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Introduction

Welcome to the Quality Account 2018/19 for Worcestershire Health and Care NHS Trust. We aim to present an open account of the quality of services provided by the Trust over the last year, and to set out our quality improvement ambitions going forward into 2019/20.

Our Quality Account complies with Department of Health requirements and a rigorous review is undertaken to ensure that the information contained in the account is balanced and accurate. The Quality Account is subject to external audit. Full assurance has been gained for all of the Trust’s published Quality Accounts to date.

Worcestershire Health and Care NHS Trust is the main provider of community, specialist primary care and mental health services to the population of Worcestershire. Our services are integrated with a variety of partners, and we work closely with our commissioners, voluntary organisations and communities to deliver high quality services.

The Trust’s services are provided from over 100 sites in a wide range of community settings including community hospital wards, acute mental health wards, recovery units, people’s own homes, community clinics and outpatient departments. The Trust also provides in-reach services into acute hospitals, care homes and social care settings.

We employ around 4,000 staff in clinical and non-clinical roles and record over 28,000 patient contacts every week.

All of our staff are expected to work within the values that we as a Trust believe are so important. We want people who display integrity, loyalty and the courage to always do what is right, to look after each patient as we would want our own family or friend looked after, and to always put patients first. These are our established trust values that form part and parcel of our work:

- Courageous: Displaying integrity and having the courage to do what is right
- Ambitious: Always striving for outstanding care
- Responsive: Listen, learn and act
- Empowering: Freedom to choose and live well
- Supportive: Support each other and be proud of what we do
Statement on Director’s Responsibilities

There are proper internal controls over the collection and reporting of indicators and the data underpinning the indicators is robust and reliable. The Trust’s directors are required to satisfy the CQC’s ‘Fit and Proper Persons Test’. This test helps ensure that providers have robust systems in place to hold directors to account. We confirm that Worcestershire Health and Care NHS Trust’s Directors have full compliance with the Fit and Proper Persons Test. We confirm that to the best of our knowledge and belief the information contained in this Quality Account is accurate and represents our performance in 2018/19 and our commitment to improving the quality of care for all people who come into contact with our services.

Statement on Quality from the Chief Executive

As in previous years, during 2018/19 our staff have been consistently working together to provide outstanding care, ensuring our patients, service users, families and carers continue to experience the best possible quality of care. Our CQC inspection report which was published in June 2018 provided many examples of the exceptional care the CQC saw at first hand in our services. Our recovery units, Cromwell House and Keith Winter Close, achieved an overall outstanding rating as well as our community hospitals achieving an outstanding rating in the well-led category. We are very proud of this recognition, as we are of all of our teams and services and I would like to take this opportunity to thank all Trust staff for their commitment to providing outstanding services each and every day.

Our work as part of the Sustainability and Transformation Partnership (STP) across Herefordshire and Worcestershire means that we are building on the joined up planning of health and care services with our partners and I would like to extend my thanks to our colleagues in our partner organisations who play a vital role in putting the patient at the centre of health and care services. For example, through positive working with our GP and social care colleagues, the Neighbourhood Teams are now providing joined up care underpinned by specialist expertise so that patients are cared for in the best place by the most appropriate people. We are continuing to develop this approach, learning from what is working best for patients and where further collaborative working will bring greater improvements in care for patients.

Looking back to July 2018 we celebrated 70 years of the NHS with staff and patients, past and present. A number of events were held right across the County. Tea parties with cakes, music, games and lots of discussion about how much we value the NHS were enjoyed by many. At all our NHS70 events we asked staff, patients and visitors for their views and here are just a couple of the quotes from people:

“My life has been saved on several occasions. I have received care from mental health services for over twenty years. My daughter and close family enjoy good health. Everyone I know has benefited from the NHS and the staff within. Thank you.”

“The NHS was there when I broke my wrist, and when I broke it again! It was there for me as I fell off horses and fell down ditches. The NHS was there when I was at my most unwell and needed admitting to hospital. The NHS is why I am here today and couldn’t be more grateful to have such a wonderful service in my life.”

We like to keep everyone in the loop with our activities all year round and encourage everyone to follow us on Facebook and Twitter, so that we can share all of the great activites our teams get up to. Find us at ‘@WorcsHealthCare’ on Twitter and ‘@Worcestershire Health and Care NHS Trust’ on Facebook.
Here are just a few more examples of our achievements from 2018/19 but much more information is available on our website and through our social media accounts:

In October 2018 we launched our ‘Now We’re Talking Campaign’ with the Worcester Warriors at the Sixways stadium. The aim of the campaign is to encourage more people to talk about mental health and to raise awareness about the Healthy Minds service. Since the start of the campaign we have seen a 45% increase in ‘hits’ to the Healthy Minds website and a 20% increase in Twitter followers, as well as an increase in referrals to the service. We really want to tackle the stigma that can surround seeking help for mental health issues, particularly with men, and we intend to keep up the momentum from this campaign in making Worcestershire a ‘mental health aware’ community.

We were shortlisted by the Health Service Journal for the ‘Creating a Supportive Staff Culture’ award. This was in recognition of a project we run with Worcester and Coventry Universities to offer placement opportunities to student Occupational Therapists. The students set-up a range of activities, including a couch to 5k group, walking clubs and wellbeing noticeboards with the overall aim to create a happier, healthier workforce providing quality care and role-modelling to patients accessing services.

In the summer of 2018 our children and young people’s services launched a ‘Getting School Ready’ campaign to give relevant and useful advice to parents who have children starting or returning to school in September. We gave out lots of information on a range of issues including sleep, separation anxiety, speech, toileting and healthy snacks and lunchboxes to help guide children and parents through what can be a busy and stressful time.

In September 2018 we launched ‘AccessAble’. These are online guides to our sites and buildings, summarising accessibility to each of these. We hope this will help enable disabled people and others who have access needs to prepare and be able to access any of our buildings by having more knowledge of the building before a visit.
I would like to reiterate my thanks to every member of our 4,000 strong team, including volunteers, students, bank and agency staff and everyone else who works together with us to provide the highest possible quality of care to each and every person who came into contact with our services during 2018/19.

“I believe to the best of my knowledge and belief the information in this document is accurate.”

Sarah Dugan, Chief Executive
Our New Approach to Innovation and Improvement for 2019/20

The Trust will establish three common approaches to delivering improvement at an operational level.

1. Improvement by All

Continuous improvement everywhere by everyone - small scale changes delivered through individuals and teams at service level – stimulated and supported through Quality Improvement Champions.

2. Rapid Improvement Action

Tackling ‘areas for improvement’ across the organisation in a focused and prompt manner – using Quality Improvement (QI) tools and know-how to deliver improvement at pace - priorities determined by the Integrated Governance Group and led and supported by our QI Mentors (Quality, Service Improvement and Redesign Practitioner programme (QSIR) community).

3. New Ways of Working

Responding to emergent opportunities and challenges using QI tools and know-how to redesign service delivery - a corporate approach to building quality improvement rigour into key areas of strategic importance. These will be identified and approved through Q&S Committee and supported by our QI Community.

The themes of Parity of Esteem and Dementia are currently termed as Quality Initiatives – it is proposed that these will be continued using the Rapid Improvement approach, with a real focus on understanding ‘the problem we are trying to resolve’ and supporting this to become business as usual.
Consistent use of Tools and Techniques

As an STP foot-print we have adopted the QSIR (Quality Service Improvement and Redesign) methodology. This will become the basis for learning and development at all tiers of the Trust’s QI Community.

Innovation and Improvement is about forging connections, strengthening relationships and using recognised and evidence based resources, tools and approaches to test ideas and accelerate new ways of working to deliver improved outcomes and impact.

During 2019-20, the Trust will refresh and enhance our ambitious, organisation-wide programme of innovation and improvement; through improved co-ordination of activities, a consistent operating framework and by implementing common ways of working. We will promote adoption, adaption and spread of good practice through our approach to ‘Learning 4 Excellence’ and celebrate and showcase our many examples of innovation and service improvement. We will continue to grow our quality improvement capability, strengthen our QI community, and explore how to best engage service users, patients and carers to ensure they are at the forefront of innovation and improvement within the Trust.

• A common and consistent operating model for delivering improvement consistently across the Trust.

• An organisational culture that encourages, supports and drives continuous improvement and excellence in all that we do.

• Access to a skilled QI community of improvement champions, mentors and experts that can stimulate, facilitate, support and lead improvement activity.

• A one-stop-shop for innovation and improvement resources and materials to include a repository of learning, good practice and latest innovation, research, technology and new ways of working. Opportunity to showcase, adopt, adapt and spread.

• A co-ordinated effort around all quality, innovation, improvement and performance initiatives (projects, development, events) to triangulate data and intelligence, minimise duplication, avoid reinventing the wheel and thereby releasing capacity.

• Strengthening of connections, networks and collaborative effort to maximise the impact of partnership working.
Quality Account Priorities - achievements during 2018/19 and plans for 2019/20

Our Trust vision for ‘Working Together for Outstanding Care’ was at the heart of our Quality Account priorities for 2018/19 and is taking us forward into 2019/20. Consultation with NHS Improvement, the Clinical Commissioning Groups (CCGs), Care Quality Commission (CQC) representatives, Healthwatch, our staff and the wider public the Trust Board concluded that the three priorities from 2018/19 would be carried forward into 2019/20. The consultation also resulted in Trust Board selecting a fourth Quality Account Initiative to improve our performance in the Accessible Information Standard.

Priority one:
Dementia - to make sure all our staff have an excellent understanding of dementia so that we can provide outstanding care and support at all stages of the condition, for both patients and carers.

In 2017 we signed up to become part of a national organisation called The Dementia Action Alliance (www.dementiaaction.org.uk). The Alliance published a set of statements highlighting what is important to people with dementia and carers such as inclusion, person-centred care, working in partnership and evidence-based, compassionate care. These statements, together with a local health-economy wide plan, provided the foundations for the Trust’s actions.

Key Achievements in 2018/19

- Dementia ambassadors in place in each community hospital and older adult ward
- “This is me” document used across the Trust when there is a diagnosis of dementia.
- Dementia forums in each community hospital and in older adult inpatient areas
- Mental Health Act documentation and principles adhered to as appropriate for a patient with dementia
- Contribution to the system wide strategy

What we aim to Achieve in 2019/20

- Actions for 2018/19 need to be sustained and will be monitored through audit.
- Dementia Tier 1 training has been updated and improved in readiness for March 2019 induction
- Champion workshops and tier 2 training dates are booked for 2019
- The Dementia strategy across the system in Worcestershire is due to be launched – lead commissioner is attending the steering group in April 2019.
Priority two: Parity of Esteem

‘Parity of esteem’ is defined as ‘valuing mental health equally with physical health’. The relationship between physical and mental health is such that poor mental health is linked with a higher risk of physical health problems, and poor physical health is linked with poor mental health.

Key Achievements in 2018/19

✓ Now We’re Talking campaign has been hugely successful increasing public awareness and need to self-manage and/or self-refer for treatment of mental health needs and promotion of physical activity.
✓ Trust has signed up to the Time to Change pledge.
✓ Parity Week in January 2019 raised awareness amongst staff. Parity pins have been distributed widely as part of promotion of clinicians viewing mental and physical health needs equally.
✓ Audit shows 90% of patients to have up to date care plan or discharge summary shared with GP

What we aim to Achieve in 2019/20

• Parity Week to be repeated in January 2020.
• Further enhance regular social media communications throughout the year to promote
• Staff to be involved in further innovative communications for ongoing promotion on website.

Priority three: Workforce

We want to further release and harness the ambition, creativity and motivation of staff at all levels to bring about improvements, as well as learning from others and working with our partners to ensure we always do what is right for patients.

Key Achievements in 2018/19

✓ Staff survey – Both indicators have increased since the previous National Staff Survey results and we are above average for staff engagement.
✓ Staff survey – improvement in the indicator for staff recommendation of Trust as a place to be treated
✓ Improvement in Trust staff turnover rate
✓ Improvement in National Staff Survey, Staff Engagement score. To be within the top 20% nationally for Trusts of a similar type.

What we aim to Achieve in 2019/20

• Refresh the Quality Initiative action plans in line with latest thinking and Quality Improvement methodology. Focus on measurement for improvement and sustainability.
• Identify a lead for the Prevention Quality Initiative and produce an action plan, defining the nature of the challenge.
• Establish an approach to share and learn from and provide constructive challenge to the Quality Initiative programmes.
Priority four: Accessible Information Standard (new priority for 2019/20)

The Accessible Information Standard aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with services. Examples of the types of support that might be required include large print, braille or using a British Sign Language interpreter. NHS and Social Care organisations must do five things:

- Ask people if they have any information or communication needs, and find out how to meet their needs.
- Record those needs clearly and in a set way.
- Highlight or ‘flag’ the person’s file or notes so it is clear that they have information or communication needs and how those needs should be met.
- Share information about people’s information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.

What we aim to Achieve in 2019/20

- 80% of all patient records have a record of whether the patient or service user has an information requirement.
- Any needs will be recorded in a clear way.
- Flags will be in place to ensure these needs are met.
- Information will be shared, if consent has been obtained, with other providers as appropriate.
- Seek patient feedback to establish whether such needs are being met.
<table>
<thead>
<tr>
<th>Core service</th>
<th>Overall rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Responsive</th>
<th>Caring</th>
<th>Well led</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute wards for adults 18-65 and psychiatric intensive care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
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<tr>
<td>Long stay/rehabilitation 18-65</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<td>Good</td>
<td>Good</td>
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<tr>
<td>People with Learning Disability/Autism wards</td>
<td>Requires</td>
<td>Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Wards for older people with mental health problems</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Community-based Mental Health Services for Older People</td>
<td>Requires</td>
<td>Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Community mental health 18-65</td>
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<td>Good</td>
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<td>Crisis services and Health Based Places of Safety</td>
<td>Good</td>
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<td>Good</td>
<td>Good</td>
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<td>Good</td>
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</tr>
<tr>
<td>Community Children and Young Peoples Mental Health Services</td>
<td>Requires</td>
<td>Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Community Health Children and Families</td>
<td>Good</td>
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<td>Good</td>
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<tr>
<td>Community Health Services for Adults</td>
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<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Community Health Services for Adults – end of life care</td>
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<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>Overall by domain</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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Care Quality Commission Inspections in 2018/19

The CQC undertake different types of inspections depending on the area of care they would like to focus on. The inspections can be announced or unannounced inspections. We underwent a major ‘Well-Led’ inspection in January and March 2018 where the CQC visited a large number of teams. The report was published by the CQC on 1st June 2018 giving an overall Trust rating of ‘Good’. We are very proud that Keith Winter Close and Cromwell House, our two long stay/rehabilitation units, achieved an outstanding rating in 3 domains, leading to an overall rating of outstanding for the service. Our community hospitals also received an outstanding rating in the well-led domain.

The CQC cited many examples of high quality care across all services, evidencing the skilled and compassionate care our staff provide to patients, service users, families and carers each and every day. The CQC in their report say they rated the Trust as ‘good’ because:

- The trust operated collaboratively as a board, that meant executives and non-executive directors shared responsibility and liability for decision-making.
- There was a holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finances.
- The trust board were very visible across all services of the trust. We were told of many examples of how the board visited and supported clinical services.
- The trust understood the challenges to quality and sustainability, and identified the actions required to address them. This was aligned to the wider health and social care economy of Worcestershire. There was good leadership at trust board and sustainability and transformation partnership level.
- The trust had refreshed their vision and values for the trust. The strategy and priorities of the trust was aligned to the vision and values, and reflected their part in local sustainability and transformation plans. Staff had an understanding of the vision and values in relation to local services.
- Overall, the trust was a good place to work in. Staff often told us it was the best organisation they had worked in. The trust was recognised as a disability confident employer and had been named in the top 100 employers of apprentices.
- Governance systems from ward to board provided good performance management information to make decisions.
- The trust communicated well with patients, carers, staff and stakeholders. The majority of groups felt included in decisions about service re-design and development. The youth board was a good example of patient involvement and demonstrated that the trust listened to their views and acted on their suggestions.
- There were robust arrangements in place to identify, record and manage risks. Patients’ mental and physical health was assessed, and care and treatment planned.
- The trust worked hard to improve quality and innovation, for example, the digital exemplar programme. Recruitment of staff was a challenge to the trust but they were proactive in attempts to employ people across many of their services.
- The trust recognised its staff in a number of ways, through a simple thank you to formal awards.
- There was a culture of learning and research across the trust.
We have implemented an action plan to address the areas that the CQC said we must improve on.

<table>
<thead>
<tr>
<th>CQC Core Service</th>
<th>‘Must Do’ Actions</th>
<th>Actions taken by the Trust</th>
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</thead>
<tbody>
<tr>
<td>Acute Wards for adults of working age and psychiatric intensive care units</td>
<td>The trust must ensure that, in accordance with fire regulations, fire doors on Holt Ward are closed at all times and not propped open.</td>
<td>Immediate communication directly with staff on Holt Ward to ensure that fire doors remain closed at all times. Clear signage displayed on fire doors instructing that doors must not be propped open for any reason. Checked mandatory fire training to ensure it includes instruction to ensure fire doors should be closed at all times. Numbered memo issued to Holt Ward staff and all other ward managers in the Trust advising of the need to ensure fire doors are not propped open. All Trust staff reminded of the importance of keeping fire doors closed via the ‘shared learning’ section of the July 2018 edition of Team Brief.</td>
</tr>
<tr>
<td>Acute Wards for adults of working age and psychiatric intensive care units</td>
<td>The trust must ensure staff used for medication management on Hillcrest ward are adequately trained and supervised to ensure safe practice is used.</td>
<td>The staff who were observed during the inspection not to be following best practice had individual, mutually agreed supportive plans in place to ensure appropriate training was undertaken and one to one supervision was in place until best practice was consistently evidenced. All registered staff on Hill Crest issued with a copy of the NMC Standards for Medicines Management with particular attention given to Section 4 concerning administration. This was also discussed in individual supervision sessions. Mental Health Pharmacy Lead reviewed practice on Hill Crest ward and discussed medicines administration with staff at the team meeting. All registered nursing staff attended a reflective learning session on medicine dispensing facilitated by Lead Mental Health Pharmacist and Lead Inpatient Nurse.</td>
</tr>
<tr>
<td>Community Health Inpatient Services</td>
<td>The trust must ensure that staff undertake decision specific mental capacity assessments when completing do not attempt cardio-pulmonary resuscitation (DNACPR) forms.</td>
<td>Review of uptake of Mental Capacity Act (MCA) training, identifying where there were any gaps. Communications out to all staff to understand barrier to completing the assessments in the notes and how these can be overcome. Clinically-led improvements to processes. Audits undertaken to establish compliance with recording the decision-specific mental capacity assessment in the clinical notes. Regular re-audits underway to ensure sustained improvement.</td>
</tr>
</tbody>
</table>
The trust must ensure that all staff receive regular supervision.

Promotional material and advertising activities throughout the year means that staff have been made aware of the importance of regular supervision. A new user-friendly clinical supervision page on the staff intranet guides staff in all aspects of supervision and provides links for further advice. In response to feedback from staff, the system for recording supervision attendance has been revised, making the system easier to use. The new system for tracking compliance allows for team-specific actions to be taken to improve uptake.

The CQC undertook 5 Mental Health Act monitoring unannounced inspections during 2018/19. Action plans are implemented to address any identified areas for improvement.

<table>
<thead>
<tr>
<th>Date</th>
<th>Service inspected by CQC</th>
<th>Key Findings and Actions</th>
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<tbody>
<tr>
<td>26/04/2018</td>
<td>New Haven - two older adult mental health wards - Woodlands Ward and Meadow Ward.</td>
<td>Carers said they were happy with the care and treatment provided to their relatives. The personalised therapy activities for patients are described in a very positive light. Areas for improvement relate to detained patients having their rights explained in a timely manner, care plans to reflect any blanket restrictions and clearer signage on bedroom doors.</td>
</tr>
<tr>
<td>14/08/2018</td>
<td>Athelon – an older adult mental health ward</td>
<td>Patients felt they were well looked after and that staff were kind. Actions relate to improving the recording of the patient’s capacity to consent to admission as well as advice to patients of their legal status under the Mental Health Act.</td>
</tr>
<tr>
<td>12/11/2018</td>
<td>Hillcrest – an adult mental health ward</td>
<td>Patients said that staff were friendly and helpful. There was clear information about patient medications. The ward was described as pleasant. Actions related to improving the involvement and support for patients in discharge planning and the provision of gluten-free meal choices.</td>
</tr>
<tr>
<td>07/12/2018</td>
<td>Cromwell House – a community based adult mental health inpatient unit.</td>
<td>Patients talked positively about preparation for discharge and described staff as caring and approachable. Actions related to improving the recording of consent discussions and recording patient views in care planning and community meetings.</td>
</tr>
<tr>
<td>29/01/2019</td>
<td>Holt Ward – an adult mental health ward</td>
<td>Report not received from the CQC at the time of drafting the Quality Account.</td>
</tr>
</tbody>
</table>
Clinical Commissioning Groups (CCGs)

CCGs are responsible for the planning and commissioning of health care services in their local area. There are 3 CCGs in Worcestershire: NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest Clinical CCG. The CCGs commission most of our services. Between 1st April 2018 and 31st March 2019, 13 services took part in a peer review with the CCG.

Action plans are drawn up after each visit and are monitored until completion. Some key themes from the 2018/19 peer reviews are:

- The compassionate care that staff provide to patients in all services is by far the most easily identifiable common element across all peer reviews. Staff often describe how proud they are of their services and their achievements in being able to evidence a high quality of care for patients.
- Staff often describe how they feel supported by colleagues, both in their own service and across other services.
- The recruitment of suitability trained staff, especially within specialist services, is sometimes cited as a challenge by services, especially where the posts relate to specialist skills.
- Some services commented on how referral routes could be simplified and how they are working on making improvements to these processes.

Healthwatch

Healthwatch England is the national consumer champion in health and care and has statutory powers to ensure the voice of the consumer is heard. You can find out more about Healthwatch here http://www.healthwatch.co.uk/about-us. Healthwatch Worcestershire gathers feedback about publicly funded local health and care services and uses this to make recommendations to those who run the services about how they could be improved from the patient perspective.

Healthwatch published 3 reports during 2018/19 that were relevant to the services we provide. As the reports are comprehensive and cover a wide range of service provision, not all of the recommendations in the reports are within the remit of the Trust’s control. We work closely with Healthwatch Worcestershire to ensure we respond to those recommendations that are within our influence so that the people who access our services receive the best possible care and treatment. The feedback that Healthwatch gathers is an invaluable insight into where we are doing well, and where we need to make improvements. We have face to face meetings with Healthwatch at regular intervals during the year to make sure we are working together to respond fully to the findings within the reports.

The following is a short summary relating to comprehensive and detailed reports, aiming to give an overview of some of the key findings and actions. The full reports and final action plans will be placed on our website pages.
<table>
<thead>
<tr>
<th>Healthwatch Worcestershire Report</th>
<th>Key findings and examples of recommendations</th>
<th>Examples of WHCT Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2019 - Going to the Dentist Between June and November 2018 Healthwatch Worcestershire engaged with 942 people, including children and young people, in a variety of ways to find out about experiences of going to the dentist.</td>
<td>Most of the people Healthwatch spoke with were attending the dentist regularly, had confidence and trust in their dentist and 91% of people rated their treatment as very good or good. Issues identified included cost of treatment, lack of information, confusion over charging, fear, and in some cases difficulty finding an NHS dentist locally. One in two people did not know how to make a complaint about their dentist should they need to. Nearly one in four of the 36 people with a learning disability went to the dentist less than once a year. There needs to be greater awareness of the impact of sight loss by dental practices and the information that could be gained from using the NHS Accessible Information Standard. Most of the homeless people Healthwatch spoke to had heard of the Dental Access Centre (DAC), and would use this in an emergency. Feedback from children and young people found that although many rated the experience positively, there is more to be done to enhance the experience and reduce potential feelings of fear and anxiety. Some parents reported that oral health was not raised by Health Visitors at the 2yr developmental check.</td>
<td>Learning Disability nurses will routinely ask people with a learning disability about their oral health as part of the assessments. This is audited in the Oral Health Strategy. Community Dental Services staff attend Magg’s day centre once a month to meet and assess the homeless population. A drop-in service is promoted for these patients. This model is to be developed in Kidderminster and Evesham. Looking after Children’s teeth Leaflet available on web page and in paper format for distribution to School Nurses, Nursery Nurses and Health visitors for school readiness events and Child health checks. Oral health including when to visit your dentist is discussed in the 9 month developmental check by Health Visitors. Written information is included in the Red Book. NHSE to imminently launch campaign for ‘A little trip to the dentist’ All relevant health care teams are being contacted and provided with resources.</td>
</tr>
</tbody>
</table>
**Healthwatch Worcestershire Report**

**March 2019 - Service User and Carer Experience of the Mental Health Home Treatment Services.**

Focus on patients and their carers who had been discharged from the Home Treatment Service between February 2017 and January 2018. Two surveys were co-designed; one for service users and one for carers. 49 surveys were received back. 22 of the respondents were interviewed.

- Levels of satisfaction with the elements of the service varied with some service users and carers talking in very positive terms about their experience, but at the same time there were a number of key learning points. Whilst no specific questions were asked about Carer assessments, none of the Carers interviewed made any reference to having an assessment. Carer assessments should address many of the issues raised by Carers in this report; it would therefore benefit Worcestershire Health and Care Trust to ensure routine signposting of Carers to the Worcestershire Association of Carers. The Trust to identify ways to better involve service users in the co-design of their care plan.
- Visited more consistently by familiar Home Treatment Service team members. Consider the use of a recorded discharge summary within the care plan to be shared with the Service User for future reference as an aid to the transition between services.
- Every relative and carer undergoes screening. Should a need be identified, Home Treatment refer the relative/Carer for a Carers assessment. All relatives and Carers are provided with a Carers leaflet with the contact details of Worcestershire Association of Carers, along with other available support for Carers. The Home Treatment Service has a “getting well plan” that is a care plan coproduced with the service user and, with consent, carer. The Service User retains a copy of the care plan and is able to add to it at any stage. The Home Treatment Service do their very best to limit the amount of clinicians visiting a Service User during their episode of care. A Consultant Psychiatrist and 2 allocated qualified clinicians along with a support worker are identified for each Service User. Where ever possible these are the clinicians who will predominantly be visiting the Service User. Home Treatment will introduce a discharge summary for service users which will be given to the service user during their final visit. This will be in place by May 2019.
<table>
<thead>
<tr>
<th>Healthwatch Worcestershire Report</th>
<th>Key findings and examples of recommendations</th>
<th>Examples of WHCT Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019 - Children and Young People’s Mental Health Report. Engagement with 233 people about mental health and emotional wellbeing support for children and young people.</td>
<td>Worcestershire Health and Care Trust to provide reassurance of the process to assess risk to children and young people in relation to not offering treatment following referral or delay to start of treatment. Commissioners and Worcestershire Health and Care Trust to provide information about actions taken to reduce waiting times. Commissioners and Worcestershire Health and Care Trust to carry out evaluation and monitoring of CAMHS service to provide reassurance that quality standards are being met. Worcestershire Health and Care Trust to ensure that staff within CAMHS have received appropriate training on Autism Spectrum Conditions and other additional needs as appropriate.</td>
<td>Risk assessment tool used within CAMHS supports the stratification of risk and supports the clinical decision making around wait times. All ‘Choice’ appointments are discussed at Multi-disciplinary team meeting; this supports decisions concerning risk and ensures consideration of appropriate signposting or advice if indicated. Capacity and demand modelling to be undertaken. Use of Routine outcome measures (ROMs) which include outcome rating and session rating from young person. Audit of all open cases across the service who have had more than 6 sessions cross referenced to determine if they have a ROM. Case by case basis discussed with clinicians in supervision. Work underway to review and strengthen case supervision. Staff within CAMHS have received training on Autism Spectrum Conditions and are able to draw on this and the expertise of colleagues to ensure children and young people are experiencing appropriate and compassionate care.</td>
</tr>
</tbody>
</table>
Duty of Candour

Our approach to candour underpins our commitment to providing high quality of care, understanding and sharing the truths about harm at an organisational as well as an individual level, and learning from them. Our organisational values are rooted in the genuine engagement of staff, our clinical leadership building on professional accountability, and on every member of staff’s personal commitment to the safety of patients.

We know that conversations between patients, families and staff about risk and the potential for harm are essential for fostering a culture of candour, both as a means of preparing patients should something happen, and in encouraging clinicians and healthcare staff to do the right thing when errors occur.

Our duty of candour policy supports this approach and covers how, when and why we share information relating to incidents and near misses with families. Our incident management tracking give us good assurance that staff are following the Duty of Candour requirements and that those staff are in turn supported by their colleagues and line managers.

Shared Learning

Ulysses, our incident reporting system, is easy to use with screen-shot guidance available to all staff. We place a great deal of emphasis on ensuring learning focuses on improvement of systems rather than on human error, recognising that people make errors when the system or process is poorly designed. This ethos is reiterated in our Serious Incident Forum, chaired by the Director of Nursing and Quality, where staff identify learning points from Serious Incidents for inclusion in the monthly Team Brief to all staff. Our stance is reinforced through Trust induction, Root Cause Analysis training, Duty of Candour policy and training and via shared learning communications out to staff. We are resolutely determined to continue to foster a genuinely open culture where staff are valued for contributing to incident reporting and learning.

Shared learning is taken forward on four distinct levels depending on the nature of the incident. Firstly, learning is shared between reporter and manager. Managers responsible for closing incidents complete a mandatory field, feeding actions/learning back to the incident reporter. Secondly learning for a team or service will be taken to the service’s quality meeting for review/group supervision. Thirdly, incident learning that could apply to our wider Trust services is shared through Team Brief. Finally learning that would apply to partner organisations is shared through the Directors of Nursing, through the Alliance Boards and by working collaboratively with commissioners and with our partner organisations.

As an example of shared learning, over the last year one of our Quality Leads has undertaken a quality improvement project with the aim of reducing the number of medication incidents in relation to insulin administration. This has led to some changes in the process and recording of insulin administration to reduce the potential for errors.
Mortality

National Context

In December 2016 the CQC published its report ‘Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England’ making recommendations about how the approach to learning from deaths could be standardised across the NHS. In response the National Quality Board published a national framework for NHS Trusts – ‘National Guidance on Learning from Deaths. The framework placed a number of new requirements on trusts for reporting, investigating and learning from patient deaths.

In addition the Learning Disabilities Mortality Review (LeDeR) programme supports local areas in England to review the deaths of people with a learning disability to identify common themes and learning points and provide support to local areas in their development of action plans to take forward the lessons learned.

Detailed mortality reports are available in our Trust Board papers here http://www.hacw.nhs.uk/our-board/board-agendas-minutes-and-meeting-dates/

Actions Taken by Worcestershire Health and Care Trust in relation to Mortality 2018/19

Learning from Deaths has been one of our key quality improvement programmes during 2018/19. We have undertaken an extensive review of how we can best learn from families and carers as well as the mortality case note reviews. This in turn is leading to better learning outcomes from our mortality reviews.

Our Mortality Surveillance Group, chaired by the Deputy Medical Director, meets every 3 months to oversee progress with our improved approach.

During 2018/19 we undertook a review into unexpected deaths involving Adult Mental Health (AMH) service users. All unexpected death serious incident investigation reports from September 2017 to August 2018 were analysed - a 12 month time period. Some key findings were:

- The most frequent reported cause of death was hanging; this is consistent with national findings and that seen during the previous annual review.
- There have been no deaths as a result of medication overdose; a reduction compared to previous reviews. This reduction is consistent with national findings.
- Deaths were more frequently reported in the 30-39 years and 50-59 years age range. This represents a change in reporting trends compared to the previous annual review where deaths were more frequently reported with increasing age.
- There was an increase in deaths reported in the younger age ranges particularly 30-39 age ranges apparent in this review.
- 40% of service users were documented as employed at the time of their death. This is a notable increase compared to the previous annual review.
We took a number of learning points from the review. These are discussed in our learning forums and are shared more widely across the Trust. Examples of learning points are:

• Several investigations highlighted the need to check patient contact details/addresses regularly with the patient to ensure they receive correspondence regarding appointments and are able to receive appropriate follow up. Staff are regularly reminded of this requirement.

• When patients are temporarily leaving Worcestershire, teams need to document (where possible) the approximate length of time they will be away from the area and consider contacting the out of county Trust to discuss the ongoing care plan.

• If a patient is an ex-employee or current employee of the trust, the appropriateness of admitting to a Trust ward is considered. Where a patient is felt to lack capacity to make a decision regarding their treatment, a formal capacity assessment is undertaken, including a best interest decision.

Our Plans for 2019/20

Our new Caring for Bereaved Families and Carers Policy, launched in April 2019 does not mandate a ‘one size fits all’ approach to how to support bereaved families, as every family has their own needs and wishes and will grieve in their own way. It does however encapsulate broader principles for how we will engage meaningfully and compassionately with bereaved families whereby:

• bereaved families are treated as equal partners

• bereaved families receive a clear, honest, compassionate and sensitive response in a sympathetic environment.

• bereaved families receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs.

• bereaved families are informed of their right to raise concerns about the quality of care provided to their loved one.

• bereaved families’ views help us to make informed decisions about whether a review or investigation is needed.

• bereaved families receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison.

• bereaved families are partners in an investigation to the extent that they wish to be involved.

Telling families that a person has died can be challenging and distressing. The support and wellbeing of our staff is also a key priority within this policy.

Our new Learning from Deaths policy, also launched in April 2019, has been subject to extensive consultation exercises including patient panels and amendments have been made accordingly. Key changes that implementation of the policy will bring are:

• In- scope deaths will be subject to screening and those that flag will go on to Structured Judgement Review (SJR). An SJR is a structured review of a clinical record carried out by one or more clinicians. It can determine whether there were any problems in care provided to a patient and can also highlight where excellent or best practice care has occurred. It requires reviewers to make safety and quality judgments over phases of care, to make explicit written comments for each phase of care and to score each phases of care. The result is a relatively short but rich set of information about each case in a form that can be aggregated to produce knowledge about clinical services and systems of care. The Trust’s SJR template is based on the Royal College of Physicians’ and the Royal College of Psychiatrists’ SJR templates.

• All deaths of patients with a Serious Mental Illness will be subject to SJR in compliance with national guidance.

• A random sample of deaths that do not flag through screening will also be subject to SJR.
• Trained reviewers who do not work in the clinical team where the patient died will undertake the SJRs.
• The improved quality of SJRs will provide more meaningful delivery of learning outcomes.
• Mortality governance will feed into the established governance systems to allow for greater thematic analysis.

Mortality
(NB the following statements are mandatory requirements for the Quality Account)

<table>
<thead>
<tr>
<th></th>
<th>The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.</th>
<th>During April 2018 to March 2019 275 of Worcestershire Health and Care NHS Trust patients died as patients on the in-patient wards. This comprised the following number of deaths which occurred in each quarter of that reporting period: 68 in the first quarter; 64 in the second quarter; 74 in the third quarter; 69 the fourth quarter.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The number of deaths included in item A which the provider 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.</td>
<td>By 31st March 2019, 274 case record reviews and 1 investigation have been carried out in relation to 275 of the deaths included in item A. In 0 cases a death 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 was: 68 in the first quarter; 64 in the second quarter; 74 in the third quarter; 69 in the fourth quarter.</td>
</tr>
<tr>
<td>B</td>
<td>An estimate of the number of deaths during the reporting period included in item A 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.</td>
<td>0% of the patient 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 patient. These numbers have been estimated using evidence from Structured Judgement Reviews. Root Cause Analysis Reports. The NHS Serious Incident Framework recommends this approach where unexpected deaths are investigated.</td>
</tr>
</tbody>
</table>
### D

A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item C.

Although our investigations did not highlight any problems in patient care, we have used the data to produce some analysis and broader learning from our mortality reviews and investigations into deaths.

The highest mortality rate occurs in our community hospitals. The hospitals provide sub-acute care, palliative care and rehabilitation. Many patients admitted to our community hospitals have multiple physical health problems. In 2018/19 the average age of patients who died in our community hospitals was 79 years; the median age was 82 years.

Some reviews identified the positive and rewarding experiences for the clinical team in providing holistic, end of life care.

There were some excellent examples of high quality clinical record keeping. These have been shared across the Trust as a means of sharing best practice.

There have been very few negative issues identified as a consequence of the 2018/19 review process. We have launched a new policy with revised processes for 2019/20 and have trained a small group of staff in undertaking Structured Judgement Reviews. Our approach to involving families and carers in the reviews has also been improved. This more focussed approach should identify richer and more meaningful learning outcomes in future.

### E

A description of the actions which the provider 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 D).

The following are some actions we have taken:

- We have worked with some GPs to promote earlier referrals to palliative care consultants.
- We have worked with staff to ensure notes that accompany patient on admissions are recorded fully in the Trust’s electronic care record.
- We have worked with staff to ensure mental capacity assessments are consistently recorded. This has been added to our Clinical Audit plan for 2019/20 to monitor sustained performance in this area.

The relative lack of negative findings, though reassuring, has raised questions regarding the present mortality review process and whether it is being undertaken with sufficient challenge and vigour. The process as a whole has therefore been revised. Nationally recognised training was procured and delivered to a small group of experienced clinicians.

Mortality reviews in 2019/20 will be carried out by a trained reviewer who is not based in the clinical team where the death occurred. This will provide greater assurance in relation to the objectivity of reviews, and will lead to an improved understanding where we are getting things right, and where improvements are needed.
An assessment of the impact of the actions described in item E which were taken by the provider during the reporting period.

Our process for mortality reviews in 2019/20 will be much clearer and provide a greater scope for the involvement of families and carers in the overall judgements and learning. The impact of this will be improved assurance and ultimately and better experience of care both for patients and for staff.

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 B in the relevant document for that previous reporting period.

0 case record reviews and 0 investigations were finished in the reporting period which related to deaths during the previous reporting period but were not included in item B in the relevant document for that previous reporting period.

An estimate of the number of deaths included in item I 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, with an explanation of the methods used to assess this.

0 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 patient. The methods used by the Trust are: Structured Judgement Reviews. Root Cause Analysis Reports. The NHS Serious Incident Framework recommends this approach where unexpected deaths are investigated.

A revised estimate of the number of deaths during the previous reporting period stated in item C of the relevant document for that previous reporting period, taking account of the deaths referred to in item J

0 deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Themes and Learning from Mortality Reviews in 2018/19

The following broad learning themes are based on SJRs that were undertaken before our improvement project had been implemented. The content and style of reviews was not therefore consistent. It should be noted however that the reviews were undertaken by experienced clinicians based in operational and corporate teams who would be able to identify key concerns within a review.

There were many positive themes from completed SJRs in 2018/19:
• We have found that good, safe and compassionate care has been provided.
• There is evidence of widespread best practice observed in notes. For example ‘patient story shared during team clinical supervision to discuss the complexities of the patient’s social situation and reflect on how well the patient and family were supported’.
• Evidence of compassionate, informative and supportive engagement with families and carers is contained within clinical notes. For example: ‘Conversations with family clearly documented demonstrating joint decision making in patients best interest. Urgent contact appropriately made as patient quickly deteriorated demonstrating compassion and concern. Post death support offered to family and arrangements made as per their wishes’.
• Clinical assessments and continuation notes reflect that multidisciplinary teams undertook thorough assessments to develop effective care plans to deliver compassionate care.
Learning points can tend to relate to particular services rather than from completed inpatient SJRs:
• Some record keeping practices needs to be improved. We are taking this forward in 2019/20 in a clinical record keeping improvement project.
• In one service it was noted that an assessment form needed to be amended so that there is a clearer correlation between identified patient needs and care planning actions that are in place.
• One review noted a complex family background which led to communication issues between the clinical team and different branches of the patient’s family. The learning from this was that there needs to be one nominated family member who agrees to coordinate the communication between the family and the clinical team.

Coroner’s Regulation 28 - Prevention of Future Deaths

There were no issues raised with the Trust by the Coroner under regulation 28 of the 2009 Justice Act to make recommendations to Prevent Future Deaths during 2018/19.

Patient Experience Feedback during 2019/20

The feedback that we receive from patients and carers enables us to identify areas for improvement in the services we provide. Recent examples of feedback leading to improvement include:

• Patients within the mental health inpatient settings told us they would like more choice on meal options and portion sizes. This was fed back to the Catering Department who have worked with inpatient areas to ensure that a wider choice of food and portion size is on offer.

• It was noted from feedback in the MIU Department at Malvern MIU that the booking in system was not clear for patient’s visiting the department. The feedback was reviewed and considered and the booking in system was changed to ensure that it was clear for all accessing the department.

• A common theme was identified in relation to parking at Community Hospitals. As a result of this feedback posters were developed and displayed to ensure that patients and visitors were made aware of concessionary parking.

• Following changes made to the way patients were able to access and book appointments in Sexual Health Services we identified that some patients were experiencing challenges with the new phone lines. A new on-line booking system is being implemented to make it easier to book appointments.

• We have used the feedback collected from patients and carers around their experience of non-clinical interactions including reception areas to develop a Customer Care Training Session that is delivered to non-clinical staff. The training is based on good practice as well as areas for improvement identified by patients and carers.

• Additional equipment for patient areas has been identified from patients an example of this is different size blood pressure cuffs within the Neighbourhood Teams.
How likely are you to recommend our services to friends and family if they needed similar care or treatment?

<table>
<thead>
<tr>
<th>Service</th>
<th>Extremely likely</th>
<th>Likely</th>
<th>Neither likely or unlikely</th>
<th>Unlikely</th>
<th>Extremely unlikely</th>
<th>Don’t Know</th>
<th>TOTAL</th>
<th>FFT Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health and Learning Disabilities</td>
<td>810</td>
<td>389</td>
<td>57</td>
<td>20</td>
<td>24</td>
<td>38</td>
<td>1338</td>
<td>90%</td>
</tr>
<tr>
<td>Countywide Community Services</td>
<td>4311</td>
<td>740</td>
<td>49</td>
<td>18</td>
<td>13</td>
<td>57</td>
<td>5188</td>
<td>97%</td>
</tr>
<tr>
<td>Integrated Community Services</td>
<td>627</td>
<td>56</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>698</td>
<td>98%</td>
</tr>
<tr>
<td>Children, Young People and Families</td>
<td>1646</td>
<td>417</td>
<td>63</td>
<td>16</td>
<td>11</td>
<td>29</td>
<td>2182</td>
<td>95%</td>
</tr>
<tr>
<td>Specialist Primary Care</td>
<td>1227</td>
<td>193</td>
<td>20</td>
<td>5</td>
<td>16</td>
<td>11</td>
<td>1472</td>
<td>96%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8621</td>
<td>1795</td>
<td>194</td>
<td>61</td>
<td>68</td>
<td>139</td>
<td>10,878</td>
<td>96%</td>
</tr>
</tbody>
</table>

National Survey
Mental Health Community Services - 2018

The CQC publish an annual report from a survey of people who use community mental health services. The full report findings are available here https://www.cqc.org.uk/provider/R1A/survey/6

In 2018 the survey was sent out to 815 people who had access these services provided by the Trust and 268 (33%) of people responded.

The survey indicates that the Trust compares in about the same range as other trusts that provide mental health services. The results also indicate that none of the response ratings fall in the worst performing trusts. One domain that has been highlighted as a significant variant is for the question “In the last 12 months, has a NHS mental health worker checked with you about how you are not getting gone with your medicines?” The score indicates that the Trust is close to one of the best performing Trusts for this indicator.

The services have developed an action plan to address the survey findings which will be monitored in the SDU quality meetings.

We are also looking at ways that we can gather more real-time feedback so that we can respond to the patient’s experience of care today, rather than to historical data. In early 2019/20 we are introducing text messaging to patients so that people can tell us as soon as they are discharged from services about their experiences. This will give us much richer data and will allow us to respond very quickly to any areas of concern.
Complaints and Compliments

We widely promote the opportunities for providing feedback about our services, as well how to make a complaint. We aim to respond as quickly as we can to concerns raised with us, so that we can learn and swiftly make any changes.

We have seen:
- A decrease in complaints compared to the previous year.
- A large increase in PALS compared to the previous year.
- An increase in reported compliments.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>317</td>
<td>322</td>
<td>297</td>
</tr>
<tr>
<td>PALS</td>
<td>1082</td>
<td>1371</td>
<td>2482</td>
</tr>
<tr>
<td>Compliments</td>
<td>3074</td>
<td>3339</td>
<td>3568</td>
</tr>
</tbody>
</table>

Four cases have been considered by the Parliamentary and Health Service Ombudsman (PHSO) in 2018/19. Of the cases reviewed this year, they remain open and we await the outcome of their investigation.

All complaints received by the Trust are published, with all person identifiable data removed, on the Trust’s website at: http://www.hacw.nhs.uk/our-services/compliments-and-complaints/complaints-received

More detail about complaints and the themes arising out of them can also be found in our annual complaints report to Trust Board in May 2019: http://www.hacw.nhs.uk/our-board/board-agendas-minutes-and-meeting-dates/

All of our complaints are reviewed to help us identify any themes. Actions from complaints are shared by the services in their team meetings and more widely through team meetings. Some examples of actions taken and lessons learnt in 2018/2019 as a result of complaints include:

- From one of our complaints we found that staff had not completed some paperwork appropriately. As a result we arranged for additional training from another team to be provided to support the staff.

- We received a concern from the family about the difficulty experienced in accessing appropriate equipment following the patient’s discharge from hospital. We found that there was a delay in equipment being arranged and as a result a working group was set up to improve the pathway for specific equipment and stock provision.

- There was a breakdown in communication between services and the patient. A review of internal processes was undertaken to understand how and why the communication problems had arisen. A revised clinical care pathway has now been implemented which should prevent this issue from reoccurring.
Staff Survey and Staff Support

The NHS National Staff Survey report contains 32 key findings and Worcestershire Health and Care NHS Trust is ranked against other combined mental health/learning disability and community trusts in England.

The results of the 2018 National Staff Survey were released in February 2019.

The top five ranking scores for the Trust were:

Key findings for which the Trust compares most favourably with other combined mental health/learning disability and community trusts in England:

• Percentage of staff working extra hours
• Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
• Percentage of staff feeling unwell due to work related stress in the last 12 months
• Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

The bottom five ranking scores for the Trust were:

• Percentage of staff / colleagues reporting most recent experience of violence
• Quality of appraisals
• Quality of non-mandatory training, learning or development
• Staff satisfaction with the quality of work and care they are able to deliver
• Effective team working

The Trust scored 90% for indicator KF21 – the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion - against a national average of 86%.

For KF26 – the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - the Trust scored 19%, against a national average of 20%.
Safe Staffing

Each ward manager has worked closely with their line managers and the Director of Nursing and Quality to make decisions about staff requirements for each shift, to ensure that patient needs can be met. The number of staff required at any time is called the planned staffing number. Sometimes the actual staffing number is below the planned number. This may be the result of staff sickness, or because there is a lower number of patients on the ward than usual, so staff have been moved to work in another area.

Sometimes the actual staffing number will be higher than the planned number. This may be because there are a lot of patients on the ward who need extra care because of their physical or mental health condition.

Information about staffing levels alone cannot tell us whether a ward is safe or unsafe, but a regular lower percentage of the planned staff being in place would be a cause for concern.

We have an electronic system in in-patient areas that records staffing levels so that senior nurses can see at a glance if there are issues. Real time staffing levels are also displayed on our huddle boards in all ward areas. Staff are actively encouraged to report any staffing levels issues onto our incident reporting system.

On average, 95% of all qualified nursing shifts on our inpatient wards / units have been filled during the last twelve months. For the same period for unqualified staff it has been on average 100% or above. The predominant reason for staffing levels to be below 100% is due to nursing vacancies and where it is above 100% it is where there has been the need to have additional nurses or health care assistants to meet the needs of patients who require closer observation. Closer observations are needed when caring for patients who are high risk of falls, caring for patients with dementia, or supporting patients who are experiencing behavioural issues due to their ill health.

Clinical Audit and Research (mandatory sections)

Clinical audit

During 2018/19 12 national clinical audits and one national confidential enquiry covered NHS services that Worcestershire Health and Care NHS Trust provides. During the reporting period, Worcestershire Health and Care NHS Trust participated in (100%) national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Worcestershire Health and Care NHS Trust was eligible to participate in during 2018/19 are as follows:

• National Early Intervention in Psychosis Service audit (EIPS)
• National Clinical Audit of Anxiety and Depression (NCAAD)
• NCAAD: Psychological Therapies Spotlight Audit
• Epilepsy 12: The national clinical audit of health care for children and young people with suspected epileptic seizures
• National Audit of Care at the End of Life (NACEL)
• POMH-UK Topic 6d: Assessment of the side effects of depot antipsychotics
• POMH-UK Topic 7f: Monitoring of patients prescribed lithium
• POMH-UK Topic 15b: Prescribing valproate for Bipolar Disorder
• POMH-UK Topic 16b: Rapid tranquillisation
• POMH-UK Topic 18a: Prescribing Clozapine
• CQUIN 3a: Physical health community and inpatients
• BASHH national audit 2019 of times to appointment, test results and treatment
• National Confidential Inquiry into Suicide and Homicide by people with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Worcestershire Health and Care NHS Trust participated in, and for which data collection was completed during the period are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>National clinical audits 2018/19</th>
<th>% of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Early Intervention in Psychosis Service audit (EIPS)</td>
<td>n/a</td>
</tr>
<tr>
<td>National Clinical Audit of Anxiety and Depression (NCAAD)</td>
<td>n/a</td>
</tr>
<tr>
<td>NCAAD: Psychological Therapies Spotlight Audit</td>
<td>100%</td>
</tr>
<tr>
<td>Epilepsy 12: The national clinical audit of health care for children and young people with suspected epileptic seizures</td>
<td>n/a</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>100%</td>
</tr>
<tr>
<td>POMH-UK Topic 6d: Assessment of the side effects of depot antipsychotics</td>
<td>n/a</td>
</tr>
<tr>
<td>POMH-UK Topic 7f: Monitoring of patients prescribed lithium</td>
<td>n/a</td>
</tr>
<tr>
<td>POMH-UK Topic 18a: Prescribing Clozapine</td>
<td>n/a</td>
</tr>
<tr>
<td>CQUIN 3a: Physical health community and inpatients</td>
<td>100%</td>
</tr>
</tbody>
</table>

The reports of four national clinical audit were reviewed by the provider in 2018/19 and Worcestershire Health and Care NHS Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Title of report</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMH-UK: Topics 1g and 3d: Prescribing high dose and combined antipsychotics on adult psychiatric wards.</td>
<td>A new Trust policy on the use of high dose and/or combined antipsychotic prescribing was developed.</td>
</tr>
<tr>
<td>POMH-UK Topic 16b: Rapid tranquillisation</td>
<td>Actions are being developed alongside a related CQC action plan.</td>
</tr>
<tr>
<td>POMH-UK Topic 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention.</td>
<td>Weakest areas are now included as an agenda item in the Multidisciplinary Team meetings to support care coordinators in reinforcing good care planning.</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life</td>
<td>Actions are currently in discussion and agreement phase.</td>
</tr>
</tbody>
</table>

The reports of 75 local clinical audits were reviewed by the provider in 2018/19. Worcestershire Health and Care NHS Trust intends to take or has taken the following actions to improve the quality of healthcare provided. Please note; this is a sample only to give an indication of the spread of audit work across the services.
<table>
<thead>
<tr>
<th>Title of clinical audit</th>
<th>Aim/ objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-audit of NICE guideline CG89 Child protection.</td>
<td>To maintain high standards already demonstrated.</td>
<td>Monthly monitoring via Enhanced Primary Care Mental Health Service (EPCMHS) Management and Governance meeting. Weekly EPCMHS bulletins to include child protection information, and reminders for staff to complete training.</td>
</tr>
<tr>
<td>Adult Mental Health Audit Bundle (Community Assessment Recovery Service).</td>
<td>Ensure risk assessments address level of vulnerability, and needs assessments are completed.</td>
<td>Monthly monitoring now takes place via the new Community Metric Standards.</td>
</tr>
<tr>
<td>Adult Mental Health Audit Bundle (Home Treatment Teams).</td>
<td>Ensure all cases where a safeguarding issue has been identified are managed in line with policy. Professionals’ meetings to be arranged in all cases and all patients must have a crisis plan on discharge.</td>
<td>The Clinical Review Sheet has been amended so as to alert the named worker to the need to arrange a professional’s meeting. Work has been done on staffs’ general use and management of the Electronic Patient Record.</td>
</tr>
<tr>
<td>Adult Mental Health Audit Bundle (Early Intervention and Perinatal Services).</td>
<td>Ensure risk of non-engagement has been appropriately care planned for. Also ensure carers are identified (where relevant), and evidence that relevant assessments/screens have been offered.</td>
<td>All issues were fed back to the service’s senior management team meeting, and outcomes shared with the teams. Ongoing monitoring via supervision in place.</td>
</tr>
<tr>
<td>Adult Mental Health Audit Bundle (Eating Disorder Services).</td>
<td>Maintain the high standards evidenced at audit as well as ensuring needs assessments have been completed, next of kin recorded, and evidence that patients have been given the patient information leaflet.</td>
<td>Patient Information Leaflets are now sent out with the assessment invitation letter to patients. These are then uploaded to the Electronic Patient Record, as evidence, along with the Eating Disorder Examination Questionnaire (EDE-Q).</td>
</tr>
<tr>
<td>Adult Mental Health Mental Health Act Audit.</td>
<td>Ensure Section 17 leave forms are always shared with the patient, and evidence that any risks are reviewed prior to leave. Ensure that the patient’s rights are revisited on a monthly basis.</td>
<td>Ward Review Standards have been introduced which includes Section 17 (S17) leave. Wards have implemented a ‘signing in &amp; out’ sheet to document mental state assessment and Patient Identifiable Data before any S17 leave.</td>
</tr>
<tr>
<td>Clinical Supervision Audit 2017: Enhanced Primary Care Mental Health Service (EPCMHS).</td>
<td>Continue to improve on the percentage of all staff receiving regular clinical supervision.</td>
<td>Recording of attendance at supervision session is being standardised. Also, the introduction of reflective group supervision sessions in addition to individual supervision sessions is to be introduced.</td>
</tr>
<tr>
<td>Title of clinical audit</td>
<td>Aim/ objective</td>
<td>Action taken</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Re-audit investigating multiple prescription of antipsychotic</td>
<td>Maintain the generally high levels of practice seen at audit, and work towards</td>
<td>Findings presented at Medicines Management Safety-Sub Committee Meeting. Request in progress to include a new tab/subheading in outpatient letters entitled 'Medication Rationale' in the Electronic Patient Record.</td>
</tr>
<tr>
<td>medication in community Adult Mental Health.</td>
<td>all patients subject to antipsychotic polypharmacy having the rationale for such documented in all clinical correspondence.</td>
<td></td>
</tr>
<tr>
<td>Monitoring of mode of infant feeding and contraception</td>
<td>Continue to maintain high level of continuity of care provided by the Perinatal Psychiatry team across the antenatal and postnatal period.</td>
<td>Findings to be shared at team meeting and emphasis placed on increasing documentation of mode of infant feeding and discussion about contraception postnataally.</td>
</tr>
<tr>
<td>information gathering during perinatal psychiatric assessment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title of clinical audit</td>
<td>Aim/ objective</td>
<td>Action taken</td>
</tr>
<tr>
<td>Admission Process Clinical Audit (LD).</td>
<td>To ensure consistent approach taken across teams, mental capacity is considered in all cases, and baseline observations completed.</td>
<td>Team managers routinely monitor performance via mini audits, and in supervision.</td>
</tr>
<tr>
<td>Epilepsy Plans Clinical Audit.</td>
<td>Ensure Constant to Share information is secured for all service users, and improve the numbers of Friends and Family Tests completed.</td>
<td>Amendments have been made, in line with General Data Protection Regulation (GDPR), to include an additional box in the Epilepsy Plan document to record Mental Capacity Assessment and discussion to share information.</td>
</tr>
<tr>
<td>Occupational Therapy (Learning Disabilities) Waiting List Audit.</td>
<td>Explore more effective ways to respond to priority referrals more quickly using OT Clinics and group work for assessment and treatment.</td>
<td>All referrals are now screened on receipt. Future developments include providing Sensory Integration Awareness training, as well as broader training demonstrating special Occupational Therapy skills. Development of a clinic which could then take on a larger volume of referrals is also planned for later in the 2019.</td>
</tr>
<tr>
<td>Positive Proactive Support Audit.</td>
<td>Ensure all sections of documentation are completed in full.</td>
<td>A guidance sheet has been circulated to assist in maximising the specific information required along with the partnership protocol.</td>
</tr>
<tr>
<td>Community Services</td>
<td>Aim/objective</td>
<td>Action taken</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Adherence to DNA (Did Not Attend) policy within Older Adult Mental Health Services.</strong></td>
<td>To Improve recording of information regarding the patient’s details, ward information and frequency of observations.</td>
<td>Key messages shared with the Older Adult Mental Health teams. DNAs are now included in nursing metrics and regularly monitored.</td>
</tr>
<tr>
<td><strong>Prescription Errors: Meeting the gold standard for prescription writing.</strong></td>
<td>Ensure all prescriptions meet the gold standard.</td>
<td>A small aide memoire card has been made available to each doctor to prompt cross-checking of medication cards.</td>
</tr>
<tr>
<td><strong>Audit assessing the validity of the recording of the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision.</strong></td>
<td>Ensure capacity is assessed for all relevant patients, and ensure there is documented evidence concerning communication with the patient.</td>
<td>Both capacity assessments and evidence of communication are now to be documented on the Electronic Patient Record.</td>
</tr>
<tr>
<td><strong>Re-audit of Memantine prescription in the Redditch and Bromsgrove Older Adult Community Mental Health Team.</strong></td>
<td>Continue to maintain the good practice evidenced at audit.</td>
<td>Clearer documentation of the severity of a patient’s dementia is required.</td>
</tr>
<tr>
<td><strong>Timeliness of discharge letters from Lickey Ward.</strong></td>
<td>Maintain level of compliance with support from administration.</td>
<td>No further action required.</td>
</tr>
<tr>
<td><strong>Mild Cognitive Impairment (MCI) within the Early Intervention in Dementia Service: rate and recording of diagnosis.</strong></td>
<td>Maintain good documentation of MCI as evidenced at audit. Explore options for development of a MCI pathway in the county.</td>
<td>Findings were shared with the senior management team, commissioners and the Clinical Commissioning Group’s Dementia Lead. Further discussions to be had with GPs and commissioner concerning increased rates of MCI and need to establish a formal MCI pathway.</td>
</tr>
<tr>
<td><strong>Physical Health Monitoring Audit: Patients with Bipolar Disorder Older Adult Mental Health.</strong></td>
<td>Maintain the high standards of care seen at audit as well as ensuring advance statements are in place, and recording in the electronic record is robust.</td>
<td>Good practice shared, and the team are reviewing the potential benefit of developing a checklist to prompt robust monitoring.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children, Young People and Families Service</th>
<th>Aim/objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Re-audit of Health Visitor Safer Sleeping Policy.</strong></td>
<td>To maintain and build on improvements made since initial audit.</td>
<td>Infant Feeding Update now includes specific information and advice to staff in relation to having meaningful conversations regarding safe sleep messages with parents. Staff reminded to scan and record pertinent information into CareNotes.</td>
</tr>
</tbody>
</table>
### Quality Account 2018/19

<table>
<thead>
<tr>
<th>Title of clinical audit</th>
<th>Aim/ objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitoring of drug treatment for depression in CAMHS.</td>
<td>To ensure all patients receive NICE –recommended psychology therapy, and all have received information about possible side effects of antidepressants.</td>
<td>The Side-effect Monitoring Questionnaire has been updated to incorporate specific aspects identified in the audit.</td>
</tr>
<tr>
<td>Starting Well Public Health Nursing Service: Staff knowledge and skills audit.</td>
<td>Continue to maintain high standards evidenced at audit as well as increasing attendance at Infant Feeding &amp; Relationship Building training.</td>
<td>Training was arranged and ran, and was well attended.</td>
</tr>
<tr>
<td>Re-audit of paediatric correspondence.</td>
<td>Continue to build on improvement seen since last audit. Agree amendments to current letter template.</td>
<td>Share findings at Team meeting, and agree processes for improving practice.</td>
</tr>
<tr>
<td>Re-audit of Medical Surveillance in Children and Young People with Down Syndrome in Worcestershire</td>
<td>Improve checking of Thyroid peroxidase (TPO) antibodies and using Down Syndrome-specific growth charts. Improve on recording growth measurements although growth charts are not available on CareNotes at time of audit</td>
<td>Community Paediatrics CPD training day to be arranged with invites to Acute and Community Audiology Services to further discuss. A recommended schedule of health checks to be put on CareNotes, to be used as a reference by paediatricians in clinic.</td>
</tr>
</tbody>
</table>

### Dental Health Service

<table>
<thead>
<tr>
<th>Title of clinical audit</th>
<th>Aim/ objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline Temperature Audit.</td>
<td>Ensure temperature monitoring, recording and storage is robustly managed.</td>
<td>New colour-coded record sheets were rolled out. ‘Epipens’ introduced across sites to replace anaphylactic shock packs.</td>
</tr>
<tr>
<td>Audit to assess compliance with the Standard Operating Procedure for Midazolam in the Community Dental Service.</td>
<td>Ensure receipt of midazolam is always recorded, and weekly stock checks are appropriately managed.</td>
<td>Findings were shared at the Dental Clinical Governance meeting, and amendments to the Grab Bag Weekly Checks Form have been made.</td>
</tr>
<tr>
<td>Dietary investigation in conjunction with increasing fluoride availability.</td>
<td>Ensure all patients should receive standardised dietary advice, and this should be comprehensively recorded.</td>
<td>Findings to be shared at Dental Clinical Governance meeting. A standardised user-friendly diet analysis sheet for clinicians to give to their paediatric patients, is to be rolled out; ‘My Food Diary’.</td>
</tr>
<tr>
<td>Periodontal screening of children and adolescents under 18 Years of age.</td>
<td>Ensure the Basic Periodontal Examination (BPE) template follows the Paediatric BPE guidelines.</td>
<td>Findings to be shared at Dental Clinical Governance meeting. To re-design the paediatric new patient examination template to reflect the correct BPE screening tool.</td>
</tr>
</tbody>
</table>
### Sexual Health Service

<table>
<thead>
<tr>
<th>Title of clinical audit</th>
<th>Aim/ objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record Keeping Audit.</td>
<td>Maintain high standard of record keeping.</td>
<td>No further action required.</td>
</tr>
<tr>
<td>Monitoring Did Not Attend (DNA) rate following implementation of new booking system for procedure appointments.</td>
<td>Ensure patients continue to have choice via the newly implemented booking system.</td>
<td>Re-evaluate the new booking system once embedded across the service.</td>
</tr>
<tr>
<td>National benchmarking audit on Emergency Contraception.</td>
<td>Ensure all women presenting for emergency contraception are advised to do pregnancy test in 3 weeks, and that they are given sexual health advice.</td>
<td>Findings to be shared and discussed at team meetings across the service.</td>
</tr>
</tbody>
</table>

### Corporate Services

<table>
<thead>
<tr>
<th>Title of clinical audit</th>
<th>Aim/ objective</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vulnerable adult police incidents (Safeguarding).</td>
<td>Encourage police personnel to obtain explicit consent from adults to share information with their GP and any other health professionals involved.</td>
<td>Safeguarding Team continue to support the quarterly meetings with Harm Assessment Unit (HAU).</td>
</tr>
<tr>
<td>Audit of the quality of clinical notes on CareNotes (Electronic Patient Record Clinical Support Team).</td>
<td>Encourage continuation of good clinical notes seen at audit. Ensure detail of treatment is recorded, any change in condition recorded, and a plan for on-going care is evident.</td>
<td>The good practice was shared with the Trust, and CareNotes refresher training is available to staff.</td>
</tr>
<tr>
<td>Inpatient Mortality Review Audit.</td>
<td>Ensure completeness of the Structured Judgement Reviews.</td>
<td>Recommendations from the baseline review were considered by the Mortality Review Group; key recommendations centred on training and monitoring.</td>
</tr>
<tr>
<td>Blended diet via Gastrostomy Audit (Nutrition and Dietetics).</td>
<td>Maintain excellent practice seen at audit.</td>
<td>The guidelines for administration of blended diets via gastrostomy devices in children are to be reviewed and updated.</td>
</tr>
<tr>
<td>Paediatric Liaison Audit.</td>
<td>Improve the communication mode between Accident and Emergency and Public Health Nursing Teams.</td>
<td>A&amp;E attendances are now received in electronic format instead of paper.</td>
</tr>
<tr>
<td></td>
<td>Ensure confirmation of uploaded attendance is completed by a professional.</td>
<td>Safeguarding Team administration now ensures Public Health Teams are informed when an attendance has been uploaded onto CareNotes.</td>
</tr>
</tbody>
</table>
The number of patients receiving relevant health services provided or sub-contracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service was 196. Please note these represent National Institute for Health Research portfolio studies only.

Implementation of National Institute of Healthcare Excellence (NICE) guidance

The Trust has an established process for the implementation of NICE guidance which ensures our services are appraised against all relevant NICE guidance, and where required, implementation plans are developed to bring services to full compliance.

Local clinical audit activity

Each Service Delivery Unit (SDU) has an agreed Clinical Audit Forward Programme which includes national audits, Trust priority audits, Service-level priority audits, policy and NICE guidance audits, audits resulting from patient safety incidents, areas of risk and complaints, and clinician-interest audits. In addition, each clinical audit is aligned with one of the Trust’s five values.

These forward programmes are agreed at SDU Senior Management Teams, the Clinical Audit and Effectiveness Group, and the Quality and Safety Committee.

Service-level ownership of and engagement in each programme is strong. SDU Quality Leads oversee each programme with support from the Audit, Research and Clinical Effectiveness Manager who facilitates the process.

Each SDU has a process for reviewing its audit reports and action plans, and each feeds back the outcomes from its audit work to the Clinical Audit and Effectiveness Group. These are reported to the Integrated Governance Group, Quality and Safety Committee and to Trust Board as well as to the Trust’s Commissioners via the Clinical Quality Review Meeting.

Reporting to the Trust’s Integrated Governance Group occurs monthly and to Quality and Safety Committee and the Clinical Quality Review Meeting quarterly; Trust Board receives the report on an annual basis. The Trust has a Quality Indicator which measures the percentage of audits running to plan. Over the period 2018/19, the average percentage of audits running to plan was 96%; the key performance indicator threshold is 95%.
### Prescribed Information

During 2018/19 the Worcestershire Health and Care NHS Trust provided and/or sub contracted 4 NHS services which were organised/delivered through the following Service Delivery Units:
- Adult Mental Health & Learning Disabilities
- Countywide Community Services
- Integrated Community Services
- Children, Young People and Families and Specialist Primary Care

Worcestershire Health and Care NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of NHS services by the Worcestershire Health and Care NHS Trust for 2018/19.

A proportion of the Worcestershire Health and Care NHS Trust’s income during 2018/19 was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation payment framework agreed between the Worcestershire Health and Care NHS Trust and the Worcestershire CCGs. Further details on this can be obtained from Worcestershire Health and Care NHS Trust’s website.

### 2018/19 CQUIN Targets

<table>
<thead>
<tr>
<th>2018/19 CQUIN Targets</th>
<th>Milestone Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement of Health and Wellbeing of NHS Staff - Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing.</td>
<td>No</td>
</tr>
<tr>
<td>Healthy food for NHS Staff, visitors and patients – Healthy food provision</td>
<td>Yes</td>
</tr>
<tr>
<td>Achieving an uptake of flu vaccinations by frontline clinical staff of 70%</td>
<td>Yes</td>
</tr>
<tr>
<td>Demonstrate cardio metabolic assessment and treatment for patients with psychosis</td>
<td>Yes</td>
</tr>
<tr>
<td>90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP.</td>
<td>Yes</td>
</tr>
<tr>
<td>Reduce by 20% the number of attendances to A&amp;E for those within two selected cohorts of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable</td>
<td>Yes</td>
</tr>
<tr>
<td>Improving transitions out of young peoples’ Mental Health Services</td>
<td>Partial achievement</td>
</tr>
<tr>
<td>Increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Worcestershire Health and Care NHS Trust is required to register with the Care Quality Commission (CQC) under section 10 of the Health and Social Care Act 2008. At the end of 2018/19 Worcestershire Health and Care NHS Trust is registered with the CQC with no conditions attached to registration. The CQC has taken no enforcement action against Worcestershire Health and Care NHS Trust during 2018/19.

Worcestershire Health and Care NHS Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during 2018/19.

Worcestershire Health and Care NHS Trust submitted records during 2018/19 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient’s valid NHS number was:

- 100% for admitted patient care (7,696 out of 7,696)
- 99.99% for outpatient care (18,909 out of 18,910)

which included the patient’s valid General Medical Practice Code was:

- 100% for admitted patient care (7,696 out of 7,696)
- 100% for outpatient care (18,910 out of 18,910)

(The data for accident and emergency care is not applicable to Worcestershire Health and Care NHS Trust as the MIU activity is submitted by the Worcestershire Acute Hospitals Trust as their activity).

Worcestershire Health and Care NHS Trust considers that this data is as described for the following reasons:
The above figures are an accurate record of activity that has taken place between April 2018 and March 2019 and is consistent with previous year’s submissions. Worcestershire Health and Care NHS Trust continue to take actions to improve the number of records without an NHS number for the Inpatient and Outpatient submissions. Each month we receive data quality reports of patients who do not have an NHS number and where possible each month check through the Summary Care Record to find an NHS number and update this in CareNotes. Services are also made aware through online data quality reports of the key demographic information that missing from patient records. There will be a small number of patient records where the NHS number is not known.

The NHS Digital Data Security and Protection Toolkit is based upon the 10 x data security standards identified in the National Data Guardian (NDG) Review. The Trust has gathered supporting evidence and submitted its end of year 2018/19 Toolkit return. The Trust has developed a comprehensive Improvement Plan to address any areas where development is needed. This Plan has been signed off by the Trust’s Senior Information Risk Owner (SIRO) and has been reviewed and approved by NHS Digital. The Trust status is ‘Standards not fully met – plan agreed’.

Action taken by Worcestershire Health and Care NHS Trust to improve data quality:
The Trust has a Data Quality Improvement Group which is a formal sub-committee of the Audit Committee. The group seeks to work on a number of fronts to ensure that the systems and processes that exist within the organisation are sufficiently robust, and provide assurance that the data collected and used by the front-line teams and used within reports for Committees and the Board are both accurate and timely.
The Trust submits quarterly information around CPA 7 Day Follow Up Discharges to Unify which is the national collection system. The Information Team believes this data is not captured with the submissions made in the Mental Health Dataset, but NHS England provides regional quarterly information that is released from the Unify Submissions and this has been provided as a comparison. Below is the quarterly information that we have submitted to Unify.

Worceshshire Health and Care NHS Trust considers that this data is as described for the following reasons:

- Reports are available to service online to check discharges and monitor whether a 7 day follow up has been completed. The information team validates this information with the services.
- Worcestershire Health and Care NHS Trust intends to take the following actions to improve this:
  - The Trust will work on making sure that where possible the performance is 100% for 7 Day Follow up but for all quarters of 2018/19 the target of 95% has been met.
  - A national average comparison table is provided below. This is the quarterly information that the Trust submits to Unify which is then released by NHS England. We do not have access to the data to show the highest and lowest of the same for the reporting period.

<table>
<thead>
<tr>
<th>Proportion of patients on CPA who were followed up within 7 days after discharge from Psychiatric Inpatient Care</th>
<th>England Average</th>
<th>Trust Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>95.8%</td>
<td>100% (122 of 122)</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>95.7%</td>
<td>100% (135 of 135)</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>95.5%</td>
<td>100% (124 of 124)</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>95.5%</td>
<td>97.76% (131 of 134)</td>
</tr>
</tbody>
</table>

The data made available to the trust by the Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

We submit quarterly information around CPA Gatekeeping to Unify. We do not believe this data is captured with the submissions made in the Mental Health Data set so we are unable to check any data or reports that come from the NHS Digital. We are not able to provide comparisons. Below is the quarterly information that we have submitted to Unify.

Worceshshire Health and Care NHS Trust considers that this data is a true reflection of performance for the following reasons:

- Reports are available to services online. Members of the information team also validate this information with the services.
- Worcestershire Health and Care NHS Trust intends to take the following actions to improve this:
  - We will continue to make sure that where possible performance reaches 100%. During 2018/19 the target of 95% has been met.
  - A national average comparison table is provided below. This is the quarterly information that the Trust submits to Unify which is then released by NHS England. We do not have access to the data to show the highest and lowest of the same for the reporting period.

<table>
<thead>
<tr>
<th>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period</th>
<th>England Average</th>
<th>Trust Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>98.1%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>98.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>97.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>98.7%</td>
<td>100%</td>
</tr>
</tbody>
</table>
The data made available to the trust by the Information Centre with regard to the percentage of patients aged: (i) 0 to 14; and (ii) 15 or over, re-admitted 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. This information is not made available to this Trust.

The data made available to the trust by the Information Centre with regard to the proportion 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:

The data is provided in scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 (the lowest possible score) and the maximum score is 5 (the highest possible score).

<table>
<thead>
<tr>
<th>Staff recommendation of the organisation as a place to work or receive treatment</th>
<th>Trust Score 2017</th>
<th>Trust Score 2018</th>
<th>Median Score 2018</th>
<th>Lowest national score 2018</th>
<th>Highest national score 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3.90</td>
<td>3.64</td>
<td>3.68</td>
<td>3.40</td>
<td>3.90</td>
</tr>
</tbody>
</table>

Worcestershire Health and Care NHS Trust considers that this data is as described for the following reasons. The survey was undertaken by an organisation that works to national guidelines and governance.

Worcestershire Health and Care NHS Trust intends to take/has taken the following actions to improve this percentage:

Worcestershire Health and Care NHS Trust takes the health and wellbeing of its staff very seriously.

There is a range of health and wellbeing support available to staff, including the following:

- Fast track physiotherapy
- Counselling
- Moodmaster courses
- Stress Awareness Training
- Stress Risk Assessment Training
- Occupational Health
- Regular pulse surveys

The Trust employs a full time Health and Wellbeing Lead whose role includes:

- The on-going promotion and development of health and wellbeing initiatives
- Staff engagement activity
- One to one support for staff
- Support for teams

Over the past twelve months the Health and Wellbeing Lead has worked in partnership with the Professional Lead for Allied Health Professional to host a number of contemporary placements for Occupational Therapy students. This project was shortlisted for a HSJ Award. The purpose of the placements has been to support the work of the Health and Wellbeing Lead and to encourage staff to maintain their own health and wellbeing.

The Trust has recently starting using the Go Engage staff engagement tool to establish where staff engagement is working well and areas for improvement. This is used on a Trust wide basis and also with individual teams to establish their enablers of engagement.
The data made available to the trust by the Information Centre with regard to the trust’s ‘Patient experience of community mental health services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust Score</th>
<th>Lowest Trust Score in England</th>
<th>Highest Trust Score in England</th>
<th>2017 score for WHCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?</td>
<td>6.2</td>
<td>4.1</td>
<td>6.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Did the person or people you saw understand how your mental health needs affect other areas of your life?</td>
<td>6.9</td>
<td>5.7</td>
<td>7.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Were you given enough time to discuss your needs and treatment?</td>
<td>7.4</td>
<td>6.2</td>
<td>8.0</td>
<td>7.7</td>
</tr>
</tbody>
</table>

All of these scores are in the intermediate of all Trusts.

Worcestershire Health and Care NHS Trust considers that this indicator score is as described for the following reasons:

- The survey is undertaken by an objective third party. All responses are anonymised.
- Worcestershire Health and Care NHS Trust intends to take/has taken the following actions to improve this indicator score and so the quality of its services: An action plan is in place to address the findings which is being monitored by the SDU. We are investing in further resources to obtain real time feedback from patients so that we can be more responsive to the findings.
The data made available to the trust by the Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>The rate of patient safety incidents reported within the trust</td>
<td>51.18%</td>
<td>52.30%</td>
<td>59.00%</td>
</tr>
<tr>
<td>Percentage of such patient safety incidents that resulted in severe harm or death</td>
<td>1.22%</td>
<td>1.16%</td>
<td>0.68%</td>
</tr>
<tr>
<td>National rate (community trusts)</td>
<td>N/A</td>
<td>N/A</td>
<td>0.2%</td>
</tr>
<tr>
<td>National rate (mental health trusts)</td>
<td>N/A</td>
<td>N/A</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

Worcestershire Health and Care NHS Trust considers that this data is as described for the following reasons:

- NRLS data shows that we are currently the 4th highest community Trust for reporting patient safety incidents.
- Each incident that is reported in the Trust is checked at the time of reporting to ensure it has been correctly coded and the harm level is a balanced and accurate assessment.
- Worcestershire Health and Care NHS Trust intends to take/has taken the following actions to improve this rate and so the quality if its services:
  - We continue to be actively committed to promoting the importance of reporting and sharing learning from incidents. Sharing of learning begins with each incident reporter receiving feedback from their line manager. We then go to discuss incidents and share learning at SDU governance level through to sharing learning in Team Brief each month. We have a monthly meeting between the Quality Leads and key patient safety leads to ensure cross-organisational learning takes place.
  - We also actively engage with our commissioners, regulators and partner providers in the spirit of openness and joined up working so that the best interests of patients and staff is at the forefront of incident reporting. The importance of incident reporting is highlighted at each staff induction with the emphasis on a Just Culture approach. There are clear instructions for all staff on the intranet on how to use Ulysses and staff tell us the system is easy to navigate.
Healthwatch Worcestershire’s response
To the Quality Account of the Worcestershire Health and Care NHS Trust for the financial year 2018/19

Healthwatch Worcestershire [HWW] has a statutory role as the champion for those who use publicly funded health and care services in the county.

Healthwatch Worcestershire welcomes the opportunity to comment on the Worcestershire Health and Care NHS Trust Quality Account [QA] for 2018/19. We meet with the Trust to discuss issues and actions arising from our work and the responses that they provide to the recommendations within our reports, as identified on page 16 of the Quality Account.

Healthwatch Worcestershire’s principal concern is that patients who live or work in Worcestershire receive safe and quality services from the Trust.

We have used national Healthwatch England guidance to form our response below.

1. Do the priorities of the provider reflect the priorities of the local population?

HWW welcome the addition of Priority 4 – Accessible Information Standard. The priorities are stated as being determined by unspecified consultation with the ‘wider public’. It would be useful to understand more about the approach taken and how the harder to reach communities were engaged.

2. Are there any important issues missed?

More emphasis on transition points would be welcome, especially from children’s services to adult services. On page 39, ‘Partial Achievement’ is recorded next to ’Transitions out of Young Peoples Mental Health Services’. It would be good to understand what this means and what the implications are?

3. Has the provider demonstrated that they have involved patients and the public in the production of the Quality Account?

It was good to see the Trust had engaged with the wider population in setting the priorities for 2019/20, however, it is not clear how the public or patients have been involved in producing the Quality Account. The section on page 26 onwards on Patient Experience and Feedback is interesting and informative. It is encouraging to note the increase in response from Friends and Family compared to 2017/18. Healthwatch Worcestershire welcome the introduction of real time feedback via text messaging to capture patient experience following discharge from services.
It is clear Worcestershire Health and Care Trust capture patient feedback however; it is not clear how these feed into the Quality Account e.g. Learning from Deaths – extensive consultation including ‘patient panels’. It would be useful to know how patients and the public are made aware of the Quality Account report.

4. Is the Quality Account clearly presented for patients and the public?

Healthwatch Worcestershire understands the challenges in clearly presenting the Quality Account for patients and the public given the content required by NHS England. None the less the draft Quality Account at times uses language which may be difficult for patients and the public.

A glossary of terminology would be useful and avoidance of acronyms where possible. It would also be useful to include links to strategies where they are referenced e.g. page 17 refers to the Oral Health Strategy.

Healthwatch Worcestershire suggest that the Trust should produce a summary of the Quality Account in an accessible format specifically for patients and the public in accordance with the Accessible Information Standard.

Peter Pinfield
Chairman
Healthwatch Worcestershire

Trust Response:

The Trust thanks Healthwatch for their feedback and notes the comments made. We will be producing a shorter summary of the Account at the AGM. We try to produce a succinct Quality Account but we are required to include mandatory statements and we are audited on this regulation. We will continue to work with Healthwatch during 2019/20 in order to build on our partnership working and mutual intentions to provide the best possible care to patients and carers in Worcestershire.
A significant component of the work undertaken by the three Clinical Commissioning Groups (CCGs) for Worcestershire - NHS South Worcestershire CCG, NHS Redditch and Bromsgrove CCG and NHS Wyre Forest CCG - involves the quality assurance of health services provided for the population of Worcestershire. This includes steps to assure the public of the content included within this Quality Account.

During 2018/19 services provided by the Trust continued to be rated overall as ‘good’ by the Care Quality Commission (CQC), with Mental Health Recovery services, and the ‘well led’ aspect of Community Hospitals achieving a rating of ‘outstanding’.

During 2018/19 the Trust effectively re-configured teams to support the closer alignment of community based teams with General Practice whilst maintaining a positive focus on care quality. As a result, Worcestershire has been able to make good progress. Further transformation will continue be required across the system in order to achieve sustainable health care that delivers safe and effective services for local people. This will require an engaged workforce that is adaptable and able to respond to the changing demographic of patient need. The Trust’s investment in models to support quality improvement and staff engagement across services has not yet resulted in anticipated improvements in staff satisfaction in the quality of care that they are able to provide, reflected in the NHS National Staff Survey. Commissioners are therefore supportive of the Trusts decision to maintain a focus on the workforce as one of the agreed Quality Priorities and wish to work with the Trust to gain a better understanding of strategic workforce plans.

Success has been achieved in a number of the schemes this year where the NHS contract with CCGs incentivised areas for improving quality through service innovation. Schemes included continuing to improve the quality of physical health care for people with mental health needs and enabling more coordinated mental health support for individuals who have attempted to access support by attending A&E departments. The Trust has made great progress in both of these areas during 2018/19 and sustainable partnership processes have been developed that will continue to benefit patients.

The Trust has engaged in campaigns to successfully promote access to services for mental health and wellbeing and deliver improvement in response times and effectiveness in some areas during 2018/19. 2019/20 will see investment in a range of mental health and wellbeing services and the Trust has been able to demonstrate a capacity for responding to patient feedback and achieving positive change through effective re-design.

The Trust has continued to demonstrate a positive culture of learning and evidence a willingness and understanding of areas that would benefit from further improvement. In this regard the Trust’s commitment to encouraging innovation and continuous improvement is evident and commissioners are supportive of plans to further extend the spread of learning from excellence.
The Trust has continued to work in partnership with commissioners to jointly review services as part of a scheduled annual programme. Different forms of shared governance are likely to evolve during 2019/20 and the level of transparency displayed by the Trust will form a solid foundation for new ways of working.

Work as part of the Learning Disability Mortality Review Programme (LeDeR) was strengthened toward the end of 2018/19 and we hope to be able to collectively demonstrate the impact that we are starting to make during 2019/20. Mortality related information within the Account, whilst focusing predominantly on learning from inpatient deaths, includes examples of the implementation of learning and further improvement plans for 2019/20.

Based on existing assurance processes adopted and the information made available to us throughout the year, we believe this Quality Account provides a representative and balanced perspective of the quality of healthcare provided by Worcestershire Health and Care NHS Trust.

On behalf of NHS Redditch and Bromsgrove Clinical Commissioning Group, NHS Wyre Forest Clinical Commissioning Group, NHS South Worcestershire Clinical Commissioning Group

Simon Trickett
Accountable Officer
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group
NHS Wyre Forest Clinical Commissioning Group

The Trust thanks the CCGs for the response to the Quality Account. No changes have been made to the Quality Account as a result of this feedback.

The following statement was received from the Worcestershire Health Overview and Scrutiny Committee (HOSC) in May 2019:

The Worcestershire Health Overview and Scrutiny Committee welcomes receipt of the draft 2018-19 Quality Account for Worcestershire Health and Care NHS Trust and through the routine work of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of healthcare across all health economy partners in Worcestershire.

The Trust thanks HOSC for the response to the Quality Account. No changes have been made to the Quality Account as a result of this feedback.
Independent Practitioner’s Limited Assurance Report to the Board of Directors of Worcestershire Health and Care NHS Trust on the Quality Account

We have been engaged by the Board of Directors of Worcestershire Health and Care NHS Trust to perform an independent assurance engagement in respect of Worcestershire Health and Care NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 (“the Regulations”).

Scope and Subject Matter

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

• Percentage of patients on CPA followed up within seven days of discharge.
• Percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations). In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

• the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
• the performance information reported in the Quality Account is reliable and accurate;
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
• the Quality Account has been prepared in accordance with Department of Health and NHS Improvement guidance.
The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

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 Account is not prepared in all material respects in line with the criteria set out in the Regulations;
• the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 (“the Guidance”); and
• the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

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

• Board minutes for the period 1 April 2018 to 26 June 2019;
• papers relating to quality reported to the Board over the period 1 April 2018 to 26 June 2019;
• feedback from NHS Redditch and Bromsgrove CCG, NHS South Worcestershire CCG and NHS Wyre Forest CCG dated 11 June 2019;
• feedback from local Healthwatch Worcestershire dated 13 June 2019;
• feedback from Worcestershire Health Overview and Scrutiny Committee dated 30 May 2019;
• the Trust’s annual complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 19 June 2019;
• the national Community patient survey dated 22 November 2018;
• the national staff survey dated 26 February 2019;
• the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 23 May 2019;
• the annual governance statement dated 23 May 2019; and
• the Care Quality Commission’s inspection report dated 01 June 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 Board of Directors of Worcestershire Health and Care NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Worcestershire Health and Care NHS 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 under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower 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 that 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 Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Worcestershire Health and Care NHS Trust. Our audit work on the financial statements of Worcestershire Health and Care NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Worcestershire Health and Care NHS Trust’s external auditors. Our audit reports on the financial statements are made solely to Worcestershire Health and Care NHS Trust’s directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to Worcestershire Health and Care NHS Trust’s directors those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of Worcestershire Health and Care NHS Trust’s financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Worcestershire Health and Care NHS Trust and Worcestershire Health and Care NHS Trust’s directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.
Conclusion

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
The Colmore Building
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Birmingham
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26 June 2019
Do you need to know about accessibility? Read our detailed guides at www.AccessAble.co.uk

Do you get stressed, anxious or have low mood? Visit www.nowweretalking.nhs.uk

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