GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 24 July 2024 **Agenda item:** *4.1*

Quality Governance Performance Report Quarter 1(1st April – 30th June) 2024/2025	
Executive lead:	Claire Birchall, Executive Director of Quality, Nursing and Allied Health Professionals
Author(s):	• Angela Cook, Assistant Director of Quality, Nursing and Allied Health Professionals • Paula Mitchell, 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

Approval/Scrutiny route:	Angela Cook, Assistant Director of Quality, Nursing and Allied Health Professionals

Purpose

The Quality Governance Report provides the Business Executive Team and QSIC with an overview of quality governance within Public Health Wales for the period Quarter 1(April – 30 June 2024). This is a new style 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
- 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 and Quality and Clinical Audit.

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.
- **Approve** the report for submission to the Quality Safety and Improvement Committee.

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
Strategic Priority/Well-being Objective	Choose an item.
Strategic Priority/Well-being Objective	Choose an item.

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.

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).

- 511 incidents were reported during Quarter 1, investigated and remedial actions identified. Of these, 24 were initially reported as moderate harm or above.
- As of 1 July 2024, there are 72 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (page 22)

- 11 safeguarding incidents were raised at PHW sites with varying concerns being reported. In this quarter there has been an increase in employees disclosing domestic abuse or mental health concerns to their managers. A safeguarding training session specifically aimed at managers has been arranged as a result of this.
- Safeguarding training compliance continues to improve and remains above the Welsh Government target of 85%.
- There is 1 safeguarding risk on the corporate risk register which relates to Disclosing and Barring (DBS) checks within PHW.

Infection prevention & Control (page 26)

- There were 15 IPC incidents reported in Quarter 1. 1 moderate harm was reported, and the remaining incidents were assessed as no or low harm.
- Compliance with Cleaning standards and mechanical ventilation systems within some screening services has raised some concerns and further actions are being put in place to address these.
- IPC level 1 and 2 training have improved since the last quarter and is now above the Welsh Government targe. Some areas still require targeted support.

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)

- 29 Early Resolution complaints were received in Quarter 1 and 10 formal complaints.
- 86% of the early resolution complaints were resolved within 2 working days target. All 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 20)

The Quality and Clinical Audit Plan for 2024-25 is being presented to QSIC on 24 Jul 25 for approval. The Quality and Clinical Audit Team have engaged with all areas undertaking audit to evaluate progress against the draft plan and an update is included in this report.

Safety Alerts Management (page 17)

- 63 alerts were received in Quarter 1 of which 2 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)

- 154 Compliments were received this quarter of which 'Beyond the level of care expected or anticipated' was the highest recorded compliment category.
- Further improvement work to capture service user experience is also detailed within this report.

BET and the Committee are asked to approve the Report as providing sufficient assurance on the actions being taken in relation to Quality and Patient Safety.

1. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 1 2024-25 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
- Quality and Clinical Audit
- Infection Prevention Control
- Safeguarding

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. Putting Things Right

2.1 Nationally Reportable Incidents/Early Warnings/Never Events

Number in Quarter	Q2 Jul – Sep 23	Q3 Oct – Dec 23	Q4 Jan – Mar 24	Q1 Apr – Jun 24
Nationally Reportable Incidents reported to NHS Executive	0	1	0	1
Early Warning reports submitted to Welsh Government	1	0	0	2
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

One **Early Warning** Incident was reported by Breast Test Wales in April 2024. This incident was reported following receipt of a notification from NHS England Breast Screening Programme. NHS England had identified they had failed to invite a cohort of individuals who for annual breast screening in line with national guidelines. This led to Breast Test Wales working with NHS England to ensure that any individuals who have been affected by this and reside in Wales are followed up appropriately. The investigation into this incident remains ongoing.

An incident that occurred within Microbiology was reported as both a Nationally Reportable Incident and as an Early Warning in May 2024. The incident relates to the incorrect reporting of several swab test results which were reported as false positive results.

2.2 Incident Management

Incidents

During Quarter 1, 511 incidents were reported. This is an increase from the 471 reported in Quarter 4 of 2023/2024.

The below table indicates the number of moderate harm or above incidents recorded for each quarter.

	Moderate	Severe	Catastrophic/ Death
Quarter 2 (Jul – Sep 23)	1	0	0
Quarter 3 (Oct – Dec 23)	1	0	0
Quarter 4 (Jan – Mar 24)	3	0	0
Quarter 1 (Apr – Jun 24)	23 (17 downgraded, 6 ongoing investigation)	1 (downgraded to no harm)	0

As of 1st of April the level of harm initially reported on datix has not been altered whilst investigations remain ongoing. Previously the PTR team would review the initial level of harm associated with the incident and amend if appropriate the overall harm level.
This process has now been changed and the harm level remains unchanged until the investigation is complete. This allows for more accurate reporting and helps the PTR team to identify areas for further learning in relation to the appropriate reporting of levels of harm.

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

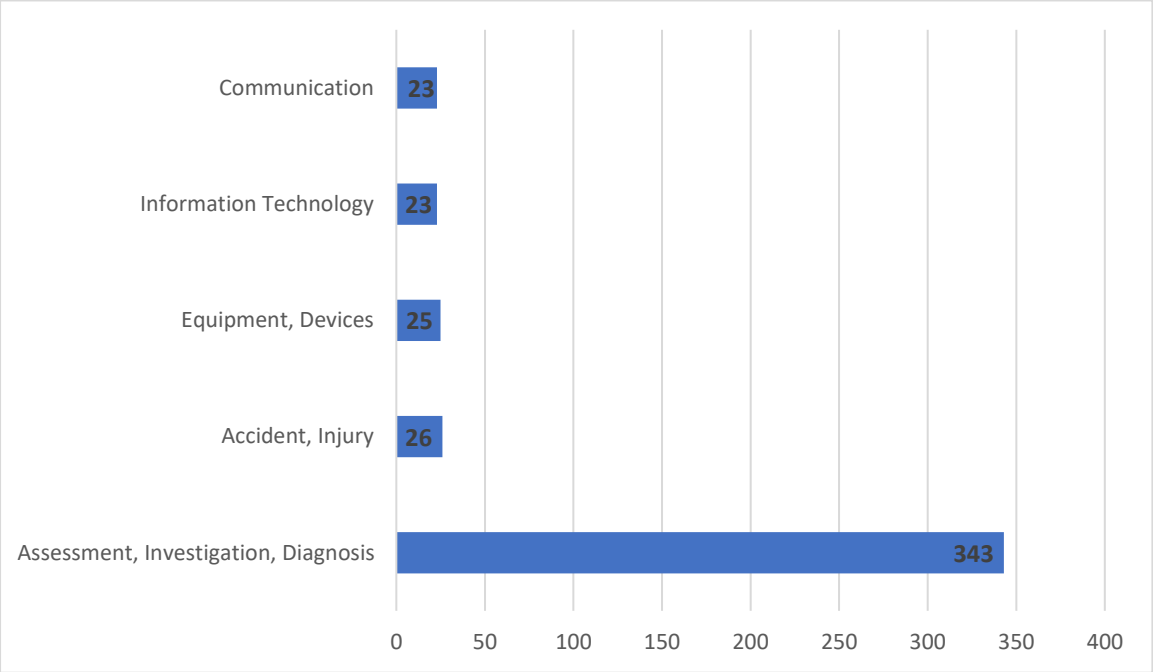


Table 1. Frequently reported incident categories

Chart 2 below indicates the highest five 'Assessment, Investigation, Diagnosis' subcategories reported for all Directorates compared with the numbers reported in Quarter 4 2023/2024.

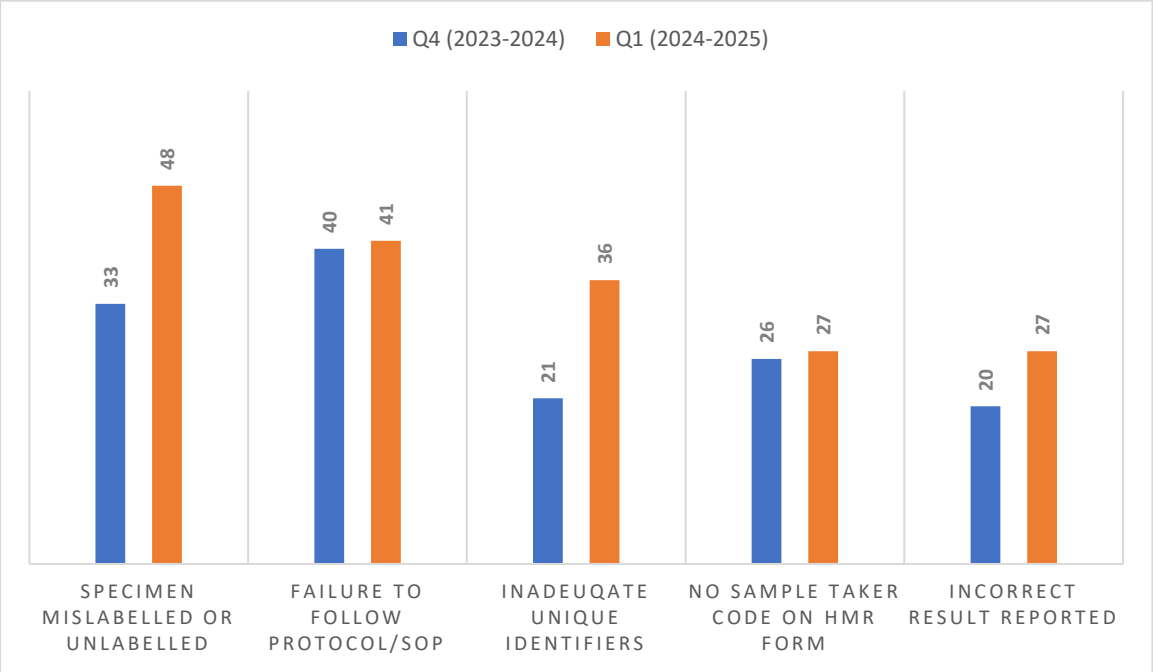


Table 2. Top five categories for subcategories

The highest reported subcategory has changed during this Quarter, from the previous 'Failure to follow protocol/SOP' being reported the most frequently to 'Specimen mislabelled or unlabelled'. 48 incidents have been reported under this category during this quarter an increase of 15 from the 33 reported in Quarter 4. 47 incidents (98%) occurred within Cervical Screening Wales and relate to sample taker errors. 1 incident (2%) occurred within Microbiology.

The second highest subcategory is 'Failure to follow protocol/SOP' with 41 incidents reported during the quarter in this category. 19 (46%) of these incidents occurred within Diabetic Eye Screening Wales and 18 (44%) within Microbiology.

Open Incidents

As of 1 July 2024, there are a total of 72 overdue reported incidents within Datix that have an 'open' status of more than 30 working days. The highest number of open incidents are currently within Cervical Screening Wales (47), followed by Microbiology (13) and Diabetic Eye Screening Wales (5). Many of the cervical screening incidents have a digital /IT element that remain unresolved preventing incident closure. As a result of these delays, a meeting was recently held with key staff from cervical screening, digital services, and integrated and quality governance to try to resolve these delays. Further work is planned to facilitate closure.

Chart 3 below shows the progression of overdue incidents throughout Quarter 1.

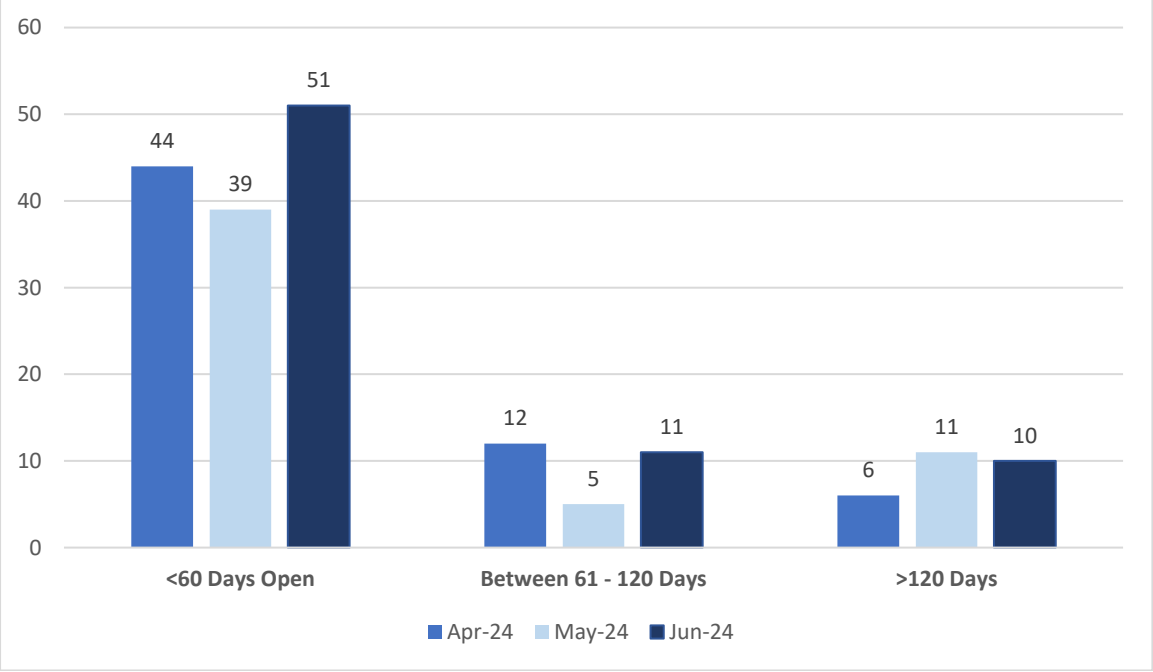


Table 3. Overdue incident progression

Of the 72 overdue incidents, 10 (14%) have been open for more than 120 working days, with the oldest being open for 349 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 with a bulk data amendment awaited and as such the incident cannot be closed. 11 incidents (15%) have been open for between 60 and 120 working days and 51 (71%) 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 is being revised to support the quality of investigation management with the aim of improving overall performance and actions.

Incident Reporting and Management Training
During Quarter 1, Datix Level 1 incident reporting training was delivered to 64 members of staff.

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.

2.3 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.

1 new Redress case was received in Quarter 1 within Cervical Screening Wales and relates to the misinterpretation of a cytology slide. Causation is yet to be determined due to ongoing investigations from independent experts.

2.4 Complaints Management

Early Resolution Complaints (Informal)
Public Health Wales endeavours to deal with any complaints received by way of early resolution wherever possible.

29 Early Resolution complaints were received in Quarter 1. This is a reduction on the 45 received in Quarter 4. 86% (25) of these complaints were resolved within the Putting Things Right target of two working days. 14% (4) 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 the required timeframe, or the investigator required further information prior to contacting the complainant in order to proceed.

The below chart indicates the service areas where early resolution complaints have been received during Quarter 1 and provides Quarter 4 (2023-2024) data for comparison.

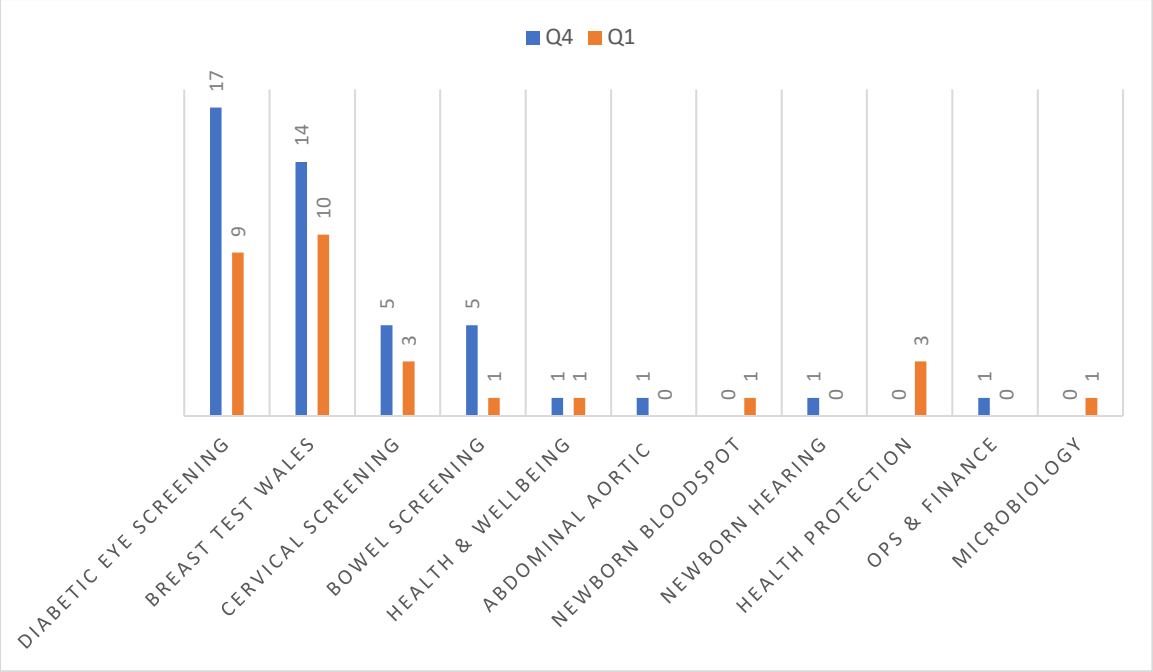


Table 3. Early Resolution Complaints by Area.

There has been a noticeable reduction in complaints received in Quarter 1 within some of the screening services, namely Diabetic Eye Screening Wales, Breast Test Wales, and Bowel Screening Wales.

Diabetic Eye Screening and Breast Test Wales continue to receive the highest volume of Early Resolution complaints, with the Health Protection service seeing an increase this quarter.

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

- Communication Issues – (9)
- Appointments - (5)
- Access (To Services) – (4)
- Attitude and Behaviour – (4)

- Test and Investigation Result – (4)
- Clinical Treatment/Assessment – (1)
- Environment/Facilities – (1)
- Referral – (1)

As a result of identified learning from the above Early Resolution complaints, improvement actions or changes have been implemented. Recent examples include:

- A complaint was received by Diabetic Eye Screening Wales (DESW) from a member of the public who was experiencing participants for the eye screening appointments knocking on their door whilst they were attempting to find the DESW screening clinic. Their house shared the same postcode as the clinic venue. The member of the public requested that the directions within the screening invitation letters be made clearer for participants to prevent this from happening.
  DESW colleagues acted promptly within two working days to resolve this as an Early Resolution complaint and arranged for the invitation letters for this particular screening venue to be updated to provide clearer directions for participants and to point out nearby buildings that participants should look out for whilst trying to locate the venue.

- A Breast Test Wales participant raised a complaint in which they expressed how they had felt uncomfortable during the screening appointment when being asked for personal information.
  The investigation identified key learning which was the importance of communicating sensitively and with empathy when dealing with service users attending their appointments, so they continue to use the screening offer. The importance of this has been discussed with staff and further customer service skills training arranged.

Formal Complaints

During Quarter 1, 10 formal complaints were received, an increase of 5 compared to 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
April 2024	1	100%	0%
May 2024	5	100%	60% (3)
June 2024	4	100%	N/A (Not yet due for response)

All formal complaints received this Quarter were acknowledged within the 5 working day target.

One complaint received in April 2024 missed the 30-working day response timeframe due to the complexity of the investigation to ascertain whether harm had been caused or not. The complainant was kept fully informed during the investigation process and of the delay in responding formally.

2 of the 5 complaints received in May 2024 missed the 30-working day response timeframe because of both complex investigations and amendments requested during the quality assurance process. Both complainants have been updated throughout the investigation process and informed of the delay in formally responding.

The complaints received in June 2024 are not yet due for their final response and are progressing through the investigation and quality assurance processes.

Formal complaints were received in the following areas during Quarter 1:

- Breast Test Wales **(4)**
- Cervical Screening Wales **(1)**
- Health Protection **(2)**
- Microbiology **(2)**
- Corporate **(1)**

The formal complaint themes are recorded as follows:

- Communication Issues **(3)**
- Referral **(2)**
- Test and Investigation Results **(2)**
- Access (To Services) **(1)**
- Attitude and Behaviour **(1)**
- Procedure **(1)**

Of the 10 formal complaints received, 3 were found to be upheld following the investigation process and 3 were not upheld. The remaining 4 complaints remain ongoing.

An example of a recent improvement and change that has been implemented as a result of one of the above formal complaints is detailed below:

- Cervical Screening Wales (CSW) received a complaint from a participant who raised concerns regarding the wording included in the CSW result letter. The complainant stated that the wording caused them to worry and could be misinterpreted by members of the public because of the way it was written.

Consequently, the result letters terminology was reviewed and amended to improve the terminology used and to aid better understanding of test results to prevent any anxiety to participants. The term 'High Risk' has been removed from the highlighted section of the letter but remains in the body of the letter and is accompanied with improved signposting to the supporting leaflet and CSW website.

2.6 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 1.

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 did not recognise the significance of the rare result and missed opportunities to inform requesting clinicians of the clinically significant results. PHW have provided our report and are awaiting C&V UHB to provide their report. The case is now with the coroner for inquest.

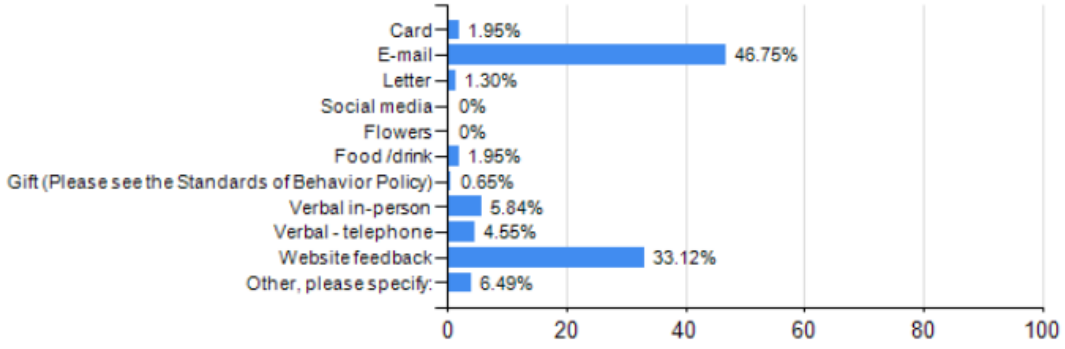
2.7 Compliments

During Quarter 1 2024/25, 154 compliments were reported on the Civica system by PHW staff. The recently introduced 'Your Feedback' pages on the PHW website also received 1 compliment however this related to Betsi Cadwaladr Health Board and not PHW services. It is hoped that more people will start to use this new facility in the coming months to provide feedback on our services.
The new page can be found at - Feedback and Complaints - Public Health Wales (nhs.wales)

The Compliment themes received for this Quarter are categorised as follows:

Available Answers	Responses	Score (%)
Beyond the level of care expected or anticipated	110	71.43%
Communication	3	1.95%
Environment	2	1.30%
Being listening to	2	1.30%
Feeling understood	2	1.30%
Dignity and respect	2	1.30%
Going the extra mile	10	6.49%
Demonstrating empathy	4	2.60%
General thank you to staff	21	13.64%
Professional and caring manner	5	3.25%
General service compliment	11	7.14%
Quality of training	2	1.30%
Other, please specify:	2	1.30%
Total	**154**	**100%**

'Beyond the level of care expected or anticipated' remains the highest reason for a compliment being left, with a 110 reported this quarter. This is followed by 'General thank you to staff' (21) and 'General service compliment' (11) and 'Going the extra mile' (10). Most compliments are received via the website or via email with the majority relate to the Screening Division.



Service User Experience and Involvement Activity

As part of PHW's commitment to understanding and meeting the needs of our population and service users, infection services have recently introduced a mechanism to capture service user experience and compliments following the update to the Website.

[Infection Services - Home (sharepoint.com)]

A similar development is underway with Screening programmes and is planned to be introduced in quarter 2 of 2024/25. Improvement work includes an embedded feedback link within results letters, the introduction of tablet devices to enable and capture feedback at the point of service delivery and the introduction of a text message functionality for screening participants to provide real time feedback following their appointments.

3.0 Safety Alerts and Notices Management

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

A total of 63 alerts were received by Public Health Wales during the reporting period 1 April – 30 June 2024. 2 required action which was dissemination for information. The main theme of the alerts being received was 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 system for alert management. Currently engagement activity is taking place with key internal stakeholders to streamline current processes, and where possible to ensure a single point of entry and distribution. This should avoid duplication and delays in required actions. In addition, greater assurance is required to demonstrate compliance with any alert actions and meeting organisational standards. This improvement work is planned to continue throughout 2024/25.

To date work includes the revision to the alert distribution process by the Quality and Clinical Governance teams along with the Records Management team to ensure points of contact are maximising SharePoint's functionality. This will allow for nominated contacts within each area to access and action alerts promptly, ensuring a timely and efficient process to ensure patient safety. This improvement work is anticipated to be completed in Quarter 3.

Table 1: The 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	14	0			
Medical Device Alert	1	0			
Medical Device (Information)	2	1	A safety recall notice for certain saline eye wash products.	09/04/2024 (received) 10/04/2024 (actioned)	This alert was shared with the Programme Manager for Microbiology.
Patient Safety Notice/Alert	0	0			
Medicine Shortages	37	0			
High Voltage Alert	8	0			
Public Health Alert	1	1	A public safety notice with updated prescribing information relating to the latest influenza levels.	23/04/2024 (received) 24/04/2024 (actioned)	This alert was shared with the Office of the Medical Director.
Totals	**63**	**2**			

Table 2: Alerts applicable by Division and Action Taken

Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received & Actioned	Action Taken
Micro/Health Protection	**2**	**2**	A safety recall notice for certain saline eye wash products A public safety notice with updated prescribing information relating to the latest influenza levels.	09/04/2024 (received) 10/04/2024 (actioned) 23/04/2024 (received) 24/04/2024 (actioned)	This alert was shared with the Programme Manager for Microbiology. This alert was shared with the Office of the Medical Director.
Not Applicable	**61**	**5**			5 alerts were disseminated for information only as they were not applicable but of a potential interest to divisions across Public Health Wales.
Totals	**63**	**7**			

4.0 Quality and Clinical Audit

Quality and clinical audit is one of the pillars of clinical governance and an important quality assurance tool. It is complementary to other improvement methodologies and is a useful way of learning about what is working well and identifying areas for improvement.

The 2024-25 Quality and Clinical Audit Plan is being presented for approval to the Quality Safety & Improvement committee in July as part of the usual annual reporting cycle. Engagement activity by the Quality and Clinical Audit Team this year has focused on the areas undertaking audit to evaluate current progress against the draft plan and to capture audit activity.

In addition, other areas of focus include:

- The procurement of a Digital Audit Management Platform. Following early consultation in 2023 with the Digital and Data Design Authority (DDDA) an initial trial of the digital tool, iPassport has taken place. Following this it was identified that this platform does not fully meet the requirements for the broader quality and clinical audit needed in PHW. Further engagement work has commenced with the DDDA regarding the potential procurement of an alternative digital platform, one that will fully meet the needs for clinical and quality audits. A mini discovery project is underway with engagement activity taking place on 23 July across the organisation, to establish the key requirements/specifications for a digital platform before progressing further.

4.1 Quarter 1 Update against plan.

A summary of key audit activities for this quarter as listed below.

Quarterly Status	Q1	Comments
Completed	1	• 1 audit from 2023-24, that was identified as being removed from the plan after Q1 and having an increased risk, was commenced and is now complete. Awaiting final report
Progressing	18	• 1 audit is continuous, with report to be received at the end of the year. • 5 audits commenced in 2023-24 plan, rolling into 2024-25 plan. • 12 audits commenced as planned
Delayed (risk of not completing before agreed timeframe)	2	• 1 team have requested support to assist with data collection and analysis, this has been approved. • 1 audit due to start in Feb 24, due to conflicting priorities, unable to commence
Removed from Plan	2	• 2 audits have been removed from the plan. ○ Both were initially added to the plan for 2024-25 as they were undertaking the analysis of their findings from previous audit in 2023-24. There are no requirements to repeat the audit this year and have been removed
Audit not due to start this quarter	19	

Other	9	• 1 audit – 1 programme are awaiting reallocation of audit activity due to staff long term absence.
		• 1 audit – changeover in senior role. Programme to decide if audit to go ahead. To be discussed in Q2
		• 2 audits on hold from programmes
		  ○ awaiting new national guidelines. to commence in Q4
		  ○ staffing constraints, will be advised if this will go ahead in Q3
		• 1 audit – no update available to due staff on Annual Leave
		• 1 audit – funding has been approved for external support to undertake the audit. Awaiting next steps
		• 1 audit – awaiting final details of audit proposal from programme

There are no risks associated with the delayed audits.

4.2. Audit Training

No audit training has been delivered in Quarter 1; however, training is planned for quarters 2 and 3 and will be available across the Organisation.

5.0 Safeguarding Group Report

Safeguarding Group Report

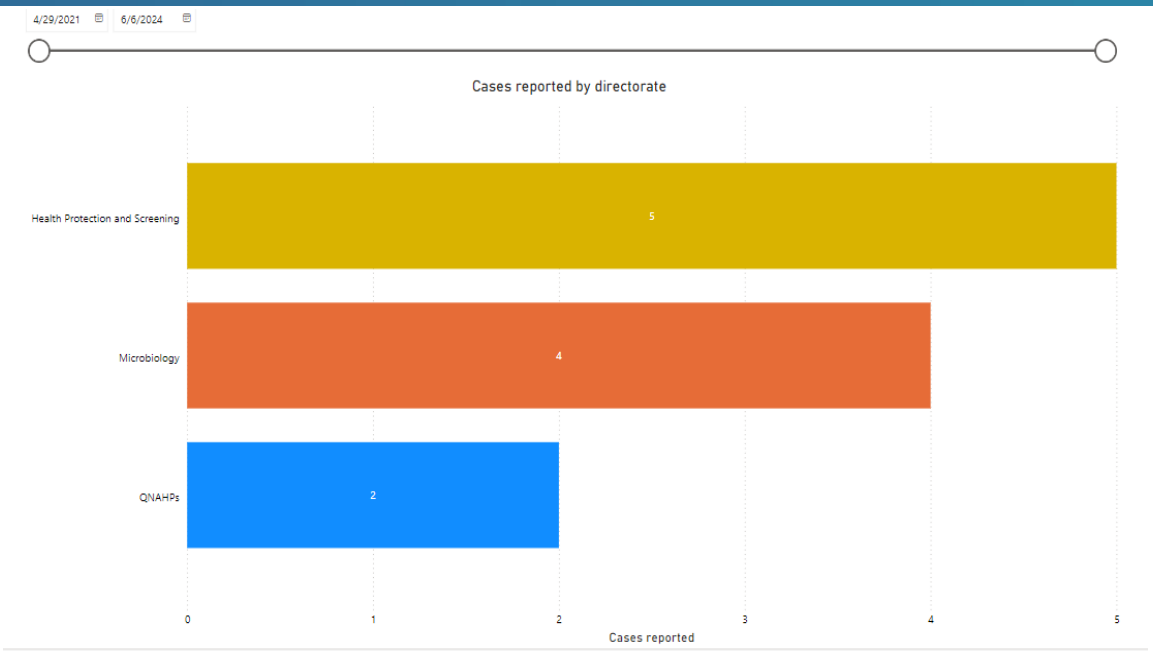
The purpose of this section is to provide an update on the work of the Corporate Safeguarding Group, and safeguarding activity in Quarter 1 2024-25.

This quarter's meeting is scheduled to be held on July 16th. The agenda will focus on:

- Safeguarding incidents, referrals and themes reported using the newly developed Power BI Safeguarding Dashboard
- Presentation and review of the Safeguarding Risk Register
- Presentation and review of the Safeguarding Maturity Matrix for self-assessment and identified improvements for 2024-25
- A review of Safeguarding Training Compliance figures
- A review of progressing actions associated with the Disclosure and Barring Service (DBS) checks compliance audit.
- A review of compliance figures for Disclosure and Barring Service checks for newly appointed employees in Quarter 1
- To receive an update from National Safeguarding Service, shared learning from safeguarding reviews and identified improvement workstreams along with emerging national and local safeguarding issues.

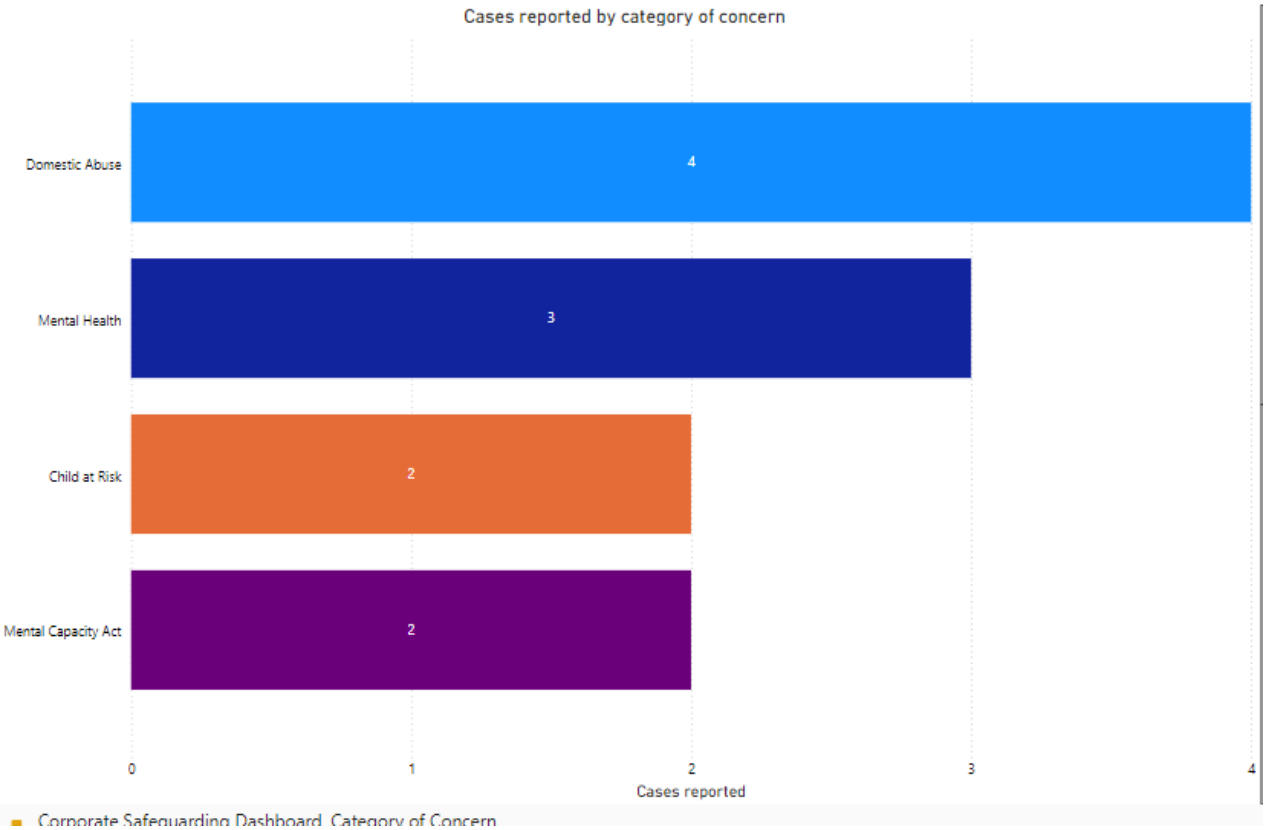
5.1 Safeguarding Incidents

During quarter 1, 11 Safeguarding incidents were reported and the graph below details these by directorate. As the largest directorate, Health Protection and Screening reported the most safeguarding concerns/incidents which is to be expected as the directorate with most public facing services. The overall number of safeguarding incidents reported by PHW staff remains small compared to the wider NHS Wales.



Number of safeguarding concerns by Directorate

The graph below highlights the types of safeguarding concern.



5.2 Safeguarding Training

All staff are required to complete level 1 safeguarding training and certain staff groups are required to complete a higher level of training dependent on their roles.

Overall organsiational compliance for quarter 1 against a Welsh Government target of 85% is as follows:

- Level 1 Safeguarding Adult training is at 92%
- Level 1 Safeguarding Children training is at 91%

- Level 2 Adult Safeguarding training is at 91%
- Level 2 Safeguarding Children training is at 88%

Both level 1 and level 2 safeguarding training compliance rates have improved since the last quarter following targeted support from managers.

Competence Name	Q4	Q1	Trend
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	88.80%	87.90%	↓
028|LOCAL|Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years|	67.26%	69.44%	↑
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	92.00%	92.27%	↑
NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	88.14%	90.87%	↑
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	90.89%	91.16%	↑
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	85.38%	87.97%	↑
028|LOCAL|Safeguarding Level 3 - 3 Years	62.73%	62.04%	↓
NHS|MAND|Mental Capacity Act – 3 Years	75.60%	85.85%	↑
NHS|MAND|Mental Capacity Act Level 2– 3 Years	87.55%	90.23%	↑

Safeguarding Training Levels Quarter 1

In addition to the required mandatory eLearning training, 44 employees have attended the locally run Group 2 Ask and Act, Violence Against Women, Domestic Abuse and Sexual Violence training, improving compliance rates for both these Safeguarding training packages.

The overall mandatory safeguarding training compliance position will be reported and discussed at the forthcoming safeguarding meeting, and specific areas below the 85% target set by Welsh Government will be targeted for improvement.

Finally, during quarter 1, a bespoke safeguarding training session was delivered to the PHW Board which provided an opportunity for further discussion on safeguarding matters. All board members who attended are now trained to level 6 Children and Adult Safeguarding, as recommended within the Royal College of Nursing (RCN) Intercollegiate document. This document details the required competencies and roles for all healthcare staff.

5.3 Key Safeguarding Risks & Issues

There is one safeguarding risk which committee should note.

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 with 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 role 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.

Significant work has progressed with the work identified through escalating the DBS risk and recommendations made in the compliance audit of Disclosure and Barring service checks. Additional short-term funding has been secured for the position of a disclosure and barring compliance officer. The post has been advertised, once appointed to the employee will undertake an organisational wide review of compliance with DBS checks.

In addition, a briefing and appraisal paper has been written to discuss the risks and cost analysis to implement regular DBS renewal checks for relevant PHW employees. This will be presented to the People and Organisational Committee Shortly

Improvements as a result of Learning
Working with in partnership with PHW Environmental Health team, the corporate safeguarding lead has created a standard operating procedure to support the identification and management of safeguarding concerns which have been identified through telephone calls to the service.

6.0 Infection Prevention and Control (IPAC) Report

The purpose of this section is to provide an update on the work of the Infection Control Group. The group met on 18th April 2024 and will next meet on 11th July to review quarter 1 data. Areas of particular focus will include:

- The ongoing development of assurance mechanisms for infection control standards by departments and services within the organisation.
- The completed 23/24 audit programme for PHW-managed sites by the IPC Lead Nurse and the monitoring of remedial actions requested.

This quarter's agenda and meeting will focus on:

- IPC incidents, themes, and areas for improvement
- Presentation and review of the IPC Risk Register
- Setting the IPC workplan using the recently drafted IPC assurance framework
- A review of IPC Training Compliance figures
- A review of progress made against identified issues namely ventilation and decontamination compliance along with environmental audits.
- To receive and discuss divisional IPC Updates
- To receive an update from the National Infection Prevention and Control Service sharing learning and areas for improvement at local and national level.

6.1 IPC-related incidents

There have been 15 incidents reported in the first quarter of 2024-25.

Category	Number of Incidents	Division where it occurred	Risk Level	Approval Status
Cleanliness	1	Screening - DESW		Closed
Contact with Needles or medical sharps	2	Microbiology	1 low and 1 no harm	X1 Closed X1 under investigation
Contact with or exposure to hazardous substance	11	Microbiology	X2 no harm X8 low X1 moderate	X10 closed X1 under management review
Delay in Infectious Diagnosis	1	Health Protection	X1 low	Closed

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

The 1 incident classed as moderate risk involved the following:

- Blood culture bottles received were grossly contaminated with blood and therefore were a risk to lab staff. Blood was noticed before contact was made, and bottles were decontaminated appropriately. It is unclear if this was fed back to the A&E unit/staff concerned.

6.2 IPC Mandatory Training Compliance

Overall IPC training compliance for both level 1 and level 2 has improved this quarter following targeted intervention by managers.

IPC level 1 training is now reported at 90.3% against a Welsh Government target of 85%.

IPC level 2 training has increased from 80.0% compliance last quarter to 90.5% compliance this Quarter a significant improvement.

Areas still requiring improvement will be discussed at the next IPC meeting and include for IPC level 1 IPC areas Corporate/Board staff and staff based at one particular Microbiology laboratory.

For IPC level 2 areas further improvement is required by SPRs and Health Protection. Managers support will be enlisted to target these specific areas during the next few months.

In addition to the required mandatory training, additional IPC training has been delivered to screening services staff who are nominated as IPC link workers. Sessions covered environmental auditing and additional IPC roles and responsibilities.

Aseptic Non-Touch Technique assessor training has also been delivered to radiographers.

Table 6.2: Quarter 1 IPC Level 1 Mandatory Training Compliance, RAG rated against the Welsh Government compliance target of 85%.

Directorate/Division	Q4 Compliance %	Required	Achieved	Q1 Compliance %	Trend
028 L3 Corporate Directorate	75.86%	28	20	71.43%	↓
028 L3 Data, Knowledge and Research Directorate	95.69%	112	107	95.54%	↓
028 L4 Health Protection Division	86.22%	223	197	88.34%	↓
028 L3 Health & Wellbeing Directorate	89.94%	167	148	88.62%	↓
028 L4 Microbiology Division	89.26%	634	568	89.59%	↑
028 L3 Operations and Finance Directorate	95.62%	138	124	89.86%	↓
028 L3 People & OD Directorate	95.35%	43	40	93.02%	↓
028 L3 Quality Nursing & Allied Profs Directorate	87.50%	46	41	89.13%	↑
028 L4 Screening Division	88.06%	552	510	92.39%	↑
028 L3 SPRs Directorate	84.21%	19	16	84.21%	–
028 L3 Policy and International Health Directorate	93.42%	77	74	96.10%	↑
028 L4 Health Protection Division	78.57%	36	29	80.56%	↑
028 L4 Screening Division	80.18%	228	210	92.11%	↑
028 L3 Quality Nursing & Allied Profs Directorate	100.00%	1	1	100.00%	–
Breast Test Wales	92.94%	83	80	96.39%	↑
Breast Test Wales	68.24%	83	57	68.67%	↑

6.3 IPC Risk Register

The IPC risk register was reviewed in quarter 4 and is detailed in the IPC annual report.

It will be reviewed again in the quarter 1 meeting, but it is worth noting that Risk ID 1501 which relates to the corporate IPC role being a single post holder has now been realised since the post holder resigned and left PHW in June. Mitigation is in place with the Healthcare Associated infection, Antimicrobial Resistance & prescribing Programme (HARP) team who are now covering this position until a replacement post holder can be found. In addition, following discussion with the Head of Nursing for HARP and the Executive Director of Nursing it has been agreed that the Corporate IPC post will now transfer to the HARP team and line management through that service to ensure greater IPC resilience and support for a single position role. However, Corporate IPC governance remains within the Quality Nursing and Allied Health Professional Directorate

6.4 IPC Policies and Procedures

Table 6.4: Progress on policies and procedures

Policy or Procedure	Update	Completion Date
Decontamination Policy & Procedure	Completed and awaiting approval from the IPC group	July 2024
Procedure foe the Transport of Pathological Specimens	Completed and awaiting approval from the IPC group	July 2024
Outbreak Management Procedure	This has been finalised and awaiting submission to the consultation process /website	September 2024
ANTT Policy	All Wales Model Policy adopted and approved	Published May 2024
Waste Management Procedure	Health & Safety /estates hold the responsibility for this, but the clinical section has been written and submitted to the H&S group.	Unknown dependent on the H&S group.

Key Risks and Issues Identified

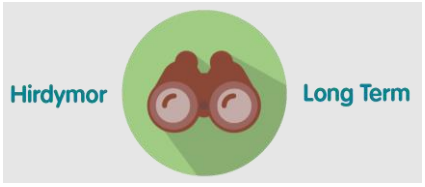
Since the start of 2024, concerns have been highlighted at the IPC group and to QSIC regarding 2 aspects of decontamination practice in screening services. The first relates to compliance with the new decontamination standards for biopsy probes within Breast Test Wales programme with delays to achieving full compliance resulting from the identification of inadequate mechanical ventilation within the clinical areas and the use of the Tristel Trio high level disinfection system.

A Task and Finish Group has been set up following the last IPC meeting to support and progress remedial work to the ventilation system and provide the assurance required for clinical environments against infection prevention control standards. In addition, the service is planning to introduce an alternative high level disinfection system using ultraviolet cabinets and have been successful in procuring these. These specific areas will be discussed at the next IPC meeting.

A further area of concern regarding decontamination practices relates to the endoscopy decontamination facilities at the Glan Clwyd hospital. Bowel Screening Wales continue to work with Betsi Cadwaladr University Health Board and PHW Corporate teams to find a longer-term solution for the decontamination unit and the required IPC assurance as a commissioned service.

Finally at the last IPC group meeting on 18th April, it was agreed that a focused piece of work is required to ensure PHW is compliant with NHS Wales cleaning standards at all its sites. A Task and Finish Group to focus on this specific area has been formed in addition to the Ventilation Group.
Both these groups are scheduled to meet in July and terms of reference have been drafted. There will be cross organisational representation for this focused work and these groups will report into the IPC group.

3. 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.
- **Approve** the report for submission to the Quality Safety and Improvement Committee.