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Hywel Dda
University Health Board

Quality, Safety and Experience Committee
Escalation/ De-escalation Criteria Progress Update
December 2025

Introduction

This paper provides the Quality, Experience and Safety Committee (QSEC) with an updated assessment of the Health Board's position against the Targeted Intervention criteria for the quality safety domains. It brings together the most recent evidence across fragile services, urgent and emergency care, planned care, hospital-acquired infections and our response to Health Inspectorate Wales (HIW) inspections and regulatory notices. The purpose is to offer a balanced view of progress, acknowledge areas where improvement is evident, and be transparent about those domains where the pace of change has not yet met the required standards.

The updates reflect the outputs of Executive Improving Together Sessions, the latest dashboard intelligence, and ongoing operational engagement across clinical care groups. While several areas demonstrate clearer structures, strengthened oversight and early signs of stabilisation, others continue to experience significant pressures that will require sustained Executive focus. The paper therefore aims to support QESC in maintaining appropriate scrutiny, ensuring actions remain aligned to the expectations set within Targeted Intervention, and confirming that the trajectory of improvement is both understood and actively managed.

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 QESC	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	QESC scrutiny of fragile services reporting before Board	Advise
MD5	Handling of concerns, complaints and incidents within Unscheduled Emergency Care (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)	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	Advise
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 (subject to updated evidence)

TI-2025/547 – Fragile Services (MD1, MD2, MD4 combined narrative)

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

The Health Board must be able to identify early signs of fragility within clinical services, understand the root causes, and ensure timely, coordinated action. This includes triangulating workforce data, incidents, patient feedback, regulatory intelligence and operational pressures. Clear leadership arrangements, improvement plans and reliable reporting to the Executive Team, QESC and the Board are essential components of Targeted Intervention oversight.

Current status

Work to strengthen the fragile services approach has continued over the past six months and is expected to consolidate further following the November cycle of the Executive Improving Together Sessions. The Fragile Services Framework introduced earlier this year is proving a useful structure for identifying risk across the system, and the heat-map process has begun to embed the discipline of considering fragility indicators in a consistent way.

Early work with **diabetes** and **ultrasound** services demonstrated how the framework can support constructive conversations between clinical teams and corporate functions. Both services have used the process to articulate the causes of fragility, set improvement priorities and clarify where additional project-management or transformation support is required. These early pilots have helped shape expectations for how the wider organisation will adopt the approach.

A Fragile Services Oversight Group has now been established to maintain visibility of the highest-risk areas and act as the link between operational performance and strategic governance. This group is beginning to review heat-map outputs, confirm escalation thresholds and ensure that services identified as fragile provide regular updates on recovery milestones. As this group matures, it will become the principal forum for coordinating assurance, providing a more structured route for escalating issues to Integrated Quality, Finance and Performance Delivery Group (IQFPD), QESC or the Board.

TI-2025/547 – Fragile Services (MD1, MD2, MD4 combined narrative)

However, the approach is still embedding across the organisation. Several services have yet to complete their initial fragility assessments, and not all teams are routinely triangulating workforce, incident, complaints and regulatory data to inform their position. This means that some fragile-service identification continues to rely on informal intelligence rather than the systematic use of the framework. In addition, while a heat-map is available at executive level, a consolidated register of fragile services and their improvement trajectories has not yet been routinely reported to QESC or the Board, mirroring the position highlighted in the dashboards where fragile services are noted as “only available at the function level” and not yet integrated into routine reporting frameworks .

The next Executive Improving Together Session is expected to provide updated heat-map outputs, refreshed improvement plans and clearer standardisation of leadership expectations. This will be a key point in ensuring that clinical leads are formally identified for all fragile services and that each service has a calibrated improvement plan with agreed milestones.

Rationale – Advise

The foundations of a robust fragile-services model are now in place, with early pilots demonstrating that the methodology is sensible and that it can generate meaningful insights when applied consistently. The Oversight Group strengthens the governance route, and the Executive Improving Together Sessions are beginning to create the rhythm required for routine monitoring.

However, the approach is not yet fully embedded. Not all services are completing fragility assessments to the same standard, several teams have stated that they lack the project-management capacity needed to drive their improvement plans, and a consolidated Board-level view of fragile-service scores and trajectories is still in development. The organisation therefore remains in a position where fragility is understood in principle however not yet monitored or reported with the consistency required for assurance. On this basis, the status remains **Advise**. With sustained focus on embedding the framework, confirming clinical leadership arrangements for every fragile service, and ensuring routine reporting to QESC and the Board, the organisation will be well placed to progress towards assurance in future quarters.

TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

Urgent and Emergency Care (UEC) remains a high-risk area on the corporate and operational risk register. The Health Board must provide clear evidence that incidents, complaints and concerns in the Community and Integrated Medicine (CIM) function are being managed promptly, with systematic learning and timely responses.

Current Status

Incidents

Incident management within Community and Integrated Medicine continues to face significant delays. Based on the dashboard (October 2025), CIM currently has:

- **1,154 incidents older than 120 days, and**
- **1,621 incidents older than 60 days,**

demonstrating sustained delays in progressing investigations and embedding learning.

Age-profile analysis shows a substantial tail of significantly aged cases, ranging from **900 to 1,505 days**. The longest-open incidents include:

- HDD7679 (**1,505 days**)
- HDD11180 (**1,432 days**)
- HDD14727 (**1,360 days**)
- HDD19101 (**1,269 days**)

and multiple others exceeding **900 days.**

TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents

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The most frequent incident categories in Community and Integrated Medicines Clinical Care Group (CIMCCG) are:

- Pressure damage / moisture damage - **562**
- Accident / injury – **238**
- Medication / IV fluids - **158**

These themes reflect pressures in frailty, unscheduled care and complex discharge pathways.

Complaints

Complaint timeliness remains a concern. The longest-open complaint in CIM has been outstanding for 742 days, with several others exceeding 500 days. Monthly new complaints continue to fluctuate between 40 and 70, aligned to operational pressures.

Rationale – Advise

Incident closure performance across most directorates is strong, and reporting behaviours remain consistent. However, the **scale of aged incidents**, the **substantial tail of extremely long-open cases (900–1,505 days),** and persistent delays in complaint resolution require further improvement before assurance can be provided, however it hasn't deteriorated against the mean. Strengthening investigation timeliness, improving patient communication and embedding learning across UEC pathways remain priorities.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

Planned care services must manage incidents, complaints and patient feedback effectively whilst delivering recovery plans that address lengthy waits across high-volume specialties such as orthopaedics, gynaecology and ophthalmology.

Current Status

Incidents

Planned and Specialist Care continues to experience delays in completing incident investigations. Using the dashboard's age-profile (October 2025), PSC currently has:

- **349 incidents aged more than 3 months (approx. >120 days),** comprising:
  - 221 incidents aged **3–6 months**
  - 97 incidents aged **6–12 months**
  - 24 incidents aged **1–2 years**
  - 6 incidents aged **2–3 years**
  - 1 incident aged **>3 years**

This demonstrates a significant backlog across multiple specialties.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback

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The longest-open PSC incidents show sustained ageing across the function, including:

- HDD24706 (**1,155 days**)
- HDD38190 (**904 days**)
- HDD41353 (**847 days**)
- HDD42299 (**828 days**)
- HDD43058 (**814 days**)

The most common incident types relate to:

- Assessment / Investigation / Diagnosis – **154**
- Maternity adverse occurrences – **122**
- Treatment / Procedure – **93**
- Access / Admission – **74**
- Communication – **50**
- Medication / IV fluids – **36**

These themes reflect the complexity of elective pathways and the fragility of specialist workforce capacity.

TI-2025/547/MD10/1 – Planned Care: concerns, complaints, incidents and patient feedback

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Complaints and patient experience

PSC complaint timeliness remains below expectation. The longest-open complaints range from **353 to 438 days**, predominantly within:

- **Gynaecology** – longest **438 days**
- **Obstetrics** – longest **434 days**
- **Orthopaedics** – multiple cases >350 days

Monthly new complaints continue to fluctuate between **40** and **80**. Only **38.15%** of PSC complaints have been resolved within the 30-day standard, and there is limited evidence that patient feedback is consistently used to inform pathway redesign or improve communication with long-waiting patients.

Service recovery context

Despite these governance challenges, operational recovery continues:

- Zero cataract pathway breaches since Q1 2025
- 18% reduction in diagnostic waits
- Single Cancer Pathway performance sustained above 60%
- Targeted investments in ultrasound, ophthalmology recovery and the new aseptic unit (Feb 2026) support longer-term stability.

Rationale - Advise

Planned care recovery programmes are improving clinical throughput, pathway compliance and diagnostic capacity. However, the backlog of 349 aged incidents, the presence of cases >1,000 days old, and persistent delays in complaint-handling mean governance and learning systems are not yet operating at the level required for assurance. Strengthening investigation timeliness, reducing aged complaints and ensuring patient feedback drives service improvement remain priorities.

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

The TI de-escalation criterion requires the Health Board to reduce hospital-onset C. difficile infections by 25% from the Q3 2023 baseline (8 cases per month) to no more than six cases per month, sustained for three consecutive months.

Current status

Dashboard data to October 2025 show hospital-onset C. difficile cases of:

- June = 11, July = 7, August = 4, September = 5, October = 11.

Performance in August (4 cases) and September (5 cases) demonstrates the organisation's capability to meet the TI threshold in individual months. However, this has not been sustained, with a marked deterioration in **October (11 cases),** representing one of the highest values recorded in 2025.

Between 1 July and 31 October 2025 there were 23 hospital-onset and 29 community-onset C. diff cases across the Health Board, highlighting the need for continued strengthened IPC practice across both community and acute pathways.

Rationale - Advise

The Health Board has demonstrated that the target can be achieved in isolated months, and improvement initiatives appear to have driven reductions in August and September. However, the criterion of three consecutive months at or below six cases has not been met, and the marked increase in October underscores a need for further sustained improvement. Continued focus on antimicrobial stewardship, environmental controls, and targeted clinical actions remains essential before assurance can be offered.

TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

The TI target requires a 33% reduction in hospital-onset S. aureus bacteraemia, from a baseline of three cases per month to no more than two cases per month, sustained for three consecutive months.

Current Status

Dashboard data for July–October 2025 show monthly hospital-onset S. aureus cases of:

- July = 4, August = 5, September = 4, October = 3.

Although October represents an improvement from August and September, the Health Board has not achieved the required threshold of two cases or fewer in any month in 2025. The Quality and Safety Assurance Report confirms that 16 hospital-onset cases were recorded between July and October 2025 (47 cases overall across community and hospital settings), demonstrating a persistent gap between current performance and the TI requirement.

Rationale - Alert

The target of ≤2 cases has not been met in any month of the reporting period, and the trajectory remains above the threshold throughout 2025. While October shows some improvement, the level of variance from the TI requirement and the absence of sustained reduction necessitates an Alert rating.

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia

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

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

Issue

The TI target requires a **25% reduction** in hospital-onset E. coli bacteraemia from a baseline of 6.7 cases per month to **no more than five cases per month**, sustained for **three consecutive months.**

Current status

Dashboard data for **July–October 2025** show hospital-onset E. coli cases of:

- July = 10, August = 6, September = 9, October = 10.

Performance in 2025 has not met the TI threshold in any month during this period (April 25-October 25), with July and October representing some of the highest values recorded. Earlier improvements in January (0) and February (5) demonstrate that the target is achievable, but there has been no sustained period of compliance with the ≤5 threshold.

The Quality and Safety Assurance Report confirms high E. coli rates, with UTI, CAUTI and biliary tract infections the predominant sources. ANTT compliance stands at 82.58%, and hand-hygiene and environmental audit compliance is monitored through AMaT

Rationale - Alert

The TI sustained-performance requirement has not been met, and monthly cases throughout the most recent period remain well above the threshold. The October value of 10 further reinforces the need for continued targeted work on UTI prevention, hydration, catheter management, and antimicrobial stewardship. The overall trend analysis continues to support an Alert rating.

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

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Lead executive - Mrs Sharon Daniel, Executive 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 Infection, Prevention and Control (IPC) 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 October 2025 shows:

- **Mixed trends across all three organisms,** with improvements in August for C. diff (4) and E. coli (6), but subsequent deterioration in October (C. diff 11; E. coli 10).
- **S. aureus fluctuating** between 3–5 cases throughout the period, without achieving the TI threshold.
- Training compliance remains variable (e.g. Level 2 IPC training 75.56%; ANTT 82.58%).

TI-2025/547/MD9/1 – Addressing root causes of Healthcare Acquired Infections (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 October data show 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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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Lead executive - Mrs Sharon Daniel, Executive 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 277 actions. While over half 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:

- 153 actions (55%) have been fully completed.
- 88 actions are still in progress, with a relatively small proportion recorded as partially complete.
- However, 72 actions are now overdue, and a further nine 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.

Across the portfolio of inspections, a number of themes recur. Services such as St Non, IRMER X-ray, and Bryngolau Ward have demonstrated strong responsiveness, with the majority of their recommendations closed and limited overdue actions. These areas show that when local oversight is robust and resourcing is stable, the Health Board can respond promptly and effectively to regulatory findings.

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

In contrast, several other inspections present a more complex picture. The recent Bronglais Hospital (BGH) Emergency Department inspection (October 2025) has generated 75 actions, of which a sizeable proportion are still outstanding, including 35 in progress, four partially complete, and 28 overdue. This reflects both the scale of the recommendations and the operational pressures within UEC services. However, given the inspection was only undertaken in October, these outstanding actions have to be viewed in the context of reasonableness and time for the respective teams to properly digest and complete the actions in a meaningful and thorough manner.

Similarly, the Derwen Ward inspection and the Joint Inspection of Child Protection Arrangements have clusters of overdue activity, with multiple actions requiring renewed attention to meet the standards expected by HIW and partner agencies. The Mynydd Mawr Ward inspection also reflects delays, including actions recorded as “unable to complete” or awaiting further evidence before approval.

It is important to recognise that the sharp increase in overdue HIW actions is largely attributable to the recent Emergency Department inspection at BGH, which alone generated 75 actions, including 28 that default into the ‘overdue’ category when aligned to HIW’s standard action framework. Prior to this inspection, the Health Board was carrying approximately 19 overdue actions. Once the 28 ED-related actions are accounted for, the underlying overdue position stands at 44 actions (72 total overdue minus 28 arising from ED). This means that while there has been some movement from the previous position of 19, the majority of the overall increase is directly linked to the scale and timing of the ED inspection rather than a broad failure of responsiveness across the wider system.

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

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Rationale - Advise

Justification

An Assure rating cannot be supported, as the Health Board must still address a material number of overdue actions (now 44 once the Emergency Department (ED) effect is removed), alongside a high volume of new work arising from Bronglais ED that will take several months to fully evidence and close. However, an Alert rating would overstate the position and misrepresent the underlying context.

The data shows:

- The bulk of the deterioration is driven by a single inspection landing less than a month ago, not by systemic slippage.
- Other service areas continue to demonstrate strong engagement, timely submission of evidence and high completion rates, with over 300 completed actions across the portfolio.
- Dialogue with HIW remains active, transparent and constructive.
- Local governance structures (including the Executive Improving Together Sessions and inspection oversight routes) are in place and functioning.

The current position therefore reflects a system that is responding, mobilising and maintaining open regulatory engagement, but which now carries more high-volume actions that will require sustained attention.

TI-2025/547/MD12/1 – Improved patient and family feedback

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

Issue

The Health Board aims to increase the proportion of complaints resolved within 30 days and to use patient-experience feedback to inform service improvement.

Current status

Only 38.15 % of complaints have been resolved within 30 days in 2025/26. The People's Experience Framework and the Fragile Services Framework incorporate patient-feedback data, but the impact of these initiatives is not yet evident. Open-complaint dashboards show cases waiting over 350 days for closure. Work is underway to improve the timeliness of responses and to reduce the number of open complaints.

Rationale - Alert

Initiatives to improve patient and family feedback are progressing, yet current performance against the 30-day standard and the persistence of long-standing complaints highlight the need for further focus or additional actions/considerations. The Health Board should prioritise increasing early resolution of complaints, responding to and closing aged complaints, communicating outcomes to families promptly and embedding learning into service improvements.

Conclusion

Across the Targeted Intervention domains reviewed, the Health Board continues to make progress, but the position remains mixed. The fragile services framework has matured further, and early pilots indicate that it is supporting more consistent identification of risk and clearer leadership expectations; however, full embedding and Board-level reporting still require development. In urgent and emergency care and planned care, there is evidence of operational recovery and strengthened reporting, yet both areas continue to carry significant backlogs of incidents and long-standing complaints, which constrain the level of assurance that can be offered at this point in time.

The Health Board's response to HIW inspections demonstrates an open and constructive approach; and whilst the recent BGH Emergency Department inspection has resulted in a sharp increase in overdue actions, the underlying position, once this effect is adjusted for, remains more stable than the headline figures suggest. Even so, the volume of work now required to close high-priority actions will demand sustained attention and clear trajectories.

Taken together, the updates illustrate a system that is developing the right structures and beginning to show tangible improvement in some areas, whilst still requiring focused oversight and targeted support in others. Continued consolidation of governance arrangements, strengthened learning processes and timely action closure will be essential for moving towards higher levels of assurance in future reporting cycles.

Recommendations for the Committee:

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To note:

- The fragile services approach is continuing to embed, with clearer structures and early evidence of improved identification and oversight, but full Board-level reporting remains under development.
- Incident management backlogs in both UEC and Planned Care remain significant, with long-standing cases demonstrating where investigation timeliness and learning processes still require strengthening.
- Performance against the TI hospital-acquired infection criteria has shown isolated improvement but not the sustained reductions needed for de-escalation.
- The recent BGH ED inspection accounts for a large proportion of the increase in HIW overdue actions and has materially altered the inspection profile within a short timeframe.

To recognise:

- Operational recovery work in planned care is generating positive impact—diagnostic waits have reduced, cancer pathway performance has stabilised, and targeted investments are progressing.
- Engagement with HIW and regulatory bodies remains constructive, with over 300 completed actions demonstrating continued focus on quality and safety.
- The Executive Improving Together Sessions are providing a more coherent platform for system-wide visibility of fragility, escalation and improvement trajectories.
- In several areas, including IRMER and ward-based inspections, services have demonstrated the ability to respond promptly and effectively to regulatory recommendations.

Conclusion

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To acknowledge:

- The Health Board now carries a larger volume of high-priority actions following the BGH ED inspection, and these will require sustained oversight and resourcing to close meaningfully.
- Several key functions continue to experience pressure on workforce capacity, which is directly impacting the pace at which improvement plans can be delivered.
- Sustained improvements across infection prevention and control domains remain a critical requirement, given the fluctuating performance and October deterioration.
- The continued presence of aged incidents and complaints limits assurance and necessitates further work to ensure learning is timely, embedded and consistently evidenced.

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