



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Patient Experience Team
Tîm Profiad Y Claf

IMPROVING PEOPLE EXPERIENCE REPORT

December 2024 – January 2025



Introduction



Service user feedback is important to monitor the experience of those who access our services and the quality of care that they receive. This allows us to identify areas for improvement, to share good practice and learn from positive experiences.



It is our priority to act on all feedback received as part of our culture of improvement and to demonstrate that we are fulfilling our pledges as set out in the Charter. The Listening and Learning Sub-Committee will oversee the communication and implementation plan for the Charter. The Committee receives feedback from across concerns, compliments and experience.



The following information demonstrates how we are capturing service user feedback by encouraging our service users and providing different ways in which this can be provided. Most importantly, service users should feel that there has been a valuable purpose to them providing their feedback.

A Charter for People and Community Experience - your healthcare, your expectations, our pledge

WE WILL ALWAYS:

Treat you with dignity, respect and kindness.

Communicate with you in a way which meets your individual, language and communication needs.

Keep you informed and involved in decisions about your health and care services, and take into account your wishes and needs.

Provide safe and effective care, in the most appropriate and clean environment.

Ensure that your information is kept secure and confidential.

Support and encourage you to share your experiences of health care, both good and bad, to help us improve the way we do things.

Service User Feedback at a Glance December 2024 - January 2024

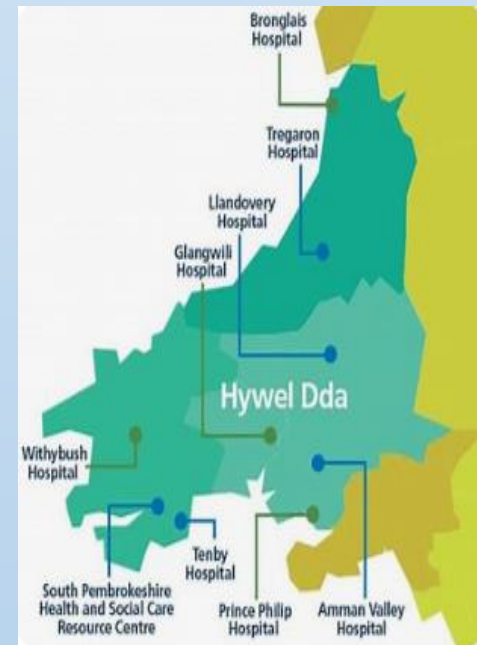
We continue to receive many positive stories and comments about the services provided by our caring and compassionate staff. We are continually sharing and celebrating these achievements across the organisation. We will share information relating to the figures later in the report.

1366 service users completed the Your NHS Wales Experience survey of which 11.3% responded with poor or very poor rating for their overall experience. 93% of the responses were from A&E areas and the negative feedback mainly related to long waits and corridor care.

201 compliments were received direct to wards, departments or Corporate Office. These frequently highlight the professionalism and compassionate care provided by healthcare teams. Example: "Your dedication to all patients that come through the Ward shows how exemplary you all are!"

Complaints: 442 new complaints were received into the health board. 424 complaints were closed, 177 were closed within 5 working days, 260 managed through the Putting Things Right formal process representing an 40%/60% split.

37633 individuals received our friends and family patient experience survey, in which 6355 responded following their attendance, representing a 18.8% response rate, 94.2% reported a positive experience. Community & Primary Care and Mental Health Outpatient saw significant improvements (30+%) from the last period. Maternity Inpatient improved by 12%. The only area to see a slight drop is Paediatric Outpatient, this relates to 1 negative response



We also received 374 new enquiries. The main enquiries are related to Primary care, Ophthalmology, A&E and Health records. These were relating to delays in transport, waiting times and communication

Friends and Family Test

This feedback is provided by patients following a visit to one of our outpatient clinics, telephone/video call appointment or hospital admission.

Positive feedback received highlights the professionalism, kindness, and efficiency of the staff and negative feedback points to long waiting times, and lack of communication, delays in treatment or poor communication from staff.

Accident and Emergency (A&E): Patients praised the professionalism and efficiency of the staff, especially in handling emergencies. Negative feedback includes long waiting times and lack of communication.

Endoscopy High ratings for staff friendliness, thorough explanations, and overall patient care. Some patients mentioned discomfort during procedures, but overall feedback is positive.

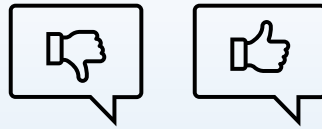
Day Surgery: Patients appreciated the kindness and professionalism of the staff, as well as the clear communication about procedures. Some patients reported issues with post-operative care and waiting times for discharge.

Gastroenterology: Professionalism, care provided by the staff, with many patients feeling well-informed. Some patients mentioned long waiting times for appointments and procedures.

Urology: Patients praised the compassionate care and detailed explanations provided by the staff. There were reports of delays in treatment and communication issues.

Gynaecology: Many patients felt comfortable and well-cared for. However, some mentioned long waiting times and issues with post-operative care.

Trauma and Orthopaedics: Patients appreciated the provided by the staff, especially in handling complex cases., however some reported long waiting times for surgery and issues with post-operative care.



Prince Philip Hospital - Minor Injuries Unit: Numerous positive comments about the efficiency and professionalism of the staff. Patients appreciated the quick service and thorough care provided.

Cardigan Integrated Care Centre - Minor Injuries Unit: Patients frequently mentioned the friendly and helpful staff, as well as the short waiting times. The care provided was described as excellent and thorough.

Withybush General Hospital - Accident and Emergency Department: Long waiting times and inadequate pre-medical care in the waiting area were mentioned and feeling neglected, uncomfortable during long waits. The medical staff received high praise for their professionalism, kindness, and thoroughness in treating patients.

Bronglais General Hospital - Accident and Emergency Department: Patients appreciated the care and attention they received from the staff. While there were positive comments about the staff, there were also mentions of long waiting times and inadequate facilities, care being delivered in corridors. Some patients felt that their needs were not met promptly.

Glangwili General Hospital - Accident and Emergency Department: Feedback highlighted issues with long waiting times, overcrowded facilities, and poor communication. Some patients felt that their concerns were not adequately addressed, and there were mentions of a lack of privacy during consultations.

People's Experience Framework

- From 1 April 2025 the Health Board will need to respond to the requirements of the new People's Experience Framework, including new Experience Questions and an Organisation Self Assessment Toolkit (what does 'good' experience look like).
- The Framework asks that all NHS Wales Bodies complete a local self-assessment rating score for each element of the framework as a basis for local quality and improvements.
- National assurance will be overseen by NHS Wales Executive to support the creation of the best quality health and care system for Wales so that everyone has access to safe, effective and efficient care in the right place and at the right time.
- The new "Experience" measure forms part of a new National People Experience Survey (PES) which will allow the benchmarking of all NHS organisations across Wales. In addition to the PES there is about to be launched a National Maternity and Neonate Survey and a National Looked After Children Survey.
- To further support the implementation of the framework the Health Board, in conjunction with Public Health Wales, is undertaking a Primary Care pilot of the PES in the Carmarthenshire managed practices. Public Health Wales will undertake an evaluation of the pilot in July 2025 to inform the all Wales roll out in primary care.

Update to People Experience Measures

The Friends and Family Test (FFT) was introduced into NHS England in April 2013 and became mandated in 2015. It was designed as a feedback tool to allow patients to provide their opinions on the care they received, helping to improve services based on their experiences.

In 2017 Hywel Dda University Health Board was the first Health Board in Wales to introduce the FFT Patient Experience Satisfaction measure. Initially launched in the A&E departments, the measure was extended into the inpatient areas in 2019 before rolling out to most outpatient and therapy areas in 2021.

The Health Board has consistently performed over the 90% target, including through the Covid 19 pandemic.

The original question asked, “How likely are you to recommend our services to your friends and family”. The score was then calculated by counting the positive responses of “very likely” and “likely” equally (numerator) then dividing by the (denominator) of all the “likely” and “unlikely” responses to provide a percentage score. The question later changed to “Overall, how was your experience of our service?” with the same calculation method.

The imminent launch by Welsh Government of the new “Peoples Experience Framework” mandates replacing the FFT question with a new question and different weighted scoring mechanism. This translates to it being a new measure that cannot be compared to the previous FFT score.



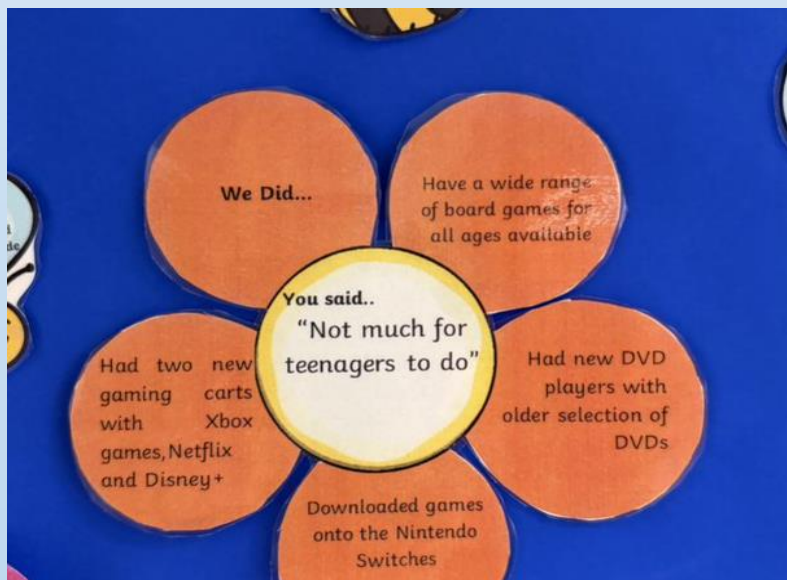


Responses to the All Wales Children Survey and FFT for Children

As mentioned in the previous report, the surveys are currently being reviewed with a view to substantially shortening them; however, as these are set at an all Wales level, they are outside the direct control of the Health Board.

The feedback that is provided to the service is shared on 'you said - we did' boards so that families know the staff are listening and learning from their experiences.

Examples of the improvements that staff have implemented following feedback from children their families and carers.





Primary Care

During this period 9 Managed Primary Care Practices have received feedback via the all Wales “Your NHS Wales Experience Survey”. It is noted that some patients provide a response to the available answers, but do not provide the reasons for their response as to why their experience was good or not so good. It was noted in the previous report that responses reflect the passive nature of the feedback capture method, in that there will be a prevalence of negative feedback when patients are not presented with an easily accessible method.

A pilot to conduct the Civica Friends and Family Test survey for our Managed Practices and out of hours will be reviewed to improve the amount of feedback we receive from this service. The team will update this progress in future reports and provide a better understanding of this feedback.

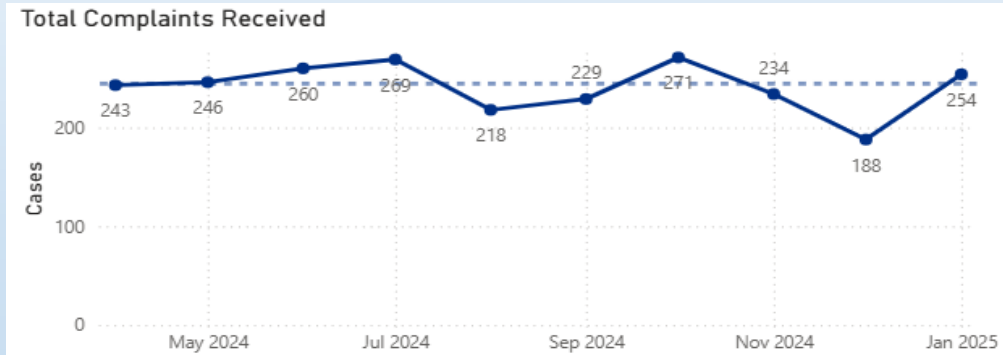


Compliments

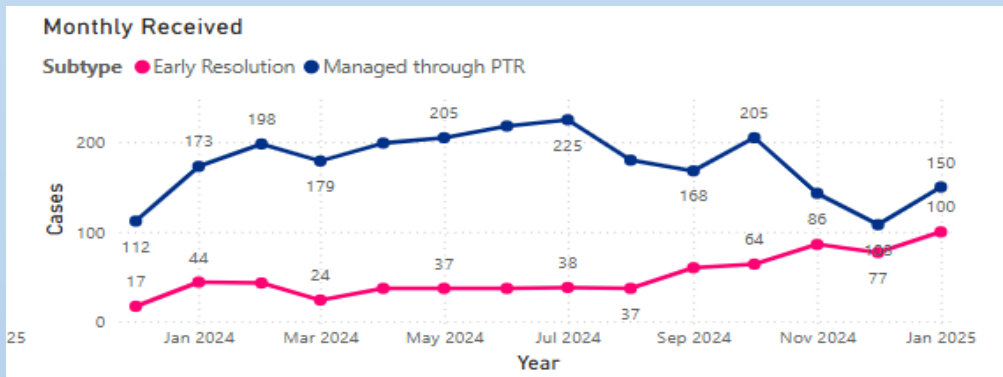
The Patient Experience team continue to visit services to provide teams with certificates of appreciation. Teams provide feedback on how great it feels to receive this recognition and look forward to seeing this every week via the “Feel Good Friday” posts on Viva Engage. Teams are continuing to receive training on the CIVICA system to enable them to review feedback and share the positive feedback received with their teams.

New Complaints and Concerns: December 2024 – January 2025

442 complaints were received in the period, a reduction of 12% on the preceding two-month period. As depicted by the graph below, 258 of the complaints were handled through the formal Putting Things Right process.



177 of the complaints in the period were closed by means of early resolutions. This is the highest number of complaints achieving early resolution since the April 2021 and close to 200% increase on the same period last year. It confirms the general trend of a decrease in formal complaints and results from quicker interventions at the point complaints are received.



General themes and trends

Of the 442 complaints received this period, the top four themes are:



In this respect the main themes are entirely consistent with those seen through the course of the year so far:

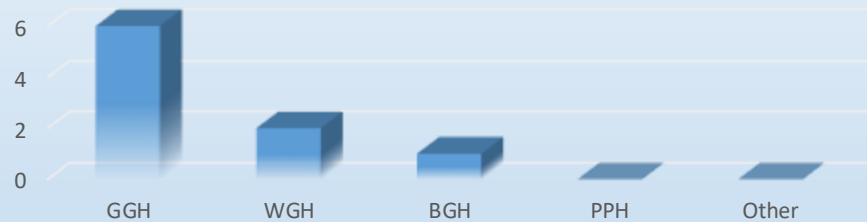
Clinical treatment: Concerns of this nature most frequently arise in our A&E, Ophthalmology, T&O and Gynaecology Services.

Appointments: Nearly a third of all complaints about appointments are linked to Ophthalmology (31%). Urology, Dermatology and Rheumatology also receive higher numbers compared to other services.

Communication, attitude and behaviour: These issues tend to be spread across all services. A&E departments have received the most communication complaints this year, this represents less than 7% of the total.

Outcomes from Concerns: December 2024 – January 2025

CASES IN PERIOD ESCALATED TO REDRESS

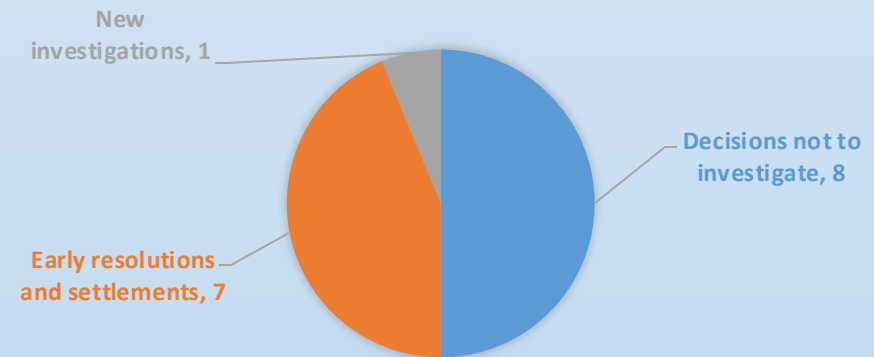


Nine complaints closed in the period were escalated to Redress because failings have caused, or may have caused, harm to patients. These have occurred at our general hospital sites (above). Where failings are confirmed to have caused harm, Learning from Events reports are produced with actions identified. In all cases where there are missed opportunities, services are encouraged to generate learning that can be implemented within their teams.

Issues identified were linked to surgery, which included surgical procedure itself (hysterectomy and knee surgeries), as well as failing to inform of risks and failing to communicate patient's allergies prior to surgery. Administrative errors were also identified in the referral processes. Investigations also identified an avoidable fall, missed findings in X-ray reporting, and the incorrect use of medications in management of meningitis.

Learning from the Ombudsman

The Ombudsman has started one new investigation in the period and will be looking at whether there were delays in a patient's cancer treatment and whether a DNACPR was completed in line with the patient's wishes. Aspects of nursing care will also be considered.



Three investigation reports were received, two of which were upheld.

The first of these reports found that the Health Board had failed to liaise with the Women's Fertility Institute to ensure that the patient received the appropriate fertility care. It had also failed to explain the potential impact of hydrosalpinx to the patient in a timely way.

The second report is discussed in the maternity theme data below.

Maternity Service

Two alongside midwifery led units (Glangwili & Bronglais)

One freestanding midwifery led unit
(Withybush)

Two obstetric led units (Glangwili & Bronglais)

Four antenatal clinics (Glangwili, Withybush, Bronglais and
Prince Phillip)

Homebirth service (across three counties)

In 2024

Hywel Dda UHB welcomed

2848 babies

Average of 8 babies born
per day

PEOPLES EXPERIENCE FEEDBACK

The maternity service uses various indicators to ensure the continued delivery of a safe, effective and high- quality service including maternity service metrics which enable monitoring of clinical outcomes.

We recognise as a service that quality reaches beyond measuring clinical outcomes. The experience of service users has long been considered a core component of quality in the NHS. As the primary mechanism by which providers of maternity services can monitor that experience, feedback has a key role to play in helping organisations to track the quality of their services, identify problem areas and shape service improvements.

There is good evidence to show a positive association between the experience of the service user and improved health outcomes and patient safety.

As the primary mechanism through which patient experience can be measured, feedback offers health care providers a means of understanding how to improve that experience and, through this, how to improve services. It is therefore key to any coherent strategy for quality improvement.

For feedback to be used to its full effect, providers of maternity services must be pro-active not only in collecting feedback but also in interpreting the information gathered and using it to inform action. Hywel Dda maternity service utilises a range of mechanisms including feedback from Civica, comment cards, QR code feedback, concerns, Duty of Candour pathway, Birth Afterthoughts Clinic, social media platforms and surveys.

A conscious effort has been adopted to reach marginalised women and service users to ensure a breadth and depth of service user feedback to ensure representation from across our diverse patient population.

Summary of 2024 Feedback

- **Civica: 222 responses**
- 197 good or very good (89%)
- **QR Code 151 responses**
- **Facebook 96 "Thank you posts and Birth Stories"**
- **"Thank you cards" 420**

Total of 864 positive feedback from various sources

- **Thematic review of positive feedback**
 - Kind, caring, compassionate staff, use of Welsh language
 - Time to care
 - Individualised care planning
 - Staff were professional and helpful
 - Consistent theme of compassionate care shared by bereaved parents

Towards the end of pregnancy became extremely anxious, I felt overwhelmed and was admitted to the triage unit several times. On each admission I was always made to feel a priority, that everyone had time for me to listen to my worries and give me reassurance that everything was ok.

I developed complications which mean my baby needed to be delivered sooner and he was born by emergency c-section but in honestly that didn't matter. The midwives and doctors supported me throughout the whole experience. It wasn't the birth I had dreamed of, but it was honestly such a magical experience. The team talked me through each step and helped manage my fears, I will never be able to say thank you enough – they listened and cared for me throughout. I am forever grateful



The knowledge that feedback from users is listened to and acted on helps to encourage a sense of responsibility and pride among staff in the services they deliver. It also helps provide assurances to the service user that the service remains committed to growth and change

There is also evidence linking the systematic collection of service-user feedback with service improvement

- Regular sharing of positive feedback across service
- Named staff receive feedback directly to support appraisal and revalidation
- Feedback embedded across perinatal learning forums
- Feedback shared during "Maternity Monthly" (Health Board wide newsletter)



Individualised care planning and supporting women to birth outside of guidelines

Choice in childbirth is not a new concept. Whilst the service believes that the safest way for birthing women and birth people to labour and give birth is to follow the Health Board's agreed guidance. We also acknowledge the importance of close multi-professional working between clinicians to ensure good outcomes for parents and babies. This is particularly important within maternity services when it involves complex decision making surrounding the planning of care with birthing women and birthing people who wish to understand their birth options in greater detail, explore the risks and benefits of these choices and make decisions about their care even if outside of Health Board's guidance.

Ultimately the service respects women's rights to make all decisions around their birth. Through the support of the Consultant Midwife and the wider multi-disciplinary team, women are supported to make choices that are right for them

I cannot thank you enough for your help during my labour. I knew I needed some help and I knew you would something when things weren't going right – you did and now we have a gorgeous baby

New parent 2024

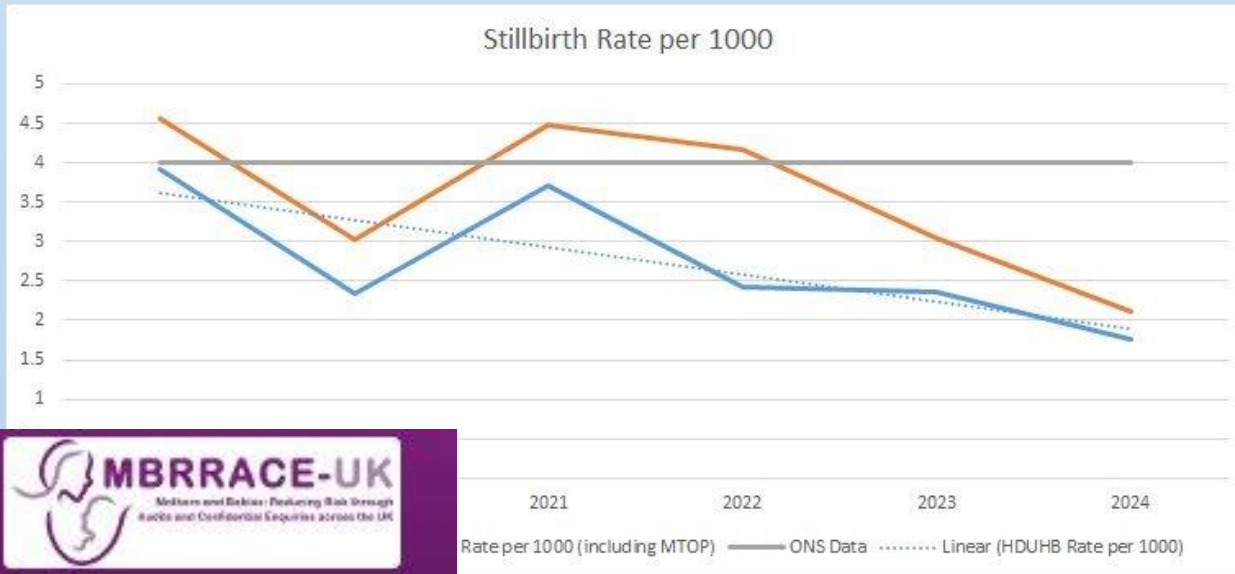
This was such a healing experience for me. I cannot thank the team enough for believing in me and making my dream experience a reality

New parent 2024

Baby Loss

Baby loss is a general term used around the world to describe various experiences which can include late miscarriage, stillbirth and neonatal death. When a baby dies before, during or after birth, the hospital where the mother and baby were looked after should review the care the mother and baby received. The hospital review forms part of standard NHS care which should be provided for every family after a death so that bereaved parents have as much information as possible about why their baby died. Another important reason hospitals carry out reviews of any baby who is stillborn or dies in their care, is so that hospitals can learn from what happened, to improve care and prevent, if possible, the death of other babies in the future. The review is referred to as a Perinatal Mortality Review Tool (PMRT) and Hywel Dda process aligns with the national scrutiny required to ensure robust and transparent reviews

The purpose of the national PMRT is to support hospital reviews by providing a standardised, structured process so that what happened at every stage of the pregnancy, birth and after, from booking through to bereavement care, and care when the family leaves hospital, is considered by staff reviewing care in a robust way. Importantly, parents will be asked if they have questions or views on their care, they would like the review panel to respond to.



Reassuringly the Health Board has seen a positive reduction in the stillbirth rate and is committed to reducing this further

A robust mechanism for collating service user feedback remain paramount, to ensure that the parent voice is reflected throughout

When a baby dies on the maternity unit all families are informed of the PMRT process and invited to contribute.

A detailed review is undertaken, and parents are invited to share feedback, questions and any concerns throughout

In 2024 100% of eligible families engaged with the process, 100% of families provided feedback, and all families were invited to attend a face-to-face meeting to discuss the review findings (in a small number of meetings, sadly this included sharing contributory care issues with families)

All meetings were facilitated by a multi-disciplinary team who had been involved in the review process and already had a rapport. All families were supported by their named bereavement nurse or midwife.

Regardless of the investigation outcome, there was a key theme highlighted around compassionate, person-centred bereavement care.

"The staff treated my baby with so much respect, they supported our family to stay and there were no restrictions to visiting"

"The room was clean, spacious and staff were so supportive throughout. In my darkest time, I couldn't have asked for more"

One bereaved family have kindly shared the following in their own words:

I think it is important to start with the fact that we were away from home, and just turned up at Glangwili looking for help, and the whole team went above and beyond to provide that. From the moment that we first rung triage, to the moment we left, and beyond – the care that we have received has been incredible.

Upon arrival at triage the midwife acted quickly to get us seen and made us feel a priority, at all times. She was very clear about what was happening, and also what would happen next. We were given time to process the news, before being taken to the bereavement suite. It was helpful to be taken through the back way instead of through the main maternity ward. All midwives introduced themselves, offered condolences, as well as offering reassurance that everything would be ok, at all times. It was reassuring that the midwives were trying to gather as much personal information as possible in order to make sure that I was cared for appropriately. This included contacting our local hospital and midwives to have my notes sent to Glangwili.

There were lots of decisions that had to be made, during a time where you are unable to think clearly. But the midwives were very sensitive, informative and encouraging, without being forceful. They were able to give guidance and support and help us be involved in all decisions that had to be made.

*After giving birth, we were given time as parents to spend with our baby. It was incredible that our baby was treated with the upmost respect at all times, and it helped a lot. **He was our son and he existed** – and at no point were we made to feel any different. Being allowed to do things such as bathing, dressing and cuddling and taking pictures were all invaluable things that we will always remember. Being allowed to have additional family members visit and spend time with us, was extremely precious and we will forever be grateful. At no point were we rushed, and our whole extended family felt cared and supported for. The opportunity to have the chaplain come and speak and bless our baby was very important too. It was a special moment for us as parents to be able to take our son to the mortuary, especially as we would be leaving him for the last time to travel home. I know it's not for everyone, but we knew he was safe and were able to spend our last moments in a lovely room together, just the three of us. Before being discharged we felt reassured about the next steps and were provided with a wealth of support and contact numbers. In addition to this, I was reassured that my GP and community midwife were informed and would be in touch the next day. It was helpful when they were, and I knew that the staff at Glangwili had done everything that they said they would.*

A special mention must be made to Midwife - she is an incredible midwife! I truly believe she made our experience extra special. She was extremely compassionate, informative and encouraging, and at no point did she make us feel fearful for what was to come. The midwife spoke to us sensitively ensuring that everything we were feeling was completely normal.

She encouraged us to think of next steps such as a post-mortem, making a memory box and having pictures taken – things that neither of us had even considered. We were extremely grateful for this, and were able to take our time to discuss what was right for us as a family. She cried with us, laughed with us, and made us feel like the most important people at every possible moment. We will remember her for ever and will for ever be grateful to her or looking after us all.

The midwife did something we never thought possible, she helped us make memories – genuine happy memories that will last a lifetime

Areas for Improvement

Having a baby is a unique and life-changing event. All maternity units face the challenge of having to meet appropriate safety standards at the same time as ensuring that the users of their services have a good experience at such an important time in their lives. As with all maternity units, there are times when we don't get this right and it is imperative that we learn from this

- 222 Civica responses
- 15 were reported as being poor or very poor (equates to 7% of feedback shared via Civica)
- 2024 – 50 formal complaints reported (equates to 1.6% of total service users)
- Duty of Candour (where moderate harm is caused as a result of an unintended or unexpected harm) 10 concerns were directly related where the service had already been in contact as part of the Duty of Candour process.

Feedback

Feedback supports more than qualitative areas of improvement, as a result of investigation findings and meeting with families the service has developed new guidelines, new patient information leaflets, new telephone records, local safety standards for invasive procedures and implementation of different forms of pain relief .

Where possible, these are co-produced with service users and they are informed of changes

“Though this is so hard to hear, I cannot thank you enough for your honesty. It doesn't change what happened to me or my baby but knowing that you've actually done something to change this for families in the future means the world. I thought we would come here today, and you would just be arguing with us and sweep it under the carpet like you read about. I wasn't expecting this level of honesty, and really, I think it's helped us to get some closure. It's so helpful to understand more about the changes and I'm so glad that you've shared this”

Parent feedback through a duty of candour meeting

For feedback to be used to its full effect, providers of maternity services must be pro-active not only in collecting feedback but also in interpreting the information gathered and using it to inform action

"You said, We did" shared via the Health Board Communications Team on approved social media platform

- Health Board is actively engaging with the national maternity and neonatal PREMS and PROMS Civica Data Capture and is working with the local Patient Experience Team to support implementation
- Data capture around alternative methods of feedback to ensure the patient voice is embedded throughout the service
- Development of a Health Board approved website for the centralisation of information for women and birthing people which will also provide women with information on how feedback can be shared
- Each month a thematic review of feedback is undertaken and a poster shared with service user to demonstrate changes made

Maternity Experience November 2024



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

| You Said... | We Listened... |
|---|---|
| 'When coming out of labour ward my partner wasn't allowed to stay with me very long as visiting times had finished' | We are reviewing the possibility of one birthing partner staying overnight on the postnatal ward to be able to better support their partners after birth. |
| 'Additional breastfeeding support' | A new infant feeding group is starting in January in Carmarthen, with infant feeding support workers, who can help assist with feeding issues. |
| 'I spent most of my day in the hospital and was not once offered any source of water or food.' | There are now a refreshments tables set up on the antenatal/triage ward and postnatal ward in Glangwilli so people can help themselves to water and food. |

We really appreciate you all taking the time to give us feedback. Your views are always read and reviewed by the team, and are used to help make improvements the maternity services for all.

All positive feedback that has people named in it is emailed to the person directly. All feedback is reviewed monthly and discussed. If you would like to feedback, please click on the text message you were sent, or click on the QR code.



Thank you!

Service User Feedback December 2024



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Microsoft forms QR code

6 Submissions of Feedback

5 positive responses thanking staff members for their care and support. 1 response which contained positives and things to work on. This person reported not being informed properly about the effect taking labetalol would have on her baby, and her baby needing the hypophasyway. She also reported finding it difficult to speak to a doctor once on the ward for induction, despite asking to speak to one before the next induction step was made. This feedback has been emailed to AJ and ML for review.

Postnatal QR Code

4 responses

Themes

Long waiting times in clinics.

Others thanking staff for the care they received.

How satisfied are you with the health professionals' care of you?

Very good
Good
Neither good nor poor
Poor
Very poor



Facebook Group

10 birth stories about positive aspects of care

Thank you cards

11 thank you cards to individuals

20 General thank you cards.

Civica

12 responses

Very good 7 responses, 2 good responses, Neither good nor poor 1 response, Poor 1 response, Very Poor 1 response.

The neither good nor poor response was due to the waiting times in clinic. The poor response reported that the receptionist in clinic was rude towards the pregnant people waiting, and they had to wait outside for 20 minutes for a doctor to arrive to start the clinic. The very poor response was due to waiting all day for either IOL or Caesarean to be told to come back the next day instead.

Service User Feedback October 2024



Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Microsoft forms QR code

6 Submissions of Feedback

6 positive responses, though two also included areas to improve on.

Facebook Group

6 birth stories about positive aspects of care

1 positive comment saying seeing other birth story posts has reassured her about giving birth.

Thank you cards

22 thank you cards to individuals

13 General thank you cards to GGH (Have not yet received information for BGH and WGH).

Civica

16 responses

14 very good. 1 Good. 1 Poor

Poor response is from someone who is still receiving hospital letters following her late miscarriage. This has now been rectified and an email apologising sent.

In total, 56 feedback responses for October 2024.

95% Positive Feedback Rate

All 3 negative responses have been noted and actioned.

Themes

| Positive Feedback | Things to improve |
|-------------------|--------------------|
| Communication | Communication |
| Caring | Language |
| Supportive | Equipment on wards |

The service delivers educational / reflective events each month (both on an individual and group setting).

One example is the Maternity and Neonatal Clinical Risk Meeting; previously these meetings focused on the clinical aspects of care, but through the implementation of the Birth Afterthoughts service and the Duty of Candour legislation, the elements of clinical outcome and patient experience helps to demonstrate that user feedback can play a valuable role in monitoring the quality of services and in shaping service improvements.

Consent is always gained from service users to share their experience and the engagement with this has been overwhelmingly positive. Utilising service user feedback can enhance "realism" associated with incident reviews and therefore promote a meaningful culture of change

The service recognises that listening and responding to service users is key to any coherent strategy for quality improvement.

"nothing had been explained and the whole procedure feel invasive. I remember breathing on gas and air, crying while looking at my husband and newborn who sat in the room. Once the doctor had finished the procedure they then just left and said nothing.

I feel however following the birth I should have had a say and options and choices should have been given"

Parent 2024

Promoting Equitable Care - "hard to reach communities or easy to ignore?"

Women from the Global Majority have significantly higher morbidity and mortality rates in the UK as well as poorer experiences of care. For some people, groups and communities in Wales, there are still unfair and avoidable inequalities in their health and health outcomes, and in their access to and experiences of NHS services.

The FiveXmore report, illustrated that although Black and Black mixed women experience overt and covert racism throughout maternal services, their experiences are rarely captured or recorded by the institutions providing their care, due to a low complaint rate and the normalisation of racism as part of their everyday experience.

“This experience has left me with significant psychological trauma. The midwives' treatment of me was inhumane and discriminatory, causing immense stress during and after labour.

The midwives' actions and behaviour were not only unprofessional but also discriminatory, potentially due to my race or religion. She refused to provide the necessary care, ignored my repeated requests for examination and pain relief”

Parent 2024

The maternity service is committed to becoming an anti-racist organisation:

- Individual reflections with staff members
- Embedding of Diverse Cymru and Cultural Competency Training
- Embedding of impact of race and maternity services within mandatory training for all midwives
- Delivery of educational sessions entitled "Cuppa Conversations" to explore impact of systemic racism
- Significant increase in the use of translation services
- Quality improvement project to improve recording of ethnicity data
- Equality, diversity and inclusion meaningfully embedded throughout service
- Representation within simulation (for example darker skin tone models)

Neurodiversity

“The midwife always said are your movements normal and I just said yeah because I wasn't sure what that meant. I'm autistic and literal so if she had said is your baby kicking then I would have known what she meant.

I also need someone for support at all of my appointments and I was told that wasn't always allowed”

Parent 2022

The Maternity Passport is designed to help autistic people to communicate their needs to doctors, nurses and other healthcare professionals.

It was co-produced between service users, the maternity service and the learning disability service

The service has also implemented additional questions to better support the individualisation of care planning by asking all service users the same question about their communication needs at the time of booking

This project was identified as an area of excellence by the NHS executive and has since been embedded across Wales in all maternity handheld records

Maternity Passport

I like to be known as: My preferred language is:

How to communicate with me:

Person with me: My Health needs:

Person who needs to be with me for appointments: Medications I take:

How I show if I am in pain or unwell:

What to do if I'm anxious:

Reasonable adjustments (Please circle the adjustments you would like)

| | | |
|---------------------------------|---|-----------------------------------|
| Longer appointment slots | Partner to stay with me at all times | No medical words |
| Videos or easy to read leaflets | Write all information down in an easy read format | Check that I have understood |
| Talk slowly | Low lighting in appointments | Please find a quiet place to talk |

Other reasonable adjustments

Midwife to sign and date:

Do you consider yourself to have any additional needs such as Autism/Dyspraxia/ Asperger's/ Dyslexia? Yes/ No
Do you need any extra support? Yes/No

LLAIS WEST WALES REGION

BABIES AND BIRTHS IN HYWEL DDA



A follow up report to our December 2022 Maternity Survey



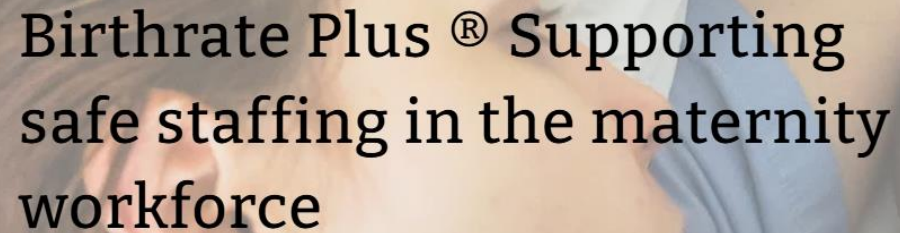
We were pleased to hear that many of the comments were positive. However, when we ask people about their NHS care often, we hear that some parts of their experience were good and others not so good. This is again what we heard in this survey. We often heard about the caring attitude shown by staff, particularly the midwives.

7 actions recommended, a detailed action plan was completed and progress monitored using our audit and monitoring system (AMAT)



A follow up report to our December 2022 Maternity Survey

1. The Health Board must continue to focus on improving the level of postnatal support for new mums. Llais understands that staffing is often very difficult, but many women felt that they needed more help and care after they had their baby. The Health Board should monitor this routinely.




Birthrate Plus[®] Supporting safe staffing in the maternity workforce

Monitored using the acuity tool, previously involved labour ward but will be extended to the postnatal / antenatal ward to support efficiency and timely rotation of staff as required.

Re-allocation of staff depending on acuity.

2.

Llais acknowledges that welcoming partners into hospital wards is a difficult balance for the Health Board to manage, as it appreciates the support that partners bring to individual women alongside protecting privacy and security for all. We would ask that the Health Board takes the opportunity to review its arrangements however, given how isolated or alone some women felt, particularly when staffing levels are limited.



Hywel Dda Health Board
28 Jan · 🌐


Are you expecting your lovely bundle of joy soon? 🤰 🤱

When the time comes, we can now welcome one partner/companion to stay overnight on the Antenatal and Postnatal wards across the Health Board, so that partners can take part in supporting and caring for their partner and baby. 🤰 🤱

We recognise that this helps reduce anxiety and stress among mothers/birthing people and aids with the family bonding. The decision to stay overnight is entirely up to you.

Please be aware, we are unable to offer comfort facilities such as a bed due to limited space however we are able to provide a chair by the bed to rest and you can bring your own blanket/pillow if you wish.

If you would like to stay, an information leaflet is available from your midwife on the ward and details of visiting can be found 📄
<https://hduhb.nhs.wales/healthcare/services-and-teams/maternity-services1/being-pregnant/maternity-visiting-times/>



- Evaluation underway.
- Early feedback suggests improved facilities required, League of Friends supported with procurement of increased numbers of recliner chairs
- Refreshments provided



LLAIS WEST WALES REGION
BABIES AND BIRTHS IN HYWEL DDA



A follow up report to our December 2022 Maternity Survey



3. There was evidence to suggest that breastfeeding support was good for some but looking at the experiences of others there is still more to do to ensure that the necessary breastfeeding expertise is available and staffing numbers allow this support to be given, particularly for babies that are struggling to feed.

INFANT FEEDING SUPPORT WORKERS

Janice Jones

Abi Hearne

Lisa-Marie Morris

Monday-Friday: 07880125501
Infant.Feeding.HDD@wales.nhs.uk

They will be covering all of the maternity wards, SCBU, and Cilgerran for feeding support. In general, Jan will work Mondays, Abi Tuesdays and Wednesdays, and Lisa-Marie Thursdays and Fridays. The plan is to have them available full time (except Bank Holidays and Annual Leave) through the end of March, as part of the Infant Feeding Pilot Project (IFPP). The IFPP is a collaboration between Public Health, Health Visiting, and Maternity Services in an effort to further support our service users in their breastfeeding goals. Our hope is that the project will demonstrate an improvement in our birth to day 10 breastfeeding maintenance rates, as well as our overall breastfeeding rates by six months of age. We are hoping that the IFSWs will be a positive addition to the support already provided by our Midwives and HCSWs.

NEW GROUP

Infant Feeding Support Group

Every Wednesday at St David's Park, Carmarthen.

What3Words: ///today.craft.email

A warm welcome to those who are pregnant, parents, carers, babies and their siblings! Come along for a cuppa and a chat, get some help and support from other parents, as they share experiences of the feeding journey.

9:30 - 11:30

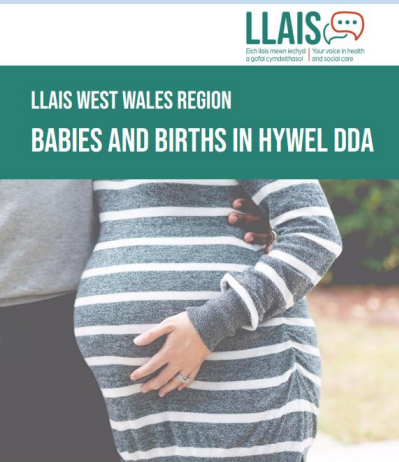
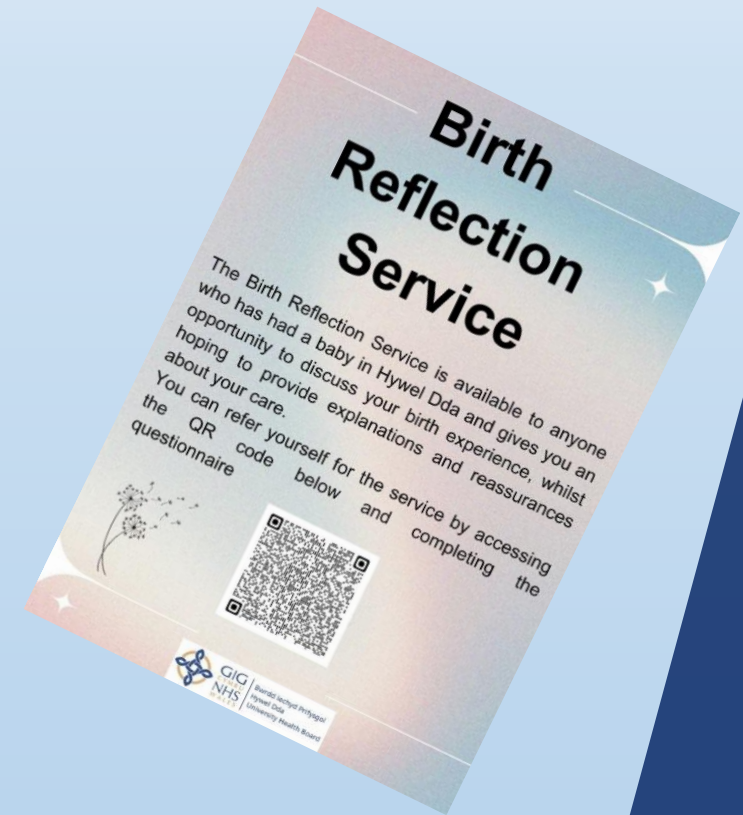
breastfeeding helpline
0300 100 0212

GIG NHS
Bristol South Pillagers
Hemel Hempstead
University Health Board

4.

Some women reported problems receiving a debrief about their birth. This was clearly important for them. Adequate staff need to be available to ensure that opportunities are not missed to do this.

- Additional staff allocated to support the service
- Allocation of dedicated admin support
- SPRING training to recognise signs of Post Traumatic Stress Disorder to better support service user needs
- Improved referral to appointment time (8-10 weeks in 2023, 4 weeks in 2025)
- Duty of Candour pathway



5.

Some women reported that their stay in some hospital areas was difficult because it was so hot. We don't know if the Health Board avoids use of fans (e.g. for infection control reasons), whether there was simply a shortage at that time, or another problem, but if it's possible for women to regulate their temperature to be more comfortable then the Health Board should ensure it can make this happen.

- Fans can promote drafts which can result in babies becoming hypothermic and increase admission rates to SCBU, also increase risk of cross infection (collection of dust and microbes which are then circulated)
- Infrastructure within the postnatal ward has limited scope for development, wider engagement with Estates Department.
- Plan for capital bid to improve estate in GGH postnatal ward

LLAIS 
LLAIS is a Welsh acronym for 'Llywodraeth Iechyd a Gwirddod' (Welsh Health and Well-being)

LLAIS WEST WALES REGION
BABIES AND BIRTHS IN HYWEL DDA



A follow up report to our December 2022 Maternity Survey

6. Communication clearly worked well for some, but Llais knows that poor communication lies at the heart of many poor patient experiences, before during and after an event such as childbirth. Once again, our survey showed that some women experienced poor communication from staff during their journey. This caused preventable stress during labour. Llais acknowledges that it can happen in settings when staff are busy and under pressure, but in a general sense it isn't acceptable. The Health Board needs to ensure that cultures of good practice around communication shown by many staff are universal and a core value of the department.

- Embedding service user feedback at every learning opportunity
- Individual reflection to promote a culture of learning
- Patient experience midwife allocated to attend key strategic meetings to support integration of service user experience
- Key learning around consent and communication within MDT learning forums, safety briefings
- Feedback from concerns, incidents, Duty of Candour, PMRT, surveys, civica, Llais a key component of wider learning to promote change
- Role modelling and compassionate leadership

7. We were interested to hear that NCT classes were difficult to access or not running locally. This made us worried about the level of antenatal and parenting support that women and partners were getting beyond clinical contact with midwives and other NHS staff. If there were alternative opportunities, we couldn't see these on the Health Board's website. Because of this, we're asking the Health Board to tell us what is available for women in the three counties, whether signposting is adequate and whether more needs to be put in place with local partners.

- Health Board has developed a dedicated maternity section on the HB website to provide key information and sign posting as well as wider public health messages
- Previously there was some inequity due to a lack of suitable locations in the community setting (anticipated improvement with "Community Hubs" eg Cross Hands)
- Development of educational video resources, shared digitally
- HB is hosting a "Maternity Fair" in March 2025 in GGH, supported by clinical and specialist staff. If successful to be replicated as a model across the HB
- Dynamic working, utilising HB locations to provide evening sessions which are delivered by community midwives