GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Improving People Experience Annual Report

2025/2026

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 Improving Experience Charter.

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. The report also provides a summary of the issues and themes identified via our complaints, and claims and redress. Most importantly, service users should feel that there has been a valuable purpose to them providing their feedback.

Our pledge to our patients and community – Our Improving Experience Charter

We will always

Treat you with dignity, respect and kindness.

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

Keep you informed and involved in decisions about your health and care services, taking 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.

Patient feedback - overview

2025/2026

The Health Board now participate in 7 NHS Wales National Surveys and through these we continued 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. The following represents the volume of contacts over the course of the financial year.

NHS Wales People's Experience Friends and Family Test Survey

Surveys sent out	270,776
Survey responses	43,246
Response rate	16%
Very good or good response	92%

Complaints received by Patient Support Services

Total of New cases	1978
Managed as early resolution	532
Complaints closed	2520
Responded <30 working days	1315

Further detail on themes/trends in complaints follows later in the report.
The main reasons for enquiries and early resolution cases related to appointments / waiting list queries, attitude and behaviour and communication inefficiencies.

Ombudsman

In this period there has been 13 new investigations started by the Public Services Ombudsman for Wales. In the same year, the Ombudsman also issued 12 final reports following investigation, of which:

- 2 were upheld and issued as Public Interest Reports
- 4 were partly upheld.
- 6 were not upheld.

Compliments received

By wards, departments or Chief Executive / Chair's office.

1549

Staff compassion and emotional and physical support were the main areas of appreciation

Patient support calls (0300 0200 159)

Calls made	7850
Calls via medium of Welsh	175

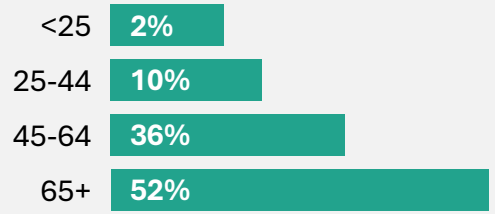
Patient feedback - demographics

Gender

41% 58%

Females provided the most feedback, with a strong lean toward positive sentiment. Responses from non-binary or undisclosed genders were reduced and evenly spread across sentiment types.

Age



As previously reported, older age groups are more likely to respond. However, during this period there is an increase in responses from persons aged 45-64. Respondents age 65+ are providing more positives responses compared to other age groups.

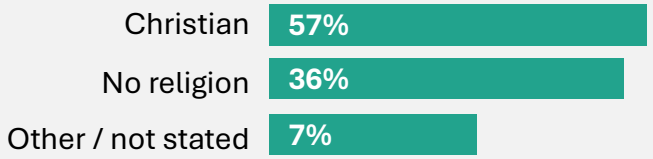
Disability

Nearly half of respondents (48.8%) report some degree of long-term impairment, highlighting the importance of accessible, inclusive services and reasonable adjustments across care settings.

This profile reinforces the importance of:

- reasonable adjustments and accessible environments
- clear communication and staff awareness
- inclusive service design and compassionate care

Religion

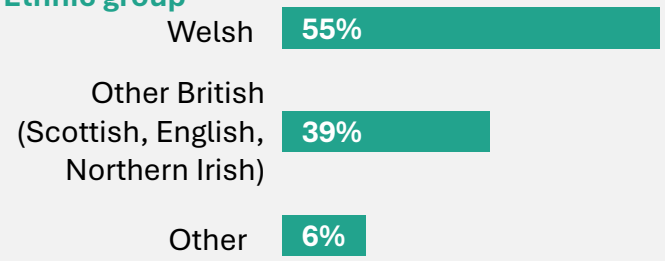


For this period there has been a fairly even split between Christian and non-religious respondents, with a small proportion choosing other or unspecified options.

Patient feedback - demographics

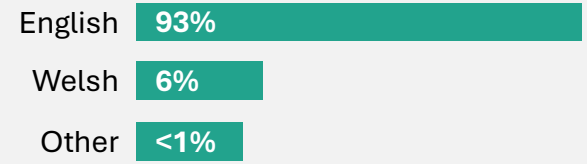
1st April 2025 – 31st March 2026

Ethnic group



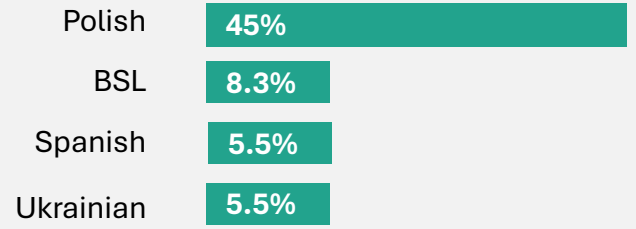
Knowing the ethnicity split of our patients is valuable for informing the development of culturally sensitive healthcare services and communication strategies. Staff are encouraged to take advantage of opportunities to learn the Welsh language, to engage confidently and respectfully with patients whose first language is Welsh.

Preferred Language



Knowing the preferred language of our patients allows us to easily grasp which languages and groups need to be supported in providing the best care possible for our patients. These figures clearly show a noticeably large difference in the use of the English language compared to Welsh and many others.

Other Preferred Languages



These figures demonstrate the <1% of people who prefer to communicate in a different language other than the two predominant languages used in Wales, with polish being the most preferred "other" language, then a steep drop down to BSL which is closely followed by Spanish and Ukrainian.

Minor Injuries Unit & Emergency Department Feedback

1st of April 2025 to 31st March 2026

Concerns continue to be raised around long waiting times and the overall patient experience. Uncomfortable seating, cleanliness issues, and lack of refreshments negatively impacted patient experience during these long waits. It is important to note that the volume of patients attending is very high, with almost 200,000 attendances over the year, the volume of feedback will be higher than other services who do not have the volume of activity.

Bronglais General Hospital

Improvement work is underway within the EUCC (Emergency and Urgent Care Centre) waiting areas. This includes collaboration with the Communications and Arts in Health teams, as well as support from the Nutrition and Hydration team to enhance food provision and introduce an additional hydration station. The team is also investing in more comfortable, height-adjustable chairs to improve patient comfort. Ongoing customer service training is being delivered to staff to further enhance patient interactions.

Prince Phillip General Hospital

The Minor Injury Unity and Same Day Emergency team are working on implementing the new Urgent Care Centre that will commence later this year.

This will see both of these service combine, making the experience for many patients more streamline.

They are focusing on creating new pathways and staffing models to ensure that the centre will work efficiently and improve overall experience for people who use either of these services

Glangwili General Hospital

Major construction work is now completed on the Same Day Emergency Care (SDEC) unit in Glangwili Hospital.

It is expected that the new, improved SDEC will reduce pressures on the Emergency Department at Glangwili and is part of on-going efforts to improve patient experience.

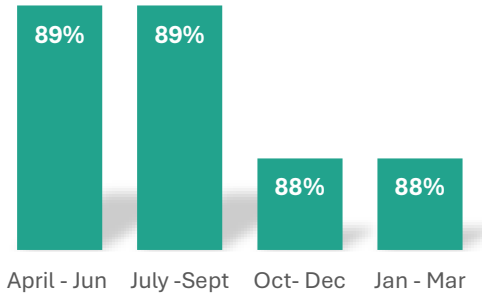
SDEC Treatment Room

Patient feedback by site and service

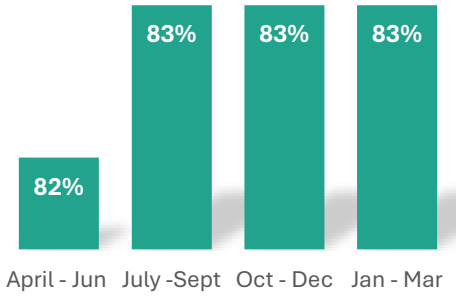
Each graph represents this period's performance for different sites. The differences in the data can be attributed to various factors such as operational changes, seasonal variations, patient feedback, and external influences.

% positive feedback

Prince Philip Hospital (PPH)



Glangwili General Hospital (GGH)

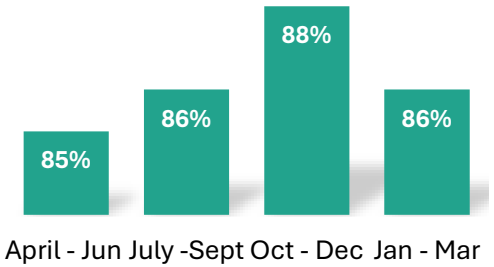


Key points raised: 1st April 2025 to 31st March 2026

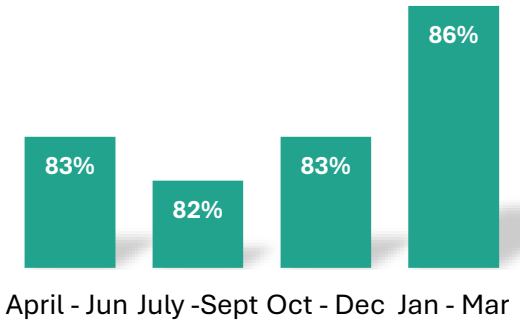
Service	Positive	For Improvement
PPH - Audiology	Consistent positive feedback on professional and competent staff. Staff were also noted as being compassionate, polite, and communicate well with patients.	The majority of negative feedback relates to the wait time for appointments as well as the quality of care and treatment.
PPH – General Medicine	The friendliness, compassion and emotional and physical support of staff were very positive areas for patients.	Concerns with the waiting time for appointments and patient comfort were the main areas of negative feedback.
PPH – Pain Management	Positive staff behaviour, such as helpfulness and friendliness were highly mentioned. So was the emotional and physical support offered by staff.	Waiting time for an appointment is one of the biggest negative aspects. This is followed by pain and discomfort.
GGH – A&E	Staff are consistently said to be professional and competent.	Many patients report long wait times, with others mentioning negative thoughts towards to facilities.
GGH - ENT	Staff are praised for being professional and competent, friendly, helpful and polite.	Feedback touches on negative aspects of patient' experience relating to parking and facilities. The wait for an appointment is overwhelmingly negative.

% positive feedback

Bronglais General Hospital (BGH)



Withybush General Hospital (WGH)

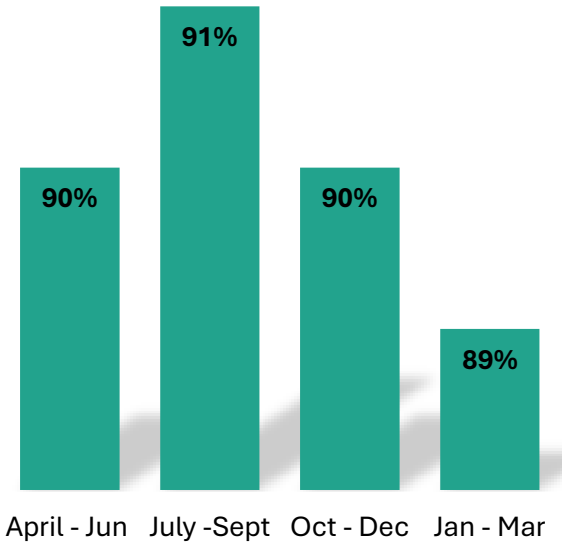


Key points raised: 1st April 2025 to 31st March 2026

Service	Positive	For Improvement
GGH - Rheumatology	Communication with patients is highly rated. So is staff compassion, hygiene, and privacy, dignity and respect.	The wait for an appointment is a negative aspect here, with other patients touching on the facilities and parking as negative issues.
BGH – Diabetes	Staff were said to be helpful and offered emotional and physical support. Their friendliness was commented upon frequently.	Patients found the wait times to be a negative experience. All comments regarding parking was negative. A few comments mention feeling unsafe.
BGH – Cardiology	Patients share that staff are overwhelmingly friendly, yet professional and competent. Staff communication is praised, as well as their helpfulness.	By far, patients share negativity with regards to the waiting times for appointments as well as parking facilities.
BGH – Gynaecology	The data shows that patient noted positive experiences with regards to the quality of their treatment and care, as well as the privacy, dignity and respect they were shown.	The wait time for an appointment was commented on negatively. Similarly, a small group of patients did feel they lacked comfort.
WGH – Dermatology	Staff behaviour is highly commended, especially their professionalism and being competent. Staff are said to be helpful, as well as good listeners involving patients.	Negative issues raise mainly towards waiting times and parking, with slight issues on information.
WGH – Ophthalmology	Staff were highly thought of as being friendly and professional.	The main area of negative feedback was the waiting time for an appointment.
WGH – Minor Injuries Unit	Patients consistently praised the waiting time, quality of treatment and care, as well as staff communication with patients.	The only negative area touched upon were the facilities.

% positive feedback

Community



Key points raised: 1st April 2025 to 31st March 2026

Service	Positive	For improvement
Community Services	Feedback for community services were mainly positive. The professionalism of staff, as well as their friendliness was mentioned.	Similarly to acute services, patients did share negative feedback with regards to wait times. With some touching upon a lack of information.
Mental Health	Positive themes were consistently observed across services. Staff compassion and helpfulness were highly praised. Communication was another strong point, with patients appreciating being listened to and having their treatment and care explained clearly.	Waiting times were another negative aspect highlighted, mainly in relation to test results, but also for treatment and general appointments. Patients did mentions negative experiences with gaining access to services.
Primary Care	Patients shared how staff were friendly and compassionate. The majority of patients felt there was consistent emotional and physical support in place for them.	Much of the negative feedback centred around the wait times for appointments, as well as the facilities of locations.

Listening to children, parents and carers

The Paediatric service continues to share updates through 'You Said – We Did' boards it communicates how patient and visitor feedback has been listened to and acted upon by the organisation. It is designed to reassure patients, families, and visitors that their views matter and lead to meaningful improvements.

To strengthen the voices of younger patients, a proactive feedback approach has been embedded into daily ward routines. Staff continue to use a handover checklist to prompt feedback collection, alongside child-friendly paper forms that are easier for children and families to complete. Patient Experience Officers support the transfer of feedback into the digital system. All feedback has been reviewed, actions taken where appropriate, and updates shared with relevant teams. No overarching themes were identified in the survey responses many children answered nothing or did not answer when asked what could be improved, reinforcing that experiences were largely positive. New NHS Wales National Surveys are being developed for Children and Young People and these will replace the current surveys which it is hoped will encourage far more feedback from this group of people.

Summary	Feedback provided....	Service response....
Overall feedback was positive. Across all surveys, feedback demonstrates consistently positive experiences of paediatric care, with staff kindness, communication and emotional support standing out as key strengths. Most respondents reported high satisfaction, and no overarching or recurring themes of concern were identified. Improvement opportunities are largely environmental or practical in nature.	**Survey children aged 4- 11** suggestions and feedback: • Visiting hours **Survey Children 11+ years** suggestions and feedback: • Toilets, shower's • Lack of communication Drs • Need a gaming room **Survey parents** – carers feedback: • Clearer signage.	• Parents are welcome at most times. However, there are times where the team are required to manage the number of people around beds to ensure space and maintain infection control, staff are reminded to communicate this with patient's, parents and carers. • Cleaning schedules have been put in place, all staff to check toilets regularly. • Reminding Dr to provide a clear plan, Dr's to be remined at the end of the discussion to ask if any questions.. • The team have purchased two gaming carts .The Xbox has built in games, these can be played by bedside or elsewhere in the hospital, • Teddy bears have been signs have been placed around the hospital for PACU. Staff to escort patients. The team to liaise with estates to improve signage

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 month via the "The Big Thank You" newsletter posts on Viva Engage.

1549 compliments were received between the 1st April 2025 and 31st of March 2026. This is 297 more than the previous year.

Day Surgery Unit - PPH

"On the 24th October 2025 I had a fibroadenoma removed from my breast in Prince Phillip Hospital day surgery unit. I have genuinely never received such amazing care- I felt like a vip patient from beginning to end. From the first nurse I met, to the junior doctor, the anaesthetists, the surgeon ,the health care assistant who sat chatting to me, the anaesthetist nurse and all the nurses in recovery. (I wish I had written down names!) I couldn't be more grateful for the amazing care you provided."

If patients were pleased with their treatment or care they can share their appreciation to an individual staff member or team, by giving them a big thank you by completing our 'Big Thank You' online form https://hduhb.nhs.wales/healthcare/services-and-teams/patientsupport-services-complaints-feedback/ or they can look out for the poster in our hospitals.

"They made a difficult time a lot easier by listening and taking time to research his rare disability to ensure they gave the best care. They explained everything in terms we could understand, and allowed us to ask any questions, no matter how small or simple it could've been. Absolutely amazing team."

Intensive Care Unit - GGH

"Amazing radiology team, lovely staff, clean waiting area. Made me feel at ease, explained what they were going to do. Greeted by reception with a smile which is always nice. I did not have to wait long which was a bonus. Thank you very much for all you do for patients."

Radiology - WGH

Chemotherapy Unit - BGH

"I am currently receiving chemotherapy at Bronglais for a colon tumour. The nurses at the chemotherapy unit have exhibited a very high standard of care which is clearly appreciated by all patients. Every member of the hard working medical staff have been so kind and caring and they are a credit to our NHS. I can confirm these people are absolutely amazing!"

Patient Stories and Feedback Messages

Dyfrig Davies - Dyfrig Davies - Patient Story

This is a story shared by a son about his 87-year-old father (2024)

His father was previously fit, independent, and active. After a cancer diagnosis, he underwent major surgery, which was successful, and his recovery initially went well. However, complications followed. He developed infections and became increasingly unwell. The most difficult experience came in A&E, where, despite being elderly, confused, and recently having major surgery, he spent many hours waiting in an unsuitable environment. This caused distress and impacted both his dignity and recovery.
After discharge, the family struggled to access the support they needed, taking on much of the care themselves. While individual staff were kind and professional, the overall system particularly emergency care and follow-up support did not meet his needs.

The key learning is clear: care for vulnerable patients must be tailored, coordinated, and compassionate at every stage. Dignity, clear communication, and safe discharge planning are essential, and no part of the system can work in isolation.

Importantly, since this experience, improvements have been made within A&E services, showing a commitment to learning and improving care for future patients.

Gary's Story - *Gary's Story*

Gary's story outlines his recovery after a serious stroke and highlights the challenges he faced with swallowing (dysphagia) while on Ward 11 at Withybush Hospital. Following admission in a critical condition, he was assessed by a multidisciplinary team. Due to swallowing difficulties, he required a period of being nil by mouth and received liquid feeding.
Specialist investigations, including X-ray swallow imaging, showed a risk of aspiration, guiding his care plan. With support from speech and language therapists, he undertook targeted exercises and regular reassessments. Over time, Gary's swallowing improved significantly, allowing him to return to a normal diet by the time of discharge.
Now at home, he feels well, manages occasional difficulties safely, and reflects positively on his recovery and the care he received. Overall, the story is one of serious illness, careful assessment, teamwork, patience, and successful rehabilitation, leading to an improved quality of life.

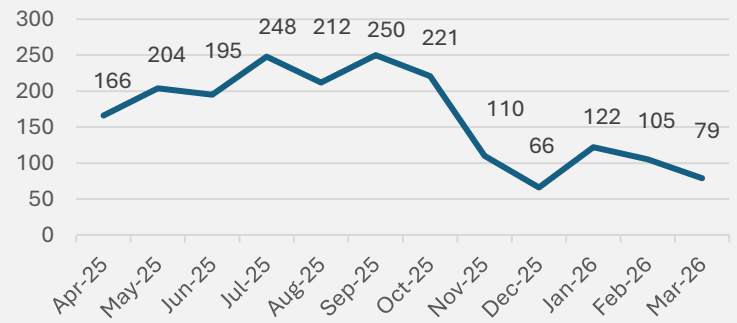
Learning
This story reinforces the importance of:
•Safe, evidence-based decision-making
•Effective multidisciplinary collaboration
•Clear communication with patients
•Patience and consistent rehabilitation support
It demonstrates how good stroke care and dysphagia management can significantly improve patient outcomes and quality of life when care is well-coordinated and patient-focused.

Complaints and concerns

April 2025 – March 2026

New concerns and complaints received

1978 new concerns and complaints were received by the Health Board. Numbers of new complaints have been at their peak during Quarter 2 during the period.



Closed complaints target

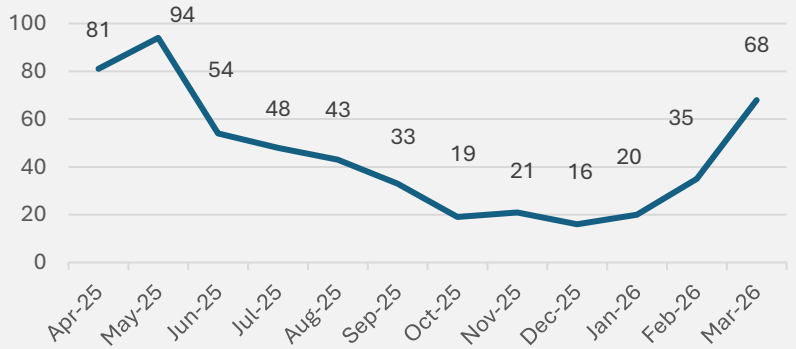
52% of complaints closed in the period achieved the 30-working day timescale under Putting Things Right, which includes those cases handled as early resolutions. The target set by Welsh Government is 75%. The Health Board is working on a trajectory for improving timescales that will enable it to achieve the Welsh Government target.

Closed within 30 working days	**52%** (1315 cases)
Closed over 30 working days	**48%** (1205 cases)

Early resolution cases by period received

532 of the complaints received in the period were managed as early resolution cases, with the aim of being resolved within five working days. There was a positive increase in the number of early resolutions in April and May, although these decreased through the summer period as the number of new formal complaints peaked, making it harder to achieve early resolutions at this time in the year. The lower numbers late in 2025 reflect the shift in focus towards the backlog of older, formal investigations which were a priority to close.

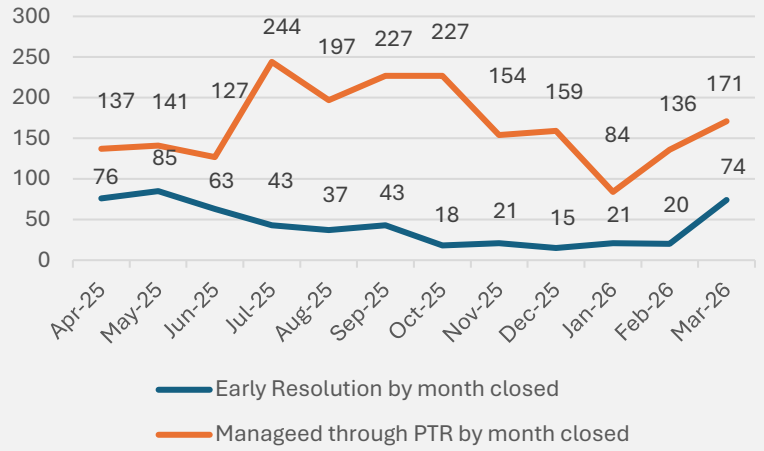
The increase in February and March 2026 represents the anticipating of the new ‘Listening to People Regulations’, during which a trial period saw a renewed focus on early resolutions.



April 2025 – March 2026

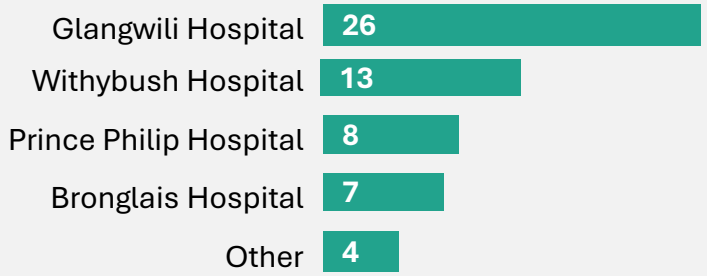
Number of concerns and complaints closed

2520 concerns and complaints were closed in the period. Of these, 2004 were managed as formal complaints and investigated under the Putting Things Right Regulations. The remaining 516 cases (20%) were resolved through the early resolution process.



Redress and upheld complaints

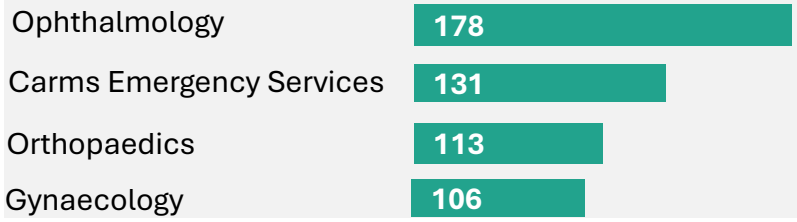
58 cases were escalated to Redress in the reporting period, because failings have, or may have, caused harm to patients. These have occurred at the following sites:



In the same period, a further 49 complaints were upheld because a breach of duty of care was identified through the course of the investigation, although the associated issues were not found to have caused harm. In these instances, learning is still identified and actions plans are put in place.

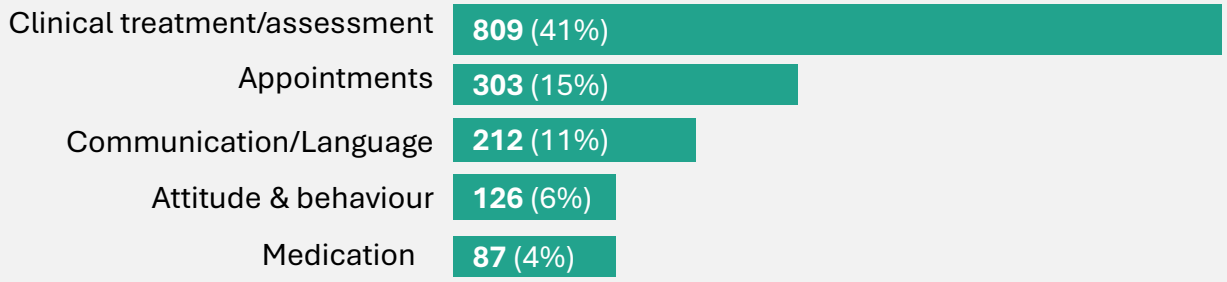
Complaints by service

The services with most formal complaints in were:



Complaints by theme

The most common themes for formal complaints remains consistent with previous years:



Learning From Complaints

This slide provides with a concise summary of the key organisational lessons identified from complaints, drawn from a thematic review of 'lessons learned' across services. It highlights the most recurrent drivers of complaints, strengths in current leaning processes, and the risks where themes continue to repeat. This summary tells us, beyond the statistics, what complaints intelligence is telling us about patient experience, culture, safety and system pressures.

Domain	Insight
Patient Experience	Primary driver of complaints is **how patients are treated and communicated with**, not clinical competence (despite this appearing so at face value).
Patient Safety	Some complaints highlight **missed escalation, delayed diagnosis and discharge risk**
Culture	Behaviour and compassion are recurring concerns, indicating cultural inconsistency
Access and Flow	Delays and cancellations reflect ongoing system pressure which are not easily rectified or preventable at team level.
Continuity of Care	Weak transitions between services and into the community remain a risk

Top 5 Learning Themes (By Frequency)

1. 🔴 Communication failures
2. 🔴 Delays and long waits
3. 🟠 Staff attitude and empathy
4. 🟠 Discharge planning and follow-up
5. 🟡 Clinical escalation and documentation

What Is Working Well?

- ✅ Learning is identified in the majority of cases
- ✅ Apologies and Duty of Candour applied
- ✅ Local reflective learning and discussions occurring
- ✅ Complaints used to highlight lived patient experience

Where Risks Remain

- ⚠️ Repetition of the same themes across multiple services
- ⚠️ Learning actions often **local, short-term or informal**
- ⚠️ Limited evidence of **measurement of impact**
- ⚠️ Dependence on staff goodwill rather than system design

Ombudsman – update and learning

Learning from Events and the Ombudsman

Where failings in care are identified by the Ombudsman, a learning process takes place and actions are taken to improve future patient safety and experience. All Ombudsman reports are taken through the Listening and Learning Sub-Committee for discussion.

The Ombudsman has powers to issue final investigation reports as 'Public Interest Reports'. It is down to the Ombudsman to deem whether their investigation findings raise issues in the public interest. In 2025 / 2026, the Ombudsman issued two public interest reports to the Health Board (see case studies)

Case A – Upheld in the Public Interest

The Ombudsman's investigation found that, when the Health Board's LD Epilepsy Service ceased in June 2021, it did not review the patients on its lists in a timely manner, nor provide adequate alternative provision to meet their needs. The Ombudsman was concerned that the shortcomings identified affected a very vulnerable group of patients and, despite several years elapsing since the concerns were first raised, that there was still no accessible pathway in place to ensure their needs were adequately met.

In response, the Health Board is developing and implementing an accessible Learning Disabilities (LD) Epilepsy pathway and has undertaken a comprehensive review of this cohort of patients to ensure that associated care plans are up to date and no patients are overlooked. Whilst work is continuing, there is Board oversight for assurance, and the Ombudsman has confirmed Health Board compliance with their recommendations.

Case B – Upheld in the Public Interest

The Ombudsman considered that earlier opportunities to recognise the seriousness of the patient's eye condition and to arrange further care were missed, noting lessons from this case for other health boards. Actions from this report included a review of outpatient appointment policies to ensure patients with the greatest clinical need are prioritised, particularly when clinics are wholly or partially cancelled.

Case C – Not upheld

Mrs C complained about the care and treatment her mother received from the Health Board and asked whether there was a missed opportunity to treat her for sepsis during her hospital admission in 2023. The Ombudsman found there was no missed opportunity to treat the patient for sepsis and their Adviser was satisfied that the treatment provided during the hospital admission was not only appropriate, but that the patient was given a better chance of survival by the treatment she received than perhaps she might have at many other hospitals.

Learning from events

Ensuring action and improvement from patient feedback, and through complaints, redress and claims is important to ensure the events are not repeated and there is continuous improvement in our services.

A small number of consistent themes emerge across services and types of concern. These themes are persistent over time and are largely cross-cutting rather than confined to individual teams or specialties. Higher volumes of cases are seen within planned and specialist care. A significant proportion relate to maternity, emergency care, orthopaedics and diagnostic services. Across all areas, the same underlying system issues recur, indicating organisational rather than isolated causes.

- Communication and involvement in care: Unclear explanations, inconsistent communication and limited involvement of patients and families frequently escalate distress and loss of confidence, even where clinical care is otherwise appropriate.
- Delays in assessment, diagnosis, treatment and follow-up: Delays are experienced as both safety and experience risks, particularly where deterioration occurs, reassurance is not provided in a timely way, or access to services is prolonged.
- Documentation, consent and continuity of care: Incomplete or unclear documentation of decision-making, escalation and follow-up plans weakens continuity of care, reduces organisational defensibility and undermines patient confidence.
- Pathway reliability and escalation: Harm often arises through a series of missed or delayed steps rather than a single error, highlighting the importance of clear escalation, ownership of follow-up and timely senior clinical review.
- Equity, accessibility and reasonable adjustments: Inconsistent identification and response to communication, sensory or accessibility needs can widen inequalities, reduce patient experience and increase the risk of harm.

Learning – What is different now?

There is increasing evidence that learning is being translated into system-level change rather than case-by-case response alone.

- Escalation thresholds and senior clinical oversight have been clarified across higher-risk pathways, supported by stronger governance and audit arrangements.
- Diagnostic and follow-up processes have been strengthened, with clearer requirements for investigations to be acted upon, explicit safety-netting and routine monitoring to test reliability.
- Documentation and consent standards have been reinforced through updated tools, clearer expectations and targeted training, improving transparency and continuity of care.
- More consistent multidisciplinary working has been embedded in complex pathways, with clearer recording of decisions and shared learning.
- There is a stronger organisational focus on learning culture, staff support and improvement, rather than blame.

Learning – Key actions underway

Review and update of clinical guidelines and care pathways.

Targeted education, training and shared learning in higher-risk services.

Use of audit, monitoring and assurance activity to test whether learning has been embedded in practice.

Improved documentation tools, templates and consent processes.

Improved identification of communication, accessibility and reasonable adjustment needs.

Service and digital redesign to improve coordination, continuity and follow-up.

The analysis provides assurance that recurring risks are being identified consistently across multiple sources of intelligence and that actions increasingly focus on system-level improvement.

Governance and oversight arrangements support monitoring of implementation and impact, while recognising the need for continued focus on sustainability and measurable improvement.