NHS
Hertfordshire
Partnership University
NHS Foundation Trust

Quality Account 2018 – 2019

as One

Our Values
Welcoming Kind Positive Respectful Professional

Contents

Part 1 Statement on Quality from our Chief Executive

This Quality Account Report has been designed to report on the quality of our services. It offers you the chance to find out more about what we do and how well we are delivering on our commitments. The report's aim is to describe in a balanced and accessible way on how we provide high-quality clinical care to our service users, the various communities we serve and our commissioners. It also shows where we could perform better and what we are doing to make those improvements.

I am pleased to present this Quality Account Report in a year when the awareness of mental health has continued to be higher than ever before. Whilst this is a welcome societal change in itself, understandably this has led to many more people seeking to access our services.

Despite such challenges, May saw the Care Quality Commission (CQC) publish the outcome of its inspection of our services that took place in February and March 2019. I am delighted to report that we achieved an overall rating of outstanding, which included being rated as outstanding for the quality of care we provide and our service being well-led. In addition, our forensic inpatient/secure wards, child and adolescent mental health wards, wards for people with a learning disability or autism and community-based mental health services for adults of working age were also judged as being outstanding. This means that four of the eleven services inspected by the CQC are now rated as outstanding, with the remaining seven rated as good.

Once again, the CQC recognised the commitment of all our staff both in living the Trust values and demonstrating leadership at every level along with our strong safety culture. I believe it is this leadership of all our dedicated and hardworking staff that has enabled us to perform well against increased demand for our services, allowing our staff to continue delivering great care and great outcomes for over 400,000 people across four counties.

We are now one of just four NHS Trusts across England providing mental health and learning disability services to achieve a CQC outstanding rating and the only such service in the east of England. This comes at a time when we have launched successfully several new initiatives that you will read about in this Quality Account Report, including a co-produced transformational learning disability model across Essex, our new Tier 4 services for children and adolescent mental health services (CAMHS) and the new psychosis pathway.

Delivering great care depends on our ability to attract and retain great people and, as with many NHS organisations across the country, ensuring we have a stable workforce remains a top priority. 2018-19 saw us recruit more staff than ever before and to streamline our processes so that the time taken to fill vacancies and people to be in post was reduced. We also introduced a range of initiatives, from greater career opportunities and improving our staff experience, has helped us to retain staff. And when it comes to the latest National NHS Staff Survey, the vast majority of our scores are in line with or above the national average, but perhaps most importantly we had the highest score in the country for safety culture.

I look forward to this coming year as one where we continue to help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well. We will do this by continuing to build and maintain key relationships with our colleagues across health and social care to help us tackle collectively the challenges we face. This is because part of that journey – as set out in the NHS Long term Plan published in January 2019 – relies on great partnerships and working with other organisations to deliver integrated services that support and treat people holistically.

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, Chief Executive
Dated: 22 May 2019

Background

Once a year, every NHS Trust is required to produce a Quality Account Report. 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 Report is to make sure that everyone who wants to know about what we do can access that information. All Quality Account Reports are presented to Parliament before they are made available to service users, carers and members of the public on the NHS Choices website.

What is NHS Choices?

NHS Choices is the UK's biggest health website. It provides information about symptoms conditions, medicines and treatment, NHS services and advice about how to live as well as possible at www.nhs.uk

What the Quality Report includes

- What we plan to do next year (2019-20), what our priorities are, and how we intend to address them
- How we performed last year (2018-19), 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, Herts Valleys Clinical Commissioning Group (CCG), East and North Herts CCG and Hertfordshire County Council Health Scrutiny Committee.

Understanding the Quality Account Report

We recognise that some of the information in this Quality Account Report may be hard to understand if you don't work in health care. We've used the coloured boxes to provide explanations and examples that should help.

This is a 'What is it?' box

These explain a term or abbreviation

This is a 'Quotes from staff, service users, carers' and others box

These support and illustrate the information in the report

This is a 'Comments' box

These include quotes from regulators and other governing bodies

A full list of the acronyms (abbreviations) we use are provided at the end of the Report.

Hertfordshire Partnership University NHS Foundation Trust

We provide 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 North Essex and learning disability services across 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

Our Vision:

Delivering great care, achieving great outcomes - together

Our Mission:

We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well

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.

"Thank you for the excellent care that you have all given [name] whilst she was staying with you. Also we would like to thank the staff for all of the support given to us as a family from you all"

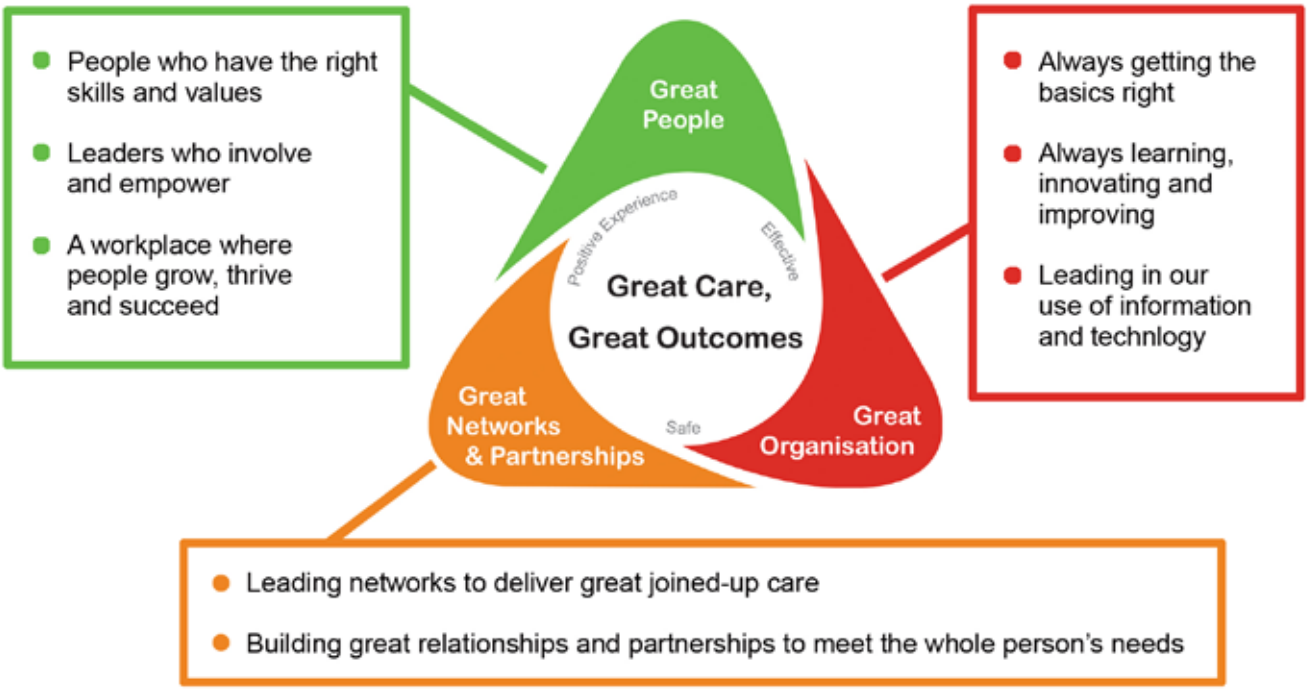
Our strategy

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 demonstrates 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.'***

"Words cannot really express how grateful we are that you have been on our journey with us - and how your calmness and positivity has enabled us to have faith that this time to say farewell would come. All the best wishes for the future"



In 2018-19 we continued to provide:

- A full range of mental health care and treatment for people in Hertfordshire with mental ill-health. This includes a comprehensive primary care service for those with more common mental health problems
- Inpatient and specialist community health care for adults with learning disabilities in Hertfordshire, North Essex and Buckinghamshire
- Secure inpatient services for adults with learning disabilities and challenging behaviour in Hertfordshire and Norfolk and an Assessment and Treatment unit for people with learning disabilities at Astley Court in Norfolk
- Specialist services for:
  - Adolescents who need mental health inpatient care
  - Community perinatal care (mother and baby)
  - Treating severe obsessional-compulsive disorder.
- IAPT services provided in three CCG areas in North Essex:
  - West Essex in partnership with Mind West Essex
  - Mid Essex in partnership with Chelmsford Counselling Foundation and Mid and North East Essex Mind
  - North east Essex in partnership with North East Essex Mind.

Across our 89 sites, we employed approximately 3,118 permanent staff, with 147 on a fixed term/temporary contract and 682 bank staff, and budgeted to spend c. £237m on our services.

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.

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), as well as the following:

- MIND – Predominantly across our IAPT services, which also include Dynamic Interpersonal Therapy (DiT). They also assist with the New Leaf service taking over from Druglink 2018
- Mental Health Matters – in relation to Employment Advisors as part of the Department of Working Pensions (DWP) Initiative
- Growing People – horticultural therapy project for service users being looked after by Adult Mental Health Services at Lister Mental Health Unit in North Hertfordshire
- Reinvent Lifestyle – providing bespoke exercise to improve and maintain wellness
- Princes Trust – provision of employment and vocational support to service users with a diagnosis of First Episode Psychosis (FEP)
- Books Beyond Words – in the production of easy read booklets for learning disability services working in partnership to develop the app

We lead a new partnership with Essex Partnership University Trust and Anglia Community Enterprise to deliver a new model of specialist health services for people with a learning disability across all of Essex.

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

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.

What is a Partnership University Foundation Trust?

NHS Foundation Trusts are not-for-profit, public benefit corporations. Like the rest of the NHS, they provide free care based on need, not ability to pay. Foundation trusts have freedom to decide locally how to meet their health care obligations. These trusts are accountable to local people, who can become members and governors and are authorised and monitored by an independent regulator.

HPFT is a Partnership Trust; meaning we provide health and social care for specific groups of people – people with mental and physical ill-health, and those with learning disabilities – in partnership with local authorities, the University of Hertfordshire and with the mental health charity, Mind.

What is Commissioning?

Commissioning is the process of planning, agreeing and monitoring services. The groups:

- assess the health needs of their local population
- plan care pathways for people with specific health problems
- specify which services their local populations need
- negotiate contracts with the organisations that provide these services
- make sure the services those organisations provide are good enough.

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 CCG
- Norwich CCG
- South Norfolk CCG
- North Norfolk CCG
- West Norfolk CCG
- Great Yarmouth and Waveney CCG
- NHS England Midlands and East
- Barnet CCG
- London Borough Hillingdon 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.

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 jacky.vincent@nhs.net This Quality Account Report was signed and approved on 22 May 2019 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 email Helen Bond: hpft.comms@nhs.net

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, Kevin Hallahan by:

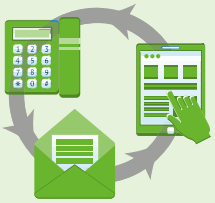
- Email - hpft.speakup@nhs.net
- Telephone - 01727 804100 on the confidential “Speak Up” Line
- In writing - to the Chief Executive or any senior person stating the concern
- The Trust’s incident reporting system (Datix)

The Trust’s nominated “Speak Up Champion” is Loyola Weeks, a Non-Executive Director on the Board.

The Trust in 2018-19

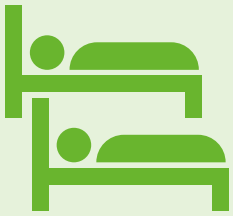
Mental Health, Community and Learning Disability Services for children and adults

407,502
secondary care contacts

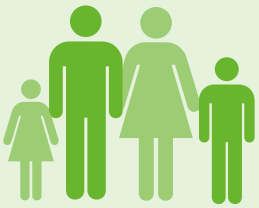


57,221 referrals through SPA

153,265
IAPT contacts



140,859
occupied bed days



87% would recommend us to friends and family

3,947 (permanent and temporary) Staff working across 89 Trust sites

What is SPA?

The Single Point of Access (SPA) is the telephone clinical triage service for all new referrals into the Trust. This service was set up in 2013 to ensure that that there was a single point of contact to access any our mental health care services, and it makes sure that service users are referred to the right service straight away.

What is IAPT?

IAPT is the government's Improving Access to Psychological Therapies initiative. Our IAPT Service is part of this and aims to reduce distress and improve general mental health through teaching coping strategies based on Cognitive Behaviour Therapy (CBT). CBT is an evidence-based psychological therapy recommended by the National Institute for Health and Care Excellence (NICE). It offers service users effective techniques and skills to manage distressing emotions. The Wellbeing Service is made up of a range of clinicians and mental health professionals who deliver treatment in a variety of flexible ways.

"I feel that the service and staff are very good, they do a good job. Very dedicated and a massive help. My CBT Therapist is a good listener and has a good way of getting me to understand and work through some problems. Very nice and very friendly, thank you to everyone and the service, very helpful to me."

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.

This part of the report sets out:

- The priorities we have identified for 2019-20 and how we decided on these
- Statements of assurance from our Trust Board
- How we performed in our priority areas during 2018-19

In this report we:

- Show how we performed in our priority areas during 2018-19
- Give an update on how we performed against the priority areas we identified in our 2017-18 Quality Report
- Describe our priority areas for 2019-20
- Showcase notable and innovative practices that we have introduced across our services during the past year.

What is assurance?

Data quality assurance is the process of ensuring that data is as accurate, relevant and consistent as it can possibly be.

2.1 Quality priority areas for 2018-19

The table below provides an overview of our quality priority areas from last year (2017-18) and how we performed during this financial year, divided into each quarter throughout the year, and then the year end.

Patient (service user) Safety		Target	Q1	Q2	Q3	Q4	2018 / 2019
1	Every discharge 7 day follow up – see Core Indicators	≥=95%	96.05%	97.11%	97.81%	96.61%	96.88%
2	CAMHS 28 day wait for routine referrals	≥=95%	50.95%	80.45%	83.33%	34.07%	60.84%
3	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death – see core indicators	-	1053* Incidents 0.66% (7)	994* Incidents 0.60% (6)	Not yet available		
4	Number of inappropriate out of area placements	1,050	339 bed days in 2018/19 = 28.25 days – per month average				
5	Cardiometabolic indicators – covered under CQUIN						
Difference							
6a)	Emergency readmission within 28 days 16+ - see Core Indicators	N/A	4.70%	5.19%	6.29%	7.85%	6.00%
6b)	Emergency readmission within 28 days 0 – 15 – see Core Indicators	N/A	0.2%	0.41%	0%	0.68%	0.31%
7	FEP waits 14 days (NHSI mandatory)	≥=53%	85.92%	86.54%	89.29%	76.67%	84.52%
8	CATT gatekeeping – see Core Indicators	≥=95%	97.1%	97.28%	96.23%	97.26%	97.02%
9a)	IAPT recovery rate	≥=50%	53.32%	53.58%	53.75%	54.98%	53.91%
9b)	IAPT 6 week wait	≥=75%	83.68%	91.92%	91.84%	77.54%	86.06%
9c)	IAPT 18 week wait	≥=95%	99.79%	99.95%	99.88%	99.67%	99.82%
Service User and Carer Experience							
10	Service users reporting their experience of Community Mental Health Services – being treated according to Trust values	≥=80%	76.55%	76.27%	80.32%	83.1%	79.00%
11	Carers feeling valued by staff	≥= 75%	73.42%	81.18%	81.82%	84.85%	80.24%
12	Staff Experience Friends and Family Test	≥= 70%	74.64%	76.21%	N/A*	76.85%	75.81%
13	Service users Friends and Family Test	≥= 80%	85.54%	85.73%	88.63%	87.76%	86.82%

**figures are provisional and taken from Datix; NRLS provide 6 monthly data*

CAMHS 28 day wait for routine referrals

CAMHS 28 day wait performance Key Performance Indicator (KPI) is measured on 'waited' data for example, cases that have been referred and seen within 28 days. The KPI only takes account of referrals that come into the service via SPA and, as a result, excludes children and young people who have been referred via other routes, such as urgent referrals from our CAMHS Crisis Assessment and Treatment Team (CATT), Trusted Assessments and also Attention Deficit Hyperactivity Disorder (ADHD) appointments, which make up a significant proportion of the CAMHS workload. The 28 day KPI does also not take into account the full range of work offered by the service; the number of first appointments the community teams are offering has increased to manage demand although there are increased waits.

We believe there are a number of reasons for the increased wait times, including:

- An increase in the overall number of referrals into SPA
- An increase in the number of presentations via Accident and Emergency departments requiring urgent follow on appointments
- Challenges with recruitment in some teams reducing the ability to offer the number of appointments required
- Pressure in the wider Tier 2 system and the reduced early intervention offer, escalating cases directly to specialist CAMHS
- Loss of counselling services or services working at capacity and cases escalating prior to receiving an early intervention offer

"Another helpful appointment with our doctor - he listens and engages so well with my son"

We are working with partners to review the wider CAMHS system in Hertfordshire. We are also undertaking a range of different initiatives to ensure we are working to improve our wait times, including:

- Working with Continuous Quality Improvement (CQI) methodology to look at how we work and where change/improvements may be made
- Reviewing our SPA process for referrals
- Reviewing job plans for existing staff
- Developing additional CAMHS Pathways
- Reviewing all current caseloads
- Leading the management of ADHD waits with support from HELIOS (the company assisting ADHD assessments)
- Continuing the recruitment drive
- Offering additional clinics for example Saturday clinics
- Developing and implementing a 'Waiters Protocol.

Number of inappropriate out of area placements

Our out of area placements are maintained at a low threshold owing to the robust clinical and operational oversight as well as the bed management processes we have in place. We also ensure that out of area placements are subject to scrutiny at all levels in the Trust. This is subject to external audit procedures; there were no areas of concern identified.

FEP waits 14 days (NHSI mandatory)

Service Users referred to the Psychosis, Prevention, Assessment and Treatment (PATH) Early Intervention in Psychosis (EIP) Service require a specialist assessment to ascertain their needs. The PATH service is required to offer an assessment within 14 days of referral to 53% or more of service users.

Our PATH service has a diverse workforce of registered nurses, social workers, Associate Practitioners, support workers, psychologists and consultant psychiatrists, all of whom are trained in specialist assessment for First Episode in Psychosis and who work together to offer rapid assessment to service users.

PATH is able to offer a flexible approach to assessment, contacting service users and carers as soon as the referral is received, to arrange a mutually suitable time and venue, within 14 days. Our PATH service recognises that referral to the team can be a difficult time for people and works to ensure our offer of assessment is coupled with opportunities to address concerns, answer questions and ensure people feel as comfortable as possible when meeting our staff. This flexible partnership approach offers service users and carers an opportunity to work together with us around their assessment and reduces missed appointments. This is subject to external audit procedures; there were no areas of concern identified.

Service users reporting their experience of Community Mental Health Services – being treated according to Trust values

The Community Survey was reviewed during 2018-19, which resulted in a different survey during quarter 1, than for quarters 2, 3 and 4. The new survey added a question for the Trust's 'positive' value – previously no questions were counted for 'positive'. As the value score is a composite score across the Trust's five values, this change is likely to have affected the overall score for the year. However, when we reviewed the data for the year, the outlier value is 'positive', which includes questions on supporting physical health and giving opportunity an to involve people who are supporting service users.

For 2019-20, the work of our Carers Plan will engage more with service users around how we can improve on our involving carers. We have quarterly targets regarding improvements in how people feel they have been supported around their physical health and included in our Annual Plan.

2.2 Priorities for Quality Improvement 2019-20

Our Board agreed our 9 key quality priorities for 2019-20 at the Board meeting on 22 May 2019.

How we chose our Quality Priorities

We:

- consulted with stakeholders including service users, carers, staff, commissioners and others
- decided to continue to build on and monitor the work we did in 2018-19 and previous years that could potentially significantly improve our services.

What is the Trust Board?

The Trust Board is the board of directors responsible for overseeing the running and management of the Trust. It is made up of Executive Directors, including the Chief Executive, who are full-time senior staff, an independent Chairman and Non-Executive Directors who do not work within the Trust.

What is a stakeholder?

A stakeholder is a person or organisation with an interest in the Trust who should be involved in our decision-making processes.

The consultation process

We started by considering:

- the feedback we have received on the quality of our services in surveys, reports and other documents
- our stakeholders' (including our commissioners') priorities.

From this we developed nine potential quality priorities to focus on next year, which we discussed with our stakeholders.

We are grateful to all who have contributed to, supported and worked with us in reviewing and setting our quality plans for 2019/20, including:

- Adult Service User Council
- Young Person's Service User Council
- Commissioners – Norfolk, Essex, Buckinghamshire and Hertfordshire
- GPs
- Carers Council
- Trust Governors, through the subgroup that leads on Quality
- Trust Board of Governors
- Trust clinicians and managers
- Trust Audit Committee
- Trust Executive Team
- Hertfordshire Health Scrutiny Committee
- Healthwatch Norfolk, Essex, Buckinghamshire and Hertfordshire

What we heard during the consultation

Our stakeholders reported that, overall, the proposed indicators were great and considered the range of services we provide. In particular, we heard that the safety focus was important. The continued focus on carers was welcomed, including the carers' involvement with discharge planning and processes with carers from acute mental health settings.

Selection and Monitoring

NHSI provides guidance on the detailed requirements for the Quality Account Report, within which our priorities cover three indicators from each of the three areas of service user quality – Safety, Effectiveness and Experience. Six of these are mandated by NHSI as marked in the table below as (NHSI). Below details those indicators that are not mandated by NHSI and the reasons we have chosen them:

- **The percentage of service users on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.** The first few days after discharge can be a vulnerable period in an individual's life and we want to support their recovery in readjusting to life in their own community
- **Carers feeling valued by staff.** This is one of our 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. This was also chosen by our Carer Council
- **Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family.** The Staff Friends and Family Test score is a good indicator of how staff feel about the services they provide and their level of engagement. We aim to further improve during this next year to enable an increased level of staff engagement and continue to improve the levels of care we provide to service users

The quality priority areas for 2019-20 agreed by the Trust Board are:

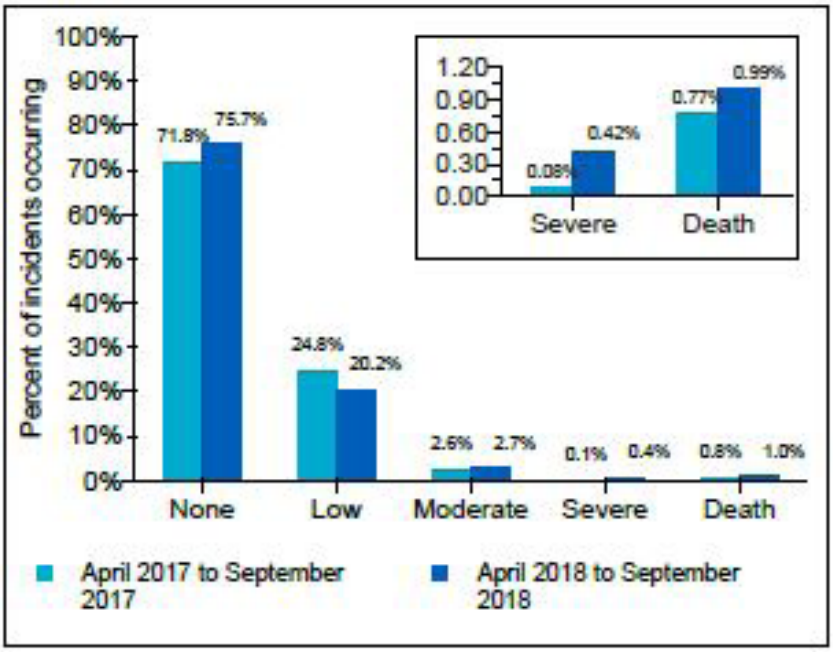
Patient (service user) Safety	
1	The percentage of service users on CPA who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period
2	Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death (NHSI)
3	Inappropriate out-of-area placements for adult mental health services (NHSI)
Clinical Effectiveness	
4	The percentage of service users aged: (i) 0 to 14 and (ii) 15 or 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 (NHSI)
5	Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)
6	The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period (NHSI)
Service User and Carer Experience	
7	Carers feeling valued by staff
8	Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family
9	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 (NHSI)

Detail of each priority

The Performance Team will report on all figures once a month for goals 1, 4, 5, 6 and 7; quarterly for goals 2, 3 and 8 and annually for goal 9. Data quality is important in ensuring the accuracy, validity and reliability of the KPIs. Where possible, the Performance Team will undertake work to ensure this. The Performance Team is internally and externally audited annually. Auditors check a sample of cases to ensure accuracy of the data being reported.

Name of Priority	**Patient (Service User) Safety** 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				
Related NHS Outcomes Framework Domain and who will report on them	1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions All Trusts providing mental health services				
Data Definition	Service user is followed up either by face to face contact or by telephone within 7 days of discharge, whether the Trust contacts the service user or the service user contacts the Trust				
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis				
Validation	Data is validated and checked by Data Quality Officers and the Performance Team				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	96.05%	97.11%	97.81%	96.61%	96.88%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
	95.6%	96.8%	96.7%	96.01%	96.64%
Target (National)	95% rate of service users followed up after discharge from the Acute Care Pathway				

Name of Priority	**Patient (Service User) Safety** 2 – Rate of service user incidents and the number and percentage of such service user safety incidents that resulted in severe harm or death
Related NHS Outcomes Framework Domain and who will report on them	Treating and caring for people in a safe environment and protecting them from avoidable harm
Data Definition	The number and 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

How this data will be collated	The Safer Care Team upload data onto the National Reporting and Learning System (NRLS) which is a central database of service user safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of service user care
Validation	This data is validated via the NRLS which is managed by NHSI
Performance in Q1 to Q4 in 2018-19	

Degree of harm, April 2018 to September 2018

None	Low	Moderate	Severe	Death
1.979	528	71	11	26

Name of Priority	**Patient (Service User) Safety** 3 – Inappropriate out-of-area placements for adult mental health services
Related NHS Outcomes Framework Domain and who will report on them	The Government has set a national ambition to eliminate inappropriate OAPs in mental health services for adults in acute inpatient care by 2020-21. The Department of Health directed NHS Digital to carry out this work.
Data Definition	Demonstrable reduction in total number of bed days service users have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21. An out of area placement is when a service user with assessed acute mental health needs who requires non-specialised inpatient care (CCG commissioned) is admitted to a unit that does not form part of the usual local network of services

How this data will be collated	Data is collated by the Bed Management Team and submitted by the Information Team				
Validation	The data is checked and signed off on a monthly basis by the relevant Senior Service Line Lead and is audited by KPMG				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	165	30	16	105	**Mean = 26.3** days per month
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
				281	**Mean = 93.7** days per month
Target (National)	Q1 = 300; Q2 = 275; Q3 = 250; Q4 = 225				

Name of Priority	**Clinical Effectiveness** 1 – the percentage of service users aged: (i) 0 to 14 and (ii) 15 or 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
Related NHS Outcomes Framework Domain and who will report on them	Helping people to recover form episodes of ill health or following injury All Trusts
Data Definition	This indicator measures the percentage of admissions of people who reside in Hertfordshire who have returned to hospital as an emergency within 28 days of discharge after an inpatient stay. It aims to measure the success of the NHS in helping people to recover effectively from illnesses. If a person does not recover well, it is more likely that they will require hospital treatment again within the 28 days following their previous admission. Thus, readmissions are widely used as an indicator of the success of healthcare in helping people to recover. This indicator is currently only reported for those residing in Hertfordshire, as required by the Hertfordshire Commissioners.
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis
Validation	Data is validated by the Strategic Business Unit who look at all re-admissions on a monthly basis

Performance in Q1 to Q4 in 2018-19		Q1	Q2	Q3	Q4	18/19
	0-15 16+	0.2% 4.70%	0.42% 6.26%	0.41% 5.19%	0.68% 7.85%	0.31% 6.00%
Performance in Q1 to Q4 in 2017-18		Q1	Q2	Q3	Q4	
		4.51%	7.8%	7.09%	5.01%	
Target (National)		No target set (National Indicator)				

Name of Priority	Clinical Effectiveness 2 - Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral				
Related NHS Outcomes Framework Domain and who will report on them	The standard requires that more than 53% of people experiencing first episode psychosis (FEP) will commence treatment with a NICE-approved care package within two weeks of referral				
Data Definition	A maximum wait time of two weeks from referral to treatment				
How this data will be collated	Data will be collated by the performance team and reported on a monthly basis				
Validation	Performance and service validate the data on the waiting time				
Performance in Q1 to Q4 in 2018-19	Q1	Q2	Q3	Q4	18/19
	85.92%	86.54%	89.29%	76.67%	84.52%
Performance in Q1 to Q4 in 2017-18	Q1	Q2	Q3	Q4	
	79.4%	66%	69.5%	64.18%	
Target (National)	56% for 2019/20				

Name of Priority	Clinical Effectiveness 3 - The percentage of admissions for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period
Related NHS Outcomes Framework Domain and who will report on them	The proportion of inpatient admissions gate kept by the crisis resolution home treatment teams.

Data Definition	A Crisis Assessment and Treatment Team (CATT) provide intensive support for people in mental health crises 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 meet all of the fidelity criteria including gatekeeping all admissions to psychiatry inpatients wards and facilitate early discharge of service users. In order to prevent hospital admission and give support to informal carers CATT teams are required to gate keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis team was involved in the decision making-process, which resulted in an admission.
How this data will be collated	Data will be collated by the Performance Team and reported on a monthly basis
Validation	Validated by CATT Leaders and Senior Service Line Lead

Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
	97.1%	96.39%	97.28%	97.26%	97.02%

Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	96%	97.8%	99.6%	98.19%

Target (National)	95% of those admitted to an inpatient unit should have been gate kept by CATT

Name of Priority	**Service User And Carer Experience** 1 - Carers feeling valued by staff
Data Definition	'Having your say' is offered to all carers. All questions are set against the Trust Values. One particular question asks "Do you feel valued by staff as a key partner in care planning?" The carer has the following options to choose from - Yes, No, Don't Know. Once the completed questionnaires are received they are entered onto the Membership Engagement System (MES) which is the Trust's Service Experience dashboard and reported upon by the Performance Team. Only replies that are recorded as 'Yes' are taken to be a positive answer.
How this data will be collated	Data will be collated by the performance team via MES and reported on a monthly basis
Validation	All surveys are re-checked for accuracy and 5% of the monthly inputs are re-checked by the Service Experience Lead

Performance in Q1 to Q4 in 2018-19	Q1	Q2	Q3	Q4	18/19
	73.42%	81.2%	80.32%	84.85%	80.24%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	
	68.7%	69.8%	71.43%	68.67%	
Target (National)	>/=75%				

Name of Priority	**Service User And Carer Experience** 2 - Staff Friends and Family Test; staff who would recommend the Trust as a provider of care to their friends and family
Data Definition	The Friends and Family Test (FFT) is a feedback tool which allows staff to give their feedback on HPFT services. The FFT asks how likely staff are to recommend the services they work in to friends and family who may need treatment or care and also as the employer of choice. Participants respond to FFT using a response scale, ranging from “extremely unlikely” to “extremely likely”. They also have the opportunity to provide a free text comment after each of the two FFT questions. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. This question is in the Trusts Pulse survey This is also an NHS England statutory submission.
How this data will be collated	Staff FFT data is to be collected and submitted quarterly for Q1, Q2 and Q4 after the end of each quarter. For Q3 18/19 (when the annual NHS staff survey is undertaken) the Pulse survey was not conducted
Validation	Validated by external company MES who manage the reporting and checked by Workforce Department.

Performance in Q1 to Q4 in 2018-19	Q1	Q2	Q3	Q4	18/19
	74.64%	76.21%	N/A	76.85%	75.81%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	
	57%	67.7%	67%	73.9%	
Target (National)	Staff Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them >=70%				

Name of Priority	**Service User And Carer Experience** 3 - 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				
Data Definition	This indicator is made up of two questions in the Community Mental health Survey: • Time: for the person or people seen most recently giving enough time to discuss their needs and treatment • Understanding: for the person or people seen most recently understanding how their mental health needs affect other areas of their life.				
How this data will be collated	Data is collected via the Annual Community Mental health Survey. Responses were received from 218 people at the Trust				
Validation	Validated independently by NHS Surveys				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**	**18/19**
					7.2%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
					7.3%
Target (National)	Service User Friends and Family Test (FFT) - recommending Trust services to family and friends if they need them >=80%				

How these targets will be monitored

We will measure and monitor our progress on the implementation of each quality 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.

What does reliable mean?

If data is reliable then it gives a consistent result. This means that if someone else was to collect the same information in the same way, the results would be the same.

What does valid mean?

If data is valid then it measures what it is supposed to measure.

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 c. £223.5m and our total income was c. £235.6m (including Provider Sustainability Fund (PSF) expected of £3.5m), thus 95%.

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.

SPIKE2 is enhancing practice audit capabilities by providing increased data granularity, the ability to look further than the headline numbers and gain insights into the quality of information. It provides the function to analyse individual questions in greater details. Furthermore, SPIKE2 enables us to follow a service user's journey through our organisation and improve our ability to sample flow and pathways more effectively and efficiently.

What is a clinical audit?

Clinical audit is a way to find out if healthcare is being provided in line with standards and tells care providers and patients where their service is doing well, and where there could be improvements.

The aim is to allow improvements to take place where they will be most helpful and improve outcomes for service users.

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).

POMH-UK 15b Prescribing Valporate for Bipolar Disorder

A baseline audit was completed in September 2015 and a re-audit carried out in September 2017. The report was published in May 2018 and therefore the results were not able to be reported in last year's Quality Report. In total, 56 Trusts participated within the re-audit. Valporate is prescribed for almost one in four women of child-bearing age (defined as 50 years of age or younger) and this proportion has not changed since the baseline audit.

The results are detailed in the table overleaf.

Practice standard 1 – do not routinely prescribe Valporate for women of child-bearing age	2017 HPFT (n=34)	2017 TNS (n=2157)	HPFT compared to TNS	2017 National ranking out of 56 Trusts	2015 National ranking out of 55 Trusts (HPFT 2015 results)
Proportion of women of child-bearing age on Valporate	24%	25%	↔	26	41 (25%)
Practice standard 2 – patients started Valporate in past 6 months	HPFT (n=0)	TNS (n=63)			
Practice standard 3 – prior to initiating treatment with Valporate – yes fully or partially documented	HPFT (n=3)	TNS (n=199)			
BMI/Weight	100%	62%	↑	2	21 (75%)
LFTs	100%	75%	↑	2	19 (88%)
FBC	100%	75%	↑	2	18 (88%)
Practice standard 4 – patients prescribed Valproate should receive written info on Valporate for treating bipolar	HPFT (n=3)	TNS (n=138)			
Provided with suitable information	33%	33%	↔	10	8 (62%)
Practice standard 5 – early on-treatment review (within 3 months of initiation) – documented evidence	HPFT (n=1)	TNS (n=235)			
Review of therapeutic response	100%	69%	↑	2	19 (90%)
Weight gain or other common side effects	0	43%	↓	45	10 (80%)
Liver Function Tests and/or Full Blood Counts	100%	37%	↑	3	10 (50%)
Medication Adherence	0	41%	↓	39	11 (70%)
Practice standard 6 – long term monitoring (past 12 months) – documented evidence	HPFT (n=31)	TNS (n=1805)			
Body weight and/or BMI	65%	51%	↑	16	30 (45%)
Blood pressure	68%	52%	↑	14	29 (43%)
Plasma glucose	81%	55%	↑	8	31 (50%)
Plasma lipids	74%	48%	↑	8	24 (50%)

What did we do well?

- Improved in the ranking position on most standards compared to 56 mental health Trusts
- Documentation in the clinical records prior to initiating treatment of weight and/or BMI, the results of liver function tests (LFT) and a full blood count (FBC)
- Documentation in the clinical records of body weight and/or Body Mass Index (BMI), blood pressure, plasma glucose and plasma lipids measured at least annually during continuing Valporate treatment.

What are the areas for development?

- Reduction in the proportion of women of child-bearing age on Valporate
- Documented evidence of safety issues discussed for women of child-bearing age on Valporate
- Documented evidence of protection against pregnancy for women of child-bearing age on Valporate
- Documented evidence that all patients prescribed Valporate received written information on Valporate for treating bipolar
- Documentation of the assessment of Valporate side effects and consideration of medication adherence at early on-treatment review.

During 2018-19, 8 national clinical audits covered relevant health services that we provide. During that period, we participated in 100% of national clinical audits we were eligible to participate in.

The national clinical audits that we participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Audit	Trust Participation	
	Number of cases required by the terms of the audit	Number of Cases Submitted by HPFT
POMH-UK Topic 16b Rapid Tranquilisation	Information not available within HPFT	103
POMH-UK Topic 18a Use of Clozapine	Information not available within HPFT	98
POMH-UK Topic 6d Assessment of the side effects of depot antipsychotic	Information not available within HPFT	206
POMH-UK Topic 7f Monitoring of patients prescribed lithium	Information not available within HPFT	92
National Clinical Audit Anxiety and Depression – Core Audit	100	100 (100%)
National Clinical Audit Anxiety and Depression – Spotlight Audit (Psychological Therapies)	125	125 (100%)
National Clinical Audit Psychosis (NCAP) Early Intervention Psychosis (EIP) Spotlight Audit (CQUIN)	100	100 (100%)
Mental Health CQUIN Indicator 3 – Physical Health for Service Users with Serious Mental Illness	150	150 (100%)

**Not the confirmed numbers for POMH – due to be realised in July 2019*

Results from National Audits are as follows

The report of 1 national clinical audit was reviewed by the provider in 2018-19; 7 reports have not been published at the time of writing this report. The results of this published audit are summarised below along with the actions we intend to take to improve the quality of healthcare provided.

POMH-UK Topic 16b Rapid Tranquilisation involves the use of medication given via the parenteral route. It is a restrictive intervention and must only be used if de-escalation and other preventative strategies including 'Pro Re Nata' (PRN, 'as and when') oral medication have failed and there is potential for harm to the service user or other people if no action is taken.

We have worked on implementing systems to support service users and staff in managing rapid tranquilisation including revising the policy and re-drafting prescription chart templates. This report includes the re-audit results for a quality improvement programme (Topic 16b) addressing rapid tranquillisation in the context of the pharmacological management of acutely disturbed behaviour.

Areas of Good Practice

- 69% of service users are offered and administered oral medication for behavioural disturbance compared to the Total National Sample (TNS) result of 43%
- Following Rapid Tranquilisation, 75% of service users had documented evidence of a debrief within 24 hours compared to the TNS of 51%
- Following an episode of rapid tranquilisation, there was documented evidence that the service user's care plan included management of future episodes of disturbed behaviour within a week in 94% of cases, compared to 53% of the TNS
- Within a week of an episode of rapid tranquilisation, there was documented evidence that the care plan acknowledged the patient's preferences should they become behaviourally disturbed again in 69% of our sample compared to 32% of the TNS.

Areas for improvement

- In 81% of our cases, there was no documented evidence of an assessment of mental and behavioural state in the hour post rapid tranquilisation being administered compared to 58% of the total national sample
- Further adherence to our Rapid Tranquilisation policy is required in particular with the documentation of physical observations (pulse, blood pressure, respiratory rate and temperature). This also includes monitoring for service users considered at risk following administration of rapid tranquilisation.

Actions

- Report to be disseminated to teams who participated in the audit
- Our Rapid Tranquilisation policy to be updated to include 72 hour timeframes for debrief to be completed
- Correspondence to be sent to staff reminding them to complete actions which were highlighted as areas for improvement within the findings.

The above actions are currently being undertaken and are being regularly monitored by the PACE team.

Local Clinical Audit

We reviewed the reports of 108 local clinical audits in 2018-19. 53 were undertaken by the PACE team as part of their annual programme and 55 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:

- This year has seen the recruitment of Clinical Audit Lead posts in each of the Strategic Business Units. These posts are filled by consultant psychiatrists with a special interest in clinical audit. The PACE team work closely with our newly appointed Clinical Audit Leads to help influence audit activity and drive change. This is an innovative approach which we will continue to develop during the forthcoming twelve months
- This year, both carer and service user participation has now become an invaluable part of audit activity through a revised membership of the Practice Audit Implementation Group and this will continue. We are particularly proud of this work and this has been recognised by being shortlisted by the British Medical Journal for the clinical leadership award 2019
- The PACE team continue to ensure that audit findings are shared with the dedicated committees that champion that particular area of health improvement, including the Physical Health Committee, the Patient Safety Committee, the Quality and Risk Management Committees across each of our Strategic Business Units as well as our Trust-wide Quality and Risk Management Committee
- During 2019-20 we envisage roll out of our 'drivers for change' certification, this is awarded to those who demonstrate commitment to the implementation of actions following audit recommendations.

The full details of all these audits are beyond the scope of this report but detailed below are examples of the results that were found.

Where audits said we did well:

Supporting People Growing Older with Learning Disabilities (Supporting Residential Service) Audit. This baseline audit considered the newly published NICE guidance on supporting people growing older with a learning disability. The results demonstrate excellent levels of compliance across all standards. Some of the areas of great compliance are as follows;

The findings demonstrated 100% compliance in the following standards:

- A 'changing our lives'/'quality of life' action plan documented in service user records
- Evidence of physical health documentation completed
- Care plan in place which supports staff in managing any identified physical health needs
- Nutrition and dysphagia completed in the last 12 months.

There were two areas which needed slight improvement in terms of compliance. The action plan devised post the audit focussed on a falls risk assessment being completed annually for all service users and dementia baselines taken and updated in the service user records.

The service have confirmed that actions post the audit being conducted have been rolled out, with falls risk assessments being an ongoing action to assure these are embedded annually for all service users.

Safe and Supportive Observations

This audit aimed to provide assurance that observations within the adult inpatient wards are being carried out safely and in line with our policy. Some great compliance was shown in terms of staff members and their knowledge around levels of observations and the rationale behind why the service user had been placed on observation. 95% of all service users had a wellbeing plan in place.

Observation paper work and documentation was consistent across all wards. Documentation on the wards around intermittent charts being completed as the service users were being observed and continuous monitoring by staff was of a high standard.

The recommendations included conducting a qualitative study on service user experience of observations. Another recommendation was to develop training in care planning across staff in inpatient services including ensuring staff offer service users information on safe and supportive information. The PACE team continue to monitor the above recommendations and are awaiting evidence of implementation.

Gatekeeping Audit

Following concerns raised about the gatekeeping process in the last financial year, the crisis teams have been developing strategies in order to ensure that the gatekeeping takes place in a safe and secure manner by ensuring that those admitted to the inpatient services are appropriately admitted. The crisis teams developed a bespoke form on PARIS to capture this information in a clear and concise manner.

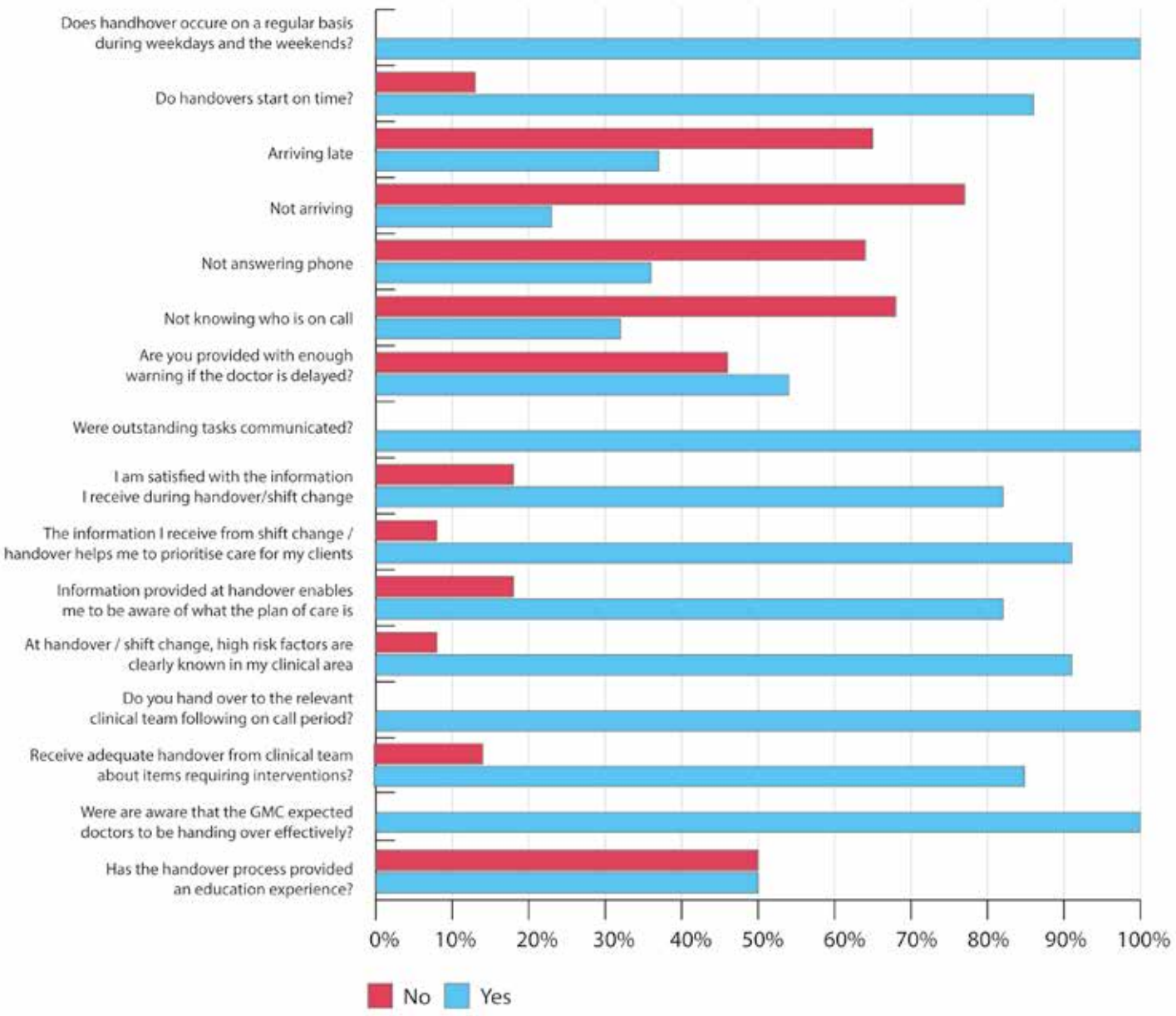
The audit aimed to analyse the quality of CATT Gatekeeping forms which were completed on PARIS, our Electronic Patient Record (EPR) system. It included a sample of service users who were gate kept between July and September 2018. As the table below shows, sufficient information was documented in 97% of cases which is of a high standard.

What is the Purpose of Admission Section		
Has this been completed on the form?	Is the information contained within this section sufficient?	If the information is not sufficient, has this area been highlighted in the casenote?
86/86 (100%)	**83/86 (97%)**	**2/3 (67%)**

Why can this not be achieved by intensive Home Treatment/Host Families/ADTU		
Has this been completed on the form?	Is the information contained within this section sufficient?	If the information is not sufficient, has this area been highlighted in the casenote?
86/86 (100%)	**85/86 (99%)**	**1/1 (100%)**

Improving the Clinical Handover Practice among the Junior Doctors

This service led evaluation was conducted by one of our junior doctors, following concerns which had been raised to them around the quality of the handover process for junior doctors when they are working on call. The service evaluation sought to attain experiences from various junior doctors via a questionnaire. Overall, the feedback from the junior doctors was very positive. It highlighted that handovers take place on a regular basis, that outstanding tasks were communicated and information is handed over to relevant clinical teams in 100% of cases.



Following the completion of this audit, a checklist has been devised and assurance measures have been put in place, to ensure that the quality of handover between junior doctors remains to a high standard.

Where audit said we need to improve:

Appointeeship Audit

Appointeeship refers to a method in which a service user's financial responsibilities are managed. Various agencies who are involved with the service user's care can be appointed as we are responsible for managing the service users' finances. For the purposes of this audit, only those service users where we are responsible have been included in the audit.

The audit looks to see if the relevant information has been included on the service user records which expressly discuss the management of their finances. This should be reviewed on a yearly basis. It is apparent from the table below that the results have declined since the previous audit cycle which was conducted in September 2017.

Cycle	Detail of the level of supervision required	Who should provide it	How it should be implemented	Capacity assessment within 12 months?	Best interest form linked to capacity assessment?	Reference to SU capacity assessment within 12 months Y?N (differs within LD)
Feb 17	12/52 (23%)	11/52 (21%)	13/52 (25%)			
Sep 17	31/53 (58%)	30/53 (57%)	31/53 (58%)			
Jun 18	**71/131 (54%)**	**66/131 (50%)**	**60/131 (50%)**	**28/118 (24%)**	**20/118 (17%)**	**28/131 (28%)**
Movement Sep 2017 – Jun 2018						
	↓ 4%	↓ 7%	↓ 8%			

Cycle	When it was assessed	Whether appointeeship / deputeeship is in place	How it should be implemented	Capacity assessment within 12 months?
Feb 17	0/52 (0%)	21/52 (40%)	22/52 (42%)	
Sep 17	25/53 (47%)	44/53 (83%)	48/53 (91%)	
Jun 18	**38/131 (29%)**	**105/131 (80%)**	**106/131 (81%)**	**53/107 (50%)**
Movement Sep 2017 – Jun 2018				
	↓ 18%	↓ 3%	↓ 10%	

While the results did not demonstrate improvement across the Trust, when looking at the breakdown, it was positive to see that our Learning Disability and Forensic SBU had demonstrated improvements of at least 71% in all measures.

Going forward from this audit, a working group has been set up with the aim of supporting staff across the Trust with managing service user finances. Since the completion of the audit, teams have been made aware of those who do not currently have an up to date CPA or capacity assessment. The group have also developed a guide on appointeeship which will provide staff with guidance on how to document these details in the electronic patient record and explain how often reviews should take place. The group also have plans to hold workshops across the community hubs to support staff when using the appropriate documents. The PACE team await evidence of implementation for the workshops to be rolled out.

'Did Not Attend' Outpatient Re-Audit

The above audit was in line with the Trust's agenda of reviewing the outpatient model with the aim of driving down Did Not Attend (DNA) rates. In addition to this the audit aimed to ensure adult clinics are compliant with our DNA policy. As this particular audit was a re-audit the findings from this audit are demonstrated below with the results from the previous cycle:

	2017 compliance (Sept 17)	2018 compliance (April 18)
Clinical Entry made in the case notes	25/42 60%	112/146 77% ↑
Reason for DNA recorded	6/42 14%	35/146 24% ↑
Was a reminder letter sent out to SU 7 days prior to OPA	7/42 17%	19/146 13% ↓
Was contact made on the same day as the DNA	11/42 26%	63/146 43% ↑
Is there any indication of Risk recorded on the EPR	2/42 5%	29/146 20% ↑
Has GP been notified in writing of the non-attendance	25/42 60%	80/146 55% ↓

Although some results had improved marginally, there are still some areas of concern predominantly in terms of a reminder letter being sent out to the service user 7 days prior to the appointment and documented evidence of this. The GP being notified in writing of the non-attendance of that particular outpatient appointment was also low in compliance.

Since the completion of the audit further exploration into the use of an SMS text messaging reminder service has been carried out and discussions have taken place in regards to revising our DNA policy. Discussions have also taken place around implementing virtual clinics as part of a quality improvement project. The PACE team is awaiting evidence of the sharing of information in order to raise awareness of the cost implications, for failing to attend an outpatient appointment.

Risk Assessment Audit

Clinical risk and management is a key part of our business and is fundamental to service user safety. As part of the audit, a qualitative analysis was carried out by clinical staff to analyse the quality of risk assessments conducted in adult community services. The results highlighted sections of the assessment which were deemed to be of poor quality.

Risk Assessment Audit

Clinical risk and management is a key part of our business and is fundamental to service user safety. As part of the audit, a qualitative analysis was carried out by clinical staff to analyse the quality of risk assessments conducted in adult community. The results highlighted sections of the assessment which were deemed to be of poor quality.

	Number	%
Assessment of current situation:		
Poor	10/32	31%
Satisfactory	17/32	53%
Good	3/32	9%
No risk assessment to evaluate	2/32	6%
Formulation of risk factors:		
Poor	23/32	72%
Satisfactory	6/32	19%
Good	1/32	3%
No risk assessment to evaluate	2/32	6%

Following the concerns raised in the audit, the service focused on improving the quality of the forms on PARIS. This has been facilitated via presentations and training to staff to create awareness of the standards of risk management and enable co-production of risk assessments with service users and carers.

Discussions are also being held on considering how Peer Experience Listeners could take forward a process for obtaining service user feedback for their involvement in developing their risk assessment.

Research and Development

Our research portfolio is a key factor in our status as a University Trust and we are working to increase the number of staff involved in Research and Development. We work closely with, and receive research funding from the National Institute of Health Research (NIHR) and Clinical Research Network (CRN) Eastern to help us deliver and participate in high quality research studies. We collaborate with several academic institutions including: the University of Hertfordshire, University of East Anglia, University of Kent, and University of Southampton. In June 2018 we jointly hosted a research showcase event with the University of Hertfordshire, which was well attended. We have a research page on the Trust website, detailing the studies we are currently recruiting to, as well as some recent research publications by Trust staff.

We are pleased to announce that we have recently been successful in securing three new research grants. The first is an NIHR Research for Patient Benefit (RfPB) Award to support a new collaborative feasibility study looking at trans-cranial direct stimulation in the treatment of OCD.

The second is another NIHR RfPB award to look at what support people with Learning Disabilities need to remain living in the community after moving under the Transforming Care Programme. And thirdly, we are partnering with the University of Hertfordshire on a study funded by the Health Technology Assessment (HTA) to investigate the benefits of exercise for depression in adolescence.

There is an obligation on all NHS Trusts to support the NIHR portfolio and we have supported recruitment to 18 different research studies over the last year (an increase of 12.5% over the previous year). All research that takes place within the Trust has the appropriate level of ethical approval in place.

"Coping strategies and techniques in 9 sessions addressed 20+ years of OCD symptoms."

In 2018-19 we have recruited 302 service users into NIHR portfolio studies, which is also an increase over the previous year. We have received positive feedback from those who took part. Most of the people who completed a questionnaire about their experience of participating in the Trust research, rated their overall experience as very good or excellent. We are currently looking to recruit participants in to the following studies:

- Identifying the prevalence of antibodies to neuronal membrane targets in first episode psychosis (PPiP) – The aim of the study is to establish the prevalence of pathogenic antibodies in people with a diagnosis of psychosis and to assess the acceptability of an immunological treatment protocol for patients with psychosis and antibodies. Participants will have a blood sample taken and undergo the Positive and Negative Syndrome Scale (PANSS) assessment
- Learning about the lives of adults on the autism spectrum and their relatives – We are looking to develop a better understanding of the lives of adults on the autism spectrum and their relatives. Participants will be provided with a contact booklet to complete and return to the study team in Newcastle. Then they will be asked to complete several questionnaires which will be sent by post
- Detecting susceptibility genes for Alzheimer's disease – We are looking to recruit individuals with a diagnosis of Alzheimer's Disease (AD), and their next-of-kin. Participants with AD will be asked to provide a blood sample. They and their carers will also be interviewed using several questionnaires. These interviews will each take around 90 minutes
- Delivery of Cognitive Therapy for Young people after Trauma - This study is examining the effectiveness of cognitive therapy in young people with post-traumatic stress disorder, compared with treatment as usual
- Supporting consolidation of recent memories in Mild Cognitive Impairment - The purpose of this study is to see whether memory aids can be used to support the formation and strengthening of new memories in people with MCI and mild dementia. The total involvement time in the study is 8 weeks
- E-support for Families of individuals affected by psychosis (COP-e) - This study aims to develop and evaluate online resources providing psychological support to carers of people with psychosis and ways to promote carers' well-being
- Smartphone App-induced Habit: A treatment ingredient in HRT for OCD - This study aims to understand more about behavioural treatment called HRT and to establish how helpful it might be in treating OCD.

Please contact the Research and Development Department on 01707 253836 if you would like to find out more about any of the above studies. Or alternatively, please email hpft.research@nhs.net We will be taking on additional studies during 2019-20.

What is the National Institute of Health Research (NIHR)?

The NIHR funds health and care research and translates discoveries into practical products, treatments, devices and procedures. It helps patients gain earlier access to breakthrough treatments and trains and develops researchers. The NIHR is committed to involving patients and the public in all its work.

Commissioning for Quality and Innovation (CQUIN) 2018-19

The Trust's CQUIN goals are agreed with our local and specialist commissioners at the beginning of each financial year. A proportion of the Trust's income is conditional on achieving these goals. Further details of the agreed goals for 2018-19 and for the following 12 month period are available electronically in 'Trust Papers' in the 'About Us' section of the Trust's website: /www.hpft.nhs.uk/about-us/our-board-papers-and-publications/other-reports-and-plans/

What is Commissioning for Quality and Innovation (CQUIN)?

CQUIN is a payment framework which enables commissioners to reward excellence by linking a proportion of the healthcare provider's income to the achievement of local quality improvement goals.

2.5% of the Trust's NHS contract income (£4,509k) in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and our commissioners through the CQUIN payment framework as described above.

At the end of the 2018/19, the final amount achieved was £3,649k (81% of the amount available). This compares to 2017/18 for which the Trust achieved £3,931k (89% of the amount available).

Details of the CQUIN amounts for each 2018-19 contract are set out below.

	Commissioner	Value	Achievements 18-19
1	Hertfordshire IHCCT	£3,523k	£2,767k (79%)
2	NHS England	£444k	£439k (99%)
3	Learning Disability: Mid Essex CCG, West Essex CCG and North East Essex CCG	**£130k**	**£74k (57%)**
4	Learning Disability: Basildon and Brentford CCG, Thurrock CCG, Castle Point and Rochford CCG, Southend CCG, North East Essex CCG, West Essex CCG and Mid Essex CCG	**£165k**	**£124k (75%)**
5	IAPT: North Essex CCG, Mid Essex CCG and West Essex CCG	**£140k**	**£140k (100%)**
6	North Norfolk CCG. Norwich CCG, south Norfolk CCG, West Norfolk CCG and Great Yarmouth CCG	**£49k**	**£49k (100%)**
7	Buckinghamshire CCG	**£56k**	**£56k (100%)**
Total		£4,509k	£3,649k (81%)

Hertfordshire CQUIN 2018-19 in relation to the main commissioner contract in Hertfordshire

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£423k (12%)	£176k (42%)
2	Improving physical healthcare to reduce premature mortality in people with serious mental illness	Improving the physical healthcare for people with serious mental illness in order to reduce premature mortality in this patient group	£423k (12%)	£357k (84%)
3	Improving services for people with mental health needs who present at A&E	Reducing the number of attendances at A&E for those who would benefit from mental health and psychosocial interventions	**£423k (12%)**	**£400k (95%)**
4	Transitions out Children's and Yong Peoples Mental Health Services (CAMHS)	Improvement in the experiences and outcomes for young people as they transition of out CAMHS services to other providers	**£423k (12%)**	**£130k (31%)**
5	Preventing Ill Health by Risky Behaviours	Tobacco and alcohol screening and the offer of interventions if appropriate	**£423k (12%)**	**£296k (70%)**
6	Support engagement with STPs	HPFT is required to contribute to STP transformation initiatives and demonstrate how it is supporting and engaging in these initiatives	**£705k (20%)**	**£705k (100%)**
7	Linked to the Risk Reserve	HPFT is required to achieve its financial control total in both 17/18 and 18/19	**£705k (20%)**	**£705k (100%)**
		Total	£3,523k (100%)	£2,767k (79%)

North Norfolk CCG, Norwich CCG, South Norfolk CCG, West Norfolk CCG and Great Yarmouth CCG CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£4k (10%)	£4k (100%)
2	Integrated Pathway	Improving the physical healthcare for people with serious mental illness in order to reduce premature mortality in this patient group.	£25k (50%)	£25k (100%)
3	Physical Health	Improving the support and care people with learning disabilities have in relation to physical health needs.	**£20k (40%)**	**£20k (100%)**
		Total	£49k (100%)	£49k (100%)

Mid Essex CCG, West Essex CCG and North East Essex CCG Learning Disability CQUIN April 2018 – October 2018

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Outcomes	Implementation of individual and service level outcome measures and their reporting.	£52k (40%)	£30k (57%)
2	Personal Health Budgets	The development of shadow/ national personal health budgets, together with the measurable outcomes they deliver.	£52k (40%)	£30k (57%)
3	Health Equality Framework	Expand use of the Learning Disability Health Equality Framework to all people known to LD Specialist Healthcare Services in a phased and manageable way.	**£26k (20%)**	**£14k (57%)**
		Total	£130k (100%)	£74k (57%)

Basildon and Brentford CCG, Thurrock CCG, Castle Point and Rochford CCG, Southend CCG, North East Essex CCG, West Essex CCG and Mid Essex CCG, Learning Disability CQUIN November 2018 – March 2019

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Place Plans	The development and agreement of the initial Place Plans that meet the local priorities of the seven Essex CCGs	£66k (40%)	£50k (75%)
2	Health Equality Framework	The development and implementation of Standard Operating Procedures to ensure a consistent approach to service delivery across Essex	£99k (60%)	£74k (75%)
		Total	£165k (100%)	£124k (75%)

North Essex CCG, Mid Essex CCG and West Essex CCG IAPT CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Improving Staff Health and Wellbeing	Health and wellbeing initiatives including the offer of flu vaccinations to staff and improving access to physiotherapy for people with musculoskeletal issues	£16k (11%)	£16k (100%)
2	Carers	To promote the IAPT Services to local carers organisations through the delivery of a range of appropriately targeted initiatives	£124k (89%)	£124k (100%)
		Total	£140k (100%)	£140k (100%)

Buckinghamshire CCG CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Prescribing of psychotropic drugs in adults with learning disabilities/ autism or both	Implement plans to review and compliance against NICE guidelines with an aim to reduce the number of service users prescribed psychotropic drugs for challenging behaviours or a % that are now on reduction plans	£56k (100%)	£56k (100%)
		Total	£56k (100%)	£56k (100%)

NHS England CQUIN 2018-19

	Goal	Description of goal	Goal value £ (%)	Achieved £ (%)
1	Reducing Restrictive Practices within Adult Low and Medium Secure Services	The development, implementation and evaluation of a framework for the reduction of restrictive practices with adult secure services, in order to improve service user experience whilst maintaining safe services.	£222k (50%)	£219k (99%)
2	Recovery Colleges for Medium and Low Secure patients	The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services.	£222k (50%)	£220k (99%)
		Total	£444k (100%)	£439k (99%)

The CQUIN income estimated to be awarded in 2018-19 represents 1.6% of the total income generated from the provision of health services by the Trust in the year.

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. As a Trust, we are not part of 'Payment by Results' (PbR) and therefore our clinical coding has not been externally audited.

The Data Security and Protection (DSP) Toolkit

The DSP Toolkit grades organisations as 'small', 'medium' and 'large'. We are a 'large' organisation and are therefore required to undertake 100 mandatory assertions on all aspects of information governance and data security.

What is the Data Security and Protection (DSP) Toolkit?

The DSP Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards. It also allows members of the public to view participating organisations' assessments. The DSP Toolkit replaced the Information Governance (IG) Toolkit.

The Trust submitted our DSP Toolkit to NHS Digital at the end of March 2019 and we are awaiting the outcome. The Toolkit covers 140 assertions based on the National Data Guardian's 10 Data Security Standards:

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

What is Hospital Episode Statistics (HES)?

Hospital Episode Statistics is a database containing details of all admissions, A and E attendances and outpatient appointments at NHS hospitals in England.

We submitted records during 2018-19 to the Secondary Uses Service for inclusion in the HES which are included in the latest published data. The percentage of records in the published data which included the service users' valid NHS number was:

- 100% for admitted patient care
- 99.87% for outpatient care

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

- 98.4% for admitted patient care
- 99.7% for outpatient care.

Ethnicity April 2018 – March 2019

The percentage of records in the published data which included the service users' ethnicity was 96.1%. 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.

Patient 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:

- Safety huddles
- Safety crosses
- Improved safe and supportive observations
- A new Suicide Prevention group
- A new Risk Strategy Education group
- The development of a Moderate Harm Review Panel, reviewing harm, exploring learning and identifying Serious Incidents
- The reflective learning initiative SWARM
- A Mortality Governance framework for reviewing and learning from deaths.

The total number of incidents reported (via our live database Datix) between 1 April 2018 and 31 March 2019 was 12,067. Of these, 45 (0.37%) are recorded under the harm category as 'severe harm' and 401 (3.3%) are recorded under harm category as 'death'.

"Supportive and safe. I had the opportunity to talk through, understand, and identify what I could do to change. I felt in crisis when I started… now I feel on the start of recovery journey. Thank you SO much."

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:

- **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 services. SWARM creates an environment in which staff share information without fear of reprisal, and integrate the reporting of safety issues into daily work. 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 our mistakes.
- **Proscreen** - as a result of learning from a serious incident, we have invested in Proscreens. These are a technology solution for detecting restricted items such as razor blades and weapons. 5 have been installed as a pilot and will be rolled out further if found to improve the quality and safety of care.
- **Itemiser** - whilst we have already had robust testing procedures in place for narcotics abuse, it was recognised that the procurement of an 'airport style' trace detection machine would provide better coverage across the range of potential narcotics within a single, rapid, non-invasive test. This is of heightened benefit in the Section 136 Suite, with the need to be particularly conscious of the potential circumstances of presentation of an individual being assessed and how the testing approach needs to be sensitive to that scenario.

  The Itemiser Enhanced are cutting edge machines in terms of narcotic trace detection and are used widely in prison and police settings, enabling the manufacturer to maintain up to date databases for new strains of drugs including synthetic cannabinoids. This has been installed in Swift Ward and 136 Suite jointly helping us with the rapid and non-invasive detection of psychoactive substances. The effectiveness will be evaluated with a view to rolling this out more widely.

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.

We have reviewed and updated the policy so that, where harm has been caused or may have been caused, staff have clear guidance on their roles and responsibilities in contacting service users and families in a way that is:

- timely
- embraces the principles of open, honest and transparent communication.

We have also included information on how we meet the Duty for moderate harm incidents.

"We considered the Trust had had significantly improved practice in [safety], reporting had improved and lessons had been learnt that would otherwise have been missed" CQC

During 2018-19 we have continued to make progress with the implementation of the Duty of Candour policy. Clinical leads are being consistent in contacting bereaved families to offer condolences and identify support needs when a death has been reported as a serious incident. We acknowledge the impact on families and friends who are bereaved by suicide or a sudden unexpected death.

When a serious incident is reported, we send a Duty of Candour letter to the person who uses our services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment affected. This is to advise on:

- our internal investigation process
- how they can contribute to establishing a factual chronology of events and help us learn from what has happened.

The person leading the investigation contacts the family and any questions or concerns the family raises are gathered, considered and included in the serious incident report. Once completed, the full report is always shared with the family and the Coroner. Trust commissioners monitor compliance with our Duty of Candour and procedures when reviewing and quality assuring serious incident reports.

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.

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 2018/19, 443 (by date of death) of our service users died. Of the 443 deaths, 82 were identified as meeting the criteria for further review either as a Serious Incident investigation (63) or as a Structured Judgement Review (SJR) (19), 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.

Quarter 1	42	0	18	33	**93**
Quarter 2	59	0	15	30	**104**
Quarter 3	75	0	17	30	**122**
Quarter 4	72	12	16	24	**124**
Total	**248**	**12**	**66**	**117**	**443**

This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 93 in the first quarter
- 104 in the second quarter
- 122 in the third quarter
- 124 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 2017/18 was 373. With the new Mortality Governance Framework, we have new lines of communication to enable us to 'scan' for service user deaths. The Root Cause Analysis (RCA) we complete enables us to learn and reflect.

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.

19 case record reviews and 63 investigations have been carried out in relation to 443 of the deaths included in item 1.

None of the cases was subjected to both a case record review and an 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	Structured Judgement Reviews
Quarter 1	14	0
Quarter 2	23	6
Quarter 3	14	7
Quarter 4	12	6
Total	**63**	**19**

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. Serious Incident Investigation reports (RCA) do not directly address the question whether the death was more likely than not owing to problems in care.

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 none 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 21 investigations completed in financial year 2018/19 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 (RCAs) not making 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 2018/19, 56 deaths have been reported by us to the LeDeR programme.

- 14 in the first quarter
- 11 in the second quarter
- 13 in the third quarter
- 18 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.

Our Mortality Governance team undertook a comprehensive audit on unexpected deaths and self-harm for January to June 2018. It addressed a number of demographics, diagnosis and explored risk factors (such as isolation/ employment/alcohol/drug use), protective factors, community, crisis plans, risk assessments and formulation. There has been considerable learning from this and an education task and finish group has been set up to look at risk assessment and risk formulation and education required. Other areas of work look at follow up with the Samaritans.

We participated in the Mortality Screening Tool Pilot study hosted by Royal College of Psychiatrists and were one of the first 14 Mental Health Trusts to pioneer this work. This has led to unifying the process of completing Structured Judgment Reviews in mental health Trusts and contribution to national guidance published by Royal College of Psychiatrists. The team were asked to do a poster presentation at the launch event of the Mortality Screening tool at the Royal College of Psychiatrists. There was considerable interest from various organisations nationally.

The Trust has been invited to present the work that we have carried out in learning from deaths at the Eastern Academic Health Science Network Learning from Deaths Forum in March 2019. A Mortality Workshop has been piloted at our Team Leader day and was well evaluated; this will now be delivered on a rolling programme for all staff.

The format of the Mortality Governance Group has be developed over the past year and ensures all learning is triangulated with the moderate harm review panel, the suicide prevention group and Safety Committee. SJRs are discussed at the safety committee, and the moderate harm panel refers cases for SJRs. Learning notes are also developed and shared across the Trust.

2.4 Reporting against our Core Indicators

This section of the Quality Account Report sets out how we performed against our 2018-19 priorities. These are the priorities we set at the beginning of the year and are published in the 2017-18 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 2018-19	Q1	Q2	Q3	Q4
	96.05%	97.11%	97.81%	96.61%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	95.6%	96.8%	96.7%	96.01%
Target (National)	95% rate of service users followed up after discharge from the Acute Care Pathway			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

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 in advance of the forthcoming national CQUIN.

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 2018-19	Q1	Q2	Q3	Q4
	97.1%	96.39%	97.28%	97.26%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	96%	97.8%	99.6%	98.19%
Target (National)	95% of those admitted to an inpatient unit should have been gate kept by CATT			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

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 – 14 and ii). 15 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 - 14				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	0.2%	0.42%	0.41%	0.65%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**
	4.51%	7.8%	7.09%	5.01%
Target (National)	No target set			

15 and over				
Performance in Q1 to Q4 in 2018-19	**Q1**	**Q2**	**Q3**	**Q4**
	4.70%	6.26%	5.19%	7.85%
Performance in Q1 to Q4 in 2017-18	*Not collected by this category in 2017/18*			
Target (National)	No target set			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

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 Q1 to Q4 in 2018-19	Q1	Q2	Q3	Q4	18/19
					7.2%
Performance in Q1 to Q4 in 2017-18	**Q1**	**Q2**	**Q3**	**Q4**	**17/18**
					7.3%
Target (National)	No target set (comparative data)				

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

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.

Performance in Q1 to Q4 in 2018-19	Q1	Q2	Q3	Q4
	1347 (44%) Severe harm = 10 (0.7%) Death = 12 (0.9%)	**1349 (47%)** Severe harm = 2 (0.2%) Death = 20 (1.5%)	**1249 (42%)** Severe harm = 0 Death = 15 (1.2%)	**1238 (42%)** Severe harm = 2 (0.2%) Death = 6 (0.5%)

Performance in Q1 to Q4 in 2017-18	Q1	Q2	Q3	Q4
	1330 (48%) Severe harm = 2 (0.2%) Death = 13 (1%)	**1300 (45%)** Severe harm = 1 (0.1%) Death = 9 (0.7%)	**1310 (41%)** Severe harm =0 Death = 12 (0.9%)	**1340 (45%)** Severe harm = 0 Death = 18 (1.3%)
Target (National)	No target set			

Benchmarked Data

	Highest	Lowest	National Average	Trust
Quarter 1 (2018/19)	*	*	*	*
Quarter 2	*	*	*	*
Quarter 3	*	*	*	*
Quarter 4	*	*	*	*

**Awaiting publication of data*

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.

Part 3 – Other Information

This part of the report gives us an opportunity to celebrate some of the notable and innovative practice that has taken place across our services in 2018-19 and to present information relevant to the quality of the health services we provide. It is not meant to be an exhaustive list, rather a sample of the many and varied initiatives our staff, service users and carers have developed and implemented to improve the quality of our services.

Local Quality Indicators

The local quality indicators for 2018-19 were set out in the Quality Account 2017-18. A brief narrative is provided on each of the indicators following the table.

	Local Indicators
	Patient (service user) Safety
1	Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards b) EIP services c) Community mental health services (people on CPA) (NHSI)
2	The use of restrictive practice, including seclusion
3	Improved response time and inclusion of Human Factors methodology in analysis of Serious Incidents
	Effectiveness
4	IAPT: • Proportion of people completing treatment who move to recovery (from IAPT dataset) • Waiting time to begin treatment (from IAPT minimum dataset): (i) Within 6 weeks of referral (ii) Within 18 weeks of referral (NHSI)
5	Inappropriate out of area placements
6	EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral (NHSI)

Service User Experience	
7	Admissions to adult facilities of service users under 16 years old (NHSI)
8	Improved employed rate for service users
9	Co-producing Future Plans for Carer and Family Support

1. Ensure that the cardio-metabolic assessment and treatment for people with psychosis is delivered

The aim is to ensure that service users with psychosis, including schizophrenia, receive comprehensive cardio metabolic risk assessments and have access to the necessary treatments/interventions. The results are recorded in their electronic care record (held by the secondary mental health provider) and shared appropriately with the individual service user, the treating clinical team and partners in Primary Care.

To ensure that staff have the skills and abilities to undertake such work, a physical health training programme was developed as well as pathways for interventions and signposting for all cardio-metabolic risk factors.

These included areas such as:

- Smoking cessation
- Lifestyle (including exercise, diet alcohol and drugs)
- Obesity
- Hypertension
- Diabetes
- High cholesterol.

A national audit was undertaken in February 2019 and we await the formal results. Local intelligence indicates that we performed as follows:

- Community Services: Compliance (target 75%) Trust predicted score is 81%
- Inpatient Services: Compliance (target 90%) Trust predicted score is at 82%
- PATH Services: Compliance (target 90%) Trust predicted score is at 91%.

2. The use of restrictive practice, including seclusion

An external review on our RESPECT training was commissioned by the Deputy Director of Nursing and Quality to establish whether RESPECT provides training to meet service area needs and to make recommendations, based on best practice and current evidence, specifically, to look at:

- Managing disturbed behaviour when more than one service user is an immediate threat to others
- Managing service users who use physical strength or weapons to prevent safe application of RESPECT techniques, with particular reference to the use of Personal Protective Equipment (PPE)
- Moving service users to a place of safety and to prevent the use of a prolonged restraint
- Managing service users who, through force or accident, place themselves into a prone positive
- Managing situations where staff are unable to withdraw or leave the service user
- Managing service users in challenging environmental situations, such as on the stairs.

Following the review, the recommendation to develop training manuals of techniques in disengagement and teamwork skills was agreed, in consideration of the clinical challenges. This recommendation allowed for full ownership of the training and the ability to review and add to the training in line with the changing clinical challenges presented. This 'hybrid' model aimed to meet the clinical challenges and close the skills gap, without the challenges of retraining the entire workforce. Having established a Task and Finish Group with representation from the service areas, key scenarios were identified which staff felt they did not have the confidence or competence to safely respond to and manage. Techniques were then agreed, which sit within current guidance and would be an addition to the current RESPECT training that is delivered and for identified service areas only, based on clinical need.

Members of our staff attended a meeting with Navigo (RESPECT Training Solutions) Senior Professional Leads to discuss the proposals for reviewing the current RESPECT training content. As a training organisation, Navigo understood the changing nature of services and the need to ensure training is developed to meet the complex healthcare challenges.

As an outcome of the meeting, and having considered the information provided to them, including physical descriptors and demonstrations, feedback was received in writing from Navigo on the scenarios relating to specific scenarios. The RESPECT training has been amended and trialled with the Oak team staff. Revisions to the training also include Human Factors and the principles of leadership and decision making.

There will also be a summative assessment on both theoretical and practical components of the training and an increased focus on the practical elements.

As an outcome of the external review, the Trust has now joined an external and already established Quad Group Partnership. As a result, the Trust are required to:

- Remain responsible for its own governance
- Submit lesson plans, tutor portfolios and schemes of work for review by Partnership members at the annual update/refresher
- In return, to carry out reviews of above said materials
- Submit manuals and risk assessments for scrutiny
- Perform 'teach backs' in front of each other for assessment
- Meet and follow the Professional Management of Violence and Aggression (PMVA) trainer Code of Practice and PMVA Partnership Group terms of reference.

The Partnership therefore reviews each other's syllabus to ensure working within the remits set by the various good practice guidelines including the Mental Health Act (MHA), NICE and the Department of Health, for example.

Seclusion can be a traumatic experience for individual service users. Ensuring that the Trust's seclusion facilities and practice as well as the training of staff is delivered to a high standard is essential to enable the experience to be less challenging for all involved. Through their inspections, the CQC raised concerns about our seclusion facilities and practice including documentation such as care plans, risk management plans and medical reviews as well as seclusion outside seclusion rooms.

A full review was therefore commissioned of how we manage seclusion across our services, being responsive to the service user, the service area and the environment resulting in recommendations for service and provision improvements. Mersey Care NHS Foundation Trust was approached to undertake the review, having been cited by the CQC as an example for good practice. A number of actions have since been implemented or currently being, including:

- Provision of refresher training on seclusion process and practice
- Audits of all seclusions rooms to ensure integrity of environment
- Revision of Frequently Asked Questions, flowcharts and checklists for seclusion.

Reviews of all seclusions regarding process and practice – including outside of a seclusion room, of all Long Term Segregation and the Mental Health Minimum Data Set (MHMDS). Staff will be commencing training in the HOPE Clinical Model of Care in April, aimed at reducing Long Term Segregation.

Furthermore, a programme is underway to build new seclusion and also long term segregation suites at a number of our service areas, configured to allow service users access to a number of areas including, as a minimum, bathroom facilities, a bedroom and relaxing lounge area; to also enable access to a secure outdoor area attached to the suites. The suites will also include an observation room to enable continuous observation and appropriate therapeutic interaction.

This Trust-wide programme will require seclusion suite extensions, refurbishments and/or upgrades and is aimed to deliver a standard of best-in-class seclusion specification on all sites, in consideration of the research undertaken by the Trust and Medical Architecture.

Significant work has taken place to ensure the least restrictive practice is used, focusing on proactive strategies. These will continue into the next year and include:

- Safety pods are used as part of a planned intervention and felt far safer and less restrictive on a service user. They can be used as a form of maintaining settled behaviour, as they provide a large 'snug-type' zone which has been described as "soothing and secure"

  We have purchased some safety pods to trial on Oak ward – our Psychiatric Intensive Care Unit (PICU), assessment and treatment and Medium Secure Units. The feedback from the trial will be discussed at the Safety Committee

- Safety cross is a visual representation of the hours of the day and allowed different colours to fill each hour zone to identify specific incidents. This provides a clear visual breakdown of each day so service users and staff could see at a glance whether the ward was settled. Prior to commencing the pilot, discussion took place with the clinical teams about how to complete these interventions. Each clinical area involved was provided with the equipment (charts, pens and stickers) to complete the safety crosses

- Safety huddles have been introduced in inpatient service areas and take place up to three times a day. All members of the huddle stand to enable the process to be fast and effective and ask the same three questions:

  1. Do you feel safe or do you have a concern?
  2. Which service user is unhappy with their care?
  3. What is the plan (and who is going to implement this and when)?

- **Safewards** methodologies have shown reductions in incidents and restrictive practice across acute mental health settings. Safewards includes a range of approaches by which routines and environments may be modified, flashpoints avoided, de-escalation achieved and alternatives to restrictive practice consolidated into practice. Safewards is a recommended set of evidence-based interventions, of which the principles used advocate the 10 key interventions so when there are 'flashpoints' present, they can be used to reduce potential conflict or containment, as listed below:
  - Clear mutual expectations: proving clear support on how to communicate and why – developed by staff and service users and posted on display in the clinical service areas for all to see
  - Soft words: being respectful and polite
  - Positive words: positive talk during shift handover
  - Bad news mitigation: being aware when bad news is given and received and develop approaches that may be used to support
  - Knowing each other: sharing common interests so relationships are developed
  - Mutual help meetings: thanking people, making suggestions, requests or offers, encouraging or supporting; these are run by service users
  - Calm down methods: having a box of 'calm down' equipment, such as iPods, scented towels, massage balls, herbal tea - the list is not exhaustive
  - Reassurance: being mindful of events that are occurring in the clinical service area and offering support, giving reassurance after an incident or challenging situation, checking in shift handover that all have been reassured
  - Discharge messages: service users who have been transferred or discharged from the clinical service area writing messages on postcards to offer support and hope, highlighting that went well, this can be via poster or tree murals with the messages and postcards on the branches.

3. Serious incidents response times and analysis

Following our CQC inspection in 2018, we were required to review our reporting and investigation process for Serious Incidents, which led to an increase of 50% in those we reported.

As a Trust, we are required to investigate and return completed reports to the CCG by the 60 day mandatory timescale. We have committed to a trajectory for outstanding Serious Incidents and are working towards improving our overall compliance. Furthermore, we have undertaken a quality improvement initiative to look at the overall process and improve quality.

We have implemented a Moderate Harm Panel which meets weekly and has representation across all Strategic Business Units including, safeguarding, Clinical Directors, Managing Directors, the Deputy Director of Nursing and Quality and the Deputy Director of Safer Care and Standards, also the Deputy Medical Director. The purpose of the Panel is to ensure that incidents reported on Datix as moderate harm, severe harm or death (not natural causes) are discussed and immediate learning is shared and themes identified. This supports a robust decision making approach to identifying serious incidents.

Learning is shared across the Strategic Business Units and has informed work in suicide prevention, restrictive practice, health and safety and safeguarding work streams and practice. Themes are discussed in the Safety Committee. The panel liaise with the mortality governance team, and refer cases where appropriate for structured judgment review.

A Moderate Harm section has been added to Datix to support the Panel process and decisions and actions are recorded in the incident module.

"Thank you for all your love and support through this difficult time in my life - I couldn't have done it without you. All the best."

4. IAPT

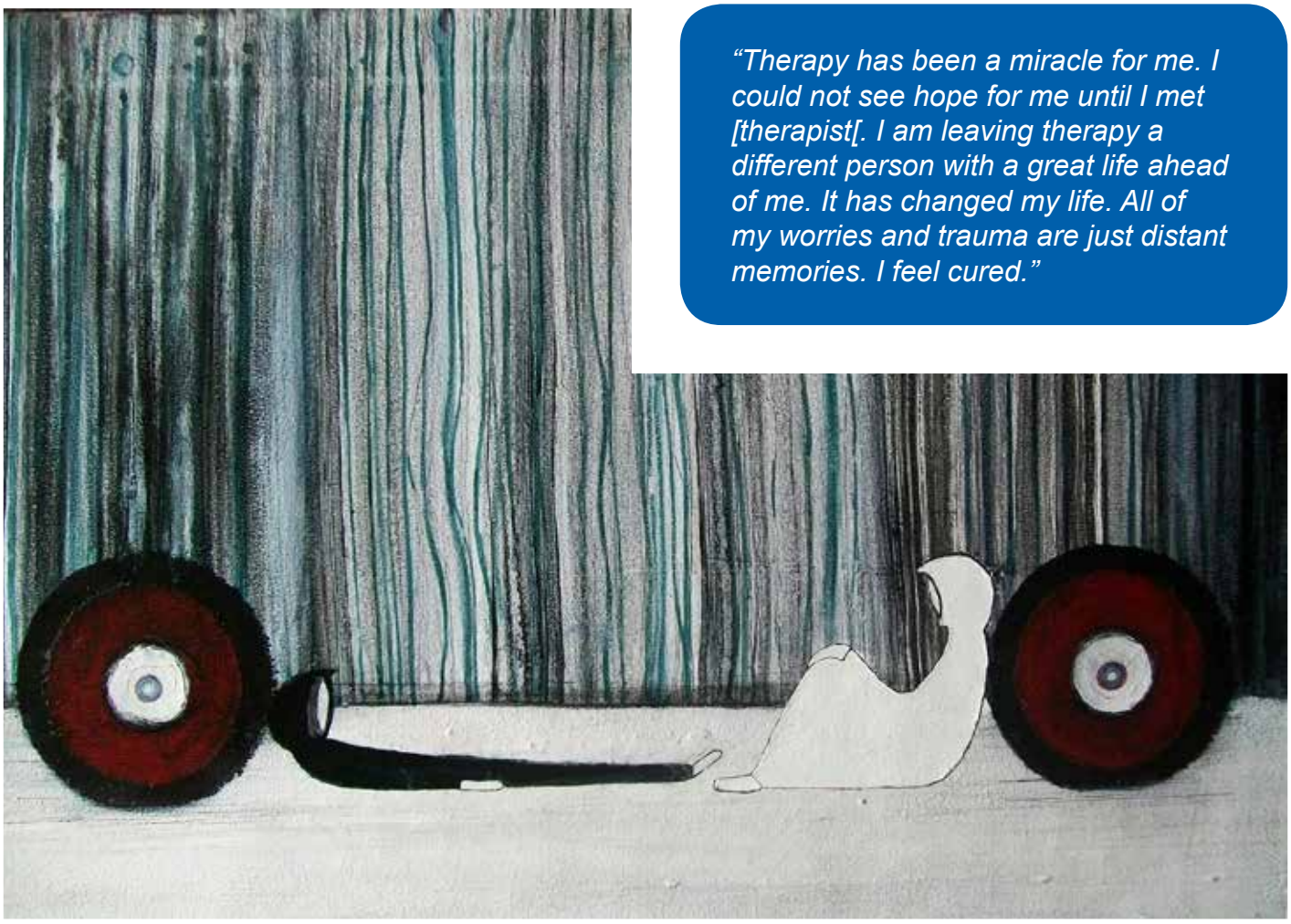
Our IAPT teams across the Trust continue to work closely with their CCGs, GPs and other local NHS providers to ensure the right people are referred in to the services and support the increasing demands for increasing access to psychological therapies. This means people from hard to reach groups, such as older people and those with long term conditions, are being supported to access the service. All teams have seen an increase in the number of people accessing their service this year.

Waiting times for the wide range of low and high intensity interventions varies depending on the type and method of treatment, such as individual, online or group interventions, and service user preferences for appointment. Wherever possible the quickest, most appropriate treatment is offered, although demand for different options can impact on how long people may have to wait.

Recruitment to all teams has been ongoing throughout the year with a cohort of trainees joining the core staff teams and ongoing continuing professional development (CPD) opportunities provided for all staff, notably to work more effectively with people with long term conditions. All teams continue to deliver higher than the national target of 50% recovery rate and good outcomes for patients are reflected in the feedback received in all areas.

"This [service] saved not only my life but also my marriage and family. It made me feel normal and not a "freak". This has been my lifeline. If it hadn`t been for my therapist, I would have lost everything. It made me understand that my reactions and thoughts were I wasn`t totally losing it."

"Therapy has been a miracle for me. I could not see hope for me until I met [therapist[. I am leaving therapy a different person with a great life ahead of me. It has changed my life. All of my worries and trauma are just distant memories. I feel cured."



5. Inappropriate out of area placements

During 2018/19, we continued to maintain inappropriate out of area placements below the trajectory set with NHS England. This has been achieved by focusing on good flow through the acute services pathway, which involves partnership working between clinicians and operational managers; by ensuring that there is always capacity to admit individuals who require a bed, the need for inappropriate admissions external to the Trust is minimised.

A weekly Inpatient Oversight Group, chaired by the Inpatient Medical Lead and supported by Senior Service Line Lead, provides early indication of individuals who are likely to experience a delay in their discharge if there is not proactive work to address social needs or accommodation; there is also clinical oversight and challenge in relation to service users with a length of stay over 25 days.

Where delays or challenges are identified, there is shared ownership across services to expedite discharge and ensure that these delays are minimised. During 2018/19, Hightown Housing Association have provided 'step down' beds at two of their services for people who are waiting for accommodation and no longer need to be in the acute pathway, this has supported inpatient services to minimise delays in the pathway.

In the last year there has been work undertaken with Crisis Teams and Mental Health Liaison, both services that undertake the gatekeeping of admissions to inpatient services, in order to introduce uniformity in gatekeeping decision making and documentation of the alternatives to admission that have been explored with the individual. Audit of the gatekeeping documents supports review of admissions with the teams and opportunity to consider whether an admission could have been avoided. Where an out of area placement is used, this is monitored between Bed Management and the Inpatient Oversight Group, with review by the Crisis Teams to facilitate early discharge and Consultant to Consultant discussion to ensure oversight of care and repatriation in a timely way. These are reviewed at least weekly.

6. EIP

Our EIP Service delivers the FEP Pathway for all people referred to and accepted into the service. The FEP pathway offers a range of evidence based interventions to service users aged 14 – 65 across 3 years. Service users are offered a rapid assessment within 14 days of referral and targeted interventions to assess and improve their physical health and lifestyle. Psychological interventions focussed on Cognitive Behavioural Therapy and Family Interventions are part of the pathway alongside Employment and Vocational interventions and regular outcome measurement.

The PATH service recently engaged with the NHSI Intensive Support team in 2018, as part of a national programme of service visits, to complete a review of the service and agree an action plan to further improve the experience and outcomes for service users and carers. The review recognised that across 2017-18, PATH has consistently offered a rapid assessment and access to the service and has made improvements to the offer of physical health assessment and intervention, to ensure over 90% of service users have access to an annual assessment and targeted health interventions for each year they are on the pathway. The service now offers dedicated Carers support programmes for carers twice a year over 10 sessions and is working to further improve access to Family Interventions for families and carers.

After the review, the PATH service formulated a detailed action plan focussed on the themes of delivering better access to psychological interventions, improving our use of data to drive improvement and recruiting to all our clinical posts, work on which is now underway and measured regularly against agreed milestones. The PATH service is subject to an annual national audit process and this year achieved a Level 2 status indicating a good level of service with excellent access rates.

"Even though we didn't have many sessions together, you helped me so much. Thank you for helping me see that I don't have to be perfect. Thank you for making me feel so comfortable that I was able to talk to you openly about my thoughts and worries. Thank you so much for everything you've done for me."

7. Admissions to adult facilities of service users under 16 years old

Young people are admitted to adult mental health wards as a last resort and when all other options have been considered; these are agreed on the basis of the individual's needs and service user safety. The decision to admit will be escalated to both a senior management and clinical level. All admissions are reported via our incident system (Datix) and will also be reportable to the CQC where the placement lasts for a continuous period of longer than 48 hours.

During November 2017 to October 2018, we reported two such cases to the CQC and there has been one further case of an admission which was for less than 48 hours and not reported. Service users are nursed on a one-to-one basis and the CAMHS multi-disciplinary team provide continued support to the adult ward, with a joint review and care plan put into place.

8. Improved employed rate for service users

Throughout 2018/19, we have been piloting a new programme which provides people using secondary community mental health services with an opportunity to undertake an 8-week work placement/internship within a Trust work place. The programme utilised Individual Placement and Support (IPS) fidelity criteria and was led by a Senior Employment and Vocational Adviser (SEVA) who worked directly with service users from across the Trust to identify suitable opportunities/ internships as a precursor to supporting people into paid employment.

Working with a full caseload, the project delivered eight outcomes for service users over an eight month period. This is in line with IPS recommendations for a SEVA to achieve one outcome per month for people on their caseload. At the year end, three people had undertaken and completed a placement across:

- Performance Team
- Horticultural Therapy
- CAMHS events administration

The following outcomes were achieved via direct work between the SEVA and prospective interns:

- 4 people referred bypassed a work placement and were supported straight into paid employment by the SEVA and remain in paid employment. This was in two full-time roles and two part-time roles
- 1 person referred for a work placement has instead been supported into full time education and began their undergraduate degree in Psychology in January 2019
- 1 person referred was supported in to full-time education and is still successfully studying for a Masters in Psychology
- 1 person who completed an Admin work placement has successfully applied and was interviewed for a Bank Admin role within the Trust.
- 1 person has successfully applied and was interviewed for Bank Healthcare Assistant role within the Trust.

The diagram below provides and overview of activity from the pilot which is currently being evaluated to be integrated into the wider Trust IPS service given the successes that have been seen in such a short space of time:

Number of referrals **35**	**Number of 90 minute 1:1s** **191**	**% of work time spent face to face at 1:1** **23%**
Number of work placements started **3**	**Average active caseload** **13**	**% of appointments that were cancelled/DNA** **24%**
Number of working hours spent on pilot **1230**	**Number of placement locations identified** **14**	**Range of different professions referring in** **12***

**Self-referrals, carer referrals, Community Psychiatric Nurses (CPN), Social Workers, Occupational Therapists (OT), Support Workers, DBT Therapists, Peer Support Workers, Psychologists, Consultants, Vocational Advisers, Herts Mind Network.*

9. Co-producing Future Plans for Carer and Family Support

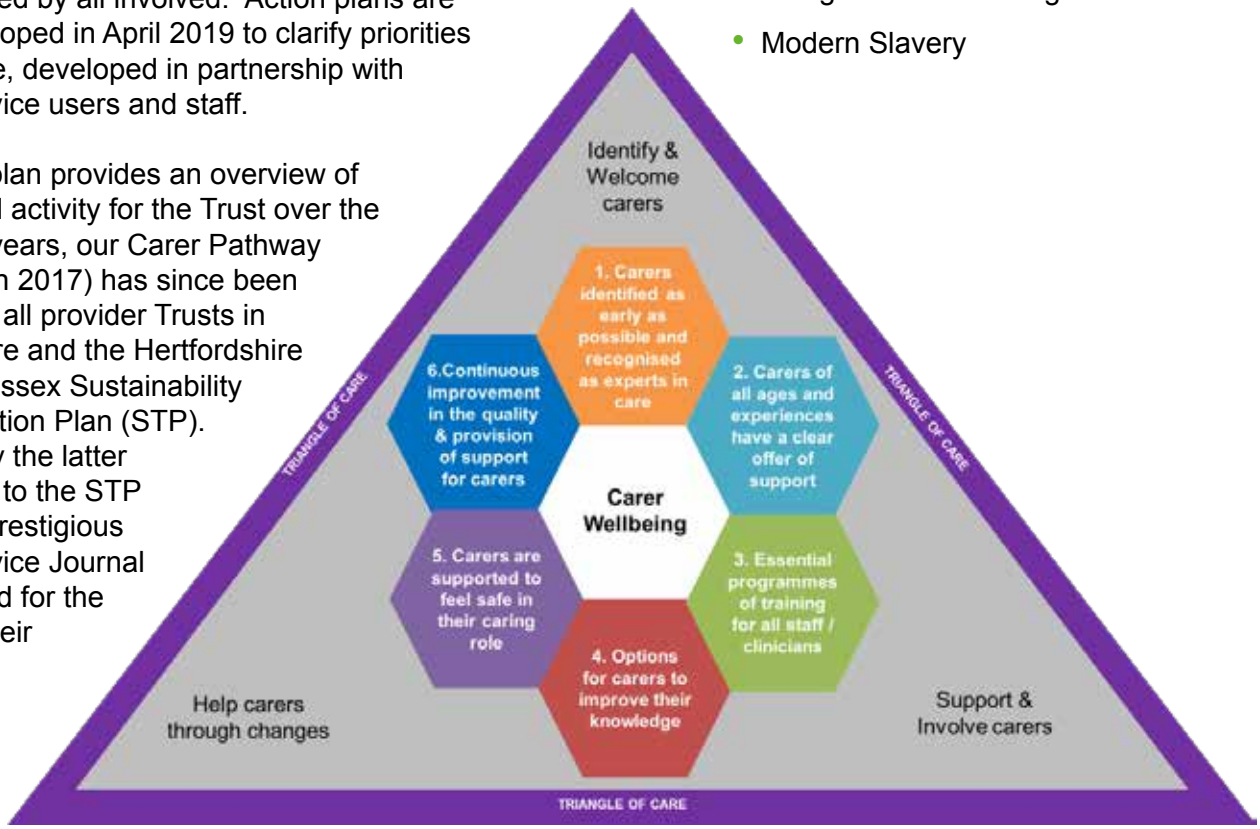
Throughout 2018/19, we have worked to co-produce a new three year plan for carer support. This involved input from carers, service users, staff and wider stakeholder groups and organisations in identifying priorities for carers against our overarching Good to Great strategy.

The plan identifies six areas of focus that are placed within the context of the national Triangle of Care model and the local Trust Carer Pathway which focuses on:

- Identifying carers
- Welcoming carers
- Supporting carers
- Involving carers
- Supporting carers through changes.

The diagram below outlines the co-produced model agreed by all involved. Action plans are being developed in April 2019 to clarify priorities for year one, developed in partnership with carers, service users and staff.

Whilst the plan provides an overview of the planned activity for the Trust over the next three years, our Carer Pathway (launched in 2017) has since been adopted by all provider Trusts in Hertfordshire and the Hertfordshire and West Essex Sustainability Transformation Plan (STP). Adoption by the latter contributed to the STP winning a prestigious Health Service Journal (HSJ) award for the quality of their systems for supporting carers in 2018.



The full Carer Plan can be viewed online at:
www.hpft.nhs.uk/carers/hpft-carer-plan-2019-2021

> *"So grateful for the gentle and kindly manner in which my sister is treated and well cared for."*

Safeguarding adults and children at risk of abuse or neglect

In line with our Strategy of delivering 'Great care, Great Outcomes – Together', our Safeguarding Team aims to improve the quality of safeguarding practice so we can prevent harm and enable safety through:

- Vigilance
- Competence
- Personalised outcomes-focussed practice.

Over 2018-19, safeguarding activity for both adults and children have stabilised, reflecting the embedding of improvements during 2017-18. The areas where we have seen the most significant improvements are:

- Domestic abuse
- Self-neglect and hoarding
- Modern Slavery

To improve our vigilance and competence in recognising and responding to potential abuse and neglect, we:

- Co-located Independent Domestic Abuse Advisors (IDVA) from Refuge into our services
- Developed dashboards for safeguarding adults and children to improve operational oversight
- Develop safeguarding website/central depository for safeguarding information
- Improved referral quality and enhanced process for Child Protection referral
- Provided a number of learning events and practice forums on Child Safeguarding referrals, self-neglect, domestic abuse and modern slavery.

A clear vision for safeguarding to improve towards has laid the foundations for a focussed improvement in all aspects of safeguarding.

A further Safeguarding Improvement Plan has been developed for 2019-20, which will build on the achievements of 2018-19 and take us further towards our vision.

Suicide Prevention

We are a key partner in the development and launch of the Hertfordshire Suicide Prevention Strategy which has representation on the Public Health Programme Board, the Steering Group and across the Task and Finish Groups. We are also a member of the Zero Suicide Alliance. Work from these has included a *'Herts journalist's charter'* agreed across stakeholders, including the police.

We are also a key member of the Hertfordshire Suicide Prevention Network, an alliance of more than 20 organisations drawing over 80 people into eight working groups with the shared ambition of making Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option. Our Trust staff input to each of the eight working groups which are:

1. **Communications –** developing relationships with media and news outputs in order that suicide is sensitively reported and the best use is made of social media. A network of news outlets recently signed a charter committing themselves to managing this issue with the mature sensitivity it deserves.
2. **Support of those bereaved by suicide –** research indicates that each suicide can touch the life of over 100 individuals, some of whom are of course deeply affected by their loss. A new Family Liaison role has been created within the Police and helpful booklets produced for families and friends.
3. **Boys and Men –** a group focusses on those most at risk of suicide, working to develop ways of reaching out to men and boys and encouraging connection when in crisis. This group has contributed to the development and launch of the Just Talk campaign which aims to normalise mental health conversations for teenage boys. At least 1 in 4 secondary schools have engaged with Just Talk and the social media campaigns on Instagram, and Facebook have been successful in reaching more than 55,000 people, 90% of whom are men.

   In addition, there have been over 9 million potential impressions on Twitter. Just Talk training was also delivered to 73 professionals in the county.
4. **Signposting and Referral –** aims to facilitate connections between those in need and those in a position to help and have enabled services to go on MiDos, the system used by the local NHS 111 service, re-established referral from custody suites to Samaritans, established a referral pathway between HertsHelp crisis service and Samaritans, and promoted pathways face-to-face with food banks, Relate, patient participant groups, interfaith organisations, local family justice board, housing associations and more
5. **Spot the Signs and Save a Life –** has been raising awareness and providing training across Hertfordshire to the public and private sectors, as well as meeting the public in everyday contexts such as the railway stations, village fairs etc. They are currently developing a smartphone app which will direct users to help and can be personalised to provide bespoke support when needed. Spot the Signs has now trained nearly 40% of GPs in Hertfordshire in Suicide Prevention methods

6. **Mental Health Transitions –** This group aims to help people move from one organisation to another through better information sharing and signposting of services available. As part of this, the group is creating a discharge pack for service users to take away when they leave a service or transition to another.

7. **Children and Young People –** focus on this most sensitive of groups and has supported the introduction of the Healthy Young Minds in Herts School Accreditation and Suicide Aware School status.

8. **Performance –** this final group does the important work of establishing the impact of the project and conducts an annual suicide audit which helps to focus the work of the other 7 groups.

In 2018, we implemented our own internal Suicide Prevention Group as part of a commitment to its zero suicide ambition. CGL Drug and Alcohol Services, a GP and a service user representative with lived experience are integral members of the group. The group commissioned a deep dive into unexpected deaths and serious self-harm for the first 6 months of 2018. An Education Task and Finish Group has been developed by the Suicide Prevention Group to take forward the actions arising from the deep dive and other Trust audits, in addition to learning from serious incidents relating to assessing and managing clinical risk.

We have supported two families and a service user affected by suicide and a suicide attempt to speak at a national learning conference and at a Hertfordshire suicide prevention event.

The Head of Safer Care and Standards chairs the Hertfordshire Support for the Bereaved by Suicide Task and Finish Group whose members have lived experience.

We are working across the system with Network Rail, attending escalation meetings for specific railway stations. We participated in a workshop in January 2019 alongside other partners from Hertfordshire Police, Public Health, Samaritans, Community Safety Partnership and the Coroner's Office which looked at a community approach to preventing suicide on the railway in Hertfordshire.

Planned work includes a collaborative approach working with the Samaritans, supporting follow ups for service users following discharge; also tackling isolation for men through activity and social interaction in social settings (i.e. pubs).

Workforce

National NHS Staff Survey results for 2018

Our 2018 National NHS Staff Survey results demonstrate that we have maintained a positive position particularly in comparison to the last two years, where we had really positive staff survey results. There were no significant differences between the 2017 and 2018 scores.

There are a number of changes to the benchmarked report this year in comparison to previous years. Most notably is that the 32 key findings have been replaced by 10 themes. A theme focussing on morale has also been introduced.

- 4 themes are above average in comparison to Mental Health and Learning Disability Trusts
- 4 themes are average
- 2 themes are below average.

It should be noted that both the below average scores were 0.1 away from being average. For the theme of safety culture, we achieved the national best score of 7.0 and scored above average for every question within the theme.

Top 5 scores (compared to average)	2018 Trust	2018 Mental Health Average	2017 Trust	Trust Improvement/ Deterioration
Q22b. Receive regular updates on patient/service user feedback in my directorate/department	73%	60%	72%	Improvement +1%
Q19e. Appraisal/performance review: organisational values definitely discussed	48%	40%	40%	Improvement + 8%
Q22c. Feedback from patients/ service users is used to make informed decisions within directorate/department	67%	59%	64%	Improvement +1%
Q17c. Organisation takes action to ensure errors are not repeated	76%	69%	73%	Improvement + 3%
Q21b. Organisation acts on concerns raised by patients/ service users	81%	73%	81%	No change

Workforce Inclusion

Our Inclusion and Engagement Team oversees the day to day work around Equality and Diversity including supporting professionals with understanding approaches they can take in ensuring inclusive workplaces for people and provision of equitable services.

Our Equality Plan was co-produced in 2018 to guide much of this work up to 2022 and includes focus on both staffing and provision of high quality services.

Additionally, to support inclusion at work, we have developed a role model programme, who are staff members from certain protected groups who are available to support and signpost other staff should they need this.

As part of our bullying and harassment action plan, there is work in progress to merge the role models programme together with a new 'dignity at work' champions' programme.

We have staff networks for the protected characteristics. The Women's Network has delivered Schwartz rounds, peer support sessions, flexible working, liaison with national women's networks. The Black, Asian and Minority Ethnic (BAME) Network is the Trust's longest running staff network and most recently has included focused work around the Workforce Race Equality Standard (WRES). The network is also instrumental in the planning of the Trust annual race equality at work event in October each year.

There has also been focus in the past year on how the network can get more engaged with reviewing outcomes of recruitment processes as a critical friend to the process.

Other areas of focus for the network include:

- How managers are relating to people
- Managers getting to know staff
- Discussion around meaningful supervision, asking "How are you" and not just going through the process
- Promoting a balanced and equitable approach across all career paths.
- Generating ideas around how the Trust could be improving approaches to recruitment to ensure equality of opportunity.
- Advocating for managers who are good role models for staff.

Specifically in relation to WRES, an open forum was advertised across the Trust to understand the reasons why staff from a BAME background are more likely to enter a formal disciplinary process and less likely to be appointed after interviewing for roles than those from other demographic groups. Across the day various staff from all backgrounds attended to give feedback on their experiences from different areas of the Trust. This was used to inform the WRES action plan.

Our WRES plan is refreshed at least annually and tracks progress across the organisation. This has been overseen, up to now, by an operational WRES management group. Over the past few months the Trust has begun to hold drop in 'surgeries' for BME staff within our business units to provide opportunity for BAME staff to meet both management and equality and diversity staff to share their experience and share ideas for improvements, as well as highlighting what works well for them.

Annually, we host an annual event for staff focused on supporting race equality across the workforce and how changes to culture can be implemented to ensure no differential, negative, experience for BAME staff.

People are our greatest asset and a focus for us was continuing to improve the experience of staff, inclusively, in the workplace. One element of this is our aspiration to eliminate any experience of bullying and harassment. We have put in place actions designed to support this aspiration which are monitored constantly and progress is evaluated on a regular basis. Our values are embedded across the organisation and the recent CQC report has confirmed this is felt by our service users. In 2019-20 we will continue to focus on demonstrating how our values translate into the workplace and develop our working relationships as a means of reducing and ultimately eliminating bullying and harassment within the Trust.

Recruitment

To overcome the recruitment challenges we face as a Trust there is an active programme of recruitment to vacancies throughout the Trust with an increased focus on hard to recruit areas. This includes recruitment campaigns, recruitment days, attendance at recruitment fairs, working with agencies, and offering students substantive roles with the Trust upon qualifying.

A significant amount of work has been undertaken to improve the on boarding process including the outsourcing of all pre-employment checks, getting all recruiting managers to undertake ID checks at interview, ensuring candidates are kept updated during the recruitment process, and ensuring all managers complete the necessary forms so that their new starter has all the equipment they need to do their job on day one. This has already helped to reduce our time to hire to 8.5 weeks.

We have recently implemented a new careers website to aid recruitment. In addition, we have changed our notice periods for new starters for band 5 and band 6 staff from 4 weeks to 8 weeks, and for Band 7 staff from 4 weeks to 12 weeks. This was effective from 1 January 2019. Our Strategic Business Units have recruitment and retention plans and are developing a welcome pack that is specific to their area of work.

We have also participated in the widening participation workshops with NHS Employers and is actively involved in the STP recruitment and attraction work stream.

Our Trust values are integral to all we do as a Trust and they are introduced early on in the recruitment process. All new recruits are screened against the Trust values at the point of application through completing a values assessment. Then interviewer packs include suggested interview questions designed to determine if candidate's values align to the trusts. All interviews must include at least one of these questions.

A values session is held at all inductions which is attended by staff, volunteers and students. We have a strongly embedded Employee Value Proposition which fosters a culture where service users, carers, staff, our partners and our referrers receive an experience that is Welcoming, Kind, Positive, Respectful and Professional. The Values and Behaviours Framework form part of all appraisals to ensure performance is measured against the Trust values.

Retention

As a Trust, we recognise the importance of retaining our staff and recognise that our retention rates are not as high as we would like. As a consequence, we have implemented a number of retention initiatives over the last year including the retire and return process, internal transfer process, piloted a buddy system for new starters which is about to be expanded, held 'Grow Don't Go' workshops within the Strategic Business Units, held flexible working workshops with managers and are embedding the 100 day interviews for new starters. Further work to be implemented includes career surgeries for staff and holding a Long Service Awards ceremony in May 2019. Communication of and embedding the schemes continue throughout the Trust. We have actively participated in the NHSI retention programme as well as the retention programme run by NHS Employers.

Our Pulse Survey

We run the survey every quarter, based on the National NHS Staff Survey questions, giving us consistent quantitative feedback from staff on their experience with the Trust. Scores indicating whether staff would recommend the Trust as a place to work or receive treatment have maintained a good level during the past few years.

The Pulse Survey questions are reviewed annually to ensure they meet the needs of the organisation and are in context with the Organisational Development Strategy.

Health and wellbeing

In 2018/19, staff were provided with an annual calendar of Health Hub events including: socials, challenges, workshops and online tutorials. Health Hub champions were supported ensuring the events had more impact.
The impact of the events has been through quantitative and qualitative data analysis. This analysis, including testimonials, has been communicated to staff via our weekly news bulletin, our staff magazine and also our Workforce reports.

The data from 2018-19, along with the National Staff Survey and Pulse Survey, will inform the areas of focus in the action plan for 2019-20 and the Staff Health and Wellbeing Strategy will be updated to reflect this.

Some of the events undertaken include:

- 140 massages to staff across sites
- Delivering mini health checks
- Schwartz Rounds in quarter 4 in our north west and our east and south east quadrants
- Mindfulness and resilience sessions in south west and Buckinghamshire.

The analysis has shown:

- Those attending a Mindfulness course had an increase of 28% mindful awareness
- Staff provided testimonials for onsite massage and mini health checks and we have quantitative information for each quarter
- Schwartz Rounds scored a feedback rating of 10% Exceptional, 55% Excellent and 18% Good.

The data from 2018/19 has provided us with the evidence-base needed to continue to evaluate the wellbeing support offered to our staff.

Staff Support

There are a number of ways in which we offer support to staff, both formally and informally. We provide Occupational Health support and an Employee Assistance programme is available to all staff 24 hours a day, 7 days a week, 365 days of the year. We have also implemented a confidential helpline which staff can contact if they have any concerns or would like to report bullying and harassment.

We have also implemented Schwartz Rounds which are a structured forum where all staff (clinical and non-clinical) come together regularly to share their personal experiences of work. The aim is not to fix problems, but to acknowledge the emotional demands of working in healthcare. Schwartz Rounds reduce feelings of stress and isolation, which make it difficult to provide compassionate care.

The benefits of Schwartz Rounds include significant improvements to staff psychological wellbeing, improved inter professional working and more compassionate care. During 2018, 16 Schwartz Rounds were held throughout the Trust with 243 participants. An evaluation of Schwartz Rounds found that 92% of participants would attend again, 95% of staff would recommend Schwartz Rounds to a colleague, 90% of staff said it would help them to work with colleagues, and 98% have a better understanding of how colleagues feel about their work.

Additional staff support also consists of workplace mediation, mindfulness courses, resilience training, stress management tutorials, and the Trust Health and Wellbeing magazine known as ‘Working Together as One’.

Where an incident has taken place, post incident support is offered on an individual as well as a team level. This is co-ordinated through the Safer Care team and continues through the serious incident investigation process to inquests and beyond.

The Spiritual Care team also contribute to staff support by offering team and individual support, particularly where a staff member or service user has died.

The importance of having support for new staff has was highlighted as needing development. As a result, a buddy scheme for new starters has been piloted in some areas of the Trust and will be rolled out over the coming months with development workshops being made available to buddies as a source of support.

Annual Staff Awards

Each year, we host our Annual Staff Awards event. The afternoon is dedicated to the development awards where we celebrate staff who have completed an academic qualification throughout the year. 164 members of staff were invited to the staff development awards with 98 members of staff attending to collect their certificates.

The evening is a black tie Staff Awards event. There are 12 Annual Staff Award categories which are as follows:

- Unsung Hero
- Council of Governors Making a Difference Award - nominations for this category are made by service users and carers
- Chief Executive's Award
- Chair's Inspire Award
- Team of the Year Award
- Outstanding Leader of the Year Award
- Rising Star Award
- Professional of the Year Award
- Innovation or Improvement of the Year Award
- Special Contribution Award
- Working in Partnership Award
- The John Lewis Customer Experience Award - Nominations for this award are made by service users, carers, their families and staff.

The last staff awards ceremony was held at Tewin Bury Farm in November 2018 and was attended by over 300 staff. Over 300 nominations for Achievement awards were received with 25 members of staff either winning an award or gaining highly commended. The awards ceremony was a wonderful opportunity to celebrate the success of our staff and all the wonderful things they do to provide great care every day to service users and carer either directly or indirectly.

Inspire Awards

The Inspire Awards are a monthly staff award to recognise and reward those staff who consistently demonstrate our values. Nominations are received, with a supporting statement, from staff, service users and carers. Anyone in the Trust can be an Inspire Award winner. Winners are invited to attend an informal presentation with the Chief Executive and members of the Executive Team where they are presented with a certificate, £50 John Lewis voucher and have a small buffet lunch. There have been 134 Inspire Award nominations with 73 winners.

Leadership

We provide a range of Leadership Development Programmes both internally and externally to meet the different requirements and learning styles of staff.

These comprise of formalised in house training programmes, covering basic management skills and leadership development, previously in our Managing Service Excellence programme, which has been reviewed and is being relaunched as the Management Fundamentals Programme and through our internal Leadership Academy, which is a level 7 accredited programme delivered in partnership with the University of Hertfordshire.

Cohort 9 of the Leadership Academy have recently graduated with 20 delegates passing and gaining accreditation. This Level 7 accredited Programme is delivered in partnership with the University of Hertfordshire and this Cohort was our most successful to date.

The Finance Team has facilitated elements of the Trust's leadership academy for some years now, writing and presenting a finance module to cover topics that leaders and future leaders need to understand in order to do their jobs effectively. For the new cohort starting in 2019, our module has expanded to 2 days and has replaced sessions which were previously covered by an external trainer, saving money for Organisational Development and providing a much more Trust-tailored training. We will also be participating in the new Management Fundamentals course again writing the material.

We are also participating in the local Mary Seacole programme within the STP, with cohort 4 recently graduating and with cohorts 5 and 6 near completion of the course. The Trust has also participated in the Bedfordshire and Hertfordshire Accelerated Directors Development Scheme (ADDS) which is a Chief Executive sponsored scheme to identify and develop leaders for Bedfordshire and Hertfordshire, who have the potential to fill key Executive Director roles. It is co-designed, owned and delivered on behalf of the Bedfordshire and Hertfordshire Talent Forum. ADDS is focused on identifying and developing high potential leaders from operational and clinical backgrounds and is a unique scheme offering automatic shortlisting for appropriate Executive Director roles, thereby linking development and job opportunities. The current Executive Director of Service Delivery and Experience, the Executive Director of Quality and Safety and the Interim Director of Workforce and Organisational Development have all been through this course. Another participant has gone on to become the Chief Nurse at the Homerton NHS Trust. In addition, 3 further participants from the Trust have just completed the last cohort.

We have also recently participated in the pilot for the Midlands and East Talent Board, with 2 candidates from the Trust being put forward. Staff have also participated in national programmes such as Nye Bevan – the current Executive Director for Quality and Medical Leadership, Mary Seacole, Aspiring Directors of Nursing programmes – the Deputy Director of Nursing and Quality and the Deputy Director of Safer Care and Standards; and the Chief Pharmacist Development programme – the Deputy Chief Pharmacist. A Senior Community Nurse Lead has been successful in her application, supported by the Trust, to join the 70@70 Senior Nurse and Midwife Research Leaders programme.

Internally, we have delivered a leadership programme for Service Line Leaders using a coaching and mentoring style, and Team Leader development days continued to run for the second year. Development days for Medical Leads have also taken place during the year and more recently for Matrons. Specific leadership development programmes are supported by additional support to managers through the coaching network and the creation of podcasts to provide 'just in time' support around key management and leadership issues. 8 members of staff have recently qualified as ILM (leadership and management) level 5 coaches and are registered with the Bedfordshire and Hertfordshire coaching network, coaching both internal and external staff.

Our 70 senior leaders meet regularly to hear from the Chief Executive about key strategic developments and to do focused thinking around strategic and operational objectives. This forum is also used for development sessions for example a session on Outward Mindset by Alec Grimsley. The national leadership framework shares the same evidence base as the collective leadership model, which we have used to inform the Organisational

Development Strategy. Succession planning also takes place within each Strategic Business Unit so that leaders of the future are identified and supported to gain the development they need.

We are also committed to increasing equality and diversity and our Unconscious Bias training is being rolled out across the organisation.

The Monthly Educational (CPD) Programme is led by senior leaders established in community teams. The programme entails teaching on risk formulation, collaborative safety planning and role play on managing difficult clinical situations. (Community Adult Mental Health Services).

Organisational Development

The Organisational Development Strategy outlines how we need to develop to deliver our strategy of going from Good to Great. It sets out a series of planned activity that develops our organisational (as well as individual) competencies. This includes embedding the desired culture, ensuring an effective workforce and developing enabling systems and processes.

In addition to leadership development and talent management and succession planning, there are a series of staff engagement programmes which take place throughout the Trust.

These include as follows:

- **Big Listen and Local Listens**

  The Executives undertake a 'Big Listen' engagement every quarter, which is open to all staff. A full day is spent meeting the Executives and discussing any issues that matter to staff. Staff are asked to put forward their comments regarding how the senior leadership team can improve both the staff and service user experience around certain themes such as WRES, bullying and harassment, recruitment and retention, for example. There is a 'Question Time' panel during the day where attendees have an opportunity to ask questions directly of the Executive Team, or anonymously should they prefer. These events receive excellent feedback and evaluation and there are actions taken from these events that are reported on at the following event to complement our 'You said, we did' approach. For example, in the October 2018 Big Listen staff complained about the backlog and length of time to get IT equipment. The Executive Team took action that day and an additional 250 laptops were ordered.

  Local listens, which follow a similar format to the Big Listen, are also held across Norfolk, Essex and Buckinghamshire to reach an even greater audience. Local Listens have also been adopted by the SBUs locally and are attended by Senior Leaders and Managers.

- **Good To Great Roadshows**

  Our Good to Great Roadshows take place every six months and provide an opportunity for our Executive Team and Senior Leadership Team to meet with staff at their work locations to discuss a certain topic. The latest Good to Great Roadshows have focussed on improvements that teams have made over the last year, making 'time to care' and the success factors to focus on. 16 roadshows were held at 15 sites with 224 members of staff attending.

- **Chief Executive Breakfasts**

  Chief Executive Breakfasts also take place throughout the year in which our Chief Executive meets with a certain staff group to understand what is going well, and what could improve their working lives. Over the last year, breakfasts have been held with 30 staff from staff groups including Medical Consultants, Matrons, Band 5 and Band 6 Registered Nurses, Assistant Psychologists and Occupational Therapists.

Statutory / Mandatory Training

A comprehensive programme of statutory and mandatory training is in place across the Trust with the requirements tailored to specific job roles. Discovery has been set up to allow the individual to know which of the statutory and mandatory training modules they are required to complete and monitor their compliance against this requirement.

Discovery now hosts all our e-learning packages which offers ease of access to staff to complete their statutory and mandatory training. For those courses which still run as face to face sessions, staff are able to book onto them directly via Discovery.

Feedback from staff has been that the system is more user-friendly and easier to navigate and as a consequence improvements in compliance rates have been seen. The functionality of the systems also allows managers to see the training compliance of their team members.

Discovery is our new learning management system accessed by staff either at work or at home. Staff can see at a glance what courses they are compliant in, what courses are about to become non-compliant and what courses are now non-compliant.

Apprenticeships

We are fully committed to utilising the Apprenticeship levy to provide alternative opportunities for the local workforce and increase our skill base. During 2018-19 we have engaged a number of apprentices across clinical and non-clinical roles. We have 82 apprentices working in the Trust through 2018-19. We have plans to provide similar opportunities during 2019-20 and are looking to potentially increase the scope of apprenticeships to include other Health Professionals and management level courses. Occupational Therapy has been identified as the next development with the University of Hertfordshire and will be accept the first students in September 2020.

Medical Education

We remain strongly committed to investing in learning and development for all our staff.

General Medical Council (GMC) Trainers and Trainees 2018 Survey.

The 2018 survey was one of our best outcomes since the GMC Training survey began, with 11 positive (green) outliers and 3 negative (red) outliers. We continue to be rated one of the best mental health trusts in terms of training in the East of England region, as in previous surveys.

Our GP trainees and Foundation Year doctors rate their placement experience with us very highly, leading to most of the positive outliers received coming from these groups of doctors.

The GP trainees rated workload, study leave and local academic teaching programme very positively, while the Foundations Year doctors gave positive responses regarding the Trust in the areas of work load, supportive environment and overall satisfaction.

The three areas which received negative outliers were amongst psychiatric trainees in the areas of work load, rota design and overall satisfaction. We identified the reasons being the recruitment challenges. This meant that there were gaps in the rota which put added pressure on trainees who sometimes had to cross-cover. The situation has improved, with the resolution of the recruitment crisis in core psychiatric posts.

We have also set up a GMC approved fellowship programme attracting overseas trained psychiatric trainees as well. Overall, the outcome of the survey was very positive with the expectation that, as the recruitment situation improves, the negative outliers will become positive. The responses of our trainers were the most positive amongst the mental health trust in the east of England region.

What is the MSc in Psychiatric Practice and Mental Health Practice?

This MSc degree programme was jointly set up and funded by the University of Hertfordshire and the Trust to provide psychiatric trainees with an academic course to help prepare them for the Royal College of Psychiatrists examinations, and to give them and other members of staff the opportunity to obtain a master's degree.

Health Education England coaching and mentoring funding 2017/18

We received funding from Health Education England of £1,500 as a one-off payment. Our Medical Education Budget has also financed a train the trainer course at which 7 of our Consultant Psychiatrists and one Organisational Development Manager attended. We plan to deliver this training in-house to our trainee medics in the future; the first workshop is arranged for 31 May 2019.

Compliments, Comments and Complaints

We place great value on the comments, compliments and complaints sent in by service users, their carers, relatives, friends and advocates. We encourage people to raise concerns with staff on the units, to use the comments, compliments and complaints leaflets available on all wards and outpatient units. Alternatively they can complete a form on the Trust website at:
www.hpft.nhs.uk/contact-us/compliments-and-complaints/online-form
email hpft.pals@nhs.net or call our dedicated phone line 01707 253916.

We also invite all service users and carers to provide ongoing feedback on their experiences by completing *'Having Your Say'* forms or Friends and Family Test (FFT) postcards, either on paper or electronically, during their recovery journey. Service Experience Volunteers visit our adult acute inpatient and rehabilitation units to provide an impartial listening ear as well as support for service users and carers providing feedback through *Having Your Say.*

What is the NHS Friends and Family Test (FFT)?

The NHS Friends and Family Test (FFT) was created to help service providers like the Trust understand whether service users are happy with the service we provide, or where we need to improve. It is a quick and anonymous way to give views after receiving care or treatment.

What we do with compliments, comments and complaints

We use information received through comments and complaints, 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 change and develop practice.

Each quarter, every clinical team is 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.

We also feel it is important to celebrate what we do well, and all teams are encouraged to send details of compliments received to the Patient Advice and Liaison Service (PALS) and Complaints Team to make sure we capture the overall picture of service users and carers' experiences. We record all the compliments we receive and these are published in the e-magazine for staff. Satisfaction levels are monitored through Having Your Say and Friends and Family Test (FFT).

PALS

PALS provide people with advice and assistance if they have a concern or enquiry. This year we received 869 contacts – an increase of 1% on last year. The table below shows the number and main categories of PALS contacts, comparing 2018-19 with 2017-18, 2016-17 and 2015-16.

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 an 11% increase in enquiries and a 93% increase in contacts about issues not related to our services.

We are being more rigorous about defining comments as feedback, informal complaints and issues for resolution which explains the changes to figures has meant an increase in contacts in that category compared to previous years.

Category	2015/16	2016/17	2017/18	2018/19
Advice	41	40	67	32
Enquiry	67	140	176	196
Feedback	98	100	240	156
Issues for resolution	363	446	183	272
Informal complaints	-	-	135	97
Other	0	1	0	1
Translation request	1	0	1	0
Non HPFT	36	32	59	114
Total	**606**	**759**	**861**	**869**

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 2018-19 was 284 compared to 206 received in 2017-18, which is a 38% increase. The increase is more marked owing to unusually low number of complaints in 2017-18, which was a 22% decrease on the previous year, as well as an increase in activity during 2018-19. Although it is difficult to ascertain the fluctuation over the last two years, the average of the two years together does remain comparable to the total received in previous years. The table below shows the number of complaints categorised by the main issue each complaint focused on, comparing 2018-19 with 2017-18, 2016-17 and 2015-16.

Category	2015/16	2016/17	2017/18	2018/19
Assault / abuse	11	3	3	4
Clinical practice	98	93	89	113
Communication	39	35	24	49
Environment etc.	3	2	4	7
Staff attitude	29	31	26	35
Security	3	0	6	6
Systems and Procedures	84	84	54	69
Transport	2	2	0	1
Total	**269**	**250**	**206**	**284**

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. 8 PALS contacts became formal complaints during the year.

The 113 complaints where clinical practice was the primary issue fell into 11 sub-categories. Most complaints fell into the following groups:

- Direct care (52)
- Assessment and treatment (23)
- Care planning (12)
- Diagnosis (10)

The 69 Systems and procedures complaints fell into 25 sub-categories. The highest numbers were for:

- Access to Treatment (17)
- Breach of Confidentiality (12)
- Mental Health Act detention (4)

The 4 complaints of alleged assault were:

- Alleged physical abuse to a service user by a member of staff (not upheld)
- Alleged physical abuse by another service user (this aspect of the complaint not upheld, subject to safeguarding)
- Alleged physical abuse by staff (under investigation and subject to safeguarding)
- Physical abuse by another service user (under investigation).

All allegations were considered carefully by the Multidisciplinary Team and through Safeguarding, where appropriate. One case, which resulted in a fracture, is being investigated as a Serious Incident. During 2018/19 we received 7 requests for files from the Parliamentary and Health Service Ombudsman (PHSO)/Local Government Ombudsman.

During the year we received 5 decisions:

- 2 not being investigated
- 3 not upheld

There are currently 5 complaints with the Ombudsmen.

Compliments

All teams are asked to forward letters of thanks from service users, carers, advocates and visitors to the PALS and Complaints Team so that they can be logged and reported. In line with increased numbers of other contacts there has been a 20% decrease in the number of compliments forwarded to the team.

- 2015/16 – 1622
- 2016/17 – 1915
- 2017/18 – 1981
- 2018/19 – 1571

In 2018/19, we recorded nearly 6 times as many compliments as formal complaints.

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 and Adolescent Eating Disorder Community
- Quality Networks for Child and Adolescent Inpatient
- Quality Networks for Child and Adolescent Community
- Quality Networks Inpatients Child and Adolescent Inpatient
- Quality Networks for Perinatal inpatients
- Quality Networks for Perinatal community
- Quality Networks for Rehabilitation services Inpatient
- National Association of Psychiatric Intensive Care Units (NAPICU)

"Absolutely fantastic people. Everyone I met was so kind. My experience with the crisis team was a fundamental part of my recovery. I could not have done it without their kindness and support. It meant so much to me! Thank you from the bottom of my heart."

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.

What is a clinical network?

These networks are dedicated to providing assurance and sharing good practice so we can improve the health service for all those who work in and use it.

We also participated in the following accreditation schemes:

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
	Early Memory Diagnosis and Support Services – South West Hertfordshire	Accredited	
	Early Memory Diagnosis and Support Services – North West Hertfordshire	Accredited	
Perinatal	Hertfordshire Partnership University NHS Foundation Trust	Member	51
	Thumbswood Mother and Baby Unit	Accredited	
Psychiatric Liaison Accreditation Network	Lister RAID (The Lister Hospital and Queen Elizabeth II Hospital)	Accredited	81
	Watford RAID Team (Watford General Hospital)	Accredited	
Quality Network for Community CAMHS	CAMHS Eating Disorders	Participating but not yet undergoing accreditation	42
Quality Network for Forensic Mental Health Services	Beech Ward (Kingsley Green)	Accreditation not offered by this Network	83
	Eric Shepherd Unit	Accreditation not offered by this Network	
	Broadland Clinic	Accreditation not offered by this Network	

Service Accreditation Programme and Quality Improvement Network			
Programmes	**Participating services in the Trust**	**Accreditation Status**	**Number of Services Participating Nationally**
Quality Network for Inpatient CAMHS	Forest House Adolescent Unit	Accredited	131
Quality Network for Inpatient Learning Disability Services	Assessment and Treatment Unit, Lexden	Accredited	41
	Dove Ward	Accredited	
	Astley Court	Accredited	
Quality Network for Older Adults Mental Health Services	Prospect House	Participating	87
Psychiatric Intensive Care Units	Oak Ward	Accredited	38
Prison Mental health Service	HMP The Mount	Accreditation not offered by this Network	40

CQC

As a Trust, we were registered with the CQC on 1 April 2010 to carry out the following regulated activities:

- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the Mental Health Act 1983.

We were inspected by the CQC between 23 January – 9 February 2018, which included an unannounced inspection of services and a well led inspection. The Trust's report was published in April 2018.

The Trust achieved an overall rating of 'Good'. The report focused on 5 different domains of quality:

- Safe
- Effective
- Caring
- Responsive
- Well led

The CQC's overall rating of the Trust stayed the same, it was rated as 'Good' because:

- Staff showed caring, compassionate attitudes, were proud to work for the Trust, and were dedicated to their roles
- Staff managed medicines safely in most services. The Trust had made improvements in medicines management since the last inspection
- Staff completed comprehensive and robust risk assessments and documentation showed clear service user involvement and inclusion
- Staff included service users in service improvement, using their feedback to change practice
- Safeguarding and incident reporting were transparent locally and thorough; review and evaluation of this was proactive. Teams shared lessons learnt effectively and in some services shared this learning with service users
- Local leadership across the majority of services was strong, visible and effective
- Local governance meetings discussed ward issues, such as incidents, safeguarding, staffing concerns, and identified and shared learning from incidents
- Quality improvement initiatives had begun to make a difference
- A system called SPIKE gave staff access to monitor performance and leaders saw this as a way to assist data collection and analysis and reduced time on administration tasks
- The CQC were provided with a good description of the way in which the Trust implemented Duty of Candour, highlighting that it is in the terms of reference for the investigation of each serious incident that the duty of candour is complied with; service users are contacted before, as part of, and at the conclusion of each investigation.

The Trust devised an action plan with a list of 'Must do' and 'Should do' recommendations to address areas identified by the CQC of which its implementation was overseen by the Integrated Governance Committee and the Board. At the time of this report we have completed the following actions:

- **Ensure that all ligature points and blind spots are identified and risks are mitigated**

  All Acute and the psychiatric intensive care unit (PICU) ligature risk assessments were reviewed and updated at the time of the inspection

  Further work to combine ligature risks, blind spots, lines of sight and floor plans into one risk assessment was initiated. Weekly environmental assessments and walk rounds take place across the Trust, with a new system provided by Advanced New Technologies (ANT)

- **Ensure that all service users receive a physical health assessment on admission and that identified health care needs are met**

  Processes are in place and the Fundamentals of Care audits are taking place to ensure and monitor physical health assessments are being completed, progress is monitored via the local Practice Governance meetings

- **Ensure adherence to the Mental Health Act Code of Practice in regards to recording of seclusion practices and the seclusion environment**

  Immediate work completed on the PICU seclusion room. Work also completed on upgrading a high intensity room to a seclusion room on Dove ward. The refurbishment of seclusion rooms programme is underway with work commenced. Furthermore, an external review by Mersey Care of seclusion practice and environments was completed in July 2018, with a final report and recommendations received

- **Ensure the proper and safe management of medicines**

  Updated expiry date Standard Operating Procedure (SOP) has been shared with nursing staff by our Chief Pharmacist. The SOP has been amended to re-enforce the importance of documenting the "date of opening" on specific medications

- **Ensure staff are supervised in line with their policy and that this is monitored**

  All supervision trees are up to date and with the Service Line Leads; supervision trackers are in place on all units and being reported on monthly. The Discovery supervision module became operational from July 2018.

This allows the recording and will enable the monitoring of supervision against our policy. Compliance of this will be audited monthly, and compliance will be monitored through this system.

At this inspection, the CQC rated two core services as 'Outstanding', one core service as 'Good' and one as 'Requires Improvement'. Therefore, two of our 11 services are rated as 'Outstanding', 8 as 'Good' and 1 as 'Requires Improvement'.

As part of the CQC's annual approach to inspections, the Trust was inspected week commencing 4 March 2019. The inspection included a core services and well led inspection.

The following core services were inspected:

- Acute wards for adults of working age and psychiatric intensive care units
- Community-based Mental Health services for adults of working age
- Child and adolescent mental health wards
- Specialist community mental health services for children and young people
- Mental health crisis services and health based places of safety
- Wards for older people with Mental Health problems.

The CQC published our inspection report in May 2019 and rated us as Outstanding. We are now one of just five mental health and learning disabilities NHS Trusts in the country to be rated as outstanding – and the only one in the east of England.

Of the eleven services that have now been inspected by the CQC, seven are good and four are rated as being outstanding.

"Staff showed caring, compassionate attitudes, were proud to work for the Trust, and were dedicated to their roles."

From Norfolk to Buckinghamshire and Hertfordshire to Essex, this has been achieved by brilliant, dedicated staff who are committed to our service users and carers by delivering great care and achieving great outcomes together.

The CQC inspectors were particularly impressed with the strength and depth of our leadership and that staff felt respected, supported and valued, with staff morale across all teams consistently high. Furthermore, they were full of practice for staff, saying that they had found examples of outstanding practice in all the core services they visited.

"Throughout the Trust, staff treated patients with kindness, dignity and respect. Consistently, staff attitudes were helpful, understanding and staff used kind and supportive language patients would understand."

The report noted our clear proactive approach to seek out and embed new and more sustainable models of care, citing the introduction of a series of new care pathways on our CAMHS ward, where we have reduced the average length of stay from 80 days to just 15.

Areas of outstanding practice also highlighted by the inspectors include our commitment as a Trust to supporting staff and learning from incidents to improve service user safety including the safety huddles, Swarms, Schwarz Rounds and Moderate Harm Review panels, as noted in this Quality Account Report.

The report also noted our service user groups' involvement in re-designing key resources including simplified care plans and information leaflets for new service users and their loved ones.

Also a Young Person's Council which had helped service users get involved in staff recruitment and met with senior management to discuss changes to our CAMHS.

Our community mental health services for adults were noted with specialists working in multi-disciplinary teams, established to meet the needs of service users.

Our journey of good to great continues and we will build on this outstanding achievement together.

"Managers ensured staff had caseload sizes depending on their level of experience, other duties and seniority."

"Achieving this highest rating is a real testament to the hard work of all the Trust's staff and its leadership."

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good ↑ May 2019	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good ↑ May 2019
Long-stay or rehabilitation mental health wards for working age adults	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015
Forensic inpatient or secure wards	Good → ← Apr 2018	Good → ← Apr 2018	Outstanding → ← Apr 2018	Good → ← Apr 2018	Outstanding → ← Apr 2018	Outstanding → ← Apr 2018
Child and adolescent mental health wards	Good ↑ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Wards for older people with mental health problems	Good → ← May 2019	Requires improvement ↓ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Wards for people with a learning disability or autism	Good → ← Apr 2018	Good → ← Apr 2018	Outstanding → ← Apr 2018	Good → ← Apr 2018	Outstanding → ← Apr 2018	Outstanding → ← Apr 2018
Community-based mental health services for adults of working age	Good → ← May 2019	Good ↑ May 2019	Outstanding ↑ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Mental health crisis services and health-based places of safety	Good ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Specialist community mental health services for children and young people	Good → ← May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Good → ← May 2019	Good → ← May 2019	Good → ← May 2019
Community-based mental health services for older people	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015
Community mental health services for people with a learning disability or autism	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015	Good → ← Sept 2015
Overall	Good ↑ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Good → ← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

CQC inspectors did identify a number of areas for improvement and said we needed to take immediate action to rectify a minor breach of legal requirements by ensuring staff on wards for older people with mental health problems received regular, good quality supervision.

You can the CQC reports at:
www.cqc.org.uk/provider/RWR

Our Sustainability and Transformation Plan (STP)

Hertfordshire and West Essex has developed and agreed an STP-wide Integrated Health and Care Strategy which is very much in line with the NHS Long Term Plan and has agreed a Medium Term Financial Plan (MTFP). The Hertfordshire and West Essex STP Integrated Health and Care Strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and West Essex. It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

The approach is based on the principles of population health management. This is a way of targeting collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services.

What is an STP?

Across England, NHS and Social care organisations have been encouraged to work together more closely to deliver more effective, joined up and affordable services. The country has been divided into 44 'Sustainability and Transformation Partnerships' or 'STP' areas by the national organisation, NHS England. Hertfordshire and West Essex is one of these 44 STP areas.

The Hertfordshire and West Essex key priorities are:

- Meeting people's health and social care needs in a joined-up way in their local neighbourhoods, whenever that is in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently for as long as possible. We will provide care and support to keep people healthy, rather than reacting when they are in crisis
- Adopting a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist. Support and treatment will be delivered compassionately, effectively and efficiently, in partnership with people and their families and carers
- Placing equal value and emphasis on people's mental and physical health and wellbeing in all we do. Improved mental health care and support for people with disabilities is a core pillar of our strategy and people's psychological and emotional wellbeing will be supported while their physical health and social care needs are being met
- Driving the cultural and behavioural change necessary to achieve the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future.

  Staff will be empowered to drive change throughout the system. We will all be supported and encouraged to take greater responsibility for our own health and wellbeing
- Ensuring that we have the workforce, technology, contracting and payment mechanisms in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

The STP has shared work underway on the following clinical priorities:

- Urgent and Emergency Care
- Planned Care
- Complex patients (service users)
- Mental health and learning disability
- Cancer
- Primary care
- Women and Children

All of the STPs' organisations, including our Trust, are committed to working together to implement this strategy, so that we can make rapid improvements to the health and wellbeing of our population and the sustainability of our health and care system.

Continuous Quality Improvement

The Executive Director of Transformation and Innovation leads the Trust's organisation-wide approach to Continuous Quality Improvement. Over the past 12 months, we have continued to evolve and develop our approaches to and our culture of Quality Improvement that enables us to continuously improve the safety, timeliness, effectiveness, efficiency, equity and person centredness of our services and the experience of using them.

We have continued to make improvements to our services using the tools, techniques and thinking of Quality Improvement with some examples being:

Safe

- Establishing the Moderate Harm Panel to review opportunities for learning from incidents other than Serious Incidents
- Developed approaches to post incident huddles (SWARM) that focus on team learning and improvement to prevent further harm
- Conducted restrictive practice reviews with a focus on reducing instances
- Continued to eliminate hazards and create safe environments

Effective

- Piloted new approaches to an Initial Response to people in crisis – enabling crisis to be self-defined
- Developed and implemented new models of care for rehabilitation, CAMHS and dementia services
- Delivering recovery focused care and outcomes

Experience

- Created new and responsive services; CAMHS crisis and treatment team and adult primary mental health
- Progressed an ethos of co-production within service delivery and service improvement and embedded shared decision making.

Our colleagues continue to generate innovative ideas and use our Innovation and Improvement Fund to help access the financial and project development support available to progress their ideas. This year the Fund has supported ideas including:

- Pro Screen Safety and Security Screening - increasing safety through the use of a non-invasive ferrous metal screening device
- Books Beyond Words App – a collaboration with the Books Beyond Words company team to develop an app to support staff to communicate with service users about the care they receive, the challenges they face and to help them identify their own solutions
- Peer Support in PATH - improving recovery outcomes and experience of the PATH service through the provision of Peer Support

Our small central support resource have worked with individuals and teams across the year to encourage and support improvement opportunities. They have commenced some focussed work with one of our community mental health teams and an inpatient ward, to start to build the capacity within those teams to make improvement a daily habit. The work is at an early stage and the teams are taking forward ideas that will improve their efficiency and effectiveness, using technology as an enabler, as well as opportunities that will improve outcomes for people who use our services.

In December 2018, we agreed the enabling elements that we would put in place to further develop our culture of Continuous Quality Improvement and innovation. These include:

- A programme of development for 320 leaders – both formal and some self-identified 'improvement enthusiasts' – in leading quality improvement
- The additional resources required to establish a central Continuous Quality Improvement Team that will be able to support colleagues across the organisation in delivering their improvement ambitions
- An Innovation Hub – a facilitated workspace unlike people's usual work environments that will be equipped to enable 'thinking differently' and working creatively and collaboratively to solve problems and generate innovative solutions.

These exciting developments will start to be put in place through the early part of 2019 and will build upon our current capability and capacity allowing us to improve more parts of the organisation and do this in increasingly sustainable ways.

Service User and Carer Involvement

Our service user involvement programme exists to provide us with assurance that processes and services are co-produced. The programme is also closely linked to individual recovery journeys and provides opportunities to build skills, confidence, hope for the future and opportunities.

During 2018/19, our service users and carers (Experts by Experience - EbE) contributed their expertise and time to interview panels, forums, working groups and helped us design and deliver our services. In total, people with experience of our services participated in 2806 hours of involvement activity across the activities below:

Activity	Hours
Specialist participation in Trust meetings and forums	824
Service User Council	459
Carer Council	339
Interview Panel	290
Direct participation in a workshop or seminar	277
Councils Together	207
Peer Experience Listening	132
PLACE Audit	120
Youth Council	65
Support at events	22
Sharing Story (E.g. filming, audio etc.)	13
Trust staff induction	11
Art Panel	11
Stakeholder workshop events	10
Public Speaking	9
SBU meeting	9
Equality Events	8
Crisis Care Pathway Training	5

In October 2017, we began a co-produced review of involvement work to ensure the involvement opportunities we offer are recovery-focused, beneficial to the Trust and – most importantly – provide development for EbEs to move on from involvement programmes to other activities. This completed in December 2018 with the launch of new policy and rewards structure for people providing their time and expertise toward Trust improvements.

Service users and carers continue to share their stories, personal accounts and suggestions with our Board and Council of Governors and through media projects within the Trust. We also continue to focus on reviewing feedback from service users and carers and working in partnership with them to develop improvements to local services. Over the coming year, we will be putting in place a new plan for service user and carer involvement/experience strategic plan that will guide local services in improvement approaches that can be taking at a local level. This will support the experience dimension of the our Quality Strategy and include a set of core priorities for involvement and experience across Trust services.

The **Peer Experience Listening** programme trains people with lived experience in semi structured interview listening techniques. This is then used to gather feedback from people currently using services.

Following a number years of delivering projects across topics such as the Mental Health Act assessment, safety on inpatient wards, carer experience, experience of dementia services, street triage and Community Mental Health Services. The programme underwent a review throughout December 2018 and will shortly relaunch using strengthened Quality Improvement methodology and research techniques to further enhance the effectiveness of information collated. This will enable front line services to continue to use this information to plan key changes to services.

As a Trust we are a member of the Triangle of Care scheme and have been awarded two stars. These are awarded when the Trust has demonstrated a commitment to becoming more carer inclusive, has shown honesty about where they are now and planned where they need to be to ensure carers are better identified and supported.

Our Carer Pathway frames the approach that services take to carer support built around five principles of:

1. Identifying carers
2. Welcoming carers
3. Supporting carers
4. Involvement carers
5. Helping carers through changes.

More recently, we have co-produced a new Carer Plan up to 2021 which details a range of outcomes we are working towards in supporting carers.

Carer Council

The Carer Council is a group of carers (primarily with lived experience of caring for people with mental health issues) who meet 6 weekly to discuss Trust business and provide feedback on quality and areas of concern and good practice. The Council has a chair and deputy (both carers) and agrees an annual work-plan of issues important for carers.

This year has included carers plan, Carers safety, CQC Report and 'From Good to Excellent', FEP pilot and the MHA Review. The agenda is agreed by both the Council and the Trust, enabling both partners to ensure issues of importance to them are raised as part of the business cycle. Agenda planning meetings are held with chairs and deputies prior to meetings to review actions and agree agenda for future meetings.

Recovery

In October, nestled around World Mental Health Day, we once again put on a series of local events in Hertfordshire, Buckinghamshire and Norfolk, managing to gather together the largest group of service users, carers, staff and other people into our annual celebration of Recovery yet. In total, 250 people attended events in Aylesbury, Stevenage, Watford, Hatfield, Ware and Norfolk and heard numerous rich voices of lived experience talk about Hope and Opportunity.

We were really pleased to have attracted lots of people with lived experience to the events – around 41% of attendees described themselves in this way – more than we have managed previously, and 95% of people who completed a feedback form rated the events as 'good' or 'excellent'. As always, the events were co-produced from beginning to end and supported financially by the Trust.

"Really wonderful to hear people talk openly about their struggles and achievements"

"I was inspired by the stories I heard and feel more confident myself that I can overcome my issues"

New Leaf: The Hertfordshire Wellbeing College

New Leaf Wellbeing College is based on the Recovery College model. The recovery approach is based on the principles of individual strength, co-production, recovery and self-management. Co-production makes sure people with lived experience are equal partners alongside a range of other stakeholders, recognising they have experience and therefore knowledge, which is used to develop services or in this case free educational courses.

The Trust is the lead in partnership with Herts Mind Network (HMN). As a Trust, we provide operational and strategic management, including co-production of courses and workshops, and HMN the peer elements, which offer students and opportunity to engage in the peer pathway and develop confidence and skills that support them into Peer Tutor roles. We also support the student council and students to develop their learning goals.

All courses are developed in the spirit of co-production, always including people with lived experience. The role of the Curriculum Board is to oversee and ratify course and curriculum development. Membership of the Board includes third sector, public services and students. All courses are presented in Board meetings, which ensures they have been co-produced with up to date evidence, and will only ratify if these assurances are met. It also offers another level of co-production ensuring the content is not discriminatory in any way, and is focused on self-management.

To date, the college has 2,194 registered students. In the Autumn Term, the college saw a rise in in students booking onto courses (975), with an average of 12+ students per session, with 16 courses out of 47 running, having 15+ student attendances; booking rates for many courses have been as high as 20+. The college has co-produced a portfolio of 18 courses, with four more being developed during the Spring Term (2019). 85% of students report the courses to be good/very good and 97% would recommend the college to friends.

Student wellbeing was measured using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Of the 303 students with two completed questionnaires, 151 (50%) have shown an improvement of at least one point. By contrast, 107 (35%) have decreased by at least a point, and 45 (15%) have remained on the same score. Our data would suggest that more women access the college, with more targeted communication and marketing taking place to attract men. The number of people reporting to have a disability, including mental and physical health challenges as steadily risen, with 55% of new enrolments stating they have a disability.

The college launched a new Peer Involvement pathway in the Spring Term, which proved successful with 3 students going on to become volunteers within the college, 2 expressing an interest in becoming Peer Tutors or Peer Mentors, both paid positions.

"It really was special and amazing and that came from the ability, I believe, ton our true authentic selves, which came from a place of trust and respect. This trust and respect was facilitated by you both, to whom I am grateful."

Marketing initiatives to attract students from the east of Hertfordshire and male members will include promotional material on a local bus route from Ware, Bishop Stortford and Waltham Cross and also a feature in a football club.

The summer term has been launched with the first course 'Understanding Depression' fully booked within 2 weeks of going live.

Student stories

"I joined New Leaf Wellbeing College in March 2018. I joined late in my recovery story; I'd long suffered from depression, and in recent years, I had noticed an increasing issue with Seasonal Affective Disorder. I had managed to independently find information and ideas to help me cope with my issues and to begin a process of recovery, and by the time I joined the college, I had managed to make significant improvements to my situation. Joining the college gave me the opportunity to continue learning about the conditions affecting me, to learn new ideas and strategies to assist me in my continuing recovery. I've been able to learn from and exchange ideas with students who have suffered from similar issues to myself, and to learn from tutors with expert knowledge and experience. To date, I have attended two courses, with more to come.

I am not only learning for myself; I have several friends who have suffered from anxiety and depression, and I hope that the knowledge gained by attending the college will help me to assist them, to either help them to look for help or to make adjustments to that could help them begin their own journey to recovery. I have already noticed that I often have a clearer picture of what I am seeing in situations with my friends, rather than just an idea or notion that I recognise from my own past experiences. Since joining the college, I have found that I am feeling increasingly more upbeat about my own personal circumstances. My journey has not been easy, but it certainly feels to me that learning with and contributing to the college can only help in my on-going journey".

Physical Healthcare

We have made progress over the past year with regards to physical healthcare. This includes, but not exclusively:

- The further development of clinics, enabling more access to our service users for physical health checks
- The implementation of the Shared Care Agreement in Hertfordshire with our GPs, improving communication and continuity for our service users
- The continuation of work to reduce falls and pressure ulcers
- The introduction of zonal observations, aimed at decreasing the number of falls in our older peoples services; we led a Falls Week in September in partnership with HCT and HCC
- The development of a Physical Health Education Framework for all clinical staff, to be launched early in 2019/20

We have also continued to develop initiatives to improve the physical health and wellbeing of service users, including increased gym sessions and outdoor activities, such as a walking group and table tennis for older people service users.

Frailty Pathway

We play an active role in ensuring that a holistic approach to health and wellbeing is taken. As a Trust, we are committed to the delivery of care in its broadest sense, and recognise the opportunities for people in providing care that is fully joined up across physical health, mental health and social needs. This aligns with the mission statement 'We help people of all ages live their lives to their full potential by supporting them to keep mentally and physically well'.

We have agreed to implement a new frailty strategy and work with partners across the system to deliver integrated care pathways for some of the most complex members of our population and our goals include:

1. Consider if frailty is an issue in every patient encounter
2. Support people to remain in their usual place of residence
3. Reduce inappropriate attendance at the Emergency Department (ED)/secondary care
4. Work as a system
5. Delivery high quality safe care for our frail population
6. Support people living with frailty to achieve their personal goals
7. Achieve frailty outcomes.

The main components of the delivery plan include the introduction of common frailty pathways and training and Improving physical health pathways and interventions. To support this we will also need to introduce a Frailty Minimum Dataset and IT capability.

Integrated Care

We continue to be committed to bringing care together across physical and mental health and across health and social care, removing the barriers to integrated care that can sometimes develop. Our priorities for 2019-20 include:

- Making sure more mental health practitioners are embedded within community Integrated Care Teams working with people with frailty and complex long term conditions - with plans to introduce more frailty hubs across the county and easier way for making referrals for support and care for frail service users
- More support and expert mental health knowledge being shared with staff working in care homes to support better care for people and help to manage complex behaviours
- Learning from what has been working well in primary care mental health and dementia diagnosis pilots with a view to seeing what can be scaled up and shared.

Primary Care

Innovative Primary Care Mental Health Pilot projects have been running in three areas of Hertfordshire and have had evaluations supporting their continuation and extension. The pilots are in Stevenage, Hertford and Watford. In Hertford and Watford, a mental health practitioner has been embedded in a number of practices to triage referrals to secondary care and signpost as appropriate, provide advice to primary care workers regarding care or passing the referral on to secondary care.

In Stevenage, a model has been piloted which has provided a stand-alone drop in clinic for GPs to refer to for triage and signposting as appropriate. Part of the pilot work across all areas has included strengthening of the relationship between designated Consultants and local GPs in order to help build and maintain relationship with GPs.

There has been a reduction in the number of initial assessments required by the community mental health teams (CMHT) as a result. GPs and service users have provided very positive feedback. Service design principles have been agreed to support the extension of the pilot engaging local systems in developing the service. The pilot service is being extended across further localities county-wide. In Stevenage, an alternative model has been piloted which has provided a drop in clinic for GPs to refer to. This has resulted in a significant reduction in demand going into the CMHT but also positive feedback from both service users and GPs particularly in terms of responsiveness. This model is being reviewed to see how it could be replicated elsewhere.

To support this their GPs have designated Consultants in order to help build and maintain relationship with GPs. Delivering physical health checks for mental health patients in collaboration with primary care. Service users are invited to GP surgery for physical health checks where they are assessed jointly by the primary and mental health clinicians.

This integrated delivery of physical health checks is enhancing patient and staff engagement in improving physical health outcomes, improving communication between secondary and primary care, enhancing primary care clinicians' knowledge and expertise in mental health problems and ensuring delivery of physical health interventions.

Pressure Ulcers – zero tolerance

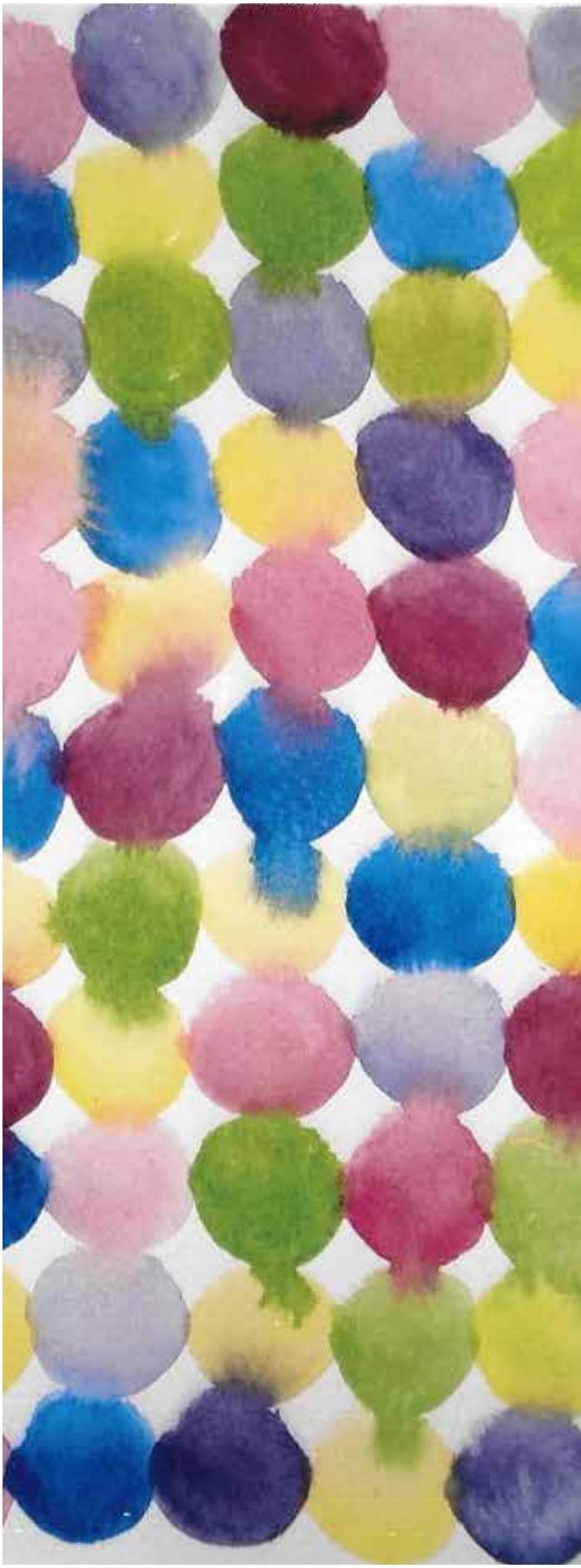
We continue with a zero tolerance approach to avoidable pressure ulcers. We have recruited a Tissue Viability Nurse (TVN) to ensure a robust care pathway in place to manage pressure damage and wound care. There has been a slight decrease in the number of incidents in 2018-19.

We have:

- a robust system in place for providing medical devices, including pressure relieving mattresses, cushions and boots
- reviewed the Service Level Agreement for pressure relieving mattresses and cushions have and further improved the quality of the product that will be provided to our service users
- made a dressing formulary available on each inpatient ward
- local Pressure Ulcer champions monitoring progress, who are having a positive impact promoting efficiency and evidence-based practice across our services
- continued to support the 'Heel Alert' campaign: evidence suggests that heels are the second most common site for pressure ulcers, and that these are becoming more common
- run our annual 'Stop the Pressure Ulcer' awareness on 15 November 2018 across our Older People Services
- displayed 'React to red' screensavers and posters and worked with the Bedfordshire and Hertfordshire Tissue Viability forum to send these out to GP surgeries across Hertfordshire, Bedfordshire and Essex
- continued to monitor pressure ulcers and to report our findings to our Safety Committee.

The procurement team and Head of Nursing for East and North Strategic Business Unit continues to monitor the purchase and use of pressure relieving mattresses and cushions, and staff continue to receive training in how to prevent and treat pressure ulcers and care for wounds.

Our audits suggest staff feel more confident and competent in preventing and managing pressure ulcers. This is predominantly due to the ongoing support from the TVN and discussions with other senior nurses.



Nutrition

Nutrition and Dysphagia Steering Group

Our Dysphagia and Nutrition Steering Group leads work across the organisation to make sure inpatient service users' nutritional needs are met. We use the CQC nutritional and hydration standards to guide our work.

Our work and future plans

Menus

We introduced new menus to our services at the beginning of 2018; these were designed to better meet the tastes and requirements of our different service user groups. We have collected instant feedback from service users at the time of eating and have collected more detailed feedback. The new menus and new dishes have been well received by service users. We continue to collate and respond to feedback.

For example, we invested in new equipment to increase capacity of the kitchens at Kingsley Green in order to include Oak and Beech wards in our fresh cook menu service, we are working with Lexden Assessment and Treatment Centre to increase flexibility of menu options to improve our person centred menus.

Service user experience of mealtimes

We have started work on looking at our service users' experience of mealtimes, how it feels to be in the dining area at mealtimes and how we can make mealtimes an enjoyable part of the day. Service users on our units have helped us identify what is important for them and we have started to implement changes

Safe and effective screening

We have added our Dysphagia and Nutrition screening tool to our EPR system. This has made it easier for staff to complete the form, monitor the outcomes, manage reviews and evaluate compliance with standards.

Supporting staff

We are continuing to develop our resources for staff to use on their teams during handovers and at local inductions. These are designed to increase staff skills and knowledge of dysphagia and nutrition.

Nutrition and Hydration week

This year we focussed on the positive messages about what we can eat and how nutrition and hydration impacts on our health, with 'eating for health' messages rather than 'healthy eating'. We concentrated our activities on snacks which are good for our health. We combined this with information for staff, service users and carers on snacks you could eat if on a modified texture diet, linking in our work on the new international descriptors.

Increasing Physical Activity in Older People

Following a two week trial of a table tennis prototype on Seward Lodge, we introduced two specialist table tennis tables (as designed by the BAT foundation in conjunction with Kings College London) on two of our older adult wards: Seward Lodge and Wren Ward. An Occupational Therapist and Physiotherapist work collaboratively on collecting baseline and post-intervention outcomes covering: mood, function, and physical abilities to measure the impact of the table tennis as an intervention for promoting the maintenance of physical and mental and well-being. This was funded through the Trust and the BAT foundation sourced a sponsor who match funded the second table.

Lifestyle Matters

Lifestyle matters Occupational Therapy for Older People group is an evidence based intervention that adds to the promotion of the Nice guidelines Mental wellbeing in over 65s: occupational therapy and physical activity interventions (NICE 2008).

This group focus is for individuals who struggle to engage in meaningful activity and are at risk of further decline in their physical and mental wellbeing For example anxiety, low mood, reduced confidence isolated and poor mobility. The aim of the 12 week group sessions is for the occupational therapist to provide

education and strategies to the attendees. To enable attendees to develop skills to make lasting changes to improve their health and wellbeing post group. Therefore minimising the risk of relapse to continue living and engaging in the community safely and independently. Feedback from the group attendees was positive they felt the support and skills gained from attending gave them the skills and confidence to join community groups and stay safe living in their home/community.

All group members reported feeling a sense of support and a safe place to share and help each other in problem solving issues that arose.

Pimp my Zimmer

The Pimp My Zimmer project in Watford was initiated through the Watford locality group. PMZ has been adopted across the country and has been proven to reduce falls as people can recognise their own, correctly adjusted walking frames. A GP from the GP Federation, a mental health OT and support worker, care home staff and a local schools joined forces to run 3 intergenerational, interagency sessions to 'pimp' 9 care home residents' zimmer frames. The team pulled in the concepts of reminiscence and life story work and measured the residents' wellbeing before and after the sessions.

The outcomes were that:

- 50% reduction in referrals to the Trust (depression)
- 86% improvement in resident wellbeing validated scores
- 66% increase in zimmer frame usage
- 50% improved mobility, 33% mobility remained constant despite deteriorating health (due to frame usage)
- 17% stable.

Digital Technology

Art Therapists have been developing art therapy programs using digital media, such as iPads, to increase the opportunities for service users who find traditional art materials too messy or unpredictable, such as those with Autism. Digital media is also available for those with limited physical abilities this might include someone who is not able to hold a pen but could use

their finger to draw on the screen. Younger clients engage with digital media on a daily basis but applying the uses of digital media in a therapeutic context has helped to foster the therapeutic relationship through a shared appreciation. It has been used in creating simple to sophisticated animations. The team have developed guidelines that consider the clinical, ethical and legal implications involved when offered in therapy and the sufficient skill and competence in using the software and digital device to ensure safe and effective use.

Pets as Therapy (PAT) Dogs

PAT dogs are engaged in many of our services. At Kingsley Green, a walking group is run once a week for service users to attend. This encourages physical activity and supports time away from the unit. Our team at Seward Lodge has facilitated the use of Pet therapy with PAT dogs that come to the unit every Thursday. This has resulted in therapeutic engagement for service users with some individuals becoming more settled.

Psychology and Spiritual care Pilot

The Spiritual Care service is working collaboratively (as second professional) with psychology on an 8 month pilot to explore the effectiveness of offering family support as a key part of inpatient care. Up to three sessions are offered to inpatients and families/ carers they identify as being significant to assess whether a systemic approach (rather than a solely service user focus) offers enhanced care.
This is an innovation fund project and is being assessed against a series of outcome measures with a view to offering it on other acute adult inpatient units. Meetings are open to all service users admitted to Albany Lodge, although are not accessed by all, for a variety of reasons. Questionnaires are administered pre and post meetings. Key data is also collated, including average lengths of stay and readmission rates is collated and will be compared to data prior to the pilot to test effectiveness.

Zonal Observations and Engagement

Zonal observations and engagement is an approach our older adult wards are taking to enhance the observation of a particular group of service users within a specified ward or clinical area. The Zonal Engagement and Observation approach ensures appropriate observation of individual service users without the need to assign a particular nurse to be in close proximity to the service user for long periods. Identified staff are responsible for observing and engaging with all service users within a particular zone (area) of the Ward. This will entail checking on people in rooms within the zone, assisting a person to find their way about within the zone and intervening when necessary to maintain safety of those in the zone. Calling for help from other staff as needed.

Host Families

The Host Families scheme was the first of its kind in the UK and is based on evidence that people with mental ill health recover better if they are out in the community, in a supportive family setting, taking part in a daily routine. It is an alternative to hospital admission or can be used following a period of inpatient care to facilitate early discharge.

A host family provides a caring family environment for a service user (guests) where this type of treatment will help to restore dignity, develop relationships and autonomy, and lead to their social or professional reintegration. Host family placements will be in a traditional family unit deemed appropriate for that particular patient at that particular time.

Access to a host family is through our CATT, with both the hosts and guests receiving intensive support through CATT. The length of stay is usually for about three to six weeks with a maximum of eight weeks.

At the time of this report, there are 8 'active' host families available across Hertfordshire, with 4 extra rooms enabling a total of 11 beds. Recruitment is ongoing – with local events and at public places proving to be the best method for expressions of interest.

Street Triage

The Street Triage service provides an immediate joint assessment by a police officer and a mental health professional, and support, to residents within Hertfordshire who may be experiencing a mental health crisis in a public place, and who may be subject to detention under Section 136 of the MHA (Place of Safety).

The Street Triage service function is also to provide opportunities and potential for both police officers and mental health service staff to reduce demand on limited resources, an opportunity to benefit from cross over training, developing a greater understanding of early warning signs of crisis and provide an opportunity to develop a better understanding of the challenges faced by each agency.

Street Triage has now been operating for over two years and is achieving good outcomes. The Street Triage team works with a paramedic on one of the shifts. By working together, we have been able to support and treat people in the community, which means they can avoid attending ED and being detained under Section 136.

Between October and December 2018 street triage attended 364 incidents, their input resulted in only

9.6% service users being detained on a Section 136 and 5.9% attended ED, with 80.6% diverted into appropriate health services

The feedback from the Police is overwhelmingly positive, they:

1. Value the access to mental health expertise
2. Say that Street Triage saves many hours of police time and ensures that people who need access to mental health services are supported to get it in a timely and efficient way
3. Feel that working with the Street Triage team has increased their knowledge and understanding of mental health.

111 Pilot

The HUC 111 Mental Health Pilot comprises of a Mental Health Clinician from the Crisis Team. Their working hours are Saturday and Sunday 0900-1700. The clinician sits within the call centre and is able to offer support/ give advice to both clinicians and Health Advisors when needed. It is evident from the outcomes shown within the data that by having an expert Mental Health Clinician available that many of the high acuity mental health conditions are receiving the help and support needed without the need to arrange an ambulance or direct the patient to Emergency Department.

First Response

A First Response model was successfully trialled in 2018 with agreement to start in February 2019. This service will progress to a 24 hour/7 day a week response, offering swift access to mental health, which is:

- more readily available than emergency services or ED
- offering intervention in a timely way which reduces demand on secondary care mental health services
- reduces inappropriate demand on services such as Section 136, Acute Admissions Unit and RAID and,
- which offers a more satisfactory experience and outcome for service users.

The first response service seeks to resolve or minimise the impact of every mental health crisis and can facilitate a rapid direct intervention for the most serious situations. The service will have a plan in place for all crises within one hour.

The service will work with partners to ensure people are signposted to services that can most appropriately meet their needs to either minimise the current crisis or help prevent future ones.

Rehabilitation

The new Rehabilitation pathway (EROS) has been co-produced with an outcomes framework specifically for rehabilitation, including an outcomes tracking database across the range of patient (service user) rated outcome measures (PROMS), patient (service user) rated experience measures (PREMS), carer rated outcome measures (CROMS) and carer rated experience measures (CREMS) for every service user. A comprehensive Rehabilitation Handbook has been developed for the Rehabilitation staff teams that advises on Recovery, Goal setting use of outcome measures, how systems work, Care planning and risk assessment management plans, as well as how to have conversations about resilience.

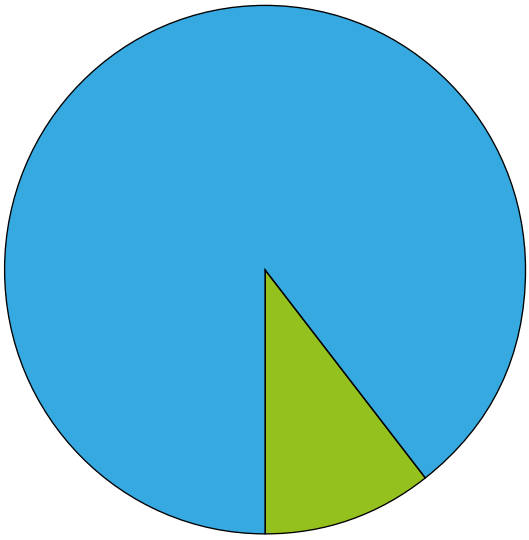
Introduction of one stop clozapine clinics

Point of Care Testing and One Stop Supply Clozapine Clinics were introduced at Waverley Road, Colne House and Roseanne House. Prior to the new clinic format, service users attended the Clozapine clinic on a Monday to have their bloods taken, the blood samples were then sent via courier to pathology and service users could collect their medication from the hospital outpatient Pharmacy on a Thursday, if results were within range.

Since the introduction of the new clinic format, blood samples are analysed in the clinic immediately service users are able to collect their tablets from the clinic at the same time providing their blood results are within range.

The service user feedback survey at Colne House on the introduction of the new clinic format was overwhelmingly positive, as detailed in the graph below:

How do you think the clinic compares to the previous system, now that you can get your blood results and medications on the same day (n = 29)?



Response %

- *It is much better than before (89.66%)*
- *Is is slightly better than before (10.34%)*
- *Is is the same as before (0%)*
- *Is is worse than before (0%)*

CAMHS

A transformation plan specific to CAMHS has been developed and is monitored via the Trust Management Group. The Children's Home Treatment Team (HTT), set up during 2018, works intensively with young people to avoid inpatient admissions. Working in a DBT informed way to cater for young people has led to successfully stepping down individuals from low secure units into the community.

The work of the team has also lead to a significant number of young people (reduced from 45 to approximately 10) being treated in the county since the service transferred from NHSE in January 2018, whereas previously they had been treated throughout the country, significantly improving the quality of the experience for young people and families. The team work closely with the Eating Disorders Team who offer intensive community work with young people and the family and carers.

These numbers refer to the number of Hertfordshire young people that were placed out of county in a number of different placements, for example Psychiatric Intensive Care Units (PICU), low secure, medium secure, general adolescent, Eating Disorders and learning disability children's units (under 13s) before we commenced the New Care Models Work.

CAMHS Place of Safety Development

Our young people at Forest House have been involved in the design and kept up to date with the development of the new Place of Safety, Section136 suite being built at Forest House. Our young people's participation lead gathered questions and concerns from the young people and took these to one of the stakeholder meetings. The answers were fed back through the lead to the young people. The project managers and Service Line Lead then attended one of the Forest House council meetings in December, to give the young people more information on who they are and why they are building the development. They gave them an update on how far the work had progressed and what was left to do.

They then asked if they had anything they wanted to discuss. As part of the development, young people were invited to paint cladding boards so they would not have to look out of the unit windows at metal and wooden boards. The young people decorated the boards with motivational quotes and pictures.

CAMHS Website and Welcome Pack

The Young People's Council has been involved in the design and development of our new CAMHS website www.hpftcamhs.nhs.uk. The young people fed back that our previous website was not very helpful and user friendly.

They gave extensive feedback on what features they think it should include such as colourful banners

and scroll bars to help navigate the information. They also thought of and co-produced many of its innovative and interactive features such as our who's who tool, our jargon buster and our POD walks of CAMHS clinics. The website launched in December and will continue to be co-productively updated.

Alongside our website update we have also been working on designing and developing our welcome pack, as part of the overall improved welcome to services project. The lead met with a group of our young people on two occasions to ask them what they wanted it to include and what design they wanted it to take.

The inclusion of note sheets, doodle pages and puzzles came from feedback that when young people are feeling anxious before or during an appointment all these tools can help. This feedback was taken on board and contributed to the final design. Additionally it was fed back that there were too many bits of paper and leaflets given out. All the essential information that we need to give as a trust and that young people and their parents and carers feel they need was incorporated into the design and development of two new leaflets. One leaflet is for young people and the other is for their parent or carer. These leaflets contain information on what to expect from appointments, support and confidentiality, as well as containing helpful numbers for our clinics and frequently asked questions that young people and their parents and carers have. This pack launched at the same time as the webpage and again we will continue to develop new puzzles and leaflets that can be slotted in as and when needed for more specialist information.

PATH

What is the Psychosis, Prevention, Assessment and Treatment (PATH)?

This is a specialist team who work specifically with individuals who are experiencing psychosis for the first time, referred to as a 'first episode of psychosis'.

The aim of this service includes:

- Early detection, assessment and treatment of symptoms
- Optimistic views about recovery focused interventions
- Provide a wide range of psycho-social interventions and support
- Provide support and interventions for family and carers
- Work in partnership with a range of statutory and non-statutory services.

What is an Associate Practitioner (AP)?

This group of staff have gained a Psychology Degree and form part of the PATH workforce. They work alongside our qualified social workers, nurses and psychologists to provide specialist care, including the delivery of carers' programmes and family interventions.

What is a Support Time and Recovery (STaR) worker?

STaR workers also work with the PATH workforce, providing practical support for service users and carers.

"I found the service very helpful. Knowing I am not alone in my feelings and anxieties was quite a relief. As I completed each section of the CBT course, I felt much more positive and can refer back if I need to. I feel as though a weight has been lifted and can continue my life in a more positive and assured manner."

SafeCare and eRostering update

Through the use of SafeCare, we have been able to redeploy staff safely and with their full visibility of skills, helping to reduce agency usage. We have also been able to request bank (and agency) cover if needed and track any red flags identifying potential staffing issues.

Service user acuity census data is recorded three times a day during a handover of each shift in all inpatient service areas. We also hold daily SafeCare conference call (Mondays to Fridays) to review safe staffing levels, utilising the data inputted onto SafeCare. Furthermore, weekly eRoster Scrutiny meetings are held to proactively review all observations, staffing and acuity levels in each inpatient service area, before agreeing the required staffing levels for the upcoming shifts.

As a result of the above, we have seen positive impacts in our service areas, particularly a reduction in our use of agency, including at peak holiday periods. This has had a positive impact including an improvement in staff morale, an improvement in the service user experience, an increase in the skill mix for staff and also cross working and learning.

What is eRostering?

The use of eRostering aids the management of our workforce, including service user demand, establishment management, staff working preferences, absence management, rostering, time and attendance as well as payroll integration. It also helps with the effective rostering of staff, ensuring that service requirements are met. Furthermore, it ensures that services run in a fair and efficient way, reducing errors in timesheets and ensuring staff are aware of their off duty in a timely manner.

What is SafeCare?

SafeCare is mounted onto eRoster and calculates the required staffing from service user numbers, acuity and dependency, three times a day. It provides as site-wide overview of required versus actual staffing, highlighting hotspots as well as areas that could help.

SafeCare enables the viewing of staffing status across many dimensions, including hours short/excess, missing skills, missing service user census, Care Hours Per Patient Day (CHPPD) and the cost of a shift. It also enables the tracking of attendance and sickness of all rostered staff.

Spotlight on Nurse Education

Trainee Nursing Associates

As a Trust, we lead for the Hertfordshire and West Essex STP Nursing Associate programme. The first cohort are due to register in May 2019. This programme was developed to give the trainees a broad range of experience across all branches of nursing and therefore strengthen the current workforce across the whole STP range of services. As every Nursing Associate will have had experience in adult, learning disability, mental health and children's nursing, the newly qualified Nursing Associates will enhance the care received by service users and not be used to replace registered nurses.

We have recognised the significant impact in quality of care the role of Nursing Associate can have and so used the apprenticeship levy in partnership with the University of Hertfordshire to train 34 Nursing Associates. The first cohort will qualify in May and start employment in the Trust in a number of our inpatient and community teams. The second cohort will qualify later in the year and additional cohorts are in place for future years.

We see this as a transformational role to support new ways of delivering care. Our Trainee Nursing Associates have a high profile nationally and we have supported individuals to write articles, present at conferences, tweet and sit on advisory groups.

New Nursing and Midwifery Council (NMC) Standards

We have been preparing for the introduction of the new NMC standards in September 2019. This includes the development of nurses and allied health professionals as supervisors and assessors, and a move away from the previous mentorship role.

SPIKE2

Building on the success of SPIKE, our reporting and business intelligence tool, in January we released an enhanced version of the tool – SPIKE2. SPIKE2 provides clinical data to help support informed decision making and improved outcomes for service users and is built on an open source platform with different dashboards available. A couple of examples of these dashboards include:

- **Service user dashboard**
  For the first time, key information from the three separate electronic patient (service user) records systems are available 'under one roof'. This helps staff to review historical information such as teams involved in service user care, contacts and assessments and when they are due for review. This gives staff access to all of the information they need to make clinical decisions and helps with improving the workflow of staff, reducing administration time and the duplication of locating clinical information.
- **Staff and Team Dashboard**
  At a glance, staff and Team Leaders are able to view their caseloads and review them, reducing the time spent on searching and gathering information.

Since its launch, SPIKE2 has had a big impact on the electronic data capture/recording by clinical and front line staff, providing accurate clinical data helping to support informed decision making and improved outcomes for service users.

Modernising Our Estate

Improving and modernising our facilities

We have a number of initiatives underway to improve our community sites at Saffron Ground, Colne House, The Colonnades and Rosanne House. This includes internal refurbishment and remodelling the working areas.

A range of life-cycle decorating and minor works requirements have also been identified across 28 key sites, arising from our Patient Led Assessment of the Clinical Environment (PLACE), Senior Leaders and Big Listen feedback and also Estate led site surveys.

A full programme estimated at £2.2m has been prioritised based on need with future requirements being formalised within a rolling refurbishment programme. We have also invested in our Facilities Management contract and refreshed our Estates and Facilities in-house team to improve Estates' response time, improve response prioritisation from our outsourced supplier and focus on seclusion and Section 136 ongoing repairs and maintenance to ensure any decommissioning of critical areas is minimal

Furthermore, we have set out a significant investment programme to our seclusion facilities including refurbishment, new build and an increase in capacity to ensure we can always keep people safe during such interventions.

Norfolk Services

Quality Improvement project: developing outcome measures for people with intellectual disability, that are determined by service users and families.

There are few nationally accepted benchmarks for PROMS, PREMS, CROMS and CREMS within specialist in-patient services for people with an intellectual disability. This Quality Improvement project was initiated to identify at least one tool within each of these areas for use within our forensic and non-forensic inpatient services for people with intellectual disability.

The project has undertaken a systematic review of 60 identified outcome studies and has identified four domains within service user and carer rated outcomes and experiences – quality of life, therapeutic environment, involvement and satisfaction.

Four externally facilitated focus groups involving service users, family members and clinicians have been held, and have identified further key themes - earlier access to meaningful work or activity and level of support post discharge.

Based on these, four outcome measures have been identified and will be piloted within the inpatient forensic intellectual disability services for a 3-month period and assessed for ease of use and acceptance. They will also be compared with existing rating tools including clinical tools and the Friends and Family test. If the pilot is deemed successful, then these new measures will be incorporated into routine clinical practice.

PENNA

In November 2018, the nominations for the Patient Experience Network National Awards opened and services were invited to submit nominations in a number of categories. The Patient Experience Network (PEN) are an independent "not for profit" network looking to provide a valuable resource/ service for NHS and other organisations wishing to improve patient experience and staff experience.

The annual National Awards allow services to celebrate good practice and share what we do to improve patient and staff experience. Broadland Clinic Forensic Service entered a video of our Carers Day on 1 December, showcasing the work we do to support carers. This particular Carers Day, we captured the carers talking about the new Trus Carers Plan and feeding back their ideas for local service improvements, carers enjoying a shared lunch with their loved ones, and presentations to carers from service users on their experiences within the clinic. The video also captured how the Clinic worked with a carer with limited mobility to help her access the event and spend time with her son. In March 2019, Broadland Clinic were awarded Runner up in the Support for caregivers, Friends and Family category and finalist in the Using Insight for Improvement (Accessibility) category at the PENNA ceremony in Birmingham.

Broadland Clinic - Services to carers

The following is a quote from the Quality Network Peer Review visit that we received in September 2018.

"The service has excelled in carer engagement and involvement. The team's social worker plays a key role in this by making an initial home visit to a carer's home to give them appropriate information on what they can expect from the service for their loved ones. Following this, a carer contact care plan is jointly produced with a patient's named nurse and the social worker, and ensures regular contact is made with carers. A carer's charter is provided to all carers, detailing what they can expect from the team and how the team will support them. The team also hold quarterly carer's days allowing feedback sessions to take place, which have been very well attended and enjoyed."

The Enhanced Assessment and Treatment Service (Community Outreach service from Astley Court)

The EATS team received 1st prize at the Eastern Division Conference with its award-winning poster. The service has been in operation from September 2016; the poster was about how the service has been effective at avoiding unnecessary admission to hospital for service users with learning disabilities and/or autism and mental health problems.

Broadland Clinic- Recovery Conference

In 2018, the 2nd local Recovery Conference was held and was even more successful than the first, with more staff and service users from an increasing number of local services presenting and participating. Feedback from the conference was excellent with lots of ideas generated for 2019! Here is just some of the feedback we received.

What did you like about the conference?

Buckinghamshire Services

The Buckinghamshire Community Learning Disability Team continues to evolve and embrace good practice from our Hertfordshire services. In 2018, the service introduced a Specialist Learning Disability Dietitian to complement the established Dysphagia Pathway, noting a positive impact on service users' care.

Following the success of the Positive Partnerships Team within Hertfordshire, we have introduced the same model in Buckinghamshire, based on Positive Behaviour Support principles and aiming to work with service users on a longer term basis to skill up providers to help recognise and reduce the triggers which may cause behaviours which challenge. This team has enabled a reduction in the caseloads of the Intensive Support nurses, allowing them to focus on hospital admission avoidance. The admission rate and length of stay for service users from Buckinghamshire to Dove Ward in Hertfordshire has reduced significantly and the Buckinghamshire team have fully embraced the Adaptive Mentalisation-Based Integrative Therapy (AMBIT) approach; using this both with service users and as a team approach.

In 2019-20, the team will focus on the integration with social care, starting with the co-location of the Buckinghamshire Social Care team from Buckinghamshire County Council to our Midshires site in Aylesbury in May.

It is envisaged this will lead to improved working relations, more joint working and less duplication for service users, resulting in improved service user experience as well as efficiency savings.

Essex Services

As a Trust, we are leading on the transformation of learning disability services across Essex, in partnership with Anglian Community Enterprise (ACE) and Essex Partnership University Trust (EPUT) through the Essex Learning Disability Partnership (ELDP).

For our service users, this means:

- **Way in –** one point of entry and a Personalised Assessment Process (PAP) based on individual need not diagnostic threshold. Also a single care plan co-produced and owned by the individual/named contact at all times.
- **Enhanced Support and Early Intervention –** advice and support available 24/7, breaking down barriers through a shift to new flexible roles and shared competencies. Community Rehabilitation and Engagement Workers, working jointly with key system partners. Also admission avoidance initiatives – for example support respite and crisis accommodation.
- **Inpatient Assessment and Treatment Services -** improved continuity of care through a responsive staffing model; integrated multi-disciplinary team working and advocacy services.
- **Community Forensic Services –** highly specialist support, individual and group offence specific interventions. Liaison and joint working as well as advice, support and training.
- **Community link service –** new community link roles for 'neighbourhoods' and acute hospitals. Named case workers offering guided support and movement between mainstream and specialist services. Health promotion and facilitation, training and consultancy to support community resilience. Extending care pathways into the other community services, for example voluntary and charity sector.
- **Community Specialist Health –** Locality based model for each CCG/Case management and crisis prevention. Also evidence-based clinical pathways.

What is AMBIT?

This is part of the development of the Personality Disorder pathway within our Learning Disability services, led by psychology. AMBIT is a mentalisation based team approach for teams working with young people with severe and multiple needs, who do not tend to access mainstream services run by the Anna Freud Centre. The plan is to train members of the Learning Disability community teams in Hertfordshire, Buckinghamshire and Essex as trainers. It will be involving all members of the team, including psychology, Allied Health Professionals, nursing and psychiatry.

Annexe 1 – Statements from Partners

Healthwatch Hertfordshire's Response to Hertfordshire Partnership University NHS Foundation Trust (HPFT) Quality Report 2019

Healthwatch Hertfordshire welcomes the opportunity to comment on HPFT's Quality Account. We would like to make the following comments:

- There are many positives within the Quality Account but worthy of particular note is that the Trust seems to be continuously reviewing and working on various initiatives, programmes and pilots including for example a programme to build seclusion suites and a pilot for a new programme to provide work placement opportunities. All of the many initiatives described could offer significant benefit to services users, carers and staff and we look forward to hearing about the outcomes from those accordingly
- The Quality Account clearly demonstrates how the quality priorities have been chosen and that consideration was given to the feedback generated from the consultation around the priorities. Measures to monitor progress of the priorities are robust though we assume that quality priority 9 (the Trust's service user experience of community mental health services' indicator) will be reviewed throughout the year before the annual report is produced
- Overall the report appears to cover most elements and facets of the service in detail and includes reports on achievements and comparisons to previous years / periods which for the most part seem to indicate improvements. However, information, reports and achievements in terms of care in the community including crisis care seem to be rather light as is any detail, reports or information on relapse and return to hospital care outside of the current 28 day measure, which could help to review success or otherwise for care in the community
- We are pleased to be working in partnership with HPFT, Viewpoint and Carers in Herts to investigate carer involvement in discharge planning and processes from acute mental health settings to improve services through the patient voice and welcome the positive approach taken by HPFT.

Healthwatch would like to thank the Trust for welcoming us at Board, committee and group meetings and for being so responsive to any questions that we raise. We look forward to working with HPFT in the coming year to continue to improve patient experience and outcomes.

Steve Palmer, Chair Healthwatch Hertfordshire, April 2019

NHS
East and North Hertfordshire
Clinical Commissioning Group

NHS
Herts Valleys
Clinical Commissioning Group

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

The information provided within this Quality Account presents a balanced report of the quality of healthcare services that HPFT provides and is, to the best of our knowledge, accurate and fairly interpreted. The Quality Account clearly evidences the improvements made and importantly where improvements are still required.

Commissioners have been working closely with HPFT during the year; gaining assurance on quality of care ensuring it is safe, effective and delivers a positive patient experience. 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.

At the end of March 2019 we agreed a new five year contract with Hertfordshire Partnership University NHS Foundation Trust (HPFT) for the provision of mental health and specialist learning disability services in Hertfordshire. This reflects our view that HPFT is an organisation that we can work with to deliver, transformed and improved outcomes for people in Hertfordshire which is open, transparent and provides high quality patient focused services.

As with last year's Quality Account our most significant area of concern has been around staffing – both recruitment of new staff and retention of high calibre staff to enable HPFT to deliver good quality, and safe, services across the range of geographical and services areas that they provide. We know that the Trust shares these concerns and has significant focus not only on recruitment but also on retaining and supporting existing staff. For example in Learning Disabilities (LD) we know that many LD nurses are nearing retirement and the numbers of LD nurses graduating are falling. This is similar to what is being seen in other areas nationally and support HPFT in the work they are doing to encourage applicants e.g. working with the University of Hertfordshire to ensure that nurses in training locally remain in Hertfordshire once they qualify

Our second most significant area of concern has been HPFT's ability to see people waiting for a routine assessment of their needs within 28 days, both in adults and in Child and Adolescent Mental Health Services (CAMHS). We have worked with the Trust on a number of approaches to mitigating these issues. These have included primary care mental health pilots in adult services and increasing capacity in early intervention services for children and young people. Alongside this the Trust has been working on reducing the number of people who Do Not Attend (DNA) appointments. Improving performance here will continue to be important for us collectively in 2019/20 as we need to response to the increasing demand for services. We are very pleased to have been successful in our bid to become a trailblazer area for the development of mental health support teams linked to schools and will be collaborating with the Trust to roll these out in the two pilot areas during the coming year.

NHS
East and North Hertfordshire
Clinical Commissioning Group

NHS
Herts Valleys
Clinical Commissioning Group

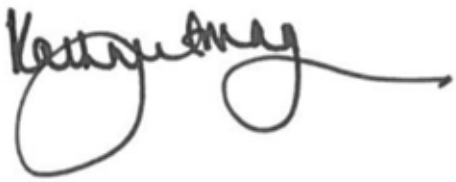
In terms of specialist LD services both the inpatient (Dove ward) and Community Assessment Treatment service (CATs) are continuing to respond effectively to the rising acuity of mental health, behavioural and forensic support needs of people with learning disabilities residing in Hertfordshire. Commissioners are particularly impressed by Dove ward's approach to managing acuity and behaviours that challenge. CATs are being out under additional pressure by the numbers and complex needs of people being placed out of area into social care provision in Hertfordshire who are requiring their specialist learning disability services.

Working with HPFT has allowed us to embed expanded psychiatric liaison services in both Watford General and Lister Hospitals over the past year. These services are now operating 24 hours a day, 7 days a week and so meet the Core 24 standard. The evaluation undertaken during the year evidenced that these teams are vital to supporting urgent and emergency care staff in Accident and Emergency and on inpatient wards to identify, manage and support people with mental health needs.

The Trust moved to a new and more robust training programme for safeguarding children. This will improve training and bring benefits in the longer term, but caused short term training challenges. They have been open and transparent and worked closely with the Designated Team and commissioners through this transition.

We have worked with HPFT during the year to consider the closure of Prospect House, an assessment and treatment unit for people with dementia. This proposal has been considered by Hertfordshire County Council's Health Scrutiny Committee.

Over the coming year we look forward to working with HPFT to improve the response to crisis in both adults and children and young people, to developing community mental health services linked to primary care and considering the potential to extend CAMHS services up to age 25.



Kathryn Magson
Chief Executive
Herts Valleys CCG

Beverley Flowers
Chief Executive
East & North Herts CCG

Hertfordshire Partnership University Foundation NHS Trust Quality Report Statement from Seamus Quilty, Chairman Hertfordshire Health Scrutiny Committee

There has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the Trust over the last 12 months. The Trust has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future. The Committee were pleased and reassured to learn that CQC had rated the Trust outstanding following the recent CQC inspection. Councillors are pleased and reassured that Hertfordshire residents are receiving quality mental health and learning disability services from the Trust.

Annexe 2 – Statement of Directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance Detailed Requirements for Quality Reports 2018/19
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to March 2019
  - Papers relating to quality reported to the Board over the period April 2018 to March 2019
  - Feedback from commissioners dated May 2019
  - Feedback from governors May 2019
  - Feedback from local Healthwatch organisations dated May 2019
  - Feedback from Overview and Scrutiny Committee dated May 2019
  - The Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
  - The 2018 national patient survey October 2018
  - The 2018 national staff survey February 2019
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated May 2019.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's Annual Reporting Manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Chris Lawrence, Chair
Dated: 22nd May 2019

Tom Cahill, Chief Executive
Dated: 22nd May 2019

Annexe 3 – External Audit Opinion

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

We have been engaged by the Council of Governors of Hertfordshire Partnership University NHS Foundation Trust to perform an independent assurance engagement in respect of Hertfordshire Partnership University NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral; and
- inappropriate out-of-area placements for adult mental health services.

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated May 2019;
- feedback from governors, dated May 2019;
- feedback from local Healthwatch organisations, dated May 2019;
- feedback from Overview and Scrutiny Committee, dated May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated October 2018;

- the 2018 national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 15 May 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Hertfordshire Partnership University NHS Foundation Trust as a body, to assist the Council of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Hertfordshire Partnership University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

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

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Hertfordshire Partnership University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
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24 May 2019

Glossary

ACE	Anglian Community Enterprises
ADDS	Accelerated Directors Development Scheme
ADHD	Attention Deficit Hyperactivity Disorder
ADTU	Acute Day Treatment Unit
A&E	Accident and Emergency
AIMS	Accreditation for Inpatient Mental Health Services
AMBIT	A metallisation based team approach for teams working with young people
ANT	Advance New Technologies
APPTS	Accreditation Programme for Psychological Therapies Service
ASYE	Assessed and Supported Year in Employment
AWOL	Absent Without Leave
BAME	Black, Asian & Minority Ethnicity
BMI	Body Mass Index
BMJ	British Medical Journal
BNF	British National Formulary
CAMHS	Child and Adolescent Mental Health Services
CASC	Clinical Assessment of Skills and Competencies
CATT	Crisis Assessment and Treatment Team
C-CATT	Children's Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCQI	Royal College of Psychiatrists' College Centre for Quality Improvement
CEDS	Community Eating Disorders Service
CGL	Change, Grow, Live – health
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CORE	Clinical Outcomes and Research Evaluation
CPA	Care Programme Approach
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CPT	Community Perinatal Team
CQC	Care Quality Commission
CQI	Continuous Quality Improvement
CQUIN	Commissioning for Quality and Innovation
CREMS	Carer Rated Experience Measures
CRN	Clinical Research Network
CROMS	Carer Rated Outcome Measures
CTR	Care and Treatment Review
CYP	Children and Young People
Datix	Trust incident reporting tool
DBT	Dialectical Behaviour Therapy
DiT	Dynamic Interpersonal Therapy
DOLS	Deprivation of Liberty Safeguards
DNA	Did Not Attend
DSP	Data Security and Protection
DToC	Delayed Transfer of Care
DWP	Department of Working Pensions
EbE	Experts by Experience
ED	Emergency Department
EDS	Equalities Delivery Scheme
EIP	Early Intervention Psychosis
EIPN	Early Intervention in Psychosis Network
ELDP	Essex Learning Disability Partnership
EMDASS	Early Memory Diagnosis and Support Services
EPMHS	Enhanced Primary Mental Health Services (IAPT)
EPR	Electronic Patient Record

EPUT	Essex Partnership University Trust
EROS	The new Rehabilitation pathway
EWS	Early Warning Score
FBC	Full Blood Count
FEP	First Episode Psychosis
FFT	Friends and Family Test
GMC	General Medical Council
HoNOS	Health of the Nation Outcome Scales
HCC	Hertfordshire County Council
HCT	Hertfordshire Community NHS Trust
HDAT	High Does Antipsychotic Therapy
HEE	Health Education England
HES	Hospital Episode Statistics
HMN	Herts Mind Network
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQUIP	Healthcare Quality Improvement Partnership
HSCA (RA)	Health and Social Care Act Regulated Activities
HSCIC	Health and Social Care Information Centre
HSJ	Health Service Journal
HYS	Having Your Say
HSC	Hertfordshire Health Scrutiny Committee
HTA	Health Technology Assessment
HTT	Home Treatment Team
IAPT	Improving Access to Psychological Therapies
IDVA	Independent Domestic Abuse Advisors
IG	Information Governance
IHCCT	Integrated Health and Care Commissioning Team
IPS	Individual Placement and Support
KPI	Key Performance Indicators
LeDeR	Learning Disability Mortality Review Programme
LFT	Liver Function Test
LQAF	Library Quality Assurance Framework
MES	Member Engagement System
MH	Mental Health
MHA	Mental Health Act
MHMDS	Mental Health Minimum Data Set
MOSS	Making Our Services Safer
MSNAP	Memory Services National Accreditation Programme
MTFP	Medium Term Financial Plan
NCISH	National Confidential Inquiry into Suicide and Homicide
NHSI	NHS Improvement
NICE	National Institute for Health and Clinical Excellence
NIHR	National Institute for Health Research
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
OCD	Obsessive Compulsive Disorder
OSC	Overview and Scrutiny Committee
OT	Occupational Therapy
PACE	Practice Audit and Clinical Effectiveness
PALS	Patient Advice and Liaison Service
PAIG	Practice Audit Implementation Group
PANSS	Positive and Negative Syndrome Scale
PAP	Personalised Assessment Process
PARIS	Electronic Patient Record system
PATH	Psychosis, Prevention, Assessment and Treatment
PC-MIS	IAPT information recording system
PbR	Payment by Results
PBS	Positive Behavioural Support
PDS	Post Diagnostic Support
PELS	Peer Experience Listening Service
PEN	Patient Experience Network
PHSO	Parliamentary and Health Services Ombudsman

PICU	Psychiatric Intensive Care Unit
PLACE	Patient Led Assessment of the Clinical Environment
PLAN	Psychiatric Liaison Accreditation Network
PMVA	Management of Violence and Aggression
POMH UK	Prescribing Observatory for Mental Health – UK
PoS	Place of Safety
PPE	Personal Protective Equipment
PREMS	Patient (service user) Rated Experience Measures
PRN	Pro Re NATA (“when required”) medicine
	Hertfordshire Community NHS Trust
PROMS	Patient (service user) Rated Outcome Measures
PSF	Provider Sustainability Fund
QNCC	Quality Network for Community Services
QNCC-ED	Quality Network for Community Services Eating Disorders
QNFMHS	Quality Network for Forensic Mental Health Services
QNIC	Quality Network for Inpatient Services
QNLD	Quality Network for Learning Disability Services
QNOAMHS	Quality Network for Older Adults Mental Health Services
QNPICU	Quality Network for Psychiatric Intensive Care Units
QNPMHS	Quality Network for Prison Mental Health Service
R and D	Research and Development
RAID	Rapid Assessment Interface and Discharge (now known as Mental Health Liaison)
RCA	Root Cause Analysis
RfPB	Research for Patient Benefit
SBU	Strategic Business Unit
SCM	Structured Clinical Management
SEVA	Senior Employment Education Advisor
SI	Serious Incident
SJR	Structured Judgement Review
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SPA	Single Point of Access
SPIKE	Reporting tool for the Trust
SSRI	Selective Serotonin Reuptake Inhibitor (a type of anti-depressant medication)
STaR	Support Time and Recovery
STP	Sustainability and Transformation Partnerships
SWEMWBS	Short Warwick-Edinburgh Mental Wellbeing Scale
TNS	Total National Sampling
TVN	Tissue Viability Nurse
UK CRN	UK Clinical Research Network
WRES	Workforce Race Equality Standard

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