’s side room on the ward was checked for anything that she might use to hurt herself and this included removing her bed. Leah’s high-risk behaviour continued, and she made several attempts to hurt herself.

2.1.13 Leah was given medication by staff to help her anxiety and make her feel calmer, after which it is documented in her medical notes that she was ‘drowsy’. The CYPMH psychiatrist advised that they would call the local CYPMH inpatient unit to see whether there were any beds and whether a registered mental health nurse (RMN) was available to support Leah on the ward.

2.1.14 The following morning at 08:35 hours (day 4), Leah absconded from the ward. Several hospital staff followed her, but she left the hospital grounds. Leah was again returned to the paediatric ward by the police at 11:55 hours. Leah had tried to self-harm by taking paracetamol but would not tell staff how many she had taken.

2.1.15 A plan was made by staff to test Leah’s blood at 15:00 hours to check for toxic paracetamol levels. When staff attempted to take a blood sample, Leah refused and was aggressive towards staff. Leah then absconded again at 15:40 hours.

2.1.16 The police returned Leah to the paediatric ward at approximately 17:00 hours and there was concern that she had taken more paracetamol. At 17:35 hours Leah became agitated; she tried to self-harm and needed to be physically restrained by police to keep her safe. Leah's behaviour continued to escalate, and the on-call consultant paediatrician and consultant psychiatrist were contacted.

2.1.17 A discussion was held between the head of nursing, chief of service and the anaesthetic team. They considered that Leah was at risk of serious harm or death from taking too many paracetamol tablets and that she needed urgent treatment. This would mean giving her medicine through a tube into one of her veins (intravenously).

2.1.18 Leah did not want (refused) the treatment to treat her paracetamol overdose. Young people under 18 are not deemed able to refuse lifesaving treatment irrespective of their mental capacity. Therefore, to ensure Leah's safety, a decision was made to act in Leah's best interests, in line with the Mental Capacity Act. Leah was given medicine to put her to sleep (an anaesthetic) and to have her breathing maintained artificially on a ventilator so that an intravenous infusion treatment for paracetamol overdose could be administered safely.

Admission to the intensive care unit

2.1.19 On day 4 (a Thursday evening), Leah was admitted to the adult intensive care unit where she stayed over the weekend. To try and make sure Leah was in the safest environment possible for her mental health needs, calls were made between the hospital's executives and directors of the CYPMH service. A plan was made for the urgent help service to continue looking for an inpatient bed for Leah over the weekend. The provider collaborative (see 1.4.18) continued to search for beds nationally on Monday; a further call between the hospital and other health and social care system partners was also arranged.

Return to the paediatric ward

2.1.20 Leah was returned to the paediatric ward on day 8 (Monday). However, she made multiple attempts to abscond, on one occasion injuring two members of staff. She was given medicine to help sedate her until an alternative placement could be found.

Transfer to an alternative place of safety and admission to a CYPMH inpatient unit

2.1.21 Following daily escalation calls between the hospital, the CYPMH service, the provider collaborative and social care staff, a plan was made to use a 136 suite (see 1.3.4) for Leah to use as a health-based place of safety while waiting for a CYPMH inpatient bed.

2.1.22 Leah was transferred to the 136 suite on the evening of day 10 (Wednesday) where she remained for approximately 23 days. Leah was then admitted to a CYPMH 4 inpatient unit. She was discharged within 24 hours.

3. Analysis and findings – the reference event

This section focuses on the investigation's findings in relation to the reference event, focusing in particular on the acute paediatric ward environment. A wide range of factors were identified in relation to Leah's care; however, some of these were outside of the scope of the investigation. There are additional details which are relevant to Leah's story in the interim report (Healthcare Safety Investigation Branch, 2023). In particular, the interim report explores the impact of caring for children and young people with mental health needs on a paediatric ward on the children and young people themselves, and on other patients, family members and staff.

This section focuses on the following themes:

- factors influencing admission to an acute paediatric ward
- the paediatric ward environment
- guidance on adapting the paediatric ward environment to support children and young people with mental health needs.

3.1 Factors influencing admission to an acute paediatric ward

3.1.1 The investigation was told by staff from the hospital and children and young people's mental health (CYPMH) services that there are few health-based places of safety that a child or young person can go to. The Mental Health Act 1983 lists a hospital as a place of safety. The investigation learned that children and young people in mental health crisis are often taken to the Trust's emergency department (ED).

3.1.2 Leah told the investigation that she left the ED without permission because she was “waiting so long”. She found the environment distressing with “crying babies around you”, which she described as triggering for her given the traumatic social situation she was experiencing. Leah stated that it was “so easy to walk out the door and they can’t stop you and by the time they call security, you’re gone already”.

3.1.3 Trust staff shared that they felt the ED was not a suitable environment for people with a mental health illness in crisis. This is explored in a previous investigation into provision of mental health care to patients presenting at the ED (Healthcare Safety Investigation Branch, 2018). The ED was reported to be noisy, had bright lights and there were many exits. The investigation was told that children and young people with mental health needs would regularly leave the ED without permission. The investigation learned that the security team were often used as a deterrent and would often bring back children and young people who left without permission. However, the hospital security team were unable to go beyond the hospital grounds, meaning that the police were often requested to assist.

3.1.4 Staff said that the only other place children and young people in mental health crisis could go was back to their home or to an inpatient unit. There was no ‘halfway house’ (also known as crisis houses, sanctuaries, or safe havens) where children and young people in mental health crisis could go. A halfway house service is available to adults experiencing a mental health crisis which offers an alternative to going into hospital. The service offers intensive treatment, overnight accommodation, and a home-like environment (Mind, 2018). The local social care team reported there used to be ‘halfway houses’ but they were experiencing recruitment issues and so were unable to keep these establishments open.

3.1.5 Another type of short-term health-based place of safety is a 136 suite. However, these suites are only available to mental health patients being held under section 136 of the Mental Health Act 1983 (that is, detained by the police). Leah was not initially detained under section 136 of the Act.

3.1.6 The investigation learned that there were very few or at times no 136 suites that children and young people could use which were local to the Trust. When Leah was later detained by the police under section 136 of the Mental Health Act, a 136 suite was not available.

3.1.7 Trust staff told the investigation that owing to the (reported) unsuitability of the ED and the lack of other health-based places of safety, there was pressure from the ED and mental health services to send children and young people to the acute

paediatric ward. The paediatric ward was perceived by staff to be a better environment than the ED for young people with mental health needs. Staff told the investigation that there was often nowhere else for children and young people in crisis to go.

3.1.8 While Leah was admitted to the paediatric ward on a weekday, the investigation learned that mental health admissions to the paediatric ward occurred routinely over weekends as there was limited mental health support during this time.

3.2 The acute paediatric ward environment

3.2.1 Trust staff told the investigation that the acute paediatric ward (referred to as ‘the ward’ throughout this section) environment was “not safe” for children and young people with mental health needs. The investigation found that there were several factors associated with the ward environment (outlined below) that influenced Leah’s care.

Ability to leave the ward without permission (abscond)

3.2.2 Leah was able to abscond from the ward many times. Staff reported that it was difficult to prevent children and young people from absconding from the ward.

3.2.3 Leah was placed in an individual unlocked side room on the ward. The side room was located near to the nurses’ station but was also on the same corridor that led to the exit. The investigation observed that lines of sight from the nurses’ station to the door of Leah’s side room were limited. This meant that staff working at the nurses’ station could not always visually monitor Leah’s side room door.

3.2.4 Staff reported that ideally, children and young people experiencing a mental health issue would be placed in another room opposite the ward manager’s office. From this room, the primary exit route went directly past the nurses’ station, affording greater lines of sight and supervision. However, this room was often used for requiring high dependency clinical care and was not available during Leah’s stay.

3.2.5 Staff reported that they tried to maintain one-to-one supervision with Leah, but that this was not always possible due to the availability of staff. The ward was reported to be short staffed during Leah’s stay and the investigation was told this was not unusual.

3.2.6 The investigation learned that registered mental health nurses (RMNs) would be brought in to help staff with children and young people with mental health needs. RMNs were agency staff or children and young people's mental health staff specially brought in when required. However, it was reported that they were not always available. Staff said that it was not always possible to get an RMN until a patient had been sectioned under the Mental Health Act and then it could take more time to organise. The investigation learned that an RMN was sourced for Leah but was not present for the entire duration of her stay. Staff told the investigation that since Leah's stay, the local CYPMH service had been supplying more staff to the Trust.

3.2.7 Staff described having a challenging workload at the time that Leah was on the ward. The ward was reported to be full, with a lot of other unwell children that staff needed to care for. Another young person with mental health needs was also on the ward during Leah's stay; this young person was also absconding. Staff reported that there were competing demands in delivering all of the care required and that this had an impact on patient safety.

3.2.8 The investigation found that most acute paediatric wards have restricted access, with access points controlled by staff. Exits were usually controlled by a door release button positioned at a height so as to prevent younger children from leaving the ward. This was the case on the ward where Leah stayed. Young people such as Leah were tall enough to reach the door release button.

3.2.9 Ward staff reported that there were often frustrations between police officers and ward staff because the police felt the hospital should be doing more to prevent children and young people absconding. Each time a child or young person absconded from the ward, it resulted in a whole-force deployment to look for them, which ward staff stated was a "huge waste of resource". Ward staff said that the police did not understand what the ward was like and that it was not a secure unit.

3.2.10 A few months after the reference event, the Trust experienced an incident involving a young person who absconded from the ward and took their own life within the hospital grounds. After this later incident, Leah's incident and other cases of young people absconding, security measures on the ward were increased. The investigation observed security guards located at ward exit doors dressed similarly to police officers, wearing combat style boots and stab vests. This was perceived by children and young people as intimidating. Staff told the investigation that having security guards was helpful, but that for some children and young people, their presence could sometimes be a factor in escalating aggressive behaviour.

Side room environment

3.2.11 The investigation learned that the ward and its individual side rooms were not originally designed to accommodate children and young people experiencing suicidal thoughts and/or self-harming behaviours.

3.2.12 The investigation observed there were many furnishings and items of medical equipment in the room which a child or young person could have used to harm themselves.

3.2.13 When Leah's behaviour escalated, staff removed perceived ligature risks (points that could be used to attach something or items that could be used for self-harm or suicide) from Leah's room, including her bed, with a view to reducing the likelihood of her being able to harm herself. Leah's behaviour continued to escalate, and she found other ways to attempt to self-harm. The investigation found it was challenging for staff to remove all ligature risks (including medical and non-medical items) from the ward environment.

3.2.14 Leah told the investigation that the ward was not quiet or calming and this raised her anger and aggression toward staff. However, Leah said that when staff engaged with her, she found this "really comforting". She also said that "the main way I calm myself down is through smoking and vaping and they wouldn't let me have a cigarette". Leah also shared that she felt staff and the security team "saw her as nuisance" and they felt she was "causing a lot of trouble".

3.2.15 During a visit to the Trust, the investigation observed that a young person in mental health crisis was placed in a room that had clear windows to enable staff to monitor them. Security guards in high-visibility jackets were patrolling the ward. The investigation observed ligature risks, including the window blind (which were the only way of making the room more private), were removed and only a mattress was left on the floor. It was reported by staff that for some children and young people, the risk would be even greater, to the extent that the mattress would also have to be removed. The investigation observed that the section of corridor that led to the young person's room was 'locked down' – that is, entry and exit of that section of corridor was controlled by staff.

3.2.16 The investigation found that staff were trying their best to keep children and young people with mental health needs safe but in doing so were potentially causing harm (Healthcare Safety Investigation Branch, 2023) and that creating more a restrictive and less private environment can cause more conflict situations (Bowers, 2014).

3.2.17 Leah told the investigation that there is a lack of privacy and dignity in the hospital environment for children and young people in mental health crisis. Leah told the investigation that it was “not really nice for other people to see” when she was “kicking off” and having to be restrained. Leah said that she didn’t “want other children who are young watching that”. Leah also reflected that “it’s not fair on the person going through the mental health breakdown with everyone watching and staring at them” and it “kind of just escalates them even more”.

3.2.18 The investigation found that the ward offered a very limited therapeutic environment. This is explored further as part of the wider investigation (see section 4).

3.3 Guidance on adapting the environment for children and young people with mental health needs

3.3.1 The investigation was told that there was no national guidance about how staff should adapt the ward to support children and young people with mental health needs. This included how to reduce the development of high-risk behaviours (such as violence, aggression and self-harm) while on the ward and how the ward should be adapted to support the de-escalation of high-risk behaviours.

3.3.2 The investigation spoke with the Trust’s security team and found that they had assessed the ward for ligature risks and made recommendations to reduce the risk of absconding and incidents of violence and aggression within the ward. The security team reported that despite the implementation of some of their recommendations, they had not seen a significant decrease in the incident rate.

3.3.3 The investigation visited a paediatric ward in another hospital, which was part of the same Trust. The investigation noted that staff had developed a checklist to prompt staff about what items to look for and remove from children and young people with mental health needs who may be attempting to self-harm. The checklist had been developed using their own experience from previous incidents on the paediatric ward and was not based on wider evidence for supporting children and young people with mental health needs.

Provision of children and young people’s mental health support to the acute paediatric ward

3.3.4 Leah told the investigation how she felt when she was at crisis point: “When having a mental health breakdown you need to be somewhere quiet and calm with a lot more support.” Leah felt that she needed someone to speak with to “stop your

brain thinking about things you don't want to". The investigation found that while staff tried to engage with Leah, there were limitations in the therapeutic mental health support she received.

3.3.5 Staff told the investigation that children and young people experiencing mental health issues were not offered treatment or therapy during their stay on the ward and that their mental health could deteriorate further. Although RMN's were recruited temporarily to support children and young people with mental health needs, it was reported that they often did not engage with the child or young person. HSSIB (2024) has conducted an investigation into the continuous observation of patients who are at risk of self-harm which explores this issue further.

3.3.6 The investigation learned that children and young people with mental health needs who had been admitted to the ward were supposed to have regular reviews by a mental health team, but that this did not always happen. Staff said that the local CYPMH service did not have capacity to see patients again or to check in and reassess them every day.

3.3.7 The investigation found that the local CYPMH psychiatric liaison team (which provides psychiatric assessments, support and treatment to people who are in an acute hospital and experiencing mental health issues) had limited staff: the equivalent of one full time and one half-time staff members to cover the three hospitals. The CYPMH psychiatric liaison team also had limited operating hours which meant that their services were not available after 17:00 hours.

3.3.8 The investigation learned that a telephone support line was available to staff, including an on-call psychiatrist. This service was used during Leah's care, however, staff reported that it was not ideal and having psychiatric support in the building would have helped rather than having to manage escalating situations over the telephone.

3.3.9 Staff reported that they did not receive training or feel prepared for caring for children and young people with mental health needs. Since the reference event, more staff training and resources have been put in place nationally in line with NHS England's e-learning for healthcare (NHS England, n.d.c) and there may be other training resources available.

Sharing the risk with the wider health and social care system

3.3.10 The investigation found that staff made daily escalation phone calls (except at the weekend when there were limited staff) with a range of stakeholders to try to find Leah an alternative place of care. Stakeholders included:

- Leah's social worker
- a social worker manager
- a CYPMH inpatient service case manager
- Leah's family nurse
- looked-after children's nurses
- the urgent help service
- a children's safeguarding nurse specialist
- the director of the local CYPMH service
- Trust executives
- the CYPMH psychiatrist.

3.3.11 Ward staff stated they had limited support in how best to care for Leah. The investigation found that due to Leah's escalating behaviour staff felt the safest thing they could do for Leah was to restrict, restrain (by the security team) and sedate her.

3.3.12 Leah told the investigation that she felt staff "were just sedating her until they found a [inpatient mental health] bed" and that it was because they didn't want her to "abscond and do something else". Leah commented that she thought it would have been better if there had been a more supportive and therapeutic environment.

3.4 Summary

3.4.1 The investigation found that adaptations to the ward were made when children and young people's behaviour escalated. The adaptations focused on trying to improve the physical safety of the environment, such as stripping the room of ligature risks. However, as evidenced by Leah's case, expert advice, research literature, and this investigation's interim report, placing an overly strong emphasis on physical safety can prove to be restrictive, leading to increased high-risk behaviours (Barnicot et al, 2017; Bowers, 2014; Healthcare Safety Investigation Branch, 2023; Van der Schaaf et al, 2013).

3.4.2 The investigation found that staff had little support, training, or guidance on how best to manage and adapt the ward environment to support children and young people with mental health needs. The issues around how acute paediatric wards are being adapted, guidance and opportunities for improving the therapeutic environment, are explored as part of the wider investigation in section 4.

4. Analysis and findings – the wider investigation

This section explores what trusts are currently doing to adapt their paediatric ward environment for children and young people with mental health needs, and how this relates to available research, expert advice, national guidance, culture, and attitudes. Opportunities to reduce the negative impact of current paediatric ward design on children and young people with mental health needs are also discussed.

The section looks at the following themes in turn:

- adaptation of the ward environment
- understanding the gap between safe and therapeutic care
- opportunities to improve the therapeutic environment.

4.1 Environment adaptations

Focus of current design adaptations

4.1.1 The investigation found that paediatric wards were often focused on making adaptations to improve the physical safety of a room for children or young people with mental health needs, and on keeping them in a localised space. Many hospitals the investigation spoke with had either built, repurposed, or were considering building side rooms to the paediatric ward or emergency department which were ‘ligature light’. Staff described that these rooms reduced the accessibility of items or fixtures in the room which could be used by patients for self-harm or suicide. The aim of these rooms was to provide a safer environment for children and young people with mental health needs.

4.1.2 The investigation found that there was variability in the design of the rooms that had been created. One paediatric ward described that their room for children and young people with mental health needs was “not nice” (see figure 1). The room’s adaptations focused on physical safety features such as auto shut-off taps, and the absence of a shower curtain or rail in the bathroom. The room had limited ventilation and the investigation was told that “it gets hot in summer”.

4.1.3 Similar images and rooms were shared with the investigation or observed during site visits and often appeared stark.

4.1.4 Staff in paediatric wards where no ‘ligature light’ room was available, either because they did not have one or it was already in use, spoke of placing the child or young person in a side room in the paediatric ward if possible. Otherwise, the child or young person was placed into a bed bay with other young patients, or by themselves (closing off beds to other patients) if their behaviour was assessed to be high risk.

4.1.5 Young people with mental health needs told the investigation that the side rooms they were placed in did not always reduce the noise levels or provide enough privacy. Parents of a young person said: “The other thing about the rooms that we found, the ones that she [the young person] were in, they had vents above the door. So, people used to stand outside the door and talk about her, but you could hear them through the vents … she found that really distressing.” Another young person told the investigation: “They're just like shouting things. That kind of made me upset and things … I could see like, yeah, like police and security rushing in, like, hearing people being like sedated and restrained and everything.”

4.1.6 Parents and young people the investigation spoke with talked about limitations in the privacy and dignity offered by the paediatric ward environment. Young people told the investigation that when they were placed in a bed bay (rather than a side room), it didn't feel private. One young person, who had a history of abuse, described the difficultly of being "alone with all these people who I don't know". Parents of a young person with an eating disorder who was force fed with a feeding tube within their bed bay told the investigation: "The biggest difficulty really was that she [the young person] was on a ward with other young people. She only had curtains separating her … she was very conscious of the noise that she would be making to other people. She's never really liked upsetting other people."

4.1.7 The investigation heard from the parents of a young person who also described the trauma, lack of dignity and intimidation of having security teams handle their daughter: "Burly gentlemen in high vis with all the security gear come striding into the ward … we've had security guards that straddled her which is completely inappropriate." The investigation is aware that national work has just started in relation to restrictive practices on acute paediatric wards.

4.1.8 Trusts spoke of measures to prevent children and young people with mental health needs leaving the paediatric ward without permission, including developing areas of the ward which they could 'lock down'. The investigation observed the use of CCTV to mitigate the risk of absconding. However, there were times the CCTV screens were left unmonitored while staff carried out their clinical duties.

4.1.9 The investigation found that trusts had limited external guidance on what and how to adapt their paediatric ward environment for children and young people with mental health needs. The investigation found that many paediatric wards had created checklists as prompts for staff on which items to adapt and remove. Most paediatric wards had created these checklists themselves, based on the experience of paediatric ward staff. When more permanent physical adaptations to paediatric ward rooms were made, for example by creating 'ligature light' rooms, hospitals consulted with the security teams, local mental health teams, and/or visited mental health inpatient facilities to inform what measures they took.

Mental health subject matter advisor opinion

4.1.10 Three mental health subject matter advisors (SMAs) the investigation spoke with challenged how appropriate it was to adapt an acute paediatric ward for children and young people with mental health needs, including the creation of

‘ligature light’ rooms. Two of the SMAs had undertaken a review (unpublished) of self-harm and suicide in mental health inpatient units and in the acute healthcare setting.

4.1.11 The SMAs told the investigation that the review highlighted challenges in managing the environment in the acute hospital setting for patients who wish to self-harm or are experiencing suicidal thoughts. The review found that it was not possible to manage all safety and ligature risks. This was because there were clinical items within the acute hospital environment (for example oxygen tubing) that could not be removed for other patient clinical safety reasons. It was also noted that anti-ligature design, which is designed to collapse, conflicts with the needs of what those with physical disabilities require for their care. There was concern about the unintended consequences that removing clinical items and adding anti-ligature fixtures could have on patient safety.

4.1.12 One of the SMAs highlighted that a lot of money was being spent on adaptations such as side rooms for people with mental health needs, but that unless all the risks in the environment could be controlled, the risk remained. This point of view was illustrated by one trust which reported that it had reduced the amount of ligature risks in its paediatric ward but that this had not changed the number of incidents it was seeing.

4.1.13 The investigation was told by one of the SMAs that acute hospitals should not be trying to apply what works in an inpatient mental health unit to acute hospital wards. They told the investigation that mental health inpatient environments are designed to enable periods of time when patients could have privacy, for example overnight in bedrooms, whereas typically children and young people with high risk of self-harm on paediatric wards would be constantly observed. Additionally in mental health wards, the adaptations to the environment are made to the whole ward and include controls on what was brought into it by everyone. Replicating this approach on a paediatric ward is unfeasible given the varied needs of other patients, and additionally might result in the child or young person with MH needs being restricted to a single room, which would be counterproductive. Evidence from research and SMAs highlights that having a more restrictive environment can create more conflict situations, including increased aggression, physical and verbal abuse, rule breaking, medication refusal, leaving the hospital without permission (absconding), and self-harm (Bowers, 2014).

4.1.14 The investigation spoke to a person with lived experience and heard that when items are taken away, it can make someone in mental health distress feel more suicidal and that “you feel you have no hope”. They reflected on their

experience of when their room was stripped of items and thinking “this is what my life has come to, this empty room, I have no human contact” and that “it’s a form of torture”. The person with lived experience highlighted that a greater focus on therapeutic care was needed.

Therapeutic environment

4.1.15 The investigation learned from multiple sources of evidence of the importance of effective therapeutic engagement for supporting children and young people with mental health needs. Therapeutic engagement is the ‘partnership relationship between staff and patients, with shared decision-making and recovery-focused goals’ (Care Quality Commission, 2023a). While it was out of scope to investigate all aspects of therapeutic care, evidence indicates that well-designed therapeutic environments can help to foster enhanced therapeutic relationships and contribute to patients’ feelings of safety and control.

4.1.16 Many mental health experts told the investigation about the importance of creating an environment that reduces stress and anxiety and where the child or young person feels emotionally safe. It was made explicit by the SMAs that “emotional safety” is different to physical safety.

4.1.17 Research suggests that creating a therapeutic environment for children and young people with mental health needs, as opposed to focusing purely on security features and damage-resistant components such as locks, observation windows, cameras and violence-proof doors and walls, can be beneficial (Ulrich et al, 2018).

4.1.18 A therapeutic environment balances patient safety, privacy, and dignity. Some of the features of a therapeutic environment include:

- Reduction of crowding stress, for example having single patient rooms with private bathrooms, communal areas with movable seating and fewer patients per room.
- Reduction of environmental stress, for example through noise-reducing design and having features within the patient’s room which enable them to control or personalise their room.
- Stress-reducing positive distractions, including access to outdoor spaces, gardens, views of nature from the windows, nature art and daylight exposure.
- Activities to engage in.

- A design that facilitates observation by staff so that they can anticipate and prevent aggressive behaviour. For example, communal spaces and bedroom doors being observable from a central area.

4.1.19 Research has shown that the provision of private or semi-private spaces, and a more home-like environment, correlate with more social interaction and a reduction in aggressive behaviours (Papoulias et al, 2014; Ulrich et al, 2018). It should be noted that research also highlights the importance of the competence and experience of staff and the quality of treatment protocols, and that other non-environmental variables can influence outcomes (Ulrich et al, 2018).

4.1.20 There is also evidence that stress and anxiety can have an impact on healing, and that the built environment can positively or negatively affect the level of anxiety and fear that children experience when in a healthcare setting (Norton-Westwood et al, 2011). Many of the attributes described for a therapeutic environment are the same as those described for a healing environment. This suggests that creating a more therapeutic environment could benefit all children and young people who are staying on an acute paediatric ward.

4.1.21 The investigation met with representatives from the Department of Health and Social Care's New Hospital Programme (House of Commons Committee of Public Accounts, 2023) and a team involved in designing a new children's hospital. Both endorsed the idea that design considerations for patients with mental health needs would benefit the wellbeing of all patients.

4.1.22 The investigation heard how some hospitals were considering the "sensory environment". A few hospitals described features they had added such as the use of "muted" or "calming" colours, soft furnishings, sensory lighting, and placing scenes of nature on the walls (see figure 2). Other hospitals had installed a TV in a protective casing or interactive screens so that children and young people had access to some form of therapeutic activity. However, the investigation noted that many of the rooms described with these added features existed in the emergency department and not in the acute paediatric ward.

4.2 Understanding the gap between safe and therapeutic care

National guidance for designing and adapting paediatric wards

4.2.1 Trusts reported that they were not aware of any national guidance on how paediatric wards should be adapted to support children and young people with mental health needs. This included if or how existing infrastructure should be adapted when creating rooms specifically for children and young people with mental health needs. The investigation found and reviewed a variety of guidance that may be applicable or could have information to help inform how an acute paediatric ward could be adapted.

4.2.2 Health building note (HBN) 23 (NHS Estates, 2004) offers design guidance for new-build and upgrades of existing hospital accommodation for children and young people. The HBN discusses the links between building design, wellbeing, healing, and outcomes. It discusses therapeutic environment elements such as encouraging close relationships with nature, natural lighting, décor, and sound.

4.2.3 HBN 23 also highlights that wards should be sufficiently flexible to accommodate the needs of children of all ages, cultures, ethnicities and a wide variety of health problems and needs. However, the HBN outlines ‘exclusion criteria’ for building facilities to support children with mental health problems in an acute hospital. The HBN states that ‘some of these children [with mental health needs] are admitted to children’s units in acute hospitals and their safety should remain a prime consideration. However, this is an operational management issue focusing on risk assessment and constant observation of the child while they are being cared for in non-dedicated facilities’. HBN 23 therefore does not align with NHS England’s strategic direction of building parity of esteem (where mental health is valued equally to physical health) and that the paediatric ward can be the right place of care (NHS England, 2022a).

4.2.4 The framework for supporting children and young people with mental health needs in acute paediatric settings (NHS England, 2022a) refers to environment adaption principles highlighted in ‘It’s not rocket science’ (National Development Team for Inclusion, 2020). There is also further guidance published in the sensory-friendly resource pack (NHS England, 2023b). The emphasis is that the adaptations are to be considered for those with a learning disability or who are autistic. However, the principles are similar to those for creating a therapeutic environment so are more widely applicable.

4.2.5 Several quality standards and guidelines published by the National Institute for Health and Care Excellence (NICE) were identified as potentially applicable depending on the type of behaviour the children and young people were exhibiting (National Institute for Health and Care Excellence, 2013, 2015a, 2015b, 2017, 2018, 2019, 2022). These behaviours included suicide, self-harm, challenging behaviour and violence and aggression. The NICE standards and guidance were primarily focused on interventions and limited guidance was given for how an environment, such as the paediatric ward, could be adapted or improved.

4.2.6 Guidance on reducing harm from ligatures in mental health wards and wards for people with a learning disability (Care Quality Commission, 2023) outlines positive features that could be considered in ward design including artwork and landscapes and access to outdoor spaces. The importance of co-designing environments with people with lived experience is highlighted so that the challenges of creating the right environment for therapeutic care can be understood.

4.2.7 The investigation heard from trusts, integrated care boards (ICBs), NHS England regional teams and mental health SMAs that there is a need for national guidance. The guidance would need to be flexible so that it could be applied to a range of mental health needs, behaviour types and pre-existing infrastructure.

HSSIB makes the following safety recommendations

Safety recommendation R/2024/027:

HSSIB recommends that NHS England, in collaboration with key stakeholders, including young people with lived experience and their families, develops guidance on how acute paediatric wards could be adapted to support children and young people with mental health needs. This work should focus on improving the therapeutic environment.

Safety recommendation R/2024/028:

HSSIB recommends that NHS England, in collaboration with key stakeholders, updates 'Health Building Note 23: Hospital accommodation for children and young people' to include the therapeutic environment for supporting children and young people with mental health needs.

Management and oversight of risk

4.2.8 The interim report of this investigation (Healthcare Safety Investigation Branch, 2023) highlighted that the responsibility for risks associated with caring for children and young people with high-risk behaviours (including those with mental health needs) were predominantly placed on frontline staff. One staff member reported: 'We are fully aware we will need to continue to care for this group of young people with mental health needs and we will continue to care for them with compassion and professionalism; however, as a team of nurses, we would be grateful for hospital management to see us, to hear us and to support us in this.'

4.2.9 The investigation sought to understand how risks associated with the design and adaptations being made to paediatric wards are escalated to the wider healthcare system. The investigation was told by some trusts and ICBs that escalating the risk around a child or young person to the ICB tended to be on a case-by-case basis and was focused on finding an alternative placement. Trusts and

ICBs told the investigation there could be limited ownership of risks associated with the paediatric ward environment for children and young people with mental health needs beyond trust level. Limitations in the ownership (accountability) for managing safety risks across the healthcare system was a finding in HSSIB's investigation report on safety management systems (Health Services Safety Investigations Body, 2023).

4.2.10 When the investigation began, ICBs had recently been introduced and have since evolved. ICBs told the investigation their priority had been on connecting with other community services to make sure there is support across mental health, education, and social care. The investigation spoke with several ICBs and regional quality boards and found there were differences in their maturity and how risks were being managed and shared.

4.2.11 One region reported that concerns about the paediatric ward environment had been raised and that its region had been providing support. It recognised that there are challenges around adapting the environment. Through charitable projects, some sensory items (such as headphones and weighted blankets) were being provided to make the experience for children and young people better.

4.2.12 The investigation heard that there were challenges to gaining suitable resources for supporting children and young people with mental health needs and the staff caring for them. It was reported that ICBs and regional quality boards were not always fully aware of, or did not fully understand, the concerns and clinical challenges associated with caring for children and young people with mental health needs in the paediatric ward environment. It was also reported that for smaller hospitals, gaining funding for improvements was more challenging as they did not have the power or voice to be heard at more senior levels of the healthcare system. The investigation also heard that there are widespread, national challenges to accessing funding.

4.2.13 The investigation spoke with representatives from the Care Quality Commission (CQC). The investigation was told there is not much data from the paediatric speciality about admissions for children and young people with mental health needs. Risks were identified on a case-by-case basis and there was no overall assurance to know how many children and young people with mental health needs were in the health system. The investigation was informed by the CQC that a paediatric dashboard is being developed to provide operational staff with the information needed to assess the level of risk in provider services.

4.2.14 There are regulations for service providers and managers that CQC uses to support its assessments. As part of regulation 12, healthcare providers should ensure that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way (Care Quality Commission, 2023b).

4.2.15 The investigation was told that CQC inspectors use a variety of guidance (that were shared with HSSIB) for supporting their assessment of mental health provisions in acute services including:

- ‘Inspection framework: NHS acute hospitals: children and young persons’
- ‘Assessing mental health in acute trusts – guidance for inspectors’
- ‘Brief guide – assessing mental health in the emergency department’
- ‘Quality standards for liaison psychiatry services’ (Royal College of Psychiatrists, 2022).

4.2.16 There is also a ‘brief guide’ for inspectors for children who are being cared for in an unsuitable hospital setting (Care Quality Commission, 2022b). A setting is deemed unsuitable if the child or young person has been assessed as requiring an alternative place of care such as a CYPMH inpatient unit. The ‘brief guide’ states that inspectors should look for evidence as follows: ‘Under Regulation 12, check whether the child or young person is receiving care in an appropriate environment where all risks (environmental and individual for each patient) are assessed and mitigated, including ligature risks’ (Care Quality Commission, 2022b).

4.2.17 There were no details given within regulation 12 and limited guidance provided to inspectors about what an appropriate acute paediatric ward environment for children and young people with mental health needs should look like. Where more guidance was provided, such as in the quality standards for psychiatric liaison facilities, these were focused on physical safety features, rather than the therapeutic environment.

4.2.18 The investigation found that NHS England has funded regions and healthcare systems to establish mental health champions. The role of the mental health champion will be to advocate for mental health care across paediatrics, facilitate linking with children and young people’s mental health services, mental health liaison teams, mental health nurses, learning and disability and autism services and other key partners (NHS, n.d.b). There were differing views between stakeholders, and the content of the NHS document (NHS, n.d.), about whether the mental health champions’ role would extend to escalating risk or linking with the ICB and wider

healthcare system. The investigation was told by national organisations that mental health champions could, however, have an important role in sharing learning and making improvements in the paediatric ward environment.

4.2.19 Evidence indicates that there is a gap in the communication, escalation, and management and oversight of risks associated with the paediatric ward environment for children and young people with mental health needs.

HSSIB makes the following safety recommendation

Safety recommendation R/2024/029:

HSSIB recommends that the Care Quality Commission uses the findings of this report to ensure healthcare providers and integrated care boards implement a robust way for risks associated with the adaptations made to acute paediatric wards to be escalated and managed.

HSSIB proposes the following safety response for integrated care boards and healthcare providers

Proposed safety response for ICB/2024/006:

HSSIB suggests that integrated care boards work in collaboration with healthcare providers to implement a robust way for risks associated with the adaptations made to acute paediatric wards to be understood, escalated and managed to ensure that adaptations enhance patient safety.

Culture and attitudes towards caring for children and young people with mental health needs on an acute paediatric ward

4.2.20 The investigation found there were differing views among paediatric ward staff, mental health SMAs and local, regional, and national senior leaders around caring for children and young people with mental health needs on an acute paediatric ward. The difference in opinions was found to be a potential barrier to making improvements.

4.2.21 There was a common perception across healthcare organisations and individuals that the paediatric ward was “not the right place”, especially if the child or young person did not have an “acute need” (that is, they did not need hospital care for a physical health condition). Comments were made such as “not our job”, “not what I trained to do” and that it was “shocking that [it is] seen as normal” to have children and young people with mental health needs on an acute paediatric ward.

4.2.22 The investigation spoke with, and heard from, young people and parents of a young person all with lived experience of staying on an acute paediatric ward with a mental health need. While all spoke of some supportive experiences, the investigation also heard that young people with mental health needs were not always made to feel welcome. Parents told the investigation that “it felt in the end that they blamed her [their child] for being there” and that their child “wasn't considered a real patient”. The investigation heard from several young people who felt like they were just waiting on the paediatric ward and were made to feel like they were not supposed to be there. Children and young people reported feeling unwanted by the system, and that ‘living’ in an acute hospital (reportedly for up to 9 months) while a placement was found caused stress and anxiety.

4.2.23 Some paediatric ward staff and mental health SMAs told the investigation that they struggled to make improvements in their organisations as their senior leaders “don’t get it” and “don’t see them [the children and young people] as children”. The investigation heard concerns from national organisations and trust staff that children’s healthcare needs sit low on the list of priorities. One trust executive commented on the challenges of balancing risk priorities and when there were key risks, such as ambulance queues, being escalated in the system.

4.2.24 The investigation heard that there was a fear that if a better environment was created then more children and young people with mental health needs would be admitted and stay longer on the acute paediatric ward. The investigation was told that some organisations refused to admit children and young people with mental health needs by keeping them in the emergency department and forcing the wider system (ICB, children and young people mental health services and/or social care) to act to find an alternative place of care.

4.2.25 Other staff, trusts, mental health SMAs and national organisations stated that the paediatric ward can be a suitable place of care and that attitudes were shifting. For example, the investigation was told that one trust’s senior leaders had

made parity of esteem part of their patient safety priorities. In that trust, the culture was about providing mental health support to all, rather than just to mental health patients.

4.2.26 The investigation heard from staff, regional quality boards, royal colleges and other national organisations that cultural change was needed and that within healthcare, there was a need to think about the child as a whole and have a more holistic model of care.

4.2.27 As a joint report by the Royal College of Paediatrics and Child Health (2021), Royal College of Emergency Medicine (RCEM) and Royal College of Psychiatrists (RCPsych) states: ‘Children and young people are too vulnerable to be told to try different doors for separate needs or to be left to wait without any support. These patients are all our patients and we must work together to ensure they receive the right treatment, in the right place, at the right time.’

4.2.28 As noted in the previous section, mental health champions are being established across England to support paediatric wards in acute hospitals. The investigation was told by national organisations that mental health champions will work to improve the culture among staff and senior leadership around caring for children and young people with mental health needs on the paediatric ward (NHS, n.d.b).

4.3 Opportunities to improve the therapeutic environment

4.3.1 This section of the report focuses on opportunities to reduce the negative features of the paediatric ward environment for children and young people with mental health needs, and how the infrastructure itself could be improved. It was outside the scope of the investigation to explore all the aspects of supporting therapeutic care, but evidence indicates that it is key to consider the overall therapeutic care when creating a therapeutic environment.

4.3.2 Staff from some paediatric wards spoke about having or looking into having ‘mental health boxes’ for children and young people with mental health needs and/or who are neurodivergent. These boxes contained items such as ear defenders, sunglasses, weighted blankets, aromatherapy, and fidget toys to mitigate aspects of the environment such as noise and offer some additional comfort and therapy.

4.3.3 All the young people and parents with lived experience the investigation spoke with talked about the high noise levels in the ward environment being “stressful”. Actions to mitigate noise, for example ear defenders, were perceived to be beneficial.

4.3.4 The young people and parents the investigation spoke with were positive about times in their own experience when they were able to have some control over their environment. Being able to personalise their space, bring in comfort items from home, have their pet visit, and control the light levels reduced stress and anxiety.

4.3.5 However, the investigation learned of occasions when comfort items were taken away or restricted for hygiene reasons and that this was deeply distressing to the young people. This shows that there can be challenges balancing different safety priorities in the acute environment.

4.3.6 Young people and parents also told the investigation that having access to activities such as arts and crafts, and the ability to do schoolwork, go for a walk, or watch a film, were helpful to take their mind off things and provide a “change of scenery”.

4.3.7 Many of the mitigations detailed above were supported by a mental health nurse involved with the Safewards Model (Bowers, 2014). The Safewards Model summarises the factors that influence rates of conflict and containment (methods used to control difficulties on the ward such as medication or placing restrictions on patients) on adult mental health wards and how conflict and containment can be reduced as much as possible. While the mental health nurse stated that it would be very challenging to create a psychiatric safe space in the paediatric ward and fully apply the Safewards Model and the 10 interventions that derive the model, there may be concepts that could be adapted to support paediatric wards in caring for children and young people with mental health needs. Examples include adapting light levels, having a more therapeutic, well-designed space, and having comfort boxes and comfort items rather than stripping rooms of all items.

4.3.8 Having some predictability and information about what children and young people could do on the paediatric ward was stated to be something that may help. One young person felt they weren’t allowed to do much and were prevented from accessing alternative spaces or reading at night with their light on, but that they “didn't feel like lying in bed all the time”.

4.3.9 Young people suggested things that may help, including “an easy-read booklet, with uh, all the information about what you're allowed to do. Are you allowed to go out or not, what activities there are?”. Young people also expressed a desire to do activities they do at home such as preparing food.

4.3.10 The investigation heard how some hospitals had created other spaces for children and young people to use including a sensory room elsewhere in the hospital and access to an outside space which they could use under supervision. However, staff said that access to outside space was dependent on staff availability and nursing priorities. The investigation also observed that a couple of hospitals had outside play areas. However, these appeared to be designed for younger children and one was on a balcony and had been placed out of bounds to patients because it was not on the ground floor of the building.

4.3.11 The investigation visited a new children and young people mental health (CYPMH) inpatient facility reported to be an exemplar of the Safewards Model. While it may not be possible for all the features of the CYPMH inpatient facility to be integrated into a paediatric ward environment, the facility demonstrated how design could encompass both physically safe and therapeutic features.

4.3.12 The CYPMH inpatient facility provided a sensory friendly environment. There was artwork on the ground floor windows which ensured privacy but also allowed natural light in. The facility was a secure environment with controlled access; staff were able to secure certain sections of corridors if needed. Children and young people had access to kitchenettes, and individual bedrooms were not locked and could be accessed with wristbands given to each child or young person. Bathrooms and bedrooms were designed in such a way that any potential ligature risks, such as shower poles and curtain poles, were mitigated, while also maintaining a home-like aesthetic. The CYPMH inpatient facility also provided internal and external play areas with access to nature and for children and young people to participate in arts and crafts.

4.3.13 The investigation heard of other examples of work by trusts to create more therapeutic spaces, including areas for activities such as music therapy and arts, de-medicalised spaces where lighting could be adapted, and interactive calming screens.

Innovations

4.3.14 The investigation spoke with clinicians and designers involved with creating a new children’s hospital which will care for children’s physical and mental health together. The hospital has developed a new joined-up model of care with a

purposefully designed building. The children’s hospital programme team told the investigation that the service model is key, and the environment around it then facilitates this.

4.3.15 The wards have a mix of different types of rooms:

- some that are clinically focused
- others that are physically safer and follow design guidance for facilities for children and young people with mental health needs
- universal rooms.

4.3.16 The design incorporates lightwells and outdoor spaces between wards. It uses materials that provide a natural look but also conform with infection control standards. There are large windows with views of the outside. The building has also been designed with noise reduction in mind.

4.3.17 Consideration towards building a community on the ward for children and young people is made through access to classrooms, family therapy space, a play programme, a universal school, interactive arts, dining rooms and access to food facilities. Family support is encouraged and parents are able to stay. The aim is to create a low-key, calming, and relaxed environment for children and young people.

4.3.18 The investigation spoke with a lead at the Best For You programme (Best For You/NHS, n.d.). This new approach to mental health care has been developed in consultation with young people and their families. As part of the programme, two state-of-the-art NHS spaces are being created where professionals can care for young people’s mental and physical health in a new and bespoke way. The lead at Best For You described how building design was being carefully considered, including the décor and provision of natural light into the building. The design offers both communal and more private quiet spaces. Providing more autonomy to young people was considered in the design. Best For You also has a digital offering including information about mental health conditions, online videos, virtual journeys, text support, directories and a library of apps that can be prescribed.

4.3.19 The investigation heard that the Best For You programme hopes to develop standards for side rooms in acute hospitals that are designed for children and young people with mental health needs. It also aims to expand the overall programme of work nationally and internationally to help support others.

4.3.20 Guidance produced by NHS England (2022a) highlights service and workforce innovation case studies that are being tested. Once they have been evaluated, the learning from these case studies will be shared in a refresh to the guidance. Innovations being tested include:

- Place of sanctuary: to provide an alternative health-based place of safety for children and young people while health and social care assessments can be undertaken.
- Liaison team: skill sharing with the paediatric and mental health workforce and improving early support for children and young people.
- Children and young peoples' mental health decision unit: triaging mental health needs away from the emergency department environment.
- Children and young people's mental health/physical health champion role: ensuring there is a designated person within each paediatric unit to champion the change needed to support the paediatric workforce in caring for children and young people with mental health needs, as well as linking in across the system. It should be noted that the roll-out of the mental health champions initiative in paediatric wards is currently underway.

4.3.21 This investigation heard of other initiatives, including creating dedicated wards/spaces for young people, that are developmentally appropriate for teenagers and young adults years, or single sex accommodation for young people. The investigation did not explore all potential improvements; however, evidence indicates there are further opportunities for enhancing the environment.

5. References

Barnicot, K., Insua-Summerhayes, B., et al. (2017) Staff and patient experiences of decision-making about continuous observation in psychiatric hospitals, Social Psychiatry and Psychiatric Epidemiology, 52(4), pp. 473-483. doi: 10.1007/s00127-017-1338-4

Best For You/NHS (n.d.) Best For You. Available at https://bestforyou.org.uk/ (Accessed 22 February 2024).

Bowers, L. (2014) Safewards: a new model of conflict and containment on psychiatric wards, Journal of Psychiatric Mental Health Nursing, 21(6), pp. 499-508. doi 10.1111/jpm.12129

Care Quality Commission (2020) Assessment of mental health services in acute trusts. Available at https://www.cqc.org.uk/publications/themed-work/assessment-mental-health-services-acute-trusts (Accessed 4 April 2024).

Care Quality Commission (2022) Brief guide: care of children and young people in unsuitable hospital setting (BG068). Available at https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.cqc.org.uk%2Fsites%2Fdefault%2Ffiles%2F2022-09%2F20220831_9 (Accessed 2 February 2024).

Care Quality Commission (2023a) Reducing harm from ligatures in mental health wards and wards for people with a learning disability. Available at https://www.cqc.org.uk/guidance-providers/mhforum-ligature-guidance/overview/therapeutic-engagement (Accessed 5 February 2024).

Care Quality Commission (2023b) Regulation 12: Safe care and treatment. Available at https://www.cqc.org.uk/guidance-providers/regulations/regulation-12-safe-care-treatment (Accessed 5 February 2024).

Department of Health (1983) Mental Health Act 1983: Code of Practice. Available at https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF (Accessed 16 April 2024).

Health Services Safety Investigations Body (2023) Safety management systems: an introduction for healthcare. Available at https://www.hssib.org.uk/patient-safety-investigations/safety-management-systems/ (Accessed 22 February 2024).

Healthcare Safety Investigation Branch (2018) Provision of mental health care to patients presenting at the emergency department. Available at https://www.hssib.org.uk/patient-safety-investigations/provision-mental-health-care-patients-presenting-emergency-department/ (Accessed 22 February 2024).

Healthcare Safety Investigation Branch (2023) Interim report. Keeping children and young people with mental health needs safe: the design of the paediatric ward. Available at https://hssib-ovd42x6f-media.s3.amazonaws.com/production-assets/documents/hsib-interim-report-keeping-children-and-young-people-with-mental-health-needs-safe.pdf (Accessed 5 February 2024).

House of Commons Committee of Public Accounts (2023) The New Hospital Programme. Available at https://committees.parliament.uk/publications/42134/documents/209464/default/ (Accessed 22 February 2024).

Hudson, L., Chapman, S., et al. (2021). Increased admissions to paediatric wards with a primary mental health diagnosis: results of a survey of a network of eating disorder paediatricians in England, Archives of disease in childhood, 107(3), pp. 309-310. doi: 0.1136/archdischild-2021-322700

Mental Health Act (1983) (UK Public General Acts) Available at https://www.legislation.gov.uk/ukpga/1983/20/contents (Accessed 16 March 2023).Mind (2018) Crisis services. Available at https://www.mind.org.uk/media-a/2897/crisis-services-2018.pdf (Accessed 2 August 2022).

National Development Team for Inclusion (2020) It's not rocket science. Considering and meeting the sensory needs of autistic children and young people in CAMHS inpatient services. Available at https://www.ndti.org.uk/assets/files/Its-not-rocket-science-V6.pdf (Accessed 5 February 2024).

National Institute for Health and Care Excellence (2013) Self-harm. Quality Standard. Available at https://www.nice.org.uk/guidance/qs34/resources/selfharm-pdf-2098606243525 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2015a) Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guideline. Available at https://www.nice.org.uk/guidance/ng11/resources/challenging-behaviour-and-learning-disabilities-prevention-and-interventions-for-people-with-learning-disabilities-whose-behaviour-challenges-pdf-1837266392005 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2015b) Violence and aggression: short-term management in mental health, health and community settings. NICE guideline. Available at https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-pdf-1837264712389 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2017) Violent and aggressive behaviours in people with mental health problems. Quality Standard. Available at https://www.nice.org.uk/guidance/qs154/resources/violent-and-aggressive-behaviours-in-people-with-mental-health-problems-pdf-75545539974853 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2018) Preventing suicide in community and custodial settings. NICE Guideline. Available at https://www.nice.org.uk/guidance/ng105/resources/preventing-suicide-in-community-and-custodial-settings-pdf-66141539632069 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2019) Suicide prevention. Quality Standard. Available at https://www.nice.org.uk/guidance/qs189/resources/suicide-prevention-pdf-75545729771461 (Accessed 23 February 2024).

National Institute for Health and Care Excellence (2022) Self-harm: assessment, management and preventing recurrence. NICE guideline. Available at https://www.nice.org.uk/guidance/ng225/resources/selfharm-assessment-management-and-preventing-recurrence-pdf-66143837346757 (Accessed 23 February 2024).

National Institute for Health and Care Research (2022) MAPS: Mental Health Admissions to Paediatric Wards Study. Available at https://fundingawards.nihr.ac.uk/award/NIHR135036 (Accessed 5 February 2024).

NHS (n.d.a) Children and young people's mental health. Available at https://www.longtermplan.nhs.uk/areas-of-work/mental-health/children-and-young-peoples-mental-health/ (Accessed 22 February 2024).

NHS (n.d.b) Mental health champions in acute paediatric settings. Available at https://www.rcpch.ac.uk/sites/default/files/2023-07/nhse_mental_health_champions_summary.pdf (Accessed 5 February 2024).

NHS (2019) The NHS Long Term Plan. Available at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf (Accessed 5 February 2024).

NHS England (n.d.a) What are integrated care systems? Available at https://www.england.nhs.uk/integratedcare/what-is-integrated-care/ (Accessed 5 February 2024).

NHS England (n.d.b) NHS-led provider collaboratives: specialised mental health, learning disability and autism services. Available at https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/ (Accessed 28 July 2022).

NHS England (n.d.c) Children and young people with mental health needs, autism or learning disability: online resources for staff in acute settings. Available at https://www.e-lfh.org.uk/programmes/cypmh_in_acute_settings/ (Accessed 22 February 2022).

NHS England (2014) Child and adolescent mental health services (CAMHS) Tier 4 report. Available at https://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf (Accessed 27 July 2022).

NHS England (2022a) Supporting children and young people (CYP) with mental health needs in acute paediatric settings. A framework for systems. Available at https://www.england.nhs.uk/long-read/supporting-children-and-young-people-with-mental-health-needs-in-acute-paediatric-settings-framework-for-systems/#element-6-innovative-practice (Accessed 17 January 2024).

NHS England (2022b) National Quality Improvement Taskforce for children and young people's mental health inpatient services. Available at https://www.england.nhs.uk/mental-health/cyp/children-and-adolescent-mental-health-service-inpatient-services/improvement-taskforce-children-young-people/ (Accessed 29 July 2022).

NHS England (2023a) Mental health of children and young people in England, 2023 – wave 4 follow up to the 2017 survey. Available at https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up (Accessed 5 February 2024).

NHS England (2023b) Sensory-friendly resource pack. Available at https://www.england.nhs.uk/long-read/sensory-friendly-resource-pack/ (Accessed 16 April 2024).

NHS Estates (2004) HBN 23. Hospital accommodation for children and young people. Available at https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_23.pdf (Accessed 22 February 2024).

Norton-Westwood, D., Pearson, A., et al. (2011) The ability of environmental healthcare design strategies to impact event related anxiety in paediatric patients: A comprehensive systematic review, JBI Library of systematic Reviews, 9(44), pp. 1828-1882. doi: 10.11124/jbisrir-2011-105

Papoulias, C., Csipke, E., et al. (2014) The psychiatric ward as a therapeutic space: systematic review, The British Journal of Psychiatry, 205, pp. 171-176. doi: 10.1192/bjp.bp.114.144873

Royal College of Paediatrics and Child Health (2021) Meeting the mental health needs of children and young people in acute hospitals: these patients are all our patients. Available at https://www.rcpch.ac.uk/resources/mental-health-needs-children-young-people-acute-hospitals (Accessed 22 January 2024).

Royal College of Psychiatrists (2022) PLAN 7th edition standards. Available at https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychiatric-liaison-services-plan/plan-7th-edition-standards.pdf?sfvrsn=718ddb5b_4 (Accessed 15 February 2024).

Salmon, P.M., Stanton, N.A., et al. (2011) Human Factors Methods and Accident Analysis. Practical Guidance and Case Study Applications. Farnham: Ashgate Publishing Limited.

Stanton, N.A., Salmon, P.M., et al. (2013) Human Factors Methods. A Practical Guide for Engineering and Design. Ashgate Publishing Ltd. Farnham.

Svedung, I. and Rasmussen, J. (2002) Graphic representation of accident scenarios: mapping system structure and the causation of accidents, Safety Science, 40(5), pp. 397-417.

Ulrich, R.S., Bogren, L., et al. (2018) Psychiatric ward design can reduce aggressive behavior, Journal of Environmental Psychology, 57, pp. 53-66. doi: 10.1016/j.jenvp.2018.05.002

Van der Schaaf, P.S., Dusseldorp, E., et al. (2013) Impact of the physical environment of psychiatric wards on the use of seclusion, The British Journal of Psychiatry, 202(2), pp. 142-149. doi: 10.1192/bjp. bp.112.118422

Ward, J.L., del Pilar Vasquez Vasquez, A., et al. (2024) Patterns of mental health admissions amongst children and young people in England 2021 to 2022 (Unpublished).

6. Appendix: Investigation approach

The Healthcare Safety Investigation Branch (HSIB) was notified of a patient safety incident relating to a young person with mental health needs being cared for in a paediatric ward in an acute hospital. The referral was made by the Trust which was concerned that the paediatric ward was not safe for children and young people with mental health needs. Staff highlighted the negative impact that staying on a paediatric ward had on children and young people with mental health needs, other patients and families, and on staff. After investigating the reference event and understanding what national work was underway, HSIB identified a potential risk around the design of the paediatric ward and the adaptations that were being made. HSIB’s Chief Investigator authorised a national investigation based on HSIB’s patient safety risk criteria, as described below.

Outcome impact – what was, or is, the impact of the safety issue on people and services across the healthcare system?

Paediatric wards are primarily designed to care for patients who only have physical healthcare needs. Paediatric wards contain many self-harm and ligature risks (points that could be used to attach something that could be used for self-harm or suicide). Paediatric wards are crowded, busy and noisy, and so can be unsuitable for children and young people experiencing a mental health crisis and/or who have sensory needs. In some paediatric wards it is also relatively easy for a child or young person to leave without permission or engage in other high-risk activities because the ward layout means that lines of sight could be limited.

Data from trusts and the Strategic Executive Information System (a database of serious patient safety incidents) shows incidents of 'apparent/actual/suspected self-inflicted harm meeting SI [serious incident] criteria' in the acute healthcare setting, including death, involving children and young people with mental health needs.

There is a focus on improving the physical safety of paediatric wards for children and young people with mental health needs by taking away items and creating a more restrictive environment. However, research has shown that ward design with an overly strong emphasis on patient safety can prove to be restrictive and can lead to negative behaviours, can disempower patients, and increases the risk of self-harm behaviours (Barnicot et al, 2017; Van der Schaaf et al, 2013).

High-risk behaviours such as self-harm, violence and aggression are particularly challenging for paediatric ward staff to manage. Staff may be physically assaulted and experience significant stress. There are challenges around trying to balance the physical healthcare needs of patients on paediatric wards with caring for a child or young person with high-risk behaviours. Other patients and families on the paediatric ward may also witness traumatic events and there are concerns about the potential for another patient or family member to be physically assaulted.

Systemic risk – how widespread and how common a safety issue is this across the healthcare system?

Over the past 10 years, there has been an increasing need for mental health services to support children and young people (NHS England, 2022b). The rates of 'probable' mental disorder in children and young people have remained stable between 2022 and 2023 with approximately 1 in 5 children and young people aged 8 to 25 years having a probable mental disorder (NHS England, 2023).

A survey of clinician perceptions (Hudson et al., 2021) indicated that 85% of paediatric departments had seen an increase in the number of children and young people with mental health needs being admitted. MAPS will gain more data nationally about admissions of children and young people with mental health needs to a paediatric ward (see 1.4.9 in the main report).

There is limited national data on the number of young people with mental health needs being cared for on acute paediatric wards. Evidence from trusts and regions indicates that the number of children and young people with mental health needs staying on paediatric wards could be high. One region found that most of the children and young people did not require a CYPMH inpatient bed and that there were those who had both physical and mental health needs. Another regional review showed that 66% of children and young people with mental health needs on acute paediatric wards were clinically ready, from a physical health perspective, to be discharged.

Learning potential – what is the potential for an HSIB investigation to lead to positive changes and improvements to patient safety across the healthcare system?

Following engagement with key stakeholders, such as NHS England, it was identified that there is limited guidance or ongoing national work around the design of paediatric wards for supporting children and young people with mental health needs.

Evidence gathering

The investigation was carried out between October 2022 and December 2023. The evidence collected included:

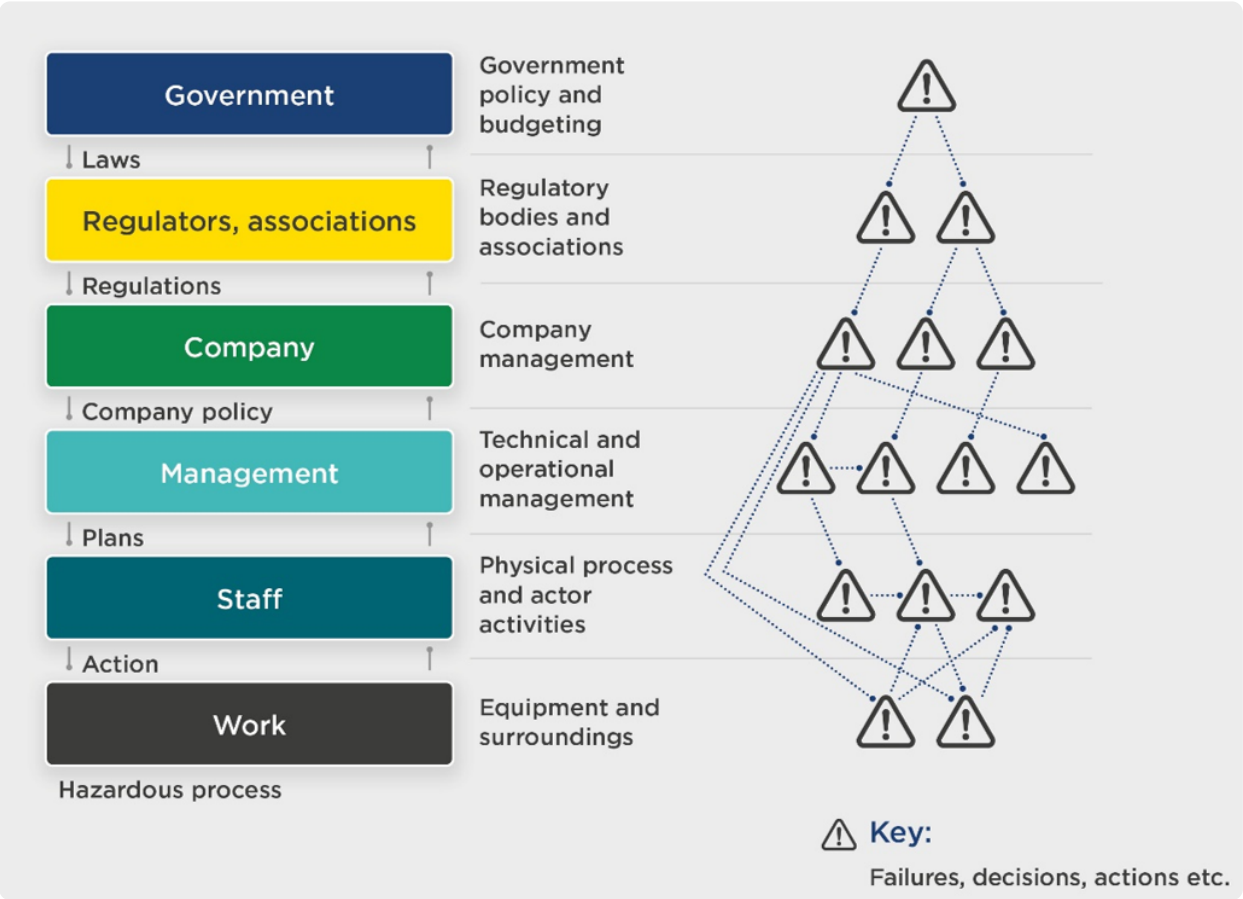
- relevant research literature
- investigation of the reference event, including interviews with staff and observations of the paediatric ward environment
- discussions with staff from 20 acute hospitals about their experience of caring for children and young people with mental health needs in their paediatric wards, and the adaptations made to their wards
- meetings with leaders of innovation programmes such as Safewards, Best For You, and teams designing future hospitals
- discussions with relevant national organisations.

Sequential Timed Event Plotting (STEP) was used to analyse the reference event. STEP shows the task process, the tasks performed and the interaction between patients and elements of the system (for example, documentation, equipment, IT systems) over time. STEP is particularly useful for analysis and representing distributed teamwork or collaborated activity.

The AcciMap model was also used to analyse the reference event information and the evidence collected from the wider investigation. AcciMap (Svedung and Rasmussen, 2002) is an incident analysis method that identifies factors within a system (in this case the healthcare system as a whole) that influence the occurrence of an incident. The analysis focuses on identifying relationships between the different levels of the system (see figure A), which include government policy and budgeting; regulatory bodies and associations; local area management; physical processes and actor activities (linked with staff, people, organisations and systems); and equipment and surroundings (Stanton et al, 2013).

AcciMap is useful for visually representing contributory factors across the entire organisational system and their interrelationships. It removes the apportioning of blame to individuals and promotes the development of systematic (ie tools, technology, environment, organisational) countermeasures as opposed to countermeasures which focus on an individual (Salmon et al, 2011).

Figure A AcciMap investigation model



The investigation engaged with stakeholders (see table A) to gather evidence during the investigation. This also enabled checking for factual accuracy and overall sense-checking. The stakeholders contributed to the development of the investigation's safety recommendations and safety action based on the evidence gathered.

Table A Investigation stakeholders

Reference event organisations	National organisations	Other organisations
The Trust where the reference event took place	NHS England	Safewards
Provider collaborative	Royal College of Paediatrics and Child Health	Best For You
Urgent help service	Royal College of Psychiatrists	New Hospital Programme
Psychiatric liaison team	Royal College of Nursing	New children's hospital team
Children and young people's mental health		Integrated care boards
		Regional quality boards

Reference event organisations	National organisations	Other organisations
services County council – social care	Care Quality Commission Association of Chief Children's Nurses Healthwatch	Mental Health Admissions to Paediatric Wards Study team Mind People with lived experience Subject matter advisors 20 acute hospitals that admit children and young people with mental health needs to their paediatric wards