GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 25th November 2025 **Agenda item:** *3.4*

Quality Governance Performance Report Quarter 2 (1st July 2025 – 30st September 2025)	
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 • 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:	Angela Cook, Assistant Director of Quality and Nursing Business Executive Team 05.11.25

Purpose

The Quality Governance Report provides the Quality Safety & Improvement (QSIC) with an overview of quality governance within Public Health Wales for the Quarter 2 period (1st July 2025 to 30th September 2025).

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

This report will also cover formal quarterly reporting for IPC, 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.

Executive Summary

The Quality Governance report is a quarterly report provided to the Quality Safety & Improvement Committee to review and take assurance on clinical quality and safety through the provision of data and summary highlights from Public Health Wales's 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 Rights -Incidents (Page 8)

- 502 incidents were reported and investigated during Quarter 2, with remedial actions identified. Of these, 5 were initially reported as moderate harm or above.
- As of 13 October 2025, there are 48 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (Page 32)

15 queries for Safeguarding advice and support were requested this quarter.
2 of these requests led to referrals being made to the local authority, meeting statutory safeguarding responsibilities.

Infection Prevention & Control (Page 36)

- 19 IP&C incidents were reported during Quarter 2 which is equal to the previous reporting quarter. 1 incident was reported as moderate harm and this related to an inoculation injury in a member of infection services staff.
- 1 new risk was added to the risk register in Quarter 2 and related to a lack of assurance for the management of water safety on the Breast Test Wales mobile units.
- IPC Level 2 and Aseptic Non-Touch Technique (ANTT) compliance reporting continues to be of questionable accuracy and Divisions are being supported to ensure that individuals have the correct competencies mapped to their roles in ESR to ensure optimal compliance reporting.

- IPC audits are now being recorded using the AMaT system following it's launch in June 2025. Issues identified during auditing include the standard of cleaning in Kimberly House, the condition of the building at St David's Park, and bare below the elbow and hand hygiene compliance.
- An Incident Management Team has been convened to support improvements in the management of water safety on the Breast Test mobile screening units and provide assurance that the organisation is meeting its statutory obligations in relation to the control of Legionella bacteria.

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 16)

- 20 Early Resolution complaints were received in Quarter 2, and 10 formal complaints.
- 85% of the early resolution complaints were resolved within 2 working days target.
- 100% of the 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 29)

- The Quality and Clinical Audit Team have met with Directorates and Divisions to evaluate progress against the 2025-26 Quality and Clinical Audit Plan for Quarter 2 (Q2).
- During Q2 meetings further audits were identified bringing the total to 68 audits to be undertaken this year.
- No requests have been received to remove audits from the plan this quarter.
- 3 requests were made to amend dates.

Safety Alerts Management (Page 23)

- A total of **42** alerts were received by Public Health Wales during the reporting period 1 July – 30 September 2025, **2** of which required action to be taken and a further **6** alerts were shared for information only.

The alerts shared for action related to updated guidance for the Respiratory Syncytial Virus (RSV) vaccination programme and the other regarding the availability of antimicrobial medication for treating tuberculosis.

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 26)

- A total of 96 compliments were recorded by staff within the Civica system.
- 22 compliments were left directly by members of the pubic using the 'Your Feedback' webpage available on the Public Health Wales website.

The Committee is asked to take **assurance** on the actions being taken in relation to Quality and Patient Safety.

1. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 2 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.

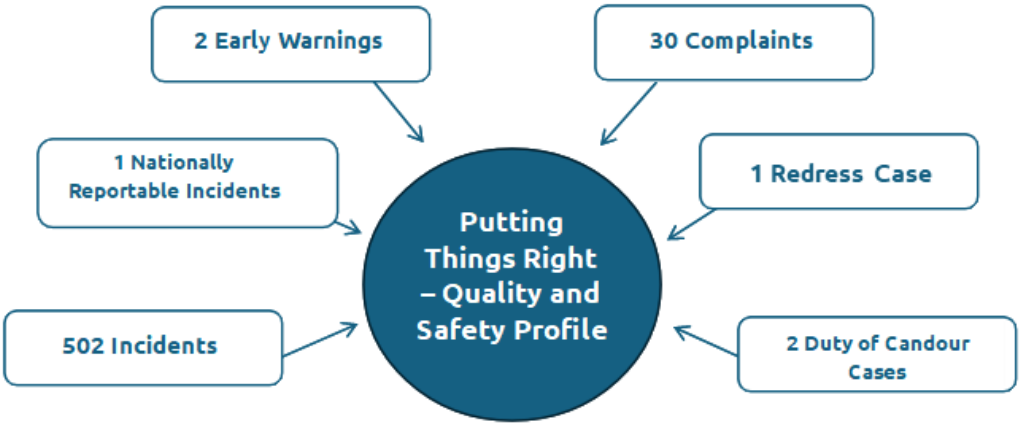
Effective: People who use our services have access to screening, specialist advice, treatment and support that provides the best outcome for them.

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.

P2.1 Putting Things Right Quarter 2 Overview



During Quarter 2 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.

2.2 Incident Management

Incidents	National Reportable Incidents	Early Warnings	Duty of Candour
↓ 502 (536)	↑ 1 (0)	↑ 2 (0)	↑ 2(0)

( ) denotes previous quarter data

Incidents

During Quarter 2, 502 incidents were reported. This is a slight decrease of 34 incidents compared to the 536 reported in Quarter 1 2025/26.

The below table indicates incidents that have been investigated and closed with any 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**

The **2** Moderate harm post investigations relate to RIDDOR reportable incidents in Infection Services.

1 related to processing Salmonella sample in a Category 2 cabinet and not a category 3 cabinet.

Identified Learning

1. **Strengthen Blood Culture Pathway Documentation**
2. **Salmonella Handling Protocol:** Reinforce the correct procedure and processing equipment
3. **Typhoid Booster Vaccinations:** promotion and uptake
4. **Strengthening Training & competency assessment** for key procedures
5. **Revision of key processes:** to strengthen Quality assurance and sample processing
6. **Dissemination of learning:** Share key learning outcomes beyond PHW Microbiology via the All Wales Health & Safety meeting**.**

1 related to contact with needles/medical sharps

Identified Learning

1. **Handling High-Risk Blood Cultures: the** correct use of a vented using a transfer device**.**
2. **CL3 Training and Competency Assessment:** Ergonomic guidance will be formally integrated into CL3 training and competency assessments to ensure safe and sustainable working practices in high-containment environments.

Early Warning and National Reportable Incidents

There have been **2** Early Warning (EW) notices sent to Welsh Government in Quarter 2 and **1** National Reportable Incident (NRI) sent to NHS Performance and Improvement. Both the EW and NRI related to issues identified within the Tarian digital system in Health Protection Division.

Issue 1- Health Protection Team (HPT) identified that a small number of cases had not been appropriately followed up on the IT system (Tarian). On investigation, it appears that Tarian was not opening cases as expected on receipt of a clinical sample result which meant that they were not passed to the Heath protection team (HPT) clinicians for appropriate action.

Issue 2- Health Protection Team discovered a previously unknown case list on the Tarian IT system titled "Out of Wales", which contains all cases with non-Welsh addresses.

Current HPT staff were unaware of this list, meaning such cases were not routinely followed up unless highlighted by infection services or a medical practitioner.

Incident Management Teams

There are currently **3** Incident management Teams (IMT) ongoing:

Breast Test Wales:

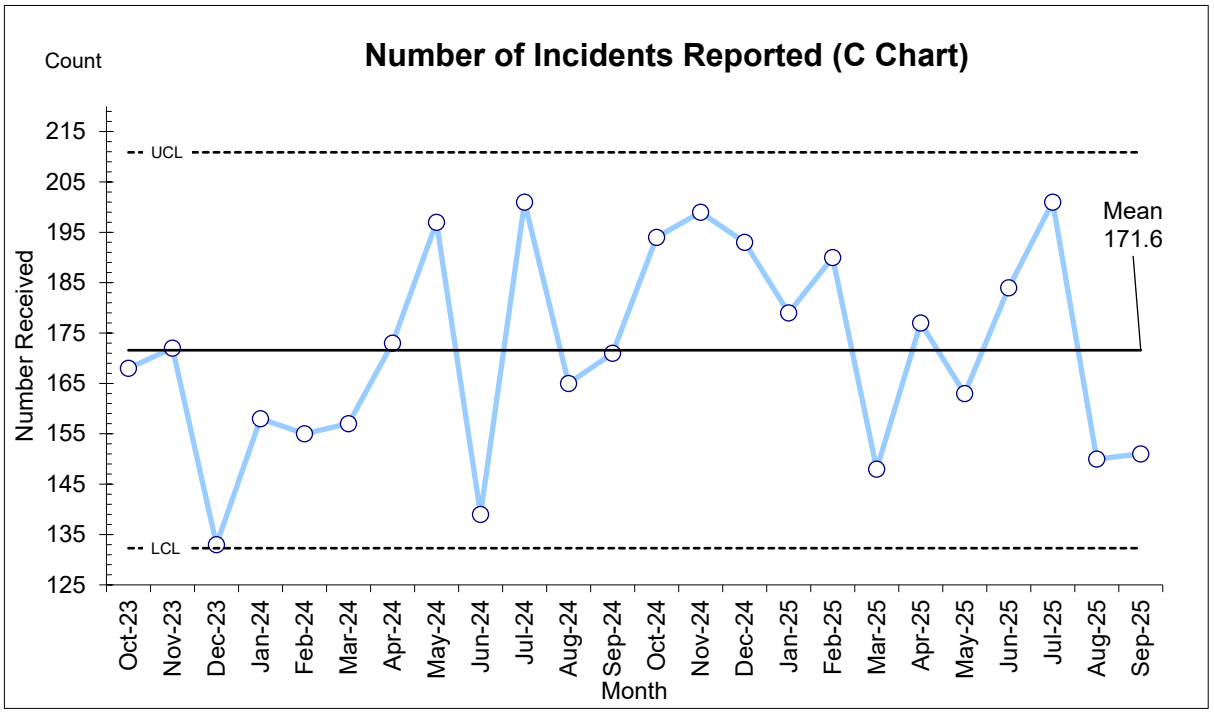
- Gateway review of BTW mobile units
- Water safety on BTW mobile units

Health Protection:

- Issues 1&2 of Tarian IT system

Open Incidents

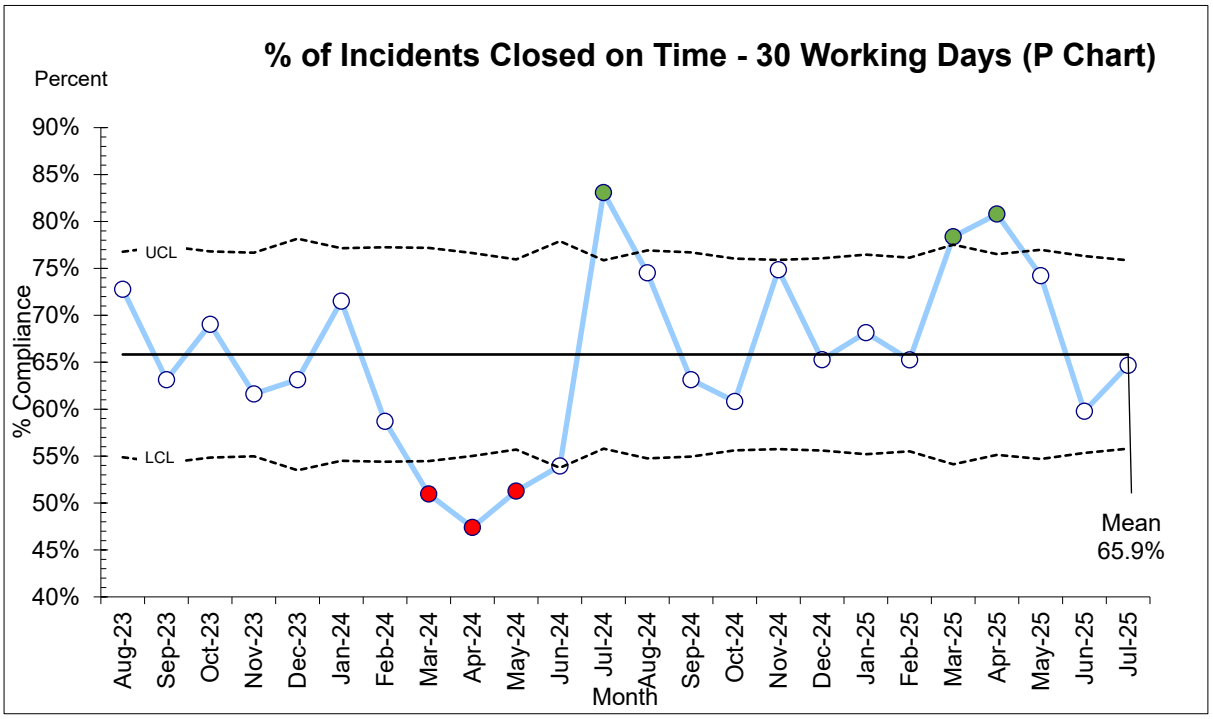
The below graph demonstrates the number of incidents reported between Quarter 1 2025/26 and Quarter 2 2025/26. The mean number of incidents has marginally decreased by 4 compared to Quarter 1, from 175 incidents to 171 incidents.



It should be noted that Infection Services are the highest reporting area for Quarter 2 increasing its reporting compared to Q1 data.

Cervical Screening Wales (CSW) reporting has decreased from 177 in Q1 to 151 in Q2. The decrease has been seen in the category of Screening and Surveillance - a drop of 22%.

The graph below highlights that the overall performance during this quarter set against a 30-working day closure rate target and indicates a decline in performance compared to the previous quarter.
62% of incidents were closed within 30 working days this is a decrease since Quarter 1 and below the PHW target of 85%. Work continues weekly with the support of the Office of the Medical Director and Nursing, Quality and Integrated Governance senior team to improve incident closure rates, and a weekly Safety Huddle has been established.



Incident Classification

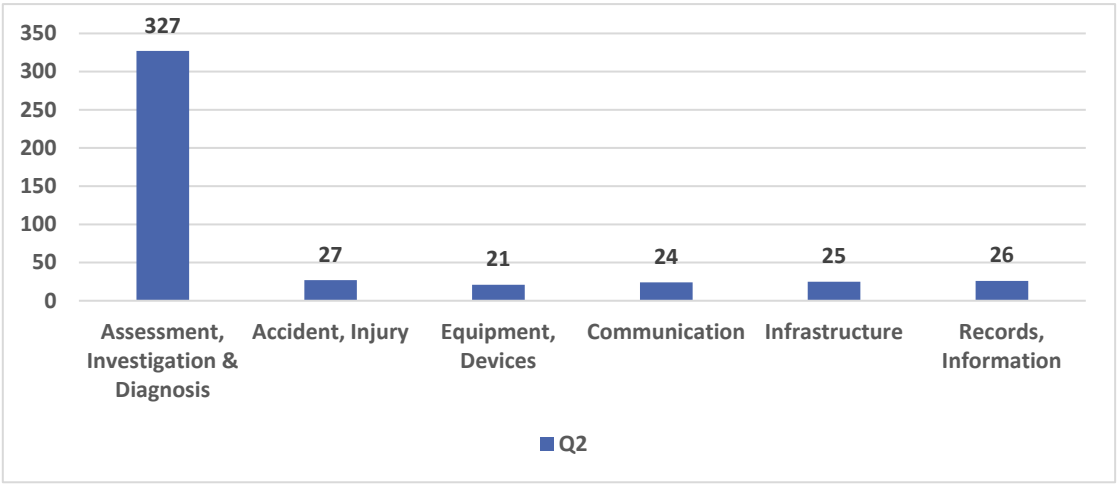


Chart 5. Top 6 incident classifications

Assessment, Investigation and Diagnosis remains the highest reported incident classification with figures comparable to those of Quarter 1.

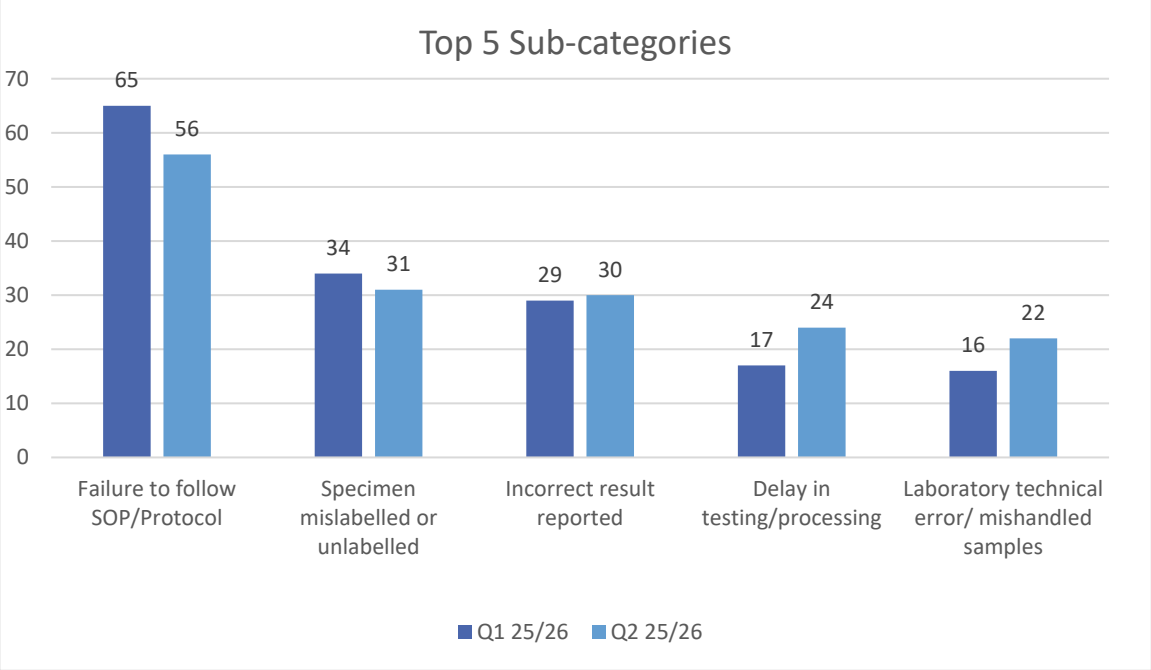
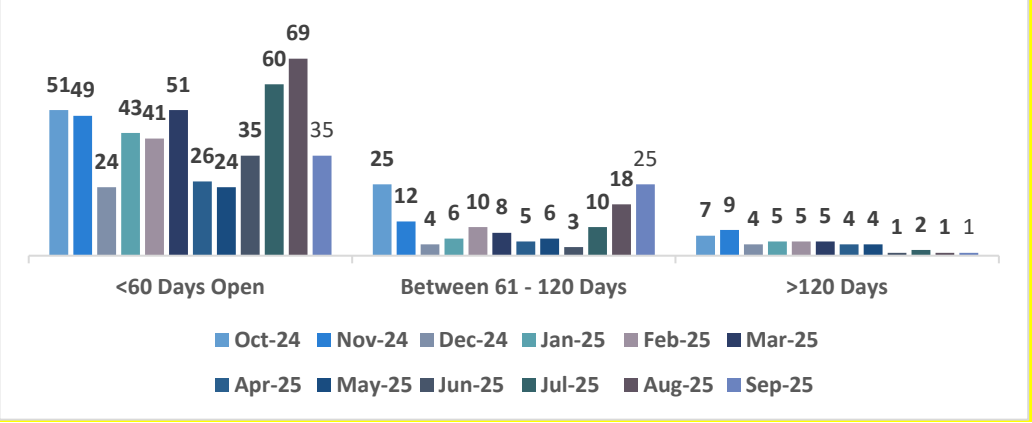


Chart 6. Top 5 sub-categories

Overdue Incidents



As of 13 October 2025, there are **213** open incidents, **48 of these have** an overdue status. The largest numbers of overdue incidents are within, Diabetic Eye Screening Wales **(20),** Infection Services **(16)** and Breast Test Wales **(9).**

There has been an increase in the number of overdue incidents in Quarter 2 compared to Quarter 1 with an increase of 9 overdue incidents.

Weekly overdue incident reports are produced by the PTR team and shared with service areas. This report details incidents that have been open for more than 30 working days along with incidents that have an open status at 20-29 working days.

This incident data is then shared with the service's designated operational and clinical leads to review and assist with the ongoing management. Progress updates are requested weekly, and support offered where barriers to achieving closure are identified. In addition, this is supplemented with monthly meetings with service areas to support incident management and closure.

Any complex overdue incidents identified are escalated to Nursing Quality and Integrated Governance (NQIG) senior managers and the office of the Medical Director for targeted support to enable closure where barriers have been identified.

Incident Reporting and Management Training

During Quarter 2, Datix level 1 incident reporting training has been delivered to 39 members of staff equating to 47% of Public Health Wales having now completed this training.
This is a 1% increase on the previous Quarter. It should be noted that Datix training is not mandatory for PHW staff however all staff are encouraged to attend with new starters being specifically targeted as part of onboarding procedures.
Monthly training sessions are available to all staff throughout the organisation along with bespoke sessions with individual teams and divisions arranged as required.

The ongoing promotion to increase uptake remains a priority. The PTR Team attend the quarterly PHW New Starter Networking Event to promote this training to all new starters. The current Level 1 training figures are a standing agenda item at the Putting Things Right Superuser Network, where all superusers are asked to review the training figures for their specific areas and to identify any staff who have not yet attended and enrolment advocated. The PTR Team have also worked with the Communications team to ensure that all Level 1 training sessions are visible on the Staff Intranet Events section.

Level 2 Investigation Training Update

Staff requiring investigation training for complaints and incidents are identified through their respective service areas, based on their

designated roles as either **owners** or **handlers** of complaints/incidents. Access permissions are defined as follows:

- **Handler**: Receives email notifications for new records within their service area.
- **Owner**: Does not receive email notifications for new records.

A review is currently underway to refine the list of staff requiring investigator access, ensuring that only those actively undertaking investigations are included in the training cohort.

Training Progress

Level 2 Incident Training

- Total staff identified for training: **432**
- Staff trained to date: **211**
- Training completion rate: **49%**

Level 2 Complaint Training

- Total staff identified for training: **403**
- Staff trained to date: **89**
- Training completion rate: **22%**

Activity continues to increase training coverage and ensure that all relevant staff are appropriately equipped to carry out investigations in line with organisational standards

2.4 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.

1 new redress case was received in Quarter 2 in Breast Test Wales.

There are **8** ongoing redress cases, **4** in Breast Test Wales and **4** in Cervical Screening Wales.

2.5 Complaints Management

Early Resolution Complaints (n)	Formal Complaints (n)	Ombudsman Complaints (n)
↓ 20 (25)	↑ 10 (9)	⇆ 0 (0)

( ) denotes previous quarter data

Early Resolution Complaints (Informal)

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

20 Early Resolution complaints were received during Quarter 2. This is a slight decrease of 5 compared to the previous Quarter. 85% (17) of these complaints were resolved within the designated Putting Things Right target of 2 working days. 15% (3) were resolved outside of the target, but all within 10 working days.

Delays to achieving the 2 working day compliance rates:

- Staff were unable to contact the complainant during the required timeframes
- Consent was not received in the required timeframe
- Investigator required further information prior to contacting the complainant to proceed.

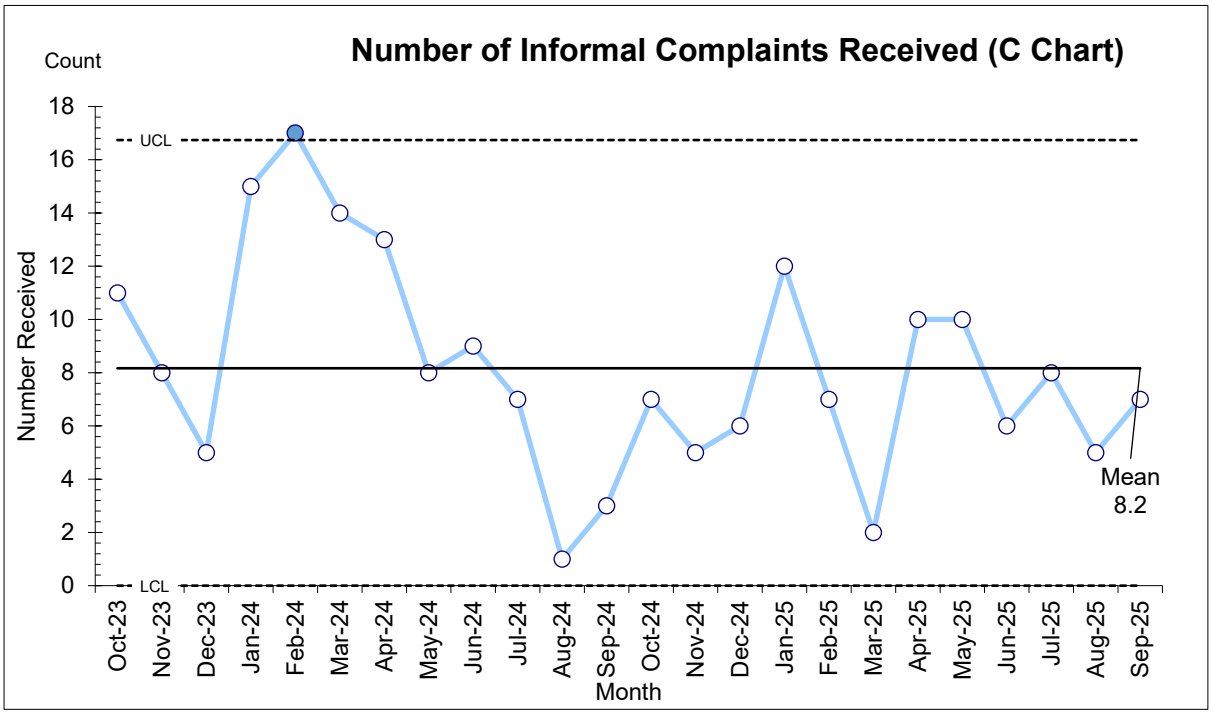
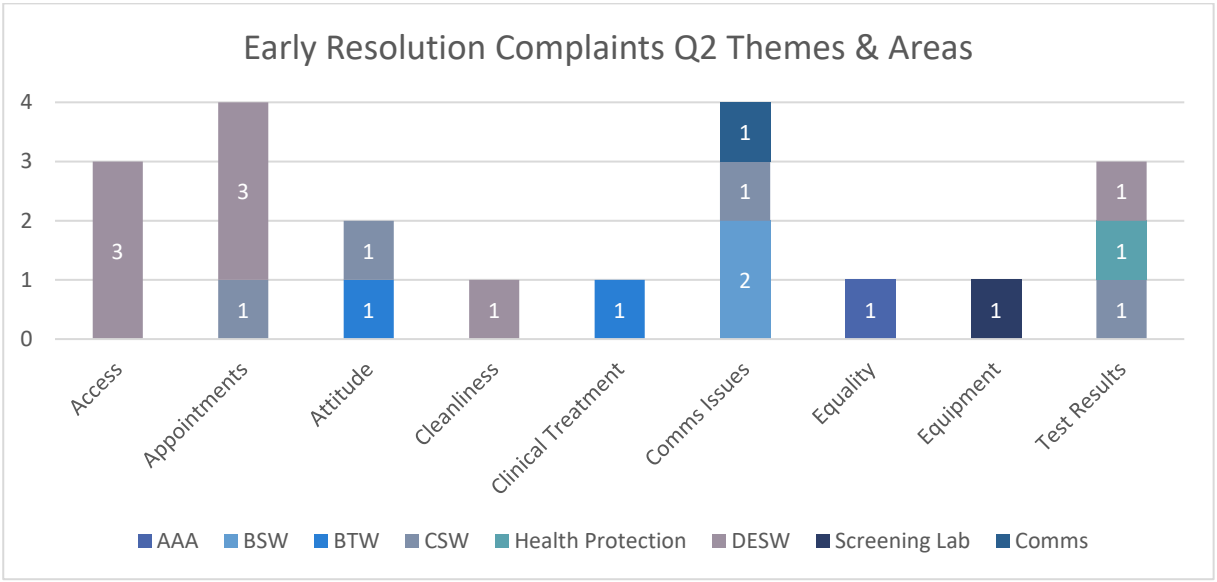
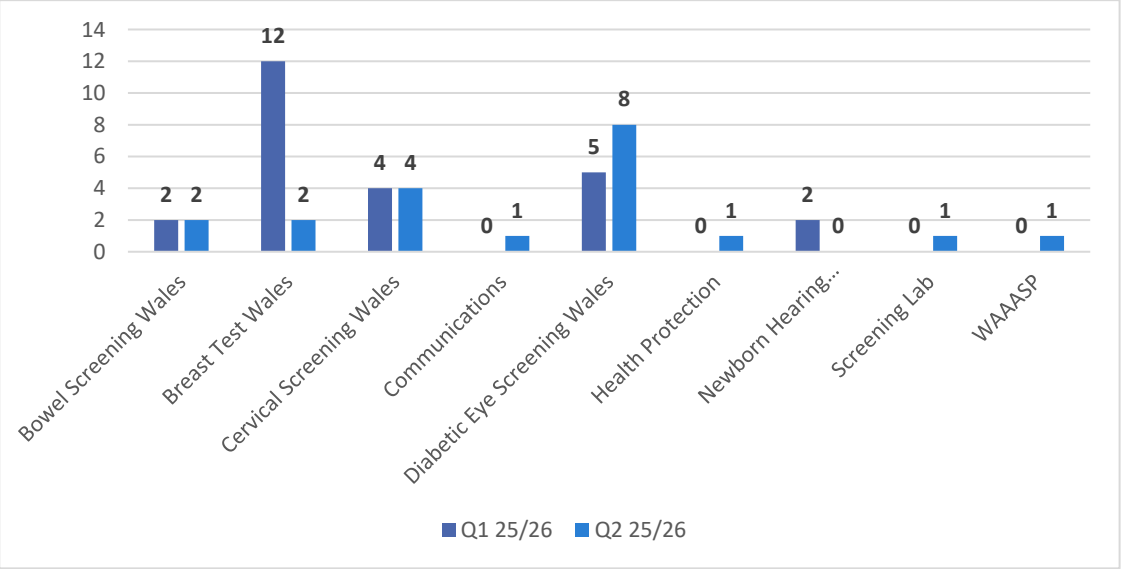


Chart 7. Informal complaints received per Month



The below chart details the service areas where Early Resolution complaints have been received during each Quarter and provides the previous quarters data for comparison.



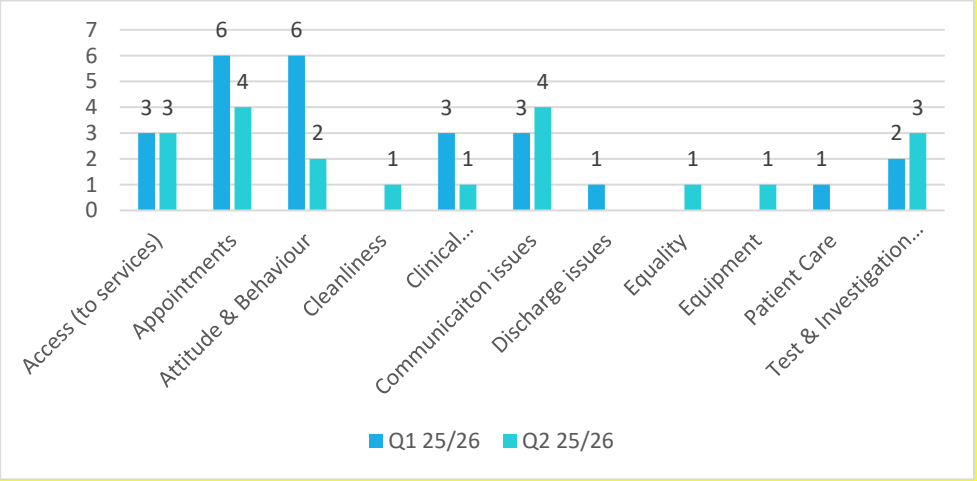
Breast Test Wales have seen a slight reduction in Early Resolution complaints 10 this Quarter compared to 12 received in the previous Quarter.

Diabetic Eye Screening Wales have received 8 Early Resolution complaints this Quarter, an increase of 3 on the previous Quarter.

'Access to Services' is the highest reported Early Resolution complaint category for Diabetic Eye Screening in Quarter 2. These complaints include issues with the journey time to clinics, accessibility issues within a clinic and one participant not being informed of a clinic cancellation and attending for their appointment.

A review is underway with DESW to gain a further understanding of the identified themes and how work can be done to address these. Appointment accessibility will is an area being focused on and data is currently being collected for this.

Further analysis of the recorded reasons/subject for the Early Resolution complaints reveals the following:



Formal Complaints

During Quarter 2, 10 formal complaints were received, an increase of 1 compared to the 9 reported in the previous Quarter. The average is 3 formal complaints per month.

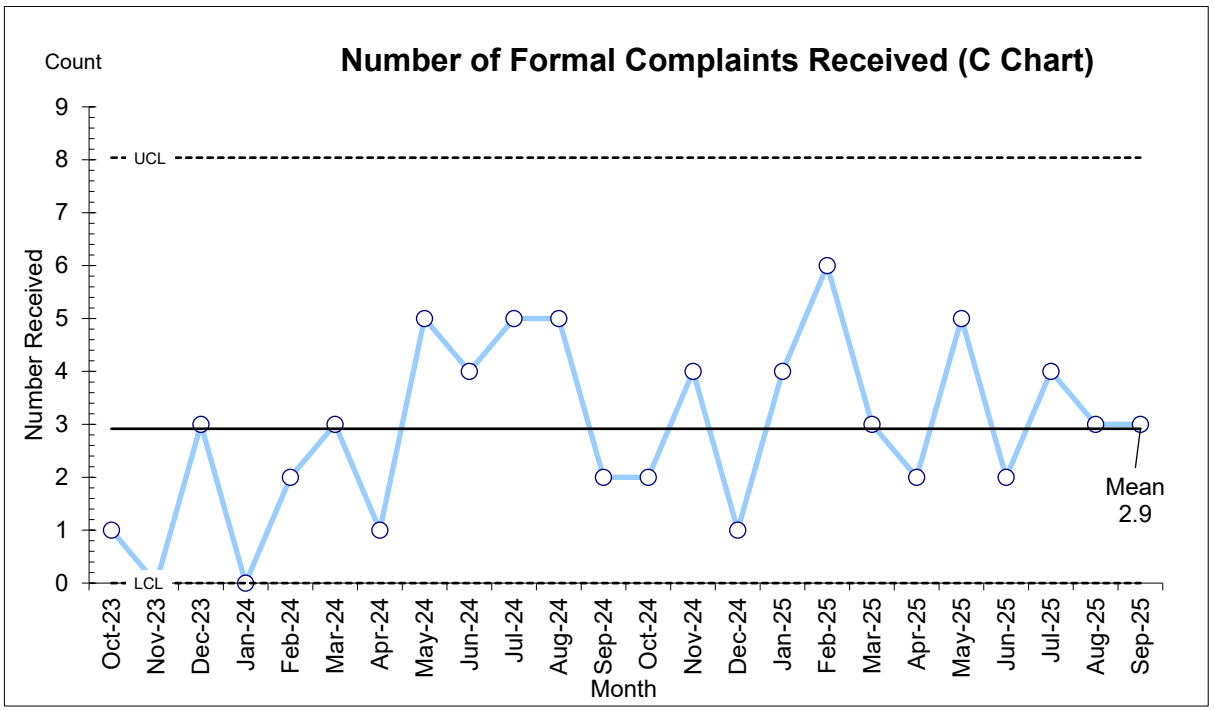
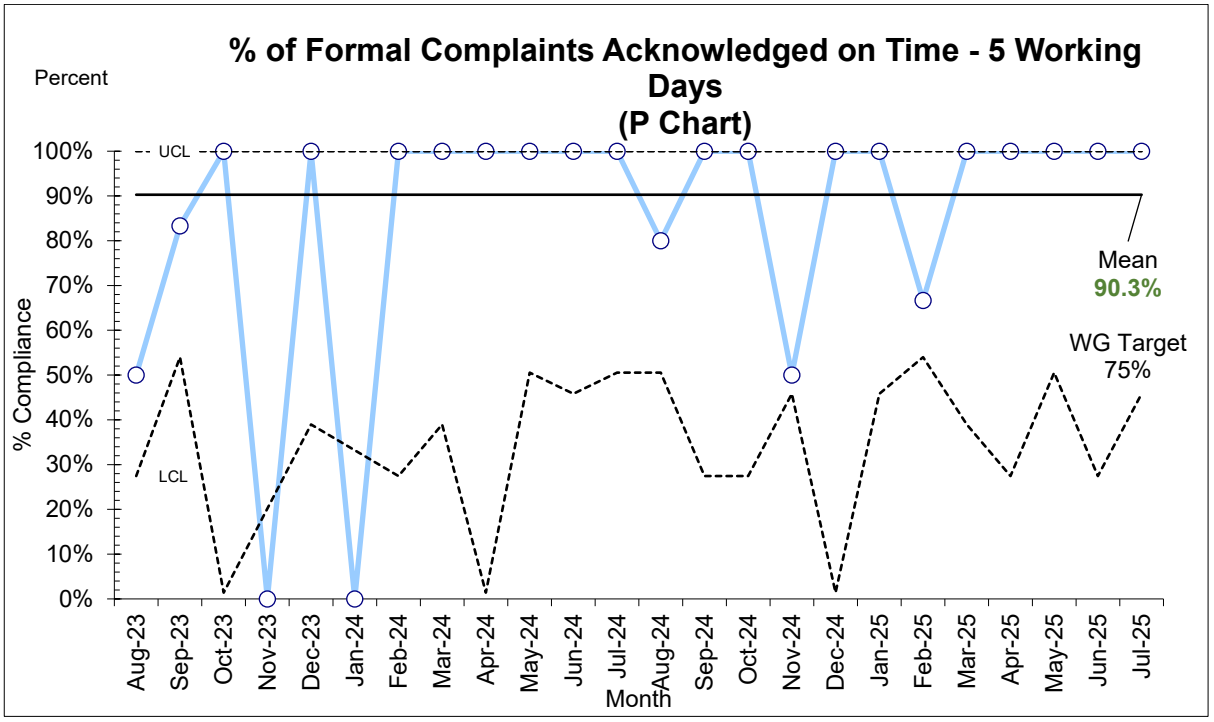
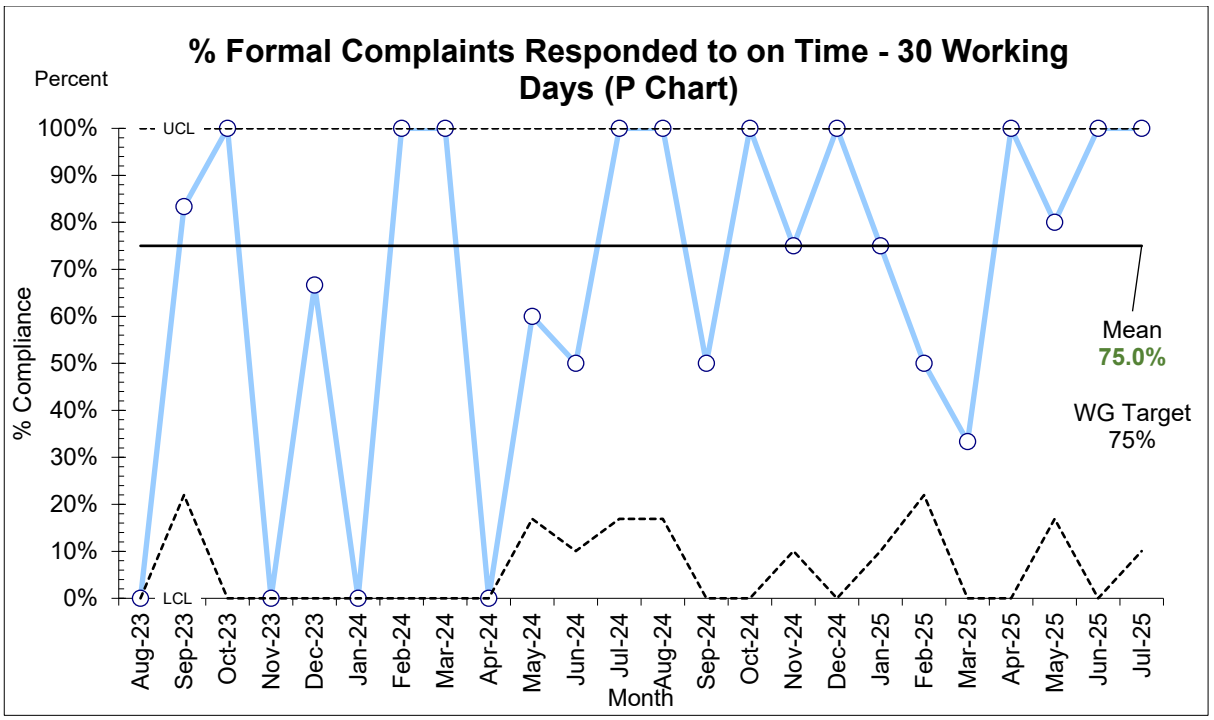


Chart 9. Formal complaints received per month

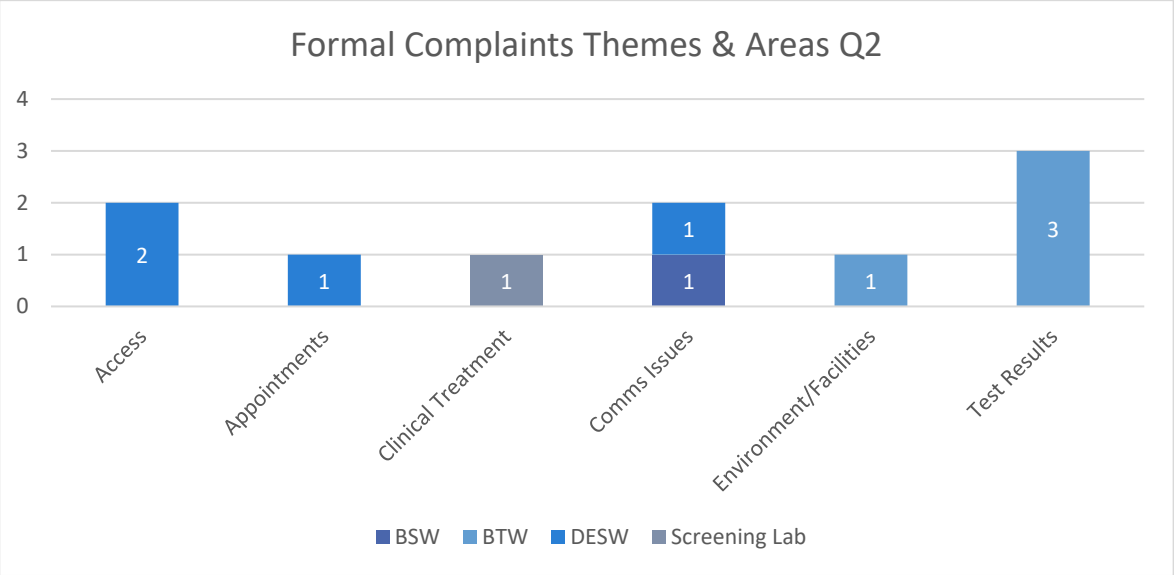
The below charts demonstrate overall performance in acknowledging and responding to formal complaints against a Welsh Government (WG) target of 75%. PHW is performing above the WG target with a mean of 90% in

acknowledging complaints and mean of 75% in responding within 30 working days against the 75% target.





The complaints received in September 2025 are not yet due for their final response and are currently progressing through the investigation and quality assurance processes.



Learning from complaints

Welsh Language Errors on PHW Social Media post

Following a complaint relating to the Welsh Language translation of a Public Health Wales (PHW) social media post, the Welsh Language Team are working closely with the Communications Team to improve translation procedures and to ensure that the robust internal translation processes is followed for all future translations, including social media posts.

The Welsh Language Officer has confirmed that both the internal PHW translation team and all external translation suppliers consistently use a standard level of Welsh. This approach is designed to avoid the use of regional dialects in order to maintain clarity and consistency across Wales-wide public communications. While the standard form is the default, there are specific instances where regional dialects may be appropriate, depending on the context and audience.

Poor signage at Diabetic Eye Screening clinic

Following a complaint from a service user who arrived late for their appointment due to poor signage at a DESW clinic within a local health board venue, DESW are now working with the venue to explore the complainant's suggestions around permanent DESW signage. While this work is ongoing, DESW staff will review signage upon arrival at this clinic venue and apply temporary signage if required.

2.6 Duty of Candour

Duty of Candour (DoC) regulations have been in effect in Wales since April 2023. There have been **2** new DOC incidents reported in Quarter 2.

1 in Infection Services relating to an extended inpatient stay due to a false positive Clostridium difficile infection result. The patients inpatient stay was extended by more than 4 days which falls into the category of moderate harm.

1 in Breast Test Wales relating to an unsatisfactory interval cancer review and a missed opportunity to diagnose a breast cancer at an earlier stage.

2.7 Concerns regulation update

The new Concerns regulation has as of the 14 October 2025 been passed into law with an implementation date of the 1 April 2026. The new regulations now known as “Listening to People” place an emphasis on putting the patient at the centre of the concerns process, ensuring access to legal advice for all, ensuring a more timely and compassionate process and increasing the threshold limit for Redress from £25,000 to £50,000.

These proposed changes will have resource implications for Public Health Wales and other NHS Wales organisations both in terms of the changes to redress management and the proposed enhanced response to concerns along with staff training to support this revised approach.

The PTR team are part of the various national working groups involved in these revisions and are working to assess and implement the proposed changes to support operational delivery within PHW.

2.8 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.
All alerts that come into the central Datix mailbox are logged on the Safety Alerts module within Datix and are also logged within Microsoft Lists. The use of Microsoft lists supports the monitoring of compliance against the applicable safety notices. This functionality does not currently exist within the Datix module that PHW is required to use. In order to provide oversight of alerts and compliance, MS Lists is used to supplement the datix process.

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 **42** alerts were received by Public Health Wales during the reporting period 1 July – 30 September 2025, **2** of which required action to be taken and a further **6** alerts were shared for information only.

The alerts shared for action related to updated guidance for the Respiratory Syncytial Virus vaccination programme and the availability of antimicrobial medication for treating tuberculosis.

Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Pharmaceutical Alert	13	0			
Medical Device Alert	4	0			
Patient Safety Notice/Alert	1	0			
Medicine Shortages	14	1	An update to inform that a number of antimicrobial medicines to treat tuberculosis are intermittently available until at least the end of 2025.	30/07/2025 31/07/2025	Shared with Health Protection, Infection Services and the Office of the Medical Director.
High Voltage Alert	9	0			
Public Health Alert	1	1	An update from the Joint Committee on Vaccination and Immunisation for the Respiratory Syncytial Virus vaccination programme.	15/08/2025 15/08/2025	Shared with Health Protection to action and Primary Care for information only.
Totals	**42**	**2**			

Table 1. Total Alerts received

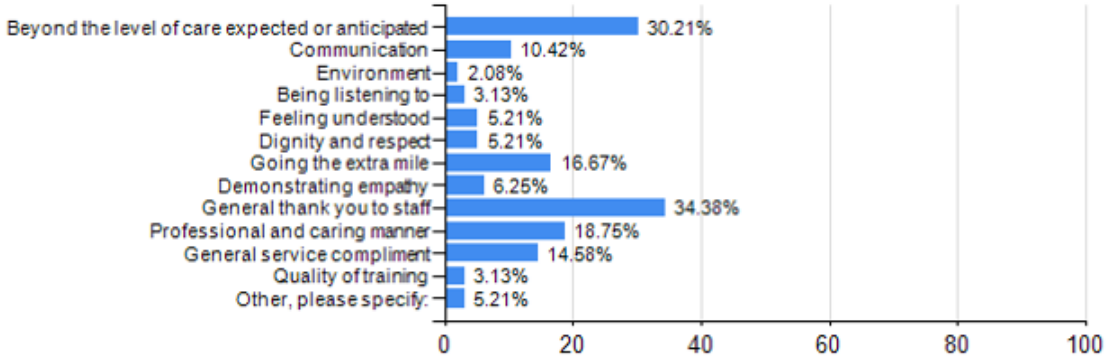
Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received a Actioned	Action Taken
Health & Wellbeing	1	1	An update from the Joint Committee on Vaccination and Immunisation for the Respiratory Syncytial Virus vaccination programme.	15/08/2025 15/08/2025	Shared with Health Protection to action and Primary Care for information only.
Micro/Health Protection	1	2	An update to inform that a number of antimicrobial medicines to treat tuberculosis are intermittently available until at least the end of 2025. An update from the Joint Committee on Vaccination and Immunisation for the Respiratory Syncytial Virus vaccination programme.	30/07/2025 31/07/2025 15/08/2025 15/08/2025	Shared with Health Protection, Infection Services and the Office of the Medical Director. Shared with Health Protection to action and Primary Care for information only.

Table 2. Alerts by Division

2.9 Compliments and Service User Experience

This quarter, **96** compliments were recorded by staff within the Civica system. In addition, **35** compliments were left directly by members of the public using the compliments form available on the Public Health Wales website. However, of these only **22** related directly to Public Health Wales services, with the remaining relating to Health Board service provision. The combined number of compliments for Public Health Wales was 118 this quarter.

A combined thematic analysis of staff-reported and direct public compliments highlighted 2 specific themes 'Beyond the level of care expected or anticipated' and 'General thank you to staff' as the leading reason for compliments.
3 compliments were classed under other, and upon further investigation, the theme included 'Dedicated support' and 'BTW pathway Video' The table below provides a breakdown of all compliments for this quarter.



The word cloud below highlights a selection of the sentiment shared via compliments.

Local Experience surveys

The promotion of local surveys is wholly reliant on the individual programmes and staff within these service areas. The chart below of local survey responses details current response rates for programmes and highlights where further attention is required to promote and increase survey use.

Local survey responses

Screening Programme	Survey	Number of responses Q4 2024-2025	Number of responses Q1 2025-2026	Number of responses Q2 2025-2026
Abdominal Aortic Aneurysm Screenin	Single local survey	4	244	243
Diabetic Eye Screening Wales	Single local survey	12	33	7
Bowel Screening Wales	No further tests needed	33	26	17
	Blood Found in bowel screening test	0	0	0
	I had further tests	221	365	349
	Bowel screening Wales Expeirnace Survey (old)	425	22 (being phased out)	1(being phased out)
Breast Test Wales	I have been for my breast screening appointment	27	26	55
	I was called for further tests	4	6	7
Cervical Screening Wales	Help-line support survey	1	48	169
	I have been for my smear test	0	0	0
Maternal and Child Screening	ASW People's Experience survey	0	0	0
	Newborn Bloodspot Screening People's Experience	0	0	0
	Newborn Hearing Screening People's Experience	5	17	26

It should be noted that the programmes with the greatest increase in local survey responses include Cervical Screening Wales, who have, over Quarter 2 increased their feedback threefold. This is followed up by an increase for Breast Test Wales and Newborn Hearing Screening Wales.

Abdominal Aortic Aneurysm Screening and Bowel Screening in Wales remain consistent in their response numbers.

The development and introduction of an all-Wales Endoscopy Experience survey will have an impact on the experience information available to Bowel Screening Wales. When this survey is introduced, the 'I had further tests' survey will no longer be used. The lead for service user Experience has been liaising with NHS Wales Performance and Improvement, the Consultant Gastroenterologist leading the national Endoscopy Experience survey, and Bowel Screening to ensure the new survey meets the needs of the PHW programme. This work includes the availability of data between all parties involved in a timely manner.
In addition, Bowel Screening Wales will be working with the Lead for Service User Experience to capture the experiences of people undergoing the Pre-assessment, carried out by a screening specialist practitioners.

Over the next 6 months, the use of text messages to ask for people's experiences after an appointment will be introduced. The questions in the text messages will be aligned to the National People's Experience survey, allowing us to benchmark.

Data using this feedback method for Diabetic Eye Screening Wales (DESW) in quarter 2 indicated that 97% of respondents rated the overall experience as Good to Very Good. 2.94% of respondents rated their overall experience from Neither good nor poor to Very Poor.

99.77% of respondents stated that they were usually and always treated with dignity and respect. The word cloud below provides a summary of feedback as analysed through the Civica system.

DESW sentiment 1 July - 30 Sept 2025

5.0 Quality and Clinical Audit

Public Health Wales (PHW) has a prioritised audit programme that relates to both local and national priorities, with the overall aim of improving patient/service user outcomes. The priorities reflect a combination of both local and national audits which are listed in the table below:

Type of Audit	At start of year	Update as of end of Q2
National Audits	6	6
Audits identified as a result of risks	29	32
Local Policy Audits Care Pathways/Local Guidelines Audits	64	68

Quality and Clinical Audit are an essential tool for quality improvement in healthcare, allowing for benchmarking against national standards, identifying and prioritising specific local areas of concern and driving sustained improvements. This is a key requirement for the Duty of Quality.

5.1 Quarter 2 Update.

Current Status following Q2 Meetings:

- 6 external audits – 5 ongoing as planned, 1 on hold. The on-hold audit is due to emerging changes within NHS England who led the audit
- 68 internal audits, update below:

Quarterly Status	Number	Comments
Completed	16	
Progressing as Planned	37	
Removed from plan this year	1	Added to plan by mistake by programme, no need to audit this year.
Not Due to Start this Quarter	12	1 audit has been identified as ad hoc to take place if the need arises.
Original timelines amended	3	• BSW Documentation Audit: Audit not commenced in Sept as planned. New audit still being scoped. Timelines amended to commence in Jan 2026 as Nursing Team have prioritised new Histology Report audit in Q2/Q3 (commenced 24/09/25) (this is an audit of a high-risk change to the programme and therefore required prioritisation) • NBHSW Change of Status: Consent for Screening: Audit not commenced in July as planned due to competing

		priorities in the programme. Timelines amended to commence in Jan 2026. • NBHSW Change of Demographics Audit: Audit not commenced in July as planned; new audit, methodology still being scoped and timelines amended to commence Jan 2026 to allow for this

5.2 Clinical Audit Policy

A new organisational Clinical Audit Policy has been drafted and is currently out for consultation from 25 Sep 25 – 23 Oct 25. Key stakeholders involved in clinical audit have been informed and invited to provide feedback. As of 21 Oct 2025, feedback has been overwhelmingly positive and no requests for change have been submitted.

Pending any feedback received, the Policy will be updated and submitted for approval through required governance routes in November 2025.

5.3 Quality and Clinical Audit Procedure

There is an organisational Quality and Clinical Audit Procedure, which is due for review in 2025. The Quality and Clinical Audit Team are fully amending the procedure to reflect updates to governance and process following the implementation of the new digital audit platform Audit Management and Tracking (AMaT) (see below for details).

It is planned that the revised procedure will go out for consultation in January 2026.

5.4 Digital Audit Platform

In Quarter 1, the Quality and Clinical Audit Team began the implementation of 3 modules for the Audit Management and Tracking (AMaT) system. To date the following has taken place:

AMaT Training:

- 2 superusers trained on Clinical Ward (assurance) and Inspection Modules.
- 21* administrators trained on Ward Module.
  *NB this training ensures they can undertake administrator roles for the whole system.
- 3 staff trained on Inspection Module.
- 112 staff across the organisation trained as system users
- Twice weekly training continues until the end of October – one session for Ward Module and the other for Clinical Audit Module.
- Tutorials and guidance documents are in development to support staff

Module Updates:

- Ward (assurance) Module is now Live with teams across the organisation transitioning "assurance" audits. 7 audits, including IPC, are operational and collecting data. Several more are in development. This work will be completed by end of financial year.
- Clinical Audit Module went live on 01 September 25. As of 09 October 2025, 5 audits were operational in the module. All audit activity transitioned by year 2026-27.
- Inspection Module now live with the Board Business Unit transitioning activity across. NQIG will pilot the use of the module for updating actions from internal audit reports in Q3 and Q4, and this will be rolled out to the whole organisation in Q1 of 2026-27. The Putting Things Right (PTR) Team is trialling the use of the module for managing recommendation and actions following learning from significant incidents.
- Guidance Module introduction planning will start at the end of Q3.

5.5. Audit Training

No training was delivered during Quarter 2. However, a Clinical Audit Masterclass, will be delivered by the Clinical Audit Support Centre (CASC) in December 2025. As part of our first-year licence with AMaT, they are funding this session for up to 50 attendees, with 20 able to undertake an accreditation.

A further, bespoke session is being developed with CASC for January 2026, for 20-25 attendees. This will focus on key considerations identified by the Quality and Clinical Audit Team as areas of improvement for audit activity across PHW. This session will focus on planning an effective audit programme, including patient safety, quality improvement, sampling and action planning, and will be aimed at colleagues with responsibility for oversight of audits in their area.

6. Safeguarding Group Report

This section summarises safeguarding related activity and performance along with key risks and improvement activity during Quarter 2, 2025-26.

The Safeguarding Group met on 16th October 2025 with directorates reporting safeguarding activity and training compliance. It was noted that there has been a reduction in Safeguarding training compliance for Group 2 VAWDASV and Level 3 Safeguarding training, recovery plans to improve training compliance where suboptimal levels were discussed.

All requests for Safeguarding advice and support, reports to the local authority and incidents are captured within the Once for Wales Safeguarding module.

6.1 Safeguarding queries for advice and support, referrals and incidents

15 Safeguarding queries for advice and support were recorded during this quarter and as the largest public facing directorate, Health Protection and Screening divisions continue to report the most safeguarding concerns queries which is to be expected given the number of contacts they have. Chart 5.1 shows the number of cases reported by directorate.

Chart 5.1 Cases Reported by Directorate

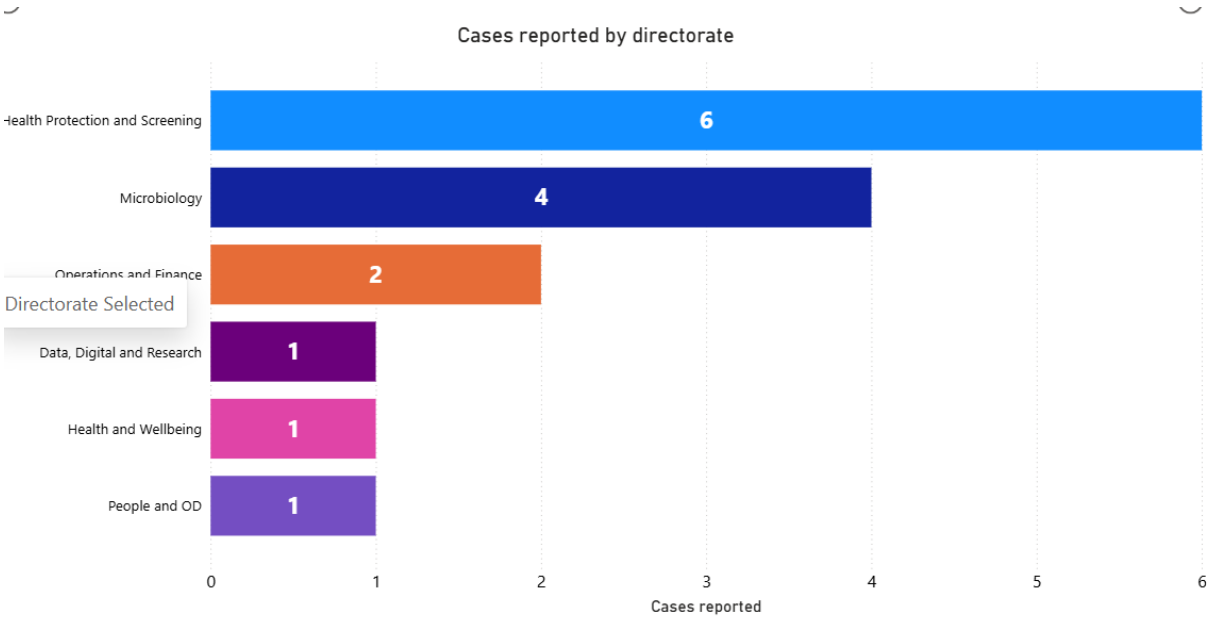
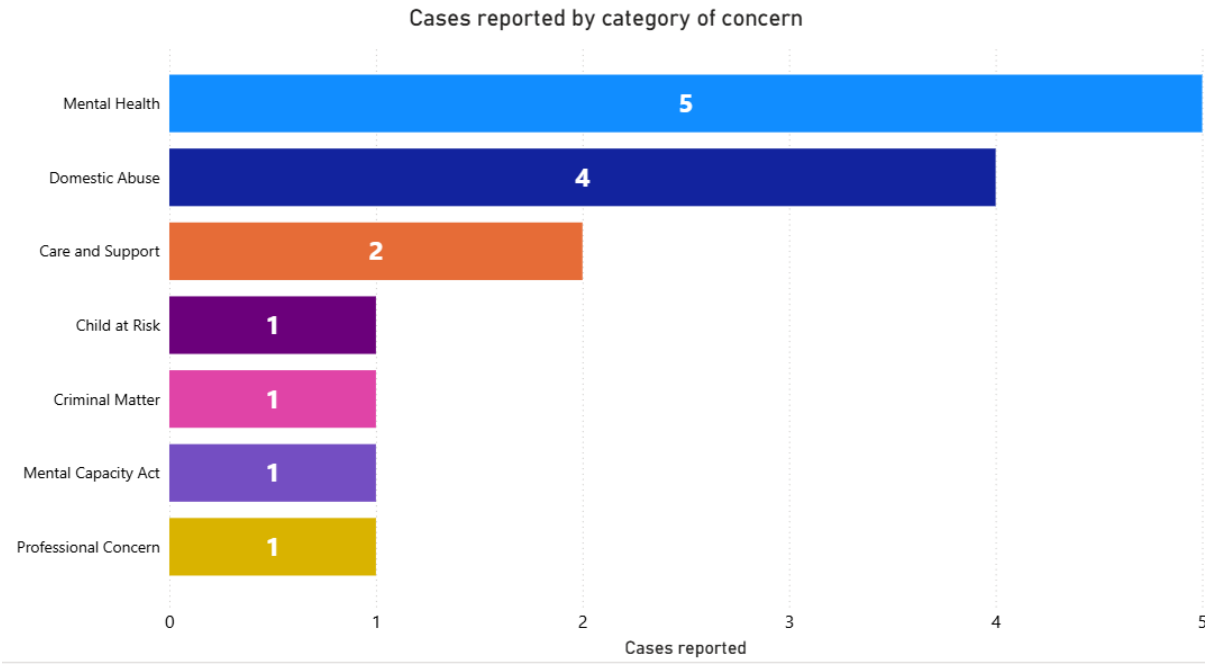


Chart 5.2 Cases reported by category of concern



Safeguarding advice themes are highlighted in chart 5.2. It is worth noting that there has been an increase in requests for mental health advice relating to screening participants or PHW employees.

Preventing adverse events from mental health events is key to acting on safeguarding concerns, shifting the focus from reactive crisis intervention to proactive support that protects individuals from harm before it occurs. This message will continue to be promoted to PHW staff during National Safeguarding Week 10 to 14th November 2025.

During this quarters safeguarding meeting it was identified that staff continue to lack the confidence in undertaking a targeted enquiry when safeguarding concerns are suspected. As a result, an improvement project has been initiated to address this and started in Breast Test Wales as this service is ideally placed to support participants who are experience sexual violence or domestic abuse.

2 of this quarter's-initiated advice queries progressed to referrals to the Local Authority for attending screening participants who required assessment for care and support packages.

6.2 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.

A compliance target of 85% is set by the Welsh Government for all this.

The tables below indicates Quarter 2 compliance with mandatory training requirements and the trend compared to the previous quarter.

Competence Name	Q1	Requir	Achiev	Q2	Trend
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	89.38%	2173	1929	88.77%	↓
028|LOCAL|Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years|	82.49%	459	368	80.17%	↓
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	92.26%	2173	1968	90.57%	↓
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	91.58%	472	420	88.98%	↓
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	92.26%	2173	1962	90.29%	↓
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	90.53%	472	411	87.08%	↓
028|LOCAL|Safeguarding Level 3 - 3 Years	83.19%	118	96	81.36%	↓
NHS|MAND|Mental Capacity Act – 3 Years	87.99%	309	272	88.03%	↑
NHS|MAND|Mental Capacity Act Level 2– 3 Years	89.51%	273	235	86.08%	↓
NHS|MAND|Consent - 3 Years	97.43%	276	270	97.83%	↑

Quarter 2 has seen a downward trend in compliance for Safeguarding training although it remains above the Welsh Government target of 85%.
In addition, Group 2 Violence against Women, Domestic Abuse and Sexual Violence and Level 3 Safeguarding Training where compliance has fallen below the Welsh Government target has also seen a reduction of employees booking onto the course impacting overall compliance. To address this additional training sessions have been scheduled in quarter 3 and managers have been asked to support attendance.

6.3 Key Safeguarding Risks & Issues

There are currently 2 safeguarding risks which committee should note, and which are recorded on the corporate risk register. Both have mitigations.

- Risk 1656 - DBS (Disclosure and Barring Service) checks
- Risk 1503 - Single Safeguarding post holder

6.4 Safeguarding Improvements

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment quality assurance tool completed by the 7 Health Boards and 3 Trusts in NHS Wales. The SMM is completed annually reporting retrospectively on activity from the previous year. The SMM is intended to inform improvements and promote horizon scanning, allowing organisations and the wider NHS Wales Safeguarding Network to understand safeguarding priorities for the following year.
The Safeguarding Group approved the Safeguarding Maturity Matrix Maturity Matrix self-assessment in October 2025. A peer review of all NHS Wales submissions will take place in Quarter 3 enabling the exchange of good practice, supporting collaboration and highlighting system wide quality improvements. The National Safeguarding Service will support work associated with any emerging safeguarding themes.

DBS Project

Work to address the risk associated with the DBS check is continuing to progress. To date the following actions have been progressed.

- Revised DBS policy approved and published on PHW intranet
- Podcast created to launch the DBS policy
- New Barring referrals guide added to the intranet
- Barring referral training for mangers arranged for Quarter 3
- Communications on the update service requirements are ready and will be published

7.0 Infection Prevention and Control (IP&C) Update

This section summarises IPC activity, incidents and risks during Quarter 2 2025-26. The IP&C group met on 9th October to review Quarter 1 data. During Quarter 2 the Decontamination and Facilities sub-groups were also established and met for the first time prior to the IPC Group. Going forward, the groups will meet quarterly, and minutes will be submitted to the IPC Group.

7.1 IPC-related incidents

During Quarter 2, **19** IPC incidents were reported, the same as Quarter 1.

1 incident was reported as moderate harm (INC 7244 relating to an inoculation injury) however, the remainder were recorded as Low or No harm. A summary of the reported incidents can be found below.

Category	Number of Incidents	Division where it occurred	Harm / Risk Level	Approval Status
Cleanliness	1	Screening, Kimberly House	No harm	Under Investigation
Environmental cleaning (process and procedures)	1	Screening, WAAASP	Low Harm	Management Review
Environmental Hazards/Issues	1	Screening, Breast Test Wales	Low Harm	Under Investigation
Hand Hygiene	1	Screening, WAAASP	No Harm	Closed
Contact with Needles or Medical Sharps	4	Microbiology	3 Low Harm 1 Moderate Harm	3 Closed, 1 under Management Review
Contact with or Exposure to hazardous substance	9	Microbiology	5 No Harm, 4 Low Harm	7 Closed, 1 Under Investigation 1 Awaiting Closure
Test Results/ Reports (Infection)	2	Microbiology	1 No Harm 1 Low Harm	Closed

7.2 IPC Mandatory Training Compliance

The table below details IPC training compliance by Division and whether this has increased or decreased since the previous report.

Subject	Directorate/Division	Q1 Compliance %	Required	Achieved	Q2 Compliance %	Trend
IPC Level 1	028 L3 Corporate Directorate	84.62%	28	24	85.71%	↑
	028 L3 Research, Data and Digital Directorate	96.65%	180	178	98.89%	↑
	028 L4 Health Protection Division	90.04%	254	223	87.80%	↓
	028 L3 Health & Wellbeing Directorate	89.60%	173	156	90.17%	↑
	028 L4 Infection Division	91.15%	641	580	90.48%	↓
	028 L3 Operations and Finance Directorate	88.04%	99	89	89.90%	↑
	028 L3 People & OD Directorate	97.96%	49	48	97.96%	=
	028 L3 Nursing, Quality and Integrated Governance Directorate	94.12%	53	50	94.34%	↑
	028 L4 Screening Division	92.74%	561	514	91.62%	↓
	028 L3 Policy and International Health Directorate	95.29%	88	83	94.32%	↓
IPC Level 2	028 L4 Health Protection Division	0.00%	1	1	100.00%	↑
	028 L4 Screening Division	87.79%	269	226	84.01%	↓
	028 L3 Quality Nursing & Allied Profs Directorate	100.00%	1	1	100.00%	=
	028 L4 Infection Division		33	5	15.15%	
ANTT e-learning	Breast Test Wales	97.85%	92	88	95.65%	↓
ANTT Assessment	Breast Test Wales	70.21%	98	38	38.78%	↓

All PHW staff are required to complete level 1 IPC training and certain staff in patient-facing roles require level 2. During Quarter 2 a meeting was held with the Health Protection Division who were asked to review which staff require the

training and ensure this is reflected within ESR to improve the accuracy of reporting.

Currently all Divisions and Directorates are above the Welsh Government mandatory training compliance target of 85% for IPC Level 1. Screening Division have dropped slightly below the target in Quarter 2 and as previously mentioned, it is not possible to report accurately the compliance for the Health Protection Division as there is only 1 member of staff who has IPC Level 2 mandated in ESR. Work to identify those staff requiring level 2 is almost complete and reporting is expected to be re-established during Quarter 3.

ANTT (Breast Test Wales Only)

Training	Q2Compliance
ANTT e-learning	95.65%
ANTT Assessment	38.78%

During Quarter 2, Screening Division have reviewed which staff require ANTT e-learning and assessment competencies for their roles. This has led to a drop in compliance with assessments which must be repeated every 3 years. The division will be supported to improve compliance during Quarter 3.

Discussions have also begun with Cervical Screening to establish whether the Nurses providing training for sample takers require ANTT competence and if deemed necessary, the team will be supported to achieve compliance.

7.3 IPC Risk Register

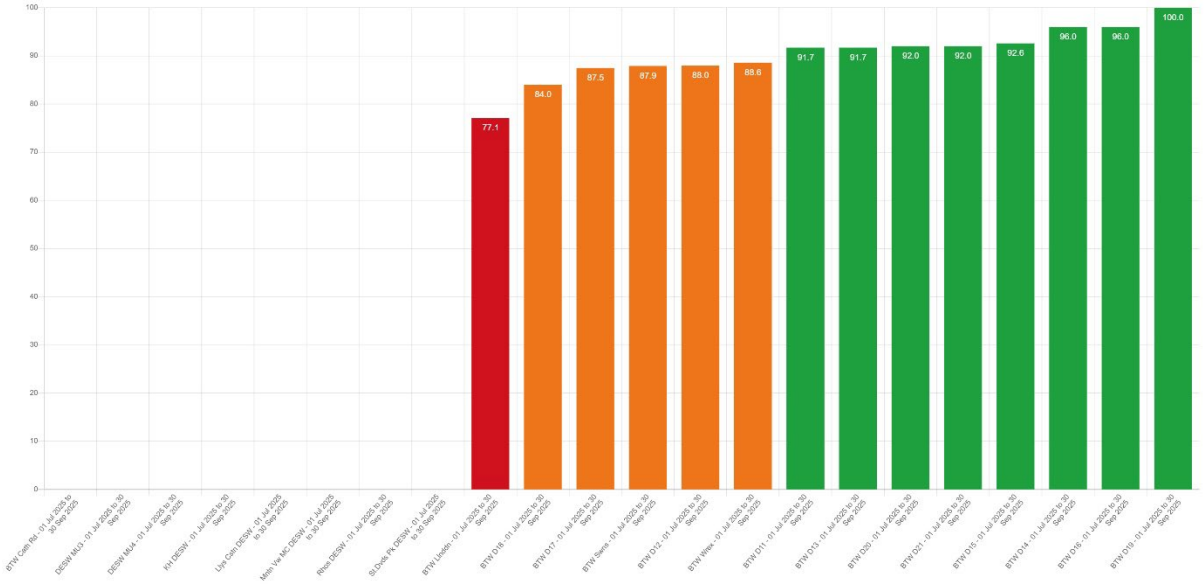
There are currently 15 risks on the IPC risk register, 2 of which were been added during Quarter 2. All risks were discussed at the infection Prevention and Control Group meeting on 9th October.
One risk for Bowel Screening Wales which refers to decontamination facilities at Ysbyty Glan Clwyd has had the score increased from 12 to 16 due to the increasing frequency of equipment breakdown which may affect BSW lists. The scores of the other existing risks have not altered.
Risk 1947 is listed as a Divisional risk for the Vaccine Preventable Disease Programme and details the risk that the winter influenza campaign will be delayed resulting in missing key operational delivery dates. This risk was added on 23rd July 2025 with an initial score of 9. The risk was to be treated and has a current score of 2 which is also the target score.

Risk 2009 is a Service Group risk for Breast Test Wales which related to the risk of service disruption, reputational damage and financial cost due to issues with the management of water quality across the mobile fleet.

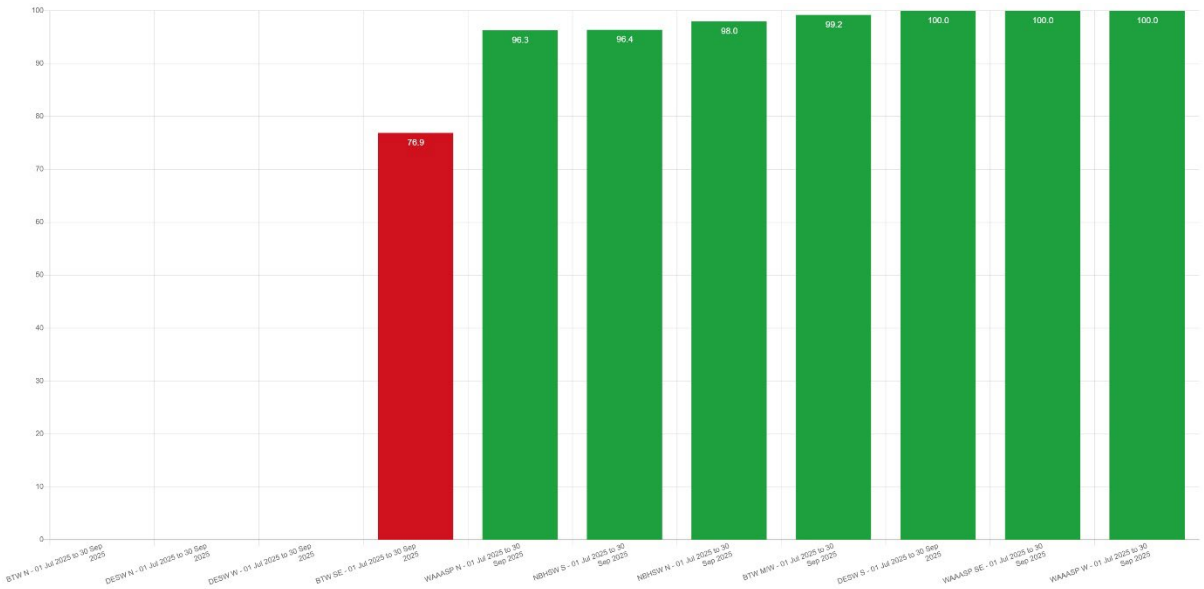
7.4 IPC Audit Activity

The IPC annual audit plan outlines the expected frequency of each type of IPC audit. As of June 2025, all IPC audits are conducted in the Audit Management and Tracking (AMaT) system.

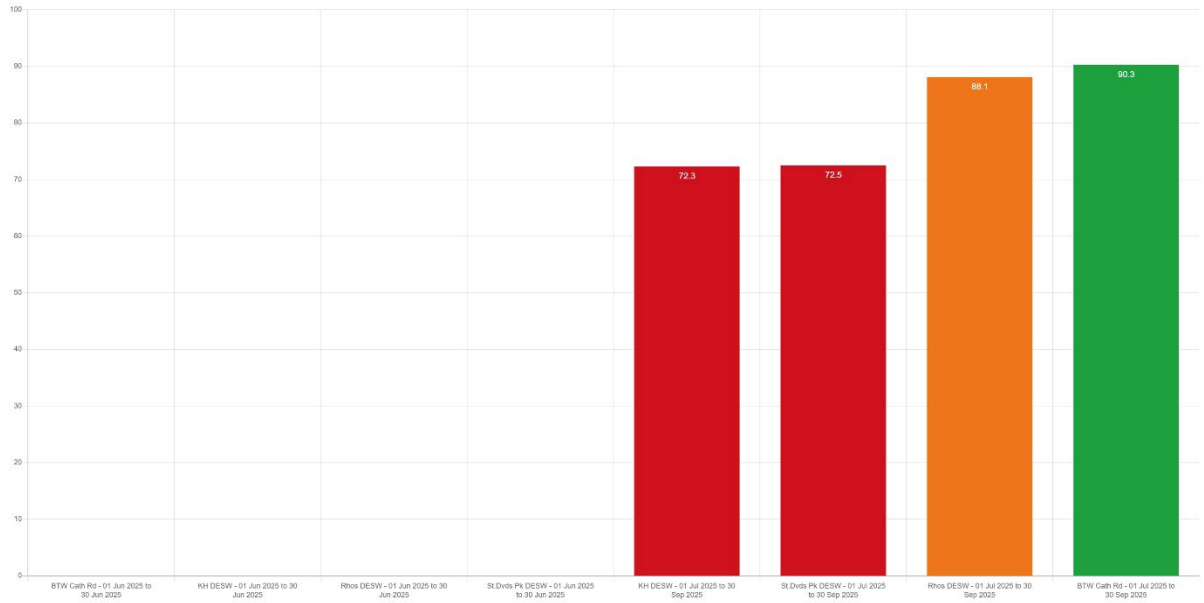
Environmental audits should be undertaken bi-annually for all PHW managed clinical sites by IPC Link practitioners within Screening Division. The graph below shows environmental audit results for Quarter 2.



Observational audits of practice are also undertaken by link practitioners. Breast Test and Diabetic Eye Screening are expected to undertake 10 observations per region per quarter, while Newborn Hearing and Abdominal Aortic Aneurism screening are expected to undertake 10 observations per quarter for the whole service due to their lower staff numbers. Results of practice observations for Quarter 2 are shown below. Breast Test in the South-East reported low practice audit scores which are associated with bare below the elbow and hand hygiene compliance amongst medical staff.



In addition to audits undertaken by IPC link practitioners, the Lead IPC Nurse undertakes an annual assurance audit at each PHW managed venues. This financial year 4 venues have been audited to date and results are shown below.



The 2 lowest scoring areas were Kimberley House and St David's Park. The concerns in Kimberley House related mainly to the standard of environmental cleanliness which facilities are managing with the contracted cleaners, whereas in St David's Park the non-compliances were associated with the condition of the building which is beyond the control of Public Health Wales. It is anticipated that services will be relocated and the site decommissioned early in the next financial year.

7.5 IPC Policies and Procedures

The Infection Prevention and Control Policy is due for review and approval by May 2026. Work to review this document has begun and this will be circulated for comments before the end of Quarter 3 to ensure that the document can be approved and reissued prior to the review date.

7.6 Key Risks and Issues Identified

An incident management team (IMT)was established on 6th August following a Legionella risk assessment and subsequent water testing on one of the Breast Test Wales Mobile Screening units. The risk assessment highlighted concerns about a lack of sufficient controls to minimise the risk of Legionella on the units in accordance with Health and Safety legislation. Although subsequent water testing demonstrated poor water quality, Legionella has not been detected on any of the mobile screening units. The incident team has been meeting regularly to review the issue and discuss short-term mitigations as well as longer term permanent resolution options.

Betsi Cadwaladr Health Board continue to work towards relocating the decontamination area for flexible endoscopes which are utilised for Bowel Screening participants. Representatives from PHW are invited to project meetings and involved in discussions relating to the capital scheme, and the challenges being faced on the Ysbyty Glan Clwyd site. The unit continues to experience frequent breakdown of equipment used in the decontamination of endoscopes; however, to date, this has not affected bowel screening patients.

Facilities have been working closely with the cleaning contractor to ensure improved standards of cleaning across the organisation but in particular in Kimberley House where concerns have been raised. A draft cleaning schedule was circulated to IPC Group members for comment, with the intention of including the final version in the tender process when the contract is reviewed in January 2026. This schedule once implemented, will also provide evidence of the organisation's commitment to high standards of environmental cleanliness and a standardised approach across all services and PHW sites.

8.0 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

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.