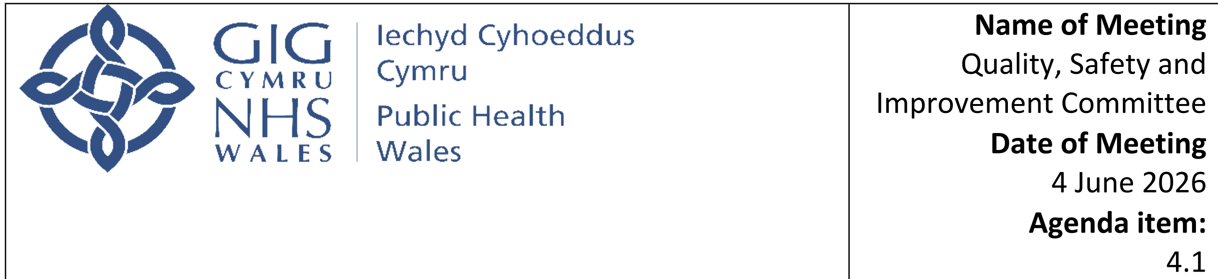
	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 4 June 2026 **Agenda item:** 4.1

Quality Governance Performance Report Quarter 4 (1st January 2026 – 31st March 2026)	
Executive lead:	Claire Birchall, Executive Director of Nursing Quality, and integrated Governance
Author:	• Angela Cook, Assistant Director of Quality and Nursing • Paula Mitchell, Quality and Clinical Governance Manager • Jessica Taylor, Quality and Clinical Audit Lead • Jacqui Westmoreland, Paisley Hartland, Louise Van Laere, PTR Team • Donna Newell, Named Lead for Safeguarding • Junaid Iqbal, Lead for Service User Experience • Nicola Lewis, Lead Nurse for Corporate Infection Prevention & Control

Approval/Scrutiny route:	Business Executive Team – 06/05/26

Purpose
The Quality Governance Report provides Business Executive Team (BET) with an overview of Quality Governance within Public Health Wales for the Quarter 4 period (1st January 2026 to 31st March 2026). It incorporates the two domains of a quality management system: quality assurance and quality improvement. Quality control is provided within the Integrated Performance Report, which contains quality measures at organisational level. The report provides specific updates and assurance on: • Putting Things Right Management • Service User Experience • Alerts Management • Clinical Audit • Quality Oversight Group

- The work of the Safeguarding Group
- The work of the Infection Prevention Control Group

This report will also include formal quarterly reporting for Infection Prevention Control, Safeguarding, Quality and Clinical Audit.

Recommendation:				
APPROVE ☐	CONSIDER ☒	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒

The Committee is asked to:

- **Receive** and **Consider** the Quality Governance Report.
- **Note** the performance standards being achieved and areas for improvement.
- Receive **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient, and person-centred services.

Link to Public Health Wales Strategic Plan Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	5 - Supporting a sustainable health and care system
Strategic Priority/Well-being Objective	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	No Equality and Health Impact Assessment is required. However, many of the areas that are identified through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity
Risk and Assurance	The information and data presented in this report help understand the quality of services/ care being delivered, and our assurance and improvement activities to provide high quality and continuous improving services. The Governance structure is operating effectively with Safeguarding, and Infection Prevention Control included on the relevant group Risk Registers.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports and/or takes into account the Health and Care Quality Standards for NHS Wales Quality Themes.
Financial implications	Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance.
People implications	The Quality Governance Report provides information related to experience and outcomes for service users and staff, and therefore the information is pertinent to Service Users, Carers, and Staff across PHW.

1. Executive Summary

The Quality Governance Report is a quarterly report presented to the Quality, Safety and Improvement Committee, providing oversight and assurance on clinical quality and safety through the submission of data and summary highlights from Public Health Wales' assurance groups.

In line with the Duty of Quality this report covers the following key quality standards.

Do we deliver safe care and services?

By safe we mean that people who use are our services receive high quality, reliable care within a safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong.

Putting Things Right - Incidents (Page 8)

- 490 incidents were reported and investigated during Quarter 4, with remedial actions identified. Of these, 2 were closed as Moderate harm or above.
- As of 31 March 2026, there are 47 incidents on Datix with an 'open' status of more than 30 working days. This is an improved position on the previous quarter.

Safeguarding of Adults & Children at Risk (Page 29)

- 62 safeguarding enquires and incidents were reported this quarter reflecting a significant increase in activity compared to the previous quarter. The majority of these are from the Sexual Health Wales service.
- 7 Duty to Report (DTR) submissions were made to local authorities, with the rise directly linked to the introductions of daily safeguarding huddles initiated in response to concerns raised and escalated through the Sexual Health IMT, resulting in improved detection and escalation of safeguarding risks.

Infection Prevention & Control (Page 35)

- 21 Infection Prevention and Control incidents were reported during Quarter 4, the majority reported by Infection services.
- The IPC risk register contains 6 risks and includes 1 corporate risk relating to the organisation's inability to evidence standards of environmental cleanliness.
- IPC Level 2 training compliance is currently below the Welsh Government target of 85%. The lowest levels of compliance are within Infection Services; however, this is attributed to the recent addition of an updated competency within the ESR training framework, which has resulted in a doubling of the number of staff now required to

complete IPC Level 2 training. Bowel Screening Wales currently utilises a number of screening sites that give cause for concern. Both Ysbyty Glan Clwyd and Bronglais are experiencing challenges associated with ageing environments and equipment. Further details are included in the report.

- During 2026–27, a significant change in Transmission-Based Precautions terminology and practice is anticipated. This work is being led by Health Protection Scotland, with the IPC Consultant Nurse within HARP represented on the project group. Further information and updates on these potential changes will be included in reports as they become available.

Are we providing timely care and services?

By timely we mean the people who use our services will have access to the high-quality services, advice, and guidance for public health interventions, at the right time and place to meet their needs.

Concerns and complaints (Page 13)

- 25 Early Resolution complaints were received during Quarter 4 and 10 formal complaints.
- 88% of the Early Resolution complaints were resolved within the 2 working day target.
- 75% of formal complaints were acknowledged within the 5 working day target.

Do we provide effective care and services?

By effective, we mean that the people who use our services have access to screening, specialist advice, treatment and support that provides the best outcome for them.

Clinical Audit (Page 25)

- Progress against the 2025–26 Quality and Clinical Audit Plan for Quarter 4 (Q4) has been reviewed. At the start of the year, the plan comprised 64 internally reported audits, which increased to 75 by year-end. However, 13 audits were subsequently approved for removal from the plan.
- 6 external audits were planned; 5 have completed and 1 placed on hold due to organisational changes within NHS England, as audit lead.

Safety Alerts Management (Page 21)

- A total of 48 alerts were received by Public Health Wales during the reporting period 1 January – 31 December 2026, **0** of which required action to be taken

Do we provide person centred services?

By person centred we mean our services meet the needs of the people we work with and for to ensure that their preferences, needs, and values are considered and guide decision-making.

Compliments (Page 23)

- A total of 126 compliments were recorded by staff within the Civica system.
- 42 compliments were left directly by members of the pubic using the 'Your Feedback' webpage available on the Public Health Wales website.
- A combined total of 168 compliments were logged for Public Health Wales this quarter.

BET and the Committee are asked to approve the Report as providing sufficient assurance on the actions being taken in relation to Quality and Patient Safety.

2. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 3 2025 and provide updates from Public Health Wales governance subgroups to provide assurance for the following areas of work:

- Putting Things Right
- Claims Management
- Alerts Management
- Service User/Peoples Experience
- Quality and Clinical Audit
- Safeguarding
- Infection Prevention Control

This report supports the achievement of quality through the following:

Safe: People who use are our services receive high quality, reliable care within a safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong.

Timely: People who use our services have access to the high-quality services, advice, and guidance for public health interventions, at the right time and place to meet their needs.

Effective: People who use our services have access to screening, specialist advice, treatment and support that provides the best outcome for them.

Efficient: We will make the most effective use of our resources, ensuring we build capacity and capability across the organisation to achieve best value healthcare in an efficient way.

Equitable: We will continually strive to ensure that people have every opportunity to live healthy and happy lives.

Person Centred: Our services will meet the needs of the people we work with and for to ensure that their preferences, needs, and values are considered and guide decision-making.

2.1. Putting Things Right Quarter 4 Overview

During Quarter 4 there has been an estimated 650, 000 contacts/tests with patients, participants and service users across Public Health Wales. The data presented in this report provides insight into the quality and safety of our services.

3. Incident Management

Incidents Reported	National Reportable Incidents	Early Warnings	Duty of Candour
↓ 490 (581)	↑ 2 (0)	⇆ 1(1)	⇆ 0 (0)

( ) denotes previous quarter data

3.1. Incidents

During Quarter 4, a total of 490 incidents were reported. This is a reduction of 91 compared to the 581 reported in Quarter 3 2025/26.
The below table indicates incidents that have been investigated and closed with the level of harm identified as moderate harm or above during each quarter.

	Moderate Harm- Post investigation	Severe harm- Post investigation	Catastrophic/ Death- Post investigation
Quarter 1 2025/26	1	0	0
Quarter 2 2025/26	2	0	0
Quarter 3 2025/26	1	0	0
Quarter 4 2026	2	0	0

The 2 cases classified as moderate harm following investigation are within Cervical Screening Wales and relate to unsatisfactory Cervical Screening Wales Audit of Cervical Cancer (CSWACC) outcomes. These cases involve a delay in referral to colposcopy and an error in the laboratory interpretation of a cytology slide.

3.2. Identified Learning from CSWACC incidents

- To promote the consistent use of approved algorithms and Standard Operating Policies and Procedures (SOPs) across all aspects of participant pathways.
- To reinforce the requirement for staff to complete tests or confirm discharge decisions fully in line with the relevant algorithm.
- For staff to seek further training and/or support where there is any uncertainty regarding participant management.
- To continue ongoing educational reviews within the laboratory, including the review of complex cases.
- To monitor performance statistics to ensure all staff are working within expected standards.

3.3. Early Warning and National Reportable Incidents

There has been 1 Early Warning (EW) notice sent to Welsh Government in Quarter 4. The Sexual Health Team within the Health Protection Division identified concerns regarding Hepatitis C testing and the provision of negative results when the test had not in fact been undertaken due to a system error.

There have been 2 Nationally Reportable Incidents (NRI) to NHS Performance and Improvement. Both relate to Sexual Health Team in the Health Protection Division and

involve safeguarding procedures for those under 18 years of age and to reported negative Hepatitis C when testing was not undertaken.

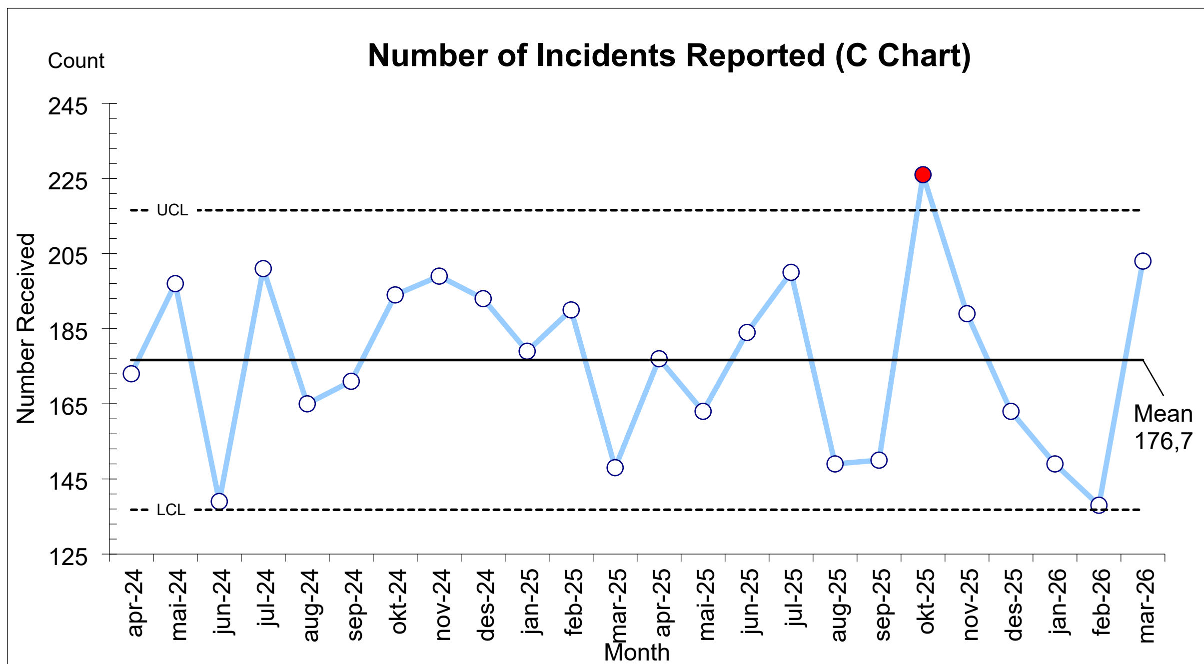
Incident Management Teams
There is currently **1** Incident Management Team (IMT) ongoing:

Health Protection:

- Sexual Health Team
    - Main IMT with a safeguarding retrospective review included
    - Hepatitis C testing IMT

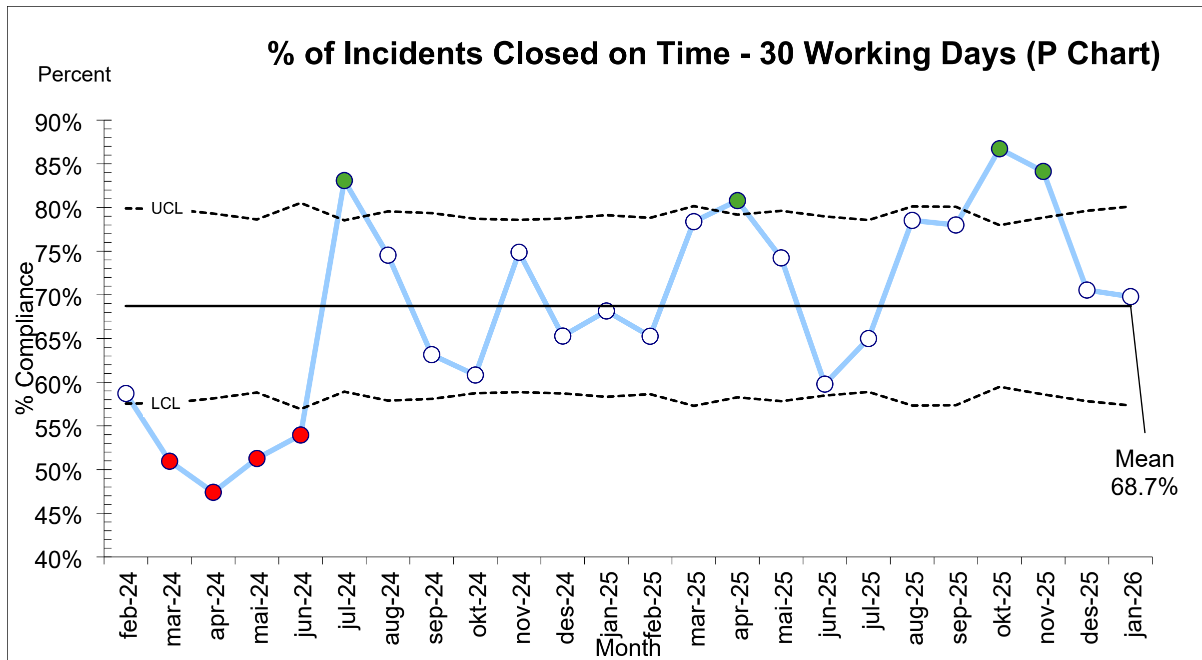
3.4. Open Incidents

The below chart demonstrates the number of incidents reported since April 2024. The mean has remained unchanged at 176 incidents between Quarter 3 and Quarter 4 2025/26.



Infection Services were the highest reporting area in Quarter 4, with 180 incidents recorded, comparable to 177 incidents in Quarter 3. In contrast, Cervical Screening Wales experienced a 47% reduction in reported incidents, decreasing from 243 in Quarter 3 to 127 in Quarter 4. This reduction is primarily attributed to fewer

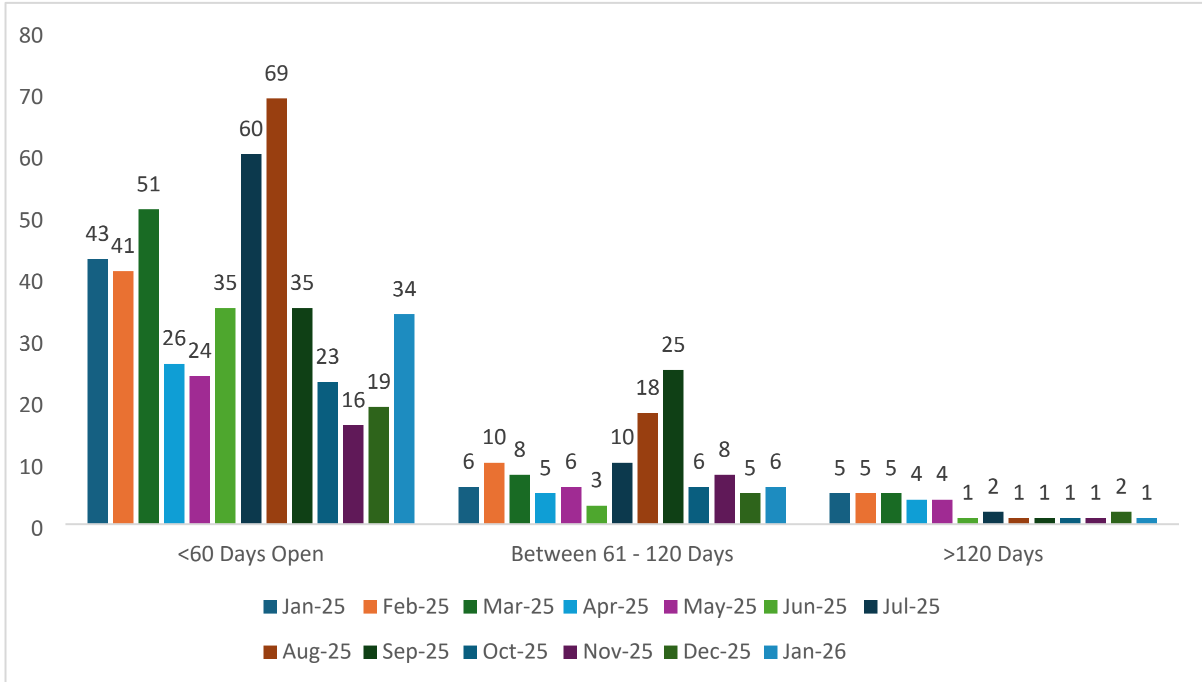
reports relating to out-of-date consumables, missing sample taker codes, and inadequate identifiers.



The above graph highlights the overall performance against the 30-working day closure rate target which has declined when compared to Quarter 3.

3.5. Overdue Incidents

Ongoing work with service areas, the Office of the Medical Director, and the Nursing, Quality and Integrated Governance (NQIG) team continues to support the timely closure of incidents, with sustained improvements being achieved.



3.5 Incident Classification

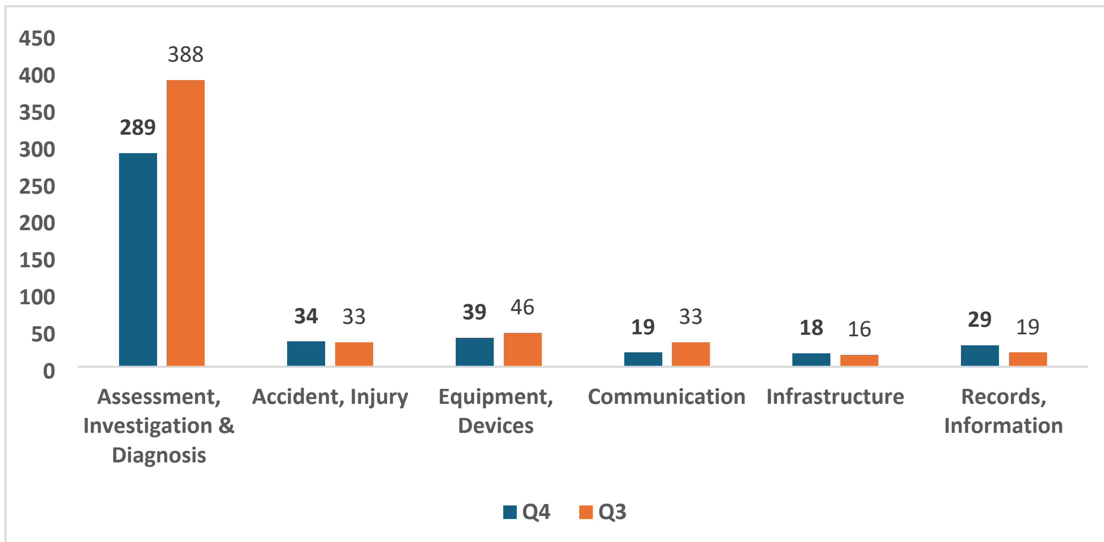


Chart 5. Top 5 incident classifications

Assessment, Investigation and Diagnosis remain the highest reported incident type, increasing in number when compared Quarter 3.

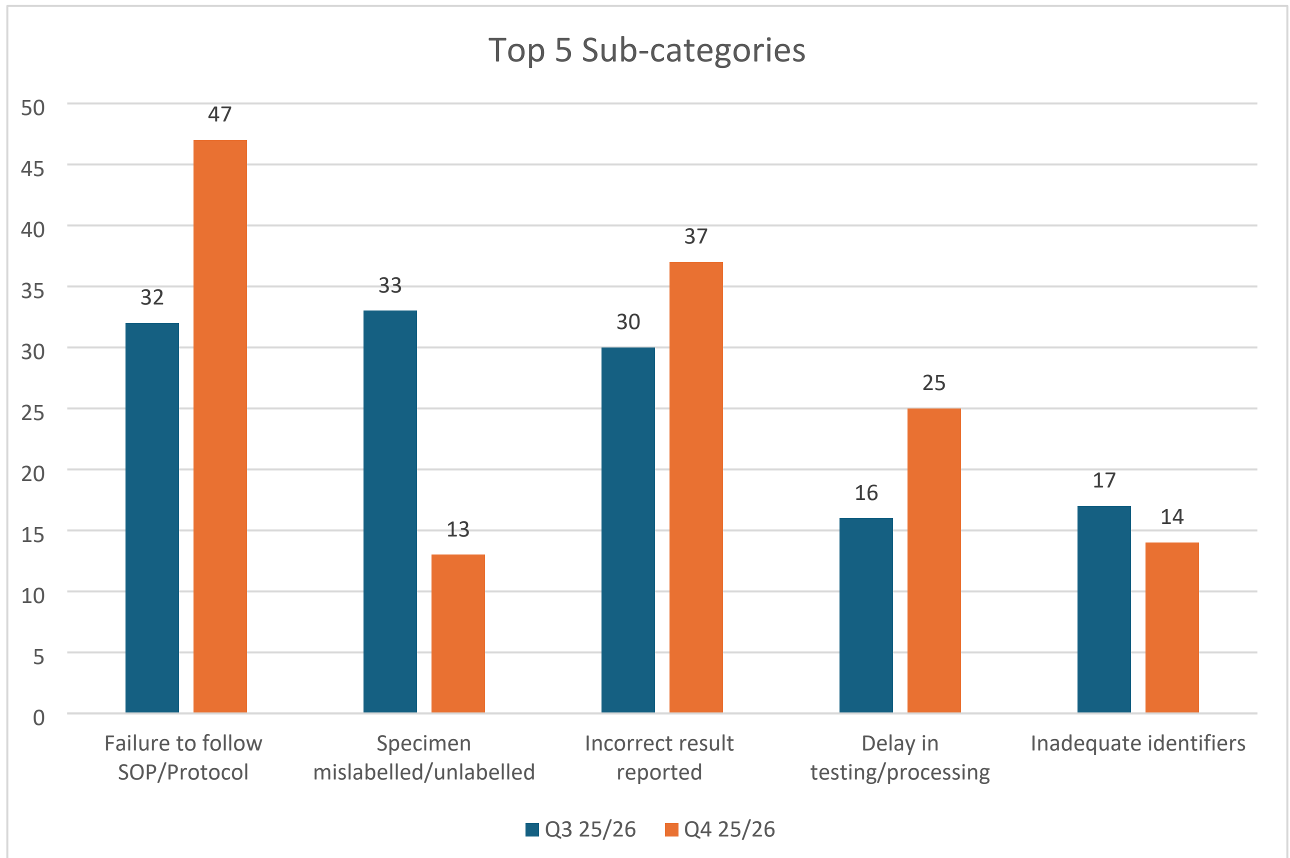


Chart 6. Top 5 sub-categories

3.6. Incident Reporting and Management Training

Datix training is not mandatory for Public Health Wales staff; however, all staff are encouraged to attend, with new starters specifically targeted through onboarding processes.
The current Level 1 Datix training offer has been temporarily paused while staff receive training on the revised Listening to People Regulations. A revised Level 1 training package is being developed, which will incorporate both complaint and incident reporting.
In the interim, the PTR Team continues to provide bespoke training sessions to service areas, ensuring that both newly appointed and existing staff can access training as required while the new package is in development.

4. Redress Management

When investigating a concern which includes an allegation that harm has or may have been caused, Public Health Wales is required to consider whether there is a qualifying liability in tort. This means consideration must be given as to whether

there has been a breach in our duty of care and whether that breach of duty is causative of any harm or loss to that person.

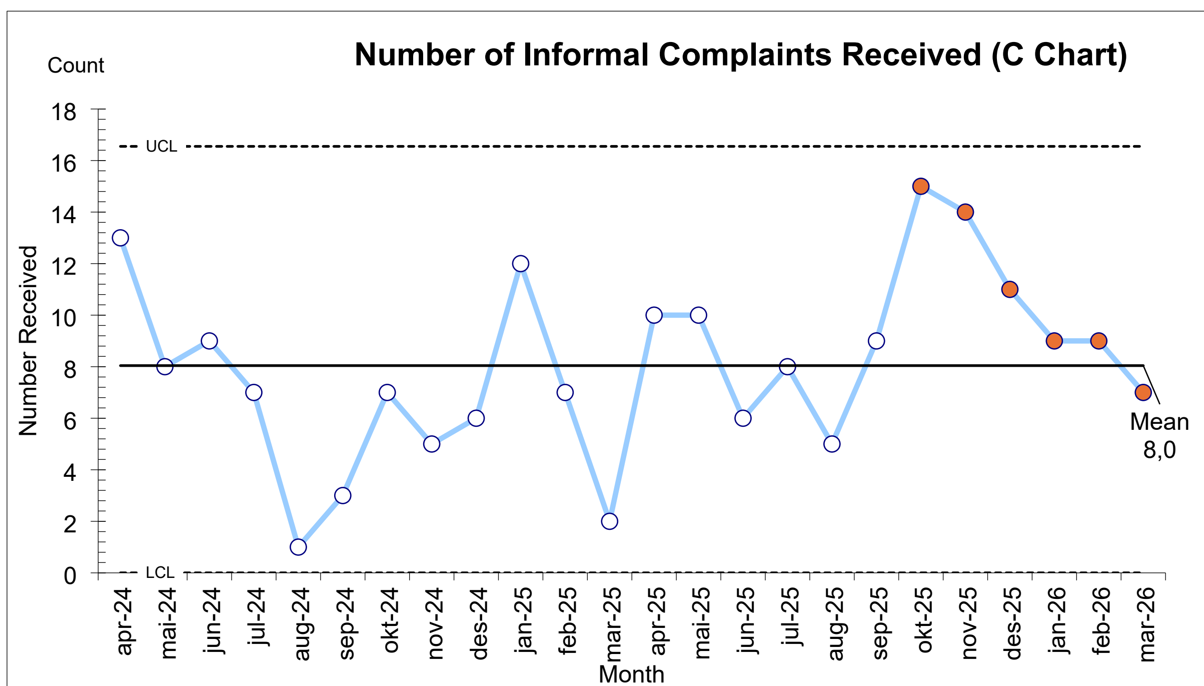
No new redress cases were received during this quarter. There are **7** ongoing redress cases, **3** in Breast Test Wales and **4** in Cervical Screening Wales. There is 1 potential Redress case for Breast Test Wales.

5. Complaints Management Q4

Early Resolution Complaints (n)	Formal Complaints (n)	Ombudsman Complaints (n)
↓ **25 (40)**	↓ **10 (11)**	⇆ **0 (0)**

( ) denotes previous quarter data

5.1. Early Resolution Complaints (Informal)

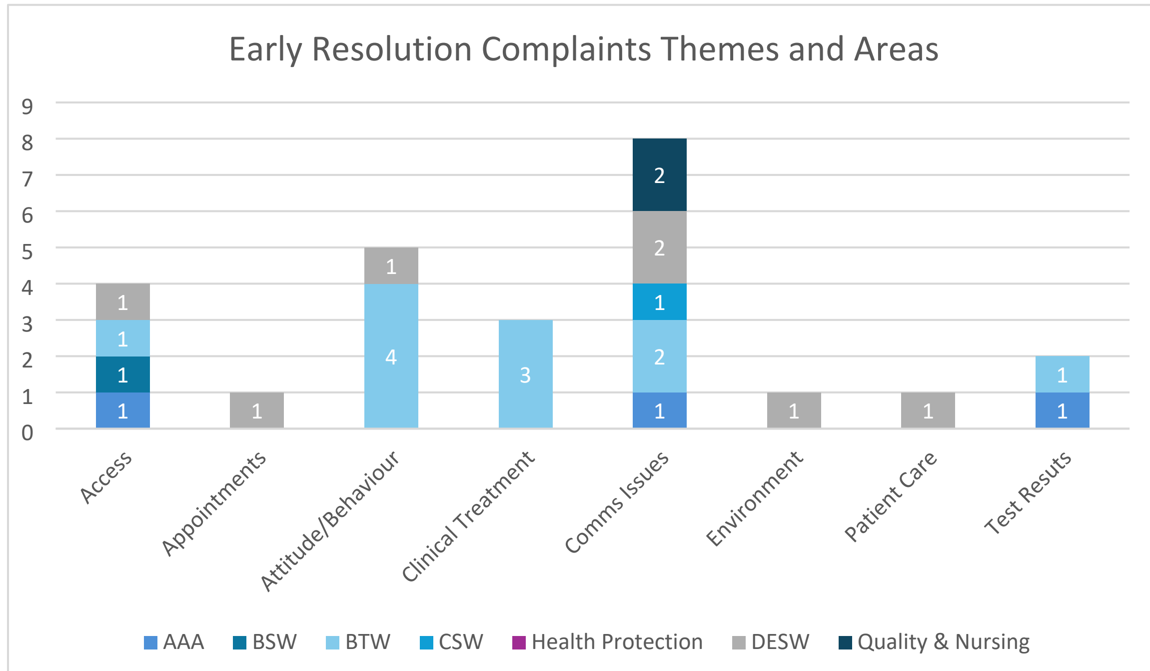


Public Health Wales endeavours to deal with any complaints received by way of early resolution wherever possible.

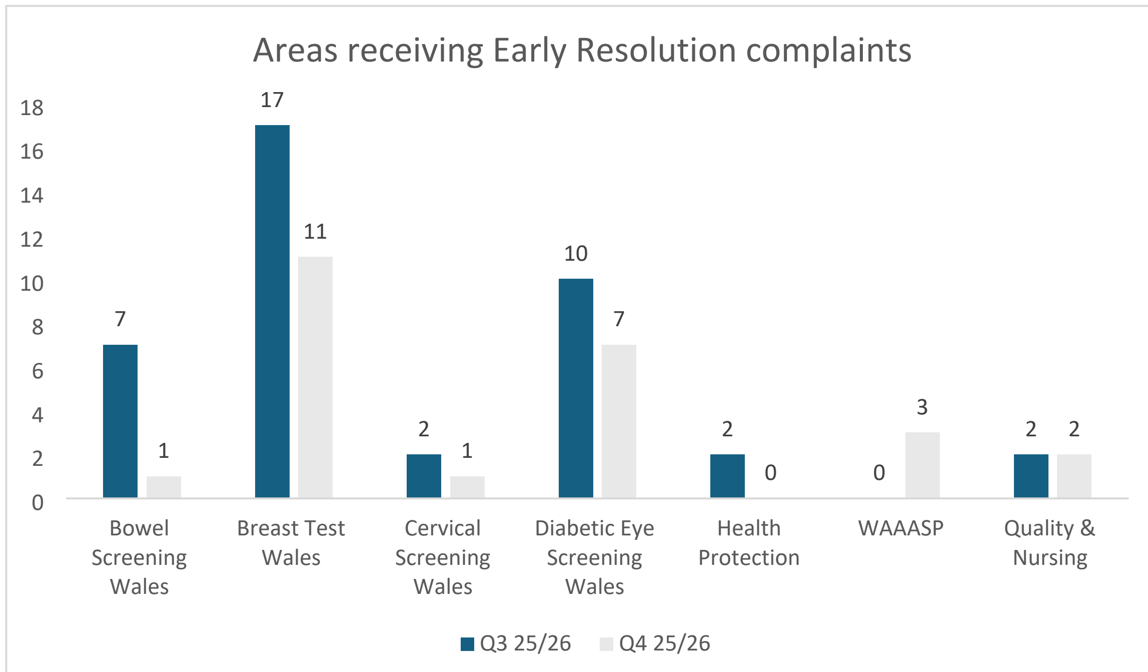
- **25** Early Resolution complaints were received during Quarter 4. This is a significant reduction compared to the 40 received in Quarter 3.
- 12% (3) were resolved outside of the target, but all within 10 working days.

Delays to achieving the 2 working day compliance rates were attributable to:

- Staff not being able to contact the complainant during the required timeframes
- The investigator required further information prior to contacting the complainant to proceed.



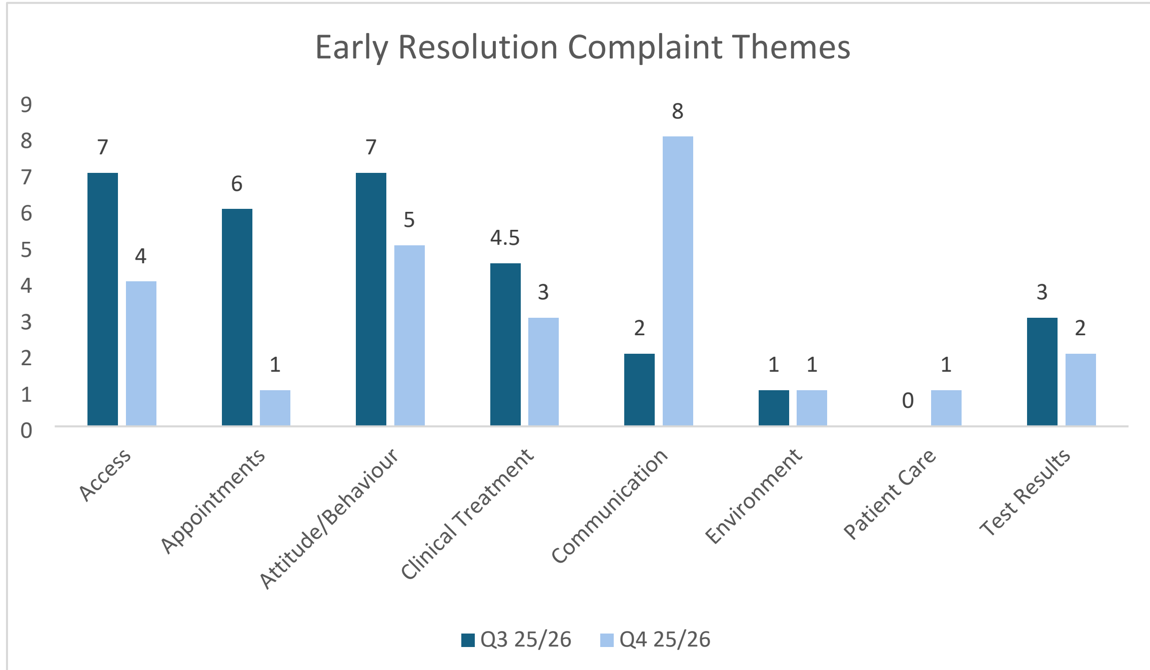
The chart below outlines the service areas in which Early Resolution complaints were received across each quarter and provides comparative data from previous quarters.



Breast Test Wales and Diabetic Eye Screening Wales both experienced a slight reduction in Early Resolution complaints during Quarter 4. Breast Test Wales received 11 complaints, compared to 17 in Quarter 3, while Diabetic Eye Screening Wales received 7 complaints, down from 10 in the previous quarter.

Wales Abdominal Aortic Aneurysm Screening recorded an increase of 3 Early Resolution complaints this quarter, compared to none in Quarter 3. No common theme has been identified across these complaints.

Communication issues and attitude/behaviour were the most frequently reported categories for Early Resolution complaints in Quarter 4. Attitude/behaviour remains one of the highest-reported categories, with 4 complaints received by Breast Test Wales during the quarter. All 4 complaints were discussed with the staff members involved, and wider learning was shared through regional team meetings.



5.2. Formal Complaints

During Quarter 4, **10** formal complaints were received, a slight change from **11** in the previous Quarter. On average 3 formal complaints are received per month.

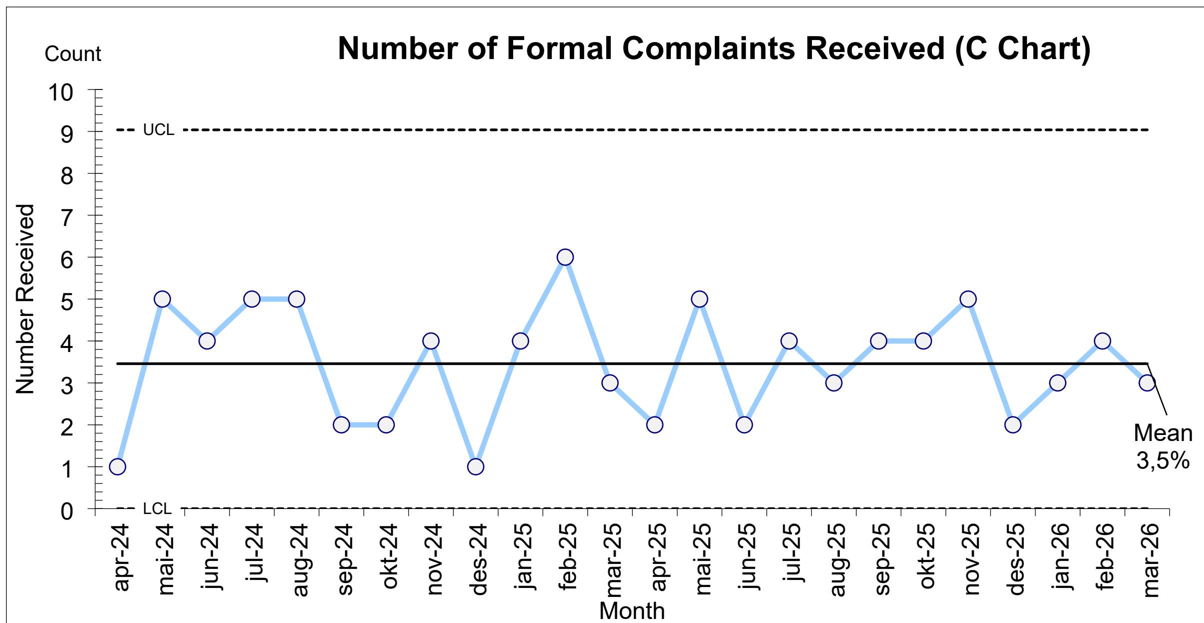
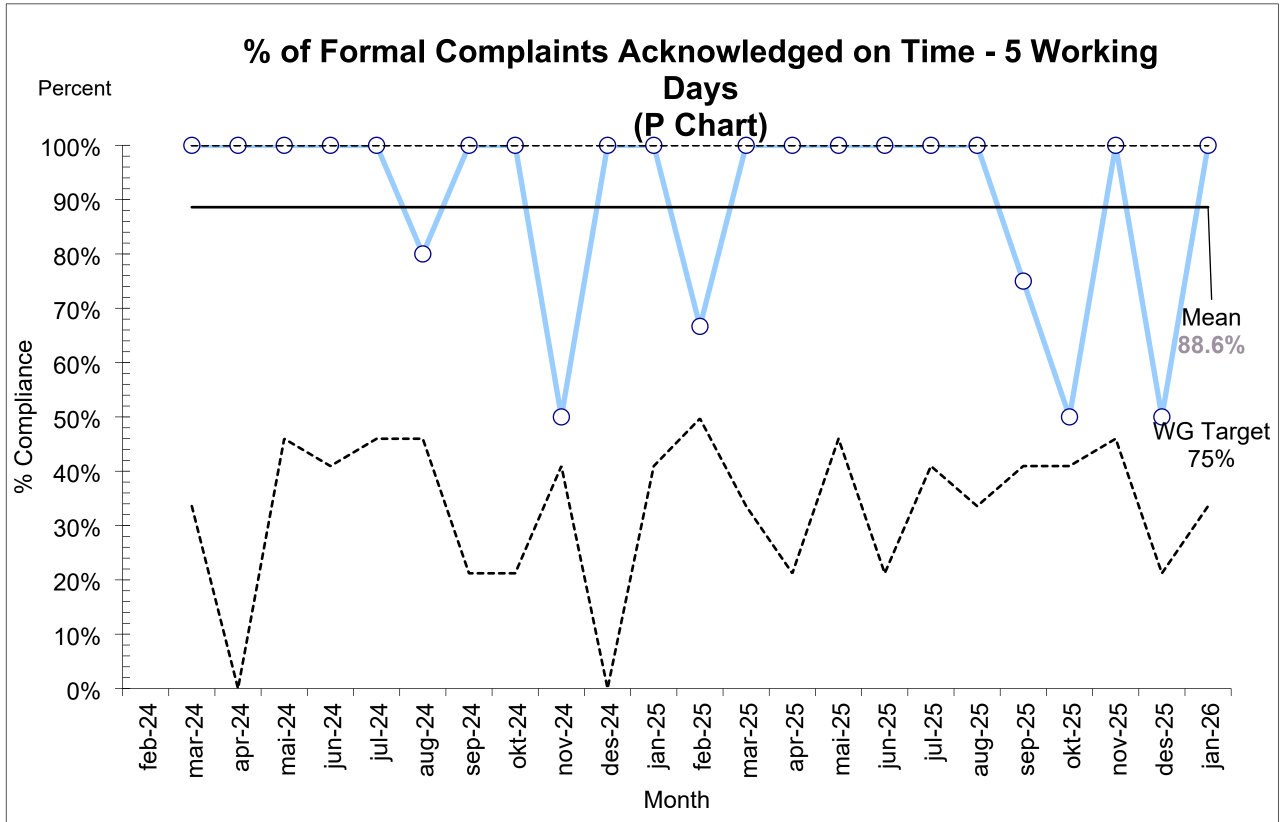
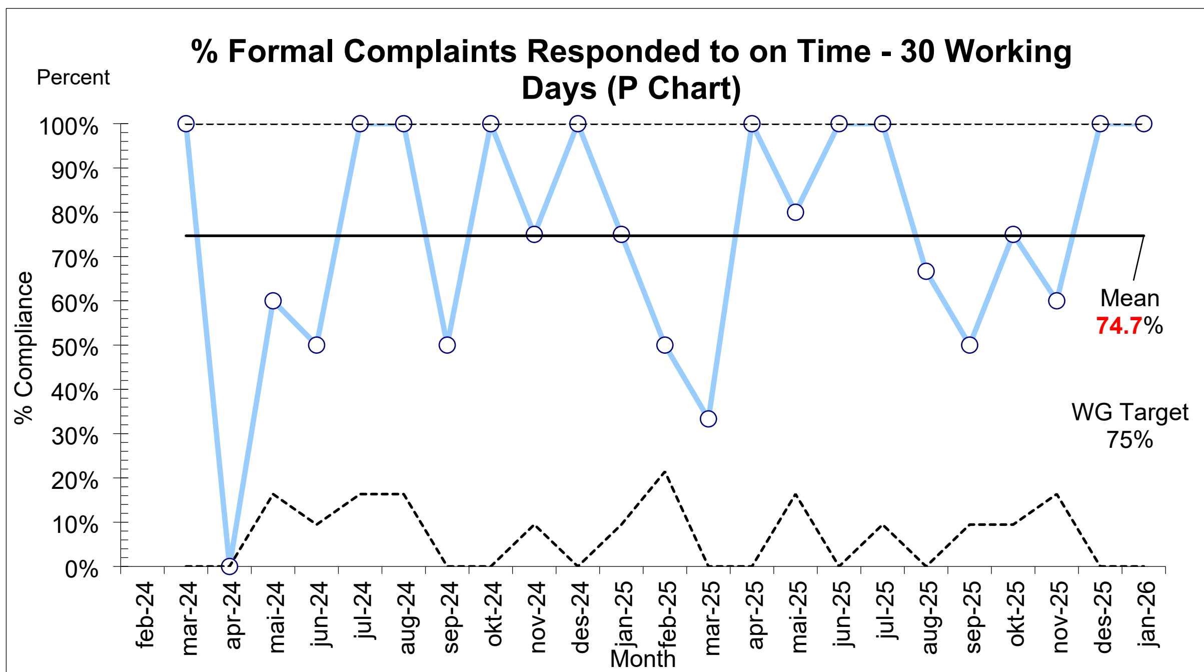


Chart 9. Formal complaints received per month

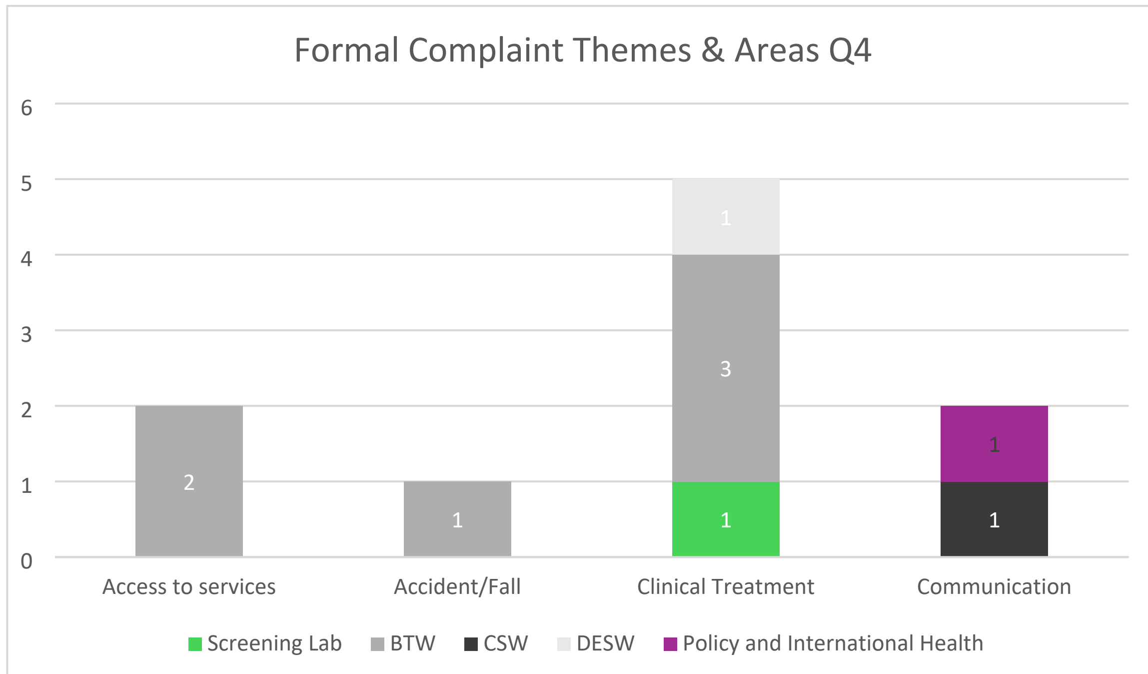
The charts below demonstrate overall performance with acknowledging and responding to formal complaints against a Welsh Government (WG) target of 75%.

PHW is achieving a mean of 88.6% complaints acknowledged and 74.7% achieving the 30-working day performance target.





The complaints received in March 2026 are not yet due for their final response and continue to progress through the investigation and quality assurance processes.



5.2.1. Learning from complaints

Welsh Language Issue

In February 2026, a complaint was received from a service user who initially sought to raise a concern regarding the Welsh translation of a Breast Test Wales leaflet. When attempting to access the complaints form, via the Public Health Wales website, the Welsh-language version of the form generated an error, meaning the service user was only able to submit the complaint using the English version.
Following receipt of the complaint, the Putting Things Right and Service User Experience Team worked promptly with the Communications team to amend the link to the Welsh-language complaints form and resolve the issue. Further improvements have since been made to the complaints form, following the launch of the new Public Health Wales website, with the aim of improving accessibility and user experience.

The Breast Test Wales leaflet highlighted by the service user is scheduled for review later this year. Feedback relating to the Welsh translation will be incorporated into this review to ensure the content is accurate, clear, and managed through Public Health Wales' robust translation and proofreading processes.

6. Duty of Candour

No new Duty of Candour cases have been identified in Quarter 4.

6.1. Cervical Screening Wales Interval Cancer Reviews

Within the programme, a quality assurance process is in place to review cases where cancer is diagnosed between screening intervals. A backlog of these reviews had developed but has now been fully completed. As a result, 16 cases were identified as unsatisfactory and have undergone further review to assess any potential harm to those involved.
The next stage is to contact the treating clinicians and the participants in these cases to inform them of the retrospective review findings and to offer a meeting to discuss the outcomes, in line with principles of openness and transparency. All 16 cases have now been contacted, and to date, 4 participants have requested a meeting with Cervical Screening Wales.

7. Concerns regulation update

The revised regulation came into effect of the 1 April 2026 and is a transformational programme where all NHS organisations and other responsible bodies will be expected to:

- Update local procedures and policies to reflect the amended regulations and Listening to People guidance.
- Train staff, particularly those involved in early resolution, listening discussions, and investigations.
- Communicate changes to people, ensuring plain language and accessibility.
- Integrate monitoring arrangements to track compliance, timeliness, equity of access and quality of learning.
- Report progress on implementation to their Board and, to Welsh Government through existing quality and performance reporting structures.

The PTR Team has delivered, and continues to deliver, training to staff on the revised regulations. Of the 200 staff identified as primary and secondary concerns handlers, 81% (163) have completed the required training to date, with further sessions planned to increase coverage.

Training on Listening discussions has been provided and continues to be delivered through a combination of in-person sessions for Tier 2 training and a pre-recorded webinar for Tier 1 training.

Internal communications have been issued to all staff through news events and a message from Claire, Executive Director for Quality, Nursing and Integrated Governance, outlining the revised regulations. In addition, new performance metrics have been incorporated into

the Quality Dashboard to support Board-level assurance and reporting to Welsh Government.

The revisions are underpinned by four core principles:

- Ensuring people raising concerns are actively listened to and treated with respect
- That concerns are investigated proportionately and effectively
- That NHS organisations are under a duty to learn from concerns and must develop effective action to prevent reoccurrence
- The leaders of organisations provide assurance that they meet regulatory requirements.

Key changes to the regulations include:

- A mandatory offer of a listening discussion where NHS organisations will take on board the experience of the individuals raising concerns
- Clear and compassionate communication throughout the process, with complex legal or medical terminology properly explained
- Active offers of advocacy and legal support for complainants
- An increase of the Redress threshold to £50,000 (from £25,000)
- Reduced timeframes for the management of Redress cases
- Early Resolution timeframe increased to 10 days from acknowledgement (from 2 working days)
- Mandatory checks that concerns have been resolved within the set timeframes and resolved to the satisfaction of the complainant.

8. Safety Alerts and Notices Management

Purpose / Situation

This section of the report provides assurance that Public Health Wales has an effective management system for the distribution, management, monitoring and appropriate record keeping of Safety alerts / safety notices received by the organisation. Reporting of Alerts is by exception.

Public Health Wales is required to ensure that all safety alerts are communicated promptly to all relevant members of staff employed within the Trust. Although in most cases, alerts received are not applicable to Public Health Wales, we must be able to satisfy ourselves that we have reviewed them, checked and confirmed the status of each alert, and where appropriate ensure that alerts are acted on in a timely manner, within the designated timescales to safeguard service users, staff and visitors from harm.

A total of **48** alerts were received by Public Health Wales during the reporting period 1 January – 31 December 2026, **0** of which required action to be taken.

6 alerts were shared for **information only** and were in relation to a shortage of an antibiotic, IV fluid bags and transdermal patches as well as medication issues with an anticoagulant, eye ointment and infant formula.

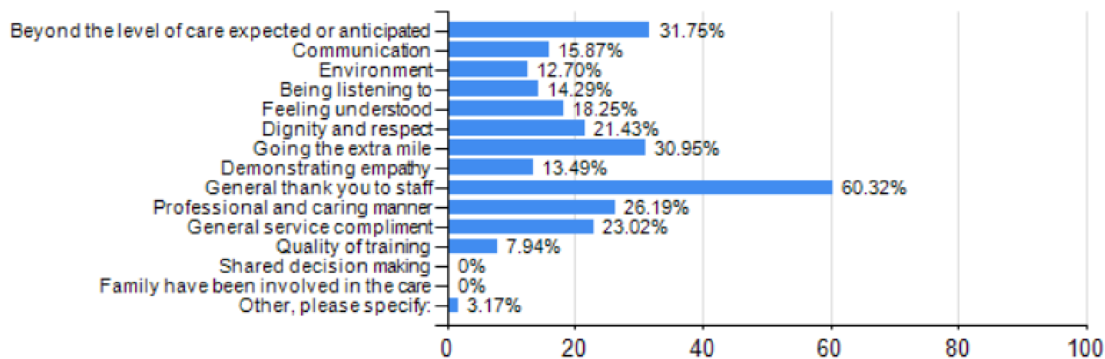
8.1. Table 1: Total Alerts received

Type of Alert	Number received	Number requiring action (Covid 19)	Number requiring action (other)
Pharmaceutical Alert	19	0	0
Medical Device Alert	0	0	0
Medical Device (Information)	1	0	0
Patient Safety Notice/Alert	1	0	0
Medicine Shortages	17	0	0
High Voltage Alert	9	0	0
Public Health Alert	1	0	0
Totals	**48**	**0**	**0**

9. Compliments and Service User Experience

This quarter, **1**26 compliments were recorded by staff within the Civica system. In addition, **42** compliments were left directly by members of the public using the compliments form available on the Public Health Wales website, equating to **168** compliments this quarter.

A new public-facing compliments survey was launched on the beta Public Health Wales website and has also been replicated across the existing website pages. This has begun to have an impact on reducing the number of compliments submitted in relation to services not provided by Public Health Wales. Further analysis of this impact will be included in the next quarterly report.
Thematic analysis of compliments received this quarter identified the key themes outlined below. Two compliments were initially categorised as ‘Other’; however, further review identified the underlying themes as ‘care and support’ and ‘participant journey experience’. The table below provides a full breakdown of compliments received during the quarter. The accompanying word cloud highlights a selection of the sentiment expressed within these compliments.



Compliment Sentiment 1 January - 31 March 2026

9.1. People's Experience Surveys

The following information focuses on the People's Experience survey and in particular, the Quality Outcomes Framework People's Experience measures. The data for 1 January – 31 March 2026 focuses on Diabetic Eye Screening Wales. Work is underway to bring other Screening programmes online with SMS and the People's Experience survey. This data will be included in the next report.

Between 1 January to 31 March 2026, 17 145 individuals were sent an SMS request from DESW with a request for feedback. This led to 4856 people responding within the set date parameters and equates to a response rate of 28.08%. This is an increase on the last quarter, which was 21.1%.

The specific Indicators that demonstrate quality of service provision (1 January – 31 March 2026) were as follows:

- *Were you able to communicate in your preferred language*?

99.23% of respondents selected ‘Always and Usually’ This is a 0.83% increase from the Quarter 3 report (98.4%).

- *Were you involved as much as you wanted to be in decisions about your care*?

A combined total of 98.79% of respondents selected ‘Always and Usually’. This is an increase of 0.39% from the Quarter 3 report (98.40%).

- *How would you rate your overall experience?*

A combined total of 96.03% of respondents rated the service as ‘Very good to Good’. This is an increase of 0.28% from the Quarter 3 report (95.75%).

SMS (text message) feedback within the Abdominal Aortic Aneurysm (AAA) Screening programme will go live on 20th April 2026 with discussions commencing with Breast Test Wales for this to be adopted during Quarter 3.

10. Quality and Clinical Audit

Public Health Wales (PHW) operates a prioritised audit programme aligned to both local and national priorities, with the overarching aim of improving patient and service user outcomes. These priorities reflect a combination of locally driven and nationally mandated audits, as outlined in the table below.

Type of Audit	At start of year	Update as of end of Q2	Update as of end of Q3	Update as of end of Q4
National Audits	6	6	6	**5**
Audits identified as a result of risks	29	32	33	**34**
Local Policy Audits Care Pathways/Local Guidelines Audits	64	68	71	**75**

- 6 external audits were planned, 5 are completed and 1 was placed on hold due to current changes within NHS England who lead on this audit. This audit has been removed from the plan as it did not progress this year, and uncertainty remains whether it will commence again in the future.
- At the start of the year, 64 internal audits were planned. This increased to 75 by the end of the year; however, 13 audits were subsequently approved for removal from the plan.

Quarterly Status	Number	Details / Comments
Completed	48	89% of completed audits had returned a completed audit report to the Quality and Clinical Audit team by year-end.
Progressing as Planned	8	
Removed from plan this Quarter	8	See below
Original timelines amended	5	• Antenatal Screening Wales - An audit of the management of HIV in pregnancy. This audit has been delayed due to the dependency on Virology to collect the data, which was not completed before year-end. The audit is now due to be completed by the end of May 2026. • Breast Test Wales – Batch Process Audit. This was a new audit that the programme has developed on AMaT. Learning to use the system has caused delays in completing the audit. The audit is now due to be completed by the end of April 2026. • Diabetic Eye Screening Wales - SSRS access and permissions. This audit has been delayed due to an interdependency with informatics to obtain the data. The data collection has been completed, however due to the delay the analysis and audit report were not completed by year-end. This is due to be completed before the end of Q1 2026-27. • Diabetic Eye Screening Wales - Not diabetic (clinical audit). This audit was due to be completed before the year-end,

		however following a change to the pathway being made in the programme, the team delayed the audit to ensure enough time had passed following the process change before the audit commenced. Data collection has commenced, and the audit is due to be completed before the end of Q1 2026-27. • Communicable Disease Surveillance Centre - Shigellosis audit. Competing demands in the service has caused a delay to the audit. At year-end, the team were reviewing the progress made so far to identify a realistic timeframe for completion in 2026-27.

Details of the 8 audits removed from the 2025-26 plan in Q4 (removal approved by Leadership Team in March 2026).

Programme/Team and Audit Title	Rationale
Diabetic Eye Screening Wales - Web view Optomize user access	This audit has been delayed due to an ongoing issue to obtain the required data from DCHW. A DPIA is being processed; the audit will be delayed until this is resolved.
Diabetic Eye Screening Wales - 3-year opt out	This was a clinical pathway audit scheduled for Q4. There was a change made in the programme to this process in Oct 2025. Following this change, the programme has decided to amend the scope of the audit. Due to this, the team would like to undertake the audit in 2026-27 as there will not be sufficient time to complete the audit before the end of March.
Diabetic Eye Screening Wales - Optimize user permissions	This audit was delayed due to dependency on informatics. A decision was made in Q4 to remove the audit from the 2025-26 plan as it was no longer feasible to complete the audit before year-end.
Diabetic Eye Screening Wales - Websites review (DESW & IFP)	This audit was delayed due to dependency with ongoing PHW web transformation. A decision was made in Q4 to remove the audit from the 2025-26 plan as it was no longer feasible to complete the audit before year-end.
Diabetic Eye Screening Wales - Performance Metrics Audit DESW SPARs	This audit was examining programme KPIs, however the scope of the work altered over the course of the year. It no longer met the definition of audit and so the decision was made to remove it from the audit plan.
Diabetic Eye Screening Wales - SharePoint document control	This audit was delayed due to a dependency with the Records Management team. A decision was made in Q4 to remove the audit from the 2025-26 plan as it was no longer feasible to complete the audit before year-end.
Bowel Screening Wales - Bowel Preparation Audit	This audit was originally planned to help identify the current effectiveness of the bowel preparation product and if there were any common themes for improvement. The other key part of the audit was to ensure bowel preparation had been assessed as being sufficient to complete the procedure. On reflection, it was very ambitious and the programme assessed that they didn't have sufficient resources to undertake this activity.

	The new three-year BSW clinical audit programme has primarily been based upon risk rather than service improvement, with the intention to re-introduce service improvement projects in the future.
Bowel Screening Wales - Nursing Documentation Audit	This was a new assurance audit planned for 2025-26, to audit documentation against NMC standards. The design of the audit was originally due to be finalised by Q3. However, the nursing team did not have the capacity to undertake the audit against competing priorities following a member of the team leaving.

10.1. Digital Audit Platform (AMAT)

During 2025–26, audit activity began transitioning to the AMaT digital audit system. The Ward and Team Assurance module is used to support regular, ongoing audit activity that contributes to quality assurance. In June 2025, IPC audits were launched within this module, alongside the development of Screening Pathway Management, consent, and documentation audits.

The Clinical Audit module, which supports quality and clinical audit projects, went live in September 2025, with teams supported as early adopters. By year-end, 14 audit projects had been registered within the module, of which 8 were completed. In preparation for the 2026–27 audit plan, a further 22 audits have been registered in the Clinical Audit module.

11. Quality Oversight Group September 2024 – March 2025 Update

The section below summaries the activities undertaken by the Quality Oversight Group (QuOG) during this period and includes:

11.1 Operational activity:

QuOG SharePoint development: QuOG SharePoint pages have been developed with access currently restricted to QuOG members and the CEO. This was discussed at BET on 15 April 2026, where it was requested that access arrangements be reviewed with a view to enabling organisation-wide access.

Forward Plan: A QuOG Forward Plan agenda has been developed.

- **QuOG Dashboard:** A comprehensive Dashboard has been developed, covering incidents, complaints, safeguarding, infection prevention and control (IPC), quality and clinical audit, operational risk, and compliments. The dashboard supports both overview and strategic oversight for members. An overview is presented and discussed at every QuOG meeting.
- **People's Experience Learning Group:** Updates were received from the People's Experience Learning Group, with discussion and oversight of progress and associated activity.

- **Organisational Learning**: Discussion took place regarding learning across the organisation, identified as a key area for improvement, with emphasis on strengthening the visibility, sharing and translation of learning into practice.

- **Quality, Safety and Improvement Committee (QSIC):** Regular updates and feedback were received from QSIC via the Co-Chairs and Deputies, providing ongoing assurance and escalation where required.

- **Medicines Management and Medical Devices**: Biannual updates were received from both groups, supporting oversight of compliance, safety and improvement activity.

- **Management of Alerts:** Governance discussions were held regarding the management of alerts across the organisation. Two process mapping sessions have been completed to identify the range of alerts received, routes of dissemination, responsible leads and existing procedures for management and oversight. Improvement actions have been proposed, alongside the development of an overarching policy to strengthen clarity, consistency and assurance in alert management.
- **Consent:** Key concerns were discussed in relation to informed decision making and the consent process across the organisation. This included identified gaps in consent training following submission of the baseline self-assessment to Welsh Risk Pool.
  Work is ongoing to identify all staff requiring role specific consent training and to ensure appropriate competency assignment and coverage.
- **Clinical Governance Group**: A Draft Terms of Reference for a clinical governance subgroup have been drafted and shared with key staff for final comments.

11.2 Health and Care Quality Standards:

- **Self-Assessment Tool**: Co-production and development of a Self-Assessment Tool aligned to the six Domains of Quality set out in the Health and Care Quality Standards (2023), supporting assessment against Safe, Timely, Effective, Efficient, Equitable and Person-Centred (STEEEP) standards.
- **Baseline Assessment**: A baseline assessment of STEEEP standards was completed across all Directorates and Divisions by March 2025. Nominated representatives were directed to determine whether completion was undertaken at Directorate or Divisional level to reflect local governance arrangements.
- **STEEEP Dashboards**: STEEEP Standards dashboards have been developed to support the identification of key themes, variation and emerging trends across Directorates and Divisions, strengthening oversight and comparative analysis.
- **Ongoing Review and Challenge**: STEEEP self-assessment ratings have been presented at meetings throughout the year, enabling professional curiosity, challenge, discussion and shared learning.

- **Peer Review**: Peer review of baseline assessments was completed between October 2025 and March 2026. A full analysis of findings is scheduled for discussion at a future meeting to inform learning, improvement priorities and assurance.

11.3 Duty of Quality (in conjunction with NQIG staff/ resources):

- Development of internal Duty of Quality Information Pages.
- Development and production of STEEEP information posters and what the standards mean to our staff.
- Development and production of STEEEP information video and what the standards mean to our staff.
- Development of Quality Impact Assessment tool for use across the organisation. This work remains in progress.
- Ongoing development of Always On' Reporting Pages accessible to the public. This work is ongoing.
    - Including use of Time to Talk Public Health resources to determine what the public would like to know about PHW services.
- Development and production of information on Quality Management System, including videos and what this means for the organisation.

11.4 Annual Quality Report:

- Annual Quality Report produced for 2023/24.
- Annual Quality Report produced for 2024/25.
- Use of Time to Talk Public Health resources to determine from the public how they would like the 2025/26 to be presented.

12. Safeguarding Group Report

This section summarises safeguarding related activity and performance along with key risks and improvement activity during Quarter 4, 2025-26.

The Safeguarding Group met on15th April 2026 with directorates requested to address the remaining areas of suboptimal training compliance for 3 specific safeguarding areas and anticipated recovery dates requested.

12.1 Safeguarding queries for advice and support, referrals and incidents

During Quarter 4, Public Health Wales experienced a significant and sustained increase in requests for safeguarding advice and support (62). Most of these enquiries were channelled through safeguarding activity within Sexual Health Wales service. This upward trend reflects increased organisational awareness of safeguarding responsibilities and growing staff confidence in seeking timely advice and support in response to safeguarding disclosures from young people sexually transmitted infections (STI) testing service.

It also demonstrates that PHW is now delivering on its legislative responsibilities in terms of Safeguarding in response to the issues identified in the Sexual health service.

7 enquires resulted in cases being refereed as a Duty to Report (DTR) to the local authority. All related to children and young people identified as being at risk of abuse. Concerns included disclosures of child sexual abuse and sexual assault, identified through Public Health Wales pathways. Of these cases, two progressed to multi-agency strategy meetings, one resulted in no further action, and four involved children already known to Children's Services, where information was shared directly with the allocated social worker to support ongoing safeguarding plans.

This quarterly total represents a significant increase when compared with the nine Duty to Report submissions recorded across the whole of the previous year, indicating a marked rise in both the volume and seriousness of concerns being identified. The pattern reflects sustained high-risk child safeguarding activity and reinforces PHW's role as a key point of disclosure for vulnerable young people, particularly through digital and public-facing services.

The nature of these cases highlights the continued need for robust internal escalation processes, timely information sharing, and strong multi-agency collaboration. Ongoing oversight from the Strategic Safeguarding Group remains essential to ensure governance, capacity and workforce competence are aligned to the level of risk being managed across the organisation**.**

To strengthen safeguarding practice within the Sexual Health service, daily safeguarding "huddles" led by safeguarding specialists have been introduced to support the effective management of concerns. This approach has enabled early identification of safeguarding issues, timely escalation, and shared learning, and has contributed to increased staff confidence and earlier engagement with safeguarding advice and support.

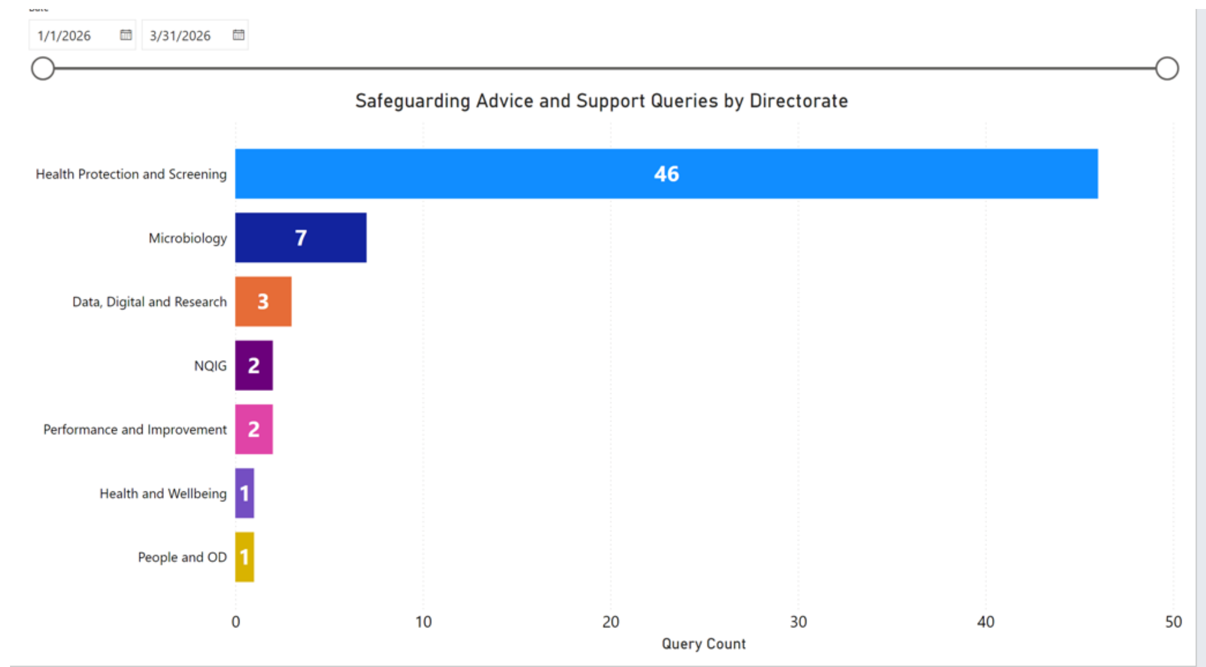
In addition, safeguarding concerns relating to employees continue to be reported, with managers and colleagues appropriately escalating issues and seeking safeguarding advice. This reflects a maturing safeguarding culture in which staff wellbeing, professional boundaries, and the organisation's Duty of Care are increasingly well understood and acted upon.

Overall, the data indicates a system that is becoming more alert, better connected, and more proactive in seeking support.

Employee-related safeguarding concerns are emerging as a notable and developing trend. A total of 12 safeguarding queries related to employees were received, highlighting clear patterns of activity, including:

- **Managerial escalation:** Managers are increasingly seeking safeguarding advice in relation to staff wellbeing, professional boundaries and conduct.
- **Organisational duty of care:** There is growing recognition of safeguarding as a core component of the organisation's duty of care to employees, alongside safeguarding responsibilities to service users.
- **Research governance:** Safeguarding queries associated with research activity remain low but continue to be relevant. 2 queries were received from research projects, reinforcing the importance of consistent and robust safeguarding governance across all research activity.

chart 5.1 Cases Reported by Directorate



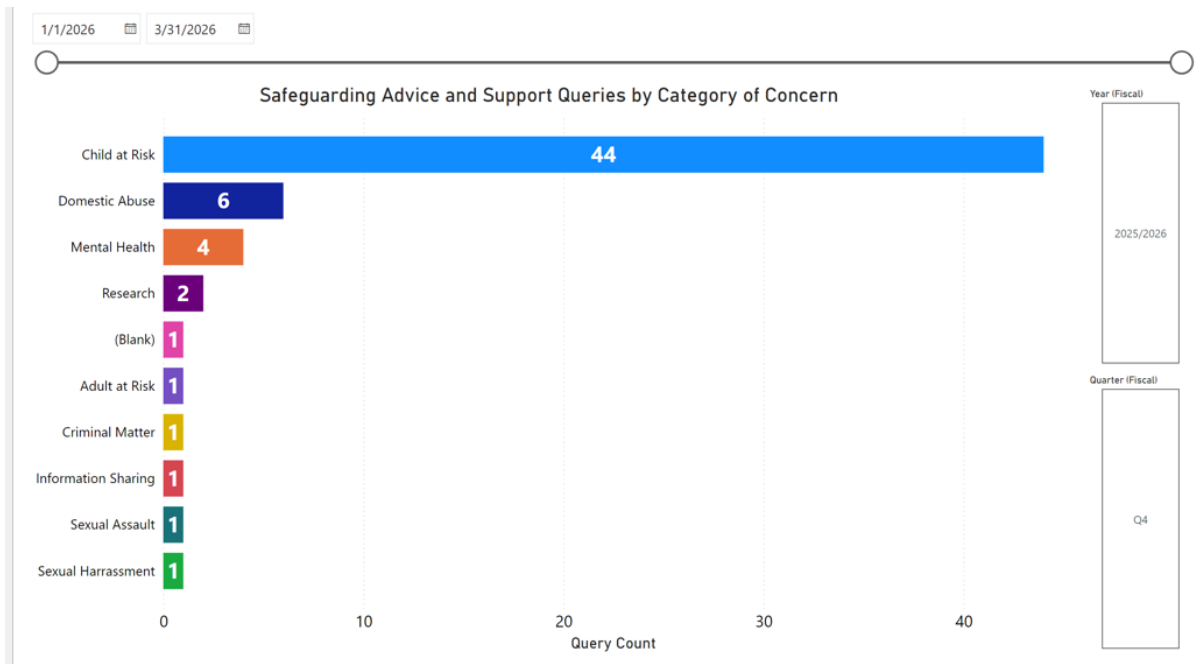


Chart 5.2 Safeguarding Queries by Category

12.2. Safeguarding Training

All PHW staff are required to complete level 1 safeguarding and group 1 Violence against Women, Domestic abuse and Sexual Violence training. In addition, specific staff groups working directly with the public are required to complete a level 2 and 3 Safeguarding along with Group 2 Violence against Women, Domestic Abuse and Sexual Violence training dependent on their roles.

The Welsh Government sets a compliance target of 85% for all mandatory training. Compliance rates for Safeguarding Adults and Children Levels 1 and 2 continue to meet this performance target. However, a reduction in compliance has been observed for higher-level, face-to-face training, particularly Safeguarding Level 3 and VAWDASV Group 2.

This contrasts with the continued improvement seen in completion rates for online safeguarding modules. The decrease in face-to-face training compliance appears to be linked to operational pressures, with several sessions cancelled due to insufficient numbers to support the required group-based learning components.

A key area of concern relates to Safeguarding Level 3 training compliance, where 54 staff currently remain non-compliant. Of these, 18 staff are within Breast Test Wales, indicating a concentrated gap that requires targeted support and intervention to mitigate the risks associated with inadequate safeguarding capability.

In response, the Safeguarding Group has formally requested that all areas with outstanding non-compliance ensure staff are booked onto the next available Safeguarding Level 3 training sessions scheduled for May and June 2026. This action reflects learning from the recent Sexual Health Incident Management Team (IMT) review, which reinforced the critical importance of a fully trained workforce in sustaining safe, effective and consistent safeguarding practice.

The table below indicates the current areas where compliance is below this target. Overall, during this quarter training compliance has seen a downward trend but the areas below continue to be an area of focused attention

Competence /Training	Compliance Quarter 4	Number of staff assigned	Number of staff achieved
028|LOCAL|Safeguarding Level 3 - 3 Years	63.51%	148	94
028|LOCAL|Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years|	68.56%	493	270
NHS|MAND| Mental Capacity Act Level 2– 3 Years	87.41%	270	236

A corporate communications message is being issued to all staff, reinforcing organisational expectations for full compliance with safeguarding training and clearly linking this requirement to statutory responsibilities and recent organisational learning. Directorates are expected to prioritise training completion and to escalate any barriers to compliance through established governance and assurance routes.

Four safeguarding-related incidents were recorded on Datix this quarter, all arising within the Sexual Health service. Each incident is currently under investigation through established governance processes. While the nature of the incidents varies, all relate to safeguarding concerns identified during service delivery and reflect the complexity of safeguarding practice within SH Wales.

The incidents highlight the importance of maintaining strong operational oversight, consistent staff adherence to safeguarding procedures, and timely escalation when concerns arise. Ongoing investigation outcomes will support learning, assurance and any required improvements to strengthen safe practice across the service.

12.3. Key Safeguarding Risks & Issues

Both BET and QSIC have previously been sighted on 2 safeguarding risks relating to Disclosure and Barring Service (DBS) checks and reliance on a single corporate safeguarding post. The Safeguarding Group has now agreed closure of the single-post-holder risk, recognising mitigation provided through National Safeguarding Service (NSS). In addition, a second Safeguarding Nurse has been appointed on a fixed term basis to support the SH incident. A further review of the current risk rating for DBS has been requested, reflecting that the DBS renewal service is now live, and agreed mitigating actions have been implemented.

2 divisional safeguarding risks remain under active management within the Communications Division. Overall, key controls are operating effectively.

In addition, the People and Organisational Development (POD)–owned risk relating to compliance with the Worker Protection Act is being actively treated. Controls are in place to address identified gaps in awareness, policy, training, monitoring and risk-assessment practice.

12.4 Safeguarding improvements this quarter

- Safeguarding Huddles and resilience of procedures within Sexual Health Wales
- Appointment of second Safeguarding Nurse.

13. Infection Prevention and Control (IPC) Update

IPC activity, incident and risks are outlined in the following section. The IPC Group met on 16th April 2026 to review Quarter 3 data, including reports from the Facilities and Decontamination sub-groups.

13.1 IPC-related incidents

During Quarter 4 there were 21 IPC incidents reported, 5 more than Quarter 3. This is largely due to an increase in exposure incidents reported by Infection Services.

Category	Number of Incidents	Division where it occurred	Risk Level	Approval Status
Cleanliness	2	DESW	2 x None	2 x Management Review
Clinical assessment, clinical diagnosis	1	BTW	1 x Low	1 x Closed
Clinical waste disposal - Sharps	1	Microbiology	1 x None	1 x Under Investigation
Contact with needles or medical sharps	2	Microbiology	2 x None	1 x Closed 1 x Management Review
Contact with object or animal	1	BTW	1 x Low	1 x Closed
Contact with or exposure to hazardous substance	13	13 Microbiology	7 x Low 6 x None	13 x Closed
Diagnostic testing - Pathology	1	BTW	1 x Moderate	1 x Management Review/Make it Safe Plus

Thematic analysis of infection services exposure incidents identified 3 incidents associated with laboratory staff not adhering to standard operating procedures (SOPs), 3 incidents resulting from specimens leaking on receipt in the laboratory, and 4 incidents linked to insufficient clinical information being provided on request forms. Infection services Health and Safety Managers are working closely with behavioural science colleagues to address deviations in practice from SOPs. Issues relating to incomplete or inadequate request

information are also being formally reported to the relevant Health Boards for follow-up and improvement.
Two additional incidents relating to environmental cleanliness were identified and were associated with unsatisfactory cleaning practices at Kimberley House by contractors. These are being actively managed by the centre manager and Facilities team, who are in regular contact with the contracted cleaning provider and are providing ongoing monitoring and oversight to ensure improvement.

13.2 IPC Mandatory Training Compliance

The table below highlights the overall compliance with IPC training throughout Public Health Wales against the Welsh Government target of 85%.

Organisational Compliance		Trend
IPC Level 1	89.26%	↓
IPC Level 2	73.95%	↓

IPC level 2 training which is required by clinical staff is currently below the target of 85%. A training needs analysis of all divisions was completed during quarter 4 and as such, all staff who require IPC level 2 training are now identified and have this competency assigned in ESR. The table below shows the divisions where IPC training compliance falls below the 85% Welsh Government target.

Subject	Directorate / Division	Q3 Compliance %	Required	Achieved	Q4 Compliance %	Trend
IPC Level 1	028 L3 Corporate Directorate	**75%**	**27**	**20**	**74.07%**	↓
IPC Level 2	028 L4 Infection Division	**38.78%**	**90**	**41**	**45.56%**	↑

The chair of the IPC Group has requested that directorate representatives support improved training compliance and aim for 100% compliance within 4 weeks of the meeting held on 16th April.

13.2.1 ANTT (Breast Test Wales Only)

During Quarter 4, 3 new ANTT Assessors were trained within Breast Test Wales. These staff are now able to undertake ANTT practical competence assessments with colleagues, which is expected to support improved training compliance and sustainability.

The table below summarises current compliance with ANTT e-learning and competence assessment for relevant staff within Breast Test Wales. While overall compliance remains below the 85% target, there has been an increase in completed competence assessments during Quarter 4. Managers have been issued with reminders for staff who still require assessment, with a continued focus on progressing compliance and strengthening assurance.

	Q3 Compliance	Q4 Compliance	Trend
ANTT e-learning	95.33%	95.19%	↓
ANTT Assessment	**59.41%**	**66.67%**	↑

13.3 IPC Risk Register

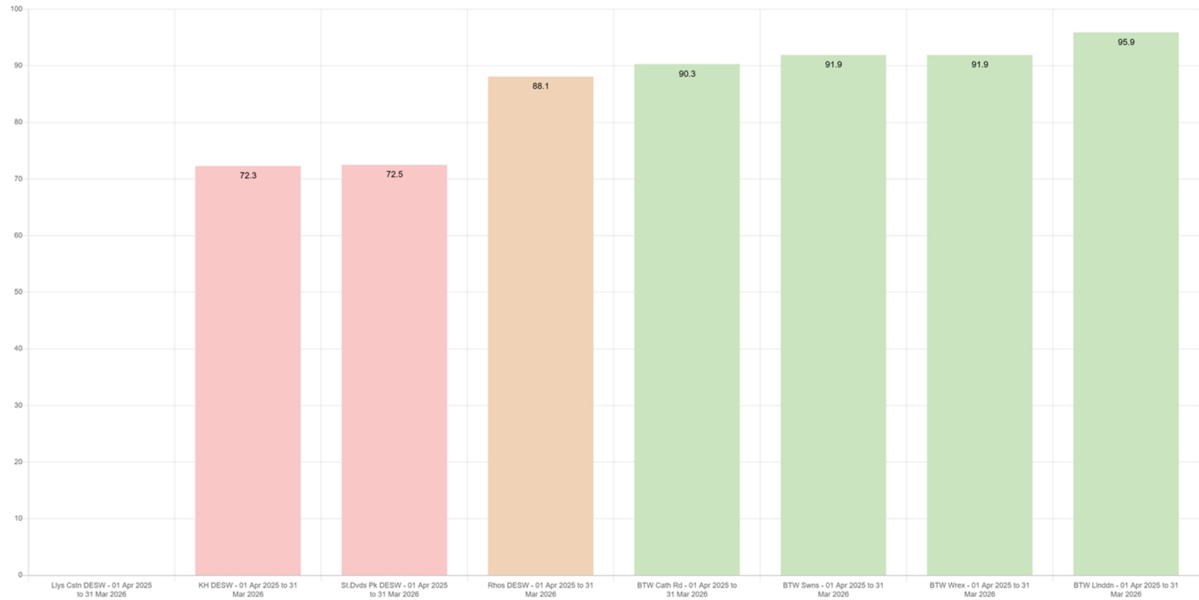
At the end of Quarter 4, 6 risks are open on the IPC risk register. 2 risks relating to operational issues within infection services were reviewed and the IPC tag removed as they are not associated with any IPC implications. There were no new risks added during Quarter 4.

Risk 1510 relates to the organisation's current inability to provide full assurance in relation to environmental cleaning standards. While a cleaning schedule has been developed, implementation has been delayed due to procurement timelines associated with the cleaning contract, which is not expected to be completed until Quarter 3 of 2026–27.
In addition, national cleanliness standards have not yet been issued by the Welsh Government. However, in response to preparatory requirements, both quality and financial impact assessments were completed and submitted to the Office of the Chief Nursing Officer ahead of the deadline of 20 March 2026.
The completion of the cleaning contract procurement, alongside implementation of the cleaning schedule and associated assurance and audit processes, represents a key mitigation within the Infection Prevention and Control (IPC) workplan for 2026–27 and will be central to strengthening assurance and reducing this risk.

13.4 IPC Audit Activity

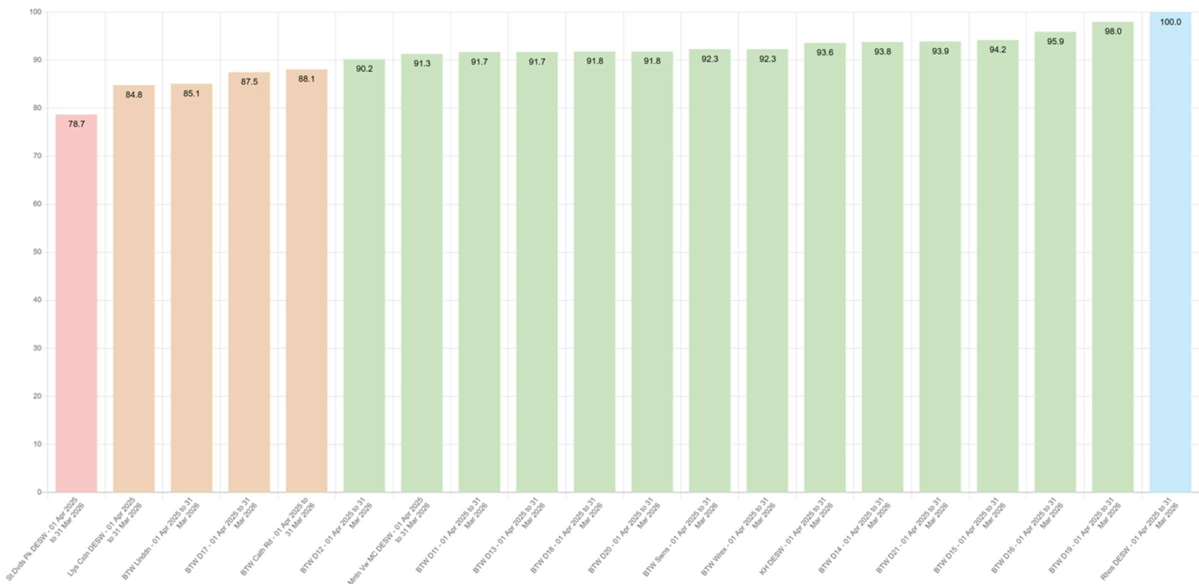
The programme of IPC Nurse annual assurance audits was completed during Quarter 4 with one site (Llys Castan) unable to be accessed due to building work. The 2 lowest scoring sites were St David's Park and Kimberley House. St David's Park has low compliance due to the fabric of the building and its facilities. The facilities team are supporting DESW to source alternative accommodation on a short-term basis until the new permanent venue is ready for occupation. Kimberley House non-compliances were mainly associated with the standard of cleanliness which the site manager and facilities are liaising with the contractor to resolve.

Graph 1: IPC Nurse annual assurance audits



In addition to the IPC Nurse assurance audits, Screening staff also undertook bi-annual audits of PHW owned and leased screening venues as shown in graph 2. St David's park was also identified as an outlier in these audits due to the condition of the building as mentioned above.

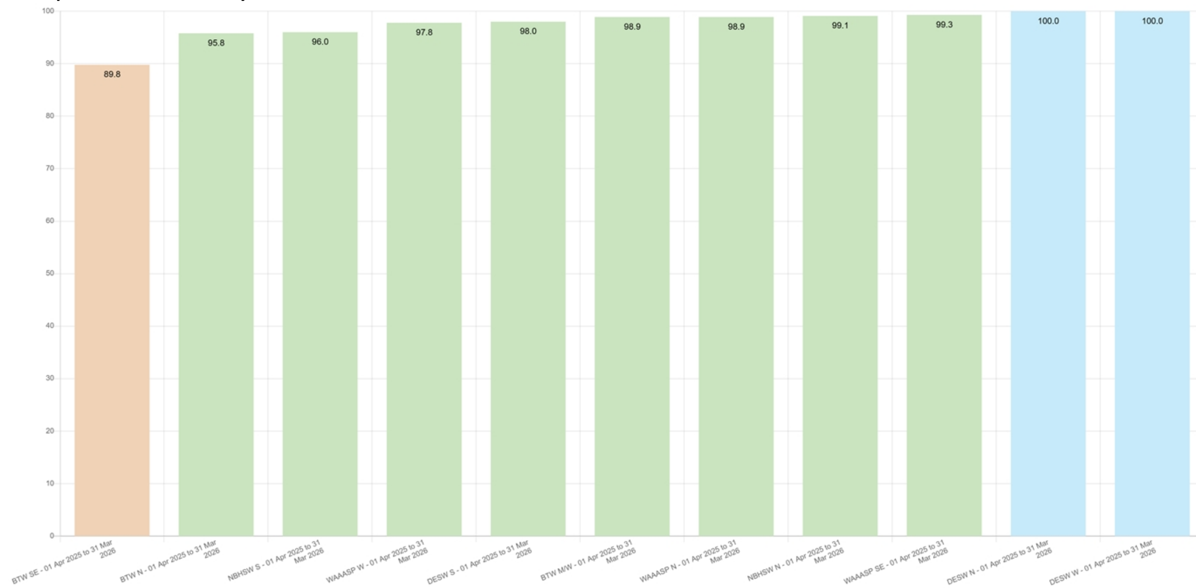
Graph 2: Bi-annual environmental audits



Graph 3 details practice audits undertaken by staff from the Screening programmes which indicate a high level of compliance with Standard Infection Control Precautions. Non-compliances were associated with staff failing to be bare below the elbows, the inappropriate

use of gloves and the five moments for hand hygiene. During quarter 4 the hand hygiene training for Screening services was reviewed and individuals found to be non-compliant with hand hygiene will be retrained regardless of when they last underwent the training. Bare Below the Elbow posters have also been developed.

Graph 3: Quarterly Practice Audits



During quarter 4 work continued to develop an audit tool for traceability of ultrasound probes in Breast Test Wales. This has been added to the AMaT system and will be piloted during Quarter 1 2026-27 with the aim to roll-out to the service shortly after.

13.5 IPC Policies and Procedures

The IPC Policy was reviewed during Quarter 2 and endorsed by the IPC Group during Quarter 3. This is now due to be reviewed at QSIC on 2nd June. During Quarter 1 2026-27 work will begin to review the Sharps Management and Inoculation Injury policies which are due to review by the end of Quarter 3.

The publication of the HCAI Code of Practice and Cleaning Standards are still awaited from Welsh Government which will inform future PHW policies & procedures.

Several sites commissioned by Bowel Screening Wales continue to present risks associated with sub-optimal decontamination area design and aging equipment, which has been identified as increasingly prone to failure.

Ysbyty Glan Clwyd (Betsi Cadwaladr University Health Board**)** has long been recognised as an area of significant concern. While a capital project to relocate the decontamination area is underway, completion is not anticipated until September 2026. In the interim, the IPC Lead Nurse and Programme team remain in regular contact with the project team and are

providing close oversight, supported by the Principal Decontamination Engineer from NHS Wales Shared Services Partnership – Specialist Estates Services (NHSWSSP SES).

At the IPC Group meeting on 16 April, it was agreed that the Principal Decontamination Engineer would undertake a site visit and complete an audit using the JAG tool, with findings to be shared with Public Health Wales to further inform assurance and oversight.

At **Bronglais Hospital (Hywel Dda University Health Board)**, an audit completed in January 2026 identified areas of poor compliance with IPC standards, particularly in relation to Bare Below the Elbow (BBE) and the use of Personal Protective Equipment (PPE). Assurance has since been received from the Health Board confirming that these issues have been addressed. However, ongoing risks remain due to the poor state of the estate and equipment that is beyond its expected service life. A project to relocate the decontamination area and replace equipment is progressing well and is expected to be completed later this year, which will provide longer-term mitigation and improved assurance.

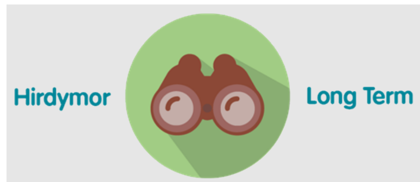
Bowel Screening Wales colonoscopy lists are currently being delivered at the University Hospital of Wales within Cardiff and Vale to mitigate the risk of excessive delays for participants. However, the site has an aging decontamination area and is not yet accredited by Bowel Screening Wales. A meeting with the Health Board was held in January, during which a formal risk assessment was undertaken. It is anticipated that the unit will undergo Bowel Screening Wales accreditation in April 2026, which will provide additional assurance regarding compliance and quality standards.

During Quarter 2 of 2026–27, changes to the terminology and approach relating to **Transmission-Based Precautions (TBPs)** are anticipated. This work is being led by Health Protection Scotland, which is developing the updated guidance and supporting resources. The IPC Nurse Consultant is a member of the project group and meets regularly with colleagues to maintain oversight of the proposed changes and emerging expectations.

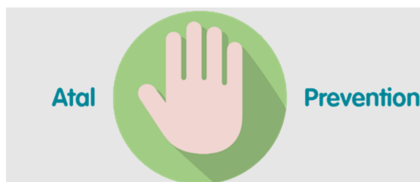
The revised approach reflects new evidence that has emerged since the COVID-19 pandemic, supporting a more nuanced, risk-based assessment of appropriate respiratory protective equipment. This considers not only the identified organism, but also the care setting, patient vulnerability and the characteristics of the built environment. These changes represent a positive shift towards embedding consistent respiratory protection practices, focusing on culture and behaviours around mask use rather than solely responding to specific pathogens or spikes in respiratory illness.

As further detail becomes available, the HARP team will ensure the proposed changes are communicated through appropriate groups and forums, supporting preparedness, awareness and a smooth organisational transition to adoption of the updated guidance within Public Health Wales

14. Well-being of Future Generations (Wales) Act 2015

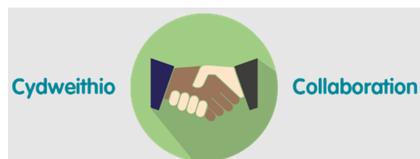


The Quality report seeks to provide the Board and relevant Board Committees with assurance that the organisation is meeting its responsibilities in relation to the management of Concerns, Safeguarding and infection prevention and control to ensure the long-term viability and effectiveness of the organisation.



Where possible Public Health Wales seeks to prevent the occurrence of concerns by taking a proactive approach to learning and quality improvement to ensure high quality safe services are provided to the users of our services.

Quality Governance work is designed to meet key performance standards and identify opportunities for improvement for the benefit the people we work with and for.



Public Health Wales is committed to dealing with incidents and concerns in an open and transparent manner. The report offers insight into how various teams are working together with Public Health Wales NHS Trust to provide the best outcomes.

This Quality report is an important aspect of the organisation's governance arrangements, and, as such, helps the organisation to improve the quality and safeguard the high standards of the services provided by Public Health Wales

15. Recommendation

The Committee is asked to:

- **Receive** and **Consider** the Quality Assurance Report.
- **Note** the performance standards being achieved and areas for improvement.
- Receive **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient, and person-centred services.