GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Board **Date of Meeting** 28 May 2026 **Agenda item:** *4.4*

Sexual Health Incident – Update Report	
Executive lead:	Professor Khaw Fu Meng, National Director Health Protection and Screening Services
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Approval/Scrutiny route:	Public Health Wales Sexual Health Incident Management Team Business Executive Team

Purpose
The purpose of this paper is to provide assurance to Public Health Wales (PHW) Board members in relation to the Sexual Health Incident. It provides and update on our response to the issues identified and the next stages of the response

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

The Board is asked to:

- **Receive assurance** in relation to the development and progress of the management of the sexual health incident
- **Receive assurance** in relation to the actions to review and improve service delivery

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	All Strategic Priorities/Well-being Objectives
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	No decision is requested from the board. Therefore no Equality of Health Impact Assessment is required.
Risk and Assurance	This is being managed as an enhanced incident. The risks posed by the incident is recorded on the appropriate risk register.
Health and Social Care (Quality and Engagement) (Wales) Act	This report sets out a number of issues where the Duty of Quality and Duty of Candor are relevant. Public Health Wales has made proactive press statements in relation to this incident and is committed to transparency with impacted service users.
Financial implications	There are no direct financial implications of the report. Financial implications of the response to the incident are not covered in this review.
People implications	There are no direct people implications of the report. People implications of the response to the incident are not covered in this review.

1. Purpose / situation

A report was tabled at the Public Health Wales Board Meeting on 26 March 2026 covering the Sexual Health Service Incident. This paper provides an update to the Public Health Wales Board on the current position on the different areas of the investigation.

The purpose of this paper is to provide assurance into the ongoing response to the incident.

2. Background

The background to the Sexual Health Service was provided in the previous paper.

There are currently three main areas of focus for the Sexual Health Incident. These are:

- Child and Adult Safeguarding
- Patient Safety Concerns in relation to Hepatitis C testing
- Information Governance and Data Protection issues

As of 15 May 2026 the incident has been de-escalated to a routine incident.

3. Description/Assessment

3.1 Child and Adult Safeguarding

The March report set out the actions that had been taken in relation to Public Health Wales failure to discharge its safeguarding responsibilities appropriately.

A review has been established to review all orders placed by children and young people under the age of 18 who had disclosed safeguarding risks between August 2022 and December 2025 when new working practices were in place. Children and young people accessing the service were asked a number of safeguarding screening questions. Where a child answered yes to one of these, this information should have been shared with the health board sexual health team.

A multidisciplinary team (MDT) was convened to support that review. Working in partnership with Local Health Board safeguarding and sexual health teams a comprehensive review has been undertaken.

The review identified that:

- Agreed sharing did not always occur in practice and that some individual safeguarding concerns were not shared with the relevant Health Board

- disclosures indicating potentially serious and high-risk safeguarding concerns that were not part of the screening questions were not routinely shared despite their severity unless specific safeguarding screening disclosures were also made

The review has examined 833 records where orders have been placed by children and young people between August 2022 and 2025 and a risk disclosure had been made. The review prioritised those who were still children (Cohort 1 – 136) but also reviewed those where the service user had subsequently turned 18 (Cohort 2 - 697).

This review process for Cohort 1 has provided assurance that statutory safeguarding responsibilities have now been discharged with relation to children and young people who accessed the service. Any retrospective actions taken were ethically and lawfully managed. Where gaps were identified, action has been taken or progressed, supported by ethical oversight and multi-agency collaboration.

In addition to the assurance over individual cases analysis of the safeguarding data for Cohort 1 also provides contextual understanding of early vulnerability. This includes disclosure patterns , and confirms that risks were identifiable within the system, with assurance dependent on timely interpretation and response rather than detection alone. Public Health Wales remains committed to continued safeguarding improvement and learning.

The incident management team acknowledges the contribution of Health Boards across Wales throughout the safeguarding lookback review. Their detailed case by case reviews enabled assurance that children and young people had been, or would be, appropriately safeguarded.

As of 12 May 2026:

- the review of Cohort 1 is complete and an interim report has been approved by the MDT. Findings and lessons learned will be shared with partners
- the validation of Cohort 2 by local health boards is complete, and the full review of information by the MDT is expected to be completed by June, with a final report expected by the late June.

In response to the issues identified the service has implemented a strengthened safeguarding model including real-time practitioner engagement for service users under 18 with identified risks. There are clear recording and escalation procedures in place to ensure that statutory duty is now discharged appropriately and action is taken to help protect vulnerable service users. Lessons learned during the review

of cohorts 1 and 2 will be shared across the system, and incorporated into future developments of the service.

3.2 Patient Safety Concerns in relation to Hepatitis C testing

In February 2026 it was identified that service users ordering a specific combination of tests who self-declared as HIV positive were not tested for Hepatitis C in line with national guidelines. The ordering platform implied that Hepatitis C was part of the test and when negative results were received for other tests the message stated "all results negative" so did not confirm Hepatitis C was not part of infections tested.

An expert sub-group group of the Incident Management Team was convened to investigate the issue and provide specialist advice and guidance on an appropriate solution. Following a review of the data Public Health Wales identified 131 individuals who did not have any recorded evidence of a completed Hepatitis C status after their last affected test.

A help line was established and two attempts were made to contact all 131 individuals with uncertain Hepatitis C status on the phone number that they had provided. 90 service users have been successfully contacted and offered re-testing. Of the remaining 41 affected service users that were not contactable by phone have been reviewed through their usual care giver, and where there is still uncertainty about their Hepatitis C status they will be offered testing.

There are 15 service users where it has not been possible to contact them and contact via mail is being considered. The expert group continues to review the results of those tests that have been completed.

A helpline set up to support this investigation received limited use and has now been decommissioned

As of 12 May 2026:

- The expert group is considering ethical and legal advice on the benefits and risk of contacting service users who were not tested appropriately but where subsequent tests carried out by NHS Wales show that they did not have Hepatitis C infection.
- The expert group is exploring reasonable and proportionate actions to contact service users who did not respond to the original call and whose Hepatitis C status remains uncertain.

In response to the issues identified the service has implemented a review and audit of all testing codes to ensure that all service users receive the tests that they have

ordered. Further improvements are planned to improve the information available to service users when ordering tests, and to ensure that testing is conducted in line with national guidelines.

3.3 Information Governance and Data Processing Issues

The IMT identified a number of concerns relating to data processing and information governance. These have been investigated, and where appropriate referred to the Information Commissioners Office.

As of 12 May 2026:

- Implemented improvements in clinical record keeping systems through migration of some recording to Tarian.
- The sexual health service has implemented a number of upstream improvements to reduce the number of manual tasks and reduce the risk associated with them
- A plan is being developed to increase the automation of data processing within the service.

In response to the issues identified the service has put in place strengthened information governance. Further improvements in the safety and security of data processes will be implemented as part of the automation plan.

4. Communication

A second proactive press statement was issued on the 31 March 2026 in relation to the Hepatitis C incident. Limited coverage was obtained.

There are currently no plans for additional press releases.

In order to ensure that all stakeholders are appropriately informed Public Health Wales has established:

- a fortnightly stakeholder briefing that is sent to all partners across NHS and Local Government.
- A regular weekly SitRep for Welsh Government to provide assurance on actions taken

5. Incident Governance and Oversight

As of 15 May 2026 the incident was de-escalated to routine response level.

As a result of this change, the strategic response group, has been stood down. Executive oversight of the response will now be through an Executive Oversight

Group chaired by the Chief Executive Officer. The Incident Management Team will maintain overall responsibility for the incident and will be chaired by the Incident Director.

As the incident phase progresses towards completion clinical governance and ongoing quality improvement activities are moving from an incident response towards business as usual management arrangements within the Health Protection Division.

This transition is expected to be completed by July 2026. To support this transition strengthened management arrangements with improved responsibilities, accountability, oversight and routes of escalation will be implemented in line with the ongoing transformation of governance arrangements within Health Protection.

5.1 Sexual Health Improvement Group (SHIG)

The SHIG was established to coordinate improvement activities and support to the service from other directorates and services. The SHIG was stood down on 19 May 2026 in line with the de-escalation to a routine incident. Remaining actions and management arrangements being passed to Health Protection Division governance structures, as service delivery and improvement transition towards business as usual. The SHIG oversaw the development of DPIAs and SOPs to support new business processes and ensure these were done in line with Information Governance and clinical safety. The Group also oversaw the delivery of new process using Tarian to enable clinical record keeping and began the work to streamline processes and automate these.

5.2 Best Practice Advisory Group

In order to support continued improvement an advisory group has been established to support the service. This group will have cross sector representation and will seek to provide advice on best practice in running similar services to ensure that the service develops in line with strategic ambitions for delivery of Excellent Public Health Services.

This group will meet for the first time week commencing 25 May 2026

5.3 External Independent Review

An external review has been commissioned. The terms of reference have been agreed. The external review group will commence work when a chair has been appointed.

As of 12 May 2026, all members of the review panel have been confirmed, with the exception of the sexual health specialist and commissioner/chair.

5.4 Independent Ethics Advice

Independent ethics advice has been sought along with advice from 3rd sector organisations representing service users to support appropriate assurance and oversight of the response. The conclusion of the ethics advice is that:

- PHW has taken appropriate and proportionate action in relation to safeguarding responsibilities, and legal obligations (including duty of candour).
- There remain ethical questions around transparency and autonomy that merit further consideration and structured reflection.
- These issues would benefit from being worked through in a staged, deliberate way, rather than under incident-response time pressure

5.5 Internal Governance Review

A Public Health Wide Service Governance Review is ongoing and forming part of a wider programme of internal assurance to ensure that lessons are shared across all public facing services.

As of 12 May 2026 Public Health Wales is committed to:

- Reflect on the how transparency and how this may be balanced with harms associated with contacting individuals affected without warning.
- Learn from independent external review of the service
- Work with experts to improve the sexual health service in line with best practice
- Complete the review of all relevant service areas across Public Health Wales

6. Risk Assessment

The Incident Management Team continues to review the risk assessment for the service. At present the risk assessment remains that the benefits associated with suspending or stopping the service whilst issues are resolved, are outweighed by the harm that would be caused to vulnerable service users.

This recommendation is made on the following assumptions

- No serious risks are identified which cannot be mitigated appropriately

- Intended mitigations can be delivered in a timely way and deliver the intended risk reductions.
- Sufficient wrap around capacity is available to deliver on required actions whilst maintaining a safe service

7. Recommendation

The Board/Committee is asked to:

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- **Receive assurance** in relation to the actions to review and improve service delivery