



Essex Partnership University NHS Foundation Trust

Assurance Review of Follow Up of Consent (Oxevision)

May 2026

Draft

Executive Summary

OVERALL ASSESSMENT			LIMITED ASSURANCE	ACTION POINTS	HIGH RISK	MEDIUM RISK	LOW RISK	OPERATIONAL
					2	5	0	0
KEY STRATEGIC FINDINGS								
Governance Framework	The follow-up review concludes Limited Assurance over arrangements to obtain and evidence patient consent for Oxevision, indicating improvement is required to manage associated quality and governance risks. Review of audit reporting (Tendable) also indicates operational barriers and low engagement affecting assurance.							
Governance Framework	The Oxevision SOP is overdue for review; there is scope to simplify the process for consent and for the Tendable audits. Evidence of staff training/competency sign-off was incomplete across sampled area							
Compliance	Record-keeping remains inconsistent: in a sample of 25 patient records, 44% lacked an admission checklist evidencing informed consent, with further gaps in documenting consent discussions and patient views in care plans and clinical notes.							
Performance Monitoring	Where patients may lack capacity, documentation of capacity assessments, best-interest rationale and associated MDT decision-making was not consistently evidenced, creating risk that decisions are not demonstrably compliant with the Trust's SOP and expected standard							
SCOPE				ASSURANCE OVER KEY STRATEGIC RISK / OBJECTIVE				
The overall objective was to follow up on previous audit undertaken in July 2025 and provide assurance on arrangements for consent for Oxevision.				SR 13 - Quality Governance.				

Assurance - Key Findings and Management Action Plan (MAP)

Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
1	Compliance	Testing of a sample of 25 patients admitted (in same sample of wards in prior audit) in January and February 2026 for whom Oxevision was used, identified the following exceptions: • For 11 cases (44%), an admission checklist evidencing informed consent was not evidenced although in one case a separate capacity and consent form was completed. The October 2025 report for patient admitted in June and July 2025 noted 53% did not have evidence of admissions checklist. • For 9 cases, there was no evidence of the patients consent and views relating to Oxevision recorded in the patients care plan. • For 12 cases, there was no evidence of conversations regarding Oxevision recorded in the patient’s case notes. • For 4 cases, there was no evidence of patient having or not having mental capacity to consent in the ward review and consent wasn’t gained on behalf of the patient.	Satisfactory documentation be maintained for Oxevision consent, including: • Ensuring that an admission checklist is consistently completed for all patients where Oxevision is used. • Documenting if patient was deemed to have mental capacity to give consent in ward reviews. • Documenting consent discussions and outcomes in the patient’s clinical case notes. • Recording patience views and preferences relating to Oxevision and Oxevision Observations to ensure these are not overlooked.	1			

PRIORITY GRADINGS

1	HIGH RISK	Fundamental control weaknesses or compliance issues that require immediate attention.	2	MEDIUM RISK	Control weaknesses that are not critical but require planned action at the earliest opportunity.	3	LOW RISK	Minor issues on which action should be taken or monitored as part of continuous improvement.
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Ref	Root Cause Indicator	Finding	Recommendation	Priority	Management Comments	Implementation Timetable (dd/mm/yy)	Responsible Officer (Job Title)
2	Compliance	Testing of a sample of 25 patients admitted in January and February 2026 for whom Oxevision was used identified three cases where the patients lacked mental capacity to consent. When a patient lacks mental capacity to make the decision and give consent best interest decisions by the Nurse in Charge (NIC) and responsible clinician are made on behalf of the patient regarding whether the use of the Oxevision system is in the patient's best interests and must be recorded on the patient's clinical record. However, this was not clearly documented for two applicable cases. In addition, for the two cases where the patients lacked mental capacity to consent, in one case a Multi-Disciplinary Team (MDT) meeting was not evidenced to have taken place. The Standard Operating Procedure states that where there is reason to believe a patient lacks mental capacity, an MDT meeting should then be arranged to specifically review this decision as soon as is reasonably possible.	Where a patient lacks mental capacity to consent, best interest decisions be clearly documented with rationale and a Multidisciplinary Team meeting be convened, and decision taken recorded, as stipulated by the Oxevision Standard Operating Procedure.	1			
3	Governance Framework	The Trust has in place a Standard Operating Procedure (SOP) for the use of the Oxehealth Oxevision and Oxevision Observations. Review of the SOP showed that the document clearly outlines the processes in place for gaining consent for the use of Oxevision, the training requirements, and the relevant roles and responsibilities. It was confirmed that the document was last approved in April 2025 by the Oxehealth Project Board, with the next review date being October 2025. However, it was confirmed by the Interim Operational Service Manager that the SOP was not updated accordingly. Follow up of cases of non-compliance from sample testing and discussions of root causes with the key officers and review of management reports relating to Oxevision (Tendable) audits, noted that it was considered that there is scope to simplify the process for consent and the Tendable audit tool.	Oxevision SOP to be updated and the review to include consideration of any potential to simplify the process for Oxevision consent and the Tendable audit.	2			

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4	Compliance	All staff need to complete a competency checklist. This is a document which demonstrates competency for Oxevision and Oxevision Observations. The document needs to be signed by an Assessor and the staff member including a date of when competency was achieved, outlining that training was completed and fully understood. Testing of a sample of ten employees (two from five areas: Christopher Unit; Grangewaters Ward; Chelmer; Larkwood and Longview (CAHMS); Beech), who were required to have undertaken Oxevision training, revealed that competency checklists signed by both the staff and relevant managers/reviewers were only available for four staff from two units (Christopher Unit and Grangewaters Ward). These were provided as scanned documents via email. For the other three units/wards, further queries were made with the Matrons. For Chelmer, completed checklists were confirmed to have been done however had not been provided; Beech confirmed there was no evidence available and no response provided for CAHMS. Performance reporting for Tendable audits also noted non-compliance as well as non-Recommendation made during the previous audit has been re-iterated.	Line manager for wards which deploy Oxevision, be reminded to complete competency checklist for Oxevision for all relevant staff and confirm compliance to appropriate officer/forum. Non-compliance be followed up and escalated as appropriate.	2			
5	Compliance	Ward review meetings should include continued consent conversations and be recorded in the patient records. Testing of 25 patients for whom Oxevision was used identified that, in the 24 applicable cases, whilst there was evidence that regular ward review meetings took place, there was no record that discussions on the use of Oxevision and Oxevision Observations took place at the meetings.	Records of discussions on the use of Oxevision and Oxevision Observations at the ward review meetings be maintained in all applicable cases.	2			

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6	Compliance	Sample testing for consent noted that in cases which were compliant, it was noted by the Interim Service Manager that the quality of records for consent, had improved considerably and was considered to be of very high quality.	Communication to include feedback on quality improvement seen in recording for consent in sample areas showing compliance. Review any learning from wards showing improvement, to be shared with other awards.	2			

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7	Performance Monitoring	Current oversight arrangements in place are fortnightly Oxevision audit update for Executive Team oversight with the report in January provided as evidence and minutes from Matron's audit review meeting. The January 2026 'Fortnightly (Tendable) Oxevision audit update for ET' report oversight to Executive Team on Oxevision compliance showed non-compliance in a number of areas and noted a number of challenges and issues, including: 1. operational barriers affecting audit accuracy 2. significant operational engagement (non-completion of Oxevision audits) 3. length of audit tool 4. Capacity of matron to undertake audits 5. Issues with accuracy of audit 6. Lack of engagement (there was no submission of Oxevision consent and staff training audit for 10/12 wards respectively.) It was also considered that further information should be provided for interpretation of the results tables to support the narrative. The audit results were not clear, and audit queries were raised on the figures reported and methodology however no response had been provided at time of reporting. Follow up on cases of non-compliance identified in testing was undertaken to establish root causes and barriers. Comments from ward service managers noted the following: • Similar issues arose from completing the audit themselves • Main issue is the discussion regarding consent in the MDT meeting and recording that the person has consented to the use of Oxevision. • There is not a specific discussion in regards of Oxevision with the patient. It was advised that the issues have been raised with the medical teams but have seen little improvement. The issues are being addressed directly via the admitting nurses. Also, that the plan is that the matron will meet with each admitting nurse to ensure all required elements are completed on admission. It was also advised that the ongoing concerns are being discussed within leadership meetings.	Reporting on Oxevision (Tendable) audits to executive team and other groups or committees, to include interpretation of Tendable audit results, follow up undertaken, reasons established and SMART actions to address issues identified, including for those areas not engaging.				

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Findings

Ref	Expected Key Risk Mitigation		Effectiveness of arrangements	Cross Reference to MAP	Cross Reference to OEM
GF	Governance Framework	There is a documented process instruction which accords with the relevant regulatory guidance, Financial Instructions and Scheme of Delegation.	Partially in place	3	-
RM	Risk Mitigation	The documented process aligns with the mitigating arrangements set out in the corporate risk register.	Partially in place	-	-
C	Compliance	Compliance with statutory, regulatory and policy requirements is demonstrated, with action taken in cases of identified non-compliance.	Partially in place	1,2,4,5,6	-
PM	Performance Monitoring	There are agreed KPIs for the process which align with the business plan requirements and are independently monitored, with corrective action taken in a timely manner.	Partially in place	7	-

Other Information



Oxevision (Oxehealth) is a medical device that uses an infrared-sensitive camera to measure patient pulse and breathing rate. Oxevision is categorised as a class IIa vital signs medical device software that supports the observations of a patient and is compatible with all skin types. Class IIa are devices that are categorised as medium risk that require regulatory approval to ensure safe usage. Oxevision falls under this category as it monitors vital signs.

Through discussion with the Quality Matron, the following process was confirmed for consent for Oxevision:

- Staff share information about Oxevision and Oxevision Observations at the time of admission, with the admitting nurse completing an admissions checklist, which evidence that an Oxevision and Oxevision Observations conversation has been completed with the patient within 6 hours of admission and informed consent has been gained or withdrawn for the use of Oxevision.
- Staff are required to also complete a full care plan within 72 hours of the patient's admission, which should be recorded on the patient's clinical record. The patient's consent and views relating to Oxevision must be recorded in the full care plan.
- If the patient has capacity to consent, this should be documented within the full care plan. Where the patient does not, best interest decision is taken for the patient, and this should be documented within the patient's clinical records.
- Oxevision and Oxevision Observations should form part of the standing agenda during ward community meetings to allow patients and members of the Multi-Disciplinary Team (MDT) to have open discussions.
- Patient discussions during ward review meetings regarding the use of Oxevision and Oxevision Observations should routinely take place and be recorded in the patient records.
- A patient has the right to withdraw consent for the use Oxevision at any time. However, if the patient consent is not given on admission, or is withdrawn during the admission process, the Oxevision system can be individually isolated by the Nurse in Charge (NIC) using the monitor to select 'Camera off' for the patient's bedroom. A decision to turn the camera off should only occur if the NIC deems the action clinically safe prior to an MDT decision meeting. If not, the Oxevision system will remain on, and the rationale will be explained to the patient, and this is to be documented in the patient clinical record.

As at the time of audit fieldwork, there were 30 wards across the Trust at time of reporting where Oxevision had been deployed. Testing was undertaken across five wards, namely: Beech ward; Grange waters ward; Chelmer ward; Finchingfield ward; and St Aubyn Child and Adolescent Mental Health Services (CAMHS).

Scope and Limitations of the Review

- 1. The definition of the type of review, the limitations and the responsibilities of management in regard to this review are set out in the Annual Plan. As set out in the Audit Charter, substantive testing is only carried out where this has been agreed with management and unless explicitly shown in the scope no such work has been performed.

Disclaimer

- 2. The matters raised in this report are only those that came to the attention of the auditor during the course of the review, and are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

Assignment Engagement Details

3.

TIAA Auditors	Title	Contact Email
[I/S]	Senior Audit Manager	[I/S]
	Director of Audit	

Effectiveness of arrangements

- 4. The definitions of the effectiveness of arrangements are set out below. These are based solely upon the audit work performed, assume business as usual, and do not necessarily cover management override or exceptional circumstances.

In place	The control arrangements in place mitigate the risk from arising.
Partially in place	The control arrangements in place only partially mitigate the risk from arising.
Not in place	The control arrangements in place do not effectively mitigate the risk from arising.

Assurance Assessment

5. The definitions of the assurance assessments are:

Substantial Assurance	There is a robust system of internal controls operating effectively to ensure that risks are managed and process objectives achieved.
Reasonable Assurance	The system of internal controls is generally adequate and operating effectively but some improvements are required to ensure that risks are managed and process objectives achieved.
Limited Assurance	The system of internal controls is generally inadequate or not operating effectively and significant improvements are required to ensure that risks are managed and process objectives achieved.
No Assurance	There is a fundamental breakdown or absence of core internal controls requiring immediate action.

Acknowledgement

6. We would like to thank staff for their co-operation and assistance during the course of our work.

Release of Report

7. The table below sets out the history of this report.

Stage	Issued	Response Received
Audit Planning Memorandum:	26 th January 2026	20 th February 2026
Draft Report:	8 th May 2026	
Final Report:		