GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 20 May 2024 **Agenda item:** *3.3*

Quality Governance Performance Report Quarter 4 (1st January – 31st March) 2023/2024

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Purpose

The Quality Governance Report provides the Business Executive Team and Quality, Safety and Improvement Committee with an overview of quality governance within Public Health Wales for the period Quarter 4 (January – March 2024). This is a new consolidated report for the Committee. It incorporates the two domains of 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, including Claims Management
- Safety Alerts and Notice Management
- Quality and Clinical Audit
- The work of the Safeguarding Group
- The work of the Infection Prevention Control Group

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☒

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 in the following areas:
  - Putting Things Right, including Claims Management
  - Safety Alerts and Notice Management
  - Quality and Clinical Audit
  - The work of the Safeguarding Group
  - The work of the Infection Prevention Control Group

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	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	No Equality and Health Impact Assessment is required. 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. The financial implications relating to Claims and Redress are detailed within the report.
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. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 4 2023-2024 and provide updates from Public Health Wales governance subgroups.

This Report covers the following areas:

- **Putting Things Right**
  - Nationally Reportable incidents / Early warning / never events
  - Incident Management
  - Redress Management
  - Complaints Management
  - Duty Of Candour
  - Compliments
  - Service User Experience and Involvement Activity
- **Safety Alerts and Notice Management**
- **Quality and Clinical Audit**
- **Safeguarding Group**
- **Infection Prevention and Control Group**

This is a new style report providing a single report covering the broader aspects of Quality Governance. This report supports the achievement of quality through the following:

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

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

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

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

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

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

2. 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 (Incident, complaint, and Claims Section (page 7).

- 471 incidents were reported during Quarter 4, investigated and remedial actions identified. Of these, 2 were for moderate harm with 1 reported externally as a RIDDOR.
- Incident closure rates are improving with a noticeable improvement in February 2024, for Cervical Screening Wales.

Safeguarding of Adults & Children at risk (page 22)

- 10 safeguarding incidents were raised at PHW sites with an increase over the last 6 months of professional concerns relating to allegations of abuse by staff.
- Safeguarding training compliance continues to improve but remains above the Welsh Government target of 85% but below the PHW target of 95%.
- There is 1 safeguarding risk on the corporate risk register which relates to DBS checks.

Infection prevention & Control (page 24)

- There were 18 IPC incidents reported in Quarter 4, all were assessed as no or low harm.
- Decontamination practice and compliance against standards within some screening services has raised some concerns and further actions are being put in place to address these.
- IPC level 1 training has improved since the last quarter but remains below the Welsh Government target and directorates have been asked to focus on this.

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 11)

- 45 Early Resolution complaints were received in Quarter 4 and 5 formal complaints.
- 73% of the early resolution complaints were resolved within 2 working days target. All the formal complaints were acknowledged within the 5 working day targe.

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 21)

- 6 Audits were completed in Quarter 4 out of the 9 expected. There is no risk associated with the delayed audits.

Safety Alerts Management (page 18)

- 61 alerts were received in quarter 4 of which 3 of which required the action of disseminating for information.

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 15)

- 145 Compliments were received this quarter of which going above and beyond remains the highest reported category.

3. Putting Things Right

The Putting Things Right (PTR) section highlights areas of the organisation where concerns have been raised or identified, and it summarises the overall performance against key targets where they apply. Thematic learning is also identified. This report complements the Performance and Assurance Dashboard (PAD) presentation in providing organisational performance assurance against PTR regulations.

The term "concern" should be taken to mean any complaint, claim or reported patient safety incident (about NHS treatment or services) to be handled under the PTR arrangements.

The reporting of all the concerns relevant to PTR are submitted via Datix, the Once for Wales Concerns Management system. The Datix Cloud IQ functionality is not yet fully matured, and some issues are still being identified with remedial action being taken by the national team at the current time.

In Quarter 4 there was a particular issue identified within the finance section in the Claims module which meant that the '" person affected" data disappeared from some Datix records. The PTR team continue to work with the Once for Wales Team to support and resolve the issues and local mitigation is in place to ensure the required information is available until this national problem is resolved.

3.1 Nationally Reportable Incidents/Early Warnings/Never Events

There were no Nationally Reportable Incidents, Early Warning Incidents or Never Events reported during quarter 4.

Number in Quarter	Q1 Apr – Jun 23	Q2 Jul – Sep 23	Q3 Oct – Dec 23	Q4 Jan – Mar 24
Nationally Reportable Incidents reported to NHS Executive	1	0	1	0
Early Warning reports submitted to Welsh Government	0	1	0	0
Early Warning reports submitted and subsequently upgraded by Welsh Government to a Nationally Reportable Incident	0	0	0	0
Never Events	0	0	0	0

3.2 Incident Management

Incidents

During Quarter 4, a total of 471 incidents were reported via the Datix Incident Management system, with 98% (460) occurring within the Health Protection and Screening Services Directorate. The Incident reporting figure remains consistent with Quarter 3.

Of those incidents reported in Quarter 4, three were reported as moderate harm. Two of those incidents were reported in Microbiology with one of these reported externally as a RIDDOR incident. Investigations on both incidents have been completed with the level of harm previously indicated on the one incident subsequently downgraded to low.
The RIDDOR incident relates to a manual handling injury for a staff member and the investigator has indicated the level of harm as moderate following the investigation, as the staff members injury prevented them from attending work for 7 or more days.
The other incident was reported in Health Protection at the end of March, and as such is currently still under investigation.

The below table provides the number of moderate or above incidents recorded in each quarter of 2023-2024.

	Moderate	Severe	Catastrophic/Death
Quarter 1 (Apr – Jun 23)	1	1	0
Quarter 2 (Jul – Sep 23)	1	0	0
Quarter 3 (Oct – Dec 23)	1	0	0
Quarter 4 (Jan – Mar 24)	3	0	0

The most frequently reported incident categories are displayed in Table 1 below:

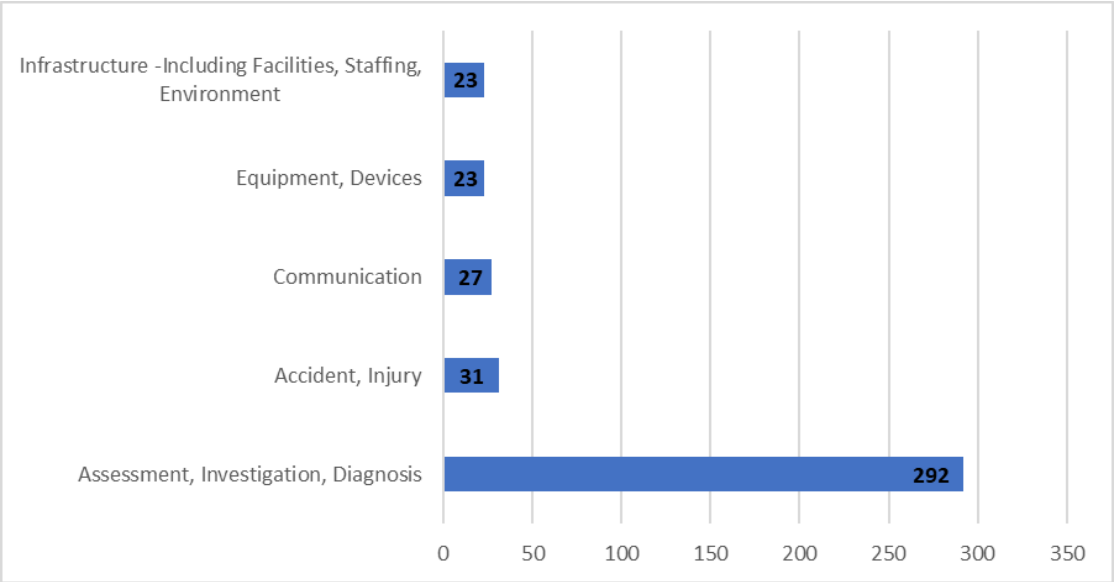


Table 1. Frequently reported incident categories

Chart 2 below indicates the top five 'Assessment, Investigation, Diagnosis' subcategories for all Directorates, compared with the numbers in Quarter 3.

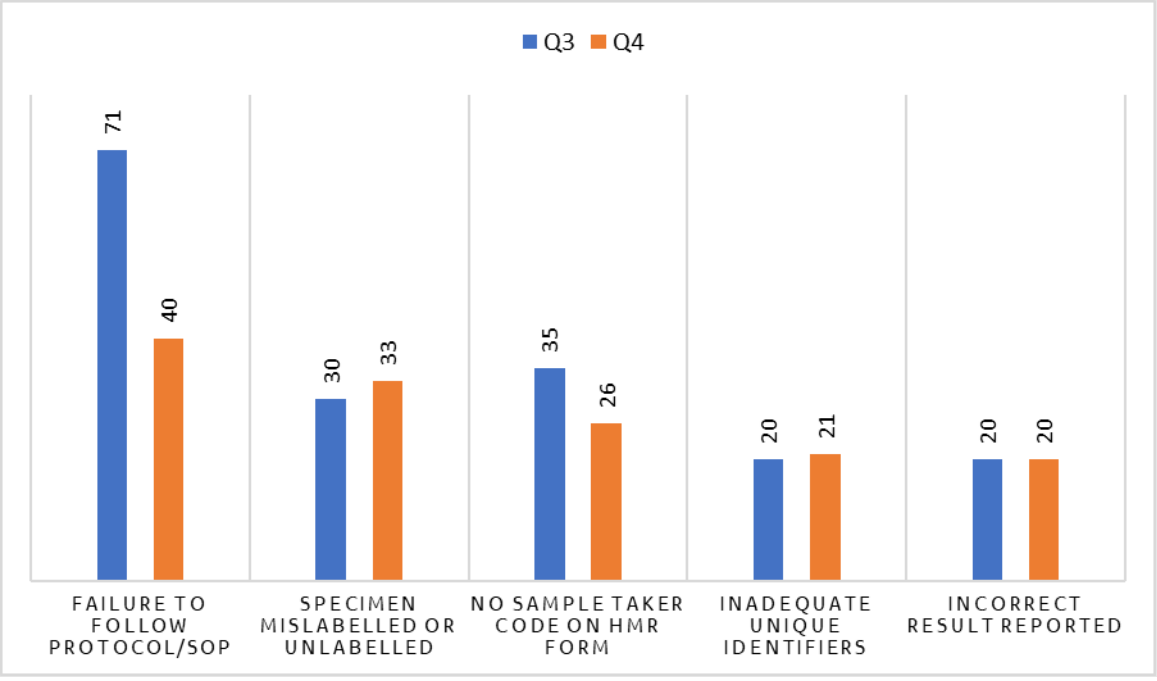


Table 2. Top five categories for subcategories

'Failure to follow protocol/SOP' remains the highest sub-category reported however, the numbers of this type of incidents have reduced from 71 incidents last Quarter to 40 reported in this Quarter. 50% of incidents reported in Q4 in this category were reported in Diabetic Eye Screening Wales.

DESW is working with the Improvement and Innovation team focusing on the grading of images which is where many of this incident type have been reported.

The second highest subcategory is 'Specimen mislabelled or unlabelled' with 98% of these incidents relating to Cervical Screening Wales (CSW) sample taker incidents. The remaining 2% occurred within Microbiology. CSW have been working with Digital Health Care Wales (DHCW) to develop an Electronic Request Form that would support a reduction of these incidents. Unfortunately, DHCW currently have no capacity to support this business request. Further work will need to be undertaken with CSW to mitigate these incidents until DHCW is able to start work on creating a digital form.

Open Incidents

As of 3 April 2024, there are a total of 83 reported incidents in Datix with an 'open' status of more than 30 days. The highest number of open incidents are currently within Cervical Screening Wales, followed by Diabetic Eye Screening Wales and Microbiology.

Of the 83 incidents, 8 (10%) have been open for more than 120 working days, with the oldest being open for 288 working days. This incident relates to an error within the Cervical Screening Information Management System (CSIMS) which is still under investigation with digital services and the software developers and therefore cannot be closed. 17 (20%) have been open for between 60 and 120 working days and 58 (70%) have been open for less than 60 working days.

Open incident data is supplied weekly to Datix leads for each service area and now also includes Directorate senior staff and business leads to support closure management with real time learning. In addition, Level 2 Incident Investigation training has been revised in Quarter 4 to support the quality of investigation management with the aim of improving overall performance.

In January 2024, 72% (113) of incidents were closed within the 30-day target period, which is an improving picture compared on the 59% (78) closed in December 2023. At the time of writing, many of the incidents reported in February and March 2024 remain within permitted closure timeframes.

It should also be noted that in February 2024, there was an improvement in the overdue incident closure rates for Cervical Screening Wales with a 55% reduction seen in the number of overdue incidents since the beginning of February. This is due to a focused support by the PTR Team and the CSW Quality Lead.

It should also be noted that from 1 April 2024, overdue incidents within the Datix Cloud system will be amended nationally from 30 total days to 30 working days total, which will reflect the actual time available for investigators to complete their investigation and manage incidents to closure.

Incident Reporting and Management Training

During Quarter 4, Datix Level 1 incident reporting training was delivered to 47 staff. This included one bespoke session with Microbiology, Cardiff.

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. Monthly training sessions are available to all staff throughout the organisation along with bespoke sessions with individual teams and divisions arranged as required.

As training numbers increase and more staff become aware of the importance of reporting incidents it is anticipated that incident reporting figures will continue to rise in line with a good reporting culture.

A Duty of Candour (DOC) training offer continues in addition to the role specific ESR training aimed at managers and investigators. During Quarter 4, 24 staff received this training.

3.3 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.

Three new Redress cases were received in Quarter 4 with all three in Cervical Screening Wales. The emerging theme for all was unsatisfactory interpretation of cervical cytology slides. Harm is yet to be determined due to ongoing investigations.

3.4 Complaints Management

Early Resolution Complaints (Informal)

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

45 Early Resolution complaints were received in Quarter 4. This is an increase on the 24 received in Quarter 3. 73% (33) of these complaints were resolved within the Putting Things Right target of two working days. 27% (12) were resolved outside of the target, but as soon as reasonably practical.
Delays occurred because either staff were unable to contact the complainant during the required timeframes, consent was not received in this timeframe, or the investigator requiring further information prior to contacting the complainant.

The below chart indicates the service areas where early resolution complaints have been received during Quarter 4 and provides Quarter 3 data for comparison.

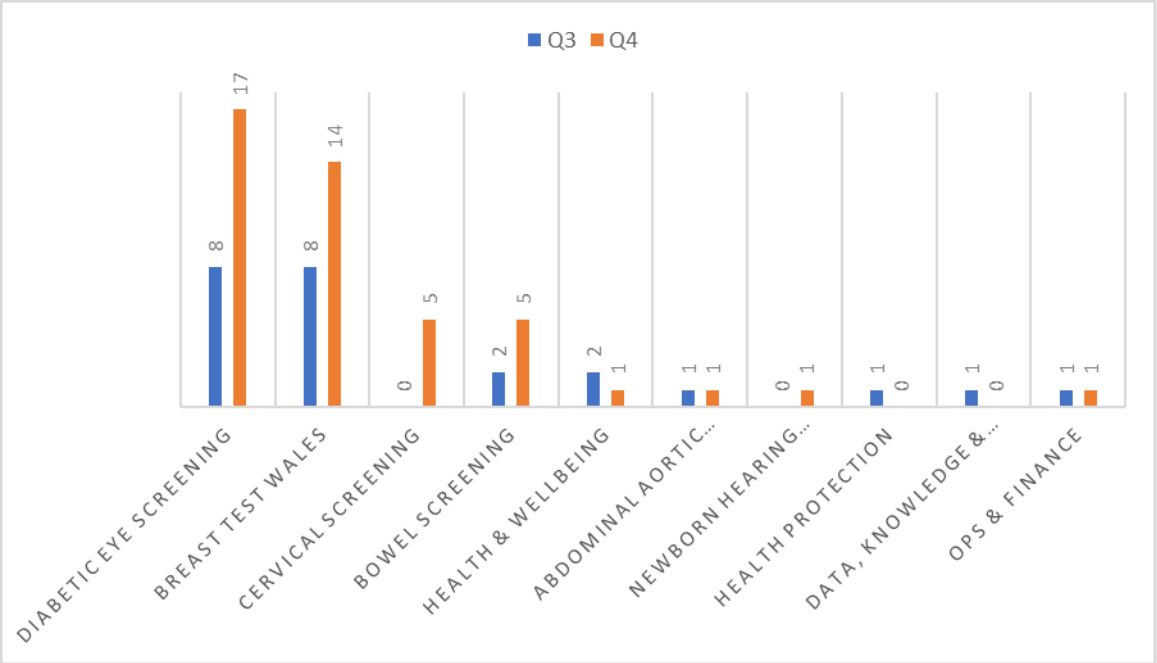


Table 3. Early Resolution Complaints by Area.

It should be noted that there has been a noticeable increase in complaints received in Quarter 4 within some screening services namely Diabetic Eye Screening Wales, Breast Test Wales, Cervical Screening Wales, and Bowel Screening Wales.
Diabetic Eye Screening and Breast Test Wales continue to receive the highest volume of Early Resolution complaints. Further analysis of these Early Resolution complaint 'subjects' reveals the following for this quarter:

- Access (To Services) – (13)
- Appointments (12)
- Communication issues – (8)
- Attitude and Behaviour – (8)
- Equality – (4)
- Test and Investigation Results (2)
- Confidentiality (2)
- Clinical treatment/Assessment – (1)
- Privacy and Dignity (1)

As a result of learning identified from the above Early Resolution complaints, improvement actions or changes have been implemented and some recent examples are included below:

- A complaint was received from a Diabetic Eye Screening participant as an interpreter was booked for their appointment but did not arrive. The participant's husband was willing to translate during the appointment, but the participant felt that the screeners on the day did not listen to this request.

  As a result of this type of complaint PHW approached the All-Wales Consent Group with a request to amend the national policy to allow a family member to translate for

participants during screening appointments. PHW's policy has subsequently been amended and service areas need to ensure staff are cognisant with this change.

- A complaint was received from a Breast Test Wales participant who felt that they were not shown empathy or concern when experiencing pain during their screening appointment.

  The investigation identified that the need for further information when communication with patients during screening procedures and recognising each participant's experience is different and staff need to be responsive to individual needs. The importance of this was discussed with all staff at the following staff meeting and further training provided.

- The Wider Determinants of Health Unit received a complaint regarding Welsh language errors on an email to network members.

  The investigation identified that some of the translations used with the email were undertaken some time ago, under a different process. As a result, the Standard Operating Procedure within Wider Determinants of Health is under review to ensure that if previously translated text is used, it is now quality assured. PHW has also recently changed its offer pertaining to Welsh translation with NHS Wales Shared Services Partnership translation service being the main offer for translation work to improve the consistency and quality of communication materials.

Formal Complaints

During Quarter 4, 5 formal complaints were received, a slight increase on the 3 received in the previous Quarter.

The below table demonstrates the percentage of complaints responded to within target of 30 working days in this quarter.

Month	Number of Complaints	Acknowledged within 5 w/d	Responded to within 30 w/d
January 2024	0	N/A	N/A
February 2024	2	100% (2)	100% (2)
March 2024	3	100% (3)	N/A (Not yet due for response)

All formal complaints received in the Quarter were acknowledged within the 5 working day target and 100% of those received in February have been responded to within the 30-working day target. The complaints received in March 2024 are not yet due for their final response and are progressing through the investigation and quality assurance process.

Formal complaints were received in the following areas in Quarter 4:

- Diabetic Eye Screening **(2)**
- Breast Test Wales **(1)**
- Cervical Screening Wales **(1)**
- People & Organisational Development **(1)**

The formal complaint themes are recorded as follows:

- Attitude and Behaviour **(2)**
- Communication Issues **(1)**
- Record Keeping **(1)**
- Test and Investigation Results **(1)**

Of the 5 formal complaints received, two were found to be upheld following the investigation process. The remaining 3 complaints received in March 2024 remain ongoing.

An example of a recent improvement action and changes that have been implemented as a result of one of the above formal complaints are detailed below:

- A complaint was received regarding Public Health Wales recent engagement with an external workshop provider.

  As a result, PHW is reviewing its current practices in when using external organisations and will also be providing guidance for Staff Networks to follow before booking external organisations for workshops/training events.

3.6 Duty of Candour

Duty of Candour (DoC) regulations have been in effect in Wales since April 2023. There were no new Duty of Candour cases identified during Quarter 4.

There remains one ongoing Duty of Candour case (reported in Quarter 2 September 2023). This is a combined DOC case with Cardiff and Vale University Health Board (CVUHB) who are the lead reporter and investigator. The case pertains to samples that had tested positive since May 2023 for a rare organism, and which had not been acted upon. PHW had missed opportunities to inform requesting clinicians of the clinically significant results. A further meeting is to be held with C&V UHB to review ongoing investigation.

3.7 Compliments

During Quarter 4 2023/24, 145 compliments were reported by staff using the Civica system across PHW.

Compliment types and themes received for this Quarter are categorised as follows:

Available Answers	Responses
Beyond the level of care expected or anticipated	112
Communication	4
Environment	0
Being listening to	0
Feeling understood	0
Dignity and respect	0
Going the extra mile	13
Demonstrating empathy	4
General thank you to staff	0
Professional and caring manner	0
General service compliment	0
Quality of training	0
Other, please specify:	12
Total	**145**

12 of compliments were recorded and classified as 'Other'. This is a slight decrease from Q3 (19) which is an improving trend.

In line with previous reporting 'Beyond the level of care expected or anticipated' remains the highest compliment reason with a Q4 figure of 112. This is followed by 'Going the extra mile' at 13, followed by 'Communications' with 4 and 'Demonstrating empathy' also with 4. Most compliments are received via the website or email and most relate to the Screening Division.

Available Answers	Responses
Card	1
E-mail	53
Letter	3
Social media	0
Flowers	0
Food /drink	0
Gift (Please see the Standards of Behavior Policy)	1
Verbal in-person	13
Verbal - telephone	10
Website feedback	61
Other, please specify:	3
Total	**145**

Directorate	Number of Survey Responses
Health and Wellbeing	2
Microbiology	9
Screening Division	134

Learning from complaints and compliments is an essential component of any learning organisation.

3.8 Service User Experience and Involvement Activity

There is a wide range of service /patient experience information from different sources led across many areas of the organisation. Each method of feedback has its strengths and weaknesses. Using all methods of information available enables PHW to better understand a person's experience of the services offered and delivered and is beneficial to help prioritise where to focus efforts on action planning. Our Young Ambassadors (YA) Programme has played a key part in supporting these objectives however this year the programme is being reviewed and refreshed. Several key activities have been taking place during the quarter which includes:

- Several Young Ambassadors are leaving the programme for university this year. A letter of thanks from the Chair and the Chief Exec will be sent along with a certificate and voucher in late April.
- The engagement team have been meeting with external organisations who run youth programmes such as Sports Wales and Diabetes UK, to understand their approach, and to share learning. We will be using this information to inform next steps for the Programme, and a paper will be taken to BET to provide recommendations for next steps.
- A meeting with the Youth Workers took place earlier in the year as an opportunity to discuss and understand progress against objectives plan for any realignment of these, and to review the approach to residential stays.
- Ongoing engagement activity with the young people and their youth workers is planned to update them and to seek their opinions and suggestions on how the programme should look going forward. We will also be asking staff across the organisation such as engagement leads, for their input too.
- The Programme Team are working on a forward look plan which will be shared through monthly updates with key stakeholders and Executives to keep them informed of progress.
- An overall review of our broader engagement activity in PHW has been agreed as a result of a recent Strategic BET session looking at the impact of Our Approach to Engagement.

Putting Things Right Section Conclusion

The Committee is asked to take **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient and person-centred services in in relation to **Putting Things Right.**

4. Safety Alerts and Notices Management

Public Health Wales has an effective management system for the distribution, management, monitoring, and appropriate record keeping of Safety alerts / safety notices it receives. Reporting of Alerts is by exception.

A total of 61 alerts were received by Public Health Wales during the reporting period 1 January – 31 March 2024, 3 of which required the action of disseminating for information. The main theme of the alerts being medicines shortages.

PHW receives alerts via multiple channels which has the potential to affect the timely management of these. As a result, improvement work is required to ensure the most effective alert management. Engagement is taking place with key internal stakeholders to streamline current processes, and where possible to ensure a single point of entry and distribution is being sought. This should avoid duplication and delays in action. In addition, greater assurance is required to demonstrate compliance with alert actions and meeting organisational standards and this improvement work will take place during 2024/25.

The distribution process for alerts is being revised by the Quality and Clinical Governance Team and Records Management team to ensure points of contacts are maximising SharePoint functionality. This will allow for nominated contacts within each area to access and action alerts promptly, ensuring that the process is timely and efficient ensuring patient safety. This improvement work is in the final stages, with plans to implement during Q1 2024/25.

Safety Alerts and Notice Management Section Conclusion

The Committee is asked to take **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient and person-centred services in in relation to Safety Alerts and Notice Management arrangements

Table 1: Total Number of Alerts received and Action Taken

Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Pharmaceutical Alert	12	0			
Medical Device Alert	1	0			
Medical Device (Information)	3	0			
Patient Safety Notice/Alert	4	1	A notice was sent to staff as a reminder that those working in healthcare settings require either natural immunity to measures or need a full 2-dose course of the MMR vaccine.	05.02.2024	This alert was shared with the Office of the Medical Director and the Head of our Vaccine Preventable Disease Programme.
Medicine Shortages	31	1	A medicine shortage for a variety of adrenaline was highlighted.	Received 14.02.2024. Actioned 21.02.2024	This alert was shared with the Head of Programme for Breast Test Wales and the Director of Primary Care. The delay in actioning is attributed to identifying whether it was appropriate to PHW services.
High Voltage Alert	7	0			
Public Health Alert	3	1	The updated communicable disease outbreak control plan was received and shared.	17.01.2024	This alert was shared with the Office of the Medical Director, the Executive Director for Quality, Nursing and Allied Health Professionals as well as the National Director of Screening and Health Protection Services.
Totals	**61**	**3**			

Table 2: Alerts applicable by Division and Action Taken

Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received & and Actioned	Action Taken
Screening	**1**	**1**	A medicine shortage for a variety of adrenaline was highlighted.	Received 14.02.2024. Actioned 21.02.2024	This alert was shared with the Head of Programme for Breast Test Wales and the Director of Primary Care. The delay in actioning is attributed to identifying whether it was appropriate to PHW services.
Micro/Health Protection	**2**	**2**	The updated communicable disease outbreak control plan was received and shared. A notice was sent to staff as a reminder that those working in healthcare settings require either natural immunity to measures or need a full 2-dose course of the MMR vaccine.	17.01.2024 05.02.2024	This alert was shared with the Office of the Medical Director, the Executive Director for Quality, Nursing and Allied Health Professionals as well as the National Director of Screening and Health Protection Services. This alert was shared with the Office of the Medical Director and the Head of our Vaccine Preventable Disease Programme.
Not Applicable	**58**	**10**			10 alerts were disseminated for information only as they were not applicable but of a potential interest to divisions across Public Health Wales.
Totals	**61**	**13**			

5. Quality and Clinical Audit

Quality and clinical audit is one of the pillars of clinical governance and an important quality control tool. It is complementary to other improvement methodologies and is a useful way of learning about what is working well when compared to a standard, and for then identifying areas for improvement. The audit cycle:

- Measures the quality of a service, function or programme being delivered.
- Identifies whether the best standards (where appropriate) are being delivered.
- Measures practice against explicit criteria and defined standards or guidance.
- Closes the loop for learning for improvement.

PHW has an annual Quality and Clinical Audit Plan, and Directorates and Divisions are required to participate. The audit programme is overseen by Quality, Nursing and Allied Health Professionals Directorate with audit leads from the respective areas meeting the audit team quarterly to provide progress updates.

The below table identifies the progress made to date during Quarter 4.

4.1 Quarter 4 Update against plan.

Number of Audits due for Completion in Q4	Audits Completed	Audits Progressing	Audits Delayed Until 2024/ 25
9	6 (67%)	1(11%) Audit Completed, final report delayed as no radiology QA assessor available to review radiology findings	2(22%) 1 x delayed due to staffing constraints, QNAHPs are assisting with data collection. 1 x delayed due to staffing constraints in service

There is no risk associated with the delayed audits.

4.2. Audit Training

Funding was obtained for a Clinical Audit Masterclass Course facilitated by the Clinical Audit Support Centre during this quarter. This training will be utilised to develop skills and enhance training delivery across the organisation during the next financial year.

The Quality, Safety and Improvement Committee can take assurance around the ongoing improvement and refinement of the PTR processes across the organisation. Response timeline for concerns remain excellent and improvements are being made around incident closure times, alerts management and robust learning mechanisms. This learning is being strengthened by engagement activity and through clinical audit.

Quality and Clinical Audit Section Conclusion

The Committee is asked to take **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient and person-centred services in in relation to **Quality and Clinical Audit**.

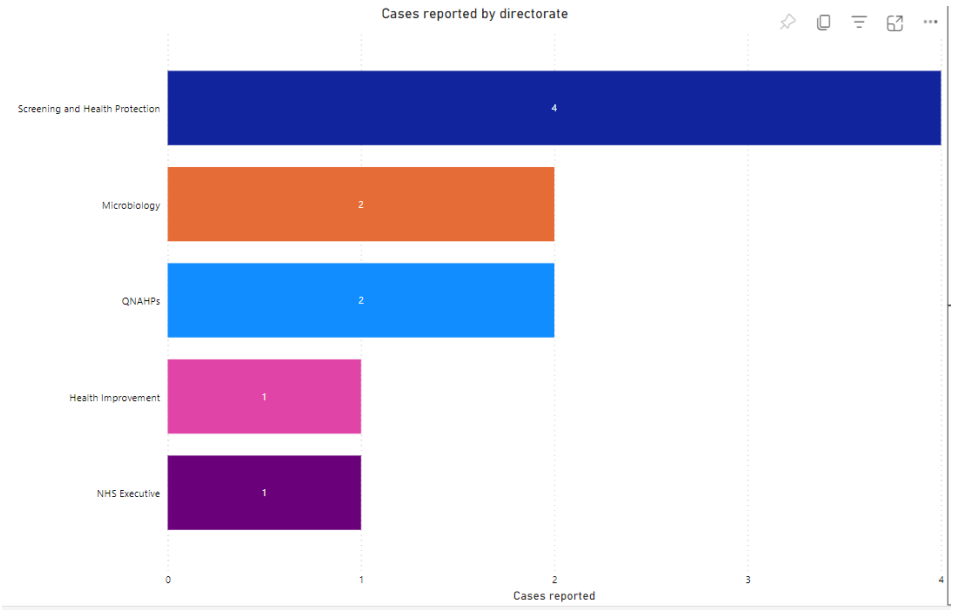
6. Safeguarding Group Report

The purpose of this section is to provide an update on the work of the Corporate Safeguarding Group, and safeguarding activity in Quarter 4.

There has been no meeting in Quarter 4 but the next one is scheduled for May 15th, 2024. The agenda will focus on:

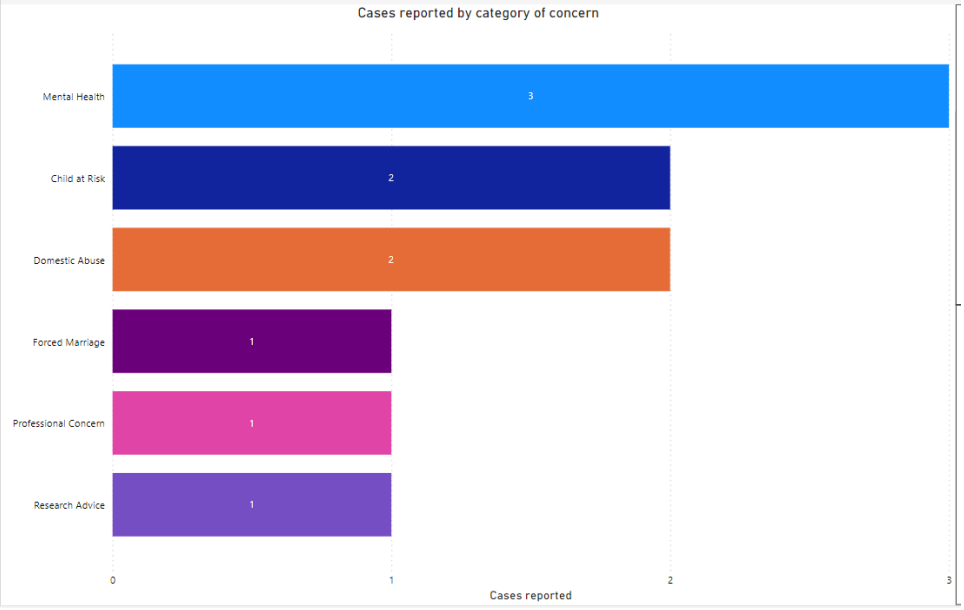
- Safeguarding incidents, referrals and themes using the Safeguarding Dashboard
- Presentation of the Safeguarding Risk Register
- Safeguarding Maturity Matrix for 24/25
- Safeguarding Training Compliance figures
- Progress with Disclosure and Barring Service Compliance Audit action plan
- Update of compliance with Disclosure and Barring Service compliance checks for newly appointed employees in Quarter 4
- Update from National Safeguarding Service Learning from reviews, workstreams, emerging issues

During the quarter 4 reporting period 10 Safeguarding incidents have been reported, the cases are reported by directorate and is demonstrated below.



The concern themes are reported below. Overall, this year there has been an increase in the reporting of safeguarding and can be attributed to increased awareness. It should also be noted that a new concern during Quarter 4 has led to further consideration for the 'Managing Allegations of Abuse by Staff' Procedure and to improve the content to strengthen organisational awareness around the

functions of the Corporate Safeguarding service in providing advice and support to line managers when confronted by these types of situations.



- During the reporting period 29 employees have been trained to meet the standard of Group 2 Violence Against Women, Domestic Abuse and Sexual Violence, 29 have been trained to meet the standard of group 3 Safeguarding training. This will directly impact on the compliance increase for both these Safeguarding training packages.
- Overall mandatory safeguarding training compliance is due to be reported and discussed at the meeting and areas below the 95% threshold will be targeted for improvement.

NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	2151	2151	1979	92.00%
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	2151	2151	1955	90.89%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	2151	2151	1955	90.89%

- The Named Lead for Safeguarding had the opportunity to collaborate and meet with Safeguarding leaders across NHS Wales at Elan Valley Lodge. The residential workshop offered an inspirational programme of sessions pertaining to clinical and restorative supervision delivered by Senior Executive Leaders across NHS Wales. Having the opportunity to take time out with colleagues the

  natural environment created safe spaces to reflect and share experiences along with challenges faced working within our own organisations and leading the complex Safeguarding agenda. Compassionate leadership and restorative

supervision are the pivotal foundations for any team or professionals working daily with vicarious trauma associated with child and adult abuse and neglect.

- A date has been arranged for the Board to undertake a Safeguarding development session led by The Named Lead for Safeguarding on 26th April. This will provide an opportunity for an update on Safeguarding as well as providing time for a facilitated discussion with board members relating to their and Public Health Wales's Safeguarding responsibilities.

Key Risks & Issues identified

One safeguarding risk should be noted.

Risk 1541 - DBS (Disclosure and Barring Service) checks

- There is a safeguarding risk that organisational DBS checks do not prevent unsuitable people from working with vulnerable groups, including children within PHW thereby placing them at risk of harm, abuse, and neglect.
- This is caused by individual DBS checks only being performed on the commencement of employment in PHW and are not renewed thereafter.
- In addition, there is a risk that employees may not have had an appropriate level of DBS check for their role or activity within PHW. The impact could mean that vulnerable people accessing and receiving PHW services, may be cared for by an employee or volunteer who is deemed unsuitable by the DBS to work with vulnerable groups.
- A recent detailed DBS audit has been completed and an action plan finalised with work initiated and progressing. To mitigate actions, an options paper including the findings of the audit and action plan is currently in development and will be presented at Business Executive Team Meeting in the coming months. This has been a key area of work in Quarter 4.

Safeguarding Section Conclusion

The Committee is asked to take **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient and person-centred services in in relation to **Safeguarding arrangements**.

7. Infection Prevention and Control (IPAC) Report

The purpose of this section is to provide an update on the work of the Infection Control Group and IPAC activity in Quarter 4. The group met in January and April. Areas of particular focus include:

- The 2023/24 IPAC audit programme for PHW-managed sites has been completed. A comprehensive report has been produced by the IPC Lead Nurse with clear remedial actions requested.
- Work on compliance with cleaning standards and the process if escalation where the service level is falling below standard.

- The current SLA contracted through shared services is being revisited to understand the details of the specification review and establish escalation procedures, agree a joint programme for cleanliness audits with the contractor, and to establish if any amendments to existing cleaning levels need to be increased within the contract.
- Greater visibility and monitoring of IPC action plans will be the focus of Quarter 1 2024/5.
- Decontamination practice and compliance against standards within some screening services has raised some concerns. These are being addressed by the services with support from the Head of Estates and Health & Safety and the NHS Wales Shared Services Partnership Senior Decontamination Engineer.

  These mainly relate to:
  - Glan Clwyd endoscopy unit reprocessing facilities,
  - Air change and ventilation within Breast Test Wales clinic environments which is currently limiting the service's ability to comply with new decontamination requirements for of breast ultrasound probes.

Further detail is outlined in the Divisional reports below.

IPC-related incidents 1st January 2024 to 22nd March 2024

Table 6.1: IPC-related incidents per quarter, focusing on contact with body fluids or other hazardous substances.

	Total	Contact with needles or medical sharps.	Contact with blood/body fluids or other hazardous substance (not sharps)
Q2	12	1	7
Q3	16	0	8
Q4 (until March 22nd)	18	3	10

All IPC incidents were assessed as no or low harm, with only two remaining under investigation which includes one sharps injury, described in more detail below, and an issue with clinical waste collection at the microbiology laboratories in University Hospital Wales.

Specific focus is given within the meeting to incidents coded as contact with body fluids or other hazardous substances, either through contact with needles or medical sharps or through other exposure. These account for half the incidents reported, in the last 3 quarters 29 of the 46and a slight increase noted in quarter 4 of this type of incident. Incidents of this nature also carry the potential of serious consequences to the health of the individual and would be RIDDOR reportable.
Because of the reasons above, a more detailed investigation of incidents involving 'contact with blood/ body fluids or other hazardous substances' was undertaken during this quarter. Recommendations have been made which include improving

adherence to the correct processes for the handling specimens and the use of microbiology equipment. Working collaboratively work with the Microbiology.

Division Health & Safety Manager an established system is now in place so that staff are better informed of learning from incident investigations.

From the reported incidents in quarter 4, only one incident coded as 'contact with needles or medical sharps' was a true contact with blood or body fluids. The staff member received the appropriate follow up care however the process followed the incident was not the most recent procedure and they were seen at a Health Board Occupational Health department rather than in the Accident & Emergency Department and subsequently followed up by Welsh Ambulance Trust Occupational Health as per PHW procedure. This meant that there will be no record of the incident in their allocated PHW OH record. This identified learning and has been raised with the Regional Nurse Lead for the service.

Divisional Updates

Each Division provides a quarterly highlight report which include IPAC related issues along with Environmental and Hand Hygiene audit scores and associated improvement actions. Quarter 4 divisional updates are detailed below.

Screening

- **Breast Test Wales (BTW):** The implementation plan to ensure full compliance with the new required standards for decontamination of ultrasound scan probes continues but has been complicated by findings from the assessment of air quality and ventilation standards for the 4 BTW Regional Centres. This has raised other potential IPAC issues which have been brought to the attention the Medical and Nursing Director for assessment and next steps with supports form the Estates team Until these are resolved, progress towards the use of the Tristel Trio wipe system cannot be made. Until this is

achieved a risk remains that service users will be exposed to healthcare-associated wound infections due to insufficient decontamination processes. In addition to the Tristel Tri system capital funding requests have been submitted for Ultra-Violet Cabinets which is the preferred method of decontamination for ultrasound probes. Full compliance with the new standards is currently not being achieved and an update is anticipated at the next IPC meeting on the progress being made to meet standards.

- **Bowel Screening Wales (BSW):**
  Discussions continue with Betsi Cadwaladr UHB (BCUHB) regarding endoscopy decontamination facilities at one of their district general hospitals, following the most recent Institute of Healthcare Engineering and Estate Management (IHEEM) annual inspection. This issue has now been added to the programme risk register and escalated internally and externally. A formal meeting took place in February between BSW and Health Board

  colleagues and the current service concerns discussed at the Screening Senior Management Team. In the short-term, BCU have submitted a high priority discretionary capital request for funding to provide a separate modular decontamination facility at Ysbyty Glan Clwyd (YGC), as well as robust SOPs to minimise the risk of cross infection. The service is also carrying out a six-monthly endoscopy decontamination audits under the direction of the BCUHB Director of Nursing. This short-term solution will allow time for longer-term options to be considered and planned for. Regular joint meetings will continue between BSW and BCU with close monitoring of the site for greater assurance and involvement of PHW's Head of Risk.

- **Diabetic Eye Screening Wales (DESW), St David's Park, Carmarthen:** ongoing concerns remain as to the suitability of this building as a screening venue. Discussions with Hywel Dda University Health Board continue in order to secure space in a new health hub situated in the previous Debenhams store in Carmarthen. This site is anticipated to be available in summer 2025. In the meantime, the venue remains on the divisional risk register, and it remains part of the IPC environmental auditing programme.

- **Auditing of screening venues:** Staff shortages continue to affect capacity to fulfil the audit programme. The lead Nurse for IPAC continues to work with Heads of Nursing to recover this audit programme.

Microbiology Division

Capital funding has been secured to resolve the affected section of flooring in the Wales Centre for Mycobacteria, which has been an ongoing risk for the division.
The main risk now for Microbiology is the increase in the likelihood of a new risk associated with requirements for autoclave replacement due to imminent failure. A report has been received from Shared Services identifying that this autoclave will

not pass next year's revalidation and a business case has been formulated with stakeholders to go forward to BCUHB.

IPC Mandatory Training Compliance

IPC mandatory training compliance for the previous quarter is discussed at each IPC Group. Quarter 4 data is displayed in the table below. Overall organisational compliance for the IPC Level 1 & 2 modules has increased from Q3, with Level 1 compliance rising from 88.90% to 89.54% and for Level 2, 80% from 78.28%. However, within directorates and teams, there are several areas that are not achieving the expected targets. Directorate representatives have been asked to provide the anticipated recovery dates at the next IPAC meeting.

Table 6.2: Quarter 4 IPC Mandatory Training Compliance, RAG rated against the PHW compliance target of 95%.

Subject	Directorate/Division	Required	Achieved	Compliance %
IPC Level 1	028 L3 Corporate Directorate	29	22	75.86%
	028 L3 Data, Knowledge and Research Directorate	116	111	95.69%
	028 L4 Health Protection Division	196	169	86.22%
	028 L3 Health & Wellbeing Directorate	169	152	89.94%
	028 L3 Improvement Cymru Directorate	108	98	90.74%
	028 L4 Microbiology Division	624	557	89.26%
	028 L3 Operations and Finance Directorate	137	131	95.62%
	028 L3 People & OD Directorate	43	41	95.35%
	028 L3 Quality Nursing & Allied Profs Directorate	48	42	87.50%
	028 L4 Screening Division	536	472	88.06%
	028 L3 SPRs Directorate	19	16	84.21%
	028 L3 WHO Collaborating Centre	76	71	93.42%
	Overall compliance in PHW staff			89.54%
IPC Level 2	028 L4 Health Protection Division	42	33	78.57%
	028 L4 Screening Division	227	182	80.18%
	028 L3 Quality Nursing & Allied Profs Directorate	1	1	100.00%
	Overall compliance in PHW staff			80.00%
ANTT e-learning	Breast Test Wales	85	79	92.94%
ANTT Assessment	Breast Test Wales	85	58	68.24%

- To support an improved position for this ANTT in BTW, an assessor's training day was run on 21st February 2024 to ensure that BTW has sufficient assessors to meet demand.

- The Group agreed that those screeners who had attended the 6 hour initial IPC Link Worker training day had met their Level 2 requirements for this year, and this would be updated on ESR.
- Mandatory training compliance reports to the group now divisional and team level data and going forward this will be compared to the previous quarter to facilitate greater scrutiny of underperforming areas and the targeting of additional support.

IPC Risk Register

- The Risk Manager attended the Quarter 4 IPC Group meeting to talk through the risk register. Several actions arose:
    - The need to formulate the mitigation plans for when the Lead Nurse for IPC leaves the organisation.
    - The need to escalate the risk around autoclave replacement to the Corporate Risk Register and therefore Quality safety and improvement committee (QSIC). In particular, the autoclave unit in Bangor which will not pass its validation next year, leaving the laboratory with no facility to sterilise Level 3, Category A waste. This will result in the need to send the waste away to specialist facilities, at great expense. The autoclaves are owned by the Health Boards, which makes the situation more complicated to resolve. The escalation process will now be taken forward by members of the Group.
    - The risks pertaining to the endoscopy decontamination units were discussed and a request by the group to seek an update on current mitigating actions. Work is progressing on this and will now be reflected within the risk register.
    - Risks associated with broken or inadequate ventilation systems in BTW will now need to be added to the register, and action to resolve require urgent action. It was agreed that a briefing paper would be prepared for BET, outlining the issues and options available, and a working group will be set up to take this remedial work forward.
    - It was agreed that a further discussion is needed regarding the contents of Service Level Agreements (SLAs) between Health Boards and the screening services to firm up cleaning baseline agreements and escalation processes in the event the service does not meet IPC standards.

Staff Flu Vaccine Programme

- The overall performance of the internal staff Flu Vaccination Campaign was discussed. achievement of first place in the leader board of all Health Boards and NHS Trusts in Wales, for both total staff and frontline staff, was noted and celebrated.
  A paper was presented at BET, with options for next year's programme, and the decision was taken for operational delivery of the programme to actioned

through the Welsh Ambulance Service NHS Trust (WAST) Occupational Health (OH) Service SLA. Meetings between both organisations to discuss how this will happen in practice have already started.

IPC Policies and Procedures

- Progress being made against key IP&C Policies & Procedures were noted at the meeting. At the end of Quarter 4, progress is as follows:

Table 6.3: Progress on policies and procedures

Policy or Procedure	Update	Completion date
Decontamination policy & procedure	External IPC resource obtained. First draft of policy and procedure complete. Some further work required but making good progress.	May 2024
Policy for the Transport of Pathological Specimens	Brought to the IPC Group on 18th April 2024 for final approval from all members by 26th April ahead of QSIC.	April 2024
ANTT policy	All-Wales model policy adapted for organisational use. Approval by IPC Group on 18th April before going to the 20th May QSIC.	April 2024
Waste management procedure	Health & Safety hold the responsibility for this. However, the IPC Lead Nurse is overseeing the development of the clinical waste management chapter. The Screening IPC Group agreed the waste streams to be used for waste items in the frontline Screening Services on 28th March 2024. The Waste Group continue to meet to complete the overall waste policy and procedure.	May 2024.
Sharps injury and safer sharps management Policy and Procedure	Approved and both English & Wales copies published on the intranet.	Completed.
Outbreak Management	Following the release of the most recent outbreak management plan for Wales, the local procedure is being finalised following these changes.	May 2024.

The Committee can take assurance from the developing workplans from the corporate safeguarding and IPAC agendas in PHW. The work is strengthening in areas of training, compliance and assurance and is extending its reach across the organisation in terms of addressing areas of concerns and sharing of good practice. Areas of concerns or in need to focus are identified as part of departmental or

corporate workplans, and as part of the maturing risk management approach overseen at the safeguarding and IPAC groups.

Infection Prevention and Control Section Conclusion

The Committee is asked to take **assurance** that appropriate governance is in place to ensure safe, timely, effective, equitable, efficient and person-centred services in in relation to **Infection, Prevention and Control arrangements**.

8. 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

9. 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 in the following areas:
    - Putting Things Right
    - Claims Management
    - Alerts Management
    - Quality and Clinical Audit
    - Infection Prevention Control
    - Safeguarding