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**Quality, Safety and Experience Committee
Escalation De-escalation Criteria Progress Update
12 February 2026**



This pack provides the Quality, Safety and Experience Committee (QSEC) with an evidence-based update against the Targeted Intervention (TI) de-escalation criteria within the Quality, Safety and Experience remit. It triangulates the latest position across Urgent and Emergency Care (UEC) services within Community and Integrated Medicine (CIM), Planned Care and Cancer within Planned and Specialist CCG (PSC), hospital-acquired infections (HCAI), and our response to HIW inspections and wider regulatory requirements.

The update draws on the 'Our Performance' dashboard (as at December 2025), aligned Datix/complaints extracts for the relevant service cuts, the Health Inspectorate Wales (HIW) inspections action dashboard (as at 29 January 2026), and the Beacon dashboard summary slides included within this pack. The purpose is to provide QSEC with clear line of sight on: (i) current position against the de-escalation thresholds; (ii) the scale and ageing of incidents, complaints and regulatory actions; (iii) the credibility of improvement trajectories and evidence of sustainability; and (iv) where assurance remains constrained and further executive intervention is required.

Introduction

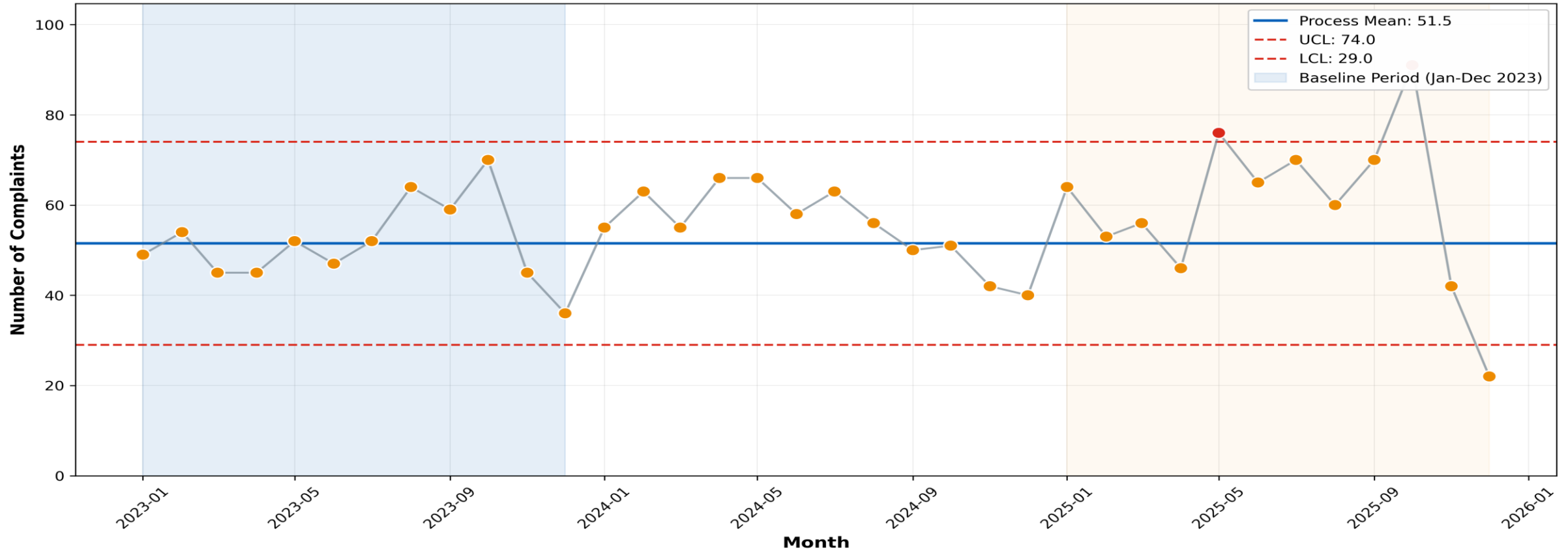


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TI Reference	Criterion Summary	Committee Relevance	Current Rating
MD1	Ability to identify early signs of service fragility through triangulation of workforce, incidents, complaints, mortality and regulatory intelligence	Fragile Services Framework oversight, escalation to QSEC	Advise
MD2	Leadership, accountability and improvement planning in fragile services, including clinical leadership appointments and Project Management support	Improvement plan integrity and leadership assurance	Advise
MD3	Tracking and closing external recommendations (HIW, Royal Colleges, regulators) through a central, reliable system	Quality governance, external recommendation assurance	Advise
MD4	Board visibility and oversight of fragile services, including routine reporting of trajectories and improvement milestones	QSEC scrutiny of fragile services reporting before Board	Advise
MD5	Handling of concerns, complaints and incidents within UEC, including responsiveness, investigation timeliness and learning	Incident/complaints governance, UEC safety and learning	Advise
MD6	Reduction in Clostridioides difficile infections (hospital-onset ≤ 6 cases for 3 consecutive months)	Infection Prevention Control (IPC) performance oversight; organism-specific reduction	Advise
MD7	Reduction in Staphylococcus aureus bacteraemia (hospital-onset ≤ 2 cases for 3 consecutive months)	IPC oversight; bacteraemia performance	Alert
MD8	Reduction in Escherichia coli bacteraemia (hospital-onset ≤ 5 cases for 3 consecutive months)	IPC oversight; urinary/biliary infection improvement	Alert
MD9	Addressing root causes of hospital-acquired infections (learning, environmental audits, HPV, training compliance, pathways)	System-wide IPC assurance	Alert
MD10	Planned care incident, complaint and feedback management, and patient experience during long waits	Incident governance, complaints performance, PX	Alert
MD11	Prompt and effective responses to HIW inspections, regulatory notices, never events and coroners' reports	Regulatory assurance oversight	Advise
MD12	Improving patient and family feedback; timely complaint resolution; embedding learning	Patient experience governance	Alert

Community & Integrated Medicine: Monthly Complaints Statistical Process Control Chart (Jan 2023 - Dec 2025)



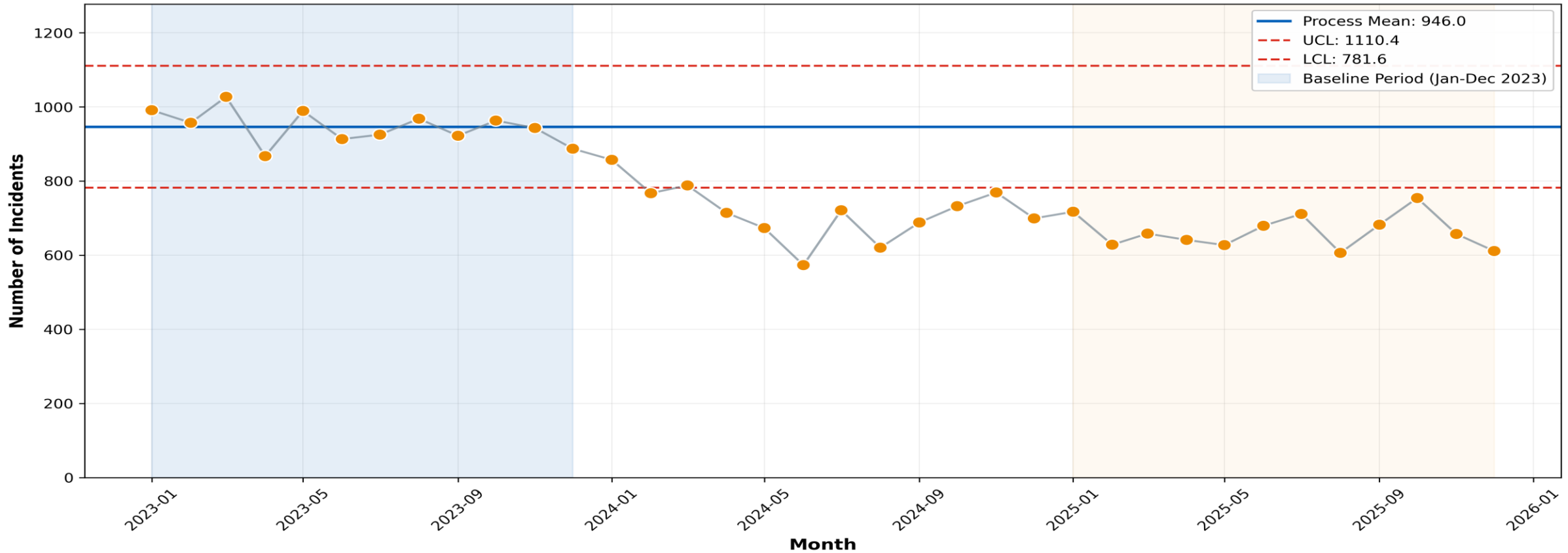
SPC Analysis Key Points

- Process mean: 51.5 complaints/month (baseline Jan-Dec 2023)
- UCL: 74.0 | LCL: 29.0
- 2025 mean: 59.6 (16% above baseline)
- October spike (91) exceeds UCL – special cause
- December drop (22) below LCL – requires investigation

Rationale – Advise

The SPC chart shows common cause variation with isolated special cause signals. The October spike (91 complaints) exceeded the upper control limit, whilst December showed an unusually low count (22). The process mean has shifted upward in 2025 compared to baseline. Whilst not demonstrating sustained deterioration, the volatility and upward drift warrant continued monitoring to ensure the underlying process remains stable.

**Community & Integrated Medicine: Monthly Incidents
Statistical Process Control Chart (Jan 2023 - Dec 2025)**



SPC Analysis Key Points

- Process mean: 946 incidents/month (baseline)
- UCL: 1,110 | LCL: 782
- 2025 mean: 664 (30% reduction from baseline)
- 22 points below LCL – sustained special cause (positive)
- 19 consecutive runs below mean confirms process shift

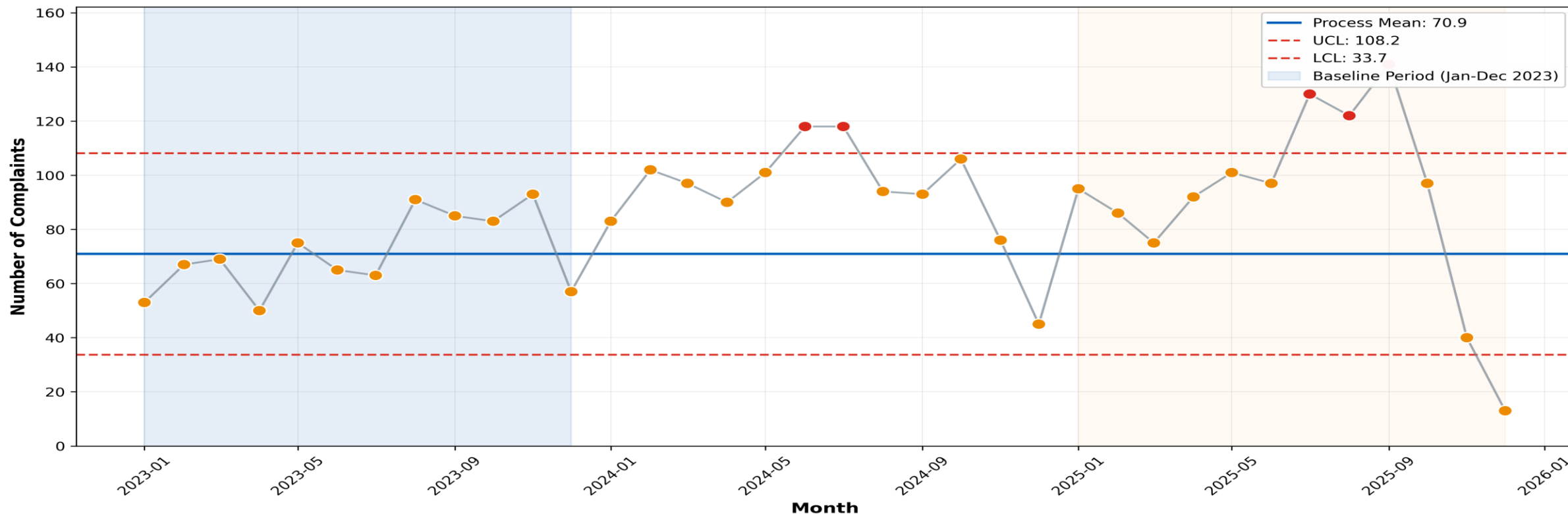
Rationale – Advise

The SPC chart demonstrates positive special cause variation, with a sustained and significant reduction in incident volumes from the 2023 baseline. The 30% reduction represents meaningful improvement in incident occurrence (New not Backlog). However, the narrative context reveals that 1,663 incidents remain over 3 months old with some cases exceeding 1,400 days. Whilst new incident volumes have reduced, the backlog clearance and investigation timeliness remain significant concerns, preventing an Assure rating.

TI-2025/547/MD10/1 – Planned and Specialist Care (SCP) Complaints

ALERT

Planned & Specialist Care: Monthly Complaints Statistical Process Control Chart (Jan 2023 - Dec 2025)



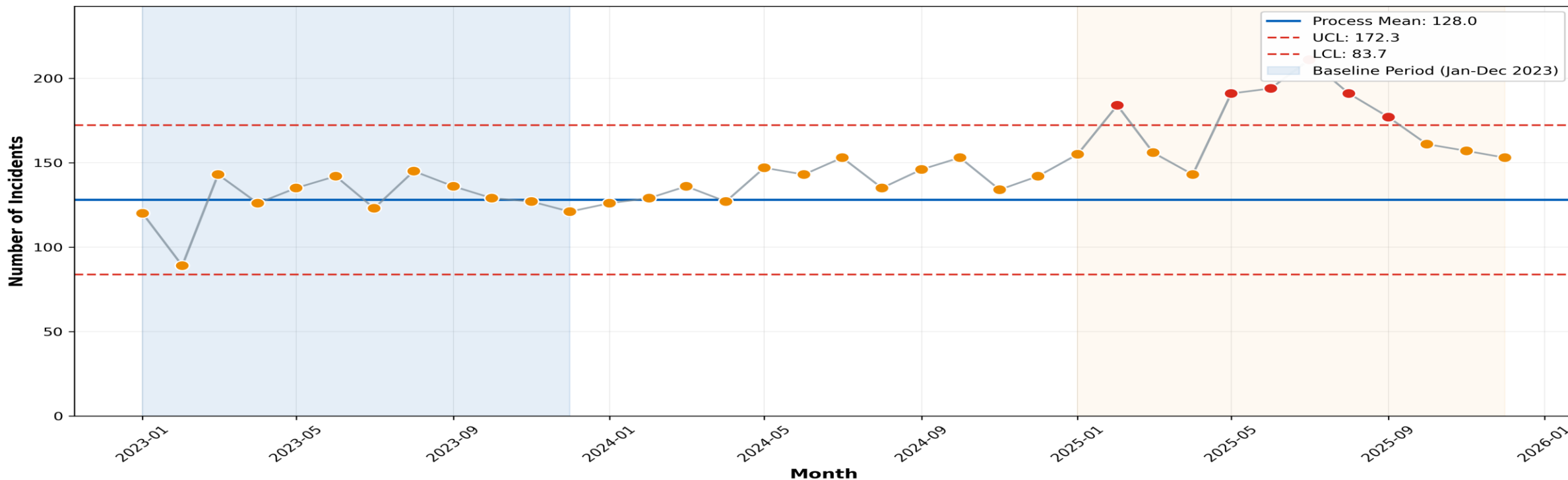
SPC Analysis Key Points

- Process mean: 70.9 complaints/month (baseline)
- UCL: 108.2 | LCL: 33.7
- 2025 mean: 90.8 (28% above baseline)
- 5 points above UCL (Jul-Sep) – sustained special cause
- September peak (141) significantly exceeds UCL

Rationale – Alert

The SPC chart demonstrates negative special cause variation with a sustained upward shift in complaint volumes and timeliness. Five consecutive months (Jul-Sep 2025) exceeded the upper control limit, with September reaching 141 complaints. This pattern, combined with complaint timeliness data showing cases outstanding for up to 495 days in Obstetrics, indicates systemic pressures within PSC. The Alert rating reflects both the statistical evidence of process deterioration and the operational context of elective pathway fragility.

Planned & Specialist Care: Monthly Incidents Statistical Process Control Chart (Jan 2023 - Dec 2025)



SPC Analysis Key Points

- Process mean: 128 incidents/month (baseline)
- UCL: 172 | LCL: 84
- 2025 mean: 173 (35% above baseline)
- 6 points above UCL – sustained special cause (negative)
- July peak (211) significantly exceeds UCL

Rationale – Alert

The SPC chart demonstrates negative special cause variation with a sustained upward shift in incident volumes. The 2025 mean (173) now exceeds the upper control limit established from the 2023 baseline. Six months exceeded the UCL, with July reaching 211 incidents. Combined with the narrative evidence of 432 incidents aged over 3 months and cases outstanding for up to 908 days, this indicates systemic pressures requiring urgent intervention. The sustained deterioration and backlog accumulation warrant an Alert rating.

Healthcare Acquired Infections (HCAI) De-escalation Criteria and 2025 Status

Requirement: Achieve target reduction and maintain for 3 consecutive months

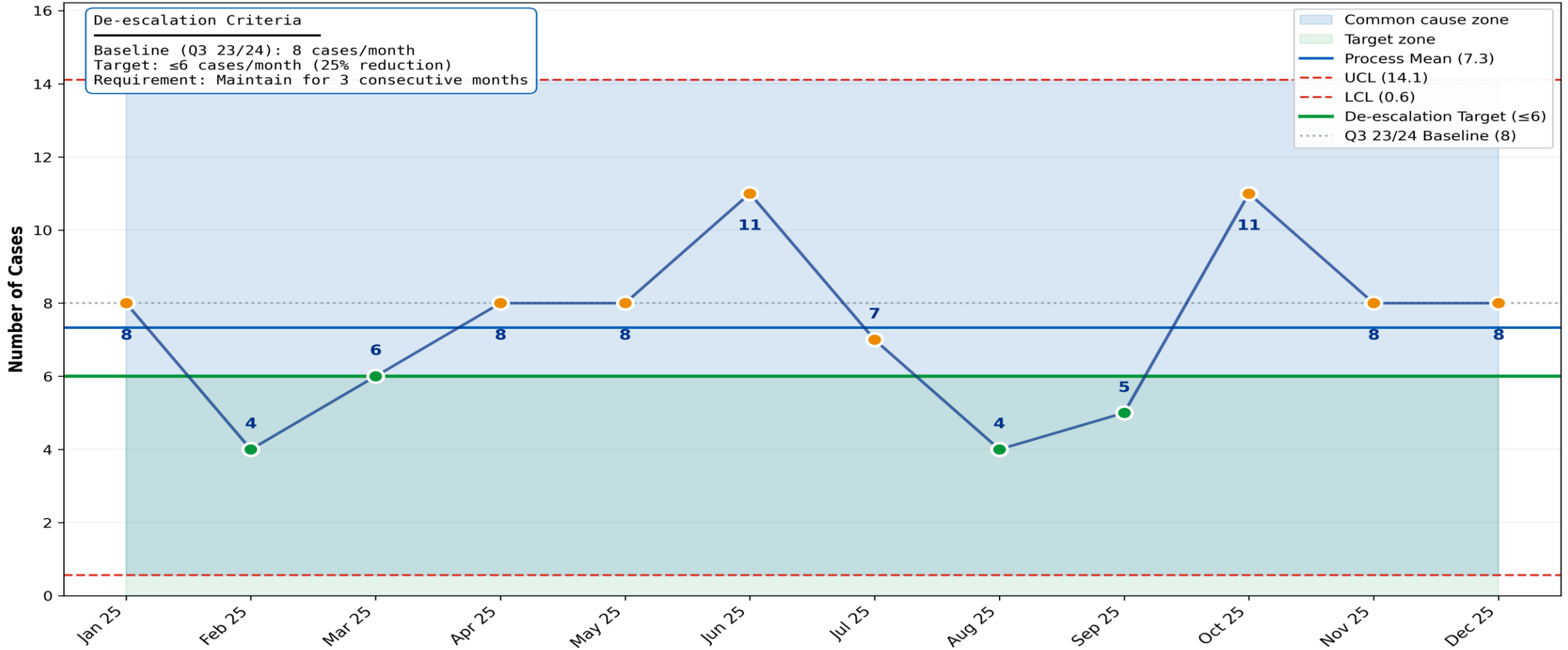
Infection	Baseline (Q3 23/24)	Target	Reduction Required	2025 Months at Target	Max Consecutive Months	De-escalation Status
C. difficile	8 cases/month	≤6 cases/month	25%	4/12	2	Alert
S. aureus	3 cases/month	≤2 cases/month	33%	0/12	0	Alert
E. coli	7 cases/month	≤5 cases/month	25%	3/12	2	Alert

Key Finding: None of the three HCAI metrics meet de-escalation criteria in 2025

- **S. aureus:** Most challenging – zero months at target throughout 2025; December spike to 6 cases
- **C. difficile:** Mid-year improvement (Aug-Sep) not sustained; recurring spikes to 11 cases (Jun, Oct)
- **E. coli:** Strong start (Jan: 0, Feb: 5) but deteriorated significantly in H2 2025

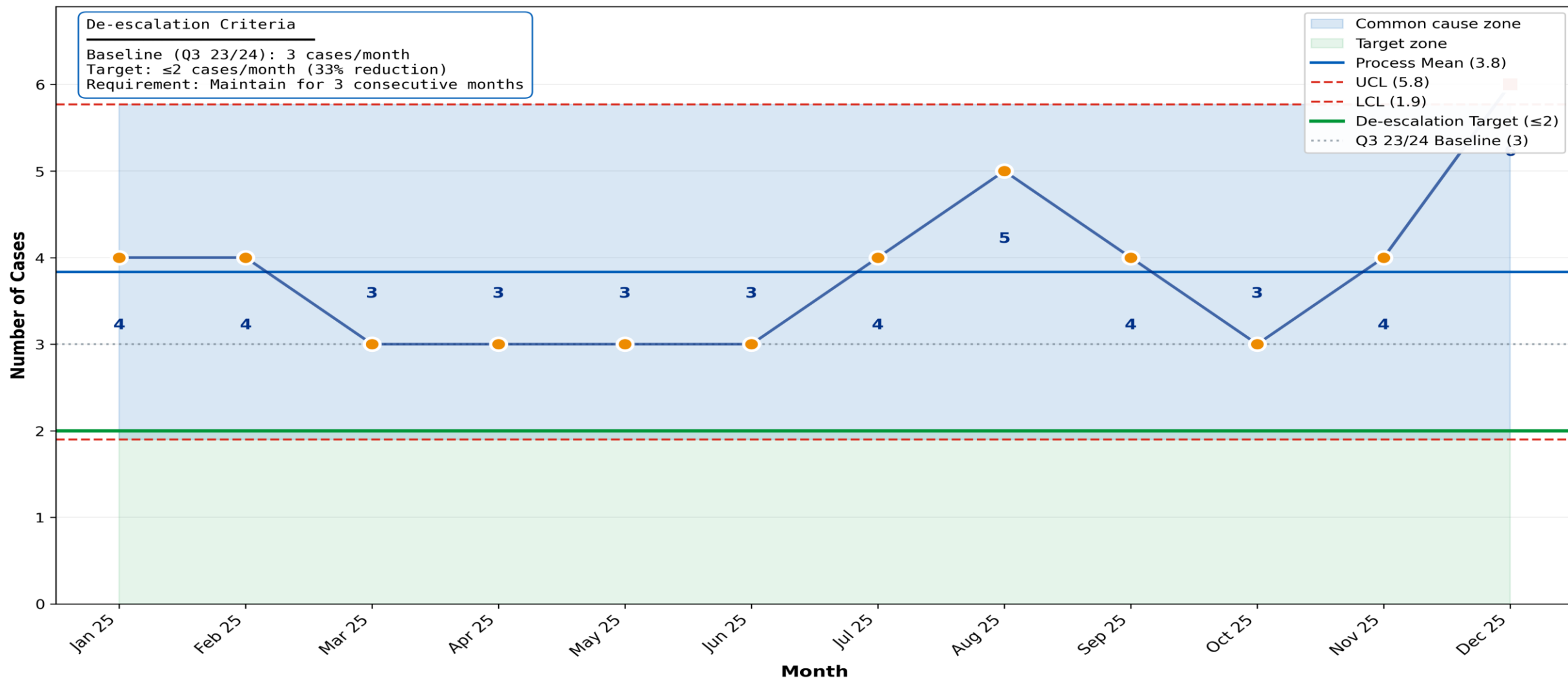
C. difficile: Statistical Process Control Chart

C. difficile Hospital-Onset Infections: SPC Analysis (2025)



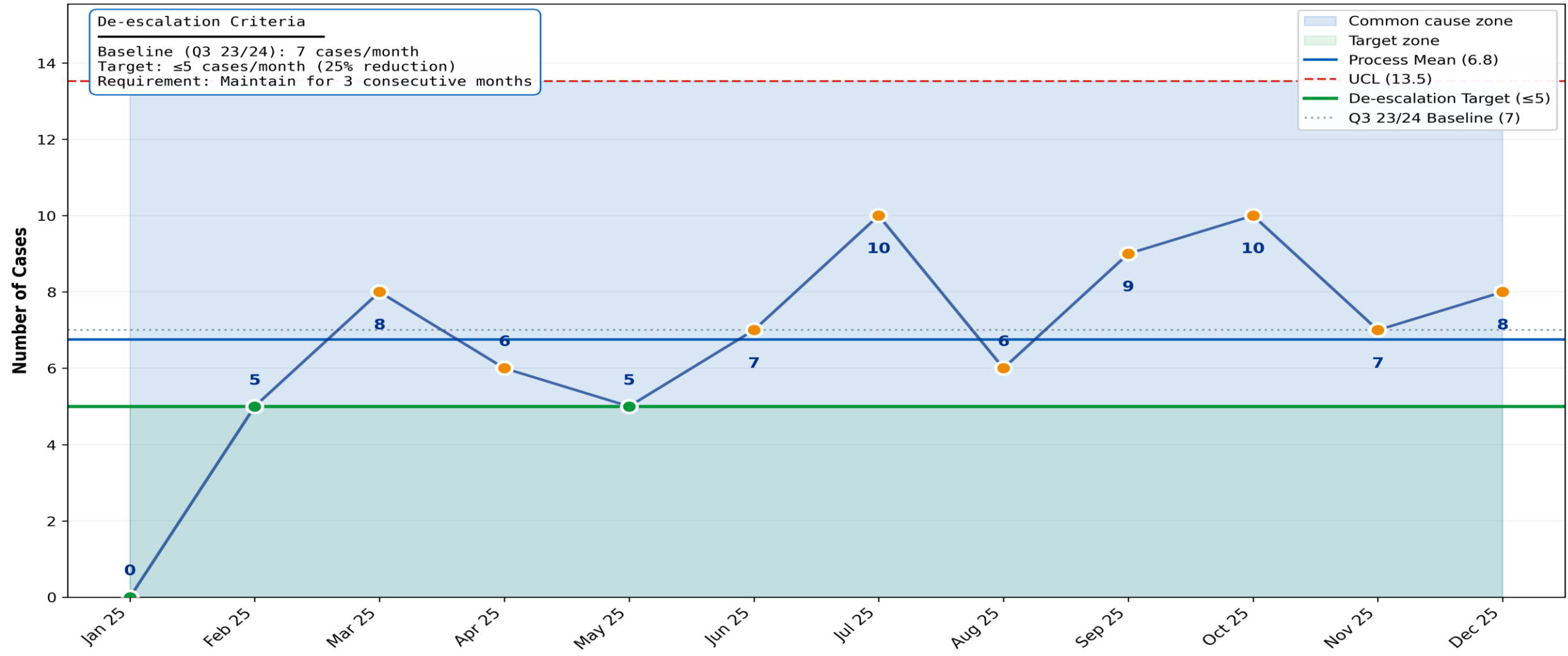
S. aureus Bacteraemia: Statistical Process Control Chart

S. aureus Bacteraemia Hospital-Onset Infections: SPC Analysis (2025)



E. coli Bacteraemia: Statistical Process Control Chart

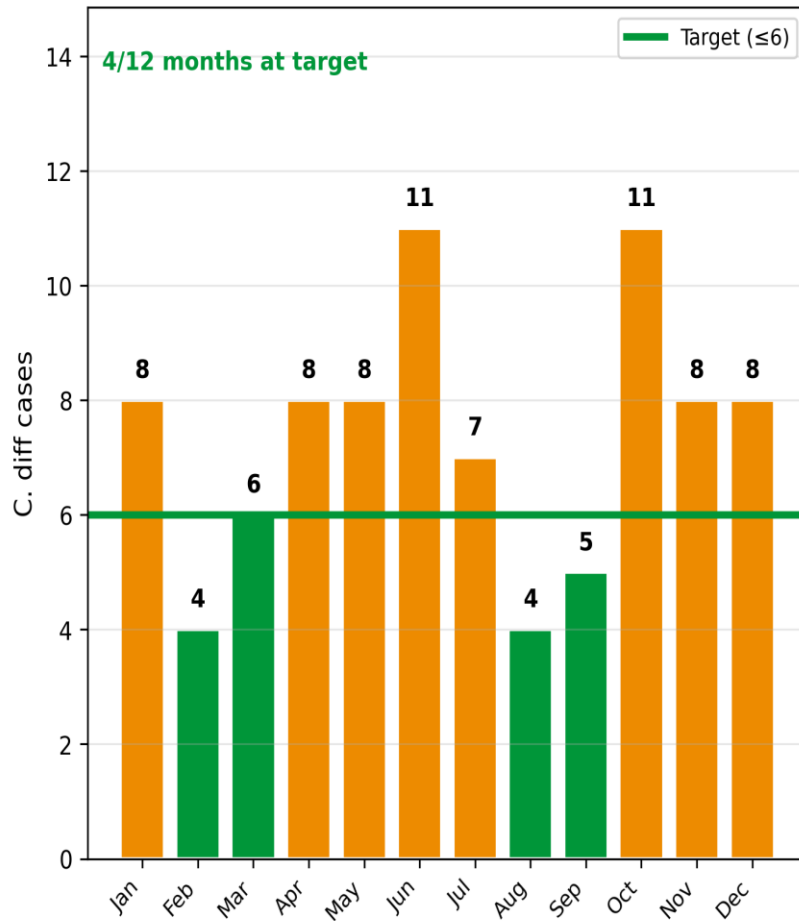
E. coli Bacteraemia Hospital-Onset Infections: SPC Analysis (2025)



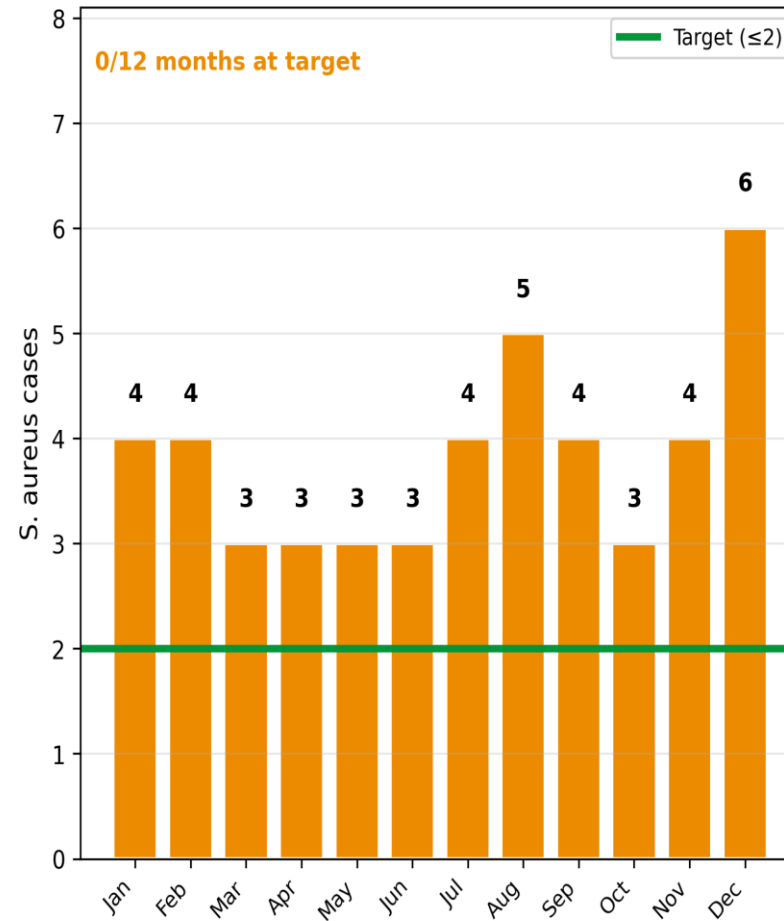
2025 Performance Summary

Hospital-Acquired Infections: 2025 Performance Summary

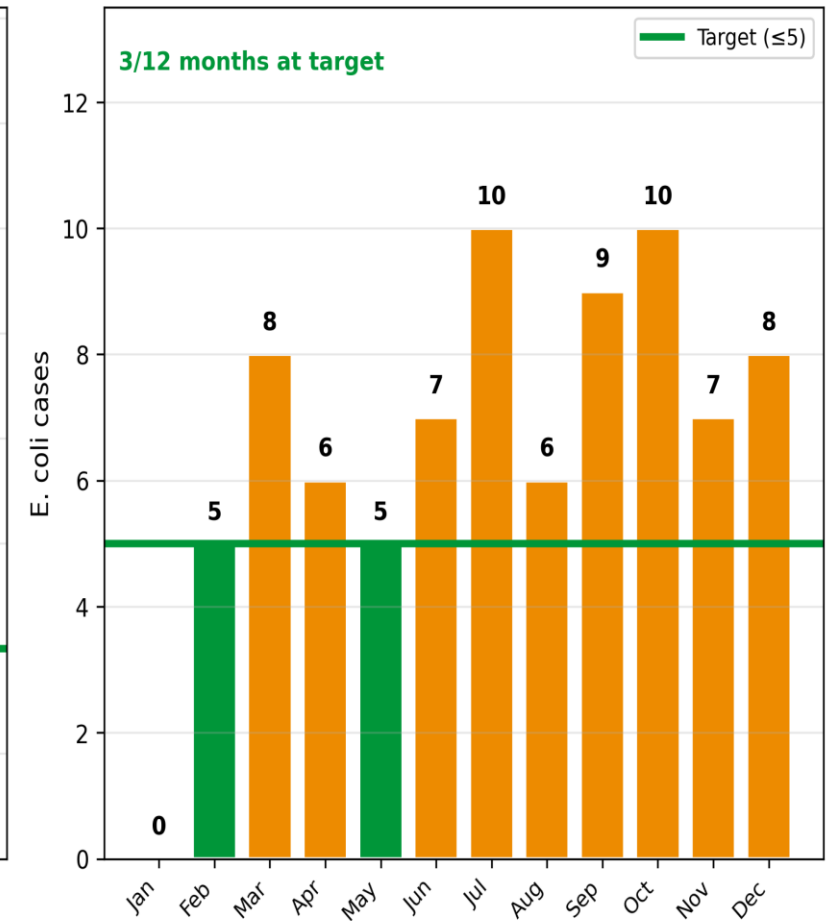
C. difficile



S. aureus bacteraemia



E. coli bacteraemia



2025 Monthly Data

Infection	Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
C. diff	≤6	8	4	6	8	8	11	7	4	5	11	8	8
S. aureus	≤2	4	4	3	3	3	3	4	5	4	3	4	6
E. coli	≤5	0	5	8	6	5	7	10	6	9	10	7	8

Colour key: Green = at or below target | Orange/Red = above target

SPC Analysis Summary

C. difficile: Process mean 7.3 cases/month (UCL 14.1, LCL 0.6). Recurring pattern of spikes to 11 cases in June and October suggests potential systemic or seasonal factors. Best performance in Feb (4), Aug (4), Sep (5).

S. aureus: Process mean 3.8 cases/month (UCL 5.8, LCL 1.9). December spike to 6 cases approaches UCL – requires investigation. Stable at 3 cases Apr-Jun but target of ≤2 requires 47% further reduction.

E. coli: Process mean 6.8 cases/month (UCL 13.5). January anomaly (0) cases. Clear H2 deterioration with Jul-Oct averaging 9 cases. Only 3 months at target, none consecutive from March onwards.

Key Findings

1. De-escalation criteria NOT MET for any HCAI metric in 2025
2. *S. aureus*: Zero months at target – requires step-change intervention
3. *C. difficile*: Recurring spikes (11 cases June -October 2025) indicate systemic issues
4. *E. coli*: H2 deterioration with 6 consecutive months above target (July-December 2025)
5. All three process means exceed their respective targets
6. Current processes display common cause variation (high non-compliant mean/average) – fundamental change needed

TI-2025/547/MD9/1 – Addressing root causes of HCAIs



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Lead executive - Mrs Sharon Daniel, Director of Nursing, Quality and Patient Experience

Issue

Beyond meeting organism-specific numerical targets, the Health Board must demonstrate comprehensive understanding of the underlying drivers of HCAIs and provide evidence that actions taken are leading to sustained reductions in infection burden.

Current status

The Infection Prevention Strategic Steering Group (IPSSG) oversees a broad Quality-Planning, Quality-Control and Quality-Improvement programme. Key actions include:

- Delivery of the annual IP&C work plan and compliance with Wales-wide HCAI improvement circulars.
- Strengthened surveillance structures via standardised scrutiny meetings for hospital-onset HCAIs.
- Environmental audit and observational audit programmes, with improvement plans monitored.
- HPV enhanced cleaning implemented across three acute sites.
- HCID/ID pathway training completed for GGH and BGH, with PPH and WGH scheduled later in 2025.
- Participation in the Wales *C. difficile* Focus Forum and National Learning Collaborative.

Dashboard data to December 2025 shows:

- **Mixed trends across all three organisms**, with improvements in August for *C. diff* (4) and November for *E. coli* (5), but subsequent relative deterioration in December (*C. diff* 8; *E. coli* 8).
- ***S. aureus* fluctuating** between 3–6 cases throughout the period, without achieving the TI threshold.

TI-2025/547/MD9/1 – Addressing root causes of HCAIs



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Rationale - Alert

The improvement infrastructure is robust and multi-layered, and there are clear examples of month-on-month improvement (e.g. August). However, no de-escalation threshold relating to said organisms is achieving sustained performance below TI thresholds, and December data show relative deterioration in both *C. diff* and *E. coli*. The mixed infection profile and the absence of sustained impact from interventions justify an Alert rating

TI-2025/547/MD11/1 – Prompt responses to inspections, incidents and regulatory notices



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Lead executive - Mrs Sharon Daniel, Director of Nursing, Quality and Patient Experience

Issue

The Health Board is required to demonstrate that it responds promptly, consistently and effectively to HIW inspections and wider regulatory notices. The reliability of these processes is an important component of assurance under Targeted Intervention, particularly given the breadth of inspections across acute, community and mental health services over the past 18 months.

Current status

The latest inspection dashboards provide a detailed and, in some areas, challenging picture. Fourteen HIW inspections are currently active, generating a combined 451 actions. While nearly 300 of these have now been completed, the remainder show a mixed pattern of timely progress, partial completion and overdue work.

A review of the inspection summary indicates that:

- 295 actions have been fully completed.
- 156 actions are still in progress, with a relatively small proportion recorded as partially complete. With 4 completed and currently waiting approval.
- However, 68 actions are now overdue, and a further 12 have been marked as unable to complete.

This means that although the Health Board is closing the majority of inspection actions, there is a persistent number of delayed actions.

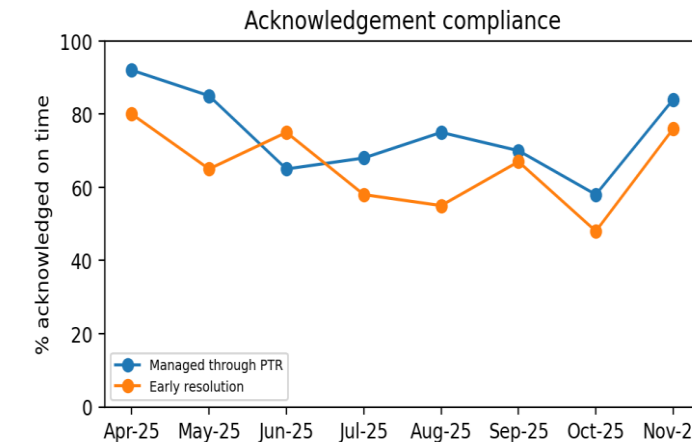
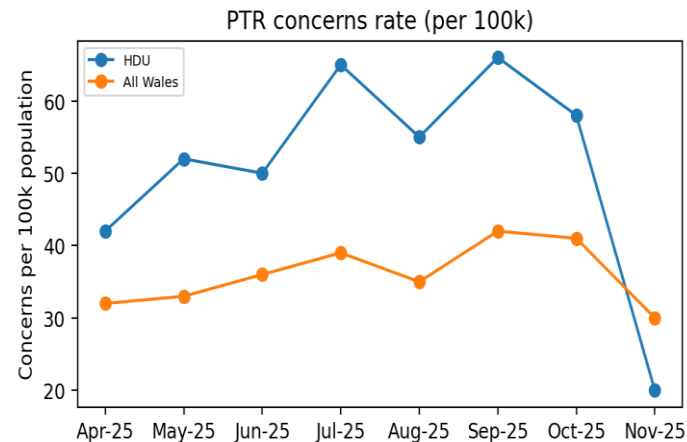
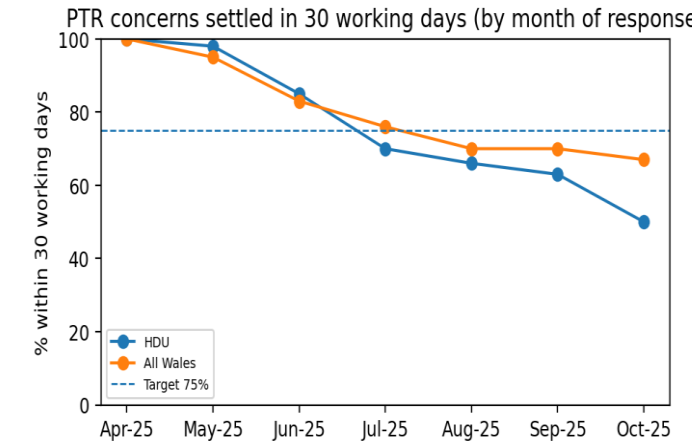
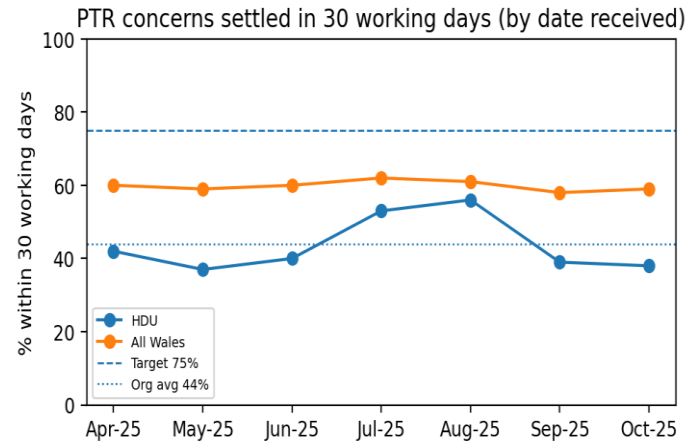
Beacon Dashboard – patient concerns (Putting Things Right (PTR)): what the Graphs are telling us

Apr–Nov 2025



Headline messages

1. Timeliness by date received is consistently below the 75% 30-working-day expectation (Oct 38% vs target 75%: -37pp; All Wales 59%: -21pp).
2. Timeliness by month of response deteriorates across the year (Apr 100% → Oct 50%), consistent with increasing backlog / throughput pressure (and possibly change to legislation/reporting).
3. Demand signal - PTR concerns per 100k is above All Wales for most months Apr–Oct (peak 66 per 100k in Sep), before a marked drop in Nov.
4. Process reliability - acknowledgement compliance is variable (approx 48–92%), with a notable dip in Oct and recovery in Nov.



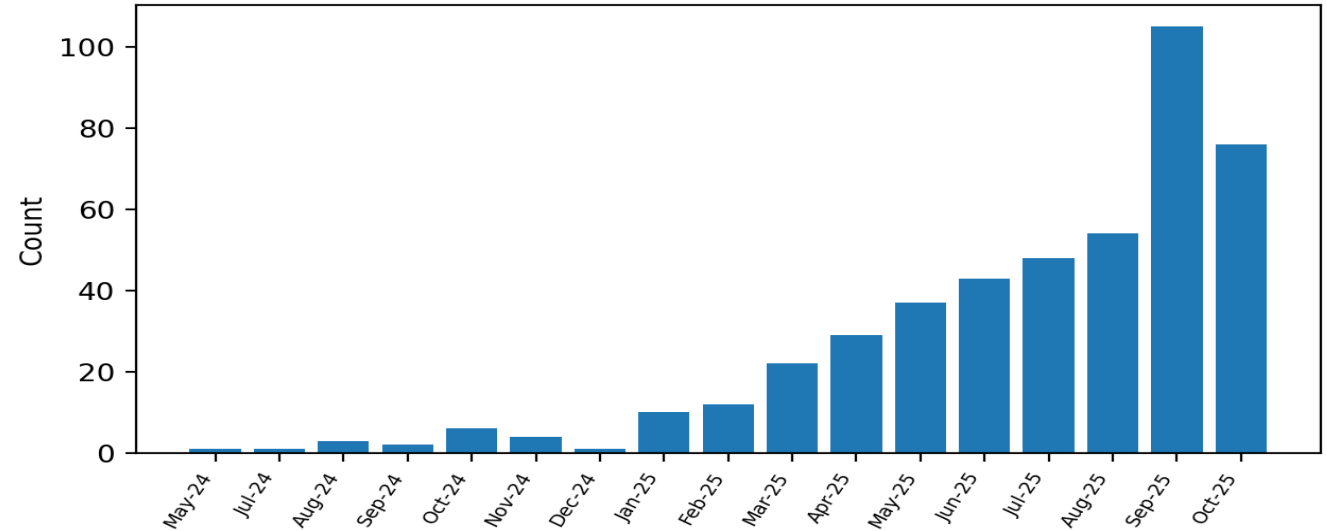
Backlog and flow – where the constraint is showing up

Overdue open concerns (Dec 2025 snapshot) and route mix (Apr–Nov 2025)

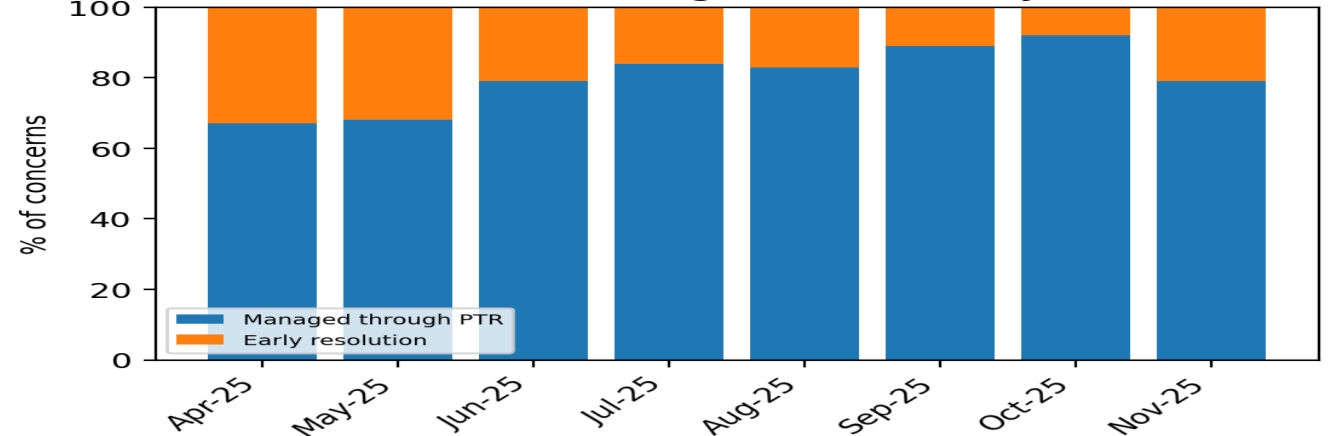
What the backlog distribution implies

1. Open overdue concerns: 454 in total (sum of all bars shown).
2. Backlog is concentrated in recent months: Aug–Oct 2025 = 235 (52%); Sep–Oct alone = 181 (40%).
3. Route mix shifted heavily towards formal PTR handling (up to 92% PTR / 8% early resolution in Oct), which is likely increasing workload and lengthening cycle time.
4. If the aim is to recover timeliness, the first order priority is reducing overdue count while stabilising inflow (triage + early resolution).
5. Learning loop - use a simple monthly 'themes → actions → impact' log so that concerns translate into demonstrable improvement.

Open concerns now overdue (count by month)



How concerns are managed (PTR vs Early resolution)



Conclusion



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- Across the TI criteria covered in this update, the position remains mixed. Unscheduled and Emergency Care (CIM integrated systems) and Planned Care and Cancer (Cancer & Scheduled Care) continue to carry sizeable backlogs of aged incidents and open complaints, and the dominant constraint remains timeliness of service responses and closure. This limits the level of assurance that can be provided at this point in time, notwithstanding improvements in parts of the reporting period.
- HCAI performance has not met de-escalation criteria for any of the organism metrics during 2025 and the broader root-cause criterion remains at Alert, reflecting the absence of sustained impact from interventions and recent deterioration in the profile. The HIW inspections portfolio shows strong overall completion, but overdue exposure has increased materially following the Emergency Department inspection cohort, requiring disciplined, time-bound closure trajectories and explicit resourcing.
- The Beacon dashboard content within this pack provides additional triangulation on performance stability, areas of volatility and the extent to which improvement is sustained over time. Taken together, the evidence indicates that on-going efforts are required to reduce the oldest and most overdue cohorts and to demonstrate sustained compliance with de-escalation thresholds.



The Committee is asked to note:

- The current position against the TI de-escalation criteria within the QSEC remit, triangulated through the 'Our Performance' dashboard for Datix/complaints extracts (PSM; CIM integrated systems), the HIW inspections dashboard, and Beacon dashboard evidence contained within this pack.
- The scale and ageing profile of open complaints and incidents, and that the principal constraint to closure remains timely "awaiting service comments" / response completion.
- The HIW inspections action position and the concentration of overdue actions within a small number of inspections, particularly the ED inspection cohort.

The Committee is asked to recognise:

- That improvement is not yet consistently evidenced as sustained across the criteria set, and that "direction of travel" alone is insufficient for de-escalation where ageing/backlog and timeliness remain outside threshold.
- That the Beacon dashboard evidence strengthens triangulation on stability/volatility and should be read as part of the overall evidence base for assurance within this pack.



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