Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

1. Finance, strategy and planning
2. Performance and outcomes
3. Fragile services
4. Governance
5. Leadership, capability and culture
6. Quality of care

Escalation Domains

Quality, Safety and Experience Committee (QSEC)

13th February 2025

Targeted Intervention Progress Report

Introduction

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- The following slides highlight five material Targeted Intervention (TI) de-escalation criteria for QSEC's consideration. These criteria have been selected due to their strategic importance, potential to escalate if not carefully managed, and relevance to ongoing quality and safety improvements. While some indicators appear relatively stable or in an 'Assure' status at present, they could quickly move into an alert status if performance or key mitigations begin to deteriorate. Consequently, it is critical that the Committee maintains clear oversight of these areas, ensuring that timely interventions and sustainable improvements are delivered.

Healthcare Associated Infections (HCAIs) & Infection Prevention

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(TI Criterion #50)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Advise

Key Points

- Trajectory & Performance - Focus on Clostridium difficile, Staph aureus, and E. coli.
- Data shows stabilisation/improvement in C. diff and E. coli rates; Staph aureus remains variable.

Quality Improvement Plan

- Root Cause Analysis (RCA) reviews, Aseptic Non Touch Technique (ANTT) training (target ≥85%), enhanced cleaning.
- Most recent plan reviewed on 30th October; feedback provided to ensure sustainability.

Risks & Actions

- Risk of reversion to higher infection rates if device management or hand hygiene lapses.
- Ongoing monthly performance monitoring at executive level to maintain scrutiny.

Complaints & Patient Concerns

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(TI Criterion #51)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Assure

Key Points

- Performance - Closure rate of complaints within 30 working days is 78.4%, exceeding the 70% TI threshold.
- 5-day early resolution window significantly reduced Putting Things Right (PTR) caseload.

Quality & Engagement

- Workshops with clinical leads to enhance the quality of responses.
- Aligning complaint processes with new PTR regulations (Q1 2025–26).

Risks & Actions

- Sustaining quality alongside the pace of closures.
- Ensuring robust escalation pathways if volumes spike or if clinical complexities arise.

Outstanding External Recommendations

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(TI Criterion #34 AND #52)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Alert

Key Points - Scope & Oversight:

- Recommendations from Health Inspectorate Wales (HIW), Ombudsman, Royal Colleges.
- Some delays persist due to capacity constraints and unrealistic initial deadlines.

Progress & Gaps

- A planned ‘deep dive’ into older/unresolved actions aims to accelerate completion.
- Ombudsman engagement remains generally positive, though three new investigations opened recently.

Risks & Actions

- Delays could create reputational/regulatory risks if not resolved.
- Recalibrate action plans with realistic deadlines; track progress through QSEC.

Patient Experience & Feedback Loop

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(TI Criterion #23)

Executive Lead: Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

Current Status: Advise

Key Points

- Data Integration - CIVICA, Datix, and FFT feedback are routinely reviewed for quality and service improvements.
- FFT consistently >90% satisfaction; high volume of feedback compared with other Health Boards.

Assurance & Improvements

- Positive external assurance from the Welsh Risk Pool audit and Ombudsman feedback.
- Further embedding patient feedback loops into directorate reporting from Q3 2024–25.

Risks & Actions

- Ensuring uniform adoption of feedback-to-improvement cycles across all services.
- Maintaining response rates and continuing to improve user engagement.

5. Fragile Services & Board Assurance

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(TI Criteria #32, #33 & #35)

Executive Lead: Lee Davies, Executive Director of Strategy and Planning (with operational input from Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience)

Current Status: Advise

Key Points

- Identification & Tracking - Existing safety dashboard (staff sickness, agency use, IPC data) provides partial view.
- Need to integrate additional metrics (mortality reviews, patient experience, complaints) for a comprehensive fragility assessment.

Board Oversight

- Clinical Service Plan (CSP) has highlighted system fragilities (e.g., site configuration, workforce pressures).
- A methodology for assessing broader service fragility was presented to QSEC; a formal register of fragile services is still in development.

Risks & Actions

- Without a fully established framework, potential blind spots may emerge.
- Plan to present an updated approach to the Public Board (March 2025), ensuring a cohesive response across all fragile services.

Summary & Next Steps for QSEC

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1. **HCAIs & Infection Prevention** – Ensure the Infection, Prevention and Control (IPC) plan is clear and on track; ensure long-term sustainability of improvements.
2. **Complaints & Patient Concerns** - Maintain above-target closure rates while improving the quality of responses; align with PTR changes.
3. **Outstanding External Recommendations** - Address capacity constraints, recalibrate deadlines, and use a ‘deep dive’ to clear any backlog.
4. **Patient Experience & Feedback** - Fully embed CIVICA and FFT data at directorate level; sustain ≥90% satisfaction.
5. **Fragile Services & Board Assurance** - Finalise and operationalise the fragility assessment framework; present updates to QSEC and the Board.

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SAFE | SUSTAINABLE | ACCESSIBLE | KIND

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Criteria	Action	Reporting Group	Committee	Status	Status Change	Status Change Date	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Delivery (Evidence)	Actions Outstanding	Evidence and Assurance	Risk
23	Improving ratings from service user feedback experience responses and evidence of use of Datix and CIVICA data to inform quality improvement processes and the experience of patients and their families.	IQFPD	QSEC	Advise			Sharon Daniel	•Better Data Integration - CIVICA, Datix, and FFT are now standard inputs in routine meetings, offering a broader view of patient feedback. •High FFT Scores - Patient satisfaction consistently exceeds 90%. •External Feedback - Generally positive Ombudsman engagement (12 decisions not to investigate, 2 partly upheld), plus significant assurance from the Welsh Risk Pool audit.	If the status for alert relates to ongoing monitoring thenm this is fair. Feedback from service users via the FFT is consistently above 90%. The amouont of feedback received in Hywel Dda is significantly higher than other HB (although there is no national standard/benchmar for this). The HB receives pt Experience report at each meeting , this is not the case across Wales. We have had favourable feedback from the Ombudsman this year and have achieved sigificat assurance from the WRP audit. “We have improved how patient experience data is used, and we will keep expanding these feedback loops to strengthen quality improvement across all services.”	•Embed patient experience data into all directorate reports (in place from Quarter 3 of 2024–25). •Provide regular updates to QSEC/Board.	•Fully incorporate Datix/CIVICA feedback into formal quality improvement projects (target: Quarter 4 of 2024–25). •Maintain FFT satisfaction above 90% and keep improving complaints response times	•FFT Scores; Ombudsman feedback; WRP audit reports. •Directorate packs and escalation meeting minutes.	1184 (P)
32	Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through the triangulation of key data points including staffing levels staff and patient feedback concerns incidents stakeholder feedback (HIW AW HMC RC Llais etc) mortality reviews duty of quality/candour infection protection control performance clinical and medical leadership.	IQFPD	QSEC	Advise			Sharon Daniel	The health board’s safety dashboard currently includes essential data points such as staff sickness, agency use, infection prevention and control, falls, medication errors, and pressure damage. These elements provide a foundational view to assess the factors affecting service resilience. The next critical step is to incorporate additional metrics, such as mortality reviews, patient experience, and complaints data, to build a more comprehensive understanding. By triangulating these expanded data points, we can enhance our ability to identify and address the underlying drivers of fragility within services, supporting more informed decision-making and targeted improvements.	Framework approved at QSEC in December. Sharepoint platform developed and Fraile Services Oversight Group established. eporting via IQPFD through to Executive Team				210 risks aligned to fragile risk theme.
33	Fragile services (including but not limited to stroke primary care orthopaedics and ophthalmology) are supported by strong clinical leadership have an effective integrated improvement plan project management structure and effective transformation support. Where appropriate key performance metrics will be agreed.	IQFPD	QSEC	Advise			Sharon Daniel	Within the Clinical Services Plan (CSP), there is robust information on specific programmes, particularly for services within its scope, such as stroke, orthopaedics, ophthalmology, and primary care. Additionally, the risk register serves as a mechanism to highlight fragile services, providing an inherent process for identifying risks due to the nature of each service. However, while these tools contribute to understanding service fragility, a structured framework specifically focused on fragile services beyond the CSP scope has yet to be fully established. For instance, the fragile services register within the TI framework remains incomplete, indicating that while there is awareness of fragility, a more defined and comprehensive framework would enhance clarity on fragile services across the board. This development remains a work in progress.	Does this sit better with mark Henwood				210 risks aligned to fragile risk theme. CSP Project Risk Register?
34	Evidence that all recommendations from the Royal Colleges HIW and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the health board's longer-term improvement plan.	IQFPD	QSEC	Alert			Sharon Daniel	As part of directorate escalation meetings, we regularly review outstanding recommendations, including those linked to Health Inspectorate Wales (HIW) reports, to ensure these are effectively discharged. However, not all areas currently have the requisite improvement plans in place, highlighting a need for enhanced capacity and coordination. This gap is largely due to the demands on teams managing multiple priorities. Strengthening our approach to improvement planning will be critical to meeting all outstanding recommendations in a timely manner moving forward.	Do we have a baseline and what is a de-escalation threshold? Currently no Royal College Visits received or pending. HIW sits under the Governance Domain & contributes to the escalation scoring. We report complaince to all DITS, Escalation Meetings - we have AMaT System and we monitor it at DITS, IQPD nd QSEC. **Action:** Undertake a Deep Dive on remaining historical actions that cannot be progressed.				No identified risk however non-implementation may result in risks on directorate and service risk resgisters
35	Evidence that the Board is sighted on fragile services and has a robust response to these issues that is being addressed by the health board.	IQFPD	QSEC	Advise			Lee Davies	The Board is regularly updated on the CSP, which has provided valuable insights into the overall fragility across services, driven in part by site configuration issues. The CSP has highlighted the degree of system-wide fragility and identified specific services under strain. While there is clinical data supporting fragility within the CSP’s scope, including complaints, claims, and cost implications, services outside this scope lack the same comprehensive oversight. A more cohesive model - integrating workforce pressures, financial assessments, service resilience, and patient accessibility - would help frame the Board’s understanding and response to fragile services more effectively. A methodology to assess fragilty in this way has been developed and presented to QSEC. However, a robust response across all fragile service areas is still evolving and work is progressing through the Quality intelligence group to introduce this methodology and develop a register of fragile services.	The work on fragile services will be overseen through QSEC and the intention is to present it to Public Board in March 25				N/A
48	A culture of listening learning and improving is embedded throughout the organisation based on early and rapid triangulation and resolution of issues from a variety of sources including quality mortality staffing levels patient outcomes user and staff feedback.	TI coordination grou	QSEC	Advise			Mark Henwood/Sharon Daniel	The Quality Surveillance Group, led by Clinical Executives, aims to embed a culture of listening, learning, and improvement across the organisation. The safety dashboard currently supports this work through data on staff sickness, agency use, infection prevention and control, and safety metrics like falls, medication errors, and pressure damage. Moving forward, integrating additional information such as mortality reviews, patient experience, and complaints data will further strengthen the group’s capacity to address gaps and drive evidence-based improvements. This expanded approach will ensure that insights from these areas are fully utilised in embedding a responsive and learning-oriented culture across the organisation. -Quality Surveillance Group: Oversees data on IPC, safety metrics, and staff sickness across the organisation -Expanded Feedback: CIVICA, Datix, and FFT data are routinely reviewed, helping identify potential concerns more quickly. -Complaints Culture: The new 5-day early resolution process reduced PTR cases from over 200 earlier in 2024 to around 100 in December, suggesting a more proactive approach		-Continue rolling out staff and patient feedback in monthly improvement huddles (by Quarter 3 of 2024–25) -Update Quality Surveillance Group metrics from January 2025 to include new feedback sources.			1184 (P) 1189 (P) 1195 (P)

50	Stabilisation of the increased trajectory of cases of HCAI and evidence of continuous improvement accompanied by a strong QI approach and plan that has oversight and monitoring by board Quality Safety Committee and Board. The health board to have a clear improvement plan based on a root cause analysis to address the issue of hospital onset HCAIs.	IQFPD	QSEC	Advise			Sharon Daniel	Our focus remains on three primary HCAI types: C. diff, Staph aureus, and E. coli. Current HCAI Trends: -C. diff: Performing below the threshold (4 cases in August/September), suggesting effective cleaning and antimicrobial stewardship. -Staph aureus: Continues to fluctuate around baseline, requiring tighter device management and hand hygiene compliance. -E. coli: Near target (5 cases); improvements need to be sustained to avoid spikes. **Quality Improvement Measures**: ANTT training (target 85% compliance), regular RCA reviews, and site specific interventions (e.g., advanced cleaning methods). A clear and well set out improvement plan, received and reviewed on 30th October, has been provided with feedback to ensure changes are sustainable. While improvements are being achieved, our focus remains on securing long-term stability rather than short-term performance gains.					1490 (S) 1640 (S)
51	70% of complaints that had final reply (Reg 24) / interim reply (Reg 26) to be closed less than 30 working days of concern received.	IQFPD	QSEC	Assure			Sharon Daniel	Current performance in responding to complaints stands at 78.43%, exceeding both the TI target of 70% and the national target of 75%, which is a positive outcome. A workshop with clinical leaders and external partners has taken place to strengthen the focus on quality in complaints handling and align with upcoming regulatory changes. Need on-going plans however such as a SoP Summary of Current Status -Performance: Current closure rate stands at 76.98%, exceeding both the TI target of 70% and the national target of 75%. -Early Resolution: Introducing a 5 day early resolution window from 1 November 2024 has helped reduce PTR caseloads (down to around 100 in December), suggesting a more efficient and patient focused approach.		-Continue staff training and refinement of complaint triage processes (rolling basis, next review Q4 2024–25). -Align with upcoming PTR regulatory changes by Q1 2025–26.		-Complaints data (Beacon Dashboard) showing closure rates. -Workshop outcomes with clinical leads and external partners, focusing on quality in complaint handling.	No risk identified
52	Effective response from the health board to external reports and reviews including those from Audit Wales the Ombudsman Royal Colleges and HIW resulting in sustainable improvements.	IQFPD	QSEC	Alert			Sharon Daniel	The health board has established oversight mechanisms for responding to external reports and reviews, with QSEC providing structured oversight and escalation processes in place at the directorate level. -Ombudsman Engagement: Three new investigations opened (Oct–Nov 2024), 12 not investigated, and 2 partly upheld, indicating generally fair external scrutiny. -Timelines & Capacity: Many historic recommendations faced delays due to unrealistic initial deadlines or resource constraints. -Resetting Improvement Plans: Directorates are recalibrating their action plans to ensure deadlines are both achievable and closely monitored.	This links to row 35 Action: Deep Dive	-Recalibrated improvement plans for all open HIW/Royal College recommendations by Q4 2024–25. -QSEC 'deep dive' on older actions (12 months+) by Q2 2025–26.	-Complete the update of all directorate action plans with new, realistic dates -Continue close monitoring of Royal College/HIW outcomes to prevent backlog recurrence.		No identified risk however non-implementation may result in risks on directorate and service risk resgisters
53	Demonstrate how service user and staff experience/involvement is being used to improve quality processes and inform service development across the organisation.	IQFPD	QSEC	Advise			Sharon Daniel	While performance has been strong, we've yet to receive a permanent, comprehensive plan addressing some of the ongoing challenges raised, particularly around consistency across services. This isn't a request for new work but rather a call for clear evidence of sustainable improvement, as we would expect from any directorate, to ensure these achievements are maintained over the longer term. -Integrated Feedback: CIVICA and FFT data are now used in local 'improvement huddles,' aligning patient experience insights with staff input. -PTR and Complaints Trends: Significant drop in PTR cases suggests that user feedback loops are having a practical impact. -Staff Engagement: Pilot schemes (e.g., monthly 'temperature checks') aim to gather staff perspectives on key issues, ensuring alignment with patient centric improvements.					1184 (P) 1189 (P) 1195 (P)
54	Demonstrate the progress made against implementing the requirements of the Duty of Candour and Duty of Quality including the embedding of the Care and Quality Standards through the organisation from Board to service area delivery.	IQFPD	QSEC	Assure			Sharon Daniel	Based on the documentation, the Health Board demonstrates a structured approach to meeting Duty of Candour requirements. The bi-monthly Quality and Safety Assurance Report to the Quality, Safety, and Experience Committee (QSEC) includes regular updates on Duty of Candour incidents, ensuring that issues are escalated and reviewed within a consistent governance framework. Additionally, the Health and Social Care Quality and Engagement Act Annual Report outlines the Health Board's adherence to statutory obligations, detailing incidents that triggered the Duty of Candour and the actions taken in response. These processes suggest that the Health Board is actively embedding Duty of Candour principles into its quality and safety culture. Regular updates to QSEC and an annual overview of compliance support a transparent and accountable approach, providing a foundation for continuous improvement and alignment with legal standards. While these mechanisms indicate a commitment to Duty of Candour, ongoing reviews and updates will be essential to ensure that these standards are consistently met and embedded across all services.		-Roll out standardised 'improvement huddles' in all major directorates by Q3 2024–25 -Finalise a comprehensive approach for capturing and acting on staff feedback by Q4 2024–25.			No risk identified

55	Oversight of safeguarding arrangements to ensure the board have sufficient meaningful assurance that organisation is delivering against its safeguarding statutory responsibilities.	IQFPD	QSEC	Assure			Sharon Daniel	The Health Board demonstrates comprehensive safeguarding oversight, structured to ensure delivery against statutory safeguarding responsibilities. The Strategic Safeguarding Working Group (SSWG) regularly reviews safeguarding practices across a wide array of areas—including adult and child safeguarding, mental health, estates, and facilities—and provides updates through the Quality, Safety, and Experience Committee (QSEC). The SSWG's remit covers critical aspects such as incidents and trends in adult and child safeguarding reports, challenges in mental health and domestic abuse cases, support for looked-after children, and violence against women, domestic abuse, and sexual violence (VAWDASV) initiatives. The regular updates from SSWG to QSEC, along with detailed safeguarding reports, provide the Board with visibility into safeguarding risks, mitigation actions, and service-specific challenges, such as training compliance and staffing gaps within certain sectors. The Health Board has also committed to ongoing capacity and demand assessments to ensure appropriate resourcing for safeguarding roles and responsibilities, including workforce compliance with safeguarding training. These mechanisms collectively ensure that the Health Board has a structured approach to monitor and improve safeguarding practices. This layered oversight provides meaningful assurance to the Board that safeguarding responsibilities are not only being met but also continually assessed to identify areas for improvement, addressing complex cases, and mitigating risks where needed.					No risk identified
56	Use of National Clinical Audit and Outcome Review Programme and Value in Health dashboards to support quality improvement and address unwarranted variation in care. (including the use of patient and staff feedback to influence service design).	IQFPD	QSEC	Advise			Sharon Daniel						No risk identified