GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 10 September 2026 **Agenda item:** 5.1

Quality Governance Performance Report Quarter 1 (1st April 2026 – 30th June 2026)	
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Approval/Scrutiny route:	Angela Cook, Assistant Director of Quality and Nursing Business Executive Team (BET) (02/09/2026)

Purpose
The Quality Governance Report provides the Committee with an overview of Quality Governance within Public Health Wales for the Quarter 1 period (1st April 2026 to 30th June 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:

- Listening to People (Management of regulations)
- Service User Experience
- Alerts Management
- Clinical Audit
- The work of the 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, and the management of risk.
- 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.

Listening to People - Incidents (Page 8)

- 513 incidents were reported and investigated during Quarter 1, with remedial actions identified. Of these, 2 were closed as Moderate harm or above.

- As of 30 June 2026, there are 27 incidents on Datix with an 'open' status of more than 30 working days. This is a much-improved position on the previous quarter.

Safeguarding of Adults & Children at Risk (Page 28)

- A total of 40 safeguarding enquires for advice and support were received this quarter, a reduction from the previous quarter. This decrease reflects increased confidence within Sexual Health Wales staff to manage safeguarding concerns and make appropriate decisions without requiring specialist advice.

- A total of 8 Duty to Report (DTR) submissions were made to local authorities during the quarter. This activity reflects safeguarding concerns identified within the Sexual Health Wales service, with established safeguarding processes supporting the timely recognition, assessment and escalation of risk where required.

Infection Prevention & Control (Page 33)

- During Quarter 1 there were 15 IPC related incidents reported, and 3 facilities incidents which related to cleaning issues.

- IPC Level 2 training remains below the Welsh Government target of 85% compliance currently at 77.07%, although this is a slight improvement on Quarter 4 (25-26) where compliance was 73.95%, it continues to require attention.

- There are currently 6 risks on the IPC Risk Register, with 3 relating to infrastructure issues within Endoscopy units which provide commissioned services for Bowel Screening Wales at Bronglais Hospital, University Hospital of Wales and Ysbyty Glan Clwyd.

- In the next quarter (August 2026) there will be a significant change to the modes of transmission listed in the National Infection Prevention and Control Manual. The Healthcare Associated Antimicrobial Resistance & Prescribing Programme (HARP) are working with both Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland and the HPSS Training and guidance team to ensure the changes are communicated to health and social care partners across Wales.

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 15)

- 19 Early Resolution complaints were received during Quarter 1 and 8 formal complaints.

- 95% of the Early Resolution complaints were resolved within the 10-working day target.

- 100% 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 26)

- Clinical Audit activity for 2026-27 has been identified and captured within Quality and Clinical Audit Plan. Audit activity is now managed and monitored using the Audit Management and Tracking (AMaT) system and will be reported quarterly.

- Progress against the 2026/27 Quality and Clinical Audit Plan for Quarter 1 (Q1) has been reviewed. 44 internally reported audits were identified at the start of the financial year with a further 12 audits added since the original plan.

- As indicated within the 2026/27 Plan, PHW's additional assurance activity captured within the Ward and Team Assurance module is not reflected in the Audit plan however updates will be provided by the Audit team

Safety Alerts Management (Page 22)

A total of 29 alerts were received by Public Health Wales during the reporting period 1 April – 30 June 2026, 2 of which required action to be taken in relation to a recall of antiseptic skin disinfectant and a public health heat notice.

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.

Patient Experience and Compliments (Page 23)

This quarter, 105 compliments were recorded by staff within the Civica system, and 74 people visited the Public Health Wales website with the intention of leaving a compliment.

People's Experience Surveys (Page 24)

Between 1 April – 30 June 2026, a total of 19,213 individuals were sent an SMS message from the two services with a request for feedback. This led to 5476 people responding and equates to a response rate of 28.53%, a slight increase of 0.45% from quarter 4 2025/26.

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 pertaining to quality performance during Quarter 1 of 2026 including updates from Public Health Wales governance subgroups to provide assurance for the following areas of work:

- Listening to people
- 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.

3. Listening to People

During Quarter 1, there were an estimated 948,500 contacts, tests and interactions with patients, participants and service users across Public Health Wales. The number of reported incidents and complaints represented just 0.05% and 0.003% of these contacts respectively. While these figures indicate that only a very small proportion of interactions resulted in concerns being raised, the data presented in this report provides valuable insight into the quality, safety and effectiveness of our services and highlights opportunities for continuous improvement.

3.1 Incident Management

Incidents Reported	National Reportable Incidents	Early Warnings	Duty of Candour
↑ 513 (490)	↓ 0 (2)	↓ 0 (1)	↑ 1 (0)

( ) denotes previous quarter data

3.2 Incidents

During Quarter 1, a total of 513 incidents were reported. This is an increase of reduction of 23 compared to the 490 reported in Quarter 4 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 2026/27	**2**	**0**	**0**
Quarter 4 2025/26	**2**	**0**	**0**
Quarter 3 2025/26	**1**	**0**	**0**
Quarter 2 2025/26	**2**	**0**	**0**

Table1. Moderate or above harm incidents closed each quarter

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.

3.3 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.

3.4 Early Warning and National Reportable Incidents

There have been no Early Warnings or National Reportable Incidents in Quarter 1 2026/27.

Incident Management Teams
There is currently one open Incident Management Team relating to the Sexual Health overarching incident.

3.5 Open Incidents

The below chart demonstrates the number of incidents reported since July 2024. The quarterly mean has remained unchanged at 176.5 incidents between Quarter 4 2025/26 and Quarter 1 2026/27.

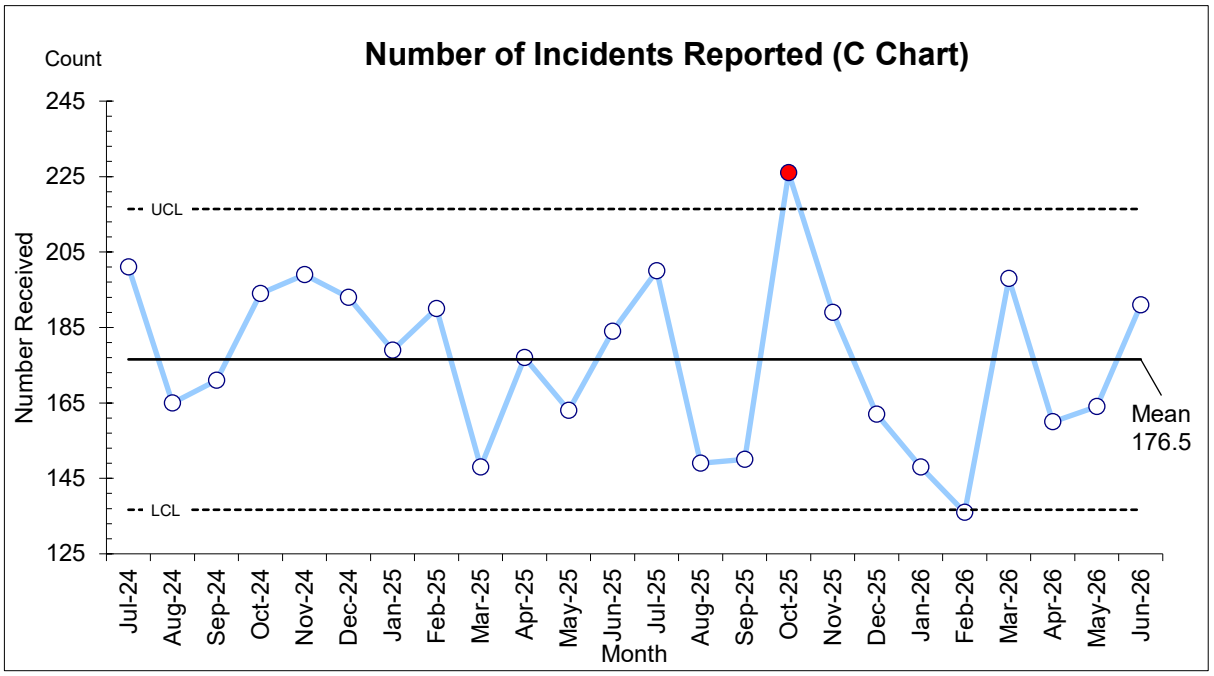


Chart1. Number of incidents reported.

Screening Division are the highest reporting area with 309 incidents followed by Infection services at 175 incidents. This is comparable to Quarter 4 2025/26 with 264 and 180 respectively during that period.

The graph below highlights Divisions within PHW that have reported incidents during Quarter 1.

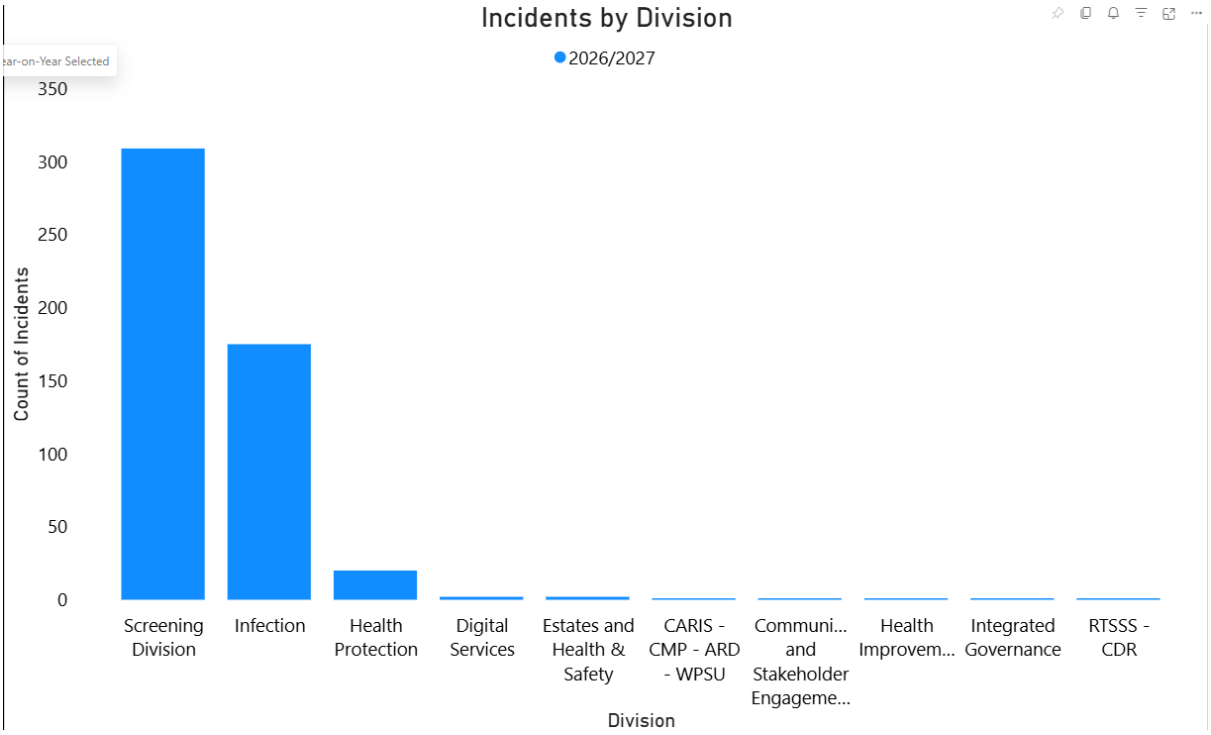
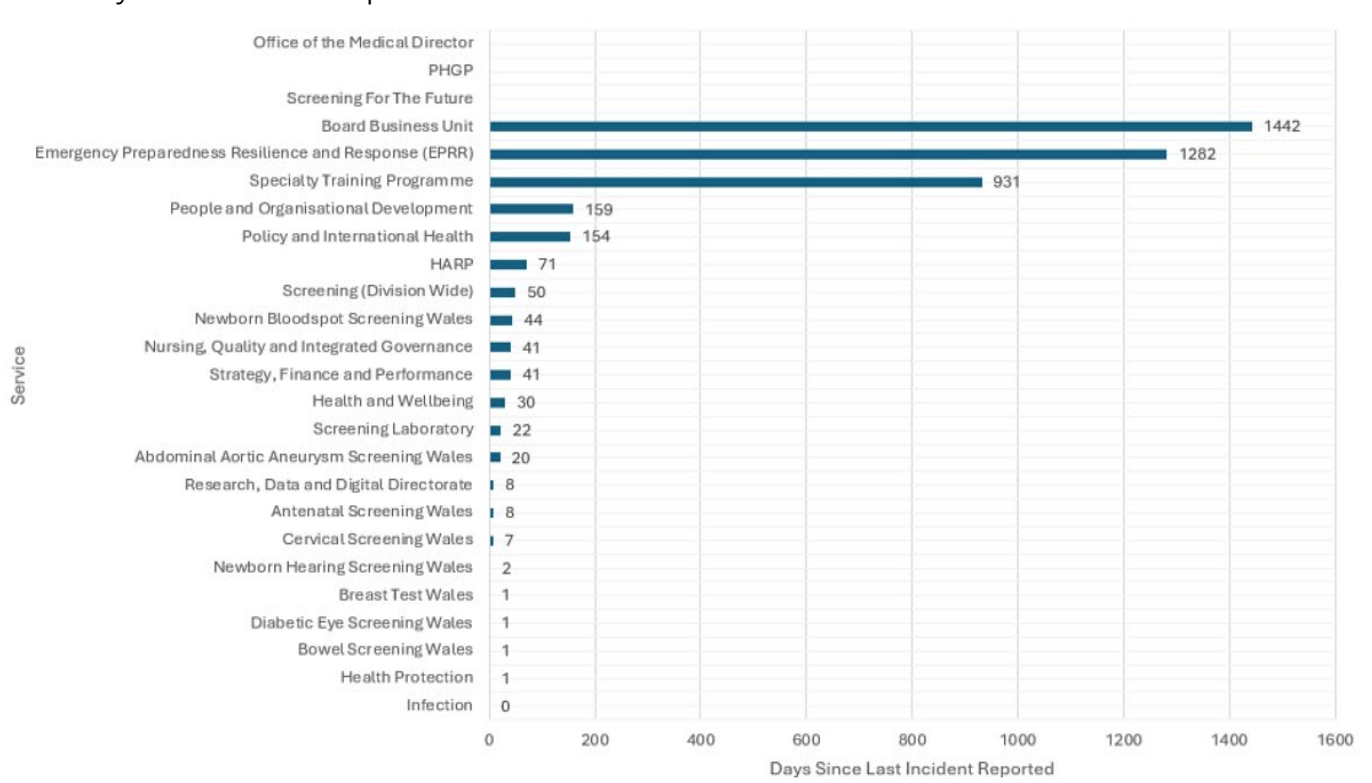


Chart 2. Incidents by Division

The above chart identifies areas that have recorded incidents in Quarter 1, and the chart below indicates the number of days since a service last reported an incident. Work is being undertaken with areas with low reporting rates to ensure and encourage a positive reporting culture, and training is being provided to support with how to recognise, report and investigate a concern.

Chart 3. Days since last incident reported



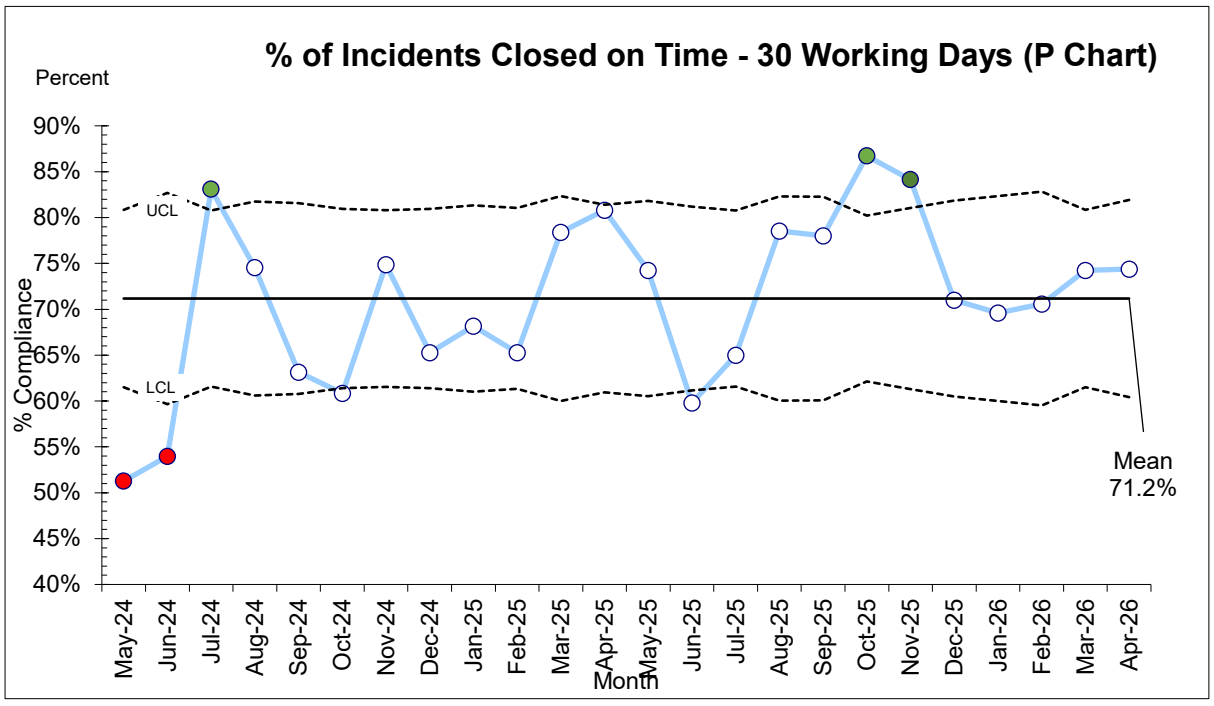
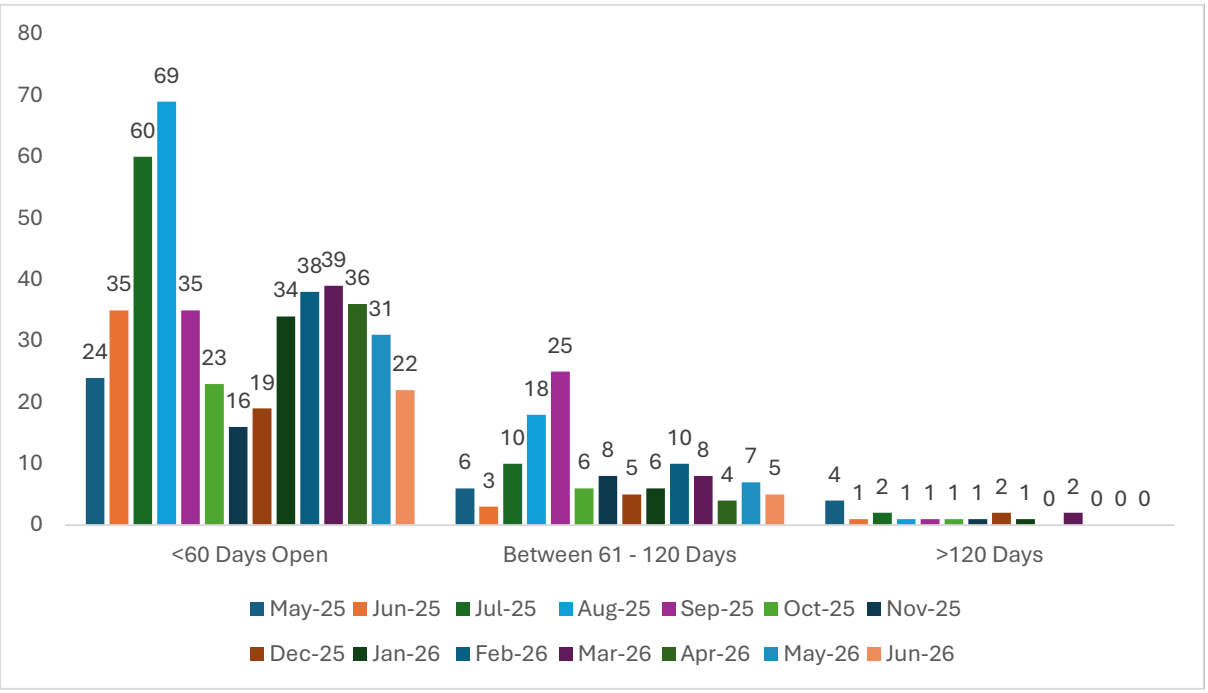


Chart 4. % of incidents closed in 30 working days

The above chart highlights the overall performance against the 30-working day closure rate target which has improved compared to Quarter 4.

3.6 Overdue Incidents

Ongoing work with service areas, the Office of the Medical Director (OMD) and the Nursing, Quality and Integrated Governance (NQIG) team continue to support the safe and timely closure of incidents, with sustained improvements being achieved through weekly incident review meetings.



Graph 5. Overdue incidents reported in days

3.7 Incident Classification

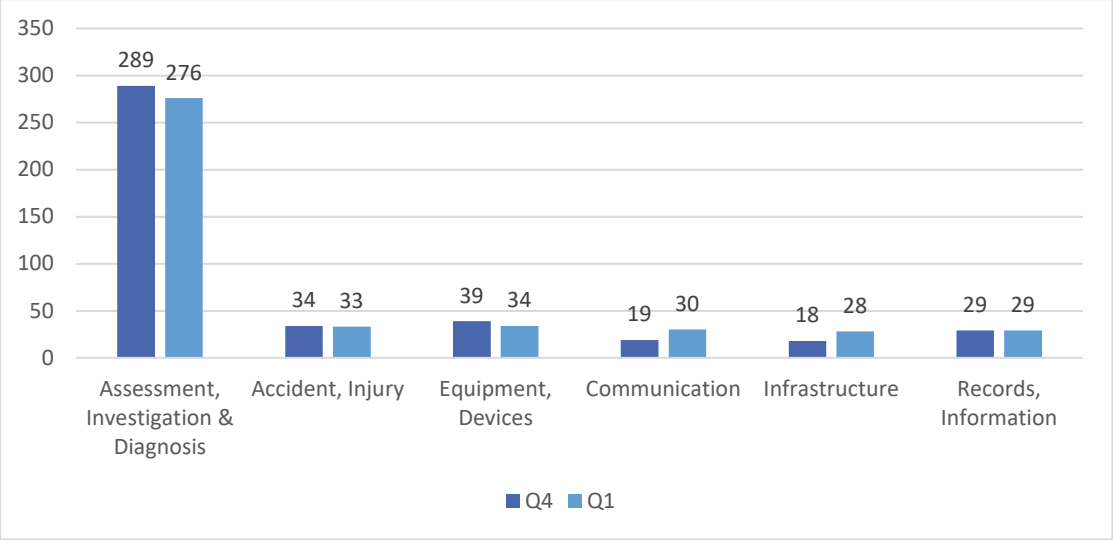


Chart 6: Top 6 incident classifications

Assessment, Investigation and Diagnosis remains the highest reported incident type, with a slight decrease in number when compared Quarter 4. There has been an increase in the communication and infrastructure classifications this Quarter. This increase is not specific to any areas. There has also been an increase in infrastructure incidents noted within the screening division notably Breast Test Wales. This increase has been attributed to failures of medical and non- medical equipment and a lack of suitably trained staff to undertaken screening appointment and assessment clinics.

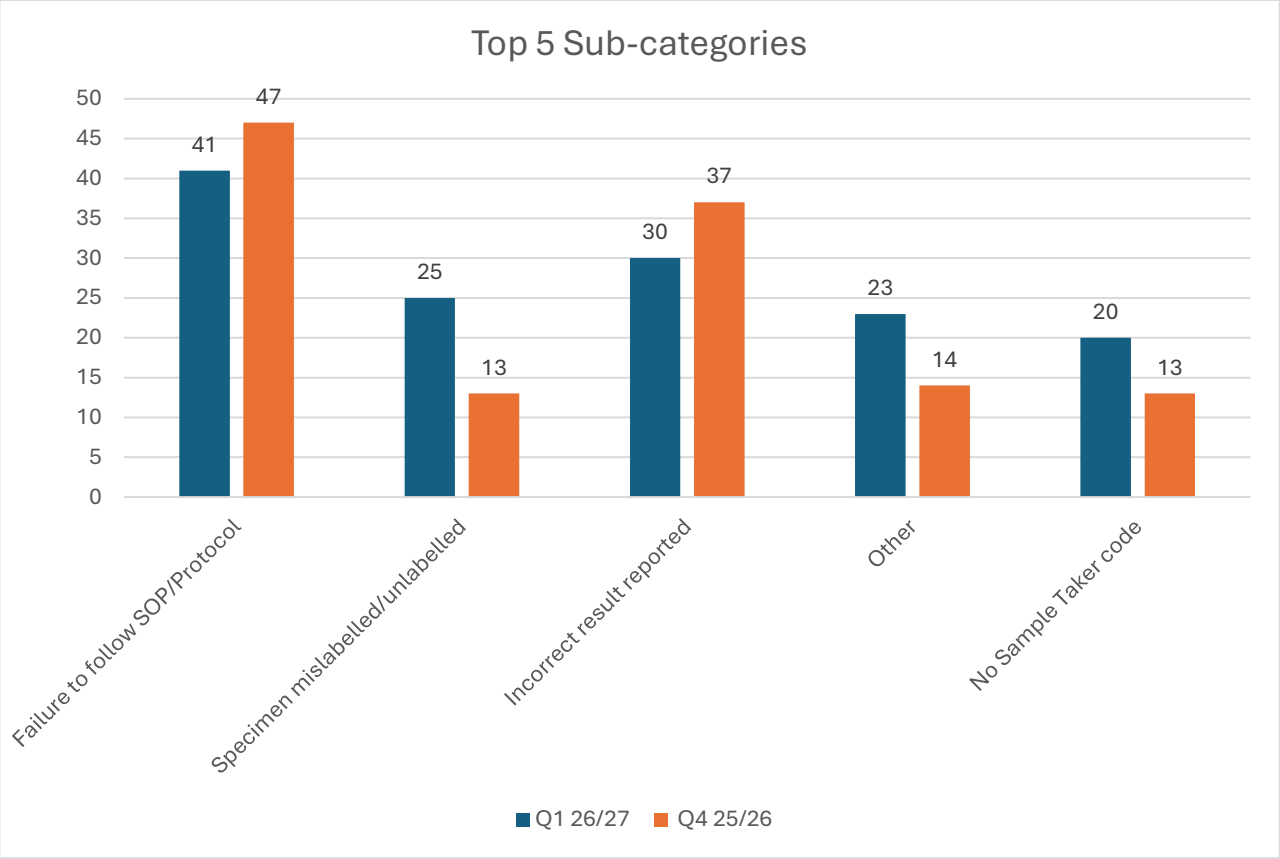


Chart 7. Top 5 sub-categories

3.8 Incident Reporting and Management Training

Incident and Datix training are not a mandatory requirement for Public Health Wales staff; however, all staff are encouraged to attend, with new starters specifically targeted through the onboarding processes.
The current Level 1 Incident and Datix training offer have 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 going forward and is expected end of quarter 2.
In the interim, the Patient Safety and Concerns 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.
Level 2 incident investigation and complaint training remains available. In addition, targeted work is underway for areas of the organisation where incident reporting is low.

3.9 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 **6** ongoing redress cases, **3** in Breast Test Wales and **3** in Cervical Screening Wales. There is 1 potential Redress case for Breast Test Wales.

4. Complaints Management

Early Resolution Complaints (n)	Formal Complaints (n)	Ombudsman Complaints (n)
↓ 19 (25)	↓ 8 (10)	↑ 1 (0)

( ) denotes previous quarter data

At the start of Quarter 1 the revised concerns regulations came into effect. The Listening to People regulations replace Putting Things Rights for the process used to for concerns management.

As of 1 April 2026, all Early Resolution complaints must now be acknowledged within 5 working days and responded to within 10 working days.

It is important to note that the new guidance sets a performance expectation that 40% of complaints received by PHW must be managed as

Early Resolution. This quarter saw 70% of complaints managed as Early Resolution.

4.1 Early Resolution Complaints (Informal)

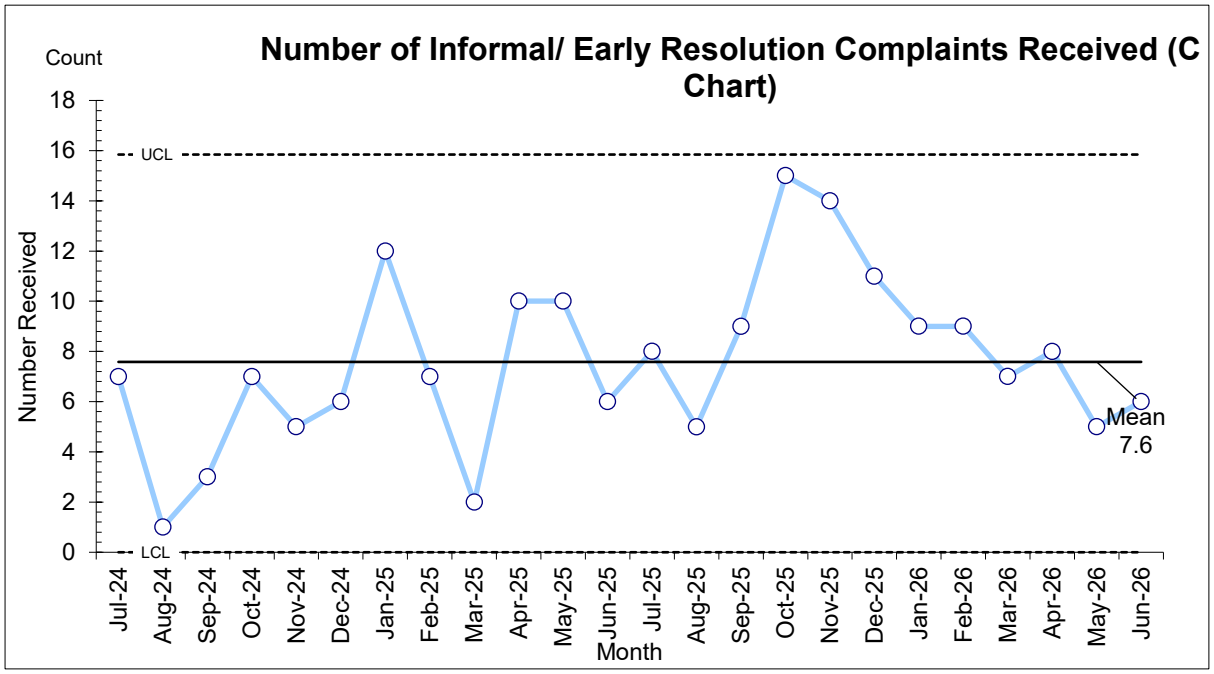


Chart 8. Number of Early Resolution Complaints Received

- **19** Early Resolution complaints were received during Quarter 1. This is a reduction compared to the 25 received in Quarter 4.
- 100% of Early Resolution complaints were acknowledged in 5-working days target.
- 95% of Early Resolution complaints were resolved in 10-working days (75% target), with 1(5%) resolved outside of the 10-working day target on day 11. The delay was a result of the complainant not responding to a request for a listening discussion. The complainant responded on day 10 and response sent on day 11.

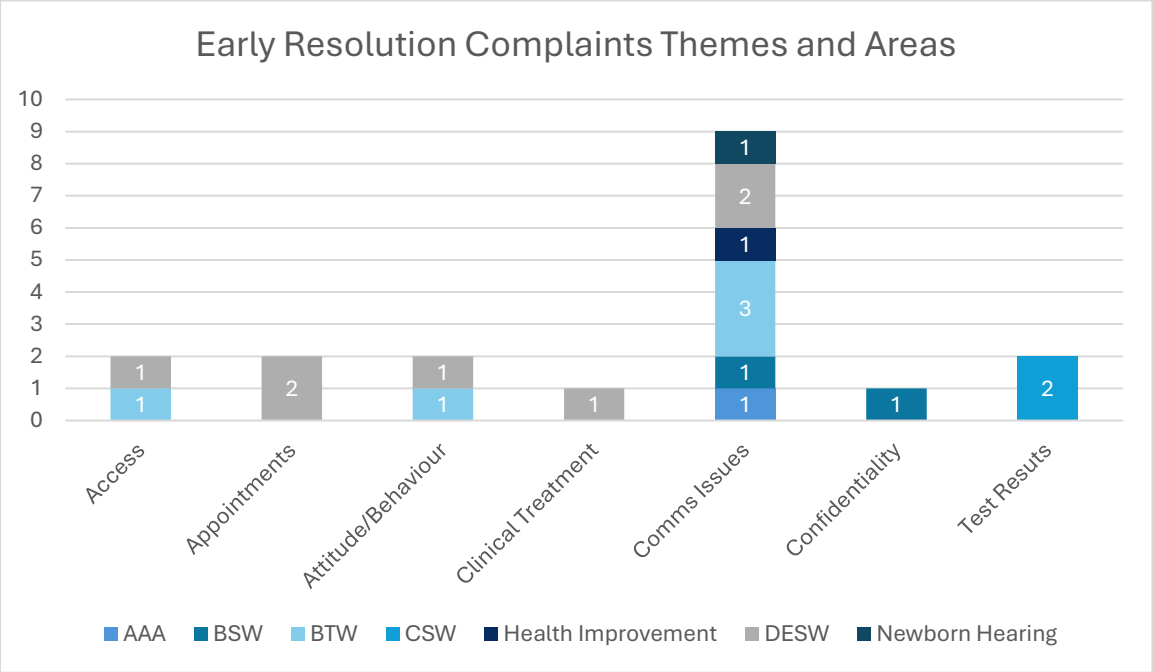


Chart 9. Early Resolution Complaints Themes/Area

The below chart details the service areas where Early Resolution complaints have been received and provides comparative data.

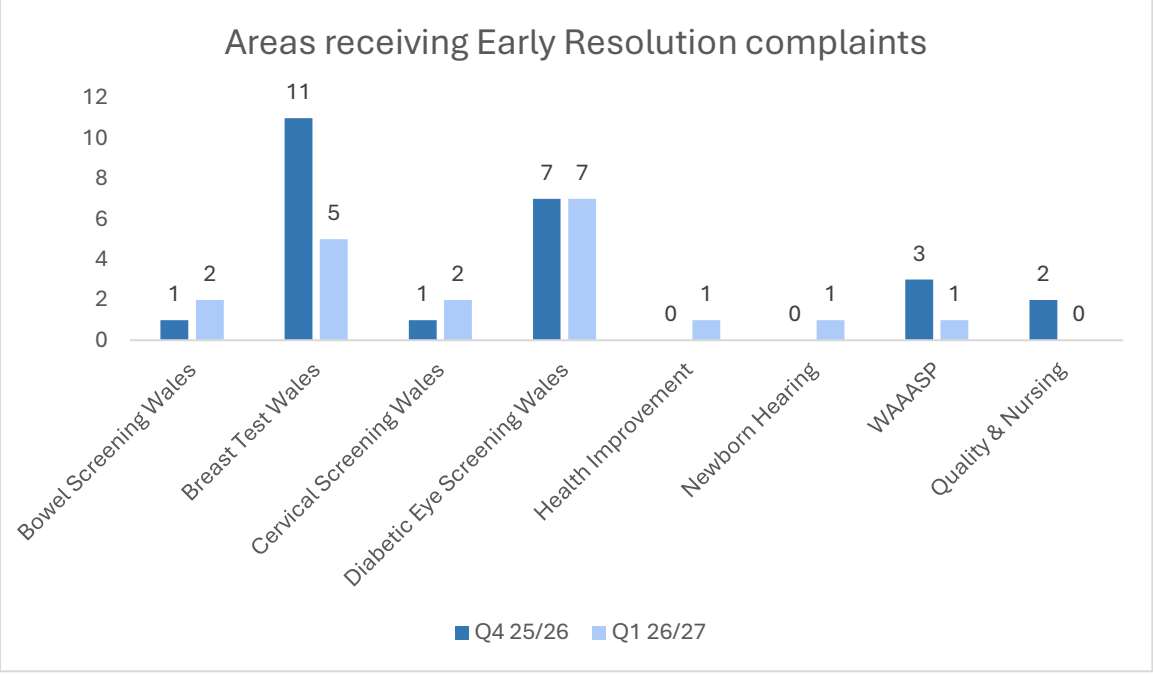


Chart 10. Areas receiving Early Resolution complaints

Breast Test Wales has seen a reduction in Early Resolution complaints during Quarter 1, receiving 5 complaints, compared to 11 in the previous quarter. Diabetic Eye Screening remains unchanged with 7 complaints.

Communication issues were the most frequently reported category for Early Resolution complaints this Quarter an unchanged position on the previous quarter. The number of Attitude/behaviour complaints received has reduced 2, compared to 5 in the previous quarter.

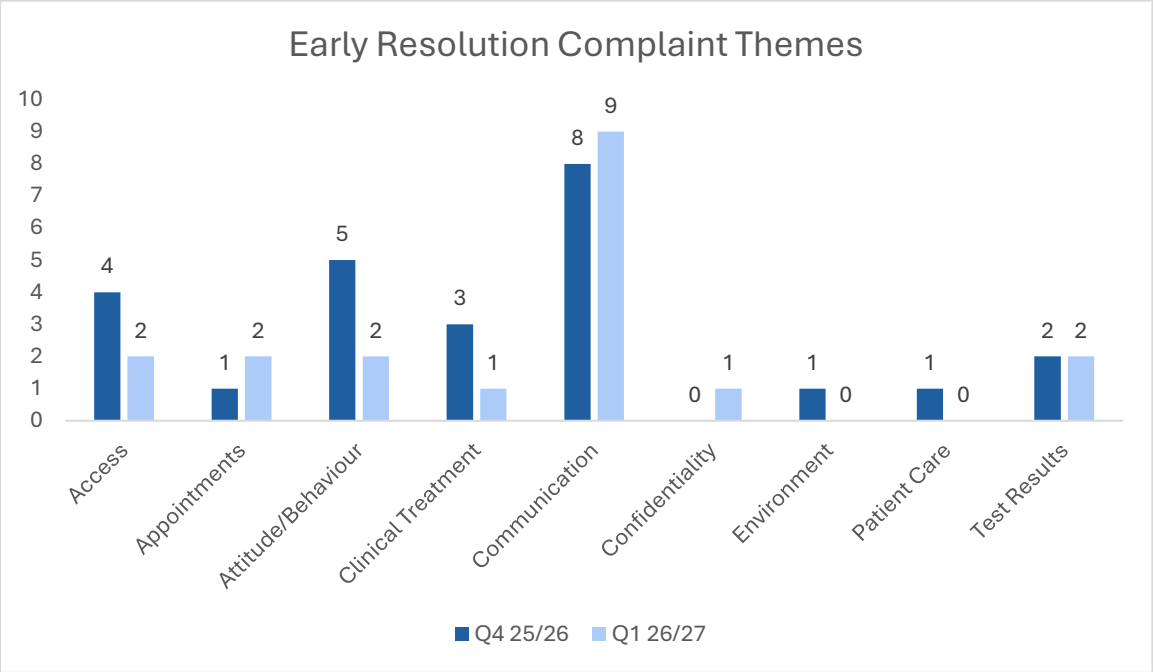


Chart 11. Early Resolution Themes

Formal Complaints, **8** formal complaints were received this quarter, a slight reduction from **10** in the previous Quarter. On average 3 formal complaints are received each month.

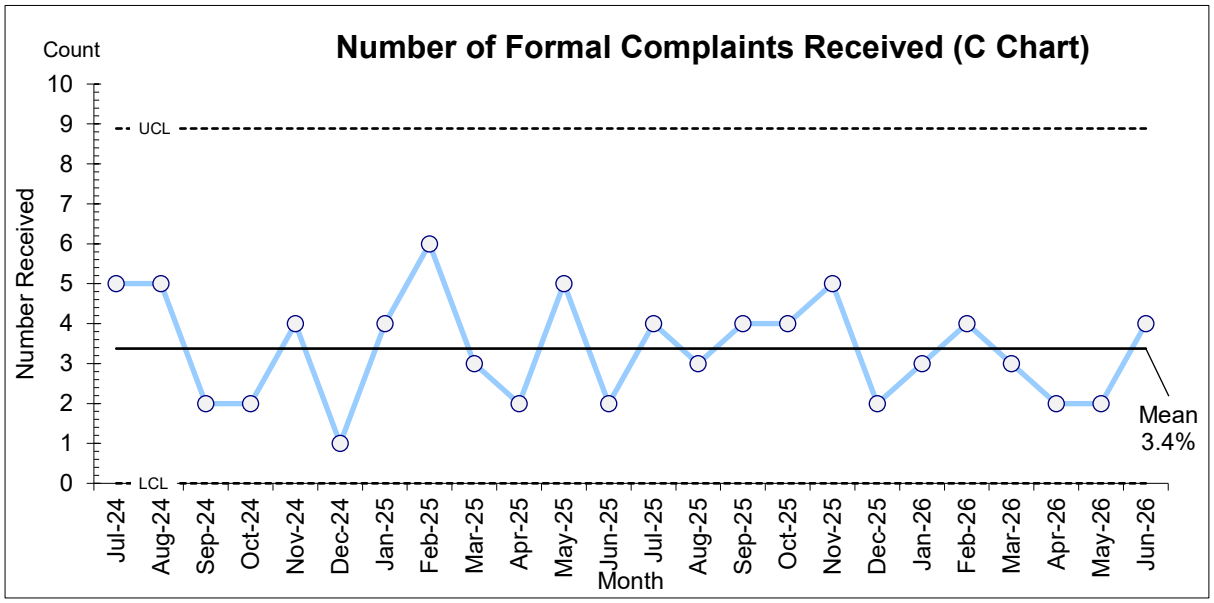


Chart 12. Number of Formal Complaints Received

The following charts demonstrate overall performance in acknowledging and responding to formal complaints against a Welsh Government (WG) target of 75%. PHW is achieving the WG target with a mean of 88.10% complaints acknowledged and 75% achieving the 30-working day performance target.

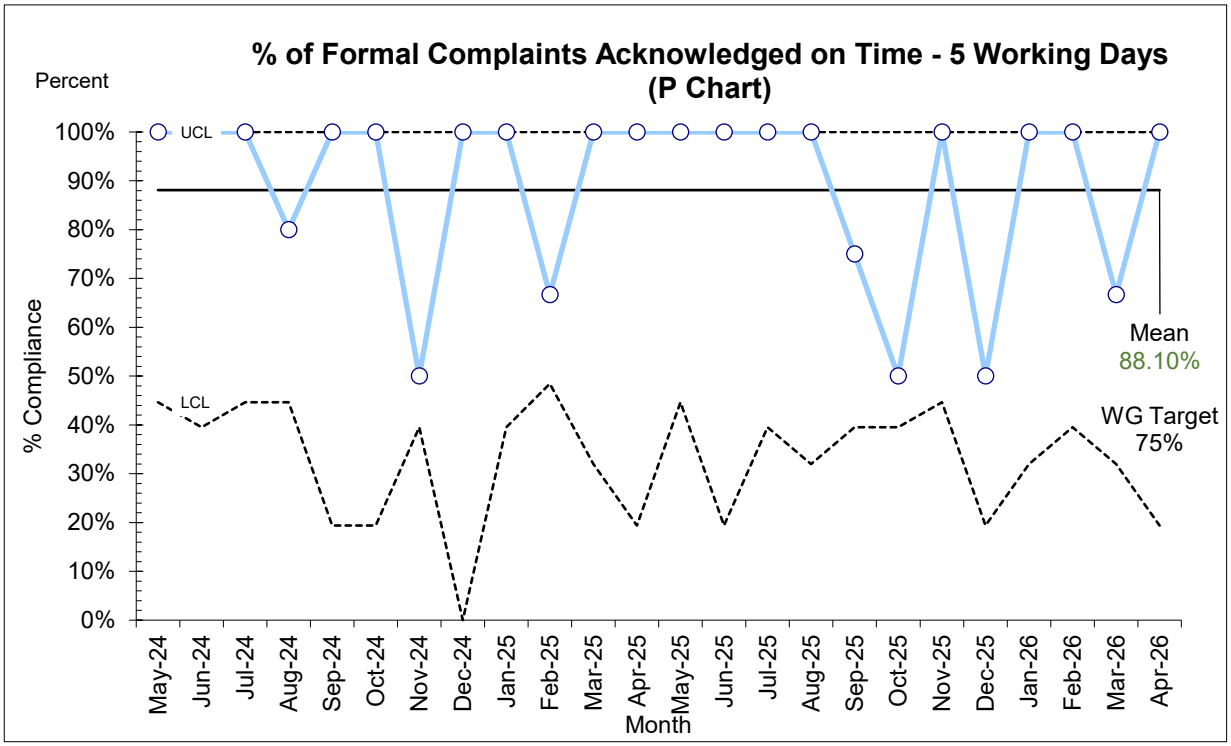


Chart 13. % Formal Complaints Acknowledged on Time

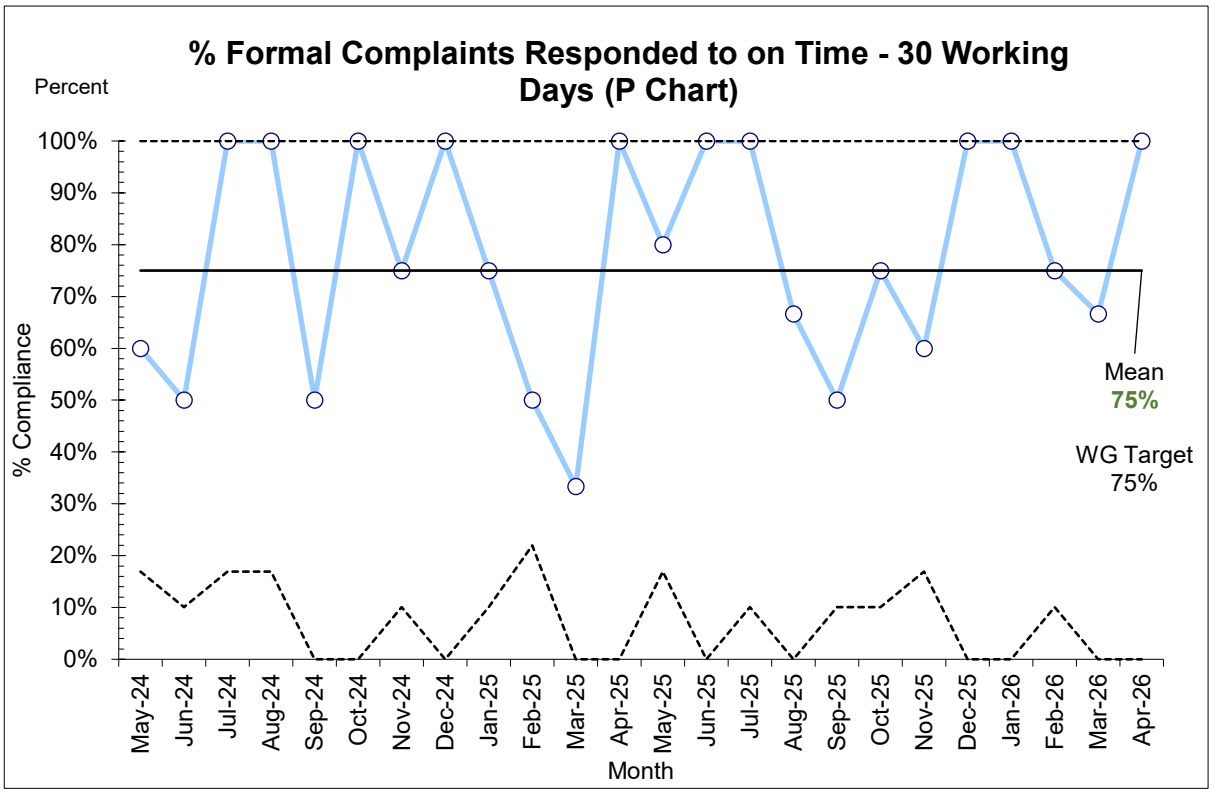


Chart 14. % Formal Complaints Responded to on Time.

The complaints received in June 2026 are not yet due for their final response and are progressing through the investigation and quality assurance processes.

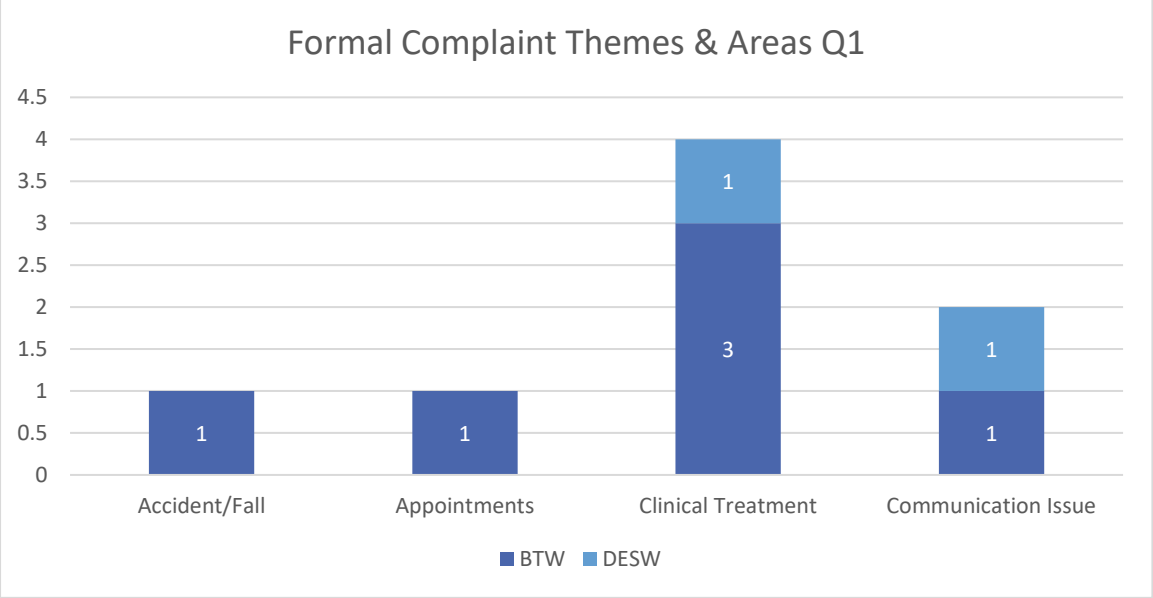


Chart 15. Formal Complaints Themes/Areas

4.2 Learning from complaints

Signage Complaints

A complaint was received by DESW in June 2026 from a service user's family member regarding the insufficient signage at a DESW venue and highlighting the impact of this. Remedial action was taken by the programme with improved signage at the venue and improved information provision.

BTW received a complaint in June 2026 from a participant raising concerns regarding having to wait outside the mobile screening unit in the rain without and insufficient customer information regarding the units' closure times for lunch. As a result, BTW are now reviewing and improving signage on mobile units to ensure open and closure times are clearer.

PHW Social Media Advert Complaint

In June 2026 a member of the public raised a complaint after being targeted by PHW social media adverts about reducing portion size and broad approach taken for public health messaging and its potential negative impact.
As a result, actions being planned include engaging with relevant partners to review how campaign messaging and delivery methods can further minimise the risk of unintended harm and to promote awareness of how individuals can manage and control the adverts they see on digital platforms, including guidance on adjusting personal advertising settings.

Public Services Ombudsman Complaint

During Quarter 1, one Breast Test Wales complaint was escalated to the Public Services Ombudsman for Wales (PSOW). The Ombudsman found no case to answer, and the complaint was not upheld.

5. Duty of Candour

1 Duty of Candour incident was reported in Quarter 1 which occurred within Infection Services and related to the disclosure of antibiotic sensitivities on Laboratory Information Management System (LIMS). The patient has subsequently met with a Consultant Microbiologist and an apology given and an investigation underway.

6. 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 29 alerts were received by Public Health Wales during the reporting period, **2** of which required action to be taken in relation to a recall of antiseptic skin disinfectant and a public health heat notice.

6 alerts were shared for 'information only' and related to guidance for the end of the influenza season. The remaining related to, a medicine recalls and shortages and a public health notice on vaping.,

6.1 Table 1: Total Alerts received

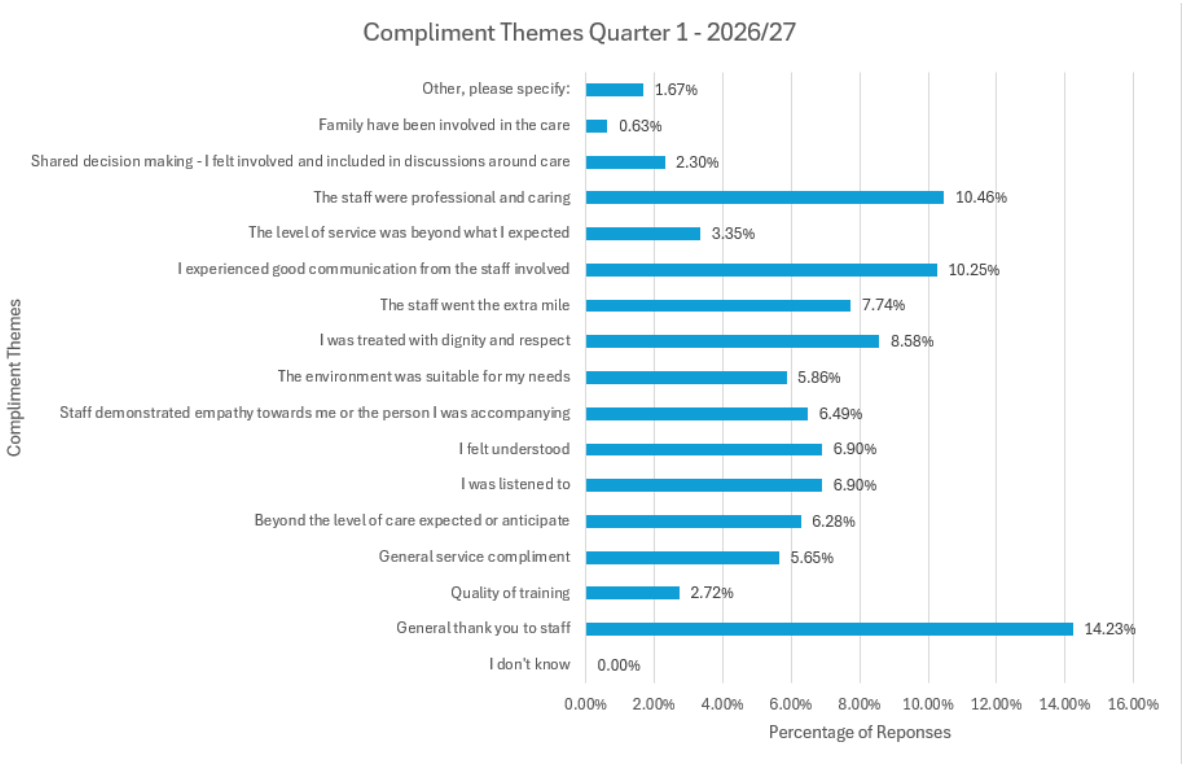
Type of Alert	Number received	Number requiring action (Covid 19)	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Pharmaceutical Alert	14	0	1	Class 2 Medicines Recall - Becton Dickinson UK Ltd, ChloraPrep 2 percent 1mL and ChloraPrep Frepp 2 percent 1.5mL applicators	03/06/2026	Shared with Screening.

Medical Device (Information)	2	0	0			
Medicine Shortages	7	0	0			
High Voltage Alert	3	0	0			
Public Health Alert	3	0	1	Heat Health Risk: Advice Note for Wales Health and Social Care System Partners	05/05/2026	Shared with Health Protection and Screening.
Totals	**29**	**0**	**2**			

7. Compliments and Service User Experience

This quarter, 105 compliments were recorded by staff within the Civica system and. 74 people visited the Public Health Wales website with the intention of leaving a compliment. Out of these, only 28 people selected a service provided by Public Health Wales and completed the required five information fields, leading to a total of 133 compliments received during the quarter

Thematic analysis of these compliments identified various themes for compliment sentiments. The 'Compliments Themes Quarter 1 – 2026/27' table below provides a breakdown of compliment themes received during quarter 1.



7.1. People's Experience Surveys

The following information focuses on the People's Experience survey and in particular, People's Experience measures included with the Quality Outcomes Framework.

The data for this reporting period focuses on Diabetic Eye Screening Wales and Abdominal Aortic Aneurysm Screening, which started using SMS to collect feedback on 1 April 2026. Work continues to facilitate the use of SMS within other Screening programmes and the People's Experience survey. It is anticipated this will be available for the next report.

Between 1 April – 30 June 2026, a total of 19213 individuals were sent an SMS message from the two services with a request for feedback. This led to 5476 people responding and equates to a response rate of 28.53%, a slight increase of 0.45% from quarter 4 2025/26.

The specific Indicators that demonstrate quality of service provision (1 April – 30 June 2026) were as follows:

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

98.57% of respondents selected 'Always and Usually'.

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

98.42% of respondents selected 'Always and Usually'.

- **How would you rate your overall experience**?

96.31% of respondents rated the service as 'Very good to Good'.

SMS (text message) feedback for Breast Test Wales Screening programme will go live on 31 August 2026.

Areas for improvement identified through feedback, which have informed our learning and development

Feedback received continues to identify recurring themes namely access and experience issues that affect people's ability to attend appointments confidently, safely and independently. Key areas include signage and wayfinding, waiting times and appointment processes (this may be due to the trial of drop-in clinics taking place this quarter), public transport access, physical accessibility and communication on arrival. These barriers can create avoidable anxiety and pose equality risks for certain groups with protected characteristics or needs.

Signage and wayfinding are the most frequent comment theme, and this has increased in June. To try mitigating this, DESW has provided all staff with additional signs which can be put up in clinic areas.

Parking and public transport continued to attract high levels of Poor and Very Poor ratings. To help address these issues, the programmes have started to include public transport timetables where appropriate.

Physical accessibility concerns, including wheelchair access, broken lifts and long routes, suggest that some environments being used are not consistently supporting accessibility standards. Although many of the venues used are not operated by Public Health Wales, there is one Public Health Wales venue (Kimberly House) which does receive a negative rating for accessibility regularly, due to the heavy manual front door.

Feedback data is now shared with programmes monthly, along with key specialist areas such as IPC, Estates Team, Welsh language and the Equality Team which inform improvement work and future planning or services.

8. Quality and Clinical Audit

A prioritised audit programme aligned to both local and national priorities is in place this year, 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 End of Q1
Clinical Audit Module – Registered on AMaT	21	33
Clinical Audit Module – Identified at start of year, still to be Registered on AMaT	23	23
Total audits on Audit Plan	**44**	**56**

At the start of the year, 44 internal audits were planned, and details are included below on the progress made this quarter:

Audit Update	Number	Rationale
Audit not started (delayed)	2	Competing demands within programmes
Audit not yet due to start	11	
Complete (ongoing action plan)	2	
Data collection commenced	1	
Data collection completed	1	
Report of findings (delayed)	1	Competing demands within programmes
Report of findings commenced	1	
Report of findings completed	2	
Still to be registered on AMaT	23	Full details still to be confirmed.

Since the plan was agreed, a further 12 audits have been added during Q1 and the details below:

Added to the Plan during Q1	Number	Rationale
Audit not started (delayed)	2	1 Competing demands within programme 1 Audit still to be agreed and finalised by programme
Audit not yet due to start	3	
Data collection commenced	4	

Data collection completed	2	
Report of findings (delayed)	1	Competing demands within programmes

9 audits were carried forward from the 2025/26 Plan to 2026/27; with an update provided below:

Audit Update	Number	Rationale
Complete (ongoing action plan)	5	
Conclusions/ Analysis Completed	1	
Report of findings (delayed)	1	Competing demands within programmes
Report of findings commenced	2	

Ward and Team Assurance Module Update is below:

Frequent audits that do not have a proposed date of completion are undertaken in the Ward and Team Assurance module. Audits in this module are usually conducted for assurance or regulatory purposes. Infection, prevention and control, health and safety and internal assurance audits are examples of projects in this module but have not been commented upon in this report as they are reported through alternative reporting routes. Quality control activity may be undertaken on AMaT in the Ward and Team Assurance module but are not included in the Quality and Clinical Audit Plan.

Project overview

Project	No. audits	Current compliance
Consent	2	A 89.4%
Nursing	2	G 98.5%
Professional Registration	2	B 100.0%
Screening Pathway Management	8	R 77.6%

The screening pathway management audit is currently showing 77.6% compliance; as this audit remains open for data collection until the end of March 2027. Currently only 2 areas of the 11 required have submitted data which is affecting the overall results at present.

8.1 Digital Audit Platform (AMAT)

Work continues to maximise the use of the AMAT system and all its modules.

9. Quality Oversight Group

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

9.1 Operational activity:

- Forward Plan for 2026/27 developed and approved by the Group June 26.
- Presentation and feedback on the People's Experience Framework/ Learning Group overview of Organisational Expectation Standards.
- Quality Impact Assessment development/ standing agenda.
- Overview of Alerts Management across PHW.

9.2 Health and Care Quality Standards:

- Shared Learning presentation for Duty of Candour incident by Infection Services following investigation.
- Post Peer Review Process review session.
- Trial of AMaT for Self-Assessment process to enable transition to process for self-assessments during 2027/28.

10. Safeguarding Group Report

This section summarises safeguarding related activity and performance along with key risks and improvement activity during Quarter 1, 2026-2027.

10.1 Safeguarding queries for advice and support, referrals and incidents

During Quarter 1, a total of **40** requests for safeguarding advice were received. This represents a reduction (22) when compared with the previous quarter. The decrease in activity is attributable to a reduction in requests from Sexual Health Wales for safeguarding advice, following the implementation of a Standard Operating Procedure (SOP). The SOP has provided greater clarity and consistency in decision-making for the service, resulting in fewer cases requiring specialist safeguarding input.

Of the 40 safeguarding advice and support requests, 27 (67.5%) related to service users, 12 (30%) related to employees, and 1 (2.5%) concerned a research project. The data indicates that most of the safeguarding activity continues to be focused on supporting concerns relating to service users, which is consistent with the organisation's public health functions.

Employee-related queries accounted for almost one-third of all advice requests, demonstrating the ongoing need for safeguarding consultation and support across the workforce.

As in previous quarters, Screening and Health Protection divisions services sought the most safeguarding advice in line with their public facing functions . The continued engagement of these divisions suggests a positive safeguarding culture, with staff appropriately recognising safeguarding concerns and seeking advice when required.

During the reporting period, **24** 'children at risk' concerns were raised. The majority related to safeguarding disclosures made by young people accessing Test and Post services within Sexual Health Wales. Child at risk concerns continued to account for the largest proportion of safeguarding activity, representing over half of all cases, predominantly arising from disclosures within Test and Post services. Of these, seven referrals were made to the relevant Local Authority Children's Services.

A further **6** professional concerns were recorded. Whilst this appears to represent a notable volume of activity, 3 of these concerns related to a single complex case, requiring ongoing safeguarding support over an extended period.

None of the professional concerns met the criteria for referral to a Local Authority under Section 5, as the employees concerned did not have contact with children or adults at risk within their professional roles. Safeguarding advice and risk assessments were provided to ensure appropriate management and organisational oversight.

The diversity of concerns managed, including mental health, domestic abuse, sexual harassment, criminal matters and DBS-related issues, demonstrates the broad remit of the PHW safeguarding team and the increasing complexity of issues presenting across Public Health Wales services. During this quarter an example of this includes the management of a case involving a reported breach of bail conditions**,** which was appropriately escalated and reported to the police. This highlights the need for effective multi-agency collaboration and timely information sharing to support risk management and the protection of vulnerable individuals.

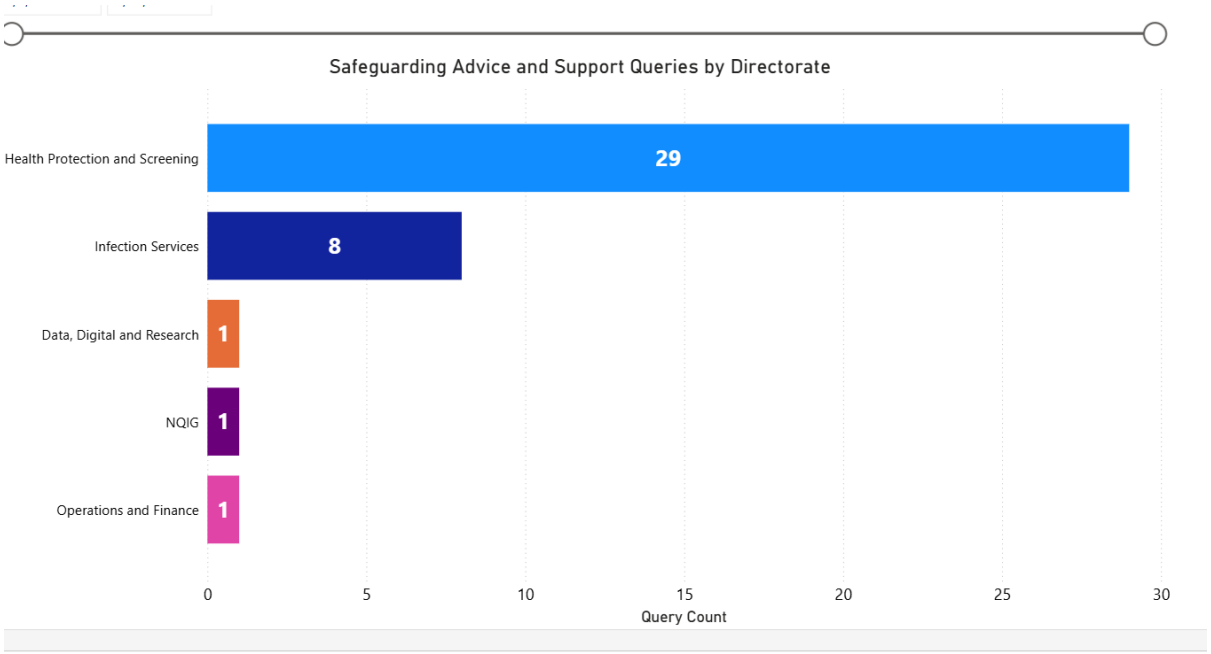


Chart 12.1 Cases reported by Directorate

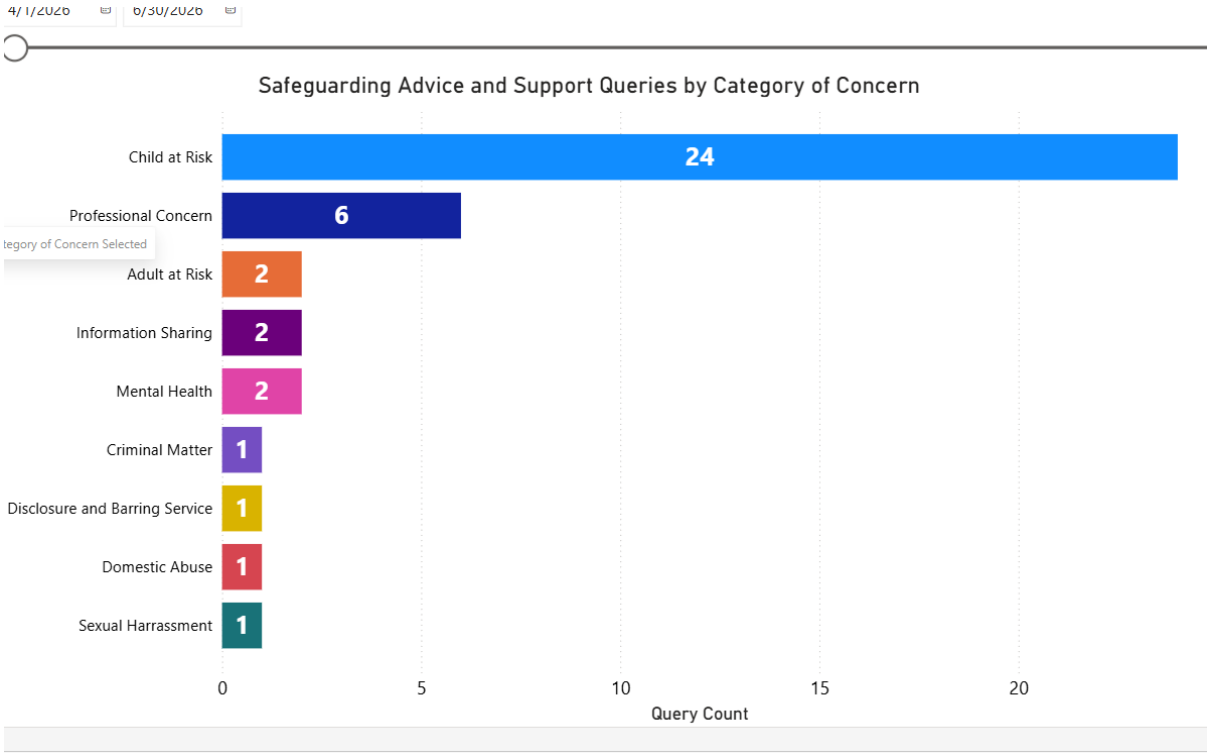


Chart 12.2 Safeguarding Queries by Category

10.2 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.

Compliance with all safeguarding and VAWDASV e-learning modules has increased this quarter, providing assurance that staff are maintaining the knowledge and skills required to fulfil their safeguarding responsibilities effectively, as shown in the table below, compliance rates have increased across all mandatory safeguarding and VAWDASV learning modules.

Competence Name	Q4	Required	Achieved	Q1	Trend
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	91.36%	2162	2005	92.74%	↑
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	87.88%	469	421	89.77%	↑
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	91.45%	2162	1998	92.41%	↑
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	86.55%	469	421	89.77%	↑
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	88.85%	2162	1951	90.24%	↑

Table 12.3 eLearning Safeguarding Training Compliance

Level 3 Safeguarding Training compliance has increased from 64.0% to 82.3%. The introduction of a training poster and clearer guidance on role-specific safeguarding training requirements has improved staff and manager awareness of this requirement leading to the identification of staff and removal of those where this level was not appropriate.

The table below highlights the areas where compliance remains below the organisational target and continues to require focused attention and targeted action to improve completion rates.
It is important to note that recent revisions to this role specific competency requirement for health protection division and other teams in PHW has affected overall compliance rates with more staff being assigned this than previously allocated.

Competence /Training	Compliance Quarter 1	Number of staff assigned	Number of staff achieved
028|LOCAL|Safeguarding Level 3 - 3 Years	82.3%	113	93
028|LOCAL|Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years|	64.27%	459	295
NHS|MAND| Mental Capacity Act Level 2– 3 Years	84.73%	262	222

Table 12.4 Taught Safeguarding Training compliance

10.3. Key Safeguarding Risks & Issues

There have been no changes to safeguarding risks during Quarter 1. 3 safeguarding-related risks remain on the risk register and continue to be actively managed through established governance arrangements.

2 divisional safeguarding risks within the Communications Division relate to the potential harm to individuals sharing personal case studies through media and digital channels, including the risk of psychological distress, online abuse, stigma, and impacts on staff wellbeing when supporting traumatised individuals. In addition, a corporate People and Organisational Development (POD) risk remains in relation to compliance with the Worker Protection Act and the duty to take reasonable steps to prevent sexual harassment.

Overall, key controls remain in place and are operating effectively, with ongoing monitoring and mitigating actions providing assurance that these risks are being appropriately managed.

10.4 Safeguarding improvement activity

- Public Health Wales submitted evidence to Healthcare Inspectorate Wales (HIW) as part of the Focused National Review of Child Safeguarding. The key

lines of enquiry related to organisational assurance, workforce competence and safeguarding culture, multi-agency decision-making, learning and improvement, and leadership and oversight of risk.

- A follow-up review meeting is scheduled with HIW for 19 August 2026.

11. Infection Prevention and Control (IPC) Update

This section outlines the IPC incidents, risks, training compliance, and audit activity which occurred during Quarter 1.

11.1 IPC-related incidents

During this quarter, there were 15 IPC incidents reported, 6 less than during Quarter 4 2025-26. All incidents were recorded as either low or no harm. In addition, there were 3 incidents reported to facilities relating to standards of cleanliness.

Category	Number of Incidents	Division where it occurred	Risk Level	Approval Status
Contact with needles or medical sharps	1	BTW	Low	Closed
Contact with or exposure to hazardous substance	10	10 Infection Services	2x Low 8x None	1 Under Investigation1 Awaiting Closure 8 Closed
Healthcare associated infection – actual	1	BTW	None	Closed
Infection Diagnosis - Delay in diagnosis of infection	1	Infection Services	None	Closed
Test results / reports (infection)	1	Infection Services	None	Closed
Treatment or procedure issues	1	BTW	Low	Closed

2 of the above incidents related to patients who had undergone breast biopsy and had subsequently sought advice from their GP for suspected infections. Following investigation, it was concluded that there was no infection was present.

Of the 10 exposure incidents reported by infection services, 5 were related to failure to follow procedures or human error, 3 were due to incomplete clinical information provided by the requester, 2 were due to leaking samples and 1 was an incorrectly packaged sample. Health and Safety managers within the laboratory

are working with behavioural sciences colleagues to identify the reasons behind the human errors.

11.2. IPC Mandatory Training Compliance

The table below shows that although there has been an increase in mandatory training compliance during Quarter 1, IPC Level 2 training remains below the Welsh Government target of 85%.

Organisational Compliance		Trend
IPC Level 1	89.92%	↑
IPC Level 2	77.07%	↑

The following table identifies the Directorates/Divisions which fall below the Welsh Government target of 85%.

Subject	Directorate / Division	Q4 2025-26 Compliance %	Required	Achieved	Q1 2026-27 Compliance %	Trend
IPC Level 1	028 L3 Corporate Directorate	74.07%	25	17	68%	↓
IPC Level 2	028 L4 Health Protection Division	60%	58	40	68.97%	↑
	028 L4 Screening Division	87.50%	256	215	83.98%	↓
	028 L4 Infection Division	45.56%	95	60	63.17%	↑

Compliance with mandatory training was discussed at length in the IPC Group meeting on 20th July and divisional representatives were asked to have targeted conversations with individuals who are non-compliant. It was also agreed that the behavioural sciences team would be asked to support the wording of an email for staff to promote completion of e-learning.

11.2.1. ANTT and Decontamination Competency (Breast Test Wales Only)

The table below summarises current compliance with Aseptic Non-Touch Technique (ANTT) e-learning and competence assessment for selected staff within Breast Test Wales. The table shows a slight increase in compliance with competency assessment however, this attributed to the staff denominator changing and not increased

activity. Achieving compliance with this competency was discussed at the IPC Group and Screening IPC group with the IPC Lead for screening to progress with BTW regional managers and the updating of ESR.

The decontamination competency has been added to the ESR records of those staff within BTW who operate the Ultrasound Ultraviolet decontamination cabinets. All staff received training from the company representatives when the system was introduced and many of those are now out of training compliance and require an update. Trainers are in place in all centres and have been asked to focus on this to improve compliance.

	Q4 2025-26 Compliance	Q1 2026-27 Compliance	Trend
ANTT e-learning	**95.19%**	**94.23%**	↓
ANTT Assessment	**66.67%**	**67.68%**	↑
Decontamination Competency	**50%**	**68.42%**	↑

11.3. IPC Risk Register

There are 6 IPC risks documented at the end of Quarter 1.

Risk 1510 is a Corporate IPC risk with a Score of 4. This risk entry articulates that the organisation will not be able to evidence effective cleaning measures in the event of a claim. Whilst a cleaning schedule has been created for the organisation, it is not possible to implement this until the cleaning contract procurement exercise has concluded during Quarter 3. In the interim, the organisation receives assurance by way of audits undertaken by the cleaning contractor, IPC Nurse and Screening staff.

3 programme level risks relate to Bowel Screening Wales commissioned services at Bronglais hospital (**2249**), University Hospital of Wales (**2250**) and Ysbyty Glan Clwyd (**1587**).

Each of these venues has longstanding issues with infrastructure which could result in decontamination incidents or disruption to Bowel Screening lists should equipment fail. Bronglais Hospital is nearing the end of a refurbishment and centralised decontamination area project which is expected to be commissioned in the coming months and will mitigate the risk. University Hospital of Wales is being used as a short-term solution to reduce waiting times and is only used for a small number of patients. Ysbyty Glan Clwyd is a unit with significant infrastructure, equipment and staffing challenges. Senior staff from Bowel Screening hold regular meetings and discussions with the Health Board, and has some agreed mitigations in place, such as the use of an adjacent decontamination area in another department

to reduce throughput in the endoscopy decontamination area. The Health Board have also agreed to increase the frequency of IPC and Decontamination audits and share these reports and associated action plans with PHW. PHW Executive Director of Nursing has asked to meet with BCUHB executive regarding a formal plan for improvement in August.

Risk 1848 is a programme risk for HARP due to a 0.6 WTE vacancy for an IPC Nurse which cannot be advertised due to financial constraints. This vacancy may affect the ability of the programme to fully deliver the workplan objectives.

Risk 1562 relates to an aging autoclave in Infection Services which could affect the ability of the service to dispose of waste. Although funding to replace the equipment has now been secured, it remains unclear how the ongoing servicing and maintenance of this equipment will be funded.

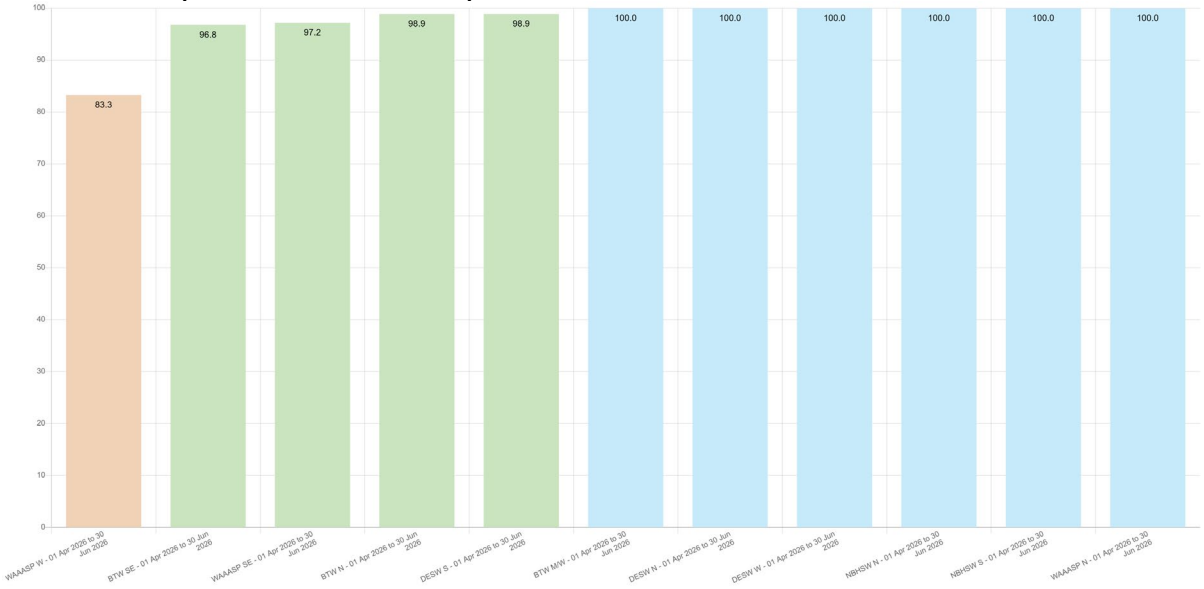
11.4. IPC Audit Activity

2 IPC Nurse assurance audits were undertaken during Quarter 1 in Kimberley House and Rhos House, scoring 88.4% and 91.5% respectively. Both scores are an improvement on the previous scores, though there are still some concerns regarding cleaning in Kimberley House which facilities and the centre manager are monitoring.

IPC Environmental audits are routinely scheduled in Quarter 2 and Quarter 4. One ad-hoc environmental audit was undertaken in Pondardawe Health Centre (DESW) and this resulted in a score of 91.3%.

Screening programmes continue to undertake audits of IPC Practice using the AMaT system and demonstrate good compliance. WAAASP West region was the lowest scoring area, and this was due to staff not cleaning the cable of the ultrasound probe between patients and remedial action taken to address

shortfalls in practice and it is expected that this will not be an issue in future.



Graph 1: IPC Practice audits

A traceability audit for semi-critical ultrasound probes utilised by BTW has been built within AMaT and was piloted during Quarter 1. This audit will be implemented in the BTW centres during Quarter 2 to comply with the recommendations of WHTM 01-06 Part F.

11.5. IPC Policies and Procedures

The IPC Policy was approved at QSIC on 2nd June and has now been translated and uploaded to the PHW Policy library. It is anticipated that a further review of this policy will be required when the HCAI Code of Practice is published by Welsh Government.
During Quarter 1, an IPC Leads Strategic Group was established, chaired by the Head of Nursing, IPC in HARP. Representatives from this group are working to develop an All-Wales IPC Assurance Framework which can be used to evidence compliance with the Code when published.

Improvement Activity

In May 2026, the Principal Decontamination Engineer (NHSWSSP SES), Bowel Screening Lead Nurse and Lead IPC Nurse undertook a joint audit visit to the Endoscopy unit at Ysbyty Glan Clwyd. The full written report will be produced by the Principal Decontamination Engineer however, key findings have already been shared with BSW and a briefing paper prepared for submission to the Business

Executive Team. Regular discussions to mitigate and monitor the findings remain in place with Betis Cadwalader Health Board.

It is important to BET and Committee to note that NHS Wales utilises the Scottish National Infection Prevention and Control Manual as it's IPC Procedure document. On 3rd August 2026 there will be a significant change to the **Transmission-Based Precautions (TBPs)** section of the manual. Key changes include, the terms Contact, Droplet and Airborne transmission will be replaced by the terms Contact and Air transmission, with the addition of respiratory pathogens being categorised as R1, R2 and R3. These changes consider multiple factors which affect transmission and ensure that IPC Practice remains evidence based.

The IPC Consultant Nurse within the HARP team has worked closely with counterparts in Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland and has shared resources to support the implementation of the amended guidance with IPC Leads throughout Wales.

12. 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

13. Recommendation

The Committee is asked to:

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