ESSEX PARTNERSHIP UNIVERSITY NHS FT

		Agenda Item: 1.5
SUMMARY REPORT	**QUALITY COMMITTEE**	**8 February 2024**

Report Title:	Mental Health Services Thematic Analysis					
Executive/ Non-Executive Lead:	Frances Bolger Interim Executive Nurse					
Report Author(s):	Tendayi Musundire Deputy Director of Nursing for Safeguarding & Mental Health Act					
Report discussed previously at:	N/A					
Level of Assurance:	**Level 1**		**Level 2**	**X**	**Level 3**	

Risk Assessment of Report		
Summary of risks highlighted in this report		
Which of the Strategic risk(s) does this report relates to:	SR1 Safety	
	SR2 People (workforce)	
	SR3 Finance and Resources Infrastructure	
	SR4 Demand/ Capacity	
	SR5 Statutory Public Inquiry	
	SR6 Cyber Attack	
	SR7 Capital	
	SR8 Use of Resources	
	SR9 Digital	
Does this report mitigate the Strategic risk(s)?	No	
Are you recommending a new risk for the EPUT Strategic or Corporate Risk Register?	No	
If Yes, describe the risk to EPUT's organisational objectives and highlight if this is an escalation from another EPUT risk register.		
Describe what measures will you use to monitor mitigation of the risk		

Purpose of the Report		
This report provides the Quality Committee with details of the Trust's response to CQC feedback received following visits between September-December 2023, and assurance around the issuing of Section 132 Rights to patients.	**Approval**	
	Discussion	
	Information	X

Recommendations/Action Required

The Quality Committee is asked to:

1 Note the contents of the report

2 Request any further information or action

Summary of Key Issues

This report:

- Sets out the Trust's response to the findings of CQC Visits carried out between September-December 2023.
- Provides assurance that the issue relating to reading Section 132 Rights to patients as soon as possible following admittance to wards, identified during the meeting of 11 January 2024 (Action Ref 01/24), has now been resolved.

Relationship to Trust Strategic Objectives	
SO1: We will deliver safe, high quality integrated care services	
SO2: We will enable each other to be the best that we can	
SO3: We will work together with our partners to make our services better	
SO4: We will help our communities to thrive	

Which of the Trust Values are Being Delivered	
1: We care	
2: We learn	
3: We empower	

Corporate Impact Assessment or Board Statements for Trust: Assurance(s) against:			
Impact on CQC Regulation Standards, Commissioning Contracts, new Trust Annual Plan & Objectives			
Data quality issues			
Involvement of Service Users/Healthwatch			
Communication and consultation with stakeholders required			
Service impact/health improvement gains			
Financial implications:			
Governance implications			
Impact on patient safety/quality			
Impact on equality and diversity			
Equality Impact Assessment (EIA) Completed	**NO**	**If YES, EIA Score**	

Acronyms/Terms Used in the Report			
CQC	Care Quality Commission	MHA	Mental Health Act 1983

Supporting Reports/ Appendices /or further reading

Lead
[redacted] Frances Bolger Interim Executive Nurse

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EPUT
Care Quality Commission Visit Report

1.0 INTRODUCTION

1.1 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. They do this by looking across the whole patient pathway experience from admission to discharge.

When a MHA focused visit has taken place the CQC submit to the trust a monitoring visit report and included within this is a Provider Action Statement for completion by the Trust.

The monitoring report sets out the findings from the visit to monitor the use of the Mental Health Act and compliance with the Code of Practice. The Provider Action Statement should set out how we will make any improvements needed to ensure compliance with the Act and its Code of Practice.

2.0 CQC FOCUSED VISITS – 1st April 2023 to date

2.1 Detailed below are the CQC MHA focused visits.

Ward	Date of visit	Ward	Date of visit
The Rainbow Unit	09/05/2023	Kitwood Ward	26/09/2023
Grangewaters Ward	25/07/2023	Peter Bruff	24/10/2023
Forest Ward	16/08/2023	Henneage Ward	08/11/2023
Lagoon Ward	16/08/2023	Ardleigh Ward	13/11/2023
Dune Ward	17/08/2023	Longview	28/11/2023
Causeway Ward	17/08/2023	Stort	06/12/2023
Finchingfield Ward	24/08/2023	Chelmer	07/12/2023
Gosfield Ward	14/09/2023	Byron Court	12/12/2023
Galleywood Ward	28/09/2023		

3.0 THEMES IDENTIFIED AND ACTIONS TAKEN

3.1 For the purpose of this report a theme has been categorised as an issue that has been identified on two or more occasions. A total of ninety-two (92) issues were identified, and of these, seventeen (17) have been noted as a theme from the visits to the Trust between 01 April 2023 to 12 December 2023.

Note: This report does not include the visits made to Roding Ward and Cedar Ward, for which the monitoring reports awaited.

Below are the identified themes, which also identify what the percentage (to the nearest whole number) the issue is against the overall total of identified issues.

1	No documented evidence that Section 132 rights had been discussed with the patient / enough information given to the state the reason given to evidence patient has understood their rights/ delay in giving rights	**8%**
2	Care Plans did not document evidence patient involvement	**5%**
3	Food – choice and portion sizes	**5%**
4	Blanket Restrictions	**5%**
5	Lack of independent mental health advocate (IMHA) Service	**4%**
6	Referral not made to IMHA Service	**4%**
7	Information about the IMHA service not on display around the ward	**4%**
8	No documented evidence on the electronic ward review form that the patient's capacity has been assessed or the form has not been fully completed	**3%**
9	Ligature points	**3%**
10	Treatment forms (T2/T3/Sec 62) not being attached to the medication charts	**3%**
11	Lack of documentation to confirm care plans had been shared with patients	**3%**
12	Consent to share information forms not evident on the patient's electronic record	**2%**
13	Information about how to complain to the CQC was not on display around the ward	**2%**
14	Informal patients not being allowed to leave the ward	**2%**
15	Lack of access to an Occupational Therapist	**2%**
16	Staff talking in their preferred language in patient facing areas	**2%**
17	Privacy and dignity	**2%**

Theme	Action taken	Action identified at previous CQC visit	Additional Governance
No documented evidence on the electronic ward review form that the patient's capacity has been assessed or the form has not been fully completed.	(3 Wards) Tendable MHA audits in place to monitor documentation of capacity and consent to care / treatment. Any gaps identified are actioned and learning feedback provided to the individual and the team.	No	Discussed at the Mental Health Act & Safeguarding Sub Committee held on the 18/01/2024. The Committee noted that a new form had been developed, its purpose is to, on admission to hospital be completed to assess the patient's capacity to consent to admission to hospital and capacity to consent to treatment. The patient's consent will then be regular reviewed by the completion of the appropriate section in the ward review minutes. Continue to monitor through Tendable MHA ward assurance audit.
Ligature points	(3 Wards) Actions have been taken to address the items identified through the CQC visits (incl. remedial garden works, new door fittings and new chairs). In circumstances where there is a need to order new items of furniture the ligature risk assessments have been reviewed and identified ligature risks added to hotspots folders. (Note: All staff are required to sign to confirm they have read and understood the contents of the 'ligature pack'). For garden items – staff rotas remain in place to supervise all garden access.	No	Potential ligatures to be included in the Trust Ligature Inspection audit, and for oversight by nominated committee.

Consent to share information forms do not evident on the patient's electronic record	(2 Wards) Staff to ensure that information sharing and involvement is discussed with carers/family on admission. Continues to monitor and audit information sharing records for new admissions to the ward.	Yes 03/02/2020 (one ward)	Reported through the Tendable report that the MHSSC has oversight
Treatment forms (T2/T3/Sec 62) not attached to the medication charts	(3 Wards) MHA Audit on Tendable (including additional Pharmacy audit regarding attachment to medication charts) – any gaps being addressed with feedback to the individual and team. MHA training provided on a monthly rotation by the MHA Office.	No	Trust's CQC action plan overseen by CQC Action Leads Meeting.
No evidence that Section 132 rights had been discussed with the patient / not enough information given to the state the reason given to evidence patient has understood their rights/ delay in giving rights	(7 Wards) All medical staff reminded of the requirement to record discussion of rights with patients when detained and all patients to be provided with the information leaflet (retaining a copy on the record). For one ward, there was an identified in one week gap where the record keeping audit had not been undertaken. The audit has bee diarised to provide positive assurance check back to the Matron for completion and any associated actions having been taken. Content of the new Welcome Pack has been checked to ensure information is included. Additional training arranged for staff requiring additional support.	No	Trust's CQC action plan overseen by the CQC Action Leads Meeting.

Care Plans did not evidence patient involvement	(5 Wards) Focus on roll out of 'My Care, My Recovery' document. This being the patient voice and support formulation of content of the individualised care plans. Training need identified in one ward (care plan writing) is being addressed and care planning / record keeping has been added as a standing item in 1-2-1 supervision sessions (noting that supervision target has been met). Record keeping audits ongoing. EPUT is adopting the principles of the International Fundamentals of Care and this will support in holistic care planning, dignity and respect. Practice Education Facilitators will support the newly qualified nurses and Matrons, Ward Managers and Charge Nurses. All nurses will receive 1 to 1 support. Part of this 1 to 1 support session will include the keyworker responsibilities and the patients care plan. This will provide an assurance of the quality of care plans, the language used and the inclusion of the patient's voice.	Yes for 3 Wards 05/12/2018 03/04/2019 17/06/2019	Trust's CQC action plan overseen by the CQC Action Leads Meeting.
Care plans not shared with patients	(3 wards) One ward has implemented a weekly sharing of printed care plans with every patient (impact to be assessed). Care plans are printed off and both staff and patients sign to confirm giving of information and receipt of information.	No	Trust's CQC action plan overseen by the CQC Action Leads Meeting.
Lack of IMHA service	(4 Wards) Up to date posters and information have been put in place. During all patient ward reviews the MDT will assess capacity and send referral to the IMHA if required.	No	

Referral not made to the IMHA service	(4 wards) Monitoring of 132 rights assessment and appropriate referral IMHA by the ward manager. Additional training provided for newly qualified staff. Looking to add IMHA referral to the admissions checklist and weekly audits.	No	The Trust has regular meetings with the IMHA service provider and commissioning services.
Information about the IMHA service not on display around the ward	**Ward A** - Posters and leaflets had been removed temporarily due to maintenance work on the ward but are now being replaced.	No	
	Ward I - Information on the IMHA is already available as part of the welcome pack, and discussed with patients at the time of admission. It is a standing agenda item in community meetings. Additionally, posters containing details on how to contact the advocacy service are displayed on the ward. Ward manager will liaise with advocacy service to reestablish regular visits of advocates to ward to promote the service.	No	
	Ward K - The process of how to request an IMHA for a patient circulated in team meeting (09/11/2023) and template form to complete sent out to the team with instructions on 23/11/2023. Advocacy, what it is and access to it are a part of both the section 132 (detained) and section 131 (informal) rights, which are completed for all patients on admission to the ward. IMHA are setting up a brief training session for staff to inform them fully of their role and how we can all support each other. IMHA staff approached ward manager to speak about this and it was agreed. They will be in touch with training dates. Rethink leaflets have been displayed throughout the ward.	No	

	Ward M Ward manager shared this information about the IMHA role with patients in a mutual help meeting. IMHA posters displayed on the ward. IMHA referrals completed for all patients. Patients being supported by IMHA. IMHA to attend Ardleigh Ward Business Meeting.	No	
Information about how to complain to the CQC was not on display around the ward	**Ward A** - Posters and leaflets had been removed temporarily due to maintenance work on the ward but are now being replaced	No	
	Ward N - Posters were placed in the social areas and family visiting areas on the ward. The young people's attention was drawn to this information in our meeting with them on 03/01/2024.	Yes	
Food – choice and portion sizes	**Ward C, D, E, F (Brockfield House)** - Facilities provide portions as to the bed numbers on every ward. The portion size from the supplier has the agreed amounts of protein and carbohydrate to ensure that patients have the correct nutritional input. For some working age patients the food is viewed as being insufficient, and a proposal is being discussed to increase each portion to an additional half. We have in the meantime bulked up the meals with additional vegetables. There are other foods available as a contingency such as frozen jacket potatoes, frozen meals and tins of beans etc., so there should not be a time when patients do not have sufficient food.	Yes, ward C, E and F	
	Ward P - During the CQC visit feedback meeting we held with patients, some said that they were shocked with what they were hearing regarding the food. They were of the mind that the food was well balanced. There were some who were in agreement with their peers that the food was insufficient and unpalatable.		

	By December, a survey was conducted with ward staff and patients to find out what the current provision is and what needs to improve. Another meeting was held and the survey results were discussed which highlighted meal, times, hot or cold preferences and portion sizes just to name a few. There will be further local and Trust wide meetings with patients to find out what they think about the current food provision and how this can be improved. To continue to attend the Trust Led Food Provision Meetings that have been taking place. We had one in November 2023 with other Clinical leads to decide what the catering provision should be going forward and how we can improve the patient experience in regards to food as the Trust acknowledged that there have been lots of challenges with food provision over the last year but have now reached a period of stability with our contractors being in a much better position to supply what we need. Lived Experience Ambassadors will be supporting with next phase of PLACE (Patient-Led Assessment of the Care Environment) visits on the wards to get more feedback from different teams.		
Blanket Restrictions	**Ward A** - Access **to Garden** - Following previous learning within the Trust, it is recognised that the garden has multiple potential risk areas in relation to ligature and anchor points, which it is not possible to completely eliminate. Therefore to enhance and maintain safety a decision was made that all inpatient gardens should be supervised at all times. On Rainbow we discussed with our patients and agreed that as patients do not always want access to the garden throughout each day it would not be the most therapeutic use of staff time to remain monitoring the garden due to the door being unlocked when not in	No	Restrictive Practice framework in place which is monitored by the restrictive practice sub committee which reports into the Quality meeting

	use, and therefore agreed that the door would be locked when patients do not want to utilise the garden space but would be unlocked at any time that a patient requests. This is discussed with each new patient at the time of admission during their welcome and induction to the unit and is regularly reviewed through community meetings as appropriate. Patients have confirmed that they are supported to access the garden whenever requested. We have added to the community meeting standard agenda discussion around restrictions on the unit to ensure ongoing collaborative review between staff and patients.		
	Ward N - **Access to Garden** - Communication has been sent to the team (email 15/01/2024) to ensure this is discussed with the young person during the admission process. This information is also being added to the care plans under restrictive practices. To be audited by the clinical lead and discussed in community meetings under restrictive practices. This action plan is also on the weekly agenda for the St Aubyn Operational meeting.	No	
	Ward N – Keys to Room - Communication has been sent to the team (email 15/01/2024) to ensure this is discussed with the young person during the admission process. This information is also being added to the care plans under restrictive practices. The Ward has trialled young people having their own access cards. Measures were put in place to do this as safely as possible such as young people needing to be on level 1 observations and low risk before they could have their own access cards. Individual access cards were also programmed to open only the specific doors needed for each individual. However, risk incidents still occurred. It was found that young people lent their cards to other patients so they could hide in corridors	No	

	and self-harm. Other young people felt pressured into handing their cards to more dominant and higher risk patients who then tied ligatures in corridors or took items with which to self-harm from other patient's rooms. This was with a different peer group to the one we have today so in the meeting on the 03/01/24 the idea was mooted again. The young people felt this idea sounded dangerous. Another said they could not be trusted with a room card and another said she would probably give her card to someone else, as she is 'Too nice'.		
	Ward O – Access to quiet room and activity room - On Stort Ward, the doors to the activity and quiet rooms must be kept open for patients to access at their leisure. Staff will discuss this in their team meetings and in safety huddles. However, in the event that the doors need to be closed for safety reasons such as to contain aggressive/violent behaviour or reduce risk of harm to patients, this will be explained and justification will be given to the patients on the ward during community meetings after conducting individual risk assessments. This will be for as short a period of time as possible to ensure access to available to all patients on the ward. This was discussed in staff safety huddles and to be discussed in staff meetings.		
	Ward P – Access to quiet room and activity room - The Ward will reflect on the current blanket restrictions of the TV Lounges and activity rooms that are kept locked when not in use, and review to see if there is a safer way to manage these rooms. Our main issue is around patient safety if the area is always left unsupervised, as we have had previous incidents of self-harm through head banging and cutting, self-strangulation, ingestion of TV remote	No	

	batteries, board games pieces, caps for pens and colouring pencil caps and other small items. To consider individualised care plans and risk assessments for those who are considered as presenting with High risks if left unattended in these areas. How can we ensure that we have enough staffing resources to make sure these patients are supervised each time they decide to use these rooms, as this is unpredictable. To discuss with the wider MDT regarding this action point in our weekly meetings.		
Informal patients not being allowed to leave the ward	**Ward B** - A 'Time Away from the Ward' document has been co-produced with patients on the Assessment Unit. The document outlines the rights of informal patients when admitted to the ward. This document includes information about the doors to the ward being locked for the safety of patients and staff on the ward and advises patients to come and tell us if they would like to leave the ward. Patient Engagement and Supportive Observations should be discussed and reviewed on a daily basis during MDT.	No	
	Ward K - All previous leave restrictions have been removed and patients can use leave at any time pending risk assessment from staff. Regular discussions will be held with staff about correct wording in conversations with patients and to explain all possible outcomes if needed, but ensure that it does not come across as threatening. The leave form used to sign out patients has also been updated. The legal status is reviewed by the wider	No	

	multidisciplinary team with consideration for legal status of their admission. The patient seen by the Care Quality Commission reviewer had a further conversation about their right to leave the ward on the same day this issue was raised.		
	Ward M - As per procedure for this to be reviewed and assessed during weekly ward review with the MDT with the patient present. If consent is not evidenced then MHA/Capacity to be considered. Patient will confirm consent to informal admission.	No	
Lack of access to a Occupational Therapist	**Wards E and F** - The service has current vacancies for 2 x band 6 Occupational Therapists, one of which is temporary as the member of staff is on secondment and expected to return in January. The vacancy is out to advert but filling the post has proved challenging. This is reflected in other services across the trust with regard to recruiting band 6 Occupational Therapists. The service has recruited an additional 2 x band 5 Occupational Therapists on rotation in addition to the allocated 1x band 5 Occupational Therapist to cover the gap. This will increase the band 5 Occupational Therapists in post within the unit to 3. They are on a rotational scheme and will be based at Brockfield House for a period of a year from October before rotating out of the service.	No	
Staff talking in their preferred language	**Ward K** - The staff involved have been spoken to and these discussions have been documented accordingly. Evidence of the discussion in staff members' one to one support meeting notes and minutes from the team meeting. All staff reminded through one to one support meetings and team meetings that staff members' preferred languages should not be used in the company of a patient that does not speak that particular language.	No	

	Ward M - Ward Manager to email all staff confirming acceptable behavior and professionalism. Estates request for the comments/complaints box to be fixed to the wall.	No	
Privacy and dignity	**Ward G** - The mesh covering the windows - A job ticket has been raised with estates to either cover the mesh with a film preventing visibility to the female garden or to fit blinds. This was raised on 23 September.	No	
	Ward H - The mesh covering the windows - This action has been reported to Estates. This action point to be discussed with patients in the community meeting to be held on the ward. The ward manager emailed the CQC MHA compliance report to the ward team. Privacy & Dignity is an agenda item in the Business Meeting for discussion with the team and how we communicate the importance of Privacy & Dignity with our patients. This action has been escalated to senior management for oversight and resolution.	No	