Commentary from Healthwatch Coventry

Healthwatch Coventry represents the interests of patients and public in local NHS and social care services. When looking at a Quality Account we are asked to consider if it:

1. reflects peoples' real experiences as told to Healthwatch
2. shows a clear learning culture in the Trust that allows people's real experiences to help the provider get better
3. has priorities for improvement that are challenging enough and is clear how improvement will be measured

This year the Trust highlights the continued impact of the COVID-19 pandemic and the role it has played in COVID-19 vaccination.

We were in touch with the trust regarding problem solving for individuals who experienced difficulties in getting their COVID-19 vaccination. This included people who were housebound. The Trust co-ordinated vaccination activity and did problem solving. Issues about the responsiveness of the contact route for people how needed help to get vaccinated were reported to us by local people. We raised this through a number of routes and this was addressed, although not as quickly as we would have liked.

Quality objectives for 21-22

The Trust had set a number of quality improvement goals for its different specialties for the last year.

For mental health services outcomes are reported for improving the recording of physical health checks for mental health patients and involving experts by experience in recruitment processes. Peer recovery workers have been recruited and the Trust shows reflection on lessons learnt from this process.

Further actions have been identified regarding putting in place patient safety plans showing that the Trust has reviewed what it has done.

For community health services the trust was working on training health care assistants to administer injections.

Work on another priory has been ended but the document does not explain why.

The actions to implement safety huddle/handover within tissue viability service state that communication processes have been improved. It would have been helpful if the document said how this had been evaluated to reach this conclusion.

Learning disability services have undertaken 23 different projects. Some of the information given is quite technical and some of the outcomes seem to be more outputs than changes/results. Lessons learnt are described.

Priorities for 2022-23

These are grouped around safety, effectiveness and patient experience.

There are less priorities this year and they are more succinct and easy to understand. However, how they will be measured is not stated. It is positive that the effectiveness and experience priorities are people focussed. This includes gathering and using feedback from patients, which we support.

It would be helpful to have more information about how the trust plans to use iWantGreatCare data.

Measuring outcomes achieved for the physical health of patients would also be a useful approach. The action seems to be focused on recording rather than health outcomes.

Patient experience of care

The iWantGreatCare approach to collecting real time feedback from service users is welcomed as an addition to methods to gather feedback from services users and family carers. Building such mechanism into a way of working is important to make sure that actions are identified and there is accountability for them.

The focus on work to develop a triangle of care approach to involving family/unpaid carers is welcome. Sharing what this means in practice would be interesting.

It is helpful that the Trust lists actions arising from patient complaints and gives examples of the help the Patient Advice and Liaison Service has given. This provides evidence of learning from what people complaints and feedback.

The Trust describes findings from the national community mental health service survey. It lists areas for improvement focus: informing the patient about who is in charge of their care; joint decision making of patient and

provider; organisation of care and services needed; discussion of side effects of medicines with patient; and checking how patients are getting on with their medicines.

However, the document does not spell out how patient experience influences quality goals.

Other quality information

The Trust lists actions in follow up to clinical audits it has taken part in, showing learning.

The Care Quality Commission (CQC) carried out a focussed inspection of the Amber Unit at Brooklands Hospital in June 2021. CQC identified six areas for improvement, which the Trust reports are now all addressed.

Readmission rates are variable and exceed the target in some months, but this is not commented on.

The trust has identified from reviews of patient deaths that two deaths were likely to be as a result of care.

Information on waiting times was not available in the version of the document we saw.

We look forward to continuing to work with the trust in the coming year.