Review of Maternity, Neonatal and Paediatric Services in Pembrokeshire and Carmarthenshire

Evidence to the Royal College of Paediatrics and Child Health

Updated report November 2015

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Foreword

This document summarises the results of the work undertaken by Hywel Dda Community Health Council (CHC) to consider the impact on the experiences of patients, carers and their families of the changes to Women and Children's services introduced by Hywel Dda University Health Board (the Health Board) in 2014. These changes saw the centralisation in August 2014 of all obstetric deliveries and neonatal services for Carmarthenshire and Pembrokeshire residents at Glangwili General Hospital (GGH) in Carmarthenshire, followed in October 2014 by the centralisation of all inpatient paediatric services at GGH.

The changes were highly controversial, and there remains a real sense of loss amongst Pembrokeshire's communities who valued an established local service. Hywel Dda CHC, in representing the interests of patients and the public wants the delivery of safe, high quality healthcare as close to home as possible. Any judgement on the clinical safety of services must necessarily, rest with others. As a statutory patient representative body our submission focuses on what the public have said and experienced as a result of these service changes.

Our CHC volunteer members have spent a significant amount of time reviewing documents, participating in meetings and debating the issues central to the changes. We have sought to maintain a balanced approach that takes into account the available performance data and wider information about the quality and safety of women and children's services since the changes alongside the detailed and heartfelt accounts we have heard from patients, carers and their families about their experiences.

Unsurprisingly perhaps, the accounts we have heard have tended to focus on the problems experienced by Pembrokeshire residents who have been most affected by the changes in terms of the distance that patients and those who care about them have to travel to access more specialised services. It is important to recognise that these views will not be representative of everyone's experience. Indeed, even where people have described their concerns about certain aspects of the care provided, they also frequently praise staff and compliment the overall quality of care they have received.

Importantly, they illustrate where the Health Board needs to further develop its services so that Pembrokeshire and Carmarthenshire communities have full confidence in the quality and safety of their health services, and the experience of patients (and those who care about them) is a positive one when accessing those services.

Referring the service change proposals to the Health Minister in 2013 was a difficult and controversial decision. Our CHC considers that, whilst the clinical case in support of the Health Board's proposals was upheld, the resulting increase in focus has strengthened the overall planning and implementation process. One year on, the invited review by the Royal College of Paediatrics and Child Health (the Royal College) is a welcome development.

Overall, the report describes what we consider to be the key issues the Royal College needs to take into account as it finalises it's evaluation of the changes in Women and Children's Healthcare Services - from the perspective of patients and the public.

November 2015

1. Background

1.1 In August 2012 the Health Board initiated its formal consultation "*Your Health Your Future*". Its wide ranging proposals for NHS service change included changes to Maternity, Gynaecology, Neonatal, and Paediatric services, with certain functions being removed from Withybush General Hospital (WGH) in Pembrokeshire and centralised in Glangwili General Hospital (GGH) in Carmarthenshire.

1.2 Between August 2012 and January 2013 the CHC worked closely with the Health Board in a bid to better understand the case for change and to address public concerns around safety. In January 2013, following the consultation period the Health Board formally agreed its favoured options which included the proposed changes to Women and Children's services.

1.3 Following the Health Board's decision, and given the continuing strength of concern amongst the public and wider stakeholder organisations, the CHC exercised its statutory right of referral to the Health Minister in February 2013. In July 2013 following further unresolved discussions between the Health Board and the CHC the Health Minister assembled an independent scrutiny panel to consider the proposals. The panel's subsequent report was endorsed by the Health Minister in January 2014.

1.4 Whilst the main proposals of the Health Board were largely supported a greater focus on safety was evident with important provisos around a phased introduction of the new model. These included additional 'safety net' arrangements to provide midwives with skilled assistance, strengthened emergency transfer arrangements, and strict guidelines for the midwife-led provision.

What the changes meant

1.5 From August 4th 2014 all obstetric deliveries and neonatal services in Carmarthenshire and Pembrokeshire were centralised at GGH with Midwifery Led Units (MLU) at GGH and WGH. Gynaecology services continue on both sites with a consultant "safety net" back up in WGH at all times. All outpatient clinics, diagnostic investigations, early pregnancy clinics, day assessment and day surgery services continue on both sites.

1.6 To comply with the Welsh Deanery's[1] requirements for training all paediatric junior doctors and obstetric and gynaecology junior doctors are based at GGH for their on call work and they cover both sites during the day.

1.7 From 20th October 2014 there is a 12 hour 7 day week paediatric ambulatory care unit at WGH led by consultants. All inpatient paediatric services are located at GGH in an expanded ward together with a new dedicated paediatric high dependency unit and paediatric ambulatory care unit. All community based paediatric services, outpatient clinics, diagnostic investigations and day case services continue as before on both sites.

How the CHC has monitored the changes

1.8 The CHC has been actively involved in both scrutinising and influencing the Health Board's detailed plans to manage the implementation of the changes. Since the changes were introduced we have actively monitored and reported back to the Health Board the impact of the changes on patients, carers and their families.

1.9 Further details about the role of CHC's is set out at Appendix 1. Our detailed approach to this service change is set out at Appendix 2.

[1] The Wales Deanery (Postgraduate Medical and Dental Education) provides training grade doctors and dentists across Wales with access to high quality postgraduate facilities and educational support so that they can achieve their potential in service provision to the NHS in Wales.

2. Our findings

2.1 What people told us about their experiences

2.1.1 We were struck by the depth of feeling and passion shown by members of the public who took the time to share their experiences with us whether in public meetings or through written accounts. Many of their stories were very powerful and it was clear that articulating them took courage.

2.1.2 We undertook our initial analysis of patient experiences in February 2015 within the first six months of the service changes and with a final analysis in July 2015. We took into account experiences told to us at public meetings as well as submitted to us in writing. We analysed every patient contact to identify the key issues and to allow comparison with others to establish trends or common themes.

2.1.3 Unsurprisingly perhaps, the accounts we have heard have tended to focus on the problems experienced by Pembrokeshire residents who have been most affected by the changes in terms of the distance that patients and those who care about them have to travel to access more specialised services. It is important to recognise that these patient stories by their nature, may not describe the whole picture of care and there may have been other factors that influenced their experience. Nor will these stories be representative of everyone's experience. Further even where people have described their concerns about certain aspects of the care provided they also frequently praise staff and compliment the overall quality of care they have received.

2.1.4 One key aspect of our analysis is that there was little evidence of clinical harm as a result of service change. One patient story described her traumatic birth which started and finished in Glangwili hospital. Sadly, her baby was born with a brain injury. Clearly a serious issue, we understand the circumstances described do not directly relate to the service changes under the terms of the Royal College's review. However, anyone who contacts us to raise concerns about the safety and quality of their care is offered support through our independent advocacy service to take those concerns forward formally with the Health Board should they want to do so. Several patient stories recount what they consider to be a "near miss" where harm could have occurred but didn't on the basis of good fortune. Many people described a poorer patient experience overall which

was felt to be worse than it should have been, or generated some measure of inconvenience which they considered may not have happened under the previous arrangements.

2.1.5 There appears to be a clear link in many of the experiences to aspects related to overall NHS pressures or long standing areas of concern (such as car parking at Glangwili Hospital) rather than being specifically the result of the service change.
It is entirely understandable that patients and their families may combine service change and general NHS pressures in their conclusions and the two issues may certainly overlap to compound issues of concern, e.g. the issue of travel time from Pembrokeshire to Carmarthen will be amplified when out of hours services are busy or stretched WAST resources may add to delays.

2.1.6 Whatever the clinical evidence that services are safer under the new model, there is no doubt that for many people, their experiences do not always feel as safe to them. In several of the accounts there is a perception that service change has complicated pathways which has led to fragmentation, occasional confusion in clinical decision making and further delays. In some cases pressured staff appear to have made comments which parents have perceived as evidence that care is unsafe.

2.1.7 In the first few months of the change the main themes identified by patients, carers and their families were:

Delays and WAST capacity

2.1.8 Some people reported long delays in ambulances arriving or more generally were concerned about the overall length of time it took from calling for help to arriving at GGH for treatment. One person whose granddaughter needed care wrote:

> "I *rang the 'out of hours' doctor and they rang back in ten minutes. After I explained what was happening they sent for an ambulance which had to come from Aberystwyth 39 miles away."*

2.1.9 Another person whose 11 month old daughter was experiencing breathing difficulties stated:

> *"From the arrival of the ambulance at home to treatment starting was approximately 10 hours"*

2.1.10 It is clear that for some patients, their experience of the new service was compounded by what was overall a very busy time for the Welsh Ambulance Services Trust (WAST) and the NHS system as a whole. Nevertheless it created concern and anxiety during a sensitive time when communities were understandably nervous about the service changes.

Managing the transition for 'regular' patients

2.1.11 Some children are regular users of paediatric services and a few parents reflected that the relationship they had established with clinical teams in Withybush were lost when their child's care was subsequently managed in Glangwili. We understand that efforts were made by the Health Board to write to "open access" patients to describe the upcoming service changes and invite them to meet teams but it is possible that this did not capture as many families as it could have.

2.1.12 One Pembrokeshire mum commented on an episode where her daughter (who has very complex disabilities) was admitted to the Paediatric Ambulatory Care Unit in Glangwili:

> *"(My daughter has)...had open access to Withybush almost since birth. They know her, know her condition. I know they would have taken complete care from the moment we got admitted. They listen to what I have to say about why she's not well"*

Uncertainty and confusion around the changes

2.1.13 Some members of the public were unclear how the changes affected them. The Health Board used a range of methods to communicate but despite this public understanding of what services existed and when or where they were situated was still inconsistent.

2.1.14 Transport options were not always well understood and it was reported that there were inconsistencies in advice about whether more than one parent could stay with a child.

2.1.15 Where there is an opportunity for forward planning for an upcoming health event, e.g., a birth, it is important that parents of children or expectant families are very clear about what is expected to happen. In some accounts parents were concerned that an ambulance might be

delayed in getting to them and so they felt they should convey a child to Glangwili themselves to save time. In some cases this could be a significant risk in terms of delays to stabilise a child's condition and underlined a need for clear guidance and understanding amongst patients and their families.

2.1.16 There also appeared to be concerns in the advice people received when they rang different numbers for help during this initial period, (i.e., Out of Hours GP services, Withybush hospital, etc.). In some cases it appeared that parents were advised to take a sick child to hospital but the severity of the symptoms may have had been underestimated.

2.1.17 For example, one Grandmother describes events surrounding her 5 month old grandson (who had previously been admitted and then discharged) and had developed further breathing problems. She rang Withybush hospital:

> *"The reply by the lady on the phone was 'As it is 5:20am we needed to drive him to Carmarthen'. I couldn't believe what I'd heard, drive to Carmarthen 45 miles away with a 5 month old baby who had difficulty breathing. I immediately phoned for an ambulance which fortunately arrived 15 minutes later. The paramedics were brilliant and spent approximately 15 minutes treating him in the ambulance before making the 50 minute journey to Glangwili hospital. The father, myself and my husband followed anxiously in the car, but just after Pembroke Dock (approx. 10 minutes after leaving home) the ambulance's blue flashing light was turned on. Approximately 50 minutes later we arrived at the hospital"*

2.1.18 In our final analysis there were fewer concerns around acute paediatric issues and more around maternity or neonatal issues. Many concerns have been consistently expressed to us since the service changes and particularly reflect public fears prior to the service change.

Travel distances

2.1.19 A number of accounts raised concerns about the safety implications of travelling long distances to access services using largely rural roads, often at times of significant stress and anxiety for patients and their families. One Pembrokeshire mum told us:

"I decided to contact the GP on call. On calling the GP a nurse called me back, she was also concerned about (my daughter's) breathing. She advised to take her straight up Glangwilli. She said there were no ambulances available and no paediatrics at WGH so I needed to go to Glangwilli… it's hard not to get flustered when your child is in distress especially when it's her airway that is the problem. I immediately got (my daughter) in the car looking a ghastly grey colour and her breathing sounding awful, and drove her at great speed to Glangwilli."

2.1.20 Interestingly, in two accounts there also appeared to be evidence to suggest that distance to travel may have influenced clinical decision making. One case described a family being sent home from A&E in Withybush to prevent a longer subsequent journey to Glangwili (which led to readmission) and another indicated a slightly earlier postnatal discharge (when a midwife suggested the family stay another night) to avoid the father making a long return journey the next day. This may raise a question as to whether clinicians when reaching finely balanced clinical decisions, may feel some pressure to reduce inconvenience or travelling for families.

2.1.21 The following extract illustrates one parent's experience:

"In December 2014 I took my 1year old into A&E in Withybush. She had x-rays which showed signs of chest infection. I was told that they couldn't keep her in overnight and would have to go to Carmarthen, as this was a long way as I live in north Pembs the doctor said he could give me antibiotics and an asthma pump to take her home. She was no better in the morning so took her back to Withybush and saw a different doctor who said she needs to go to Carmarthen straight away. She had pneumonia and bronchitis. She had to have intravenous drugs and oxygen through the night at Carmarthen. My poor child had had a whole night of suffering at home when she should have been admitted straight away but the doctor was very hesitant as Carmarthen was quite far for me. I would have driven if I'd have been told how poorly she was."

2.1.22 Two accounts describe the impact of needing to attend Singleton Hospital in Swansea for specialised care for premature babies. These accounts assume that this care would have been provided in Withybush Hospital before the service changes. Great care is needed in accepting this assumption as some Pembrokeshire parents may have needed to access very specialist care in Singleton Hospital before the changes.

2.1.23 Whatever the case, the travelling, costs and potential health impact for Pembrokeshire residents having to travel such long distances over long periods highlights the need for more support for parents and increased efforts to ensure only very specialist care is delivered outside the Hywel Dda area with patients transferred back to receive care closer to home as soon as possible.

2.1.24 One Dad provided a compelling account of his experiences which showed the impact of regularly travelling long distances;

> *"In the 3 months it took my son to come home I drove in excess of 8,000 miles. I took out an £8,000 pound loan to cover the financial burden of having to travel and then live out of hospitals during that time. I can honestly say I spent £4,000 to £5,000 on fuel, food and clean clothing for when we had to stay longer than expected in hospital family rooms for me and my partner. I even had to buy a new car as the one I had at the time of my son's birth and the first 2 weeks of him being in Singleton hospital was not up to the task of doing all this mileage."*

Maternity services at Glangwili General Hospital – patient environment and staffing

2.1.25 Some patients accessing maternity services in the initial period following the service change reported a poor environment and staff who were rushing and weren't able to be as attentive or supportive as they could have been. This is a likely outcome of a very busy period in conjunction with a new system that was "bedding in" resulting in poor experiences for some people.

2.1.26 One new mum on Dinefwr ward said:

> *"The bathrooms were run down and I had to use the shower head to fill the bath which took ages as the taps were not working"*

Another mum reported:

> *"The day of my induction, I was shown to a room where 3 other ladies were being induced. It was about an hour later when someone appeared (not sure if she was a midwife) and seemed surprised to see me there, she said she hadn't realised there had been a new admission and that they were very busy"*

2.1.27 Capacity in maternity units in terms of both staffing and physical space continues to be a common theme. It is worth reflecting further on the words of mums who raised these issues in their accounts. One mum whose premature son spent some time in the Special Care Baby Unit (SCBU) said:

> *"Being a mum to a premature baby in a neonatal unit is very difficult. Holding your baby is not always possible and can be delayed for several weeks following birth. This makes it even more important to mum that she's there for as many feeds, nappy changes etc. as possible.*
>
> *There was little facility to speak with staff privately & the space between babies did not meet the stipulated standard of neonatal care. The cot area did not really have space even for a comfy chair to sit on whilst feeding your baby.*
>
> *It fast became apparent that the Paediatric medical staff were 'spread thinly' between the neonatal unit and the children's ward. There was no dedicated doctor in the neonatal unit which seemed to contribute to communication breakdowns between shifts."*

2.1.28 The lack of space in rooms remains an issue:

> *"After caesarean… I was taken back to labour room where another bed had been placed ready for next delivery making the room even more cramped. Midwife had to climb over furniture to get to drip stand etc.. Barely room for baby's cot inside the door."*

2.1.29 Concerns about staffing levels also continue. In a separate account from another mum:

> *"Being in a bay on my own for most of the Saturday we noticed how busy it was and the midwives and healthcares were run off their feet. One of which had worked 6am till 9pm Friday and was doing the same again on the Saturday. This cannot be right. During the Saturday evening my bay filled up with 3 other new mums. During the night the midwives and healthcares on duty were helpful, however come Sunday morning this changed. There was only one healthcare on to look after the whole ward, in the end another was called from another department to cover.*

On the Sunday morning the midwifery department was completely over run with new mums, mums in labour and those mums who had been induced, it was mayhem. There is just not enough room for everyone. It took over 6 hours for us to be discharged as they were so busy."

2.1.30 The cleanliness of the environment has concerned some patients with one mum in Dinefwr ward commenting:

"During Monday night I had quite a heavy bleed and an auxiliary nurse came to assist me, she helped me get out of the bed which caused more blood loss all over the floor, she proceeded to change the bed and then helped me get back into bed, when I asked if she could change my surgical stockings which were covered in blood she replied that I had to wait until morning. She did a rough mop of the floor using the bed pad and left. The blood splatters were still on the bed, floor and skirting board when I was discharged on the Wednesday afternoon."

Family facilities to support new mums in Glangwili Hospital

2.1.31 The lack of facilities and flexibility for new dads or visiting families was a problem for some. In the Maternity unit if mums are not in established labour dads are seen as visitors and are generally asked to leave when visiting hours finish. One mum felt this was not right:

"How come husbands/partners are allowed to stay with their pregnant partners in other hospitals? Probably one of the most nerve wracking moments in a woman's life and she had to spend some of it alone, with the thought of her loved one being an hour plus away? I'm just glad my husband decided to sleep in the car the night/early morning I went into labour as I would've been petrified without him there! And how can he be expected to leave after the baby is born if it reaches kicking out time, the baby's first night in the world, the first nappy change or night time feed etc. and the father had been sent home so he can't join in these precious moments!"

Paediatric services at Glangwili Hospital

2.1.32 Concerns were expressed about the environment on Cilgerran ward (which provides paediatric care) particularly in the early months of the service change:

"The condition of the hospital came over as poor, run down and uncared for. Certain areas were none too clean…"

"A large area of the corridor in Cilgerran Ward was stacked with cleaning materials. These included a trolley, on the handle of which were suspended bottles of cleaning fluids… ambulant children had easy access to them."

2.1.33 Some accounts suggested that staff were very stretched and that this led to limited checks on children in rooms. No harm was indicated but some parents felt their children had been forgotten at times. For some, the pressure staff were seen to be under meant that they were sometimes unhelpful or unable to provide assistance and support to help parents who needed a brief break or some advice.

Healthcare staff are highly valued by patients and their families

2.1.34 Perhaps one of the most consistent themes in the experiences described to us by patients and their families is how much they value the service provided by healthcare staff. With occasional exceptions staff who were recognised as working in challenging and demanding environments were consistently praised:

"Monday night midwife was outstanding, spent a lot of time talking to me whilst I was up feeding baby, assisted with everything due to my limited mobility."

"The team in Glangwili were reassuring and very professional"

"I would like to state before raising my concerns that every member of staff that cared for my baby or myself were a credit to the health service."

2.2 What we heard from patients at our most recent visit

2.2.1 On 6th August 2015 we visited Glangwili Hospital to speak to patients and their families about their experience accessing Women and Children's Services. During our visit we listened to the views of as many parents and children as we could. Our discussions on the wards revealed

generally positive experiences whilst also highlighting a few areas for improvement consistent with earlier patient experiences reported to us. For example, talking with one Pembrokeshire mum on Cilgerran Ward the distance to travel was clearly problematic, as it was difficult for family to support her supporting her child. However she was able to stay overnight on the ward and reported a positive experience overall with good facilities for her child.

2.2.2 The Midwifery Led Unit in Glangwili Hospital received positive feedback from patients, with the parents of one new born baby reporting that they "can't fault" the unit. However the parents were less happy with their experience on Dinefwr Ward and reported delays in receiving pain relief. Another Mum we spoke with was more complimentary but noted some inflexibility in visiting rules for family.

2.2.3 Further details about our visits are set out at Section 3.

2.3 What we saw and heard from staff on our visits

Dedicated Ambulance Emergency Vehicle

2.3.1 An important component of the 'safety net' required by the Health Minister has been the introduction of a Dedicated Ambulance Emergency Vehicle, or "DAEV", enabling the emergency transfer of patients between hospital sites supported by specially trained staff. We visited the DAEV ambulance on the 26th August 2014. We looked to establish whether from a patients perspective the arrangements in place in terms of staffing and facilities was capable of providing the support needed. Our members who undertook the visit asked a number of predetermined questions about the arrangements in place covering cleanliness, staff roles, and patient environment.

2.3.2 Overall, our members reported a positive visit and they were satisfied with the information provided by the ambulance crew and Midwifery Manager in response to their questions.

Cilgerran Ward, Glangwili Hospital

2.3.3 Cilgerran Ward houses the Paediatric Ambulatory Care Unit (PACU) with 8 beds, a paediatric inpatient area with 30 beds and a paediatric high dependency unit with 3 beds. The ward receives transfers from Withybush hospital when required.

2.3.4 Around the end of 2014/2015 the CHC had been made aware that paediatric services were significantly stretched in Glangwili Hospital. Following concerns raised with us through patient experiences received in January 2015 about what was considered by some patients and their families to be an unsuitable patient environment CHC members and staff carried out two initial visits to Cilgerran Ward. The first visit was brief and informal, intended to make rapid spot-checks on the issues raised. This was followed up with a more formal and comprehensive visit on 24 January 2015 using standard ward visiting methods.

2.3.5 The findings of these visits were largely positive. When visited the ward was relatively quiet and our visiting members and staff did not observe the same problems described in some of our earlier experiences, and what had been reported as a less than ideal situation during the busy periods in December and early January was not apparent during our visit later in January. This does not mean that the environment was ideal on the dates where complainants visited. More storage would clearly help things but this is the case on many wards. We were concerned though as to whether the quality of the environment and care could be maintained when the ward is under pressure or if understaffed.

2.3.6 On 6th August 2015 we made a further visit to Cilgerran Ward to follow up on our earlier visit and to see whether any changes had occurred. Clinical staff told us that the ward had stabilised and improved over recent months. Although still not staffed fully, nurse capacity had increased and a "Consultant of the Week" model[2] which had been put in place earlier in the year was considered to be leading to improved consistency of care from paediatric consultants for patients and families during their stay on the ward. Paediatric ward rounds were now started much earlier and pharmacy processes have been developed to help discharge patients who would otherwise be waiting unnecessarily.

2.3.7 The physical environment was generally good with improved bathroom and disabled facilities although in some areas the décor looked tired.

[2] "Consultant of the week" means that the same Consultant is in attendance on the ward, or on call to provide more consistent care for patients over that period.

Special Care Baby Unit (SCBU), Glangwili Hospital

2.3.8 This unit incorporates 4 high dependency cots and 1 stabilisation cot. In addition there are 8 special care cots. We visited the unit on the 6th of August 2015 to follow up on the concerns expressed by some mums that the environment in SCBU wasn't ideal and staffing levels insufficient.

2.3.9 We found that the setting has a makeshift feel and the staff there seemed less settled than in some of the other areas we visited. This stood out as most of the wards and units we looked at appear to have stabilised after the original changes. Nursing staff confirmed that covering shifts remained problematic and this created problems in releasing staff for important training.

The accommodation for mums of premature babies was limited in both size and numbers with 2 of the 5 rooms located some distance away from the unit.

2.3.10 We were left with the clear view that further development of the unit as part of the Health Boards planned "Phase 2 development" [3] is crucial for babies, parents and staff.

Midwifery Led Unit (MLU), Glangwili Hospital

2.3.11 We visited the MLU on 6th August 2015. This is a new unit which was completed in August 2014 as part of the Health Boards first phase of building works designed to support the service changes. As might be expected this modern area has a wide range of facilities to meet the needs of patients and their families.

Dinefwr Ward/Labour Suite/Antenatal, Glangwili Hospital

2.3.12 Dinefwr is an older ward with a mixture of 4 bedded bays and single bedded side rooms with postnatal and antenatal corridors. We also visited the Labour Suite. These areas had been previously criticised by some families when describing their experiences. Such criticisms were acknowledged by the Midwife who showed us around the areas. It was agreed that rooms could feel cramped in some situations with mums having to make use of shared facilities. Further there is currently no access to a birthing pool which is generally in high demand amongst mums in labour. She reflected that staff were "making the best of what they had" however.

[3] Proposed "phase 2" developments will lead to refurbishment and extension on the Glangwili site, allowing more facilities for parents wanting to be with new born babies receiving special care, a modern delivery suite and more parking spaces.

Scrutinising the Health Board's progress since the service changes

2.3.13 After the introduction of the service changes the Health Board has monitored and regularly reported upon its performance since the service changes. The key issues drawn from our regular involvement with this are as follows.

Since the changes, services have developed

2.3.14 Having attended the Health Board's Evaluation and Monitoring Group, its Programme Board, and through making recent visits to the wards ourselves, there is anecdotal but strong evidence to show that it has learned from initial problems and that services are functioning better now compared to the first few months immediately following the changes. At these meetings there has been sense of progress. Tensions and fragility remain on the wards, however whilst most staff we spoke to reported a rushed and difficult time immediately after the changes they also described how they felt more settled and confident now with systems working better. For example, the rules and guidelines around when a child is transferred from Withybush to Glangwili (known as the "transfer protocol") have been updated relating to roles and responsibilities in response to problems arising from the management of one case. Additionally there is evidence of improvement on the wards with the introduction of small changes such as the improved working of pharmacy, a switch to morning ward rounds in paediatrics and the "Consultant of the Week" system as described earlier.

2.52 Activity and monitoring data published by the Health Board doesn't capture such improvement but we have noted that improved recruitment has helped improve cover in some areas although staffing remains a challenge.

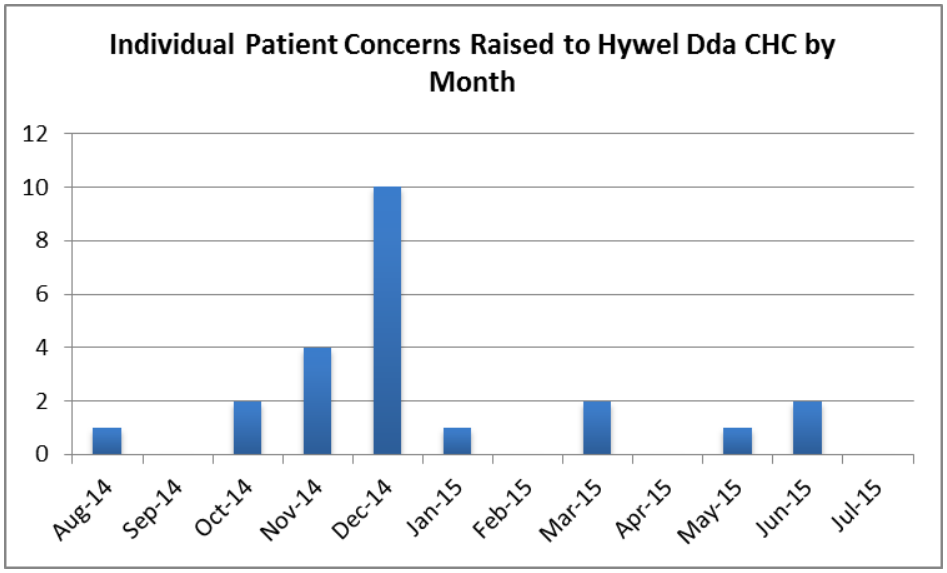
2.53 Through CHC complaints advocacy we have seen that the Health Board has acted on concerns. In one case we supported plans were in place to improve patient experience on this specific clinical issue.

Capacity during "activity spikes" is a challenge

2.54 One of the notable issues when attending Programme Board meetings in the early part of 2015 was the difficulty paediatric services had experienced during December and early January to

keep up with demand. Staff reflected that the "pace had been relentless" and that they had been struck with the severity of health problems displayed by the children being admitted as is often the case in winter periods. Concerns submitted to us by the public peaked around this time (see Fig. 1 below).

Fig. 1



The service needs to mature further

2.3.15 Even though improvements have been made, it is recognised that more needs to be done. Through our attendance at the Health Board's Monitoring & Evaluation Committee we are aware of a number of logistical issues that are yet to be resolved. These include midwifery-led-unit (MLU) staffing in Glangwili, Special Care Baby Unit (SCBU) staffing in Glangwili, the status of Withybush's non-resident paediatric rota and neonatal cot capacity amongst other issues.

The Health Board needs to develop its arrangements for gathering and responding to patient feedback

2.3.16 The Health Board needs to further develop its arrangements for gathering and responding to patient feedback.

2.3.17 The Health Board has already recognised that it has not made the best use of the information available from concerns and patient feedback about all its services to shape its strategy, improve services and enhance patients experience overall. There is now some real tangible evidence of a drive to take this forward.

2.3.18 With regard to Women and Children's services the Health Board missed some opportunities to proactively gather and respond to patient feedback following the service changes. Despite its early intention to establish a Patient, Family and Staff Experience group, the first meeting of this group did not take place until July 2015. Further whilst the Health Board did publish in its Board Papers quarterly monitoring reports on performance since the service changes these reports provided very little qualitative information on patient experience, specifically in terms of positive feedback but also for concerns and complaints. Clear, regular reporting to local communities about patients' experiences of accessing services is an important way in which public confidence may be built in a service that is performing well or, where problems are identified, it can reassure people that action is being taken to address poor service so that their experience is not repeated for others.

2.3.19 Although in its infancy we are encouraged by the inclusive and patient centred approach the Health Board is now taking to the establishment of its Patient, Family and Staff Experience Group.

2.3.20 One clear example where the Health Board has responded to patient feedback is its decision to commission a transport service run by a voluntary sector provider to help young families return home to Pembrokeshire if they have been transported or transferred to Glangwili hospital. We will monitor this service as it becomes more established and are hopeful that it helps to ease some of the concerns members of the public have voiced about being stranded at Glangwili when a long way from home with limited transport options.

2.3.21 Again, whilst a positive move there is a general sense that this additional service could have been introduced much earlier in the implementation process as concerns raised by the public on lack of transport and isolation predated the service changes.

3. Our conclusions

3.1 The changes to Women and Children's services affecting Pembrokeshire and Carmarthenshire residents were highly controversial and there remains a real sense of loss amongst Pembrokeshire's communities who valued an established local service. Hywel Dda CHC in representing the interests of patients and the public wants the delivery of safe, high quality healthcare as close to home as possible. Any expert or technical judgement on the clinical safety of services must, necessarily rest with others. In evaluating the service change full and fair consideration must be given to what the public have said and experienced since the changes were introduced.

3.2 So far public fears around the safety of the new arrangements have not been realised. Whilst patients report stress, inconvenience or "near misses", to date there is limited evidence of harm following from the service changes. This does not equate to a perfect picture of patient care but there is clear evidence that the service has matured as there is generally strong evidence to show that the arrangements are working better now compared to the first few months immediately after the changes. Nevertheless, there remains amongst some local communities a continued lack of public confidence in the centralised model. This cannot be addressed by simply looking to expert clinicians to say whether the model is better than before in terms of clinical safety. The Health Board must continue to develop the way it communicates with patients and the public about their services and how they are delivered. People must be properly informed if they are to be confident of accessing services in the right way, and they must be told – clearly and meaningfully - how well their services are performing in terms of both clinical quality and patient experience.

3.3 The Health Board must demonstrate it has the necessary planned resilience to respond to busy periods where activity levels may be high and patients receiving care have complex needs. Tackling wider NHS pressures is key to this. WAST capacity, delays in busy and fragile accident and emergency settings, and pressured local out of hours primary care systems have a direct impact on patient experience regardless of service change. The current problems in medical staffing in Withybush are an added concern on top of seasonal fluctuations in demand. The need for the Health Board to demonstrate strong and effective management of this wider system is as important for those using women and children's services as it is for all patients.

3.4 The introduction of the WAST Dedicated Ambulance Emergency Vehicle has been a key component in the safety net arrangements required by the Health Minister. Whilst the Health Board has commissioned this service for a further period up to March 2016 arrangements beyond then are not clear. We know that ambulance capacity is very stretched in times of high demand and the DAEV provides a crucial contingency. The Health Board needs to take action now to ensure the availability of emergency transport with appropriately skilled and equipped staff.

3.5 In addition the much improved facilities anticipated with the planned second phase of building are desperately needed.

3.6 There is a real sense of fragility in some of the wards we visited and "phase 2" is seen as critical when speaking with staff. In terms of patient experience many of the negative stories have some root in the pressured and makeshift units which will be improved by more modern and spacious clinical areas. Dinefwr ward facilities should be included in the development as we understand that current outline plans do not incorporate this outdated area.

3.7 Inconvenience and anxiety matters. Clearly there is a hierarchy of priorities in dealing with acutely ill children, new-born babies and mothers in labour. Quality and safety is the first consideration and healthcare staff are absolutely committed to this. However, what is sometimes evident from accounts sent to us by the public is a gap between good clinical outcomes and a good patient experience. Positive clinical outcomes must be matched by a positive patient experience overall. This is fundamental if patients are going to feel their services are safe. Patients are travelling long distances, sometimes in a state of high anxiety with ill children. They frequently report experiencing difficulties in parking and at times have subsequently entered very busy healthcare settings where staff are rushed and thinly spread. Communication can suffer and as a consequence confusion and raised levels of anxiety can result. The experiences of parents who have to travel long distances from Pembrokeshire to be with their premature babies demonstrate a significant psychological and financial toll.

3.8 Arrangements for dads, partners or family who live a long way away are underdeveloped and this affects mums and children when they want support. Relatively small changes could be made to improve this. There may also be potential to explore further ways in which transfers to Glangwili may be prevented. Whether this could be achieved in Withybush Hospital, community

settings or primary care, patient experiences we have received describe long and stressful transfers for which some parents questioned the necessity.

3.9 There is clearly a desire on the wards to capture and learn from patient experiences and the recent establishment of the "Patient, Family and Staff Experience Group" will help create a more robust link between the experiences of patients and service improvement. However, it is clear that basic issues such as (for example) car parking, adequate staffing levels and staff attitudes have the constant potential to determine whether people feel their NHS experience was good or bad. In improving patient experiences overall the Health Board has a significant opportunity to regain the trust of a concerned Pembrokeshire public.

Appendix 1

The Role of Community Health Councils in Wales

Community Health Councils (CHCs) have an important job to do in representing independently and without bias, the interests of patients and the public in the way health services are planned and provided in Wales. We are amongst the longest-surviving organisations in the NHS today.
CHCs were established by Act of Parliament in 1974 to represent the interests of patients and the public in the National Health Service. Made up of members appointed by Welsh Ministers, local authorities and the voluntary sector as well as a number of permanent support staff, they have several specific functions and duties connected to the scrutiny and monitoring of health services on behalf of local communities.

What we believe:

We believe that every person using any aspect of our health service should be treated as a unique individual.

Our aims:

We exist to improve the patient experience and to provide support if things go wrong.

How we achieve our aims:

We work with patients, practitioners and policymakers. We are independent from government and the health service. Patients and the public govern all of our activities.

We:

- Carry out regular visits to health services, talking to the people using the service, and the people providing the care, to influence the changes that can make a big difference;
- Get involved with health service managers when they are planning service developments and larger scale service change, to emphasise the patient view right from the start;

- Provide free and confidential support through advocacy if things go wrong and if the health service complaints process isn't working.

- Reach out more widely to patients and their families across communities, to provide information, and to gather views and experiences so that we can represent your interests to health service managers and to policy makers.

Appendix 2

Monitoring the impact of the changes: What we have done and how we have been involved

Health Board Governance: Scrutinising Health Board activities and influencing service improvement and development

- **Maternity, Neonatal, Paediatrics and Gynaecology Services Programme Board**
  From July 2014 the CHC sat on this committee with either member or officer representation. It dealt with planning and implementation of the changes.

- **Evaluation and Monitoring Group**
  The Health Board agreed to run a specific Evaluation and Monitoring Group as a sub-group of the Programme Board in early 2015 for which the CHC has provided representation.

- **Meetings of the Health Board**
  The CHC has scrutinised and commented upon Women and Children's services themed reports and general reports on service delivery presented to Board meetings (e.g. Evaluation and Monitoring Reports)

- **Inaugural "Patient, Family and Staff Experience Group".**
  We attended the first meeting of this Health Board run group which aims to develop a systematically gather feedback on the experiences of patients, their families and staff regarding women and children's services.

- **Patient Transport Pilot**
  We've had some involvement in the implementation of a Third Sector delivered project which seeks to help people who have been transferred to Glangwili but who have no means of returning home to Pembrokeshire.

- ***The role of CHC Committees***

  The CHC operates two tiers of scrutiny meetings, one at a County level and another at a more strategic, "Services Planning" level covering all 3 counties. The Health Board is required to attend Services Planning meetings.

  We have received regular updates from the Health Board in our statutory Services Planning meetings and local issues have been discussed as relevant in the quarterly Locality Meetings in Pembrokeshire which are open to the public.

Public engagement

Listening and Engagement Events

- To date, two rounds of joint CHC/Health Board listening and engagement events "Sgwrs Iach – Let's Talk Health" events have been held, totalling 14 meetings in various communities. In Pembrokeshire, there have been events in Pembroke Dock, Letterston, Tenby and Haverfordwest. Each of these areas would have been affected by the service changes. CHC members and staff attending these events listened to peoples experiences and offered further advocacy support where appropriate.

- CHC members and staff also attended the public meeting in Haverfordwest on 28th July 2015 arranged by the Royal College of Paediatrics and Child Health.

Gathering Patient Experiences

- The CHC is always keen to hear about patient experiences, good and bad and has welcomed views and experiences from the public. There were two main 'spikes' of activity where we received a number of patient experiences, firstly in January 2015 after public events and a rise of social media comment and secondly in July 2015 when the RCPCH evaluation was announced. Overall, we have received around 45 accounts of patient experiences.

Other CHC activities

Complaints Advocacy

- A key part of the CHC's role is to support people who wish to make a complaint through our Advocacy Service. Despite receiving a range of concerns from the public relatively few people went on to use our advocacy service for individual support in raising their complaints with the Health Board. Our records show that 9 individuals contacted the advocacy service with a view to make a complaint where there are apparent links to the service changes and 5 complaints remain open at time of writing.

CHC Visiting

- CHCs have statutory powers to enter NHS healthcare settings to see for ourselves how health services are delivered. This means visiting hospitals, ambulance or primary care premises, talking to staff and speaking with patients. Visits can be announced or unannounced (with or without prior notice) and may use standard forms or specifically designed methods and questions, depending on what each situation demands. As part of our monitoring of Women and Children's service changes, our members and staff undertook 6 visits to various settings relating to this service change.

Media Scrutiny

- The CHC has monitored media coverage of stories about to the service changes. It has also monitored social media where many of the patient stories and local concerns were raised.

Appendix 3

Summary of patient experiences received by Hywel Dda CHC

The following provides an anonymised précis of each patient experience sent to the CHC. For the purposes of providing a focus on women and children's services, a small number of other NHS concerns that were received from the public via the same route have not been used here but have been followed up by the CHC's complaints advocacy service. Everyone who got in touch with us to share their experiences has received guidance about our role and how we can help them.

Not all emails and letters were based on a specific experience of the service. Some were general views and concerns which people wanted to share with us.

Experience 1

Route: Email via 3rd party

Identifying details: Name and address supplied by patient.

Incident: 24th November 2014.

Synopsis: Pregnant mother with risk of complex birth has contractions and told birth needs to happen in Glangwili under care of consultant. Contractions start, calls Withybush and it is confirmed she must attend Glangwili. Ambulance apparently not called, urgent car journey with mother trying not to push leading to birth in Glangwili with predicted complications apparently arising.

Issues of concern:

(1) Patient worried this was a near miss due to distance from help (Milford to Glangwili). Felt unsupported.
(2) Some further issues arising when in Glangwili, 7hr delay before someone gave her a jug of water, bathroom run down, bath taps not working (Dinefwr ward).

Experience 2

Route: Via email

Identifying details: Name and contact details supplied

Incident: 31st Dec 2014

Synopsis: Following prior contact with GP and brief admission to Withybush for chest infection, child of 5 months becomes unwell and apparently hypoxic with breathing difficulties at home. Withybush is called at 5.20am and parents told to drive child to Glangwili. Grandparents very concerned and call ambulance instead. Child conveyed by ambulance and following grandparents notice blue light put on. 02 saturation reportedly 86%. Individual wishes to make formal complaint.

Issues of concern:

(1) Grandparent feels this was a near miss and recommendation for family to take child to Glangwili in their own car unsafe due to apparent deterioration in ambulance.

Experience 3

Route: Via email

Identifying details: Name and email, no address

Incident: 21st December 2014

Synopsis: Child with rare and complex condition became ill. OOH Dr called. Ambulance sent for (apparently from Aberystwyth 39 miles away). After some delays in decision making OOH Dr is contacted again by WAST who recommended admission to Glangwili. Mother then describes situation where Dr in Glangwili didn't listen to her adequately until she threatened to remove her daughter and take her to GP.

Issues of concern:

(1) Mother concerned at delay in ambulance arriving
(2) Mother was concerned that Dr ignored her insight into child's problem given she knows her daughter's health problems well.
(3) Mother complains of child being ignored for 7 hours despite supposedly being under observation.
(4) Mother feels that her daughter's condition was well known to the staff at Withybush and that they had been excellent in the past, but Glangwili experience was poor

Experience 4

Route: via email

Identifying details: Name and address supplied

Incident: 18th Oct 2014

Synopsis: Patient noted significant vaginal blood loss. OOH service called at 8:30 am and callback promised, but no call received and patient left for Withyush A&E at 10:10am. Blood loss continued and was significant enough to warrant a subsequent transfer and surgery at Glangwili due to tear in major blood vessel.

Issues of concern:

(1) Patient feels this was a near miss and that various delays (OOH and transfer to Glangwili) made it a frightening experience.

Experience 5

Route: via email

Identifying details: Name and email, no address supplied

Incident: Not specified but post service change.

Synopsis: Mother notes child's previous history of bronchiolitis and a tertiary care admission at the Heath, Cardiff. Subsequent admission to Withybush. Most recent event concerns febrile convulsion with admission to Withybush before being sent home. Later, child deteriorates with high temp and further convulsion, ambulance called. Ambulance conveys mother and child to Glangwili, before being discharged again next morning. Mother still concerned after discharge and attends Withybush later on.

Issues of concern:

(1) Mother felt that ambulance staff were casual in their approach.
(2) Mother was concerned that child was not secure enough in ambulance during journey.
(3) It was felt that ward (not named) was cold and 'unkept'.
(4) Concerns that after initial check, child was not subsequently checked for a further 6 hours, then discharge felt rushed and no information given.

Experience 6

Route: Via email

Identifying details: Name and address supplied

Incident: Precise date not supplied, November 2014

Synopsis: Complainant has had regular involvement with local NHS services after son born prematurely with blood disorder. As a 15 month old, child is taken to Withybush with breathing difficulties. Mother told breathing could not be stabilised and required ambulance transfer to Glangwili at 5.30pm. Mother on crutches and felt isolated at Glangwili, was not offered some time to take a food break or shower. Family could not afford to come and support mother. Discharged after 2 days.

Issues of concern:

(1) Mother felt isolated on ward, hungry and was not afforded opportunity to take shower visit canteen.
(2) Concerned about return journey after discharge, mother asked doctor for information but doctor unhelpful.
(3) Mother preferred care at Withybush in past as staff knew her and her son.

Experience 7

Route: Via email

Identifying details: Name and address supplied

Incident: Precise date not supplied, December 2014

Synopsis: 2 separate episodes: Mother brings 2 year old child to Withybush A&E. Initial attempt made to triage in waiting room but mother did not want this, subsequently triaged in cramped baby milk room. A week later, child accidentally ingests uncontrolled amount of calpol at home. Parents attend Withybush A&E at 7pm. A&E doctor unwilling to take bloods and recommended trip to Carmarthen. Mother doesn't drive and was told patient transport would take her but would not take her back if discharged that evening. Grandparents took mother and child to Carmarthen, confusion where to go. Bloods taken and no treatment needed.

Issues of concern:

(1) Mother unhappy that triage for a personal matter was initially attempted in waiting room then in cramped room not designed for triage.
(2) Mother feels that second issue involved an unnecessary and very inconvenient set of events for a blood test when she brought child into A&E at 7pm. She reports staff seemed confused.

Experience 8

Route: via email

Identifying details: Name and address supplied

Incident: 2nd Dec 2014

Synopsis: Gynae patient initially attends Withybush for pre-op tests for laparoscopic surgery which should confirm or rule out presence of cancer. Asks about current MRSA status but staff unable to tell her. Patient has subsequently had elective surgery date cancelled.

Issues of concern:

(1) Patient very concerned that she has undiagnosed ovarian cancer. Feels Health Board is unresponsive through complaints and cannot answer questions about MRSA/infection control.

Experience 9

Route: via email

Identifying details: Name and address supplied

Incident: 6th Jan

Synopsis: Complainant attended Glangwili for EEG appointment with potentially autistic 2 year old child. Reports taking 45 mins to park and stresses that no other transport solution available to her.

Issues of concern:

(1) Felt frustrated that child became very upset in car whilst trying to find parking space.

Experience 10

Route: via email

Identifying details: Name and address supplied

Incident: 6 November 2014

Synopsis: Pembrokeshire mother under care of consultant gave birth to son at Glangwili.

Issues of concern:

(1) After contractions started and journey to Glangwili mother felt journey made her admission rushed and delayed onset of pain management.
(2) Staff praised but patient environment at Glangwili reported as being dirty with overflowing bins.

Experience 11

Route: via email

Identifying details: Name and email address supplied

Incident: N/A

Synopsis: No incident desribed. General concern at service change from ex theatre staff.

Issues of concern:

(1) Concerned at distance to consultant obstetric help

Experience 12

Route: via email

Identifying details: Name and address supplied

Incident: N/A

Synopsis: 6 year child with history of ganglion on foot. Managed previously in Withybush but now requires operation at Glangwili.

Issues of concern:

(1) Parent concerned at waiting time.
(2) Parent concerned at inconvenience of travel to Glangwili.

Experience 13

Route: via email

Identifying details: Name and email address supplied

Incident: N/A

Synopsis: Pregnant Pembrokeshire mother has scheduled C-section at Glangwili.

Issues of concern:

(1) Concerned at inconvenience and difficulty for visitors to see her. Feels service model is unsafe.

Experience 14

Route: via email

Identifying details: Name and email address supplied

Incident: 6th August 2014

Synopsis: Pregnant mother booked for induction 6th August. Gives account of birth which becomes emergency C-section.

Issues of concern:

(1) Concerned at attitude of some staff in Glangwili, feeling that some were rude.
(2) Describes dissatisfaction with facilities and patient environment at Glangwili.

Experience 15

Route: Via post

Identifying details: Name and contact details supplied

Incident: 4th December 2014

Synopsis: Neyland child of 11 months seen by OOH Dr at 1:00am after breathing difficulties. Ambulance called and child arrives in Glangwili at 2.40am. Child assessed and x-rayed (5 hr wait) and eventually leaves 4:30pm next day.

Issues of concern:

(1) Complainant concerned at chain of delays and that it took approximately 10 hours for treatment to begin.
(2) Complainant unhappy with condition of Glangwili ward with exposed screw sticking out of floor and rooms were cold.
(3) Clutter and cleaning materials stacked in corridor.
(4) Feeling that capacity at Glangwili was being stretched to limit and that Glangwili had not been bolstered enough to take additional paediatrics demand.
(5) Complainant feels anxious about future safety of daughter.

Experience 16

Route: via post

Identifying details: Name and email address supplied

Incident: 27th December 2014

Synopsis: 5 year old child noted as having chest infection and parents become concerned at 10pm. Child apparently becoming hypoxic and increasingly responsive so ambulance called. 40 minute wait for ambulance led one parent (a GP) to administer a steroid and salbutamol to aid breathing. Ambulance subsequently arrived, crew reporting that they were in Llanelli.

Issues of concern:

(1) Given wait, parent concerned that child could have died without intervention of father who was GP.
(2) Complainant felt that part of the increased risk was the distance to travel to Carmarthen

Experience 17

Route: via post

Identifying details: Name and email address supplied

Incident: 19th December 2014

Synopsis: 11 year old Pembs child brought to Withybush A&E with suspected appendicitis at 10:30am. Perforated appendix diagnosed by 12 noon. 3 hour delay to transfer to Glangwili. Further 2 hour delay after arrival at Glangwili before being taken to theatre, (approx 7:00pm).

Issues of concern:

(1) Complainant feel this was a 'near miss' incident in terms of delays re peritonitis
(2) Complainant not satisfied with standard of care in Glangwili in terms of staffing
(3) Complainant feels that service change is leading to unsafe care.

Experience 18

Route: via email

Identifying details: Name and email address supplied

Incident: 10th October 2014

Synopsis: Pregnant mother is induced at Glangwili and reports poor care in which she believes caused brain damage to her child.

Issues of concern:

(1) Feels that she was left alone during labour and midwives weren't attentive.
(2) Struggled to get help and was left in a corridor when being returned to the delivery room.
(3) Believes that her established labour was longer than her records suggest.

Experience 19

Route: via email

Identifying details: Name and email address supplied

Incident: 22nd December 2014

Synopsis: Parent brought child in to A&E with breathing difficulties who is initially sent home with antibiotics and asthma pump but is admitted the next day by a separate doctor.

Issues of concern:

(1) Parent was concerned that there was inconsistency of approach from Withybush A&E doctors.
(2) The first doctor seemed hesitant to admit the child due to the distance the family would have to travel from the far west of the county and the parent feels the acuteness of the incident was played down.

Experience 20

Route: via email

Identifying details: Name and email address supplied

Incident: Covers period from 20th May to late June

Synopsis: A lengthy account of a mother's experiences of care of a premature baby from the Grandmother. The experience spans the birth in Singleton to transfer at Glangwili.

Issues of concern:

(1) Grandmother feels that due to the closure of SCBU in Withybush, her daughter and granddaughter were isolated in Singleton as family struggled to travel due to problems around access to a car. These problems continued when mother and baby were transferred to Glangwili.
(2) After transfer to Glanwili Mother was very distressed at not being able to be with her new baby more through lack of transport. Grandmother was concerned about daughter's mental health.
(3) Mother was called to give blood for an urgent transfusion for son, and again this was difficult due to transport problems.

Experience 21

Route: via email

Identifying details: Name and email address supplied

Incident: Date not specified

Synopsis: The account describes a stressful experience as an MLU birth becomes an emergency transfer to Glangwili. The mother describes a birth experience she feels was unsafe with an additional lack of pain control.

Issues of concern:

(1) The parent feels that in the early stages of labour she was told to go home from Withybush MLU largely through lack of midwifery capacity during the night rather than her needs.
(2) She subsequently reports a stressful experience, during an emergency transfer in a cold ambulance without effective pain control.
(3) Staff were reported to be excellent in Glangwili but on some shifts didn't have enough capacity and were not coping.

Experience 22

Route: via email

Identifying details: Name and email address supplied

Incident: Not specified

Synopsis: Pembrokeshire husband of pregnant wife not happy with experience of travelling to Glangwili for monitoring appointments and feels this is unfair.

Issues of concern:

(1) Car parking problems in Glangwili were stressful and led to the wife being unsupported whilst finding a space.
(2) Parent feels that the experience was inconvenient.

Experience 23

Route: via email

Identifying details: Name and email address supplied

Incident: No incident but concerns raised

Synopsis: Individual feels that service changes are not safe based on her own experiences giving birth in Withybush in the past.

Issues of concern: Individual did raise the issue that a bereavement room that was opened when her child died has since been closed.

Experience 24

Route: via email

Identifying details: Name and email address supplied

Incident: 5th June 2015

Synopsis: Parent reports bringing child with breathing problems into Withybush out of the PACU opening hours. Problems were increasingly acute and at one point a helicopter is due to be called. A&E stabilise son and consequently transfer him to Glangwili. A further episode some days later leads to an A&E visit in Withybush which leads to long waits through the night.

Issues of concern:

(1) Parents were unsettled by lack of paediatric care although A&E staff did stabilise breathing by use of nebuliser.
(2) Parent alleges that on-call doctor (unclear if this was paediatric on-call rota) did not pick up phone when A&E nurses rang.
(3) Consequent transfer to Glangwili was stressful and father not allowed to stay with his wife overnight despite ward largely empty leading to another journey.
(4) Subsequent additional visit to A&E in Withybush some days later led to another transfer with tiring journeys for father.

Experience 25

Route: via email

Identifying details: Name and email address supplied

Incident: January 2015

Synopsis: Pregnant mum-to-be has a scare of waters breaking at work. She visits Withybush midwives who tell her to drive to Glangwili.

Issues of concern:

(1) Mum-to-be describes very stressful and emotional journey on her own to get to Glangwili, unsure if her baby is safe.

Experience 26

Route: via email

Identifying details: Name and email address supplied

Incident: Date not specified

Synopsis: Pregnant mum suffers vaginal bleed at 11 weeks and attends A&E at Withybush. She then describes a period of care and delays which she feels was poor. She also subsequently describes difficulties in accessing midwives for an appointment in Withybush.

Issues of concern:

(1) Mum says she feels uncomfortable waiting in pain in the waiting room in A&E with others.
(2) She is told that she needs to go to Carmarthen and has a place organised in an ambulance but is apparently forgotten and eventually arrives in Carmarthen via another ambulance some 8 hours after first attending A&E.
(3) After checks and scans she tries to book follow-up appointments with midwives but can't get one for 3 weeks and describes problems in getting through to midwives' mobile phones.

Experience 27

Route: via email

Identifying details: Name and email address supplied

Incident: 3rd November

Synopsis: Mum brought in to Glangwili to be induced and describes a range of issues during this period.

Issues of concern:

(1) Mum reports lack of privacy for intimate examinations and not being able to have 2 birth partners unlike Withybush.
(2) Consultant had requested close monitoring due to previous induction going wrong but drugs were administered and subsequently nobody monitored after initial monitoring until evening.
(3) She describes care throughout labour as outstanding by midwives and surgeon and anaesthetist as "fantastic".
(4) After the baby was born she describes a very cramped room with barely enough room for the cot.
(5) Staff were quite variable, one midwife was seen as unapproachable whilst others were excellent.
(6) Following a heavy bleed, blood spatters were inadequately cleaned and remained during duration of stay. Room also had sweet wrappers and old cannula caps on floor.

Experience 28

Route: via email

Identifying details: Name and email address supplied

Incident: Date not specified

Synopsis: Lady from Pembrokeshire under consultant care whose first birth was very short was concerned that she might not make it to Glangwili. She reports giving birth in an ambulance en route to Glangwili.

Issues of concern:

(1) This lady notes the birth went well but was unsettled to give birth this way and believes this would not have happened under the previous system.

Experience 29

Route: via email

Identifying details: Name and email address supplied

Incident: August 2014

Synopsis: Father recounts experiences after son is born prematurely. He describes the impact of travelling to Singleton over 3 months and the significant problems this has created.

Issues of concern:

(1) The main issue raised is that the closure of SCBU in Withybush created huge strain on him and his wife. He describes the substantial financial costs and impact on his own health of travelling to Singleton on a regular basis. He feels this was a preventable situation had Withybush still been operating with a SCBU.

Experience 30

Route: via email

Identifying details: Name and email address supplied

Incident: 29/05/2015

Synopsis: Mum describes her experiences as her pregnancy develops up to birth and postnatal care. This is far from a negative experience but she notes a range of issues and points of concern.

Issues of concern:

(1) Mum reports feeling in the dark during the early weeks of pregnancy when trying to access community midwives and understand how the process works.
(2) Late notification of first scan (arrived in post on the day of the procedure) meant that husband could not take part.
(3) Waits to be seen for clinics appointments could be hours after the original allotted time.
(4) She reports wanting to arrange a visit to the labour ward at Glangwili but made to feel unwelcome by staff member she spoke with on the phone.
(5) The knowledge and experience of the midwives would benefit the women on the ward if they had more time to spend with each one.
(6) After a complicated birth she reports staying on the birthing bed with all of the 'mess' from the birth around her until nearly 4 hours after birth.
(7) Mum reports that blood test results for her baby were not read for 37 hours. She felt this could have created problems if her baby had needed antibiotics or medication.

(8) Discharge was delayed by the analysis of these results and also the lack of paediatric consultants to sign off final health checks. Mum reports being ready to leave from the morning but through waiting for the paediatrician they left at 11:30pm.
(9) She says the ward was becoming very crowded on the evening of her discharge and had she stayed that night, she would have been sharing a room with a woman in labour.
(10) Whilst waiting for labour to become more established Mum says her husband was asked to leave. In this case (and due to living an hour away) the husband stayed in his car but was worried that other fathers who are sent home may miss the labour due to the distances involved.

Experience 31

Route: via email

Identifying details: Name and email address supplied

Incident: 14th December

Synopsis: The Pembrokeshire mother of a 12 year old child describes her daughter struggling to breathe normally and her experiences in accessing emergency care. Initially she contacts the Out of Hours GP and subsequently travels to A&E at Glangwili.

Issues of concern:

(1) The nurse who rang this lady back advised that she make her way to Glangwili herself as no ambulances were available.
(2) Out of Hours say they will ring ahead but Glangwili deny this happened when mother and daughter arrive at A&E.
(3) A&E is described as chaotic and there are long delays before the daughter is seen.
(4) The mother feels that for those in a similar situation with no car, this could have been dangerous.