CQC Mental Health Act
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
(press option 1 when prompted)
Email: mhamonitoring@cqc.org.uk

www.cqc.org.uk

Ruth Brown
Chief Executive
Sheffield Children's NHS Foundation Trust
Western Bank
Sheffield
S10 2TH

20 June 2022

Our ref: **MHV1-12912794571**

Dear Ms Brown

Mental Health Act 1983 (MHA) monitoring visit

Service	Child and Adolescent Mental Health Service
Location	Sheffield Children's Hospital, Northern General Hospital, The Becton Centre for Children and Young People
Date of visit	24 to 27 April 2022

We visited the child and adolescent mental health service (CAMHS) to monitor the use of the MHA and compliance with the Code of Practice within the assessment and admission portion of the service. Our visit was announced to each of the three trusts involved in providing the service. Sheffield Children's NHS Foundation Trust is responsible for the CAMHS provision in Sheffield and for Sheffield Children's Hospital, the Becton Centre and the Supportive Treatment and Recovery Team (STAR). Sheffield Teaching Hospitals NHS Foundation Trust is responsible for the Northern General Hospital. Sheffield Health and Social Care NHS Foundation Trust provides the Psychiatric Liaison Team into the Northern General Hospital and the MHA administration support to both the other trusts. There is more information about MHA monitoring visits in the appendix to this letter.

The CAMHS emergency assessment pathway consists of a health-based place of safety for people under 16 years of age at the accident and emergency department of the Sheffield Children's Hospital and a health-based place of safety for people aged 16 and 17 years of age at the accident and emergency department of the Northern General Hospital. These are supported by the STAR service in the community and Sheffield Children's Hospital for people aged under 16. The psychiatric liaison team assesses young people aged 16 and 17 who present at the Northern General Hospital.

A health-based place of safety for children under 16, in the form of the section 136 suite at the Becton Centre, has been closed for some time, although we were told that there were plans to reopen this.

On the day of our visit there were six patients admitted for mental health care and treatment across two paediatric medical wards at Sheffield Children's Hospital. One patient was subject to section 3 of the MHA, the others were informal patients. There were no under 18-year-olds admitted to the Northern General Hospital for mental health care.

How we carried out this MHA monitoring visit

During our review we:

- visited the accident and emergency departments of the Sheffield Children's Hospital and the Northern General Hospital and spoke with nursing and medical staff whilst we were there
- visited two paediatric wards (Ward 3 and Ward 4) at the Sheffield Children's Hospital
- visited the acute medical unit at the Northern General Hospital and spoke with nursing staff whilst we were there
- visited Emerald Lodge, Ruby Lodge and Sapphire Lodge at the Becton Centre
- interviewed the following staff from Sheffield Children's Hospital, either face-to-face or remotely
    - emergency department: matron (Medicine), lead nurse, one staff nurse, one healthcare assistant, consultant in emergency medicine
    - Ward 3: ward manager, matron, two nurses
    - Ward 4: nurse in charge, eating disorders consultant, matron
    - STAR Team: consultant psychiatrist (CAMHS), team manager, two nurses
    - mental health nurse specialist working across the unit
- interviewed the following staff at the Becton Centre
    - ward managers
    - staff from all wards
    - the clinical director
    - the chief nurse
- interviewed the following staff from Sheffield Teaching Hospitals NHS Foundation Trust
    - the clinical lead mental health
    - the clinical director, accident and emergency department
    - a consultant physician, acute medical unit
    - the operations director, acute and emergency medicine
- interviewed the following staff from Sheffield Health and Social Care NHS Foundation Trust
    - the head of mental health legislation and the manager of MHA legislation administration
- interviewed the hospital director of Cygnet Hospital Sheffield

- interviewed a police sergeant in the mental health and vulnerabilities team, South Yorkshire Police
- held focus groups for 20 nursing staff from the accident and emergency department at the Northern General Hospital
- held a focus group for four members of the psychiatric liaison team, including a consultant psychiatrist
- held a focus group for three independent mental health advocates (IMHAs)
- held a focus group for five Sheffield approved mental health professionals (AMHPs)
- at the Sheffield Teaching Hospitals NHS Foundation Trust
    - we reviewed the records of five patients currently admitted to wards 3 or 4 for assessment or treatment of a mental health condition.
    - we reviewed three records in depth of three patients previously detained at Sheffield Children's Hospital.
    - we spoke with two patients, including the patient subject to section 3 of the MHA
    - we spoke with one carer of an informal patient.

What patients told us

At Sheffield Children's Hospital

We interviewed two patients on paediatric wards at Sheffield Children's Hospital, one who was detained and one who was admitted subject to her parent's consent. They told us:

- they felt informed and involved in their care and treatment
- they had access to schooling and were in touch with their home school
- they did interesting activities such as puppet making and baking
- the detained patient confirmed that she had a leaflet explaining her rights and that staff had explained her status and rights. The MHA assessment team had explained why her detention was required
- they were able to go out for fresh air even when on one-to-one observations
- the staff were kind and supportive
- they were able to keep their phones and laptops.

At the Becton Centre

We spoke with one patient who told us they were happy with the care they were receiving.

What carers told us

We spoke to the mother of an informal patient who had been admitted to the Sheffield Children's Hospital paediatric ward for the first time six days previously. She told us:

- she felt that staff offered her support as well as her daughter
- she was well informed and involved with her daughter's care and treatment for an eating disorder.

- she fully understood the admission and plans for future care and gave her consent for decisions as they arose
- visitors were allowed during the day and to stay at night but this was restricted in numbers due to COVID restrictions. She was able to stay overnight
- she was very positive about the ward environment.

Summary of review findings

Least restrictive option and maximising independence

Sheffield Children's Hospital Wards and Emergency Department
There was a personalised approach to patient care where restrictions were introduced to manage risk arising from mental disorder or behavioural disturbances. We heard from patients and carers that they felt involved in decision making and understood why restrictions were necessary for their recovery. We observed staff involving young people in activities on the wards. Staff and family members took patients out for brief periods to local shops and for fresh air.

Patients were able to access their phones and laptops unless there was a risk assessment for an individual patient to restrict this. The ward also provided tablets and games consoles.

Some staff had been assaulted and they said that other patients staying on the ward for physical health concerns were upset by some patients who were mentally distressed and waiting for tier four CAMHS beds. They told us that there were now enhanced support officers on the wards. Staff told us that at times they provided twice daily nasogastric feeds to patients with eating disorders. Sometimes these feeds had to be administered under restraint, which staff found difficult and upsetting.

The STAR team delivered short term intensive support at home for the majority of mental health patients attending the ED. Since January 2022 the STAR team had widened their remit from suicidal ideation and self-harm to include all mental health presentations, except eating disorders who had an established pathway with the Sheffield Eating Disorder Assessment and Treatment Team.

Becton Centre
One patient was being nursed in the decommissioned section 136 suite because of risk of infection and antisocial behaviour. The door was locked with two staff in attendance and no seclusion or segregation policy was being followed. We were provided with emails following our visit informing staff that this bed was not to be used for the care and treatment of inpatients.

A purpose designed area of Sapphire ward had been designated for patients who needed to be segregated from the main group. Segregation guidance was being prepared and the area was not in use at the time of our visit.

Northern General Hospital
Care environments placed significant restrictions on patients. This forms an action below.

However, staff in the accident and emergency department and on the acute medical unit were very aware of the restrictions that the environment placed on the patient. They tried to reduce this by supporting patients to go outside, subject to risk assessment, for fresh air or for a cigarette. We saw that this was supported by section 17 leave forms where these were required for detained patients. Staff told us that they had sourced an activity box with a range of suitable activities that could be done by or with the patient to help reduce the risk of boredom.

The side rooms on the acute medical unit were small with a full range of acute health care fittings that needed to be removed. Because of the nature of the ward patients were not permitted to freely access the whole ward.

One patient with a complex mental health presentation that resulted in fixed, ritualised behaviours was cared for in the accident and emergency department for several days rather than being transferred to the acute medical unit. There had been consultation about this with family and clinicians. Despite this being an inappropriate placement, adjustments had been made, such as bringing a hospital bed into the patient's cubicle and accommodating their behaviours within the routine. Staff recognised that this was a very specific adjustment for a single patient and was a response to meet the requirement for reasonable adjustments to the patient's needs.

Empowerment and involvement

Sheffield Children's Hospital Wards and Emergency Department
Children were able to continue their education while in hospital and the teaching staff developed individual programmes in consultation with the child's home school. Families were included and consulted about their children's care and treatment.

Becton Centre
Capacity and consent assessments were usually undertaken by the medical staff and reviewed monthly in ward rounds. Parents were invited to attend the ward rounds.

Respect and dignity

Sheffield Children's Hospital Wards and Emergency Department
The environment of the two wards we toured were pleasant and suitable for children. Staff made a big effort to meet the needs of child inpatients, some of whom spent many months on these wards. Wards 3 and 4 were pleasant and bright having been well designed for children and their families. Every child's bed space had a large pull-down bed so their family member could stay overnight.

Becton Centre
Patients on Sapphire Lodge were supported with nasogastric feeding in the treatment room. On occasions patients needed to be escorted under restraint to the

treatment room and other patients in the area were asked to move to protect the patient's dignity. The treatment room was not soundproofed so other patients could hear distressed patients being fed under restraint. We were told soundproofing had been discounted as an option by staff as there was a view that this would mean that personal alarms might not work and staff would be isolated. Staff told us that patients were occasionally fed in other areas of the ward. This forms an action below.

However, staff were generally warm, welcoming and friendly. Staff told us that they worked together and shared staff as and when needed to respond to the needs of patients.

Northern General Hospital
The staff we spoke with had a positive attitude to young people with mental health problems. They accepted that patients with a mental health problem needed treatment in the same way as those with a physical health problem. From this point of view there was parity of esteem. However, staff were frustrated that once any physical health condition had been managed the patient was not able to receive the specialist mental health care and treatment that they needed while they were in the department or on the ward. Staff were aware of the risk of boredom for the patient and had obtained a box of activities for the patients to do. They told us of reasonable adjustments that they had made for some patients with specific needs, relating to visiting arrangements and accommodation arrangements whilst they were in the hospital.

Purpose and effectiveness

Sheffield Children's Hospital Wards and Emergency Department
We were told that MHA assessments were not common in the emergency department. Some patients with disordered eating were appropriately transferred to the medical ward but some required a tier four specialist bed, if one had been available. Triage nurses had some mental health training to support their role in identifying the correct pathway for patients. Leaders had oversight of admissions. There were biweekly updates of children with mental health conditions in the hospital so that the demand could be monitored and delays to discharge identified.

Staff told us that the involvement of the STAR team, who supported patients with any mental health presentation except eating disorders, had reduced the number of patients admitted to the hospital. The Sheffield Eating Disorders Assessment and Treatment Team worked with any patient with disordered eating in the community. The STAR Team had eased some of the pressures from the emergency department and had reduced the need for admission to the medical wards at the Northern General Hospital. They were also supporting the community CAMHS service that had waiting lists of one year.

A mental health nurse specialist had been appointed by the trust. Their role was trust wide and they offered mentoring, training and reflective practice to staff. They had prepared standard operating procedures for the MHA that included the use of section 5(2), section 2 and section 3.

Staff raised the concern that patients on a medical acute ward were not in full receipt of mental health care that they would get in a CAMHS setting, such as psychological interventions and family therapy.

Eight clinical records were reviewed, four for detained patients. All the detention paperwork was in order. All treatment for detained patients was appropriately authorised. Section 17 leave forms were fully completed by the RC.

Becton Centre
There was inpatient provision for all children and young people up to the age of 18, with a specialist ward for children and young people with a learning disability. One ward was being used to provide day provision for children and young people across South Yorkshire, which we were told reduced unnecessary admissions to other wards.

Staff told us that the number of patients with eating disorders that could be admitted was not capped, but the decision to admit was based on the current acuity and the dependency needs of patients already on the ward. Sapphire Lodge had seen an increase in patients with eating disorders since the pandemic. We were told staff were trained and supported to hold and feed patients when necessary. It was not clear how much involvement the Sheffield Eating Disorders Access Team had once a patient had been admitted to the Becton Centre. The team, which included a paediatrician, was only available to patients from the Sheffield area and seemed to work more closely with wards in the Children's Hospital in preventing admission and supporting discharge.

There was some conflicting information about access assessments. The clinical director said that access admissions were available at any time, with in-hours assessments done by the ward multidisciplinary team and out-of-hours by ward staff. The ward manager and ward staff said that there were no out-of-hours admissions.

We heard conflicting views about the reopening of a section 136 suite, the model of care that it will operate and how it will be staffed. This was internal to the Becton Centre but also expressed by partners outside of the Becton Centre. This forms an action below.

We were told by the mental health legislation team at Sheffield Health and Social Care Trust that the mental health detention documents for patients detained at the Becton Centre were sent to the MHA administration team at Sheffield Health and Social Care Trust, who scrutinised them and arranged for medical scrutiny. The original detention documents were stored by Sheffield Health and Social Care NHS Foundation Trust. The MHA administration team organised hospital managers hearings and mental health tribunals and provided reminders of key dates for statutory actions to the responsible clinicians. Hospital managers to carry out hospital managers hearings were provided by Sheffield Health and Social Care Trust.

Northern General Hospital
Young people aged 16 or 17 requiring urgent mental health assessment attended the accident and emergency department, where they underwent a physical health assessment and were then referred to the psychiatric liaison team. Following assessment, they were either discharged or an MHA assessment was organised. If the patient was assessed as requiring detention under the MHA they remained in the accident and emergency department until a specialist CAMHS bed was found. If a specialist bed was not available the patient was detained to the acute medical unit at the hospital, where they were cared for in a side room.

The acute medical unit is a 56-bed unit plus an ambulatory care unit, for patients with acute medical conditions awaiting speciality specific beds within the hospital. Staff said there was typically a turnover of between 50 and 60 patients each day.

All staff we spoke with were very aware of the restrictions and risks created by the environment. A bespoke cubicle was available in the accident and emergency department which had all the usual equipment removed from the wall and had been made into a ligature-free environment, with alarm bars on the wall and two exit doors. Rather than a bed, the cubicle had two settees. This made it unsuitable for patients who were subject to an extended stay in the accident and emergency department. We were told that when this was not available, or not appropriate because of the physical presentation of the patient, specific side rooms had been identified as being the most appropriate and these could be stripped of any medical equipment that was not required. Staff had access to a photograph of a stripped cubicle so that they knew what could be removed.

Staff in the acute medical unit felt well supported by the psychiatric liaison team and the hospital mental health team. They said it was difficult to get involvement from the CAMHS team and the STAR team and that it was usually only available if the patient was already under their care. They said that these teams were able to provide care plans for patients they were working with, which the ward team found helpful but said they needed earlier access to them.

The ward had an MHA-specific folder with information for the ward team including a mental health checklist, information about advocacy, transfer of care forms to Cygnet hospital, Mental Capacity Act assessment guidance, section 136 risk assessment, missing persons form, rapid tranquilisation policy, law relating to 16 and 17-year-olds and details about support networks for young people. Staff said they were not always clear about who the consultant was from the CAMHS service and that they did not always have copies of T2 or T3 forms when patients who had these were admitted. This forms an action below.

Nursing and medical staff at the hospital were not trained in the use of physical interventions and relied on their core nursing skills to engage with and de-escalate patients. If patients were aggressive and presented a risk to themselves or to other patients, hospital security or the police were contacted for support. Staff told us that security staff were not trained using a restraint reduction network approved syllabus, although we were told that this training was being put in place. This forms an action below.

Due to the general level of activity within both the accident and emergency department and the acute medical unit it was often not possible for a staff member to stay with a patient. On the acute medical unit one nurse was allocated to work with four cubicles which included the cubicles most likely to be used for young people with mental health conditions that were detained to the ward.

Staff told us that young people were often brought to the accident and emergency department as a result of social breakdown. They also said that for young people with autism or learning disabilities the environment could be over stimulating and it was not easy to find somewhere that was quieter and calmer in the department.

We were told by the mental health legislation team at Sheffield Health and Social Care Trust that a nurse on the acute medical unit received the mental health detention documents and sent copies to the MHA administration team at Sheffield Health and Social Care Trust, who scrutinised them and arranged for medical scrutiny. The original detention documents were kept by Sheffield Teaching Hospitals Trust. The MHA administration team organised hospital managers hearings and mental health tribunals and provided reminders of key dates for statutory actions to the responsible clinicians. Hospital managers to carry out hospital managers hearings were provided by Sheffield Health and Social Care Trust.

We reviewed the clinical records for three patients recently detained to the hospital. All documentation was fully completed for two patients. For the third patient the documentation had been forwarded to the specialist provider when the patient was transferred without a copy being kept. The hospital had requested a copy from the provider but it was not with the clinical notes. This forms an action below.

Efficiency and equity

System wide

There was a provider collaborative consisting of the Children's Hospital, Cygnet Sheffield Hospital which provided a general adolescent and a psychiatric intensive care bed and an independent hospital which provided beds for children and young people with eating disorders. There was a lack of clarity in relation to the number of beds available. For example, the children's hospital described that there was some uncertainty about the number of psychiatric intensive care beds. The hospital director of Cygnet Sheffield Hospital told us that the hospital was commissioned to the provider collaborative to provide two psychiatric intensive care beds, but only one had ever been used at a time. We were unsure on the role of the Sheffield Teaching Hospitals Trust and the Sheffield Health and Social Care Trust within the CAMHS provider collaborative.

There was a difference in the treatment offer for children under 16 and young people aged 16 and 17. Children under 16 were admitted onto a paediatric ward through the accident and emergency department at Sheffield Children's Hospital. Young people aged 16 and over were assessed in the accident and emergency department of the Northern General Hospital and admitted to the medical assessment unit if no CAMHS bed was available. There were also differences in the out-of-hours offer to

16 and 17-year-olds, with conflicting views between partners about who should be responsible for this age group. This made the treatment offer difficult to understand and led to some confusion amongst professionals working in the system.

We were told by the AMHPs that they received about 1,800 referrals per year, of which five to seven percent were children and young people, equating to about eight referrals per month. They told us that these referrals were the most time-consuming because of the problem in finding suitable beds and because patients were held in unsuitable environments, or returned home, when an admission was necessary.

A CAMHS clinician attended MHA assessments in 19.7% of cases and helped secure a specialist CAMHS bed in 14.7% of cases. Staff within the assessment pathway told us that the CAMHS doctors on call were employed by Sheffield Children's Hospital Trust and said they were not commissioned or not insured to work on other sites.

South Yorkshire police said that the use of section 136 of the MHA was low in Sheffield, being used for people under the age of 18 on five occasions between November 2021 and March 2022, with ages ranging between 15 and 17 years old. They said that young people took up a lot of police time and the police told us that they would prefer all child patients to go to the Children's Hospital.

The police had clear escalation procedures with designated liaison officers who attended multiagency forums.

Sheffield Children's Hospital Wards and Emergency Department
Staff reported that community CAMHS services had very long waiting lists and GPs were directing patients to the emergency department as a method of seeking help more rapidly

General hospital staff were concerned that they were not able to provide the specialist mental health care that the patients needed and that would be available in the specialist services. There was also frustration that there were specialist CAMHS beds in the trust but that these were regional beds and not always available to Sheffield patients.

Becton Centre
The Becton Centre accepted admissions from South Yorkshire as well of out of area because Ruby and Emerald Lodges were nationally commissioned. We were told that three patients were reported to be waiting for admission but the clinical director generally felt that the Becton Centre was able to meet the demands for admission from the local area without patients going out of area, unless it was a psychiatric intensive care or other highly specialised bed. This view was supported by the chief nurse.

Northern General Hospital
The psychiatric liaison team had a target of one hour to triage young people in the accident and emergency department. The team also provided cover to the whole hospital. Team members told us that they were a small team in comparison with national norms and saw twice as many patients as comparable teams. A mental

health team consisting of three nurses had been developed by the hospital in November 2020 and provided seven-day cover, but not 24-hour cover. They provided support to the whole hospital in terms of advice, training and direct support to patients. The mental health lead said that they liaised with the psychiatric liaison team and the STAR team.

Next steps

We have some concerns about the use of the MHA, compliance with the Code of Practice and/or the experience of detained patients on this ward. The actions we have raised as a result of this MHA monitoring visit are detailed in the attached report of action required.

Your action statement should include the areas set out in the report of action required. This should be emailed to MHAvisitingservices@cqc.org.uk by 8 July 2022.

Thank you for your support with our MHA monitoring work.

Yours sincerely

Simon Plummer
MHA reviewer

Enclosed:
Report of action required
Appendix – What is a MHA monitoring visit?

This report was also sent to:
Kirsten Major, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
and
Beverley Murphy, Executive Director of Nursing, Professions and Operations, Sheffield Health and Social Care NHS Foundation Trust

Action required

MHA visit reference: MHV1-12912794571

Section 120B of the Mental Health Act 1983 gives CQC power to require providers to produce an action statement as a result of a monitoring visit. Based on this visit, we are raising the following actions:

All providers

Action no. 1 **Empowerment and involvement**	**CoP chapter: 1**
Standard action for all providers	
Please advise how you have shared with patients the actions and findings from our visit and how patients responded to the information shared. Please include how you involved patients in developing your response to our findings and how they will be involved in monitoring completion of the actions, where appropriate.	

Action no. 2 **Efficiency and equity**	**CoP chapter: 1**
We found:	
Throughout the MHA review we found that there were conflicting interpretations about the availability of services and their access criteria. This included the route of access to specialist CAMHS advice for 16 and 17-year-olds detained in the Northern General Hospital, the number and type of beds contracted with the local specialist independent provider, the timescale for the opening of health-based place of safety at the Becton Centre and the patient group it will be available for.	
Your action statement should address:	
How the communication process can be improved to ensure that all specialist mental health staff and acute healthcare staff who treat children and young people presenting with mental health conditions are aware of service developments, service criteria and access routes. This is in line with the Code of Practice paragraphs 1.20 and 1.21.	

Sheffield Children's Hospital NHS Foundation Trust

Action no. 3 Respect and dignity	CoP chapter: 1
We found:	
On occasions patients who needed nasogastric feeding were escorted under restraint to the treatment room and other patients in the area were asked to move to protect the patient's dignity. The treatment room was not soundproofed so other patients could hear distressed patients being fed under restraint. Soundproofing had been discounted by staff because they were concerned that their alarms would not work.	
Your action statement should address:	
The actions the trust will take to ensure that the dignity of patients given nasogastric feeding against their will is fully protected. The actions the trust will take to review the appropriateness of the room used to give nasogastric feeds or how the room can be soundproofed without reducing the effectiveness of staff alarms.	

Action no. 4 Purpose and effectiveness	MHA section: 131 CoP chapter: 13
We found:	
For one patient at Sheffield Children's Hospital we raised concerns about how their admission and treatment was authorised. We were told that they did not have the mental competence to consent to their admission or treatment. They were under an interim care order, with the effect that local authority had parental responsibility. We raised the question of how their current admission and treatment had been authorised as the restrictions required amounted to a deprivation of liberty and as they were subject to a care order the local authority could not consent to that deprivation. We were assured that the trust took swift legal advice and an application to the court had been made before our review was completed.	
Your action statement should address:	
The action the trust has taken to address this situation including a progress report on the outcome of the court application and the patient's legal status.	

The action the trust will take to ensure that admission and treatment for all children and young people, including children under a care order, is appropriately legally authorised.

Action no. 5 **Purpose and effectiveness**	**CoP chapter: 1**
We found:	
The level of involvement of eating disorders specialists in the Becton Centre was unclear. We were told that the specialist eating disorders access team was a Sheffield resource, with more input into the Sheffield Children's Hospital than the Becton Centre.	
Your action statement should address:	
How the need for eating disorders specialists is met in the Becton Centre. Whether this resource is available to patients from Sheffield or available to all patients in the Becton Centre, in line with paragraphs 1.15 and 1.16 of the Code of Practice.	

Action no. 6 **Efficiency and equity**	**MHA section: 131 & 140** **CoP chapter: 19**
We found:	
Professionals raised the issue that CAMHS doctors would not attend MHA assessments for 16 and 17-year olds at Northern General Hospital. This was less of a problem at Sheffield Children's Hospital for younger children as there was a CAMHS consultant who was a member of the STAR team based in the emergency department.. This means that some assessments did not involve a CAMHS specialist, contrary to the guidance in the Code of Practice. AMHPs and the MHA administration office reported being told that CAMHS doctors on call were "not commissioned" or "not insured" to attend Northern General Hospital. Consequently, we were told of examples of delays to young people awaiting transfer to a suitable service for their age. AMHPs told us that they were being asked to complete the application for a tier 4 bed and that they were not CAMHS specialists.	
Your action statement should address:	
How Sheffield Children's NHS Foundation Trust, as the lead trust, will ensure that CAMHS doctors or an AMHP with CAMHS background are available to undertake MHA assessments, as required by paragraph 19.73 of the Code of Practice.	

That the application for specialist CAMHS beds is completed by a person with the ability to fully complete the application process without undue delay.

Action no. 7 **Efficiency and equity**	**CoP chapter: 19**
We found:	
A new, purpose-built health-based place of safety was due to open at the Becton Centre later this year.	
Your action statement should address:	
Please provide further information about the planned arrangements for the new health-based place of safety including: • the patient group that will be able to use this facility and the arrangements for any groups of patients under 18 years of age who are excluded from its use • the staffing arrangements for the place of safety, including medical cover • the proposed opening date	

Action no. 8 **Least restrictive option and maximising independence**	**CoP chapter: 26**
We found:	
Patients detained to the Northern General Hospital were nursed in a side room on the acute medical unit. This was a large and busy ward and patients might be restricted to the side room for reasons other than the containment of severe behavioural disturbance.	
Your action statement should address:	
The criteria and assessment process staff use to determine whether a detained patient is being secluded. How hospital managers are assured that, should patients be assessed as being secluded, they are provided with the necessary safeguards in terms of observation and reviews that are required by chapter 26 of the Code of Practice.	

Action no. 9 **Purpose and effectiveness**	**MHA section: 58** **CoP chapter: 25**
We found:	
Staff in the hospital did not always have copies of T2 or T3 authorisation certificates for medication for treatment of a mental health condition for patients requiring it.	
Your action statement should address:	
The steps the trust take to ensure that registered nurses can assure themselves that medication for the treatment of the mental health condition is properly authorised before they administer the medication.	

Action no. 10 **Purpose and effectiveness**	**CoP chapter: 26**
We found:	
Hospital staff were not trained in the use of physical interventions. Security staff were not trained in techniques from the syllabus approved by the restraint reduction network and could take up to 10 minutes to reach the clinical area of an incident. As a result the police were often contacted for support.	

Your action statement should address:
How the trust ensures the safety of staff and patients when physical intervention is required to manage violent or aggressive behaviour. The action the trust is taking to ensure that staff carrying out physical interventions will be trained in techniques recognised as current best practice.

Action no. 11 Purpose and effectiveness	CoP chapter: 26
We found:	
Staff identified that people with sensory processing disorders could be overstimulated in the busy accident and emergency department or acute medical unit. These disorders are frequently experienced by autistic people or people who have a learning disability.	
Your action statement should address:	
The actions the trust can take to make reasonable adjustments for people with sensory processing disorders in line with the primary preventative strategies identified in paragraph 26.18 of the Code of Practice and the requirements of the Equality Act 2020.	

Action no. 12 Purpose and effectiveness	CoP chapter: 37
We found:	
The hospital failed to retain copies of the detention papers for one patient when they were transferred to a specialist hospital.	
Your action statement should address:	
The learning and actions from this incident that remove or reduce the chance of a recurrence. Assurance from the trust that the hospital has a process in place to retain copies of documents authorising detention, as required by Code of Practice paragraph 37.27 and that these copies are available for inspection when required.	

Appendix

What is a MHA monitoring visit?

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act.

MHA reviewers do this on behalf of CQC by interviewing detained patients, or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.

Visits to places of detention under the MHA are one way in which CQC carries out its duties as part of the UK National Preventive Mechanism (NPM) under the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT recognises that people in detention are particularly vulnerable and requires states to set up a national level body that can support efforts to prevent their ill treatment, in part through making recommendations with the aim of improving the treatment and conditions of persons deprived of their liberty.

This letter sets out the findings from a visit to monitor the use of the MHA at the locations named. It will feed directly into our public reporting on the use of the Act and to our monitoring of the service's compliance with the Health and Social Care Act 2008. This letter is shared with the CQC inspection team.

We do not publish this letter but it would not be exempt under the Freedom of Information Act 2000 and may be made available on request.

Section 120B of the MHA gives CQC the power to require providers to produce a public statement of the actions that they will take as a result of a monitoring visit. That statement must set out how the service will make any improvements needed to ensure compliance with the Act and its Code of Practice.

Services should involve patients appropriately in developing and monitoring the actions that they will take. Services should tell CQC of action taken to inform patients of what you are doing to respond to these findings.