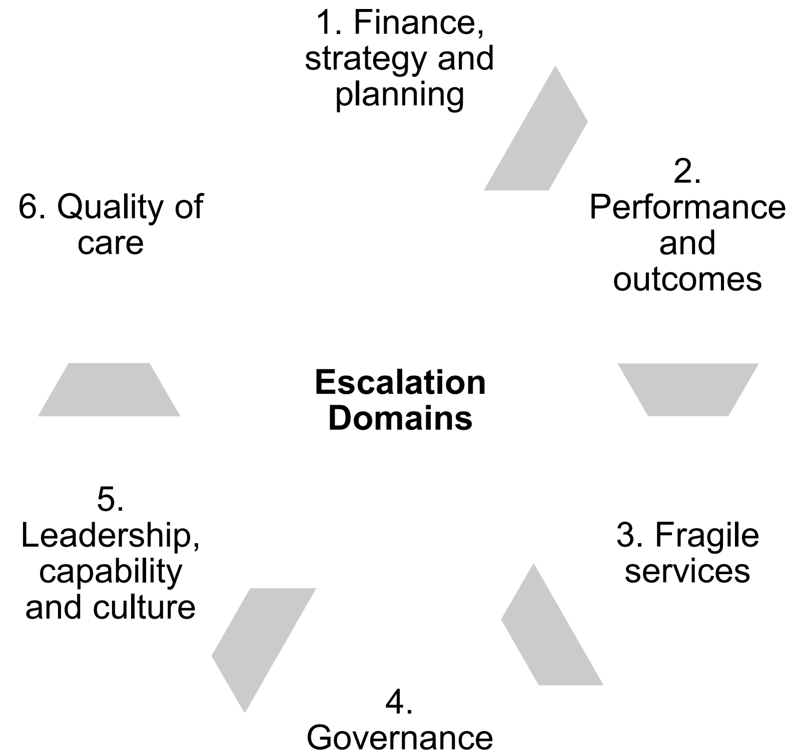

Quality, Safety and Experience Committee (QSEC)

Targeted Intervention Progress Report

April 2025

Introduction

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

Introduction

This report provides a comprehensive update on key Targeted Intervention (TI) criteria for the Quality, Safety and Experience Committee's (QSEC) consideration. The Health Board continues to make significant progress across multiple domains, with two criteria demonstrating sufficient improvement to warrant de-escalation from 'Alert' to 'Advise' status.

The progress detailed herein reflects the Health Board’s commitment to embedding sustainable quality improvements and addressing regulatory requirements. Particular focus is placed on areas with material significance to patient safety, clinical governance, and service quality. This includes healthcare-acquired infections, complaints management, service user feedback, and the oversight of fragile services.

While progress is evident, there remain areas requiring continued vigilance and focused improvement. This report aims to provide QSEC with sufficient detail to exercise appropriate scrutiny while highlighting both achievements and ongoing challenges that require both strategic and on-going operational attention.

Targeted Intervention – Criteria 34

Outstanding External Recommendations (Criterion 34) Significant Updates and Status Changes - Status Change: Alert → Advise (20/03/25)

Rationale for Status Change

- Significant Action Closure Rates - Overdue actions reduced from 51 to 14, and partially complete overdue actions from 17 to 9. The Stroke and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) reports have been fully completed and closed, demonstrating the health board's capacity to bring older actions to a successful conclusion.
- Strong Governance Framework - The Quality, Assurance and Safety Team is systematically following up on all open external recommendations through bi-monthly chasing with a clear escalation protocol. Services can directly update actions and attach evidence in the live AMaT system, ensuring transparency, accountability, and quicker turnarounds.
- New Health Inspectorate Wales (HIW) Report on Children & Young People's Mental Health - Although this has added 9 recommendations and 23 actions, there is a clear governance pathway to embed these actions within existing directorate improvement plans. Early tracking via Audit Management and Tracking System (AMaT) suggests a proactive approach to ensure no backlog is created.

Recommended Next Steps

- Continue the bi-monthly escalation approach to clear the remaining 14 overdue actions
- Incorporate the 23 new actions from the Children & Young People's Mental Health Review into live action plans with measurable milestones
- Consider further reduction to an 'Assure' status once outstanding and newly added actions have reached a manageable level (e.g., single digits overdue and clear tracking and completion of new actions)

Targeted Intervention – Criteria 52

External Reports and Reviews (Criterion 52) - Status Change: Alert → Advise

Rationale for Status Change

- Marked Reduction in Outstanding Actions - The Health Board has seen a substantial decrease in overdue recommendations, with strong performance in closing or partially completing older HIW actions. Directorates are increasingly adept at setting realistic deadlines, responding to external scrutiny, and embedding improvements.
- Evidence of Sustainable Processes - Real-time updates via AMaT enable prompt responses to queries and swift escalation of risks or delays. Regular assurance reporting to QSEC ensures improvements are tracked and remain on course.
- New Additions, but Strong Handling - While the Children & Young People Mental Health Review adds a fresh set of actions, early signs show a proactive integration into established governance frameworks rather than creating a backlog.

Recommended Next Steps

- Continue efforts to close the 14 remaining overdue items and embed a 'right first time' ethos for new recommendations
- Capture and share real-world examples of how completed actions have led to measurable service improvements
- Consider transitioning to 'Assure' status if progress remains on track over a sustained period (approximately 6 months)

Targeted Intervention – Criteria 56

National Clinical Audit and Outcome Review (Criterion 56) - Status Change: Alert (20/03/25)

Reason for escalation and Key Issues:

This criterion has remained blank for nearly 12 months. To fully satisfy Criterion 56, future reports should incorporate:

- Specific reference to National Clinical Audit participation and findings
- Evidence showing how Outcome Review Programme data informs service development decisions
- Examples demonstrating Value in Health dashboard utilisation in addressing unwarranted variations in practice
- Clear linkage between these national datasets and local improvement initiatives
- Case studies illustrating how combined data sources drive specific quality improvements

As there has been no evidence provided and the criterion has remained blank, there is a need to change this to an Alert. The committee may be aware of actions around this, however, in the absence of any evidence within the Targeted Intervention folder, there is a need to flag this to the QESC committee.

Targeted Intervention – Criteria 23

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Service User Feedback (Criterion 23)

Current Status: Advise

The QESC April 2025 report demonstrates robust implementation of patient feedback mechanisms that are actively driving quality improvement:

- Patient satisfaction metrics show consistently strong performance with 94.2% of respondents reporting positive experiences
- The Friends and Family Test (FFT) survey reached 37,633 individuals with a response rate of 18.8% (6,355 responses)
- This response volume significantly exceeds comparable Health Boards in Wales

Particularly noteworthy improvements in specific service areas:

- Community & Primary Care services: >30% improvement from previous reporting period
- Mental Health Outpatient services: >30% improvement
- Maternity Inpatient services: 12% improvement

Hospital-specific satisfaction rates reveal consistent performance:

- Bronglais General Hospital: 93.6% positive feedback (784 responses)
- Glangwili General Hospital: 92.2% positive feedback (1,854 responses)
- Prince Phillip Hospital: 96.1% positive feedback (1,560 responses)
- Withybush General Hospital: 94.1% positive feedback (1,204 responses)

Integration of patient experience data into operational processes represents significant progress, with CIVICA, Datix, and FFT data now standard inputs in routine management meetings and quality improvement initiatives.

Targeted Intervention – Criteria 32, 33, 35

Fragile Services (Criteria 32, 33, 35)

Current Status: Advise

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.

There are a number of systems reports that at a basic mechanism can be used as an indicator of service fragility:

- Dashboard effectively captures patient safety incidents with detailed categorisation
- Healthcare Acquired Infection metrics with site-specific analysis
- Complaint patterns highlighting pressure points in specific services
- Performance Metrics
- Financial Metrics i.e. increase in agency or medical variable pay

External perspectives are incorporated through Healthcare Inspectorate Wales findings and Welsh Risk Pool assessments, with structured processes for tracking recommendations.

Targeted Intervention – Criteria 32, 33, 35

Key gaps and next steps:

- Need to incorporate additional metrics such as mortality reviews, comprehensive patient experience data, and more robust staff feedback mechanisms
- Incomplete "Speak Up Safely" section suggests this component requires further development
- Limited evidence of a centralised methodology for integrating disparate elements into a coherent assessment of service vulnerability

A structured framework specifically focused on fragile services beyond the CSP scope has yet to be fully established. 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.

Targeted Intervention – Criteria 50

Healthcare Acquired Infections (Criterion 50)

Current Status: Advise

The Health Board demonstrates a clear data-driven improvement plan with mixed performance against established reduction expectations:

- C. difficile: 4 hospital-onset cases in February 2025 (below goal of 6, representing successful 25% reduction.
- Staph aureus: 4 hospital-onset cases in February 2025 (above goal of 2, failing to meet the 33% reduction target)
- E.coli: 5 hospital-onset cases in February 2025 (meeting the goal of 5, achieving the 25% reduction target)

Long-term Trend Analysis (March 2023 - February 2025) - Analysis of the 24-month infection data reveals significant patterns that inform the current status.

C. difficile cases show considerable month-to-month volatility with values ranging from 3 to 11 infections. The data indicates:

- Periodic achievement of the target (≤6 cases) in 13 of 24 months.
- Recent improvement with February 2025 showing 4 cases (below target)
- Several clusters of increased incidence throughout the reporting period, with notable spikes in July 2023 (10 cases), October 2023 (10 cases), and November 2024 (11 cases)

Targeted Intervention – Criteria 50

Staph aureus infections display similar volatility, ranging from 0 to 7 cases:

- The stretch target of 2 or fewer cases achieved in 8 of 24 months (31% of the time)
- A concerning period in Q2-Q3 2024 with elevated cases (peaking at 7 in June 2024)
- Recent stability but consistently above target in Q4 2024 and Q1 2025, with February 2025 showing 4 cases
- Episodes of zero cases (April 2023, December 2024) demonstrate that elimination is achievable but not sustained

E.coli infections show the highest variance, with cases ranging from 2 to 12:

- Target achievement (≤5 cases) in 13 of 24 reported months
- Significant spike in July 2024 (12 cases) followed by substantial improvement
- Recent trend showing stability with February 2025 at 5 cases (meeting target)

Site-level analysis reveals variation in infection control performance across hospitals, with targeted data enabling focused improvement efforts:

- Hospital-onset cases in February included 3 Meticillin-Sensitive Staphylococcus. Aureus (MSSA) bacteraemia cases at Withybush
- 3 E.coli cases at Glangwili and 2 E.coli cases at Withybush
- The data demonstrates that while periodic improvements occur, sustainable reduction below thresholds remains challenging, suggesting that deeper systemic factors may be contributing to the persistent variability in infection rates.

Targeted Intervention – Criteria 50

Interventions include:

- Implementation of specialised disinfection technologies (DiffX and HPV)
- Targeted deep cleaning programme initiated at Prince Philip Hospital on 10 March 2025
- Focused attention on Aseptic Non-Touch Technique (ANTT), currently showing 80.60% practical compliance
- Enhanced monitoring of Peripheral Venous Catheter (PVC) bundle compliance
- Root cause analysis of all hospital-onset cases to identify common factors and improvement opportunities

The improvement plan includes clearly defined quarterly milestones extending through January 2026, with first quarter priorities including rolling out the new environmental cleaning policy and completing HPV machine trials. The plan now includes additional interventions targeting the identified periodic spikes, with enhanced surveillance during historically problematic months; all of which is also reflected in the annual plan for 2025/26.

Targeted Intervention – Criteria 51

Complaints Management (Criterion 51)

Current Status: Assure

The Health Board demonstrates exceptional performance in complaints management:

- 80% of complaints closed within 30-working day target timeframe during 2024/25, exceeding both the Targeted Intervention requirement (70%) and national standard (75%)
- 466 new complaints received during the reporting period
- 424 complaints closed, indicating effective throughput
- 164 complaints closed within 5 working days through early resolution processes
- 260 complaints managed through the formal Putting Things Right (PTR) process

Trend analysis reveals significant improvements:

- 27% reduction in complaints managed through PTR in Quarter 3 compared to Quarter 1
- Substantial increase in early resolutions at the end of Quarter 3
- 20% fewer complex complaints (grade 3 and above) in Q3 2024/25 compared to the same quarter in previous year

The implementation of process improvements, including more systematic triage and earlier intervention, has contributed significantly to the enhanced performance. However, recognising going into 25/26 the reporting may be liable to change, this area will require on-going oversight to understand how any changes impact on performance

Summary & Next Steps for QSEC

Conclusion

The Health Board has demonstrated substantial progress across several Targeted Intervention domains, with notable improvements in complaints management, infection control processes, and the handling of external recommendations. The de-escalation of two criteria from 'Alert' to 'Advise' status reflects the organisation's commitment to addressing areas of concern through structured, evidence-based approaches. However, the revised status of criteria 56 to Alert will need to be urgently addressed.

Despite these positive developments, certain challenges persist and require continued focus. The integration of patient experience data into improvement processes, while progressing well, needs further embedding at directorate level. Similarly, the framework for identifying and managing fragile services requires additional development to ensure comprehensive coverage beyond those services included in the Clinical Services Plan.

Critical to sustaining progress will be the Health Board's ability to:

1. Maintain momentum in areas showing improvement, particularly in complaint resolution timescales and infection prevention
2. Accelerate progress in completing outstanding external recommendations
3. Develop more robust mechanisms for identifying and monitoring fragile services
4. Strengthen the use of national clinical audit data to drive quality improvement
5. Ensure quality assurance processes are embedded consistently across all service areas

The evidence presented in this report demonstrates that the Health Board is making tangible improvements in key areas while developing the governance infrastructure to sustain these gains. QSEC is asked to recognise and affirm the progress made, endorse the recommended next steps for each criterion, and specify any assurance requirements to support the continued journey toward de-escalation of the remaining TI domains.

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Criter	Action	Reporting	Commit	Status	Status Chang	Status Change	Executive Lead	Summary of Current Status	Lead Executive Response (if applicable)	Documented Plan and Dates for Deli	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	The April 2025 report demonstrates robust implementation of patient feedback mechanisms that are actively driving quality improvement across the Health Board. Patient satisfaction metrics show consistently strong performance with 94.2% of respondents reporting positive experiences, indicating successful patient-centered care delivery. The Friends and Family Test (FFT) survey reached 37,633 individuals with a response rate of 18.8% (6,355 responses), providing statistically significant feedback across service areas. This response volume significantly exceeds comparable Health Boards in Wales, though no national benchmark exists. The large sample size enables meaningful analysis of trends and service-specific insights. Particularly noteworthy are the substantial improvements in specific service areas: - Community & Primary Care services showed more than 30% improvement from the previous reporting period - Mental Health Outpatient services achieved similar gains exceeding 30% - Maternity Inpatient services improved by 12% - Only one negative response was recorded in Paediatric Outpatient services Hospital-specific satisfaction rates reveal consistent performance across all facilities: - Bronglais General Hospital: 93.6% positive feedback (784 responses) - Glangwili General Hospital: 92.2% positive feedback (1,854 responses) - Prince Phillip Hospital: 96.1% positive feedback (1,560 responses) - Withybush General Hospital: 94.1% positive feedback (1,204 responses) The granular department-level data further illustrates areas of excellence and opportunity, with many departments achieving 100% positive ratings (e.g., Day Surgery Units at Bronglais and Glangwili, Same Day Emergency Care Units at Prince Philip). Services with lower satisfaction scores, such as Emergency Departments (ranging from 83.7% to 88.3%), provide targeted improvement opportunities. The integration of patient experience data into operational processes represents significant progress. CIVICA, Datix, and FFT data	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 sigificant 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)
28	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. (UEC)	IQFPD	QSEC	Advice			Sharon Daniel	Efforts are underway to incorporate patient experience data more systematically across the organisation. This data, now feeding into escalation meetings and being linked with updates on the patient safety dashboard, aims to enhance quality improvement by providing directorates with greater visibility into feedback trends. Although the roll-out has been slower than anticipated, this month marks the start of broader inclusion in directorate packs for escalation and improvement meetings. As the data becomes embedded in these processes, we expect it will strengthen our ability to respond to service user feedback and drive improvement initiatives effectively.	Duplication	SA= we can amalgamate with 23 and close them down subject to the evidence and move to assure			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 April 2025 report demonstrates that the organisation has established basic mechanisms to monitor several important indicators of service fragility. The dashboard effectively captures patient safety incidents with detailed categorisation, Healthcare Acquired Infection metrics with site-specific analysis, and complaint patterns highlighting pressure points in specific services. External perspectives are incorporated through Healthcare Inspectorate Wales findings and Welsh Risk Pool assessments, with structured processes for tracking recommendations and implementation. The "Learning from the Ombudsman" section offers additional insights into service vulnerabilities, particularly regarding high-risk pregnancy management and outpatient appointment processes. However, the next critical step for the Health Board is to incorporate additional metrics, such as mortality reviews, comprehensive patient experience data, and more robust staff feedback mechanisms. The incomplete "Speak Up Safely" section suggests this component requires further development to fully capture frontline concerns that might indicate service fragility. While individual data streams are well-monitored, the report provides limited evidence of a centralised methodology for integrating these disparate elements into a coherent assessment of service vulnerability. The organisation appears to have the necessary components but has yet to develop a truly integrated approach to understanding the multifaceted drivers of fragility within services. By triangulating these expanded data points more systematically, the Health Board would enhance its ability to identify and address the underlying drivers of service fragility, supporting more informed decision-making and targeted improvements. This represents an important area for continued development as the organisation matures its quality management processes.	Framework approved at QSEC in December. Sharepoint platform developed and Fraile Services Oversight Group established. Reporting 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. (no signifcant update since last reported)	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	Advise	Alert	20/03/25	Sharon Daniel	Rationale for Status Change Significant Action Closure Rates - Overdue actions reduced from 51 to 14, and partially complete overdue actions from 17 to 9. This reflects a substantial improvement in finalising and evidencing completion of outstanding recommendations. The Stroke and DNACPR reports have been fully completed and are closed, demonstrating the organisation's capacity to bring older actions to a successful conclusion. Strong Governance Framework - Bi-monthly Chasing and Escalation: The Quality, Assurance and Safety Team is systematically following up on all open external recommendations, with a clear escalation protocol (progress check within 14 days). Real-Time Updates via AMaT: Services can directly update actions and attach evidence in the live AMaT system, ensuring transparency, accountability, and quicker turnarounds for queries from HIW and other external bodies. New HIW Report on Children & Young People's Mental Health - Although this has added 9 recommendations and 23 actions, there is a clear governance pathway to embed these actions within existing directorate improvement plans. Early tracking via AMaT suggests a proactive approach to ensure no backlog is recreated. Robust Oversight Maintained - Despite the recommendation to de-escalate from Alert to Advice, robust oversight remains crucial. With 14 overdue items still open, it is important to maintain structured follow-up to prevent slippage. The focus in the coming period will be on sustaining the rate of closure and ensuring all newly identified actions (e.g., from the Children & Young People's Mental Health Review) are given realistic timeframes.	Recommended Next Steps Consolidate Gains - Continue the bi-monthly escalation approach to clear the remaining 14 overdue actions. Integrate New Actions - Incorporate the 23 new actions from the Children & Young People's Mental Health Review into live action plans with measurable milestones. Monitor De-Escalation Thresholds - Once the outstanding and newly added actions have reached a manageable level (e.g., single digits overdue), consider further reduction to an 'Assure' status if evidence of sustained compliance is demonstrated.				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 coordir	QSEC	Advise			Mark Henwood	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	The Health Board's approach to Healthcare Acquired Infections demonstrates a methodical, data-driven improvement strategy with clearly defined targets and comprehensive interventions. Current performance shows a mixed picture against the established reduction expectations for hospital-onset infections: - C. difficile: 4 hospital-onset cases in February 2025 (below goal of 6, representing successful 25% reduction) - Staph aureus: 4 hospital-onset cases in February 2025 (above goal of 2, failing to meet the 33% reduction target) - E.coli: 5 hospital-onset cases in February 2025 (meeting the goal of 5, achieving the 25% reduction target) The Health Board successfully met expectations for C. difficile during August through October 2024, indicating a positive trajectory. However, challenges remain with Staph aureus infections, where rates continue to fluctuate month-by-month, consistently remaining above expected targets. For E.coli infections, whilst February data meets the target, historical data reveals significant fluctuation. The report provides a detailed breakdown distinguishing between community-onset infections (present on admission or detected within the first 48 hours) and hospital-onset infections (developing after 48 hours in hospital). This distinction is crucial for accurately measuring the effectiveness of hospital infection control practices. Whilst the total infection burden includes both types, the performance targets specifically address hospital-onset cases that are more directly attributable to healthcare practices. Site-level analysis reveals variation in infection control performance across the Health Board's hospitals. Hospital-onset cases in February included 3 MSSA bacteraemia cases at Withybush, 3 E.coli cases at Glangwili, and 2 E.coli cases at Withybush. This targeted data enables the Health Board to direct improvement efforts to specific locations where hospital-acquired infections are more prevalent. The Health Board has established a robust governance structure to drive improvement, including a dedicated C.diff Infection Improvement Group chaired by the Deputy Medical Director. An Antimicrobial Group continues to operate, supporting implementation of the Welsh Health Circular on AMR & HCAI Improvement Goals 2024-2025. This governance framework ensures senior clinical leadership and accountability for infection prevention and control across all sites and services.					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	The Health Board demonstrates exceptional performance in complaints management, substantially exceeding both the Targeted Intervention requirement and national standards. The report for QESC reveals that 80% of complaints were closed within the 30-working day target timeframe during the 2024/25 financial year, surpassing both the Targeted Intervention criterion (70%) and the national target established in the Putting Things Right Regulations (75%). Complaint activity and processing metrics show a well-functioning system: - 466 new complaints received during the reporting period - 424 complaints closed, indicating effective throughput - 164 complaints closed within 5 working days through early resolution processes - 260 complaints managed through the formal Putting Things Right (PTR) process - 40%/60% split between early resolution and formal process, demonstrating appropriate triage The trend analysis reveals significant improvements in complaints management efficiency: - 27% reduction in complaints managed through PTR in Quarter 3 compared to Quarter 1 - Substantial increase in early resolutions at the end of Quarter 3 compared to the start of the financial year - 20% fewer complex complaints (grade 3 and above) in Q3 2024/25 compared to the same quarter in the previous year The complaint theme analysis provides insight into systemic issues requiring attention: - Clinical treatment/assessment (particularly in A&E, Trauma & Orthopedics, and Ophthalmology) - Appointments and waiting times (with nearly one-third linked to Ophthalmology services) - Communication issues - Staff attitude and behavior concerns - 79.87% of complaints were closed within 30 days, with only 20.13% exceeding this target. The Health Board also processed 374 new enquiries during the reporting period, primarily concerning Primary Care, Ophthalmology, A&E, and Health Records. These enquiries typically related to transport delays, waiting times, and communication issues, representing opportunities for service improvement before formal complaints arise.		-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	Advise	Alert		Sharon Daniel	Rationale for Status Change Marked Reduction in Outstanding Actions - The health board has seen a substantial decrease in overdue recommendations, with a correspondingly strong performance in closing or partially completing older HIW actions. This indicates that directorates are increasingly adept at setting realistic deadlines, responding effectively to external scrutiny, and embedding improvements within operational practices. However, there are some issues which will need on-going monitoring. Evidence of Sustainable Processes - Live Monitoring via AMaT - Real-time updates enable the organisation to give prompt responses to HIW queries and swiftly escalate risks or delays. Regular Assurance Reporting - QSEC and relevant committees receive ongoing updates, ensuring that improvements are tracked and remain on course. This supports a culture of transparency and accountability. New Additions, but Strong Handling - While the new Children & Young People Mental Health Review adds a fresh set of actions, early signs show the health board is taking a proactive approach, integrating them into established governance frameworks rather than creating a new backlog. However, to move from Advise to Assure, all Directorates/CCGs will need to demonstrate this level of oversight. Assurance queries from HIW during Q3–Q4 2024–25 have been addressed promptly, illustrating a continued capacity to handle parallel streams of external scrutiny. Continued Oversight - Moving from Alert to Advice should not dilute the focused monitoring needed to keep these improvements on track. Indeed, ensuring new recommendations do not become overdue is key to sustained success. The management response, including clarity of timelines and strict follow-up, appears sufficiently robust to warrant de-escalation at this juncture	This links to row 35 Action: Deep Dive	Recommended Next Steps Maintain the Accelerated Closure Trajectory - Continue efforts to close the 14 remaining overdue items and embed a 'right first time' ethos for new recommendations. Strengthen Evidence of Embedding - Continue capturing and sharing real-world examples of how completed actions have led to measurable service improvements, reinforcing that these are not just 'paper exercises'. Review Status in Next Committee Cycle - If progress on the recently added or future actions remains on track and overdue items drop further, consider transitioning to			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		-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.					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	Alert	Advise	20/03/25	Sharon Daniel	This has remained blank for nearly 12 months, To fully satisfy Criterion 56, future reports should incorporate: - Specific reference to National Clinical Audit participation and findings - Evidence showing how Outcome Review Programme data informs service development decisions - Examples demonstrating Value in Health dashboard utilisation in addressing unwarranted variations in practice - Clear linkage between these national datasets and local improvement initiatives - Case studies illustrating how combined data sources drive specific quality improvements					No risk identified