Hertfordshire Partnership University NHS Foundation Trust

QUALITY ACCOUNT 2020/21

as one

Our values
Welcoming Kind Positive Respectful Professional

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Quality Account
Part 1 – Statement on Quality from our Chief Executive

The Quality Account has been designed to report on the quality of our services in line with regulations. A more detailed description of how the Trust has continued to deliver high quality, safe and effective care for our service users during what has been an exceptional year can be found in our Annual Report for 2020/21, using the link https://www.hpft.nhs.uk/about-us/our-board-papers-and-publications/annual-report-annual-review-and-quality-account/

Our aim in this report is to describe in a balanced and accessible way how we provide high-quality clinical care to our service users, the local population and our commissioners. It also shows where we could perform better and what we are doing to improve.

I am very pleased to present the Quality Account for this year, which has seen us deliver care in one of the most challenging and difficult periods we have ever faced. Despite the challenges presented by the COVID-19 pandemic, our teams have responded magnificently, by continuing to deliver high quality, safe and effective care to our service users against a backdrop of increased demand and complexity of need.

Our standout achievement from 2020-21 was receiving the prestigious Health Service Journal (HSJ) Mental Health Trust of the Year award. This is a real testament to the tremendous hard work of our staff and their commitment to making a difference to the lives of our service users and carers, not just over the past year but over many years. The award judges were highly impressed with our culture of keeping everyone safe from harm.

As well as being awarded the HSJ's Mental Health Trust of the Year, we were successful in other award schemes during the year, in particular:

- Our North East Essex IAPT service, and North East Essex Diabetes Services (NEEDS) won the Mind and Body Together category of the 2020 Quality in Care (QiC) Diabetes Awards.
- Psychiatrists from our North Essex Learning Disability services won first and second prizes in a prestigious annual poster competition run by the Royal College of Psychiatrists' Faculty of Intellectual Disability and we were shortlisted for three of the Royal College of Psychiatrists awards in 2020.
- Our CAMHS Dialectical Behaviour Therapy (DBT) Service was shortlisted for both the Team of the Year and the Nursing in Mental Health categories in the 2020 Nursing Times Awards and we were shortlisted in two categories of the Health Service Journal Patient Safety Awards.

The past year has been one of the most challenging and difficult periods we have ever faced. The COVID-19 pandemic has touched everyone and changed our way of life in a manner that many of us have not experienced in our lifetime. Despite these challenges, our staff have responded magnificently, rapidly embracing different ways of working and new technologies to help provide our service users with the care and support they need, even when face to face meetings have not been possible and 'going the extra mile' at every call. All our services have remained open and we established processes to ensure that anyone in mental health crisis could come directly to us rather than needing to attend a local Accident and Emergency department.

Our Emergency Preparedness, Resilience and Response (EPRR) plan and our Business Continuity Plans (BCP), have proved themselves to be thorough and robust during this most challenging and unprecedented time. Most importantly, these plans ensured that we could to adapt our services as necessary and remain open for our service users. Our team of truly outstanding staff have risen to all the challenges we have faced with continued positivity,

professionalism and resilience - always keeping the safety and quality of care for our service users at the heart of everything they do. This year has seen a particular focus on the physical health of our service users and the enhancement of provision of guidance to support the required changes in practice for example physical health monitoring, co-horting, risk formulation, infection prevention and control.

We have continued to focus on developing a culture of safety over the last year, continuing to build safety into the heart of all we do. We have delivered this culture by approaching safety through collective ownership and leadership and promoting a shared understanding and belief that safety is paramount. This work has been supported through a number of safety initiatives, including the development of a simulation training facility, the use of Structured Judgement Reviews as part of the Mortality Governance framework for reviewing and learning from deaths and working on a 'Just Culture' with dedicated training and development sessions.

We want to ensure that our service users are treated with the upmost respect, dignity and compassion and this is reflected in our MOSStogether (Making our Services Safer Together) Strategy. This Strategy promoted the delivery of the least restrictive practices and enabling service users to feel safe in all our services as a partner in their own care and treatment.

During the year we continued to invest in our estate and service user environments. We began work on four new safety suites at Dove Ward, 4 Bowlers Green, Warren Court and Broadlands. We continued to improve the physical environment for our service users, carers and staff, including the refurbishment and upgrade of the CAMHS unit at 15 Forest Lane and refurbishment of Forest House.

As well as significant investment in backlog maintenance works, we also started the planning process for a major new in-patient unit in Stevenage.

With continued demand for services during the year, we have focussed on ensuring that our service users continue to receive the right service at the right time to meet their individual needs. We adapted how we deliver care, introducing online and virtual consultations as part of the implementation of our Digital Strategy. Examples include:

- Developing a chatbot (a computer program that's designed to simulate human conversation. Users communicate with these tools using a chat interface or via voice, just like they would converse with another person) with artificial intelligence that will help our Improved Access to Psychological Therapy (IAPT) service users and carers to access self-help resources and support them with engaging our service.
- Implementing a digital solution that will enable our service users and carers to report their clinical outcomes online more regularly, should they wish to do so.
- Piloting remote physical health monitoring equipment to make it easier for service users to record basic observations such as blood pressure and blood oxygen levels, with data automatically uploaded into their clinical record

Supporting and caring for our service users continued to be a priority for the Trust. We implemented a programme to ensure that all our active service users received an individual risk assessment in relation to COVID-19. This approach enabled us to have a clear picture of service users and the input they needed from services.

The quality of the care we provide is heavily reliant on our ability to recruit and retain great people and enable them to develop and flourish. We have worked hard to ensure we have a 'Just Culture' that actively encourages inclusion and diversity. We have had a strong focus on staff wellbeing, including all staff having an individual risk assessment in relation to COVID-19. The assessment considered a number of factors such as likely exposure to the virus, personal health risks and demographic data to generate a risk score. Throughout the pandemic a number of staff have needed to 'shield', based on their individual health issues

and risk factors. We supported these colleagues to work from home whilst shielding wherever possible and we regularly reached out to them to keep them engaged and to ensure they were being supported. This work was supported by our staff networks, particularly the Black Asian Minority Ethnic (BAME) network which has been active, supporting staff who were identified at higher risk of COVID-19 and anyone affected by the Black Lives Matter movement.

We implemented a significant programme of support for all staff with, a number of wellbeing initiatives, such as access to meals, hotel accommodation and a simplified remuneration process for additional hours. We also established a 24/7 helpline for health and social care staff in Hertfordshire, which our staff were able to access whenever they wanted. We increased our engagement with staff, with regular online question and answer sessions with our executive team and other opportunities for staff to have their say.

Our response rate for the NHS national staff survey was 52 percent, with an increase in number of responses compared to the year before. Our results this year were overwhelmingly positive and demonstrate the value of our wellbeing initiatives and engagement events. We scored above the national average in comparison to the other 51 mental health and learning disability trusts in England for seven of the ten survey themes. In particular:

- 76 per cent of staff would recommend HPFT as a place to work – second highest score
- 88 per cent of staff say that care of service users is HPFT's top priority – second highest score
- 92 per cent of staff say they know their role makes a positive difference to our service users – third highest score
- 76 per cent of staff would recommend HPFT as a place to receive treatment and care – seventh highest score

We have seen an increase in demand for our services in particular Children and Adolescent services with the number of young people waiting for access to specialist beds, in particular Eating Disorder beds. The Mental Health and Learning Disability Collaborative are leading a piece of work across the ICS to look at ways to provide alternatives to admission for young people with Eating Disorders and support those currently waiting in an Acute Trust Paediatric bed. This year has also seen Access across all of our five Wellbeing Services below target, due to a lack of referrals during the COVID-19 pandemic.

Collaborating with our partners has been a key feature of the year, in particular providing mutual aid across the system during the COVID-19 response. We also continued our work to develop and implement the East of England Collaborative and to establish Hertfordshire the Mental Health and Learning Disability collaborative. We are committed to these initiatives which form an important part of our work to ensure that people with mental health issues and learning disabilities receive the best care possible.

As well as our determination to ensure we continue to maintain high quality services over the next year, as always, will be on providing safe and high quality support and care, at the right time and in the right place for anyone who needs our services.

Declaration

Data accuracy

There are factors involved in preparing this Quality Account Report that can limit the reliability or accuracy of the data reported, and we are required by NHS Improvement (NHSI), the body responsible for overseeing our Trust, to tell you about these.

- Data is taken from many different systems and processes. Not all this information is checked for accuracy by independent assessors from other organisations, or audited by the Trust every year

- Information is collected by many different teams across the Trust. Sometimes different teams apply or interpret policies differently, which means they might collect different information or, perhaps, put it in different categories
- In many cases, the information provided is based on clinical judgements about individual cases. Because clinical judgements can vary, so can the data drawn from them
- National data definitions do not cover all circumstances and some local interpretations may differ
- We sometimes change how we collect, define and analyse data and it is often difficult or impossible to adjust older data to fit with a new method. To avoid confusion, we indicate when and where we have made these kinds of changes.

The Board of Directors and Executive Team have taken all reasonable steps and have exercised due diligence to ensure the accuracy of the data reported. However, we recognise that the data is subject to the limitations described above. To the best of my knowledge, the information presented to you in this document is accurate and provides a fair representation of the quality of service delivered within the organisation.

Tom Cahill: **Date: 30 June 2021**
Chief Executive

1.1 Background

In line with NHSE/I end of year guidance every NHS Trust is required to produce Quality Accounts for 2020/21. This report includes information about the services the Trust delivers, how well we deliver them and our plans for the following year.

Our aim in this Quality Account is to make sure that everyone who wants to know about what we do can access that information. All Quality Account are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

1.2 What the Quality Accounts include

- What we plan to do next year (2021/22), what our priorities are, and how we intend to address them.
- How we performed last year (2020/21), including where our services improved.
- The information we are required by law to provide so that people can see how the quality of our services compares to those provided by other NHS Trusts.
- Stakeholder and external assurance statements including our independent auditor's report, statements from Healthwatch Hertfordshire, Hertfordshire Valley Clinical Commissioning Group (CCG), East and North CCG and Hertfordshire County Council Health Scrutiny Committee.

1.3 Hertfordshire Partnership University NHS Foundation Trust

During this period we provided mental health and learning disabilities inpatient care and treatment in the community for young people, adults and older people in Hertfordshire, along with:

- Learning disability services in Buckinghamshire
- Improving Access to Psychological Therapies (IAPT) services in Essex in partnership with as follows:
    - West Essex with Mind west Essex
    - Mid Essex with Chelmsford Counselling Foundation and mid and north east Essex Mind
    - North east Essex with north east Essex Mind.
- Forensic and learning disability service in Norfolk
- Since November 2018, we have been the lead provider in a partnership with Essex Partnership University Trust to deliver a new model of specialist health services for people with a learning disability across all of Essex.

1.4 Our principles

We provide services that make a positive difference to the lives of service users and their carers and which are underpinned by the principles of choice, independence and equality.

1.5 Our Strategy

Our Good to Great Strategy (2016-2021) describes how we are delivering our vision of 'Delivering Great Care, Achieving Great Outcomes – Together'.

Achieving our vision means that we put the people who need our care, support and treatment at the heart of everything we do. It means we will consistently achieve the outcomes that matter to those individuals who use our services and their families and carers, by working in partnership with them and others who support them. Furthermore, it means we keep people safe from avoidable harm, whilst ensuring our care and services are effective. That they achieve the very best clinical outcomes, support individual recovery and are of the highest quality.

Our Good to Great Strategy demonstrate the key areas of focus for the Trust, in terms of the people, the organisation and partnerships. It focuses on the three domains of service user quality – safety, effectiveness and experience. Through providing consistently high quality care that is joined up, individuals will be supported and empowered to recover and to manage their mental and physical wellbeing. This will enable us to achieve our mission – 'We will help people of all ages live their lives to their fullest potential by supporting them to keep mentally and physically well.'

1.6 Quality Strategy

Our Quality Strategy, which we launched in 2019, sets the direction for the delivery of quality services within the Trust for the next 5 years. It supports and builds upon our proven delivery of high quality services, whilst supporting our ambition for a continuous improvement of services and sustainable growth.

With the aim to put quality right at the heart of everything we do in order to deliver our Good to Great Strategy, it ensures that quality services are delivered in the Trust in response to

the specific requirements of our service users, carers, our staff, the public, our commissioners and regulators.

It was developed through reviewing the Quality and Service Delivery Strategy and a number of consultations and its aim is to deliver Great Care and achieve Great Outcomes together. It sets out 3 objectives under each of the 3 quality domains and provides details of what this will mean to our staff, service users and carers.

- **Safe**
  - Delivering safe care in top quality environments
  - Fostering a learning and just culture
  - Fostering a culture of safety
- **Effective**
  - Delivering evidence based care which is benchmarked nationally
  - Delivering recovery focused care and clinical outcomes
  - Continuously improving quality
- **Experience**
  - Responsive and accessible services
  - Embedding shared decision making
  - Co-production at the heart of service development.

We aim to deliver great care and great outcomes and are keen to share information about the quality of our services and how we are working to improve these. This report is one of the many ways in which we share information.

1.7 Our Partnerships

Our partnership with Hertfordshire County Council helps us to develop an approach based on a holistic assessment of each service user's health and social care needs, which focuses on recovery. Working in partnership with the Council also means we can help improve integration between mental health, physical wellbeing and social care services.

We also work with other NHS partners, including Hertfordshire Community NHS Trust (HCT), Central London Community Healthcare NHS Trust (CLCH) East and North Hertfordshire NHS Trust, West Herts Hospitals NHS Trust and East London NHS Foundation Trust (ELFT) (which sub-contracts us to provide the Hertfordshire Liaison and Diversion Service), as well as the following:

- MIND – Predominantly across our IAPT services providing Support Time and Recovery Workers, Counselling and Dynamic Interpersonal Therapy (DiT). They also assist with the New Leaf service
- Mental Health Matters – in relation to Employment Advisors in IAPT as part of the Department of Working Pensions (DWP) Initiative
- Reinvent Lifestyle – providing bespoke exercise to improve and maintain wellness
- IESO provide additional Step 3 IAPT support with online therapists
- CHS Healthcare – providing Continuing Health Care (CHC) assessments and reviews for older adults
- BEAT – A National Eating Disorders charity commissioned to deliver a range of support services for CYP and families including coaching and support

As a University Trust, our close links with the University of Hertfordshire mean we can contribute to clinical research, and offer our staff excellent learning and development opportunities.

During this year we have continued our leadership of the Mental Health and Learning Disability Integrated Care Partnership, working with our partners and stakeholders as an advocate for people with mental health needs and those with a Learning Disability. The

Trust has also been an active member of the East of England Collaborative, working with partners from across the region to transform care for CAMHS, forensic and eating disorder services. Both of these collaboratives will develop further in 2021/22, seeing the Trust enter into firm partnership with providers and taking on an increased commissioning role.

1.8 Our Commissioners

As a Trust, we continue to work closely with many organisations that commission and pay for our services. These include both the County Council and the CCGs.

As a Trust, we have services commissioned by each of the following:

- East and North Hertfordshire CCG
- Herts Valleys CCG
- Hertfordshire County Council (HCC)
- Cambridge and Peterborough CCG
- North east Essex CCG
- Mid Essex CCG
- West Essex CCG
- Basildon and Brentwood CCG
- Southend CCG
- Thurrock CCG
- Castle Point and Rochford
- NHS Norfolk and Waveney CCG
- South Norfolk CCG
- NHS England Midlands and East
- Barnet CCG
- London Borough Hillingdon CCG
- Buckinghamshire CCG.

Of the Nationally Commissioned Services that NHS England commissions, the Trust delivers on the following Specialist Services:

- Tier 4 CAMHS
- Perinatal Services
- Low Secure Mental Health
- Medium and Low Secure Learning Disabilities
- Highly Specialist Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder Service.

1.9 Freedom to Speak Up

Speaking Up is when a staff member reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest'. A staff member can report things that are not right, are illegal or if anyone at work is neglecting their duties, including:

- An individual's health and safety is in danger
- Damage to the environment
- A criminal offence
- The company is not obeying the law (breach of legal obligation)
- Covering up any wrongdoing.

If preferable, a concern may be raised from a distance by contacting the **Freedom to Speak Up Guardian, Yusuf Aumeerally** by:

- Email - hpft.speakup@nhs.net
- Telephone - 01727 804100 on the confidential "Speak Up" Line
- In writing - to the Chief Executive or any senior person stating the concern
- The Trust's incident reporting system (Datix).

The Trust's nominated "**Speak Up Champion**" is Diane Herbert, a Non-Executive Director on the Board.

1.11 Trust Information

The Trust in 2020/21	
	**Mental Health,** Community and Learning Disability Services for children and adults
	**441,245** secondary care contacts
	**54,633** referrals through **SPA**
	**205,383 IAPT** contacts
	**126,196 occupied bed days**
	**88% would recommend us** to friends and family
	**4,506 (permanent and temporary) Staff** working across **36 Trust** sites

This report

If you have any questions about anything in this report, would like to comment on it or want to know more about the Trust, contact Jacky Vincent, Deputy Director of Nursing and Quality/Director of Infection Prevention and Control (DIPC) jacky.vincent@nhs.net
This Quality Account Report was signed and approved 30 June 2021 and is available on the NHS Choices website www.nhs.uk and on our website: www.hpft.nhs.uk
If you would like a paper copy of this report, or to see it in other formats, please call our Communications team on 01707 253902, or: comms@hpft.nhs.uk.

Part 2 – Priorities for Improvement and Statement of Assurance from the Board

We are committed to delivering great care and great outcomes for our service users. To help us achieve this, we work in partnership with other organisations, for example to identify areas for improvement. These fall into three categories:

- Patient (service user) Safety
- Clinical Effectiveness
- Patient (service user) Experience.

In this report we show:

- How we performed in our priority areas during 2020/21

2.1 Quality priority areas for 2020/21

The table below provides an overview of our quality priority areas from last year (2020/21) and how we performed during this financial year, divided into each quarter throughout the year.

Service User Safety		Target	Q1	Q2	Q3	Q4	Total
1	The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period	≥=95%	96.98%	97.28%	96.04%	97.39%	96.90%
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)	N/A	Severe Harm 3 (0.26%) Death 37 (3.18%) Includes 26 Covid inpatient deaths 1160 Incidents	Severe Harm 2 (0.15%) Deaths 12(93%) 1284 Incidents	Severe Harm 4 (0.33%) Deaths 18 (1.5%) Includes 3 Covid Inpatient deaths 1199 Incidents	Severe Harm 0 Deaths 15 (1.19%) Includes 5 Covid inpatient deaths 1252 Incidents	Severe Harm 9 (0.18%) Deaths 82 (0.17%) Includes 34 Covid inpatient deaths 4895 Incidents
3	Crisis Assessment and Treatment Team – 4 hour wait to assessment	≥=98%	100%	100%	100%	100%	100%
4	Safeguarding – Social Care Assessments	N/A	50.2%	62.6%	56.9%	57.1%	57%
Clinical Effectiveness							
5	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)	≥=95%	95.33%	97.69%	97.67%	98.26%	97.18%
6	Rate of Service Users saying they know how to get support and advice at a time of crisis	≥=83%	84.38%	85.19%	88.76%	90.48%	87.89%
7i)	Readmitted to a hospital within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI) The percentage of service users aged: **0 to 15**	≤=7.5%	0.0%	0.0%	0.0%	0.0%	0.0%

7ii)	**16 or over**	≤=7.5%	5.7%	6.2%	4.3%	1.9%	4.7%
8	The proportion of those on Care Programme Approach (CPA) for at least 12 months who had a CPA review within the last 12 months	≥=95%	88.58%	81.01%	87.70%	87.57%	87.57%
9	Service User experience in the community (Mandated)	N/A					7.3/10
10	Rate of Service Users saying they have been involved in discussions about their care	≥=85%	90.63%	85.19%	88.76%	85.37%	87.83%
11	Rate of carers that feel valued by staff	≥=75%	85.19%	95.45%	84.09%	95.45%	88.70%
12	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them	≥=70%	84.98%	83.72%	N/A†	84.16%	84.28%

†Q3 Pulse Survey not carried due to Staff Survey

Section 2.16 provides detail on the comparison on achievement against the priority areas between 2019/20 and 2020/21.

Definition of areas in table

The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period
The first few days following discharge can be a vulnerable period of time in an individual's life and we want to support their recovery in readjusting to life in their own community. We follow up every person who is discharged from our inpatient services within 7 days. This is usually through face to face contact; under exceptional circumstances this may be via telephone. Throughout 2020/21, we exceeded the 95% target for this indicator, with an average percentage of 97%.

Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
All incidents that occur in the Trust are reported to the NRLS (NRLS) which is a central database of patient (service user) safety incident reports. All information is analysed to identify any hazards, risks and opportunities to continuously improve the safety of service users care. As a Trust we regularly review all levels of harm sustained to consider areas of learning and development, agree actions for implementation and also to share lessons learned as well as areas of good practice. Throughout 2020/21 we saw an increase in the number of incidents by 25.

Crisis resolution home treatment team (CRHTT) – 4 hours wait to assessment
Service users experiencing a mental health crisis should be able to access care quickly in their own home or community, as prompt assessment may prevent a further deterioration in an individual's mental health and avoid an inpatient admission. Crisis resolution home treatment team (CRHTT aim to review any service user referred to their services within four hours so that appropriate care and support can be provided. In 2020/21 we exceeded the 98% target in every quarter, by achieving 100% each quarter

Safeguarding – Decision to investigate within 2 working days
There are a number of factors to consider in relation to a safeguarding concern, including the wishes of the individual who may be at risk. An assessment of immediate risks and action needed should be undertaken within two working days of receiving the safeguarding concern. This ensures that the individual can be positively supported and protected appropriately via the safeguarding protocols as their safety is of utmost importance. In 2020/21 we had not set a target as this was a new indicator. However, every quarter our compliance increased from 50% in quarter 1 to 57% in quarter 4.

The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)
A Crisis Assessment and Treatment Team (CATT) provide intensive support for people in mental health crisis in their own home. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Teams are required to gate keep all admissions to psychiatry inpatient wards and facilitate early discharge of service users. In 2020/201 we exceeded the target in every quarter, with an average percentage of 97%.

Rate of Service Users saying they know how to get support and advice at a time of Crisis
For a service user experiencing a crisis there is a need for urgent invention and support to be provided to them. It is important that the individual knows how they can access the help and support they need in a timely and effective way. Service users will have discussed how to access the support they need in a crisis with their clinical team and will have been

provided with the details of how to access the help they need. In 2020/21 we exceeded the target of 83% in every quarter, with an average of 87%.

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period (NHSI)
The percentage of service users aged:
0 to 15 and 16 or over
This indicator measures the percentage of admissions across all Trust services who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure our success as a Trust in helping individuals to recover effectively from illness. If an individual does not recover well, it is more likely that they will require hospital treatment again within 28 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare in helping individuals to recover. In 2020/21 we exceeded the target with no Service User been readmitted between the age of 16 or younger in hospital within 28 days of been discharged. For adults of 16years or older the Trust averaged a readmission rate of 5%.

The proportion of those on Care Programme Approach (COA) for at least 12 months who had a CPA Review within the last 12 months
Care Programme Approach (CPA) is a package of care for service users requiring support with severe mental health conditions. CPA is used to assess an individuals needs, risk and the level of support required from mental health services. It is important that a review is conducted as least every twelve months so that the service users clinical team can meet with the individual to discuss their current situation and mental health concerns. This forms the treatment plans for the next few months and ensures their needs continue to be met appropriately. In 2020/21 we missed our target of 95% in every quarter, with an average of 87%. This is due to the fact that it was more challenging to see people face to face during COVID-19.

Service User Experience in the community (contact with health and social care workers) (Mandated)
Service user experience is an important part of measuring the quality of the service provided. The experience of receiving care can have an impact on the wellbeing of the service user, and positive experiences can improve the individuals relationship with their clinical team and aid their recovery. We achieved 73%.

Rate of Service Users saying they have been involved in discussions about their care
Service users play a valuable and important role in partnership working to support their care and treatment. The care coordinator and clinical team should work collaboratively with an individual to develop treatment and support plans. This encourages partnership working between the service user and the care coordinator which promotes a respectful and inclusive relationship for the service user. In 2020/21 we exceeded the target of 85% in every quarter, with an average of 88%.

Rate of Carers feeling valued by staff
This is one of the indicators around the Triangle of Care and relates to the question ‘do you feel valued by staff as a partner in care planning?’ and sits in our internal quality dashboard as an indicator. It was also chosen by our Carer Council. In 2020/21 we exceeded the 75% target in every quarter, with an average of 81%.

2.2 Priorities for Quality Improvement 2021/22

The national guidance regard to the Quality Indicators for 2021/22 has yet to be published. In the absence of guidance the Trust has agreed 10 indicators that maintain focus on key

priority areas for the Trust. The Trust has consulted internally with the Strategic Business Units and councils. In the table below are listed the agreed Quality Indicators for 2021/22.

Number	Service User Safety
1.	The percentage of service users who are followed up within 48 hours after discharge from psychiatric inpatient care during the reporting period.
2.	Reduction in the rate and percentage of service user safety incidents that result in moderate or severe harm
3.	Rate of service users who have a completed risk assessment within the last 12 months.
	Clinical Effectiveness
4.	Reduction on the number of inappropriate out of area placements
5.	Reduce the readmission rate within 28 days of being discharged from a hospital.
6.	At least one outcome measures to be used on all LD F inpatients (HONOS in all inpatient units)
7.	Completed annual care plans within LD community services Herts and Essex
	Service User, Carer and Staff feedback
8.	Rate of Service Users saying they have been involved in discussions about their care.
9.	Appropriate Carer Essential Training is undertaken by ALL staff at ALL levels
10.	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them

The Performance Team is internally and externally audited annually. External Audit will check a sample of cases to ensure accuracy of the data being reported.

How these targets will be monitored
We will measure and monitor our progress on the implementation of each quality indicators throughout the year. There will be additional audits to ensure that the data collected is reliable and valid.

We have put a robust reporting framework in place to make sure we keep progressing and can address any challenges that arise as early as possible. We will:

- report our results to our Board and our commissioners every quarter at our Quality Review Meeting.
- engage with our key stakeholders to discuss our progress throughout the year.

Once the Board has agreed targets, we will develop plans to ensure that these priorities are achieved and progress monitored quarterly.

We will report progress towards targets through our Governance structures. Our Performance Team will check and assure the quality and accuracy of our data in accordance with Trust policies.

2.3 Statements of Assurances

This section of the report explains how we have provided assurance in relation to the services it provides. This is demonstrated through clinical networks, audit and our CQC inspection report. We have reviewed all the data available to us relating to the quality of care we provide in these services. Our total income from service users activities was £273.7m and out total income was c. £295.0m thus 92.8%.

2.4 Clinical Audits

Our Practice Audit and Clinical Effectiveness (PACE) team leads on our clinical audit work, offering guidance, support and assurance for quality and service improvement.

At the start of each financial year, our PACE team consults with our leaders and managers to develop a programme of audits. This includes the audits that every NHS Trust is required to complete, those needed to monitor our contractual arrangements, and those requested by our teams to assess and improve the quality of their own work.

When an audit is completed, we develop an action plan so that we can make and monitor improvements to our services. Our Practice Audit Implementation Group (PAIG – members include the Deputy Medical Director, Chief Pharmacist and representation from other clinical disciplines) discuss and approve the reports. We then share them throughout the Trust so everyone can learn from the results.

National Clinical Audits

Participating in Healthcare Quality Improvement Partnership (HQIP) programmes and quality accreditation programmes helps us compare our performance against other mental health trusts across the country. This not only helps us to benchmark our performance, but also gives us an opportunity to provide assurances that our services are continuously striving to reach the highest standards set by the professional bodies, such as The Royal College of Psychiatrists and the National Prescribing Observatory for Mental Health (POMH-UK).

During 2020/21, five national clinical audits and one national confidential enquiry covered relevant health services that HPFT provide. During that period HPFT participated in 100% of national clinical audits it was eligible to participate in. The national clinical audits that HPFT participated in during 2020/21 are as follows:

- National Audit of Inpatient Falls
- National Audit of Epilepsy
- POMH- UK Topic 20a: Valproate Prescribing in Adult Mental Health Services
- POMH-UK Topic 18b: Use of Clozapine
- National Clinical Audit of Psychosis (First Episode of Psychosis)
- National Confidential Enquiry into Patient Outcome and Death

National Audit / National Confidential Enquiry	**Trust Participation**	
	Number of cases required by the terms of the audit	**Number of Cases Submitted by HPFT**
National Audit of Inpatient Falls	3	3
National Audit of Epilepsy	As many as applicable	124
POMH- UK Topic 20a: Valproate Prescribing in Adult Mental Health Services	As many as applicable	103
POMH-UK Topic 18b: Use of Clozapine	As many as applicable	62*
National Clinical Audit of Psychosis (First Episode of Psychosis)	100	100
National Confidential Enquiry into Patient Outcome and Death	9	6

*This number is an estimate as the POMH-UK report has not been published yet

One national clinical audit was reviewed by the HPFT in 2020-21, which was POMH- UK Topic 20a: Valproate Prescribing in Adult Mental Health Services. The practice standards that were audited as found in the table below.

No	Practice Standards
1	A clinician's reasons for initiating valproate treatment (i.e. target symptoms or behaviour) should be documented in the clinical records.
2	If valproate is being prescribed 'off-label', it should be documented that this has been explained to the patient.
3	Prior to initiating treatment with valproate, the following should be documented in the clinical records: weight and/or BMI, the results of liver function tests (LFTs), and a full blood count (FBC).
4	Review within the first three months of valproate treatment should include: screening for common side effects of the medication (e.g. weight gain, nausea, and tremor) and assessment of the response of the target symptoms/behaviour.
5	Patients prescribed continuing valproate treatment should have an annual review of the risk-benefit balance. This should include assessment of therapeutic benefit, adverse effects and medication adherence.
6	If valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the conditions of 'prevent', the pregnancy prevention programme, are fulfilled.

The findings for POMH- UK Topic 20a: Valproate Prescribing in Adult Mental Health Services are as follows:

Practice standard number	**Practice Standards**	**HPFT 2020 result**	**TNS 2020 result**	**HPFT compared to TNS**	**National Ranking (out of 64 trusts)**
1.	**A clinician's reasons for initiating valproate treatment (i.e. target symptoms or behaviour) should be documented in their clinical record**				
		N = 103	**N = 5320**		
	Initiation rationale documented	78%	72%	↑	20
2.	**If valproate is being prescribed 'off label', it should be documented that this has been explained to the patient (sub sample of patients treated with valproate for less than a year)**				
		N = 2	**N = 363**		
	Off label use documented	0%	6%	↓	
3.	**Prior to initiating treatment with valproate, baseline physical health checks should be documented in the clinical records (sub sample of patients treated with valproate for less than a year)**				
		N = 4	**N = 919**		
	Full blood count	25%	67%	↓	
	Liver function tests	25%	66%	↓	
	Body weight/BMI	75%	62%	↑	
	Plasma glucose/HbA1c	25%	56%	↓	

	Plasma lipids	0%	55%	↓	[redacted]
	Blood pressure	75%	66%	↑	
4.	**Review within the first 3 months of valproate treatment should include screening for common side effects(weight gain, nausea and tremor) and assessment of the response of the target symptoms/behaviour (sub sample of patients treated with valproate between 3 months and 1 year)**				
		N = 2	**N = 631**		
	Therapeutic benefit/response to target symptoms	100%	70%	↑	[redacted]
	Side effects of valproate treatment	100%	53%	↑	
	Medication adherence	100%	59%	↑	
5.	**Patients prescribed continued valproate treatment should have an annual review of the risk-benefit balance. This should include assessment of therapeutic benefit, adverse effects and medication adherence (sub sample treated with valproate for more than 1 year)**				
		N = 99	**N = 4401**		
	Therapeutic benefit/response to target symptoms	81%	63%	↑	13
	Side effects of valproate treatment	72%	49%	↑	11
	Medication adherence	79%	56%	↑	8

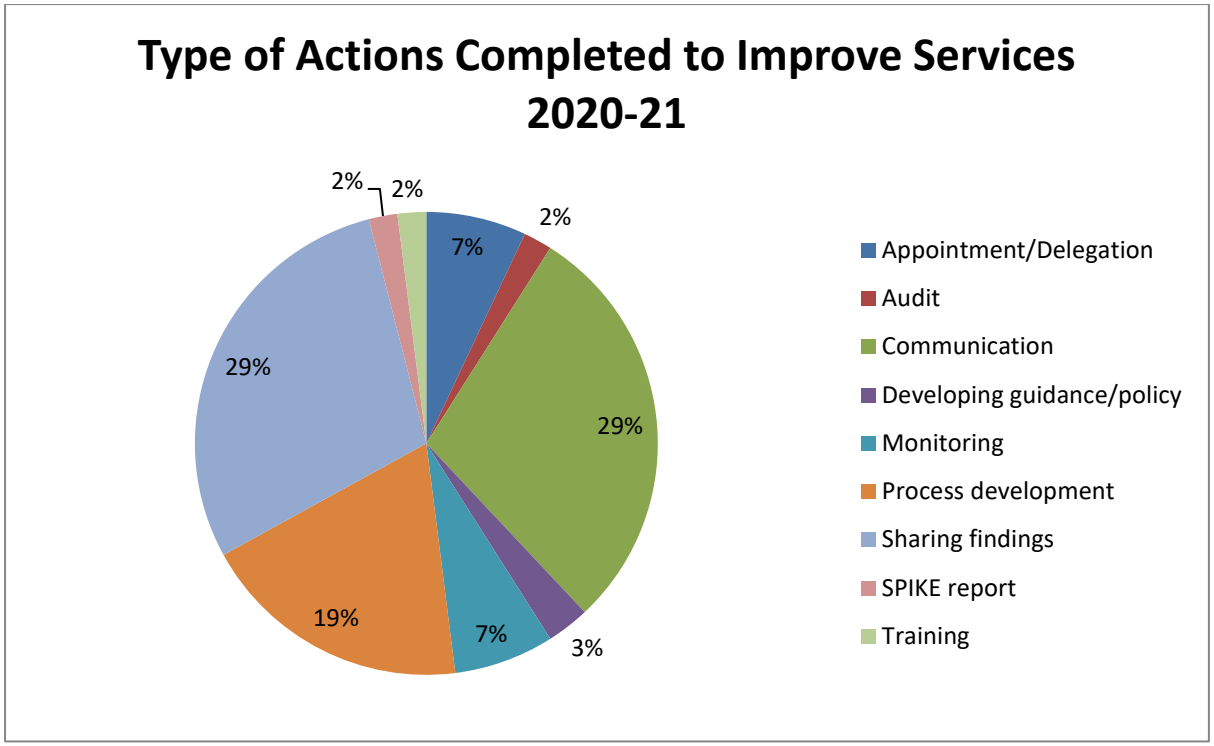
6.	**If valproate is prescribed for a woman of child-bearing age, there should be documented evidence that the conditions of 'prevent', the pregnancy prevention programme, are fulfilled**					
Step 1	Documented evidence of a completed risk acknowledgement form	**N=23**		**N=1197**		POMH-UK recommend limited value in benchmarking practice standard 6 due to small sample size
		No/more than 1 year ago	Yes, completed in the last year	No/more than 1 year ago	Yes, completed in the last year	
		N=20	**N=3**	**N=798**	**N=399**	
	Documented reason for permanent absence of pregnancy risk	20%	33%	16%	9%	
	Documented reason for non-permanent absence of pregnancy risk	20%	33%	13%	28%	
	No reason provided for 'prevent' being inapplicable	60%	33%	71%	63%	
	Step 1 signed by the patient or carer	-	67%	-	62%	
	Patient guide given to the patient or carer	-	100%	-	49%	
Step 2	Reasons for valproate prescribing documented for women <55years of age for whom prevent was implemented	**N=1**		**N=253**		
	Inadequate response to other treatments	100%		83%		
	Does not tolerate other treatments	100%		59%		
	Currently switching from valproate to another treatment	100%		46%		
	None of the above	**-**		11%		
	Provision of information to the subsample of women <55 years of age for whom prevent was implemented (all boxes initialled by clinician)	**N=1**		**N=253**		
	Risks of valproate in pregnancy and the	100%		79%		

	need for contraception discussed with the patient			
	Patient guide given	100%	84%	
	Discussions should pregnancy occur	100%	61%	
Step 3	Patient acknowledgement documented that prevent information received (all boxes initialled/signed by patient)	**N=1**	**N=253**	
	Risks of valproate in pregnancy and the need for contraception discussed with the patient	0%	76%	
	Patient guide given	0%	85%	
	Discussions should pregnancy occur	0%	74%	
	Step 3 signed by the patient or responsible person	-	90%	
Treatment target	**Plasma level monitoring of valproate treatment should not be used unless there is evidence of ineffectiveness, concerns about medication adherence or dose-related side effects (subsample of patients treated with valproate for more than 1 year).**			
		N=86	**N=3543**	
	No documented plasma valproate level	99%	90%	↑
	Part of routine monitoring or reason unclear	0%	7%	↑
	Clinical rationale for valproate level documented	1%	3%	↑

At the time of writing, the action plan for this audit is being drafted.

Local Clinical Audit

As of April 2021, PACE have reviewed the reports of 80 local clinical audits during 2020/21. Forty were undertaken by the Practice Audit and Clinical Effectiveness (PACE) team as part of their annual programme and forty were local audits registered with the PACE team by clinicians throughout the Trust. We undertook the following actions to improve the quality of healthcare provided:



In addition, the PACE team achieved the following aims throughout 2020-21:

- PACE Team conducted a review into how audits for HPFT service are RAG rated, and implemented change with the aim to drive greater improvement through audit.
- The Trust celebrated Clinical Audit Awareness Week in November 2020.
- To continue to encourage services to conduct more clinical audits locally, the PACE Team continue to provide generic and bespoke based audit training for staff.
- The PACE Team continue to work closely with the service user and carer councils to ensure that audits gain there unique perspective in order to increase richness within audit findings and action plans.

2.5 Research and Development

Our research portfolio is a cornerstone of the Trust's status as a University Trust. We work closely with the National Institute of Health Research (NIHR) and Clinical Research Network Eastern (CRNE), to deliver high quality health science. This year has seen the finalisation of a new Research Strategy, to be launched in the summer of 2021. The strategy outlines the way that Research and Development (R&D) will be embedded in clinical services, within four workstreams (dementia, neurodevelopmental, CAMHS and general adult psychiatry), and how this will report into a new governance structure.

The Trust has directly supported recruitment to eighteen NIHR Portfolio studies over the last year. This was a slight decrease from last year, but this is because COVID-19 has dominated the research picture, and many other studies were put on hold or delayed from starting. Across those eightenn studies, we recruited 560 service users, carers and staff - an increase of 27% over the previous year's figure of 440. There has been a consistent upward trend in our total annual recruitment figure over the last five years. The table below shows the different NIHR portfolio studies we have supported over the last year.

As well as increasing the opportunities for our service users to take part in NIHR portfolio research studies, it is also part of our strategy to seek funding for research that is sponsored and led by HPFT. We are currently contracting with the NIHR Research for Patient Benefit Program, for delivery of two studies led by HPFT clinicians in collaboration with colleagues at the University of Hertfordshire. The first is for a randomised controlled feasibility trial to look at the use of trans-cranial direct stimulation (tDCS) in the treatment of OCD (FEATSOCS study). The recruitment target has just been met, which is a fantastic achievement given the challenges of COVID-19. The second is called Making Positive Moves, and is a qualitative study looking at the support needed by people with learning disabilities in the community as part of the transforming care programme.

The outbreak of COVID-19, and associated restrictions, had a major impact on our Research Portfolio. The majority of our active research studies were suspended in March 2020, to be resumed later in the year. All focus was on supporting the NIHR Urgent Public Health studies, which we continue to do. The R&D Team has been collecting a significant amount of data for the ISARIC/WHO Clinical Characterisation Protocol for Emerging Infectious Diseases study. The data from this study informs central government statistics and policy on COVID-19. We also supported 3 different national surveys looking at wellbeing, stress and anxiety related to the COVID-19 situation in NHS staff, service users and the general public. We expect to continue supporting COVID-19 research for the foreseeable future but the workload for this is lessening and we have now restarted all of our suspended research studies.

Table 1. NIHR Portfolio studies recruited to between 1/4/20 and 31/3/21

Study name	S**ponsor**	Number of recruits
Psychological impact of COVID-19 pandemic and experience: An international survey.	Southern Health NHS Foundation Trust	303
Clinical Characterisation Protocol for Severe Emerging Infection: COVID-19	University of Oxford	141
University of Cambridge NHS health data consent survey	University of Cambridge	32
ESMI-II: The effectiveness and cost effectiveness of community perinatal Mental health services	Devon Partnership Trust	25
Investigating the feasibility of inducing a non-maladaptive habit using mobile app technology, as a novel interventional component of habit reversal therapy (HRT) for treating obsessive-compulsive disorder (OCD).	Hertfordshire Partnership Trust	13
Feasibility and Acceptability of Transcranial Stimulation in Obsessive Compulsive Symptoms	Hertfordshire Partnership Trust and University of Hertfordshire	8
Online Acceptance and Commitment Therapy for family carers of people with dementia: A feasibility study of a new mode of delivery (iACT4CARERS)	University of East Anglia	7
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	University of Manchester	12

Cognitive Therapy for the treatment of post-traumatic stress disorder (PTSD) in youth exposed to multiple traumatic stressors: a phase II randomised controlled trial (DECRYPT)	University of East Anglia	4
Patient preferences regarding psychological therapies for distressing voice-hearing experiences.	University of Sussex	3
The Prevalence of Social Communication PRoblems in Adult Psychiatric INpaTients (SPRINT)	University of Leicester	3
Hearing nasty voices: Developing new ways to measure the experience	University of Oxford	2
Making Positive Moves What support do people with Learning Disabilities need to remain living in the community after moving under the Transforming Care Programme. A qualitative longitudinal study.	HPFT/UoH	2
Prevalence of neuronal cell surface antibodies in patients with psychotic illness (PPiP2)	University of Oxford	2
UK National Autism Diagnostic Services survey 2020	Sussex Community Trust	1
Early evaluation of the Children and Young People's Mental Health Trailblazer Programme	University of Birmingham	1
Supporting Memory Services to enable people with dementia and their families' timely access to Assistive Technology.		1

2.6 Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence by linking a proportion of health care providers' income to the achievement of local quality improvement goals. The Trust's CQUIN goals are agreed with our local and specialist commissioners at the beginning of each financial year.

2020/21

In 2020/21 CQUIN were paused and so the Quality Accounts do not include any information of CQUIN for the year.

2021/22

Latest information from NHSE is that they are expecting CQUIN reporting to recommence in October 2021. They have identified eight goals for 2021/22 and formal reporting to commissioners with recommence following guidance from NHSE.

2.7 The Data Security and Protection Toolkit (DSPT)

The DSP Toolkit grades organisations as 'small', 'medium' and 'large'. We are a 'large' organisation and are therefore required to undertake 110 mandatory evidence items on all aspects of information governance and data security.

2.8 Clinical coding

We use clinical coding to categorise the information we gather about our service users and the services and treatments they receive from us. This information is then used to analyse the data that informs our quality indicators. Although we are not part of 'Payment by Results' (PbR) our clinical coding is still externally audited.

The Trust will submit our Toolkit before the 30 June 2021 deadline. The Toolkit covers 42 assertions based on the National Data Guardian's 10 Data Security Standards:

Personal Confidential Data
Staff Responsibilities
Training
Managing Data Access
Process Reviews
Responding to Incidents
Continuity Planning
Unsupported Systems
IT Protection
Accountable Suppliers

We submitted records during 2020/21 to the Secondary Uses Service for inclusion in the HES which are included in the latest published data. National figures for 2020/21 have not yet been published, based on a Trust calculation based on the NHS Digital rules the percentages are detailed below. The percentage of records in the published data which included the service users' valid NHS number was:

- 99.47% for admitted patient care
- 99.12% for outpatient care.

The percentage of records in the published data which included the service users valid General Medical Practice Code was:

- 98.15% for admitted patient care
- 97.66% for outpatient care.

2.9 Ethnicity

The percentage of records in the published data which included the service users' ethnicity was 90%. We plan to improve our data quality and clinical coding by:

- conducting regular audits
- supporting staff with data quality issues through reviewing KPI guides
- developing front end reports which are updated daily.

2.10 Patient (service user) Safety

This section shows how we ensure that we are providing safe care. We have continued to focus on developing a culture of safety over the last year, building safety into the heart of all we do. This has been supported through a number of safety initiatives, including:

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- The MOSStogether Strategy underwent a soft launch this year due to the pandemic.
- The Trust appointed a new Head of Safety and Patient Safety Specialist as per the requirements of the Patient Safety Strategy. The Patient Safety Specialist provides dynamic, senior leadership and visibility whilst supporting the development of a patient safety culture, safety systems and improvement activity and networking with other Patient Safety Specialists.

- The use of Datix, the information technology system for managing incidents, has been developed in response to changing needs, for example COVID-19, and feedback to strengthen its usefulness.
- A Patient Safety Dashboard has been developed on our internal performance and information system (SPIKE) and following testing is ready to be launched.
- From August 2020, the Trust has requested GP summaries to inform our Serious Incident (SI) reviews and there has been good support of this approach from our primary care colleagues. The final SI report is shared with the GP practice once completed to aid wider learning.
- Work was undertaken throughout the year by the training faculty to set up the simulation hub to support risk formulation. Case scenarios have been developed based on our priorities and learning from our incidents and facilitators have been trained A pilot day has been arranged.
- A Dual Diagnosis protocol has been refreshed with CGL and work is being undertaken as part of community transformation around harm minimisation and improving joint working and communication.
- A joint partnership with Samaritans with offer of support to service users commenced in 2020/21 which includes follow up to those seen by the MHLT.
- A Care Leavers CQI Project commenced to improve communication and joint working for service users within Adult Community Mental Health Services who are also Care Leavers; the project team includes key partner agencies
- Work has continued with services to reduce self-injurious behaviours, including through the use of ligatures. ISBARD has been introduced where the reporting, actions taken and sharing of learning have been reviewed framed around ISBARD:
    - I - the person reporting
    - S - describing the situation
    - B – setting the context and background
    - A - assessment of current situation and how it relates to concerns hazards
    - R - recommendation: stating what will happen and why
    - D - decision: act on the changes / who will do what (using SMART objectives).

- ANT technology continues to be used in ligature audits that ensure that risk in relation to ligature anchor points in ward environments is mitigated.
- A review of the Ligature Awareness Training has taken place, which includes additional advice on the use of ligature cutters.

The total number of incidents reported (via our incident reporting system Datix) between 1st April 2020 and 31st March 2021 was 13,394. Of these, 38 (0.28%) are recorded under the harm category as ‘severe harm’ and 582 (4.3%) are recorded under harm category as ‘death’. There was an increase in reported deaths of 36.7% compared to the previous year which can be largely attributed to deaths of people with COVID-19.

2.11 Restrictive Practice and our MOSStogether Strategy

Restrictive Practice refers to the implementation of any practice restricting a service user’s movement, liberty and/or freedom to act. Where an individual service user’s behaviour places themselves or others at imminent risk of significant harm, a restrictive practice may be necessary as a proportionate and reasonable response. To enable a reduction in the use of restrictive practice, high quality and safe services need to be provided in therapeutic environments with staff engaging in therapeutic relationships, providing value-based care that is person-centred and focuses on recovery.

To create and maintain a safe and supportive environment for staff, service users and carers, we need to ensure processes are designed and in place, learning about what works well and why, and to replicate and optimise these behaviours and processes. As a Trust we have a comprehensive training in the Prevention of Management of Violence and Aggression, which includes developing competence in both proactive and reactive approaches, focused on the best interests of the service user.

Our MOSStogehte strategy enables us to deliver on the strategic objective - “we will provide safe services, so that people feel safe and are protected from avoidable harm”. It aims to support this objective by ensuring the least restrictive practices are used, setting out how service users will feel safe across our services, and as a partner in their own care and treatment, enabling a positive experience. It also aims to support in the reduction of violence and aggression to both staff and services users, across all of our services.

The MOSStogether Strategy sets out an approach which aims to ensure that safety is at the heart of everything we do in order to deliver our Good to Great Strategy. It ensures that safe services are provided, so that people feel safe whilst receiving our services. It sets the direction for providing safe and effective services, enabling a positive experience for those who receive our services and has been developed from and builds upon the Trust’s previous Making Our Services Safer (MOSS) Strategy. Following the Strategy’s launch key actions from it including the Hope model implemented, Safewards methodology, Safety Pods Safety Huddles and crosses continue to be implemented.

The priorities of the MOSStogether Strategy are:

- To introduce the HOPE Model, resulting in the least restrictive practice being used.
- To use the least restrictive practices, as a last resort, and as a safety intervention, considering alternative approaches to ensure safe care.
- To reduce the negative impact on service users and staff when restrictive practice is used.
- To involve service users in their recovery and care through shared decision making.
- To ensure this at practice is responsive to the changing needs of service users and services as well as best practice and the evidence base.

The strategy is monitored by our Restrictive Practice Committee. The implementation of the Restrictive Practice Committee has led to greater oversight and responsiveness, with representation from each of the Strategic Business Units (SBU). The Committee supports the actions detailed in the Annual Plan, including aiming to reduce both violence and aggression and ensuring the use of the least restrictive practice.

Notable Achievements this year are:

- There has been a reduction in the number of reported Absence Without authorised Leave (AWOL) following targeted work and awareness raising in the service areas.
- Targeted work with regards to the use of Long-Term Segregation (LTS) and increased training and awareness including multi-disciplinary Team (MDT) review, documentation and attention to individual’s human rights.
- Reduced levels of harm sustained from service user to service user and service user to staff actual assaults which has also resulted in reductions in moderate harm. There does, however, continue to be a focus on the lower level harm sustained, in consideration of both proactive and reactive measures and support.
- A review of the RESPECT training syllabus to help meet the needs of staff and service users through the pandemic in consideration of the challenges that have been faced within the service areas.

- Availability of live data to the service areas via a Patient Safety Dashboard, following the development of SPIKE 2, including the ability to monitor seclusions as they are reported through PARIS.
- Review of services and implementation of a supportive action plan following increase in the number of reported incidents at the Lexden inpatient services. Action plan related to use of restrictive practice and incidences of violence and aggression towards staff.
- Positive assurance from an internal audit report of Trust's Violence and Aggression related processes including training, incident reporting and investigation. Stating that the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied.
- Refresh of the Police Liaison Safety and Security Committee which supports a just culture through embedding of the Memorandum of Understanding between healthcare and the police for dealing with concerns around potential criminality in mental health settings.
- Brøset Violence Checklist has been devised following a CQI project addressing aggression on Oak Ward, to allow staff to better predict when people are at risk of becoming aggressive and provide earlier intervention. Following on from the introduction of the Brøset Violence Checklist – The Dynamic Appraisal of Situational Aggression (DASA) scale is being piloted within Q1 2021/22 in PICU and Norfolk services.
- Following a procurement exercise, introduction of new Lone Working Devices into community services to support individuals working alone and at potential risk.
- In order to meet the aims and objectives of the Mosstogether strategy the following mechanisms are in place:

2.12 Culture of Safety

As a Trust, we have focused on developing a culture of safety over the last year. This has been delivered through approaching safety through collective ownership and leadership as well as a shared understanding and belief that safety is paramount. Some of the initiatives that have supported this approach are:

- Trust appointed to the a new post of Head of Safety and Patient Safety Specialist in quarter 3 as per the requirements of the Patient Safety Strategy. The Patient Safety Specialist provides dynamic, senior leadership and visibility whilst supporting the development of a patient safety culture, safety systems and improvement activity and networking with other Patient Safety Specialists. The post is also key in embedding learning from incidents into the clinical areas and in practice.
- Trauma Risk Management (TRiM) was implemented using Continuous Quality Improvement (CQI) methodology in Essex and IAPT services to support wellbeing and resilience of staff affected by a potentially traumatic incidents and REACT which is an approach to facilitate conversations about difficulties at work and effect on mental wellbeing.
- Search training has been delivered and there is ongoing work to support staff to remain vigilant around potential risks, supported by an internal safety alert has been disseminated.
- Action during quarter 2 was taken to improve the use and ensure compliance of the Applied New Technologies (ANT) system for recording weekly ligature audits and to ensure audits are consistently completed in the weekly cycle. This includes:
    - Heads of Nursing and Matrons routinely sent the ANT audit for their areas of responsibility to advise of the start and finish of a weekly cycle
    - An additional reminder added as a prompt 48 hours before the audit needs to be completed

- A summary of compliance rates by area sent to the Heads of Nursing and Matrons weekly with an additional 24 hours given to Team Leaders to complete the audit with robust follow up.

- SWARM enables a culture of openness, transparency and learning in a blame free environment. SWARM is a multidisciplinary forum which provides open support, guidance and feedback following serious incidents in order to learn from it and improve our service. SWARM creates an environment in which staff share information without fear of reprisal, and integrate the reporting of safety issues into daily work. Over the past year SWARMS have become embedded across the Trust. It is held as soon as possible after a service user safety incident and carried out in a blame-free environment and while the incident is still fresh in everyone's mind. The meeting gives frontline staff a chance to review the facts, discuss what happened, as well as how and why it happened. This helps the team build a more accurate picture of the organisational and human factors involved, and allows staff to identify the key lessons and list actions which can be implemented immediately by the team. SWARM is identifying learning themes to be shared across the organisation, ensuring that our services are safe and we learn from incidents.
- The Trust continues to work alongside key partners including Public Health, Samaritans, British Transport Police, Network Rail Hertfordshire Constabulary, HM Coroner for Hertfordshire, CGL, service user council and carers council and Spot the Signs to collaborate on reducing suicides in the population. The Trust has been part of three suspected suicide cluster responses this year working with partners to support local communities and prevent future suicides.

2.13 Duty of Candour

We are committed to the principles of openness, honesty and transparency. We aim to learn from all incidents and engage service users and families in the review process. Our Duty of Candour policy defines the incidents to which Duty of Candour applies and sets out the duties and responsibilities of senior staff after an incident. The Trust's Duty of Candour policy sets out the requirement to meet the Statutory Duty and this is assessed through the Quality Schedule. Every investigator contacts the person involved in an incident and/or their carer, as appropriate, and offers to meet them as part of the investigation. Their views are routinely recorded and considered in the reports and recommendations made. A copy of the Serious Investigation report is shared in full with the service user or the family and also with HM Coroner, when a death has occurred. Signposting to suicide bereavement support and resources is included in the Duty of Candour letter sent to families, with a Help is at Hand booklet if appropriate.

2.14 National Confidential Inquiry into Suicide and Homicide (NCISH)

The NCISH is led by the University of Manchester. An annual report publishes findings and recommendations which we respond to through our internal Suicide Prevention Group and also our collaborative working across other stakeholders, including Public Health.
The NCISH process requests clinicians to complete questionnaires where a suicide is suspected or confirmed. As a Trust, we disseminate the key findings of the NCISH annual report and associated infographics via our Strategic Business Unit (SBU) governance meetings and also our Continuing Professional Development (CPD) meetings. The NCISH annual report is used to help prioritise the Trusts Suicide Prevention Group work plan for 2021/22.

2.15 Learning from deaths

From April 2017, all Trusts were required to collect and publish information on deaths and serious incidents, including evidence of learning and improvements being made as a result

of that information. This is part of a systematic, NHS-wide approach to reviewing and learning from deaths, being led by the Department of Health, NHS Improvement and the CQC. Guidance for Trusts was published in March 2017 to provide a consistent approach to identifying and reporting, investigating and learning from deaths, and where appropriate, sharing information with other services and organisations.

The following elements capture 'Learning from Deaths' updates as required in the quality accounts regulations:

1. **The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.**
   We capture data regarding all service users who die while they are in our services and all people who have received care in the twelve months preceding their death. During the financial year 2020/21 635 (by date of death) of our service users died. Of the 635 deaths, 147 were identified as meeting the criteria for further review either as a Serious Incident investigation (49) or as a Structured Judgement Review (SJR) (98), as detailed in the table below. A large number of the deaths reported are due to natural causes, ill health or accident and not related to the Trust. Natural cause deaths include deaths from COVID-19.

	East & North SBU	Essex and IAPT SBU	LD&F SBU	West SBU	Total
Quarter 1	158	15	22	16	211
Quarter 2	78	15	12	18	123
Quarter 3	80	12	14	24	130
Quarter 4	109	22	17	23	171
Total	425	64	65	81	635

   This comprised the following number of deaths which occurred in each quarter of that reporting period:
   - 211 in the first quarter
   - 123 in the second quarter
   - 130 in the third quarter
   - 171 in the fourth quarter.

   This number is the reported deaths of all service users in the year we had contact with in the previous 12 months. The number for 2019/20 was 448. Deaths are recorded on Datix, our incident reporting system, which has a mortality section enabling reporting and recording of screening information. In 2020/21, the 'possibly deceased' dashboard Spike 2 was introduced which enables access to information on deaths recorded on NHS Spine.

2. **The number of deaths included in item 1 which the Trust has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.**

61 case record reviews and 49 investigations have been carried out in relation to 635 of the deaths included in item 1.

None of the cases were subject to both a case record review and a Serious Incident investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out are detailed in the table below.

	Serious Incident Investigations
Quarter 1	11
Quarter 2	12
Quarter 3	15
Quarter 4	11
Total	49

	Structured Judgement Reviews
Quarter 1	20
Quarter 2	10
Quarter 3	19
Quarter 4	12
Total	61

Note: Serious Incident investigations and Structured Judgement Reviews are separate process, so the data in each column is not linked.

3. **An estimate of the number of deaths during the reporting period included in item 2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.**

   These numbers have been estimated using the Mortality Case Record Reviews (using SJR methodology) only. In keeping with Root Cause Analysis methodology and national reporting requirements, Serious Incident investigations do not directly address the question whether the death was more likely than not owing to problems in care. Instead serious incidents reports analyse and comment on care or service delivery problems, contributory or influencing factors and a root cause where identified.

   0 representing (0%) of service user deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

4. **A summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 3**
   Not applicable as none such deaths identified.

5. **A description of the actions which the Trust has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 4).**
   Not applicable as no such deaths identified.

6. **An assessment of the impact of the actions described in item 5 which were taken by the provider during the reporting period.**
   Not applicable as none such deaths identified.

7. **The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 2 in the relevant document for that previous reporting period.**
0 case record reviews and 36 serious incident investigations were completed in financial year 2020-21 which related to deaths which took place before the start of the reporting period.

8. **An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the service user, with an explanation of the methods used to assess this.**
0 representing 0% of the service user deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user. This is accounting for the fact that Serious Incident Investigation reports do not make that specific judgement.

9. **A revised estimate of the number of deaths during the previous reporting period stated in item 3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 8.**
0 representing 0% of the service user deaths during the previous reporting period are judged to be more likely than not to have been due to problems in the care provided to the service user.

The Learning Disability Mortality review programme (LeDeR) has been implemented in a phased way by the local areas where we provide services. During 2020/21 99 deaths have been reported by us to the LeDeR programme.

- 31 in the first quarter
- 18 in the second quarter
- 18 in the third quarter
- 32 in the fourth quarter.

Each of the Local Authority Areas implementing the LeDeR programme have done so in a phased way with different approaches to the process. A significant number of reviews have still to be finalised and this process is overseen by the Local Authority. We have a number of reviewers trained in the LeDeR methodology to support the programme. Learning from the programme is shared via our Mortality Governance Group and the Safety Committee.

2.16 Reporting against our Core Indicators

This section of the Quality Accounts sets out how we performed against our 2020-21 Core (local) Indicators. These are the priorities we set at the beginning of the year and are published in the 2019/20 Quality Account Report. We will look at each of these in turn after considering the nationally mandated quality indicators set by the NHSI Regulation Framework.

Core Indicators

1. The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reported period

Performance in Q1 to Q4 in 2019-20	**Q1**	**Q2**	**Q3**	**Q4**
	98.41%	96.99%	97.86%	98.70%
Performance in Q1 to Q4 in 2020-21	**Q1**	**Q2**	**Q3**	**Q4**
	96.98%	97.28%	96.04%	97.39%
Target	95% rate of service users followed up after discharge from the Acute Care Pathway			

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely checked and validated internally as well as by internal and external auditors. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by working to a 3 day follow-up standard throughout 2020/21.

Comment on benchmarking

2. The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	96.9%	97%	96.8%	97.26%
Performance in Q1 to Q4 in 2020/21	**Q1**	**Q2**	**Q3**	**Q4**
	95.33%	97.69%	97.67%	98.26%
Target	95% of those admitted to an inpatient unit should have been gate kept by CATT			

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Data is routinely validated by services as well as the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this indicator and so the quality of its services, by additional validation by clinical service line leads as well as performance with regular feedback to teams on practice and recording issues.

3. The Percentage of Patients aged i). 0 – 15 and ii). 16 and over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

0 – 15

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	0%	0%	0.3%	0.3%
Performance in Q1 to Q4 in 2020/21	**Q1**	**Q2**	**Q3**	**Q4**
	0%	0%	0%	0%
Target	No target set			

16 and over

Performance in Q1 to Q4 in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**
	7.4%	7%	7.1%	5.1%
Performance in Q1 to Q4 in 2020/21	**Q1**	**Q2**	**Q3**	**Q4**
	5.7%	6.2%	4.3%	1.9%
Target	No target set			

Hertfordshire Partnership NHS University Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Trust's Business Intelligence System and then validated by the Performance Team on a monthly basis. Hertfordshire Partnership NHS University Foundation Trust has taken the following actions to improve this data and so the quality of its services, by validation and reviews of reasons for readmissions by the appropriate Service Line Lead, with appropriate learning.

4. The Trust's 'Service User Experience of Community Mental Health Services' indicator score with regard to a service user's experience of contact with a health or social care worker during the reporting period.

Performance in 2019/20	**Q1**	**Q2**	**Q3**	**Q4**	**19/20**
					7.2
Performance in 2020/21	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
					7.3
Target	No target set (comparative data)				

CQC rating is 7.3/10 which is 'about the same as other Trusts'.

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Forms part of an externally run national survey. Hertfordshire Partnership University NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by continuing to develop our recruitment and retention focus and actions and continuing to also focus on the Trust's value based training.

5. The number and, where available, rate of service user safety incidents reported within the Trust during the reporting period and the number and percentage of such service user safety incidents that resulted in severe harm or death.

<table>
<tr><td>Performance in Q1 to Q4 in 2019/20</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Severe Harm 2 (0.14%) Death 10 (0.73%) 1363 Incidents</td><td>Severe Harm 2 (0.14%) Death 13 0.93%) 1384 incidents</td><td>Severe harm 1 (0.08%) Death 13 (1.03%) 1251 incidents</td><td>Severe harm 0 (0%) Death 10 (.81% 1224 incidents</td></tr>
</table>
</td></tr>
<tr><td>Performance in Q1 to Q4 in 2020/21</td><td>
<table>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Severe Harm 3 (0.25%) Death 37 (3.18%) Includes 26 Covid inpatient deaths 1160 Incidents</td><td>Severe Harm 2 (0.15%) Deaths 12(.93%) 1284 Incidents</td><td>Severe Harm 4 (0.33%) Deaths 18 (1.5%) Includes 3 Covid Inpatient deaths 1199 Incidents</td><td>Severe Harm 0 Deaths 15 (1.19%) Includes 5 Covid inpatient deaths 1252 Incidents</td></tr>
</table>
</td></tr>
<tr><td>Target</td><td></td></tr>
</table>

Hertfordshire Partnership University NHS Foundation Trust considers that this data is as described for the following reasons: Routine report generated from the Datix system. Hertfordshire Partnership University NHS Foundation Trust has taken the following actions to improve this: encouraged a high reporting culture and scrutiny on the level of harm including the weekly Moderate Harm Review panel.

Note: due to COVID-19 there has been no published benchmarking data for the indicators during this period.

2.17 Accreditation

Accreditation by the Royal College of Psychiatrists (RCPsyh) and other organisations offers external assurance around quality. Accreditation standards are nationally agreed evidence based best practice standards, with the added bonus of gaining detailed insightful feedback from Service Users and Carers on the service they receive. The Care Quality Commission (CQC) has announced that they will use accreditation as part of their assurance processes. In some instances, inspection activity will be reduced: CQC states that "A trust's participation in accreditation schemes is reflected in the well-led key question at provider level as evidence of a commitment to quality improvement and assurance. Achieving accreditation under a specific scheme is reflected in the effective key question for the relevant core service."

The accreditation process offers HPFT systematic opportunity to achieve quality and service delivery ambition. Beng accredited means that the service generally performs well, service users and carers are engaged with the services, has good systems in place and that the people who use and work in the service are satisfied with it overall. Whilst problems may be less likely to occur in an accredited service, accreditation does not guarantee that problems will not occur from time to time.

Along with The Royal College of Psychiatrist, National Autism Society(NAS) also offer Accreditation. There are no plans currently to go through a separate accreditation process with NAS as there is a significant overlap between the RCPsyh and NAS. The quality network and accreditation projects will use the set of core standards most relevant to them (i.e. inpatient or community). Each project will adopt these core standards which will be used alongside their own specialist standards. The standards have also been linked to the CQC's 'Regulations for service providers and managers, 2014'.'

There is variation between accreditation schemes but they share broadly similar approaches and formats. For example, the community services accreditation scheme ACOMHS highlights that the full set of standards and criteria are aspirational and it is unlikely that any service would meet all of them. Therefore, each standard is categorised at one of three levels:

Type 1: criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;

Type 2: criteria that a service would be expected to meet;

Type 3: criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

All type 1 standards must be met for a service to be accredited, along with 80% type 2 standards and 60% type 3 standards.'
Accreditation runs on a **three year cycle**, each following the cyclical process outlined below.

- a detailed self-review, which includes completion of patient, carer, staff and referrer questionnaires and a health record audit during the self-review phase
- a detailed peer review
- Decision about accreditation category and feedback.

Teams that satisfactorily complete the accreditation process will be accredited for three years. Teams that are participating in the accreditation process will be listed on the Royal College of Psychiatrists' website, with their accreditation rating.

Scheme Type	Scheme Name	Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved).
Schemes commonly, but not exclusively, applicable to acute and / or community health service providers	Joint Advisory Group on Endoscopy (JAG)	Not applicable to HPFT
	Gold Standards Framework Accreditation process, leading to the GSF Hallmark Award in End of Life Care	No
	Anaesthesia Clinical Services Accreditation (ACSA)	Not applicable to HPFT
	Imaging Services Accreditation Scheme (ISAS)	Not applicable to HPFT
	Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	Not applicable to HPFT
	Improving Quality in Physiological Services Accreditation Scheme (IQIPS)	Not applicable to HPFT
	Commission for the Accreditation of Rehabilitation Facilities (CARF)	Not applicable to HPFT
	CHKS Accreditation for radiotherapy and oncology services	Not applicable to HPFT
	Code of Practice for Disability Equipment, Wheelchair and Seating Services (CECOPS)	No
	MacMillan Quality Environment Award (MQEM)	"The Macmillan Quality Environment Mark" (MQEM) is a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer and it is the first assessment tool of its kind in the UK - so this is not applicable to HPFT

Scheme Type	Scheme Name		Please provide details of any services, labs, units or wards that have achieved accreditation (including date accreditation was achieved).
Schemes commonly, but not exclusively, applicable to mental health providers	Accreditation for Inpatient Mental Health Services (AIMS)	AIMS - WA (Working Age Units)	Albany Lodge -Yes
		AIMS - PICU (Psychiatric Intensive Care Units)	Yes
		AIMS - AT (Assessment and triage wards)	No
		AIMS - OP (Wards for older people)	Yes (Lambourne Grove)
		AIMS - Rehab (Rehabilitation wards)	Yes
	Quality Networks	Quality Network for Inpatient Learning Disability Services (QNLD)	Yes - Astley Court
			Yes - Dove Ward
			Yes - Lexden ATU
		Quality Network for Inpatient CAMHS (QNIC)	No
		Quality Network for Community CAMHS (QNCC)	No
		Quality Network for Perinatal Mental Health Services (QNPMH)	Yes
	ECT Accreditation Scheme (ECTAS)		Yes - ECT Suite (Kingfisher Court)
	Psychiatric Liaison Accreditation Network (PLAN)		Yes - CORE 24 MHLT based at Lister General Hospital and Watford General Hospital.
	Memory Services National Accreditation Programme (MSNAP)		Yes (EMDASS North)

	Memory Services National Accreditation Programme (MSNAP)	Yes - EMDASS North West
	Memory Services National Accreditation Programme (MSNAP)	Yes - EMDASS South West
	Memory Services National Accreditation Programme (MSNAP)	Yes (EMDASS East)
	Accreditation for Psychological Therapies Services (APPTS)	Yes (Wellbeing Services in Hertfordshire Accredited).
	Adult Mental Community in North and East Herts (ACOMHS)	Rosanne House- East Yes Holly Lodge- East Yes Cygnet House- East Yes Oxford House- East Yes Centenary House- North Herts Yes Saffron Ground Yes
	CAMHS Community Eating Disorder - Quality Network Community CAMHS (QNCC - ED)	No.
	Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users	Beech Ward - Full review on new standards in November fully meeting 87% of standards – action plan in place.

	and commissioners of services to assess and increase the quality of care they provide.	
	Forensic MH inpatient wards - Royal College of Psychiatrists Centre for Quality Improvement - Peer Review. Aim to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide. Prison In- Reach team	Broadland Clinic – Full review on new standards in January – awaiting final report
		Warren Court - developmental review in February – report received (no score) and action plan in place
		3 Bowlers Green - developmental review in February – report received (no score) and action plan in place
		Accreditation is not offered by QNPMHS
	Perinatal Community Service	Yes - Peer review took place in April 2021 -awaiting feedback

2.18 Clinical Networks

We are members of the following networks:

- Learning Disability Clinical Network
- Clinical Outcomes and Research Evaluation (CORE) CAMHS
- AIMS Accreditation Scheme (Royal College of Psychiatrists)
- East of England clinical senate
- The Trust is part of the larger Eastern Clinical Research Network (CRN). CRN Eastern is funding two consultant psychiatrist research sessions as well as one consultant psychologist research session.
- The Psychiatric Liaison Accreditation Network (PLAN)
- Quality Network for Forensic Mental health Services (Adult Forensic) Community
- Quality Networks for Community Forensic Mental Health Inpatient
- Quality Networks for Early Intervention Psychosis
- Quality Networks for Child & Adolescent Eating Disorder Community
- Quality Networks for Child & Adolescent Inpatient
- Quality Networks for Child & Adolescent Community
- Quality Networks Inpatients Child & Adolescent Inpatient
- Quality Networks for Peri-natal inpatients
- Quality Networks for Peri-natal community
- Quality Networks for Rehabilitation services Inpatient
- National Association of Psychiatric Intensive Care Units (NAPICU)

We continue to:

- contribute to the regional and national transforming care programme through regional expert reference groups
- work with Health Education England on the development of competency frameworks to create and sustain models of good practice in community learning disability and forensic teams
- support NHS England in the development of service specifications and quality commissioning products through our membership of the regional senate and national clinical reference groups.

Part 3 – Other Information

3.1 Care Quality commission (CQC)

The Trust is fully compliant with the registration requirements of the Care Quality Commission under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During 2020/2021 and the height of the COVID-19 pandemic the CQC made changes to the way that it undertook its regulatory role by using a transitional approach to monitoring Trusts and services specifically using a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so that they could continually monitor risk in a Trust and target inspection activity where they identified concerns, rather than continuing the cyclical comprehensive inspections of Trusts.

The Transitional Monitoring Approach (TMA) uses intelligence and Key lines of Enquiry (KLOE) questions to assist in gaining an understanding of the risk level of the Trust and if any regulatory action is required.

The Trust participated in the TMA commencing November 2020 which required a KLOE document to be completed and submitted along with evidence. Through the document, the CQC were seeking overall Trust information but also wanted to focus on Seward Lodge, where their intelligence - complaints and Serious Incidents (SI) - had been highlighted as an area of possible concern. This was provided in a separate document.

There was a scheduled TMA interview with the Executive Director of Quality and Safety (Chief Nurse) and the Deputy Director of Nursing and Quality (DIPC) on 21th January 2021, to complete the TMA process. This was undertaken virtually and the outcome was shared at the meeting. There will not be a published report at the end of the process nor a written report that will be provided.

At the end of the interview, CQC indicated that they were satisfied and, for the Trust, that the TMA process had concluded. Ongoing monitoring will continue in the form of MHA inspection visits and quarterly engagement meetings.

3.2 Serious Incidents response times and analysis

We reported a total of 124 serious Incidents in 2020/21 compared to 112 in 2019/20. This should be seen within the context of the continued work undertaken to encourage a positive reporting culture, and an ongoing commitment to learning and continuous quality improvement. The Trust recognises that variation in numbers of Serious Incidents reported in any one year can be expected, and an over focus on numbers only can discourage reporting, dis-incentivise information sharing and inhibit learning. Unexpected or avoidable death continues to be the highest reported serious incident category, however this has reduced from 51 in 2019/20 to 47 in 2021/21. When compared to the previous reporting year the number of disruptive, aggressive or violent behaviour incidents reported as serious incidents in 2020/21 has increased from 11 to 15. There has been an increase in self-harm incidents declared serious incidents from 25 in 2019/20 to 35 in 2020/21.

Category	2019/20	2020/21
Unexpected or avoidable deaths	51	47
Disruptive, aggressive or violent behaviour	11	15
Apparent, actual or suspected self-inflicted harm	25	35
Slip, trip or fall	10	12
Abuse or alleged abuse of adult patient by staff	1	0
Abuse or alleged abuse of adult patient by a third party	0	2
Medication incident	1	2
Unauthorised absence	0	2
Pressure Ulcer meeting SI criteria	1	0
Sub-optimal care of deteriorating patient	1	0
Confidential information leak/information governance breach	0	1
Health care associated infection or infection control	1	2
Adverse media coverage or public concern about the organisation or the wider NHS	1	0
Apparent, actual or suspected homicide	2	2
Commissioning incident meeting SI criteria	6	0
Diagnostic incident including delay meeting SI criteria	1	0
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	0	1
Treatment delay meeting SI criteria	0	1
Medical equipment	0	1
Allergy incident on ward	0	1
TOTAL	112	124

Serious Incidents are investigated using Root Cause Analysis (RCA). At the beginning of the year the Trust had a significant number of Serious Incidents that were not investigated within the mandated time frame within the Serious Incident Framework. At the start of Quarter 1of 202/21, there were 40 cases outside of the 60 working day timeframe. At the end of Quarter 4 2020/21 there were 0 cases outside of the 60 working day timeframe. During 2020/21 work has continued to understand why this was proving a challenge to turn around. This revealed that work needed to be done on setting clear expectations, timely allocation of reports and protected time for report authors. In addition, the consistent quality of the reports needed strengthening. Weekly update meetings with the SBU's and the Safer Care Team were put in place, along with circulation of cases in process each week. Together these measures have led to a sustained period where all Serious Incident reports have been submitted within the 60 working day timeframe. In keeping with the Serious Incident Framework; for a small number of cases, extensions are agreed between the Executive Director of Quality and Safety and Commissioners on an exception basis for example to support family involvement in the review process.

The NHS Patient Safety Strategy was published in July 2019 which included the Patient Safety Incident Reporting Framework (PSIRF). This was due to be launched in Spring 2021 however due to the effects of the pandemic NHS organisations are expected to transition to using the new framework in Spring 2022. As an organisation, we are expected to establish effective systems, processes and behaviours that enable recovery from the effects of an incident and where learning and improvement are more likely to happen. The strategy provides guidance on how to respond to patient (service user) safety incidents with a focus on a Just Culture, openness and candour, engagement of families in learning from our

incidents, support for staff and trained investigators. These principles are in evidence within our existing processes, and will be built on further in 2021/22. The Trust have commissioned training for 50 staff to undertake incident investigations looking at human and system factors rather than root cause analysis, in preparation for the launch of PSIRF.

The themes that emerged through the learning from serious incidents and structured judgement reviews in 2020/21 included risk assessment and management, record keeping and access to records, liaison with drug and alcohol services, diagnostic overshadowing, physical health monitoring and search procedures. In response to this learning Practice and policy relating to risk formulation was reviewed and funding agreed for a Trust Simulation Training Hub. Work was undertaken throughout the year by the training faculty in recruiting a technician, developing case scenarios based on our priorities and learning from our incidents, facilitator training, recruiting actors, development of the training strategy, purchasing equipment and props. This is being piloted in Q1 of 2021/22. Trauma Risk Management (TRiM) was implemented using CQI methodology in Essex and IAPT services to support wellbeing and resilience of staff affected by potentially traumatic incidents.

We have a suite of measures in place to share learning following serious incident investigations. Learning notes are shared across the Trust which outline what happened in the incident, what was the learning and what teams need to do. This ensures learning is not just limited contained to the local team. These are also discussed at local Quality and Risk meetings. Reflective sessions are held following the completion of a Serious Incident investigation to share the learning, involving multiple stakeholders to enable system wide learning. Recent reflective sessions have included attendance from GPs, British Transport Police, Network Rail, CGL, The Samaritans, neighbouring Trusts as well as HPFT staff. The Trust also holds a monthly virtual learning session where learning from incidents are discussed. This is open to all staff in the Trust and recent topics have included safeguarding, domestic violence, coercive control and risk formulation. Learning from incident investigations is also used to help inform case scenario's in our Simulation Hub where staff can practice their skills in risk formulation and risk management in a safe space. A copy of the Serious Incident Investigation report is also shared with the individuals GP to enable them to embed any learning and improve integration. Where it is thought learning from a serious incident could help prevent incidents elsewhere, we share this on the national Mental Health forum with other Trusts and independent hospitals.

3.3 Compliments, Comments and Complaints

Feedback
We place great value on feedback: comments, compliments and complaints sent in by service users, their carers, relatives, friends and advocates. We encourage people to give feedback using Having Your Say surveys available on the trust website, or to complete a comments, concerns and complaints leaflets available on all wards and outpatient units. We encourage people to raise concerns with staff in the first instance, however if matters cannot be resolved informally people can contact the Experience Team by calling our dedicated phone line 01707 253916 or emailing hpft.pals@nhs.net

Volunteers provide an impartial listening ear as well as support for service users and carers providing feedback.

What we do with feedback
We use information received from all feedback, together with the outcomes of any investigations to improve our services. We work closely with the Safer Care and Practice Governance Teams to ensure that lessons learnt are turned into action plans to ensure continuous quality improvement.

Usually each quarter, clinical teams are required to produce a 'you said, we did' poster based on all the feedback they have received, sharing what they will do to improve the service with those who have taken the time to provide feedback, however these were temporarily suspended to release time to teams for essential clinical work during the pandemic. It is hoped that these will be restarted shortly. Meanwhile the new Quarterly Feedback Group has started which will bring all feedback themes and trends to the group for discussion each quarter, deciding on future work plans to ultimately improve the experience for service users and carers.

Each month compliments are published in the e-magazine for staff. Results of Having Your Say and Friends and Family Test data are sent to teams and they are expected to discuss all feedback in their team meetings.

PALS

PALS provide people with advice and assistance if they have a concern or enquiry. This year we received 932 contacts – an increase of (5%) on last year. The table below shows the number and main categories of PALS contacts, comparing 2020-21 with 2019-20, 2018-19 and 2017-18.

As in previous years, most contacts raised issues for resolution by the PALS team or, more commonly, by the clinical teams. However, there has been a 473% increase in people looking for advice/information, 29% increase in non-HPFT issues and 61% decrease in feedback.

This year we have contacted complainants to discuss the option of informal resolution and as a result, have seen an increase in the number of PALS contacts.

Category	2017/18	2018/19	2019/20	2020/21
Access to Records	0	0	0	8
Advice/Information	67	32	34	195
Enquiry	176	196	208	214
Feedback	240	156	113	43
Issues for resolution	183	272	330	248
Informal complaints	135	97	71	55
Other	0	1	0	6
Non HPFT	59	114	126	163
Total	**861**	**869**	**887**	**932**

Formal Complaints

When we investigate complaints we aim to provide a fair, open and honest response, and to learn from them, so service users and carers can benefit from the resulting changes. The number of complaints received in 2020-21 was 271 compared to 371 in 2019-20. There were also 71 MP enquiries received compared to 47 in the previous year.

Main complaint issue	2017/18	2018/19	2019/20	2020/21
Assault / abuse	3	4	12	5
Clinical practice	89	113	141	144
Communication	24	49	43	47
Environment etc.	4	7	5	4
Security	6	6	8	3
Staff attitude	26	35	35	17
Systems & Procedures	54	69	120	36
Transport	0	1	0	0
Other	0	0	7	15
Total	**206**	**284**	**371**	**271**

Emerging themes
Some PALS 'issues for resolution' and 'Informal complaints' are transferred to the formal complaints process, either because they cannot be resolved within one working day, or because they raise serious issues. Most issues and enquiries are dealt with immediately, or very quickly, by the clinical teams and do not result in a complaint.

The 144 complaints where clinical practice was the primary issue fell into 4 main categories. Most complaints fell into the following groups:

- Care (59)
- Assessment and Treatment (38)
- Care planning (30)
- Communication breakdown with service user (17)

During 2020-21 we received 4 requests for files from the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman.

Compliments
All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the Experience Team so that they can be logged and reported. During the year a new complaints email address has been introduced to highlight the importance of positive feedback. During the last year there has been a 14% decrease in compliments received.

- 2017-18 – 1,981
- 2018-19 – 1,571
- 2019-20 – 1,529
- 2020-21 – 1,321

The table below details some of the positive feedback we have received this year:

Service Line	Service Type	Comment
CAMHS	Community CAMHS DBT	To Liz Hill, When we first met I was completely lost. Thanks to you and the DBT Team, I have the skills to ride the wave and I am beginning to see my life worth living. I cannot thank you enough for the kindness, patience and honesty you have shown me. You have truly brightened my life and made me so much less alone. You are amazing at what you do and I'm so lucky to have had the chance to work with you.
Adult MH NW Locality	Adult Community	Most helpful care I have had. Since being here, I have processed my symptom thoughts way more and understand myself and other peoples intentions better and have more boundaries. Candice helped me achieve things I didn't think I could. Overall, best treatment I could have had, as I have now pushed goals I thought were impossible and now feel more confident overall. Very caring.
Acute 24/7 services	Inpatient	The staff are the most amazing people and I thank them for all their help. Thank you so much.
Norfolk LD	Enhanced Assessment and Treatment Service	Thank you for all you have done for * and us all here at Creswick House. I have never witnessed such a successful team effort and I'm extremely proud to have been a part of it. Well done all involved, we have a happy * and a happy staff team. Thank you all for everything.
Acute 24/7 services	Inpatient	Thank you all for taking care of me and giving me my life back.
Older Peoples` Services	Community Older People	Sympathetic, caring, constructive and kind. My wife (who came with me) was most satisfied at the treatment, we both felt much better as a result. Please keep up the good work and stay safe. Thanks for everything.
Older Peoples` Services	Early Memory Diagnosis and Support Service	Dear Robin (Firminger) Just a short email on behalf of * and myself following the appointment we had with you on *. We wanted to thank you really sincerely for the time and patience exercised in listening very carefully to everything that we said and your professionalism and sensitivity in what was a difficult time with a difficult diagnosis. * tells me that he has already received your report which is amazing. I will attempt to read through this week when I am able to collect but wanted to say that * really took on board the thing that stood out to you quite clearly in that he needs to look at the stresses and strains in his life and make some suitable adjustments. Well done for that also! Thank you again.
CAMHS	Mental Health Support Team	"Every problem or issue I had, they responded with a good solution every time. They also explained everything really well and also explained how it will help. She, Kate Melville, also seemed like she did care when I told her about my problems or anything else." "It was really helpful, not only for personal problems but it was really nice having someone to be able to talk to every week."

Service Line	Service Type	Comment
Adult MH E&SE Locality	Adult Community	Dear Mandy, I just wanted to convey my appreciation for the support received from my support worker, Leyla Omar. Leyla's support since January, during what has been a very difficult time, has meant more than she will ever understand. The reassuring manner in which she conducted her 'check-ins' with me has been of great benefit. With Leyla's encouragement, I joined the Herts Mind Groups and this too has had a positive effect on me. Always kind, unfailingly cheerful, Leyla's empathetic nature has been pivotal in helping me cope. She is an asset to your team. Best wishes *.
Herts LD	West Community Assessment and Treatment Service	Dear Sarah Brown, I can't thank you enough for what you have done, there are not words. I have never felt listened to or understood before, and you have done that, made me feel understood and that you genuinely care. All your effort to protect my Sister and get her the help she needs has meant everything to us, you are a credit to your profession as a Nurse and to your family. From Sister of Service User.
Essex IAPT	Essex IAPT	The service has been excellent and staff friendly and take time to listen and explain, both in Hospital and Community. I am very pleased that my brother is now happier than ever due to the care provided.
Norfolk LD	Community Psychiatry	Service has been consistent, nothing too much trouble, consultations have happened quickly and can't fault the service in any way.
Acute 24/7 services	Inpatient	Thank you so much for your caring, patience and dedication towards * recovery. Our family are extremely grateful. Thank you very much to you all.
Adult MH N Locality	Psychosis Prevention Assessment & Treatment	I now feel ready to try to deal with things myself without the regular support, thanks to the guidance, support and useful strategies which I have received. This has built my confidence in my own ability to manage my mental health and to ask for help if/when needed. Thank you!
Adult MH NW Locality	Psychosis Prevention Assessment & Treatment	I am very happy with all of the services I have received. I feel happier & more positive. Thank you to all of the team that have helped me.
Older Peoples` Services	Occupational Therapy Team	Dear Tracey (Maybury) Thank you so much for your support and kindness over the past few months. Our weekly sessions have really helped to bring back my confidence, which has greatly improved my everyday life. Many thanks.
Adult MH E&SE Locality	Adult Community	To Tracey Maybury, I really cannot thank you enough for all your help.
CAMHS	Child and Family Clinic	Hi Ella (Dr Ella Beeson) and Dr John Fawole, Thank you for your ongoing support, means so much and its lovely to see our old * coming back through now.....really appreciate all that you have both done. Many thanks and kindest regards. Michelle Atherton ADHD Nurse Specialist Child Development Centre

Service Line	Service Type	Comment
CAMHS	Child and Family Clinic	Luke Phelps – CAMHS North, has been absolutely amazing. I didn't see a way forward for myself, I have been struggling to parent my 15 year old and was living in fear about his future and therefore mine. Now I feel that I have been given the tools to be able to cope and feel in control of our future and I'm feeling that the future will be OK. Thank you
Acute 24/7 services	Crisis Resolution Home Treatment Team	To All the lovely Staff Members of the Crisis Team, Thank you so much for all the help, support and care you've provided to me and my family in our difficult time. We really appreciate it!!
Older Peoples` Services	Early Memory Diagnosis and Support Service	Theresa was extremely professional and very caring and supportive. Everything was explained to myself and Mum very well. Thank you!
Older Peoples` Services	Occupational Therapy Team	I am so much better than I was before I started this course. Several methods of learning to cope with anxiety & stress has certainly helped me. Thank you so much for allowing this course for me.
CAMHS	Mental Health Support Team	Just to say thank you again. This has really helped us evaluate the support that we needed to give our son, and helped us make some big decisions which I know are the right ones.
Acute 24/7 services	Inpatient	Just huge thanks to the CATT/Crisis Team, Colne House. Dr W. Pasternak and Team, Molly Smith, Psychologist. All the Medics and Nurses on CATT. All are amazing and deserve huge thanks! Also to all the staff on Swift Ward, Kingsley Green, Kingfisher Court. So many people and not forgetting Kayla Dennison, Social worker and Care Co-Ordinator, a truly lovely, kind, helpful and huge professional support to us.
Acute 24/7 services	Crisis Resolution Home Treatment Team	Dear Joe, I just wanted to thank you for my support during my recovery. Whether it be in the groups or just seeing your friendly face every time I came to The Orchards, I knew you were always there to help me and quite frankly, I wouldn't be here without you! From *
Acute 24/7 services	Inpatient - Mother and Baby Unit	To All the Lovely Staff at Thumbswood, I still think of you all often and I am so grateful for the amazing care * and I received during our time at Thumbswood – you actually saved me! We would love to come and visit when we can and say hello.
Forensic	All Service Types	Outstanding care from all that work there, especially the doctors.

3.4 Infection Prevention and Control

During the year there has been a significant focus on Infection Prevention and Control (IPC) and its role in ensuring the Trust provided high quality, safe and effective care. Detailed below are the key strands to this work and what the Trust did.

Outbreak Management

There were a total of 17 confirmed outbreaks of COVID-19 reported during 2020/21. All were fully investigated and monitored through daily Outbreak Control Team (OCT) Meetings. There were good working relationships between HPFT and external organisations including PHE, CCG and NHSI/E who attended the OCT meetings on a regular basis. A learning note was produced following the outbreaks/incidents after the first wave of the pandemic and all SBUs are in the process completing a fact finding report from the outbreaks that occurred in quarter 4. The findings will be supported by a CQI approach to embed learning.

IPC practices and procedures were implemented in line with the PHE guidance which was regularly reviewed. This included implementing isolation/co-horting practices, nasopharyngeal swabbing and adhering to standard and transmission based precautions. Root cause analysis reports and risk assessments were developed and implemented for staff and service users who were identified as being COVID-19 positive.

Testing

Twice weekly lateral flow tests (LFT) for staff were introduced and the uptake monitored. Managers continuously encouraged staff to carry out this regular testing

Vaccination

Staff were encouraged to have the COVID-19 vaccination and the figures at the end of April were reported at 85.2% for the first vaccine and 32.4% for the second dose which has continued.

Weekly flu meetings continued to be implemented throughout the duration of the flu campaign. The flu vaccination season finished at the end of February 2021 and the number of frontline staff vaccinated was recorded at 72.38%, as detailed in the table below. The SBU teams monitored the administration of the vaccine at a local level and feedback sessions will be implemented to learn to support the aim to improve the overall compliance for 2021/22 flu campaign.

	2018/19	2019/20	2020/21
Frontline staff, flu vaccinations	51.9%	63.9%	72.38%

Cleaning

It was a challenging year with many changes to “normal operating” and service delivery. Aside from the COVID-19 pandemic and the changes to safe working practices across Trust services, all Hard, Soft Facilities Management and waste services have been put out to tender with a more robust specification to improve services for service users and staff. Three contracts were awarded after rigorous checking and evaluation and approval from the Trust Board, which came into effect from 1 April 2021. Waste collection and disposal services were also reviewed and are now provided by two specialist companies audited by the Trust Estates Facilities Management team. The Estates team negotiated and initiated 24/7 rapid response cleaning services for Section 136 and all safety suites at Kingsley Green, which will continue as part of the new contract service.

During the year the Trust worked closely with the cleaning service provider. The Trust also used specialist trained cleaning teams to conduct all COVID-19 related cleaning, separate to regular site cleaning teams with all cleaning conducted in line with PHE guidance. Enhanced cleaning of high touch points/usage areas initiated within site cleaning schedules across the Trust’s estate. A COVID-19 waste standard operating

procedure (SOP) was also developed in compliance with national NHSI/E guidance. Jointly developed internal COVID-19 cleaning procedures for all sites to follow were developed which were in conjunction with PHE guidance. Overall cleaning audit scores remain high throughout the year with an improvement from the previous year, as detailed in **tables below**.

Year	Inpatient	Increase	Overall	Increase
2019-20	96.77%		95.53%	
2020-21	97.17%	+ 0.4%	96.53%	+ 1.01%

Training

All Trust staff were required to be compliant with either level 1 or level 2 training. At the end of quarter 4, the training compliance was reported at:

- Level 1 – 85%; a decrease from quarter 3 which was reported at 93%
- Level 2 – 94%; the same that was reported in quarter 3.

The reduction is believed to be due to the challenges of COVID-19 and the senior nursing team have followed up the non-compliant staff. IPC link practitioners are also offered additional training and development.

'Donning' and 'doffing' training has been provided for multi-professional staff and competencies developed. PPE guidance has been developed and updated in line with national PHE guidance. PPE supplies were monitored on a weekly basis to ensure that staff had sufficient supplies available.

An introduction to Antimicrobial Resistance training was agreed to be essential training for staff and, at the end of quarter 4, the training figures were recorded as 86% compliant which is an increase from quarter 3 (76%).

Throughout the year we continued to undertake surveillance and management with regard to alert organisms such as MRSA, E-coli bacteraemia and Clostridium difficile.

3.5 Safeguarding

Covid-19 – Impact on Safeguarding Activity 20-21

Three national lockdowns has triggered extensive societal change which resulting in some of our most vulnerable children and adults being isolated in their homes with fewer opportunities for professionals and others to intervene and offer support. The impact of these changes has been seen in spikes in safeguarding children activity in Quarters 2 and 3. In addition, safeguarding adults activity in Hertfordshire has also increased significantly in March 2021, however, it is too early to say whether this is linked to the pandemic.

Statutory Safeguarding for Adults in Hertfordshire in 20-21

Despite the pressure of the pandemic, the percentage of safeguarding adults concerns raised to the Trust in Hertfordshire that are converted into a S.42 enquiry has improved significantly as a result of an action plan that was put in place in the early part of the financial year. The plan was put in place because of a marked drop in the number of enquiries taking place, and audits identified the need for improved recording and decision making in investigating teams.

Safeguarding Children

The Trust has developed a child safeguarding form on it's main Electronic Patient Record which allows for the recording and reporting of concerns, offering improved oversight of outcomes for children.

Safeguarding Assurance/Section 11 Visit

This year's safeguarding visit by the Hertfordshire CCGs took the form of a joint child and adult 'Think Family' review for the first time. The CCGs were assured overall and in particular noted areas of good practice including our planned enhanced training offer of a safeguarding training passport, and also the embedding of learning from incidents across the Trust.

Safeguarding Audits

The Trust also continues to audit practice around Safeguarding children and adults across a range of services and areas of good practice have been highlighted, including:

- Good adherence to safeguarding children policies & procedures
- 100% staff are receiving supervision that is rated very good quality
- Evidence the use of the child safeguarding assessment is being embedded into practice
- Good knowledge of the Bruising Policy for Pre-Mobile Babies
- Improvement in recording of Safeguarding Adults decision making and subsequent investigations, including the prompt circulation of minutes.
- Capacity of the service user to make decisions around Safeguarding was recorded.

Safeguarding Improvement Plan

Next years' safeguarding improvement plan includes:

- Continue work to embed the Think Family ethos into practice – this includes hosting an online Think Family conference (June 21) which was attended by over 120 people from HPFT and a range of external agencies.
- Develop online training for staff around domestic abuse (sessions are delivered throughout the year).
- Improve and develop data analytics for the outcome of child safeguarding referrals.
- Fully implement the safeguarding training passport & achieve the minimum target for level 3 safeguarding children compliance. The Trust now publishes a Safeguarding Training Directory of all in-house seminars for it's staff with links to e-learning.
- Closer partnership working with the general hospitals in Hertfordshire, particularly around Safeguarding Children referrals.
- Undertake a Continuous Quality Improvement (CQI) project around Safeguarding supervision recording and reporting.
- Improve support and training offer to teams carrying out enquiries to ensure that recording is accurate and timely, and that decisions are made in line with HSAB policies.

Annexes – Statements from Partners

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Accounts 2020/21

Healthwatch Hertfordshire values the relationship with Hertfordshire Partnership University NHS Foundation Trust and looks forward to continuing to work closely with the Trust to help improve services for patients including supporting the quality priorities outlined in this Quality Account.

Steve Palmer, Chair Healthwatch Hertfordshire, May 2021

Hertfordshire Partnership University Foundation NHS Trust Quality Account Statement from Herts Valleys Clinical Commissioning Group and East and North Hertfordshire Clinical Commissioning Group

This has been a year like no other due to the impact of the Covid pandemic. This has meant significant changes in the delivery of all NHS services and in the way that commissioners work with providers to monitor and assure the quality of the services being delivered. Many of the formal quality monitoring mechanisms used by commissioners such as quality visits and performance reporting were suspended for all or part of the year as part of the national NHS focus on concentrating all possible resources on responding to the pandemic. Throughout the pandemic HPFT have remained open and transparent with commissioners on the challenges that they, along with the rest of the NHS, were facing. The Trust were recognised by the Health Service Journal's award of Mental Health Trust of the Year.

In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, commissioners have reviewed the information contained within the HPFT annual account and checked this against data sources, where this is available to us as part of our existing monitoring discussions and confirm this to be accurate and fairly interpreted to the best of our knowledge.

HPFT have continued to implement Hertfordshire's 'connected lives' approach to social care, although progress has been hampered by business continuity issues arising from the Covid response. The Trust is reorganising its community mental health teams in order to deliver a more robust social care assessment and support process. HPFT maintains strong links and alignment with the County Council and shows commitment to continuing to elevate the role of social care within the Trust.

HPFT's dementia services have been significantly impacted by the Covid pandemic, with many staff from community teams redeployed to support inpatient wards during the acute phases of the incident. The EMDASS memory assessment service was suspended between March and June. HPFT have followed up patients who were referred during this time and by the autumn had recovered the waiting list position to pre-Covid levels. Demand for dementia assessment and treatment beds appears to have dropped as a result of the pandemic and other factors, and HPFT are reviewing their bed base in light of local needs. HPFT continued seeking to integrate their various dementia community teams more closely with primary care and care homes through frailty clinic MDTs and other projects. This work was affected by Covid, and we look forward to working with HPFT to continue these programmes at pace in the coming year.

For HPFT's Specialist Learning Disability Service Covid presented challenges around staffing, bed pressures on Dove ward, delays to treatment and discharge pathways for inpatients, compounded by pressures on social care services in Hertfordshire. The move to virtual therapeutic support has been challenging to people with LD who are already digitally disadvantaged. HPFT responded quickly to the pandemic with a Covid care plan put in place for all service users and a hospital

passport and a treatment escalation plan for all inpatients. HPFT were quick to introduce a physical and mental health RAG rating system across the service to identify vulnerable service users to target support. This included both inpatients and outpatients and was soon followed by work to share and integrate with Hertfordshire's Adult Disability Services who had undertaken risk stratification for social care needs. The amalgamation of this intelligence certainly assisted the accelerated Covid vaccination roll out to people with LD.

Given the pressures and closures happening in the independent hospital sector commissioners would welcome HPFT continuing to work in partnership with us to ensure that we have the appropriate community and inpatient pathways in place, in Hertfordshire, as the independent sector 'rehabilitation' services shrink and inpatient beds outside of the Trust become scarcer.

During the latter part of last year and spanning into this year the Trust has seen a large increase in referrals for the CAMHS Community Eating Disorder service. This is a trend that has been realised across the country and is having an impact on the need for Tier 4 Eating Disorder specialist beds. Consequently, this has meant we have a number of children and young people sitting within our acute hospitals needing to be monitored whilst waiting for Specialist placements. We have been and are currently working with the Trust and our acute colleagues to support these children and young people and manage this demand both now and in the future.

Throughout the year the Trust has continued to form and build partnership working arrangements to allow them to affect positive change across the system for children and young people.

Transformation of Primary and Community Mental Health services has commenced. The Trust have been working with partner organisations and GPs to develop and evolve the Primary Care offer for service users. The primary care roles are part of the overall development of the community mental health transformation programme which is aiming to improve the entire delivery of community mental health services. HPFT are also working with stakeholders on this programme which is being coproduced with service users, carers, Primary Care Networks and other GPs. The NHS, the Trust and the VCSE sector has been significantly affected by the Covid pandemic, however due to the increased use of Teams meetings online and availability of clinicians to join coproduction meetings more regularly the coproduction of service transformation has been more effective at an incredibly challenging time.

HPFT increased their number of referrals for Domestic Abuse during the year and delivered virtual training to staff on Domestic Abuse and safeguarding related topics which were well attended. They supported both acute Hospital Trusts with the care of young people with Eating Disorders and worked well in partnership with other providers, HCC Children's Services and the Police during the year on safeguarding children and young people. However, risk assessment were not always completed when new information emerges and the effectiveness of virtual appointments on outcomes for people of all ages is not yet clear.

A continued focus on strengthening partnership working is, in our view, essential for further improvements around the MH patient experience. This would include partnership work with CGL (who provide drug and alcohol services), local acute hospitals, EEAST and Primary Care.

HPFT have continued with a number of work streams around involvement and engagement for people who use services in order to have their say, including relating to the 'virtual offer' during 2020/21. This was really welcomed, including a focus on improving feedback from specific equality groups. It would be helpful if assurance can be provided of how the feedback has been utilised in planning for future services i.e. "You Said We Did".

HPFT have undertaken a significant amount of critical work to support staff in terms of Health and Wellbeing during 2020/21 including relating to Covid staff risk assessments , vaccinations roll out, BAME network focus, and for 'morale' in the 2020 annual staff survey results, the Trust received the highest score since the survey began 3 years ago. The creation of the NHS and social care wide staff wellbeing hub (Here For You) is another positive example which supports staff across the health and social care system and will be expanded further in the coming year.

We would like to recognise the work HPFT have undertaken to reduce the backlog of Serious Incident reports. The next area of focus is timely responses to clarifications. In terms of priorities for 2021/22 we think there needs to be a continued focus on work around the implementation of learning from 'themes' into robust action through close monitoring/audit, and the identification of causal factors remains key to reduce repeat occurrences where this is possible.

The Trust has experienced additional demand across a number of other areas over the year, notably in activity in the Single Point of Access and in out of area bed placements. We have welcomed receiving regular performance information from the Trust throughout the year as we have worked together as a system to manage and mitigate the pressures experienced.

David Evans

Managing Director

Herts Valleys CCG

Sharn Elton

Managing Director

East & North Herts CCG

Hertfordshire Partnership University Foundation NHS Trust Quality Report Statement from Dee Hart, Chair Hertfordshire Health Scrutiny Committee

2020 / 2021 has required all of us to adapt our ways of working. On behalf of the Hertfordshire Health Scrutiny Committee I would like to thank the Herts Partnership University Foundation Trust for the services it continued to deliver during the pandemic and its response in recovery. We are aware of the challenges facing the NHS and will seek to continue working constructively with the trust.

Members of the committee have been appreciative of the support the Herts Partnership University Foundation Trust has provided during this challenging period. The contribution from the trust has enabled the committee to maintain its overview of the health system in Hertfordshire. It ensured our scrutiny members heard about the impact on services and how it was seeking to address on-going needs and additional pressures. The Herts Partnership University Foundation Trust has participated in committee meetings in December 2020 and March 2021; contributed a briefing for members on hospital visiting during the pandemic (November 2020); and officers of the trust also hosted a virtual site visit in January 2021.

Despite the demands of the pandemic there has also been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the Herts Partnership University Foundation Trust over the last 12 months. The Trust has supported the scrutiny process when approached and the Committee look forward to working with the Herts Partnership University Foundation Trust in the future.

Yours sincerely

Dee Hart
Chairman Hertfordshire Health Scrutiny Committee