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Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

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

09 October 2025

Introduction

Reference	Criterion	Description	Status	Lead Executive
TI-2025/547/MD1/3	9	Evidence that the health board has the appropriate mechanism to understand the drivers behind a fragile service through triangulation of key data points	Advise	Mr Lee Davies
TI-2025/547/MD2/1	10	Fragile services are supported by strong clinical leadership, have an effective integrated improvement plan, project management structure and effective transformation support	Advise	Ms Sharon Daniel
TI-2025/547/MD3/1	12	Evidence that all recommendations from Royal Colleges, HIW and other reviews are discharged and either verified or delivered or scheduled for delivery	Advise	Ms Sharon Daniel
TI-2025/547/MD4/1	13	Evidence that the Board is sighted on fragile services and has a robust response to these issues	Advise	Mr Lee Davies
TI-2025/547/MD5/3	19	Assessment of health board response and handling of concerns, complaints, incidents and patient experience feedback related to UEC	Advise	Ms Sharon Daniel
TI-2025/547/MD6/1	22	C. difficile: reduce hospital onset infections by 25% and maintain for 3 months (target: ≤6 per month)	Advise	Ms Sharon Daniel
TI-2025/547/MD7/1	23	S. aureus: reduce hospital onset infections by 33% and maintain for 3 months (target: ≤2 per month)	Alert	Ms Sharon Daniel
TI-2025/547/MD8/1	24	E. coli: reduce hospital onset infections by 25% and maintain for 3 months (target: ≤5 per month)	Alert	Ms Sharon Daniel
TI-2025/547/MD9/1	25	Addressing the root cause of HCAIs and having effective response mechanisms	Alert	Ms Sharon Daniel
TI-2025/547/MD10/1	N/A	Planned care: concerns, complaints, incidents and patient feedback	Advise	Ms Sharon Daniel

- **Scope and sources** - This update covers performance to August 2025 drawing on the Quality & Safety Assurance Report, Infection Prevention & Control (IP&C) dashboards, AMaT external-recommendations tracker, and complaints/incidents dashboards. Where relevant, targets require three consecutive months at/under threshold to evidence sustainability.

- **How classifications are applied** - Advise is used where core controls and improvement actions are in place and there is evidence of progress, but sustained delivery against the defined threshold is not yet demonstrated; Alert where material risk persists and/or performance is deteriorating against the threshold. (Applied across HCAI targets and experience measures in this report.)

- **Data presentation** - The Committee should note minor presentational nuances between Improving Together and Beacon dashboards (e.g., calendar vs working days) when interpreting trends.

Introduction

Focus of Today's Update

This report focuses on providing the Committee with a comprehensive overview of progress across all 10 criteria. We have prioritised detailed reporting on:

- **Healthcare-associated infections** - where quantitative targets provide clear metrics for measuring sustained improvement over the required three-month periods
- **Management of concerns, complaints and incidents** - where timeliness of response and resolution directly impacts patient experience
- **External regulatory compliance** - where demonstrating systematic closure of recommendations evidences our quality assurance processes

These areas have been selected because they represent key measurable indicators of our quality and safety systems, allow the Committee to assess both current performance and sustainability of improvements, and demonstrate our responsiveness to external scrutiny and internal learning.

TI-2025/547/MD3/1 – Discharging external recommendations

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TI-2025/547/MD3/1 – Discharging External Recommendations
Lead Executive - Ms Sharon Daniel

Issue
Royal College reviews, Healthcare Inspectorate Wales (HIW) inspections and other external reviews have generated multiple recommendations that need to be closed or planned into the Health Board's longer-term improvement programme.

Current Status
The Health Board has established comprehensive tracking systems through the Audit Management and Tracking system (AMaT), which provides direct access for leads to update progress and upload evidence. During the reporting period 22nd August 2025 to 30th September 2025, the Health Board received five inspections - Maternity Glangwili (13th-14th May), WGH Radiology Nuclear Medicine (17th-18th June), EUCC Bronglais (28th July), Mynnyd Mawr at Prince Philip Hospital (5th August) and Derwyn ward at Glangwili (2nd September). Feedback has been generally positive, though EUCC, Mynnyd Mawr and Derwyn ward raised immediate actions which have been addressed within the timeline provided. The Maternity Glangwili report was published on 14th August 2025 and the WGH Radiology Nuclear Medicine report on 18th September 2025. Draft reports are awaited for EUCC Bronglais, Mynnyd Mawr and Derwyn ward.

The Health Board has maintained enhanced dialogue with HIW following the May 2025 correspondence regarding collective concerns about quality governance arrangements. Between 20th May and 12th September 2025, the Health Board received 17 letters from HIW requesting assurance on matters including paediatric medical workforce, mental health provision (North Ceredigion and Bro Cerwyn), radiology staffing concerns, ward assurance issues, and service user concerns. All responses have been provided within the requested timescales, with multiple touchpoints maintained throughout the period.

TI-2025/547/MD3/1 – Discharging external recommendations

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Rationale – Advise

- **Controls and system in place -** AMaT provides a live register for recommendations with evidence upload and lead access, underpinning systematic tracking and closure.

- **Regulatory throughput and responsiveness** - Five inspections in-period (Maternity GGH; WGH Radiology Nuclear Medicine; EUCC Bronglais; Mynnyd Mawr PPH; Derwyn Ward GGH) with immediate actions raised at three sites and addressed within the required timelines; 17 HIW assurance letters responded to within timescales, demonstrating timely engagement.

- **Direction of travel on external actions** - Overdue HIW actions reduced 57% (51→22) and actions in progress reduced 79% (119→25), evidencing traction in closure.

- **Why not "Assure" yet** - Draft reports remain outstanding for several inspections; while immediate actions have been completed, the Health Board must evidence verified closure of all recommendations (within the agreed timescales) and benefits realisation across services to demonstrate sustained compliance. However, there has clearly been a significant level of progress within the criterion

TI-2025/547/MD5/3 – Handling Unscheduled Emergency Care (UEC) concerns, complaints and incidents

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TI-2025/547/MD5/3 – Handling UEC concerns, complaints and incidents
Lead executive - Ms Sharon Daniel

Issue

Urgent and Emergency Care (UEC) remains a high risk on the corporate risk register, and the Health Board must demonstrate that it responds effectively to incidents, complaints and concerns.

Current Status

Incidents - Analysis of the **Our Performance Dashboard** for the Community and Integrated Medicine function (August 2025 data) reveals -

- Open incidents - 1,059 incidents remain open for over 120 days; 1,495 incidents have been open for over 60 days
- Incident trends - Reported incidents by month have stabilised between 120-200 since 2023, demonstrating consistent reporting patterns
- Closure rates - Almost all directorates now close over 94% of incidents, showing improved incident management processes
- Longest open incidents - Several incidents remain open for over 600 days (HDD7679 at 1,444 days, HDD14727 at 1,299 days, HDD19101 at 1,208 days), indicating significant delays in investigation and learning
- Top incident categories - Pressure damage/moisture damage (767 cases), accident/injury (527 cases), and medication/IV fluids (258 cases) represent the most common incident types

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

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Complaints

The complaints dashboard shows -

- 30-day performance - Only 40.55% of complaints have been resolved within 30 days for the Community and Integrated Medicine function
- Open complaints - The longest open complaint has been outstanding for 681 days
- Volume trends - New complaints fluctuate between 40-80 per month, with ongoing challenges in timely resolution

Healthcare Inspectorate Wales (HIW) Progress

- Monthly meetings with HIW now established
- Overdue HIW actions reduced from 51 (February 2024) to 22 (August 2025) – a 57% reduction
- Actions in progress reduced from 119 to 25 – a 79% reduction

Rationale - Advise

Timely closure of incidents is improving, with over 94% closure rates across most directorates demonstrating that effective processes are in place. The significant reduction in overdue HIW actions (57%) and actions in progress (79%) demonstrates sustained focus on regulatory compliance.

However, the following concerns remain:

- Volume of aged incidents - 1,059 incidents open over 120 days suggests learning from events is not consistently timely
- Very long-standing incidents - Cases open for 1,200+ days indicate systematic investigation delays
- Poor complaint performance - Only 40.55% resolution within 30 days (against a 75% target) demonstrates ineffective complaint management
- Longest open complaint - 681 days significantly exceeds acceptable timeframes

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

TI-2025/547/MD6/1 – Reducing Clostridioides difficile infections
Lead executive - Ms Sharon Daniel

Issue - The TI de-escalation criterion requires a 25% reduction from the Q3 2023 baseline of eight C. difficile cases with hospital onset to a maximum of six cases per month, sustained for three months.

Current status - Between April and August 2025, the Health Board reported monthly hospital-onset C. difficile counts of 8, 8, 11, 7 and 4 cases respectively. August 2025 achieved 4 cases, meeting the target threshold for the first time in the reporting period and representing a significant reduction from both the July figure of 7 cases and the June peak of 11 cases. The infection prevention report states there were 31 hospital-onset cases and 30 community-onset cases during the period from 1 April to 31 July 2025. During the April to July period, four patients had two positive samples and one patient had three positive samples. These patients will be reviewed for suitability for Faecal Microbiota Transplantation (FMT). Carmarthenshire accounted for 22 hospital-onset cases between April and August 2025. The C. difficile Infection (CDI) Improvement Group has discussed the C. difficile collaborative, and many staff have taken part in interviews and focus groups relating to potential projects. HPV enhanced cleaning is now available at three acute sites. Mandatory Level 2 training stands at 75.56%. No new outbreaks have been reported since the last update.

Rationale - Advise - August 2025 represents a positive development with 4 cases, the lowest monthly count in the reporting period and below the target threshold of six cases. However, the de-escalation criterion requires this level of performance to be sustained for three consecutive months, which has not yet been achieved. The June figure of 11 cases represents the highest monthly count in the reporting period. Continued focus on the improvement initiatives currently underway will be essential to demonstrate sustained performance at or below the target threshold

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

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TI-2025/547/MD7/1 – Reducing Staphylococcus aureus bacteraemia
Lead executive - Ms Sharon Daniel

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

Current Status - Between April and August 2025, the Health Board reported monthly hospital-onset S. aureus cases of 3, 3, 3, 4 and 5 respectively. The Quality and Safety Assurance Report states that during April to August 2025, 53 patients were diagnosed with S. aureus bacteraemia across the region, of whom 18 were hospital-onset. The IP&C section notes that "MRSA rates in August increased" and that "early cases review indicates that these cases are linked to cannulas/invasive devices." Most sources related to wounds, musculoskeletal sites or lines/devices, with some sources still to be confirmed following further review. Antiseptic Non-Touch Technique (ANTT) compliance is 82.58% for critical care and other inpatient areas seeking accreditation. ANTT is to be made mandatory on ESR for the Health Board. Hand hygiene audits encompassing bare below the elbow are profiled, with validation audits conducted as indicated. Ward manager and senior nurse hand hygiene audits are now on AMaT and monitored. Line-care audits are ongoing.

Rationale - Alert - The target of two cases per month has not been achieved in any month during the April to August 2025 period. Cases increased from 3 in June to 4 in July and 5 in August, representing an upward trajectory (albeit marginal). MRSA rates in August increased with early case reviews linking infections to cannulas and invasive devices; potential improvement through enhanced device care and ANTT compliance.

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

TI-2025/547/MD8/1 – Reducing Escherichia coli bacteraemia
Lead executive - Ms Sharon Daniel

Issue - A 25% reduction from the baseline of 6.7 cases per month means hospital-onset E. coli bacteraemia should not exceed five cases per month, sustained for three months.

Current status - Between April and August 2025, the Health Board reported monthly hospital-onset E. coli cases of 6, 5, 7, 10 and 6 respectively. May 2025 achieved the target of five cases per month. August showed improvement, reducing from the July peak of 10 cases to 6 cases. The Quality and Safety Assurance Report states that during April to August 2025, 150 patients were diagnosed with E. coli bacteraemia across the region, of whom 35 were hospital-onset whilst 115 were community-onset. The IP&C section notes that "E. coli bacteraemia rates remain high" and that urinary tract infections were the predominant source, followed by biliary tract infections and catheter-associated urinary tract infection (CAUTI). Age-profile analysis shows the burden falls predominantly in the 80-89 age bracket. Aseptic Non-Touch Technique (ANTT) compliance stands at 82.58%. Hand hygiene audits encompassing bare below the elbow are profiled, with validation audits conducted as indicated. Ward manager and senior nurse hand hygiene audits are now on Audit and Management Tracking System (AMaT) and monitored. The burden for both E. coli and S. aureus infections remains in the community, with proactive prevention work ongoing with public health.

Rationale - Alert - The quality report explicitly states that "E. coli bacteraemia rates remain high." Whilst May 2025 achieved the target threshold of five cases and August demonstrated improvement from the July peak, sustained performance at or below target has not been achieved. The target requires five or fewer cases sustained for three consecutive months. The July figure of 10 cases represents the highest monthly count in the reporting period, though the subsequent reduction to 6 cases in August indicates an improvement.

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

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TI-2025/547/MD9/1 – Addressing root causes of HCAIs
Lead executive - Ms Sharon Daniel

Issue - Beyond meeting numerical targets, the Health Board must demonstrate that it understands and addresses the underlying drivers of hospital-acquired infections (HCAIs).

Current status - The Infection Prevention Strategic Steering Group (IPSSG) oversees a comprehensive programme. Quality-planning measures include an annual IP&C work plan, compliance with Welsh Health Circulars on antimicrobial resistance and HCAI improvement and working with public health and community services to prevent infection in high-risk populations and community settings. Quality-control efforts involve standardising assurance and scrutiny meetings across clinical care groups, reviewing Health Board IPC policies, self-assessment against the C. difficile Framework for Wales and attendance at the Wales C. difficile Focus Forum Meeting. Quality-improvement activities include assurance and scrutiny meetings where all hospital-onset HCAIs are discussed with learning obtained and action plans implemented, with themes derived and a move to learning panels; working with managed practices presenting infographics for infections, sources and learning; environmental audit programme and observational audits programme in place with improvement action plans produced; HPV in use in three acute sites; HCID/infectious disease pathway training completed for GGH and BGH with dates in September and October for PPH and WGH; and engagement in the National C. difficile Learning Collaborative. Mandatory Level 2 training stands at 75.56%. ANTT compliance is 82.58%. HPV enhanced cleaning is now available at three acute sites. IPC environmental audits focus on very high-risk and high-risk areas, with theatres, ITUs, maternity and oncology completed. HCAI and IP&C are included within all CCG Escalation Improving Together Sessions. The IP&C section states "There is a mixed trend for HDUHB, with some infections improving and others being more challenging." August 2025 showed significant improvement for C. difficile (4 cases, the lowest in the reporting period) and improvement for E. coli (reducing from 10 to 6 cases), though S. aureus cases increased from 4 to 5.

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

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Rationale - Alert - the Quality and Safety Assurance Report explicitly states that "E. coli bacteraemia rates remain high" and that "MRSA rates in August increased." The IP&C section notes "There is a mixed trend for HDUHB, with some infections improving and others being more challenging." Whilst August demonstrated significant improvement for C. difficile (achieving the lowest count in the reporting period at 4 cases) and improvement for E. coli following the July peak, sustained performance below target thresholds has not been achieved for any of the three organisms. S. aureus showed an upward trajectory during the period. The comprehensive quality improvement infrastructure is in place, and the marked month-on-month improvements in August for C. difficile indicate that improvement activities are having impact, though this requires consolidation and sustained delivery across all three organisms.

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

TI-2025/547/MD10/1 – Planned care - concerns, complaints, incidents and patient feedback
Lead executive - Ms Sharon Daniel

Issue - Planned care services, including outpatient clinics and theatres, must manage incidents and complaints effectively whilst implementing recovery plans for lengthy waiting lists.

Current status - Quality dashboards for planned and specialist care show that incidents by month have fluctuated between 120 and 200 since 2023. Top open-incident categories include maternity adverse occurrences (147 cases), assessment/diagnosis (145) and access/admission issues (114). The longest open incidents have been outstanding for over 600–900 days, indicating delays in closure. Complaint dashboards reveal that new complaints received each month oscillate between 60 and 100, with peaks in June and October 2024. Ophthalmology, orthopaedics and gynaecology carry the highest numbers of open complaints, and some cases have been open for more than 350 days. Improvement actions taken during 2025 include insourcing and training posts for ultrasound, investment to support ophthalmology recovery, and planned replacement of ageing radiology equipment and a new aseptic unit to open in February 2026. On the positive side, there have been zero cataract pathway breaches since Q1 2025, diagnostic waits have reduced by 18% and Single Cancer Pathway performance has improved above 60%. However, only 38.15% of complaints in 2025/26 were closed within 30 days, demonstrating slow complaint resolution.

Rationale: Advise - recovery plans are delivering improvements in waiting times and diagnostic performance (which is a theme within complaints and patient feedback), but the volume and duration of open incidents and complaints highlight weaknesses in implementation of the agreed management process and patient-experience management. Strengthening complaint-handling processes, improving communication with patients and increasing timely investigation of incidents should be priorities before assurance can be given.

Conclusion

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NOTE:

- Significant progress in regulatory compliance with overdue HIW actions reduced by 57% (51 to 22) and actions in progress reduced by 79% (119 to 25), with all responses to 17 HIW assurance requests provided within timescales

- C. difficile achieved 4 cases in August 2025 - the lowest monthly count in the reporting period and first achievement below the target threshold of 6 cases

- Comprehensive governance infrastructure now established including AMaT tracking system, Infection Prevention Strategic Steering Group, and standardised Clinical Care Group assurance meetings

- The Health Board is using Improving Together dashboards for reporting, and whilst data aligns with Beacon Dashboard, there can be nuances in data presentation between the two systems (calendar days vs working days)

RECOGNISE:

- No infection target has achieved the required sustained performance of three consecutive months at or below threshold, with S. aureus showing deteriorating performance (3 – 4 - 5 cases) and E. coli remaining volatile with rates described as "remaining high“

- Unscheduled care complaint resolution at 40.55% and planned care at 38.15% fall significantly short of the 75% target, with the longest open complaint at 681 days

Conclusion

- In unscheduled care (Community and Integrated Medicine function), 1,059 incidents remain open over 120 days with several exceeding 600 days (longest at 1,444 days), indicating systematic delays in learning from incidents

- Planned care also shows longest open incidents at 600-900 days

ACKNOWLEDGE:

- The Health Board has built the foundational infrastructure and improvement programmes required for sustained improvement, with early indicators (particularly August C. difficile performance) suggesting interventions are beginning to have impact

- The critical challenge is now translating this infrastructure into consistent, sustained performance over the required timeframes for de-escalation

- Almost all directorates now close over 94% of incidents, demonstrating that effective processes are in place, though aged incidents require accelerated resolution

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