Mental Welfare Commission for Scotland

Report on announced visit to: National Child Psychiatry Inpatient Unit, Ward 4, Royal Hospital for Children, 1345 Govan Road, Glasgow, G51 4TF

Date of visit: 23 and 24 September 2026

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The National Child Psychiatry Inpatient Unit (NCPIU) is the nationally commissioned unit for children with significant mental health difficulties in Scotland. The ward provides six beds and admits children from all over Scotland who are between five and 11 years old. We were told that there is some flexibility at either end of the age range, based on clinical need.

On the day we visited, there were six children on the ward and no vacant beds. Some of the children were slightly older than 12 years. The service is located on the top floor of the Royal Hospital for Children, based on the Queen Elizabeth University Hospital campus in South Glasgow.

As part of our work, we were interested to hear about progress against improvement actions identified during our joint visit with Healthcare Improvement Scotland in 2025. These highlighted the need to develop a seclusion policy in Ward 4 and to embed the discussion of developing an advance statement into practice as part of discharge planning.

Who we met with

We met with and reviewed the care of six children. We met with all the children in person, observed them in their care setting, and we also reviewed their care notes.

We also met with or were able to speak to four parents. We met with the senior charge nurse, multiple members of nursing staff, the occupational therapist, the consultant psychiatrist and the family and systemic psychotherapist.

We very much appreciated the children taking the time to show us round the ward during our visit and sharing some of their experiences of care.

Commission visitors

Mark Richards, nursing officer

Kathleen Liddell, social work officer

Keri Duffin, social work officer

What people told us and what we found

The children we met with described Ward 4 as “fun” and told as that “the staff are nice”.

Importantly, the children who spoke with us told us that they felt safe in the ward. We heard from one of the children that they didn’t want to be in the ward when they first came in but that they had now adjusted and liked it.

We attended various meetings during our visit, including the ‘friendship group’. The interactions we observed between staff and young people were consistently warm, positive and supportive, and it was clear throughout our visit that there were positive therapeutic and caring relationships.

We heard positive feedback from parents and carers, who commented on Ward 4 compared to other services, saying that “the change here is massive”, who described the care of their child as “amazing” and “phenomenal” and that the ward felt safe.

Carers described feeling involved in care decisions and that staff listened to them and took their views on board. They also felt that the ward was well equipped and there was enough for the children to do.

They spoke positively about the carer’s group and found this to be a valuable source of support. One carer did wonder if, alongside the existing format for the carer’s group, there could be a meeting which would offer more structured wellbeing support or provide an opportunity to hear from invited speakers.

We also heard from one carer who felt that communication could be improved at times. They found that having to communicate with multiple disciplines every week on an individual basis could be challenging for them, and they wondered if this could be done differently to join this up more. We fed this back to the service leaders on the day of our visit and invited them to consider if there was scope for improvement in this area.

We also heard positive feedback about clinical leadership in the ward and how this contributed to a positive culture. Throughout our visit, we heard about and observed how well staff work together, with a sense of shared ownership and investment in the ward.

Staff were consistently positive about working in the ward and voiced how proud they are of the work that they do. We heard consistent feedback about them being part of a really good team. The staff group described themselves as very being well supported, committed, and that they know each other’s worth. They told us that high value is placed on each other’s work and each other’s unique professional contribution.

Staff told us they felt very well supported with access to professional activities such as clinical supervision, along with a range of continuous professional development opportunities and that there is team-based and individual learning.

They also told us about the important role they play in caring for parents and carers, and that they were proud of this area of their work.

Care, treatment, support, and participation

Clinical records were located on NHS Greater Glasgow and Clyde's (NHS GGC) electronic information system (EMIS). We found EMIS easy to use and accessible, with key information that was easy to find.

All the clinical records we reviewed were of a very high standard, with detailed, child-centred risk assessments and care plans that addressed the full range of care for mental health, physical health, and the more general health and wellbeing of the child. We also heard about and could see work that has been done on care plans to develop more of an outcomes focus and for these to align with the UN Convention on Rights of the Child (UNCRC).

There were care plans in place for all disciplines. These were clear, and we thought the child-centred focus to them was excellent. The treatment goals of the care plans were clearly described, and we could see evidence of regular reviews, with progress towards each goal documented regularly. The language used was jargon-free although still professional. Clinical risk assessments such as FACE were subject to very regular review, and there were clear links between these and care plans in areas such as low weight for height.

During our visit, we observed individualised care plan content being translated into direct clinical care in important and sensitive areas such as nasogastric feeding. This was informed using 'all about me' documentation and other child-centred care approaches. Easy read versions of the care plans, safety plans, and pass plans were provided for each child in a way that was tailored to their needs; we considered that this approach helped ensure there was meaningful involvement in their care.

In the weekly multidisciplinary team (MDT) meetings, we saw good evidence of the views of children and their families being proactively sought and considered as part of the MDT decision-making; the standard of communication between the clinical team, the child, their family and other professionals appeared robust.

From our review of the record of these meetings, we felt that it was not always clear what discussion had taken place which led to clinical decisions being made. This is important in areas such as restrictive practice, where there should be a clearly recorded rationale to changes, such as where there is the use of continuous interventions.

We could see that that the children engaged in regular one-to-one interventions with the different members of the MDT. The care records recorded the young person's views, thoughts and feelings, and demonstrated a rights-based and participative approach to care as well as supporting their right to express their views and have these meaningfully considered. We felt that these were in line with UNCRC principles.

During our visit, we learned that speech and language therapy staff have been involved in training a number of staff in ways to support communication through the use of visual aids. We could see evidence of this practise throughout the unit, including recording of this in the children's clinical notes, in guidance and leaflets that were available, and with visual aids and timetables on the walls. We also saw regular use of 'talking mats' as a communication aid which we thought was positive.

Multidisciplinary team (MDT)

The ward has an MDT that consists of medical, nursing, occupational therapy, physiotherapy and speech and language therapy, systemic and family therapy, and psychology staff. There are also school staff who are employed by Glasgow City Council. This broad range of disciplines are either based in the ward or are readily accessible to it.

We were told that there is currently a vacancy for a consultant psychiatrist which was in the process of being recruited to; there were no other vacant posts. We were told that there was a strong level of interest in posts for the ward.

It was clear from the very detailed MDT meeting notes that everyone involved in an individual's care and treatment is invited to contribute to the meetings and to give an update from their professional perspective. Actions and action owners were clear.

Every four weeks, meetings are arranged to directly include the child's family or carers and the child's community child and adolescent mental health service (CAMHS) staff.

It was clear to see from the care records that when a child is moving towards discharge, community services are involved in preparatory meetings. We also heard about outreach work that ward staff are involved in that related to discharge planning, which included liaison with the community teams.

We heard that, as Ward 4 is a national service, these meetings can be held on-line to support attendance by people located in different parts of the country. We were assured that parents or carers wishing to attend were given the opportunity to do so in person, and that the children can also attend. Even where discharge was not imminent, we could see evidence of discharge goals being discussed.

After each MDT meeting, the ward's care manager had an important role in supporting communication with the child's family or carers, as well as the community services, with information from the meeting.

During our visit, we had the opportunity to attend the morning 'huddle'. We observed thorough and considered discussions, which covered feedback from the previous day and care planning for the day ahead. There were clear actions agreed and the clinical staff responsible for carrying them out was identified. We noted that all huddle attendees had an equal voice and we were pleased to see active contributions to this meeting from the student nurse.

We noted that there was no dedicated social worker in the ward MDT. While we found positive evidence of rights-based and person-centred care, we invited service managers to consider whether dedicated social work input could further strengthen the MDT. Social workers bring a distinct holistic perspective, considering the child within the context of their family, relationships and wider social circumstances. They can also provide constructive professional challenge, particularly around risk, restrictions, safeguarding and discharge planning, and support children's rights and participation in decision-making. Given the complexity of some children's needs and the multi-agency planning often required for discharge, we consider that more consistent social work input would add an important professional perspective to the MDT and strengthen multi-agency working.

Use of mental health and incapacity legislation

On the day of our visit, three children in the ward were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 ('the Mental Health Act'). All documentation relating to the Mental Health Act was readily accessible via EMIS and was up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained individuals, who are either capable or incapable of consenting to specific treatments. We found that consent to treatment certificates authorising treatment (T3b) under the Mental Health Act were in place where these were required. These were up-to-date and corresponded to the medication that was prescribed, including nasogastric feeding.

Where nutrition by artificial means had been necessary as an emergency medical intervention, the appropriate T4 form had been completed and submitted to the Mental Welfare Commission. Copies of this were stored in EMIS and were readily accessible.

Service managers shared a new policy and standard operating procedure on advance statements and personal statements. This addresses a recommendation from our visit in 2025 with Healthcare Improvement Scotland. This was implemented

in June 2026, and through our review of clinical records, we could see advance statements being actively considered and discussed. We expect that this work will become more fully embedded as time goes on and that we will be able to see more evidence of advance statements being completed and referred to.

One of the duties of a mental health officer is to produce a Social Circumstances Report (SCR). This is an important document which should examine the interaction of the child's social and family circumstances with their mental health and wellbeing. In our review of the clinical records, we could not see copies of SCRs for any of the children on short term detention certificates or compulsory treatment orders. We explored this with the service who clarified that SCRs are normally received by the responsible medical officer but that these had not been uploaded to EMIS. We would expect to see all Mental Health Act documentation to be visible to the MDT via EMIS and expect that this will be actioned going forward.

Rights and restrictions

The ward had several areas that were locked and entry into and egress from the ward was prevented without appropriate permission. Staff told us they felt a reasonable balance had been achieved, as the doors provided the necessary barriers to limit access and egress, yet could also create an unnecessary obstacle to appropriate movement. We did not observe or hear about any issues regarding access or egress throughout our visit.

We saw information on rights clearly on display in the ward and could see that the children had contributed to this. This included information on the United Nations Convention on the Rights of the Child (UNCRC). We could also see information regarding advocacy provision and found evidence of this being discussed with the young person through the record of MDT meetings.

The use of mobile phones/tablets and access to social media was discussed. We heard that this was managed in partnership with the children and their parents or carers, and in line with ward policy. We considered that that this individualised approach was reasonable, proportionate and aided communication for some of the children and their families.

We noted that continuous intervention was being used as part of mealtime support, and that two other children were also cared for using continuous intervention out with mealtimes. There were no safe holds being used for nasogastric feeding. The need for continuous intervention was reviewed daily at the multidisciplinary 'huddle'.

On our last visit we made a recommendation regarding seclusion and highlighted that a seclusion policy was required. On this visit, we heard that an NHS Greater Glasgow and Clyde wide seclusion policy has been drafted, with implementation of

this anticipated in late 2026. A room in Ward 4 is also being converted to ensure it meets the required standards for safe use as a seclusion facility.

We heard that the right to a carers assessment was not routinely discussed with parents and carers. We checked to see if parents and carers were signposted to any resources/information through the QR code links on the ward notice boards. Through using the QR code, parents and carers are taken to links to various resources, one of which is information from the Carers Trust on carers assessments. It would be helpful if the ward ensured that information about a carer's right to a carers assessment (Carers (Scotland) Act, 2016) was more readily available. This was discussed with service managers during our visit.

Activity and occupation

The unit has several rooms available for different sorts of recreation and activity, and a room in which a few children can watch television together. There is an indoor soft play and sensory room which are well equipped and are valuable resources when the children are unable to go outside. We were able to see all these rooms on the day of our visit and spent some time watching the children play in the rooftop garden which the children told us they really enjoyed using.

We saw the weekly planner which was on display in the ward corridor and the children also showed us their own daily activity planners. We saw this reflected in the care records on a profession-by-profession basis, and in the care information that the child receives.

The children in the unit access school facilities and activities relating to education and this forms an important aspect of most children's daily timetables. We heard that there were currently no issues regarding schooling, with the children supported to attend school for two hours per day while in hospital; one child was attending her local school. We did hear that there continues to be challenges accessing education for children who are admitted from the West Dunbartonshire area. We heard that there was no provision from West Dunbartonshire and consider this to be inequitable and a breach of the basic rights of the child.

Recommendation 1:
West Dunbartonshire Council Educational Services must engage with NHS Greater Glasgow and Clyde and agree how equitable education will be provided for any children who are admitted from that local authority area.

We heard that the while an increase in the number of different professions and staff has been positive, it has also made it more difficult to see the children at times for scheduled clinical work. We saw some evidence in our review of records where sessions have had to be rescheduled due to other professionals already working with the child at the time of the planned intervention. We would encourage the

service to think about how this is better planned and co-ordinated, and to consider if an overarching activity care plan, aligned with care goals and outcomes could help with this.

The physical environment

Ward 4 is located on the top floor of the hospital and is shaped in an arc with all rooms, including the children's bedrooms, off to one side with views out over the city and many glass windows looking out onto the rooftops.

During our visit, the ward appeared clean, bright and airy, clean and well decorated; it felt calm and peaceful.

The entrance to the unit has a reception area, with noticeboards providing information about the ward, and suggestions for families about places to go in the nearby area. The was also information about various supports available for carers including Crossbasket House, which can provide cost-free accommodation for families with a child in Ward 4.

We were told that the families of children who come from other parts of the country, and do not know the area well, find this practical information very helpful. We also heard about plans to develop a virtual digital walk-round of the ward which we think could be helpful and reassuring as it would familiarising people with the ward in advance of an admission or visit.

There was a wealth of information on notice boards for children and parents/carers, and we noted some of the early work that has been done for 'Safe Wards' which shares some personal information about the staff's likes and dislikes.

It has been noted in previous visits that the ward has developed resources for children and their families and carers on a range of topics. We saw that the ward has made good use of technological advances such as QR codes to increase the accessibility of this information. We were impressed by the work that has been undertaken and the range and depth of the information provided.

The wall space in the main corridor of the ward is used creatively to support each child's care, with timetables for the day in easy read format that are attractively decorated, and versions displayed on the walls to help orientate and act as a reference point for both children and staff throughout the day. Information was also available on which staff were on duty each day so the children, parents and carers could easily see who was on duty when.

Many of the walls displayed artworks developed by the children. These were attractive, personalised and thoughtful, serving as a touchpoint for the children in supporting their connection to the ward environment. The communal wall artworks are refreshed regularly to reflect the turnover in the ward and to try and ensure that

all children who are currently inpatients are provided with the opportunity to contribute to this.

Some of the children's bedrooms are en-suite and the bedrooms we saw appeared well lit, clean and tidy. All the rooms were personalised to reflect personal interests, hobbies and preferences and many had materials on the wall, reflective of and supportive of individual treatment goals for the child.

Any other comments

Throughout the visit, we saw and heard evidence about care that was rights and strengths-based, and which was aiming to equip young people with the tools to thrive post discharge. We met a team who genuinely care about the children they look after and who make every effort to create a safe, welcoming, and therapeutic place.

Committed, visible and engaged service and clinical leadership was making a positive difference to care culture and care delivery. We heard feedback on this from different sources throughout our visit and witnessed this in action. We were also impressed with activities such as ward events and fundraising and we heard staff members' pride in their personal and collective contribution to this.

Good practice

We also heard lots of feedback about the importance of the inclusion of and support for families. Parents and carers were clearly important partners in care, with multiple opportunities for involvement. The care in Ward 4 is an excellent example of the benefits and impact of the therapeutic alliance between the child, their parents/carers and the staff.

Summary of recommendations

Recommendation 1:

West Dunbartonshire Council Educational Services must engage with NHS Greater Glasgow and Clyde and agree how equitable education will be provided for any children who are admitted from that local authority area.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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