Independent Quality Assurance Review
Essex Partnership University NHS Foundation Trust
StEIS 2017/30950

Final Report

July 2022

insight integrity impact

Niche Health and Social Care Consulting
4th Floor, Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

06 July 2022

Dear Mette,

Independent Quality Assurance Review, Essex Partnership University NHS Foundation Trust.

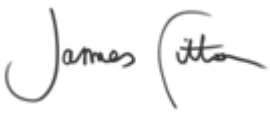
Please find attached our Final Report of 6 July in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user in Essex that was completed in November 2020.

This report is a limited scope review and has been drafted for the purposes as set out in the terms of reference for the independent investigation alone and is not to be relied upon for any other purpose. The scope of our work has been confined to the provision of an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF). Events which may occur outside of the timescale of this review will render our report out of date.

Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

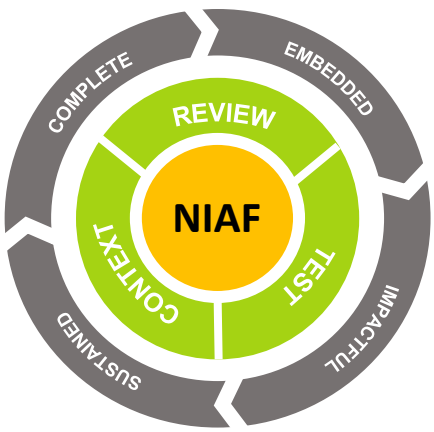
This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,



James Fitton

Niche Health and Social Care Consulting Ltd



Niche Investigation Assurance

insight integrity impact

Contents

Contact
Emma Foreman
Associate Director
07557 083543

1. Method

1.1 Background and context for this review

NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting Ltd. (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the care and treatment of a mental health service user (referred to as James in the report) in Essex.

1.2 Review method

This is a high-level report on progress to NHS England and NHS Improvement, undertaken through desktop review only, without site visits or interviews. The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our work comprised a review of documents provided by Essex Partnership University NHS Foundation Trust ('the Trust' or 'EPUT'). These included action plans, policies, procedures, meeting minutes, audits and staff communications.

We have not reviewed any health care records because there was no requirement to re-investigate this case in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

1.3 Implementation of recommendations

The Niche independent investigation made seven recommendations to the Trust; these are listed opposite.

1	The Trust must ensure that NICE guidance for the care and treatment of patients with psychosis is adhered to, including specific reference to structured family education.
2	The Trust must revise their clozapine administration guidance to include the education of patients and families, and the management of risk if clozapine is stopped suddenly.
3	The Trust must ensure that community teams have structures and processes to ensure that the Care Programme Approach (CPA) Policy is adhered to, and systems in place to monitor compliance.
4	The Trust must provide clarity about protocols and responsibilities with respect to responding to increased need for interventions, zoning, and the process for considering and effecting inpatient admissions from the community.
5	Standards for note keeping must be monitored by the Trust, to include how medical consultations are recorded.
6	When going through large-scale service changes, the Trust must ensure that risks to patient care are assessed, documented and mitigated.
7	Serious incident investigation reports must meet the timeliness standards expected by NHS England guidance.

2. Assurance summary

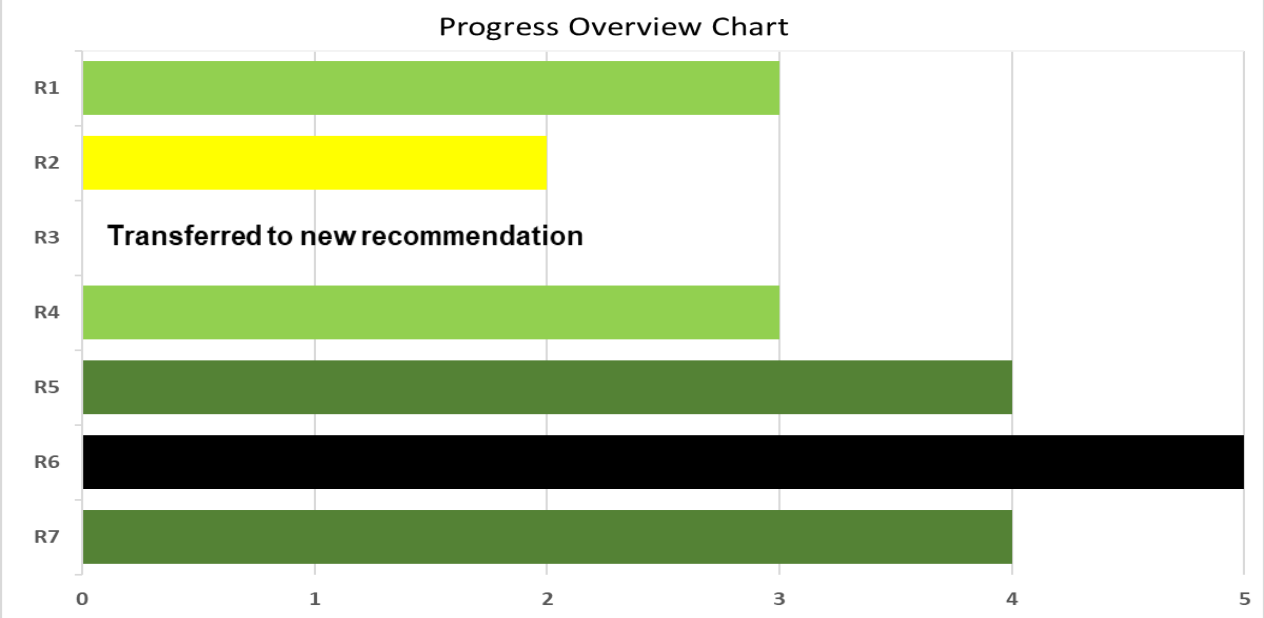
Scoring criteria key

The assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained.

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

Implementation of recommendations

We have rated the progress of the actions which were agreed from the recommendations made. Our findings are summarised below:



Summary

Progress has been made in relation to most of the recommendations. Where appropriate, we have provided examples of further assurance which is required to demonstrate actions are complete, tested, embedded and/or sustained as appropriate.

Some headline commentary to support these ratings has been provided in the following pages and Appendix 1 (evidence review) provides a more detailed assessment against each piece of evidence which has been submitted to Niche.

2. Assurance summary (continued)

Recommendation 1

The Trust must ensure that NICE guidance for the care and treatment of patients with psychosis is adhered to, including specific reference to structured family education.

Niche assurance rating for this recommendation	3

Key findings: Three operational policies that we have reviewed include reference to NICE psychosis guidelines and to family involvement in care planning and risk assessments; however, one of the policies is considerably out of date and none specifically mention family education. Only one of the policies describes how interventions will be monitored but we have seen no evidence of these activities being undertaken or of audits, testing or reporting (for example, to a standing committee or sub-committee) to ensure that required NICE guidance is being met. The Trust does participate in national audit programmes to monitor adherence to NICE guidance although we have not seen the outputs or outcomes of these audits.
While the Trust's action plan includes a list of initiatives from individual teams/services that reflect aspects of good practice identified in NICE guidance, we have seen no examples of the activities described or how this good practice is shared with other teams.

Residual recommendations:

The Trust should complete the action to ensure that the families of patients with psychosis receive structured education as required, with compliance monitored through audits and dashboard reporting.

Recommendation 2

The Trust must revise their clozapine administration guidance to include the education of patients and families, and the management of risk if clozapine is stopped suddenly.

Niche assurance rating for this recommendation	2

Key findings: The Formulary and Prescribing Guidelines for Psychosis have been updated and these include guidance on the use of clozapine. A Consultant (prescriber) Checklist requires discussion of the medication with the patient/family/carers but does not include specific discussion of the risks if clozapine is suddenly stopped. While local and national audits have been undertaken, compliance with standards varies across the teams including in relation to there being a documented discussion with patients/carers about the potential risks and benefits of clozapine before treatment with this medication was started. Incidents involving clozapine continue to be reported in line with policy requirements although we have seen no evidence of these being thematically reviewed to ensure the same causal factors have been addressed.

Residual recommendations:

The Trust should further refine prescribing guidelines to include patient/family education regarding the risks of suddenly stopping clozapine. Also include this as a specific requirement of the Consultant (prescriber) checklist.

The Trust should complete actions from audits and continue to test compliance until required standards are consistently met.

2. Assurance summary (continued)

Recommendation 3

The Trust must ensure that community teams have structures and processes to ensure that the CPA Policy is adhered to, and systems in place to monitor compliance.

Niche assurance rating for this recommendation | **Transferred to new recommendation**

Key findings: The CPA and Non-CPA Policy and Procedure documents are out of date (they were due for review in November 2020 but granted several extensions due to COVID-19). They state that implementation and compliance will be measured through a range of mechanisms, but we have seen no evidence of these activities being undertaken. We note, however, that national policy changed since this recommendation, with CPA being replaced by the Community Mental Health Framework. This recommendation is therefore superseded (see below).

Residual recommendations:

The Trust needs to ensure that the principles of the Community Mental Health Framework (which have replaced the CPA approach) are introduced and adhered to.

Recommendation 4

The Trust must provide clarity about protocols and responsibilities with respect to responding to increased need for interventions, zoning, and the process for considering and effecting inpatient admissions from the community.

Niche assurance rating for this recommendation | **3**

Key findings: There are a range of operational policies and procedural documents that contain information relating to the increased need for service user interventions and zoning, and also the processes for considering and effecting inpatient admissions from the community. However, these documents do not include how the Trust will monitor implementation or compliance with the training that is referred to, and we have seen no evidence of audits or other testing of processes described.

Residual recommendations:

A cycle of audits should be undertaken to check that interventions and zoning are appropriate for the needs of service users and that processes are complied with for admission to hospital from the community.

Recommendation 5

Standards for note keeping must be monitored by the Trust, to include how medical consultations are recorded.

Niche assurance rating for this recommendation | **4**

Key findings: There are a range of operational policies and procedural documents which include reference to record keeping. Specific record keeping policies also confirm the need to ensure that clinical records are an accurate account of treatment, care planning and delivery. Audits and re-audits of key record keeping standards have been undertaken but we have seen no evidence of these reports being presented at service Quality and Safety meetings and, while some improvements have been noted, there are areas of significant variation across teams and services.

Residual recommendations:

The Trust should continue to repeat the audit, action planning and training cycles to demonstrate sustained improvements.

2. Assurance summary (continued)

Recommendation 6

When going through large-scale service changes, the Trust must ensure that risks to patient care are assessed, documented and mitigated.

Niche assurance rating for this recommendation **5**

Key findings: The Trust has a Service Improvement and Development Team. We have been told that they use NHS Improvement methodology and project management principles for supporting clinical and transformational change, but we have seen no documentary evidence of the guidance or its application or of the quality impact assessments which are completed for the annual cost improvement programmes. However, risks to implementation and service delivery, staff and patient risks, were included in the project action plans that we reviewed. These action plans are subject to assurance processes whereby exceptions to time, cost and the quality of programmes of work are monitored, and support put in place as required. Post-implementation reviews are not routinely undertaken, although a Clinical Senate brings together a range of clinicians to periodically review and sign off clinical transformational work to ensure that changes are relevant and the required outcomes achieved.

Residual recommendations:

The Trust should ensure that there is documented guidance for the project management and risk assessment of key transformation projects.

Recommendation 7

Serious incident investigation reports must meet the timeliness standards expected by NHS England guidance.

Niche assurance rating for this recommendation **4**

Key findings: The Trust has been identified as an ‘early adopter’ of the new NHS Patient Safety Incident Response Framework (PSIRF). Local arrangements have been reflected in a Standard Operating Procedure and Plan and these include timeframe requirements for the completion of investigations (ordinarily within one to three months of their start date with extensions only in exceptional circumstances but always in agreement with the patient/family/carer). Monitoring is undertaken by the central Patient Safety Team via an excel spreadsheet and reporting is made by exception to the service and Executive teams. The current spreadsheet does not include reference to families having agreed to the timeframes for investigations; this will require adding or testing via other means. Of the investigations listed, most are within their target dates for completion although some fields have been left blank and one is red rated.

Residual recommendations:

The Trust needs to continue the monitoring of investigation progress for serious incidents and help to support completion within agreed timeframes.

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust must ensure that NICE guidance for the care and treatment of patients with psychosis is adhered to, including specific reference to structured family education.

Key evidence submitted	Niche review
Mid Essex Specialist Psychosis Service Operational Policy Version 3, 1 April 2015	This document aims to define the Mid Essex Specialist Psychosis Service for the Trust but does not include any reference to NICE guidance. While there is reference to family involvement in care planning and risk assessments, family education is not mentioned. It is considerably out of date (2015) despite stating that the Policy will be evaluated and if necessary revised on a six-monthly basis. The document does not include how the Trust will monitor implementation and compliance.
Operational Policy West Specialist Mental Health Service, 1 February 2020	This policy aims to support decisions concerning the care and treatment of individuals who are referred to the service. It states that the service will follow the NICE guidance for the care treatment and support of those with a diagnosis of psychosis. While there is reference to family involvement in care planning, risk assessments and transfers, family education is not mentioned. Furthermore, this policy does not include a review date or whether it has been approved/ratified. It states that the policy will be evaluated and if necessary revised on a six-monthly basis, but we saw no evidence that reviews have taken place. The document does not include how the Trust will monitor implementation or compliance with the training that is referred to.
Neighbourhood Community Treatment Team Operational Guidance, Version 1, July 2021	This guidance sets out the operational framework for the neighbourhood community mental health team with reference to NICE guidelines on psychosis and schizophrenia in adults. However, it does not include guidance on family involvement (other than determining the level of support they provide) or family education. The document does not include in the relevant section details of how the Trust will monitor implementation and compliance. Local audits are mentioned but we have seen no evidence of these being undertaken. The Policy does describe that interventions will be monitored to ensure in line with NICE guidance. It also states that the senior neighbourhood team will attend the Trust-wide Community Quality and Health and Safety meeting to receive NICE guideline updates and health and safety considerations for dissemination across their wider teams. We have seen no evidence of these activities being undertaken.

Appendix 1: Evidence review

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Statement from the Independent Investigation Action Plan, December 2021	We have been told that EPUT participates in national audit programmes to monitor adherence to NICE guidance including: • the National Audit of Psychological Therapies; • the National Audit of Psychosis; and • the Prescribing Observatory for Mental Health UK – use of depot/long-acting antipsychotic injections. The Trust did not provide the outputs or outcomes of these audits.
Independent Investigation Action Plan, December 2021	The Independent Investigation Action Plan (December 2021) states that the ways in which NICE recommendations are addressed varies across the Trust and across the range of teams in which people with psychosis are seen. In Early Intervention in Psychosis (EIP) services, psychologists take a lead on this work in some areas, with other multi-disciplinary team (MDT) members leading on carers work in the south of the Trust. The Action Plan lists some examples of good practice within the EIP services: • Service user and carer information packs are made available at the point of initial assessment. These include information about psychosis, support available for carers, information about the team, and crisis contact details. • Carers groups are run jointly across community services. • In the North East region, carers information evenings have been held focusing particularly on those in the early stages of their contact with services. These sessions include information about the service, what is offered, the nature of psychosis and recovery, and advice on looking after yourself as a carer. • In the South region of the Trust each EIP team has a dedicated lead clinician for carers. • In the North Mid-Essex team a carers' workshop forms part of the regular Wellbeing Sessions programme. • Family Intervention for Psychosis (FIP) sessions with significant psychoeducation components are available in each team. In the North East, an FIP clinic has been run in the evening to offer these sessions in an accessible way to families. Psychologists along with other trained MDT colleagues provide these interventions. Referrals to FIP are discussed in MDT zoning meetings and the FIP sessions are provided for EIP service users and carers. • Psychology services are leading on providing Trust-wide FIP supervision groups. • There is currently a review taking place regarding carer information and support programmes within the EIP service across the trust. The Trust did not provide further documentary evidence of these initiatives.

Appendix 1: Evidence review (continued)

Recommendation 2	
The Trust must revise their clozapine administration guidance to include the education of patients and families, and the management of risk if clozapine is stopped suddenly.	
Key evidence submitted	**Niche review**
Audit of physical health monitoring of patients treated with clozapine in E-SPT, July 2020	This audit aimed to determine whether the clozapine clinics in Colchester and Clacton-on-Sea followed standard procedures when dealing with clozapine physical health monitoring and medication reviews. Compliance and good practice were identified as were areas for improvement. An action plan was marked complete for four of five resultant recommendations as at August 2020.
Prescribing Observatory for Mental Health (POMH-UK) Audit of annual physical health check for of the patients under the care of a community mental health team and treated with clozapine, August 2020	This audit for the use of clozapine in 2018 included a recommendation to improve compliance with Standard 6 (annual medication review). The audit in 2020 focused on annual physical health checks for 226 patients under the care of a community mental health team and treated with clozapine. Results varied but there was a noticeable decline in the performance of teams in carrying out annual physical monitoring for these patients. However, it was also noted that more than one third of the period selected for audit was during the COVID-19 pandemic, when some patients were not able to be compliant with the required annual health checks especially if they were shielding and vulnerable. Re-audit was recommended for August 2021.
Clozapine incidents January 2020-March 2021	This spreadsheet contained information relating to 110 no or low harm incidents and 15 moderate harm and above incidents linked to clozapine. This includes reporting of 'red alert' blood results (i.e. when blood results require the service user to stop taking clozapine until further notice), and the need to stop clozapine in line with policy requirements.
Section 2: Treatment Of Psychosis Formulary and Prescribing Guidelines, July 2021	This contains guidance on the use of clozapine including management following a 'red alert' result. The document references the need to record the expected benefits and risks upon initiation but does not include the requirement to discuss these with the patient/family. While there is also a checklist which requires the consultant (prescriber) to discuss the medication with the patient/family/carers, this does not include discussion of the risks if clozapine is stopped suddenly. The guidance does not include how implementation/compliance will be monitored.
POMH-UK - The Use of Clozapine Audit, August 2021	This summary report reflects a re-audit undertaken during January-March 2021. 61 NHS Trusts/healthcare organisations participated, submitting data for 8155 patients under the care of 840 clinical teams. From EPUT, 11 teams participated in this audit with 198 cases reviewed. Overall EPUT performed on par with most of the practice standards although compliance varied including in relation to there being a documented discussion with patients/carers about the potential risks and benefits of clozapine before treatment with this medication was started (2/18 cases had discussions documented).

Appendix 1: Evidence review (continued)

Recommendation 3	
The Trust must ensure that community teams have structures and processes to ensure that the CPA policy is adhered to, and systems in place to monitor compliance.	
Key evidence submitted	**Niche review**
CPA Policy, Version 1.1, December 2018	This outlines the implementation of CPA and Non-CPA for the Trust and states that it should be read in conjunction with the CPA Procedure. The Policy is brief (seven pages) and out of date (it was due for review November 2020 but was granted several extensions due to COVID-19). It refers to implementation of and compliance with this Policy being measured through performance standards, key performance indicators (not specified), audit, supervision, 'one-to-ones' and the Trust-wide CPA Steering Group, but we have seen no evidence of these activities.
CPA Procedure, Version 1.5, December 2018	This Procedure provides guidance on the implementation of the CPA Policy (see above) and includes assessment, risk assessing and planning, care planning (including crisis and contingency planning), co-ordinating care, reviewing and transitions.
Supplementary information received	Operational policies (various) - these contain some references to CPA and direct the reader to the CPA Policy and Protocols (also see commentary in recommendations 1 and 4).

Appendix 1: Evidence review (continued)

Recommendation 4	
The Trust must provide clarity about protocols and responsibilities with respect to responding to increased need for interventions, zoning, and the process for considering and effecting inpatient admissions from the community.	
Key evidence submitted	**Niche review**
Mid Essex Specialist Psychosis Service Operational Policy Version 3, 1 April 2015	This document aims to define the Mid Essex Specialist Psychosis Service. It includes their scope, working arrangements, access, assessment processes (and zoning), caseload management and discharge. It states that the Policy will be evaluated and if necessary revised on a six-monthly basis, but we saw no evidence that reviews have taken place. The Policy does not include how the Trust will monitor implementation or compliance with training that is referred to.
Capacity, Flow and Escalation Protocol, February 2018	This operational protocol aims to support consistent gatekeeping in order to facilitate admitting “the right patients, to the right beds, at the right time and for the right duration”. The section which describes how the Trust monitors implementation and compliance with this policy is blank. The document states that training and regular updates are essential in attaining successful outcomes but we have seen no evidence to support delivery or monitoring of compliance with this. The protocol was due for review in February 2019 and is now being updated.
Capacity, Flow and Escalation Protocol (MHOP4) Appendices 1-12, February 2018	These documents include: • Red to Green & Safer Mental Health Patient Flow Bundle; • the safer staffing situation report template; • the Operational Pressures Escalation Levels Framework; • choice letter and zoning templates; • discharge planning and caseload management processes; • whole system ‘sit rep’ reports; • High Intensity Users Group terms of reference; • Trust-wide Bed Situation Report template; • daily bed management handover template; • overnight bed management handover template; and • the social care validation of delayed transfers of care flow chart.
Operational Policy Mental Health - 24/7 Crisis Response & Home First Service, 30 March 2020	This includes the aims and objectives of the service. It references the need to ensure that a 24/7 community-based mental health crisis response is available in all areas, and that these teams are adequately resourced to offer intensive home treatment and not just assessment as an alternative to an acute inpatient admission. The model of care is described in a flow chart as is the Mental Health Emergency Department Diversion Pathway; however, details on monitoring to ensure compliance with the policy are not included and the section on key performance indicators states “See appendix to be confirmed”. We did not see evidence of how the training described is being monitored or how feedback from patients and/or carers and staff about the quality of service and their experience is being used to assess the standards of care being delivered (page17 of the Policy).

Appendix 1: Evidence review (continued)

Recommendation 4 (continued)	
Key evidence submitted	**Niche review**
First Response Team Standard Operating Procedure, Essex Mental Health and Learning Disability Service, Version 2, June 2021	This includes information about self referrals and drop-ins, requests for domiciliary visits/home visits, screening, inclusion and exclusion criteria, assessment and treatment options following assessment. The document does not include information on how compliance with the procedure will be monitored.
Neighbourhood Community Treatment Team Operational Guidance, Version 1, July 2021	This guidance sets out the operational framework for the neighbourhood community mental health team with reference to access and zoning. The guidance is incomplete; it does not include details of the service (section 1.0), or how the Trust will monitor implementation and compliance. It does, however, include reference to an annual audit of high-risk medications being prescribed by the neighbourhood team and a monthly sample audit of the caseload to ensure quality improvement. It also states that case load management will take place on a six-weekly basis as directed by the Flow and Capacity Case Load Manager using the case load dashboard and weighting tool. We have seen no evidence of this monitoring.
Operational Policy West Specialist Mental Health Service, reviewed September 2021	This document includes reference to access, referrals and zoning. It states that the Policy will be evaluated and if necessary revised on a six-monthly basis, but it does not include how the Trust will monitor implementation or compliance with the training that is referred to. Local audits (monthly CPA and medical audits) are referred to, but we have seen no evidence of these being undertaken.

Appendix 1: Evidence review (continued)

Recommendation 5	
Standards for note keeping must be monitored by the Trust, to include how medical consultations are recorded.	
Key evidence submitted	**Niche review**
Mid Essex Specialist Psychosis Service Operational Policy Version 3, April 2015	This operational policy states that systems will be in place for monitoring record keeping standards which will include data completeness and the quality of record keeping.
Structure And Content Of Health/Social Care Records, Version 5, February 2019	This procedure aims to make staff aware of their responsibilities to meet the requirements and standards relating to the content and quality standards of health records of all types, and should be read in conjunction with the Records Management Policy (see below). It states that an annual audit of record keeping will be undertaken in all clinical areas with Mental Health and Specialists Mental Health services conducting ongoing audits to be reported twice a year. The audits are to include communication, legality, integration and partnership.
Operational Policy West Specialist Mental Health Service, February 2020	This operational policy states that systems are in place for monitoring record keeping standards which include data completeness and associated key performance indicators.
Operational Policy Mental Health - 24/7 Crisis Response & Home First Service, March 2020	This operational policy states that systems are in place for monitoring record keeping standards including through data completeness audits and associated key performance indicators.
Records Management Policy, Version 2, December 2021	This Policy sets out the overall aims and objectives of the Trust for the effective management of its records. It states that the Clinical Audit Department will include clinical/healthcare records audit as part of the annual programme supported by the Service Leads. It also requires that clinical audit reports are presented within the service Quality and Safety meetings to address any initial actions, escalating any issues and concerns via the reporting structures. The Trust did not provide evidence of this being implemented in practice.
Audit of Health Records template	The audit template is centred around access to records and integration across professions and organisations. It refers to “high quality practice – evidence-based guidelines” although it is not clear how this would be measured.
19124 - Inpatient ward safety documentation audit (Older adults wards in North East), undated	A request was made by the Medical Director that inpatient ward rounds should be recorded on PARIS. The audit of two wards (data used from October 2018 and April 2019) aimed to ascertain the extent to which key elements were being recorded and to ensure that important and relevant facts are within the patient record. A primary finding was that information had been coded inconsistently for these particular topic areas for two main reasons: either the topic was not discussed and recorded, or it may have been referred to indirectly.

Appendix 1: Evidence review (continued)

Recommendation 5 (continued)	
Key evidence submitted	**Niche review**
21110 - Inpatient ward safety documentation audit Adult wards in West, Mid and North East), October 2021	The aim of the audit was to identify areas for improvement and suggest recommendations to improve medical record keeping which would lead to more clarity and accuracy, effective communication between professionals, ensuring patients' needs are met comprehensively. 70 patients were randomly selected, and the results varied significantly across the 14 questions asked. It concluded that: • when the answers are automated or mandatory, above 90% of fields were completed; • questions related to legal status, name of participants, patients and relatives' views, plan/to do list about next week had high overall documentation rates; but that • several areas also lacked sufficient documentation rates.
Audits of Record Keeping – various, Quarter 2 2021/22, October 2021	Sample of six inpatient and community mental heath team audits with data from the previous two years included for comparison. Audits looked at general (not specified), care planning, risk assessment, physical health, crisis plans, consent/capacity, carers and involvement. Action plans were included for each audit report, but results varied across the teams.
Re-audit of Inpatient ward review safety documentation, January 2022	This referenced the previous 2019 audit and focused on six questions with a sample of 25 patients taken from one ward. The report concluded that compared to the 2019 audit, overall compliance with the required documentation was over 80% in all audited points with the exception of resuscitation status for all audited weeks (40-50%).

Appendix 1: Evidence review (continued)

Recommendation 6	
When going through large-scale service changes, the Trust must ensure that risks to patient care are assessed, documented and mitigated.	
Key evidence submitted[1]	**Niche review**
EPUT 2021/22 Transformation Assurance Governance Structure	This diagram details the corporate, operational, workforce/Human Resources and finance meeting structures for oversight of the transformation programme.
Equality Impact Assessment Transformation Programme, March 2021	This was a form completed for the Trust Project and Transformation Portfolio (programmes and projects across Essex). It includes extensive narrative and an assessment of whether a particular group of people might be affected differently in either a negative or positive way by the projects/strategy/policies.
Essex Clinical Senate presentation slides, June 2021	These include a Transformation Plan Overview with details on key projects, timescales, key risks, outcomes and benefits. Progress and update reports were given for each scheme with examples of improved outcomes for patients and staff.
Thurrock Enhanced Primary Care Mobilisation Project Action Plan, November 2021	This is an example of a live project implementation plan including workstreams, actions and owners. A risk log is incorporated in the plan with nine risks listed and rated. These are risks to implementation but also include potential service delivery, staff and patient risks.
Transformation Assurance Meeting, January 2022	This meeting agenda looks at transformation projects and includes an action log dating back to June 2021 (all historic actions were rated ‘green’) with evidence of risks being discussed.
Statement from the Business Development and Service Improvement Team, February 2022	This advised that post-implementation reviews are not used to manage risk. Risks are, instead, assessed against each action within an implementation plan (risks to implementation). In this way all risks logs are integral to implementation plans.
Supplementary information received	Essex Clinical Senate agenda, June 2021

Appendix 1: Evidence review (continued)

Recommendation 7	
Serious incident investigation reports must meet the timeliness standards expected by NHS England guidance.	
Key evidence submitted[1]	**Niche review**
Patient Safety Incident Response Plan March 2021	This sets out how the Trust will learn from patient safety incidents. It includes timeframes for the completion of investigations (ordinarily within one to three months of their start date with extensions only in exceptional circumstances but always in agreement with the patient/family/carer). Monitoring mechanisms are described (such as through the Executive Assurance Group, local business unit clinical governance structures, the Patient Safety Assurance Group and thematic review) but we have seen no examples of reporting from these.
Standard Operating Procedure Patient Safety Incident Management, May 2021	Interim process for the early adopter stage of Patient Safety Incident Response Framework (PSIRF) implementation. This describes the roles and responsibilities of key staff in the implementation of the new PSIRF which will replace the 2015 Serious Incident Framework. It includes aims and objectives, how learning from incidents will be identified and shared, and quality assurance process with reporting through the Executive Patient Safety Incident (PSI) Assurance Group and the PSI Clinical Review Group. It states that the Head of PSI Management will report regularly to the Executive Team, Clinical Quality & Governance Sub-Committee and Learning Oversight Sub-Committee. Reporting will include patient safety incident reporting activity, investigation outcomes, Patient Safety Review outcomes, emerging themes/risks, and system improvement plans; we have seen outputs from the meetings listed.
Statement from the Independent Investigation Action Plan, December 2021	The Patient Safety and Incident Management Team provides oversight of incident investigations to ensure all milestones are met, with regular contact with the police for updates regarding investigations which are required to be paused. The Trust did not provide examples of where this has been enacted.
Learning From Deaths Policy and Procedural Guidelines (Review of Individual Deaths), 1 April 2022	This includes that an independent assessment of the quality of a sample of Patient Safety Incident Investigations undertaken under the PSIRF (which also constitute Learning from Deaths Stage 3 Reviews) will be undertaken annually. These have yet to be enacted given that changes to policy have only recently been introduced.
Incident Management Position Statement, 16 May 2022	This excel spreadsheet includes all live investigations and stages of progression. Dates of Patient Safety Incident Investigations being reported on StEIS are captured as are target and actual dates of investigation completion.

Appendix 2: Glossary of terms

Appendix 2: Glossary of terms

CIP	Cost Improvement Programme
CPA	Care Programme Approach
EIP	Early Intervention in Psychosis
EPUT	Essex Partnership University NHS Foundation Trust
FIP	Family Intervention for Psychosis
MDT	Multi-disciplinary team
NIAF	Niche Investigation Assurance Framework
NICE	National Institute for Health and Care Excellence
POMH-UK	Prescribing Observatory for Mental Health
PSI	Patient Safety Incident
PSIRF	Patient Safety Incident Response Framework
StEIS	Strategic Executive Information System

Niche Health & Social Care Consulting
4th Floor
Trafford House
Chester Road
Stretford
Manchester
M32 0RS

Tel: 0161 785 1000

www.nicheconsult.co.uk

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492.