

 <p> GIG CYMRU NHS WALES </p> <p> Iechyd Cyhoeddus Cymru Public Health Wales </p>	<p> Name of Meeting Quality, Safety and Improvement Committee </p> <p> Date of Meeting 24th February 2026 </p> <p> Agenda item: 5.1 </p>
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Quality Governance Performance Report Quarter 3 (1st October 2025 – 31st December 2025)	
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Approval/Scrutiny route:	Angela Cook, Assistant Director of Quality and Nursing Business Executive Team Meeting 04.02.26

Purpose
<p>The Quality Governance Report provides Business Executive Team (BET) with an overview of quality governance within Public Health Wales for the Quarter 3 period (1st October 2025 to 31st December 2025).</p> <p>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:</p> <ul style="list-style-type: none"> • Putting Things Right Management • Service User Experience • Alerts Management • Clinical Audit



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

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

Recommendation:

APPROVE <input type="checkbox"/>	CONSIDER <input checked="" type="checkbox"/>	RECOMMEND <input type="checkbox"/>	ADOPT <input type="checkbox"/>	ASSURANCE <input checked="" type="checkbox"/>
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The Committee is asked to:

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



Link to Public Health Wales [Strategic Plan](#)

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

This report contributes to the following:

Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	5 - Supporting a sustainable health and care system
Strategic Priority/Well-being Objective	Choose an item.

Summary impact analysis

Equality and Health Impact Assessment	No Equality and Health Impact Assessment is required. However, many of the areas that are identified through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity
Risk and Assurance	The information and data presented in this report help understand the quality of services/ care being delivered, and our assurance and improvement activities to provide high quality and continuous improving services. The Governance structure is operating effectively with Safeguarding, and Infection Prevention Control included on the relevant group Risk Registers.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports and/or takes into account the <u>Health and Care Quality Standards for NHS Wales</u> 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.



1. 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 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 Right - Incidents (Page 8)

- 581 incidents were reported and investigated during Quarter 3, with remedial actions identified. Of these, 10 were initially reported as moderate harm or above.
- As of 13 January 2026, there are 30 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (Page 30)

- 19 Safeguarding queries for advice and support were requested this quarter.
- 2 referrals were made to the local authority, meeting statutory safeguarding responsibilities.

Infection Prevention & Control (Page 34)

- 16 IPC incidents were reported during Quarter 3. All were low or no harm incidents. Work is ongoing with the PTR team and services to ensure that IPC incidents are coded and reported correctly.
- 1 new risk was added to the risk register during Quarter 3 relating the water safety on the Breast Test Wales mobile units. As mitigations and control measures have been implemented the risk owner has been asked to review the score.
- The endoscopy decontamination unit at Ysbyty Glan Clwyd remains the highest scoring risk with a score of 16. This score is not anticipated to reduce until the unit is relocated during the next financial year.
- Health Protection division are continuing to work to identify the staff that require IPC Level 2 training and mapping this to ESR.



- Work to review the use of sterile ultrasound gel and antiseptics for skin preparation during breast biopsy is being undertaken within Breast Test Wales to ensure compliance with best practice guidance.

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 15)

- 40 Early Resolution complaints were received in Quarter 3, and 10 formal complaints.
- 80% of the Early Resolution complaints were resolved within the 2 working day target.
- 80% of 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 27)

- Progress against the 2025-26 Quality and Clinical Audit Plan for Quarter 3 (Q3) has been reviewed.
- During Q3 further audits were identified bringing the total to 71 audits to be undertaken this year.
- 4 requests have been received to remove audits from the plan this quarter.
- 3 requests were made to amend dates.

Safety Alerts Management (Page 22)

- A total of **30** alerts were received by Public Health Wales during this reporting period, **5** of which required action.

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 24)

- A total of 134 compliments were recorded by staff within the Civica system.
- 23 compliments were left directly by members of the public using the 'Your Feedback' webpage available on the Public Health Wales website.
- A combined total of 157 compliments logged for Public Health Wales this quarter.

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



2. Purpose / situation

The purpose of this report is to provide information on quality performance during **Quarter 3 2025 (October to December 2025)** and provide updates from Public Health Wales governance subgroups to provide assurance for the following areas of work:

- Putting Things Right
- Claims Management
- Alerts Management
- Service User/Peoples Experience
- Quality and Clinical Audit
- Safeguarding
- Infection Prevention Control

This report supports the achievement of quality through the following:

Safe: People who use 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.

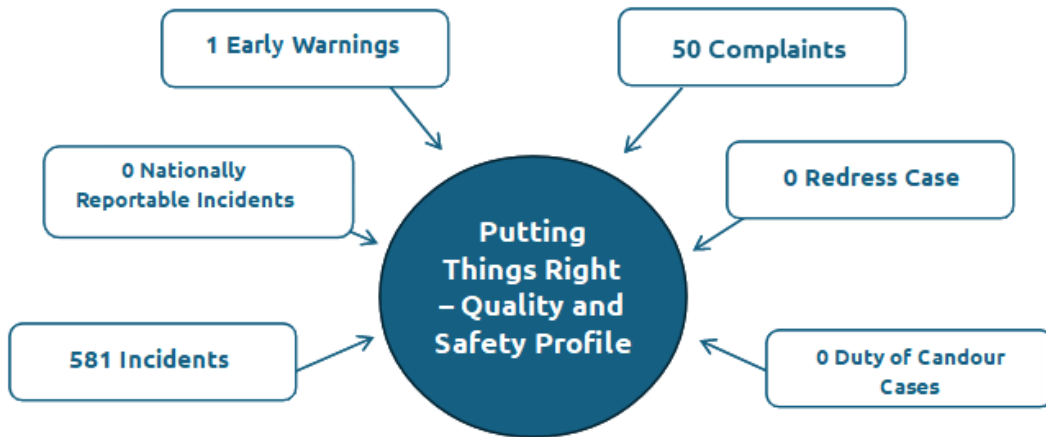
Efficient: We will make the most effective use of our resources, ensuring we build capacity and capability across the organisation to achieve best value healthcare in an efficient way.

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.



2.1. Putting Things Right Quarter 3 Overview



During Quarter 3 there has been an estimated 650,000 contacts/tests with patients, participants and service users across Public Health Wales. The data presented in this report provides insight into the quality and safety of our services.

3. Incident Management

Incidents	National Reportable Incidents	Early Warnings	Duty of Candour
↑ 581 (502)	↓ 0 (1)	↓ 1 (2)	↓ 0(2)

() denotes previous quarter data

3.1. Incidents

During Quarter 3, 581 incidents were reported. This is an increase of 79 incidents compared to the 502 reported in Quarter 2 2025/26.

The below table indicates incidents that have been investigated and closed with any harm identified as moderate harm or above during each quarter.

	Moderate Harm- Post investigation	Severe harm- Post investigation	Catastrophic/ Death- Post investigation
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Quarter 1 2025/26	1	0	0
Quarter 2 2025/26	2	0	0
Quarter 3 2025/26	1	0	0

The **1** Moderate harm post investigation relates to RIDDOR reportable incident in Breast Test Wales and relates to a participant injuring themselves following walking into the lift equipment outside the breast test mobile van after their screening appointment.

3.1.1. Identified Learning

- Review of risk assessments for the siting and operation of BTW mobiles, particularly water safety compliance.
- Consider installing reflective tape on exposed edges to reduce likelihood of injuries being through accidental contact and the use of cones to prevent people walking too close to the unit.
- Review first aid arrangements for mobile unit sites to ensure that adequate support is in place for staff and service users.

3.2. Early Warning and National Reportable Incidents

There has been 1 Early Warning (EW) notices sent to Welsh Government in Quarter 3. The Sexual Health Team within the Health Protection Division identified concerns regarding data collection and sharing processes, weaknesses in providing accurate results and weaknesses in the safeguarding processes.

3.3. Incident Management Teams

There are currently **2** Incident management Teams (IMT) ongoing:

Breast Test Wales:

- Gateway review of BTW mobile units, which now include the management of water safety on the mobile units.

Health Protection:

- Sexual Health Team

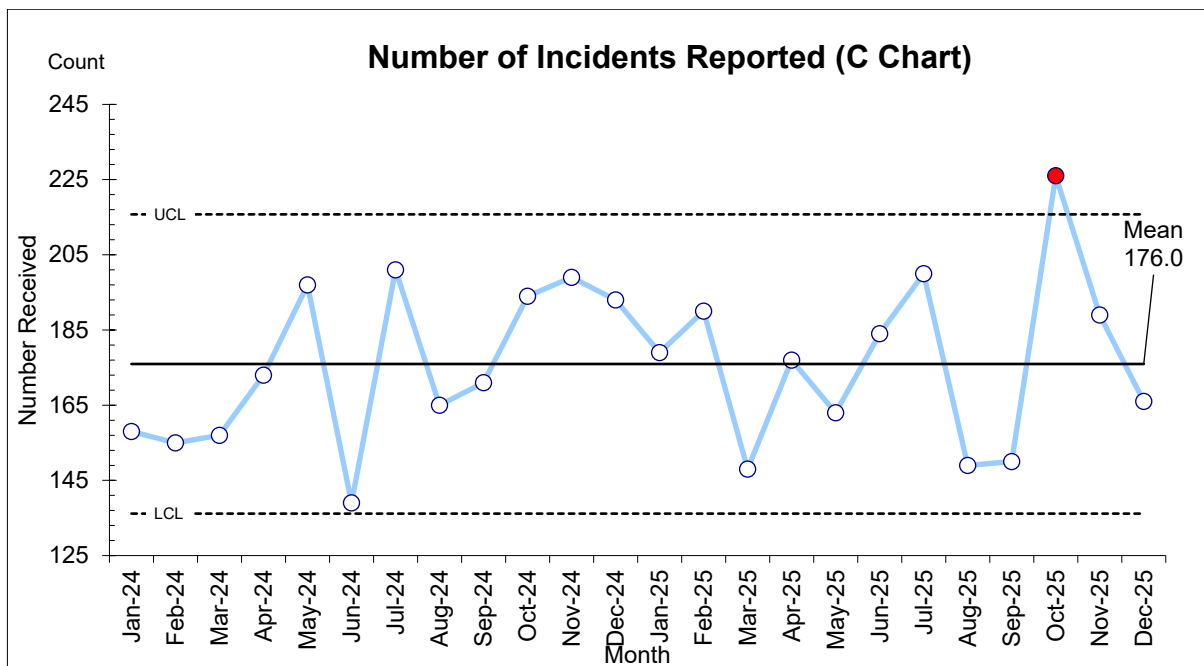


3.4. Emerging Issue:

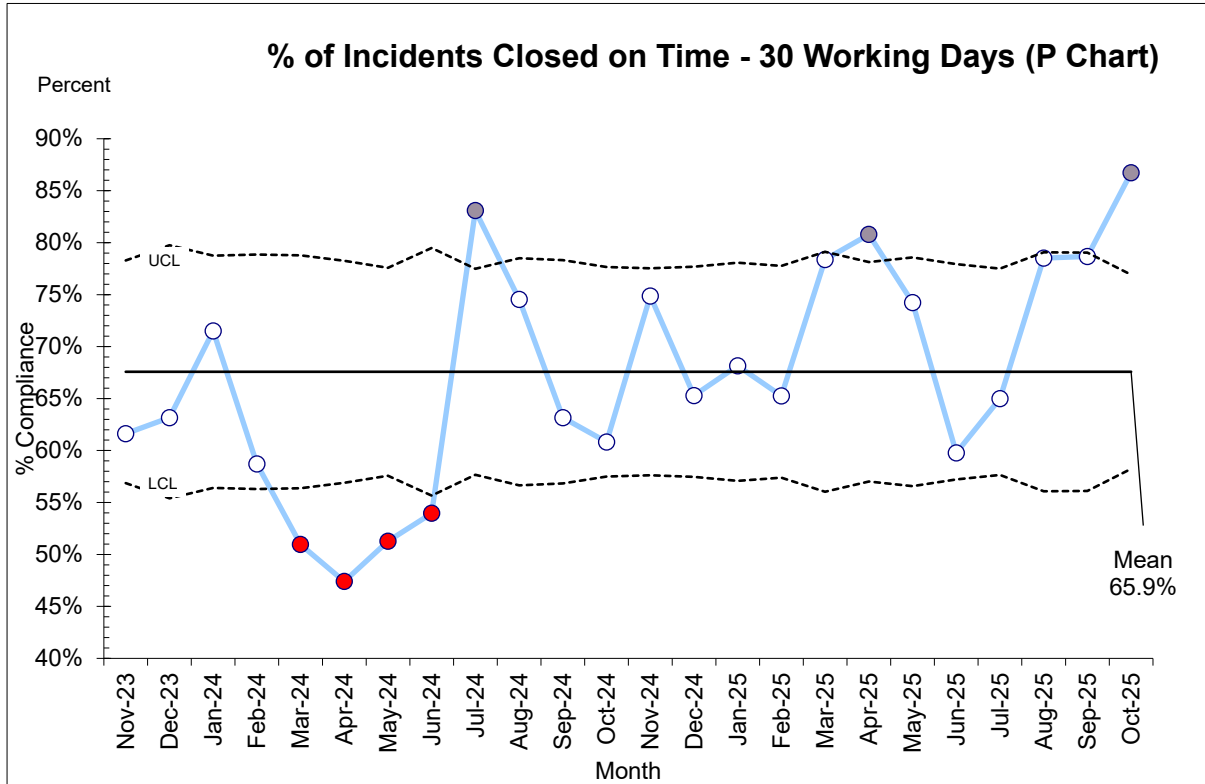
- Following a recent service review of the Cervical Screening Wales Audit of Cervical Cancer it was identified that there were a significant number of cases which were overdue for their review. The review of these overdue cases has now been completed. 16 cases have been identified where the outcome was unsatisfactory and where potential harm may have occurred.
- A process is now in place to contact these individuals and offer them an invitation to meet with the service.
- The collective identification of all 16 cases could present a financial risk, as some may meet the criteria for Redress or progress to clinical negligence claims.

3.5. Open Incidents – Quarter 3

The below graph demonstrates the number of incidents reported since January 2024. The mean has increased slightly between Quarter 2 2025/26 and Quarter 3 2025/26 with an increase of 5 compared to Quarter 2, from 171 incidents to 176 incidents.



Cervical screening wales (CSW) are the highest reporting area in Quarter 3 with 244 reported incidents, an increase from 151 reported in Quarter 2 relating to out-of-date consumables being used in primary care. Infection services also saw an increase in reported incidents from 176 in Quarter 2 up to 182 in Quarter 3.



The above graph highlights the overall performance against the 30-working day closure rate which has seen an improvement when compared to Quarter 2.

3.6. Incident Classification

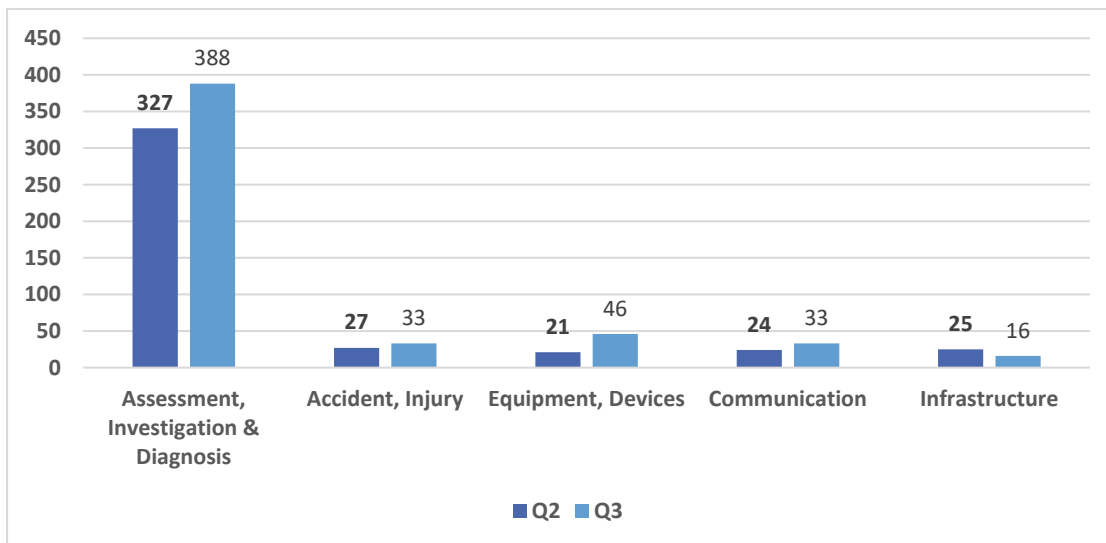


Chart 5. Top 5 incident classifications



Assessment, Investigation and Diagnosis remains the highest reported incident type, increasing in number when compared Quarter 2.

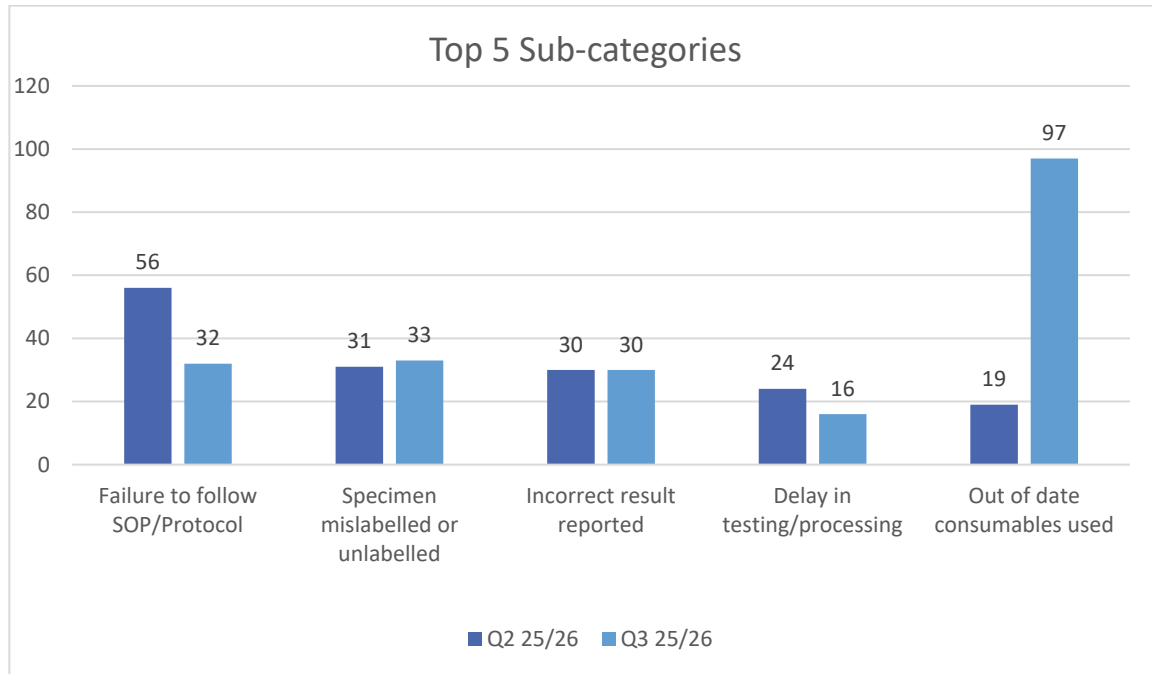
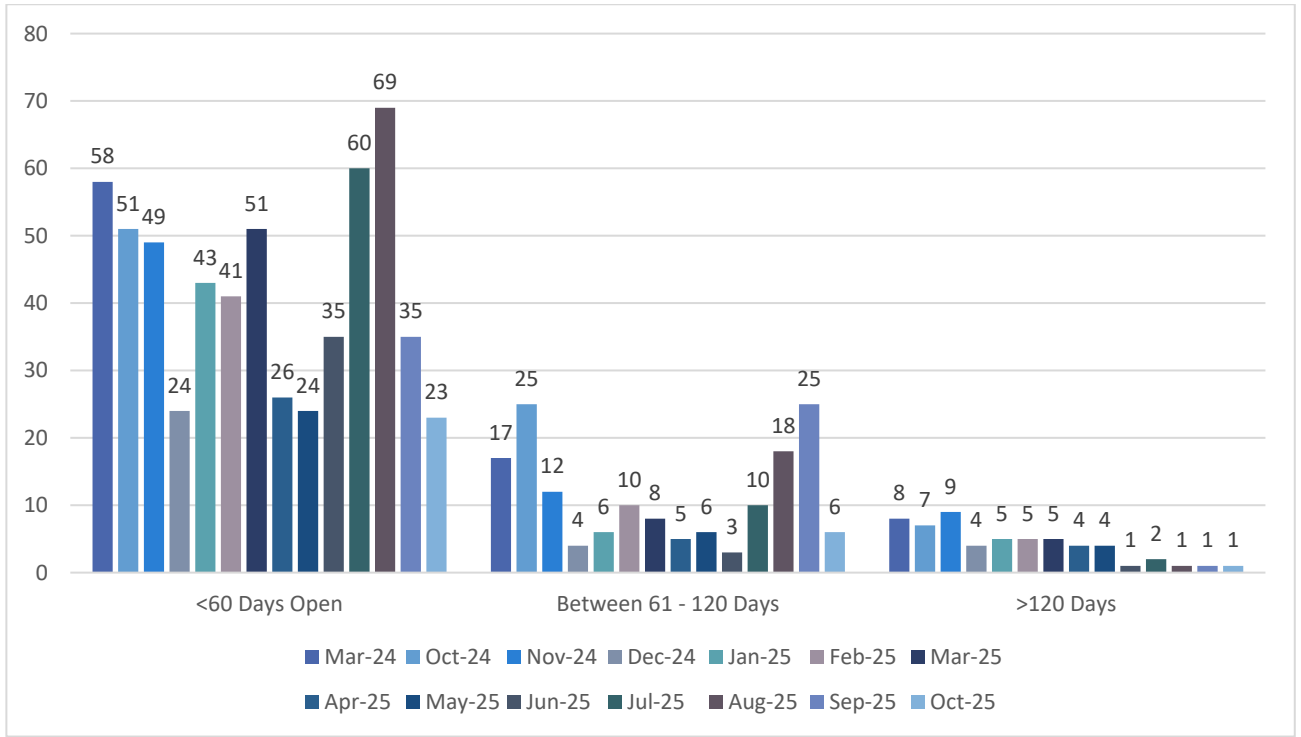


Chart 6. Top 5 sub-categories



3.7. Overdue Incidents



As of 31 December 2025, there are **159** open incidents, **30** of which have an **overdue** status. The largest numbers of overdue incidents are within Breast Test Wales (**9**), Infection Services (**5**) CDIHP-Sexual Health (**4**) and Diabetic Eye Screening (**4**).

There has been a decrease (13) in the number of overdue incidents in Quarter 3 compared to previous quarter.

3.8. Incident Reporting and Management Training

During Quarter 3, Datix Level 1 incident reporting training has been delivered to 77 members of staff equating to 47% of Public Health Wales having 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 as part of onboarding procedures.

The current Level 1 Datix training offer has been paused at present whilst a new training package is initiated to train staff on the revised Listening to



People Regulations. NHS P&I are developing the national training which is anticipated to be ready by March 2026.

The PTR Team are still offering bespoke training sessions to areas in the interim to ensure any new staff joining the organisation as well as existing staff can receive training if required whilst the new package is being developed.

4. Redress Management

When investigating a concern which includes an allegation that harm has or may have been caused, Public Health Wales is required to consider whether there is a qualifying liability in tort. This means consideration must be given as to whether there has been a breach in our duty of care and whether that breach of duty is causative of any harm or loss to that person.

No new redress cases were received this quarter. There are **8** ongoing redress cases, **4** in Breast Test Wales and **4** in Cervical Screening Wales.

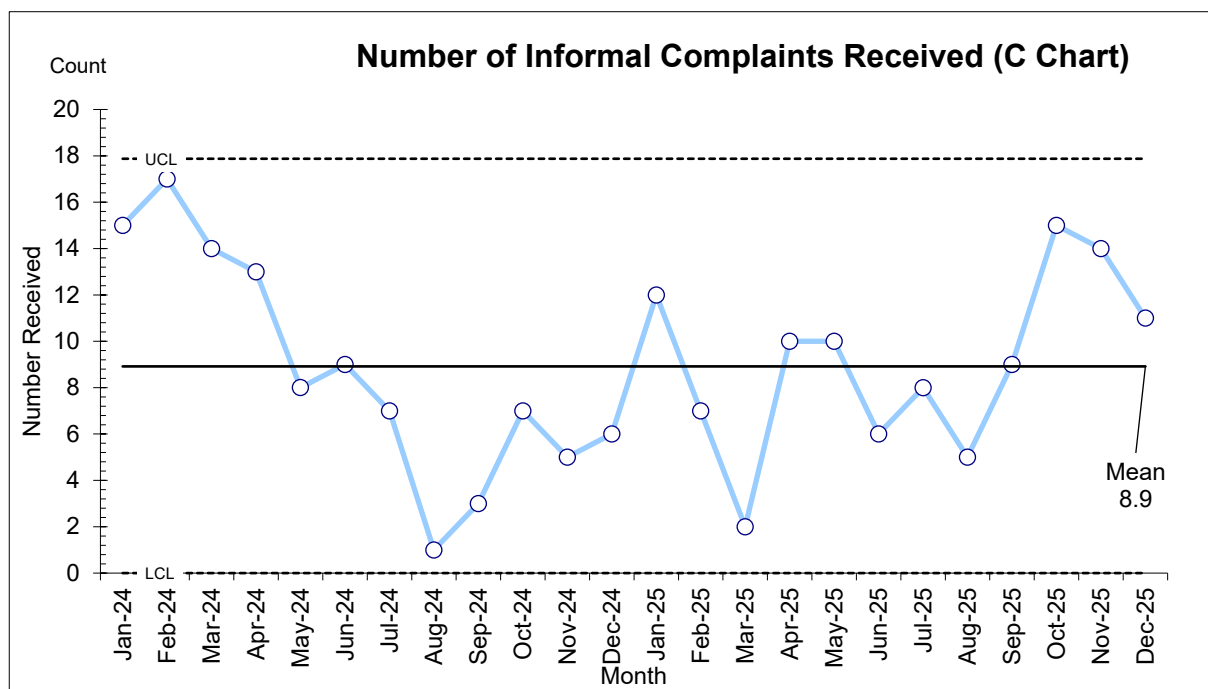


5. Complaints Management

Early Resolution Complaints (n)	Formal Complaints (n)	Ombudsman Complaints (n)
↑ 40 (20)	↔ 10 (10)	↔ 0 (0)

() denotes previous quarter data

5.1. Early Resolution Complaints (Informal)



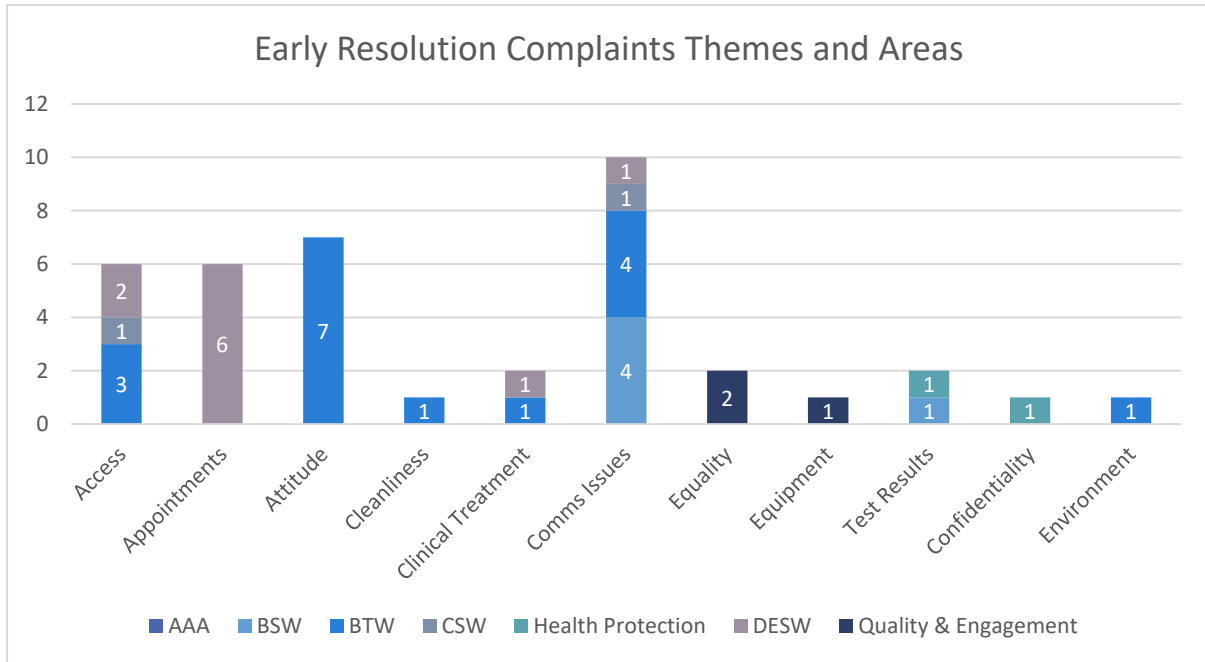
Public Health Wales endeavours to deal with any complaints received by way of early resolution wherever possible.

- **40** Early Resolution complaints were received during Quarter 3. This is a significant increase compared to 20 in Quarter 2.
- 20% (8) were resolved outside of the target, but all within 10 working days.

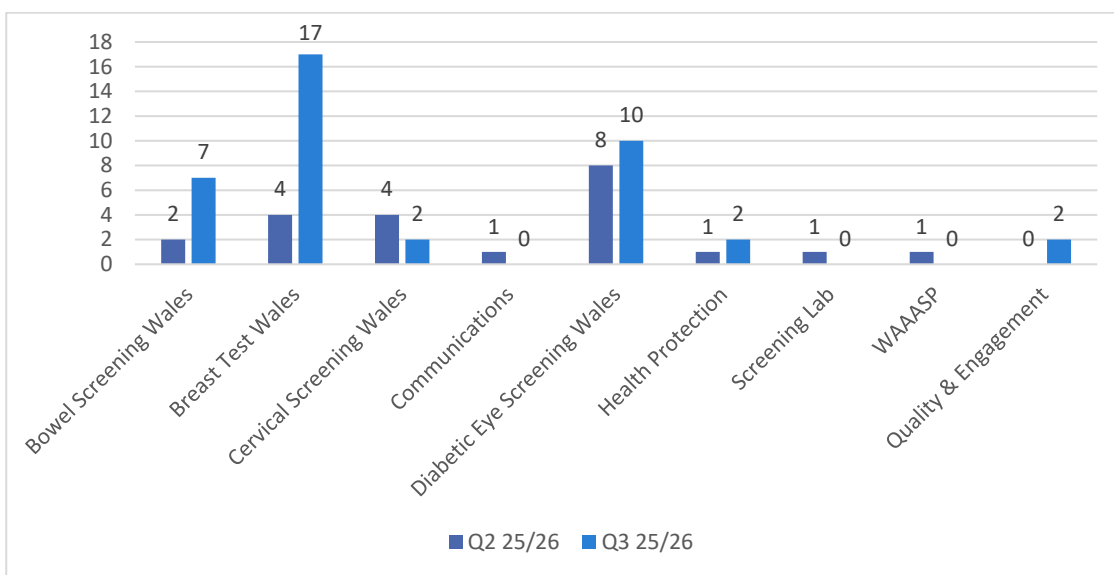


Delays to achieving the 2 working day compliance rates:

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



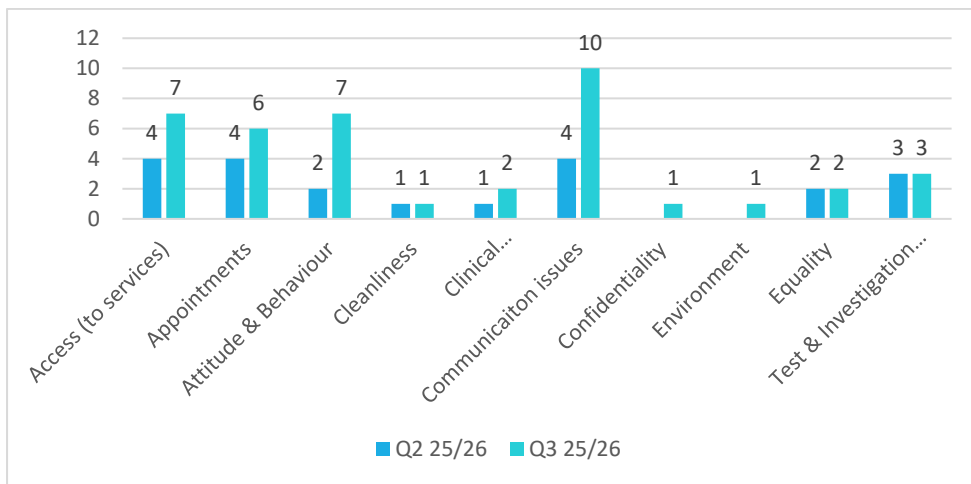
The below chart details the service areas where Early Resolution complaints have been received during each quarter and provides the previous quarters' comparative data.



Breast Test Wales have seen a significant increase in Early Resolution complaints this Quarter, 17 compared to 4 received raised in the previous Quarter with 'Attitude and Behaviour' being the highest reported category in Quarter 3. These complaints include communication issues with staff, staff attitude and 1 interaction that lacked empathy.

As a result of these complaints, both verbal and non-verbal communication skills training has been scheduled in January 2026 for one region of the service. In addition, within team meetings importance of tone and empathetic manner when communicating with participants has also been discussed with further training scheduled.

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



5.2. Formal Complaints

During Quarter 3, **10** formal complaints were received, this figure remains unchanged compared to the previous Quarter. The average is 3 formal complaints per month.

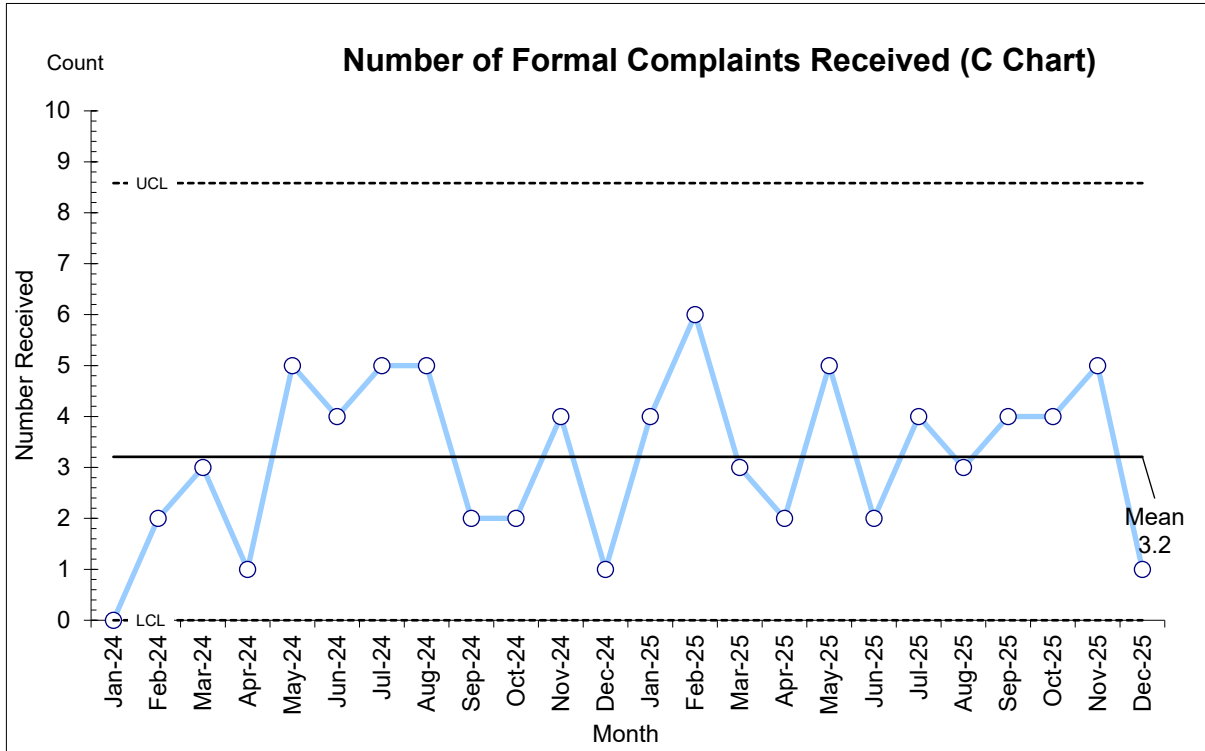
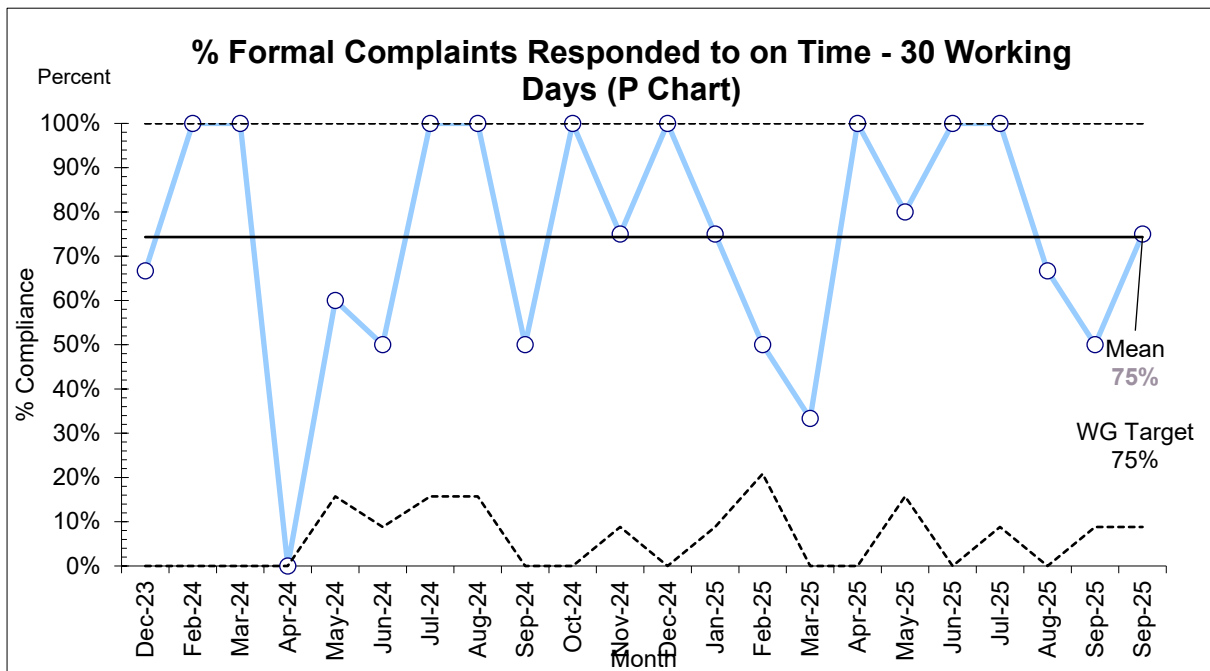
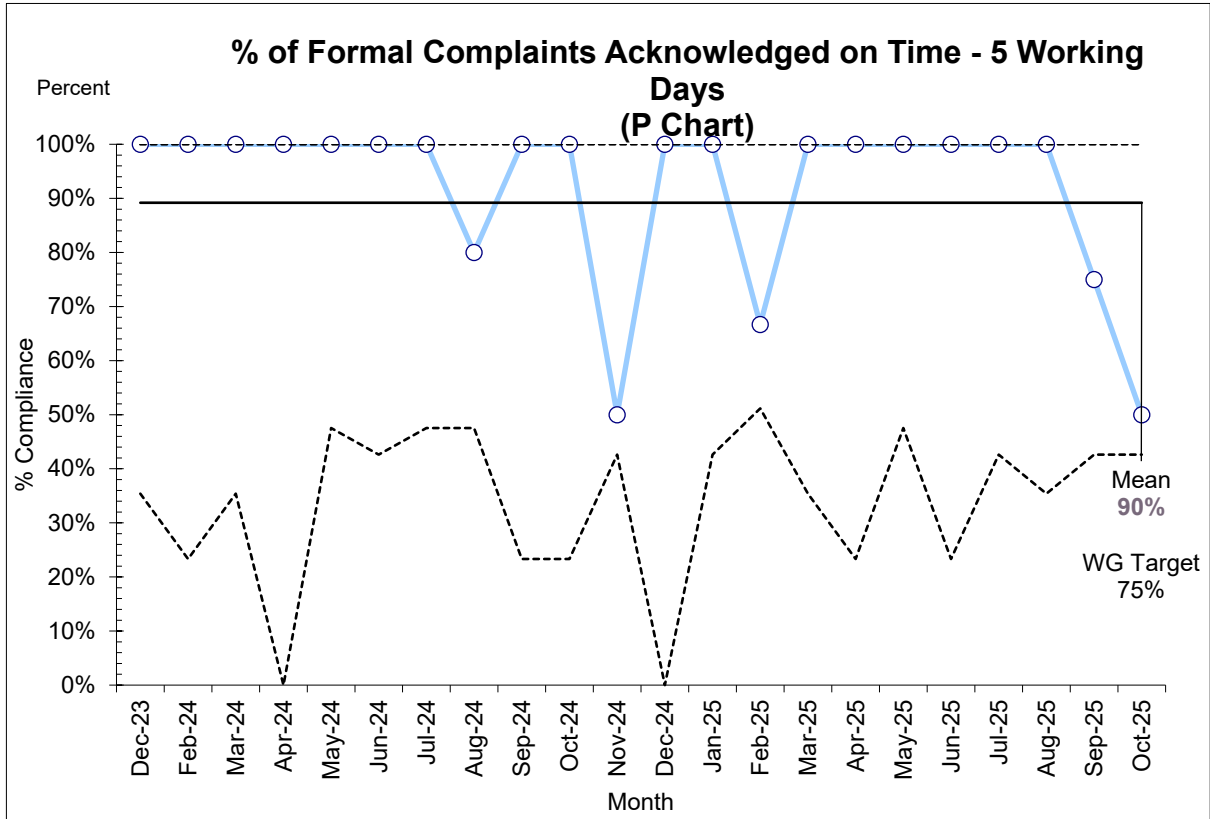
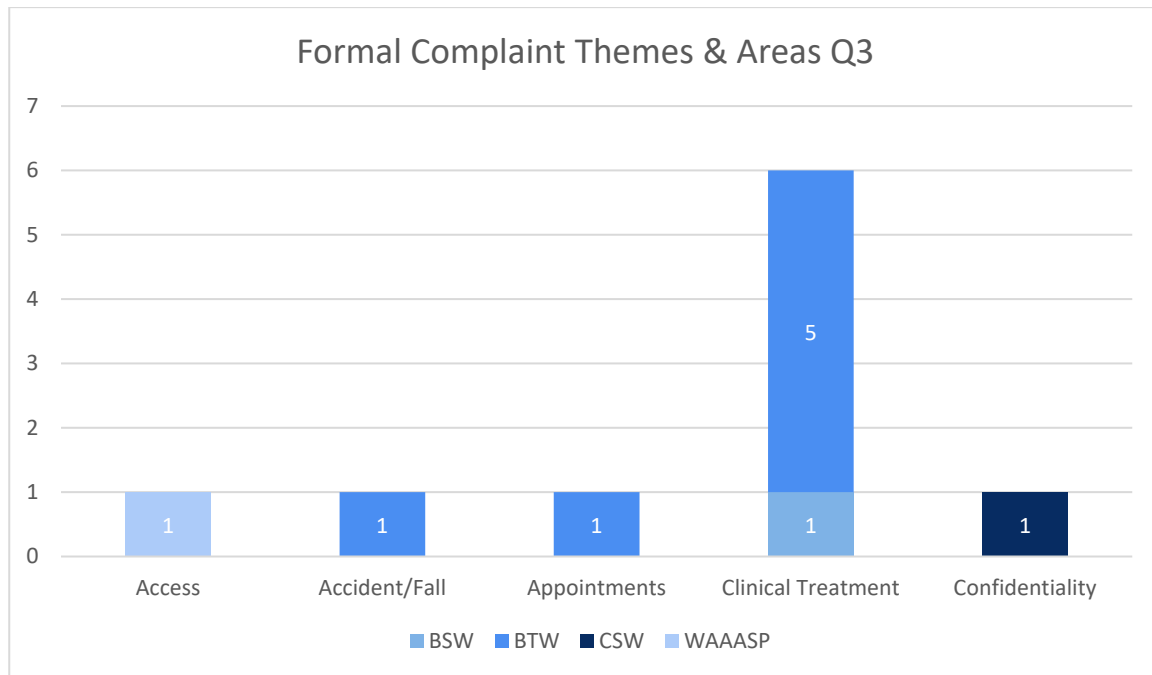


Chart 9. Formal complaints received per month

The below charts demonstrate overall performance in acknowledging and responding to formal complaints against a Welsh Government (WG) target of 75%. PHW is performing above the WG target with a mean of 90% complaints acknowledged and 75% achieving the 30-working day performance target.



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



5.2.1. Learning from complaints

5.2.2. WAAASP access to services

A complaint was received in November 2025 from a Member of the Senedd on behalf of one of their constituent who was initially informed by WAAASP that they would not be able to be offered a screening appointment due to their physical limitations, as the screening test requires the participant to independently transfer to an examination couch for the screener to undertake an ultrasound of their abdomen.

Following receipt of this complaint, WAAASP undertook further discussions with the participant and identified that an additional member of staff could be present to provide the support required for the participant to safely transfer to the couch and return to the sitting position. An appointment was scheduled and held successfully for this participant in early January 2026.

5.2.3. BTW communication issue

A complaint was received in November 2025 from a Breast Test Wales service user who felt they did not receive a general welcome greeting with clear communication when attending for their appointment. The complainant also raised concerns that Welsh language services were not being offered and in addition that one poster was displayed at an entrance was only available in English, and also that the Welsh version of one poster 'the Benefits and Risks notices' was also missing.



As a result of this complaint, a session with the PHW Welsh Language Team has been arranged to provide staff with basic Welsh greetings and reinforce our obligations under the Welsh Language Standards. Additionally, as outlined above, both verbal and non-verbal communication skills training has been scheduled in January for one region of Breast Test Wales.

6. Duty of Candour

No new Duty of Candour cases have been identified in Quarter 3.

6.1. Cervical Screening Wales Interval Cancer Reviews

Within the programme a Quality assurance programme is in place to review any cases when a cancer has developed between screening intervals. There has been a backlog pertaining to these, which has now been completed. However, 16 cases have been identified as unsatisfactory and have been reviewed further for any potential harm for those involved. The next stage is to now contact the treating clinicians and the participant in these cases to inform them of this retrospective review and to offer a meeting to discuss the findings as part of being open and transparent.

7. Concerns regulation update

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

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

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

The revisions are underpinned by four core principles:

- Ensuring people raising concerns are actively listened to and treated with respect
- That concerns are investigated proportionately and effectively

- That NHS organisations are under a duty to learn from concerns and must develop effective action to prevent reoccurrence
- That leaders of organisations provide assurance that they are meeting regulatory requirements.

The implementation date of the new regulations is **1 April 2026**. The guidance to accompany the regulations is currently being updated.

Key changes to the regulations include:

- A mandatory offer of a listening discussion where NHS organisations will take on board the experience of the individuals raising concerns
- Clear and compassionate communication throughout the process, with complex legal or medical terminology properly explained
- Active offers of advocacy and legal support for complainants
- An increase of the Redress threshold to £50,000 (from £25,000)
- Reduced timeframes for the management of Redress cases
- Early Resolution timeframe increased to 10 day from acknowledgement (from 2 working days)
- Mandatory checks that concerns have been resolved within the set timeframes and resolved to the satisfaction of the complainant.

8. Safety Alerts and Notices Management

8.1. Purpose / Situation

This section of the report provides assurance that Public Health Wales has an effective management system for the distribution, management, monitoring and appropriate record keeping of Safety alerts / safety notices received by the organisation. Reporting of Alerts is by exception.

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

8.2. Table 1: Total Alerts received

Type of Alert	Number received	Number requiring action (Covid 19)	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Medicine Shortages	18	0	1	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment	24/10/2025	Shared with Health Protection and Infection Services/Microbiology.
Public Health Alert	6	1	3	Increase in respiratory illness and risk of transmission in hospitals Influenza season 2025: Antiviral medicines Current Influenza A Epidemiology and Clinical Responses Cold Weather Health Risk: Advice Note for Wales Health and Social Care System Partners	09/10/2025 23/10/2025 10/11/2025 12/11/2025	Shared with Health Protection. Shared with Assistant Director of Quality and Nursing, Health Protection and Infection Services/Microbiology. Shared with Health Protection. Shared with Health Protection.
Totals	30	1	4			

9. Compliments and Service User Experience

This quarter, **134** compliments were recorded by staff within the Civica system. In addition, **23** compliments were left directly by members of the public using the compliments form available on the Public Health Wales website, equating to **157** compliments this quarter.

A new Compliments public-facing survey will be in place by the end of February 2026, which aims to reduce the number of non-Public Health Wales compliments being left via this medium.

Thematic analysis of compliments indicates the below main themes.

6 compliments were categorised under 'other' and upon further investigation, the theme included 'praising the quality of a publication', 'Quality of presentation', and a thank you for a 'Lab Tour'.

The table below provides a breakdown of all compliments for this quarter. The word cloud below highlights a selection of the sentiment shared via these compliments.





Compliments sentiment 1 October 2025 - 31 December 2025

9.1. People’s Experience Surveys

The All-Wales People’s Experience survey went live within Diabetic Eye Screening Wales (DESW) on 28 November 2025, following a successful SMS (text message) Pilot. The collated responses focus on the Experience measures (Phase 1) included in the Quality Outcome Framework. The Quality Outcome Framework provides a suite of quality measures for national and local assurance against key safety indicators, enabling learning and informing improvements nationally.

Between 28 November to 31 December 2025, 5456 individuals were sent an SMS request from DESW with a request for feedback, which led to 1153 people responding within the set date parameters. This equals a response rate of 21.1%.

Since launching the People’s Experience Survey within DESW, the service has received feedback from participants from across all the local authority areas within Wales.

The specific Indicators that demonstrate quality of service provision (28 November – 31 December 2025) were as follows:

- *Were you able to communicate in your preferred language?*



98.4% of respondents selected 'Always and usually' for 'Usually'.

- *Were you involved as much as you wanted to be in decisions about your care?*

A combined total of 98.40% of respondents selected 'Always and Usually'

- *How would you rate your overall experience?*

A combined total of 95.75% of respondents rated the service as 'Very good to Good'.

Work has commenced on implementing SMS (text message) feedback within the Abdominal Aortic Aneurysm (AAA) Screening programme. Once successfully delivered work with Breast Test Wales begin. Both services will start using SMS feedback methodology in 2026.

The People's Experience Learning Group are currently constructing a public-facing 'You Said, We Did' information page, along with a 'Wall of Thanks'. This new approach whilst enable greater transparency and openness supporting the Duty of Quality and organisational culture.

10. Quality and Clinical Audit

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

Type of Audit	At start of year	Update as of end of Q2	Update as of end of Q3
National Audits	6	6	6
Audits identified as a result of risks	29	32	33
Local Policy Audits Care Pathways/Local Guidelines Audits	64	68	71

- 6 external audits were planned, 5 remain ongoing and 1 was placed on hold due to current changes within NHS England who led on this audit
- 71 internal audits were scheduled and their status is listed below.

Quarterly Status	Number	Details / Comments
Completed	27	
Progressing as Planned	32	
Removed from plan this Quarter	4	See below
Not Due to Start this Quarter	4	
Original timelines amended	4	<ul style="list-style-type: none"> • BSW Audit of Delegation of Authority for Histology Validation: Audit originally planned to be completed in Dec, however changed to Mar to allow final data collection from health board to be completed. Sample achieved in January, and team have begun work on the report. • DESW Performance Metrics Audit: Scope of the audit increased from what was initially planned, so the audit project timeline has been extended to completion by Apr 26 to account for the additional work. • DESW Websites review (DESW & IFP): delay for information from informatics, resulting in inability to complete audit by end of Q3 as planned. Additionally, audit on hold due to PHW website review and at risk of not being completed before year-end. Plan for completion by end of Q4 2025/26.

		<ul style="list-style-type: none"> • POD Sickness absence Management: Audit project extended from Sept to Jan; data collection period required extension to ensure sufficient sample was captured.
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Details of the 4 audits removed from the 2025-26 plan

Programme/Team and Audit Team	Rationale
Breast Test Wales Breast Care Nursing Service User Experience Audit. (West Region)	<p>This is a repeat of a service user experience audit previously undertaken in other regions. The purpose of the audit is to gain the views of our service users on the service they receive from the Breast Care Nursing Team to measure if the Breast Care Nursing Standards are being met.</p> <p>The audit questions have been under review for the suitability and value added of each question. This work needed to be paused due to staff capacity constraints and operational pressure. The Nursing Team plan to recommence this review in Q4 with support from the Quality and Clinical Audit Lead, and undertake the new audit in 2026-27.</p> <p>Low risk associated with delay to audit; service user experience continues to be captured and reviewed by the programme.</p>
Newborn Hearing Screening Wales All Wales Change of Demographics Audit	<p>The programme was planning to implement a change to process, which would involve a change to baby/carer demographics on AWNBHS/NBSWS and Child Health System. The audit was planned to take place following the change to measure the outcomes and adherence to the change in process.</p> <p>The programme prioritised other high-risk and high-priority changes within the service and therefore have not been able to implement the change to demographics. It is therefore not necessary to undertake the audit until the changes have been implemented. Low risk associated with delaying the implementation of this change and therefore this audit, and other, higher-risk areas for improvement were prioritised.</p>
Newborn Hearing Screening Wales Electronic Clinic Lists process audit	<p>This audit has been combined with the All-Wales NBHSW Community Screening Audit, which is also in the 2025-26 Plan. Therefore, this audit will still be undertaken this year, but the separate audit has been removed from the plan to avoid duplication.</p>
Diabetic Eye Screening Wales Clinical Review of Optomize Participants without True Diabetes Diagnosis	<p>This audit was added to the plan by the programme lead nurse following anecdotal speculation participants referred to diabetic eye screening may be pre-diabetic rather than true diabetic. The programme has sought further information about the referral process, and are now satisfied this is not the case and therefore the audit is not required.</p>



10.1. Clinical Audit Policy

The new organisational Clinical Audit Policy was published in November and is available [here](#).

10.2. Quality and Clinical Audit Procedure

The revision of this Procedure is complete and it will be presented to the Leadership Team for approval in February 2026.

10.3. Digital Audit Platform (AMAT)

Work continues to implement the digital platform across the organisation along with the associated training.

- 2 superusers trained on all modules.
- 20 administrators trained on Ward Module (this ensures they can undertake administrator roles for the whole system).
- 143 staff trained as system users
- Guidance document created on how to view, collate and analyse findings in the Ward and Team Assurance module, available on the intranet [here](#)
- Within the Ward, Area and Service Projects module there are 5 active IPC audits, 3 active assurance audit and 8 draft assurance audits in pilot stage.
- The Inspection Module for the management of actions for Internal Audit and Audit Wales reports is currently being trialled.
- The management alerts and notifications is currently being explored with a trial planned for Patient Safety Notices in Q4.

An Audit Masterclass session was delivered by the Clinical Audit Support Centre (CASC) in December with good uptake. Further training is being considered for delivery in quarter 4.



11. Safeguarding Group Report

This section summarises safeguarding related activity and performance along with key risks and improvement activity during Quarter 3, 2025-26.

The Safeguarding Group met on 20th January 2026 with directorates requested to address the remaining areas of poor training compliance for 3 specific safeguarding areas with a request for anticipated recovery dates.

11.1. Safeguarding queries for advice and support, referrals and incidents

19 Safeguarding queries for advice and support were recorded during this quarter with the largest number being seen in Health Protection and Screening divisions as the public facing directorate. 2 led to referrals being made to the local authority. Safeguarding advice and support queries were received across five directorates in Quarter 3, with the majority arising from Health Protection and Screening. This distribution reflects the routine exposure to safeguarding concerns in public facing services. The presence of queries within corporate functions such as Operations and Finance further suggests the need for consistent, well-governed pathways that enable all staff, regardless of their role to access timely safeguarding guidance and suggests a need for ongoing workforce training and support.

This quarter has seen a large increase in safeguarding related activity due to the identification of safeguarding concerns within the Sexual Health Service. An Incident management team (IMT) is currently in place to address this and immediate actions to ensure safe operational delivery initiated supported by the Named Lead for Safeguarding and colleagues within the National Safeguarding Service. Safeguarding controls are in place and being actively strengthened, including coordinated operational oversight and clear escalation pathways. A communications plan for external partners has been developed in line with the duty of candour and organisational transparency, providing high-level assurance that risks are being managed proactively.

The Sexual Health incident has had a significant impact on the capacity from the Named Lead, and the NSS who have also been supporting. This has included training, supervision, working alongside practitioners daily to gain confidence, and case management, as well as technical support to the IMT. The Quarter 4 report will give a more detailed summary of this activity and impact.

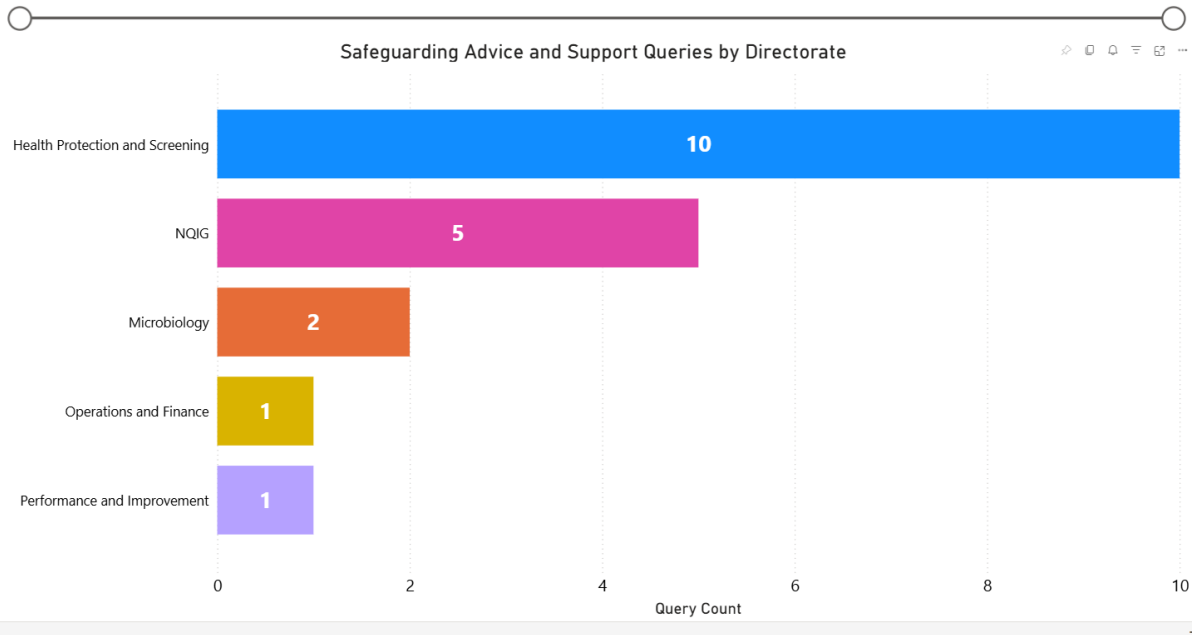


Chart 5.1 Cases Reported by Directorate

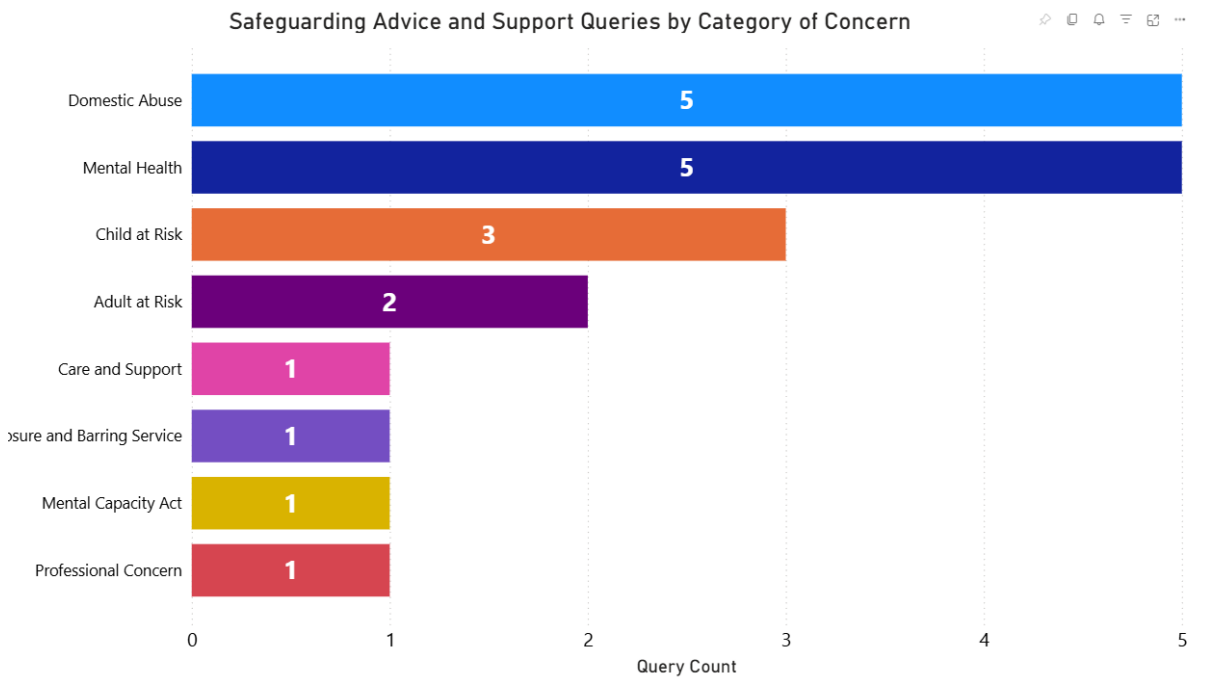


Chart 5.2 Cases reported by category of concern



Safeguarding advice themes are highlighted in the above chart. During Quarter 3 2025/2026, safeguarding advice and support queries reflected a broad spectrum of concerns, with domestic abuse and mental health emerging as the most frequently cited categories. These trends align with known patterns of vulnerability demonstrating the importance of trauma-informed, safeguarding responses. Queries relating to child and adult risk further demonstrate active engagement with statutory duties, while lower numbers of enquiries relating to DBS, Mental Capacity Act, and professional concern continue to highlight the need for accessible specialist advice and proportionate escalation pathways.

2 cases were appropriately escalated to the local authority this quarter, demonstrating effective multi-agency coordination, professional curiosity, and adherence to safeguarding pathways for both adults and children at risk.

11.2. Safeguarding Training

All PHW staff are required to complete level 1 safeguarding and group 1 Violence against Women, Domestic abuse and Sexual Violence training. In addition, specific staff groups working directly with the public are required to complete a level 2 and 3 Safeguarding along with Group 2 Violence against Women, Domestic Abuse and Sexual Violence training dependent on their roles.

A compliance target of 85% is set by the Welsh Government for all mandatory training. The table below indicates the current areas where compliance is below this target. Overall, this quarter's training compliance has seen a slight improvement, but the areas below continue to be an area of focused attention.

Across Safeguarding Adults and Children Levels 1 and 2 and Group 1 VAWDASV compliance has continued to rise into Q3, consistently maintaining performance around or above the 90% benchmark.

Quarter 3 shows a clear reduction in compliance for higher-level, face-to-face delivered training, particularly Safeguarding Level 3, VAWDASV Group 2, and MCA Level 2. This contrasts with the continued improvement in online safeguarding modules. This decline appears to have been related to operational pressures, with several sessions cancelled due to insufficient numbers to deliver the required group-based learning components.

A notable area of concern is Level 3 Safeguarding training, where 25 staff remain out of compliance. Of these, 18 are within Breast Test Wales, indicating a concentrated gap that will require targeted support and training to reduce the risks around failure to appropriately safeguard. The Safeguarding Group has made

a formal request in its January meeting for all areas which are out of compliance to ensure staff are booked on next available training in February and March.

Competence /Training	Compliance Quarter 2	Compliance Quarter 3	Number of staff assigned	Number of staff achieved
028 LOCAL Safeguarding Level 3 - 3 Years	81%	79%	120	95
028 LOCAL Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years	80%	77%	458	352
NHS MAND Mental Capacity Act Level 2– 3 Years	86%	83%	278	232

11.3. Key Safeguarding Risks & Issues

The 2 safeguarding risks which committee have previously been made aware of DBS (Disclosure and Barring Service) checks and a Single Safeguarding corporate post. The Safeguarding Group agreed to the closure of the single post holder risk, given the mitigation by the NSS. It requested a further review of the current risk level for the DBS risk as this service is now live and the mitigating actions implemented. Two divisional risks remain under active management with Communications, relating to potential psychological harm arising from case study use and the risk of misinformation, with mitigation in place and scheduled for review. Overall, key controls are operating effectively, and further action is planned with Communications to strengthen assurance and enhance the robustness of existing measures. The POD-owned risk relating to compliance with the Worker Protection Act is being actively treated, with key controls in place to address gaps in awareness, policy, training, monitoring, and risk-assessment practice, providing high-level assurance that organisational duties are being strengthened and progressed.



11.4. Safeguarding improvements this quarter

Chaperone Training

A Chaperone training programme and competency has been initiated in Breast Test Wales and Abdominal Aortic Aneurysm (AAA) with staff now undertaking the training. 159 staff have been assigned this competency this quarter and 83 (52%) have now completed this.

Targeted Safeguarding Inquiry

Previous reports highlighted the emerging theme from safeguarding incident reviews that certain staff group within Breast Test Wales lacked the confidence to initiate a target inquiry if sexual violence and domestic abuse was suspected. As a result, bespoke training sessions have commenced with the aim of improving this subsequent reporting and ongoing referral to Live Fear Free community support.

DBS Project

Work to address the risk associated with the DBS service for all PHW staff where this applies has been completed and has now become an established process in Public Health Wales. Compliance data is reported at the Safeguarding group for assurance.

12. Infection Prevention and Control (IP&C) Update

This section summarises IPC activity, incidents and risks during Quarter 3 2025-26. The IP&C group met on 15th January 2026 to review Quarter 3 data. During this Quarter the newly established Decontamination and Facilities sub-groups also met and reported into the IPC Group.

12.1. IPC-related incidents

During Quarter 3 there were 16 IPC-related incidents reported, 3 less than in Quarters 1 and 2. All were reported as no or low harm. A breakdown of the incidents can be seen in the table below.

Category	Number of Incidents	Division where it occurred	Harm / Risk Level	Approval Status
Cleanliness	1	Screening, Llys Castan	No harm	Under Investigation
Clinical waste disposal – sharps	1	Infection Services	No harm	Closed
Non-compliance with bundle	1	Health Protection	No harm	Closed
Contact with needles or medical Sharps	3	Infection Services	Low harm	2 Closed 1 Under Investigation
Contact with or Exposure to hazardous substance	8	Infection Services	3 No harm 5 Low harm	5 Closed 3 Under Investigation
Environmental hazards/issues	1	Screening, Breast Test Wales	Low harm	Closed
Test Results/ Reports (Infection)	1	Infection Services	Low harm	Awaiting closure

One of the reported incidents (INC-7707, non-compliance with bundle) was incorrectly reported as an IPC incident and a request has been sent to

the investigator to amend the reporting categories as the IPC Group agreed that this was a medicines incident.

12.2. IPC Mandatory Training Compliance

The table below shows Organisational compliance with IPC Mandatory training and demonstrates that overall, the Organisation is above the minimum accepted compliance of 85% for IPC Level 1 but is below the accepted standard for IPC Level 2.

The second table outlines the Divisions which are below 85% compliance and whether this has increased or decreased since the previous Quarter.

Organisational Compliance		Trend
IPC Level 1	89.46%	↓
IPC Level 2	76.64%	↓

Subject	Directorate / Division	Q2 Compliance %	Required	Achieved	Q3 Compliance %	Trend
IPC Level 1	028 L3 Corporate Directorate	85.71%	28	21	75%	↓
	028 L4 Health Protection Division	87.80%	254	215	84.65%	↓
IPC Level 2	028 L4 Infection Division	15.15%	49	19	38.78%	↑

It is important to note that not all staff require IPC Level 2 training and work is ongoing within the Health Protection Division to identify those who require this competence and to update ESR records. Until this exercise is complete it is not possible accurately report IPC Level 2 compliance for this Division and it is anticipated that this work will be complete by February 2026.

12.2.1. ANTT (Breast Test Wales Only)

All staff who participate in invasive procedures are required to undertake ANTT e-learning and 3-yearly competence assessment. The table below outlines the compliance within Breast Test Wales where these procedures are undertaken and the trend compared to the previous quarter.

	Q2 Compliance	Q3 Compliance	Trend
ANTT e-learning	95.65%	95.33%	↓
ANTT Assessment	38.78%	59.41%	↑

12.3. IPC Risk Register

There are currently 8 risks on the IPC risk register with one added during Quarter 3 and these were reviewed at the meeting.

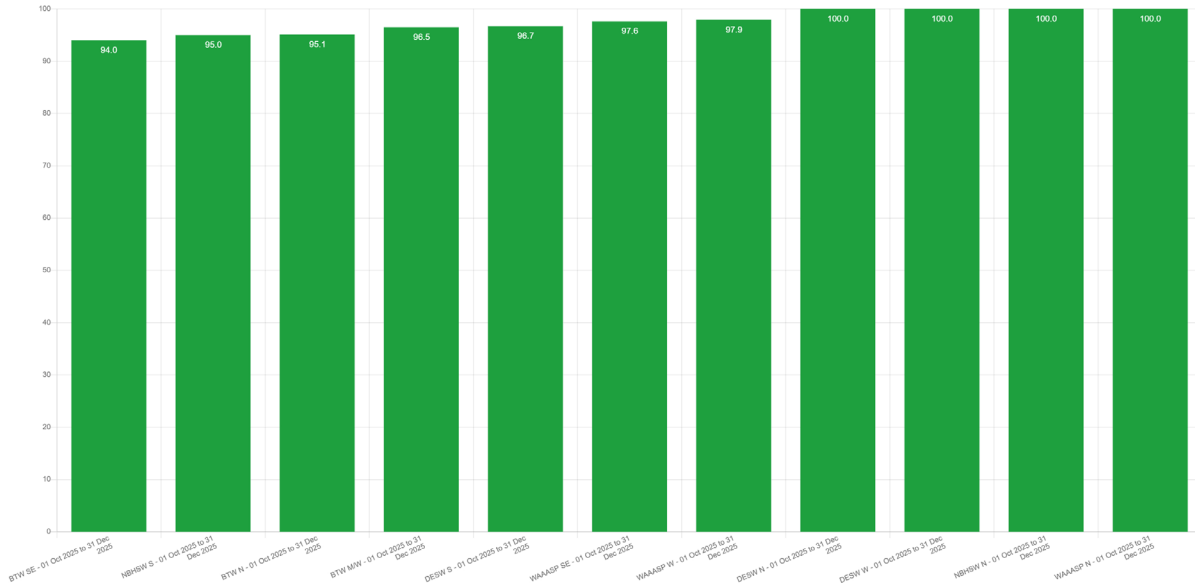
Risk 1587 currently has the highest risk score at 16 and this relates to the endoscopy decontamination unit as Ysbyty Glan Clwyd. This unit is utilised as part of Bowel Screening Wales services and programme representatives continue to sit on project meetings with BCU. The decontamination unit is expected to be relocated during the next financial year, at which time this risk score will be reviewed and is expected to significantly reduce. In the interim, the programme continues to monitor and evaluate the risk.

Risk 2037 was added during Quarter 3, and this pertains to water quality and monitoring in the Breast Test Wales mobile fleet. The risk rating was initially set at 9 however this has now been reduced to 6 due to the mitigations which have been put in place. The IPC Group has requested that the risk owner reviews this score as further control measures have since been implemented.

Risk owners have been asked to review their risks to ensure that action plans are in place and the register remains an accurate representation of the IPC challenges in the organisation.

12.4. IPC Audit Activity

Routine IPC environmental audits of screening services take place bi-annually and are next due to be undertaken during Quarter 4. Observational audits of practice are undertaken on a quarterly basis and results are shown below.



All regions reported high standards of compliance with standard infection control precautions. Non-compliances related to Bare Below the Elbow, appropriate use of hand sanitiser and gloves. These have been addressed by staff at the time of the audit but are also included in the hand hygiene training package which is being implemented throughout Screening Division.

There have been no IPC Nurse Assurance audits undertaken during Quarter 3 however, as these are annual audits it is still expected that the requirements of the audit programme will be fulfilled by the end of the financial year.

12.5. IPC Policies and Procedures

The IPC Policy was reviewed and consulted upon during Quarter 3 and presented to QSIC for approval. A further review is likely to be required during the next financial year following the publication of a number of key documents by Welsh Government. In addition, a proposed cleaning schedule for care equipment, office spaces and clinical environments was discussed and endorsed by the IPC group. This will now be discussed with facilities and inform the procurement for the environmental cleaning contract.

12.6. Key Risks and Issues Identified

The Water Incident Management Team meetings for the Breast Test Wales mobile units have now concluded. Mitigations and procedures have been put in place to minimise the risk of water-borne organisms including Legionella to both staff and the public with the support of engineering colleagues from Shared Services. There are plans in place for ongoing maintenance and remedial actions to ensure that water safety is maintained.



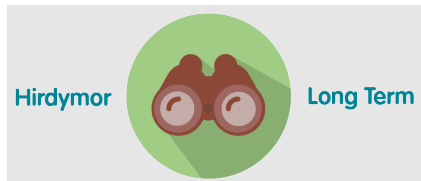
During December 2025 support from an Infection Control Doctor was secured for a three-month trial period with a PHW Consultant Microbiologist from Velindre Trust. This additional IPC resource will then be evaluated and inform the Organisation going forward.

The environmental cleaning contract was due to end during January 2026 however, the organisation has an extension of 6-months to allow to the procurement of a new cleaning contract. IPC and facilities are working closely to review the current provision and outline the requirements for the contract going forward, including the assurance process from the contractor to the Organisation.

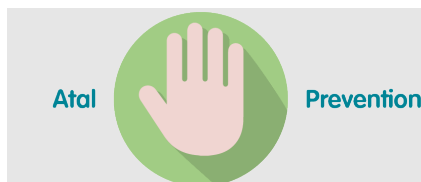
The current IPC practices within BTW related to skin preparation against best practice and national guidance is under review with a multi-disciplinary meeting scheduled for February 2026 to review the antiseptic products used for skin preparation during Breast biopsy procedures and the use of sterile and non-sterile ultrasound gel.



13. Well-being of Future Generations (Wales) Act 2015



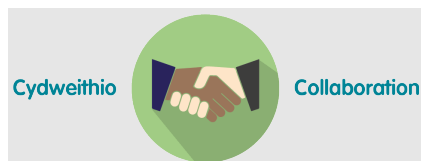
The Quality report seeks to provide the Board and relevant Board Committees with assurance that the organisation is meeting its responsibilities in relation to the management of Concerns, Safeguarding and infection prevention and control to ensure the long-term viability and effectiveness of the organisation.



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



14. 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.