Independent Quality Assurance Review

Essex Partnership University NHS Foundation Trust
Mid and South Essex Integrated Care System

Mr Z

Final Report August 2023

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1. Method

1.1 Background and context for this review

NHS England 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, Mr Z, that was completed in July 2021.

1.2 Review method

This is a high-level report on progress to NHS England, undertaken through desktop review and interviews where required. 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 (EPUT) and Mid and South Essex Integrated Care System (ICS). These included action plans, policies, procedures, audits, meeting minutes 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 independent investigation made four recommendations for the Trust and one joint recommendation for the Trust and the Clinical Commissioning Groups (CCGs), now Mid and South Essex Integrated Care System (ICS). The recommendations are listed opposite.

1	The Trust should evaluate the senior primary care mental health nurse practitioner role in South East Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.
2	The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.
3	The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.
4	The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.
5	The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

2. Assurance summary

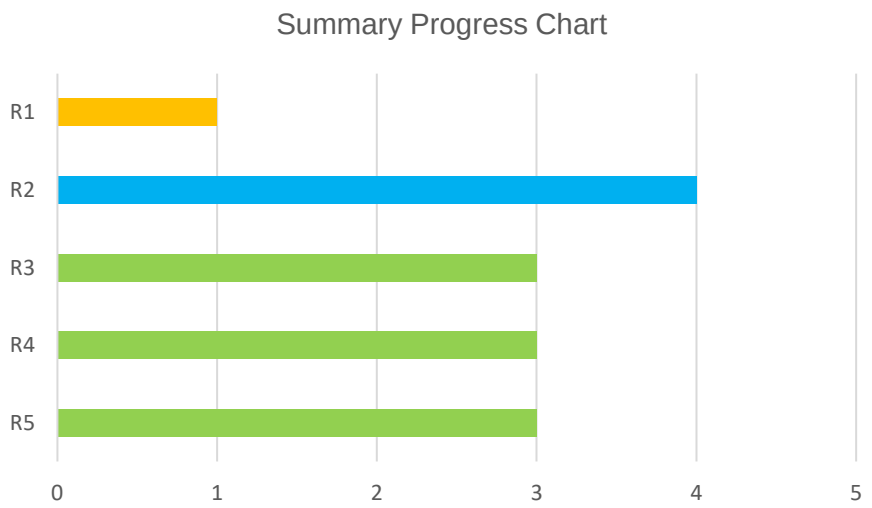
Scoring criteria key

The assessment is meant to be useful and evaluative. We use a numerical grading system to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. 3 is regarded as a good score as it reflects action completion. Scores of '4' and '5' are harder to achieve due to the cycle of testing that is required to demonstrate sustained improvements being achieved (for at least 12 months).

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

We have seen evidence of progression for all recommendations although this is more limited for recommendation 1. Where appropriate, we have provided examples of further assurance which is required to demonstrate actions are progressed, 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 (cont.)

Recommendation 1

The Trust should evaluate the senior primary care mental health nurse practitioner role in South East Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.

Niche assurance rating for this learning point	1

Key findings: In August 2021 a memorandum from the Interim Director of Mental Health for Mid and South Essex to the Community Mental Health Teams, Urgent & Emergency care teams provided a high-level reminder for staff to be alert to the need for ensuring appropriate oversight of patients' depot medication. This was re-distributed in June 2023. The remaining evidence provides limited assurance in relation to this recommendation. A survey was administered in June 2023 to staff from the primary care mental health team and those working in secondary care depot administration clinics. This asked about depot administration and requests within primary care with no instances recorded. A proposal for the administration of depot medication in primary care with support from mental health primary care networks has also been drafted but for a different locality within the Trust; it is not clear what stage of development the proposal is currently at, but this may be an initial opportunity to test and evaluate the approach and arrangements for roll out to other teams.

Residual recommendations:

Progress the recommendation and ensure there is clarity on the roles and responsibilities of the senior primary care mental health nurse practitioner in the management of depot medication.

Recommendation 2

The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.

Niche assurance rating for this recommendation	4

Key findings: Mid and South Essex Integrated Care Board (ICB) has provided evidence of some of the recent transformation work in primary care which is also supporting implementation of the Community Mental Health Framework for Adults and Older Adults across Mid and South Essex (MSE). This has included the introduction of additional pharmacists and mental health practitioners who are providing expert support to GPs and their practice staff for a range of patients including those requiring depot injections. Working arrangements, service specifications and operational guidance are in draft form and being developed further.

An addendum to EPUT's prescribing guidance for antipsychotics has been agreed in consultation with key stakeholders to ensure clarity on sharing of prescribing responsibilities between primary and secondary care pending further joint work to review all guidance. This is supported by a traffic light rating for the range of antipsychotic drugs within the formulary and a clear description of which can be prescribed and maintained by which practitioner. A snapshot audit of GPs has also been undertaken and a further review of the arrangements for managing patients on depot injections is planned to provide assurance that the work that has been progressed is embedded into practice.

Residual recommendations:

Further progress the work that is being undertaken to improve the administration of depot medication and shared care responsibilities.

2. Assurance summary (cont.)

Recommendation 3

The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.

Niche assurance rating for this learning point	3

Key findings: We have seen evidence of two emails being sent to administrative and (some) clinical staff in August 2021 and June 2023. These described the current process for the updating of GP contact details and the potential risks of this and of information not being up-to-date. The key control is for staff to ensure GP details are correct at each patient contact. Records management policies and procedures require the GP address and practice telephone number to be recorded where known, and the Information Technology Team are trying to ensure that updates made by Trust staff are retained on the system; however, we have seen no further communications or reminders about this subject or testing to ensure that only current GP details are displayed on the electronic patient records.

Residual recommendations:

Cycles of audit and testing are required to ensure that electronic patient records only give staff access to the patient's current GP contact details.

Recommendation 4

The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.

Niche assurance rating for this learning point	3

Key findings: The Trust has retained Care Programme Approach (CPA) and Clinical Risk Assessment policies and procedures during the transition to the Community Mental Health Framework. These include the requirement for families to be involved in care planning and risk assessments. Also, that risk assessments must be reviewed on receipt of concerns from family and/or carers and shared with the MDT or with a senior member of the clinical team for discussion.

Additionally, a Clinical Risk Assessment Electronic Standard Operating Procedure is currently being drafted. This explicitly references the need to record any risks/concerns raised by family/carers/ members of the public and any actions required. It states that risk assessments should be updated to reflect these.

Policy and procedural documents are available; testing is now required to ensure that concerns raised by families and/or carers about a patient are appropriately acted on.

Residual recommendations:

Audits and monitoring should be completed in line with the requirements of the CPA policies and associated procedures to ensure that concerns of family members or the public are appropriately documented and acted on.

2. Assurance summary (cont.)

Recommendation 5

The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

Niche assurance rating for this learning point	**3**

Key findings: The Trust's Action Plan includes that the Trust's status as an early adopter of the NHS Patient Safety Incident Response Framework (PSIRF) has resulted in a fundamental change to the way patient safety incidents are investigated and this includes how findings and learning are shared with patients, families and other affected parties. Where previously they had been absent, local PSIRF plans and training packs for 2021-23 now include a requirement to share draft and final reports with families (dependent on the level of review or investigation being undertaken). The role of the Family Liaison Officer that has been introduced also aims to ensure that families are involved, and their concerns responded to.

We understand that the Trust's PSIRP for 2023-25 has been shared widely for comment and it is anticipated that it will have gone through the approval process by mid-August 2023.

As the Trust were early adopters of PSIRF, there was local, regional and national focus and oversight of PSIRF activity. Now that the Trust have embedded this new approach, part of the plan moving forward is to develop an audit cycle for the quality assurance review of learning response and investigation reports.

Residual recommendations:

Cycles of testing are now required to ensure that service users and families are appropriately involved in patient safety investigations.

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1

The Trust should evaluate the senior primary care mental health nurse practitioner role in South East Essex to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it.

Action listed on the Trust action plan:
Undertake evaluation of the senior primary care mental health nurse practitioner role and report on:
a. Whether the role has facilitated the management of depot medication
b. Mitigated the risks of patients not receiving prescribed depot medication.
Following the evaluation, implement any recommendations/required changes to the role.

Key evidence submitted	Niche review
Southend Primary Care Mental Health Practitioner (PCMHP) Band 6 Job Description (undated)	This includes a job summary which states, *'The delivery of an enhanced Primary Care Team as part of a new approach to the delivery of Mental Health Primary Care services in Southend Locality…The post will be based in General Practices, working with existing Primary Care teams to triage, manage and follow up patients registered with GPs in the area'.* In relation to depot management, it includes *'The team will offer a range of interventions from active mental health monitoring, guided self -help, physical health checks and the administration of depot injections for those patients discharged from Secondary Care. The Primary Care Mental Health Practitioner will work with the wider local network (e.g., IAPT) to ensure early "help" interventions and proactive care and treatment is delivered at the Primary Care level.*
North East Essex Primary Care Network Mental Health Clinical Lead Person Specification and job description Band 7 (undated)	This role is designed to facilitate discharge from secondary care community treatment to primary care. It does not specifically relate to the recommendation although there is reference to engagement between primary and secondary care on page 6. '*Engage in a systematic case discussion process with all community treatment clinical staff'.*
South East Essex Senior Primary Care Mental Health Practitioner (SPCMHP) Band 7 Person Specification and job description (undated)	This includes that '*the team will offer a range of interventions from active mental health monitoring, guided self-help, physical health checks and the administration of depot injections for patients who may be discharged from secondary care*'. Also, that they will *'be responsible for the prescribing, administration of medications, assessment of side effects, review concordance and clinical effectiveness of medication regime in line with Trust policy including* • *Ensuring safe transportation and storage of medicines, checking* • *receipt, storage of medicines in medicine cupboard* • *Providing education around the medication prescribed, side effects, actions and aids to compliance*'. There is reference to collaborative working including with key partner organisations, service users, carers, clinicians and other practitioners within the multi-disciplinary team in delivering services.

Appendix 1: Evidence review

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Memorandum to all Community Mental Health Teams and Urgent & Emergency care teams, 23 August 2021 and June 2023	The memorandum from the Interim Director of Mental Health for Mid and South Essex provides a high-level reminder to staff to be alert to the need for ensuring appropriate oversight of patients' depot medication. It refers staff to the support of the primary care mental health practitioners for depot medication where necessary: *"In areas where there are primary care mental health nurses in place, they can support by administering depot injections in circumstances where this is necessary and by being the conduit between our current secondary care teams and the patients GP practice."*
Statement from the Trust May 2023	*'There is no Shared Care Protocol in place with GPs in Southend for depot injections, therefore they do not prescribe/deliver them. The Primary Care Mental Health Nurse's role is to facilitate and support the Recovery and Wellbeing teams to administer depot injections in Primary Care if required guided by individual patients and in agreement with the GP practice team. In the last 18-months, there has been no requirement to deliver a depot in Primary Care'.*
Audit Summary Report, 5 July 2023	Audit to evaluate the South East Essex Senior Primary Care Mental Health Nurse Practitioner role in order to establish whether it has facilitated the management of depot medication and mitigated the risk of patients not receiving it. The audit method was a local survey with eight questions distributed to South East Essex Primary Care Mental Health Practitioners, and Recovery and Wellbeing depot clinic registered nursing staff and a review of 10 patient case notes. Summary findings included that none of the 19 respondents had been required to deliver depot medication in a primary care setting or when undertaking the role of the Primary Care Mental Health Nurse. 10 patient records were also reviewed and there were no documented objections in relation to them receiving their injections in the Recovery and Wellbeing depot clinics. However, the risk related to this recommendation was patients not currently attending or under the care of secondary mental health services. The report also cited anecdotal evidence of two patients who currently had depot medication administered by the practice nurse but not whether these had been facilitated or arranged with primary care mental health staff. One additional patient had depot medication administered at the GP practice by depot clinic staff as a specific risk-based plan. Actions were to share the report findings, ensure staff were matched to essential criteria, to update the draft Primary Care Mental Health Service Standard Operating Procedure and to repeat the audit in six months' time.

Appendix 1: Evidence review

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Draft standard operating procedure document – 'Antipsychotic (excluding clozapine) prescribing support in psychoses and related disorders in adults', undated	This early draft, undated document states that for a cohort of patients under the care of West Essex Adult Community Mental Health Service, the administration of long-acting antipsychotic injections is via planned depot clinics. The procedure outlines a proposal to realign the administration of antipsychotic depots to systems partners within the GP setting by: • Identification of patients who meet an identified cohort criteria • Describing the comprehensive care planning process • Describing urgent re-access to mental health services Specialist support is described and there are contact details of local Primary Care Network (PCN) mental health team members for a same day response, or within 48 hours, for the GP to use if the patient does not attend their depot clinic appointment. There is no reference to monitoring of the SOP to ensure staff are compliant with its use.

Appendix 1: Evidence review

Recommendation 2

The Trust, Local Medical Committee and relevant Clinical Commissioning Groups should develop and agree a shared protocol for the administration of depot medication in the community. This should include agreement as to which party is responsible for undertaking the initial patient assessment, and for the initial and ongoing administration of depot medication.

Actions listed on the Trust's action plan:

Requirement One: To develop a new model of care for SMI (Serious Mental Illness) Mental Health for Adults and Older Adults to be embedded and delivered in Primary Care Networks across Mid and South Essex.

Actions:

1. *Task and finish group to co-produce a Mental Health Continuing Care and Prescribing Protocol for General Practitioners and Psychiatrists in relation to identified medications (including depot antipsychotics).*
2. *To develop a 'Principles of Continuing Care' document that will include more clear guidelines on patient care and where the responsibility and accountability will lie.*
3. *Undertake patient focus groups to ensure patients, carers and families voices inform these protocols.*
4. *Ratify protocols through the medicines management committee and mental health governance structures.*

Requirement Two: To develop a business case to support EPUT's delivery of a robust model of SMI Mental Health care patient long term medication needs.

Action: Mental Health Commissioners to produce a business case to support EPUT delivery

Key evidence submitted	Niche review
Self-harming and high-risk medicines – Guidance for Prescribers, July 2020	This guidance is intended to be used to assist the prescriber when conducting patient medication reviews; when in consultation with a patient who has flagged as at risk of harm e.g., recent diagnosis of severe depression, or patient has recently self-harmed; or when starting a new medicine on the red or amber list in a patient who is known previously to be at risk of self-harm. It is recommended that these risk assessments are carried out once per year as part of the medication review, or sooner if there are any changes to the patient's mental health status, or any new medicines prescribed to the patient which are categorised as red or amber on the medicines risk assessment.
EPUT, Section 2 Treatment of Psychosis Formulary and Prescribing Guidelines, July 2021	This describes the principles of antipsychotic prescribing, approved drugs in the treatment of psychosis in adults (including depot injections), NICE clinical guidelines, physical health monitoring requirements, prescriber registration requirements, patient registration and initiation, management and monitoring.
Antipsychotic Depots Review Summary, June 2022	This paper states that the EPUT formulary includes some information on antipsychotic depots, although not specific prescribing guidance and does not state a red/amber/yellow classification for these. It lists evidence suggesting that the administration of antipsychotic depots in primary care has been historically more supported in Mid than in South Essex CCG areas.

Appendix 1: Evidence review

Recommendation 2 (continued)	
Key evidence submitted	**Niche review**
Antipsychotic Depots Review Summary, June 2022 (continued)	The paper concludes that, given the different level of antipsychotic depot administration across Mid and South Essex (MSE) GP practices, the existence of system wide locally agreed prescribing guidance could: provide additional support to ensure the safe and effective operation of the care pathways involved both in secondary and primary care; formally confirm the importance of continued depot dosing, plus the ongoing routine monitoring required for all patients being prescribed atypical antipsychotics, oral or injection, including physical health checks. Additionally, for GP practices that do not routinely offer antipsychotic depot administration, prescribing guidance would support this to safely occur on an occasional patient basis if warranted.
Email from the Deputy Alliance Director (interim) and Chief Pharmacist Mid Essex: Request for update re: Action Plan - depot injections, July 2022	Email confirming the risk around sharing of care for mental health patients (not just associated with depot injections) and GPs' perceptions that they cannot prescribe such medications. '*We still need to socialise the solution with GPs but these community mental health teams* [that are now forming around all the PCNs] *will be able to provide the support that the GPs need to manage these patients, and support practice based prescribing. We are aiming to write Medicines Management section of the operational guidance which is developed between EPUT and the PCN operational managers, and then finalise the continuing care guidance for depot injections and drugs for adult ADHD. Aiming for final documents to go to the next Medicines Optimisation Committee meeting which is on 21 September*'. Assurance is also given that teams supporting patients with SMI are already in place around PCNs and will mitigate the risk of patients moving into the area not being supported.
Email from the Head of Clinical Health Psychology (MSE) & ICB Clinical Lead for Mental Health re: Thurrock Integrated Care Hub, November 2022	Email in relation to the system challenge in supporting clients who have depot injections to get them at primary care sites/via primary care teams. '*I was really interested that you have started to bridge this gap by offering the secondary care MH nurses' spaces to offer depot clinics at the hub. As we discussed this was in line with the person's care plan and monitoring of risk, but you felt the hub could offer maybe 5 people per session x2 week*'. Although acknowledging capacity issues around staffing which has prevented commencement, this was highlighted as an example of good practice.
Medicines Optimisation Group (MOG) Agenda, 24 November 2022	The agenda includes consultation on the Treatment of Psychosis Continuing Care Prescribing Guidance and Formulary
Draft Co-operation Agreement, undated	"*The scope of this agreement is restricted to the employment of PCN part-funded Community Mental Health Non-Medical Prescribers (NMPs). It is intended to provide a basis for the working relationship, management, patterns of deployment and governance in relation to the employment of NMPs within the [unspecified] Primary Care Network to carry out duties as specified in the [unspecified]".*

Appendix 1: Evidence review

Recommendation 2 (continued)	
Key evidence submitted	**Niche review**
Draft Co-operation Agreement, undated (continued)	The agreement lists the prescribing duties of the NMPs, the governance framework that they will work within, their management, continuing professional development responsibilities and opportunities, and the link between EPUT and the PCN.
Paper to the Mid and South Essex Medicines Optimisation Committee (MSEMOC) - Prescribing Guidance for Antipsychotics, 7 December 2022	Paper to the MSEMOC asking for approval of the Prescribing Guidance for Antipsychotics as an addendum to the Treatment of Psychosis Formulary and Prescribing Guidance and associated formulary chapter The paper states that '*the addendum and formulary were developed to support sharing of care in relation to specialist and primary care prescribing and monitoring responsibilities. The expectation is that this will provide sufficient information to enable primary care clinicians to be confident to accept clinical responsibility for prescribing and monitoring of medication in stable patients. It also aims to meet the immediate need for guidance following the incident involving Mr Z whilst EPUT undertakes a full review to produce guidelines for agreement for use in the three ICBs where the Trust delivers services*'.
Prescribing Guidance for Antipsychotics, undated	This document is an addendum to, and should be read in conjunction with, the Treatment of Psychosis Formulary and Prescribing Guidance. This describes the role of mental health practitioners who have been recruited across Mid and South Essex and are being embedded into PCNs. Mental health specialist responsibilities are included as are pre-treatment assessment, primary care clinician responsibilities and monitoring requirements. It also lists communications that are required with GPs and that mental health services should continue to prescribe and manage the patient until transfer of prescribing and/or care management has been agreed, to be available for advice to discuss any problems or if the patient's condition changes, and to advise on any change of dose required. Primary care clinician responsibilities are also detailed.
Draft Part Antipsychotic Chapter Formulary v1, undated	This lists the traffic light rating for the range of antipsychotic drugs within the formulary i.e., medications which are not recommended for prescribing by secondary or primary care (Black), not recommended for prescribing in primary care (Red), for prescribing but only considered suitable for initiation by specialists in secondary and tertiary care (Yellow, Continuing Care), for prescribing but only considered suitable for initial prescribing by specialists in secondary and tertiary care with prescribing continued by GPs and primary care clinicians in conjunction with a Share Care Agreement (Amber, Shared Care), recommended for prescribing and treatment considered to be suitable for initiation in primary or secondary care and continuation in primary care (Green).

Appendix 1: Evidence review

Recommendation 2 (continued)	
Key evidence submitted	**Niche review**
Mid and South Essex ICS Integrated Primary and Community Care (IPCC) mental Health – adults and older adults service specification, June 2023	This includes service aims and desired outcomes state that the Integrated Primary Care Community offer will meet the needs of adults 18+ with common and serious mental illness by offering access to a wide range of services including, but not limited to, personalised and trauma-informed care, psychological therapies, physical health checks, medicine management, care services. Depots are not specifically referenced but in relation to medication reviews, the document includes that '*the PCN medic/pharmacist can review patients on multiple medications to avoid review in specialist care, commence medication where needed, and support continuation of psychotropics with the aid of prescribing guidelines*'.

Appendix 1: Evidence review

Recommendation 3

The Trust should assure itself that electronic patient records only give staff access to the patient's current GP contact details and that all other out-of-date contact details are archived.

Action listed on the Trust action plan:

Review of electronic patient records to confirm that all out of date contact details are archived.

Key evidence submitted	Niche review
Email from the Medical Director to all administration staff, medical secretaries and Community Mental Health Teams, 16 August 2021	Email headed 'Updating information regarding GP practice: IMPORTANT MEMO'. This aims to ensure that clinical information and/or medication changes are shared with the correct GP and in timely manner. Administration staff are: "reminded to check GP details are accurately held on electronic records; and specific GP surgery needs to be recorded in address when corresponding with a primary care centre, which contains multiple GP practices.
Email from Director of IT to Inquest and Family Liaison Lead, Patient Safety Incident Management Team, 19 August 2021.	The email describes the current process and controls for the updating of GP contact details and the potential risks of this information not being up-to-date. The key control is for staff to ensure GP details are correct at each patient contact. The email states as follows: *"GP records are updated via the NHS tracing service on a nightly basis, 9pm since 2018. Any changes to the previous GP name or address will be amended at that time. Historical data would be kept but only the current GP details are visible on the system. This is based on the fact that GP's data is used as the most accurate data. This is not always the case as some people move locally and don't tell the GP until they next visit.* *As a result of this clinicians and clinical support officers are all asked to check the GP details at the time of contact, either via phone, video or Face to Face. They are also asked to check other demographics to ensure they are correct as well.* *A reminder to staff was sent out recently reminding them of their responsibility for ensuring data is correct.* *There is also a risk that the data is correct at 9pm and then something changes the next day at the GP surgery, this will not be updated until the next tracing at 9pm. Therefore, there is a 24 hour period when the data could be incorrect. Hence the need to check with patients when contacting them."*
Records Management Policy, December 2021	*This includes a range of procedures for the management of clinical records.*

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Structure and Content of Health/Social Care Records Procedure, February 2022	This procedure applies to all staff in '*making them aware of their responsibilities to meet the requirements and standards relating to the content and quality standards of health records of all types...to achieve assurances, clinical records must be timely, accurate, concise and up to date accounts of the assessment and treatment of individual patients*'. Core patient information requirements include contact name and number for person to notify in an emergency (next of kin/nearest relative) and GP, with GP address and practice telephone number where known.
CPA (Care Programme Approach) Procedure, March 2023	This procedure provides guidance on the implementation and operation of the CPA Policy for EPUT. This includes a requirement to share relevant aspects of patient information with the GP such as assessment outcomes and care plans.
Email, June 2023	This email confirms that the electronic patient record system should update to reflect GPs automatically without the involvement of Trust staff if a patient informs the GP that they have moved address. If changes are made on Mobius (the Trust system) to GP records, it automatically reverts back to the information held by the GP i.e., the system can be updated but it will change it back to match the GP records the without the Trust's knowledge. The email includes that there have been complaints about this, and Trust staff therefore now ask the patient to advise the GP of any changes to address etc as the Trust system links back to theirs. The Trust IT team are currently working on this issue.

Appendix 1: Evidence review

Recommendation 4

The Trust should assure itself that concerns submitted by families or members of the public regarding a patient are documented, subject to assessment and review, and where appropriate proactively acted on. In instances where action is not taken, the rationale should be documented.

Action listed on the Trust action plan:

Review of the Trust's CPA Policy and Procedure (CLP30) and Clinical Risk Assessment and Safety Management Policy and Procedure (CLP28) to ensure that both policies include explicit guidance on actions required following concerns raised by families or members of the public about a specific patient.

Key evidence submitted	Niche review
CPA [Care Programme Approach] Policy, version 1.3, updated December 2018. Policy reference: CLP30	This is a summary policy document which is supported by the more detailed procedures for staff. The policy refers to the associated Clinical Risk Assessment and Management procedure (see further below). The policy is clear on its mandatory application to all staff in mental health services delivering a CPA or a non-CPA approach (for less complex patients). It explicitly states that: *"Risk assessment is inclusive of the patient, family and/or carers views and concerns raised should lead to a review of the risk."* The policy states that adherence to the policy will be monitored through *"Performance Standards, KPI's, Audit, Supervision, 1-1s and Trust wide CPA Steering Group"* although we have seen no evidence of this monitoring being undertaken. The review date of the policy was extended to at least August 2021 with the approval of the Quality Committee.
CPA Procedure, version 1.3, updated December 2018. Policy reference: CLPG30	This is the more detailed guidance for staff underpinning the CPA Policy. The procedure document has followed the same review and governance process as described for the associated policy above. The document is clear on its mandatory application to all staff working within mental health and learning disability services and its use for patients on CPA and non-CPA. The procedure clearly states when opportunities should be taken to listen to a patient's family and/or carer either at assessment or subsequent review. The document states: *"Risk assessments must take into account all the available information from the patient, and other sources, such as the GP, carers, family members, forensic, other professionals and agencies that have knowledge of the individual."* Ongoing risk review and update of care plans is a clear mandatory requirement, at least once every six months, and provides a further opportunity for families and/or carers to raise concerns. The procedure specifically refers to concerns raised by families and/or carers and what needs to happen in such circumstances: *"All concerns raised by family and/or carers must lead to a review of the risk assessment and the Multidisciplinary Team (MDT) should be informed."* The role of MDTs is highlighted to discuss the support a patient in such circumstances may need. The care coordinator role for patients on CPA is clearly described with regards to their role in risk assessment, review and working with the patient and their families/carers to respond to crisis situations.

Appendix 1: Evidence review

Recommendation 4 (continued)	
Key evidence submitted	**Niche review**
Clinical Risk Assessment And Safety Management Policy, updated July 2019 Policy reference: CLP28	This is a summary policy document which is supported by the more detailed procedures for staff (see below). It was approved by the Clinical Governance and Quality Sub-Committee (June 2019) and ratified by the Quality Committee in July 2019. Its planned review date was July 2022. The policy's focus is on the safety of patients, carer and the public in relation to clinical risks to self and others. It states explicitly that *"Family and carers views and concerns will be included in the risk assessment."* The document appropriately cross-references the CPA Policy. The policy describes local induction training which covers clinical policies and record keeping. In addition, it states that clinical staff undertake clinical risk training every three years with monitoring of compliance with training through the Workforce Development department. The document states that the Director of Nursing is responsible for ensuring that the policy and procedure are embedded into clinical practice, that training needs are identified, and training implemented to address learning required from audits, reviews and reports. The document also refers to local monitoring although we have seen no evidence of this being undertaken.
Clinical Risk Assessment And Safety Management Procedure (version 3.2), updated July 2019 Policy reference: CLPG28	This is the more detailed guidance for staff underpinning the Clinical Risk Assessment and Safety Management Policy. The procedure document has followed the same review and governance process as described for the associated policy above and is clear on its mandatory application to all staff working within mental health and learning disability services. Section 5.5 references the need for all Registered Practitioners to consider the patient's family, carers and the public in undertaking clinical risk assessment, to: "*Extend their vision of risks to include: the patient; the patient's family, friends and carers; the public; children; Trust staff colleagues; workers in other agencies."* The procedure states that "*Risk assessment must be reviewed, and the MDT informed when family and/or carers raise concerns about the risk and/or safety of the patient or others."* The policy provides clear and helpful specific guidance on the proactive steps practitioners should take upon the identification of risks and that line managers should escalate areas of concern and actions taken to their Director. The document provides appropriate references to associated Trust documents and was updated in July 2019 to provide latest NICE guidance. Monitoring and audit requirements are clearly stated.

Appendix 1: Evidence review

Recommendation 4 (continued)	
Key evidence submitted	**Niche review**
Clinical Risk Assessment And Safety Management Procedure (version 3.2), updated July 2019 (continued)	Monitoring of the procedure refers back to the Clinical Risk Assessment and Safety Management Policy. Full details are provided of the training requirements and audits to be undertaken to cover this procedure. These include monthly care plan and risk assessment audits covering care planning, risk assessments, physical health, crisis plans, consent and capacity, carers and service user involvement in care planning. The audits are completed by ward managers in the team with generally a sample of five records audited per month. The document states that the results of audits are spot-checked at random by the Quality or Audit Teams with a view to providing additional support where needed. Checks of care planning and risk assessment are also required to be undertaken by team managers as part of monthly supervision sessions.
CLPG28 Appendix 1 Aide Memoire for Assessing Risk and Compiling a Safety Management Plan	Appendix 1 to the procedure provides a useful checklist for risk assessment and preparing a safety management plan. This includes the question: *"Have any concerns been raised by family and/or carers, even if the patient has declined to involve them?"*
Email to Assurance and Policy Lead, 12 August 2021	The email confirms that the CPA Policy was reviewed by the Director for North East Essex Community Services at this time, with no changes other than to reference the transition to the national Community Mental Health Framework.
Email from Assurance and Policy Lead, 13 February 2022	The email to the Director for North East Essex Community Services confirms that the CPA Policy has been updated to reflect the transition to the national Community Mental Health Framework. The next review date for the policy is stated as May 2022.
CPA Procedure CLPG30, March 2023	This procedure was reviewed prior to implementation of the Community Mental Health Framework and move from CPA. It states that it will remain operational while the transformation of services in line with the Community Mental Health Framework is underway. The procedure requires risk assessments to be reviewed on receipt of concerns from family and/or carers and shared with the MDT or with a senior member of the clinical team for discussion.
Clinical Risk Assessment Electronic Standard Operating Procedure (eSOP), undated draft	This draft document describes the process for conducting an initial risk assessment upon admission of the patient to adult inpatient services and the sequence of updating the risk assessment and risk management plan during their stay. In response to the incident involving Mr Z, this requires staff to record any risks/concerns raised by family/carers/members of the public, to consider the mitigating actions required, and to update the risk assessment in accordance with these if there is a change in real or potential risk.

Appendix 1: Evidence review

Recommendation 4 (continued)	
Key evidence submitted	**Niche review**
Your Care and the Care Programme Approach Information for Patients and Carers CLPG30 – Appendix 1, undated	Leaflet describing the CPA approach and the processes involved.
Guidelines for Good Documentation CLPG28 – Appendix 2, undated	Guidelines for staff.

Appendix 1: Evidence review

Recommendation 5 (continued)

The Trust should put a system in place to ensure that internal investigation report findings are shared with service users, their families, and that other affected parties are taken into account.

Action listed on the Trust action plan:
Review and improve the Trust's system for sharing the findings and learning of patient safety incident investigations and reviews.

Key evidence submitted	Niche review
Independent Investigation, undated	The Trust's Action Plan states: *"The Trust's status as an early adopter of the NHS Patient Safety Incident Response Framework (PSIRF) has resulted in a fundamental change to the way patient safety incidents are investigated and this includes how findings and learning are shared with patients, families and other affected parties."* The action is marked as complete in September 2021, but no further detail has been provided as to how the Trust's internal processes have been updated to reflect the PSIRF requirements.
Patient Safety Incident Response Plan, March 2021	This plan sets out how the Trust will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of their work to continually improve the quality and safety of the care provided. The plan is also intended to help improve the efficacy of local patient safety incident investigations (PSIIs). The document includes that some patient safety incidents will not require PSIIs but may benefit from a different type of review to gain further insight or address queries from the patient, family, carers or staff. A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs. Different review techniques can be adopted, depending on the intended aim and required outcome; the most commonly used are cited, There are also details of the FLO role and their requirement to actively listen to the patient, family and carer queries/concerns and to engage with other staff to ensure these are responded to openly and honestly.
PSIRF, October 2021	This slide deck gives an overview of the PSIRF and the processes for 2021-23. It includes that final PSI reports should be shared with the family/services involved and that PSIIs should be shared at the draft report stage for factual accuracy comments.
EPUT Safety Access Command Call Process	This describes the process that the Lessons Team will adopt to develop content for Safety Action Alerts in response to new or significant opportunities for learning. Actions are required to be implemented by operational teams within given timeframes, with assurance testing completed by the Lessons Team.
Family Liaison Officer (FLO) Training, June 2023	This training pack incudes an outline of the learning response that is being adopted by the Trust following an incident. Also, the role of the FLO as a point of contact for families about questions/concerns they might have and involving them in the process.

Appendix 2: Glossary of terms

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ADHD	Attention deficit hyperactivity disorder
CCG	Clinical Commissioning Group
CMHP	Community mental health practitioner
CPA	Care Programme Approach
EPUT	Essex Partnership University NHS Foundation Trust
GP	General Practitioner
ICB	Integrated Care Board
MDT	Multi-disciplinary team
MSE	Mid and South Essex
MSEMOC	Mid and South Essex Medicines Optimisation Committee
NIAF	Niche Investigation Assurance Framework
PCMHP	Primary Care Mental Health Practitioner
PCN	Primary Care Network
PSIRF	Patient Safety Incident Response Framework
SMI	Serious mental illness
StEIS	Strategic Executive Information System

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