Unconfirmed Minutes of the Public Health Wales
Quality, Safety and Improvement Committee Meeting
04 June 2026, 10:00 – 12:25
Held in Capital Quarter 2 and via Microsoft Teams

Present:		
Clare Jenkins	(CJ)	Chair of Committee, Vice-Chair of Board and Non-Executive Director
Nick Elliott	(NE)	Non-Executive Director (Data and Digital)
Sian Griffiths	(SG)	Non-Executive Director (Public Health) and Chair of the Knowledge, Research and Information Committee
Pippa Britton	(PB)	Chair of Board
In Attendance:		
Liz Blayney	(LB)	Deputy Board Secretary and Deputy Head of the Board Business Unit
Claire Birchall	(CB)	Executive Director of Nursing, Quality and Integrated Governance
Bethan Bowden	(BB)	Consultant in Public Health Screening (For item 4.4)
Graham Brown	(GB)	Consultant in Public Health Medicine (For item 4.4)
Angela Cook	(AC)	Assistant Director of Nursing, and Quality and Integrated Governance
Haydn Childs	(HC)	Improvement and Innovation Hub Manager (Observing)
Neil Desmond	(ND)	Head of Estates and Health & Safety (for items 3.3.1 and 4.6)
Tom Fowler	(TF)	Deputy Director of Health Protection and Screening Services
Sophie Fuller	(SF)	Assistant Director Corporate Governance and Business Support, NHS Performance and Improvement (for Item 7)
Danielle Gething	(DG)	Head of Risk Management (for item 4.5)
Meng Khaw	(MK)	National Director of Health Protection and Screening Services, Executive Medical Director
Jim McManus	(JM)	National Director of Health and Wellbeing
Sarah Owen	(SO)	Head of Quality (Observing)
Zoe Pietrzak	(ZP)	Executive Director of Strategy, Finance and Performance
Stuart Silcox	(SS)	Assistant Director of Integrated Governance
Sikha de Souza	(SdS)	Consultant in Public Health Screening (For item 4.4)
Paul Veysey	(PV)	Board Secretary and Head of Board Business Unit

Huw Williams	(HW)	Head of Emergency Preparedness Resilience and Response(For item 3.2)
Apologies		
Tracey Cooper	(TC)	Chief Executive
Jo Kondra	(JK)	Trade Union representative
The meeting commenced at 10:00		

Part A	
QSIC 2026.06.04/1	**Welcome, Introductions and Apologies**
The Chair welcomed all to the public session of the Quality, Safety and Improvement Committee meeting. The apologies for absence were noted.	
QSIC 2026.06.04/2	**Declaration of Interest**
There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.	
QSIC 2026.06.04/3	**Items for approval**
QSIC 2026.06.04/3.1	**Minutes and action log**
The Committee considered and **approved** the minutes of the meeting held on 24 February 2026 as an accurate record of the meeting. The Committee **approved** the closure of completed actions on the action log.	
QSIC 2026.06.04/3.2	**Emergency Preparedness, Resilience and Response report (EPRR)**
MK introduced the Report, confirming that it formed part of statutory reporting to Welsh Government and reflected continued strengthening of organisational preparedness. HW presented the report, outlining progress against statutory requirements, including the update of the Emergency Response Plan (version 4), incorporating learning from COVID-19 and national exercises. He highlighted extensive participation in Exercise Pegasus and other system-wide exercises, alongside significant involvement in live multi-agency incidents. HW concluded the update by identifying key risks relating to sustaining organisational capability and pressures in digital infrastructure, particularly surveillance and modelling. He outlined priorities for the next 12 months, which included embedding learning, refreshing business continuity arrangements and strengthening four nations collaboration, including Chemical, Biological, Radiological and Nuclear (CBRN) preparedness.	

The Committee:

- Sought assurance on the strength of relationships with UK partners and queried whether there were any risks associated with England-centric approaches.
- HW confirmed that relationships were strong and had improved significantly, supported by regular engagement and a well-established four nations group. He noted that collaboration had been effective in recent live incidents, enabling rapid responses.
- MK added that from an emergency response point of view, relationships operated effectively both formally and informally, citing examples of rapid communication and coordination during recent incidents. He advised that further clarity on UK-wide roles and responsibilities was being progressed through national discussions.
- Queried how health inequalities were being addressed within emergency preparedness planning and how progress would be measured.
- HW outlined the development of an inequalities tool, informed by research and workshops, to support planning and response. He advised that outputs would be shared through governance structures.
- MK added that inequalities had been embedded into response arrangements, including the establishment of an inequalities function during Exercise Pegasus, which had informed national discussions.
- TF advised that learning from previous emergency responses, particularly COVID-19, had informed a more structured approach to embedding health inequalities within preparedness arrangements. He highlighted that a dedicated inequalities function had been established in recent exercises, which ensured this aspect was not deprioritised during operational response. He noted that this approach had produced practical outputs, including briefings recognised as valuable by system partners, demonstrating that inequalities considerations were now more consistently integrated into response planning and delivery.

The Committee:

- Took **assurance** that Public Health Wales was compliant with statutory emergency planning duties and was maintaining effective preparedness and resilience arrangements.
- **Approved** the submission of the Public Health Wales Annual EPRR Report 2025/26 to Welsh Government by the required deadline of 31 July 2026.
- **Noted** the key organisational risks and 2026/27 priority areas that would guide the forthcoming EPRR work programme.

QSIC 2026.06.04/3.3.1	**Policies and Procedures for approval**

ND presented the Fire Safety Policy and Water Management Policy, noting both had been reviewed, consulted upon and strengthened, particularly in relation to incident response and record keeping.

PV presented the Claims Management Policy and Procedure, confirming these had been updated to reflect current legal requirements and governance arrangements, including changes to leadership oversight.

AC presented the Infection Prevention and Control (IPC) Policy and the Managing Allegations of Abuse by Staff Procedure, noting both were routine renewals, had been updated to reflect legislative requirements, and had undergone appropriate consultation and governance review.

The Committee:

- Raised concern regarding the format and consistency of policy documentation.
- LB clarified that the policies should be concise, with detailed procedural content held separately, and that the documents had been combined for Committee purposes, which had affected presentation.
- PV confirmed that the governance approach separated policy statements from detailed procedures and acknowledged the need for greater consistency across the organisation.
- Sought confirmation that the IPC Group had reviewed and endorsed the IPC policy.
- AC confirmed that the IPC Group had endorsed the policy and would update the approval cover paper to reflect the date.

Action: AC

The Committee approved the:

- Fire Safety Policy
- Water Management Policy
- Infection Prevention and Control (IPC) Policy
- Managing Allegations of Abuse by Staff Procedure
- Claims Management Policy
- Claims Management Procedure

QSIC 2026.06.04/3.3.2	Ratification of Chair's Action

LB presented the paper, which set out the Chair's action taken between meetings to approve a 12-month extension to the All-Wales Consent to Examination or Treatment Policy. LB confirmed that the policy had been updated to ensure any risks arising from an out-of-date policy were mitigated and that the changes were minor in nature.

The Committee:

- **Noted** the occasion on which Chair's action was taken;
  - **Ratified** the approval of a 12-month extension to the All-Wales Consent to Examination or Treatment Policy.
- Took **assurance** that the action had been taken in accordance with Section 8 of the Standing Orders.

QSIC 2026.06.04/3.4	Quality and Clinical Audit Plan and Forward Look

AC presented the update on progress against the Quality and Clinical Audit Plan, outlining both national and local audit activity.

AC highlighted:

- That all five national audits had been completed and that there had been a significant increase in the number of clinical and quality audits over recent years, demonstrating an improving organisational position.

- 75 local audits had been undertaken across pathways and services, with details of completed, delayed and removed audits provided within the report.
- That the Screening and Health Protection divisions continued to undertake the majority of clinical audits and noted that additional audit activity took place across other services, including Infection Services and Health and Safety, which were not fully captured within the report.
- The introduction of the Audit Management and Tracking (AMaT) system to support audit tracking, improve oversight of actions, and strengthen monitoring of audit completion and follow-up activity.

The Committee:

- Queried the discrepancy between the number of completed audits and the number of audit reports received, noting that completed audits should be supported by formal reporting.
- CB clarified that this was a known issue, whereby services completed audits but did not always provide the final reports back to the audit team. She advised that this represented an improving position over time and that the introduction of AMaT would strengthen reporting compliance through improved tracking and prompts.
- Noted that the improving trend provided reassurance but emphasised the importance of ensuring that completed audits resulted in accessible organisational learning.
- Raised a broader question regarding how the organisation could demonstrate the impact of audit activity, noting the importance of ensuring that audits led to measurable improvement rather than becoming a mechanical process.
- AC advised that the introduction of AMaT enabled a more robust end-to-end audit cycle, including recording improvement actions, setting review dates, and scheduling re-audits. She confirmed that future reporting would provide greater visibility of the impact of audit activity and evidence of improvement.
- Welcomed this approach but emphasised the importance of demonstrating outcomes, particularly in terms of improving services and addressing identified gaps.

The Committee:

- Took **assurance** on the progress made against the Quality and Clinical Audit Plan for 2025-26.
- **Approved** the Quality and Clinical Audit Plan for 2026-27.

QSIC 2026.06.04/4	**Items for Assurance**
QSIC 2026.06.04/4.1	**Quality Governance Performance Report Q4**

AC provided an overview of the Quality Governance Performance Report for Quarter 4, drawing the Committee's attention to specific areas for consideration:

<u>Putting Things Right (PTR), Q4</u>

AC summarised the PTR section, which covered the incidents, complaints and

concerns reported and acted upon during Quarter 4, noting the intention to rename this section Patient Safety and Concerns, in line with the new 'Listening to People' updated regulations:

- 490 incidents were reported, 2 incidents were classified as moderate harm following investigation, and related to Cervical Screening Wales.
- There was 2 Nationally Reportable Incidents, 1 Early Warning Report and no duty of candour cases.
- Incident closure performance had declined in quarter 4; however, there had been an overall improving trajectory over the preceding 12 months, including reductions in the number of open long-outstanding incidents.

Patient/Service User Experience and Safety Alerts and Notices Management, Q4

AC highlighted:

- 25 early resolutions were recorded, with concern themes including communications, staff attitude and behaviour.
- 10 formal complaints were received, most of which originated from screening services. Complaints management performance remained good overall.
- 168 compliments were received, most commonly thanking staff.
- 48 safety alerts were received, with none requiring action by the Organisation.

The Committee:

- Suggested that complaint volumes would benefit from clearer contextualisation against service activity levels to provide proportional understanding. AC noted that while the number of contacts was displayed later in the report, she would update the section to provide further clarity in future reports.

Action: AC

The work of the Corporate Safeguarding Group, Q4

AC provided an update on the work of the Safeguarding Group, highlighting:

- 62 Safeguarding enquiries, the highest number of which came from the Sexual Health Service and related to children at risk; work was underway to support the service and strengthen their safeguarding arrangements.
- An overall reduction in level 3 safeguarding compliance and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Group 2 compliance; targeted areas had been asked for a trajectory of performance recovery.
- Ongoing safeguarding risks across the Sexual Health service, Communications Division and the People and Organisational Development Directorate.

The Committee:

- Sought clarification on the reduction in training compliance.
- AC explained that the allocation of additional training requirements to the Health Protection Division and specifically the Sexual Health Service staff groups had impacted compliance rates, however this was an improving picture. Operational pressures had also affected attendance at face-to-face training. The team had offered bespoke sessions, and targeted actions were in place to support recovery of the compliance rates.

- Expressed reassurance regarding the level of support being provided to the Sexual Health Service.

The Work of the Corporate Infection, Prevention and Control (IPC) Group, Q4

AC provided an update on the work of the Corporate IPC group, highlighting:

- There were 21 IPC related incidents, with one initially reported as moderate harm and still under review.
- Infrastructure improvements were identified as an ongoing risk. AC noted that environmental audit compliance remained a concern at Kimberley House, although improvement had been noted. There were ongoing concerns regarding decontamination facilities at Glan Clwyd, affecting Bowel Screening Wales and further auditing and discussions were underway.

The Committee:

- Raised broader awareness of potential IPC related risks associated with water and environmental hazards in the River Wye over the summer months and sought assurance that clear responsibilities and reporting pathways were in place. MK highlighted Natural Resources Wales' responsibilities and advised that the Organisation would work alongside them to respond to any alerts.

The Committee:

- **Noted** the performance standards being achieved and areas for improvement.
- Took **assurance** that appropriate governance was in place to ensure safe, timely, effective, equitable, efficient, and person-centred services.

QSIC 2026.06.04/4.2	**Engagement Update**

CB presented the report, outlining progress made against previously agreed actions to strengthen the organisation's approach to engagement and alignment with equality and diversity requirements.

CB highlighted:

- Movement towards a more coordinated organisational approach, including closer working with the communications team and the development of a community of practice to support engagement capability. She noted that, while progress had been made, the organisation remained at an early stage of maturity and further work was required to embed a consistent approach.
- Progress in relation to youth engagement, advising that 12 young people had been recruited to a refreshed Young People's Programme following strong interest, which would support a more structured and meaningful approach to engagement with this group.

The Committee:

- Reflected that the work represented a positive direction of travel, particularly noting the importance of moving towards a more coordinated and purposeful approach to engagement across the organisation.

- Welcomed the development of the Young People's Programme, noting that a structured programme with a clear purpose and defined outputs would strengthen the organisation's ability to demonstrate impact.

The Committee:

- Took **assurance** on the progress made to date in strengthening Public Health Wales' approach to engagement with people and communities.
- **Noted** the actions taken to improve capability and partnership working across the organisation within current organisational arrangements.
- **Noted** that the Engagement and Collaboration Team would be transitioning toward an Equalities, Involvement and People's Experience (EIPE) function, to support organisational compliance in relation to our equality duties.

QSIC 2026.06.04/4.3	Putting Things Right & Duty of Candour Annual Report 2025/26

AC presented the Putting Things Right Annual Report and Duty of Candour Annual Report, highlighting:

- The annual position and recent legislative changes.
- The introduction of the "Listening to People" regulations, including revised timescales for managing concerns and an increase in the financial threshold for redress from £25,000 to £50,000.
- That the key benefit of the revised arrangements was an improved service user experience, particularly through more meaningful engagement at an earlier stage in the process. AC noted that this approach supported clearer expectations, more timely responses and more effective resolution.

The Committee:

- Reflected that the absence of increased workload following regulatory change was a positive position but queried whether this would remain stable as awareness of the new arrangements increased.
- AC confirmed that a baseline assessment had been undertaken to understand the potential impact of these changes and confirmed that, to date, there had been no significant increase in workload. AC attributed this to the Organisation already operating with similar practices, including early engagement with complainants and noted that the revised approach strengthened the quality of complaint handling, particularly through improved early conversations with complainants and clearer agreement on desired outcomes.

The Committee:

- Took **assurance** on the organisation's effective management of the implementation of the Putting Things Right Regulations (2011).
- **Noted** the learning from the two Duty of Candour (DOC) Cases.
- Took **assurance** that DOC cases were being managed in accordance with regulatory guidance and the relevant policies and procedures, including organisational learning.

QSIC 2026.06.04/4.4	Screening Service Assurance

MK introduced the report, advising that it provided an overview of performance across screening programmes and outlined improvement plans for areas below standard, including bowel, breast and diabetic eye screening.

SdS presented an overview of the approach to assurance, noting that the report was structured around quality domains and included detailed improvement planning where performance was below required standards.

GB highlighted that bowel screening performance was impacted by delays in colonoscopy capacity, with a recognised shortfall driven by workforce constraints and increasing demand due to programme expansion and increased sensitivity of testing. He outlined actions being taken, including workforce development, cross-border accreditation arrangements, and closer working with Health Boards through recovery planning and the Screening Colonoscopy Improvement Programme.

GB highlighted that breast screening performance continued to improve in some areas; however, challenges remained in assessment timeliness, particularly in North Wales, driven by workforce pressures. Mitigating actions included cross-regional working, expansion of radiology-led clinics, and continued workforce development.

The Committee:

- Sought clarification on whether the capacity gap had been fully understood, including both recovery requirements and future demand, and whether there was alignment with Health boards regarding the scale of the capacity gap and how to bridge it.
- GB confirmed that capacity modelling had been undertaken, that demand and required capacity were well understood, and that Health Boards had visibility of this through Exec to Exec discussion. He noted, however, that while there was alignment with health boards regarding the scale of the capacity gap, the challenge remained in delivering the additional capacity required.
- Asked whether the constraint was primarily workforce-related or infrastructure-related and queried whether workforce planning and timelines for training could be clearly articulated to support assurance on recovery trajectories.
- GB advised that the main constraint related to the availability of trained colonoscopists, although infrastructure and support requirements were also relevant when increasing capacity. GB confirmed that workforce development was a key component of ongoing improvement work.
- Highlighted the importance of understanding the full system (including health board) implications of increasing capacity, including estate, equipment and supporting workforce requirements, noting that these factors could significantly impact delivery timescales.
- Queried whether the use of Artificial Intelligence (AI) had been considered to support prioritisation within breast screening pathways, and to support the management of capacity pressures.

- GB confirmed that while AI was being explored through trials, it was not currently implemented within operational service delivery and advised this could be explored further to help support the capacity gap.

BB reported that Diabetic Eye Screening Wales (DESW) continued to face capacity pressures, with increasing demand and a significant number of participants overdue for screening. Timeliness remained the primary challenge, particularly for the annual recall cohort. BB outlined actions to increase capacity and utilisation, including extended hours, mobile clinics, improved booking processes and clinic utilisation initiatives, and noted workforce pressures and venue constraints as ongoing risks. BB went on to highlight innovation work, including an in-service camera evaluation, which had the potential to increase capacity and improve efficiency.

The Committee:

- Reflected on the ongoing gap between capacity and demand and suggested seeking support from NHS Performance and Improvement Unit around clinic utilisation and the proportion of use.
- BB confirmed that actions were focused on both increasing capacity and improving utilisation, with improvements already being seen in clinic fill rates.
- Sought clarification on the expected timeline for implementing the outcomes of the camera evaluation. BB advised that implementation planning would take place over the summer, with potential rollout from early 2027.

BB provided an update on equity and engagement, highlighting the refreshed screening equity strategy and targeted actions to address inequalities in screening uptake, including engagement with primary care and community partners to improve uptake across underserved populations and use of local data to focus on areas of low uptake.

The Committee:

- Queried how effectively underserved populations were being reached, the potential impact of increasing uptake on system capacity, and how the Organisation addressed inequalities in the screening pathway. The Committee also asked how the Organisation was working with the wider system partners including health boards and primary care and the input and outcome of population segments.
- BB confirmed that a structured equity approach was in place, including targeted interventions, collaboration with primary care, and use of local data to focus on areas of low uptake. She noted that inequalities remained a recognised challenge, with ongoing work required to demonstrate measurable impact.

SdS outlined the approach to quality within screening services, highlighting the use of a “three lines of defence” governance model operating across programme, divisional and organisational levels. She advised that work had been undertaken to embed a consistent understanding of quality domains and reported improvements in incident management, including timeliness of closures and quality of investigations, supported by strengthened processes for sharing learning across programmes.

The Committee:

- Suggested further discussion on digital solutions within screening including AI could be considered by the Knowledge, Research and Information Committee.
- MK welcomed this suggestion and agreed to work with Iain Bell, National Director for Public Health Knowledge and Research to table a paper at the Committee outlining digital opportunities including AI, to improve efficiency and effectiveness within screening services.

Action: ~~MK~~ CB

The Chair thanked the team for the comprehensive presentation and noted that further discussion would be held with Chair of the Board and Cross Committee Chairs around future assurance and reporting requirements.

The Committee took **assurance** that there was focus on working to deliver quality screening programmes in line with delivery of excellent public health services to the population in Wales.

QSIC 2026.06.04/4.5.1	Risk Assurance - Strategic Risk Register

DG introduced the report, highlighting the organisation's position as of 1 April 2026, noting that there had been no changes to risk scores since the previous reporting period. Strategic Risk 3 remained just outside of tolerance and DG advised of the intention to provide an in-depth triangulated risk session on screening assurance at the September meeting.

Action: DG

MK highlighted a recent deep dive into the risk which covered actions and mitigations, noted recent operational challenges around the hantavirus and Ebola response, and the support of members of staff across the Organisation to support the ongoing response and preparedness for Ebola. He noted the intention to undertake a system wide exercise due on 23 June.

The Committee:

- Highlighted the interrelationship between Strategic Risk 3 and Strategic risk 2 the impact on staff and staff wellbeing, and the need to align consideration of the two risks, alongside the People and Organisational Development Committee.
- DG confirmed that work was underway to strengthen the intersection between strategic risks across the Committee structures.

The Committee took **assurance** on the management of Strategic Risk within its remit.

QSIC 2026.06.04/4.5.2	Risk Assurance - Corporate Risk Register

DG introduced the report, which presented the Corporate Risk position last approved by the Leadership Team. She advised that there were no new risks and that arrangements for managing corporate risks were continuing to mature, with more dynamic and engaged discussions at leadership level.

The Committee thanked DG for the update and took **assurance** on the updated Corporate Risk Register within their remit.

QSIC 2026.06.04/4.6.1	Health and Safety Quarter 4 2025-26

ND presented the report, highlighting:

- There had been no Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents during the reporting period and that the organisation maintained 100% compliance with statutory inspection requirements across gas, electricity, water, fire and asbestos safety.
- Work continued to progress the recommendations that arose from the Breast Test Wales water incident management process.
- Continued improvement in compliance with statutory and mandatory training, including home working assessments.
- The completion of the Health and Safety Culture Survey, which had identified both positive findings and areas for improvement, including leadership visibility, communication, and support for new ways of working.

The Committee took **assurance** that appropriate measures were in place to monitor compliance and to address areas identified for improvement.

QSIC 2026.06.04/4.6.2	Health and Safety Annual Report

ND presented the report, noting that it had been strengthened to provide greater assurance and clarity on organisational performance.

He highlighted that:

- Health and safety assurance arrangements had continued to develop and strengthen and visibility of compliance and training data had improved.
- Digital solutions, including AMaT and the Computer Aided Facilities Management system, had been implemented to support audit and estate compliance/ management.
- The Organisation had maintained compliance with statutory requirements and strengthened incident management, with improving closure rates.
- Key priorities for 2026/27 included implementation of the Health and Safety Culture Action Plan, which focused on leadership, communication, training and workforce support.

The Committee queried whether the number of RIDDOR reports could be benchmarked to provide assurance on whether reporting levels were within expected norms.

ND acknowledged the point and advised that while benchmarking had not yet been undertaken, RIDDOR reporting levels appeared low relative to organisational activity. He confirmed that no concerns had been raised by the Health and Safety Executive, indicating that reporting levels were not disproportionate.

The Committee took **assurance** that appropriate arrangements were in place to monitor health and safety performance, manage risks, respond to incidents and regulatory engagement, and progress improvement actions through the Health and Safety Group and established governance routes.

QSIC 2026.06.04/4.7	**Bi-Annual Corporate Policies Update**

LB presented the bi-annual corporate policies update, advising that there were 32 policies within the Committee's remit. She reported that significant progress had been made, with the majority of policies in date (90%) following approvals earlier in the meeting agenda. Three policies remained out of date, with clear timelines in place for completion.

The Committee sought clarification on terminology within the report. LB confirmed the reference to Alerts and Safety notices related to a policy.

The Committee took **assurance** on the prioritisation and progress being made to review policies, procedures and other written control documents.

QSIC 2026.06.04/5.	**Items to Note**
QSIC 2026.06.04/5.1	**Audit**

The Committee **noted:**

- The Audit Recommendations Tracker update and considered any impact on the Committee's workplans / areas of focus.
- Final Internal Audit Report on Welsh Risk Pool (substantial assurance rating).

QSIC 2026.06.04/5.2	**Committee Workplan**

The Committee **noted** the Committee Workplan.

Part B	**NHS Performance and Improvement Business**
QSIC 2026.06.04/6	**Declaration of Interest**

There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.

QSIC 2026.06.04/7.1	**NHS Wales Performance and Improvement (P&I) Quarterly Governance Compliance Report (Q4)**

SF presented the NHS Performance and Improvement (NHS P&I) Unit update, highlighting:

- Six health and safety incidents were recorded during the period, none of which required escalation as National Reportable Incidents.
- One complaint was received, relating to Welsh language compliance. In response to the complaint proactive action has been put in place. SF also advised on the planned recruitment of a Welsh language compliance officer.
- No claims were reported during this quarter.
- Statutory and mandatory training compliance remained at a satisfactory level.
- Work was underway to review safeguarding training requirements and strengthen organisational awareness, supported by the identification of a dedicated safeguarding lead.

The Committee queried whether the absence of safeguarding concerns reflected under-reporting.

SF acknowledged the point and advised that, while no concerns had been identified, additional work was planned to strengthen awareness, speaking-up culture and safeguarding understanding across the organisation. She noted that the relatively small size and connectivity of the organisation supported early identification of issues and agreed that ongoing review was appropriate.

The Committee:

Health and Safety

- Took **assurance** that there were appropriate measures in place to monitor compliance and to address areas identified for improvement.

National Reportable Incident Reporting compliance

- **Noted** there had been no reportable incidents to report.

Complaints (including PTR if applicable) compliance

- **Noted** that one complaint was received during this period.

Claims reporting (staff and third-party claims)

- **Noted** that there had been no claims received this period and **took assurance** that Claims were being managed appropriately.

DATIX compliance

- **Noted** that there had been six incidents reported on Datix for this period and took **assurance** that the appropriate process has been followed to manage these incidents.

Safeguarding compliance

- **Noted** there had been no safeguarding issues reported for this period.

QSIC 2026.06.04/7.2	**NHS Wales Performance and Improvement (P&I) Annual Assurance Statement**

SF presented the report, outlining the governance, compliance and accountability arrangements in place under the hosting arrangements with Public Health Wales and confirmed that statutory and regulatory requirements had been met.

She further outlined improvements in risk, estates and compliance oversight, including the centralisation of estates and health and safety functions, and noted ongoing work to strengthen compliance with wider statutory duties, including integration of wellbeing considerations into organisational planning.

The Committee thanked SF for the comprehensive report and took **assurance** on NHS Performance and Improvement governance compliance.

QSIC 2026.06.04/8	**Closing Administration**
QSIC 2026.06.04/8.1	**Close of Public Meeting**
The Chair closed the meeting. The date of the next meeting: 10 September 2026	
The open session closed at 12:35	