Confirmed Minutes of the Public Health Wales Quality, Safety and Improvement Committee Meeting 25 November 2025, 10:00 – 12:50 Held in Capital Quarter 2 and via Microsoft Teams

Present:		
Clare Jenkins	(CJ)	Chair of Committee, Vice-Chair of Board and Non-Executive Director
Nick Elliott	(NE)	Non-Executive Director (Data and Digital)
Sian Griffiths	(SG)	Non-Executive Director (Public Health) and Chair of the Knowledge, Research and Information Committee
In Attendance:		
Claire Birchall	(CB)	Executive Director of Nursing, Quality and Integrated Governance
Liz Blayney	(LB)	Deputy Board Secretary and Deputy Head of the Board Business Unit
Neil Desmond	(ND)	Head of Estates and Health & Safety (for items 3.6)
Sikha de Souza,	(SdS)	Consultant in Public Health, Screening (for item 3.1)
Sophie Fuller	(SF)	Assistant Director Corporate Governance and Business Support, NHS Executive (for item 9)
Danielle Gething	(DG)	Head of Risk Management (for items 3.3)
Robin Howe	(RH)	Consultant Microbiologist and Director of Infection Services (for item 5)
Meng Khaw	(MK)	National Director of Health Protection and Screening Services, Executive Medical Director (part of the meeting)
Jim McManus	(JM)	National Director of Health and Wellbeing (part of the meeting)
Lizzie Nickerson	(LN)	National Safeguarding Service Designated Doctor, observing
Paul Veysey	(PV)	Board Secretary and Head of Board Business Unit
Zoe Wallace	(ZW)	Director of Primary Care (for item 6)
Apologies		
Pippa Britton	(PB)	Chair of Board
Tracey Cooper	(TC)	Chief Executive
Angela Cook	(AC)	Assistant Director of Nursing, Quality and Integrated Governance
Olusola Okhiria	(OO)	Trade Union representative
Catherine Purcell	(CP)	Non-Executive Director
Stuart Silcox	(SS)	Assistant Director of Integrated Governance
Angela Williams	(AW)	Interim Executive Director of Operations and Finance
The meeting commenced at 10:00		

Part A	
QSIC 2025.11.25/1	**Welcome, Introductions and Apologies**
The Chair welcomed all to the public session of the Quality, Safety and Improvement Committee meeting. The apologies for absence were noted.	
QSIC 2025.11.25/2	**Declaration of Interest**
There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.	
QSIC 2025.11.25/3	**Items for Assurance**
QSIC 2025.11.25/3.1	**Medicines Management**

MK introduced the medicines management update, confirming that the organisation had reviewed its medicines use and governance processes to ensure regulatory compliance.

SdS highlighted:

- That a Medicines Management Group for Public Health Wales was set for establishment from January, with terms of reference developed and attached for noting.
- A revised policy intended to support the new Groups work was out for consultation and comments from the Committee were invited.
- A baseline assessment and risk assessments had been completed, with no significant risks identified, and ongoing monitoring was in place.
- The Service Level Agreement (SLA) with Cardiff and Vale pharmacy, noting positive engagement and plans to review the SLA at year-end to ensure alignment with organisational needs.

The Committee:

- Queried the definition of 'Medicines' and scope of review. SdS clarified that the policy defined medicines narrowly, covering only eye drops for diabetic eye screening, local anaesthetic for breast assessment, and adrenaline for anaphylaxis, with no inclusion of supplements or health promotion items. SdS confirmed the initial review included representatives from across the organisation and that the scope was limited to the three medicines identified.
- MK added that medical devices were managed separately under a different governance process, covered by the Medical Devices Management Group and Medicines and Healthcare products Regulatory Agency (MHRA) regulations.
- Commented positively on the clarity and proportionality of the work.

The Committee took **assurance** on the progress of actions to strengthen governance around Medicines Management within the organisation.

QSIC 2025.11.25/3.2	**Winter Planning**

MK presented an update on the organisation's winter/ seasonal planning preparations, outlining:

- The ongoing coordination with Welsh Government and the Chief Medical Officer.
- That the Respiratory syncytial vircus (RSV) vaccination programme had been evaluated, showing a significant reduction in hospital admissions and a less steep rise in RSV cases this season.
- Infection control measures were reinforced in response to rising influenza rates, with reminders sent to hospitals and care homes, and ongoing surveillance of communicable diseases was maintained through the Communicable Disease Surveillance Centre.
- Collaboration with Welsh Government on notification triggers and briefings, and highlighted additional measures including health and well-being campaigns, staff flu vaccination efforts, and the publication of the winter well-being report.
- That staff flu vaccination uptake had improved compared to the previous year, and that the organisation remained actively engaged in the NHS system's resilience group for coordinated winter response.

The Committee:

- CB highlighted that based on lessons from the previous year, the organisation had decided to implement mask-wearing in clinical-facing services from the start of December, rather than waiting for regional triggers, to better protect staff and patients.
- Noted the close collaboration with the Chief Medical Officer and the improvement in staff vaccination uptake, and stressed the importance of maintaining momentum on vaccination efforts. CB highlighted the positive direction in staff vaccine uptake and the importance of applying lessons learned for future planning.

The Committee took **assurance** on the implementation of winter planning / seasonal planning activities.

QSIC 2025.11.25/3.3.1	Risk Assurance - Strategic & Corporate Risk Register

DG presented the Strategic Risk report, focusing on risks related to Breast and Bowel Screening Delivery. DG noted the stable risk score for strategic risk 3, and that the risk appetite remained within tolerance levels for this risk, with 1 new additional action plan added to the register to strengthen participant pathways for workforce capacity and digital transformation. DG concluded the introduction by welcoming feedback on the new report style and contents.

MK highlighted:

- That meetings with Health Boards on screening colonoscopy had been completed, and a report summarising lessons learned was being prepared. This would be shared with the Leadership Board as a joint approach with the NHS Performance and Improvement Unit to seek a long term commitment and support for long term sustainable solutions.

- That the Breast Test Wales review was well underway, with staff interviews conducted and early findings helping to identify quality improvements, both specific to Breast Test Wales and applicable across all screening programmes.
- Reference to the completion of Exercise Pegasus, a multi-phase exercise on pandemic response, and noted ongoing review of COVID inquiry recommendations to inform future organisational responses.

The Committee:

- Sought clarification on Public Health Wales' employment responsibilities regarding consultant surgeons and radiologists for screening, and whether Health Board cost-saving measures had impacted screening programmes. MK clarified that Public Health Wales employed radiologists for Breast Test Wales but not surgeons, who were contracted from Health Boards. MK acknowledged concerns about the resilience of these arrangements, especially in North Wales, and described escalation to health board senior leadership to address assessment clinic delays. MK also explained that some elements of the screening pathway were commissioned from health boards and that contract management meetings and escalation processes were in place to address underactivity.
- Provided feedback on the risk report, suggesting clearer visual representation of risk tolerance, inclusion of audit dates, clarification of report titles, tracking of digital programme delivery, concerns about pandemic planning becoming too focused on COVID-19, and clarification on the process for converting assurance gaps into controls. MK and DG commented on the process for converting actions to controls, and plans to broaden scenario planning beyond pandemics, including consideration of chemical and nuclear threats.

The Committee:

- Took **assurance** on the management of Strategic Risk within their remit.

QSIC 2025.11.25/3.3.2	Corporate Risk Register

DG introduced the report, noting that the Committee had previously considered the report at its September meeting and due to timings, a verbal update would be provided on the recent discussions at the Leadership Team meeting on 19 November 2025.

DG highlighted that two new risks had been accepted:

- Risk 2.0.0.3, on climate change and the failure to achieve net zero on 2030. Action plans for climate change were being developed for 2026–2028, and leadership team members were encouraged to influence directorates to reduce carbon emissions.
- Risk 2.0.7.6 that Public Health Wales would be unable to meet the Equality Act duties. The Leadership Team agreed to recommend a centralised approach to resourcing and impact assessment work for further consideration by the strategic Business Executive Team.

CB commented on the ongoing improvements to risk management, highlighting the register's increased maturity and dynamic nature, and reflecting on the Leadership

Teams engagement and its role in driving business improvement and risk mitigation below the strategic level.

The Committee took **assurance** on the updated Corporate Risk Register within their remit.

QSIC 2025.11.25/3.4	Quality Governance Performance Report Q2

AC provided an overview of the Quality Governance Performance Report for Quarter 1, drawing the Committee's attention to specific areas for consideration:

Putting Things Right (PTR), Q2

CB summarised the PTR section, which covered the incidents, complaints and concerns reported and acted upon during Quarter 2:

- One Nationally Reportable Incident and two early warnings in quarter two, all related to the Tarian system, with ongoing resolution work and no harm identified.
- Two duty of candour cases were noted: one involving a false positive C. diff report causing moderate harm, and one interval cancer review.
- Two IPC incidents were also reported as RIDDORs, with clear learning identified.
- The highest incident category remained failure to follow protocol, highlighting the need for adherence to Standard Operating Procedures (SOPs) and the need for ongoing training and compliance monitoring.
- Overdue incidents increased due to staff availability, but improvements were underway, especially in screening and diabetic eye services.
- All incidents were actively monitored, with particular attention to those with potential for harm, and that learning from complaints and incidents was a key focus.

The Committee:

- Sought clarification on the definition and management of overdue incidents, the level of harm, whether the 30-day threshold was meaningful and if incidents were being properly tracked. CB responded that all incidents were monitored on a weekly basis with prioritisation based on severity, and that legitimate extensions were sought for complex incidents. CB assured the Committee that learning was prioritised and that recent improvements had been made.
- Inquired about incident training progress, specifically whether first-time staff received prompt training. Claire explained that training requirements were tracked via ESR, with different levels for incident managers and owners, and that efforts were made to provide targeted accessible training, though Datix training was not mandated.
- Asked about thematic issues with SOPs, such as version control and accessibility. CB acknowledged good governance but noted risks with printed copies and digital access, especially in mobile units. CB reflected on the ongoing work underway to refine SOP management and that a specific update would be considered for the next committee

Patient/Service User Experience and Safety Alerts and Notices Management, Q2
CB highlighted:

- 20 early resolution complaints, the majority resolved within 2 days.
- 10 formal complaints, common themes recorded as investigation results and access.
- 96 Compliments received, common themes beyond the level of expected care.
- That performance in acknowledging and responding to concerns remained strong. The team focused on learning from both formal complaints and trends in early resolution cases. Compliments were mostly received via the website, and all negative feedback was followed up.
- 6 out of 42 alerts were applicable to PHW. with efforts underway to streamline their distribution and ensure learning was captured.

The Committee:

- Referenced a possible discrepancy in table 1 regarding alerts in Microbiology Health Protection. CB agreed to review and update the Committee as part of the minutes.

Action: CB

The work of the Corporate Safeguarding Group, Q2
CB provided an update on the work of the Safeguarding Group, highlighting:

- A rising trend in safeguarding concerns, particularly related to mental health and domestic abuse, both from service users and staff.
- Training compliance in safeguarding was noted as very good, attributed to Donna Newell's efforts in supporting staff.
- The committee was informed of successful delivery of DBS improvements and policy changes, positioning the organisation as a system leader in Wales.

The Work of the Corporate Infection, Prevention and Control (IPC) Group, Q2
CB provided an update on the work of the Corporate IPC group, highlighting:

- 19 infection prevention and control (IPC) incidents, including two RIDDORs related to contact with hazardous substances in laboratory areas.
- Water safety issues within Breast Test Wales (BTW) mobile screening units, which had required significant IPC capacity and led to an incident management team (IMT) response.
- Ongoing concerns were noted regarding cleaning standards, particularly at Kimberley House, with daily visits and a review of cleaning contracts underway to align with national standards.
- There was a delay in repurposing decontamination facilities at Glan Clywd, but assurance from Betsi Cadwaladr University Health Board (BCUHB) was given that progress was expected by the end of the financial year.
- Training compliance remained good overall, with a focus on improving assessment and training for aseptic non-touch technique (ANTT).
- The team had integrated IPC audits into the AMAT system to enhance assurance and drive improvement work.

- CB commended NL, the Lead Nurse for IPC for transforming corporate IPC within the Organisation.

The Committee:

- **Noted** the performance standards being achieved and areas for improvement.
- Took **assurance** that appropriate governance was in place to ensure safe, timely, effective, equitable, efficient, and person-centred services.

QSIC 2025.11.25/3.5	Bi-annual Corporate Policy Update

LB presented the Corporate Policies report, highlighting:

- Eight out-of-date policies and 24 in-date policies. Out-of-date policies have been risk assessed and deemed low risk.
- All but one out-of-date policy were under review and expected to be brought to the February meeting for approval; the exception was the All Wales Uniform Dress Policy, which was pending a national update.
- Out-of-date policies have been risk assessed and deemed low risk.
- A change was made to the safeguarding policy to reflect the new Disclosure and Barring Service (DBS) policy, recently approved by the People and Organisational Development Committee.

The Committee:

- Queried why some policies were out of date after previous efforts to catch up and whether there was a system in place to avoid policies becoming out of date, such as reviewing them ahead of expiry. LB explained that policies were reviewed every three years, and the current out-of-date ones had only recently passed their review dates. LB acknowledged that the rolling schedule and approval process can take several months and noted that the team was working to get the review process started earlier.
- Queried the communication and support in place for staff affected by the new DBS policy. CB advised that a manager's toolkit and individual emails had been sent out, and emotional support was available for staff affected, with input from the National Safeguarding Service team to ensure sensitive handling.

The Committee:

- **Noted** the amendment to the Safeguarding Policy following approval of the Disclosure and Barring Service (DBS) policy by the People and Organisational Development Committee.
- Took **assurance** on the prioritisation and progress being made to review policies, procedures and other written control documents within the remit of the Committee

QSIC 2025.11.25/3.6	Health and Safety Quarter 2 2024-25

ND presented the report, noting that changes had been made following comments from a recent Business Executive Team meeting requesting clarification on compliance rates and management arrangements for static and mobile estates. ND agreed to circulate the updated report to the Committee following the meeting.
Action: ND

ND highlighted:

- The organisation was 100% compliant with key regulatory assessments (gas, asbestos, electrical, water, and fire risk).
- Two RIDDOR incidents were reported and investigated within infection services, with Health and Safety Executive follow-up visits scheduled and one completed.
- Four new risks were added: North Wales admin estate relocation, two water-related issues in the BTW mobile fleet (one high, one medium risk), and an intruder alarm issue at Breast Test Wales in Cathedral Road.
- Mitigations for water safety included installing point-of-use water filters in all mobile units and establishing a task and finish group to oversee actions and reporting.
- The team planned to implement a system for real-time management of risk assessment actions and was exploring fleet management options for the growing mobile and EV fleet.
- The health and safety culture survey was extended to increase staff engagement, with results intended to inform future actions.

The Committee:

- Raised concerns about the low response rate to the health and safety culture survey and supported the need to understand and improve staff engagement with health and safety. ND acknowledged that health and safety was often seen as a barrier rather than an enabler and agreed on the importance of drilling into the reasons behind low engagement.
- Asked about the risk level associated with overdue Level 2 resuscitation training, seeking assurance on staff safety. CB explained that while training was essential and sometimes delayed due to scheduling, staff remained aware of its importance, and provision for improving face to face access was being looked into with the People and Organisational Development team.

The Committee

- Took **assurance** that appropriate measures were in place to monitor compliance and to address areas identified for improvement.

QSIC 2025.11.25/4	**Items for approval**
QSIC 2025.11.25/4.1	**Minutes and action log**

The Committee considered and **approved** the minutes of the meeting held on 29th September 2025 as an accurate record of the meeting.

The Committee **approved** the closure of completed actions on the action log and noted that one item was on track for delivery by the next Committee meeting.

QSIC 2025.11.25/4.2	**Policies and Procedures for approval**

CB introduced the draft Clinical Audit Policy, explaining its purpose in supporting learning and quality improvement within the organisation, and described the governance process and impact assessments included in the pack.

CB confirmed that the Leadership Team had endorsed the policy and that a supporting procedure was in development.

The Committee **approved** the Clinical Audit Policy.

QSIC 2025.11.25/5	Deep Dive- Infection Division

RH presented the deep dive on the infection division, providing an overview on the background of the service and scope across Wales, noting its 14 laboratories, direct care for 400 HIV patients, and over 44,000 annual consults.

RD highlighted:

- RH presented an overview of the infection division, highlighting its 14 laboratories, direct care for 400 HIV patients, and over 44,000 annual consults.
- Key achievements included the rollout of rapid molecular testing in hot labs across Wales, enabling faster diagnosis and treatment, especially for sepsis cases, as illustrated by a patient story.
- RH described the value-based healthcare programme, focusing on improving wound care, and highlighted the building of a collaborative community through improvements and standardisation of wound care and education.
- The division led Welsh Government initiatives for point-of-care blood-borne virus (BBV) testing, implementing HIV and hepatitis C testing in sexual health clinics and prisons, and supporting mass screening and rapid referrals.
- Molecular diagnosis of septic arthritis
- RH emphasised the impact of these improvements on patient care, service efficiency, and alignment with quality principles.
- MK thanked RD for the presentation and commented on the ambition to establish infection services as a centre of excellence and the aspiration to be a leader in the field.

The Committee:

- Asked about the hepatitis C elimination programme and how infection services worked with other system partners nationally to achieve the 2030 goal. RH explained that Welsh Government coordinated the BBV programme, with infection services providing diagnostics and clinics, and emphasised the importance of smooth patient pathways.
- Commented on the need for an All Wales clinical and diagnostic infectious services and the importance of AI diagnostics. RH agreed, noting the benefits and future potential of AI-supported diagnostics and reporting.
- Queried if the new Laboratory Information System (LIMS) would support innovation. RH clarified that LIMS would maintain business as usual but would not directly enable AI innovations, which would require separate solutions.
- Reflected on the value of linking patient impact to service improvements and praised the collaboration on wound care developments and the equality opportunity in wound care, especially for diverse skin types, and supported the ongoing work.

The Committee thanked RH for the comprehensive deep dive presentation and took **assurance** regarding the operations and development of the Infection Division.

QSIC 2025.11.25/6	**Population Health Programmes**

JM presented an overview of the population health programmes within the Health and Wellbeing directorate, noting that there were 21 major programmes and 64 supporting programmes covering wider determinants, health improvement, and primary care, including dental health.

JM highlighted:

- That safety and quality were embedded through audit, case reviews. dashboard reporting, evidence-based programme design, digital systems, and value-based approaches.
- Each of the leads had undertaken service / programme reviewed which had led to improvements in several programmes which have improved our offer to service users. Examples included diabetes prevention programme and the relaunch of Healthy Working Wales website and in person support, which aimed to streamline processes and improved outcomes, and improvements across child poverty, grant-making, and drug and alcohol services, with further work underway in social marketing and school programmes.
- JM described governance structures, including programme boards and stakeholder groups, and outlined a directorate-wide approach to embedding the duty of quality and risk management.
- That user engagement had improved service reach and experience and identified main risks: misalignment with population needs, resource constraints, and the need for regular risk and quality audits.
- The next steps, including completing programme reviews, building sector-led improvement, developing digital quality assessment tools, and increasing benchmarking and peer review.
- ZW added that the directorate also supported system-wide quality improvement, including dental public health, and highlighted the upcoming update on dental services at the next Committee meeting.

The Committee:

- Queried how the directorate prevented confusion and duplication across programmes, especially in diabetes, and how system-wide focus was maintained. JM explained that coordination had improved through forums, programme reviews, and clearer roles, but acknowledged ongoing work was needed for system leadership and narrative clarity.
- Inquired about how front-line professionals received a coherent picture of priorities. JM and ZW described the use of evidence-based frameworks to influence the system; foundational work to tackling health and social care; and professional collaboration to align priorities. ZW noted that upcoming forums would gather feedback from cluster and professional leads to help shape and inform messaging going into Welsh Government. ZW went on to highlight the risk that, despite evidence and agreement, lack of sustainable funding threatened the continuation of successful programmes like diabetes

prevention and noted the challenge of shifting investment from acute services to prevention.

- Suggested future deep dives could focus on life course approaches and working in NHS settings and raised concern about funding gaps for prevention. ZW proposed Musculoskeletal (MSK) and women's health as possible life course examples for future sessions due to its relevance across working age adults and the frailty/falls agenda.
- Acknowledged the improved linkage to the duty of quality in the directorate's work. JM thanked the team for their support of this.
- Noted optimism about the new Chief Medical Officer led approach but warned that lack of funding remained a key risk for prevention strategies and suggested reviewing the origins of programmes to ensure alignment.

The Committee:

- **Considered** the range of programmes being delivered by the Health and Wellbeing Directorate and their associated governance arrangements to inform the future work programme of the committee.
- Took **assurance** that the Directorate was actively working to embed the Duty of Quality

QSIC 2025.11.25/7	**Items to Note**
QSIC 2025.09.29/7.1	**Audit**

The Committee **noted:**

- An Internal Audit Report on Non-core funding – Health Improvement (Reasonable Assurance).
- An Internal Audit Report on Policies and Procedures Management (Substantial Assurance).
- An Audit Wales External Audit Report on Improving Quality Governance and management response, which noted that the Organisation had addressed 19 of the 23 recommendations arising from the 2022 audit, and 4 recommendations were partially complete.

QSIC 2025.09.29/7.2	**Committee Workplan**

The Committee **noted** the Committee Workplan.

Part B	**NHS Performance and Improvement Business**
QSIC 2025.09.29/8	**Declaration of Interest**

There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.

QSIC 2025.09.29/9	**NHS Wales Performance and Improvement (P&I) Quarterly Governance Compliance Report (Q1)**

SF presented the NHS Performance and Improvement Unit update, highlighting:

- Three incidents arouse during quarter 2 which were reported on Datix, two related to environmental issues and one concerning confidentiality, which was managed with the information governance team and was not reportable to the Information Commissioner's Office.

The Committee:

- CB highlighted a risk regarding the temporary band 6 post supporting Datix governance, noting upcoming changes to Putting Things Right and Datix risk module and the need to ensure continued support, which would be addressed offline.
- MK asked about assurance mechanisms for the P&I Units work plan. PV clarified that the Unit is answerable directly to Welsh Government for its work plan and performance, and that the committee's remit is limited to ensuring their activities do not create risk for Public Health Wales.

The Committee:

Health and Safety

- **Took assurance** that the NHS P&I has appropriate measures are in place to monitor compliance and to address areas identified for improvement.

National Reportable Incident Reporting compliance

- **Noted** there have been no reportable incidents to report.

Complaints (including PTR if applicable) compliance

- **Noted** there have been no complaints received regarding the NHS Wales Performance and Improvement for this period to report to Committee.

Claims reporting (staff and third-party claims)

- **Noted** there have been no claims received this period and **took assurance** that Claims within the NHS Wales Performance and Improvement are being appropriate managed.

DATIX compliance

- **Noted** three incidents reported on Datix for this period and **took assurance** that the appropriate process has been followed within NHS P&I to manage these incidents.

Safeguarding compliance

- **Noted** there have been no safeguarding issues reported for this period to report to Committee.

QSIC 2025.09.29/9	**Closing Administration**
QSIC 2025.09.29/9.1	**Close of Public Meeting**
The Chair closed the meeting.	
The open session closed at 12:55	