**healthwatch**
Coventry

# Healthwatch Coventry commentary

Healthwatch Coventry represents the interests of patients and public in local NHS and social care services. This is our 'commentary' on the evidence WMAS has produced about how it addresses quality of service.

We found this document mostly clear and easier to read than many quality accounts. The version we received to produce this commentary did not contain some of the data.

**Performance evidence**
The Trust has a CQC rating of outstanding, however patient transport services were identified as requiring some improvement and this corresponds with feedback we receive.

Unfortunately, the current nationally set format for reporting emergency ambulance response times is not easily understandable to the public. It would be helpful if WMAS included information to help people understand these figures. WMAS highlights it achieves better response time results than other ambulance trusts. It also highlights that a paramedic is present on 95% of its crews.

A number of 'care bundles' for conditions such as Cardiac Arrest are described and it would be useful for information about implementation levels to be given.

WMAS achieved 4 of the 6 targets (CQUINS) set for improvement by its commissioner. It did not achieve improved responses to staff wellbeing questions in the staff survey or reducing the proportion of people it took to A&E.

**Learning culture**
The document provides evidence of learning from audit in relation to patients discharged at the scene i.e. not taken to hospital.

The Trust shows it has set up mechanisms to review and work to improve areas raised under the staff survey, but does not mention the staff health and wellbeing areas of the survey which formed one of its targets that were not achieved.

The Trust identifies 4 priorities from patient safety incidents, patient experience information and clinical audit. It would have been helpful if the document contained an action plan in relation to these.

**2018-19 priorities**
The Trust reports it met or exceeded the targets for 2018-19 for increasing patient experience feedback. However, these were not particularly ambitious and the level of feedback when compared with the number of people helped by the Trust is small.

As the Patient Transport Survey took place in February 2019 findings are not yet available. The Trust should change the timing of the survey so that it can be reported in the quality account. This would give a greater prominence to patients within the document.

The Trust reports it achieved its priority for educating clinicians in the use of a form to record the treatment and end of life wishes of patients. Some evidence from audit of its implementation rates and feedback from patient/families would add weight to this section.

The actions undertaking to help promote every contact counts i.e. promoting healthy lifestyles were the development of a handbook and a fridge magnet. It is unclear what impact this had.

The Trust reports it is 'on track' with its patient safety priorities. It has achieved its aim of Stroke Care Bundle compliance above 97%.

The Trust concludes its learning from deaths process from mortality reviews is on track. It has made its Patient Safety Officer post an ongoing role and this is a positive step. However, there is a question of whether there is sufficient resource to address the issue of 47% of serious incident reviews not completed within timeframe.

The Trust is reporting more patient safety incidents (this could be due to greater awareness) and an increase in those shown to have led to harm. The Trust identifies 5 areas for improvement from the learning from serious incidents. They also identify 5 patient safety risk factors.

**Priorities for 2019-20**
The patient experience priorities are similar to those of the previous year and aim to address the low level of feedback the Trust collects from patients and families about its services. This is an important aim.

More explanation would have been helpful in all of the priorities to describe how these priorities are to be achieved and how outcomes will be measured. For example what is the Trust aiming for in relation to amount of patient feedback?

The Trust should explore what other methodologies it could use to gather feedback. Feedback gathered by Friends and Family Test survey is only useful if a trust understands why patients give a particular rating. They should bear in mind that people may not want to raise concerns directly with a member of the WMAS team and how to gather feedback once a WMAS episode of care is complete.

Investigation of serious incidents is rightly included as a priority but is not clear what level of improvement the Trust is seeking in 2019-20.

Similarly, a baseline and target for reducing incidence of harm would be helpful.

**Involvement of patients**
One of the things Healthwatch is asked to consider is how Trust demonstrates their quality goals are linked to feedback from patients/public. It is not possible for us to see a direct link between patient feedback and the quality account priorities, although learning from incidents and complaints is linked. The Trust remains on a journey to developing how it gathers feedback and involves patients and families. Healthwatch Coventry would like to see more involvement of patients via different methods eg a patient partner scheme for patient transport.

The document details topics of complaints and 3 learning areas with actions including delay in patient transport services, which is something which gets flagged to Healthwatch Coventry by patients.

There were just 22 responses to the patient transport real time survey for those using our local hospital in Coventry. The document helpfully lists actions or reasons why action could not be taken, in response.

The Trust has included a positive section about how it has listened to feed back in production of this document. However, we feel that we have repeated some previous feedback regarding how priorities are measured and evidenced.