Joint Healthwatch Response

This is a joint response from Healthwatch Worcestershire, Healthwatch Herefordshire, Healthwatch Warwickshire and Healthwatch Coventry to the Quality Account of the West Midlands Ambulance University NHS Foundation Trust (WMAS) for the year 2025/26.

This collaborative response reflects the evolving commissioning landscape, with these Healthwatch organisations covering the geographic footprint of both the Herefordshire and Worcestershire Integrated Care Board (ICB) and the Coventry and Warwickshire ICB.

Healthwatch Worcestershire (HWW), alongside our partner Healthwatch organisations, has a statutory role as the champion for people who use publicly funded health and care services. We welcome the opportunity to comment on the WMAS Quality Account for 2025/26.

We recognise that this has been another challenging year for NHS providers and acknowledge the continued effort and commitment of staff across the Trust. We note that WMAS is not commissioned to deliver Non-Emergency Patient Transport in Worcestershire.

Our response has been informed by Healthwatch England's national guidance.

We would make the following comments:

Section 1: Feedback from Healthwatch Worcestershire on progress against 2024/25 improvement priorities

Focus: Do the priorities of WMAS reflect the priorities of the local population?

- **Hospital Handover Delays Reduction**

  Hospital handover delays remain one of the most significant issues affecting patient care and operational performance. We agree that this should continue to be a priority and note the stated ambition to achieve average handovers of 15 minutes or less, with no handover exceeding 45 minutes.

Although this metric has not been achieved the Quality Account would be strengthened by setting out more clearly what practical steps will be taken to achieve this improvement. It would also be helpful to explain what additional changes are required across the system for WMAS to remain on the right trajectory to meet national performance targets. We can see a mid-table performance for H&W ICB, we are unable to see the performance by hospital. In particular, we would welcome more localised reporting, including breakdowns by hospital and Integrated Care Board area, so that people in Worcestershire can better understand performance in their area.

- **(b) Clinical Practice and Supervision Review**

  We support the proposed review of clinical supervision. This is an important area, with the potential to improve both staff support and the quality of patient care.

  Our main concern is that the measures currently described appear to focus more on actions being taken than on how success will be judged. A review and a dashboard is not a patient outcome. We would therefore encourage WMAS to set out more clearly how the impact of this priority will be measured, including how improvements in supervision will translate into better patient outcomes, safer care, and stronger clinical practice.

- **(c) Patient Experience to include Equality, Diversity and Inclusivity for communities**

  With regard to patient experience, equality, diversity, and inclusion, we welcome the intention to improve how people experience WMAS services.

We have looked back at WMAS QA for last year's EDI objectives:

Rationale

Following the introduction of improved complaints standards from NHSE, there is a requirement to implement and operate these improvements. Whilst completing this work there is also an opportunity to review EDI access to services and identify any further gaps identified by service users

Measured by

- Complaints standard – reflecting a proposed new way of progressing concerns quickly, which once resolved may prevent some from becoming formal complaints for full investigation
- There may be an opportunity to incorporate equality and diversity monitoring as part of the new method of responding to complaints.
- Services which are not being accessed by certain community groups
- Planning, promoting and monitoring clinical services with equality, diversity and inclusion in mind

In this year's QA WMAS have been unable to compare data from previous years to the new complaint standards and have scored this metric as green: 'actions on schedule and expected outcomes being achieved'. This report does not indicate whether on reviewing EDI access to services any gaps have been identified or not. HWW would welcome some commentary on progress on EDI since last year as this was a priority for WMAS last year.

- **(d) Use of Alternative Pathways for Patients**

There are many examples of a range of referral pathways, call before you convey with associated use of single points access which together redirect patients to more appropriate services, with better outcomes for patients. These approaches can help ensure that patients receive the right care in the right place. Scored green, achieved.

Section 2: Feedback from Healthwatch Herefordshire

Healthwatch Herefordshire continues to hear generally positive feedback from patients and families regarding the professionalism, compassion and responsiveness of West Midlands Ambulance Service staff.

However, feedback also suggests there are opportunities to strengthen how WMAS works as a wider system partner, particularly in supporting older frail people and those at end of life to avoid unnecessary conveyance and admission where this is not aligned with advanced wishes or best outcomes. We hear concerns that out of hours decision-making can at times become overly risk averse, resulting in avoidable tests, urgent care attendances and hospital stays.

There is also an opportunity to improve local urgent care NHS111 decision-making pathways and confidence in alternatives to A&E where clinically appropriate. Findings within Healthwatch

Herefordshire's 2026 Urgent Care Report highlighted that current approaches can feel overly risk focused, with limited utilisation of community alternatives (community pharmacy and primary care enhanced access) and personalised care planning.

We would welcome continued partnership working across the system to strengthen person-centred, proportionate responses that better balance safety, patient wishes and avoidance of unnecessary hospital attendance.

Christine Price, CEO Healthwatch Herefordshire

Section 3: Feedback from Healthwatch Coventry

Performance against indicators: Healthwatch recognises the significant pressure facing West Midlands Ambulance Service during 2025/26 and acknowledges the hard work of staff responding to very high demand. We welcome the continued focus on the most seriously ill patients and note that response times for life-threatening emergencies remain better than the national average.

We are encouraged to see **recent improvements in response times**, particularly for Category 2 calls, and welcome the positive impact of the **Call Before You Convey** approach at some hospitals. This shows that joint working across the system can make a difference.

However, we remain **concerned about long waits for other patients**, especially those classed as Category 3 and 4. These delays can last several hours and may cause distress, discomfort, and worsening health for people waiting for help.

While we understand that hospital pressures are a major cause, the impact on patients and families is significant. Healthwatch believes continued system-wide action is needed to reduce delays, improve patient flow, and ensure clear communication with the public.

We will continue to listen to people's experiences and work with services to help improve ambulance response and patient care across the region.

Learning from deaths: Although the figure of 0.8% may appear small, from a patient, family and Healthwatch perspective any death linked to problems in care is one too many. Behind every percentage is a real person and a family who may be experiencing loss, grief and

unanswered questions. People consistently tell Healthwatch that they want services to be open, honest, and willing to learn when things go wrong. It is therefore essential that every death linked to care concerns is carefully reviewed, that learning is shared transparently, and that clear actions are taken to prevent similar harm from happening again. The aim must always be to reduce the risk of avoidable harm to zero wherever possible, by listening to patients and families and ensuring that learning leads to meaningful and lasting improvements in care.

Leigh-Anne Howat

Service Delivery Manager Healthwatch Coventry

Section 4: Feedback from Healthwatch Warwickshire

Looking back over our records we have not received a large amount of feedback on WMAS. This is probably not surprising, and within that the feedback was evenly spread between positive and negative feedback.

Almost all of the feedback relates to patient experience, - mostly relating to waiting and response times. This particularly applied in rural areas such as in outlying areas of Rugby, in the south of the County and in rural North Warwickshire. What I think is needed is a greater acknowledgement and understanding of the effect that those delays have on the anxiety levels experienced by patients and on their feelings of reduced psychological safety. This increased understanding could perhaps be reflected in the protocols and communications that are in use.

This also has an impact on the family and friends of the patient awaiting the ambulance – perhaps to an even greater extent

We have also heard concerns about eligibility for, and availability of NEPT, but that has already been reflected in the QA.

Chris Bain FRSA

Chief Executive & Company Secretary Healthwatch Warwickshire

Section 5: Are there any important issues missed?

Overall because the way WMAS QA is written as an amalgamation of all the West Midlands ICB performances it is not possible to see the WMAS performance for our local area. At best we see ICB

performances as a number however commentary on underlying reasons and plans for improvements are not given.

Healthwatch Worcestershire would like to see not only overall scoring but evidence of the spread of performance with outliers being identified with appropriate commentary.

Section 6: Has the provider demonstrated that they have involved patients and the public in the production of the Quality Account?

There should be clearer evidence of how patients and the public have been involved in producing this Quality Account, beyond routine feedback such as complaints and compliments. A dedicated contribution from the *patient experience team* would strengthen this considerably.

Section 7: Is the Quality Account clearly presented for patients and the public?

We would also encourage WMAS to make the document more accessible for patients and the public by reducing the use of acronyms or by explaining their meaning. A summary version of these quality accounts would benefit patients and the public by providing an overview of delivery and performance over last year.

Overall, Healthwatch Worcestershire supports the direction of travel set out in these priorities. We hope these comments are helpful and we look forward to continued engagement with WMAS as this work develops.

Yours sincerely,

Chris Byrne

Director Healthwatch Worcestershire