GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 04 February 2025 **Agenda item:** *5.1*

Quality Governance Performance Report Quarter 3 (1st October 2024 – 31st December 2024)	
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Approval/Scrutiny route:	Angela Cook, Assistant Director of Quality and Nursing

Purpose

The Quality Governance Report provides the Quality Safety & Improvement Committee (QSIC) with an overview of quality governance within Public Health Wales for the Quarter 3 period (1st October 2024 to 31st January 2025). It incorporates the two domains of a quality management system: quality assurance and quality improvement. Quality control is provided within the Integrated Performance Report, which contains quality measures at organisational level. The report provides specific updates and assurance on:

- Putting Things Right Management
- Service User Experience
- Alerts Management
- Clinical Audit
- The work of the Safeguarding Group
- The work of the Infection Prevention Control Group

This report will also cover formal quarterly reporting for IPC, Safeguarding and Quality and Clinical Audit.

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

The Committee is asked to:

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

Link to Public Health Wales Strategic Plan

Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives.

This report contributes to the following:

Strategic Priority/Well-being Objective	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. However, many of the areas that are identified through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity
Risk and Assurance	The information and data presented in this report help understand the quality of services/ care being delivered, and our assurance and improvement activities to provide high quality and continuous improving services. The Governance structure is operating effectively with Safeguarding, and Infection Prevention Control included on the relevant group Risk Registers.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports and/or takes into account the Health and Care Quality Standards for NHS Wales Quality Themes.

Financial implications	Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance.
People implications	The Quality Governance Report provides information related to experience and outcomes for service users and staff, and therefore the information is pertinent to Service Users, Carers, and Staff across PHW.

Executive Summary

The Quality Governance Performance 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 Section (page 7).

- 591 incidents were reported during Quarter 3, investigated and remedial actions identified. Of these, 17 were initially reported as moderate harm or above.
- As of 31th December 2024, there are 32 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (page 30)

- 14 safeguarding incidents were raised at PHW sites with varying themes behind those safeguarding reports.
- 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 35)

- There were 14 IPC incidents reported in Quarter 3 a reduction of 7 compared to Quarter 2 and all were low or no harm incidents. There were no moderate harms were reported this quarter compared to the 2 the previous quarter.
- Compliance with Cleaning standards within some Screening services has raised some concerns, and further remedial actions are being put in place to address these.
- IPC level has remained static at 91.5% since the last quarter and remain above the Welsh Government target.

Are we providing timely care and services?

By timely we mean the people who use our services will have access to the high-quality services, advice, and guidance for public health interventions, at the right time and place to meet their needs.

Concerns and complaints (page 16)

- 16 Early Resolution complaints were received in Quarter 3 and 7 formal complaints.
- 75% of the early resolution complaints were resolved within 2 working days target. 71% of the formal complaints were acknowledged within the 5 working day target.

Do we provide effective care and services?

By effective, we mean that the people who use our services have access to screening, specialist advice, treatment and support that provides the best outcome for them.

Clinical Audit (page 28)

The Quality and Clinical Audit Team have engaged with all areas undertaking audit to evaluate progress against the approved Plan for Quarter 3 and this is included in this report. An update is provided on the procurement of a digital audit management system.

Safety Alerts Management (page 26)

- 56 alerts were received in Quarter 3, of which 4 of which required action - 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 21)

- 120 Compliments were reported by staff on the Civica system this quarter.

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

1. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 3 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
- Safeguarding
- Infection Prevention Control

This report supports the achievement of quality through the following:

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

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

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

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

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

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

2. Putting Things Right

2.1 Nationally Reportable Incidents/Early Warnings/Never Events

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

One Nationally Reportable Incident (NRI) was reported in October by the Microbiology Division. This is a jointly owned incident along with Cardiff and Vale University Health Board and relates to antibiotic prescribing for a patient on discharge from hospital. This joint incident investigation remains ongoing.

2.2 Incident Management

Incidents

During Quarter 3, a total of 591 incidents were reported. This is an increase from the 473 reported in Quarter 3 of 2023/2024.
The below table indicates the number of moderate harm or above incidents recorded for each quarter.

	Moderate	Severe	Catastrophic/Death
Quarter 3 2024/5 (Oct – Dec 24)	**15** (3 remain under investigation, 2 remain at moderate & 10 now recoded low/no harm)	**2** (1 downgraded to no harm & 1 to low harm)	**0**
Quarter 2 2024/5 (Jul -Sep 24)	**16** (12 downgraded, 2 ongoing investigation)	**0**	**0**
Quarter 1 2024/5 (Apr – Jun 24)	**23** (17 downgraded, 6 ongoing investigation)	**1** (downgraded to no harm)	**0**
Quarter 4 2023/4 (Jan – Mar 24)	**3**	**0**	**0**

When an incident was previously reported on the Datix system, the PTR team would review the initial level of harm assigned by the reporter and amend this if appropriate based on the actual level of harm ahead of the incident investigation concluding. However, from 1 April 2024 this practice has changed and the level of harm initially reported is not altered and remains unchanged until the investigation is complete. This change enables more accurate reporting and supports the PTR team to identify areas for further learning and ensures the appropriate levels of harm are reported by the organisation.

Of the incidents reported as moderate harm this quarter, 3 relate to Diabetic Eye Screening Wales (DESW) following the introduction of new screening cameras and tables. Following the introduction of these new cameras in October 2024, moving and handling incidents have increased and the service has undertaken remedial actions to reduce the risk of further handling incidents occurring. This includes specific manual handling training for staff, sourcing and fitting of alternative wheels for the camera tables and providing video guidance on best practice for movement of the cameras.

Open Incidents

The below graph demonstrates a continued rise in the number of incidents reported between Quarter 2 to Quarter 3. The mean number of incidents compared to the same time period last year has increased from 152 incidents to 197 incidents.

It should be noted that the screening division has been the area of increased reporting with increased activity seen by Diabetic Eye Screening Wales and Breast Test Wales.

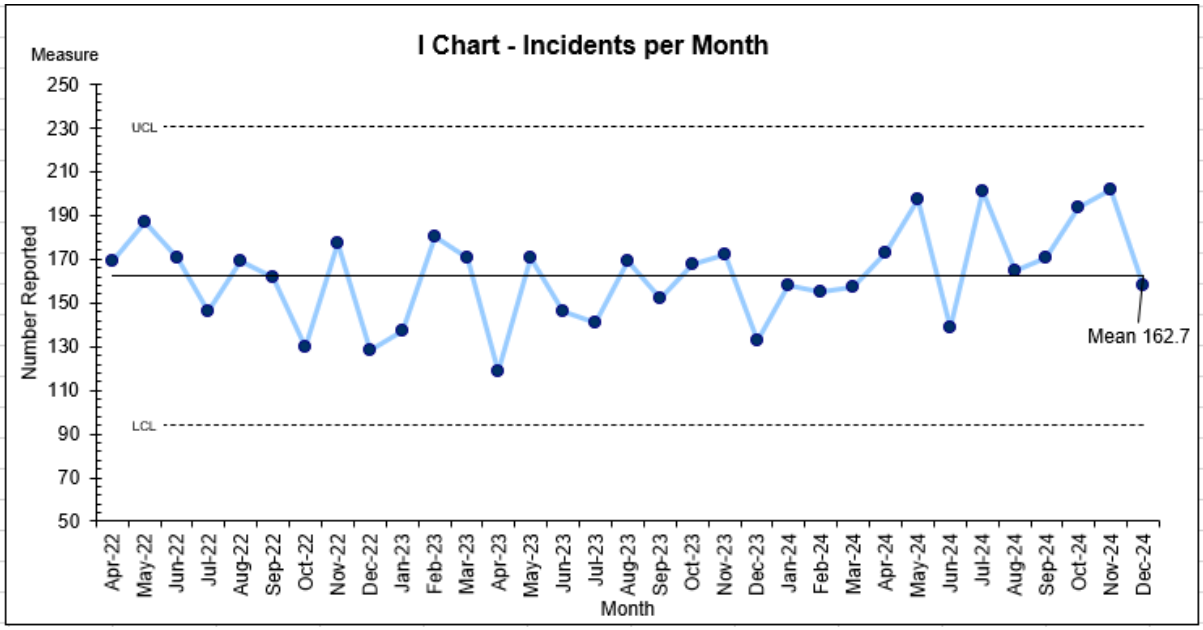


Chart 1. Incidents per Month

The below graph highlights that overall performance against the 30-working day closure rate which has deteriorated this quarter and appears to be attributable to the increased reporting rates seen throughout Quarter 2 and 3 and the associated workload with this increased reporting. .

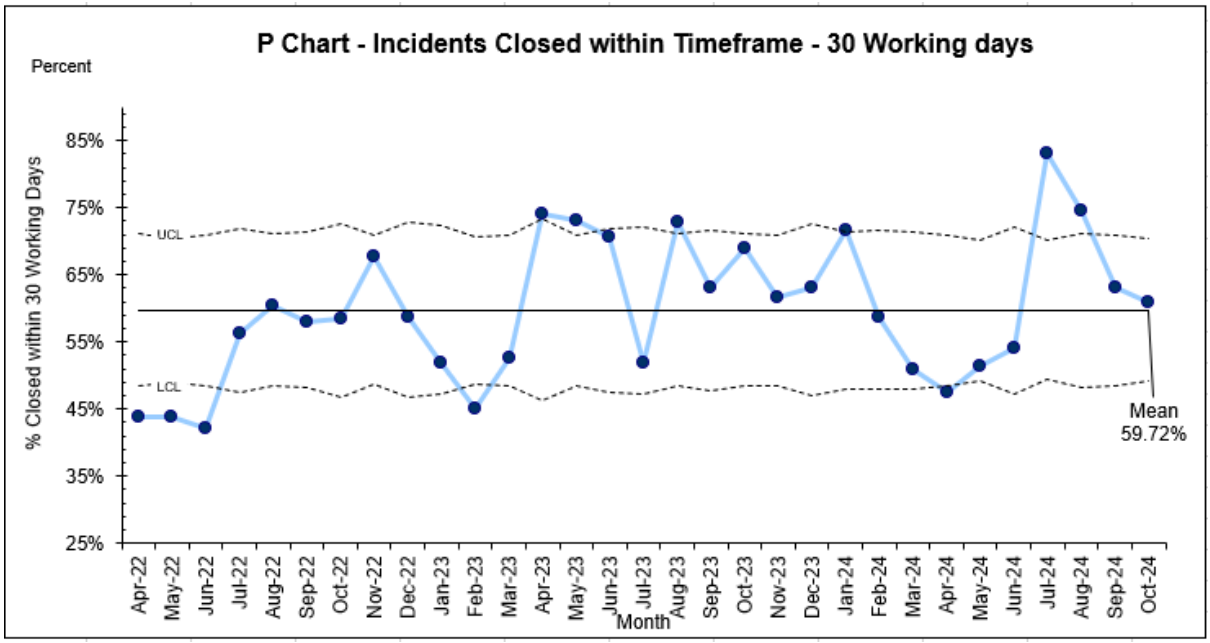


Chart 2. Incidents Closed within Timeframe

No. of incidents closed in October	160
Closed in < 30 days	115
Closed 31 – 60 days	31
Closed 61 – 120 days	11
Closed 120 days+	3 **(127, 175, 365 days)**

No. of incidents closed in November	199
Closed in < 30 days	117
Closed 31 – 60 days	60
Closed 61 – 120 days	19
Closed 120 days+	3 **(125, 308, 452 days)**

It should be noted that there has been an overall improvement in the number of incidents being closed throughout October and November with over 350 incidents

closed during this period. 6 of these were for incidents that were over 120 days old, including the oldest overdue incident that had been open for 452 days.

It is worth noting that due to the 30-working day timeframe, incidents reported in November and December do not appear in the Quarter 3 data currently. Further improvement will be seen in Quarter 4 as both November and December closures will be included.

As of 24 December 2024, there are a total of 32 overdue reported incidents within Datix that have an 'open' status of more than 30 working days. This is a significant improvement on the 66 reported in the Quarter 2.

The highest number of open incidents are currently within Cervical Screening Wales (11), followed by Diabetic Eye Screening Wales (9), Microbiology (4) and Breast Test Wales (4).

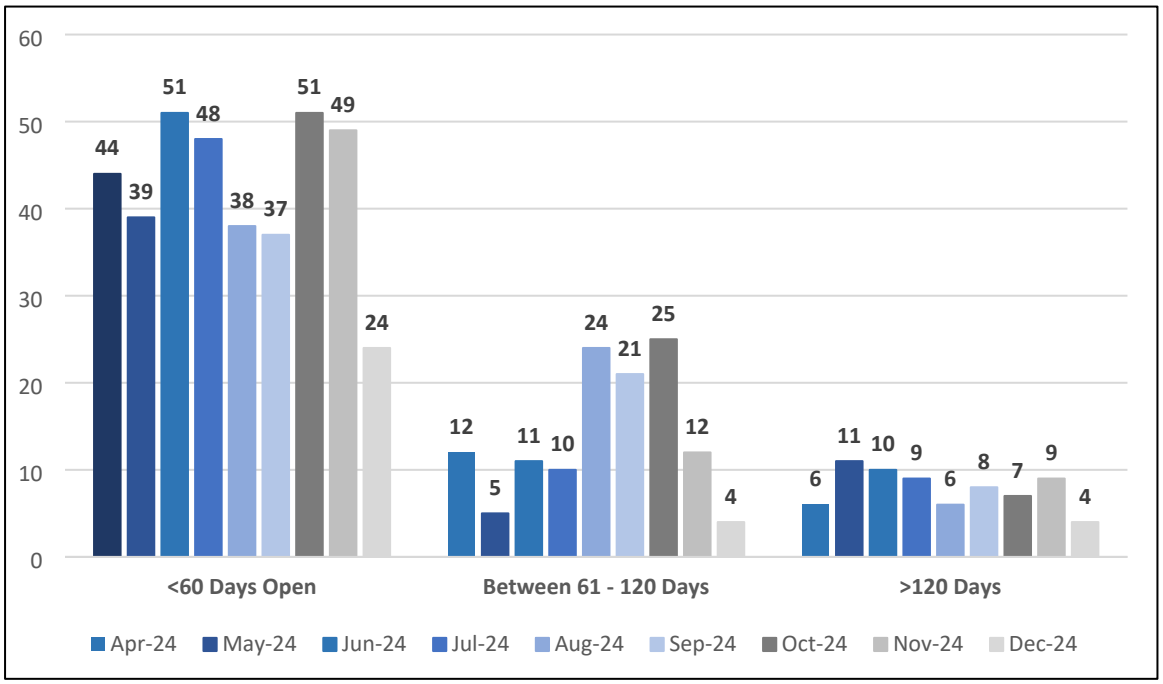


Chart 3. Overdue Incidents Apr24 – Dec24

Of the 32 overdue incidents, 4 (12.5%) have now been open for more than 120 working days, with the oldest open for 275 working days. This incident pertains to a Welsh Laboratory Information Management System (WLIMS) issue that has been found to have affected the transmission of a small proportion of Microbiology test results for GP patients.

This incident is a jointly owned incident with Digital Health and Care Wales (DHCW). This has been escalated with DHCW and they are in the process finalising and getting approval on their investigation report.

4 incidents (12.5%) have been open between 60 and 120 working days and 24 (75%) have been open for more than 30 days but less than 60 working days.

Ongoing work to address the performance of incident closure rates continues with a weekly overdue incident report generated and reviewed by the PTR team. This report details incidents that have been open for more than 30 working days and incidents that are at open status for 20-29 working days. This incident data is then shared with the service's designated operational and clinical leads to review and assist with the ongoing management.

Update requests on incident management progress are made to the service areas weekly and support offered where barriers to achieving closure are identified. In addition, monthly meetings are scheduled with service areas to support incident management and closure.

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

Incident Classification

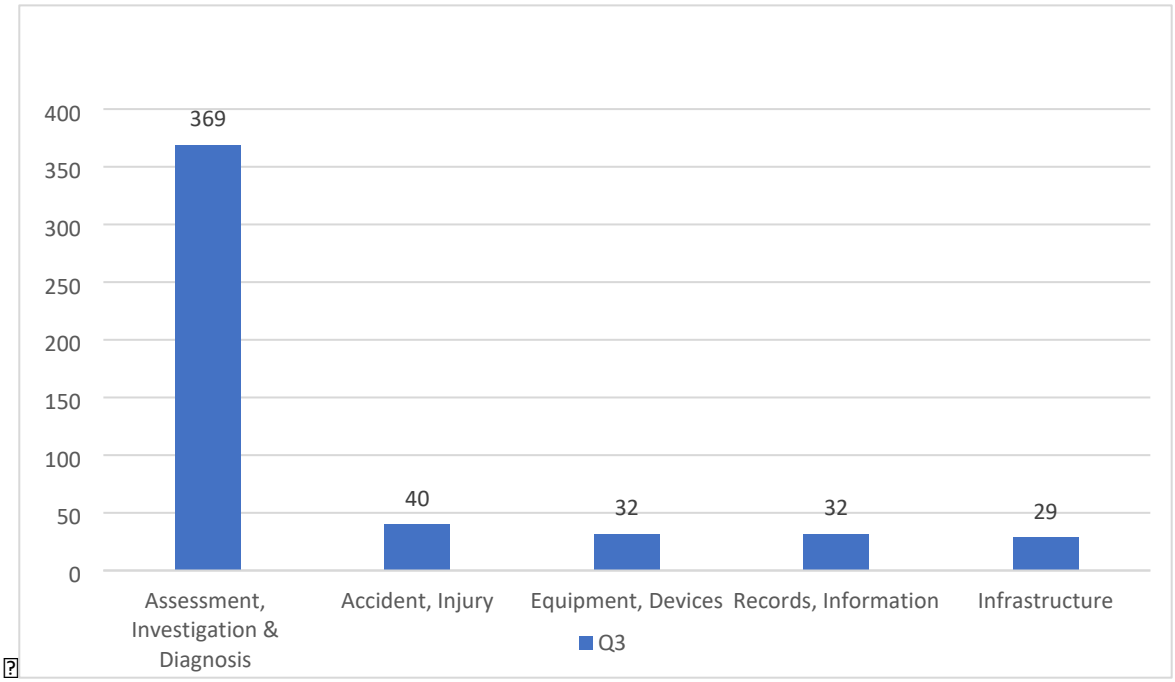


Chart 5. Top 5 incident classifications

Assessment, Investigation and Diagnosis remains the highest reporting incident classification with reporting figures comparable to Quarter 2 figures.

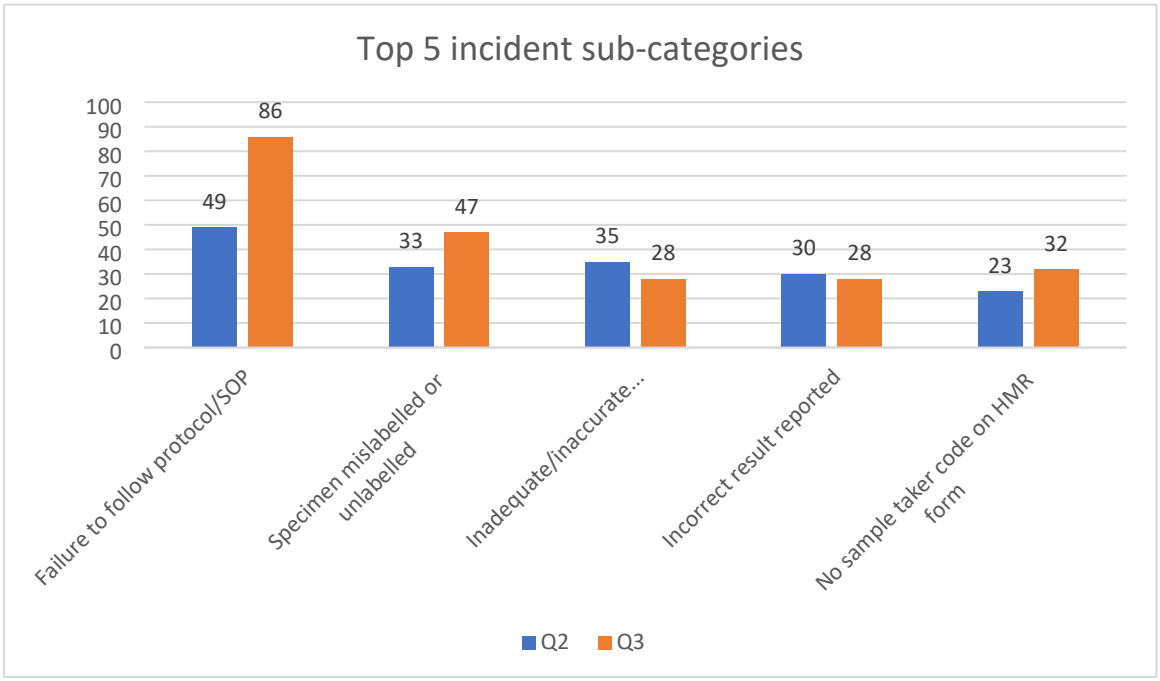


Chart 6. Top 5 incident sub-categories

There has been a 75% (86) increase in incidents reported in Q3 for the sub-category 'failure to follow protocol/SOP' compared to Quarter 2 (49).

This increase is attributable to DESW and the reporting of Image capture related incidents. Image Capture was introduced as a new Service on Datix for DESW at the start of Quarter 3 to support staff within the programme with the accurate reporting of incidents relating to images that do not comply with the service's protocol or standard operating procedure. For example, too many images sent for grading or inadequate images taken.

A 42% increase has also been noted in the reporting subcategory of Specimen mislabelled or unlabelled. The increase is distributed evenly between Cervical Screening Wales (CSW) and Microbiology. Work is ongoing within the areas to identify any needed support. It is to be highlighted that whilst the reporting of these incidents is done by PHW the incidents are by staff not employed by PHW.

Incident Reporting and Management Training

During this quarter Level 1 Datix incident reporting training has been delivered to 54 members of staff meaning that 43% of Public Health Wales have now completed this training.

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.

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

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

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.

No new redress cases were received in Quarter 3. There are 5 ongoing redress cases, 3 in Breast Test Wales and 2 in Cervical Screening Wales.

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.

16 Early Resolution complaints were received during Quarter 3. This is an increase of 11 compared to Quarter 2. 75% (12) of these complaints were resolved within the designated Putting Things Right target of 2 working days. 25% (4) were resolved outside of the target, but all within ten working days.

Delays to achieving the 2 working day compliance rates were either because staff were unable to contact the complainant during the required timeframes or consent was not received in the required timeframe, or that the investigator required further information prior to contacting the complainant to proceed.

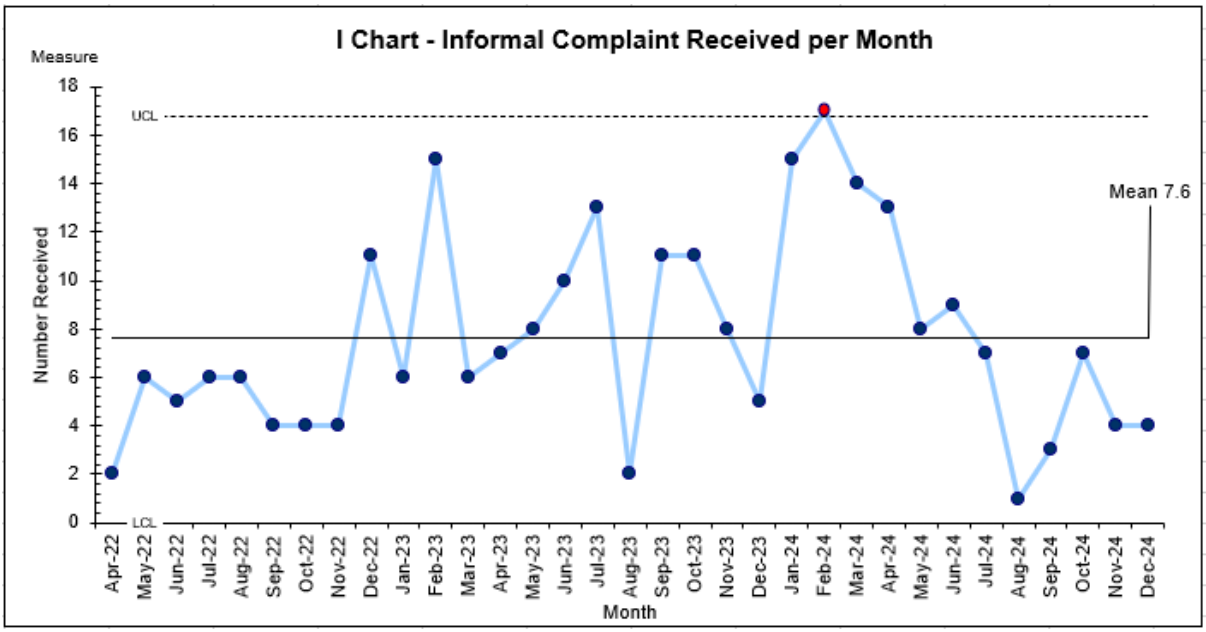


Chart 7. Informal complaints received per Month

The above chart indicates that there has been a reduction in the number of Early Resolution complaints received since the start of Quarter 2 with each month exhibiting below the mean of 7.6 complaints.

The below chart details the service areas where Early Resolution complaints have been received during Quarter 3 and provides the previous quarters data for comparison.

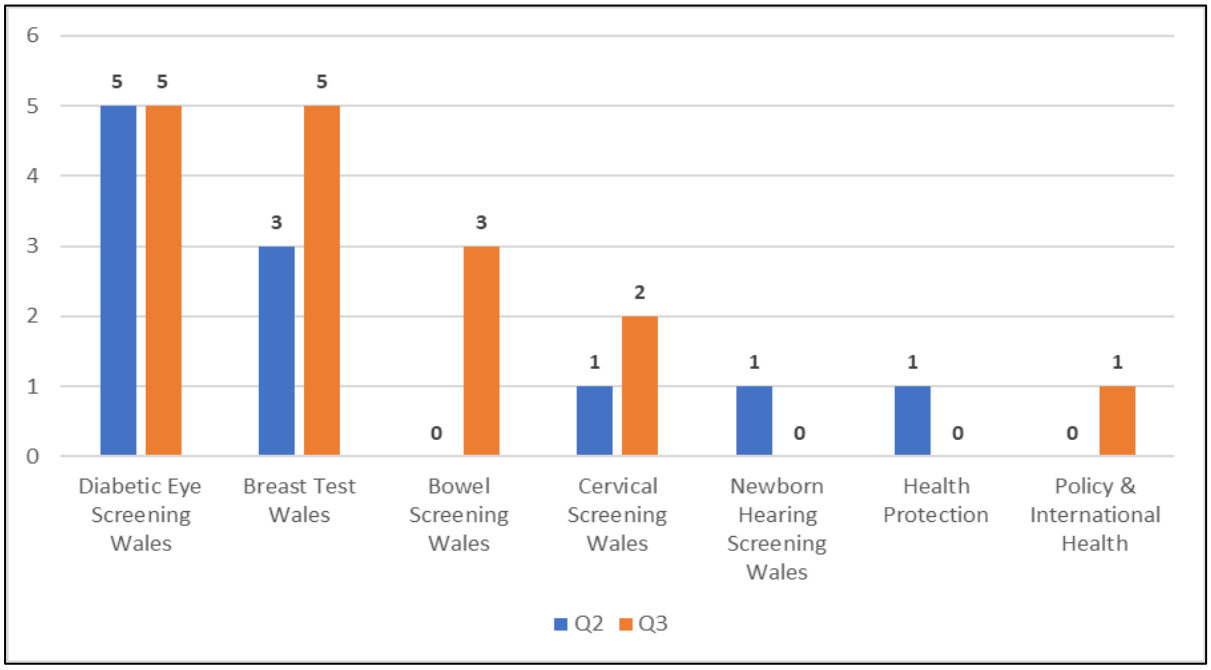


Chart 8. Services where Early Resolution complaints received.

Diabetic Eye Screening and Breast Test Wales continue to receive the highest volume of Early Resolution complaints, with increases also being seen in Bowel Screening Wales and Cervical Screening Wales.

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

- Communication Issues – (5)
- Appointments - (3)
- Equality (2)
- Test and Investigation Results (2)
- Access (to Services) - (1)
- Clinical Treatment/Assessment – (1)
- Confidentiality (1)
- Environment / Facilities (1)

Formal Complaints

During Quarter 3, there were 7 formal complaints received, a reduction of 6 compared to the 13 reported in the previous Quarter. The monthly average is 3 complaints with the last quarter showing a reduction on this.

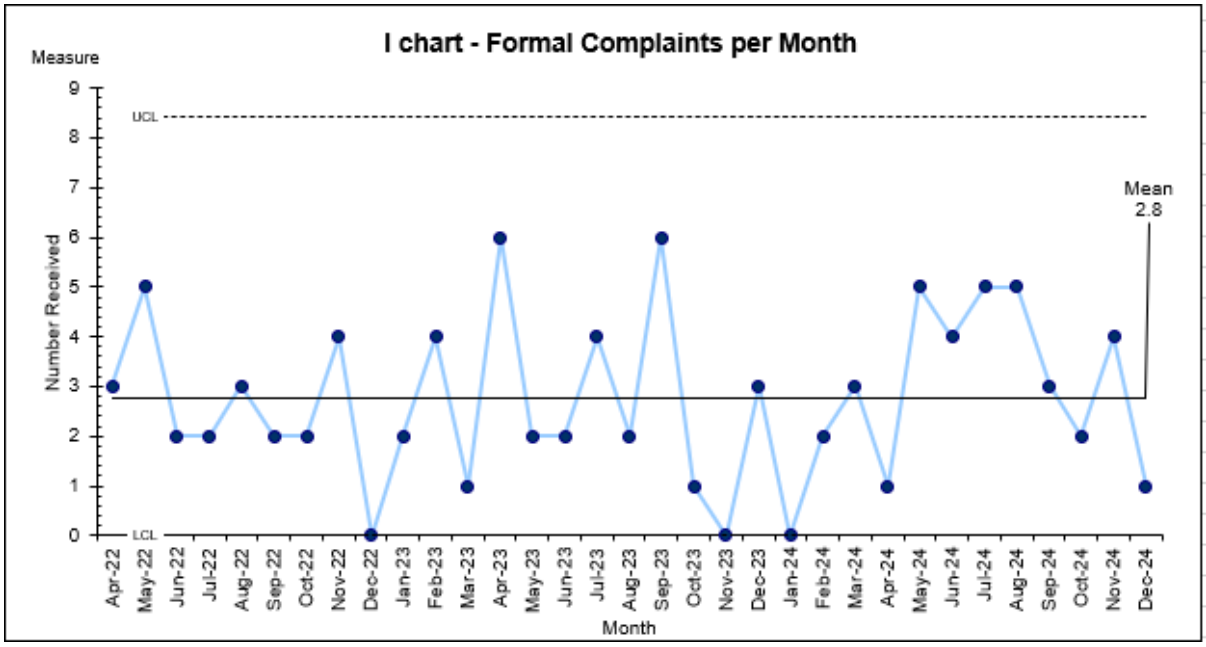


Chart 9. Formal complaints received per month

The below charts demonstrate overall performance in acknowledging and responding to formal complaints against a Welsh Government (WG) target of 75%. PHW is performing above the WG target with a mean of 88% in acknowledging complaints and mean of 84% in responding with 30 working days against the 75% target.

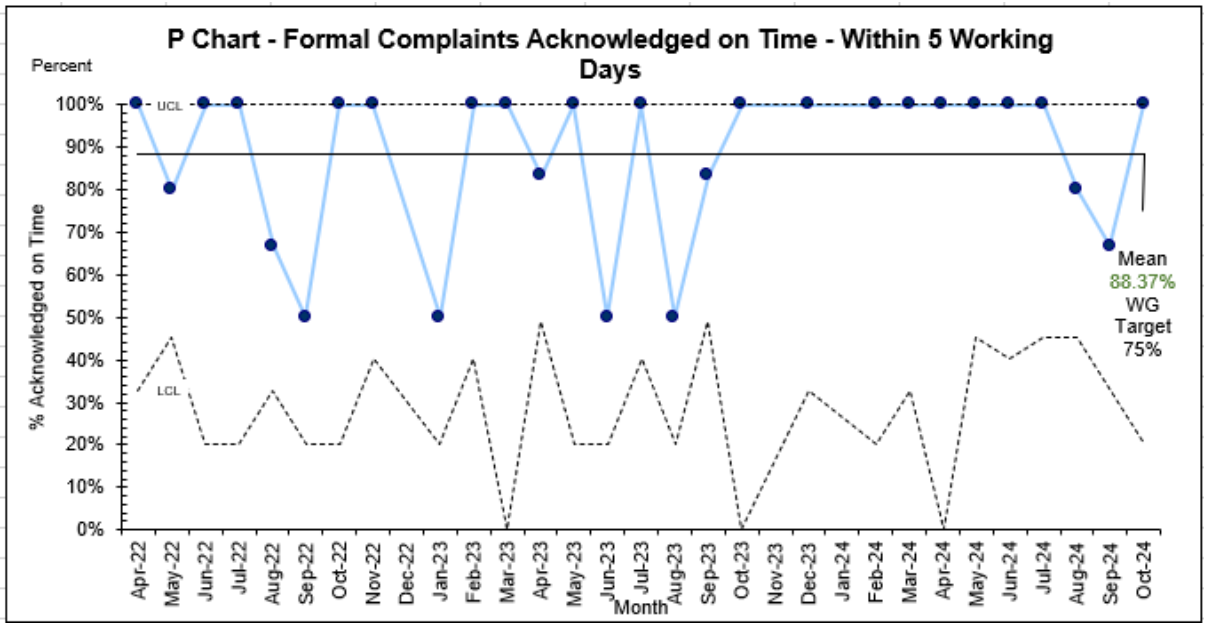


Chart 10. Formal complaints acknowledged on time

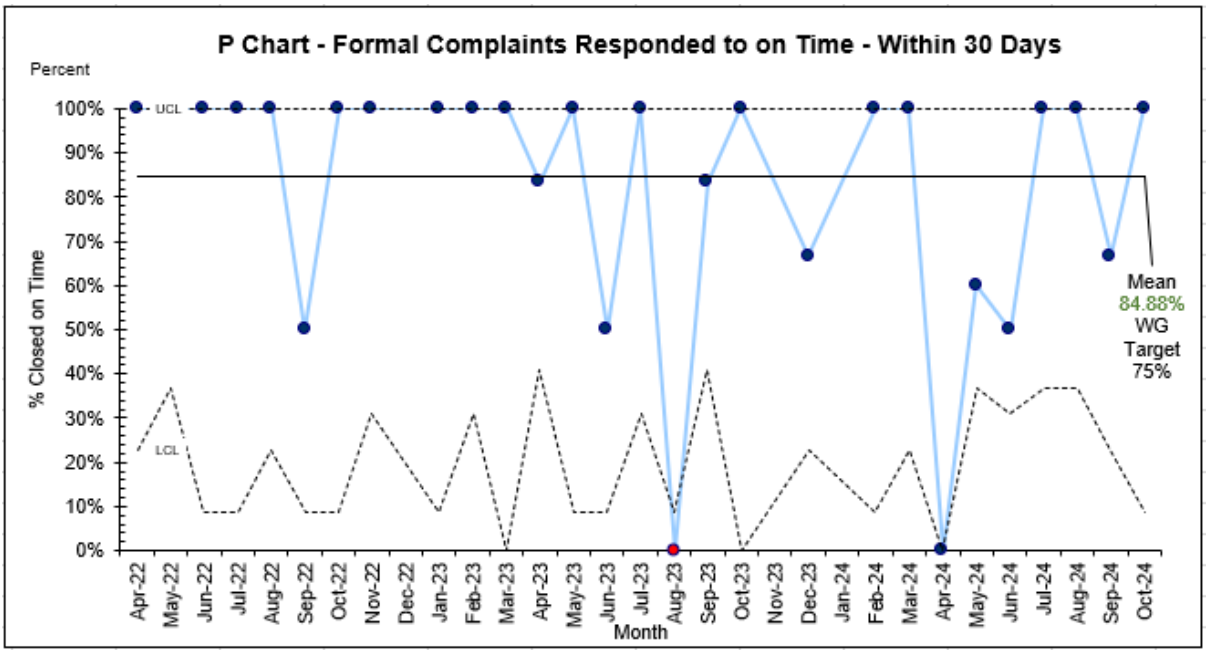


Chart 11. Formal complaints responded to on time

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

Formal complaints received during Quarter 3 pertained to the following areas:

- Diabetic Eye Screening Wales **(5)**
- Breast Test Wales **(1)**
- Cervical Screening Wales **(1)**

The themes from these formal complaints were recorded as follows:

- Clinical Treatment/Assessment **(3)**
- Attitude and Behaviour **(2)**
- Appointments **(1)**
- Access (to Services) **(1)**

Following the receipt of 3 complaints relating to Bowel Screening Wales private colonoscopy policy which were received in Quarter 2, the programme agreed to undertake a review of this policy during their Programme Board meeting in November.
Following this review, a decision was made to change this BSW policy and return all participants who had received a private colonoscopy to routine, FIT-based, screening every two years, irrespective of whether a screening colonoscopy or computed tomography colonography (CTC) has been performed. The revised policy to re-invite for a screening FIT will ensure that all eligible participants continue to have access to screening every two years. A plan will now be developed to enable the implementation of this policy change during 2025.

2.6 Duty of Candour

Duty of Candour (DoC) regulations have been in effect in Wales since April 2023. There have been no new DOC incidents reported in Quarter 3.

2 DOC cases remain ongoing. One reported in Quarter 2 is a joint case with Cardiff and Vale University Health Board (CVUHB) and relates to incorrect antibiotic prescribing and a failed discharge which resulted in a patient being readmitted and having to undergo further corrective surgery. This DoC is a National Reportable Incident with Public Health Wales leading on the DoC and investigation.

The other reported in Quarter 2 September 2023 is a combined DOC case 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 has provided its report and are awaiting C&V UHB to provide their report. The case is now with the coroner for inquest.

2.7 PTR Regulations Proposed Revision

It is worth noting the PTR regulations are currently under review by Welsh Government with proposed revisions aimed at placing patients at the centre of the process, improving the PTR process itself so it is more compassionate and inclusive along with refreshing the arrangements for legal advice, expert reports and the financial thresholds for redress.

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

The PTR team are part of the various national groups involved in these revisions and will be scoping the resource implications for PHW once finalised and published. The publication of these revised regulations is expected to be September 2025.

2.8 Compliments and Service User Experience

This quarter 120 compliments were recorded on the Civica system. In addition, 36 compliments were left directly by members of the public using the compliments form available on the Public Health Wales website. However, only 14 of these direct compliments related to Public Health Wales services, with the others directed towards a mixture of Health Board provision and Primary Care.

An audit of direct compliments is planned for Quarter 4. This should help identify ways to reduce the likelihood of this type of compliment being left on Public Health Wales's website and establish an information-sharing mechanism to forward these non-Public Health Wales compliments onto the relevant organisations.

The 14 direct compliments are not included in the analysis below.

The 120 compliments were received via Screening Programmes and the Microbiology team. The table below provides a further breakdown.

Abdominal Aortic Aneurysm Screening	50
Bowel Screening	5
Breast Test Wales	19
Diabetic Eye Screening Wales	14
Microbiology	17
Newborn Hearing Screening Wales	15

Using the functionality available within the Civica system and the compliment themes selected by staff the 120 compliments can be aligned to the following categories:

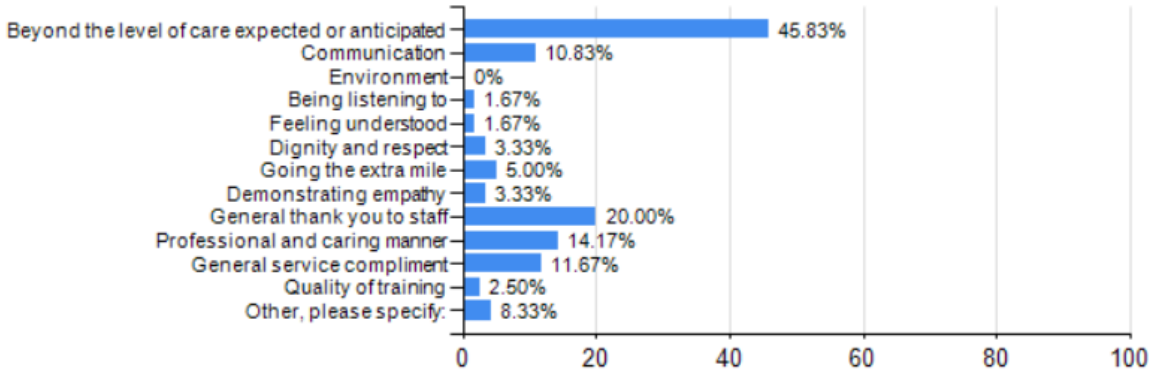


Chart 1 : Compliment categories

A thematic analysis of these comments has identified the following themes:

- Professionalism and Efficiency
- Professionalism, Expertise and Efficiency
- Timeliness and Punctuality
- Positive Attitude and Approach
- Communication and Information (Clear Communication and Information)
- Person centred (Collaborative, Positive Customer Experience, Reassurance, Supportive environment)
- Accessibility (venue, appointment times)
- Environment and Facilities

Experience Surveys

In Quarter 4 a pilot project is due to commence in which service user experience is captured via a SMS prompted request. This initial pilot will start 20 January 2025 within Diabetic Eye Screening Wales. Upon successful completion of the pilot a large-scale rollout across main public facing programmes will be planned.

Local Experience surveys

Local screening surveys have now been developed for use across all screening programmes. However, currently implementing these fully presents operational challenges with some programmes opting for leaflet distribution as an interim measure which is expensive and potentially limits the numbers of people who can provide feedback.

Best practice would be to include the survey details in all result letters and at present this poses a challenge due to the current letter format limitations. Maximising these approaches will provide a comprehensive offer to seek people's experience and feedback of our services.

The chart below is an example of the feedback received via the survey methodology.

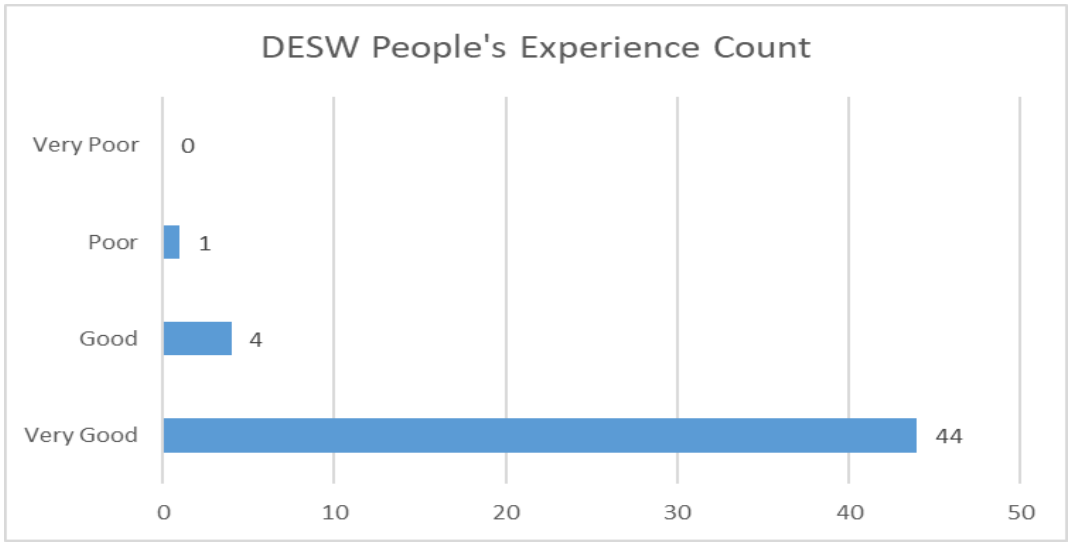


Chart 2 Diabetic Eye Screening Wales – Overall Experience

As a result of this survey data, Diabetic Eye Screening Wales have been able to identify areas for improvement based on peoples' comments. This can be summarised under the following topics:

- Accessibility
- Parking and Signage
- Building Accessibility
- Facilities and Amenities
- Online Booking System
- Evening Appointments

Bowel Screening Wales

Bowel Screening Wales has introduced pathway specific surveys to capture the experience of participants at different stages. These pathways include:

- No blood found – Participants have completed a bowel screening test kit and do not need further tests.
- Blood found - Participants have completed a bowel screening test kit and faecal blood found.
- Further investigation – Participants attended for further tests e.g. Colonoscopy.

Distribution for these surveys is still being finalised and in the case of 'Further Investigation' a quality improvement opportunity has been identified regarding the standardisation of information provided to participants. The 'Further Investigation' pathway is also provided through a commissioning arrangement with Health Boards and further exploration is required to maximise experience/ feedback opportunities.

Whilst the transition to new pathway specific surveys takes place Bowel Screening continues to capture experiences using a previously used survey. The information below relates to both the old and the 'No Blood Found' Surveys.

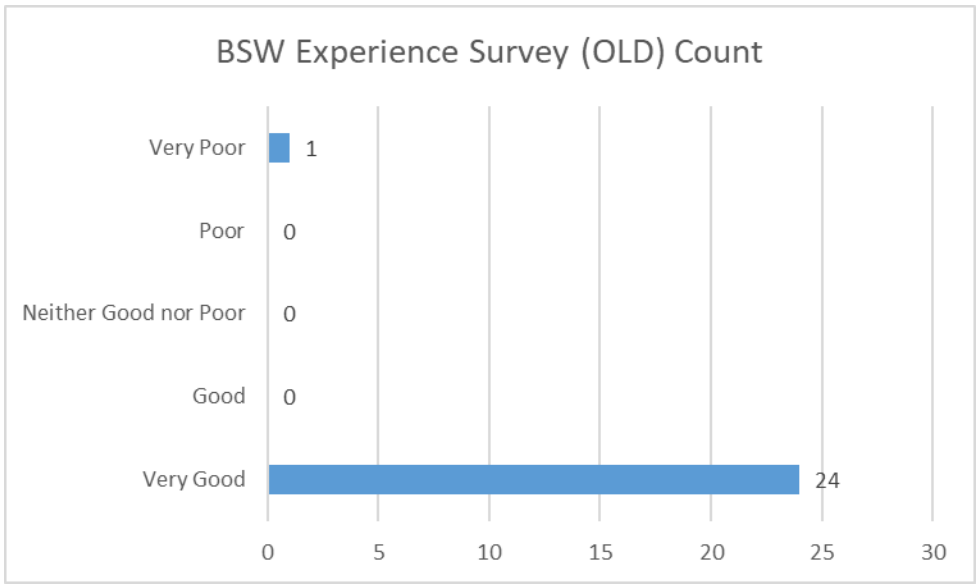


Chart 3: Old survey – Overall Experience

New Survey Overall Experience: No Blood Found Pathway

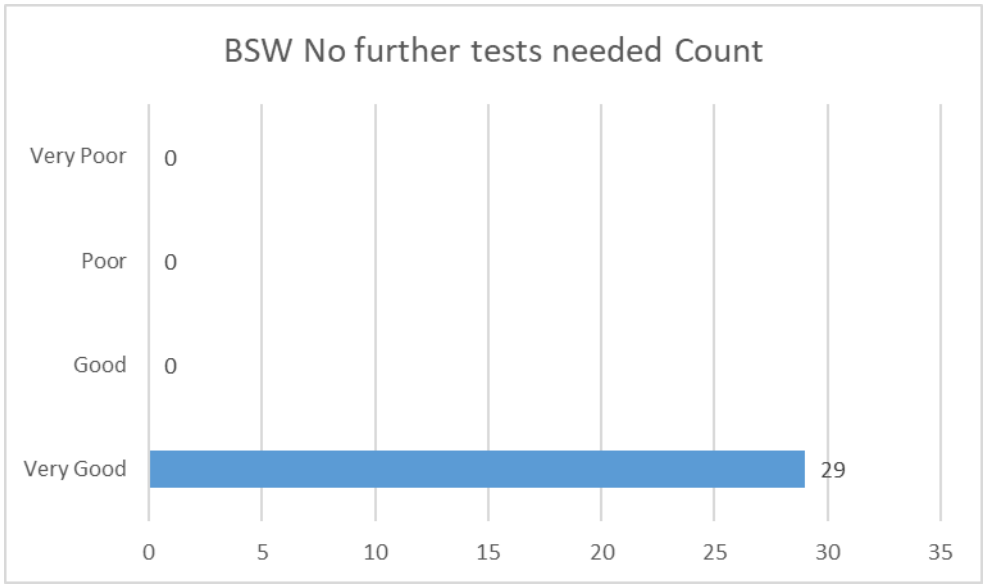


Chart 4: No Blood Found Pathway

As a result of these BSW surveys and participants comments, BSW has been able to identify areas for improvement. This can be summarised under the following topics:

- Communications (general awareness of age limitations)
- Test and further investigation information to be clearer (procedure)
- Online results access

3.0 Safety Alerts and Notices Management

Public Health Wales is required to ensure that all safety alerts are communicated promptly to all relevant members of staff employed within the Trust. Although in most cases, alerts received are not applicable to Public Health Wales, it must be able to demonstrate that they have been checked and the status of each alert confirmed, and where appropriate ensure that alerts are acted on in a timely manner, within the designated timescales to safeguard service users, staff and visitors from harm.

A total of **56** alerts were received during the reporting period 1 Oct – 31 December 2024, **4** of which required further action to be taken. The primary theme of these applicable alerts was Public Health Patient Safety Alerts. All alerts received were disseminated to the organisation within 6/24/48 hours of receipt as required by the policy and procedure.2 alerts were shared for information only with Health Protection, Microbiology and Screening.

Type of Alert	Number received	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Pharmaceutical Alert	22	0			
Medical Device Alert	1	0			
Medical Device (Information)	0	0			
Patient Safety Notice/Alert	2	0			
Medicine Shortages	9	0			
Estates and Facilities Alert	0	0			
High Voltage Alert	16	0			
Public Health Alert	6	4	Clade 1 mpox virus (MPXV) infection Cold Weather Health Risk: Advice Note for Wales Health and Social Care System Partners Clade 1 mpox virus (MPXV) infection Folic Acid Supplementation	08/10/2024 06/11/2024 31/10/2024 26/11/2024	Shared with The Office of the Medical Director. Shared with The Office of the Medical Director. Shared with The Office of the Medical Director and the Vaccine Preventable Disease Programme. Shared with The Office of the Medical Director.
Totals	**56**	**4**			

Table 1. Total Alerts received.

4.0 Quality and Clinical Audit

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

Type of Audit	Number
National Audits	7
Audits identified as a result of risks	12
National Institute of Clinical Excellence (NICE)Guidance (including Technology Appraisals, Interventional Procedures and Guidelines)	0
Local Policy Audits Care Pathways/Local Guidelines Audits	59 (12 of which are linked with risk, as above) *NB Increased from 51 at start of reporting year

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

A clinical audit programme should:

- Reflect key national and local drivers for quality improvement.
- Balance key drivers with directorate/division/service/clinician priorities
- Include a system for prioritisation of clinical audit.
- Enable monitoring to ensure clinical audits selected for the programme are complete.

4.1 Quarter 3 Update.

The 2024-25 Plan initially included 7 external audits and 51 internal audits and was approved in July 2024. During Quarters 1 – 3 a further 8 audits have been added to the plan, with 3 added in Quarter 3: bringing the total to 59 internal audits.

Figures 1 and 2 below, summarise the status of these audits:

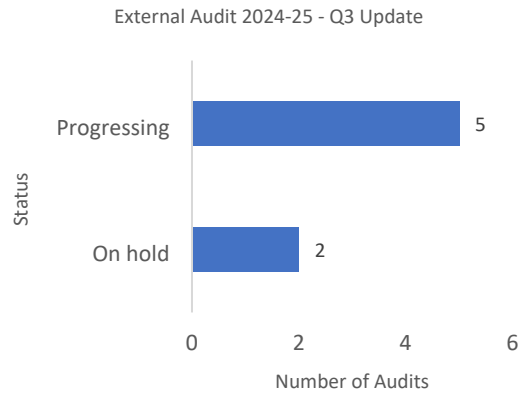


Figure 1: External Audit Activity

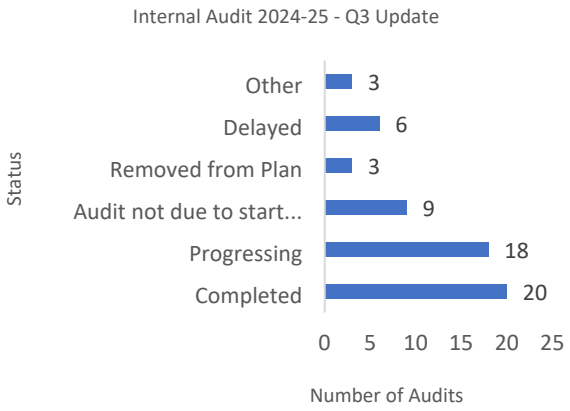


Figure 2: Internal Audit Activity

Key points to note:

6 audits have been delayed with plans in place for 5 to be completed by the end of the reporting year and 1 being dependent on specialist Practitioner staff based in the Health Board to complete and it is anticipated this will be undertaken in Quarter 4. There is no risk associated with this delay.
3 audits have been classified as "Other". This is due to staffing changes within the programmes whereby currently nobody is identified to lead on these. The audit team are liaising with programmes to determine if these audits will take place before the end of the financial year.

4.2 Digital Audit Platform

Quarter 3 saw the successful procurement of a Digital Audit Platform for PHW. The Audit Management and Tracking (AMaT) system is designed to manage clinical audits, quality improvement, service evaluation, inspection information and NICE compliance, through real-time data and action control.
The implementation phase is now progressing with preparatory work taking place and data processing documentation submitted for approval. Information Technology support has been requested for the next phase of the implementation plan.

4.3. Audit Training

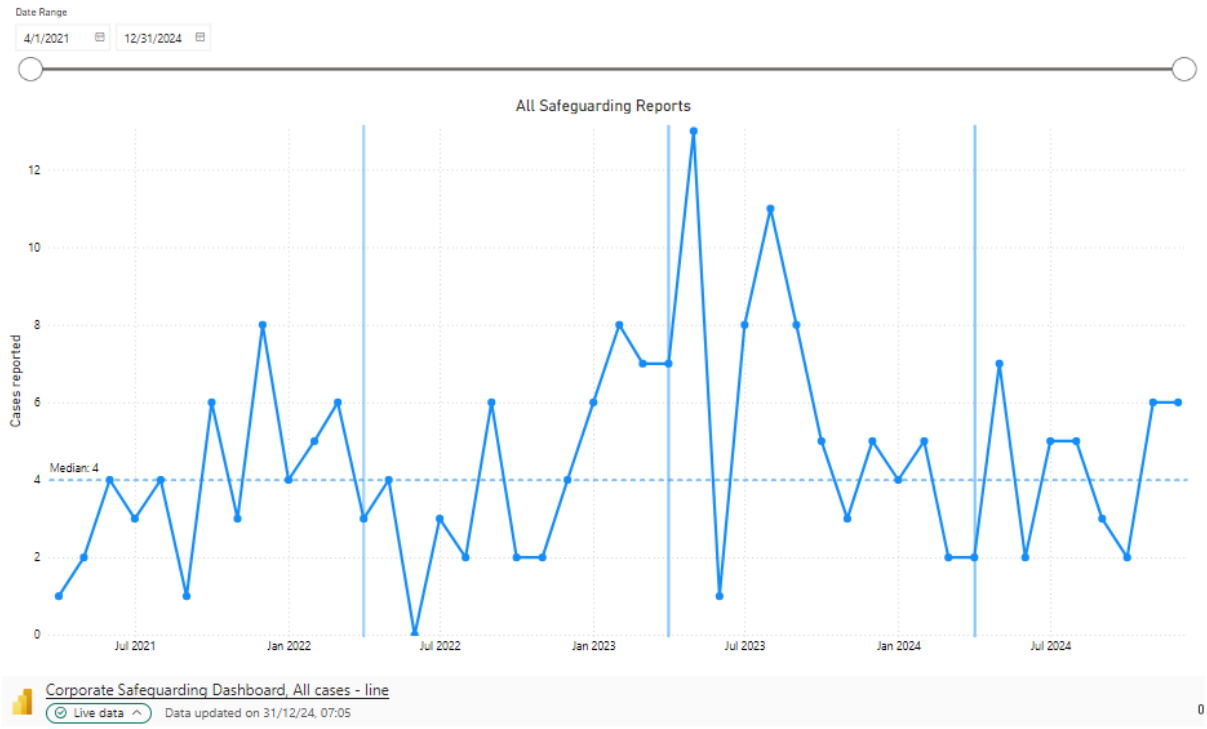
The second part of the internal audit training package "The Audit Cycle" was delivered in December by the Quality and Clinical Audit team. Participant feedback was positive with a strong desire for attendees to attend the Clinical Audit Masterclass provided by the external trainer Clinical Audit Support Centre. These are scheduled for 22 January 2025 and 11th February 2025.

5.0 Safeguarding Group Report

This section provides an update on safeguarding related activity and improvement during Quarter 3, 2024-25.
The Safeguarding Group is next scheduled to meet on 16th January 2025.

5.1 Safeguarding Incidents

During quarter 3, 14 Safeguarding incidents relating to advice and support were reported. This quarter has seen a slight increase in the number of requests for this safeguarding advice, a trend which has been sustained over the last year demonstrating increased safeguarding awareness across the organisation. The graph below shows the data over the last 4 years. The median for monthly safeguarding advice and support queries is 3.

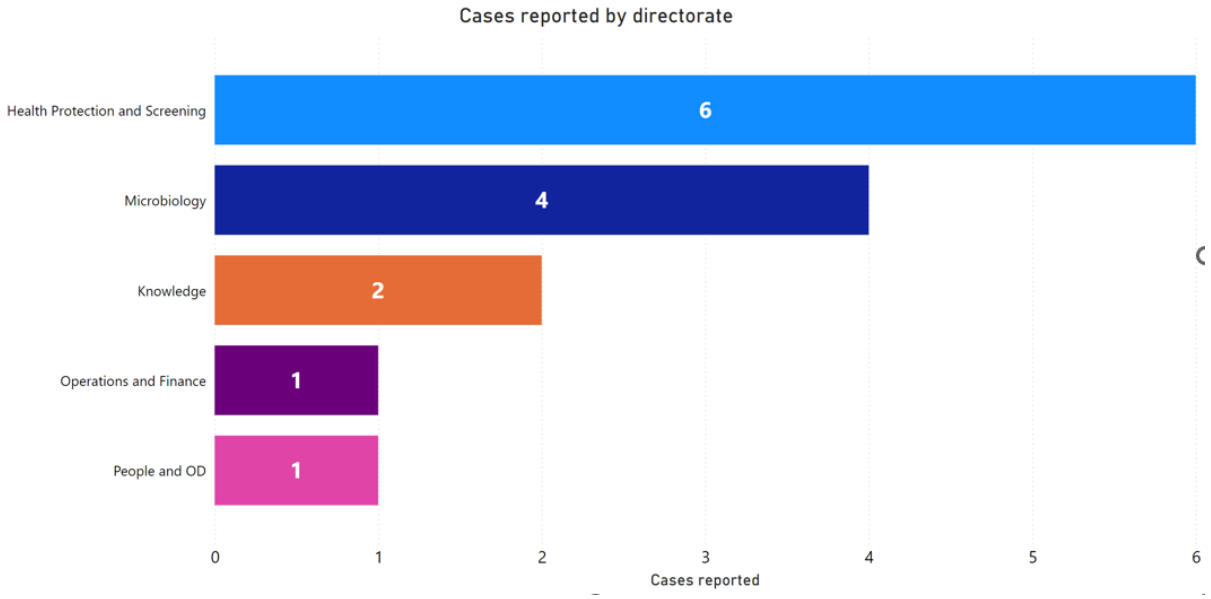


Graph5.1

The overall number of safeguarding incidents reported by PHW staff remains low compared to the wider context of NHS Wales.

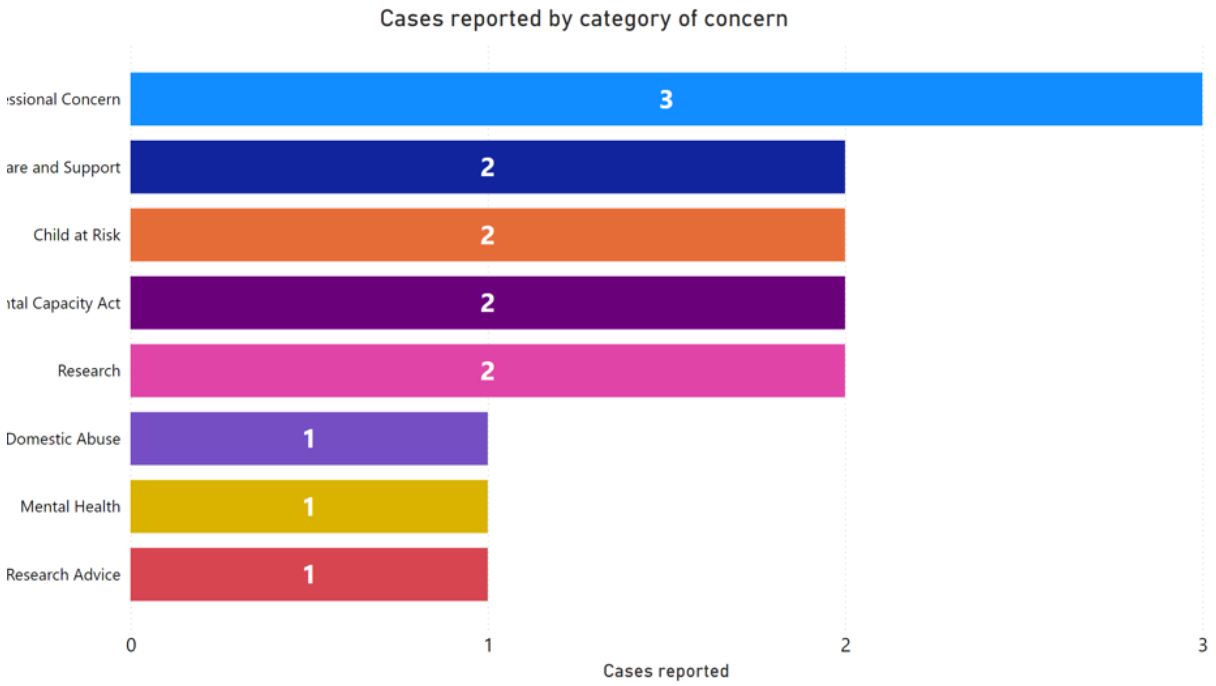
As the largest public facing directorate, Health Protection and Screening continue to report the most safeguarding concerns/incidents which is to be expected.
However, safeguarding advice and support is being sought by other directorates, highlighting increased Safeguarding awareness across the organisation.

The graph below demonstrates the cases by directorate.



Graph 5.2

The emerging safeguarding themes have changed this quarter, with professional concerns accounting for 3 of the Safeguarding queries for advice and support.
The nature of the 3 professional concerns varied in complexity and required partnership working with People and Organisational Development to ensure a plan was in place to manage these concerns proficiently. The below graph details the different categories of recorded concern.
3 of the Safeguarding queries resulted in referrals to the local authority and included 1 for a child at risk and 2 for care and support for adults that presented to screening with difficulties in meeting their own care and support needs. The table below demonstrates the themes of concern reported.



Graph 5.3

5.2 Safeguarding Training

All PHW staff are required to complete level 1 safeguarding training and specific staff groups are required to complete a higher level of training dependent on their roles.
Since the recent introduction of new position numbers within ESR by the Health Protection and Screening Directorate it has not been possible this month to accurately report in the higher levels of Safeguarding training compliance. The core mandatory training competencies are not affected only the higher-level role specific competencies. Remedial work is in progress, and it is anticipated that reporting will be available at the end of January 2025. As this is a newly identified risk it has been added to the risk register and further details are included in the next section.

Overall organizational compliance for quarter 3 against a Welsh Government target of 85% is as follows:

- Level 1 Safeguarding Adult training is at 92.3%.
- Level 1 Safeguarding Children training is at 92.3%
- Group 1 Violence Against Women, Domestic Abuse and Sexual Violence 91.17%

4 sessions of the Group 2 Ask and Act, Violence Against Women, Domestic Abuse and Sexual Violence training have been delivered with a total of 38 employees attending. This has led to the overall compliance rate improving. In addition, 2 Level 3 Safeguarding people training sessions have been delivered with a total of 22 employees being trained. Feedback is generally positive with 45% of the attendees strongly agreeing and 48% agreeing that the session met expectations. Feedback that suggested improvements included using smaller

discussion groups and having more case studies. These have been considered, and changes have been made to the training package with this feedback.

5.3 Key Safeguarding Risks & Issues

There are 3 safeguarding risks which committee should note 2 are recorded on the corporate risk register and 1 new risk identified in December.

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

New Risk identified in December.

Risk 1733 – Reporting Safeguarding Training compliance for certain position number in Health Protection and Screening divisions.

5.4 Safeguarding Improvements

Datix Safeguarding Module
The National Safeguarding Service are leading an all-Wales improvement project to relating to safeguarding reporting and oversight nationally which will enable improved, multiagency partnership working arrangements with Regional Safeguarding Boards and the development of an All-Wales Safeguarding reporting form. Once this is developed it will provide a consistent approach of reporting Safeguarding concerns to the 22 local authorities across Wales, providing greater assurance functionality.
PHW is an early adopter of this new approach and significant work has been undertaken to implement the Once for Wales Safeguarding module within the organisation. Working in partnership with NHS Wales Shared Services Partnership an implementation date of 6th January 2025 is scheduled. This will enable corporate safeguarding to provide greater assurance to the Committee that all Safeguarding queries and reports are held centrally within one Datix module.

DBS Project
Work to address the 3 risks associated with the DBS check is progressing. To date the following actions have been taken or initiated:

- Trade Union partners have been advised regarding the intention to develop and update PHW's DBS policy to support the move to the DBS Update subscription service.

- Colleagues from People and Organisational Development are planning a policy development workshop with key staff and Trade union representatives in January

2025. Following this a draft policy will go out to all staff for Consultation for 28 days, and staff engagement will continue to through Trade Unions and staff networks.

- Work is progressing across the organisation to ensure the DBS levels on all active ESR position numbers are correct, and this is due to be completed by 31 March 2025. This will enable PHW to identify who requires DBS checks and at what level. In turn this will enable accurate reporting on DBS compliance when subscriptions to the Update Service are in place.

- From April/May 2025, new DBS checks will be undertaken on all eligible roles to enable colleagues to subscribe to the DBS Update service. This work should take approximately 5 months to complete.

- The Disclosure & Barring Service announced a price increase in December and the impact of this is being reviewed by Finance colleagues to ensure these additional costs are accounted for and the additional resourcing required to administrate the DBS re-checks.

6.0 Infection Prevention and Control (IPAC) Update

This section provides an update on Infection Prevention and Control work during Quarter 3. The IP&C group is scheduled to meet on 14th January 2025 to review quarter 3 data.

6.1 IPC-related incidents

There have been 14 incidents reported in Quarter 3, a reduction of 7 compared to the previous quarter. Of the 14 incidents reported this quarter, none were reported as moderate harm or above, again a reduction compared to 2 reported in the previous quarter.

Category	Number of Incidents	Division where it occurred	Harm / Risk Level	Approval Status
Cleanliness	1	Screening BSW	No Harm	Closed
Contact with Needles or medical sharps	1	Microbiology	Low	Closed
Contact with or exposure to hazardous substance	9	Microbiology	Low	7 closed 2 under management review
Sterilisation /decontamination of equipment (including vehicles)	1	Screening -BTW	None	Closed
Infection Outbreak/Period of increased incidence	1	Screening BTW	Low	Closed
Test Results	1	Microbiology	Low	Closed

6.2 IPC Mandatory Training Compliance

All PHW staff are required to complete level 1 IPC training and specific staff groups are required to complete a higher level of training dependent on their roles.
Since the recent introduction of new position numbers within ESR for the Health Protection and Screening Directorate it has not been possible this month to accurately report on the higher levels of IPC level 2 training or Aseptic Non-Touch Technique training compliance. Remedial work is in progress, and it is anticipated that reporting will be possible by the end of January 2025.

Overall IPC training compliance for level 1 has remained static this quarter at 91%, the same as quarter 3.

6.3 IPC Risk Register

The IPC risk register was reviewed and agreed as accurate at the most recent IPC meeting.

It will be reviewed again in the quarter 4 meeting, but it is worth noting that Risk ID 1501 which related to the corporate IPC role being a single post holder has been reassessed and the risk rating reduced following the successful recruitment to the post, which is now part of the Healthcare Associated infection, Antimicrobial Resistance & Prescribing Programme (HARP) team. They will take up post early January. **6.4 IPC Policies and Procedures**

The Outbreak Management Policy and y Procedure has been endorsed by the group virtually and was noted at the meeting.

6.5 Key Risks and Issues Identified

Since the start of 2024, concerns have been highlighted at the IPC group and to QSIC regarding various aspects of decontamination practice within Screening Services.

The first related to compliance with the new decontamination standards for biopsy probes within Breast Test Wales programme and as a result a Task and Finish Group was subsequently set up to support and progress remedial work to ensure the ventilation systems were functional and all that all units procured and implemented Ultraviolet cabinets to decontaminate the breast probes. These are now fully operational within Breast Test Wales and no longer an issue or risk.
A further ongoing area of concern regarding decontamination practices relates to the endoscopy decontamination facilities in North Wales particularly 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. Capital funding has now been agreed from WG for BCUHB to improve the facilities to deliver the required decontamination standards.
In addition, the decontamination unit at Wrexham Maelor moved to a new facility in November.

7.0 Well-being of Future Generations (Wales) Act 2015

The Quality report seeks to provide the Board and relevant Board Committees with assurance that the organisation is meeting its responsibilities in relation to the management of Concerns, Safeguarding and infection prevention and control to ensure the long-term viability and effectiveness of the organisation.

Where possible Public Health Wales seeks to prevent the occurrence of concerns by taking a proactive approach to learning and quality improvement to ensure high quality safe services are provided to the users of our services.

Quality Governance work is designed to meet key performance standards and identify opportunities for improvement for the benefit the people we work with and for.

Public Health Wales is committed to dealing with incidents and concerns in an open and transparent manner. The report offers insight into how various teams are working together with Public Health Wales NHS Trust to provide the best outcomes.

This Quality report is an important aspect of the organisation's governance arrangements, and, as such, helps the organisation to improve the quality and safeguard the high standards of the services provided by Public Health Wales

Recommendation

The Committee is asked to:

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