as One

Hertfordshire Partnership NHS
University NHS Foundation Trust

Quality Account 2014-2015

Our Values
Welcoming Kind Positive Respectful Professional

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Photo on Front Cover is from the Kingfisher Court opening, June 2014

Quality Account

Part 1 – Statement by the Chief Executive

I am delighted to have the chance to introduce you to the 2014/2015 Quality Account, where we offer all those who have an interest the chance to find out more about what we do.

As usual, this report tries to describe in a balanced and accessible way how we have approached the challenges of improving quality of care across all our services last year.

The fourth year of major savings being necessary in the Trust - reflecting the acute pressures on NHS budgets locally and nationally – has meant that services have needed to continue to change radically if they are to remain efficient and clinically effective. Inevitably at times, such pressures have been felt negatively – by service users carers and staff.

And yet I believe this has also been the year when our changes and robust financial management have begun to bear fruit.

We have used our status as a Foundation Trust to enable us to invest £42 Million capital to build Kingfisher Court at Kingsley Green – a major Inpatient Service for 86 people to be formally opened this summer by Simon Stevens Chief Executive Officer of NHS England.

Again, our new Learning and Development Centre at The Colonnades, Hatfield which opened in June 2014, has been widely appreciated by staff and all our partners who have visited for meetings or conferences.

I know that the experience of service users and carers can still be varied, and this account includes some frank acknowledgments of where we need to improve.

But it seems to me that this year's developments – alongside the many examples of service users progressing to recovery and recognising how we have helped them on that journey – are the early signs of true "parity of esteem" for mental health care.

In this report:

Part 2 introduces the Trust and the services we provide.

Part 3 describes how we plan to improve quality of care in the coming year and where we will focus our efforts.

Part 4 provides many details of how we have performed in 2014/2015 – on our chosen quality priorities and also the wider aspects of quality in a mental health and specialist learning disabilities NHS Trust.

Part 5 rounds off the account with some final pieces of information.

Appendix 1 provides a glossary.

Appendix 2 presents details of performance against quality priorities in a table.

Appendix 3 contains stakeholder responses to the draft report.

Appendix 4 is the statement of directors' responsibilities

As required by Monitor, with regard to data accuracy, I would ask readers to note that there are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits' programme of work each year.

- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably have classified a case differently.

- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.

- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.

The Executive Team and Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognise that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate.

Please use this account to publicise and raise awareness of what we are doing – across Hertfordshire and in Essex and Norfolk.

If you have comments on anything we have said, or simply want to know about HPFT, please do not hesitate to contact Jonathan Wells Head of Practice Governance via:
jonathan.wells@hpft.nhs.uk

The Quality Account will be published before 1st July 2015 on the NHS Choices website and on ours *www.hpft.nhs.uk*

Paper versions and other formats are available from our Communications team on 01727 804459.

Tom Cahill
Chief Executive

Date: 27/05/2015

Part 2 – Introduction

In November 2014 our Board of Directors joined hundreds of staff from across the NHS at the prestigious Health Service Journal awards ceremony. The Board won the award for Board Leadership.

Judges commended our Board for its vision and dedication to ensuring individuals suffering mental ill health are treated equally to those with physical illnesses. They were also impressed by the Board's "strong commitment to equality and diversity that is having a real impact on service delivery" as well as "excellent use of feedback."

This year the Board renewed its commitment to quality and our vision to be:

"..the leading provider of mental health and specialist learning disability services in the country."

For us, to be "leading" means to deliver sustainable services of the highest quality.

To make sure we keep on track, we agreed eight overarching objectives as part of our five year strategic plan (2014/15 to 2018/19).

These are:

- **Quality and Service Development**
  1. We will deliver safe and effective services.
  2. Service users, carers, referrers and commissioners will have a positive experience of our services.
  3. We will transform services, putting the needs of service users and carers at the centre.

- **Workforce**
  4. Staff will have a positive experience of work
  5. We will have a productive and high performing workforce
  6. We will embed a culture that promotes our values

- **Sustainability**
  7. We will secure the financial sustainability of our services
  8. We will develop an enviable reputation for quality and innovation, and strong relationships with commissioners, GPs and our key partners

Many of these objectives will be met if we make sufficient progress each year as reported in the Quality Accounts.

In 2014/2015 we continued to provide:

- The full range of mental health care and treatment for people in Hertfordshire with mental health difficulties, including a comprehensive primary care service for those with common mental health problems alongside GPs

- Inpatient and specialist community health care for adults with learning disabilities in Hertfordshire and North Essex

- Secure inpatient services for adults with learning disabilities and challenging behaviour in Hertfordshire and Norfolk and an Assessment and Treatment unit for people with learning disabilities at Astley Court in Norfolk

- Specialist services for adolescents who need mental health inpatient care, for peri-natal care and for the treatment of severe obsessional-compulsive disorder

From 1st July 2015 we will begin to provide (in partnership with MIND) enhanced primary care mental health services in West Essex.

In the year we employed 2,900 staff based at 60 sites (fewer than before), and our services cost £197, 000,000.

We received around 30,000 referrals through our Single Point of Access service.

We provided 391,444 clinical contacts during the year, of which 100,306 were with people using our primary care mental health services.

This account attempts to explain the quality of all this activity, and the extent to which we are meeting the needs of those who very much rely on our help.

Opening of the Learning and Development Centre at the Colonnades – September 2014

Part 3 – Priorities for Quality Improvement 2015/2016

3.1. Consultation

We were busy in the first three months of 2015 developing our plans and thinking about where we needed to concentrate our efforts in the coming year. Internally this is done through our three Strategic Business Units agreeing their priorities for improvement which are aligned with the Trust's overall annual plan reported to Monitor our regulator.

Led by our three Clinical Directors, practitioners from psychiatrists and psychologists to nurses, social workers and Occupational Therapists contribute their ideas.

Through the Service User and Carer Councils we have heard that:

- Community mental health services are taking a long time to settle down after their major reorganisation and there are too many temporary staff
- Whilst our two acute day treatment units are highly valued, this can contrast with the pressurised atmosphere on acute inpatient units at times and the lower levels of support in community services
- It can still be too complicated to access care and treatment for children and young people with mental health difficulties

Through ongoing dialogue over the year with local commissioners – the Clinical Commissioning Groups – we have a common understanding of the areas requiring improvement. We appreciate the close working relationships we have with our many partners including the CCGs, Hertfordshire County Council and Hertfordshire Healthwatch, The CCGs in particular have provided positive feedback following their inspection visits and have welcomed the good practice reports which we provide to them through the year.

The Hertfordshire commissioners have noted room for improvement in the following areas:

- better management of the acute care pathway, so that those who are acutely unwell get good help at home where appropriate, and if admitted to inpatient care receive well planned treatment leading to well organised discharge arrangements
- in community mental health services, the need for high quality risk management in every case, and reduced staff turnover
- better communication with GPs so that physical and mental health needs are met together for each individual
- maintenance of the improvements made in access to CAMHS services – for urgent, semi-urgent (within 7 days), and routine referrals – together with a clearer message about the place of Trust CAMHS as part of mental health services for children and young people overall

Healthwatch Hertfordshire have continued to take a close interest in Trust services and in discussion they echoed many of the views outlined above. They also raised questions about continuity of care and prompt access to a care co-ordinator being problematic at times in community mental health services, reflecting the Trust's challenges with regard to retention and recruitment of permanent staff.

3.2. Selection and Monitoring

This year we remain very clear that our priorities should cover all three domains of quality.

This means:

Safety: avoidance of preventable incidents from serious incidents such as suicides to more low level incidents such as slips trips and falls; helping inpatients feel safer, reducing actual or threatened assaults on inpatient units, planning services so that they are as safe as possible; assessing and managing each service user's risks with them effectively.

Clinical effectiveness: making sure that access to services is good – both urgent and routine; enabling service users to move on when they are ready, (whether from units for people with learning disabilities, community services or from older people's inpatient units); providing interventions that work.

Service user and carer experience: recognising that a service is not good unless it is experienced as good; having flexible ways of hearing from service users and carers and acting on what is said; using the Friends and Family Test questions to measure quality

On the basis of our consultation and planning we will also retain some workforce priorities, as it is clear that good staff are essential for provision of good services.

Therefore, our quality priority areas for 2015/2016 are as shown below.

Domain	Number	Area
Safety	**1.**	We have begun a major programme of work to increase the skills and resources of staff so that inpatients are kept safe. Numbers of incidents of actual or threatened violence on wards continue to decrease, but there is more to be done. We plan to have an indicator which measures full achievement of this programme which is entitled Making our Services Safer.
	2.	We know that the service user experience of acute inpatient care is sometimes disjointed, with acute bed pressures occasionally leading to care being found in the private sector. A major project to improve the movement of service users through acute inpatient care – strengthening arrangements for admission, care and treatment and discharge – is underway. We plan to use an indicator which measures whether this project achieves its aims and improves acute inpatient safety.
	3.	Last year in community mental health services, we were successful in reaching a position where nearly 90% community service users had had a risk assessment within the past year. It is important now to maintain this level of performance and also ensure that the quality of these assessments is good. We plan to use an indicator which measures maintenance of a consistently high rate of service users with an effective and up to date risk assessment.

Domain	Number	Area
Clinical Effectiveness	**4.**	Last year in Child and Adolescent Mental Health major reductions in waiting times were achieved for routine and urgent first appointments. Again, it is important now to maintain this level of performance and ensure the quality of these Choice appointments is good. We plan to make further use of the access data to measure that good performance is maintained.
	5.	We are developing our mental health services for older people, with newly configured community teams and re-organised inpatient care in modernised units. We want to make sure that the aims of the transformation of these services, which have to do with more effective and more accessible community services, are achieved. We plan to use an indicator for this which reflects improved performance of community and inpatient services; this is likely to be around maintenance of good movement through assessment and treatment inpatient units, measured via length of stay data.
	6.	In response to Winterbourne View and the Transforming Care Programme (Improving the Lives of People with a Learning Disability), we want to make more rapid progress in working with the relevant local authorities to enable these service users Specialist Residential Services at Kingsley Green to fulfil their aspirations in the community. We plan to adopt a set of measures which will show whether these aims are achieved.
	7.	The numbers of people in any population who might benefit from Improving Access to Psychological Therapies (IAPT) Services remain high, and in our Essex services we need to continue last year's progress in engaging with the required numbers of people. Because our performance on recovery rates (eg. effective psychological treatment) is good, we want to focus on access in the coming year. We plan to use current performance indicators to show whether we achieve our targets.
	8.	We have made considerable progress last year in improving our identification of the physical health needs of our service users, but more remains to be done. We will have a set of Commissioning for Quality and Innovation (CQUIN) goals for this again this year around physical health checks and interventions for inpatients with psychosis and those with first episode of psychosis, and better communication with GPs about physical health needs. We plan to use aspects of the CQUIN measures to measure whether these aims are achieved.

Domain	Number	Area
Service User and Staff Experience	**9.**	We will continue to use our wide range of service user and carer feedback mechanisms to make adjustments to the care we provide. We want to see improvements in several aspects of the service user experience as shown in the national service user survey. We plan to identify an indicator which covers many aspects of this experience; this is likely to be the Service User Friends and Family Test (FFT).
	10.	We recognise that staff experience is also a key quality priority for us, and have a range of initiatives in place to support staff and help them work as therapeutically as possible. We plan to identify an indicator which covers many aspects of the staff experience; this is likely to be the Staff Friends and Family Test (FFT) (would recommend as a place to receive care).
	11.	Improving recruitment and retention of staff has been identified as a key priority area if good care is to be guaranteed. Many initiatives are already underway. We will agree the best overall indicator of progress in this area. This is likely to focus on community mental health services where pressures are greatest.

Monitoring of progress – as previously – will be by the Board and the Integrated Governance Committee. As many of the indicators are also part of Commissioning for Quality and Innovation (CQUIN) goals (reflecting the close alignment this year between commissioner and provider priorities), there will also be robust scrutiny of progress by local commissioners.

HSJ Award for Board Leadership – November 2014

Part 4 – Review of Quality Performance

4.1. Background

We are very much aware that each of the 20 000 or more service users working with us at any given time is a unique individual, with a unique experience of HPFT. For each, there is a complex and subtle relationship between their mental health difficulties or learning disability, their past experience and their current circumstances, and Trust services may make a limited impact on many of these factors. But at HPFT we believe firmly in the recovery model of mental health, which – if it is about anything – is about understanding what is important to each individual we work with and working in such ways that we really do make a difference in what matters most to them.

Some of our staff – as well as some service users and carers – say that the things they do that cannot be measured are often the most important; this can range from the receptionist who remembers each service user from one appointment to the other, to the social worker who knows how important a pet is to an individual each time she or he is admitted and makes the necessary arrangements, to the healthcare assistant who understands why some of the older people on her ward do not like to be addressed by their first name.

In this section, we first state how we have performed in each of the indicators selected as priorities for the year.

We then show how we have done against a range of indicators that are reported on by every Mental Health NHS Trust – offering information on how our performance compares to others and to our own previous record.

Thirdly, we provide information on some other aspects of quality, aiming to get beyond the numbers and offer some other perspectives on what we do. We provide statements of assurance as prescribed by Monitor where necessary using the specified wording.

We very much hope this together will give a picture of HPFT in 2014/2015 that is recognisable to those who know and at times rely on us.

4.2. Local Quality Indicators – Results

For each of our chosen indicators for 2014/2015 we present our results below.

First we give the definition of the indicator.

Then we explain the rationale of why it was selected as a measure.

We go on to state the source of the data and finally we describe our performance using simple graphs and some narrative.

In summary, our performance was as follows:

Achieved	8	
Partially achieved	2	
Not achieved	3	
Total	**13**	

Partial achievement is defined as where the data shows performance within a 5% tolerance interval of the target.

The full data set is included in Appendix 2.

A. Rate of service users with a completed up to date risk assessment.

Definition: The proportion of all service users (excluding those under primary care mental health services) who have had a risk assessment properly recorded on our electronic patient record within the past 12 months of their care – shown as a percentage.

We set a trajectory aiming for steady improvement by quarter through the year.

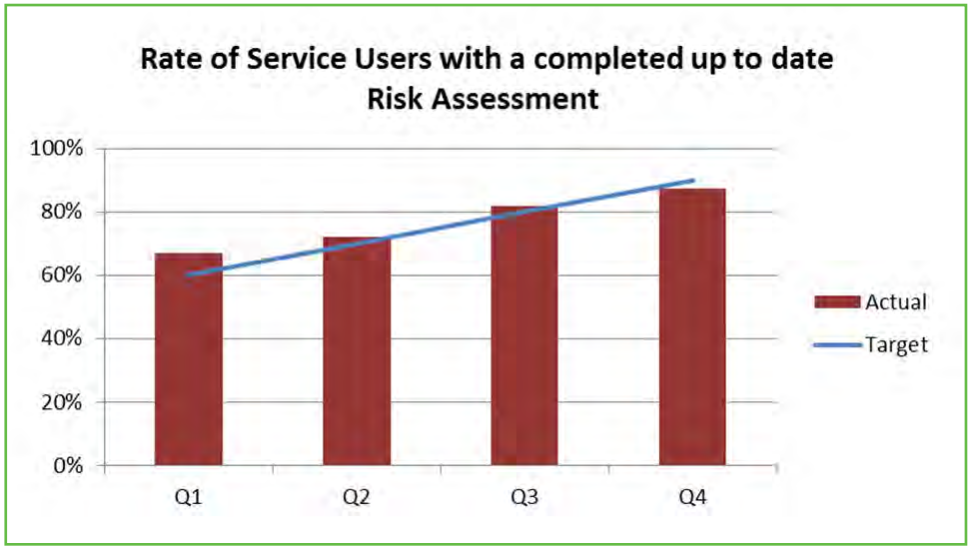
Rationale: In choosing some of our priorities last year we unashamedly went back and checked some fundamental aspects of good traditional mental health care. Those receiving our services are often vulnerable and may be at risk from others as well as needing help to look after themselves and safely manage thoughts of self-harm or suicide.

The starting point for this crucial work is often a thorough, evidence-based and well recorded discussion about risks which can be seen to inform the care plan that is then agreed with the service user.

Last year we became aware that risk assessments were not being completed as they should in a number of cases. It has been a focus of attention throughout the year for managers to achieve improvement in this area.

Data source: Our electronic patient record (Paris).

Result: This goal was **partially achieved**.



The target was 90% to be achieved in Q4 and we achieved 87.2%.

It can be seen that performance steadily improved through the year and narrowly failed to reach the final target. Our performance falls within a 5% tolerance interval and therefore is rated as “partially achieved”.

We are now determined to reach at least 90% and maintain that level in future, which is why this remains a quality priority for 2015/2016. In addition it is appreciated that this metric does not prove that all such risk assessments are of good quality. We are therefore going to be undertaking further work to examine the sensitivity and thoroughness of risk assessments and drive up their quality through audit and re-audit.

B. Rate of inpatients reporting feeling safe.

Definition: The proportion of all service users answering this question in Having Your Say who say that they have not found the inpatient environment safe.

NB: the wording of this question was slightly altered when the Having Your Say questionnaires were revised in mid-year.

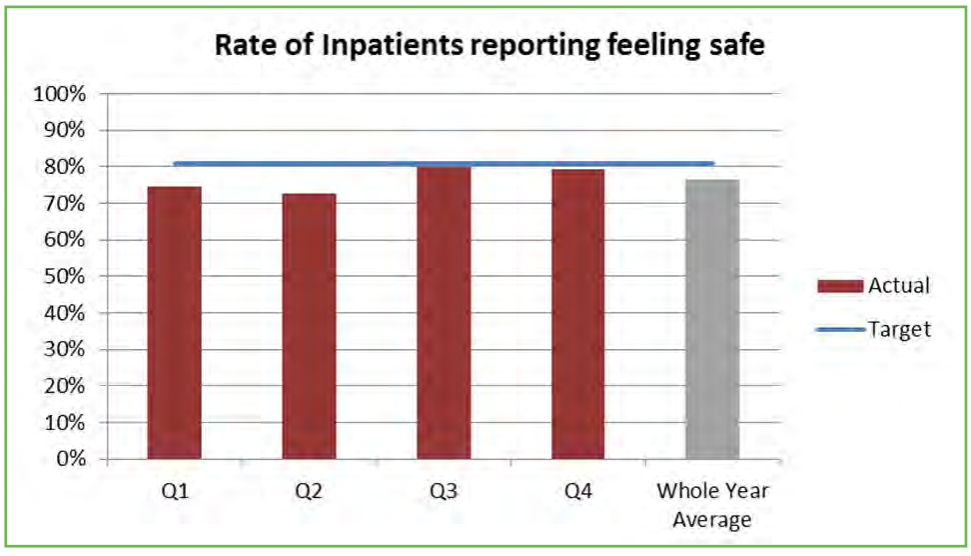
As an indicator this is vulnerable to variations in response rate and response source (eg. a higher response rate in one quarter by acute inpatient service users may lower the satisfaction rate). Because of this limited validity, we took our baseline from a whole year average and set the target of an improvement measured again as a whole year average.

Rationale: We have asked this question for several years and last year's overall figure of 81% was our highest yet. It felt right to continue to aim for better at a time when we were about to open our new Inpatient Services at Kingfisher Court.

We believe that this indicator has remained a very powerful source of information for us, especially when backed up with descriptions from service users about what has helped them feel safe and what has unsettled them at times.

Data source: Having Your Say (HYS), our well established set of questionnaires that service users and carers can complete on paper, on line or over the phone.

Result: this goal was **not achieved**.



The target was 81% over the year and we achieved 76.3%.

We are disappointed not to have achieved this goal. Our analysis indicates that the physical environments in which we provide care – especially Kingfisher Court - have had a positive impact, but this has been more evident in the second half of 2014/2015.

There have been considerable pressures on acute inpatient care for most of the year, with service users sometimes having to move from one unit to another during an inpatient episode, and occasionally having to be admitted to a non-HPFT bed.

Such bed pressures are not confined to HPFT and have been hard to avoid at a time of ongoing savings required in mental health services. Our alternatives to admission such as host families and the two acute day treatment units have been very well received and we have plans to make further improvements to the acute care pathway so that there is a consistent threshold for inpatient admission 24/7 and more attention paid to housing solutions.

C. Delivery of Making Our Services Safer CQUIN Goal.

Definition: Our commissioners set us a CQUIN goal to make sure we made the maximum use of our new project to make services safer. In May they will confirm whether we have provided strong evidence throughout the year of the impact of the project and their judgment will decide if this indicator has been achieved.

Rationale: Particularly because we provide inpatient care for adults with learning disabilities in Hertfordshire, Essex and Norfolk, we tend to report high levels of actual or threatened violence on inpatient units – whether between service users or from service users towards staff. Staff also reported last year that a significant minority had experienced such incidents and inevitably this at times was having a negative effect on staff morale and sickness rates.

This coincided with a range of national initiatives to support better practice in making inpatient care safe. Our Deputy Chief Executive Dr Oliver Shanley decided to bring this together and set up a major new programme entitled Making Our Services Safer (MoSS).

Key elements of MoSS include:

- Compliance with the Department of Health's "Positive and Safe: Two Year Plan"
- Staff better trained in de-escalation and restraint through the RESPECT programme leading to the phasing out of seclusion as a way of controlling disturbed behaviour
- Adoption of the Institute of Psychiatry's Safe Wards initiative – so far on two wards (Oak Psychiatric Intensive Care Unit at Kingsley Green and Aston Acute Inpatient Unit at The Lister Hospital, Stevenage)

Data source: We have a MoSS strategy and provide reports each quarter with evidence of its implementation. For the first three quarters these reports have been accepted by commissioners. Commissioners' verdict on the end of year report in May will decide if this goal is achieved.

Result: This goal was **achieved**.

D. Achievement of Child and Adolescent Mental Health Services (CAMHS) Waiting Time Targets.

Definition: We had a CQUIN Goal for 2014/2015 which required us to assess all urgent referrals within 4 hours, 75% of all semi-urgent referrals within 7 days and 75% of all routine referrals within 28 days by the final quarter of the year.

Achievement of this CQUIN goal will constitute achievement of the quality priority.

Rationale: Both locally and nationally it has sometimes taken too long for children, young people and their families to get the mental health care and treatment they may desperately need. This has been exacerbated at times by unclear arrangements where different organisations provide CAMHS services for different "tiers" of referrals. A further factor – the dramatic increase of mental health difficulties amongst young people reported both locally and nationally – has put further pressure on access.

The Trust therefore welcomed the challenge from commissioners to make major improvements in the accessibility of its services in the course of the year. We are committed to providing timely and responsive services to children and young people in need and recognise that such early interventions can be pivotal in young people's lives.

Data source: The electronic patient record (Paris).

Result: This goal was **achieved.**

Recovery Conference – October 2014

E. Rate of community service users saying the services they receive have helped them look to the future more confidently.

Definition: The proportion of all community service users who completed a HYS questionnaire each quarter who said the services they receive have helped them look to the future more confidently

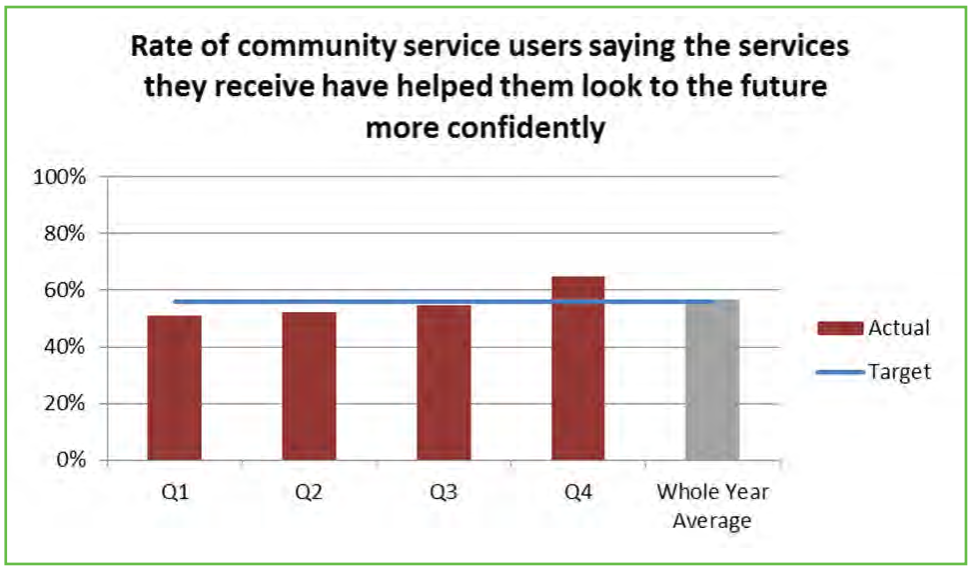
As an indicator this is vulnerable to variations in response rate and response source. Response rates vary by quarter which affects the validity of the results and makes quarter-on-quarter comparisons hazardous. Because of this, we took our baseline from a whole year average and set the target measured again as a whole year average.

Rationale: We like this indicator as a powerful measure of whether our services are truly recovery-oriented. Hope and optimism are important ingredients of good mental health, and the positivity of staff - one of the key values and behaviours that we have all adopted – can rub off on those with whom we work.

This indicator gives us some hard evidence about whether these approaches are having the desired effect.

Data source: HYS

Result: This goal was **achieved.**



The target was 56% over the year and we achieved 56.6%. Because of strong performance in Q4, it was possible to achieve the target as it was based on a whole year average.

This year we have made progress in reducing the bureaucratic burden on practitioners and have co-produced with service users a statement about what makes a really good care plan. Motivated by the Care Act, we have stressed the importance of engaging with service users as individuals and as whole people; alongside this, we have concentrated on seeing the strengths of each service user and understanding their hopes and aspirations.

This indicator offers evidence of achieving something based on the subtleties of all the human relationships between service users, carers and our staff. We are very encouraged to have achieved this goal.

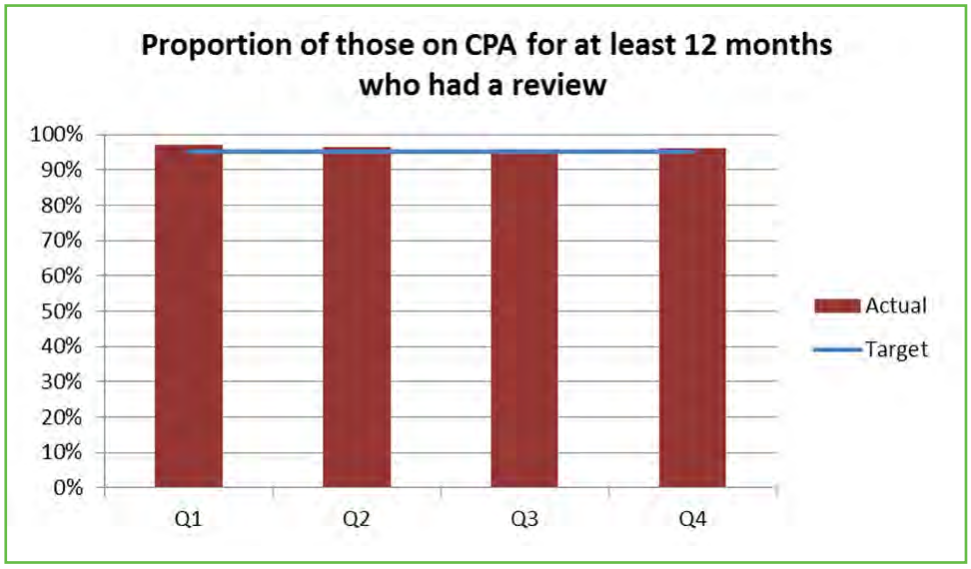
F. Proportion of those on CPA for at least 12 months who had a review within the last 12 months.

Definition: The percentage of all those receiving care under the Care Programme Approach (CPA) who have had a correctly documented review of their care plan within 12 months.

Rationale: Service users and carers had told us that some essential aspects of community mental health care had suffered from the major re-organisation of services a year ago. Those who receive care under CPA are the 20% most at risk and with the most complex needs. A key element of the support they receive is that their care co-ordinator makes sure that those involved in their care (including their family as agreed), get together at least annually to consider what other help in each person's recovery journey might be needed.

Data source: The electronic patient record (Paris).

Result: This goal was **achieved.**



The graph indicates that a consistently high standard was maintained as would be expected by Monitor, for whom this is a mandatory target. The target was to exceed 95.0% in each quarter and we did this.

G. Friends and Family Test (FFT) asking whether the service user would recommend the service to friends and family.

Definition: This This year this indicator became mandatory for Mental Health Trusts with wording and calculation of results being the same for all NHS Trusts.

It is defined as: *"… a proportion of all service users responding in a given period, the percentage of service users saying "Extremely Likely" or "Likely" in answer to the question:*

"How likely are you to recommend our service to family or friends if they needed similar care or treatment?" "

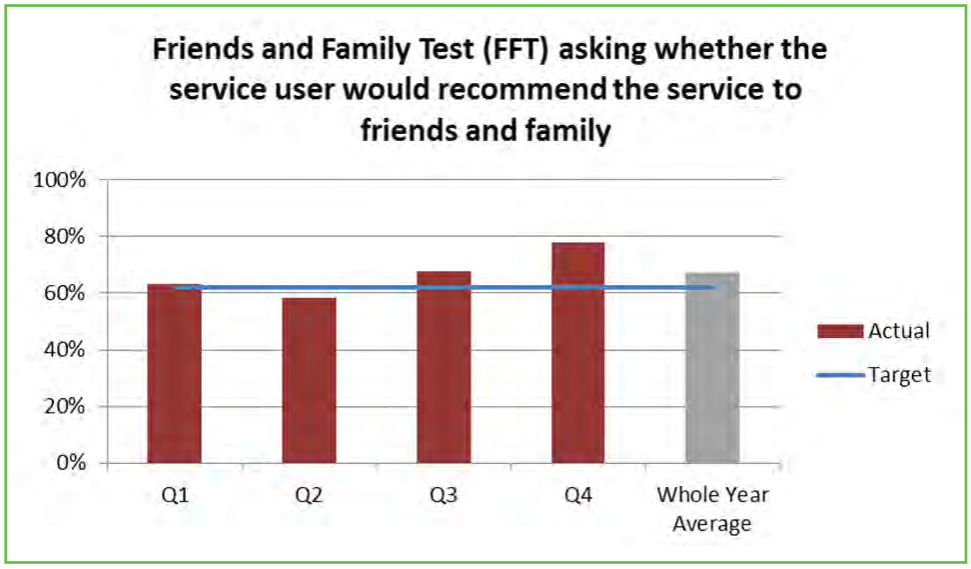
Rationale: We have a strong tradition of putting this and other key questions to service users over the past eight or nine years. Since 1st January it has been mandatory in all our services

and before then we asked it in most services and with slightly different wording. As one figure its significance is limited, but when considered alongside the two FFT questions for staff it can give a powerful impression of quality of care as a whole.

The national question also gives service users an immediate opportunity to say what helps or hinders the provision of good care; we find that the more negative comments are often very precise and we have evidence of many teams each quarter telling us and the respondents themselves what they have done about the issue.

Data source: Having Your Say.

Result: This goal was **achieved.**



Because of some internal changes to the wording of the question we took a baseline from the results in the first two quarters which was 61.8%. Our target was to make sure we maintained this over the full year and we achieved this clearly with a whole year average of 67.5%.

Having agreed our core values and behaviours with staff in 2013/2014 we ran team sessions with over 2 000 staff between August 2014 and March 2015 to help staff think through how their behaviours could help them be more effective and therapeutic in all that they do, whether receptionists or Consultant Psychiatrists. At the same time, we co-produced with service users and carers strong clear statements about care planning and true engagement with service users and we jointly ran sessions with acute inpatient staff.

We recognise there is more to do, but we believe such initiatives have enabled us to achieve this important goal.

H. Rate of carers that feel valued by staff.

Definition: As a proportion of all those responding, the percentage of carers who say they feel valued by staff.

Rationale: The Trust very much appreciates the partnerships our staff are able to form with carers, in working together to provide the best for their loved ones and in addressing the widespread needs of carers in their own right.

This question gives an indication of how well carers actually feel supported by Trust staff.

Data source: Having Your Say.

Result: This goal was **partially achieved.**

We aimed to maintain a level of carer satisfaction on this question of 78.0%. We achieved 74.3%. This is defined as “partially achieved” as performance falls within the 5% tolerance interval.

Whilst we receive many compliments from carers that give us great encouragement, we also know that sometimes carers still feel unsupported and at worst excluded from the care that is being provided.

In the past year we have recuited to new peer support worker posts in community mental health services. More recently, we have also been training staff on the wider duties towards carers that are introduced from 1st April 20915 by the Care Act. Our commitment to carers remains undiminshed, and we were encouraged this year to achieve a Gold Award for our strong performance in the Triangle of Care – the assessment of the ways in which we support carers organised by the Carers’ Trust.

I: Staff Friends and Family Test (FFT) – staff saying they would recommend Trust services to friends and family if they needed care and treatment.

Definition: The proportion of staff answering a given questionnaire who say “Extremely Likely” or “Likely” in response to the question:

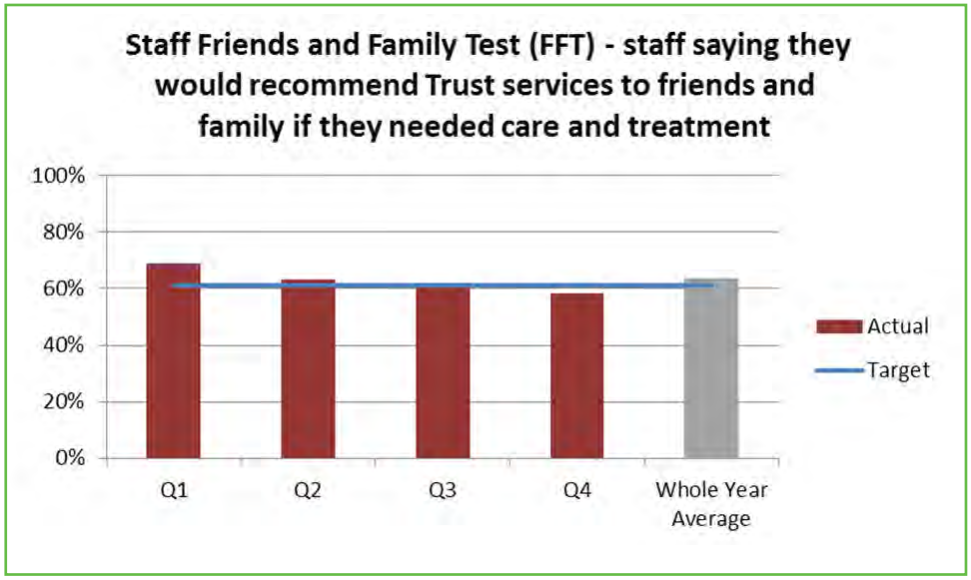
“How likely are you to recommend HPFT to family or friends if they needed care or treatment?”

Rationale: This has become a mandatory question for Mental Health Trusts such as HPFT in the past year. It is one of several indicators which pay attention to the staff perspective, because we know that after a year in which over one quarter of all staff have been going through changes to their job at any one time, the levels of disruption - for staff and for service users and carers -have taken some time to reduce.

This is the first of two FFT questions for staff which combine well with the service user FFT question to give a strong message about quality of care.

Data source: Internal staff surveys (Pulse surveys) and the National Staff Survey.

Result: This goal was **achieved**.



We set out to improve our baseline (derived from earlier versions of the question) of 57.8% to a whole year average this year of 61.0%. We achieved 63.5%.

We have been implementing our Customer Care Strategy and Workforce and Organisational Development Strategy this year and our Board has paid close attention to several indicators of staff engagement and effectiveness throughout the year.

Staff say they are glad to have been involved in making explicit our values and behaviours and to see the Trust investing in the Living Our Values team sessions to help them reflect. The monthly staff awards and the annual glitzy Awards Ceremony are also well received by staff – with over 150 staff taking the trouble to nominate colleagues for the 12 annual awards. However, we recognise that there is more to do to maintain and improve this score.

J: Staff Friends and Family Test (FFT) – Staff saying they would recommend the Trust as a place to work.

Definition: The proportion of staff respondents to internal Pulse surveys who say "Extremely Likely" or "Likely" in response to the question:

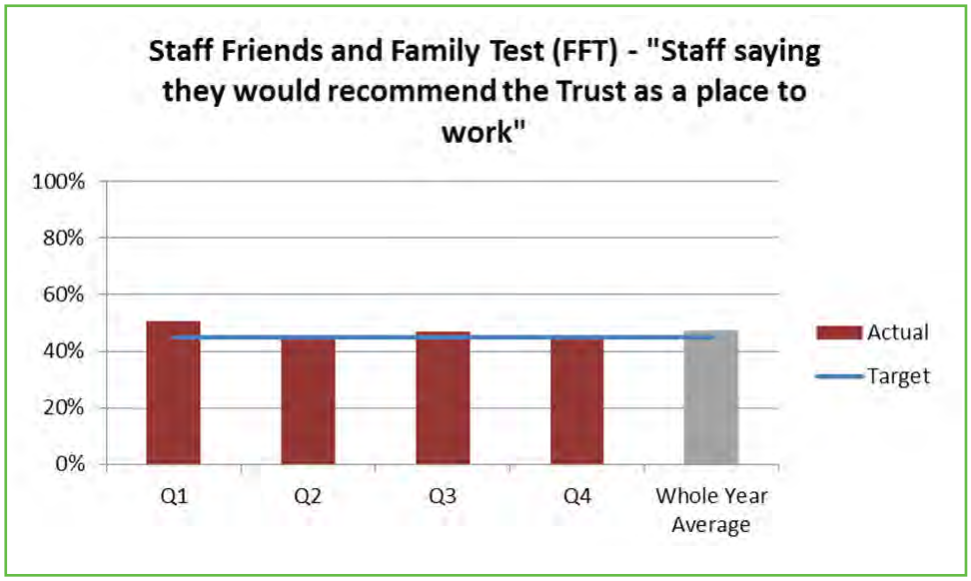
"How likely are you to recommend HPFT to family or friends as a place to work?"

Rationale: This question is closely paired with the one above, although focussing on the staff experience.

Like the other, over time it will generate important data which can increasingly be used to examine staff morale in specific services, as well as benchmarking our position with other Mental Health Trusts.

Data source: Internal staff surveys (Pulse surveys) and the National Staff Survey.

Result: This goal was **achieved.**



We derived a baseline of 43.2% from last year's performance. We set ourselves an improvement target of 45.0%. We achieved a score of 47.2% (year average).

This result is gratifying and indicates the positive impact of many workforce initiatives during the year. Our leadership programmes such as the Mary Seacole Programme at the Leadership Academy have enabled our staff – from team leaders to senior clinicians - to support staff sensitively through change and energise them thereafter.

We are keen to make further improvements in the coming year, through offering more flexible working arrangements, providing a wider range of training in change management to managers, harnessing the views of staff to reduce experiences of bullying or harassment and bringing in colleagues from the King's Fund to help us shift our organisational culture.

K: Rate of staff reporting feeling engaged and motivated at work.

Definition: The proportion of staff respondents to internal Pulse surveys who say they feel engaged and motivated at work.

Rationale: This question is specifically about staff engagement. Whilst most staff say they identify strongly and positively with their team, they are less likely to relate closely to the Executive Team and Board and our stated objectives. Our Board believe that there is a strong relationship between staff feeling engaged and as one as a Trust, and their ability to provide the highest quality of care according to our values and behaviours.

Data source: Internal staff surveys (Pulse surveys).

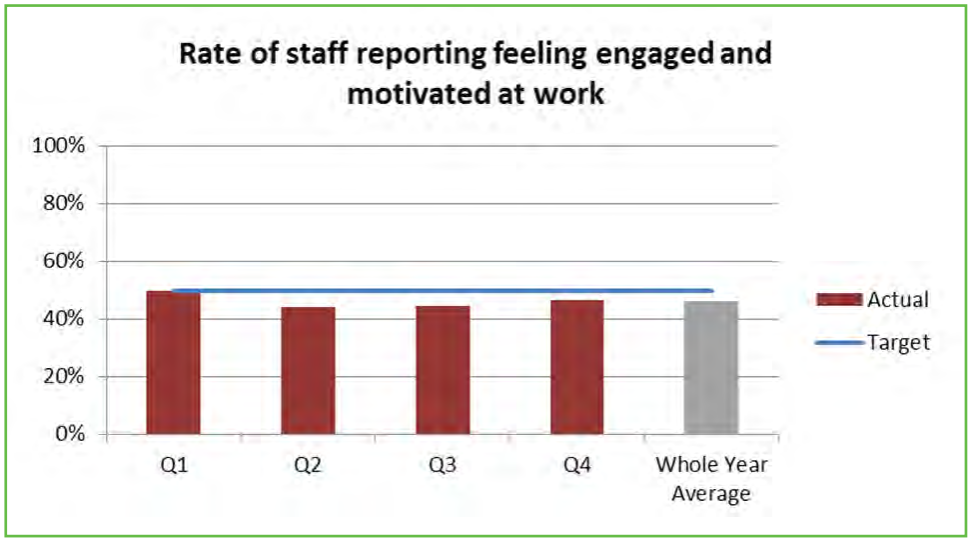
Result: This goal was **not achieved.**

We aimed to maintain last year's satisfaction rate of 49.5% but our year average for 2014/2015 was 46.2%.

Our workforce indicators have shown inconsistent performance this year, with several proving harder to shift than we would like. Our initiatives to support staff in what they do have been widespread this year and have included:

- Monthly and annual awards
- Greater visibility of the Executive Team and the Strategic Business Units' Senior Management Teams – through visits, blogs and events
- Showcasing Events for teams in SBU West
- Monthly briefings in SBU Learning Disabilities and Forensic Services
- Cascade Briefings "from top to bottom of the Trust and up again"
- Big Listen events at The Colonnades and team breakfasts with Tom Cahill
- A new confidential staff counselling service, supplemented by stress management sessions and advice via the Organisational Development Team
- Practical changes in response to staff issues – such as the project led by the Executive Director – Medical Leadership and Quality to reduce bureaucracy (Creating Time to Care)

Increasingly we are finding ways of using the ideas of staff in many services to support them in what they do. This work inevitably will continue in 2015/2016.



L: Rate of staff that report experiencing physical violence from service users.

Definition: The proportion of staff respondents to internal Pulse surveys who say they have experienced physical violence from service users.

Rationale: This indicator links closely with the earlier one around implementing the programme Making our Services Safer.

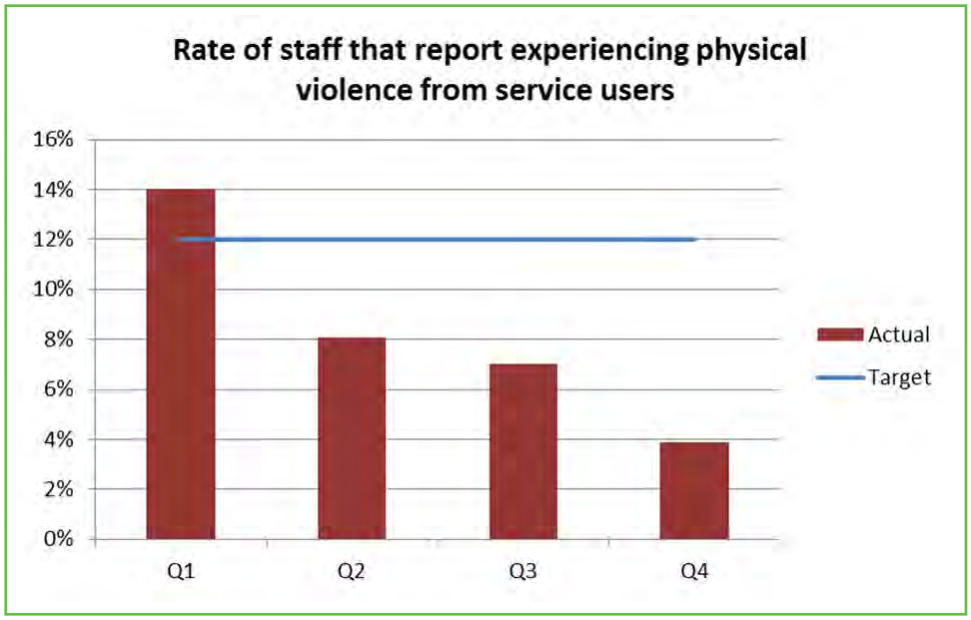
Both became important in response to the high rates of incidents of actual or threatened violence on inpatient units being reported in HPFT compared to other Mental Health Trusts.

We were clear that one reason for this was the fact that we are a major provider of inpatient care for adults with learning disabilities and challenging behaviour in Hertfordshire, Essex and Norfolk. But there was also a relationship between these traumatic experiences and staff morale, motivation and sickness levels.

We were convinced that we owed it to staff and service users to do more to introduce best practice in restraint skills, and to do more to learn across units about how to design the safest care environments and engage therapeutically with people who are inpatients.

Data source: Internal staff surveys (Pulse surveys).

Result: This goal has been **achieved.**



The target has been to reduce from last year's 13.4% baseline to 12% in Quarter 4. We have achieved it consistently and easily.

Factors that we have used to do this include the Making Our Services Safer project, the project at Lexden Hospital, Colchester to understand and reduce seclusion, new inpatient environments (above all, Kingfisher Court), and the more explicit attention paid to safe staffing levels.

Our commitment to staff and service user safety is illustrated by Dennis Hunt, Health, Safety and Security Manager who was named winner in the award for 'Keeping Staff Safe at Work' category (sponsored by NHS Protect), .at the National Patient Safety Awards, This award is for an inspiring individual who has demonstrated commitment, and dedication to protecting NHS lone workers from violence, abuse and aggression.

M: Rate of staff that report having access to relevant training and development.

Definition: The proportion of staff responding to Pulse surveys who say each quarter that they do not have sufficient access to relevant training and development.

Rationale: This final workforce indicator refers to another area which we have been keen to improve. We want to make sure that all staff – temporary or permanent, employees or agency staff – are equipped and supported to provide the best possible care.

Data source: Internal staff surveys (Pulse surveys).

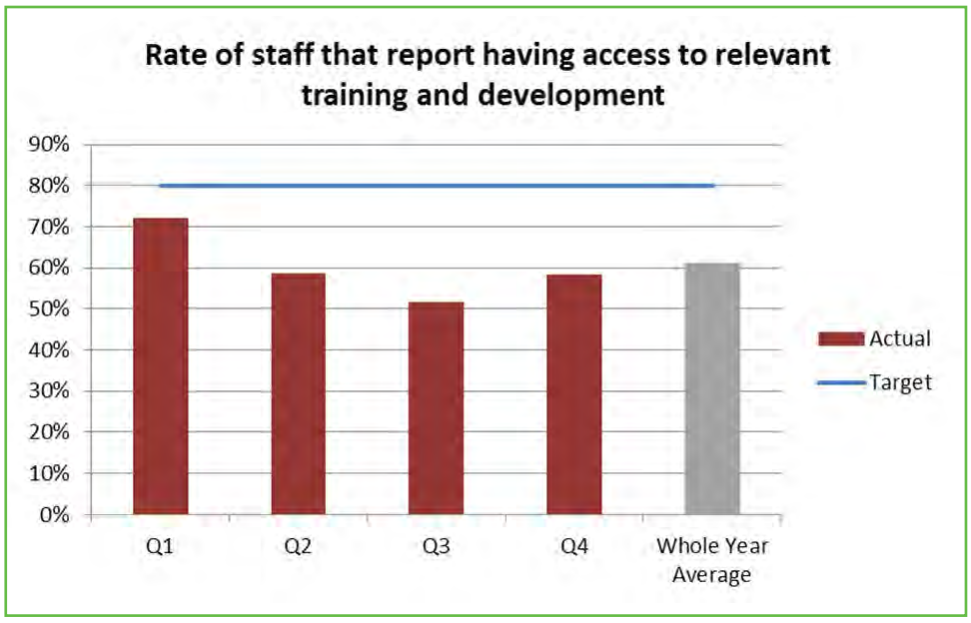
Result: This goal was **not achieved.**

We set out to maintain our average last year of 79.8% satisfaction as a whole year average this year. But our performance declined to 61.1%.

The possible reasons for this include:

- An inevitably strong focus on mandatory training completion which is not directly about clinical skills and so may not be seen as relevant (90% of staff were up to date with their mandatory training at the end of the year)
- Difficulties in releasing staff for clinical training because of pressures on staffing levels in community as well as inpatient teams
- The Trust-wide learning and development manager post remaining unfilled through the year
- Movement of many staff between posts, teams and locations with changes of manager and delays in settling into new roles
- The focus on major training projects such as over 2000 staff having Living our Values sessions in eight months, which may have led to a neglect of bespoke clinical training

Our workforce directorate have developed plans to ensure that this situation is remedied in 2015, with a fuller training needs analysis leading to opportunities that better match the requirements of individuals and services.



4.3. National Quality Indicators

Foundation Trusts are required by Monitor to report performance against a set of indicators using data made available by the Health and Social Care Information Centre.

A second list is required to be reported for all Mental Health Trusts.

measure	target	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	
Adults on CPA receiving annual care review	95%	94.9%	95.2%	97.9%	96.5%	95.7%	96.3%	

Delayed transfers of care	<7.5%	5.05%	5.46%	5.98%	6.35%	5.02%	4.26%	
Early Intervention in Psychosis Service – 150 new cases by end of year	150	41	63	51	48	34	44	
MHMDS data completeness - identifiers	97%	99.6%	99.5%	99.6%	99.7%	99.5%	99.6%	
MHMDS data completeness - outcomes	50%	83.6%	86.9%	74.7%	89.2%	57.3%	55.7%	

The set of indicators shown above is that required by Monitor. It includes performance for the last two quarters of the previous year. The first is described in more detail in F. above.

Whilst we plan to do more work to improve discharge arrangements from inpatient care (especially acute units), the low figures for Delayed Transfer of Care show that we have been managing these pressures well.

This very good set of results provides assurance that several key aspects of the care we provide remain well managed.

The 5 indicators that need to be included by all Mental Health Trusts are shown below in turn.

1. Seven Day Follow Up

This refers to the percentage of patients on the Care Programme Approach (CPA) who were followed up within 7 days after discharge from mental health inpatient care during the reporting period.

Results:

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	target	
score	98.9%	97.8%	98.7%	98.6%	97.3%	98.3%	100%	98.7%	95%	

We consider that this data is as described for the following reasons:

- It has been subject to external audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager
- We have taken the following actions to improve this score – and so the quality of our services
  - Performance continues to be closely monitored by our Managing Directors
  - Individual cases are highlighted by the performance team to the relevant service whose manager takes the necessary actions to ensure follow up

We are happy with our performance in this area which shows consistent achievement of the standard of 95%. We see this area as extremely important in terms of patient safety, including prevention of suicides – knowing that these days are crucial for those who have felt depressed and possibly suicidal.

2. Crisis Resolution and Home Treatment

This refers to the percentage of admissions to acute wards for which the Crisis Team, (known in this Trust as the Crisis Assessment and Treatment Team – CATT), acts as a gatekeeper. Gatekeeping by the RAID (Rapid Assessment Interface and Discharge) Service, which assesses people with mental health problems in Hertfordshire's two Acute Hospitals, is also included in this definition.

Results:

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	target	
score	100%	100%	100%	100%	100%	99.6%	100%	99.5%	95%	

We consider that this data is as described for the following reasons:

- It has been subject to external audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager

We have taken the following actions to improve this score and so the quality of our services:

- Performance continues to be closely monitored by Managing Directors

Performance has been consistently good with complete achievement of the standard of 95%. We see this as another key area of acute care, making sure that our crisis teams do good assessments of individual risks and provide care and treatment at home to those for whom this is clinically appropriate.

3. Readmission Rates

This refers to the percentage of patients readmitted to a hospital that forms part of the Trust within 28 days of being discharged from a hospital that forms part of the Trust.

In HPFT we concentrate on using our own data to track readmission rates for acute inpatient units only. We measure readmission within 30 days.

Results:

	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	target	
score	4.4%	6.3%	10.7%	6.0%	6.8%	4.8%	7.5%	

Overall we achieved a rate of 7.12%, so were successful in keeping below the target figure of 7.5%. It is very important to us to support people well in the early days and weeks after discharge so that they can progress at home; but because we provide an acute care pathway which offers

more than inpatient care, we do not always see it is a failure if someone moves for a short period from acute day treatment to inpatient care and back again as long as that is what they need and want.

We consider that this data is as described for the following reasons:

- It has been subject to internal audit in the past, and we have acted on the advice from such audits
- We have internal data quality controls with random checks by the responsible manager

We have taken the following actions to improve this score and so the quality of our services:

- Performance is closely monitored by senior managers especially those responsible for acute inpatient care where length of stay tends to be the shortest
- On acute units we have introduced daily checks with regard to the readiness for discharge of each inpatient, and new posts to facilitate and support service users in making this move; this remains a priority area in 2015/2016.

4. Service User Experience of Community Mental Health Services

This refers to our score provided by the Care Quality Commission (CQC) with regard to a service user's experience of contact with a health or social care worker during the reporting period.

It is about whether the member of staff is felt by the service users responding to the national survey to listen carefully, take their views into account, and give them enough time. It also covers whether the service user has trust and confidence in staff and feels they are treated with respect and dignity.

It is taken from the National Service User Survey 2014 in which all Mental Health Trusts participated.

Results:

2012	2013	2014
8.6	8.5	7.6

This compares with the lowest 2014 score nationally by a Mental Health Trust of 7.3 and the highest of 8.4 and is rated as average.

A lower score indicates a lower level of service user satisfaction.

We consider that this data is as described for the following reasons:

- It derives from the national NHS community mental health service user survey which is administered independently of the Trust to national standards. This includes data collection and reporting.

The survey was sent to a sample of 850 people who had used our community services in summer 2013. There were 272 responses (a rate of 32%), with the Trust scoring in the "average" range for 7 of the 8 overall sections. Most of those responding were users of working age community mental health services, where disruption to services because of the major transformation in 2013/2014 had been considerable.

Steps to support the new ways of working – where there are fewer separate teams, fewer bases, and a different mixture of staff – have included:

- Sessions from staff with expertise in change management to enable new teams to develop effective teamwork
- Concentration on the screening role of the Single Point of Access service and on enabling service users to move on from Trust care when they are ready, so that the demand for services is better managed
- Introduction of an extra tier of managers to support the teams
- A range of initiatives to improve recruitment with new Recruitment Fairs, better publicity about HPFT and more support for new staff

5. Safety Incidents involving serious harm or death as a proportion of all patient safety incidents

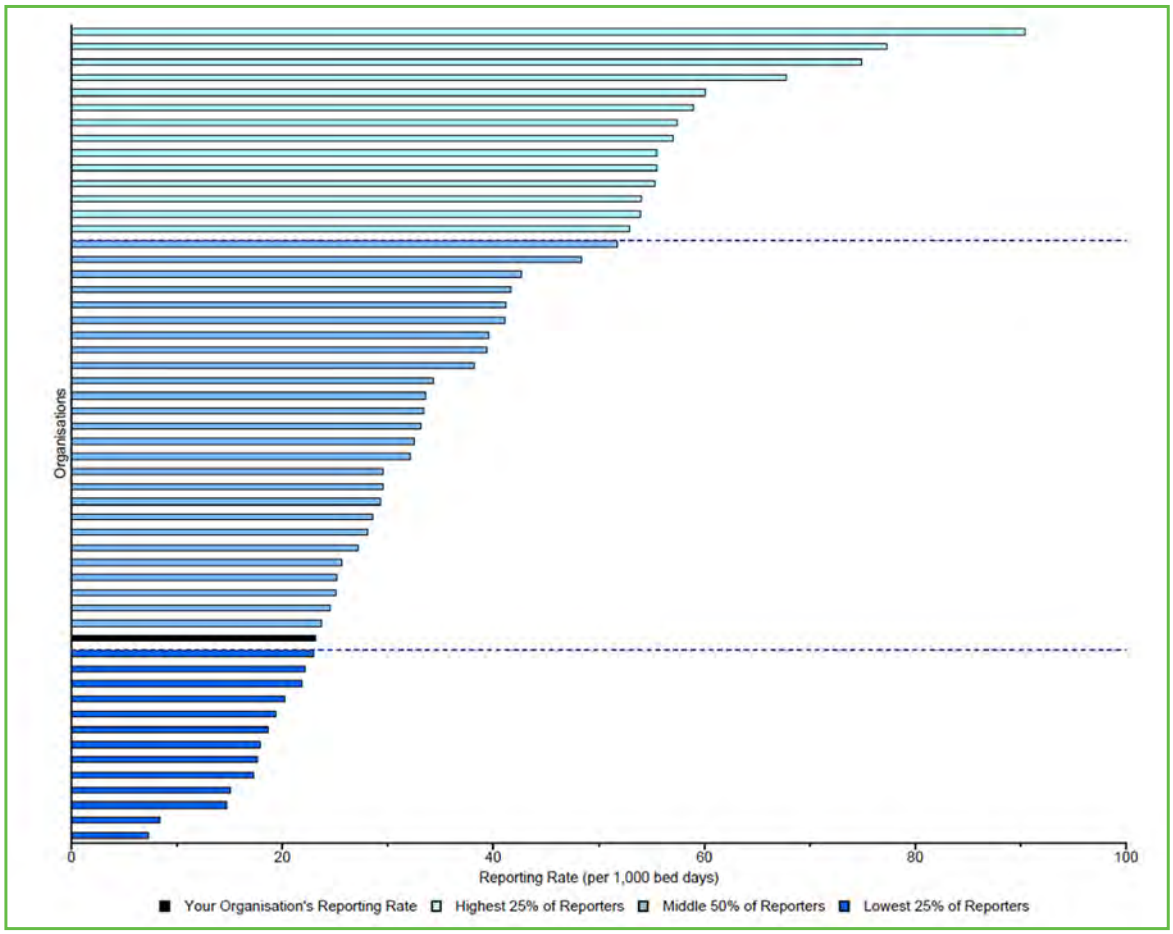
The information below is presented as required. It gives an overview of this Trust's number and type of reported incidents in the past year.

A. April 2014 - September 2014

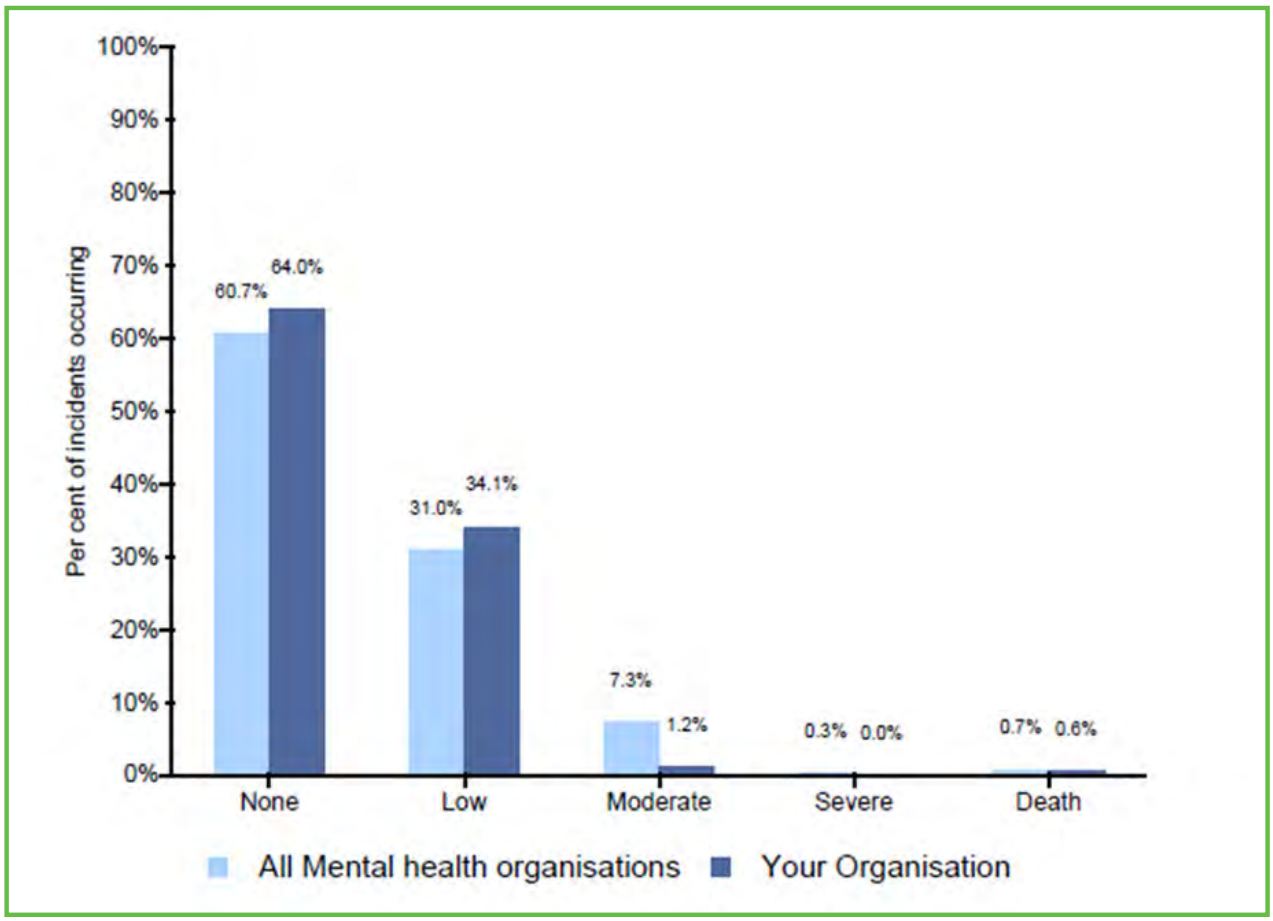
- 2,086 incidents reported by the Trust
- Rate per 1,000 bed days – 23.1
- Severe Harm – 1 incident reported
- Death - 12 incidents reported

The comparative reporting rate per 1,000 bed days for 57 mental health organisations during this period is shown below.

Figure 1: Comparative reporting rate, per 1000 bed days, for 56 Mental Health organisations.



For the same period, the incidents reported by degree of harm for mental health organisations is shown below.



- Highest reporting MH Trust – 5,852 incidents
- Lowest reporting MH Trust - 4 incidents
- Highest number of incidents resulting in Severe Harm - 41 incidents
- Lowest number of incidents resulting in Severe Harm - 7 Trusts reported no Severe Harm incidents
- Highest number of Deaths reported - 61 incidents
- Lowest number of Deaths reported - 3 Trusts reported no Deaths

It can be seen that we were a relatively low reporter of severe harm incidents and deaths in this period. The considerable variations in reporting between Trusts suggest that comparisons are hazardous as we may not be comparing like with like.

B. October 2014 to March 2015

The following information is provided on a provisional basis only, and should be treated with caution as it has not yet been validated by the National Reporting and Learning System (NRLS).

- 1,752 incidents reported by the Trust (as at 14/04/2015)
- Safety incidents involving severe harm (as a percentage of all patient safety incidents reported) – 0 (0%).
- Safety incidents involving death (as a percentage of all patient safety incidents reported) – 11 (0.6%).

Summary:

	April 14 to Sept 14	Oct 14 to Mar 15
Total patient safety incidents	2,086	1,752
Rate per 1000 bed days	23.1	Not yet available
Severe harm incidents as % of all	1 (0.05%)	0 (0%)
Deaths as % of all	12 (0.6%)	11 (0.6%)

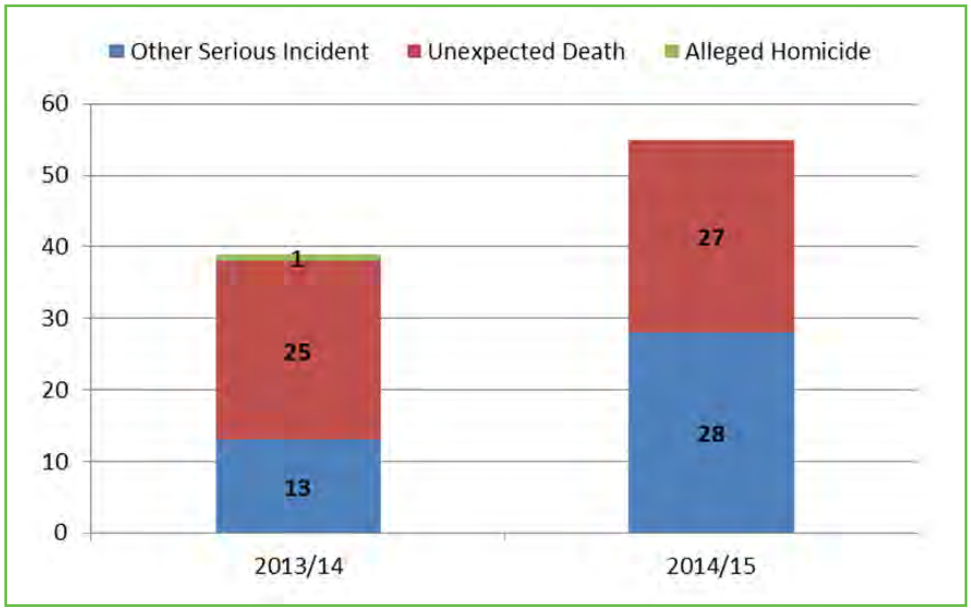
Overall, the Trust's reporting rate is generally within the middle 50% of Mental Health services reporters. This provides some assurance that our systems are consistent and reliable and that the Trust has an open reporting culture.

The NRLS system is about certain types of incident only; it does not include many of the Trust's incidents which occur in community settings.

In the past two years our pattern of serious incidents is as shown in the graph below. It can be seen that the number of unexpected deaths, is very similar in each year. It should be noted that some of these cases are apparent suicides but the number may reduce when the verdict is recorded at the coroner's inquest. One homicide was reported in 2013/2014 and no homicides were reported in 2014/2015.

There has been a significant increase in the number of other serious incidents reported in 2014/15 when compared to the previous year. This is in the main as a result of changes in the definition of a serious incident in the revised national guidance. The Trust is also committed to openness, transparency and using the opportunity to learn from serious incidents. The other cases have included falls resulting in fractures, infection control outbreaks, safeguarding incidents and some disciplinary matters.

By reporting and investigating all types of serious incidents it has enabled us to examine and improve practice in these areas by creating an improved awareness of falls risk and falls prevention primarily on older people's inpatient units, and an increased awareness in Child and Adolescent Mental Health Services, and the wider Trust, on thresholds for reporting allegations of historical child abuse.



Our overall aim remains to be a good reporter of all incidents (from which we can always learn), whilst reducing serious incidents with an aspiration to reach zero suicides per year by 2018/2019.

To that end, we are involved in two key patient safety projects; **Sign up to Safety** a NHS England safety initiative which aims to deliver harm free care for every patient and supports staff to improve the safety of patients and **Safer Care Pathways in Mental Health** a two year project to support clinical teams with care pathway improvement in mental health care, funded by the Health Foundation.

We are also co-ordinating another project – **Spot the Signs: Save a Life** – funded by East and North Herts CCG, where we have organised training for over 100 primary care staff including GPs this winter in detection of depression and suicidal thoughts, as part of an initiative to raise awareness of suicide in Hertfordshire, especially among males aged 40 to 65.

It can be seen that our approach to patient safety in all its forms is to combine staff with expertise in assessing and managing clinical risks when they find them, with systems that are safe and supportive to operate within – for staff, service users and carers alike.

4.4. Statements of Assurance

4.4.1. Review of Services

During 2014/2015 the Trust provided 18 services with their own specification in the contract with commissioners.

In compiling this quality account, the Trust has reviewed all the data available to it about quality of care across all services. This has been done in terms of the three domains of quality – safety, clinical effectiveness and service user and carer experience – but also with a focus on staff measures. There was enough information for this to be done across the whole Trust.

The income generated by the NHS services reviewed in 2013/2014 represents 100% of the total income generated from the provision of services by the Trust in this period.

4.4.2. Clinical Audits

National Audits

During the year, three national clinical audits and one national confidential enquiry covered the services that we provide.

In this period, we participated in 66% (2 of 3) of relevant national audits and 100% (1 of 1) of relevant national confidential enquiries.

The audits and enquiries that we were eligible to participate in during the year are as follows:

- POMH UK Topic 14a: Prescribing for Substance Misuse (Alcohol Detoxification)
- POMH UK Topic 12b: Prescribing for Personality Disorder
- POMH UK Topic 9c: Prescribing for People with a Learning Disability
- National Confidential Enquiry into Suicides and Homicides

The audits and enquiries that we did participate in during the year are as follows:

- POMH UK Topic 12b: Prescribing for Personality Disorder
- POMH UK Topic 9c: Prescribing for People with a Learning Disability
- National Confidential Enquiry into Suicides and Homicides

We did not participate in the national audit of prescribing for substance misuse because we no longer provide stand-alone substance misuse services.

This year, as previously, we have made sure we contribute data fully to the National Confidential Inquiry into Suicides and Homicides and have received our own report which allows us to compare our performance with other Trusts.

In most respects we are close to average, but we are different from the average on two points:

Indicator	HPFT	National average
Proportion of suicides by those under care of the mental health service	15%	27%
Proportion of suicides under mental health service where last contact was within 7 days	53%	49%

This information can be interpreted in various ways. We are encouraged that we have a good record in keeping Hertfordshire residents safe. We also share the second figure with staff, telling them that they seem to be focussing their efforts on those who are most at risk, whilst reminding them of the privileged opportunity they have to intervene to prevent a suicide in many cases because they are so closely involved.

It should be noted that this information refers to the period 2002 to 2012 so does not reflect the position now.

Spot the Signs: Save a Life Campaign – St Albans Market Place, February 2015

Prescribing Observatory for Mental Health – UK (POMH – UK)

Our participation in these audits is shown below.

The Topic 12b report findings have been reviewed by us during the year and we will take the following actions:

- Ensure that good results are widely shared so that all teams achieve equally high standard
- Examine whether prescribing is complementing psychological therapies effectively so that admissions to acute inpatient care are prevented wherever possible

Our results were above the national average as shown below:

	HPFT compliance rate	National compliance rate
Audit standard 1	80%	70%
Audit standard 2	85%	80%

This means that our prescribing of benzodiazepines and sedatives was more controlled and clinically appropriate than the national average.

Topic 9c data is still being analysed nationally.

Topic	Trust Participation		National Participation	
	Teams	Submissions	Teams	Submissions
Topic 14a: Prescribing for Substance Misuse (Alcohol Detoxification)	0 Teams	0 Submissions	174 Teams	1197 Submissions
Topic 12b: Prescribing for Personality Disorder	12 Teams	136 Submissions	522 Teams	4014 Submissions
Topic 9c: Prescribing for People with a Learning Disability	19 Teams	359 Submissions	TBC	TBC

National Audit of Schizophrenia

Although we participated in this audit in 2013/2014, we received the results in late 2014 and have since published our action plan.

This assessed the quality of care for people with schizophrenia across a number of domains including service provision and experience, physical health and prescribing practice.

Findings: Monitoring of physical health risk factors was above average. Availability and uptake of psychological therapies, as well as prescribing practice were average. Reports from service users saying they received a psychological intervention were below average.

Some more detailed results are shown below:

NAS standard	HPFT	national
S14 a) CBT has been offered to all Service Users b) Family intervention has been offered to all Service Users who are in close contact with their families	 45-50% (above average) 25-30% (above average)	 40% 20%
S15 Each Service User has a current care plan	100% (above average)	95%
S16 Each Service User knows how to contact services if in crisis	80-85% (above average)	70-75%

Actions:

- Educate service users on what psychological therapies are available. The psychology lead for the targeted treatment teams will ensure all patients in contact with the team will receive a leaflet outlining what psychological services are available by June 2015.
- An HPFT psychologist will deliver training to community teams in the Trust on psychological interventions for psychosis by June 2015.
- Physical health training for nursing staff – a series of training sessions have been organised by the training department.
- The medicines management department will organise training for community teams in HPFT on obtaining medicines information by June 2015.

Local Audits

The formal Clinical Effectiveness Programme which contains 440 audits completed 37, with three being withdrawn in the year.

A further approximately 40 local audits have been completed during the year.

The reports of these 77 audits were reviewed by the Trust during the year. Examples of actions taken are shown below.

Audits both local and wider have produced examples of excellent practice which have given considerable assurance to senior clinicians and managers with regard to the quality of services.

Positive results have been found in areas as diverse as timely and accurate GP letters after psychiatric outpatients appointments, use of the nutrition and dysphagia screening tool on inpatient units, NICE compliant practice with regard to the treatment of epilepsy in adults with learning disability, and high quality care in the Specialist OCD Clinic.

Audits have often been effective as a quality improvement tool; for example audit confirmed a concerning position with regard to completion of risk assessments last Autumn, this led to a major project which has achieved a rate of 87% completion at the end of the year

All – whether local or on the programme – are subjected to the same scrutiny at the Practice Audit Implementation Group– where each audit is approved if it reaches an acceptable standard and then decisions are made about who needs to know about the results.

We ensure that local audits have areas of priority for the Trust as their subject; this year this has meant a good range of audit evidence around topics such as timeliness of GP letters, physical health checks and discharge notifications and summaries

The following audit reports caused some concern during the year and results were shared with commissioners:

- **CAMHS Response to Missed Appointments**

  In 2013 the Trust audited practice around the responses of CAMHS clinic staff when children and young people do not attend appointments. Results were uneven and were shared with commissioners because of the potential patient safety issues. It was agreed to complete the audit cycle by making some changes in policy and practice and then re-auditing this year.

  The Trust policy was duly revised with acknowledgment of the sensitive confidentiality issues for young people and the need to take further steps only where current clinical risks had been identified. CAMHS staff were made aware of the revised procedures, and their importance.

  The re-audit did not show significant improvement. The Senior Management Team was engaged in agreeing a stronger set of actions which included reducing DNAs through “assertive calling” in SPA once a first appointment has been sent.

- **Discharge Notifications and Discharge Summaries**

  Good communication of key clinical information for each service users discharged from inpatient care is an essential aspect of discharge planning and support to GPs.

  The 2014 re-audit found improvement in all areas compared to the previous audit, but room for more. The relevant Clinical Directors were involved in agreeing actions for improvement and it is expected that this will be included in a CQUIN Goal in 2015/2016 so that improvements are first made and then sustained.

National Accreditations and Quality Networks

Our record is reported here by HQUIP. We very much value these chances to share our practice with others and to adopt these nationally recognised quality standards in several of our services.

Often there is considerable preparatory work before formal accreditation begins. This is the case for us with ECT Accreditation, where now that our whole ECT service is on one site at Kingfisher Court we are undertaking our own audit before applying for accreditation.

	Trust Participation	National Participation
Service Accreditation Programmes and Quality Improvement Networks		
Eating Disorder Inpatient Wards	0 wards	36 wards
Forensic Mental Health Units	3 services	110 services
Inpatient Child and Adolescent Wards	1 wards	120 wards
Inpatient Rehabilitation Units	0 wards	45 wards
Learning Disability Inpatient Wards	0 wards	20 wards
Mother and Baby Units	1 units	15 units
Older Peoples' Inpatient Wards	1 wards	54 wards
Psychiatric Intensive Care Wards	2 wards	37 wards
Working Age Inpatient Wards	0 wards	163 wards
Child and Adolescent Community Mental Health Teams	0 teams	56 teams
Crisis Resolution and Home Treatment Teams	0 teams	36 teams
Electroconvulsive Therapy Clinics	0 clinics	82 clinics
Memory Clinics	4 clinics	91 clinics
Perinatal Community Mental Health Teams	0 teams	20 teams
Psychiatric Liaison Teams	2 teams	57 teams

In a recent article for her SBU's Sharing Good Practice newsletter Dr Ann Roberts Consultant Psychiatrist wrote about her experience of accreditation at the Mother and Baby Unit:

"Thumbswood is currently accredited by the Royal College Perinatal Quality Network and is due a re-accreditation visit on 17 April 2015. Re-accreditation visits occur every three years and peer review visits occur annually between the accreditation visits.

We would not exist without accreditation since we are dependent on national Specialist Commissioning which in turn is dependent on us being accredited.

The Perinatal Quality Network has over 300 national standards against which Thumbswood Mother and Baby Unit and all other MBUs in the UK are assessed.

The standards are in the areas of access and admission, environment and facilities, staffing, care and treatment, information confidentiality and consent, rights and safeguarding, audit and policy and discharge. Prior to the visit we provide information on all these aspects of care and then the whole day visit takes place.

While some people may view this process as challenging and critical, we have embraced it and used it to continually review and improve our service and the care we provide. As a result, we have improved our staffing ratios, recruited a psychologist, nursery nurse and music therapist and improved the environment. We have encouraged ex and current service users and their partners and relatives to be part of the process.

Being part of the Perinatal Quality Network enables all senior staff to visit other Mother and Baby units as part of their peer review and accreditation process. We learn a huge amount from these visits which we can embed in our own practice to improve the care for our mothers and babies.

Thumbswood firmly believes in the principle of 'Doing the Basics Well'. This includes having an open, honest, collaborative approach to care, involving partners and family as much as possible and respecting each person's role and expertise. Everything leads from this resulting in a ladder to excellence. Here are a few examples of what we have done to provide better care for our mothers and babies. Most of these are very simple and simply require organisation and a will to implement rather than more staff or money.

All this has helped us to feel very proud of what we do and privileged to be able to care for women at a most vulnerable and challenging time of their life. I hope we remain humble enough to realise that we sometimes get things wrong and can still do better. Our accreditation visit will inform us of the areas in which we have to improve."

Thumbswood – Sensory Room

4.4.3. Research and Development

The Trust R&D Department has expanded over the last year as a result of increased network funding and several successes with grant applications.

In April 2014 HPFT moved from the Hertfordshire and Essex Comprehensive Local Research Network (CLRN), to the much larger Eastern Clinical Research Network (CRN). CRN Eastern is funding 3 consultant research sessions (one in Old Age Psychiatry, one in Learning Disability and one in Obsessive Compulsive Disorder) and also provides a full-time Clinical Studies Officer to the Trust R&D Department to facilitate recruitment of HPFT service users into UK CRN portfolio studies. These are the research studies that are recognised as being of national priority within the NHS.

The number of service users receiving Trust services provided by us during the year that were recruited during this period to participate in research approved by a research ethic committee was approximately 190. Many of the studies are quite complex and involve long-term interventions and follow-up. This is an increase on our previous year's recruitment to portfolio research and means that we will retain the current level of CRN support and funding into 2015/16.

We also had a number of smaller-scale studies running, including projects that have been carried out as part of clinical doctorates and other post-graduate qualifications. Some of these smaller studies involve service users but many involve Trust staff and services. All research studies involving our service users have full ethics and R&D approval, and are routinely monitored by the Trust R&D Department and R&D Committee.

HPFT has a strong track record of success with National Institute of Health Research (NIHR) Research for Patient Benefit (RfPB) grants. In the past year we have just completed an NIHR-RfPB funded Evidence Synthesis Project on behavioural problems associated with dementia. This was a collaborative study with colleagues at The University of Hertfordshire and involved an extensive literature review, and multi-stage consultation with our staff, service users and carers. We expect the results to be published in the forthcoming year.

We also began work on 3 new NIHR-RfPB funded studies, all in which HPFT is the sponsor and lead clinical site. The first one (OTO) is a feasibility study comparing pharmacological and psychological approaches, both separately and in combination, in the treatment of Obsessive Compulsive Disorder in adults. The second is a randomized controlled trial of a personalised psychological intervention for people with learning disability who would benefit from reducing their alcohol intake. The third is a randomized controlled study of a new educational aid (Books Beyond Words) which is targetted at service users with learning disability who suffer from epilepsy. Recruitment to all three studies is still open and much more detailed information about them can be found on the Trust website or by contacting the Trust R&D Department.

We are also very pleased that two new funding applications to NIHR-RfPB have also been successful and we are finalising details of these before the funding contracts are signed. The first of these will look at the relationship between autism and forensic mental health problems, with particular emphasis on the relationship between subtypes of autistic spectrum disorder, care pathways and outcomes. The second will be a randomized controlled trial of a new mentalisation-based family support therapy for foster carers and looked-after children within CAMHS. Being the sponsor for these NIHR-funded studies generates additional Research Capability Funding for the Trust R&D Department and brings prestige to the Trust.

A recent research initiative in Older Peoples Services, which has led to the development and feasibility assessment of a first aid course for carers of people with dementia, has been shortlisted for a British Medical Journal (BMJ) Award. We will be undertaking more extensive work to look at the longer term benefits to carers who attend such a course over the coming year.

In HPFT we are keen that all staff interest themselves in evidence-based practice and in understanding better the nature of the psychiatric disorders that trouble service users. R &D is seen as playing a small but significant role in promoting this culture, as well as providing staff with the opportunity to stretch the frontiers of knowledge themselves.

4.4.4. Commissioning for Quality and Innovation (CQUIN)

2.5% of our income in 2014/2015 was conditional on achieving quality improvement and innovation goals agreed between us and our commissioners, through the CQUIN payment framework.

We have CQUIN goals with all our commissioners – local and specialist – but the one with our two Hertfordshire CCGs is the most significant. Details of this are shown below.

CQUIN Table: Summary of goals

	Name	Description	Weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain (Safety, Effectiveness, Patient Experience or Innovation)
1	Friends and Family Test	mandatory	15%	£448,650	Patient Experience
2	NHS Safety Thermometer	mandatory	5%	£149,550	Safety
3	Improving diagnosis in mental health	mandatory	20%	£598,200	Effectiveness
4	Dementia	Use of the dementia challenge toolkit to improve quality of care	15%	£448,650	Patient Experience
5	CAMHS	Improving access to CAMHS services	15%	£448,650	Patient Experience
6	Green Light toolkit (2 years)	Improved access to mental health services for people with learning disabilities	15%	£448,650	Patient Experience
7	Values and Behaviours	Developing a workforce whose values and behaviours ensure the highest quality of care	15%	£448,650	Innovation
		Totals:	100.00%	£2,991,000	

Achievement of all these goals has been a high priority; several also feature as Quality Account indicators.

Income conditional on achievement of these goals is £2,991,000. We achieved £2,739,008 – 92% of the total available.

4.4.5. Care Quality Commission

We are required to register with the Care Quality Commission and our current registration status is “fully registered without conditions”. This has been the case throughout the year.

The CQC has not taken enforcement action against us throughout the year.

We have not participated in any special reviews or investigations by the CQC during this period.

We have continued to receive Mental Health Act Commission inspection visits and have a robust process in place for responding to any recommendations that are made.

At the end of April we had a full CQC inspection following the new comprehensive model. In the latter months of 2014/2015 this gave us an added incentive and framework to check the quality of care we provide using the Key Lines of Enquiry headings of “Safe, Effective, Caring, Responsive, and Well-led”.

We have also made careful use of the Quality and Risk Profiles and more recently the Intelligent Monitoring Reports to test out our internal view of the quality of services.

Big Listen – April 2015

4.4.6. Information Governance

We submitted records during the year to the Secondary Uses service for inclusion in the Hospital Episodes Statistics which are shown in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.3% for admitted patient care
- 99.9% for outpatients

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 98.2% for admitted patient care
- 100% for outpatients

Our overall score for the Information Governance Assessment Report 2014/2015 was 79%. We attained Level 2 or above on all requirements.

We were not subject to the Payment by Results clinical coding audit during the year by the Audit Commission. We were audited in November 2014 by the London Clinical Coding Academy:

The results were:

- Primary Diagnosis Correct - 100%
- Secondary Diagnosis Correct – 97.65%

We will take action to improve data quality and clinical coding as follows:

- Continue to carry out regular clinical coding audits on the new electronic patient record system (PARIS).
- Continue to undertake an annual audit of clinical records keeping standards
- Continue to be involved in the development of PARIS to ensure clinical coding requirements are embedded.

4.5. Other Aspects of Quality

4.5.1. Trust Services

In this section, further information is given about quality of care by service.

Child and Adolescent Mental Health Services have had a very busy year. In the Specialist CAMHS Clinics there has been a particular push this year to improve access (see D. above).

Results were as follows:

	Target (proportion of referrals to which we respond in the given time)	Q4	Result
Access in crisis within 4 hours of referral	90%	95.6%	
Urgent access within 7 days of referral	75%	92.1%	
Routine access within 28 days of referral	75%	87.9%	

We feel strongly that there is no point having good services if they are not easily available when needed. We are very proud of these results which we believe are hard to beat on a national scale.

Our adolescent inpatient unit at Forest House, Kingsley Green has had a tough year now that it is subject to specialist commissioning, which means that it provides inpatient care to young people from much further afield than just Hertfordshire. The worrying increases in demand for CAMHS care nationally, combined with a historical lack of investment in services and a national shortage of inpatient beds have been reflected in the pressures on Forest House.

We are grateful that local commissioners have recognised these pressures and provided some new funding which has enabled us to set up a new Crisis Service for those most urgently in need.

Mental Health Services for Older People have seen a great deal of change. We now have fewer separate teams in the community services, but the same functions which are now operating more efficiently. For example our Intensive Outreach Teams have been disbanded, but we are now able to see older people in urgent need more quickly than before.

The Early Memory Diagnosis Assessment and Support Services (EMDASS) have experienced very high demand, which means that at the end of the year waiting times were too long with around 60% of those referred waiting more than 6 weeks. We have made proposals to GPs and commissioners about how this can be improved.

Our new Deputy Director of Nursing and Deputy Director Safer Care are having a significant impact on the quality of nursing care for older people on inpatient units. Care standards for falls and pressure ulcer prevention have been driven up through training and strong leadership.

Many aspects of community mental health services and acute mental health care have been noted elsewhere in this account. We are proud of the alternatives to admission that we can offer such as the Acute Day Treatment Units now based in Hemel and Stevenage, and the host families scheme. But for each month in 2014/2015 there was some non-HPFT bed usage, meaning that there was not always an inpatient place available for Hertfordshire residents when they needed it. This illustrates the pressures the service has been under. A range of initiatives are underway to improve the capacity and efficiency of the acute services so that everyone who needs it can access acute care in a timely fashion.

Kingfisher Court has taken more than four years of designing and planning by staff, service users and carers, an investment of £42million and is a fantastic achievement for the Trust. In November 2014, the final three wards, Owl, Robin and Dove, opened with service users being transferred from inpatient units in Watford and the QEII Hospital in Welwyn.

The design of Kingfisher Court drew upon international best practice to create a therapeutic environment to support people in their recovery from mental illness and people with a learning disability. The building has been highly praised by visitors, including leaders in mental health in England and overseas, and the former Deputy Prime Minister Nick Clegg who visited the facility after the first two wards had opened. In May 2015 Kingfisher Court was named Project of the Year at the national Design in Mental Health Awards Ceremony, with particular praise for its visual impact and the team work shown by the many staff and agencies involved in the project.

In community services, we have concentrated on core aspects of care such as completion of risk assessments and CPA reviews, in a year when the new model of care has needed to become fully established. At times, in the face of increased demand for services, our capacity has been greatly stretched and there have been some teams where recruitment difficulties have exacerbated the problem.

In response to challenges in community mental health services, we have brought in extra managers to support teams in their effectiveness and begun to use the peer support worker and employment and accommodation worker posts to their full effect to help service users take more control over their own lives.

From April 2014, we have also worked with Hertfordshire County Council's Money Advice Unit to bring this support closer to community service users. Money advisors have operated through the year at our community bases helping people with problems with benefits and debt. This project began because of a recognition of the vulnerability to depression and even suicide for those experiencing financial difficulties because of the recession.

Movements into the new purpose-built hubs – culminating in the NW services moving to Waverley Road in St Albans in April - have helped service users and staff alike appreciate the investment in their well-being and provided premises to be proud of.

Kingfisher Court – Inner garden

In Learning Disabilities Services, as part of the National Transforming Care Programme (Improving the Lives of People with a Learning Disability), we have taken part in external care and treatment reviews to make sure that all those who are able to live outside a hospital campus are enabled to do so. The 23 reviews so far in the Specialist Residential Services at Kingsley Green have gone well. Services have been deemed to be providing good, safe care, although we have been challenged with our social care colleagues to show more positive risk taking and care planning in our practice.

This review also included Lexden Hospital, Colchester. The review team's feedback about the management of a particularly challenging individual including these comments:

"Many thanks again for accommodating us for the Care and Treatment Review yesterday…The experience again was very positive and both the Independent Clinician and Expert by Experience asked me to feedback to the unit that the staff team should be commended for their commitment to the patient and the quality of support they provide. The Expert by Experience actually said "if my son had to go into hospital I would like him to go here!"

In Hertfordshire the IAPT service (now known as the Well-being Service) achieved its access targets, meaning that 4,902 people entered treatment during the year. In Mid Essex and North East Essex access targets were also achieved (1,517 and 1,418 people respectively entering treatment). This means that HPFT is now bringing psychological treatment to a considerable number of people each year who have not previously had a service.

Our reputation in this area helped us win the contract to branch out further and provide IAPT services from 1st July 2015 in West Essex also.

4.5.2. Safer Care – Other Issues

In March 2014, the Supreme Court made a ruling with regard to deprivation of liberty which changed the law. Like many other providers, HPFT was obliged to re-consider all current informal inpatients and determine whether they were being cared for under circumstances amounting to a deprivation of liberty under the revised test.

The Directorate Manager (Mental Health Legislation) co-ordinated this review of cases, which led to around 170 Deprivation of Liberty Safeguarding applications being made to the relevant supervisory bodies. Some DOLS assessments led to service users being deemed to be ineligible to be cared for under these safeguards, which meant that for their care to be provided legally they then required to be assessed under the Mental Health Act.

The Executive Team were assured that responsible managers reacted quickly to this rapidly changed legal context, and we moved to a position where care for each patient was provided lawfully and without undue disruptions or anxieties.

A second major area of service development in the year has been our response to the national strategy "Positive and Proactive Care: reducing the need for restrictive interventions (DH, 2014)." This challenged all care providers to reduce restrictive practices - physical Interventions (sometimes known as restraint), rapid tranquilisation and seclusion), so that they are only used as a last resort.

As a major provider of inpatient services for people with learning disabilities and challenging behaviour in three counties, we have very much welcomed this authoritative new guidance. We have developed it into our "Making Our Services Safer Strategy 2015 to 2017" and share our approach at regional and national events.

Our initiatives include:

- Restrictive Intervention Reduction (using Safewards – the nationally recognised set of tools developed at the Institute of Psychiatry)

- Development of Positive Behavioural Support Plans with service users with learning disabilities in bed-based units – so that their care is more sensitive to their needs and stressors as individuals

- Review of training under the heading "Respect" – so that service users in whatever setting and their carers can be confident that staff will all be trained in the most therapeutic and safe ways of preventing and managing challenging incidents, using evidence –based practice

- Review of our de-briefing support to staff – so that they are genuinely encouraged and supported in the difficult work that they do

- Data Informed Practice – so that we know if our practice is changing as it should and can see the effects

After one year we can see a reduction in the number of violence and aggression incidents reported in Quarter 4 to 445 from 783 in the previous quarter. These figures are also in keeping with National Staff Survey 2014 findings which identified that staff felt there was more training available in how to handle incidents of violence - and they also reported they had experienced less physical violence from service users, their relatives or other members of the public.

In 2015/2016 we plan to reduce such incidents by a further 10% and roll out Safe Wards across Inpatient Services.

In the area of Safeguarding, during the year we established a full team with Consultant Psychiatrist leads for safeguarding adults and safeguarding children separately. The CQC produced a wide-ranging report on Safeguarding Children inter-agency arrangements in March 2014. This prompted us to improve aspects of our recording of such activity and our supervision of this area of practice. Two actions are on record as not complete because we have decided to undertake a further audit of recording practice later in 2015 and the Lead Nurse (Safeguarding) will now be continuing her audits of samples of cases through 2015.

In safeguarding children, we have promoted to staff the importance of thinking hard about every disclosure (through supervision or expert advice if necessary), and considering not just the individual affected but others who may have been or may be at risk. Our numbers of safeguarding children referrals went up from 50 in 2013 to 88 in 2014 and now 115 in the first five months of 2015. We attribute this rise primarily to greater awareness of child abuse – especially historic allegations - amongst CAMHS staff after additional training.

4.5.3. Service User Experience

It seems fitting towards the end of this account to return to the service user experience and what we have done during the year to improve it. We know that each individual's experience of HPFT is different, and that there can be good and bad in each person's views of the Trust.

Our team that deals with complaints and Patient Advocacy and Liaison services (PALS) also leads on organising a range of other ways we can now hear from service users and carers about their experience – together called Having Your Say.

A short summary of this activity is as follows:

	Q1	Q2	Q3	Q4	total
PALS contacts received	138	138	148	138	562
Compliments received	304	308	267	383	1262
Complaints received	56	71	62	59	248
Service User HYS completed	821	906	719	713	3369
Carer HYS completed	111	96	72	137	416

IAPT services use the Patient Experience Questionnaire as their main source of feedback. For example, in Quarter 4 364 people completed the PEQ, with over 95% reporting that they were listened to and that their concerns were taken seriously at all times.

The overall figure of 248 is a slight increase on the figure for the two previous years where it was 232 each time. We cannot say whether this figure alone is a feature of an increased population serviced by the Trust, different thresholds for reporting complaints to the central office, or a higher rate of service user dissatisfaction.

At times, we have found that a relatively high rate of complaints is an indicator of a service under pressure. For example, the highest number of complaints were in the community mental health services. We know that historically this has not always been the case, even though they have the highest numbers of service users (apart from IAPT). Given the demand pressures on these services and the recruitment issues mentioned earlier, this complaints information confirmed our assessment that extra support was needed. Extra managers and practitioner posts have been created, alongside the other measures to help these services provide consistently good care.

HYS data is rich, with considerable numbers of responses and many comments made as well as boxes ticked. We are especially encouraged by the increase in carer responses in Q4.

Often we use this feedback data alongside other quality indicators about clinical effectiveness, incidents or staffing, to understand both where services are operating very well and where there are particular problems. When there are problems, sometimes the solutions lie in the suggestions we receive.

In Quarter 3 many units told us and their service users what actions they had taken in response to HYS. We were then able to shown that satisfaction rates in the following quarter as shown by HYS had improved considerably in those particular areas. Whilst we cannot prove a causal link, we see this as a very positive indicator of the value of service user feedback in directing us to where we can make further improvements in their experience.

Some examples are:

Team	Type	Action in response to HYS (Q3)	Change in score (Q4)	HYS question
Beech Unit	low secure mental health unit, Kingsley Green	Individual weekly cookery sessions introduced and table top activities and table tennis table bought	50% increase in satisfaction	Physical activities
Broadlands Clinic	Medium secure learning disabilities unit, Norfolk	Be more aware of need to use easy words as well as easy-read	83% increase	Do staff use easy words?
Hampden House	Inpatient rehabilitation unit, Hitchin	Use residents' meetings to encourage service users to engage in activities	14% increase	Physical activities
Oak Unit	Psychiatric intensive care unit, Kingsley Green	Ask individuals which activities they prefer. Use community meetings to ask for group activity ideas. Promote use of the gym.	21% increase	Physical activities
Owl	Acute inpatient unit, Kingfisher Court	Make best use of one to one time with service users Have regular discussions about care plans and provide copies	23% increase	Staff explain the service and how it will help me
Thumbswood Unit	Mother and baby inpatient unit, Kingsley Green	We will make sure we explain the service and how it will help you	37% increase	Staff explain the service and how it will help me

Part 5 – Final Notes

This report has been produced in accordance with the Quality Accounts Toolkit 2010-2011 (Department of Health 2010).

Other relevant documents are Quality Accounts: Reporting Arrangements for 2014/2015 (Department of Health 2015) and 2014/2015 Detailed Requirements for Quality Reports (Monitor, 2015).

The NHS Foundation Trust Annual Reporting Manual 2014/2015 and Monitor's 2014/2015 Detailed Guidance for external assurance on quality reports have also been sources of information.

The report is written to form the quality report section of the annual report and to be the Quality Account. We appreciate the feedback we have received from partner agencies shown in Appendix 3. We will show we have reflected this feedback in the final Quality Account when it is published in June.

Some acronyms are used, although they are avoided where possible. A glossary is to be found in Appendix 1.

Dementia Awareness Walk – October 2014

Appendix 1

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
AMH	Adult Mental Health
BMJ	British Medical Journal
CAMHS	Child and Adolescent Mental Health Services
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CEDS	Community Eating Disorders Service
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DOLS	Deprivation of Liberty Safeguards
EDS	Equalities Delivery Scheme
EMDASS	Early Memory Diagnosis and Support Services
EPMHS	Enhanced Primary Mental Health Services (IAPT)
FFT	Friends and Family Test
HoNOS	Health of the Nation Outcome Scales
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQUIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
HYS	Having Your Say
IAPT	Improving Access to Psychological Therapies
JCT	Joint Commissioning Team
LD	Learning Disabilities/Disability
MH	Mental Health
MHMDS	Mental Health Minimum Data Set
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder

PBR	Payment by Results
POMH UK	Prescribing Observatory for Mental Health – UK
Q	Quarter (3 month period)
R and D	Research and Development
RAID	Rapid Assessment Interface and Discharge
RfPB	Research for Patient Benefit
SBU	Strategic Business Unit
SPA	Single Point of Access
SSRI	Selective Serotonin Reuptake Inhibitor (a type of anti-depressant medication)
UK CRN	UK Clinical Research Network

Area		Indicator	Result	Baseline	Target	Q1	Q2	Q3	Q4	Year average
Safety	**1**	Rate of Service Users with a completed up to date Risk Assessment		60.0%	90% in Q4	66.9%	72.0%	81.7%	87.2%	n/a
	2	Rate of inpatients reporting feeling safe		81.0% (year average)	81.0% (year average)	74.5%	72.8%	79.8%		76.3%
	3	Delivery against 'Making Our Services Safer' CQUIN target		n/a	Achievement of CQUIN goal	n/a	n/a	n/a	achieved	n/a
Effectiveness	**4**	Waiting time targets as contractually defined for CAMHS		n/a	Achievement of CQUIN goal	n/a	n/a	n/a	achieved	n/a
	5	Rate of community service users saying the services they receive have helped them look to the future more confidently		56.0% (year average)	56.0% (year average)	50.9%	52.4%	54.8%	65.0%	56.6%
	6	Proportion of those on CPA for at least 12 months who had a CPA review within the last 12 months		n/a	95.0% in all quarters	97.1%	96.5%	95.6%	96.0%	n/a
Experience	**7**	Friends and Family Test (FFT) asking whether the service user would recommend the service to friends and family		n/a	61.8% (year average)	63.1%	58.2%	67.9%	78.0%	67.5%

Area		Indicator	Result	Baseline	Target	Q1	Q2	Q3	Q4	Year average
Experience	**8**	Rate of carers that feel valued by staff		78.0% (year average)	78.0% (year average)	68.3%	72.8%	84.1%	74.7%	74.3%
Staff	**9**	Staff Friends and Family Test (FFT) -staff saying they would recommend Trust services to friends and family if they needed care and treatment		57.8% (year average)	61.0% (year average)	68.9%	63.2%	60.0%	58.3%	63.5%
	10	Staff Friends and Family Test (FFT) – "Staff saying they would recommend the Trust as a place to work"		43.2% (year average)	45.0% (year average)	50.7%	45.2%	47.0%	44.9%	47.2%
	11	Rate of staff reporting feeling engaged and motivated at work		49.5% (year average)	49.5% (year average)	49.3%	44.2%	45.0%	46.6%	46.2%
	12	Rate of staff that report experiencing physical violence from service users		13.4%	less than 12%	14.0%	8.1%	7.0%	3.9%	n/a
	13	Rate of staff that report having access to relevant training and development		79.8%	79.8%	72.0%	58.7%	52.0%	58.3%	61.1%

Appendix 3: Statements from Partner Agencies

3.1. Lead Commissioners

Hertfordshire Partnership University Foundation NHS Trust Quality Account Statement from Herts Valleys CCG & East and North Herts CCG

Both Herts Valleys Clinical Commissioning Group (HVCCG) and East and North Herts Clinical Commissioning Group (ENCCG) have considered the information provided in the Quality Account. We believe the information is a true reflection of the Trust's performance during 2014/15, based on the data submitted during the year as part of the on-going quality monitoring process.

Firstly we acknowledge the positive achievement of the Trust in achieving six of the local Quality Indicators in 2014/15. The three areas not achieved (concerning inpatients feeling safe, staff feeling engaged and motivated at work and staff accessing relevant training and development) echo some of the areas where commissioners consider more work is required. In addition the Hertfordshire target for service users with an up to date risk assessment is 95%, higher than the overall target of 90% set out in the quality account and so this target was not met for Hertfordshire. The reduction in the rate of carers who feel valued by staff is also a concern and we expect this to be a key area of attention in the coming year. Whilst we support the Trust ambition to make improvements across a broad range of quality areas we would recommend a focus on fewer areas to ensure there is sufficient focus for these to be achieved.

The opening of Kingfisher Court in 2014 has dramatically improved the environment for people accessing inpatient care and we welcome the Trust's continued investment in other sites around Hertfordshire as well. We look forward to seeing the full year impact of this investment on service user and carer experience, on indicators such as the Friends and Family test and more inpatients feeling safe. As set out in the report one key area for commissioners is for HPFT to improve the physical health of people experiencing mental ill health and whilst considerable progress was made in completing physical health checks in 2014/15, there is more to do in 2015/16.

The lack of avoidable pressure ulcers reported during the year is extremely pleasing. We have been impressed by the work within the Trust on reducing physical violence against staff and the reduction seen is to be commended, as evidenced by Trusts' success at the National Patient Safety Awards.

In mental health community services the Trust has made extensive changes to team structures in the year and there have been some implementation issues which the Trust has shared with commissioners promptly. Recruitment and retention within these teams is a concern we share with the Trust due to the impact on service users and carers and we welcome the acknowledgement of these issues in the Quality Account. These issues are reflected in the Trust's feedback from staff in the National Staff Survey and Staff Friends and Family test where commissioners share HPFT's view that improvement is essential.

The results of the CQC Community Mental Health survey were also disappointing. We continue to work with the Trust to mitigate these issues and this is a CQUIN goal for the Trust in the coming year. The initiatives the Trust have developed to reduce suicides are also valued, particularly as these come against a backdrop of an increase in suspected suicide rates, albeit from a low base.

We are pleased that the Trust has made considerable progress in delivering IAPT to substantially more people across Hertfordshire than in previous years and will continue to work closely with the Trust to focus on both maintaining this progress and in delivering excellent recovery rates and we would expect a focus on Hertfordshire within quality priority 7, as well as the Trust's Essex services. Consistent achievement of targets for initial contact and treatment starts will assist this.

Within Learning Disability services we appreciate the Trusts plans to develop measures to monitor progress against Transforming Care.

Across Hertfordshire the Health and Wellbeing Board has commissioned a review of Child and Adolescent Mental Health services. The outcomes of the reviews will be considered by the Trust, along with other stakeholders early in 2015/16. Support for children and young people with mental health issues is a concern for all Health and Wellbeing Board partners and will require more work across all organisations. We acknowledge the Trust's improvement in initial waiting times within CAMHS in 2014/15 and the commitment to continuing to improve these, alongside a need to reduce waiting times for treatment after the initial assessment.

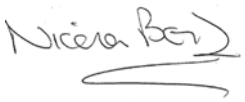
The Trust's Patient Safety team have been through a period of change but as the year has gone on commissioners have seen a noteworthy improvement in Root Cause Analysis reports with more robust Action Plans and greater sharing of learning across the whole organisation, however there is further improvements to make. The section in the report on Patient Safety would be strengthened by greater detail on the types of Serious Incidents reported by the Trust and the key actions and learning resulting from these. Reporting on the NRLS system remains within the middle 50% of Trusts but has declined from 2013/14 so should be monitored closely within the Trust in the coming year.

We welcome the summary of audits provided in the Quality Account and the learning from these. We are disappointed that a similar summary of feedback from complaints and compliments and the changes the Trust has made as a result of the learning from both these elements of feedback has not been included as this is key information. Whilst we know the outcomes of the Francis and Berwick reports have been considered by the Trust the actions taken as a result are not specifically mentioned in the Quality Account and a section on this would strengthen the report.

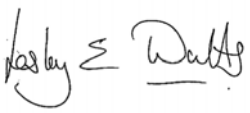
The Quality Account would be strengthened further if, where a quality priority was not met, the Trust provided more detail on the reasons for this and the actions being taken to deal with this. More benchmarking data and greater triangulation of data would also strengthen the report. Detail on areas where the Trust has experienced difficulties in year would be welcomed in order to provide a totally balanced picture.

Commissioners would also have expected to see sections in the Quality Account on safeguarding both children and adults as both continue to be areas where the Trust has experienced challenges in the year. For children in particular a summary of the Trust's response to the whole system CQC inspection published in March 2014 should have been included. The impact of the Cheshire West ruling on Deprivation of Liberty Safeguards (DoLS) has also been significant for the Trust and many other organisations and a summary of the Trust's response to this would be valuable.

We look forward to continuing to work closely with HPFT to further improve the quality and safety of the vital services they provide for the people of Hertfordshire over the coming year.



Nicola Bell
Accountable Officer
Herts Valleys CCG



Lesley Watts
Chief Executive
East & North Herts CCG

Note
In response to the above feedback, the following additions have been made to the account:

- Paragraph 10: a section on serious incident types has been added on page 28.
- Paragraph 11: a section on learning from complaints has been added on page 42
- Paragraph 17: a section on Deprivation of Liberty safeguards and safeguarding has been added on page 44

3.2. Hertfordshire Healthwatch

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Account 2015

Healthwatch Hertfordshire (HwH) is pleased to submit a response to HPFT's Quality Account which is a clear and accessible report. It is evident that the Trust has used its extensive consultation methods and outcomes of last year's priorities to identify priorities for the coming year.

In general the most relevant aspects have been identified, though we feel that more emphasis should be placed on the Child and Adolescent Mental Health Services (CAMHS) as a whole, in response to the current major national and local reviews of this service and the need for substantial improvement all round in its effectiveness.

CAMHS has been subject to a major review this year, led by Hertfordshire County Council (HCC) Public Health, and has shown some impressive improvements already as a result of previous Scrutiny and reviews, specifically in terms of access times post-referral. However, this whole service requires a major focus in the coming year to provide the full range of reorganised and service-user focused services needed for this age cohort.

The reports on last year's performance are appropriately reflected in the selection of priorities for this year. The progress on Kingsley Green and Kingfisher Court within it are commendable, although the challenging issue of public transport services to it is still not resolved. There is also no further information on the proposed development of general housing on the site to support the original concept of the facility being located in a community rather than on a separate specialist site, which would provide a much better and more normalising environment for resident and visiting service users.

Staff morale, recruitment, training and retention is clearly a vital aspect of overall performance. It is still a priority, but needs to be very high on the list of matters requiring resolution and improvement this year.

Tier 4 provision at Forest House is a concern, not so much for performance, but because of its becoming a nationally commissioned resource, rather than a local one. This reduces the capacity to provide for increased Tier 4 need locally. We await the outcomes of the National and local reviews of CAMHS on this issue.

HPFT has demonstrated that they have involved a wide variety of people and organisations to produce the Quality Account. Consultation with the Service User Council, Carer Council, Healthwatch Hertfordshire and the Transformation Stakeholder Group is robust, open, regular and respected. Their members are consistently communicated with and HPFT Governors meet regularly and communicate with members.

The Equalities Unit liaises well with representatives from all these groups to help meet equalities targets. Representatives are members of the HwH Mental Health and Learning Disabilities Service Watch Group and attend regularly.

There has been considerable development in services for older people and, in particular, the collaboration between HPFT, HCC, the Clinical Commissioning Groups, community organisations

and the Alzheimer's Society and its Dementia Friends initiative, has begun to enhance and broaden the range of provision and community support for this age group.

We are also pleased to see that the lives of people with learning disabilities have benefited from the scheme to enable them to live well in the community, rather than in residential care.

We congratulate the Board for winning the Board Leadership Award at the Health Service Journal awards ceremony. HwH is also pleased to have supported HPFT with the Patient Led Assessment of the Care Environment (PLACE) audits in 2014 (and currently in 2015) and commended the Trust on the way it carried out the 2014 assessments and the improvements resulting from these inspections.

HwH is pleased that the Trust meets with us on a regular basis and keeps us informed of developments and issues. HwH looks forward to working with HPFT in the coming year to support further quality improvements.

Michael Downing, Chairman Healthwatch Hertfordshire, May 2015

3.3. Hertfordshire County Council Health Scrutiny Committee

Chairman
Health Scrutiny Committee

Seamus Quilty
County Councillor
Bushey South

County Hall
Postal Point: CH0147
Pegs Lane
Hertford
SG13 8DE

Tel 01992 556557
Fax 01992 556575

email:
seamus.quilty@hertfordshire.gov.uk

Dear Colleague

Unfortunately, due to purdah and Health Scrutiny Committee hosting the Budget café, the committee is unable to provide the resource needed to respond to the Quality Account. Despite this, regular communication between the Health Scrutiny Committee and the Trust over the past 12 months leaves us confident of continued support for the scrutiny process. The committee anticipates working with the Trust on future Quality Accounts.

Yours sincerely

Seamus Quilty
Chair, Health Scrutiny Committee

Appendix 4: Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the quality report is not inconsistent with internal and external sources of information, including:
  - board minutes and papers for the period April 2014 to end of April 2015
  - papers relating to quality reported to the board and the Integrated Governance Committee over the period April 2014 to end of April 2015
  - feedback from the commissioners, dated 14th May 2015
  - feedback from governors, dated 12th February 2015
  - feedback from Hertfordshire Healthwatch, dated 11th May 2015
  - the Trust's draft annual complaints report, to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 14th May 2014
  - the 2014 national patient survey
  - the 2014 national staff survey
  - the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2015
  - Care Quality Commission quality and risk profiles and Intelligent Monitoring reports for the year
- The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the above report.

By order of the board

Chair date 27/05/2015

Chief Executive date 27/05/2015

Appendix 5: Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the council of governors of Hertfordshire Partnership University NHS Foundation Trust to perform an independent assurance engagement in respect of Hertfordshire Partnership University NHS Foundation Trust's quality report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Hertfordshire Partnership University NHS Foundation Trust as a body, to assist the council of governors in reporting Hertfordshire Partnership University NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Hertfordshire Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital; and
- admissions to inpatient services had access to crisis resolution home treatment teams.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the '*NHS foundation trust annual reporting manual*', and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the specified documents in the guidance.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality

report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual'.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual';
- the quality report is not consistent in all material respects with the sources specified in the guidance; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual'.

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans
27 May 2015

If you require this information in a different language or format please contact the Patient Advice and Liaison Service:
Tel: 01727 804629

W razie potrzeby powyższy tekst można otrzymać w innymformacie
lub innym języku. Informacji w tej sprawie udziela: Patient Advice & Liaison Service:
Tel: 01727 804629
(Polish)

Se avete bisogno di queste informazioni in una lingua o in unformato
differente, vi preghiamo di contattare: Patient Advice & Liaison Service
(Servizio relazioni e consigli per i pazienti)
Tel: 01727 804629
(Italian)

اگر آپ کو یہ کسی دوسری زبان میں یا کسی دوسرے طریقہ سے درکار ہو تو برائے مہربانی ذیل سے رابطہ کریں:

پیشنٹ ایڈوائس اینڈ لیژاں سروس (Patient Advice & Liaison Service)

ٹیلیفون: 01727 804629

(Urdu)

আপনি যদি এই লেখাটি অন্য কোনও ভাষায় বা অন্য কোনও প্রকারে পেতে চান
তাহলে অনুগ্রহ করে নিচের নাম্বারে যোগাযোগ করবেন :

পেশেন্ট অ্যাডভাইস অ্যান্ড লিয়েজন সার্ভিস
(রোগীদের পরামর্শ দেওয়া ও তাদের সাথে যোগাযোগ রাখার পরিষেবা)
টেলিফোন : 01727 804629
(Bengali)

Hertfordshire Partnership University NHS Foundation Trust works toward eliminating all forms of discrimination and promoting equality of opportunity for all

www.hpft.nhs.uk
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