Quality and Safety Improvement Committee (Open session) / Y Pwyllgor Ansawdd, Diogelwch a Gwella Cyfarfod Agored

Mon 29 September 2025, 10:00 - 12:50

Dydd Llun 29 Medi 2025

Agenda

Part A / Rhan A

10:00 - 10:05
5 min

1. Welcome, Introductions and Apologies for Absence / Croeso, Cyflwyniadau ac Ymddiheuriadau am Absenoldeb

(5 mins)

Clare Jenkins

Chair / Chadeirydd

10:05 - 10:05
0 min

2. Declarations of Interest / Datganiadau o Ddiddordeb

10:05 - 10:20
15 min

3. Items for Approval / Eitemau i'w cymeradwyo

3.1. Minutes, Action Log and Matters Arising of meeting - 02 June 2025 and 26 August 2025 / Cofnodion, Log Gweithredu a Materion Yn Codi Cyfarfod - 02 Mehefin 2025 ac 26 Awst 2025

10:05-10:10 *(5 mins)*

Clare Jenkins

Chair / Cadeirydd

- 3.1 QSIC 2025_09_29 - Unconfirmed QSIC Public Minutes 02 June 2025.pdf (11 pages)
- 3.1 QSIC 2025_09_29 - Unconfirmed QSIC Public Minutes 02 June 2025 cymraeg.pdf (11 pages)
- 3.1 QSIC 2025_09_29 - Unconfirmed QSIC Public Minutes 26 August 2025.pdf (3 pages)
- 3.1 QSIC 2025_09_29 - Unconfirmed QSIC Public Minutes 26 August 2025 Cymraeg.pdf (3 pages)
- 3.1 QSIC 2025_09_29 - QSIC Action Log.pdf (1 pages)

3.2. Policies and Procedures for Approval / Polisïau a Gweithdrefnau i'w cymeradwyo

Draft Mobile Phone Policy / Polisi Ffôn Symudol

- 3.2 QSIC 2025_09_29 - Draft PHW Mobile Phone Approval Cover Paper.pdf (4 pages)
- 3.2 QSIC 2025_09_29 - Draft PHW Mobile Phone Policy for approval.pdf (9 pages)
- 3.2 QSIC 2025_09_29 - Draft PHW Mobile Phone EqHIA .pdf (12 pages)

3.3. Quality and Clinical Audit Plan Annual Report 2024/25 and Forward Look 2025/26 / / Adroddiad Diwedd Blwyddyn Archwiliad Clinigol ac Ansawdd 2024/25 a Rhagolwg 2025/26

10:10 - 10:20 *(10 mins)*

Angela Cook
Assistant Director of Nursing and Quality / Cyfarwyddwr Cynorthwyol Nyrsio a Ansawdd

Claire Birchall

Executive Director of Nursing, Quality and Integrated Governance / Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu

3.3 QSIC 2025_09_29 - Q&CA EOY Report and 2025-26 Annual Plan_Final v1.pdf (20 pages)

10:20 - 12:00
100 min

4. Items for Assurance / Eitemau i'w sicrhau

Total for all assurance items / Cyfanswm ar gyfer pob eitem sicrwydd: xx (xxx mins)

4.1. Quality Governance Performance Report /Adroddiad Perfformiad Llywodraethu Ansawdd

10:20 - 10:45 (25 mins)

Angela Cook
Assistant Director of Nursing and Quality / Cyfarwyddwr Cynorthwyol Nyrsio a Ansawdd

Claire Birchall

Executive Director of Nursing, Quality and Integrated Governance / Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu

- Putting Things Right /Gweithio i Wella
- Management of Alerts / Rheoli Rhybuddion
- Update on Implementation of Duty of Quality & Duty of Candour / Diweddariad ar Weithredu'r Ddyletswydd Gonestrwydd a'r Ddyletswydd Ansawdd
- Infection, Prevention & Control / Atal a Rheoli Heintiau
- Safeguarding / Diogelu
- Quality and Clinical Audit / Archwiliad Ansawdd a Chlinigol
- Quality / Clinical Governance Framework/QUoG / Fframwaith Llywodraethu Clinigol/Ansawdd

4.1 QSIC 2025_09_29 - Quality Governance Performance Report Q1 2025-26 .pdf (36 pages)

4.2. National Safeguarding Annual Report 2024/25 / Adroddiad Blynyddol Diogelu Cenedlaethol 2024/25

10:45 - 10:55 (10 mins)

Louise Mann
Director of Safeguarding / Cyfarwyddwr Diogelu

Claire Birchall

Executive Director of Nursing, Quality and Integrated Governance / Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu

Request to add to the agenda 23.07.25 (replaced Duty of Quality allocated time)

4.2 QSIC 2025_09_29 - NHS Wales Safeguarding Network Annual Report 2024-2025.pdf (4 pages)
4.2 QSIC 2025_09_29 - NHS Wales Safeguarding Network Annual Report 2024-25 (ENGLISH).pdf (34 pages)

4.3. Staff Flu Vaccination Campaign Annual Report 2024/25 and Forward Look 2025/26 / Adroddiad Blynyddol Brechiad y Ffliw i Staff 2024/25 a Rhagolwg 2025/26

10:55-11:05 (10 mins)

Angela Cook
Assistant Director of Nursing and Quality / Cyfarwyddwr Cynorthwyol Nyrsio a Ansawdd

Claire Birchall

Executive Director of Nursing, Quality and Integrated Governance / Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu

4.3 QSIC 2025_09_29 - End of Year Flu Report and Plan 2025 V1 7.2025.pdf (10 pages)

4.4. Risk Assurance (Corporate and Strategic Risk Register)/ Sicrwydd Risg (Y Gofrestr Risg Strategol a Gorfforaethol)

11:05 - 11:15 (10 mins)

Danielle Gething

Head of Risk Management / Pennaeth Rheoli Risg

Claire Birchall

Executive Director of Nursing, Quality and Integrated Governance / Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu

Strategic Risk Officers/ Swyddog Risg Strategol

- 4.4 QSIC 2025_09_29 - Risk Assurance Cover Report.pdf (5 pages)
- 4.4 QSIC 2025_09_29 - Strategic Risk Register 3.pdf (11 pages)
- 4.4 QSIC 2025_09_29 - Corporate Risk Register Cover Paper.pdf (11 pages)
- 4.4 QSIC 2025_09_29 - Corporate Risk Register.pdf (3 pages)

Break/ Egwyl

11:15 - 11:25 (10 mins)

4.5. Screening Service Update / Diweddariad ar Wasanaethau Sgrinio

11:25 - 11:55 (30 mins)

Steve Court

Head of Bowel Screening Wales / Pennaeth Sgrinio Coluddion Cymru

Meng Khaw

National Director of Health Protection and Screening Services, Executive Medical Director / Cyfarwyddwr Cenedlaethol Gwasanaethau Diogelu Iechyd a Sgrinio a Chyfarwyddwr Meddygol Gweithredol

- 4.5 QSIC 2025_09_29 - Screening Update.pdf (24 pages)

4.6. Health and Safety / Iechyd a Diogelwch

11:55 - 12:00 (5 mins)

Neil Desmond

Head of Estates and Health and Safety / Pennaeth Ystadau a Iechyd & Diogelwch

- **Health and Safety Report Quarter 1 2025-26/ Adroddiad Iechyd a Diogelwch Chwarter 1 2025-26**
- **Health and Safety Terms of Reference / Cylch Gorchwyl Iechyd a Diogelwch**

- 4.6 QSIC 2025_09-29 -Health & Safety Quarterly Report - Q1 2025-26.pdf (22 pages)
- 4.6 QSIC 2025_09_29 Appendix D HSE feedback plan update 180325.pdf (19 pages)
- 4.6 QSIC 2025_09_29 - Appendix E Health and Safety Group TOR - V6.pdf (6 pages)

12:00 - 12:45
45 min

5. Deep Dive (Health and Safety) / Archwiliad Dwfn (Iechyd a Diogelwch)

Neil Desmond

Head of Estates and Health and Safety / Pennaeth Ystadau a Iechyd & Diogelwch

Angela Williams

Interim Executive Director of Operations and Finance / Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau a Chyllid

- 5 QSIC 2025_09_29 - Health and Safety Deep Dive Presentation.pdf (18 pages)

12:45 - 12:45
0 min

6. Items to Note / Eitemau i'w nodi

6.1. Winter Planning / Seasonal Planning /Cynllunio ar gyfer y Gaeaf/Cynllunio Tymhorol

Meng Khaw

National Director of Health Protection and Screening Services, Executive Medical Director / Cyfarwyddwr Cenedlaethol Gwasanaethau Diogelu Iechyd a Sgrinio a Chyfarwyddwr Meddygol Gweithredol

- 6.1 QSIC 2025_09_29 - Winter Planning Update.pdf (20 pages)
- 6.1 QSIC 2025_09_29 - Winter Planning Appendix 1 Falls Prevention.doc.pdf (17 pages)

6.2. Committee Workplan / Committee Workplan / Cynllun Gwaith y Pwyllgor

6.2 QSIC 2025_09_29 - Committee Workplan 2025-26.pdf (2 pages)

6.3. Audit /Archwilio

Audit Action Tracker / Traciwr Gweithredu Archwilio

Part B NHS Executive Business / Rhan B Busnes Gweithredol y GIG

12:45 - 12:45
0 min

7. Declarations of Interest / Datgan Buddiannau

12:45 - 12:50
5 min

8. NHS Executive Quarterly Governance Compliance Report (Q1) / Adroddiad Cydymffurfiaeth Llywodraethu Chwarterol Gweithrediaeth y GIG (C1)

(5 mins)

Sophie Fuller

Assistant Director of Corporate Governance and Business Support / Cyfarwyddwr Cynorthwyol Llywodraethu Corfforaethol a Chymorth Busnes

8 QSIC 2025_09_29 - NHS Wales Performance and Improvement Q1.pdf (6 pages)

12:50 - 12:50
0 min

9. Closing Administration / Gweinyddiaeth i gau

- **Any Other Business / Unrhyw Fusnes Arall**
- **Committee Feedback / Adborth y Pwyllgor**
- **Date of Next Meeting / Dyddiad y Cyfarfod Nesaf:**
  25 November 2025 / 25 Tachwedd 2025

9.1. Close of Public Meeting / Diwedd y Cyfarfod Cyhoeddus

Yn unol ag [Adran 1 (2) o Ddeddf Cyrff Cyhoeddus (Mynediad i Gyfarfodydd) 1960 (c.67)] bydd cynrychiolwyr o'r wasg ac aelodau eraill o'r cyhoedd yn cael eu gwahardd o weddill y cyfarfod hwn oherwydd natur gyfrinachol y busnes sydd i'w drafod, gan y byddai rhoi cyhoeddusrwydd iddo yn niweidiol i les y cyhoedd.

That representatives of the press and other members of the public will be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with [Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

Unconfirmed Minutes of the Public Health Wales
Quality, Safety and Improvement Committee Meeting
02 June 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
Sian Griffiths	(SG)	Non-Executive Director (Public Health) and Chair of the Knowledge, Research and Information Committee
Pippa Britton	(PB)	Chair of Board
Kate Young	(KY)	Non-Executive Director and Chair of the People and Organisational Development Committee (left 10:57)
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
Angela Cook	(AC)	Assistant Director of Quality and Nursing
Neil Desmond	(ND)	Head of Estates and Health & Safety (for item 5.4)
Danielle Gething	(DG)	Head of Risk Management (for items 5.3)
Iain Hardcastle	(IH)	National Director of Planning (for item 9)
Nicola Lewis	(NL)	Lead Nurse, Infection Prevention & Control (left 11:00)
Meng Khaw	(MK)	National Director of Health Protection and Screening Services, Executive Medical Director
Jim McManus	(JM)	National Director of Health and Wellbeing
Olusola Okhiria	(OO)	Trade Union representative
Stuart Silcox	(SS)	Assistant Director of Integrated Governance
Paul Veysey	(PV)	Board Secretary and Head of Board Business Unit
Jacqui Westmoreland	(JW)	Safety and Putting Things Right Manager (for item 6)
Angela Williams	(AW)	Interim Executive Director of Operations and Finance
Huw Williams	(HW)	Head of Emergency Response Resilience Preparedness (for item 3.2)
Apologies		
Tracey Cooper	(TC)	Chief Executive
Sophie Fuller	(SF)	Assistant Director Corporate Governance and Business Support, NHS Executive
The meeting commenced at 10:00		

Part A	
QSIC 2025.06.02/1	**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 2025.06.02/2	**Declaration of Interest**
There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.	
QSIC 2025.06.02/3	**Items for Approval**
QSIC 2025.06.02/3.1	**Minutes and Action Log**
The Committee considered and **approved** the minutes of the meeting held on 04 February 2025 as an accurate record of the meeting. The Committee considered the action log update, noting that one item was on track for delivery by the next Committee meeting.	
QSIC 2025.06.02/3.2	**Emergency Preparedness, Resilience, and Response Annual Report (EPRR)**
MK introduced the annual report, which was a detailed reflection of the Organisations Emergency Preparedness, Resilience and Response (EPRR) efforts over the past year and plans for the next year. MK also advised of the minor revisions made to the Emergency Response plan which had recently been approved by the Board, and included for information and assurance in the private session due to the sensitive nature of the Plan. HW went on to provide an overview of the report, highlighting: • The enhancements made to the EPRR team, wide engagement across the Organisation and the establishment of a 24/7 on-call service. • The Digital resilience exercises underway and efforts to continue to strengthen the Organisation's position in terms of pandemic preparedness. • International work underway with the International Association of National Public Health Institutes (IANPHIs) and the upcoming tier one national exercise and internal validation planned for Q4 2024-25. Committee members thanked HW for the overview of the comprehensive work underway. The Committee: • Took **assurance** in relation to the organisation's compliance with the requirements of the Civil Contingencies Act [2004] and the NHS Wales Emergency Planning Core Guidance [2015].	

- Took **assurance** that the Public Health Wales Emergency Response Plan (V3.1, now 3.2) had undergone a rapid internal annual review and been updated within minor amendments (available in private session papers).
- Took **assurance** that the Public Health Wales Business Continuity Strategy (V2), Impact Analysis and Plan templates were reviewed and updated; with further confirmation that all directorates/Divisions have reviewed their business continuity arrangements to specifically consider digital resilience.
- **Approved** the Health Emergency Planning Annual Report submission to the NHS Executive.

QSIC 2025.06.02/3.2	Policies and Procedures

AC introduced the draft Chaperone Policy, which was a new policy designed to support staff and service users during intimate examinations.

OO sough more information about the training package that would be available to staff. Offering to share the training package details with OO in due course, AC went on to confirm that face to face sessions would be provided, predominantly within the screening programme services such as Breast Test Wales and Wales Abdominal Aortic Aneurysm (AAA) screening programmes. The training would cover staff members roles and responsibilities and how to report concerns so that staff feel fully supported and confident to fulfil their role in full.

Highlighting the importance of staff safety, CB thanked AC for her leadership and the team for their support in developing the Chaperone policy.

The Committee:

- **Noted** that the Leadership Team had endorsed the Policy to the Committee and approved the accompanying procedure
- **Approved** the Chaperone Policy.

QSIC 2025.06.02/4	Ratification of Recommendation to Board

LB introduced the Committee Effectiveness presentation, revised Terms of Reference (TOR) and workplan for 2025-26, highlighting that the Committee Terms of Reference and Workplan for 2025/26 had been endorsed by the previous Chair, Diane Crone, prior to her departure, and were presented to the Committee in retrospect due to the timing of the Board meeting (held on 29 May 2025).

CJ noted that there had been changes agreed at Board to the Committee terms of reference relating to the naming of the NHS Executive that would be reflected in the final versions published.

The Committee:

- **Considered** the Committee Effectiveness presentation
- **Ratified** the approval of the Terms of Reference, noting the change from the NHS Executive to the NHS Performance and Improvement Unit.
- **Ratified** the approval of the Committee Work Plan for 2025/26
- **Noted** that the Effectiveness presentation, TOR and Workplan were presented at the May Board meeting.

QSIC 2025.06.02/5	Items for Assurance
QSIC 2025.06.02/5.1	Quality Governance Performance Report

AC provided an overview of the Quality Governance Performance Report for quarter 4, drawing the Committee's attention to specific areas for consideration:

Putting Things Right (PTR), Q4

AC summarised the PTR section, which covered the incidents, complaints and concerns reported and acted upon during quarter 4, including:

- There were 528 incidents reported, 13 of which were initially reported as moderate harm. 12 have since been downgraded and 1 remained open. AC advised of a key piece of work underway to improve the initial assessment of incidents and the level of harm.
- There were 64 incidents with overdue status. Similar to quarter 3, the biggest category related to assessment and investigation; and in particular failure to follow Standard Operating Procedures (SOPs).
- There were no redress cases in quarter 4. 6 previously reported cases remained ongoing and under investigation.

The Committee discussed:

- Noting the time being taken to manage cases, the Committee sought assurance on the action being taken to reduce overdue cases. AC advised that the longest overdue case was reliant on a third party, but there was a resolution due. AC went on to highlight the significant efforts undertaken to close long waits which included liaising with the Office of the Medical Director to improve incident management.
- Improving access to datix training. AC advised that all new starters were offered training and a monthly offer was made available to all staff. AC also noted that the Putting Things Right team were working with user groups to target areas as necessary, and awareness would also be raised as part of the national safety week in September. AC confirmed that she would ask for the Business and Planning Leads Group to raise awareness with their staff groups and place in the Line Managers Newsletter.

Patient/Service User Experience Q4

AC highlighted:

- 22 early resolution complaints, and 13 formal complaints.
- There was no duty of candour case reported this quarter.
- 139 compliments were received.
- Progress with the revised Putting Things Right regulations and the anticipatory preparations due to be carried out in light of the potential implications for the Organisation and service users.
- The successful rollout of a pilot SMS survey across 8 Diabetic Eye Screening Wales venues. AC advised of the good uptake and that initial feedback centred around the building accommodation and car parks.

The work of the Corporate Safeguarding Group, Q4

AC provided an update on the work of the Safeguarding Group, highlighting:

- 20 Safeguarding queries, mainly relating to advice and support were reported.

- The work underway to improve Safeguarding training compliance.

The Committee:

- Queried the increase in safeguarding queries. AC advised that these were likely as a result of raising the profile of safeguarding, and the team welcomed the opportunity to provide more advice and support at an early stage.

<u>The Work of the Corporate Infection, Prevention and Control (IPC) Group, Q4</u>
AC provided an update on the work of the Corporate IPC group, highlighting:

- 14 incidents were reported, and all deemed to be of low or no harm.
- Plans to roll out further training on Aseptic Non-Touch Technique, particularly across screening services.
- Remedial actions in place to address compliance concerns with cleaning standards in some screening services.
- The great work underway to support audit through the implementation of a new audit management system.

<u>Safety Alerts and Notices Management, Q4</u>
The Committee noted that 1 safety notice applicable to the Organisation was being actioned accordingly.

<u>Quality and Clinical Audit, Q4</u>
The Committee noted the progress to the Quality and Clinical Audit plan.

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 2025.06.02/5.2	**Putting Things Right Annual Report 2024-25 and Duty of Candour Annual Report 2024-25**

CB introduced the annual reports, noting that they were prepared in accordance with various regulations and summarised the information provided to the Committee at each meeting as part of the Quality Governance Performance report.

AC provided an overview of the Putting Things Right Annual Report for 2024-25, which provided an overview of the concerns management and subsequent actions taken to improve services. AC highlighted:

- An increase in reported incidents thought to be due to efforts to embed a positive reporting culture.
- An increase in complaints and highlighted actions to address this such as the revised process for complaints management to support a timelier and person-centred approach to complaint management.
- The annual reduction in the number of reported early resolutions, redress cases, claims and long over due cases.
- The focus on improvement work related to incident reporting, including those long overdue and improvements to the escalation process.

- 1 financial penalty to the Organisation from Welsh Risk Pool due to a late Learning For Events Report submission.

AC went on to provide an overview of the Duty of Candour Annual Report for 2024-25, highlighting:

- The investigation of two confirmed cases, one of which was a joint case with Cardiff and Vale University Health Board. Updates on both cases within the Breast Test Wales and Microbiology areas had been previously considered by the Committee and identified learning had been shared in order to improve services and staff development.
- The duty of candour e-learning training was at 88%.

The Committee thanks AC for presenting the annual reports and:

- Took **assurance** on the organisations effective management of the implementation of the Putting Things Right Regulations (2011).
- Took **assurance** that Duty of Candour cases were being managed in accordance with regulatory guidance and the relevant policies and procedures, including organisational learning and the reasonable assurance received from the Internal Audit report.

QSIC 2025.06.02/5.3	**Risk Assurance**
QSIC 2025.06.02/5.3.1	**Strategic Risk Register**

CB introduced the report and expressed her thanks to all colleagues who had reviewed and remapped the strategic risk register and contributed to the revised templated approach. The revised approach, risk appetite and architecture would be considered in-depth at the July 2025 Board meeting.

DG provided an overview of the new risk, noting that the new actions were mapped across to the previous controls and actions to the new in order to maintain transparency. The corporate risks that support this risk were also highlighted.

MK advised that the updated risk articulation was a good reflection of the controls and activity in place to mitigate the risk of providing excellent public health services and anticipated there would be a further focus on impact, surge capacity and training, and finally the route maps for digital resilience.

The Committee:

- Acknowledged the positive focus around unexpected events and sought assurance on the partnership with the rest of the United Kingdom (U.K) on potential risks. MK confirmed he was confident that Wales / Public Health Wales was connected into U.K conversations around horizon scanning, and early warnings and confirmed that were formal mechanisms and less formal mechanisms in place for 4 nation intelligence sharing, and consideration of pandemics and global threats.
- Commended MK and his team for their efforts, particularly around prevention themes.

The Committee took **assurance** on the management of strategic risk within the Committee's remit.

QSIC 2025.06.02/5.3.2	**Corporate Risk Register**

CB introduced the Corporate Risk Register, which outlined the approved changes since the last Committee meeting and concluded the update by highlighting that the Board had held good discussion on the Corporate Risks at its May Board meeting.

The Committee took **assurance** on the management of Corporate Risk within the Organisation.

QSIC 2025.06.02/5.5	**Bi-annual Policy Update**

LB introduced the report, noting that 93% of policies were in date. LB highlighted the 2 out of date policies for the Committee's review; a Uniform policy awaiting an all Wales review and a Water Management policy which was due to be submitted for approval at the next Committee meeting.

The 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.

Break

QSIC 2025.06.02/5	**Items for Assurance (Continued)**
QSIC 2025.06.02/5.4	**Health and Safety Report Quarter 4 2024-25**

ND presented the Health and Safety Report for Quarter 4, 2024-25, which provided an overview of health and safety activities undertaken for this period. ND noted several highlights from the report:

- Good progress had been made against the recommendations of the Health and Safety Executive's routine audit of microbiology labs.
- There were no Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) incidents.
- There was 100% compliance across all sites for statutory and regulatory building management requirements.
- Statutory and mandatory training levels were at 85% and home working e-learning training also remained a priority for the Organisation

The Committee noted the rise in road traffic related incidents, in addition to increased rates of slips, trips and falls. ND advised that both were routine incidents with did not present a cause for concern. He highlighted the recent introduction of a Vehicle Telematics Procedure for screening services which aimed to support staff safety.

ND went on to present the Health and Safety Annual report for 2024/25, which outlined and demonstrated progress made and key issues that had been addressed throughout the course of the year. He highlighted:

- Engagement with Microbiology services and People and Organisational Development in order to improve and support incident management.
- Introduction of new comprehensive audits undertaken across the Organisation's site.

ND concluded by presenting the Health and Safety workplan for 2025-26, highlighting the planned policy development, proposed development of a set of Key Performance Indicators and progress with a potential workplace safety culture survey.

The Committee discussed:

- CB advised that revised cleaning standards were awaited, which would likely result in some additional resource and capacity requirements for the Health and Safety Team.
- The need to ensure Health Boards comply with appropriate facilities management. ND confirmed that they were working with Health Boards to improve facilities and that there were Service Level Agreements (SLAs) and Memorandum of Understandings (MoUs) in place that could be utilised to address concerns if required. The Team continued to foster good relationships with Health Boards in order to seek compliance data in a timely manner.

The Committee:

- Took **assurance** that appropriate measures were in place to monitor compliance and to address areas identified for improvement.
- Took **assurance**, based on the information available within the annual report, that health and safety in the workplace is proactively managed, and was monitored through audits, Datix, RIDDOR reporting and supported by appropriate policies and procedures.
- **Noted** the workplan for 2025-26.

QSIC 2025.06.02/6	Deep Dive – Complaints and Incidents

CB introduced the deep dive, welcoming the opportunity to share the improvement work around processes, investigation and the sharing of learning.

JW presented the deep dive overview through the lends of the six domains of quality, highlighting:

- Key achievements such as improved engagement across the system which had led to a positive increase in the incident reporting culture, a reduction in complaints, particularly within the Diabetic Eye Screening Wales service, and process improvements such as faster resolution of complaints / concerns. This had reduced the backlog in a safe and timely manner, and increasing patient and staff confidence.
- A service user centred health provision story, and a number of 'You Said, We Did' examples which helped to highlight the accessibility and equality issues faced by service users and the mitigating actions take to address these. Examples of this were extending opening hours/days and the introduction of mobile screening units to address some of the concerns raised, and the plans in place to improve the demonstration of learning from incidents.
- Service programme risks, such as changes due to the Putting Things Right regulations and the impact on the Organisations resources, in particular the expected requirement to offer a listening in person meeting and potential mitigating actions.

The Committee discussed:

- How the learning could be applied systematically throughout the Organisation and the suggestion of accessibility standards to be adhered to in order to resolve the accessibility concerns raised in the service user story. JW advised of the aim to ensure directorates feel confident and supported to be able to share their learning and commented on the need to embed this as normal practice. AC raised the importance of the self assessment process. CB reflected on the Duty of Quality Internal Audit action plan which outlined the need to improve dissemination and resilience of learning and evidence and highlighted that a proposal would be rediscussed at the Quality Oversight Group.
- Consideration of how to frame our outward communication to ensure maximum inclusion and accessibility, so that service users are aware that the Organisation would make the necessary adjustments needed to facilitate their screen upfront, and considered a suggestion to explore accessible transportation and the opportunity to provide reimbursement in line with other Health Boards.
- Improvements in the identification of informal and formal complaints and the use of Datix as a single source of truth. JW confirmed that she met regularly with all directorates, and in particular public service facing programmes, to ensure Datix was embedded across the organisation, and commented on the usefulness of Datix to be able to identify themes across the services that could be addressed and improved.
- Welcomed the enabling function provided and noted that the Putting Things Right team provided dedicated areas that they support, for both routine queries and complex complaints / concerns.

The Committed thanked JW for the comprehensive deep dive presentation and thought provoking patient story and took **assurance** on the arrangements in place for Putting Things Right Regulations.

QSIC 2025.06.02/7	**Items to Note**
QSIC 2025.06.02/7.1	**Audit**

The Committee **noted**:

- The Internal Audit Recommendation Tracker.
- The Duty of Candour Internal Audit Report
- The Health Protection and Screening Services Procurement Improvement Plan Internal Audit Report

QSIC 2025.06.02/7.2	**Reporting Groups Annual Review**

The Committee **noted**:

- The Infection Prevention and Control Terms of Reference
- The Safeguarding Group Terms of Reference

Part B	NHS Performance and Improvement Business
QSIC 2025.06.02/8	**Declaration of Interest**
There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.	

QSIC 2025.06.02/9	NHS Executive Quarterly Governance Compliance Report (Q4)

IH introduced and provided an overview of the Quarterly Governance Compliance Report for Quarter 4, highlighting:

- That from today the NHS Executive would be named the NHS Performance and Improvement Unit.
- One complaint had recently been resolved, and there was one ongoing claim.
- While there were no National Reportable Incident Reports for quarter 4, one has been submitted after the 31 March 2025 and was currently under investigation.

The Committee thanked IH for the update and:

Health and Safety

- Took **assurance** that there are appropriate measures to monitor compliance and to address areas identified for improvement.

National Reportable Incident Reporting compliance

- **Noted** there have been no reportable incidents for the reporting period.

Complaints (including PTR if applicable) compliance

- **Noted** there was one complaint received for this period which was review during quarter 4.

Claims reporting (staff and third-party claims)

- **Noted** there has been one claim ongoing, first reported in quarter 3.

DATIX compliance

- **Note** that five health and safety related incidents were reported via Datix during the reporting period and take assurance that the appropriate process has been followed to manage these incidents.

Safeguarding compliance

- **Noted** that there have been no safeguarding matters reported in this period.

QSIC 2025.06.02/10	Closing Administration
QSIC 2025.06.02/10.1	**Close of Public Meeting**

The Chair asked for any feedback to be sent to LB.

Date of next meeting: 26 August 2025.

The Chair closed the meeting.
The open session closed at 12:05

Cofnodion Iechyd Cyhoeddus Cymru heb eu Cadarnhau
Cyfarfod Pwyllgor Ansawdd, Diogelwch a Gwella
02 Mehefin 2025, 10:00 – 12:50
yn Capital Quarter 2 a thrwy Microsoft Teams

Yn bresennol:		
Clare Jenkins	(CJ)	Cadeirydd y Pwyllgor, Is-gadeirydd y Bwrdd a Chyfarwyddwr Anweithredol
Sian Griffiths	(SG)	Cyfarwyddwr Anweithredol (Iechyd y Cyhoedd) a Chadeirydd y Pwyllgor Gwybodaeth ac Ymchwil
Pippa Britton	(PB)	Cadeirydd y Bwrdd
Kate Young	(KY)	Cyfarwyddwr Anweithredol a Chadeirydd y Pwyllgor Pobl a Datblygu Sefydliadol (gadawodd 10:57)
Yn Bresennol:		
Claire Birchall	(CB)	Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu Integredig
Liz Blayney	(LB)	Dirprwy Ysgrifennydd y Bwrdd a Dirprwy Bennaeth Uned Fusnes y Bwrdd
Angela Cook	(AC)	Cyfarwyddwr Cynorthwyol Ansawdd a Nyrsio
Neil Desmond	(ND)	Pennaeth Ystadau ac Iechyd a Diogelwch (ar gyfer eitem 5.4)
Danielle Gething	(DG)	Pennaeth Rheoli Risg (ar gyfer eitem 5.3)
Iain Hardcastle	(IH)	Cyfarwyddwr Cynllunio Cenedlaethol (ar gyfer eitem 9)
Nicola Lewis	(NL)	Nyrs Arweiniol, Atal a Rheoli Heintiau (gadawodd 11:00)
Meng Khaw	(MK)	Cyfarwyddwr Cenedlaethol Gwasanaethau Diogelu Iechyd a Sgrinio, Cyfarwyddwr Meddygol Gweithredol
Jim McManus	(JM)	Cyfarwyddwr Cenedlaethol Iechyd a Llesiant
Olusola Okhiria	(OO)	Cynrychiolydd Undeb Llafur
Stuart Silcox	(SS)	Cyfarwyddwr Cynorthwyol Llywodraethu Integredig
Paul Veysey	(PV)	Ysgrifennydd y Bwrdd a Phennaeth Uned Fusnes y Bwrdd
Jacqui Westmoreland	(JW)	Rheolwr Diogelwch a Gweithio i Wella (ar gyfer eitem 6)
Angela Williams	(AW)	Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau a Chyllid
Huw Williams	(HW)	Pennaeth Parodrwydd am Argyfwng, Gwydnwch ac Ymateb (ar gyfer eitem 3.2)
Ymddiheuriadau		
Tracey Cooper	(TC)	Prif Weithredwr
Sophie Fuller	(SF)	Cyfarwyddwr Cynorthwyol Llywodraethu Corfforaethol a Chymorth Busnes, Gweithrediaeth y GIG

Dechreuodd y cyfarfod am 10:00

Rhan A	
QSIC 2025.06.02/1	**Croeso, Cyflwyniadau ac Ymddiheuriadau**
Croesawodd y Cadeirydd bawb i sesiwn gyhoeddus cyfarfod y Pwyllgor Ansawdd, Diogelwch a Gwella. Nodwyd yr ymddiheuriadau am absenoldeb.	
QSIC 2025.06.02/2	**Datganiad o Fuddiant**
Nid oedd unrhyw ddatganiadau o fuddiant yn ychwanegol i'r rhai a ddatgelwyd eisoes ar y Gofrestr Datganiadau o Fuddiant.	
QSIC 2025.06.02/3	**Eitemau i'w Cymeradwyo**
QSIC 2025.06.02/3.1	**Cofnodion a Log Gweithredu**
Ystyriodd a **chymeradwyodd** y Pwyllgor gofnodion y cyfarfod a gynhaliwyd ar 04 Chwefror 2025 fel cofnod cywir o'r cyfarfod. Ystyriodd y Pwyllgor y diweddariad i'r log gweithredu, gan nodi bod un eitem ar y trywydd iawn i'w chyflawni erbyn cyfarfod nesaf y Pwyllgor.	
QSIC 2025.06.02/3.2	**Adroddiad Blynyddol Parodrwydd am Argyfwng, Gwydnwch ac Ymateb (EPRR)**
Cyflwynodd MK yr adroddiad blynyddol, a oedd yn adlewyrchiad manwl o ymdrechion Parodrwydd am Argyfwng, Gwydnwch ac Ymateb (EPRR) y Sefydliad dros y flwyddyn ddiwethaf a chynlluniau ar gyfer y flwyddyn nesaf. Cynghorodd MK hefyd am y mân ddiwygiadau a wnaed i'r cynllun Ymateb i Argyfwng a oedd wedi'i gymeradwyo'n ddiweddar gan y Bwrdd, ac a gynhwyswyd er gwybodaeth a sicrwydd yn y sesiwn breifat oherwydd natur sensitif y Cynllun. Aeth HW ymlaen i roi trosolwg o'r adroddiad, gan dynnu sylw at: • Y gwelliannau a wnaed i'r tîm EPRR, ymgysylltiad eang ar draws y Sefydliad a sefydlu gwasanaeth ar alwad 24/7. • Mae'r ymarferion gwydnwch digidol ar y gweill ac ymdrechion i barhau i gryfhau safle'r Sefydliad o ran parodrwydd ar gyfer pandemig. • Gwaith rhyngwladol ar y gweill gyda Chymdeithas Ryngwladol y Sefydliadau Iechyd Cyhoeddus Cenedlaethol (IANPHIs) a'r ymarfer cenedlaethol haen un sydd ar ddod a'r dilysu mewnol wedi'i gynllunio ar gyfer Ch4 2024-25. Diolchodd aelodau'r pwyllgor i HW am y trosolwg o'r gwaith cynhwysfawr sydd ar y gweill. Gwnaeth y Pwyllgor y canlynol:	

- Cymryd **sicrwydd** mewn perthynas â chydymffurfiaeth y sefydliad â gofynion y Ddeddf Argyfyngau Sifil [2004] posibl a Chanllawiau Craidd Cynllunio at Argyfyngau GIG Cymru [2015].
- Cymryd **sicrwydd** bod Cynllun Ymateb i Argyfwng Iechyd Cyhoeddus Cymru (F3.1, 3.2 nawr) wedi cael adolygiad blynyddol mewnol cyflym ac wedi'i ddiweddaru gyda mân ddiwygiadau (ar gael mewn papurau sesiwn breifat).
- Cymryd **sicrwydd** bod templedi Strategaeth Parhad Busnes (F2), Dadansoddiad Effaith a Chynllun Iechyd Cyhoeddus Cymru wedi'u hadolygu a'u diweddaru; gyda chadarnhad pellach bod pob cyfarwyddiaeth/Is-adran wedi adolygu eu trefniadau parhad busnes i ystyried gwydnwch digidol yn benodol.
- **Wedi cymeradwyo** cyflwyniad yr Adroddiad Blynyddol Cynllunio at Argyfyngau Iechyd i Weithrediaeth y GIG.

QSIC 2025.06.02/3.2	Polisïau a Gweithdrefnau

Cyflwynodd AC y Polisi Hebryngwyr drafft, sef polisi newydd a gynlluniwyd i gefnogi staff a defnyddwyr gwasanaethau yn ystod archwiliadau personol.

Ceisiodd OO fwy o wybodaeth am y pecyn hyfforddi a fyddai ar gael i staff. Gan gynnig rhannu manylion y pecyn hyfforddi gydag OO maes o law, aeth AC ymlaen i gadarnhau y byddai sesiynau wyneb yn wyneb yn cael eu darparu, yn bennaf o fewn gwasanaethau'r rhaglen sgrinio fel Bron Brawf Cymru a rhaglenni sgrinio Anewrysm Aortig yn yr Abdomen (AAA) Cymru. Byddai'r hyfforddiant yn cwmpasu rolau a chyfrifoldebau aelodau staff a sut i roi gwybod am bryderon fel bod staff yn teimlo eu bod yn cael cefnogaeth lawn ac yn hyderus i gyflawni eu rôl yn llawn.

Gan dynnu sylw at bwysigrwydd diogelwch staff, diolchodd CB i AC am ei harweinyddiaeth ac i'r tîm am eu cefnogaeth wrth ddatblygu'r Polisi Hebryngwyr.

Gwnaeth y Pwyllgor y canlynol:

- **Nodwyd** bod y Tîm Arwain wedi cymeradwyo'r Polisi i'r Pwyllgor ac wedi cymeradwyo'r weithdrefn gysylltiedig.
- **Cymeradwywyd** y Polisi Hebryngwyr.

QSIC 2025.06.02/4	Cadarnhau Argymhelliad i'r Bwrdd

Cyflwynodd LB y cyflwyniad ar Effeithiolrwydd y Pwyllgor, y Cylch Gorchwyl (TOR) diwygiedig a'r cynllun gwaith ar gyfer 2025-26, gan dynnu sylw at y ffaith bod Cylch Gorchwyl a Chynllun Gwaith y Pwyllgor ar gyfer 2025/26 wedi'u cymeradwyo gan y Cadeirydd blaenorol, Diane Crone, cyn iddi ymadael, a'u bod wedi'u cyflwyno i'r Pwyllgor o edrych yn ôl oherwydd amseriad cyfarfod y Bwrdd (a gynhaliwyd ar 29 Mai 2025).

Nododd CJ fod newidiadau wedi'u cytuno gan y Bwrdd i gylch gorchwyl y Pwyllgor yn ymwneud ag enwi Gweithrediaeth y GIG a fyddai'n cael eu hadlewyrchu yn y fersiynau terfynol a gyhoeddir.

Gwnaeth y Pwyllgor y canlynol:

- **Ystyried** cyflwyniad ar Effeithiolrwydd y Pwyllgor

- **Cadarnhau** cymeradwyo'r Cylch Gorchwyl, gan nodi'r newid o Weithrediaeth y GIG i Uned Perfformiad a Gwella'r GIG.
- **Cadarnhau** cymeradwyo Cynllun Gwaith y Pwyllgor ar gyfer 2025/26
- **Nodi** bod y cyflwyniad Effeithiolrwydd, y Cylch Gorchwyl a'r Cynllun Gwaith wedi'u cyflwyno yng nghyfarfod y Bwrdd ym mis Mai.

QSIC 2025.06.02/5	**Eitemau ar gyfer Sicrwydd**
QSIC 2025.06.02/5.1	**Adroddiad Ansawdd, Llywodraethu a Pherfformiad**

Rhoddodd AC drosolwg o'r Adroddiad Ansawdd, Llywodraethu a Pherfformiad ar gyfer Chwarter 4, gan dynnu sylw'r Pwyllgor at feysydd penodol i'w hystyried:

<u>Gweithio i Wella (PTR), Ch4</u>
Crynhodd AC yr adran PTR, a oedd yn cynnwys y digwyddiadau, cwynion a phryderon a adroddwyd ac y gweithredwyd arnynt yn ystod Chwarter 4, gan gynnwys:

- Adroddwyd am 528 o ddigwyddiadau, ac adroddwyd am 13 ohonynt yn wreiddiol fel niwed cymedrol. Mae 12 wedi cael eu hisraddio ers hynny ac mae 1 wedi aros ar agor. Cynghorodd AC am ddarn allweddol o waith sydd ar y gweill i wella'r asesiad cychwynnol o ddigwyddiadau a lefel y niwed.
- Roedd 64 o ddigwyddiadau gyda statws hwyr. Yn debyg i Chwarter 3, roedd y categori mwyaf yn ymwneud ag asesu ac ymchwilio; ac yn benodol methu â dilyn Gweithdrefnau Gweithredu Safonol (SOPs).
- Nid oedd unrhyw achosion o wneud iawn yn Chwarter 4. Roedd 6 achos a adroddwyd yn flaenorol yn parhau ac yn destun ymchwiliad.

Trafododd y Pwyllgor y canlynol:

- Gan nodi'r amser a gymerir i reoli achosion, ceisiodd y Pwyllgor sicrwydd ynghylch y camau gweithredu a gymerir i leihau achosion hwyr. Cynghorodd AC fod yr achos hwyr ers amser yn dibynnu ar drydydd parti, ond bod datrysiad i'w gael. Aeth AC ymlaen i dynnu sylw at yr ymdrechion sylweddol a wnaed i gau arosiadau hir a oedd yn cynnwys cysylltu â Swyddfa'r Cyfarwyddwr Meddygol i wella rheoli digwyddiadau.
- Gwella mynediad at hyfforddiant datix. Dywedodd AC fod hyfforddiant yn cael ei gynnig i bob dechreuwr newydd a bod cynnig misol ar gael i'r holl staff. Nododd AC hefyd fod y tîm Gweithio i Wella yn gweithio gyda grwpiau defnyddwyr i dargedu ardaloedd yn ôl yr angen, a byddai ymwybyddiaeth hefyd yn cael ei chodi fel rhan o wythnos diogelwch genedlaethol ym mis Medi. Cadarnhaodd AC y byddai'n gofyn i'r Grŵp Arweinwyr Busnes a Chynllunio godi ymwybyddiaeth gyda'u grwpiau staff a'i roi yng Nghylchlythyr y Rheolwyr Llinell.

<u>Profiad y Claf/Defnyddiwr Gwasanaeth Ch4</u>
Tynnodd AC sylw at y canlynol:

- 22 o gwynion datrysiad cynnar, a 13 cwyn ffurfiol.
- Ni adroddwyd unrhyw achos dyletswydd gonestrwydd y chwarter hwn.
- Derbyniwyd 139 o ganmoliaeth.
- Cynnydd gyda'r rheoliadau Gweithio i Wella diwygiedig a'r paratoadau rhagarweiniol sydd i'w gwneud yng ngoleuni'r goblygiadau posibl i'r Sefydliad a defnyddwyr gwasanaethau.

- Llwyddiant mewn cyflwyno arolwg SMS peilot ar draws 8 lleoliad Sgrinio Llygaid Diabetig Cymru. Cynghorodd AC am y nifer dda o dderbyniadau a bod yr adborth cychwynnol yn canolbwyntio ar yr adeilad a'r meysydd parcio.

Gwaith y Grŵp Diogelu Corfforaethol, Ch4
Rhoddodd AC ddiweddariad ar waith y Grŵp Diogelu, gan dynnu sylw at y canlynol:

- Adroddwyd ar 20 o ymholiadau diogelu, yn bennaf yn ymwneud â chyngor a chymorth.
- Y gwaith sydd ar y gweill i wella cydymffurfiaeth â hyfforddiant Diogelu.

Gwnaeth y Pwyllgor y canlynol:

- Holi am y cynnydd mewn ymholiadau diogelu. Cynghorodd AC fod y rhain yn debygol o fod o ganlyniad i godi proffil diogelu, a chroesawodd y tîm y cyfle i roi mwy o gyngor a chefnogaeth yn gynnar.

Gwaith y Grŵp Corfforaethol ar gyfer Atal a Rheoli Heintiau (IPC), Ch4
Rhoddodd AC ddiweddariad ar waith y grŵp IPC Corfforaethol, gan dynnu sylw at y canlynol:

- Adroddwyd am 14 digwyddiad, ac ystyriwyd bod pob un ohonynt o niwed isel neu ddim niwed o gwbl.
- Cynlluniau i gyflwyno hyfforddiant pellach ar y Dechneg Aseptig Di-gyffwrdd, yn enwedig ar draws gwasanaethau sgrinio.
- Camau unioni ar waith i fynd i'r afael â phryderon cydymffurfio â safonau glanhau mewn rhai gwasanaethau sgrinio.
- Y gwaith gwych sydd ar y gweill i gefnogi archwilio drwy weithredu system rheoli archwilio newydd.

Rheoli Rhybuddion a Hysbysiadau Diogelwch, Ch4
Nododd y Pwyllgor fod 1 hysbysiad diogelwch sy'n berthnasol i'r Sefydliad yn cael ei weithredu yn unol â hynny.

Archwiliad Ansawdd a Chlinigol, Ch4
Nododd y Pwyllgor y cynnydd o ran y cynllun Archwiliad Ansawdd a Chlinigol.

Gwnaeth y Pwyllgor y canlynol:

- **Nodi'r** safonau perfformiad sy'n cael eu cyflawni a meysydd i'w gwella.
- Cymryd **sicrwydd** bod trefniadau llywodraethu priodol ar waith i sicrhau gwasanaethau diogel, amserol, effeithiol, teg, effeithlon sy'n canolbwyntio ar yr unigolyn.

QSIC 2025.06.02/5.2	**Adroddiad Blynyddol Gweithio i Wella 2024-25 ac Adroddiad Blynyddol Dyletswydd Gonestrwydd 2024-25**

Cyflwynodd CB yr adroddiadau blynyddol, gan nodi eu bod wedi'u paratoi yn unol â gwahanol reoliadau a chrynhoi'r wybodaeth a ddarparwyd i'r Pwyllgor ym mhob cyfarfod fel rhan o'r adroddiad Perfformiad Llywodraethu Ansawdd.

Rhoddodd AC drosolwg o Adroddiad Blynyddol Gweithio i Wella ar gyfer 2024-25, a roddodd drosolwg o'r broses o reoli pryderon a'r camau dilynol a gymerwyd i wella gwasanaethau. Tynnodd AC sylw at y canlynol:

- Credir bod cynnydd yn nifer y digwyddiadau a adroddwyd oherwydd ymdrechion i ymgorffori diwylliant adrodd cadarnhaol.
- Cynnydd mewn cwynion a chamau gweithredu wedi'u hamlygu i fynd i'r afael â hyn megis y broses ddiwygiedig ar gyfer rheoli cwynion i gefnogi dull mwy amserol a mwy person-ganolog o reoli cwynion.
- Y gostyngiad blynyddol yn nifer yr atebion cynnar, achosion iawndal, hawliadau ac achosion sydd wedi bod yn hwyr iawn a adroddwyd.
- Y ffocws ar waith gwella sy'n gysylltiedig ag adrodd ar ddigwyddiadau, gan gynnwys y rhai sydd wedi bod yn hwyr a gwelliannau i'r broses uwchgyfeirio.
- Un cosb ariannol i'r Sefydliad gan Gronfa Risg Cymru oherwydd cyflwyno Adroddiad Dysgu ar gyfer Digwyddiadau yn hwyr.

Aeth AC ymlaen i roi trosolwg o Adroddiad Blynyddol y Ddyletswydd Gonestrwydd ar gyfer 2024-25, gan dynnu sylw at:

- Ymchwiliad i ddau achos wedi'u cadarnhau, ac un ohonynt yn achos ar y cyd â Bwrdd Iechyd Prifysgol Caerdydd a'r Fro. Roedd y Pwyllgor wedi ystyried y diweddariadau diweddaraf ar y ddau achos o fewn meysydd Bron Brawf Cymru a Microbioleg yn flaenorol ac roedd dysgu a nodwyd wedi'i rannu er mwyn gwella gwasanaethau a datblygiad staff.
- Roedd y ddyletswydd gonestrwydd ar gyfer hyfforddiant e-ddysgu yn 88%.

Diolchodd y Pwyllgor i AC am gyflwyno'r adroddiadau blynyddol a:

- Cymerodd **sicrwydd** bod y sefydliad yn rheoli gweithrediad Rheoliadau Gweithio i Wella (2011) yn effeithiol.
- Cymerodd **sicrwydd** bod achosion Dyletswydd Gonestrwydd yn cael eu rheoli yn unol â chanllawiau rheoleiddio a'r polisïau a'r gweithdrefnau perthnasol, gan gynnwys dysgu sefydliadol a'r sicrwydd rhesymol a dderbyniwyd o adroddiad yr Archwiliad Mewnol.

QSIC 2025.06.02/5.3	**Sicrwydd Ansawdd**
QSIC 2025.06.02/5.3.1	**Cofrestr Risg Strategol**

Cyflwynodd CB yr adroddiad a mynegodd ei diolch i'r holl gydweithwyr a oedd wedi adolygu ac ailfapio'r gofrestr risg strategol ac wedi cyfrannu at y dull templed diwygiedig. Byddai'r dull diwygiedig, parodrwydd i dderbyn risg a'r bensaernïaeth yn cael eu hystyried yn fanwl yng nghyfarfod y Bwrdd ym mis Gorffennaf 2025.

Rhoddodd DG drosolwg o'r risg newydd, gan nodi bod y camau gweithredu newydd wedi'u mapio ar draws i'r rheolaethau blaenorol a'r camau gweithredu i'r rhai newydd er mwyn cynnal tryloywder. Tynnwyd sylw hefyd at y risgiau corfforaethol sy'n cefnogi'r risg hon.

Cynghorodd MK fod y datganiad risg wedi'i ddiweddaru yn adlewyrchiad da o'r rheolaethau a'r gweithgaredd sydd ar waith i liniaru'r risg o ddarparu gwasanaethau iechyd cyhoeddus rhagorol a rhagwelodd y byddai ffocws pellach ar effaith, capasiti ymchwydd a hyfforddiant, ac yn olaf y mapiau llwybrau ar gyfer gwydnwch digidol.

Gwnaeth y Pwyllgor y canlynol:

- Cydnabod ffocws cadarnhaol o amgylch digwyddiadau annisgwyl a cheisio sicrwydd ynghylch y bartneriaeth â gweddill y Deyrnas Unedig (DU) ynghylch risgiau posibl. Cadarnhaodd MK ei fod yn hyderus bod Cymru / Iechyd Cyhoeddus Cymru wedi'i gysylltu â sgyrsiau'r DU ynghylch sganio'r gorwel, a rhybuddion cynnar, a chadarnhaodd fod mecanweithiau ffurfiol a mecanweithiau llai ffurfiol ar waith ar gyfer rhannu gwybodaeth rhwng y pedair gwlad, ac ystyried pandemigau a bygythiadau byd-eang.
- Canmolodd MK a'i dîm am eu hymdrechion, yn enwedig o amgylch themâu atal.

Cymerodd y Pwyllgor **sicrwydd** ynghylch rheoli risgiau strategol o fewn cylch gwaith y Pwyllgor.

QSIC 2025.06.02/5.3.2	**Y Gofrestr Risg Corfforaethol**

Cyflwynodd CB y Gofrestr Risg Corfforaethol, a oedd yn amlinellu'r newidiadau a gymeradwywyd ers cyfarfod diwethaf y Pwyllgor ac yn cloi'r diweddariad drwy dynnu sylw at y ffaith bod y Bwrdd wedi cynnal trafodaeth dda ar y Risgiau Corfforaethol yn ei gyfarfod Bwrdd ym mis Mai.

Cymerodd y Pwyllgor **sicrwydd** ar reolaeth y Risg Corfforaethol o fewn y Sefydliad.

QSIC 2025.06.02/5.5	**Diweddariad Polisi ddwywaith y flwyddyn**

Cyflwynodd LB yr adroddiad, gan nodi bod 93% o bolisïau yn gyfredol. Tynnodd LB sylw at y 2 bolisi sydd allan o ddyddiad ar gyfer adolygiad y Pwyllgor; polisi unffurf sy'n aros am adolygiad Cymru gyfan a pholisi Rheoli Dŵr a oedd i'w gyflwyno i'w gymeradwyo yng nghyfarfod nesaf y Pwyllgor.

Cymerodd y Pwyllgor **sicrwydd** ynghylch y blaenoriaethu a'r cynnydd a wneir i adolygu polisïau, gweithdrefnau, a dogfennau rheoli ysgrifenedig eraill o fewn cylch gorchwyl y Pwyllgor.

Egwyl	
QSIC 2025.06.02/5	**Eitemau ar gyfer Sicrwydd (Parhad)**
QSIC 2025.06.02/5.4	**Adroddiad Iechyd a Diogelwch Chwarter 4 2024-25**

Cyflwynodd ND yr Adroddiad Iechyd a Diogelwch ar gyfer Chwarter 4, 2024-25, a oedd yn rhoi trosolwg o weithgareddau iechyd a diogelwch a gyflawnwyd ar gyfer y cyfnod hwn. Nododd ND nifer o bwyntiau pwysig o'r adroddiad:

- Roedd cynnydd da wedi'i wneud yn erbyn argymhellion archwiliad arferol yr Awdurdod Gweithredol Iechyd a Diogelwch o labordai microbioleg.
- Nid oedd unrhyw ddigwyddiadau o dan y Rheoliadau Adrodd ar Anafiadau, Clefydau a Digwyddiadau Peryglus (RIDDOR).
- Roedd cydymffurfiaeth 100% ar draws pob safle ar gyfer gofynion rheoli adeiladau statudol a rheoleiddiol.
- Roedd lefelau hyfforddiant statudol a gorfodol ar 85% ac roedd hyfforddiant e-ddysgu gweithio gartref hefyd yn flaenoriaeth i'r Sefydliad.

Nododd y Pwyllgor y cynnydd mewn digwyddiadau sy'n gysylltiedig â thraffig ffyrdd, yn ogystal â chyfraddau uwch o lithro, baglu a chwympo. Dywedodd ND fod y ddau yn ddigwyddiadau arferol ac nad oeddent yn destun pryder. Tynnodd sylw at gyflwyniad diweddar Gweithdrefn Telemateg Cerbydau ar gyfer gwasanaethau sgrinio a oedd â'r nod o gefnogi diogelwch staff.

Aeth ND ymlaen i gyflwyno'r adroddiad blynyddol Iechyd a Diogelwch ar gyfer 2024/25, a oedd yn amlinellu ac yn dangos y cynnydd a wnaed a'r materion allweddol a oedd wedi cael sylw drwy gydol y flwyddyn. Tynnodd sylw at:

- Ymgysylltu â gwasanaethau Microbioleg a Pobl a Datblygu Sefydliadol er mwyn gwella a chefnogi rheoli digwyddiadau.
- Cyflwyno archwiliadau cynhwysfawr newydd a gynhaliwyd ar draws safle'r Sefydliad.

Daeth ND i ben drwy gyflwyno'r cynllun gwaith Iechyd a Diogelwch ar gyfer 2025-26, gan dynnu sylw at y datblygiad polisi arfaethedig, y datblygiad arfaethedig o set o Ddangosyddion Perfformiad Allweddol a chynnydd gydag arolwg diwylliant diogelwch yn y gweithle posibl.

Trafododd y Pwyllgor y canlynol:

- Cynghorodd CB eu bod yn aros am safonau glanhau diwygiedig, a fyddai'n debygol o arwain at rai gofynion adnoddau a chapasiti ychwanegol ar gyfer y Tîm Iechyd a Diogelwch.
- Yr angen i sicrhau bod Byrddau Iechyd yn cydymffurfio â rheoli cyfleusterau priodol. Cadarnhaodd ND eu bod yn gweithio gyda Byrddau Iechyd i wella cyfleusterau a bod Cytundebau Lefel Gwasanaeth (SLAs) a Memoranda Cyd-ddealltwriaeth (MoUs) ar waith y gellid eu defnyddio i fynd i'r afael â phryderon pe bai angen. Parhaodd y Tîm i feithrin perthnasoedd da â Byrddau Iechyd er mwyn ceisio cael data cydymffurfio mewn modd amserol.

Gwnaeth y Pwyllgor y canlynol:

- Cymryd **sicrwydd** bod mesurau priodol ar waith i fonitro cydymffurfedd ac i fynd i'r afael â meysydd a nodwyd i'w gwella.
- Cymryd **sicrwydd**, yn seiliedig ar y wybodaeth sydd ar gael yn yr Adroddiad Blynyddol, bod iechyd a diogelwch yn y gweithle yn cael ei reoli'n rhagweithiol, a'i fonitro trwy archwiliadau, Datix, adroddiadau RIDDOR a'i gefnogi gan bolisïau a gweithdrefnau priodol.
- **Nodwyd** y cynllun gwaith ar gyfer 2025-26.

QSIC 2025.06.02/6	Archwiliad Dwfn - Cwynion a Digwyddiadau

Cyflwynodd CB y broses archwiliad dwfn, gan groesawu'r cyfle i rannu'r gwaith gwella o amgylch prosesau, ymchwilio a rhannu dysgu.

Cyflwynodd JW y trosolwg archwiliad dwfn drwy ystyried y chwe maes ansawdd, gan dynnu sylw at:

- Cyflawniadau allweddol megis gwell ymgysylltiad ar draws y system a oedd wedi arwain at gynnydd cadarnhaol yn y diwylliant adrodd ar ddigwyddiadau, gostyngiad mewn cwynion, yn enwedig o fewn gwasanaeth Sgrinio Llygaid

Diabetig Cymru, a gwelliannau prosesau megis datrys cwynion / pryderon yn gyflymach. Roedd hyn wedi lleihau'r ôl-groniad mewn modd diogel ac amserol, ac wedi cynyddu hyder cleifion a staff.

- Stori darpariaeth iechyd sy'n canolbwyntio ar y defnyddiwr gwasanaeth, a nifer o enghreifftiau 'Dywedoch Chi, Gwnaethom Ni' a helpodd i amlygu'r problemau hygyrchedd a chydraddoldeb y mae defnyddwyr gwasanaethau yn eu hwynebu a'r camau lliniaru a gymerir i fynd i'r afael â'r rhain. Enghreifftiau o hyn oedd ymestyn oriau/diwrnodau agor a chyflwyno unedau sgrinio symudol i fynd i'r afael â rhai o'r pryderon a godwyd, a'r cynlluniau sydd ar waith i wella'r arddangosiad o ddysgu o ddigwyddiadau.
- Risgiau rhaglen gwasanaeth, megis newidiadau oherwydd rheoliadau Gweithio i Wella a'r effaith ar adnoddau'r Sefydliad, yn enwedig y gofyniad disgwyliedig i gynnig cyfarfod gwrando wyneb yn wyneb a chamau lliniaru posibl.

Trafododd y Pwyllgor y canlynol:

- Sut y gellid cymhwyso'r dysgu yn systematig ledled y Sefydliad a'r awgrym o safonau hygyrchedd y dylid eu dilyn er mwyn datrys y pryderon hygyrchedd a godwyd yn y stori defnyddiwr gwasanaeth. Cyfeiriodd JW at y nod o sicrhau bod cyfarwyddiaethau'n teimlo'n hyderus ac yn cael eu cefnogi i allu rhannu eu dysgu a gwnaeth sylwadau ar yr angen i ymgorffori hyn fel arfer arferol. Cododd AC bwysigrwydd y broses hunanasesu. Myfyriodd CB ar gynllun gweithredu Archwilio Mewnol y Ddyletswydd Ansawdd a oedd yn amlinellu'r angen i wella lledaeniad a gwydnwch dysgu a thystiolaeth ac amlygodd y byddai cynnig yn cael ei ail-drafod yn y Grŵp Goruchwylio Ansawdd.
- Ystyriaeth o sut i fframio ein cyfathrebu allanol i sicrhau'r cynhwysiant a'r hygyrchedd mwyaf posibl, fel bod defnyddwyr gwasanaethau yn ymwybodol y byddai'r Sefydliad yn gwneud yr addasiadau angenrheidiol i hwyluso eu sgrinio ymlaen llaw, ac ystyriwyd awgrym i archwilio cludiant hygyrch a'r cyfle i ddarparu ad-daliad yn unol â Byrddau Iechyd eraill.
- Gwelliannau yn y ffordd y caiff cwynion anffurfiol a ffurfiol eu hadnabod a'r defnydd o Datix fel un ffynhonnell gwirionedd. Cadarnhaodd JW ei bod hi'n cyfarfod yn rheolaidd â phob cyfarwyddiaeth, ac yn benodol â rhaglenni sy'n ymwneud â gwasanaethau cyhoeddus, i sicrhau bod Datix wedi'i ymgorffori ar draws y sefydliad, a gwnaeth sylwadau ar ddefnyddioldeb Datix i allu nodi themâu ar draws y gwasanaethau y gellid mynd i'r afael â nhw a'u gwella.
- Croesawodd y swyddogaeth alluogi a nodwyd bod y tîm Gweithio i Wella yn darparu meysydd pwrpasol y maent yn eu cefnogi, ar gyfer ymholiadau arferol a chwynion / pryderon cymhleth.

Diolchodd y Pwyllgor i JW am y cyflwyniad cynhwysfawr a manwl a stori'r claf a oedd yn ysgogi'r meddwl a chymerodd **sicrwydd** ynghylch y trefniadau sydd ar waith ar gyfer Rheoliadau Gweithio i Wella.

QSIC 2025.06.02/7	**Eitemau i'w Nodi**
QSIC 2025.06.02/7.1	**Archwilio**

Nododd y Pwyllgor y canlynol:

- Y Traciwr Argymhellion Archwilio Mewnol
- Adroddiad Archwilio Mewnol Dyletswydd Gonestrwydd

• Adroddiad Archwilio Mewnol Cynllun Gwella Caffael Gwasanaethau Diogelu Iechyd a Sgrinio

QSIC 2025.06.02/7.2	Adolygiad Blynyddol Grwpiau Adrodd

Nododd y Pwyllgor y canlynol:

- Cylch Gorchwyl Atal a Rheoli Heintiau
- Cylch Gorchwyl y Grŵp Diogelu

Rhan B	Busnes Perfformiad a Gwella'r GIG
QSIC 2025.06.02/8	Datganiad o Fuddiant

Nid oedd unrhyw ddatganiadau o fuddiant yn ychwanegol i'r rhai a ddatgelwyd eisoes ar y Gofrestr Datganiadau o Fuddiant.

QSIC 2025.06.02/9	Adroddiad Cydymffurfedd Llywodraethu Chwarterol Gweithrediaeth y GIG (Ch4)

Cyflwynodd a rhoddodd IH drosolwg o'r Adroddiad Cydymffurfedd Llywodraethu Chwarterol ar gyfer Chwarter 4, gan dynnu sylw at y canlynol:

- O heddiw ymlaen byddai Gweithrediaeth y GIG yn cael ei henwi'n Uned Perfformiad a Gwella'r GIG.
- Roedd un gŵyn wedi'i datrys yn ddiweddar, ac roedd un hawliad yn parhau.
- Er nad oedd unrhyw Adroddiadau Digwyddiadau Adroddadwy Cenedlaethol ar gyfer Chwarter 4, mae un wedi'i gyflwyno ar ôl 31 Mawrth 2025 ac roedd yn cael ei ymchwilio ar hyn o bryd.

Diolchodd y Pwyllgor i IH am y diweddariad a gwnaeth y canlynol:

Iechyd a Diogelwch

- Cymryd **sicrwydd** bod mesurau priodol i fonitro cydymffurfedd ac i fynd i'r afael â meysydd a nodwyd i'w gwella.

Cydymffurfedd Adrodd ar Ddigwyddiadau Adroddadwy Cenedlaethol

- **Nodwyd** na fu unrhyw ddigwyddiadau adroddadwy yn ystod y cyfnod adrodd.

Cydymffurfedd Cwynion (gan gynnwys PTR os yn berthnasol)

- **Nodwyd** bod un gŵyn wedi'i derbyn ar gyfer y cyfnod hwn a bod adolygiad yn ystod Chwarter 4

Adrodd ar hawliadau (hawliadau gan staff a thrydydd parti)

- **Nodwyd** bod un hawliad yn mynd rhagddo, a adroddwyd amdano gyntaf yn Chwarter 3.

Cydymffurfedd DATIX

- **Nodwyd** bod pump o ddigwyddiadau yn ymwneud ag iechyd a diogelwch wedi'u hadrodd drwy Datix yn ystod y cyfnod adrodd a chymerodd sicrwydd bod y broses briodol wedi'i dilyn i reoli'r digwyddiadau hyn.

Cydymffurfedd Diogelu

- **Nodwyd** nad oedd unrhyw faterion diogelu wedi eu hadrodd yn ystod y cyfnod hwn.

QSIC 2025.06.02/10	**Gweinyddiaeth Cloi**
QSIC 2025.06.02/10.1	**Cau'r Cyfarfod Cyhoeddus**
Gofynnodd y Cadeirydd i unrhyw adborth gael ei anfon at LB. Dyddiad y cyfarfod nesaf: 26 Awst 2025 Daeth y Cadeirydd â'r cyfarfod i ben.	
Daeth y sesiwn agored i ben am 12:05	

Unconfirmed Minutes of the Public Health Wales
Quality, Safety and Improvement Committee Meeting
26 August 2025, 15:30 – 16:00
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
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
Tracey Cooper	(TC)	Chief Executive
Angela Cook	(AC)	Assistant Director of Quality and Nursing
Tom Fowler	(TF)	Deputy National Director of Health Protection and Screening Services
Meng Khaw	(MK)	National Director of Health Protection and Screening Services, Executive Medical Director
Jim McManus	(JM)	National Director of Health and Wellbeing
Stuart Silcox	(SS)	Assistant Director of Integrated Governance
Paul Veysey	(PV)	Board Secretary and Head of Board Business Unit
Apologies		
Pippa Britton	(PB)	Chair of Board
Olusola Okhiria	(OO)	Trade Union representative
Sophie Fuller	(SF)	Assistant Director Corporate Governance and Business Support, NHS Executive
Sian Griffiths	(SG)	Non-Executive Director (Public Health) and Chair of the Knowledge, Research and Information Committee
Angela Williams	(AW)	Interim Executive Director of Operations and Finance
The meeting commenced at 15:30		

Part A	
QSIC 2025.08.26/1	**Welcome, Introductions and Apologies**
The Chair welcomed all to the public session of the Quality, Safety and Improvement Committee meeting. Noting recent changes to the Committee membership, CJ welcomed NE to the meeting and acknowledged and thanked Kate Young in her absence for her previous support and contributions to the Committee. The apologies for absence were noted.	

QSIC 2025.08.26/2	Declaration of Interest
There were no declarations of interest in addition to those already declared on the Declarations of Interest Register.	

QSIC 2025.08.26/3	Items for Approval
QSIC 2025.08.26/3.1	Duty of Quality Annual Report 2024/25

CB introduced the Duty of Quality annual report, thanking everyone across the Organisation for their commitment and contribution to the development of the report, which was developed to meet Duty of Quality requirements. The report aimed to celebrate the Organisation's achievements within healthcare standards and identify areas requiring further work and improvement. CB concluded the introduction by thanking AC, her team and Hilary Wilderspin for their support in assembling the report.

AC went on to provide an overview of the reports structure, which centred around the 12 quality standards, and outlined background information, the current situation, service contributions, and next steps. The report aimed to showcase both ongoing work from last year and new initiatives started this year, with ambitions and achievements summarised for the past 12 months.

CB went on to request the Committee's feedback and approval of the report, noting the intention to translate and publish the annual report as a patient and public facing document which would be presented to the Board at its September meeting.

The Committee:

- Thanked CB and AC for the presentation of the report.
- NE welcomed the opportunity to return to the Committee and praised the quality of the report.
- NE queried why the Performance and Improvement (P&I) Unit were mentioned in isolation and not referenced elsewhere. CB advised that the P&I Unit were formerly the NHS Executive and agreed to reference this throughout the report. CB also clarified that there was no requirement for the P&I Unit to produce their own report.
- NE provided a number of detailed observations about the report, including: the visual layout of the workforce section; the need for consistent measurement of improvements and the contextualisation of statistics within the areas of risk and the Health Protection and Screening Service areas; the wording around waiting times; the context for digital image sharing and Artificial Intelligence (AI); the evidence for the 1st 1000 days return; and the need for population context in MMR vaccine numbers.
- CB thanked NE for his feedback on the reports layout and data presentation and agreed to review and strengthen the improvement data, clarify the wording around waiting times and add in further detail around AI and appropriate sharing/Information Governance.
- Addressing the other points raised, CB agreed to follow up with MK around the Health Protection and Screening Service areas raised, and with JM to address the evidence base for 1000 days.

- Responding specifically to NE's question on whether there was a measurable impact of reducing the fail safe netting system to 11 days within the Newborn blood spot screening, MK advised that the rational was clear within the background section and that actual impact may not be demonstratable due to the small numbers involved.
- TC thanked NE for his helpful comments and feedback, and expressed appreciation to CB, AC and the team, as well as everyone involved, highlighting that the report felt even more personal for people this year as they captured the Organisations history and narrative and that the report highlighted the strong display of the breadth and quality of the work of the Organisation.

The Chair expressed strong support for the report, emphasising that the report served as a "front window" to the organisation, showcasing both achievements and a robust level of assurance of how quality is managed and measured.

The committee **approved** the draft annual quality report, subject to CB reviewing and addressing the specific feedback and suggestions raised during the meeting with the relevant wider teams.

QSIC 2025.08.26/4	**Closing Administration**
QSIC 2025.08.26/4.1	**Close of Public Meeting**
Date of next meeting: 29 September 2025. The Chair closed the meeting.	
The open session closed at 15:50	

Cofnodion heb eu Cadarnhau
o Gyfarfod Pwyllgor Ansawdd, Diogelwch a Gwella Iechyd Cyhoeddus Cymru
26 Awst 2025, 15:30 – 16:00
Cynhaliwyd yn Capital Quarter 2 a thrwy Microsoft Teams

Yn bresennol:		
Clare Jenkins	(CJ)	Cadeirydd y Pwyllgor, Is-gadeirydd y Bwrdd a Chyfarwyddwr Anweithredol
Nick Elliott	(NE)	Cyfarwyddwr Anweithredol
Yn Bresennol:		
Claire Birchall	(CB)	Cyfarwyddwr Gweithredol Nyrsio, Ansawdd a Llywodraethu Integredig
Liz Blayney	(LB)	Dirprwy Ysgrifennydd y Bwrdd a Dirprwy Bennaeth Uned Fusnes y Bwrdd
Tracey Cooper	(TC)	Prif Weithredwr
Angela Cook	(AC)	Cyfarwyddwr Cynorthwyol Ansawdd a Nyrsio
Tom Fowler	(TF)	Dirprwy Gyfarwyddwr Cenedlaethol Gwasanaethau Diogelu Iechyd a Sgrinio
Meng Khaw	(MK)	Cyfarwyddwr Cenedlaethol Gwasanaethau Diogelu Iechyd a Sgrinio, Cyfarwyddwr Meddygol Gweithredol
Jim McManus	(JM)	Cyfarwyddwr Cenedlaethol Iechyd a Llesiant
Stuart Silcox	(SS)	Cyfarwyddwr Cynorthwyol Llywodraethu Integredig
Paul Veysey	(PV)	Ysgrifennydd y Bwrdd a Phennaeth Uned Fusnes y Bwrdd
Ymddiheuriadau		
Pippa Britton	(PB)	Cadeirydd y Bwrdd
Olusola Okhiria	(OO)	Cynrychiolydd Undeb Llafur
Sophie Fuller	(SF)	Cyfarwyddwr Cynorthwyol Llywodraethu Corfforaethol a Chymorth Busnes, Gweithrediaeth y GIG
Sian Griffiths	(SG)	Cyfarwyddwr Anweithredol (Iechyd y Cyhoedd) a Chadeirydd y Pwyllgor Gwybodaeth ac Ymchwil
Angela Williams	(AW)	Cyfarwyddwr Gweithredol Dros Dro Gweithrediadau a Chyllid
Dechreuodd y cyfarfod am 15:30		

Rhan A	
QSIC 2025.08.26/1	**Croeso, Cyflwyniadau ac Ymddiheuriadau**
Croesawodd y Cadeirydd bawb i sesiwn gyhoeddus cyfarfod y Pwyllgor Ansawdd, Diogelwch a Gwella. Gan nodi newidiadau diweddar i aelodaeth y Pwyllgor, fe wnaeth CJ groesawu NE i'r cyfarfod a chydnabod a diolch i Kate Young yn ei habsenoldeb am ei chefnogaeth a'i chyfraniadau blaenorol i'r Pwyllgor.	

Nodwyd yr ymddiheuriadau am absenoldeb.

QSIC 2025.08.26/2	Datganiad o Fuddiant

Nid oedd unrhyw ddatganiadau o fuddiant yn ychwanegol i'r rhai a ddatgelwyd eisoes ar y Gofrestr Datganiadau o Fuddiant.

QSIC 2025.08.26/3	Eitemau i'w Cymeradwyo
QSIC 2025.08.26/3.1	Adroddiad Blynyddol y Ddyletswydd Ansawdd 2024/25

Cyflwynodd CB adroddiad blynyddol y Ddyletswydd Ansawdd, gan ddiolch i bawb ar draws y Sefydliad am eu hymrwymiad a'u cyfraniad at ddatblygu'r adroddiad, a ddatblygwyd i fodloni gofynion y Ddyletswydd Ansawdd. Nod yr adroddiad oedd dathlu cyflawniadau'r Sefydliad o fewn safonau gofal iechyd a nodi meysydd sydd angen gwaith a gwelliant pellach. Daeth CB â'r cyflwyniad i ben drwy ddiolch i AC, ei thîm a Hilary Wilderspin am eu cefnogaeth wrth lunio'r adroddiad.

Aeth AC ymlaen i roi trosolwg o strwythur yr adroddiadau, a oedd yn canolbwyntio ar y 12 safon ansawdd, ac amlinellodd wybodaeth gefndirol, y sefyllfa bresennol, cyfraniadau gwasanaeth, a'r camau nesaf. Nod yr adroddiad oedd arddangos gwaith sy'n mynd yn ei flaen ers y llynedd a mentrau newydd a gychwynnwyd eleni, gan grynhoi yr uchelgeisiau a'r cyflawniadau ar gyfer y 12 mis diwethaf.

Aeth CB ymlaen i ofyn am adborth a chymeradwyaeth y Pwyllgor ar yr adroddiad, gan nodi'r bwriad i gyfieithu a chyhoeddi'r adroddiad blynyddol fel dogfen ar gyfer cleifion a'r cyhoedd a fyddai'n cael ei chyflwyno i'r Bwrdd yn ei gyfarfod ym mis Medi.

Gwnaeth y Pwyllgor y canlynol:

- Diolch i CB ac AC am gyflwyno'r adroddiad.
- Croesawodd NE y cyfle i ddychwelyd i'r Pwyllgor a chanmolodd ansawdd yr adroddiad.
- Holodd NE pam y soniwyd am yr Uned Perfformiad a Gwella (P&I) ar ei phen ei hun a heb gyfeiriad atynt yn unman arall. Dywedodd CB fod yr Uned Perfformiad a Gwella yn arfer cael ei hadnabod fel Gweithrediaeth y GIG a chytunodd i gyfeirio at hyn drwy gydol yr adroddiad. Eglurodd CB hefyd nad oedd unrhyw ofyniad i'r Uned Perfformiad a Gwell gynhyrchu ei hadroddiad ei hun.
- Darparodd NE nifer o sylwadau manwl am yr adroddiad, gan gynnwys: cynllun gweledol yr adran gweithlu; yr angen i fesur gwelliannau'n gyson a rhoi cyd-destun ystadegau o fewn y meysydd risg a'r meysydd Gwasanaeth Diogelu Iechyd a Sgrinio; y geiriad ynghylch amseroedd aros; y cyd-destun ar gyfer rhannu delweddau digidol a Deallusrwydd Artiffisial; y dystiolaeth ar gyfer enillion Y 1000 Diwrnod Cyntaf; a'r angen am gyd-destun poblogaeth yn niferoedd y brechlyn MMR.
- Diolchodd CB i NE am ei adborth ar gynllun yr adroddiadau a chyflwyniad y data a chytunodd i adolygu a chryfhau'r data gwella, egluro'r geiriad ynghylch amseroedd aros ac ychwanegu rhagor o fanylion ynghylch deallusrwydd artiffisial a rhannu/Llywodraethu Gwybodaeth priodol.

- Gan fynd i'r afael â'r pwyntiau eraill a godwyd, cytunodd CB i drafod gyda MK ynghylch y meysydd Gwasanaeth Diogelu Iechyd a Sgrinio a godwyd, a chyda JM i fynd i'r afael â'r sail dystiolaeth am Y 1000 Diwrnod Cyntaf.
- Gan ymateb yn benodol i gwestiwn NE ynghylch a oedd effaith fesuradwy o leihau'r system atal rhag methiant i 11 diwrnod o fewn sgrinio smotyn gwaed newydd-anedig, cynghorodd MK fod y rhesymeg yn glir yn yr adran gefndir ac efallai na fydd yr effaith wirioneddol yn ddangosadwy oherwydd y niferoedd bach dan sylw.
- Diolchodd TC i NE am ei sylwadau a'i adborth defnyddiol, a mynegodd werthfawrogiad i CB, AC a'r tîm, yn ogystal â phawb a oedd yn rhan o'r broses, gan bwysleisio bod yr adroddiad yn teimlo hyd yn oed yn fwy personol i bobl eleni gan eu bod yn cynnwys hanes a naratif y Sefydliad a bod yr adroddiad yn tynnu sylw at led ac ansawdd gwaith y Sefydliad.

Mynegodd y Cadeirydd gefnogaeth gref i'r adroddiad, gan bwysleisio bod yr adroddiad yn gweithredu fel "ffenestr flaen" i'r sefydliad, gan arddangos cyflawniadau a lefel gadarn o sicrwydd o sut mae ansawdd yn cael ei reoli a'i fesur.

Cymeradwyodd y pwyllgor yr adroddiad ansawdd blynyddol drafft, yn amodol ar fod CB yn adolygu ac yn ymdrin â'r adborth a'r awgrymiadau penodol a godwyd yn ystod y cyfarfod gyda'r timau ehangach perthnasol.

QSIC 2025.08.26/4	**Camau dod â'r cyfarfod i ben**
QSIC 2025.08.26/4.1	**Cau'r Cyfarfod Cyhoeddus**
Dyddiad y cyfarfod nesaf: 29 Medi 2025 Daeth y Cadeirydd â'r cyfarfod i ben.	
Daeth y sesiwn agored i ben am 15:50	

RAG Rating/Status

At risk	Red - Action date passed or revised date needed
On track	Yellow - Action on target to be completed by agreed/revised date
Complete	Green- Action complete
No longer needed	Blue - Action to be removed and/or replaced by new action

QUALITY, SAFETY AND IMPROVEMENT COMMITTEE								
Meeting Item Reference	**Action Reference**	**Lead**	**Meeting Item Title**	**Details of action**	**Update on progress**	**Original target date**	**Revised target date**	**RAG rating/Status**
OPEN ACTIONS								
None								
OPEN ACTIONS - IN PROGRESS BUT NOT YET DUE								
None								
ACTIONS RECOMMENDED TO BE CLOSED AT (29 SEPTEMBER 2025) MEETING								
QSIC 2025_02_04/5.3	QSIC 2025/01	SH	Screening Service Update	The Committee sought further information on 'Did Not Attend' (DNA) rates for screening programmes. SH commented on the rebooking service in place to manage capacity and agreed to provide details on the impact of true DNA rates on service capacity in the next iteration of the report, due August 2025.	29/06/25 Update: SH confirmed that this discussion was in relation to the Diabetic Eye Screening Wales Programme and agreed to incorporate it into the Screening Services report.	26/08/2025	29/09/2025	**Completed**

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *3.2*

Policy / Procedure Approval Report

Section 1 - Policy / Procedure Information

Policy / Procedure Title	**Public Health Wales Mobile Devices Policy**
Policy Lead	**Zara Walker**
Lead Executive	**Angela Williams**
PHW / All Wales?	**PHW**
Date of last Review	**2009 (Velindre NHS Trust Policy)**
Is the current policy / procedure within review date?	**No (Review Date March 2012)**
Approving Body /Group	**Quality, Safety and Improvement Committee**
Version Number	**2**

Section 2: Recommendation
That Quality, Safety and Improvement Committee: • Considers the information contained within the Policy and Equalities Impact Assessment (Appendix 1a) • **Note** that the Leadership Team considered and endorsed the policy at its meeting on 18th September. • **Approve** the Mobile Phone Policy as amended (Appendix 1),

Section 3 – Details of the Review:	
Background:	
Reason for review	New policy developed to replace Black 123, Velindre NHS Trust Staff Mobile Phone Policy
Description/Assessment	The policy will ensure that the use of Public Health Wales mobile devices are used securely, efficiently and responsibly to protect organisations assets, sensitive information and the privacy of employees. This policy outlines the standards and expectations for the use, management, and safeguarding of all devices issued by or used for business purposes. All employees and authorised users are required to adhere to this policy to maintain the integrity, confidentiality, and availability of corporate resources. Public Health Wales will provide the necessary support, training, and resources to enable compliance with this policy and will regularly review and update it to reflect evolving security risks and business needs. By using a Public Health Wales device, users acknowledge their responsibility to comply with this policy and contribute to a secure and productive working environment.
Consultation	
Has this Policy / Procedure been through the appropriate 28 day consultation process?	Yes
Date range of consultation:	07 July 2025 – 05 August 2025
Please provide details of any feedback received and outline what changes if any were made to the document as a result:	Comments were received from IT and Information Governance staff. All feedback was reviewed, and the document was subsequently updated to reflect all of the input provided.
(Add detail)	IT comments received: Additions to policy:

	• Corporately owned smartphones must be managed via "Intune" or "Apple business" (mobile device management). • Hardware that has reached end of life must be returned for decommissioning. (EoL - no further security or operating systems updates) • Any operating system or security update must be applied to devices as soon as reasonably possible to maintain compliance, any non-compliant devices may be disabled. • No Additional applications are to be installed to the mobile devices outside of business requirements, any new applications must be authorised by IT. • No sensitive information should be stored on mobile devices. • Corporately owned and managed devices are monitored for security purposes. Possible updates/ changes: • **Security Requirements** - The current advise for mobile device inactivity lock period is 5 minutes, consider reducing this to 2- or 1-minute lock period • **Data Usage and Connectivity** - It may be worth while expanding on the advice of connecting to "trusted" networks - how would a user know if the network is trusted or not? I'd maybe advise only connect to known, trusted networks (such as home). **Information Governance comment received:** 'The document in Para 8 under Prohibited Use says 'The use of mobile phones, or other hand-held devices is not permitted whilst driving and all users are advised that for safety reasons hands free use is not endorsed by the Trust.' This is sending out mixed messages particularly in light of the Safe Driving at Work Procedure which states 'Although hands free can be used when driving it is important to consider if the road conditions are such that it is safe to do so.''
Had this policy / procedure been considered by any other groups?	Leadership Team considered the policy at its meeting on 18th September 2025.

If so, please provide detail of any comments / feedback or amendments made to the documents as a result of this	N/A

Section 4: Impact Assessments	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment has been completed and found there to be no negative impact.
Welsh Language Impact	The Policy / Procedure will be translated to welsh and available on the internet bilingually.
Risk and Assurance	N/A
Health and Social Care (Quality and Engagement) (Wales) Act	N/A
Financial implications	N/A
People implications	N/A
Socio Economic Duty	N/A

Section 5 - Implementation

Implementation plan (with timescales)		
Next steps	Timescale	Responsible officer(s)
Operations and Finance Executive sign off	TBC	Angela Williams
Leadership Team endorsement	Sept 2025	BBU
Quality, Safety and Improvement Committee approval	Sept 2025	BBU

Section 6 – Dissemination

The primary source for dissemination of the Mobile Phone Policy within the organisation, wider community and our partners will be via the internet site.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Reference Number:** xxxx **Version Number:** xxx **Date of next review:** xxx

PUBLIC HEALTH WALES MOBILE DEVICES POLICY

Policy Statement

The purpose of this policy is to outline the procedures and arrangements relating to provision and management arrangement of Public Health Wales mobile devices, and to define the responsibilities of managers and employees in relation to the provisioning of devices and their appropriate use.

Policy Commitment

This Policy will ensure that the use of Public Health Wales mobile devices are used securely, efficiently and responsibly to protect organisations assets, sensitive information and the privacy of employees. This policy outlines the standards and expectations for the use, management, and safeguarding of all devices issued by or used for business purposes.

All employees and authorised users are required to adhere to this policy to maintain the integrity, confidentiality, and availability of corporate resources. Public Health Wales will provide the necessary support, training, and resources to enable compliance with this policy and will regularly review and update it to reflect evolving security risks and business needs.

By using a Public Health Wales device, users acknowledge their responsibility to comply with this policy and contribute to a secure and productive working environment.

Supporting Procedures and Written Control Documents

All corporate policies and procedures are available on the Public Health Wales website

This section is to list the following:

- Underpinning procedures, and what they describe
- Identify interdependencies with other policy/control documents.

Other supporting documents are:

- Low voltage electrical safety and electrical equipment procedure
- Information security policy
- Safe driving at work policy

Scope

All Public Health Wales owned mobile devices are in the scope of this policy, including all types and models of devices.	
Impact Assessments	An Equality and Health Impact Assessment has been completed.
Approved by	Quality, Safety and Improvement Committee
Approval Date	TBC
Review Date	TBC
Date of Publication:	TBC
Group with authority to approve supporting procedures	Leadership Team
Accountable Executive Director/Director	Angela Williams, Interim Executive Director of Operations and Finance
Author	Zara Walker, Project Support Manager

Summary of reviews/amendments				
Version number	**Date of Review**	**Date of Approval**	**Date published**	**Summary of Amendments**

1 Introduction

This document sets out Public Health Wales policy concerning the allocation and use of corporate owned mobile phones, tablets, MiFi and Wi-Fi dongles and wireless devices (together termed and referred to as 'mobile devices' for the purposes of this policy) issued to staff. Staff issued with corporate mobile devices are referred to as 'Users' in this document. Further clarification on any points can be obtained by emailing the PHW Mobile Devices inbox (PHWMobileDevices@wales.nhs.uk).

2 Scope

All Public Health Wales owned mobile devices are in the scope of this policy, including all types and models of devices. For clarification, this policy does **not** extend to personal or non-corporate mobile devices, even if they are used on Public Health Wales premises or for PHW business related activity.

3 Definitions

Network data: Data transferred over the cellular network (3G, 4G or 5G). Data used over Wi-Fi (wireless) network does NOT count as cellular data.

Data roaming: Data roaming occurs when using network data outside of the United Kingdom.

4 Criteria for issue of corporate mobile devices

Public Health Wales will only issue a mobile device where there is a clear business requirement, dictated by the requirements of the user's role. It is ultimately at the discretion of their manager, budget holder and Head of Estates or team member with delegated responsibility whether to issue a mobile to a staff member or not. The eligibility of a user for provision of a mobile device should be evaluated against one or more of the following criteria:

- The User is required to be available outside business hours to assist with critical business functions (e.g. responding to emergency situations or 'on-call' service requirements).
- The User is required to regularly make or receive business calls when away from the office.

Mobile devices may be issued on an individual or shared basis (e.g. a screening services 'pool' mobile).

5 Procuring of corporate mobile devices

The Estates team work with the Digital Services department to identify an appropriate mobile devices for distribution. Users can choose to request the following

- a voice/ text only mobile,

- smartphone,
- Wi-Fi / MiFi device
- Networked enabled Tablet

Mobile devices are provided to staff members of Public Health Wales for business use only. The mobile devices and all peripheral equipment leads / chargers etc. remain the property of Public Health Wales and must be returned to the Estates Division if the device is upgraded, withdrawn, or on termination of employment. Spare chargers and protective screens / covers will not be provided but can be purchased by individuals. For Health & safety reasons replacement chargers will be provided for damaged chargers in line with section 5.12 of the Low Voltage and Electrical Equipment Procedure.

Devices that have reached the end of their working life must be returned for decommissioning in line with section 2.12 of the Information Security Policy.

6 Requesting a mobile device

All requests for mobile devices must be submitted using the Mobile Device Request Form, which is available on the Facilities team's intranet page. Each request will be assessed individually, with the justification for the device evaluated against established criteria. Requests that do not meet these criteria may be declined. This process supports Public Health Wales' commitment to sustainability and cost-effectiveness and effective resource management.

7 Mobile device options

When a new mobile device is purchased, a one-off purchase cost will apply. The cost of devices will vary depending on the model. In addition, each device will incur a monthly connection charge, which may fluctuate from month to month. For up-to-date information on current one-off and monthly costs, please email the PHW Mobile Devices inbox (PHWMobileDevices@wales.nhs.uk).
To support Public Health Wales' commitment to sustainability, mobile devices that are returned and deemed fit for reuse will be reset to factory settings (all data will be securely erased) and made available to fulfil new device requests. Devices reissued in this way will **not** incur the one-off purchase charge.
Where necessary, mobile devices may be replaced due to business requirements or changes in technology. In such cases, the cost of the replacement device will be charged to the user's cost centre.

7.1 Voice and text only mobile phone

The user will be provided with a basic mobile phone device which will only allow incoming and outgoing calls and text messages. Users must ensure there is a security lock (e.g., PIN or password) to gain access to the device. Requests for specific brands or models cannot be accommodated. However if a user has any specific accessibility need they should advise the Estates Division at the time of requesting a device and alternative model / brand options will be looked at.

7.2 Smartphone

Users will be issued a smartphone that has been selected by the Estates and IT departments based on compatibility, functionality, and business needs. Requests for specific brands or models cannot be accommodated. However if a user has any specific accessibility need they should advise the Estates Division at the time of requesting a device and alternative model / brand options will be looked at.

Users are required to implement a security lock (e.g., PIN or password) to restrict access to the device. All users must follow the provided setup instructions to ensure the device is configured securely in accordance with organisational security standards.

7.3 Wi-Fi device

An appropriate device will be issued to users by the Estates Division. Please note that users are not able to select the brand or model of the device provided.

The Estates Division does not retain or manage device passwords for users. It is the responsibility of the user to securely store and manage their device password to ensure continued access and security of devices.

7.4 Tablet

Tablet requests will be reviewed by the Digital Services team to determine if a device can be issued. If approved, an appropriate device will be provided by IT; however, users cannot select the brand or model of the device. However, if a user has any specific accessibility need they should advise the Estates Division at the time of requesting a device and alternative model / brand options will be looked at.

If mobile data is required on the tablet, a 'data-only' sim card can be requested by emailing the PHW Mobile Devices inbox (PHWMobileDevices@wales.nhs.uk). Please note, a monthly connection fee applies to the sim card.

8 Mobile device usage

Mobile devices issued by Public Health Wales are strictly only to be used for work-related communication and business purposes. Corporately owned and managed devices are monitored for security purposes.

Prohibited Use

The use of, or subscription to, premium or interactive mobile services is not permitted. This includes, but is not limited to, downloading or streaming videos, TV services, or similar non-work-related content. Misuse of a device may result in the provision of a device being removed or temporarily suspended. Any and all associated costs incurred as consequence of prohibited use will be the responsibility of the user and the Trust may seek to reclaim such costs.

Although hands free can be used when driving it is important to consider if the road conditions are such that it is safe to do so, as referenced in the safe driving at work policy.

Security Requirements

Corporately owned smartphones must be managed via "Intune" or "Apple business" (mobile device management).

All mobile devices must be secured with a strong password or PIN. The current advise for mobile device inactivity lock period is 5 minutes, consider reducing this to 2- or 1-minute lock period. Users must take appropriate steps to protect the confidentiality of conversations, especially in public places. If you're unable to ensure privacy (for example, while on public transport or in public spaces) it is recommended to delay the call until you are in a more secure environment.

Voicemail Use

Relevant mobile devices are equipped with voicemail to ensure messages can be received when you're unavailable. If you change your voicemail greeting, it should include a clear and professional message.

Data Usage and Connectivity

If you're using a data-enabled device (e.g., smartphone or tablet), it is recommended that you connect to known, trusted Wi-Fi networks when available to reduce mobile data usage.

Sim Card Policy

The sim card provided with your mobile device must not be removed or transferred to another device. Doing so may result in significant security risks, particularly if the device holds confidential or sensitive information.

9 Roaming abroad

Roaming is disabled by default on all Public Health Wales mobile devices.

If you are required to work abroad and need roaming activated for business purposes, you must contact the Estates Division as early as possible, and no later than seven working days before the departure date. Requests submitted with less than seven working days notice may result in delays in activating the roaming service, which could render the device unsuitable for use while abroad.

9.1 Requesting roaming abroad

All roaming requests must be emailed to the PHW Mobile Devices inbox (PHWMobileDevices@wales.nhs.uk). To ensure your request is processed promptly, please include the following information:

- **Name:**
- **Directorate & Division**
- **Mobile phone number:**
- **Date of arrival:**
- **Date of return:**
- **Country you are visiting:**
- **Budget Holder for the device:**
- **Business justification for roaming:**
- **Confirmation of approval of budget holder roaming request to be made:**

Failure to provide this information will cause delays in processing the request.

Each request will be reviewed on a case-by-case basis by the Estates Division and must be approved by the relevant budget holder. Final approval will be sought from the Operations and Finance Directorate Executive or their nominated deputy – in the event of either being unavailable the decision will rest with the Head Estates or their nominated deputy. The outcome of all requests received will be communicated to both requesting user and the approving budget holder.

If approved, roaming will be activated only for the specified travel dates. Roaming services will be deactivated on the date of the user's return. A new request must be submitted for any subsequent aboard visits requiring roaming. Users should not assume that roaming will be left enabled for the device.

It is the responsibility of the user if roaming is approved to ensure that on arrival at an overseas destination they correctly connect to the appropriate contracted roaming network. All additional costs incurred for roaming will be charged to the user's cost centre.

All users intending to travel outside of the should ensure that they are familiarise themselves with the Public Health Wales Business Travel Policy phw.nhs.wales/about-us/policies-and-

procedures/policies-and-procedures-documents/corporate-governance-communications-and-finance-policies/business-travel-policy/

10 Responsibilities

10.1 User responsibilities

Users who are issued with a mobile device are responsible for:

- Complying fully with all relevant legislation, this policy and all related Public Health Wales policies relevant to mobile device use.
- Any operating system or security update must be applied to devices as soon as reasonably possible to maintain compliance, any non-compliant devices may be disabled.
- Appropriately securing the device and all information held on it.
- No Additional applications are to be installed to the mobile devices outside of business requirements, any new applications must be authorised by IT.
- No sensitive information should be stored on mobile devices.
- Deleting information from the mobile device when no longer required or sooner if requested to delete it.
- Public Health Wales' mobile devices must not be used to take photographs of an individual(s) without that individual's consent.
- Users must take reasonable care of the devices they receive.
- Users must notify the Estates Division via PHWFacilities@wales.nhs.uk of any damage relating to a mobile device the loss of any mobile device that results in the device being unusable at the earliest opportunity and no later than 48hrs. of the issue being identified.
- Users must notify the Estates Division via PHWFacilities@wales.nhs.uk of the loss of any mobile device at the earliest opportunity and no later than 48hrs. of the loss being identified.
- Users must not pass their mobile device to other staff members due to security reasons. At the end of their lifecycle, devices must be returned to the Estates Division to either be reissued or securely decommissioned.

- If the user no longer requires the mobile device it is their responsibility to notify the Estates Division via PHWFacilities@wales.nhs.uk to cancel the contract to prevent reoccurring monthly charges being incurred.

10.2 Line Managers responsibilities

It is the responsibility line manger of any the user of a mobile device to check and ensure the mobile device is returned along with other any other Public Health Wales equipment if the staff member is leaving the role. The mobile device should be returned to the Estates Division directly.
If the line manager wishes the device to be reallocated to another staff member the line manger is responsible for informing the Estates Division of the details of the proposed new user so that the appropriate arrangements can be made to make the changes to the devices deployment and management to ensure compliance with Public Health Wales' and NHS Wales Security protocols for Mobile devices. Failure to inform the Estates division as required may lead to the device network connection being suspended until details have been received.

11 Audit and Monitoring

This policy will be reviewed every three years, or sooner as required to ensure relevance to developments in technology.

Equality & Health Impact Assessment for

(Public Health Wales Mobile Devices Policy)

Part 1

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	N/A – No service change
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Operation and Finance / Estates and Facilities Neil Desmond, Head of Estates and Health & Safety
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The objective of this policy is to outline the procedures and arrangements relating to provision and management arrangement of Public Health Wales mobile devices, and to define the responsibilities of managers and employees in relation to the provisioning of devices and their appropriate use.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines	As this is the first formal mobile device policy for Public Health Wales, the following sources of evidence and background information were considered during its development: • **Staff and Service User Data**: Consideration was given to the diverse needs of our staff, including on-call staff, and those with flexible or remote working arrangements. An understanding of varied job roles and technology access levels informed the scope of the policy.

	• participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	• **Needs Assessment**: Informal discussions with staff identified a lack of awareness and understanding around the processes for requesting, issuing, and using mobile phones. This highlighted the need for a clear and standardised policy to ensure consistency, security and accountability. • **Equality Impact Considerations**: The policy was reviewed with attention to accessibility, particularly for staff with disabilities who may rely on assistive mobile technologies. Flexibility was built into the policy to allow for reasonable adjustments. • **Future-proofing Considerations**: The policy is designed to be adaptable to evolving technologies and work practices, with a commitment to regular review and revision based on feedback and technological changes.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service Consider staff as well as the population that the project/change may affect to different degrees.	All Public Health Wales staff that own a corporate mobile device.

Part 2- Equality and Welsh language

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	**Recommendations for improvement/ mitigation/ identified gaps or opportunities**
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term	Consideration to both positive and negative impacts has been taken and there is no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	Recommendations for improvement/ mitigation/ identified gaps or opportunities
medical conditions such as diabetes			
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.4 People who are married or who have a civil partner.	Consideration to both positive and negative		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	Recommendations for improvement/ mitigation/ identified gaps or opportunities
	impacts has been taken and there is no impact.		
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.7 People with a religion or belief or with no religion or belief.	Consideration to both positive and negative impacts has been taken and there is no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	**Recommendations for improvement/ mitigation/ identified gaps or opportunities**
The term 'religion' includes a religious or philosophical belief			
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.9 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.10 People according to where they live:			

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps**	**Action taken by Directorate.** Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	**Recommendations for improvement/ mitigation/ identified gaps or opportunities**
Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.11 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Consideration to both positive and negative impacts has been taken and there is no impact.		
6.12 Welsh Language			
There are 2 key considerations to be made during the development of a policy, project, programme, service to ensure there are no adverse effects and/or a positive or increased positive effect on: (please note these will continue to be reviewed to ensure Public Health Wales fulfils their duties to comply with one or more standards outlined within the Welsh Language Standards (No 7) Regulations 2018)			
Opportunities for persons to use the Welsh language	Consideration to both positive and negative impacts has been taken and there is no impact.		

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts (unintended consequences) Opportunities or gaps	Action taken by Directorate. Make reference to where the mitigation is included in the document, as appropriate **This column is to be updated in future reviews**	Recommendations for improvement/ mitigation/ identified gaps or opportunities
Treating the Welsh language no less favourably than the English language	Consideration to both positive and negative impacts has been taken and there is no impact.		

Part 3 – Health

Questions in this section relate to the impact on the health and wellbeing outcomes of the population **and** specific population groups who could be more impacted than others by a policy/project/proposal.

The part of the assessment identifies;

- which specific groups in the population could be impacted more (inequalities)
- what those potential impacts could be across the wider determinants of health framework?
- Potential gaps, opportunities to maximise positive H&WB outcomes
- Recommendations/mitigation to be considered by the decision makers

7. Identification of specific population groups

Use the WHIASU Population Groups checklist as a reference to identify the population groups who could be more impacted than others by a policy/project/proposal. The check list can be found on the PHW Integrated EqHIA guidance pages (requires link to PHW Intranet pages for additional information and resources)

The groups listed have been identified as more susceptible to poorer health and wellbeing outcomes (health inequalities) and therefore it is important to consider them in a HIA assessment. In a HIA, the groups identified, as more sensitive to potential impacts will depend on the characteristics of the local population, the context, and the nature of the proposal itself.

7.1 Groups identified	Rational/explanation
No groups have been identified	

Assessment

Complete the wider determinants framework table below providing rational/evidence where appropriate:

1. Consider how the proposal could impact on the population and specific population groups identified above (positive/negative) for each of the wider determinants (the bullets under each determinant are there as a guide)
2. Record any unintended consequences (negative impacts) and/or gaps identified
3. Record any positive impacts or missed opportunities to maximise positive health and wellbeing outcomes
4. identify and record mitigation/recommendations where appropriate

Please note you may find that not all determinants are relevant to the project/plan however recording N/A is not acceptable a rational or evidence should be explained/referenced

Wider determinant for consideration	Positive impacts or additional opportunities	Unintended consequences or gaps	Population groups affected	Mitigation/recommendations
7.2 Lifestyles • Diet/nutrition/breastfeeding • Physical activity • Use of alcohol, cigarettes, e-cigarettes • Use of substances, non-prescribed drugs, abuse of prescription medication • Social media use	Consideration to both positive and negative impacts has been taken			

• Sexual activity • Risk-taking activity i.e. gambling, addictive behaviour	and there is no impact.			
7.3 Social and community influences on health • Adverse childhood experiences • Citizen power and influence • Community cohesion, identity, local pride • Community resilience • Domestic violence • Family relationships • Language, cultural and spirituality • Neighbourliness • Social exclusion i.e. homelessness • Parenting and infant attachment • Peer pressure • Racism • Sense of belonging • Social isolation/loneliness • Social capitol/support/networks • Third sector & volunteering	Consideration to both positive and negative impacts has been taken and there is no impact.			
7.4 Mental Wellbeing • Does this proposal support sense of control? • Does it enable participation in community and economic life? • Does it impact on emotional wellbeing and resilience?	Consideration to both positive and negative impacts has been taken and there is no impact.			
7.5 Living/ environmental conditions affecting health • Air quality • Attractiveness/access/availability/quality of area, green and blue space, natural space. • Health & safety, community, individual, public/private space	Consideration to both positive and negative impacts has been taken and there is no impact.			

• Housing, quality/tenure/indoor environment • Light/noise/odours, pollution • Quality & safety of play areas (formal/informal) • Road safety • Urban/rural built & natural environment • Waste and recycling • Water quality				
7.6 Economic conditions affecting health • Unemployment • Income, poverty (incl. food and fuel) • Economic inactivity • Personal and household debt • Type of employment i.e. permanent/temp, full/part time • Workplace conditions i.e. environment culture, H&S	Consideration to both positive and negative impacts has been taken and there is no impact.			
7.7 Access and quality of services • Careers advice • Education and training • Information technology, internet access, digital services • Leisure services • Medical and health services • Other caring services i.e. social care; Third Sector, youth services, child care • Public amenities i.e. village halls, libraries, community hub • Shops and commercial services Transport including parking, public transport, active travel	Consideration to both positive and negative impacts has been taken and there is no impact.			
7.8 Macro-economic, environmental and sustainability factors • Biodiversity • Climate change/carbon reduction/flooding/heatwave	Consideration to both positive and negative impacts has been taken			

• Cost of living i.e. food, rent, transport and house prices • Economic development including trade • Government policies i.e. Sustainable Development principle (integration; collaboration; involvement; long term thinking; and prevention) • Gross Domestic Product • Regeneration	and there is no impact.			

Stage 3
Summary of key findings and actions Please answer question 8.1 following the completion of the EHIA and complete the action plan

Key findings: Impacts/gaps/opportunities	Actions (what is needed and who needs to do) to address the identified mitigation and recommendations	Lead		
Consideration to both positive and negative impacts has been taken and there is no impact.				

Alternatively, if appropriate, please explain the steps taken to consult with and consider the differential impact of the changes on the various protected characteristic groups (part 2) or any specific identified population groups (part 3).

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *3.3*

Quality and Clinical Audit End of Year Report 2024-25 and Audit Plan 2025-26	
Executive lead:	Claire Birchall, Executive Director of Nursing, Quality, and Integrated Governance.
Author:	Paula Mitchell, Quality and Clinical Governance Manager

Approval/Scrutiny route:	Leadership Team - 21/08/25

Purpose

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with an end of year report for the 2024-25 Annual Quality and Clinical Audit Plan. The Plan contains both National (UK and Welsh) audits (externally determined) and Local audits (internally determined), and this paper includes analysis of the completed audits.

This paper also outlines the 2025-26 Annual Quality and Clinical Audit Plan for approval from Quality, Safety and Improvement Committee.

Recommendation

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☒	☐	☐	☐	☒

The Quality, Safety and Improvement Committee is asked to:

- **Receive assurance** on the progress made against the Quality and Clinical Audit Plan for 2024-25
- **Approve** the Quality and Clinical Audit Plan for 2025-26

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	An equality and health impact assessment is not required as there is no impact on policy or decisions relevant to Race, Disability and Gender duties.
Risk and Assurance	Welsh Government expects that all NHS Wales organisations participate in both quality and clinical audit. Healthcare organisations are required to have a cycle of continuous quality improvement that includes clinical audit in line with the Duty of Quality.
Health and Social Care (Quality and Engagement) (Wales) Act	Quality and Clinical Audit is one of the key tools for ensuring service delivery is in line with ALL Quality Standards.
Financial implications	There are no anticipated financial implications however should equipment or resources be identified following audit this may incur additional financial expenditure.
People implications	There is no anticipated impact on the workforce of Public Health Wales, however, should resources be identified following audit this may impact workforce capacity.

1. Purpose / situation

The purpose of this paper is to provide the Quality, Safety and Improvement Committee (QSIC) with the end of year report for the 2024-25 Annual Quality and Clinical Audit Plan ('the Plan').

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 as part of clinical and quality governance frameworks. The priorities reflect a combination of both local and national audits which are listed in the table below (Table 1):

Type of Audit	**Number**
National Audits	7
Audits identified based on Risks –	12* (*NB 7 are in relation to consent audits carried out by screening programmes)
NICE Guidance (including Technology Appraisals, Interventional Procedures and Guidelines)	0
Local Policy Audits Care Pathways/Local Guidelines Audits	60

Table 1

Key to Audit Priority levels (Table 2):

Priority Level	**Description**
Priority 1	External/National - Must do audit
Priority 2	Internal Must do audit
Priority 3	Divisional priority audit
Priority 4	Staff member led project

Table 2

For further information of the classification of audit priority levels please refer to the Quality and Clinical Audit Procedure V2.2.

This paper provides further detail on the status of all the audits included in the 2024-25 Plan, as well as an analysis of the nature of the audit activity undertaken.

The results and work achieved against the 2024-25 Plan have informed the 2025-26 Annual Quality and Clinical Audit programme. A summary of the number of proposed audits from each area is outlined within this paper. This paper will also provide an update on the

organisational implementation of the Audit Management and Tracking System (AMaT) procured in 2024-25.

2. Background

Clinical Effectiveness is a key quality domain, ensuring that the provision of care is in accordance with high quality, evidence-based clinical guidelines. The evaluation of practice using Clinical Audit or outcome measures can lead to further improvement in both quality of care and service provision.

Quality and Clinical audit is therefore an essential tool for quality assurance and improvement in healthcare, allowing for assessment and benchmarking against national standards, to ensure minimum requirements / standards are being met, identifying gaps, developing action plans to ensure compliance and driving sustained improvements. This is a key requirement within 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.
- Ensure learning from audit is embedded

Each year an annual audit work plan is created, with all the planned audit activity being collated into one master document reflecting both national and local audit activity overseen by the Quality and Clinical Audit Lead based in the Nursing, Quality and Integrated Governance Directorate (NQIG).

Due to the diversity of work within Public Health Wales there is also quality and clinical audit activity that is not currently reflected in the Quality and Clinical Audit Plan, such as Infection Services audits, Infection Prevention and Control and Health & Safety audits. These are reported elsewhere within the organisation. A summary of this additional audit activity is provided within the paper.

3. Description/Assessment

3.1 Summary of Audit Activity

In 2024-25 there were 7 external audits, and 60 internal audits included in the Plan. Figures 1 and 2 below, summarise the status of these audits:

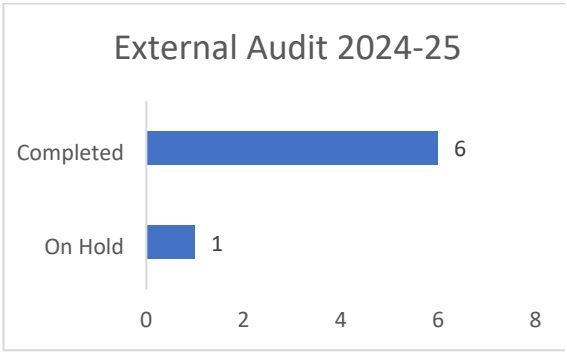


Figure 1: External Audit Activity

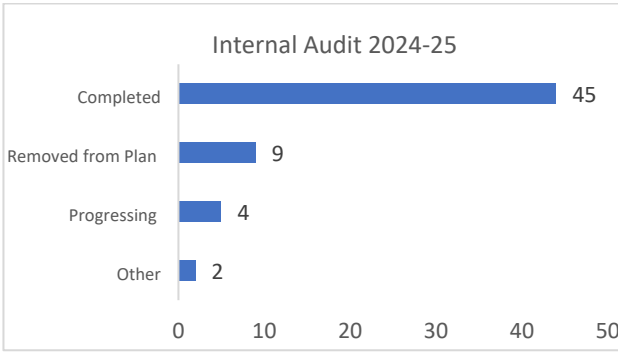


Figure 2: Internal Audit Activity

An interim paper submitted to Senior Leadership Team and Quality Safety Improvement Committee in December 2024 saw the removal of 3 audits from the approved 2024-25 plan. A further 6 audits have been removed from the plan. Information detailing the rationale for removal and any associated risks are shown in Table 3 below

Programme	Audit	Priority level	Summary	Potential Risks associated with withdrawal
Bowel Screening Wales Removal Approved Nov 24	Re-Audit CT Colonoscopy Quality Assurance Audit	3	An alternative to a Colonoscopy is CT Colonoscopy (CTC). A recommendation to audit was made by a previous Quality Assurance Advisor (QAA) post holder to ascertain if the correct criteria for referral for this procedure was being met. The QAA position has not been filled for some time and in the 2023-24 Plan, the Report of Findings submitted was found to be a Quality Assurance Report with high level information. No analysis had taken place or learning or action plan in place. Discussed with BSW	There is risk attributed to the removal of this audit, as no analysis is currently being undertaken to ensure the right participants are being referred for CTC. This impacts the Health and Care Quality Standards of Safe, Timely, and Efficient. This is because there is no QAA to undertake this work.

			and decision made to request removal from Plan for 2024-25. BSW will continue to provide the QA reports to their leadership team for review and analysis at programme/ divisional level.	
Breast Test Wales Removal Approved Nov 24	Non-operative diagnosis rate for non-invasive cancer	3	Report of findings analysis and learning was undertaken after the re-audit was added to the plan. Discussed at LT in July 24, approved for removal.	No risk. Audit findings were good, plan to re-audit in the future.
New-Born Hearing Screening Removal Approved Nov 24	Re-audit of Referrals for Diagnostic Hearing Assessment Following Automated Auditory Brainstem Response (AABR) Screening	3	Report of findings analysis and learning was undertaken after the re-audit was added to the plan. Discussed at LT in July 24, approved for removal.	No risk. Audit findings were good, plan to re-audit in the future.
Bowel Screening Wales Removed from plan Q4	Ceased No Functioning Colon Audit - SSP	3	SOPs changes in Feb 25. Audit not undertaken to allow changes to embed before auditing.	No risk. Has been added to 2025-26 Plan.
Breast Test Wales Removed from plan Q4	Breast Care Nursing Service User Experience Audit. Location to be confirmed	3	Due to staffing constraints this audit was unable to take place. New audit lead nominated late Q4, plan for audit to be completed in 2025-26.	No risk.

Diabetic Eye Screening Removed from Plan Q4	GREG External Audit – Image Capture for Retinal Photographers	3	Due to change of equipment within the programme, this audit was removed. New equipment/ standards to be audited in 2025-26 Plan.	Some risk attributed to removal of this audit but will be rectified with new audit in 2025-26.
Diabetic Eye Screening Removed from Plan Q4	Audit of primary and secondary grading of all participants who were primary graded as R0M0	3	Removed from plan due to operational changes within the programme. No requirements to audit.	No risk. To add new standards for audit to 2025-26 Plan.
Diabetic Eye Screening Removed from Plan Q4	Letters and Leaflets Audit	3	Work is ongoing with the Behavioural Insights team to review all letters. Need to engage service users in this work. Due to these requirements to be removed from plan.	No risk associated.
Health Protection Removed from Plan Q4	Quality Audit of the Improvement to Quality Objectives and Governance.	2	Due to wider piece of work being undertaken for Directorate wide governance structure review, led by Deputy Head of Ops.	No risk associated.

Table 3: Update of Audit Removed from Plan

3.2 Analysis of Audit with Outstanding Activity and Identified as 'Other'

Area	Description	Priority Level	Rationale
Progressing –	Audit of SOPs Guidance Implementation	3	Due to competing work pressures within areas to be audited. Rolled into Q1 for 2025-26 Plan, report due by Sep 25.

Nursing, Quality and Integrated Governance			
Progressing – People and Organisational Development	Fixed Term Contracts	4	Audit has commenced, but auditor is having difficulty obtaining data responses from Line Managers to complete audit activity. Advice also given to increase sample size to ensure audit findings can be generalised. Added to Plan for 2025-26.
Progressing – People and Organisational Development	Sickness Absence Management	4	Audit has commenced, but auditor is having difficulty obtaining data responses from Line Managers to complete audit activity. Advice also given to increase sample size to ensure audit findings can be generalised. Added to Plan for 2025-26.
Progressing – People and Organisational Development	DBS Reaudit	2	Due to delays in recruitment and staff absence, audit has been commenced. Currently reviewing data, with plans for report to be finalised by Jul 25.
Other – Breast Test Wales	Consent Audit	1	Audit has not followed All Wales/ PHW Template with insufficient sample size, therefore not able to ratify results. This audit will be completed in Q3 of 2025-26.
Other – Wales Abdominal Aortic Aneurysm Screening	Consent Audit	1	Audit not undertaken in Q3 of 2024-25. Discussed with programme and this audit has been completed in Q1 of 2025-26. This also will be repeated in Q3 of 2025-26 as per All Wales/ PHW direction.

Table 4: Analysis of Audit with Outstanding Activity

3.3 Analysis of Completed Audit and Submission of Report of Findings

There has been as increase in the number of audits completed this year however, there has also been an improvement in the number of final audit reports received at year end. The quality and clinical audit team continue to follow up with services and teams to ensure reports are submitted. Greater emphasis and oversight will be given in the coming year to ensure the completion and timely return of final audit reports. The number of deferred audits has reduced this year compared to the previous year. Table 5 below highlights the overall audit performance compared to previous years.

Internal Audit Activity	2024-25	2023-24	2022-23	2021-22
Completed audits	45 (75%)	31 (78%)	23	16
Audit reports received	26 (58%)	14 (45%)	11 (48%)	14 (88%)
Number of audits deferred to next reporting year	0	1	2	6
No of audits progressing but delayed at year-end	4	1	6	4

Table 5: Internal Audit Completion Activity

3.4 Summary of Audit Activity by Area

The following section summarises the key audit figures by Directorate and Divisions detailing service areas and specialties.

As seen within Table 6 below (page 10) the areas undertaking Quality and Clinical Audit in 2024-25 are predominantly Health Protection and Screening Services, Nursing Quality and Integrated Governance, along with Policy and International Health directorates. Following engagement activity across the organisation further audit activity has been identified within the Vaccine Preventable Disease Programme, People and Organisational Development.

	Externally reported (National)		Internally reported (Local)				
	Status						
Programme/ Division	Completed	Ongoing/ On Hold	Completed	Progressing (as per original time frame)	Progressing (end date delayed)	Removed from plan)*	Other**
Antenatal Screening Wales			1 (PL3)				
Bowel Screening Wales			1 (PL1) 2 (PL2) 5 (PL3)			2 (PL3)	
Breast Test Wales		1 (PL1)	1 (PL2) 2 (PL3)			2 (PL3)	1 (PL1)
Business & Planning, Policy and International Health			1 (PL3)				
Cervical Screening Wales		1 (PL1)	1 (PL1) 2 (PL2) 5 (PL3)				
Diabetic Eye Screening Wales			1 (PL1) 6 (PL2) 1 (PL3) 3 (PL4)			3 (PL3)	
Health and Well-Being			1 (PL1)				
Health Protection - Operations	4 (PL1)		2 (PL2)			1 (PL2)	
Health Protection - VPDP			1 (PL3)				
Newborn Screening	1 (PL1)		1 (PL1)			1 (PL2)	

			2 (PL3)				
Screening Pathway Administration			2 (PL3)				
Nursing, Quality and Integrated Governance			3 (PL2)		1 (PL2)		
People and Organisational Development					1 (PL2) 2 (PL4)		
Wales Abdominal Aortic Aneurysm Screening			1 (PL1)				1 (PL1)
Total	**5**	**2**	**45**	**0**	**4**	**9**	**2**

*Table 6: Summary of all quality and clinical audits as of 31 March *See analysis in Section 3.1/ Table 3 **See analysis in Section 3.2/ Table 4*

In summary, 6 out of 7 Public Health Wales directorates are represented in the annual audit 2024-25 plan. The Quality and Clinical Audit team are actively engaging across the organisation to identify areas where audit activity is taking place but has not been reported, so this activity can then be included in the plan.

4. Annual Quality and Clinical Audit Plan 2023-24: Analysis

4.1 2024-25 Audit Plan Categories Type

The table below outlines the categories and origins of the internal audits in the 2024-25 Plan. It indicates the domains of quality that these audits are aligned to, demonstrating how these can be used to provide quality assurance. This particularly relevant to assist PHW in ensuring it is meeting its legislative requirements in line with the Duty of Quality (Table 7).

Audit Category	No of Audits Per Category	Origin	Domains of Healthcare Quality
Administration	1	To review SOPs across programmes to baseline and agree standardisation	Safe, Timely, Efficient, Person-Centred
Business Support/ IT	1	Reviewing leavers x1 local procedures	Timely, Effective, Efficient
Clinical Audit	16	Monitoring compliance with procedures x 15 Never Event x 1 (historic, ongoing audit following NE)	Safe, Timely, Effective, Efficient, Person-Centred
Compliance	18	National Standards x 3 – Professional Reg, DBS National Standards x 4 – Smoking Cessation, Radiation, Bowel Screening National Guidance x 6 – Consent NICE x 1 – Pregnancy in Diabetic Patients Baseline Activity x 1 – to gather information to develop a Standard Organisational Procedure x 1 Local procedure x 2	Safe, Timely, Efficient, Effective, Equitable, Person-Centred
Documentation	3	Professional documentation requirements x 1 Programme guidelines being followed x 1 Programme Letters and Leaflet Templates x 1	Safe, Timely, Efficient, Effective
Experience	1	Understand the views of service users to improve services x 1	Person-Centred
Governance	1	Monitoring application of Contributory Factors of reported incidents x 1	Safe, Timely, Effective, Efficient, Equitable, Person-Centred
Improvement Audit	1	Baseline audit to inform new procedure x 1	Safe, Timely, Effective, Efficient, Equitable, Person-Centred
Operational	3	Monitoring compliance with local procedures x 5	Safe, Timely, Effective, Efficient, Equitable, Person-Centred

Pathway – Admin Pathway	1	Monitoring compliance with procedure x 1	Safe, Timely, Person-Centred
Pathway – Clinical and Admin Pathway	1	Monitoring compliance with procedure x 1	Safe, Timely, Effective, Efficient
Process Audit	4	Monitoring compliance with process/ procedure x 2	Safe, Timely, Effective, Efficient
Quality Audit	12	Monitoring compliance with Policy x 1 Monitoring compliance with National Policy x 1 Monitoring compliance with local procedures x 5 Monitoring compliance with Quality Manuals x 3 Monitoring compliance with national recommendations x 1 Baseline Audit to establish feedback x 1	Safe, Timely, Effective, Efficient, Equitable, Person-Centred

Table 7: Analysis of Audit by Origin and Quality Domain

5. Additional audit activity in 2024-25 in PHW

5.1 Infection Services

As part of ongoing accreditation to International Organisation for Standardisation standards (ISO 15189: 2012) and regulatory compliance, Infection Services adheres to a strict scheduled audit programme. Each laboratory follows a timetable that ensures every test in the scope of accreditation has a vertical audit performed to ensure compliance to ISO 15189:2012 clauses on a four-year rolling basis. As tests are added to the scope of Infection Services, the tests will be added to the schedule. These can also be performed ad hoc to help with implementation of a new test.

All laboratories also perform local scheduled audits according to a four-year rolling plan. The Infection Services Quality Team also have an audit manager that performs a quality management audit for every laboratory. This is to check that they are adhering to the quality management system (QMS). PHW Infection Services also perform intermittent 'business resilience audits' on their large suppliers.

Audit reports are prepared monthly for discussion at the Infection Services network quality meeting. Audits findings are reviewed, non-compliances issues/items are examined and overall performance across the network compared to identify themes and trends.

5.2 Facilities and Estates Health and Safety Audits

There is an ongoing audit programme whereby premises where PHW staff are tenants or hosted with a Health Board are audited. These audits primarily focus on compliance to the Workplace (Health, Safety and Welfare) Regulations 1992, but additionally focus on several Estates related statutory regulations e.g., Regulatory Reform (Fire Safety) 2005, Control of Asbestos Regulations 2012 etc. Quarterly updates are provided to the Quality, Safety and Improvement Committee as part of the Health and Safety Report to ensure they are sighted on actions undertaken across the organisation.

5.3 Infection Prevention and Control (IPC)

For 2024-25 there has been excellent engagement and compliance from the screening leads and teams in the IPC audit process. There are two key performance indicators audited for screening. Environmental audits at PHW-managed static sites are conducted quarterly, with Health Board-based sites audited annually, and hand hygiene audit results are collated and submitted quarterly. These audits are discussed, and any non-compliance issues identified at the quarterly Screening Leads IPC meeting and then shared with the quarterly corporate IPC group meeting. These audits are also referenced in the quarterly Quality Governance and performance report which goes to Quality, Safety, and Improvement Committee.

6. Annual Quality and Clinical Audit Plan 2025-26

6.1 Audit Plan Development

At the start of the financial year 2025-26, 7 external audits have been added to this year's annual plan, 2 of which are "on hold" due to amendments in national standards, with the programmes awaiting further guidance.

58 internally reported audits were identified as suitable to be included in the 2025-26 Plan. There are a number of pending audits that are either awaiting confirmation of start dates or awaiting further guidance and direction by external agencies. The number of proposed internal audits for 2025-26 are detailed below in Table 8:

Division/ Programme	Number	Comments
Antenatal Screening Wales	0	Have been advised audit will be added to the plan once identified
BSW	9	Awaiting confirmation on 2 audits regarding audit timeframes
BTW	5	Awaiting confirmation of 1 audit regarding timeframes
Policy, International Health	0	Prioritising Internal Audit this year
CSW	6	
DESW	14	
Integrated Governance	1	
Health Protection Screening Head of Nursing	1	
Health Protection Operations	2	
Health Protection VPDP	1	
Newborn Hearing Screening	9	
Newborn Blood Spot Screening	2	
POD	3	
Quality and Nursing	1	
Screening Pathway Administration	0	All audits have been disseminated to programmes to carry out
WAAASP	4	

Table 8: Proposed Internal Audits

The opportunity exists to add further audits to the plan throughout the year, and these will be reported in the interim report.

6.2 Planned Engagement activity

A key work objective for the quality and clinical audit programme in 2025-26 is to raise the profile of audit, its benefits and showcasing audit work within the organisation. Planned activity includes introducing audit training, a dedicated intranet page to share resources and promoting audit during the national Clinical Audit Awareness Week in June 2025.

7. Audit Management and Tracking System (AMaT) Implementation Update

In 2021, Audit Wales audited PHW's quality governance arrangements and made several recommendations to support improvements in the coordination of audit work, with the priority being the procurement and implementation of a digital system for all audit activity. In 2024-25, PHW procured AMaT to manage and report audit activity across the organisation.

The system consists of the following modules:

7.1 Ward (Assurance) Module – Planned Activity Feb – Dec 25

This module is utilised for any audit activity that contributes to quality assurance. This audit activity can be undertaken weekly, monthly, quarterly, bi-annually or annually. This allows for comparison of data, and the building and monitoring of action plans. Dashboards are automatically produced with organisational results.

Activity to support the introduction of this module to date

- 2 superusers trained, by 12 Jun 25
- 19 administrators from across the organisation trained, completed by 12 Jun 25. Quality and Clinical Audit (Q&CA) Team working with service administrators and audit leads to identify audit activity relating to assurance and the prioritisation of installing these on the system.
- Q&CA Team working with service administrators configuring site and ward (location) details with the system to enable the identification of audit activity across the organisation. Due to be completed by end of Quarter 3.
- IPC Audits went live on the system from 2 Jun 2025, with link IPC practitioners trained to use the system.
- Training Plan for wider organisational training during Jul/ Aug 2025.

7.2 Clinical Module – Planned Activity May 25 – Mar 26

This module is utilised for Quality and Clinical Audit projects including national audits and local quality and clinical audit. It allows for visibility of non-compliance and areas of future focus across the organisation and potentially direct improvement activity. It easily identifies re-audit activity.

Activity to support the introduction of this module to date

- 2 superusers trained, on 26 Jun 2025.
- Plans for wider organisational training Jul/ Aug 25.
- Q&CA Team identifying with organisational audit leads and register these onto the AMaT system.
- Plan to have Clinical Audit Module fully implemented, with all activity on to the system for end of Quarter 4 2025-26.

7.3 Inspection Module – Planned for Activity Jun – Jul 25

This module will allow PHW to manage all recommendations, information requests, actions and evidence before, during and after inspections. Provides an instant overview, an approval process for actions and evidence completion, links themes and regulation to recommendations and provides notifications and alerts for any overdue activity. The full activity in this module can only be reviewed/managed by superusers and administrators. Prioritisation for this module has been given to staff from the Board Business Unit (BBU) at the present time.

Activity to support the introduction of this module

- 2 superusers trained on the module, due to complete 19 Jul 25.
- 2 staff from BBU trained on module, due for completion by 19 Jul 25.
- Plan for BBU to begin using this module from Quarter 2 2025-26.
- Q&CA Team assisting BBU with the provision of time/ series data for analysis and evaluation of how AMaT has contributed to improved time management within their area of work.
- Q&CA Team working with BBU to identify key user for module and target training.
- Further training activities for wider organisational use of the module by Q3.

7.4 Guidance Module – Planned Activity for Jul – Dec 25

This module ensures that all updated National Institute of Clinical Excellence (NICE) guidance is available for teams and individuals to access. It also allows for local and national policy/ directives such as Patient Safety Alerts, Welsh Health Circulars and many other types of guidance to be uploaded onto the system and managed. This can also be linked with audits and projects on the AMaT system.

This module will be utilised to manage compliance statements and action plans against guidance, providing a dashboard to display progress made allowing teams to manage compliance at a local level. A number of alerts from agencies such as NICE, UK Health Security Agency (UKHSA) and National Patient Safety Alerts are added to the system within 24 hours. It is important to note that not all Welsh Alerts are automatically added to the AMaT system and those that are not will require uploading by PHW staff.

Activity to support the introduction of this module

- 2 superusers will be trained on this module.
- The identification of further users who require training.
- A Briefing Paper is to be submitted to the Quality Oversight Group for information/ oversight and to the Business Executive Team seeking approval for the management of all Alerts, Guidance, within PHW Process mapping session completed to understand current processes for Alerts, Guidance, management and how the organisation receives these.
- Further process mapping required to support full implementation, specifically around the management of those alerts that are not automatically added to the system by AMaT and those from areas such as the UKHSA which may require tight response timescales.

7.5 Risk and Quality Improvement Modules.

The Risk Team and Improvement and Innovation Hub teams have received demonstrations of both these modules and have currently taken the decision not to use these due to the functionality currently available within the modules.

7.6 Morbidity and Mortality Module.

This module is not being utilised by PHW.

Well-being of Future Generations (Wales) Act 2015

The report contributes to Goal 3 “Support the NHS to deliver high quality, equitable and sustainable services”. This below information follows the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

An annual audit plan is conducted to support services to engage in activities to continuously improve by evaluating, developing and implementing innovative ways of working. The plan demonstrates the organisations commitment of continuous improvement

Where possible Public Health Wales seeks to validate the efficacy of its practice and to make continuous improvements. The annual audit plan is integral to supporting this work.

The audit plan impacts a number of the wellbeing goals, including “A Resilient Wales” and “A More Equal Wales”.

The annual audit plan contains work across UK and Wales and includes other NHS bodies working together with Public Health Wales NHS Trust to provide the best outcomes.

The audit plan 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

4. Recommendation

The Quality, Safety and Improvement Committee is asked to:

- **Receive assurance** on the management of audit activity against the Annual Quality and Clinical Audit Plan 2024-25
- **Approve** the Annual Quality and Clinical Audit Plan for 2025-26.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *4.1*

Quality Governance Performance Report Quarter 1 (1st April 2025 – 30th June 2025)	
Executive lead:	Claire Birchall, Executive Director of Nursing Quality, and integrated Governance
Author:	• Angela Cook, Assistant Director of Quality and Nursing • Paula Mitchell, Quality and Clinical Governance Manager • Jacqui Westmoreland, Paisley Hartland, Louise Van Laere, PTR Team • Donna Newell, Named Lead for Safeguarding • Junaid Iqbal, Lead for Service User Experience • Nicola Lewis, Lead Nurse for Corporate Infection Prevention & Control

Approval/Scrutiny route:	Business Executive Team – 03/09/25

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 1 period (1st April 2025 to 30th June 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, Quality and Clinical Audit.

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

The Committee is asked to:

- **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 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 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 -Incidents, complaints (Page 8)

- 536 incidents were reported and investigated during Quarter 1, with remedial actions identified. Of these, 18 were initially reported as moderate harm or above.
- As of 1 July 2025, there are 39 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (Page 28)

9 queries for Safeguarding advice and support were requested

- 2 of the requests led to referrals being made to the local authority meeting statutory safeguarding responsibilities

Infection Prevention & Control (Page 32)

- There were 19 IP&C incidents reported in Quarter 1, 5 more than in Quarter 4 of 2024/25. One incident was initially reported as moderate harm but amended to no harm following a management review. The majority of incidents are reported by Infection (Microbiology) Services.
- All IPC audits are now live in the new Audit Management & Tracking system (AMaT) with the first data expected to be available in reports for Quarter 2.
- PHW Divisions have been asked to review staff IPC Level 2 role specific competency in ESR to ensure all those who require the training are included in compliance reporting.
  Betsi Cadwaladr Health Board have notified Bowel Screening Wales of delays to the relocation of the endoscopy decontamination unit at Ysbyty Glan

Clwyd. The original project was due for completion in August 2025; however, this has now been delayed to February 2026. This has been escalated to the Health Board. Risk is being mitigated by an increased frequency of audit in the current unit.

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 14)

- 25 Early Resolution complaints were received in Quarter 1, and 9 formal complaints.
- 76% of the early resolution complaints were resolved within 2 working days target.
- 100% 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 26)

- The Quality and Clinical Audit Team have met with Directorates and Divisions to evaluate progress against the 2025-26 Quality and Clinical Audit Plan for Quarter 1 (Q1).
- A total of 58 internal audits were added to the plan at the beginning of the financial year, which is an increase from 49 compared to the previous year.
- During Q1 meetings a further 6 audits have been identified and added to the plan.

Safety Alerts Management (Page 19)

A total of **64** alerts were received by Public Health Wales during the reporting period 1 April – 30 June 2025, **3** of which required action to be taken. 2 were circulated to Health Protection and 1 to Screening. In addition, 1 Public Health heat alert was also circulated to the Office of the Medical Director and the Executive Team.

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 20)

This quarter, 113 compliments were recorded by staff on the Civica system. In addition, 15 compliments relating to Public Health Wales services were left directly by members of the public using the compliments form available on the organisation's website.

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

1. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 1 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 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 Putting Things Right Quarter 1 Overview

In Quarter 1 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.

2.2 Incident Management

Incidents	National Reportable Incidents	Early Warnings	Duty of Candour
↑ 536 (528)	⇆ 0 (0)	↓ 0 (3)	⇄ 0(0)

( ) denotes previous quarter data

Incidents

During Quarter 1, 536 incidents were reported. This is a slight increase of 8 compared to the 528 reported in Quarter 4 2024/25.

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

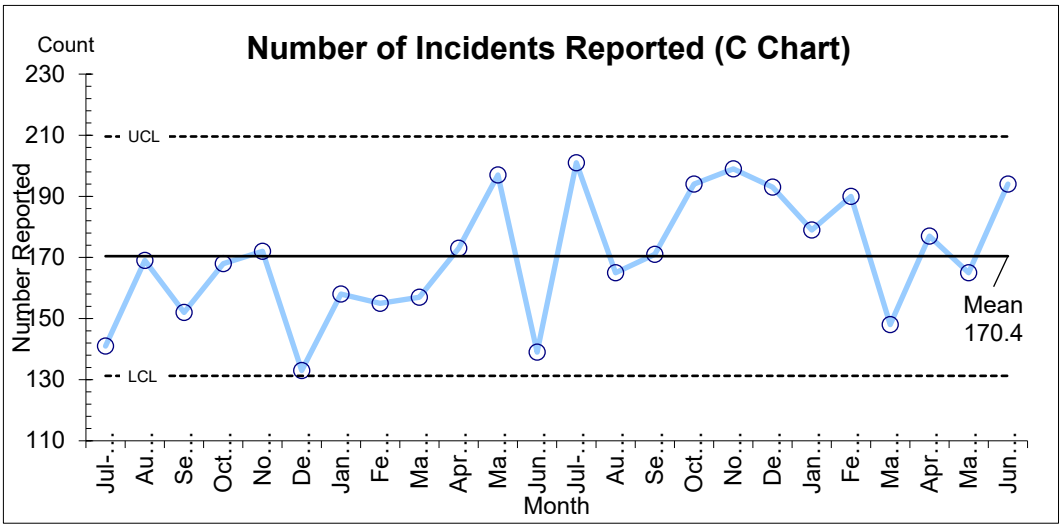
	Moderate Harm- Post investigation	Severe harm- Post investigation	Catastrophic/ Death- Post investigation
Quarter 1 2025/26	1	0	0
Quarter 4 2024/25	1	0	0

The Moderate harm post investigation relates to a RIDDOR reportable incident in Breast Test Wales where harm has occurred to a staff member due to repetitive strain injury.

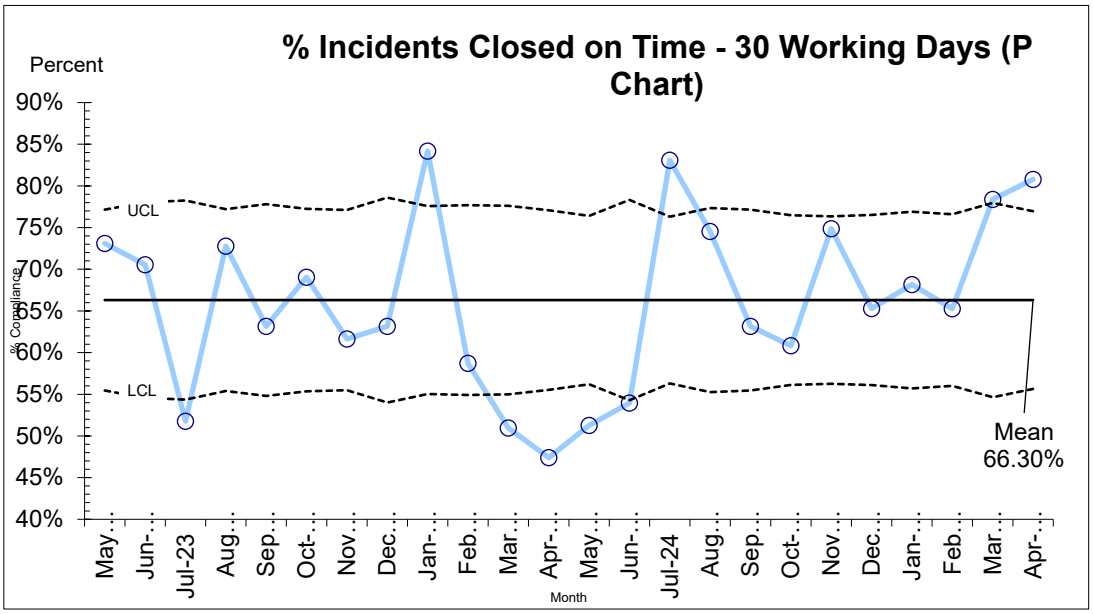
Open Incidents

The below graph demonstrates the number of incidents reported between Quarter 1 2025/26 and Quarter 4 2024/25. The mean number of incidents compared to the same period last year has marginally increased by 12, from 163 incidents to 175 incidents. This suggests an increase in reporting activity or actual incidents.

It should be noted that Cervical Screening Wales (CSW) is the highest reporting area for Quarter 1 and has increased its reporting compared to Q4 followed by Microbiology. CSW reporting has increased from a mean of 52 incidents to 62 incidents demonstrating an increase in reporting rates along with potential emerging service-related issues.



The below graph highlights that the overall performance against the 30-working day closure rate target and indicates improved performance since in Quarter 4. Performance for Quarter 1 is at 81% of incidents closed within 30 working days suggesting improved responsiveness and incident management.



Incident Classification

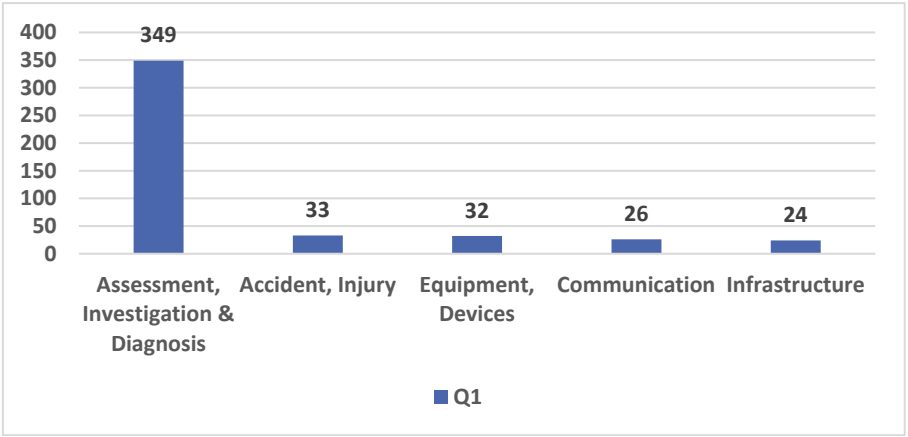


Chart 5. Top 5 incident classifications

Assessment, Investigation and Diagnosis remains the highest incident classification of reporting with figures comparable to those of Quarter 4.

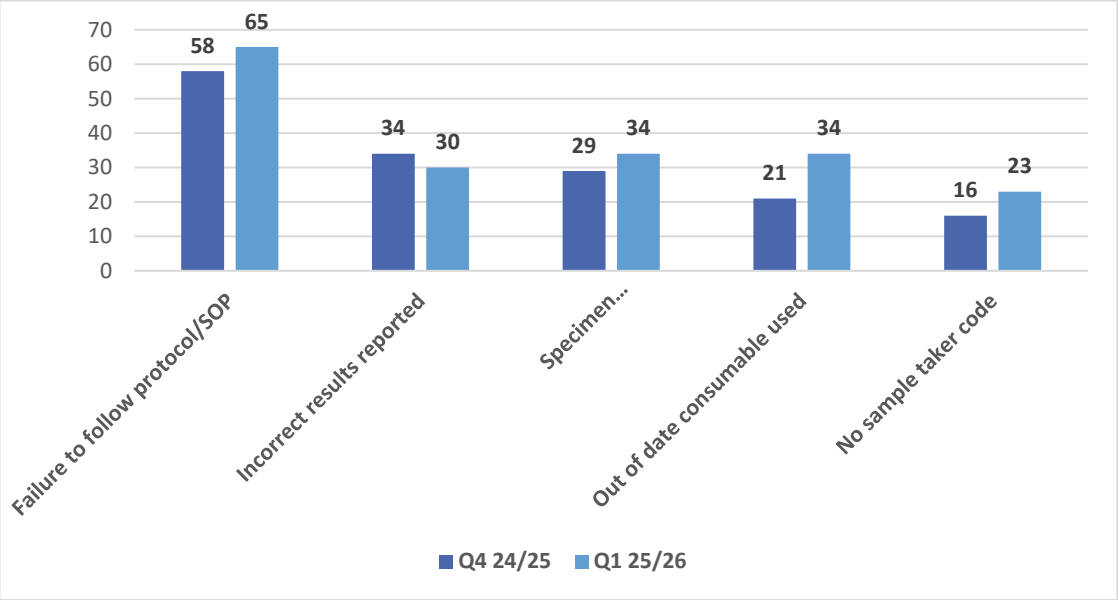


Chart 6. Top 5 sub-categories

Emerging Issues

There has been an increase in reporting across 4 of the 5 top incident categories. The biggest increase has been seen within the subcategory of "out of date consumables used" with all the incidents in Quarter 1 occurring within CSW. This is an increase from 21 incidents in Quarter 4 to 31 incidents reported in Quarter 1, and all incidents related to the use of out-of-date vials. Following investigation, it was identified that the Standard Operating Procedure (SOP) used by the sample takers when taking cervical smears did not state that vials must be received in the laboratory by the expiry date, rather than just used by that date. Sample takers had been continuing to use vials when out of date.

Lessons Learnt

Following this, Cervical Screening Wales (CSW) undertook a review of its procedures and identified key areas for improvement:

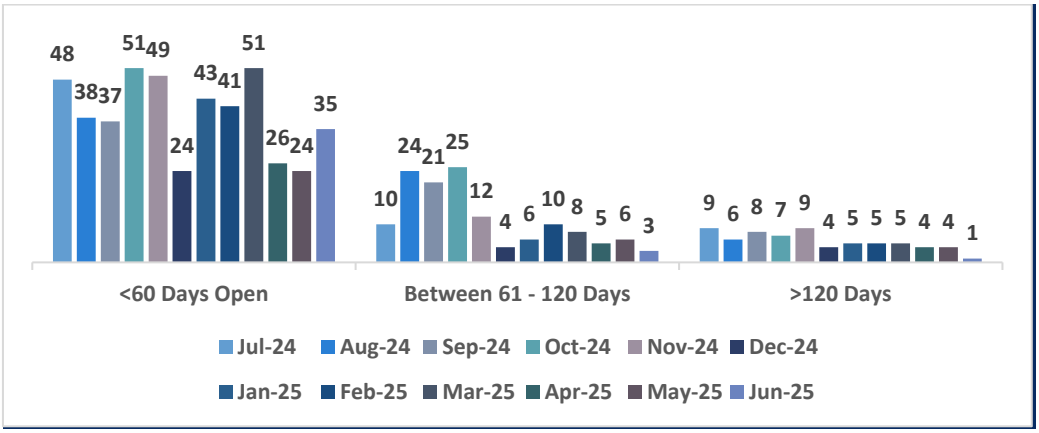
- The Standard Operating Procedure (SOP) has been amended to clearly state that vials may only be used if there is at least 14 days remaining before their expiry date.

- CSW is also reviewing stock management processes to ensure that consumables are dispatched with sufficient lead time, reducing the risk of near-expiry date usage.

- Communication was sent out to all sample takers, General Practices and stakeholders to inform them of the out-of-date vials and to ensure that these are removed from use.

These actions aim to reinforce safe clinical practices, improve compliance, and prevent recurrence of similar incidents.

Overdue Incidents



As of 1 July 2025, there are **193** open incidents with **39** having an overdue status. The largest numbers of overdue incidents are within Cervical Screening Wales **(14)**, Diabetic Eye Screening Wales **(13)** and Bowel Screening Wales **(4).**

Although this remains suboptimal, this is a marked improvement to the previous Quarter demonstrating an improving safety culture and timely investigation and closure of incidents.

Ongoing work to address the performance rates for incident closure continues with a weekly creation and review of overdue incident reports by the PTR team. This report details incidents that have been open for more than 30 working days along with incidents that have an open status at 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. Progress updates are requested to the service areas weekly, and support offered where barriers to achieving closure are identified. In addition, this is supplemented with monthly meetings 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 Reporting and Management Training

During Quarter 1, Level 1 Datix incident reporting training has been delivered to 146 members of staff equating to 46% of Public Health Wales having now completed this training. This is a 3% increase on the previous Quarter. 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. 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 this training to all new starters. The current Level 1 training figures are a standing agenda item at the Putting Things Right Superuser Network, where all superusers are 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.

2.4 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.

One new redress case was received in Quarter 1 in Breast Test Wales.

There are 8 ongoing redress cases, 4 in Breast Test Wales and 4 in Cervical Screening Wales.

2.5 Complaints Management

Early Resolution Complaints (n)	Formal Complaints (n)	Ombudsman Complaints (n)
↑ 25 (21)	↓ 9 (13)	⇆ 0 (0)

( ) denotes previous quarter data

Early Resolution Complaints (Informal)

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

25 Early Resolution complaints were received during Quarter 1. This is an increase of 4 compared to the previous Quarter. 76% (19) of these complaints were resolved within the designated Putting Things Right target of 2 working days. 24% (6) 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.

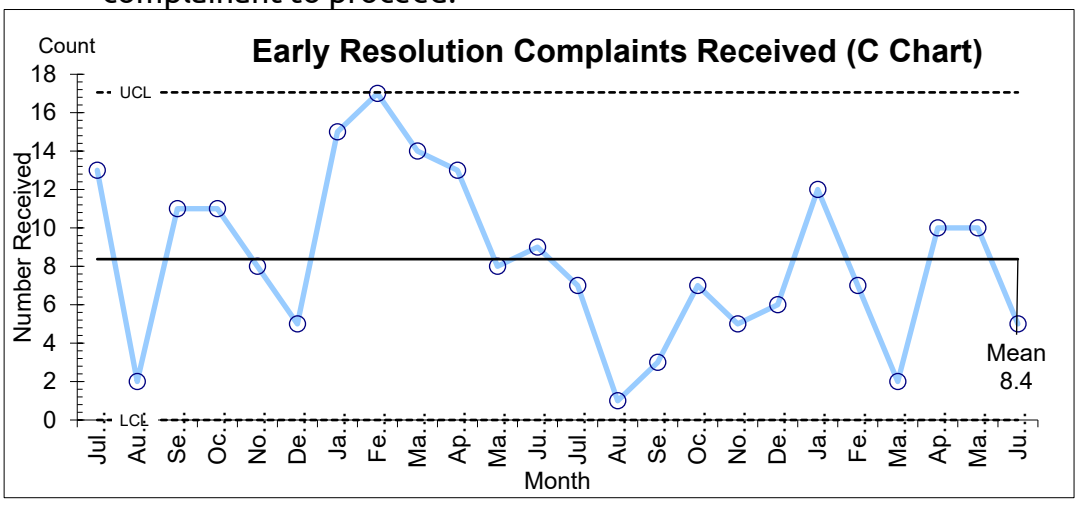
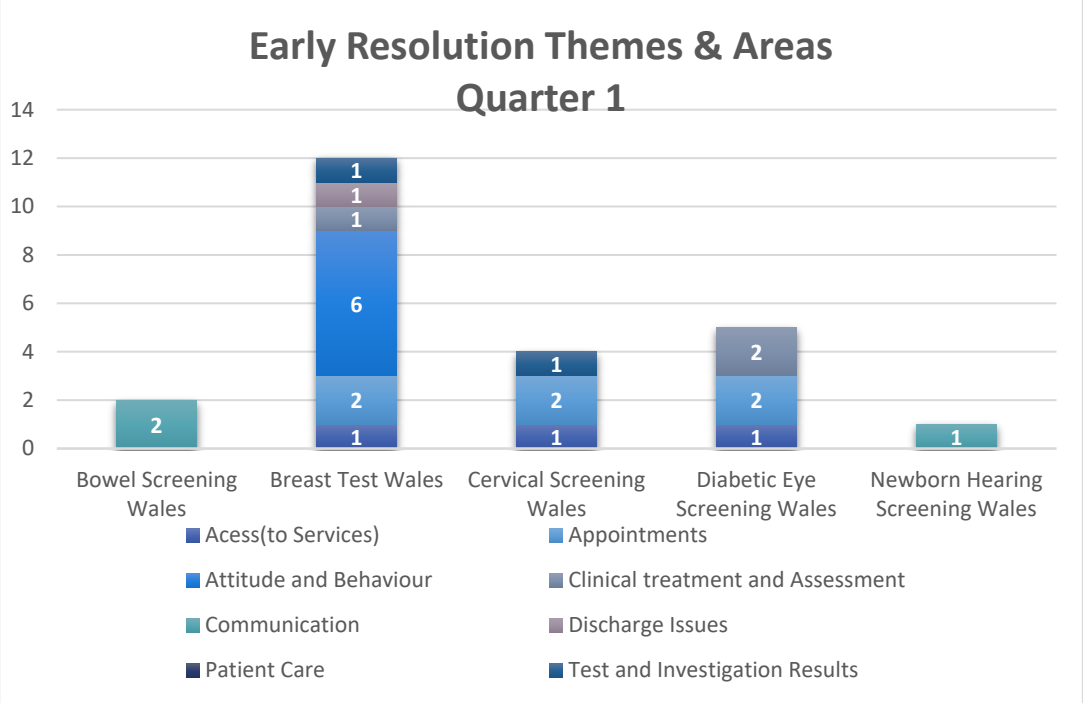
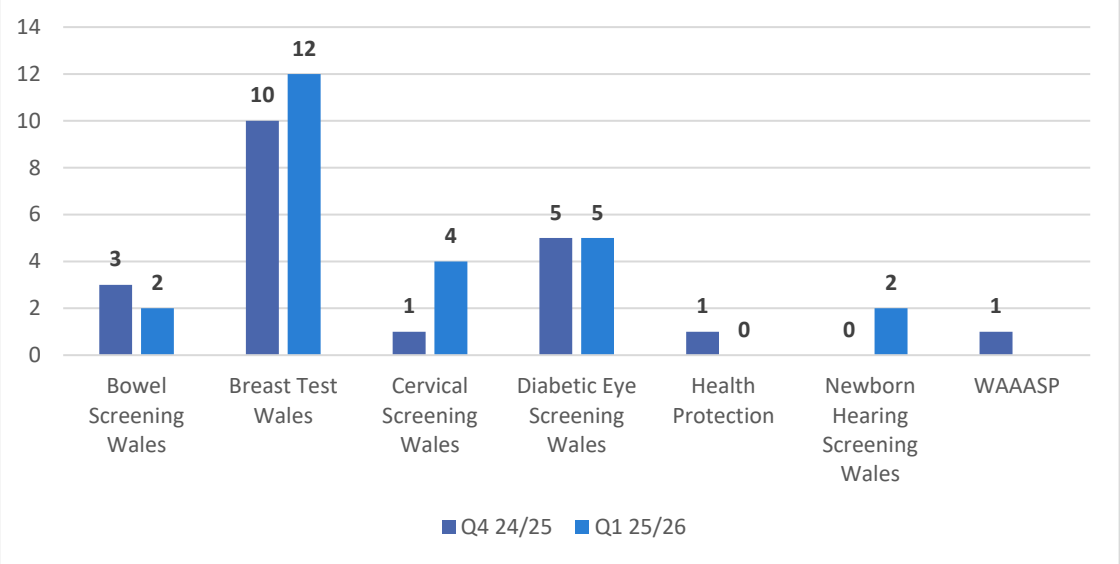


Chart 7. Informal complaints received per Month



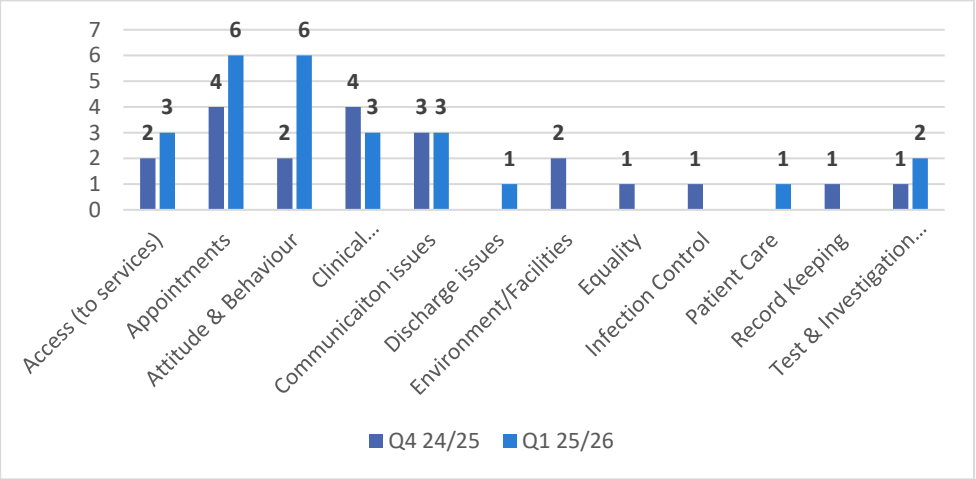
The below chart details the service areas where Early Resolution complaints have been received during each Quarter and provides the previous quarters data for comparison.



Breast Test Wales continue to receive the highest volume of Early Resolution complaints with a 20% increase noted on the previous Quarter. Attitude and Behaviour is the reason/subject for the increase in the number of informal complaints. A further review into this type of incident does not identify any recurring areas or staff groups relating to attitude and behaviour complaints. BTW is ensuring all staff are compliant with customer

care training and reviewing offer of external agency who can support staff in their interactions with participants.

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



Formal Complaints

During Quarter 1, 9 formal complaints were received, a reduction of 4 compared to the 13 reported in the previous Quarter. The average is 2 complaints per month.

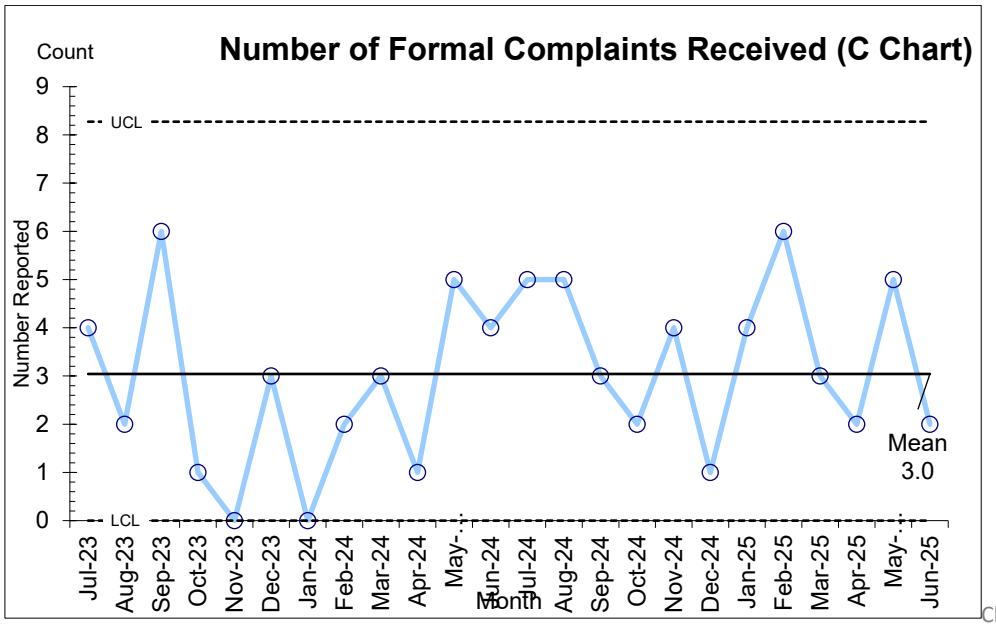
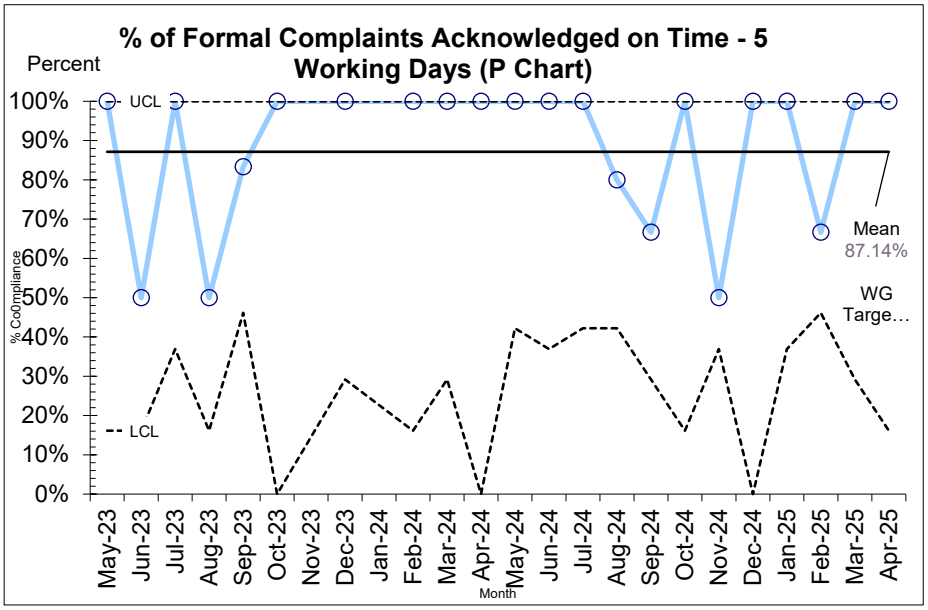
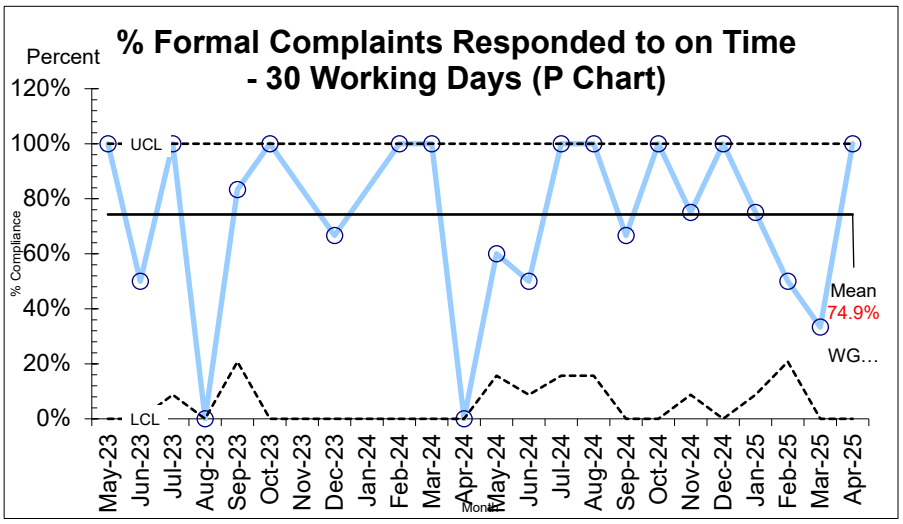


Chart 9.

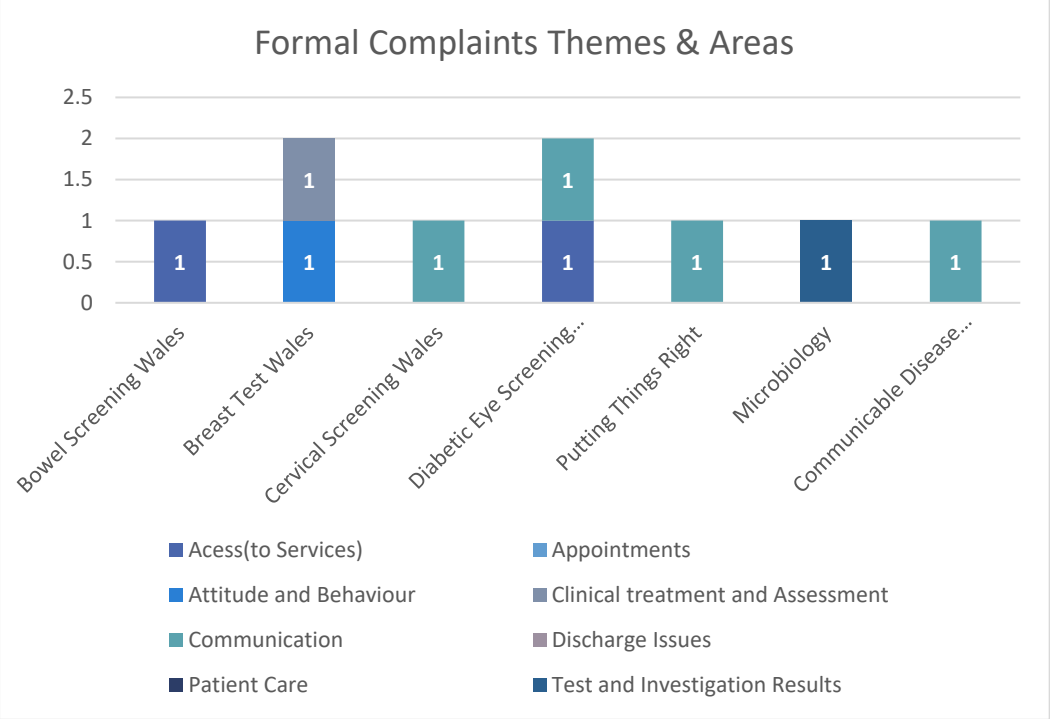
Formal complaints received per month

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 87% in acknowledging complaints and mean of 75% in responding within 30 working days against the 75% target.





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



Learning complaints

Grammatical Errors in the Welsh Version of a Questionnaire

Following a complaint, the Welsh Language Team worked closely with Signum and the Sexual Health Team to review the sexual health testing kit ordering questionnaire and, as a result, have identified several grammatical errors in addition to the ones that the complainant had identified. These have now been rectified. The Welsh Language Team are working on a quality assurance process with Health Protection to ensure all forms are now reviewed prior to use.

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 1.

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 working groups involved in these revisions and will be scoping the resource implications for PHW once finalised and published. The implementation of these revised regulations is expected to be April 2026.

2.8 Safety Alerts and Notices Management

1. Purpose / Situation

The purpose of the report is to provide 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.

2. Background

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.

3. Description/Assessment

A total of **64** alerts were received by Public Health Wales during the reporting period 1 April – 30 June 2025, **3** of which required further action to be taken.

The majority of alerts received related to high voltage notices which did not affect Public Health Wales equipment. 2 drug recall alerts in and a drug batch error were shared with Health Protection, Microbiology and Screening Services for information only.

Applicable alerts were primarily seasonal notices for influenza and heat health risks and prescribing antiviral treatments for COVID-19.

Type of Alert	Number received	Number requiring action (Covid 19)	Number requiring action (other)	Subject Matter	Date Received and actioned	Action taken
Pharmaceutical Alert	16	1	0	Prescribing COVID-19 antiviral treatments	20/05/2025	Shared with the Office of the Medical Director and Vaccine Preventable Disease Programme.
Medical Device Alert	2	0	0			
Medicine Shortages	21	0	0			
Estates and Facilities Alert	1	0	0			
High Voltage Alert	22	0	0			
Public Health Alert	2	0	2	Influenza season 2024/25 Heat Health Risk	16/05/2025 18/06/2025	Shared with the Office of the Medical Director and Vaccine Preventable Disease Programme. Shared with the Office of the Medical Director.
Totals	**64**	**1**	**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
Micro/Health Protection	0	1	2	Influenza season 2024/25 Prescribing COVID-19 antiviral treatments Heat Health Risk	16/05/2025 20/05/2025 18/06/2025	Shared with the Office of the Medical Director and Vaccine Preventable Disease Programme. Shared with the Office of the Medical Director and Vaccine Preventable Disease Programme. Shared with the Office of the Medical Director.
Not applicable	61	0	0			
Totals	**61**	**1**	**2**			

Table 2. Alerts by Division

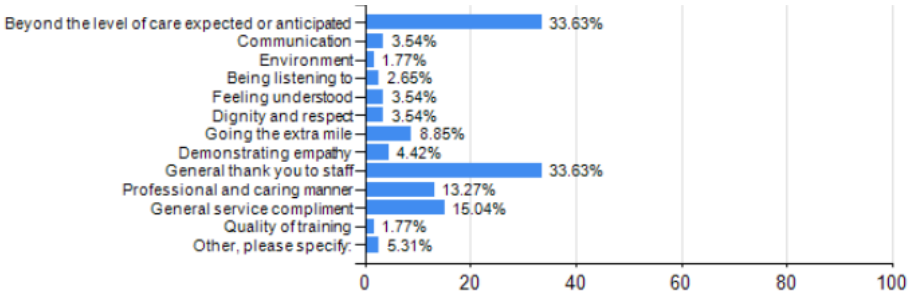
4. Compliments and Service User Experience

This quarter, 113 compliments were recorded by staff on the Civica system. In addition, 39 compliments were left directly by members of the public using the compliments form available on the Public Health Wales website. However, of these only 15 related directly to Public Health Wales services, with the others directed towards a mixture of Health Board provision and Primary Care services.

The table below provides a further breakdown of both staff-recorded compliments and direct public compliments for Public Health Wales.

Row Labels	Sum of Staff reported compliments	Sum of Direct public Compliments
Abdominal Aortic Aneurysm Screening	26	6
Antenatal Screening Wales	0	1
Bowel Screening	3	2
Breast Test Wales	46	1
Cervical Screening Wales	1	0
Diabetic Eye Screening Wales	17	2
Estates and Health & Safety	3	0
Health Protection	0	1
Microbiology	16	0
Newborn Hearing Screening (All Wales)	0	1
Screening (Division Wide)	1	0
Sexual Health Wales (SHWales)	0	1
Grand Total	**113**	**15**

A thematic analysis of the combined direct public submitted, and staff-reported compliments is not yet available due to data quality. This is because as many of the compliments left within the Civica system are not related to Public Health Wales services. A solution to address and resolve this is being developed and will be shared at the September PHW People's Experience Learning Group. The compliment themes pertaining to the 113 compliments can be aligned to the following categories:



Experience Surveys

The following section is broken into two parts, with data presented accordingly

- Local Experience surveys (Pathway-specific questions)
- Organisational SMS survey (a single set of consistent questions)

Local Experience Surveys

Local experience surveys have now been developed for use across all PHW Screening programmes. This medium of providing feedback has been promoted

using posters, flyers, and business cards along with the provision of 30 digital tablets that are available for use within the Screening Services. Additionally, kiosk stands are also available to increase accessibility at PHW-operated Screening venues, which will enable contemporaneous feedback at the time of appointments. The Lead for Service User Experience continues to advocate for the integration of feedback methods to be included in all results letters, reinforcing our commitment to hearing the voice of our service users and the opportunity for continuous improvement. The inclusion of a feedback request has yet to be incorporated into any results letters.

The promotion of local surveys is reliant on the individual programmes and staff within these service areas. The chart below of local survey responses details current response rates for programmes and highlights where further attention is required to promote and increase survey use.

Screening Programme	Survey	Number of responses Q4 2024-2025	Number of responses Q1 2025-2026
Abdominal Aortic Aneurysm Screenin	Single local survey	4	244
Diabetic Eye Screening Wales	Single local survey	12	33
Bowel Screening Wales	No further tests needed	33	26
	Blood Found in bowel screening test	0	0
	I had further tests	221	365
	Bowel screening Wales Expeirnace Survey (old)	425	22 (being phased out)
Breast Test Wales	I have been for my breast screening appointment	27	26
	I was called for further tests	4	6
Cervical Screening Wales	Help-line support survey	1	48
	I have been for my smear test	0	0
Maternal and Child Screening	ASW People's Experience survey	0	0
	Newborn Bloodspot Screening People's Experience	0	0
	Newborn Hearing Screening People's Experience	5	17

It should be noted that the programmes with the greatest increase in Local survey responses are AAA Screening, Bowel Screening and Cervical Screening.

The overall experience for AAA screening was rated 98.6% Good or Very Good. Out of 222 people who answered this question, only three people rated the service as Poor or Very Poor, which is 1.35%. The dissatisfaction rating is due to venue-based issues and venue directions. This is an area now identified for improvement by AAA will be addressing over the next few months.

Bowel Screening Wales commissions Colonoscopy via Health Boards. Feedback collected by Bowel Screening colonoscopy is shared back with the relevant Health Board. The feedback is discussed as an agenda item at a monthly meeting with each Health Board and is also reviewed annually with Health Boards as part of the Quality Assurance and/or Service Review Meetings of commissioned services.

The main themes from the feedback relate to bowel preparation (taste and volume). The programme has shared this feedback information with Norgine, the manufacturer, to support any developmental work they may undertake to address this. In response to this recurring theme BSW are improving the information provided to participants when supplied with their bowel preparation to improve

pre-procedure information. A Task & Finish group has been created to take this work forward and will also include scoping the use of other information resources such as a, e.g. videos, dietary specific guidance to improve the patient experience and preparation process.

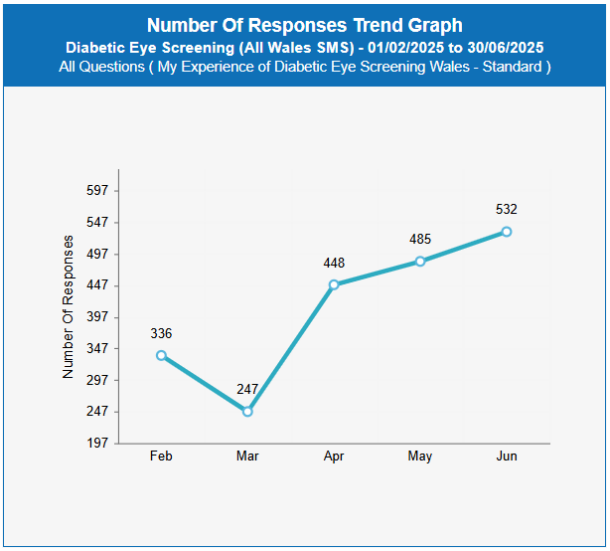
The current operational delivery model for Antenatal and Bloodspot screening poses some challenges in capturing experience and feedback. Conversations between Head of Antenatal Screening and NHS Performance and Improvement are underway on how best to utilise the experience information collated through the single maternity experience survey.

As programmes increase and promote the availability of local surveys, it is anticipated that the feedback rates will increase. Furthermore, the recent publication of the Welsh Government People's Experience Framework, will ensure question consistency, and allow for a standardised approach to support benchmarking across PHW local surveys

Organisational SMS survey

A pilot for the use of an SMS organisational survey commenced on 17 February, within 8 Diabetic Eye Screening Wales clinics and was completed in May 2025. The findings and outcomes of this pilot has formed the basis for an Executive paper. Whilst a decision is sought on the future use of SMS, the collection of feedback across the 8 Diabetic Eye Screening Clinics continues.

The graph below provides a month-on-month response trend for the SMS feedback project. The dip in March was due to technical issues experienced with Civica SMS across UK, which prevented SMS messages from being distributed.



During quarter 1 of 2025-2026, 1465 people left feedback via SMS. 96.31% of people rated the service as 'Good or Very good', with 2.49% (33) as 'Neither good nor poor' and 1.21% (14) as 'Poor and Very poor'.

The feedback received overwhelmingly demonstrates, the staff in Diabetic Eye Screening go out of their way to make people feel welcome and cared for whilst attending their appointment. This is evident through both the ratings and comments left, 2 examples detailed below.

"The 2 people that did my test were very professional and explained everything that was going to be done and why. Both put me at ease, which was much appreciated"

"Both members of staff were polite, friendly and courteous"

Out of the 44 people who rated the service as either neutral or poor, very poor. One person negatively commented on staff attitude, which was subsequently passed onto the Head of Programme, whilst the remaining 43 people rated the service as poor due to venue location, venue facilities, including parking. The comments below are taken directly from people's experiences.

"Service was excellent, but walking 3/4 Mile to get there, and the same distance from the car park made the experience very poor. When you have walking problems and breathing COPD"

"Also because of the extremely poor parking at the hospital, I had to take a taxi there and back, which cost £14 out of my pension, which I cannot afford."

Although the SMS feedback project is currently only operating over 8 clinics, the data to date is beginning to highlight that venue location, venue facilities, including parking, need to be carefully considered when selecting future and reviewing current clinic locations.

The word cloud below is a sample of the comment analysis taken from the Civica system and left via the SMS project.


supportive
"put me at ease"
"put at ease"
helpful
helpfull
reassuring
assisted
helped
very understanding"
"put you at ease"
"staff were fantastic"
competent
thorough
"excellent service"
efficientall
capable
professional
knowledge
precise
efficient
professionalism
competence
efficiently
excellence
"well organised"
"explain everything"
"explained what would happen"
"everything explained"
"kept me informed"
"clearly explained"
"explained everything"
informative
"fully explained"
"everything was explained"
"explained to me"
"kept informed"
"good communication"
"room so not"
"room was too small"
"lift buses not"
"no phone"
"facilities poor"
"signage was poor"
"no wifi"
"waiting room was too small"
"waiting room could"
"waiting room needs"
"room needs"
"room could"
"room needed"
"waiting room needed"
"access not"
"not enough seats"
"broken bed"
"building was a run down"
"waiting room so not"
"minutes to findparking spacewhendid park"
"parking is atrocious"
"not enough disabled parking"
"more parking"
"no disabled parking"
"parking is awful"
"parking was difficult"
"no parking"
"parking was terrible"
parking issue"
"parking issues"
"lack of parking"
"difficulty parking"
"have to park"
"hard to park"
"had to park"
"parking is an issue"
"trying to park"
"nowhere to park"
"parking a nightmare"
approachable
chatty
welcoming
likeable
friendly-
friendly
happy staff"
warm
personable
pleasant
relaxed
"toilet not
cheerful
friendlyvenue
friendliness

5.0 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	6
Audits identified as a result of risks	29
National Institute of Clinical Excellence (NICE)Guidance (including Technology Appraisals, Interventional Procedures and Guidelines)	0
Local Policy Audits Care Pathways/Local Guidelines Audits	64

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.

5.1 Quarter 1 Update.

The 2025-26 Plan initially included 7 external audits and 58 internal audits. This is currently awaiting approval by the Leadership Team (LT). The plan was presented to LT on 18 Jul 25 and is pending approval. HPSS Directorate requested a delay to approval so that they may present both the Report for 2024-25 and Annual Plan for 2025-26 at their leadership team. It will then be represented to LT for approval prior to QSIC.

Current Status following Q1 Meetings:

- 6 External Audits – 5 ongoing as planned, 1 on hold. The on-hold audit is due to emerging changes within NHS England who led on the audit.
- 64 Internal Audits – update below:

Quarterly Status	Number	Comments
Completed	10	
Progressing as Planned	26	
Delayed (risk of not completing)	0	
Removed from plan this year	1	Added to plan by mistake by programme, no need to audit this year.
Not Due to Start this Quarter	27	1 audit has been identified as ad hoc to take place if the need arises.

5.2 Digital Audit Platform

During Quarter 1 the Quality and Clinical Audit Team have been working on the implementation of 3 modules for the Audit Management and Tracking (AMaT) system. To date the following has taken place:

AMaT Training:

- 2 superusers trained on Clinical Ward (assurance) and Inspection Modules.
- 13* administrators trained on Ward Module.
  *NB this training ensures they can undertake administrator roles for the whole system.
- 3 staff trained on Inspection Module.
- 47 staff across the organisation trained as system users
- Bi-Weekly Training continues until the end of August where this will be re-evaluated – one session for Ward Module and the other for Clinical Audit Module.

Module Updates:

- Ward (assurance) Module. This is now Live with teams across the organisation transitioning "assurance" audits. Several audits, including IPC, are operational. This work will be completed by end of financial year.
- Clinical Audit Module. Training currently taking place with a plan to go live in September 25, with all audit activity transitioned by year 2026-27.
- Inspection Module. Now live with the Board Business Unit transitioning activity across.
- Guidance Module. Planning for this introduction will start at the end of Q3.

5.3. Audit Training

No clinical audit masterclass training has taken place during Q1 however scoping available dates for the latter part of 2025-26 is underway. AMaT training remains ongoing.

6. Safeguarding Group Report

This section summarises safeguarding related activity and performance along with key risks and improvement activity during Quarter 1, 2025-26.

The Safeguarding group met on 17th July 2025. with representation across PHW directorates. Directorates reported safeguarding activity and training compliance along with recovery plans to improve training compliance where it was suboptimal.

Since the implementation of the 'Once for Wales' Safeguarding module in January 2025, directorates now have oversight of activity for Safeguarding queries relating to advice and support, referrals to the local authority and safeguarding incidents. This new module ensures that all safeguarding activity is being recorded in one central point within Public Health Wales strengthening safeguarding record keeping. Since the implementation of the Once for Wales Safeguarding module PHW has now been able to accurately distinguish safeguarding incidents from safeguarding queries resulting in a reduction in Safeguarding incidents reported now. There were no reported Safeguarding incidents reported during quarter 1

6.1 Safeguarding queries for advice and support, referrals and incidents

9 Safeguarding queries for advice and support were recorded during this quarter as the largest public facing directorate, Health Protection and Screening divisions continue to report the most safeguarding concerns queries which is to be expected given the number of contacts they have. Chart 5.1 shows the number of cases reported by directorate.

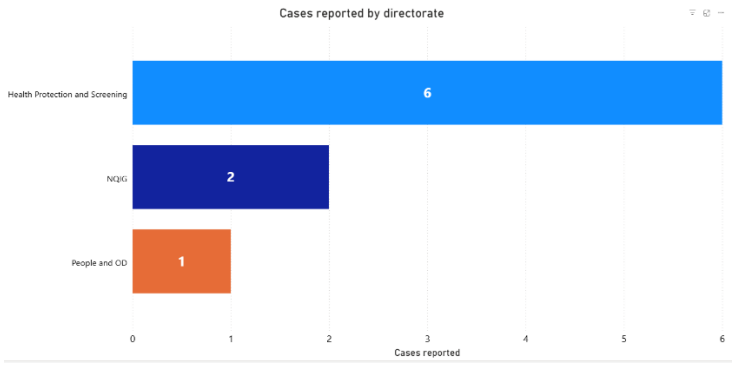


Chart 5.1 Cases Reported by Directorate

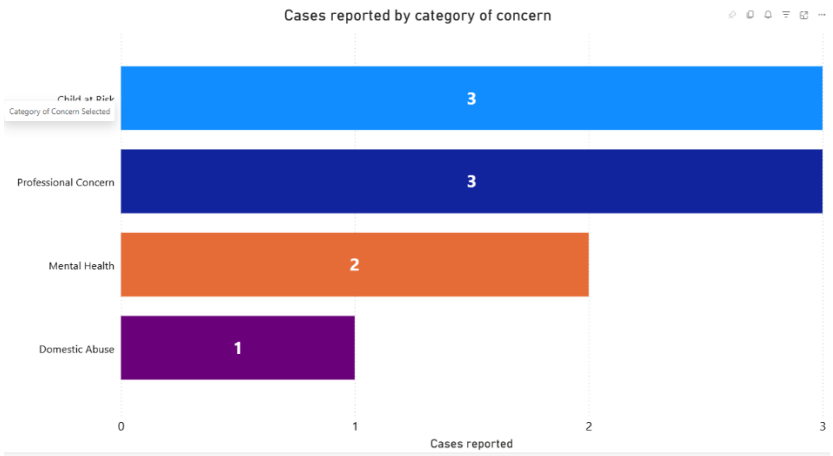


Chart 5.2 Cases reported by category of concern

Of the requests made for safeguarding advice and support 3 related to children at risk, 3 regarding professional concerns, 2 mental health concerns and 1 case of Domestic abuse. 2 of the queries for safeguarding advice resulted in reports to the local authority, one for a professional concern against an employee within a care home and a referral for children witnessing domestic abuse within the home.
Both referrals were made within recommended time scales as identified within Wales Safeguarding Procedures meeting our statutory Safeguarding duties. Access and responses to advice have all been timely with all Safeguarding queries and documented on the Once for Wales Safeguarding module in Datix.

6.2 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 this.

The tables below indicate Quarter 1 compliance with mandatory training requirements and the trend compared to the previous quarter.

Competence Name	Q4	Required	Achieved	Q1	Trend
NHS|MAND|Violence Against Women, Domestic Abuse and Sexual Violence - 3 Years|	90.43%	2146	1918	89.38%	↓
028|LOCAL|Violence Against Women, Domestic Abuse and Sexual Violence Group 2 - 3 years|	82.57%	457	377	82.49%	↓
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	92.80%	2146	1980	92.26%	↓

NHS|CSTF|Safeguarding Adults - Level 2 - 3 Years|	92.08%	475	435	91.58%	↓
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	92.61%	2146	1980	92.26%	↓
NHS|CSTF|Safeguarding Children - Level 2 - 3 Years|	90.63%	475	430	90.53%	↓
028|LOCAL|Safeguarding Level 3 - 3 Years	62.18%	113	94	83.19%	↑
NHS|MAND|Mental Capacity Act – 3 Years	91.12%	308	271	87.99%	↓
NHS|MAND|Mental Capacity Act Level 2– 3 Years	90.77%	267	239	89.51%	↓
NHS|MAND|Consent - 3 Years	94.57%	272	265	97.43%	↑

2 sessions of the Group 2 Ask and Act, Violence Against Women, Domestic Abuse and Sexual Violence training were delivered to 15 employees. The information below highlights the directorates where improvement is required to achieve compliance. These areas have been targeted.

Division	Required	Achieved	Q1
028 L4 Infection Division	28	16	57.14%
028 L4 Quality & Nursing Division	2	1	50.00%
028 L4 Screening Services Division	412	347	84.22%

Safeguarding level 3 training compliance has increased to 83.19% with only 19 employees outstanding to train. It is anticipated that compliance with improve in the next quarter and attempts are being made to benchmark performance against other NHS organisations.

6.3 Key Safeguarding Risks & Issues

There are currently 2 safeguarding risks which committee should note, and which are recorded on the corporate risk register. Both have mitigations.

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

6.4 Safeguarding Improvements

Safeguarding Maturity Matrix

The Safeguarding Maturity Matrix (SMM) is a self-assessment quality assurance tool completed by the 7 Health Boards and 3 Trusts in NHS Wales. The SMM is completed annually reporting retrospectively on activity from the previous year. The SMM is intended to inform improvements and promote horizon scanning, allowing organisations and the wider NHS Wales Safeguarding Network to understand safeguarding priorities for the following year.
This self-assessment has commenced with the peer review of all NHS Wales submissions scheduled on 13th October 2025.

DBS Project

Work to address the risk associated with the DBS check is continuing to progress. To date the following actions have been progressed.

- Requirement for all new and existing employees in roles requiring a Standard or Enhanced DBS check to subscribe to the DBS Update Service, with reimbursement of the subscription fee included within the Safeguarding policy, this clarifies safeguarding expectations and consequences for non-compliance. This is due for Consultation and endorsement by PHW Safeguarding Group in the next month with progression and ratification to QSIC in September 2025.
- A policy development workshop with key staff and Trade union representatives was held in January 2025.The draft DBS policy will go for Consultation, and staff engagement will continue to through Trade Unions and staff networks. Time frames for have yet to be confirmed by People Organisation and Development.
- POD are in the process of drafting letters for colleagues requiring subscription to the DBS update service. A Communication plan is being developed to disseminate the information and provide frequently asked questions via the staff intranet.

7.0 Infection Prevention and Control (IPAC) Update

This section provides an update on Infection Prevention and Control activities, incidents, risks and training compliance during Quarter 1 2025-26. The IP&C group met on 10th July 2025 to review quarter 1 data.

7.1 IPC-related incidents

There were 19 incidents reported in Quarter 1, 5 more than the previous quarter. One of the incidents was initially reported as moderate harm however this was amended to no harm following a management review. A breakdown of the reported incidents is as follows.

Category	Number of Incidents	Division where it occurred	Harm / Risk Level	Approval Status
Delay in environmental cleaning	2	Screening – DESW, NBHSW	1 No Harm 1 Low Harm	1 closed, 1 under management review
Failure to follow correct process or procedure for environmental cleaning	2	Screening – DESW, NBHSW	Low Harm	1 under investigation, 1 awaiting closure
Contact with or exposure to hazardous substance	14	13 Microbiology, 1 Screening BTW	6 No Harm 7 Low Harm 1 Moderate Harm, amended to No Harm	12 Closed, 1 awaiting closure, 1 under investigation
Hand Hygiene	1	Screening – DESW	Low Harm	Closed

7.2 IPC Mandatory Training Compliance

All PHW staff are required to complete level 1 IPC training and certain staff in patient-facing roles require level 2. Currently, it is unclear whether all staff who require IPC Level 2 training have this assigned to their position numbers in ESR. This was discussed in the IPC Group, and Divisional representatives have been asked to review their data and provide assurance that all staff who require IPC Level 2 training are allocated this in ESR. This will improve the accuracy of reporting of IPC mandatory training compliance.

The tables below demonstrate current compliance with mandatory training requirements and training trends compared to the previous quarter.

It is expected that all Divisions/Directorates will achieve and maintain at least 85% compliance with these training requirements. Monthly compliance reports are shared with managers by the People and OD team. In addition, at the IPC meeting all directorate representatives were tasked with reviewing their areas with falling compliance trends and liaise with relevant managers to address. It is important to note that screening had an additional 21 people added to an IC competency in ESR which has contributed to the downward trajectory. Discussion was also had about the feasibility of exempting staff who are on external secondments from the current reports, and this also affects compliance figures.

IPC Level 1

Directorate/Division	Q1 Compliance	Increase/Decrease compared to Q4
028 L3 Corporate Directorate	84.62%	↓
028 L3 Research, Data and Digital Directorate	96.65%	↑
028 L4 Health Protection Division	90.04%	↓
028 L3 Health & Wellbeing Directorate	89.60%	↓
028 L4 Infection Division	91.15%	↑
028 L3 Operations and Finance Directorate	88.04%	↓
028 L3 People & OD Directorate	97.96%	↑
028 L3 Nursing, Quality and Integrated Governance Directorate	94.12%	↓
028 L4 Screening Division	92.74%	↓
028 L3 Policy and International Health Directorate	95.29%	↓

IPC Level 2

Directorate/Division	Q1 Compliance	Increase/Decrease compared to Q4
028 L4 Health Protection Division	0.00%	↓
028 L4 Screening Division	87.79%	↓
028 L3 Quality Nursing & Allied Profs Directorate	100%	↑

It is important to note that the Health Protection division are unable to report their IPC level 2 training figures this quarter due to the recent realignment of budgets which has affected ESR records and the ability to report accurately. This is being addressed and training figures should be available for the next reporting period. In addition

The division are also taking the opportunity to review the Level 2 training requirements to ensure this role specific competency is assigned to all those roles that require it.

ANTT (Breast Test Wales Only)

Training	Q1 Compliance	Increase/Decrease compared to Q4
ANTT e-learning	97.85%	-
ANTT Assessment	70.21%	-

Screening division have undertaken work to ensure that Aseptic Non-Touch Technique (ANTT) training is accurately recorded in ESR. As a result, learning and development staff are awaiting the dates of staff competence assessments to be sent by line managers. There is confidence within the service that once this data is provided, the rate of compliance with ANTT Assessments will demonstrate improvement.

7.3 IPC Risk Register

The Risk Register is noted to have 12 risks listed, 2 of which are to be tolerated and 10 to be treated. All risk scores are less than 12.
9 of the risks listed relate to laboratories and specifically to equipment which is reaching or beyond end of life and environmental conditions which could impact service provision. These risks were discussed during the meeting, along with ongoing mitigation, and are being managed by the Division.

7.4 IPC Policies and Procedures

There are currently no IPC Policies due for review during this financial year. The IPC Workplan was endorsed by the IPC group alongside the IPC Link Practitioner Framework. The National Standards for Cleanliness in Healthcare Facilities in Wales is expected to be published by the Chief Nursing Officer (CNO) Office during Quarter 2.

7.5 Key Risks and Issues Identified

Risk Register entry 1587 relates to Bowel Screening Wales and the decontamination facility in the endoscopy unit at Ysbyty Glan Clwyd. A capital scheme of work to relocate the endoscopy decontamination facility has been agreed and was due for completion in August 2025. This would have enabled the risk to be closed, however site surveys have identified that upgrades are required to the existing ventilation system and as such, the project has now been delayed until February 2026. Regular contact is being maintained with operational staff in Betsi Cadwaladr Health Board and the risk will be updated accordingly and is being escalated as required.

IP&C audits are now operational within the AMaT system and staff have received training and ongoing support to start using these. This includes audits of practice, the environment, decontamination of Ultrasound probes within Breast Test Wales and Abdominal Aortic Aneurysm Screening as well as an assurance audit undertaken by the IPC Nurse. Data from these audits will be available to view in AMaT and will be reporting on in Quarter 2.

The Wales Abdominal Aortic Aneurysm Screening programme are meeting with key stakeholders to progress the development of a standard operating procedure for the decontamination of Ultrasound probes within their service. The decontamination lead and IPC Nurse have also been included in the tender process for the purchase of new probes for the service.

Facilities and IPC have worked collaboratively to draft a cleaning schedule to form part of the tender documents for a cleaning service for clinical and non-clinical venues. The contract tender is progressing through the usual procurement channels and the frequencies of cleaning included in the document have been mapped to the anticipated National Standards for Cleanliness which is due for imminent publication. The schedule also includes guidance for PHW staff working in clinical spaces which once published, will support the standardisation of cleaning across the organisation.

8.0 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 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.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *4.2*

NHS Wales Safeguarding Network Annual Report	
Executive lead:	Claire Birchall, Executive Director NQIG
Author:	Shamala Govindasamy, Planning & Performance Manager Louise Mann, Director of Safeguarding

Approval/Scrutiny route:	Approved by the NHS Wales Safeguarding Network Business Executive Team - 16/07/25

Purpose

This paper presents the NHS Wales Safeguarding Network Annual Report, which demonstrates the system leadership of the National Safeguarding Service, and the valuable work that has been undertaken by the Safeguarding Network across NHS Wales, to keep children and adults safe from abuse, neglect and avoidable harm.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- Take **assurance** that that system leadership of the National Safeguarding Service is working across the Organisation as detailed in this report.

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	5 - Supporting a sustainable health and care system
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	2 - Promoting mental and social wellbeing

Summary impact analysis	
Equality and Health Impact Assessment	An Equality or Health Impact Assessment is not required as the paper references an Annual Report
Risk and Assurance	N/A
Health and Social Care (Quality and Engagement) (Wales) Act	The report supports improvements in quality and assurance of NHS safeguarding activity and performance in Wales.
Financial implications	No financial implications
People implications	No potential impact on workforce or staff survey plans.

1. Purpose / situation

This paper presents the NHS Wales Safeguarding Network Annual Report for 2024-25, which demonstrates the system leadership of the National Safeguarding Service, and the valuable work that has been undertaken by the NHS Wales Safeguarding Network, to keep children and adults safe from abuse, neglect and avoidable harm.

The report details key achievements throughout 2024-25, another impactful year of safeguarding activity across NHS Wales. This report highlights the collective effort, innovation, and dedication of our safeguarding community in promoting the health, safety, and rights of the people we serve.

2. Background

The Network is professionally led by the National Safeguarding Service (NHS Wales) and chaired by Louise Mann, PHW Director of Safeguarding. The group provide a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people.

The Network and its subgroups provide a community of practice environment, facilitating collaboration, upskilling, horizon scanning, sharing challenges and best practice, problems solving and innovation. At its heart is evaluation of the efficiency and efficacy of safeguarding arrangements and interventions, as well as reduction in practice variation across the NHS.

3. Description/Assessment

Report linked as below:-

NHS Wales Safeguarding Network Annual Report 2024-25 ENGLISH

NHS Wales Safeguarding Network Annual Report 2024-25 WELSH

The Report expands on the challenging deliverables achieved in the last period through collaborative work undertaken across the Network and the implementation of innovative ways of working and initiatives to improve safeguarding effectiveness across Wales. Going forward the Network is committed to improving quality and assurance in safeguarding and will be supporting Welsh Government and NHS Performance & Improvement to strengthen the need to measure the effectiveness of safeguarding activity and practice through the agreement and implementation of key quality indicators.

4. Recommendation

The Committee is asked to:

- Take **assurance** that that system leadership of the National Safeguarding Service is working across the Organisation as detailed in this report.

NHS WALES SAFEGUARDING NETWORK

Annual Report 2024-25

GIG CYMRU NHS WALES

GIG CYMRU NHS WALES
DIOGELU RHWYDWAITH | SAFEGUARDING NETWORK

Contents

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Email: NSS@wales.nhs.uk

June 2025

Chair's Introduction

Welcome to the 2024–2025 Annual Report of the NHS Wales Safeguarding Network.

It is a privilege, as Chair, to reflect on another impactful year of safeguarding activity across NHS Wales. This report highlights the collective effort, innovation, and dedication of our safeguarding community in promoting the health, safety, and rights of the people we serve.

Over the last year, the Network has delivered meaningful progress across a range of complex safeguarding issues. From updated guidance on child protection medical assessments, to national standards for missed appointments, and the development of pathways for managing pregnancy in children under 13, our work continues to respond to the evolving needs of our populations and workforce.

The introduction of a Safeguarding Strategy Template supports all NHS Wales organisations to align to a common vision, while enabling tailored local delivery. This tool promotes consistency, strengthens assurance, and reinforces collective accountability for safeguarding practice.

We have continued to prioritise learning and professional development. Our national Spotlight Sessions have brought safeguarding to life, with powerful, scenario-based learning and expert insight. One session focused on professional curiosity, challenging practitioners to reflect on their thinking, assumptions, and decision-making. Another focused on adults at risk, drawing on recurrent themes from safeguarding reviews and highlighting the importance of keeping the voice of the adult central to service planning and delivery. These events have strengthened practice and inspired reflective learning across health and care systems.

We have also taken deliberate steps to care for the people who lead safeguarding in Wales. Through our Restorative Supervision offer, we've supported the well-being and sustainability of safeguarding leaders, creating safe spaces for reflection, connection and renewal – critical in sustaining the emotional resilience needed for this complex work.

Despite all that has been achieved, we recognise that there is still much to do. Too many vulnerable people in Wales continue to experience poor outcomes. Continued progress depends on embedding learning, prevention and early intervention as core principles of our practice, while ensuring safeguarding remains everyone's responsibility.

We welcome and support the Chief Nursing Officer's (CNO) commissioned Strengthening Safeguarding in Health Review, which provides an important opportunity to enhance quality assurance, governance, learning and national consistency. The establishment of a Delivery Group and dedicated workstreams will shape a deeper understanding of the safeguarding landscape and inform our direction as a system.

As we look ahead to 2025–2026, we remain committed to working alongside Welsh Government and the NHS Wales Performance and Improvement to drive improvements that are ambitious, inclusive, and grounded in what matters most to the people of Wales.

All citizens have the right to live free from fear, abuse, neglect, exploitation, and harm. Together, we are committed to making this a reality.

I hope you find this report both informative and inspiring, and I encourage you to share it widely across your organisation and networks.

Louise Mann
Chair, NHS Wales Safeguarding Network

About the National Network

Professionally led by the National Safeguarding Service (NHS Wales), 'the Network' provides a vital bridge between strategies and arrangements at local level and national policy developments to support NHS Wales Health Boards and Trusts in discharging their responsibilities for safeguarding people.

The Network and its subgroups provide a community of practice environment, facilitating collaboration, upskilling, horizon scanning, sharing challenges and best practice, problem solving and innovation. At its heart is evaluation of the efficiency and efficacy of safeguarding arrangements and interventions, as well as reduction in practice variation across the NHS.

The Network is led by Louise Mann from the National Safeguarding Service (NSS) and co-chaired by Fiona Davies from Velindre University NHS Trust.

Sub-Groups

Network sub-groups act as a community of practice and facilitators of joint safeguarding improvement activity. 6 sub-groups cover the following areas:

1. Training and Learning
2. Safeguarding Maturity Matrix
3. Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)
4. Mental Capacity Act/Deprivation of Liberty Safeguards
5. Looked After Children
6. Wales Lead Doctors for Safeguarding

Multi-Agency Working

Network partners outside of NHS Wales include the Regional Safeguarding Boards, Older People's and Children's Commissioner Offices, the Wales Violence Prevention Unit and other key agencies. This system wide approach facilitates the sharing of good practice, and the cascading of intelligence to promote effective safeguarding across all organisations.

Gwasanaeth Diogelu Cenedlaethol
Diogelu GIG ar gyfer Cymru Ddiogelach

National Safeguarding Service
NHS Safeguarding for a Safer Wales

About the National Safeguarding Service

The National Safeguarding Service (NSS) provides credible system leadership, inspiring others and building quality improvement approaches to safeguarding across the NHS system. The service co-ordinates and manages the Network delivery.

The team comprises skilled professionals who provide strategic expertise, standardised practice, upskilling and specialist guidance to colleagues across NHS Wales, multi-agency organisations and Welsh Government.

Information and Sharing

A National Approach to Child Protection Medical Assessments

Background

A Child Protection Medical Assessment (CPMA) is a specialised assessment conducted as part of the statutory multi-agency investigation in response to concerns regarding potential child abuse or neglect, focusing on identifying signs of harm and gathering evidence for a report shared with partner agencies including Children's Social Services and the Police.

The examination involves a thorough medical history, including questions about the child's development, health, social circumstances, family history and a head to toe physical examination.

A National Standard

The Royal College of Paediatrics and Child Health (RCPCH) Audit of Child Protection Medical Assessments recommended that an essential part of the child protection medical process was to have a published accessible Standard Operating Procedure (SOP) for Child Protection Medical Assessments.

Guidance

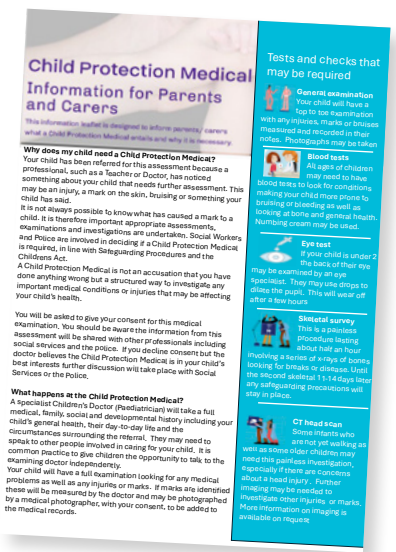
To fulfil this requirement and in order to reduce national variation in examinations, and improve the quality of clinical decision making relating to physical abuse and harm, the Network has produced comprehensive guidance for all medical staff undertaking assessments.

Objectives

The guidance will ensure that all CPMAs are undertaken promptly whilst ensuring they are child focused and of the highest standard. The objectives are as follows:

- Clearly set out the procedures for arranging and completing a Child Protection Medical Assessment.
- To ensure that Health Practitioners understand their role and responsibilities in safeguarding children at risk.
- To ensure all Health Practitioners recognise that safeguarding and protecting children is everybody's responsibility.
- To ensure practice is in accordance with the legislative requirements and expectations of the Social Services and Well-being (Wales) Act 2014 and the accompanying safeguarding guidance.

The guidance includes a referral flowchart to aid clarity and is accompanied by an Assessment Proforma. Additionally a leaflet for Children and families has been developed to explain what to expect in a Child Protection Medical which will inform consent and ensure communication is optimised. Additionally, a patient information video is in production.


Child Protection Medical
Information for Parents and Carers

Why does my child need a Child Protection Medical?

Tests and checks that may be required

General examination

Blood tests

Eye test

Skeletal survey

CT head scan

Guidance for Was Not Brought and No Access Gained

Background

Missed healthcare appointments and no-access visits are recurring themes in Child Practice Reviews, Adult Practice Reviews, and Domestic Homicide Reviews across Wales and the UK. These missed opportunities may reflect neglect or risk of harm, especially when repeated and unexplained. Therefore it is essential that patterns around these appointments are recognised to facilitate optimal multi-agency safeguarding decision making.

Guidance

In response, The Network has developed guidance for NHS Wales staff and relevant safeguarding partners. The guidance outlines key principles and expectations to ensure a proactive and coordinated safeguarding response to situations where a child or adult at risk is:

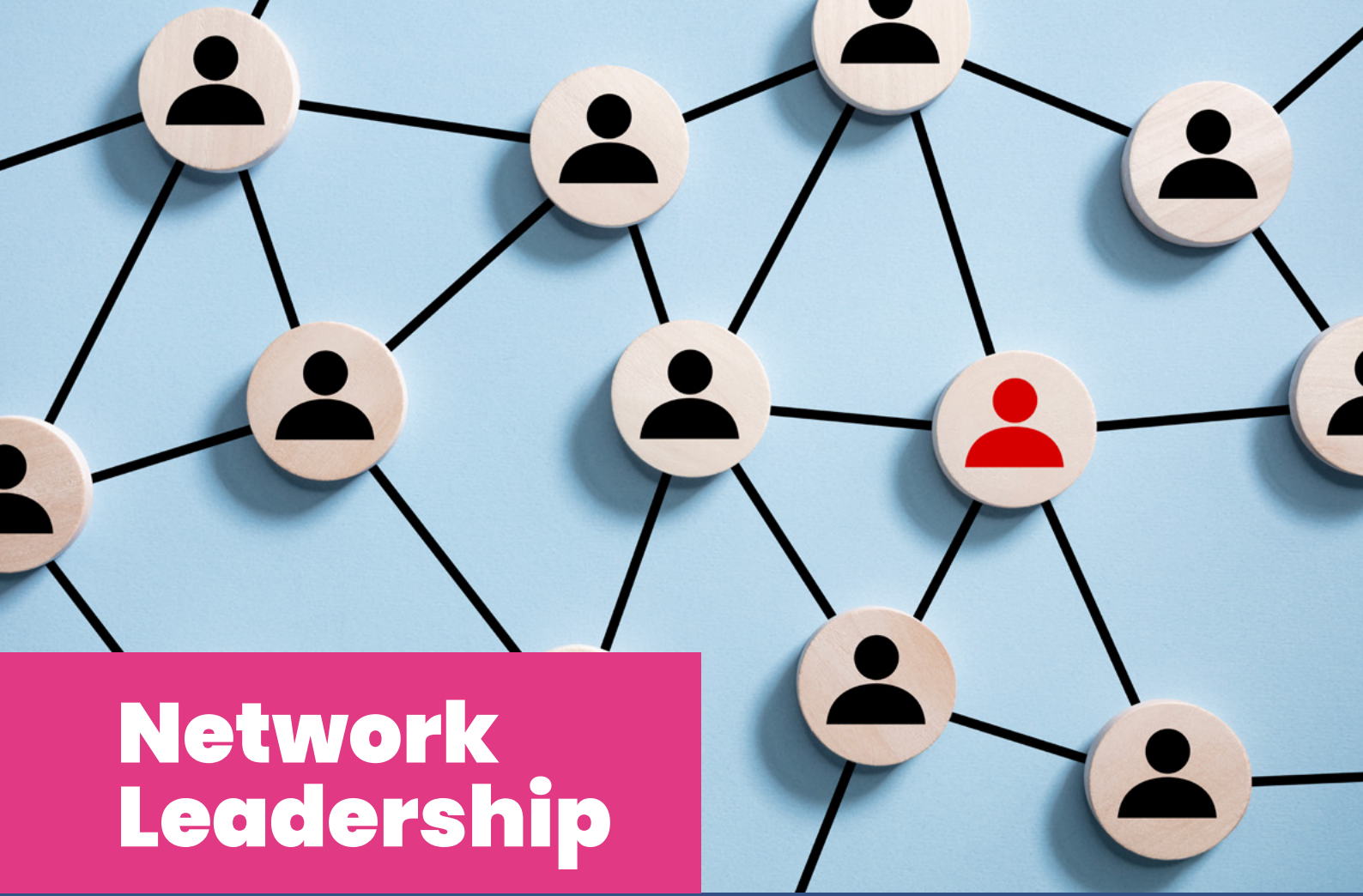
- Not brought to a scheduled appointment (face to face or virtual), or
- Professionals are unable to gain access during a planned home visit.

Whole Picture Approach

To support practitioners in whole picture understanding, a Risk Identification Checklist has been developed to assess risk when children, young people, or adults at risk are not brought to appointments, or when access is not gained for scheduled home or virtual visits. The checklist is for use in conjunction with professional judgement and multi-agency procedures.

Outcome

Going forward the guidance will ensure that missed health appointments and inability to access home visits will not be viewed in isolation or dismissed as routine. By utilising the guidance, NHS Wales can strengthen its safeguarding culture and ensure no child, young person, or adult at risk is overlooked.



Network Leadership

Sexual Safety Principles Fact Sheet

Context

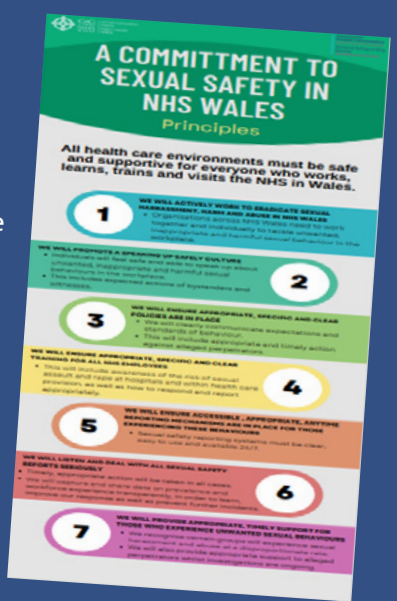
Following numerous reports, media attention and data work it has emerged that sexual safety, in relation to NHS patients, clients, visitors, workforce and estates, is a priority area for greater assurance and improvement.

In response a Sexual Safety National Action Plan is under development, led by the NHS workforce, to promote sexual safety in NHS Wales The Plan will cover national sexual safety policy, guidance, reporting and training considerations.

Fact Sheet

In support this national work, the Network has developed a Sexual Safety Principles fact sheet which supports the aim that: *All health care environments must be safe and supportive for everyone who works, learns, trains and visits the NHS in Wales.*

The fact sheet covers 6 key principles that raise awareness and demonstrate commitment to sexual safety in the healthcare environment, whether they work in it or use it, to feel safe and confident to report issues, feeling supported and heard.



To promote this work, a video infographic is under development to support NHS Wales organisations disseminate the principles across their organisations.

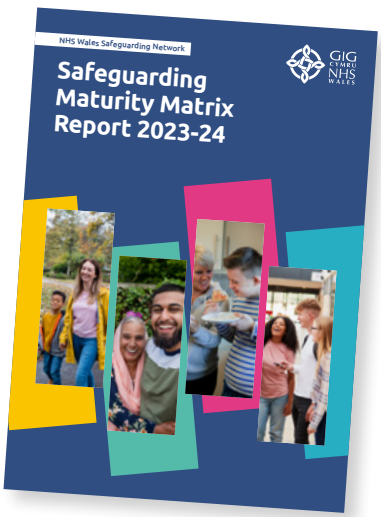
Safeguarding Maturity Matrix: Implementation and Review

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool which supports safeguarding quality improvement across NHS Wales.

It comprises of six domains that underpin the self assessment process and is completed annually by all health boards and trusts as a part of each organisation's assurance system.

- **1 | Well-led, Effective Leadership, and Governance**
- **2 | Confident and Competent Workforce**
- **3 | Person-Centred**
- **4 | Learning Culture**
- **5 | Multi-agency Partnerships**
- **6 | Responsive and Resilient**

The NSS use this information to provide a report that identifies national improvements seen as beneficial from an all Wales approach. Alongside the SMM Peer Review discussion the analysis and findings aim to inform The Network forward workplan priorities.



Limitations

Whilst the SMM tool is updated to reflect the dynamic safeguarding portfolios across NHS Wales, The Network recognises the analysis and report process has limitations. The thematic information gathered is not contemporaneous and therefore lacks timely outcomes to identify current priorities. The Strengthening Safeguarding in Health Review (Welsh Government 2024) identifies the need for real time quality assurance, and more robust measures for safeguarding.

The NSS will deliver this work as part of the Network 2025/26 Workplan, utilising multi-professional groups working together to progress quality statements, key safeguarding metrics and an accompanying suite of quality measures.

Going Forward

Organisations will continue their use of the SMM, collating their assurance information, reporting and accounting through individual governance processes. The SMM Peer Review will continue, enabling the exchange of good practice, supporting collaboration and highlighting system wide quality improvements.

The NSS will support this work, ascertaining any emerging safeguarding themes, and reporting this into The Network.

Remote Consultation Guidance

Context

The COVID-19 pandemic saw the rise in remote consultations in health care. Initially this rise was a response to isolation and lockdown protocols. However, recently remote consultations are still being used to effectively manage time for clinicians in the face of increasing demand.

Furthermore NHS Wales specialist practitioners, working in out of hours emergency care using remote consultation, highlighted the lack of safeguarding training available to meet this change in their practice.

The Network subsequently commissioned work to explore the availability and suitability of safeguarding training relevant to remote health care consultations in NHS Wales.

The Work

A working group comprising NHS Wales, Health Education and Improvement Wales (HEIW) and the NHS Wales Performance and Improvement came together to complete the following tasks:

1. An overview of the current safeguarding training materials that pertain to remote consultation.
2. Identification of potential gaps.
3. An analysis leading to recommendations to support the implementation of safeguarding training for practitioners using remote consultation.

Recommendations

The recommendations to facilitate a consistent approach and enhanced awareness of safeguarding considerations and protections in remote consultation are as follows:

- National Safeguarding Service to consider the inclusion of spotlight learning session on safeguarding and remote consulting.
- The Network Training and Learning subgroup to discuss the findings and recommendations.

Next Steps

During the upcoming year the National Safeguarding Service (NSS) with the support of wider specialist NHS practitioners will deliver a Spotlight training session on safeguarding in remote consultation situations.

In addition the Training and Learning Sub-group have agreed to share learning materials across Wales and is investigating the use of a hub to facilitate this.

Safeguarding Strategy Template

Context and Purpose

In 2023–2024, it was recognised that there was a need for greater consistency across NHS Wales in how safeguarding priorities, responsibilities, and actions are articulated and implemented within individual health boards and trusts.

In response, a Safeguarding Strategy Template was developed to provide a clear and consistent framework that aligns with the Health Care Quality Standards, and is underpinned by a shared safeguarding vision and statement. This initiative was designed to support organisations in articulating their local safeguarding objectives while maintaining national coherence and compliance.

Our Shared Vision

Safeguarding means protecting people's health, well-being and human rights; enabling them to live free from fear, harm, abuse and neglect. It is an integral part of providing high-quality health care. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing, or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.

Our Safeguarding Statement

The NHS in Wales is committed to safeguarding children, young people and adults at risk across health care organisations. The welfare of our populations who come into contact with our health services, either directly or indirectly, is paramount, and all our workforce have a responsibility to ensure that practice is robust, evidence-based and complies with statutory requirements.
By working closely with partners and other agencies, it is required that all NHS services deliver good quality, safe and effective care.

Activity and Impact

The template was co-designed with input from safeguarding leads across all NHS Wales organisations, ensuring it is practical, proportionate, and adaptable to different service contexts.
It provides a structured yet flexible approach for health boards to set out their safeguarding priorities, governance structures, workforce responsibilities, training standards, and assurance mechanisms.

By embedding a common language and vision, the strategy template enables improved alignment, assurance, and collective accountability across the system. It strengthens our ability to demonstrate compliance with statutory safeguarding duties, drive continuous improvement, and ultimately ensure that all people who use NHS services in Wales are safe and protected.

Voice of the Child/Adult at Risk

Pregnancy for Children Under 13 Guideline

Context

While pregnancy in children under 13 is a rare event, it is always a result of statutory rape. Under the Sexual Offences Act 2003, children under the age of 13 are not able to consent to penetrative sexual intercourse. Due to the age of the pregnant child, with every week that passes the risk to the pregnant child increases. Therefore it is paramount that clear, pre-arranged guidance is in place to avoid any delays.

Following a landmark legal case for Wales, with a particular focus on lessons learnt for health services, a need was evident for national guidance to consistently and ethically manage pregnancy in under 13s keeping the pregnant child's wellbeing at the forefront of any decision-making. This can be increasingly complex due to the fact that many of these children are already on a safeguarding plan.

Collaboration

The Network coordinated a multi-disciplinary, multi-agency expert group of practitioners including: legal, midwifery, paediatrics, sexual health, neonates and the British Pregnancy Advisory Service (BPAS) to work on All Wales Pregnancy Guidelines for Children Under 13 years.

This guidance is vitally important as there is a significantly increased risk of harm to the child with any delay in understanding what interventions are required. Therefore, actions need to be taken in a timely manner with full consideration and understanding of the legal aspects of consent and parental responsibility.

All Wales Pregnancy for Children Under 13 Guidance

The guidance clearly sets out an equitable, clear procedure for NHS Wales staff managing under 13 pregnancies, ensuring the best outcome for the child.

The guidance considers the child's feelings about continuing the pregnancy or termination of pregnancy (TOP), incorporating practice that does not retraumatise, but does prioritise their safeguarding and immediate medical care to further prevent harm. There are detailed and clear pathways for termination at differing gestations, continuing with the pregnancy and adoption with complexities of consent and when further legal advice is necessary.

The guidance comprises:

- A protocol flowchart for when a child under the age of 13 discloses they may be pregnant to a member of staff
- The duty to report to the local authority
- Roles and responsibilities covering health, social care and the police
- Aftercare advice including future contraception, referral to therapeutic psychological support and enhanced post-natal midwifery in the case of a birth

Ultimately the guidance should lead to a streamlined process putting the pregnant child at the centre of all decision making and reducing the trauma to the child, the family and all professionals involved in these very challenging cases.

Deprivation of Liberty Safeguards

Context

The purpose of the Mental Capacity Act, 2005 (MCA) is to promote and safeguard decision-making within a legal framework to all people 16 years old and above, who may lack the mental capacity to make their own decisions about their care and treatment.

Deprivation of Liberty Safeguards (DoLS) are part of this act. The 5 key principles act as a set of rules to protect a person receiving care whose liberty has been limited when they lack decision making capacity, by checking that this is appropriate and is in their best interests.

Activity

The MCA/DoLS Network Sub-Group provides a joint working forum on national projects and a strategic voice on behalf of NHS Wales. The group also highlight issues that need escalation with partner agencies and Welsh Government, in the interest of safeguarding those who lack capacity.

Despite the delay in the implementation of the Mental Capacity (Amendment) Act 2019, the transition to Liberty Protection Safeguards (LPS) and a new code of practice, the network have been busy in the last period.

Key Activities include:

- Production of an all-Wales referral form for DoLS
- Update of the NHS Wales MCA/DoLS level 1 & 2 e-learning package
- Planning with Welsh Government for possible inclusion of aspects of MC(Amend)Act 2019 into current process in Wales
- Working in collaboration with social services MCA and DoLS teams to consider how joint working will work
- Engagement with NHS England MCA/DoLs Strategic Forum

Going Forward

The plans for 2025-26 include:

- Piloting the all-Wales referral form.
- Developing an MCA & DoLS training framework compatible with the Intercollegiate Documents level 3/ National safeguarding training, learning and development standards group C
- Producing an all-Wales assurance matrix for MCA & DoLS

Looked After Children Questionnaire Response

Looked after children are amongst the most vulnerable groups in society.

Children often come into care with poorer physical and mental health than their peers, due to their earlier life adversity, meaning that longer term outcomes may also be worse for them. At present there are over 7200 children who are currently Looked After by the local authority in Wales.

Listening for Change

As part of the identified need to develop person experience feedback within safeguarding for shaping services and triangulation of data, a national survey has been developed with stakeholders and crucially with care experienced young people supported by Voices From Care Cymru – a national organisation dedicated to upholding the rights of care experienced children and young people.

Developing a Person-Centred Service

The survey will be used to seek feedback in relation to the statutory health assessments of looked after children and their carers. The aim is to establish a person-centred service, using real time data to drive service improvement that includes what matters to looked after children and their carers, and ensure that the voice of vulnerable children and young people is integral to service provision. The survey will permit standardised responses on satisfaction of service delivery as well as identification of well-being themes and trends, access to services and quality improvement.

Surveys

Three client surveys have been designed for younger children, young people and for carers. Questions focus on the core values including dignity, respect, safety and most importantly whether the children and young people feel involved in decisions made in respect of their health, that they feel valued and safe and that they have had information shared with them in an age appropriate format. There is also a free text box for the child, young person or carer to suggest improvements health assessment experience. The survey has been built using the CIVICA platform and surveys are available currently in both English and Welsh. Future developments may include providing the surveys in other languages, easy read format and British sign language, and hope that one day voice recording of answers will be a function available to all service users.

Next Steps

Every child looked after and their carer will be given the opportunity to complete the survey via a QR code following their statutory health assessment.

Health boards will be responsible for collating and analysing their own data, and reporting back key indicators to the Looked After Children's Steering Group, which is a sub-group of the Network. This will allow themes to be analysed at a health board level allowing for specific local service developments, and also on a national level to identify and address common themes and issues for improvement.

The survey went live in April 2025 and analysis of the data received from the survey will be report on at the end of this year.

Assessment and Professional Curiosity

Updated Female Genital Mutilation (FGM) Guidance

The Network has updated All-Wales FGM Clinical pathway, to support professional practice in the identification and management of FGM.

Female Genital Mutilation (FGM) is a criminal offence. It is a form of violence against women and girls and in the latter case it is child abuse (UK Crown Prosecution Service, 2024; FGM Act 2003, Serious Crime Act, 2015). FGM is when a female's genitals are deliberately altered or removed for non-medical reasons. It is also known as female circumcision or cutting.

Who is the Guidance for?

There is a mandatory duty for regulated health professionals in Wales to report known cases to the police in girls under the age of 18.

Sanctions for not reporting will be determined by the regulatory authority for the relevant professionals.

The updated guidance for professionals working across NHS Wales advises on how to respond appropriately to concerns regarding FGM and their duty to report. All regulated health professionals are expected to familiarise themselves with the updated pathway and assessment tools FGM (Female Genital Mutilation) - Public Health Wales (nhs.wales)

All Wales use of the audit tool will provide valuable intelligence which will facilitate increased professional awareness, adherence with correct process, reduce variation and contribute to better outcomes for women and girls experiencing or at risk of FGM.

Audit Tool for Routine Enquiry into Domestic Abuse

Context

Routine Enquiry into Domestic Abuse involves asking all pregnant women about abuse regardless of whether there are any indicators or suspicions of abuse. Research has shown domestic abuse often starts or is exacerbated in pregnancy. Disclosures of domestic abuse require privacy, confidentiality, and sensitive questioning by non-judgemental staff.

Minimum Standards

The minimum standards of All Wales Minimum Standards Routine Enquiry into Domestic Abuse, Pregnancy and Early Years (2021) were created so that NHS Wales staff are clear about their roles and responsibilities around the routine enquiry throughout pregnancy and the postnatal period.

Inconsistent Activity

Following a scoping exercise by the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Network sub-group it became apparent that the Minimum Standards, specifically Standard 2, was not being applied consistently across Wales.

Standard 2 states that "All women will be routinely asked about domestic abuse at every opportunity during Pregnancy and Early Years, within Maternity, Neonatal Care and Health Visiting Services".

Evidence showed that recording for quality and assurance purposes was inconsistent, with some using paper records and others different electronic systems and data fields, that did not necessarily demonstrate compliance with the standards.

Audit Tool

An audit tool was subsequently developed to set out clear expectations to ensure Routine Enquiry is undertaken consistently and effectively, to improve response and quality of service provision. The tool has been shared with Network members to monitor and ensure implementation of Routine Enquiry across their organisations.

Safeguarding Learning

Professional Curiosity Spotlight Session

Context

Professional Curiosity is when a practitioner explores and proactively tries to understand what is happening within a family, or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value.

Session Activity

Our professional curiosity spotlight session challenged practitioners to think differently about safeguarding, to help transform the lives of children, young people and adults at risk. It brought together multi agency practitioners across Wales, to learn more about what professional curiosity means, how they can implement it, and how they can challenge barriers to change.

The session involved drama-based scenarios and input from experts learning, academia and behavioural science.

Attendees heard that to be professionally curious they need to:

- Understand how we think and process information
- Challenge assumptions
- Understand what the barriers to professional curiosity may be
- Listen to the individual and their lived experience.

I had an increasing awareness that I could be missing a piece of the puzzle.

The actors helped cement the theme and showed how to use professional curiosity and encourage others to use it.

By far the best and most well delivered safeguarding event I've attended.

Safeguarding Adults at Risk Spotlight Event

The '*My Voice My Life: Safeguarding Adults at Risk'* event took place in North Wales. The session focused on listening and understanding the lived experience of adults who find it difficult to make their voice heard.

Expertise was provided from academics and specialists in the field of adult safeguarding, advocacy and learning disability.

The event utilised a unique drama-based approach to present powerful real-life scenarios to impart lasting impact and truly effect change. Additional learning came from people and families who have found and amplified their voice; sharing their experiences with attendees highlighted the importance of person centred, holistic approaches to safeguarding.

The scenarios carried out by actors were very powerful.

The focus on lived experience whilst emotionally challenging was so impactful.

I will be cascading the shared resources with my team and other leads.

Restorative Supervision Event for Named and Designated Doctors

Context

The importance of establishing a Restorative Supervision model is clearly outlined in the recently published National Safeguarding Supervision Guidance.

Safeguarding supervision is an essential mechanism to delivering excellent care quality and should take place as part of a supportive and learning culture. In order to ensure succession planning with a resilient staff, this model is vital. This event for Named and Designated Doctors built on the initial Restorative Supervision event which was held for Heads of Safeguarding.

Event

A 2 day event in the Elan Valley focussed on the restorative supervision of Named Doctors and what an appropriate model would look like moving forward. The Level 4 Safeguarding Training, included talks from national speakers around psychological safety, compassionate leadership and wellbeing for Medical Leaders as well as providing a vital opportunity to network.

We need to actively develop safeguarding supervision for doctors to reduce the risk of them experiencing burnout.

The location away from work allowed formation of relationships. This was invaluable as a newer member of the group.

Review of Safeguarding Learning Dissemination

Context

Many of the themes found in Adult Practice Reviews, Child Practice Reviews and Domestic Homicide Reviews are predictable and unchanging, including recommendations specific to Health. This is despite significant efforts to ensure that learning from reviews is disseminated and put into practice.

The UK government and the Medical Research Council suggest that in complex interventions process evaluation should be used to examine how processes work to generate outcomes. Therefore the Network commissioned an examination of the dissemination of safeguarding learning from reviews using this methodology.

The Review

Initial research was carried out on process evaluation methodology in relation to health, education, training and behaviour change.
A questionnaire was shared with the Heads of Safeguarding in NHS Wales health boards and trusts, concerning how learning from reviews is carried out in their organisation inclusive of policies, recommendation dissemination, target workforce recognition and governance.

Analysis

Analysis of the data revealed that no organisations have developed a formal policy in relation to the dissemination of lessons learned from reviews. Indeed there is no consistency of approach across Wales and all the organisations appear to have different methods of distribution.

The review also demonstrated the considerable amount of work that safeguarding teams and wider health organisations are putting into ensuring learning from reviews is used to inform training and practice. Numerous difficulties were reported which include but are not limited to:

- Competing priorities for organisations and staff
- Staff workload
- Difficulties in recruitment leading to understaffing
- Rapid staff turn-over
- Difficulties accessing IT

Recommendation

Going forward it is recommended that the Network run a pilot Quality Improvement project based in one health board to improve the dissemination of learning from reviews. Upon completion, this activity could be considered for use across all NHS Wales health organisations.

Innovative Regional Practice

Network members regularly share effective safeguarding practice in order to highlight what works in their area, build effective practice and contribute to improving safeguarding across NHS Wales.

Organisation-based and multi-agency practice innovations over the last period follow.

Bwrdd Iechyd Prifysgol
Aneurin Bevan
University Health Board

Improving Children's Experience of Colposcopy

Aneurin Bevan University Health Board (ABUHB) has completed the first stage of a programme to improve the holistic experience of children attending for colposcopy.

A colposcopy is an exam that looks closely at the cervix using a microscope.

Context

Children undergoing colposcopy access a standard outpatient appointment for this procedure, regardless of whether it is part of the Child Protection Medical process or connected to other clinical purposes.

It was noted that, while children have access to experienced clinicians, who are able to explain the procedure and support from an appropriately trained chaperone, there was no dedicated specialist safeguarding support.

Specialist Safeguarding Support

Consequently the Corporate Safeguarding Team has undertaken a trial, whereby a Specialist Safeguarding Nurses is able to support the Paediatric Colposcopy Clinic to focus on the voice of the child. They are also able to offer further support to the child, their family, carers and other professionals who may be supporting or accompanying the child. This approach offers all parties additional time to talk either side of the procedure, either in relation to what may be involved clinically or to ask questions related to the wider safeguarding process.

Results and Evaluation

Initial shadowing of the process and fact finding is complete. All intelligence will inform a longer term service improvement project looking at environmental factors and the educational needs of those supporting the clinic. This will include the role of the chaperone and whether appointments slots need to be lengthened to ensure the voice of the child is central to the process.

Initial feedback from children, carers and clinical staff has been positive, with a formal evaluation planned for Quarter 2 2025-2026.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Early Identification of Safeguarding Concerns

Velindre University NHS Trust (VUNHST) provides specialist non-surgical oncology services across South-East Wales for a population of 1.6 million.

The trust also manages the Welsh Blood Service (WBS) which is responsible for the collection, processing, and distribution of blood and blood products to all hospitals across Wales, serving a population of 3.3 million.

Increase in Safeguarding Reporting

Over the last period, an increased focus on safeguarding training and awareness amongst staff has seen an increase in safeguarding reports related to children whose parents are in receipt of care at the Velindre Cancer Service. This provides assurance that the Trust is 'making every contact count' protecting children from harm, abuse and neglect.

Case Example

A newly referred patient met with an oncology nurse prior to beginning treatment at the Cancer Centre. During the consultation, the nurse learned that the patient lived with their partner and baby who was several weeks old.

The patient raised several concerns regarding their partner including: being dismissive about their cancer diagnosis, shouting at the baby and an isolated occasion of leaving the baby on their own. The nurse gained consent from the patient to share information with the local authority. Arrangements were also made for the patient and baby to stay with a close family member. A Child at Risk report was submitted and all relevant health records updated.

During a following appointment an oncologist noted that the patient was still living with the partner, alongside the partner's negative interaction with the baby. Aware of previous concerns, the oncologist contacted the local authority resulting in an urgent child protection strategy meeting. A unanimous decision was made to trigger Section 47 Child Protection processes which involve a multi-agency assessment to determine the need for action to safeguard a child's welfare.

Learning

This case study highlights the challenges faced by the Trust's staff when trying to safeguard the welfare of children whilst supporting parents/guardians through their cancer diagnosis.

It demonstrates how timely identification of potential safeguarding concerns enables early intervention to prevent potential harm.

Ymddiriedolaeth Brifysgol GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services University NHS Trust

Welsh Ambulance Quality Improvements

Over the last period the Welsh Ambulance Services University NHS Trust (WAST) have taken various measures to improve the service they provide.

The Safeguarding Team work collaboratively with colleagues within the Welsh Ambulance Service and external agencies to ensure positive outcomes for children and adults at risk of harm. Within the organisation the team respond to a high volume of colleague enquiries related to safeguarding, providing feedback to inform future practice.

Cross Organisation Collaboration

WAST Safeguarding Team work closely with the Patient Safety Team and participate in the WAST Serious Case Incident Forum (SCIF) to address safeguarding issues identified within concerns and adverse incidents. This ensures stakeholder collaboration to support and protect colleagues, patients and service users.

The team fully embrace the Trust's Duty of Candour and 'Putting Things Right' process. They aim to provide a supportive framework for staff to learn from safeguarding incidents and therefore inform continual improvement of safeguarding processes.

National Collaboration

The WAST Assistant Director of Safeguarding chairs the National Ambulance Safeguarding Advisory Group (NASAG). The group promotes a consistent approach to safeguarding across the UK Ambulance Services. It connects, supports and guides the safeguarding practice of its practitioners across the UK providing a space for Ambulance Safeguarding leads to access peer support. This high level engagement helps WAST to incorporate UK wide improvements into their practice.

Upskilling Staff

Induction training for patient facing staff in the organisation resulted in positive feedback indicating improved confidence in practice.

Gives you the ability to help others.

A good outline on how on how to spot and help individuals that may be suffering from abuse in this area of their lives.

Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Multi-Agency Safeguarding Training

Multi-agency training was developed and facilitated by the Named Doctor for safeguarding, safeguarding paediatricians and clinical nurse specialist for the Child Protection Medical at Hub Cwm Taf Morgannwg Health Board (CTMUHB).

Content

This training was delivered in partnership with colleagues from Sexual Assault Referral Centre (SARC), South Wales Police, Local Authority, the third sector and Education. Content covered child sexual abuse, exploitation, suspected physical abuse and fabricated illness.

Delivery Success

The first training day in April 2024 saw attendees from multiple disciplines within CTMUHB and partner agencies participate in group discussions and receive presentations from subject experts.

Training benefits include enhanced communication and greater understanding between agencies. It is envisaged this will lead a more collaborative and holistic approach to safeguarding, ultimately leading to improved outcomes for children and young people.

Going forward a further health led multi-agency training session is planned for 2025.

Excellent quality and knowledge of speakers.

I have an improved awareness of services outside of my organisation.

I now feel able to explain a Child Protection Medical and a forensic examination following sexual assault.

My confidence in managing a Safeguarding concern and the following procedures has improved.

Health Independent Domestic Abuse Advocate

Cwm Taf Morgannwg Health Board (CTMUHB) and Rhondda Cynon Taf County Borough Council have collaborated to pilot the role of a Health Independent Domestic Abuse Advocate (IDVA) within one of its district general hospitals, funded by a grant provided by the Police and Crime Commissioners Office.

An IDVA is a trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members.

An Essential Role

The CTMUHB Health IDVA has been integral to the health board's delivery of the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) strategy and blueprint. Over the last year 101 victims were supported, including 76 new referrals.

Service User Feedback

Service user feedback on how they felt prior to support and at the end of involvement with the health IDVA with the following results:

Improved Health & Wellbeing

39

Better informed and empowered to cope with aspects of everyday life

68

Increased feelings of safety

56

Learning and Improvement

Learning from Adult Practice Reviews and Domestic Homicides has recognised the links between domestic abuse and poor mental health. This has resulted in the health IDVA supporting patients and facilitating safe discharge from mental health wards.

Going forward CTMUHB have secured funding from Value Based Health Care to extend the service to 2025-2026.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Violence Prevention Team

A Violence Prevention Team (VPT) based at Swansea Bay University Health Board (SBUHB) is working to reduce crime and associated harm by providing appropriate support and signposting.

They aim to break the cycle of violence by using teachable moments at the point of crisis to eventually reduce the number of hospital attendees who have been assaulted.

Multi-Agency Approach

The Team work in partnership with the Local Authority, Police and third sector agencies to ensure that patients are cared for and receive the appropriate support for their needs.

The importance of the VPT been recognised nationally. Together with Cardiff and Vale University Health Boards Violence Prevention Team they won the 2024 Wales Safer Communities Network award for Safeguarding.

Nurse Led

The Team is a Nurse led initiative that focuses on support for patients who have experienced violence. The VPT take referrals for patients that attend hospital following an assault, or an injury resulting from a weapon such as a knife. While they are based in the hospital Emergency Department, they also support staff with referrals across the Health Board.

Team actions include:

- Providing patients with information and resources to enable them to make informed decisions.
- Ensuring that Safeguarding procedures are followed in a timely manner.
- Supporting staff to report all injuries to Police where a weapon has been used.
- Raising awareness across the Health Board and other agencies to increase awareness of the team's provision.
- Ensuring that staff are aware of the threats relating to knife injuries and how to protect themselves as well as their patients.

Since the team's implementation there have been multiple high-risk cases that have received support, which would have not been possible without this specialist service.

Quality Improvement Measures

Quality Improvement is the cornerstone of safeguarding practices, requiring clear reporting, structures and transparency.

In the last period Betsi Cadwaladr University Health Board (BCUHB) Safeguarding and Public Protection Team has taken a proactive approach to deliver assurance across services.

Safeguarding Reporting Framework

As the Safeguarding agenda continues to grow in scope and complexity, the need for rigorous governance and a quality reporting framework has never been more critical.

BCUHB's Safeguarding Reporting Framework supports frontline to board compliance by ensuring critical safeguarding information, risks and incidents are effectively communicated across all levels of the organisation. It establishes a structured process that ensures accountability, oversight and adherence to statutory responsibilities.

Regular audits, safeguarding reviews, and adherence to quality standards ensure that safeguarding measures are not only compliant but also effective in practice. The framework ensures safeguarding arrangements meet the statutory requirements of true engagement and reporting relating to the National, Regional and Local agenda.

Data Analysis

The support of a dedicated Data Analyst embedded in the Safeguarding and Public Protection Team since 2018, informs the strategic and operational agenda, which evidenced the continued improvement in safeguarding practice across the Health Board. This specialist resource supports the development and identification of IT platforms and collates data that translates to safeguarding performance, risk reporting and analysis.

These real-time updates further support onward reporting within BCUHB and relevant partners. The Organisation is fully engaged in the wider work on National Reporting Dashboards.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cardiff and Vale
University Health Board

Guidance for Birthmarks

Context

There has been a notable rise in inappropriate safeguarding referrals due to misdiagnosis of Congenital Dermal Melanocytosis (CDM), a benign and common birthmark, often mistaken for bruising. This lack of awareness has led to avoidable harm, including:

- Unnecessary child protection medicals involving two sequential skeletal surveys and associated radiation exposure
- Significant emotional distress for families
- Erosion of trust between healthcare professionals (HCPs) and families

A lack of recognition and understanding of CDM among healthcare professionals emerged as a key contributor to this trend, underscoring the urgent need for targeted education and clear clinical guidance.

Training Package

In response Cardiff and Vale University Health Board (CAV UHB) have developed an interactive, evidence-based teaching package to improve awareness, diagnostic confidence, and clinical documentation relating to CDM. Content included:

- Pre- and post-session confidence scales, allowing learners to self-assess their understanding and track progress
- "Spot the Diagnosis" image-based quizzes to reinforce visual learning and highlight key differences between CDM, bruises, and other skin findings
- A 15-minute animated video covering the pathophysiology, epidemiology, and clinical presentation of CDM
- Guidance on documentation best practices, emphasising the importance of recording marks for future reference
- Practical communication tips for explaining CDM to families and colleagues
- A curated set of resources for ongoing learning

The training has been piloted with nearly 100 HCPs across disciplines including General Paediatrics, Midwifery, Health visiting, and Community Paediatrics. Feedback has been overwhelmingly positive, leading to refinements such as clearer side-by-side image comparisons and a real-time quiz feedback.

Next Steps

The teaching pack will be finalized and a stage 2 pilot launched through the Child Health, Midwifery, and Health Visiting Forums.
A wider rollout will follow, with plans to re-audit safeguarding referrals to assess impact.

In parallel, a supportive pathway for community HCPs facing diagnostic uncertainty is being developed. This will enable enabling prompt second opinions from experienced colleagues in a safe, structured, and accessible manner.

The video is great! Really important topic. Have seen a young mum in a lot of distress after being accused inappropriately in ED (Emergency Department).

Loved the video, very useful and clear. Great level of info for all medical professionals as not something we had received teaching on before.

Quality Improvement for Self-Neglect Cases

Context

Over the last year Cardiff and Vale University Health Board (CAV UHB) have been raising awareness of the increase in the number of cases involving adults who are, or are at risk of, self-neglect.

Training

The organisation's Mental Capacity act (MCA) Team have been pivotal in supporting this awareness. As part of National Safeguarding week the team provided a lunch and learn training session titled 'Self Neglect and the MCA'. This was well received and rolled out to staff from November to December 2024.

Toolkit and Assessment

The organisation have also actively promoted the Regional Safeguarding Board's Self Neglect Toolkit to clinicians across the Health Board, with a particular focus on areas that see the higher volume of these cases.

In addition, it is hoped that the new Mental Capacity Assessment Proforma, will prove to be a valuable tool for clinicians to capture relevant information and conduct a robust assessment of the person's capacity where necessary. The proforma aims to improve documentation and compliance with the MCA 2005, which is essential in complex cases such as those involving vulnerable adults at risk of harm due to self-neglect.

Going Forward

To build on this work over the next period the organisation's Corporate Safeguarding Team are developing a Level 3 Self-Neglect study day which will launch in Autumn 2025.

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Professional Curiosity Training

Background

Professional curiosity is an essential skill for health practitioners which enables them to explore and understand the complexities of various situations more deeply. Previously Hywel Dda University Health Board (HDdUHB) collaborated with the Mid and West Wales Regional Safeguarding Board to develop a professional curiosity resource pack. To offset this work the health board have rolled out dedicated professional curiosity training.

Training

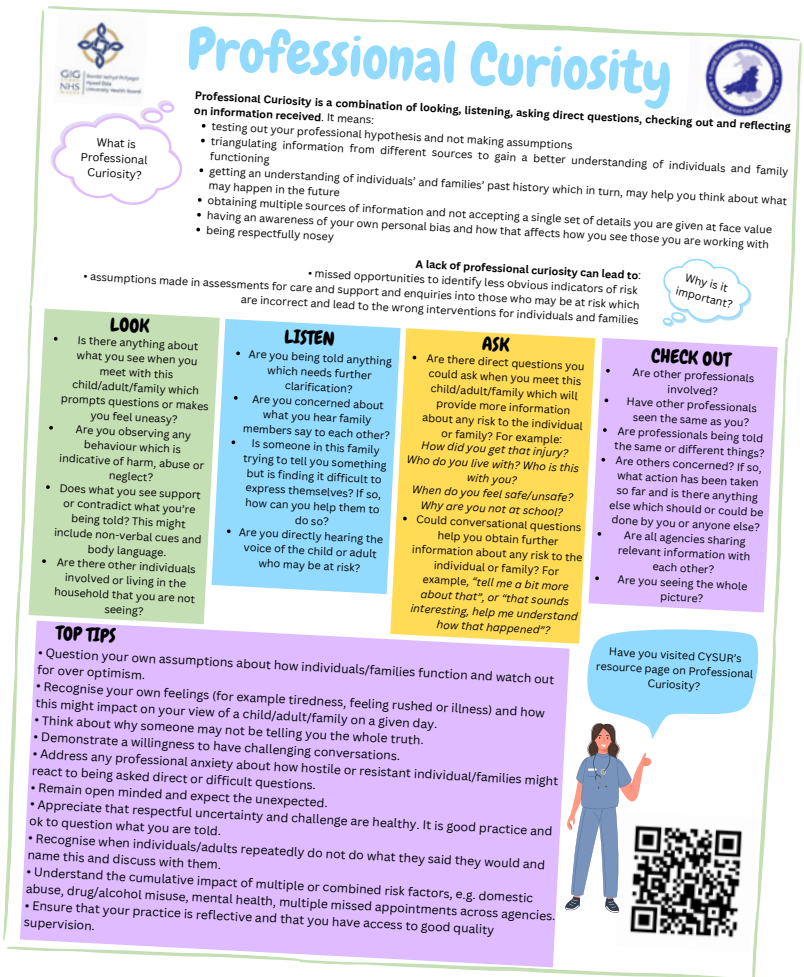
Customised training sessions have been developed which are tailored to accommodate the specific nuances presented by different services. Each session consistently covers key themes including: child and adult abuse and neglect, exploitation, duties under the prevent strategy, violence against women, domestic abuse sexual violence and other safeguarding related topics.

Top Tips Approach

During training participants are encouraged to engage deeply and thoughtfully with the material, fostering a comprehensive understanding of the issues at hand. The top tips: LOOK, LISTEN, ASK and CHECK OUT are embedded in each case scenario.

Health care is delivered via many methods, face to face, via telephone, one off contact, or longer term care. The ability to adapt the scenario ensures that the training remains relevant to a range of services, encouraging participants to think beyond the patient in front of them. This approach reinforces the foundation of professional curiosity which should be an integral part of every practitioner's daily practice.

To supplement the training a poster has been developed which provides an overview of professional curiosity, guidance for the top tips and signposts to further resources.



Disclosure and Barring Service Project

A key area of improvement in Public Health Wales (PHW) has been the identification of risks associated with the frequency and compliance with Disclosure and Barring Service (DBS) checks.

This led to an audit and development of an action plan and framework. These steps will assure a safe workforce, which is key to safeguarding the wider public.

Context

The quality improvement initiative followed a series of incidents concerning an NHS Wales Health Board staff member. A review and follow-up report from the Healthcare Inspectorate in Wales (HIW) recommended that Welsh Government should consider how the renewal of DBS checks for NHS staff can be facilitated across Wales as an important part of safeguarding patients.

Action

As a result, PHW's Safeguarding Group led the following:

- An audit of DBS checks compliance with which identified several risks and a corrective action plan
- The frequency of DBS Checks being raised on the organisational risk register

Various initiatives were progressed with Board support to mitigate the current risk and ensure a robust process is in place for ongoing safe recruitment.

These included:

- The development of a DBS policy with consultation from key stakeholders.
- Engagement with Trade Union partners advising the intention to develop and update PHW's DBS policy to support the move to the DBS Update subscription service.
- Work to ensure DBS levels on all active staff are correct enabling PHW to identify and action gaps. This will also facilitate accurate reporting on DBS compliance when subscriptions to the Update Service are in place.
- New DBS checks will be undertaken on all eligible roles to enable colleagues to subscribe to the DBS Update service.

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Pick up the Phone Campaign

Context

Over many years it has been noted that Regional Safeguarding Adult and Child Practice Reviews, National Safeguarding Reviews and Joint Inspections highlight similar themes and areas for improvement across many services. These include practitioners working in silos, not sharing timely, relevant and proportionate information and the lack of professional curiosity.

Campaign

In response Powys Teaching Health Board (PTHB) Safeguarding Team added to the work of NHS England-Midlands and designed an electronic poster encouraging staff to go *back to basics! Pick Up the Phone and have a conversation* with colleagues across Health Boards in Wales as well as across borders and with partner agencies.

To further embed the message, the Safeguarding Team highlight the *Pick Up the Phone* message at all opportunities including safeguarding supervision, training and while attending Service Group team meetings.

Safeguarding Management Application Goes Live

Powys Teaching Health Board (PTHB) observed that the production of safeguarding metrics required significant manual effort.

To overcome this inefficiency PTHB implemented a Safeguarding Management App to optimise workflows and improve operational efficiency and effectiveness across key activities including safeguarding quality, assurance and accountability.

Notable benefits include:

1. **Increased Capacity:** Time saved gives the team more resource for complex or high-priority work.
2. **Improved Accuracy:** Automation reduces the likelihood of errors, enhancing the quality and reliability of outputs.
3. **Enhanced Responsiveness:** Faster processing times produces quicker responses to internal and external requests.

These efficiencies ultimately contribute to improved service delivery and long-term sustainability. Ongoing monitoring and refinement will ensure these measures remain effective and will be enhanced to meet evolving organisational needs.

Future Priorities

Looking to 2025/2026 the Network will continue to build upon the strong relationships and knowledge base they have built to date, working together to achieve 'A Wales where everyone is safe'.

There will be a strong focus on safeguarding quality and assurance, learning and strengthening partnerships. Future work is driven by current and pending changes in legislation and statutory guidance, learning from the Safeguarding Maturity Matrix, recent safeguarding reviews, recommendation and feedback.

Emerging issues that would benefit from leadership and consistency across NHS Wales are considered throughout the delivery period.

Deliverables over the next period include:

- National child protection principles for NHS Wales representation at safeguarding conferences
- A Safeguarding Quality and Safety Framework
- A Safeguarding Learning Framework
- A Safeguarding Quality, Assurance and Accountability Framework
- A Quality Statement and Safeguarding Metrics
- Stage 2 of an All Wales Under 13 Pregnancy Guideline
- A national standard on managing safeguarding allegations against NHS Employees
- An improvement-focused audit on the views of Looked After Children on health assessments
- Safeguarding principles for the use of chaperones
- Guidance in relation to Was Not Brought and No Access Gained (Adults & Children)
- Scoping to commission an update of the Child Sexual Exploitation Risk Questionnaire (CSERQ)
- Delivery of Multi-Agency Safeguarding Listening, Learning and Improvement Events at ICD Level 3 and above

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *4.3*

End of Year Report for Staff Influenza Vaccination Programme 2024-25 and Proposed Internal Influenza Vaccination Delivery Plan 2025-26	
Executive lead:	Clare Birchall, Executive Director, Quality Nursing and Integrated Governance
Author:	Angela Cook Assistant Director of Quality & Nursing

Approval/Scrutiny route:	Business Executive Team – 06/08/25

Purpose

To provide an end of year report for the 2024-25 Staff Influenza Vaccination campaign and provide the proposed approach for the 2025-26 Staff Influenza Vaccination programme.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☒

The Committee is asked to:

- Take **assurance** from the Internal Influenza Vaccine Campaign end of year report for 2024-25.
- Take **assurance** on the approach for the Internal Staff Influenza Vaccination Programme for 2025 -26

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	All Strategic Priorities/Well-being Objectives
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	An Equality and Health Impact Assessment is not required as there is no impact on policy or decisions relevant to the Race, Disability and Gender Duties
Risk and Assurance	Public Health Wales has a legal duty of care towards service users, staff and members of the public, who come in to contact with the services it provides. Maximising the front-line staff uptake of the flu vaccination will help protect the public and staff. The risk associated with the delivery of this programme current sits on the NQIG Directorate Risk Register.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act, in relation to the Duty of Quality and Candour by fulfilling the following quality standards Safe, Effective, Person centred along with the Quality enablers of workforce and a whole system approach.
Financial implications	There is a risk that the Welsh Ambulance Services NHS Trust (WAST) will not be able to maximise PHW staff vaccination uptake as identified within the Service Level Agreement (SLA). Monitoring arrangements are in place with the Flu Delivery group and People and Organisational Development Contract meetings. There will be an additional financial cost associated with purchasing the electronic staff Flu vouchers, on a pay as activated basis

People implications	Failure to maximise the uptake of the Flu Vaccine may increase staff absence form work through short term sickness. There is an impact on staff workload for those involved in the Flu Delivery Group, and the management of associated enquires and Flu Voucher administration.

1. Purpose / situation

The purpose of this paper is to provide the Quality, Safety and Improvement Committee with a summary of activities and overall performance of the Staff Influenza Vaccination 2024-25 campaign and provide a proposed approach for 2025-26 programme. This report provides assurance that systems and processes are in place to ensure that eligible staff groups have access to the annual occupational flu vaccination offer.

2. Background

Annual Influenza (Flu) vaccination is recommended for all health and social care staff with direct patient/client contact. It is a World Health Organization (WHO) priority and actively encouraged as part of the annual flu programme in NHS Wales. Public Health Wales has a significant system leadership role for Vaccine Preventable Diseases.

The annually published Welsh Health Circular 'the National Influenza Immunisation Programme' recommends achieving high influenza (flu) vaccination uptake rates as a priority in the autumn/winter. The Welsh Government publish a Winter respiratory vaccination strategy for autumn and winter informed by the latest advice from the Joint Committee on Vaccination and Immunisation (JCVI) and the Chief Medical Officer for Wales. Vaccination uptake rates for all NHS organisations are published across Wales.

For the 2024-25 programme, the organisation took the decision to adopt the Joint Committee on Vaccination and Immunisation (JCVI) guidance which recommends that flu vaccinations should be only offered to front-line staff or direct patient contact staff, in line rather than an all-staff approach which had been taken in previous years.

In addition to this, several key areas of risk and concerns regarding the use of the peer vaccinator model to supplement the commissioned Occupational Health models, along with Infection Prevention and Control (IPC) issues were taken into consideration and the decision was made to maximise Service Level Agreements (SLA) only supplemented with a Flu voucher offer.

3. Description/Assessment

3.1 Uptake and Delivery

At the end the 2024-25 Flu season, the organisation achieved an overall uptake figure of 26% for front-line staff equating to c. 400 staff. It is important to note that the organisation was unable to fully report staff vaccinated under SLA with its 5 Occupational Health providers due to ongoing issues with data sharing and extraction

from the Opas Occupational Health system, and so this figure will underestimate the overall uptake to a certain extent.

Across all NHS Wales organisations the uptake figure achieved was 34% for front-line staff, a declining position compared to the previous year (36.4%).

The model used for this year's programme solely on SLA with the Welsh Ambulance Service (WAST) being the main provider, delivering sessions at Public Health Wales static sites supplemented by WAST mobile units and their Swansea Matrix One site as well as the SLAs within Health Board Occupational Health departments.

Community pharmacy voucher scheme
The community pharmacy voucher scheme allows staff to obtain the flu vaccine from a local pharmacy, facilitating a convenient method for some staff to receive their flu vaccination. This option was also made available to staff as part of the 24/25 programme. 100 vouchers were purchased, 74 were supplied to staff.

3.2 Data Issues

3.2.1 Electronic Staff Record
This year the organisation was able to use the enhanced functionality in ESR that allowed 'Front-line status' to be recorded at position or employee level. A data cleansing exercise was completed ahead of the programme start and this functionality applied to support accurate data capture however it is reliant on managers identifying front-line roles and staff. 1,473 staff were identified as front-line.

3.2.2 Data Capture
As with previous years, staff members were able to access flu vaccines from several additional providers, including community pharmacies and GP practices and Aneurin Bevan University Health Board (ABUHB) and Cwm Taf Morgannwg University Health Board (CTMUHB) through our existing SLA contracts. The intranet self-reporting form enabled these data to be captured, although it was reliant on the willingness of staff to report their vaccination. The existence of these different recording mechanisms means that identification of, and access to, robust staff flu vaccination data for internal reporting is complicated and potentially not wholly reflective of the total uptake.

3.3 Reported Safety Incidents
In addition to the data collection issues described above, there are several other issues and risks relating to the delivery of the internal programme this year, with BET being kept appraised of these during the flu season and including 3 incidents reported on Datix. The first related to the procurement and initial administration of a suboptimal influenza vaccine in the first 2 weeks of the programme by WAST. The second related to obtaining informed consent from Public Health Wales staff by WAST Occupational Health staff and the recording of this. The third related to information governance and clinical record keeping by WAST staff. All 3 incidents were managed through an internal incident management team and oversight of remedial action supplemented

with regular meetings with the WAST Occupational Health Services Manager, Business Manager and a senior clinician.

4.0 Proposed Staff Influenza Vaccination plan for 2025-26

4.1 Introduction

A review of the previous year's revised delivery model was undertaken with key Public Health Wales staff during spring 2025 and included the VPDP Programme Lead, the Behavioural Insights Unit, and the Executive Medical and Nurse Directors. Following this review key areas of learning were identified as follows:

- Clinical and delivery concerns by the main occupational health provider (WAST)
- Mixed messaging and our staff feeling undervalued i.e. front-line versus non-frontline
- Accessibility and availability of staff vaccination clinics at times when staff can attend. This was particularly notable for the North Wales locality.
- Reduced opportunistic access to flu clinics.
- The lack of Flu champions
- Reduced Communications /promotion on the staff intranet
- Data capture and provision of data from Occupational Health systems and Community providers
- A national decline in vaccination uptake by NHS staff and the general population
- Misinformation in the Public domain

The key message emerging from these discussions was not to segregate staff but have an organisation-wide offer to all staff and to make the vaccine as available and accessible as possible.

Due to the time constraints between the end of the 2024-25 programme and the procurement of Flu vaccines and trying to secure an alternative provider for 2025-26 season, it has not been possible to change the current providers for this year's programme. The current Occupational Health provision SLAs remain in place for this year's programme, but the SLA is under review by the Director of People and OD.

4.2 Staff Target Estimate for 2025 /26

Based on the current ESR data, as of 30 June 2025, there are approximately 2,700 employees, including NHS Wales Performance and Improvement as a hosted organisation. Approximately 1,300 are identified as front-line (based on last year's figure) with the remaining being non-front-line staff.

4.3 Flu Vaccination Programme 2025-26

Vaccination delivery will continue to be via a mixed model approach utilising the WAST SLA to deliver vaccination sessions at the main Public Health Wales sites such as

CQ2, Magden Park and front-line screening services such as the Breast Test Wales Regional Centres. This will be supplemented with WAST mobile units and static WAST sites such as Matrix One and St. Asaph. The multi-pronged approach is targeted at maximising availability and ease of access for staff to the vaccine based on last year's evaluation. This year there will be no segregation of staff eligibility, and all staff will have an opportunity to receive a flu vaccination. This is based on a review of last year's overall performance and advise from our behaviour's science team.

4.3.1 Health Board Occupational Health Departments

Where SLAs exist, this approach will be continued to be offered to our staff in the Infection Services Division. If non-laboratory staff are vaccinated outside of the SLA agreements by their local Health Board OH department, for example Neonatal Screeners on the postnatal wards, the Health Board is able to cross-charge Public Health Wales for this service (and this is addressed in the SLAs with all 4-health board Occupational Health providers), so this will be promoted this year.

4.3.2 Flu Vouchers via a Community Pharmacy Provider / Pay As You Activate (PAYA) Vouchers

In addition, the proposal this year is to supplement the Occupational Health provision through the use of an electronic Flu voucher using an enhanced offer of Pay As You Activate (PAYA) Vouchers.

PAYA Vouchers offer a flexible and convenient solution to allow staff to access a community provider at a time and location that is convenient to them. With this option, vouchers are only paid for as they are activated, rather than covering the full cost up front. Key features include:

- A single activation code for all team members, simplifying distribution and tracking
- Weekly or monthly reporting to monitor voucher activations
- Monthly invoicing based on actual usage
- The cost of this is £17.50 per activated voucher and includes full tracking and reporting to show who has activated their voucher and when, which would support vaccination rate reporting
- Does not require additional administration support to monitor voucher requests and post to individuals
- No postage costs (as with hard copy vouchers)

It is anticipated that this method is likely to be more appealing to staff based in North Wales. A purchase order has been raised for an initial 250 flu vouchers and budgeted for within NQIG. These are in addition to the 100 paper flu vouchers already purchased. Should more be digital vouchers be required these can be purchased and protected funding for this is in place within the NQIG budget. It is important to note that with the PAYA method, PHW will only pay for what they use.

4.3.3 Community Administration

Self-referral to General Practice and/or community pharmacy as appropriate will also continue for staff identified as eligible due their health risk factors.

4.3.4 Appointment Scheduling

The organisation will advertise Flu vaccine clinics and the online appointment system hosted by WAST will be available for staff to view and book available appointments. A dedicated Flu Team email address will be in place to ensure staff enquiries are answered.

4.3.5 Flu Champions

The Flu champion model will be re-introduced to support conversations in the workplace and signposting to available Flu clinics and alternative provision. Planning for this has commenced.

4.3.6 Data Recording Collection and Reporting

This year there is an expectation that all providers operating under the national programme will be required to use the newly improved Welsh Immunisation System (WIS) to digitally record flu vaccinations given to adults as specified in the Welsh Health Circular WHC/2025/020.

PHW staff data is currently not up to date within WIS system and following a preliminary discussion with Digital Health Care Wales (DHCW) it is anticipated that an update can take place in September making it easier for vaccinators to record flu vaccinations and assign the correct employer to the staff record. This will enable more accurate reporting and minimise the risk of PHW staff being included in health Board data. Work is currently progressing with the Research Data and Digital Directorate and DHCW to facilitate this process.

Data collection will be managed by the Epidemiology team and continue using the current methodology and format. It is anticipated that all staff vaccinated by WAST OH department will be captured within the WIS system and WAST are due to do their training on this system shortly. Weekly vaccination uptake rates will be provided to Public Health Wales by WAST.

It is anticipated that staff receiving vaccines at ABUHB, CTM and Swansea Bay will be reported via the WIS system. Staff who receive their vaccination via primary care and community pharmacies will be asked to self-report via the online internal form due to the ongoing data provision issues.
A staff flu vaccination dashboard will continue to be used and shared with Divisional Leads for further dissemination and actions.

4.3.7 Governance

The internal Vaccine Delivery Group will be responsible for the monitoring of the delivery of the delivery plan for the Seasonal Flu Vaccine plan chaired by the Assistant Director of Quality & Nursing supported by the People and OD team.

This year the service manager for WAST has been invited to attend this internal group to provide operational updates and assurance regarding clinical safety. In addition, regular peer to peer meetings with be held outside of this group between POD and WAST in the initial planning stages of the programme and for the duration of the 2025-26 programme.

Updates will also be provided on progress and for assurance to the Business Executive Team on a regular basis as agreed, and further assurance reporting to the Quality, Safety and Improvement Committee as required.

Formal work is being led by the Director of People and Organisational Development to review the OHD contract and provision ahead of next year's programme at the request of the Chief Executive.

4.3.8 Communications

The organisation's Communications team are key to supporting the Flu Campaign and informing staff of the seasonal Flu Immunisation programme and how to obtain the vaccination. A communications plan is being drafted and will be finalised once detailed plans are received from WAST and the approval for the introduction of electronic vouchers (PAYA).

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

The annual 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 infection prevention and control.

Public Health Wales works to prevent avoidable infection risk to its staff and service users, and this vaccine programme helps this goal, through providing protection against influenza.

The staff flu vaccination programme aligns with PHW's Wellbeing goals 3, 4 and 5.

The staff flu vaccine programme is successful due to the collaboration of staff from several departments, and through joint working with WAST. This report shows how successful this has been.

The staff flu vaccination programme is run with the intention of continuous improvement, and this is shaped by engaging with staff members and members of the flu programme itself to evaluate it and modify the approach as necessary.

4. Recommendation

The Committee is asked to:

- Take **assurance** from the Internal Influenza Vaccine Campaign end of year report for 2024-25.
- Take **assurance** on the approach for the Internal Staff Influenza Vaccination Programme for 2025 -26

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** 4.4

Public Health Wales Strategic Risk Register

Medical Director/ National Director	SR 3

Purpose

Receive this revised Strategic Risk Register for the purpose of scrutiny and challenge, noting the updates to action plans and controls and progressing risk maturity going forward since the last reporting period.

The Committee is asked to note the revised strategic risk that falls within the remit of the Committee's Terms of Reference and the inclusion of new action plans and controls, where appropriate.

Appendix 1 includes the full risk assessments for Strategic Risk 3.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☒	☐	☐	☒

The Committee is asked to:

- Take **assurance** on the management of Strategic Risk within the Organisation.

Link to Public Health Wales Strategic Plan

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

This report contributes to the following:

Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis

Equality and Health Impact Assessment	No decision is required.
Risk and Assurance	This submission is the Strategic Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Quality Standards. All themes
Financial implications	The financial implications of failing to manage risk effectively are significant, both in terms of the potential for loss and also the failure to capitalise on opportunities.
People implications	There are both Corporate and Strategic Risk(s) relating to workforce and organisational development.

1. Purpose

This paper updates the Committee on the key developments in the risk agenda.

This paper must be read in conjunction with the Strategic Risk Register (*Appendix 1*). The Strategic Risk Register should be considered alongside the Board Assurance Framework (BAF), the Integrated Medium-Term Plan (IMTP) and Public Health Wales Strategic Objectives.

In line with due process and the approach of all Health bodies in Wales, risks are measured against a 5x5 risk scoring matrix:

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely (61-90%)	4 (Moderate)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible (41-60%)	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely (11-40%)	2 (Low)	4 (Moderate)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare (1-10%)	1 (Low)	2 (Low)	3 (Low)	4 (Moderate)	5 (Moderate)

Organisational risk reporting provides a snapshot of a point in time, and this will continue to be an iterative process. This report outlines the strategic risk position as of **1st August 2025**. In line with the current Risk Management Policy, strategic risks are reviewed and updated every other month. As risk management processes and practice becomes more mature throughout the organisation enhanced reporting, including the measurement and impact of mitigating actions, will continue to be refined.

2. Risk Description, Architecture and Ownership and Changes Since the Last Reporting Period

Since the last reporting period, significant work has been undertaken to understand and clarify the strategic risks to the organisation achieving its strategic objectives and the delivery of the IMTP. Understanding the threats to attaining strategic objectives is key to identifying accurate strategic risks and to ensure that Board and Committee attention is focussed on the most appropriate business areas of the organisation.

The Committee is reminded that a rolling programme of strategic risk deep dive sessions will commence in October 2025 starting with strategic risks 1 and 2. This will facilitate discussions at an Executive level and enable the risk assessment template to continue to be populated as

accurately as possible and will reflect the interdependencies between strategic risks and respective Directorates/Programmes of work.

The only significant change is the review of SRR3, the organisational ability to provide excellent public health services, where it has determined that the **risk scoring should increase from 9 to 12**, specifically on the **likelihood** of the risk manifesting (see Appendix for more detail)

3. Overarching Strategic Risk Profile

The revised strategic risks show a significant change in the overarching strategic risk profile for the organisation. This is based on the severity of the strategic risks and their scores and is visually depicted as follows: [1]

The spider diagram illustrates that the most significant area of risk is **SRR5, we fail to fully exploit digital and data fully to improve public health in Wales.** This is a change since the last reporting period, primarily due to the consistent and robust review of each strategic risk over the summer period.

The Committee is requested to take assurance that Strategic Risk 3 is being managed within their respective agreed risk appetite threshold.

[1] The diagram does not include SRR6 as this risk is considered in private session of the Board due to the nature of the risk.

3.1 Risk Appetite Reporting

The Committee is asked note that currently, strategic risks 1-5 are being managed within an agreed risk appetite level, with all risks incorporating a tolerance level, should the risk profile worsen.

SRR6 is currently being managed outside of its risk appetite and tolerance levels. More details on this are included in the separate paper, specifically for SRR6.

4. Links to the Corporate Risk Register

The Corporate Risk Register (CRR) reflects the most significant operational risks that impact Public Health Wales. The CRR summary table that was formerly presented within this report has now been removed as BET, Committees and the Board have taken assurance that corporate risks are being managed appropriately across the organisation. Assurance has also been taken that the management of the corporate risks support and underpin the management of the strategic risks.

5. Strategic Risks

A full assessment of Strategic Risk 3 can be viewed in *Appendix 1.*

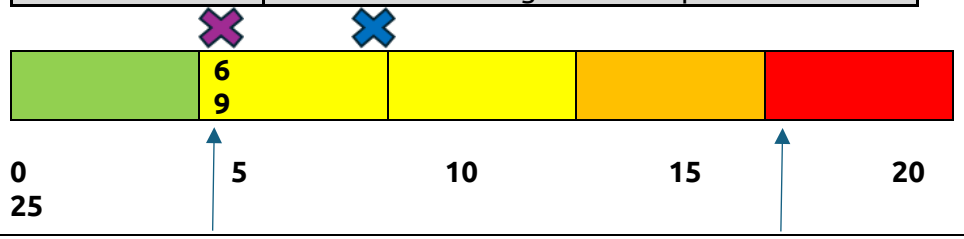
6. Equality Impact Assessment

No decision required.

7. Recommendation

The Committee is asked to:

- Take **assurance** on the management of Strategic Risk within the Organisation.

Risk Reference and Link to Strategic Priority	Risk Description	
SRR3 **Strategic Priority 5** "Delivering excellent public health services to protect the public and maximise population health outcomes."	**There is a risk that**: We fail to deliver our contribution to excellent public health services in population health screening, infection, health protection and emergency response. **Caused by**: **1.** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery. **2.** Inability to maintain capacity and capability of the specialist workforce. **3.** Absence of innovation and continuous quality improvement. **4.** Exceedance in unplanned activities arising from unexpected acute threats to health. **Resulting in:** Poor quality and unsafe services, sub-optimal population health outcomes for population screening and health threats, and a breach of legal duties on Civil Contingencies and Duty of Quality.	
Executive Director Sponsor	**National Director of Screening and Health Protection Services/Medical Director**	
Assuring Committee	**Quality, Safety and Improvement Committee**	
Trend	**Current Position of Risk Including Risk Appetite and Risk Decision**	**Position Statement – Executive Director Update**
to be confirmed via a run chart after monitoring for 3 months, will be produced via excel/pivot table to visualise risk score trend over time	**Open** — PHW is open to consider all potential options, subject to continued application and/or establishment of controls recognising that there could be a high risk of exposure.  	Work continues to improve operational delivery for services that are not meeting performance targets, particularly for Breast, Diabetic Eye and Bowel screening. The screening pathway relies on commissioned providers to carry out further diagnostic tests and the wait times for these are sub-optimal and there is ongoing work to address these concerns. Work is ongoing to improve the uptake of screening and reducing inequity. Optimisation and transformation of Diabetic Eye Screening continue to develop a sustainable

	 = **Current Score** = **Target Score**	delivery model. Several digital developments are ongoing to support service delivery. Workforce capacity across the Health Protection and Screening Services directorate is continuously reviewed, with key mitigations on the health protection and bioinformatics workforce being progressed. The position on screening workforce particularly in the North Wales workforce for Breast Test Wales, remains an area of focus to ensure resilient capacity across the clinical team. There has been a significant outbreak of Cryptosporidiosis in relation to a farm, but this has been managed with existing resources.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Development, implementation, and maintenance of emergency and business continuity arrangements, including participation in EPRR training and exercises, alongside debriefing and implementing lessons identified from incidents and outbreaks.	• PHW Emergency Response Plan (V3.2) • PHW Countermeasures Protocol • PHW Business Continuity Arrangements.	• Annually reviewed, tested by exercise, with written assurance to Board. • Reviewed biennially, tested by exercise. • Annually reviewed by Directorate with assurance via Emergency Preparedness Resilience and Response (EPRR) Group Meetings (Quarterly) reported to Board.

[1] Three Lines of Defence Model
First – Operational Management control of organisational risks
Second – Risk management and compliance functions, reporting to senior management
Third – Internal audit to provide assurance.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
		• Communicable Disease Plan for Wales • PHW Annual Assurance Return to Welsh Government on EPRR • Work with partners to locally, regionally and nationally to continually review, update, train for and exercise multi-agency plans and procedures for emergencies. **NB.** This is via Local Resilience Fora (LRF), Wales Resilience Partnership, Wales Resilience Forum and the 4 Nations Public Health (PH) Emergency Preparedness, Resilience & Response (EPRR) Group.	• Reviewed biennially, tested by exercise in conjunction with Health Protection • Annually produced, with approval from EPRR Group, HPSS DMT, BET, QSIC & Board. • Schedules for meeting, training, testing and exercising vary. For further detail, please contact phw.eprr@wales.nhs.uk
C1.2	Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-clinical *Standard Operating Procedures and Protocols.*	• Comprehensive suite of organisational policies and procedures. • HPSS directorate and divisional policies and standard operating procedures aligned where relevant to clinical and operational delivery standards and agreements. • Population Screening Programmes delivered in line with UK National Screening Committee recommendations and as approved by the Wales Screening Committee and Welsh Government Policy.	• Corporate Policy and Control Document Reviews via Leadership Team. • Regular Clinical Audits undertaken against Standard Operating Procedures. Clinical audits undertaken on outcomes eg Cervical Screening Wales audit of all cervical cancers in Wales • Health Inspectorate Wales routine inspections. Clinical review and also specifically inspection of IR(ME)R regulations in Breast Screening Programme (radiation regulations)

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
		• HPSS laboratory systems accredited to ISO 15189:2022, with re-validation required yearly.	• UKAS inspections and resulting accreditation guarantees the highest levels of impartiality and competence through the continuous assessment process.
C1.3	Variation / risk-based prioritised approach to directorate delivery assurance.	• Cross directorate operational delivery reporting. • Action plans, spotlight sessions and reports to HPSS Divisional SMT's, DMT QSIC. • Annual clinical audit programme	• Broad monthly monitoring at HPSS Divisional SMT's. Focused monthly monitoring at HPSS DMT with selected reporting and insights to PHW Board. • Rolling monthly programme at HPSS DMT / SMT and QSIC • Reports to divisional SMT's and QSIC • Monthly performance updates to Health Boards on their aspects of delivery of screening programmes. (SH)
C1.4	An HPSS programmatic approach to benchmarking, reviewing and improving corporate and business operational systems and processes within the directorate supported by corporate enabling functions.	• Excellent operations programme scope • Excellent operations delivery dashboard • Range of diagnostic / review reports	• Monthly DMT update reporting • Reports into corporate committees and Board • Internal audit reports on programme projects
C1.5	HPSS adoption of the PHW Clinical Governance Framework and the divisional	• PHW Clinical Governance Framework • Divisional Quality Lead resources	• HPSS SMT / DMT reporting

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	systems of quality monitoring aligned to delivery context and mandated or quality standards.	• Divisional Quality reports and action plans • Contribution to the PHW Duty of Quality reporting • Compliance with quality inspections (e.g. UKAS)	• Quality Oversight Group participation and workplan • Corporate reporting (patient / service user experience including incidents, complaints, claims and Duty of Candour) • External inspections
C1.6	HPSS mapping of current and future digital transformation needs aligned with strategic priorities and operational needs	• Comprehensive mapping document • Inclusions in 10 year strategic capital plan • Bi Monthly inter directorate DKR and HPSS executive led meeting	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme) • Monitored at internal HPSS Programme Meeting • Reporting to HPSS DMT

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Uphold high professional standards: Professional Regulation – Medical, Nursing & Midwifery, and Multi-Professional Staff	• Medical, Nursing & Midwifery, HCPC, Allied Health Professional and Multi-Disciplinary Staff Revalidation process and audit • Medical Job Planning Process	• Annual Report to POD COM / QSIC • Oversight by OMD, with assurance reporting via HPSS DMT (or NQIG for Nursing and Midwifery) to BET and Board
C2.2	Evolving system of workforce planning aligned to future operational and strategic needs	• Divisional level workforce plans in development	• POD oversight
C2.3	In addition to being an approved specialist training provider there are a range of	• Training provider status • Agreed competency standards	• HEIW contracting, reviews and audits • Workforce development plans

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
	professional competency standards and associated "pathways" for internal staff development aligned to current and future operational and strategic needs	• Approved professional pathways • NSHCS Training status accreditation with IBMS every 5 years and the • Maintenance of Specialist Scientific workforce skills.	• Training completion reporting • External accreditation • Assessed internally every 3 years using defined criteria underpinned by ISO 15189:2022 standards
C2.4	Extensive people development opportunities to maintain and expand knowledge, skills and competency	• Training attendance records • Developing and maintaining of staff competency framework and staff Training Needs Assessments (TNA)	• Training and development spend via financial monitoring • Training records
C2.5	Working with HEIW and developing strategic links with HEI's providers to develop future workforce pipeline	• Via POD assurance processes	• Organisational workforce planning

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Absence of innovation and continuous quality improvement.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	Specialist / subject area leads and divisional systems for horizon scanning and staying abreast of service and technological advancements.	• Professional leads for scientific areas • Detailed work with procurement specialists to undertake regulated market research to scope and test innovation opportunities/providers • UK National Screening Committee	• Documented Leads • Procurement documentation and reports
C3.2	Research and development strategy and agreed directorate priorities	• HPSS fully engages in PHW wider research structures which includes an	Both specific review of areas of excellent public health service and via PHW wider research structures are reported to the KRIC

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Absence of innovation and continuous quality improvement.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
		organisation wide research strategy and development of priority areas	
C3.3	See C1.4 and 1.5		

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Exceedance in unplanned activities arising from unexpected acute threats to health.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Maintenance resilient dedicated 24/7 EPRR On-Call Service which helps to ensure that the organisation meets its statutory obligations under the Civil Contingencies Act 2004 and receives Emergency and Major Incident notifications in a timely manner.	• 24/7 Resilient EPRR On Call Service Standard Operating Procedure.	• Performance monitored monthly via HPSS DMT Metrics, annually reviewed, and reported on via the PHW Annual Assurance Return to Welsh Government on EPRR approved through the EPRR Group, HPSS DMT, BET, Quality, Safety, and Improvement Committee & Board.
C4.2	Extensive system for surveillance of health threats to inform timely and effective response.	• Exceedance reports and protocols with agreed criteria for escalation and response management • Weekly HP issue summary produced	• Circulated to PHW Executives

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.1	Develop resilient, coordinated and effective	Arrangements to be validated via an	Align with UK National Respiratory Pandemic	Huw Williams / Tom Fowler	Q4; 2025/26	**February 2025:** Work ongoing via the

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	Pandemic Response Arrangements for PHW.	organisation-wide internal desktop exercise.	Framework (draft) incorporates lessons identified from internal Covid-19 debrief, lookback and reflection processes; as well as recommendations from the UK Covid-19 Module 1 Report. Provides organisational assurance for preparedness.			Internal Pandemic Preparedness subgroup. Terms of reference agreed, workstream leads identified and key actions for delivery agreed.
AP1.2	Develop digital programme approach to all digital development activity and improved processes for identifying and agreeing digital activity	Timely delivery of digital programmes	Substantial digital development is required across a variety of systems, coordination on a portfolio level will enable more coordinated and therefore more effective delivery with HPSS and identification of the most appropriate forum within digital governance structurers for actioning.	Tom Fowler/Michelle Battlemuch	Q4; 2025/26	Preliminary mapping of major project alignment to Digital governance structures in place.

Gaps in Assurance / Action Plans for the cause C2 Inability to maintain capacity and capability of the specialist workforce.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.1	Undertake a broader review relating to retention and TNA of regulated professions	This will either provide assurance that we have a stable, competent workforce or require a set of actions to achieve this	By providing relevant information to determine actions.	Tom Fowler/ Ruth Tofton	Mar 26	Initial discussions with Nursing and Midwifery professional leads
AP2.2	Working with HEIW colleagues to broader HEI links offering public health placement opportunities for Allied Health professions	Feedback from participants	This will provide trainees in allied health professions to experience public health placements to support their future careers to promote prevention and healthy lifestyle	Tom Fowler/ Ruth Tofton	Mar 26	HEIW have produced plan, paper being drafted for consideration and agreement by BET to engage.
AP2.3	Improved involvement by OMD in the education commissioning process, working with POD and Divisional L&D Leads	N/A	Improved oversight of education commissioning funding and allocation	Tom Fowler/ Eleri Davies/ Ruth Tofton	Mar 26	Annual commissioning recently completed – allocation confirmation due May 25.

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.1	Next steps on development and	Route maps are required to inform IMTPs going	By developing a longer term and more	Meng Khaw (Exec sponsor)	Route maps	A draft route map has been developed

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	implementation of Route Maps for priority area 'Excellent public health services'	forward which will be monitored through existing approaches	coordinated approach to development and implementation of innovation and continuous quality improvement in service provision	Tom Fowler (priority lead)		and submitted centrally.
AP3.2	Development of approach to assess impact of research activity (IMTP Aim)	Via IMTP objective monitoring	Assessment will include service impact in addition to academic impact metrics enabling assurance that research activity is meeting innovation and improvement needs	Tom Fowler	March 2026	Initial discussions with Research, Data, Digital on existing metrics collected
AP3.2	Development of a Directorate approach to assurance and coordination of research an innovation activities	Via IMTP objective monitoring	HPSS Divisions currently have internal review and assurance processes for research and innovation – a Directorate approach is in development that will enable a more coordinated approach	Tom Fowler	March 2026	Forum has been set up for working with key leads

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.1						

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *4.4*

Corporate Risk Register	
Executive lead:	Claire Birchall, Nursing, Quality and Integrated Governance
Author:	Bethan Osborne, Risk Manager

Approval/Scrutiny route:	Corporate Risks are scrutinised and updated by the relevant Directorate Senior Leadership Teams. All Executives have had sight of the Corporate Risk Register via BET.

Purpose
The Leadership Team have delegated responsibility to scrutinise the Corporate Risk Register on behalf of the Business Executive Team and ensure the ongoing management of corporate risks. This paper provides the outcome of the most recent review of the corporate risks and any notable updates.

Recommendation:				
APPROVE ☐	CONSIDER ☐	RECOMMEND ☐	ADOPT ☐	ASSURANCE ☒
The Quality, Safety and Improvement Committee is asked to: • **Take assurance** that the corporate risks are being scrutinised appropriately.				

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	All Strategic Priorities/Well-being Objectives
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	No decision required.
Risk and Assurance	This submission is the Corporate Risk Register.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports the implementation of the Health and Social Care (Quality and Engagement) (Wales) Act, in relation to the Duty of Quality and Candour by ensuring that the organisations most significant risks are being managed appropriately. They relate to all the Health and Care Quality Standards.
Financial implications	The financial implications of failing to manage corporate risks effectively are significant, both in terms of the potential for loss and also the failure to capitalise on opportunities.
People implications	The people implications of failing to manage corporate risks effectively are significant, both in terms of the potential implications to staff and also the failure to capitalise on the effective deployment of the workforce.

1. Purpose / situation

This paper presents the organisation's corporate risks highlighting any significant updates that required further discussion and any proposals for the escalation/de-escalation of risks from or onto the Corporate Risk Register. The Corporate Risk Register details the highest-level operational risks that are being managed on a day-to-day basis by relevant Directorate Senior Leadership Teams and their associated Executives. Leadership Team consideration provides assurance to the relevant Committees and the Board that corporate risks are being effectively identified and managed.

2. Background

The Corporate Risk Register is submitted to the Leadership Team to ensure compliance with the organisation's Risk policy and procedure. Where corporate risks are in part addressing any strategic risks, these linkages are referenced on the electronic risk management system and the Strategic Risk Register. If further assurance or detail is required in respect of interdependencies between strategic and corporate risk registers, this can be requested through the risk management team.

3. Description/Assessment

The Corporate Risk Register was submitted to the Leadership Team on the 18th September 2025. The following significant points have been summarised to indicate the outcome of the decision making at Leadership Team that are applicable to the Quality, Safety and Improvement Committee.

New risks accepted onto the Corporate Risk Register

- None.

Existing risks accepted onto the Corporate Risk Register

- **1946** - There is a risk that the organisation will fail to implement a suitable Datix Web replacement that matches the current risk maturity when the system is decommissioned in November 2027.

  This is caused by no current funding allocated to procure, develop and implement a replacement system.

This would result in a failure to effectively manage risks resulting in inability to achieve strategic objectives.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
12	12	6

Background

In 2017, PHW signed up to the national procurement for a replacement system which included the capture or risks, incidents, complaints, claims/redress and safeguarding. RL Datix was awarded the contract to migrate organisations over from their current system (Datix Web) to the new system (Datix Cloud) with the cost to organisations each year as a complete package rather than based on the number of modules adopted or retained. It was anticipated that the last module remaining active in Datix Web (risk) would be migrated over to Datix Cloud in April 2022. However, due to the core build, it was identified that many essential requirements could not be achieved. Workarounds were proposed but in early 2024, the decision was reached that the risk module would not be fit for purpose and the Datix Cymru team advised that organisations would need to individually seek an alternative solution in readiness for Datix Web being decommissioned. As such, organisations have been left to seek additional funds for a replacement risk system as no money can be clawed back from RL Datix due to the contract being based on a package rather than modular.

Rationale for escalation

An options appraisal was submitted to Leadership Team in June 2025 who agreed that this project should be progressed through the Digital and Data Design Authority. The Risk Team presented to the Digital and Data Design Authority in August 2025 who advised that without funding for technical expertise, they would be unable to advise on the most suitable solution for a replacement system. In addition, a fixed term Senior Project Manager has been recruited into the Risk Team to lead on the project, however, any further activities be required after the end of the contract in March 2026 would need to be absorbed by the existing risk team consisting two colleagues are currently support PHW and NHSWPI on strategic and operational risk management. As the risk system is utilised across all areas, the risk of not securing funding for resourcing a replacement system and the system itself will affect the whole of PHW and NHSWPI.

Outcome at Leadership Team

Leadership Team approved the escalation of the risk onto the Corporate Risk Register. The current scoping of the project will enable Leadership Team to assess the risk in its entirety to allow for decision making in relation to the appropriate management of the risk going forward.

Risks de-escalated from the Corporate Risk Register

- None.

Risks closed

- **1677** - There is a risk that the integrity of the data for recording risks to evidence robust risk management will be compromised.

  This is caused by less functionality in Datix Cloud in comparison to Datix Web. In addition, Datix Cloud does not include PHW/NHSWE specific requirements.

  This would result in a failure to effectively manage risks resulting in inability to achieve strategic objectives.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
9	9	4

Progress Update

- Successful recruitment to the senior project manager post and staff member formally commenced in post on 10th September. Risk was presented to Leadership Team and DDDA for comment and subsequent meetings with key colleagues on 11th September 2025 to agree way forward. Agreed to take the options appraisal paper through BET at the next opportunity to seek support from Executive colleagues around approach to determine what functions are necessary for a new system and support to scope the market for a new system, if required.

Outcome at Leadership Team

Given the decision of risk 1646 being accepted onto the Corporate Risk Register, it was agreed that the risk would be closed down as it represents an outdated position where Datix Cloud was anticipated to be the replacement for Datix Web.

Changes to Risk Scores

- None.

Current Risks on the Corporate Risk Register

- **1533** - There is a risk of reputational damage and failure to effectively implement the Health Impact Assessment statutory regulations that form part of the Public Health (Wales) Act which requires Public Health Wales to give assistance to other public bodies carrying out health impact assessments.

This is caused by a lack of capacity in the WHIASU team and limited knowledge, skills and capacity across PHW, outside of WHIASU, to meet the anticipated high volume of requests for assistance, guidance and training from Welsh Government, internally in PHW and externally from public bodies.

This would result in PHW not being able to fulfil its statutory duties either as a public body carrying out HIAs nor as a body which is required to provide assistance to other public bodies, as well as ineffective implementation of the regulations leading to missed opportunities to reduce inequalities and improve and protect public health in Wales.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
16	9	4

Progress Update

- Feedback received from Welsh Government, revisions are in hand. PHW Board meeting in October to review. E-Learning has had a soft launch. Regulatory Impact Assessment has been developed and shared with Health Minister. Regulations to come into place April 6th 2027, with a year for transition to prepare for this date. Guide to be published Jan 2026.

Outcome at Leadership Team
Leadership Team are content with the management of the risk with the identified actions and their associated timescales.

- **1541** - There is a risk of harm to service users and employees within PHW, specifically in relation to vulnerable groups such as children and adults, due to the absence of regular disclosure and barring service checks.

  This is caused by the organisation not carrying out disclosure and barring service renewal checks in additional to the initial check that is undertaken at recruitment (whilst this is not a legal requirement it is best practice).

  This would result in the potential misuse of position of trust, resulting in abuse of service users and potentially employees. Detrimental and adverse impact on levels of public confidence and credibility. Financial implications relating to claims made against the organisation.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
15	10	5

Progress Update

- The remaining action was reviewed which related to the approval of the DBS policy. The planned date for implementation is 1st October 2025 which will reduce the risk.

Outcome at Leadership Team
Leadership Team are content with the management of the risk with the identified actions and their associated timescales. It was noted that an additional action is currently underway to identify any existing staff that require a repeat DBS check which would be added to the risk action plan to provide additional assurance that the risk is being appropriately managed.

- **1593** - There is a risk that we are unable to demonstrate that the quality standards and the Duty of Quality are in embedded in all aspects of PHW business.

  This is caused by organisational capacity and capability to operationalise and embed due to competing priorities.

  This will result in noncompliance with the legislative requirements, and a lack of progress in strengthening quality improvement and governance in the delivery of safe services, programmes and functions.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
9	6	2

Progress Update

- QMS approach- Work to embed approach and evidence this continues. Recent Visit to BCUHB undertaken. Always on reporting Task & Finish group in place.

Outcome at Leadership Team
Leadership Team are content with the management of the risk with the identified actions and their associated timescales.

- **1648** - There is a risk that Public Health Wales will lose access to Primary Care data.

  This is caused by Audit+ (the current tool) used to gather primary care data is being discontinued in July 2024 and there will be no further support of Audit+ from March 2026.

  This would result in the loss of Audit+ without a replacement equivalent service would lead to PHW being unable to meet its statutory responsibilities.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
20	12	2

Progress Update

- Sam Hall, Director of Primary and Mental Health, DHCW are recommencing public briefings on the Audit+ replacement. They are working to 'step into' informatic issues and act as a data processor to provide a data extraction product that supports the current data analysis and visualisation needs for Wales. DHCW commit to continuity of support for all EXISTING/CURRENT Audit + use cases. Other cases need to apply to using the DQS form. Deep Dive scheduled for DDDA in September 2025.

Outcome at Leadership Team

Leadership Team are content with the management of the risk with the identified actions and their associated timescales.

- **1678** - There is a risk that the organisation will fail to provide sufficient assurance that it is identifying and managing risks effectively through the endorsed Risk Management Procedure and failing to identify themes and trends.

  This is caused by inconsistencies of appropriate utilisation of Datix across the organisation, contrary to the approved process.

  This would result in a loss in Board confidence and omission of reportable risks at all levels. In addition, a failure to instigate improvement projects resulting in potential harm to service users, reputational damage and financial implications.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
15	15	4

Progress Update

- Policy and Procedure has been consulted on and has been received in draft by leadership team. There are a few minor changes to make following feedback, then the policy and procedure will be formally endorsed by BET and Board, hopefully September 2025. This will strengthen the policy and procedure in being a control for this risk and potentially increase compliance. Numbers of staff accessing online training has increased, specifically in microbiology. Recommend reducing the risk score if this trajectory continues.

Outcome at Leadership Team

It was noted that over the past two months, PHW has seen an increase of risks being recorded on Datix Web by 50%. This is due to all tier 1 and 2 programme risks being migrated onto Datix Web as a result of the newly launched Portfolio

Management Office standards dictating that risks must be recorded and managed on Datix Web. Leadership Team were content with the management of the risk and indicated that an additional action of presenting the benefits of the use of Datix Web should be scheduled for each Directorate Leadership Team.

- **1758** - There is a risk of further service disruption due to excessive dust damaging the detectors of the mammography units on the Mobile Breast Screening Units. 1 mobile unit is currently out of service due to this issue. 9 other units could potentially be at risk of failure.

  This is caused by dust entering the casing containing the image detector potentially damaging the detector, rendering the machine inoperable.

  This would result in delayed and cancelled breast screening appointments. >36 month round length screening time, reputational risk and financial implications (detector costs circa 62k).

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
16	16	2

Progress Update

- No update provided.

Outcome at Leadership Team

Leadership Team were informed that an IMT has been set up with the National Director of Screening and Health Protection Services as Chair. Leadership Team were content with the management of the risk.

- **1779** - There is a risk that PHW will lose our ability to monitor its impact due to declining survey response rates across many sources of official statistics including the National Survey for Wales, the Annual Population Survey and the Labour Force Survey.

  This is caused by declining survey response rates across multiple sources of official statistics.

  This would result in the inability to monitor our impact and losing the oversight to be able to manage our resources effectively and be able to make evidence informed decisions about managing our services.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
15	12	6

Progress Update

- Risk reviewed by LN and no change to scores or mitigations identified. No new actions noted.

Outcome at Leadership Team

Leadership Team are content with the management of the risk with the identified actions and their associated timescales.

- **1780** - There is a risk that PHW are unable to deliver our digital agenda due to dependencies on national programmes, DHCW and Welsh Government.

  This is caused by a lack of governance, programme management, visibility, prioritisation, effective working practices and inconsistency within its partner organisations.

  This will result in failure to deliver PHW programmes as our dependencies are not delivered by our partners.

Inherent Risk Rating	Residual Risk Rating	Target Risk Rating
16	16	6

Progress Update

- Risk reviewed by DJ. Risk score remains unchanged, however some actions have been completed but the full value of attendance and outputs from those meetings hasn't been fully realised at this stage to impact the score. Review in one month.

Outcome at Leadership Team

Leadership Team are content with the management of the risk with the identified actions and their associated timescales.

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

This work has been put together following the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

The effective management of corporate risks supports the longevity of the organisation

The effective management of corporate risks reduces the likelihood or consequence of harm being realised.

The identification and management of risks are integrated into decision making activities.

Owners of corporate risks collaborate within their areas and any relevant Directorates to manage risks effectively.

Senior Managers engage with relevant colleagues to ensure staff are empowered to raise risks.

4. Recommendation

The Quality, Safety and Improvement Committee is asked to:

- Take **assurance** that the corporate risks are being scrutinised appropriately.

CORPORATE RISK REGISTER - 11.09.2025 v2					RISK ARTICULATION			INHERENT SCORING			CONTROLS	RESIDUAL (CURRENT) SCORING			DECISION	OVERALL RISK PROGRESS	ACTION PLAN				TARGET SCORING		
Datix ID	Risk Theme	Identification Date	Executive Sponsor	Directorate	Risk Description	Cause	Effect	Likelihood	Consequence	Rating	Key Controls	Likelihood	Consequence	Rating			Action Summary	Action Due date	Action Done date	Progress	Likelihood	Consequence	Rating
1533	Adverse Publicity	14/06/2023	PHW - National Director of Policy and International Health	Policy and International Health	There is a risk of reputational damage and failure to effectively implement the HIA statutory regulations that form part of the Public Health (Wales) Act which requires the Public Health Wales to give assistance to other public bodies carrying out health impact assessments (see Part 6 here: https://www.legislation.gov.uk/anaw/2017/2/part/6/enacted)	This is caused by a lack of capacity in the WHIASU team and limited knowledge, skills and capacity across PHW, outside of WHIASU, to meet the anticipated high volume of requests for assistance, guidance and training from Welsh Government, internally in PHW and externally from public bodies.	This would result in PHW not being able to fulfil its statutory duties either as a public body carrying out HIAs nor as a body which is required to provide assistance to other public bodies, as well as ineffective implementation of the regulations leading to missed opportunities to reduce inequalities and improve and protect public health in Wales.	4 Highly Likely	4 Major	16	Action plan is now in place to support this on going risk. Temporary changes have been put in place to bolster the WHIASU team as it delivers its IMTP deliverables as well as prepares for the duty. A highly experienced Band 7 is remaining as part of retire and return at 0.4 WTE from 0.6 WTE in October. Other preparations include revamping training, providing quarterly Network of Practice meetings and masterclasses, mapping the stakeholder landscape and writing guidance and FAQs for example.	3 Likely	3 Moderate	9	Treat	15.08.2025 - Feedback received from Welsh Government, revisions are in hand. PHW Board meeting in October to review. E-Learning has had a soft launch. Regulatory Impact Assessment has been developed and shared with Health Minister. Regulations to come into place April 6th 2027, with a year for transition to prepare for this date. Guide to be published Jan 2026.	A comprehensive workplan will be further developed to increase engagement, training, capability and capacity building and to the further develop the guidance to support the requirements of the legislation by end of Q3	31/10/2025		This action is ongoing, however the publication of the legislation has been delay. 14/05/2025 - A comprehensive workplan has been drawn up. A Paper has been shared with BET for assurance. Welsh Government has established a HIA Project Board with PHW as the key partner. Capacity and timeframes will be discussed as part of the ongoing meetings. Planning continues including finalising the new guidance, capacity building in the system and updating training materials in line with the new regulations.	2 Unlikely	2 Minor	4
1541	Patients and Clients (Clinical) Risks	06/07/2023	PHW - Director of People and Organisational Development	People and Organisational Development	There is a risk of harm to service users and employees within PHW, specifically in relation to vulnerable groups such as children and adults, due to the absence of regular disclosure and barring service checks.	This is caused by the organisation not carrying out disclosure and barring service renewal checks in additional to the initial check that is undertaken at recruitment (whilst this is not a legal requirement it is best practice)	This would result in the potential misuse of position of trust, resulting in abuse of service users and potentially employees. Detrimental and adverse impact on levels of public confidence and credibility. Financial implications relating to claims made against the organisation.	3 Likely	5 Critical	15	Appointment of DBS Compliance Officer to undertake organisational position number cleansing Policies and Procedures in place for recruitment and safeguarding Recruitment process includes the correct level of DBS check for the position number DBS guidance available for managers and online tool to ensure correct level of DBS check completed on successful appointment of new starters Quarterly reporting of DBS compliance checks for new starters discussed at PHW safeguarding group for assurance Named Lead for Safeguarding in post for managers to access for Safeguarding enquiries associated with safe recruitment ESR Mandatory safeguarding training for adults and children and appropriate level of training assigned to position numbers and reported monthly to managers DBS audit completed and actions in place to improve the management of risk for established staff Safeguarding incidents reviewed by PTR team and named lead for safeguarding and escalated as required All Safeguarding incident and concerns reported and reviewed at the quarterly safeguarding group and themes identified Availability of DBS workshops advertised on PHW'S intranet	2 Unlikely	5 Critical	10	Treat	03.09.2025 - The remaining action was reviewed. The planned date for implementation is 1 October	Subscription to DBS Update service that will provide repeat checks	01/10/2025		We are moving to the DBS Update service and the action will remain open until the Update service is adopted.	1 Highly Unlikely	5 Critical	5
1593	Statutory Duty	04/10/2021	PHW - Executive Director of Nursing, Quality and Integrated Governance	Nursing, Quality and Integrated Governance	There is a risk that we are unable to demonstrate that the quality standards and the Duty of Quality are in embedded in all aspects of PHW business.	This is caused by organisational capacity and capability to operationalise and embed due to competing priorities.	This will result in noncompliance with the legislative requirements, and a lack of progress in strengthening quality improvement and governance in the delivery of safe services, programmes and functions.	3 Likely	3 Moderate	9	1. Established Innovation and Improvement Hub creating a culture of improving and innovating for quality within the organisation and transferred to QNAHPs in April 2024. 2. Planned refresh of the I&I offer for 24/25 due to staffing changes 3. Implementation plan for PHW strategic priorities with identified leads for each theme and completed against road maps 4.Developed coaching support to be provided by I&I Hub for improvement projects 5.National guidance and support materials and designated Sharepoint site available for PHW staff. 6.Annual Quality Report published for 23/24 detailing quality work against 12 standards and available to the public 7. Quality oversight group formal meetings commenced with reporting EDON and EMD 8. Quality standards with key lines of enquiry self assessment in progress with a full schedule of self assessment planned for all 6 standards by March 2025 9. Leadership forum and spotlight on sessions delivered in July 2024 for the duty and a QMS approach 10. Strategic priority 5 - excellent public services now linked into the STEEP format and roadmap being formulated 11. Quality Governance report submitted to QSIC quarterly framed around STEEP domains. 12. Active participation in the NHS Executive Quality Standards Meetings.	2 Unlikely	3 Moderate	6	Treat	04.09.2025 - QMS approach-Work to embed approach and evidence this continues. Recent Visit to BCUHB undertaken . Always on reporting Task & Finish group in place	Quality Management System (General) - Quality Management System road map agreed and implementing	29/12/2025		Update 3.9.25: Socialisation work continues along with a T&F group for always on reporting. Recent visit to BCUHB to see how they have introduced visual system in power apps .	1 Highly Unlikely	2 Minor	2
																	Introduction of Quality Impact Assessment and governance process.	31/12/2025		Update 3.9.25: QIA tool built in power apps and been through UAT testing, now entering pilot testing phase with presentation of results planned for Q3 to QUOG. Procedural document now being drafted for consultation and process to be decided at QUOG			

1648	Statutory Duty	24/06/2024	PHW - National Director for Public Health Knowledge and Research	Research, Data and Digital	There is a risk that Public Health Wales will lose access to Primary Care data.	This is caused by Audit+ (the current tool) used to gather primary care data is being discontinued in July 2024 and there will be no further support of Audit+ from March 2026.	This would result in the loss of Audit+ without a replacement equivalent service would lead to PHW being unable to meet its statutory responsibilities.	5 Almost certain	4 Major	20	Start a programme of work to ensure that all regular reports from Audit+ are migrated to the NDR by DHCW, and that any new requirements are developed in the NDR by either PHW or DHCW. Managed via the DARC Programme. Requirement merged with Lung Screening and on DHCW list of action. DHCW have committed that those services that are current users will be unaffected.	3 Likely	4 Major	12	Treat	04.09.2025 - Sam Hall, Director of Primary and Mental Health, DHCW are recommencing public briefings on the Audit+ replacement. They are working to 'step into' informatic issues and act as a data processor to provide a data extraction product that supports the current data analysis and visualisation needs for Wales. DHCW commit to continuity of support for all EXISTING/CURRENT Audit + use cases. Other cases need to apply to using the DQS form. Deep Dive scheduled for DDDA in September 2025.	To update the Business Continuity Impact Assessment and Business Continuity Plans, to reflect the impact of Audit+ removal/not updating and mitigations. Plans and assessment to be uploaded into this risk as supporting documentation by 30 November 2024.	30/04/2025		08/07 - Update from Eric Maljian - it will have an impact on and slow down our sentinel work, and the team will work on contacting GP services directly to gather the information. Therefore, due to the fact that it is not deemed to have direct clinical impact, this specific matters has not been flagged as a business continuity issue and our arrangements have not been specifically updated to address that. HP - Awaiting update to confirm this covers HP only or whole of HPSS. Date moved due to capacity and change with DHCW continuing to support.	1 Highly Unlikely	2 Minor	2
																	Start a programme of work to ensure that all regular reports from Audit+ are migrated to the NDR by DHCW, and that any new requirements are developed in the NDR by either PHW or DHCW. Check progress milestone in July 2025.	31/07/2025	04/09/2025	Engagement with NDR Team has now commenced. New requirements have risen from Lung Screening and Tackling Diabetes Together programmes. There is a need to document all data required to feed into NDR team. Programme to update via DDDA - action closed			
																	Replacement of Audit+ was raised through a prioritisation form with the NDR - 25/06/2025. Awaiting outcome of prioritisation board 01/07/2025.	31/07/2025	04/09/2025	This action has not been triaged but has been merged with the Lung Cancer Screening request which is being progressed with Emma Barnes-Lewis. Action closed			
																	To complete a deep dive risk review at DDDA on 15/09/2025.	30/09/2025		Agenda agreed			
1758	Operational	28/03/2025	PHW - National Director of Health Protection and Screening Services	Health Protection and Screening Services	There is a risk of further service disruption due to excessive dust damaging the detectors of the mammography units on the MBSU's. 1 mobile unit is currently out of service due to this issue. 9 other units could potentially be at risk.	This is caused by dust entering the casing containing the image detector potentially damaging the detector, rendering the machine inoperable.	This would result in delayed and cancelled breast screening appointments.>36 month round length screening time, reputational risk and financial implications (detector costs circa 62k).	4 Highly Likely	4 Major	16	The origin of the dust is being investigated. The units are being cleaned daily. Specialist contractor is assessing cause and possible solutions Sufficient controls are not in place	4 Highly Likely	4 Major	16	Treat	None provided.					1 Highly Unlikely	2 Minor	2
1779	Operational	09/04/2025	PHW - National Director for Public Health Knowledge and Research	Research, Data and Digital	There is a risk that we will lose our ability to monitor our impact due to declining survey response rates across many sources of official statistics including the National Survey for Wales, the Annual Population Survey and the Labour Force Survey.	This is caused by declining survey response rates across multiple sources of official statistics.	This would result in the inability to monitor our impact and loosing the oversight to be able to manage our resources effectively and be able to make evidence informed decisions about managing our services.	5 Almost certain	3 Moderate	15	Communication is ongoing with the data source providers to understand their mitigations and timescales. National Survey has been confirmed to not be available for one year which will need to be tolerated. National Survey for Wales: The contract to deliver the new survey design has now been awarded to the National Centre for Social Research (NatCen), who will spend 2025-26 setting up and testing the survey ready for launch in March 2026. First results from 2026-27 fieldwork are due to be published in July 2027.The expected sample size is 24,000. Exploring alternative and proxy indicators and modelling is continuing. ONS will release Healthy Life Expectancy on 4 July 2025.	4 Highly Likely	3 Moderate	12	Treat	27.08.2025 - Risk reviewed by LN and no change to scores or mitigations identified. No new actions noted.	Continue to monitor ONS publications and plans.	30/09/2025			2 Unlikely	3 Moderate	6
																	Explore Primary Care obesity data in SAIL	30/06/2026		Project is set up in SAIL. Initial data exploration has taken place.			
1780	Business Objectives	09/04/2025	PHW - National Director for Public Health Knowledge and Research	Research, Data and Digital	There is a risk that PHW are unable to deliver our digital agenda due to dependencies on national programmes, DHCW and Welsh Government.	This is caused by a lack of governance, programme management, visibility, prioritisation, effective working practices and inconsistency within our partner organisations.	This will result in failure to deliver our programmes as our dependencies are not delivered by our partners.	4 Highly Likely	4 Major	16	Welsh Government have now shared the governance of DDaT, providing a level of clarity. Communication with our partners to further establish their position in terms of prioritisation/resource/agenda/governance. Escalation process in place within the partner organisations and digital directors. PHW planning in place in regards to our dependencies and uncertainties. Strengthened our representation at National Programme boards - includes PHW representation at NDR prioritisation board. Early identification has been completed to identify dependencies on DHCW and WG and early engagement.	4 Highly Likely	4 Major	16	Treat	29.08.2025 - Risk reviewed by DJ. Risk score remains unchanged, however some actions have been completed but the full value of attendance and outputs from those meetings hasn't been fully realised at this stage to impact the score. Review in one month.	Implement regular update and escalation meetings with DHCW: SLA meetings (quarterly), planning meetings (quarterly), Programme Leads meetings, specific meetings for projects or programme alignment	31/03/2026	29/08/2025	Quarterly meetings set up with DHCW, covering SLA's, planning and specific projects.	2 Unlikely	3 Moderate	6
																	Review PHW / DHCW SLA annual letter	31/03/2026					
																	Ensure attendance at Digital Directors peer group meetings and WG Digital updates.	31/03/2026	29/08/2025	Exec Director attends Digital Directors and Peer group. Intention is the pas the peer group meetings to Head of Digital Services.			
																	Ensure robust governance and programme management for PHW digital and data portfolio.	31/03/2026		29/08 - Portfolio Lead appointed starting 29/09/2025. Portfolio Lead needs to drive supporting the governance management. Action to remain open.			
																	Escalation of issues through the National Service Management Board (NSMB) and other Service Management Boards managed by DHCW	31/03/2026	29/08/2025	Attendance at all DHCW Service Management Boards to enable escalations.			

1677	Quality	30/04/2024	PHW - Executive Director of Nursing, Quality and Integrated Governance	Nursing, Quality and Integrated Governance	There is a risk that the integrity of the data for recording risks to evidence robust risk management will be compromised	This is caused by less functionality in Datix Cloud in comparison to Datix Web. In addition, Datix Cloud does not include PHW/NHSWE specific requirements.	This would result in a failure to effectively manage risks resulting in inability to achieve strategic objectives.	3 Likely	3 Moderate	9	Continuation of the use of Datix Web	3 Likely	3 Moderate	9	Treat	11.09.2025 - Successful recruitment to the senior project manager post and staff member formally commenced in post on 10th September. Risk was presented to Leadership Team and DDDA for comment and subsequent meetings with key colleagues on 11th September 2025 to agree way forward. Agreed to take the options appraisal paper through BET at the next opportunity to seek support from Executive colleagues around approach to determine what functions are necessary for a new system and support to scope the market for a new system, if required.	Follow up meeting to be scheduled with AMaT representative to further probe the system.	01/05/2025	23/07/2025	Fixed term Project Manager being recruited to scope out available systems. Will be incorporated into this scoping piece.	2 Unlikely	2 Minor	4
1678	Quality	30/04/2024	PHW - Executive Director of Nursing, Quality and Integrated Governance	Nursing, Quality and Integrated Governance	There is a risk that the organisation will fail to provide sufficient assurance that it is identifying and managing risks effectively through the endorsed Risk Management Procedure and failing to identify themes and trends.	This is caused by inconsistencies of appropriate utilisation of Datix across the organisation, contrary to the approved process.	This would result in a loss in Board confidence and omission of reportable risks at all levels. In addition, a failure to instigate improvement projects resulting in potential harm to service users, reputational damage and financial implications.	5 Almost certain	3 Moderate	15	Approved Risk Policy and Procedure	5 Almost certain	3 Moderate	15	Treat	11.09.2025 - Policy and Procedure has been consulted on, and has been received in draft by leadership team. There are a few minor changes to make following feedback, then the policy and procedure will be formally endorsed by BET and Board, hopefully September 2025. This will strengthen the policy and procedure in being a control for this risk, and potentially increase compliance. Numbers of staff accessing online training has increased, specifically in microbiology. Recommend to reduce the risk score if this trajectory continues.	Draft revised policy and procedure to go out to consultation in line with due organisational process. With a view to getting the revised versions formally endorsed and approved by end of Q3.	30/09/2025		Formal consultation has taken place, awaiting approval from LT, BET, Board and ACGC in September.	2 Unlikely	2 Minor	4
1946	Finance	23/07/2025	PHW - Executive Director of Nursing, Quality and Integrated Governance	Nursing, Quality and Integrated Governance	There is a risk that the organisation will fail to implement a suitable Datix Web replacement that matches the current risk maturity when the system is decommissioned in November 2027	There is no current funding allocated to procure, develop and implement a replacement system	This would result in a failure to effectively manage risks resulting in inability to achieve strategic objectives.	3 Likely	4 Major	12	None	3 Likely	4 Major	12	Treat	Discussed at NQIG SMT on 28th July 2025, and decision was made to escalate to Leadership Team to request for this risk to be included on the Corporate Risk Register, as the impact of this risk were it to be realised, is organisational wide.	Submission to DDDA for agreement of way forward contained within the options appraisal document.	31/12/2025			2 Unlikely	3 Moderate	6
																	Funding bid submitted	31/12/2025					
																	Recruitment of fixed term Project Manager	29/08/2025	10/09/2025	Completed			

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29 September 2025 **Agenda item:** *4.5*

Screening Programmes Update	
Executive lead:	Professor Fu-Meng Khaw National Director Health Protection and Screening Services and Executive Medical Director
Author:	Sharon Hillier, Director Screening Division, Public Health Wales on behalf of Screening Division Senior Management Team

Approval/Scrutiny route:	HPSS DMT – 09/09/25

Purpose

To provide an overview and assurance of the screening services focused on the domains of quality following the discussion held at a previous Committee Workshop. These are focused on the main issues within the programmes performance that are not in line with the standards set. The paper also outlines key quality improvement, policy implementation and project work to further improve health of population in Wales.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- Take **assurance** that there is a focus on working to deliver quality screening programmes in line with delivery of excellent public health services to the population in Wales.

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

Summary impact analysis	
Equality and Health Impact Assessment	Not applicable within scope of the paper.
Risk and Assurance	Paper outlines the focus on the main performance issues that are being addressed in the programmes that are being delivered and provides assurance on the plans in place to improve. The paper also outlines improvement and project work to improve health of population.
Health and Social Care (Quality and Engagement) (Wales) Act	Paper aligned to the Duty of Quality as using domains of quality to highlight key aspects of the screening programmes performance and improvement plan.
Financial implications	No specific financial implications within the scope of the paper. To note there are financial constraints for some of the workstreams that would have been taken forward to improve timeliness.
People implications	Paper outlines the focus on the main performance issues that are being addressed in the programmes that are being delivered to the population in Wales and provides assurance on the plans in place to improve. The paper also outlines improvement and project work to improve health of population.

1. Purpose

To provide an overview and assurance of the screening services focused on the domains of quality following the discussion held at previous Committee Workshop. These are focused on the main issues within the programmes performance that are not currently in line with the standards set. The paper also outlines key quality improvement, policy implementation and project work to further improve health of population in Wales.

2. Assessment: Programme Performance

2.1 Bowel Screening Programme: Quality Domain Timely

Table 1 Screening Colonoscopy Waits

Percentage of participants with for Index Colonoscopy/Flexi-Sig Procedure Within 4 weeks of Booking SSP Appointment. Standard 90%								
2024/25	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
All Wales	32.3	19.7	15.2	20.9	8.4	6.8	3.9	4.9

Colonoscopy capacity across Wales is challenged, with insufficient Colonoscopists, theatre space and nursing staff to meet demand and reduce existing backlogs. Optimisation of bowel screening (in a phased approach since 2021) in line with evidence based recommendations has resulted as expected in increased demand on colonoscopy services. This has been in line with expectations and funding provided based on modelling that was shared with Health Boards in advance of the first phase.

Whilst the expected increase demand from screening has been funded for Health Boards, there has also been an increase in demand from other sources and colonoscopy capacity has not kept pace. Colonoscopy Insourcing and Waiting Time List are being used across many Health Boards to support increased demand, but these do not provide a long-term solution.

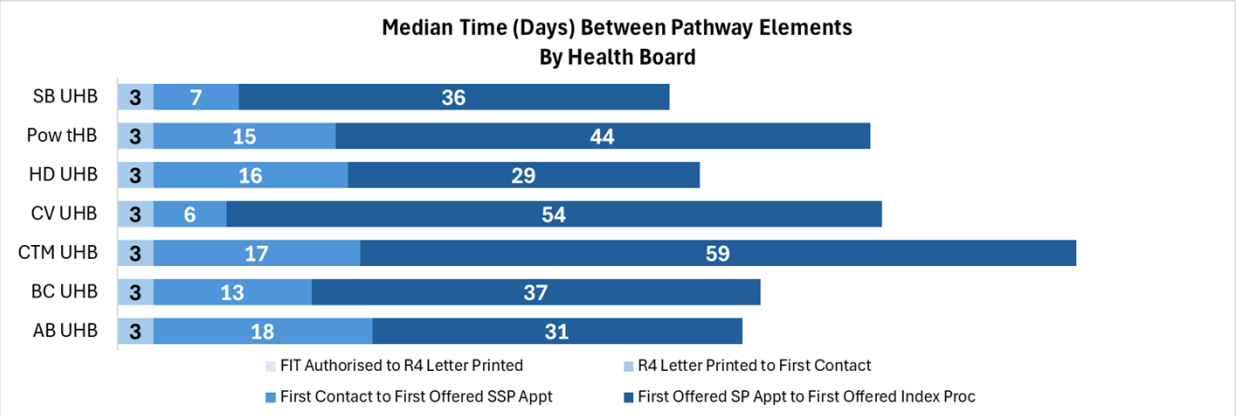
Waiting times for screening colonoscopy remain outside the Bowel Screening Wales 4-week standard across Wales. The latest waits as of 29 August range from 6-17 weeks with average total wait of 9 weeks and 5 days.

Figure 1 Waiting time for Bowel Screening Colonoscopy for each Local Assessment Centre - 29 August 2025

Local Assessment Centre	Waiting time SSP assessment	Waiting time colonoscopy	Total waiting time
1	0 weeks 4 days	8 weeks 6 days	9 weeks 3 days
2	0 weeks 4 days	11 weeks 2 days	11 weeks 6 days
3	1 weeks 5 days	10 weeks 5 days	12 weeks 3 days
4	0 weeks 6 days	6 weeks 4 days	7 weeks 3 days
5	1 weeks 3 days	7 weeks 0 days	8 weeks 3 days
6	0 weeks 5 days	7 weeks 3 days	8 weeks 1 days
7	1 weeks 0 days	5 weeks 4 days	6 weeks 4 days
8	5 weeks 6 days	11 weeks 4 days	17 weeks 3 days
9	5 weeks 6 days	10 weeks 0 days	15 weeks 6 days
10	0 weeks 4 days	5 weeks 5 days	6 weeks 2 days
11	0 weeks 4 days	8 weeks 3 days	9 weeks 0 days
12	0 weeks 6 days	6 weeks 0 days	6 weeks 6 days
13	0 weeks 4 days	6 weeks 5 days	7 weeks 2 days

Reviewing the waiting time component waits from October 2024 to July 2025 show that the waiting times are consistently outside the standard.

Figure 2. Median Time in Days of waiting time component waits for Health Boards for Bowel Screening Colonoscopy from October 2024 to July 2025



Actions in place:
Bowel Screening Wales meets monthly with all the endoscopy teams to discuss screening waiting times and screening capacity.
The screening programme is expanding the pool of accredited Screening Colonoscopists and has increased Specialist Screening Practitioner resource to help meet the screening demand.
The screening programme works with Health Boards when there are delays in the Specialist Screening Practitioner timeliness to provide direct support or facilitate other Health Boards supporting.
BSW works closely with the Health Boards to enable quality assured insourcing colonoscopy.
The Business Team routinely meet with the health boards to monitor activity aligned to commissioned capacity via the Long-Term Agreements.

As a results of sustained performance outside of the stated waiting times there has been escalation to CE level and joint meetings have taken place with all Health Boards at CE level. These meetings have taken place over the summer period and have been well attended with an open, constructive and solution focused discussion.

All health boards are committed to provide high quality and timely screening colonoscopy and pre-assessment services for their eligible screening population. Challenges meeting the core screening demand were acknowledged in all meetings and all are currently providing screening colonoscopy outside the Bowel Screening Wales 28-day standard, with some, but not all, using insourcing to increase screening capacity. The levels of delivered commissioned index colonoscopies were below expectation in most health boards.

The following common themes emerged from the discussions:

- **Insufficient number of planned sustainable lists in place**

The is a capacity gap in each Health Board between the number of colonoscopy planned list that were in place compared to the number of colonoscopy lists funded and required for the demand. This is across Wales and a key factor for backlogs and requires solution to enable a sustainable service.

- **Clinical Nurse Endoscopists**

The employment of Clinical Nurse Endoscopists (CNE's) for screening is limited in Wales, with just two individuals currently undertaking screening colonoscopy. Most health boards want to train CNEs for screening in the future, but few have plans in place. HEIW have a developed training programme for CNE's, but the training commitment required to support candidates limits the number of candidates, with very few cohorts fully subscribed. All Health Board

recognised the need to support this workforce development for a sustainable service and this is a key for them to take forward.

- **Bowel Screening Accreditation**

It was acknowledged that the screening programme cannot lower the standard for Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation and that only JAG accredited colonoscopists can undertake screening colonoscopy. There was a general consensus that the current accreditation process in Wales is protracted and would benefit from further refinement to ensure candidates are able to progress to formal assessment in a timely manner. The following points were also raised by some health boards in relation to the accreditation:

- Whilst the current process is designed to be supportive to ensure candidates are in the best possible position to meet the JAG standards at the first attempt, the approach is proving to be a deterrent and leading to long timescales
- Bowel Screening Wales should survey candidates to gain an understanding of their experience of the accreditation process
- Bowel Screening Wales and the health boards should develop processes to promote the role of the Screening Colonoscopist and the benefits of screening to encourage more candidates to become accredited
- Options to improve the capacity for existing Screening Colonoscopist to provide local mentorship need to be considered. E.g. possibility of using screening lists for mentorship, the use of peripatetic Screening Colonoscopist trainers)

- **Regional Working and Mutual Aid**

Several health boards expressed a need to utilise regional working arrangements to provide additional screening capacity (particularly additional theatre space) and to provide regional service resilience between two or more health boards. The ability to provide cross-health board mutual aid, with those having capacity assisting others with prolonged waits was also highlighted during some of the meetings. Participant choice was also discussed as being key as participants keen to travel to a location nearer to their home.

- **Innovation and shared learning**

Opportunities to share learning between health boards and innovative ideas. For example, it was suggested surveillance and repeat colonoscopies to be referred to the symptomatic service to prioritise the Screening Colonoscopist to undertake the index (first) screening colonoscopy.

2.2 Breast Screening Programme: Quality Domain Timely

Breast screening assessment waits

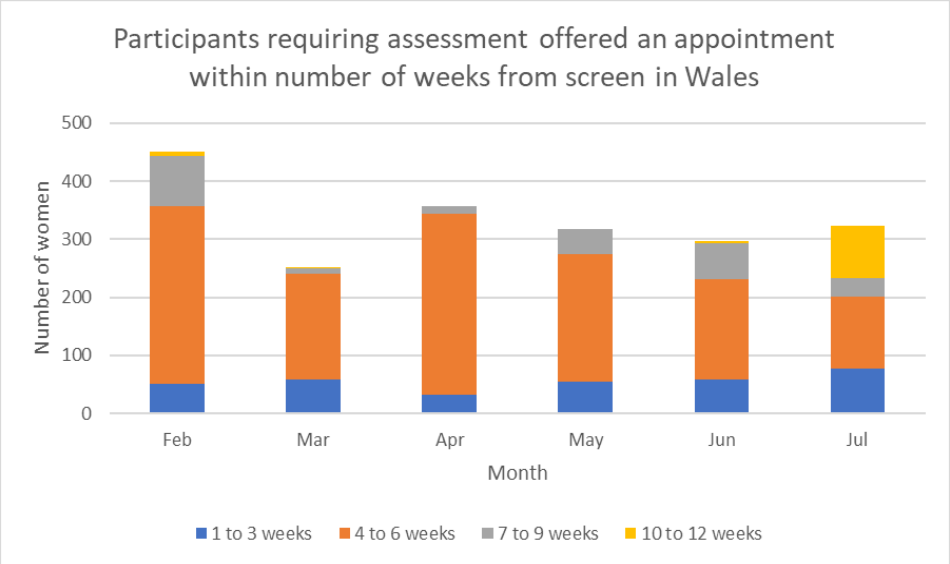
Timeliness of the assessment appointments has not met the standard of within three weeks of screening mammogram since the programme has worked to recover the timeliness of the round length due to the impact of the Covid pandemic.

Table 2 Breast Screening Assessment Waits

Percentage of Assessment Invitations Given Within 3 Weeks of Screen. Standard 90%									
2024/25	Nov	Dec	Jan	Feb	Mar	April	May	June	July
Wales	28.3	37.8	26.3	11.1	23.1	8.8	16.7	19.6	24.1

All regions had a marked reduction in timeliness of reading since February which was due to the implementation of new PACs system and issues with monitors supplied by the company. Slow speed of system continues to impact on reading in Wrexham.

Figure 4 Number of weeks participants waited for assessment



There are two other standards that the programme monitors which are key to understand this pathway:

- Timeliness of reading mammograms which is measured in normal results sent within 2 weeks of screen
- Assessment date offered within 2 weeks of abnormal results (arbitration). The date of suspicion as part of the Single Cancer Pathway is the date of arbitration.

Timeliness of reading is consistently met in West and is improved in South region but not improved in North.

South and West regions consistently meet standard for women having assessment date within 2 weeks of abnormal result. North is not meeting this standard.

West region was close to meeting the standard for assessment waits in July with all women being offered assessment within 4 weeks. South were offering all women assessment within 6 weeks in July. North Region were not able to offer within standard due to constraints for assessment clinics.

Figure 5 Timeliness of normal results being sent

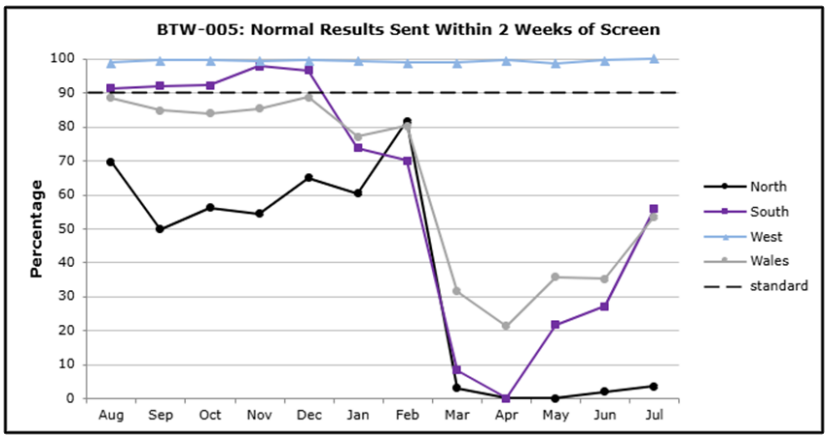


Figure 6 Timeliness of assessment offered within 2 weeks of abnormal result (point of suspicion)

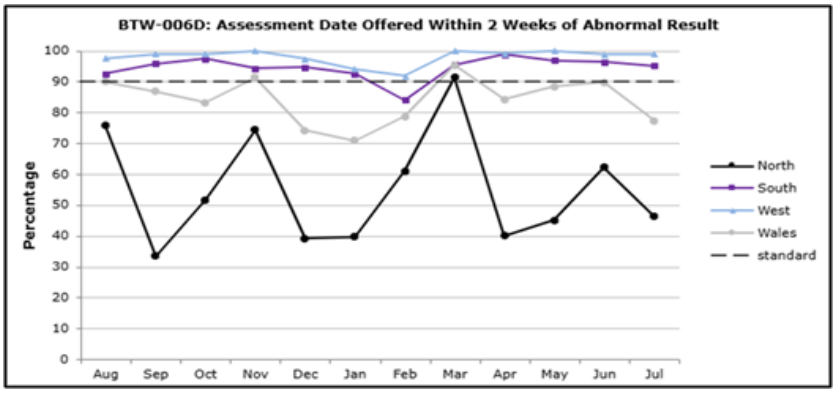
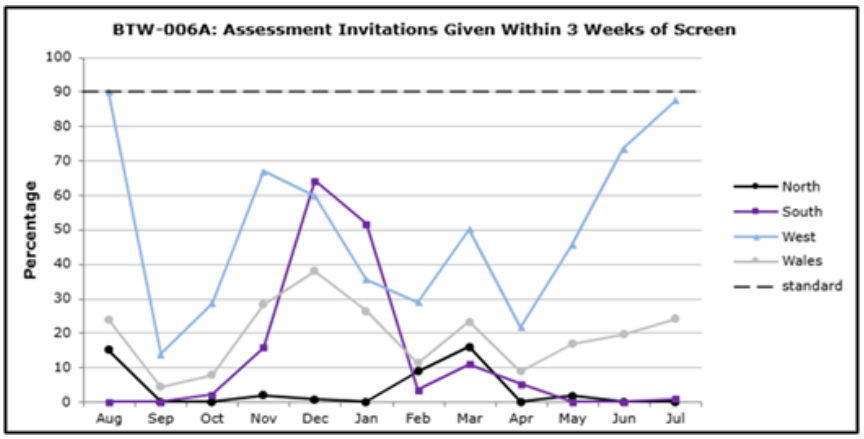


Figure 7 Timeliness of assessment offered within 3 weeks of screening appointment



Significant shortages in the medical workforce at the breast screening north centre has limited capacity for image reading, result reporting, and clinic assessments. Reduced surgical workforce availability, has led to delays in the pathway. Due to surgical staffing constraints there was 6 months when no assessment clinics took place in Wrexham centre. Participants were attending Llandudno centre with two consultant surgeons undertaking all surgical workload. Assessment clinics have been reinstated in Wrexham from middle of July.

Constraints in how assessment clinics are able to be staffed in North Wales with no radiology lead assessment clinics been able to be taken forward in Llandudno (in contrast to other regions) has impacted recovery and this has been urgently raised at Medical Director level directly with BCU Medical Director.

Actions underway:
North Wales:
West Wales is supporting North Wales with reading capacity.
Participants requiring assessment in Wrexham were booked into Llandudno clinics. Since July the Wrexham assessment clinics have been reinstated.
Additional evening clinics were held in Wrexham as out of hours.
Radiological lead clinics were run for women at low risk of having cancer, but this stopped due to difficulty with referral pathway for treatment.
The rate of screening in the Betsi Cadwaladr UHB area has been safely reduced slightly.
In discussion with Betsi Cadwaladr UHB (MD level) about reducing backlog for assessment and addressing sustainable surgical service in North Wales.
Film readers are in training in the north region. There is a Breast Clinician in training in North Wales and a Radiologist Fellow in training both will be able to undertake reading and

assessment clinics when trained. A radiologist in from the south region is providing virtual support to North for assessment clinics.
South Wales:
Prioritising staff who are qualified film readers to undertake reading over other work activities.
Across Programme:
NHS Exec Performance and Assurance Team scoping out tracker for breast screening taking similar approach to bowel screening.
A review of the BTW programme to be undertaken to identify other areas of improvement in line with delivering excellent services.

2.3 Breast Screening Programme: Quality Domain Safety

Healthcare Inspectorate Wales (HIW) conducted an announced Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection at Breast Test Wales, Swansea, on 8 and 9 April 2025.
The inspection focused on the following areas:

- Quality of patient experience
- Delivery of safe and effective care
- Quality of management and leadership

This was a full re-inspection of the service following an inspection at Breast Test Wales Llandudno in August 2024 which had a detailed improvement plan that the service took forward at pace.

The inspection in Swansea was a very positive experience and the report was published on 10 July 2025. The report detailed the improvement plan to further improve the service in line with the recommendations from the inspection. This is being taken forward and an update sent to HIW on 27 August 2025.

The summary of the Health Inspectorate Wales's findings from the inspection April 2025:

Quality of Patient Experience

Clients provided positive feedback about their experiences of attending Breast Test Wales, Swansea. We found staff provided individualised care and treated clients with courtesy, respect and kindness. We also found staff provided care in a way that protected and promoted client's rights.

This is what the service did well:

- Delivering a flexible service for women and providing additional screening capacity within the department when mobile screening vans were out of action.

- Clients provided positive feedback and comments about the attitude and approach of the staff looking after them.
- Commitment to Welsh language information and provision of Welsh language care.
- Provision of a wide range of health promotion information.

Delivery of Safe and Effective Care

Arrangements in place to provide people with safe and effective care. We reviewed extensive documentation including Employer's Procedures that had been reviewed, updated, ratified and disseminated to staff.

The setting was clean, tidy and free from clutter. Rooms were modern, well appointed and equipment was in good working order.

This is what is recommended the service can improve:

- Continue to refine and update Employer's Procedures in line with recommendations from the inspection, best practice, staff feedback and IR(ME)R amendments.
- Review and update clinical and IR(ME)R audit planning and processes to include an audit schedule, appropriate compliance targets and standardised reporting, learning and re-audit processes.

This is what the service did well:

- Updated Employer's Procedures that were document controlled and available to all staff, including staff working on mobile screening units.
- IR(ME)R training videos have been developed by medical physics for all staff
- Communication of benefits and risks of mammography exposures for users of the service.
- Staff understanding of IR(ME)R and continued training around the regulations.
- Commissioning and testing of new equipment.
- Quality assurance programme for equipment.
- Well maintained, clean, modern and welcoming environment free from obvious hazards to those visiting the setting.
- Safeguarding arrangements.

Quality of Management and Leadership

The Chief Executive of Public Health Wales was the designated employer under IR(ME)R. The trust was able to demonstrate improved structure for lines of reporting and accountability under IR(ME)R during the inspection.

We met with a dedicated management team who have worked hard in a short period of time to update documents and processes appropriately, to ensure IR(ME)R compliance in Breast Test Wales was in place and consistent across the three Breast Test Wales sites.

This is what the service did well:

- Passionate, engaged and dedicated team of staff that cared about the clients and Breast Test Wales service.
- Policies, procedures and documentation were detailed and well written, ratified, version controlled and accessible to staff.
- IR(ME)R awareness training for all duty holders.
- Training compliance for mandatory training.

2.4 Diabetic Eye Screening Wales: Quality Domain Timely

Recovery of timeliness for eye screening is improving but not in line with standards. As of July 2025, there are 199,543 participants registered with DESW who are eligible for screening. There were 48,099 participants currently overdue their eye screening appointment with the length of time a participant is delayed reduced to 10 months. The recovery plan is underway for the programme and is taken forward with two strategic approaches: optimise the current service provision to support recovery and transform the service to put in place a sustainable service model.

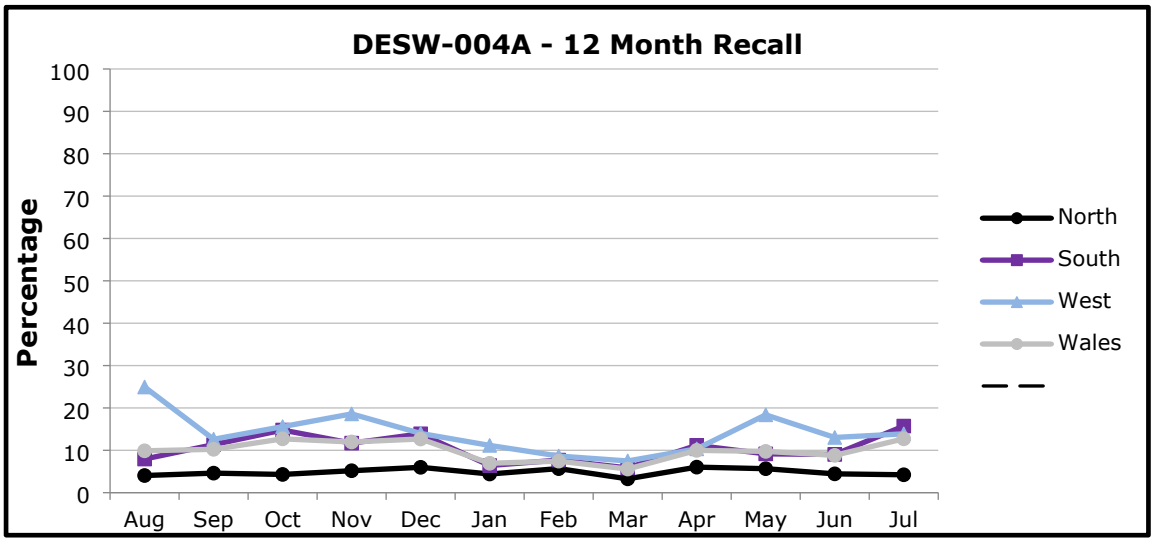
To improve timeliness, the priority for the programme is to increase appointment capacity to meet both current and future anticipated demand due to an increasing prevalence of diabetes. An overarching clinic capacity project has been established to review the number of participants seen within each clinic. Four separate service improvement initiatives are being tested to see if improvements in numbers seen can be increased without compromising quality of the appointment and the images captured. This includes using a 2 screener to 1 photographer template model; shorter appointments for low-risk recall participants; drop in clinic model and an evaluation into the safety and effectiveness of using the new TopCon cameras to capture images without the use of tropicamide drops.

The low risk recall pathway (LRRP) was implemented in June 2023 with the aim of increasing capacity within the programme and reducing the inconvenience of annual screening for participants who are low-risk of diabetic retinopathy. Nearly 37000 participants were moved to the LRRP in June 2023 reduced demand by 9.6% however, this was lower than pre-implementation modelling. At time of implementation of the LRRP, approximately 19% of all eligible active participants in DESW were on the LRRP, this has increased to 32% by December 2024. There are currently 63,097 participants on the low-risk recall pathway with coverage in December 2024 at 78.3% (standard 80%). There is no evidence that extending screening intervals has resulted in poor attendance or reduced motivation of participants to attend eye screening with uptake of 91% for those on the LRRP.

The standard for participants to be offered a recall appointment at 12 months has not been met though has improved from 6.9% in January 2025 to 12.7% in July 2025. Participants who have been waiting the longest are prioritised for recall and it will be expected to see an improvement in this standard as the round length for participants decreases. Recall at 24

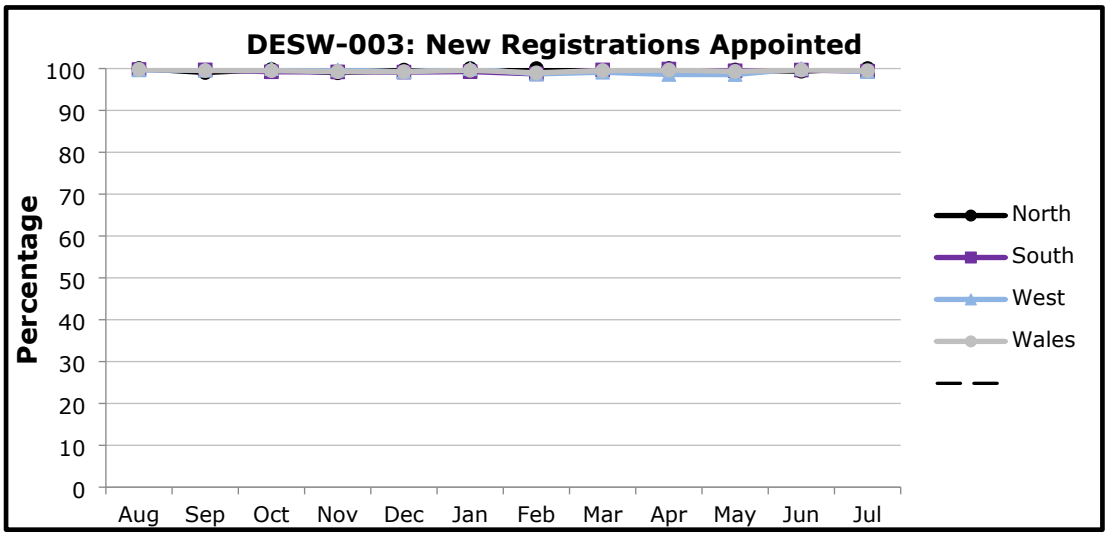
months for participants on the 12 month recall pathway is now at 97% reflecting staged improvements in timeliness.

Figure 8 Percentage of Participants recalled at 12 months



The total number of new registration referrals received is on average 1400 a month which the programme has to absorb without additional resources. This impacts on timeliness of recall for recall participants as new registrations require to be appointed within 90 days and so are prioritised over recall participants. New referrals are prioritised over recall participants as they have not had a diabetic eye screen previously and therefore their risk of sight threatening diabetic retinopathy is unknown. New referrals are called in a timely way with the standard overachieved with 99.7% of new registrations receiving an appointment offer within 90 days.

Figure 9 Percentage of New Registrations invited within 90 days



Actions underway to improve timeliness

Action to ensure delivery of excellent screening services that meet standards for timeliness are addressed through optimisation of current service delivery, delivered through the service improvement plan, and transformation to develop, adopt and implement innovative approaches to service delivery and digital transformation within the transformation five year road map. Current actions:

Action	Update September 25
Implementation of Low-risk recall pathway from June 2023.	Approximately 1/3 of total eligible participants now on LRRP. Coverage at 74% therefore just below standard of 80%. Cohort will continue to increase as participants become eligible for LRRP following two negative retinopathy screens.
Staff workforce – new recruitment to increase capacity and develop resilient and flexible workforce.	Mid-Wales screening team recruited, trained and now deployed to support additional appointment capacity within Mid Wales and free up appointment capacity in North and South as no longer required to cover clinics.
Clinic templates adjusted to increase screening appointments.	Ten minute templates undertaken in fixed sites and Tenovus Mobile units Roll out across further clinic sites across Wales as appropriate to venue. Service improvement plan to consider new clinic template models including LRRP clinic

	(shorter appointment times), 2:1 workforce model and drop in clinic model.
Provide mobile clinics in areas where there is longest wait and no suitable community venues to increase screening appointment capacity.	Mobile clinics have provided increased capacity and flexibility to target longest wait areas. However, has been highlighted that no further funding stream currently identified post 25/26. Options appraisal in progress for future service delivery model that includes longer term option of mobile clinic delivery model however will require capital investment from WG and new additional revenue from PHW.
Introduction of new cameras across Wales to improve quality of image capture and reduce proportion of inadequate images requiring repeat attendance or hospital eye service referral.	Inadequate image rate declined since introduction of camera. Aim to undertake evaluation of use of image capture without tropicamide drops in Q3 2025/26 which likely to improve efficiency and person centred approach.
Understand participant user requirements and preferences to ensure provision of person-centred service and increase attendance.	Pilot of gathering user preferences by photographer during appointment. Data will be used to inform digital requirements for management of user preferences.

2.5 Diabetic Eye Screening Programme Quality domain: Efficiency

To provide an efficient screening service the programme are working to maximise clinic utilisation. This includes active backfilling of any cancelled appointment. Backfilling is prioritised for mobile clinic venues as these are situated in longest wait areas.

To decrease cancellations and non-attendance the Programme implemented an organisational change process in September 2024 to enable the service to regularly run clinics during evenings and on a weekend. This is a response to participant user feedback that people were not able to attend appointments during working hours demonstrated by the highest non-attendance rate in working age adults. Evaluation of the extended hours clinics has demonstrated that participant feedback from those who have attended is very positive regarding the provision however, non-attendance rates for Saturday and evening clinics are equivalent or higher than for working day clinic appointments. Due to the increased cost of delivering services on Saturdays and financial constraints a temporary change has been implemented to reduce the frequency of Saturday clinics to monthly from every 2 weeks. This will still provide an accessible clinic model for participants who can only attend on a Saturday but will enable a more efficient and cost-effective service to be delivered during regular working hours.

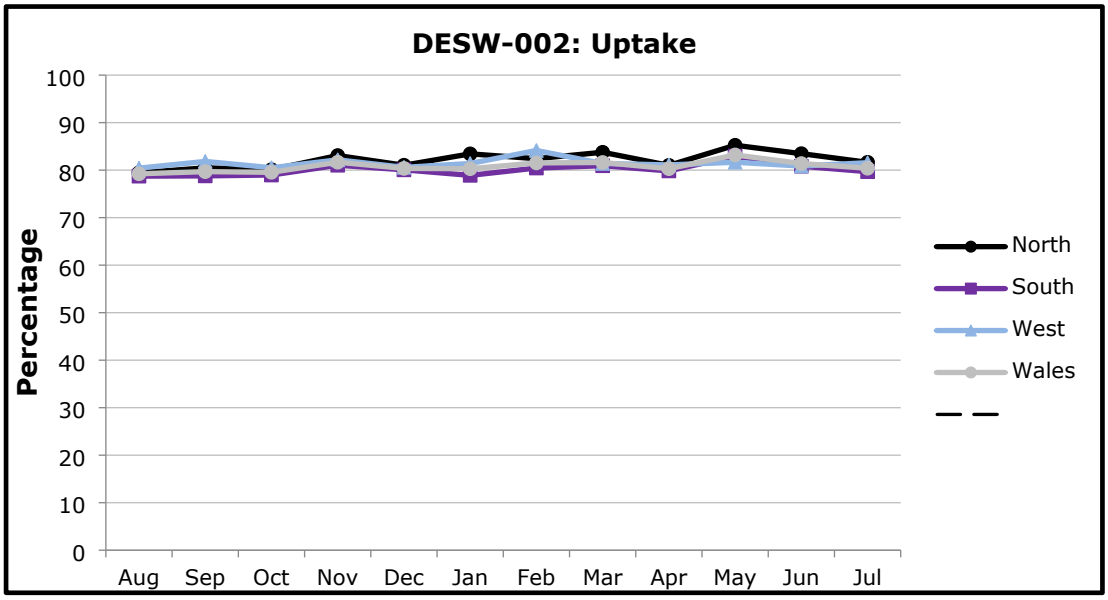
Excluding extended hours clinics, non-attendance at DESW clinics across Wales from January 2025 to July 2025 for people with a booked clinic appointment is 18%. There is variation in non-attendance by venue location with the lowest non-attendance of 7% ranging to highest non-attendance of 34%.

Approximately 5% of filled appointments are cancelled by participants. High numbers of cancellations reduce clinic utilisation. Following cancellation at present a participant can cancel their screening appointment an unlimited number of times. This impacts upon the longest wait as participants remain open and awaiting appointment despite multiple allocated appointments provided by the service. New business rules are due to be introduced to enable closure of screening rounds for participants who have cancelled multiple appointments.

2.6 Diabetic Eye Screening Programme: Quality domain Person-centred

Uptake of the diabetic eye screening offer is consistently achieving the standard of 80% at an All-Wales level and across all three regions in Wales.

Figure 10: Uptake: Percentage of participants who attended their eye screening appointment

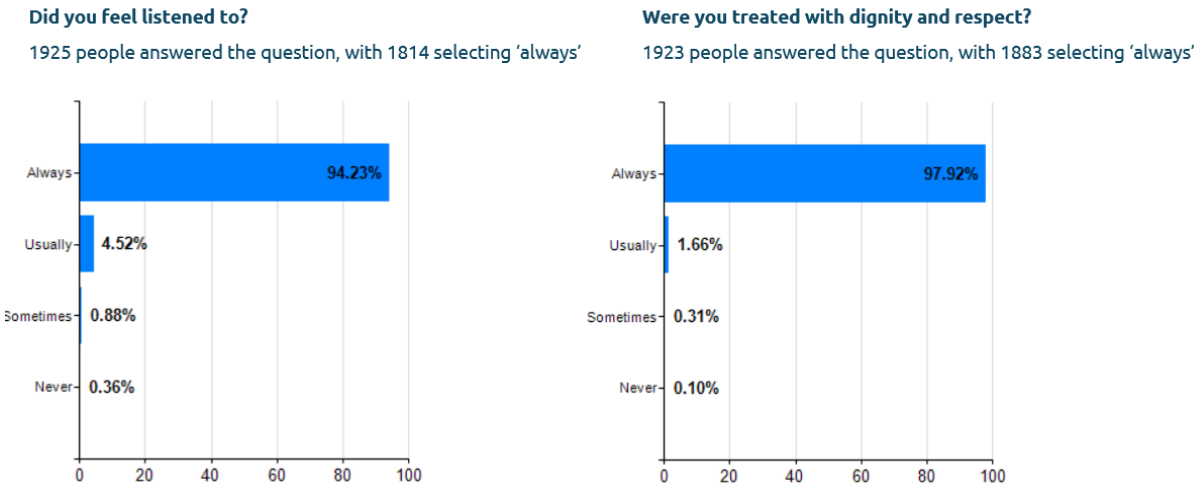


DESW have been working with Service User Experience colleagues within NQIG as part of a SMS Quality improvement project to gather Service User Experience survey data using SMS (text message) feedback. Due to the high completeness of telephone numbers held by DESW

within their information system nearly 2000 people have provided feedback on the service they received across eight different clinics location from February to June 2025.

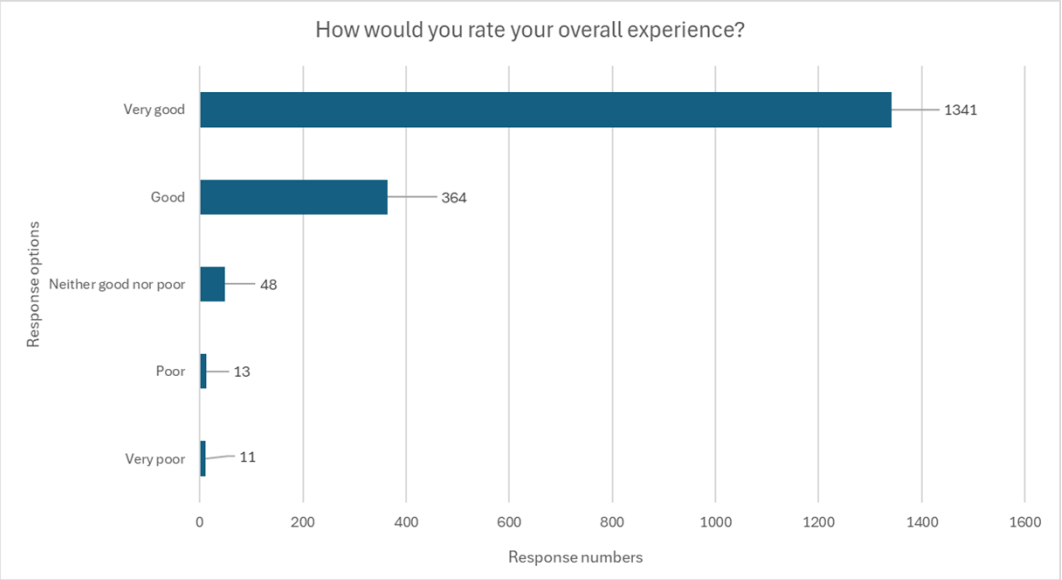
When asked if they felt listened to, 94% of people (1814 of the 1925 people who answered the question) selected always. Nearly 98% of people (1883 of the 1923 people who answered the question) responded that they were always treated with dignity and respect.

Figure 11: SMS (Text message) feedback



When asked to rate their overall experience, nearly 96% (1705 out of 1777 people) rated their overall experience as Good or Very Good.

Figure 12: SMS (text) message feedback



Issues raised within the survey related to parking and standard of clinic facilities within non-PHW run screening centres.

3. Assessment: Programme Improvement/ Development

3.1 Cervical Screening Self Sampling

Quality domains: Effectiveness; Person-Centred; Equitable

In June 2025, the UK National Screening Committee (UKNSC) made the permissive recommendation for the UK cervical screening programmes to introduce a cervical self-test option to women and people with a cervix who do not routinely or never attend cervical screening appointments. This allows for the use of self-sampling as a strategy to improve uptake.

Cervical self-sampling differs to traditional cervical screening as it uses a sample collected by the individual (usually with a swab or brush), instead of a sample taken by a healthcare professional. Like primary cervical screening, HPV self-sampling is used to detect high risk strains of HPV. Where the self-sampled test finds high-risk HPV, further investigation is required to check for any cell changes or early signs of disease. This approach makes cervical screening more convenient and less intrusive, particularly for individuals who may find it difficult to attend clinic-based appointments.

Whilst self-sampling offers an alternative means of undergoing screening, it does have limitations. A clinician taken sample is still required if cytology is indicated due to the need to visualise the cervix, therefore HPV positive self-samples will need a modified screening pathway. The recommendation at present is therefore to offer self-sampling to those who rarely or never engage with screening, i.e. it is a better option than no test for these individuals.

In June 2025 Cervical Screening Wales has set up a self-sampling project with the primary objectives:

- Improve cervical screening coverage to a minimum of 70% to meet the goals set out in the WHO Cervical Cancer Elimination Initiative.
- Improve access to cervical screening for the under screened population.
- Improve equity and equality for cervical screening.
- Meet the recommendation for self-sampling set out by the UKNSC.
- Deliver a cost effective solution.
- Timely introduction (2026).

In addition, Cervical Screening Wales are also involved in further work as part of an in-service evaluation to explore self-sampling as a universal offer. This work is anticipated to begin in late 2026/early 2027 subject to successful application for NIHR funding.

3.2: Implementation of recommended conditions for Newborn Bloodspot Screening

Quality domains. Safe, Effective, Equitable, Person-centred

In November 2022, the UK National Screening Committee (UKNSC) recommended the introduction of screening for an additional condition, Hereditary Tyrosinemia type 1 (HT1), into the newborn bloodspot screening programmes.

A UK Tyrosinemia Task Group was established, working across the four UK nations to look at requirements for implementation. Detailed recommendations were presented to the UKNSC Fetal, Maternal and Child Health Group in September 2024. Following this, the Wales Implementation Group was established. Membership of the group included representatives from relevant specialist services and groups across NHS Wales, the third sector, and the NBSW programme.

Implementation in Wales will be at a different time to England, with their current estimate of implementation being Late September 2025.

There are two main barriers to implementing sooner in Wales which are our IT system and the lab infrastructure. Phase 1 of the work to make the IT system suitable is complete and the

system is now re-platformed. The development phase is planned to start soon once contract details have been finalised.
Cross border issues associated with the differential start date have been challenging but good to identify as affect other conditions screened for.

The proposal is for the implementation of HT1 to be a step change for the programme and the laboratory. This will set up Newborn Bloodspot Screening in Wales in a strong position for not only the implementation of HT1 but also the two other conditions likely to be recommended soon (SCID and SMA), and further evaluations and new conditions being included at scale and pace leading from building the evidence base in an innovative way within service evaluation.

3.3: Implementation of Both Ears Clear model for Well Babies in Newborn Hearing Screening

Quality domains. Safe, Effective, Equitable, Person-centred

The Newborn Hearing Screening Wales (NBHSW) programme aims to identify newborn babies with permanent childhood hearing impairment as early as possible to allow for early support to mitigate the impact of hearing loss on language, communication, educational and social outcomes. Currently, NBHSW operates a well baby service model that is focussed on identifying hearing loss in both ears which is different to other areas of the UK. Babies that have no clear result in both ears are referred on to audiology for diagnostic testing. Babies that receive a one ear clear result in Wales are offered a follow up with audiology, but this this offer is not well taken up and that there is inequity in access further tests.

The Wales Screening Committee have approved the proposal in principle for a change to a service model that requires a clear result from both ears for discharge, bringing us in line with the rest of the UK.

A key aim of any new service model is to minimise unnecessary referrals to audiology. An outline service model proposal has been developed, and a number of service developments have been progressed already to help refine our current model and inform what a future model could look like, including more accurately predicting future referral volumes to audiology.

Developments that have happened already:

- Expansion of Well baby Automated Auditory Brainstem Response (AABR) Testing into the clinic setting. This development standardises the screening pathway for babies irrespective of screen location (hospital or clinic) and ensures equitable service provision.
- Following a consultation with Audiology services, the NBHSW Programme Board approved proposals to align NBHSW diagnostic protocols with British Society of

Audiology (BSA) guidance. This supports discharge of babies where clear responses from both ears are recorded (using OAE which is simpler and shorter) without full AABR assessment. This aligns with the rest of the UK.

- Changes have been made to recruitment for Screeners to improve recruitment and retention of staff. This will strengthen the workforce to deal with the additional capacity required to meet timely Both Ear Clear service delivery. Senior Screener posts have been redesigned, increasing dedicated time for training and support for Screener colleagues and quality assurance tasks.

Further developments planned an ongoing include:

- NBHSW are working with Audiology services to benchmark current provision for babies diagnosed with unilateral hearing loss, with the aim of agreeing an evidence-based all-Wales approach prior to service model change.
- Development of AWNBHS Clinical IT System. A phased approach to improvement of the IT system is underway with the replatforming, phase 1, recently completed which mitigates the stability and cyber risks and allows for development work to start.
- NBHSW are working with the National Deaf Children's Society to explore service user engagement regarding planned changes to the service model.

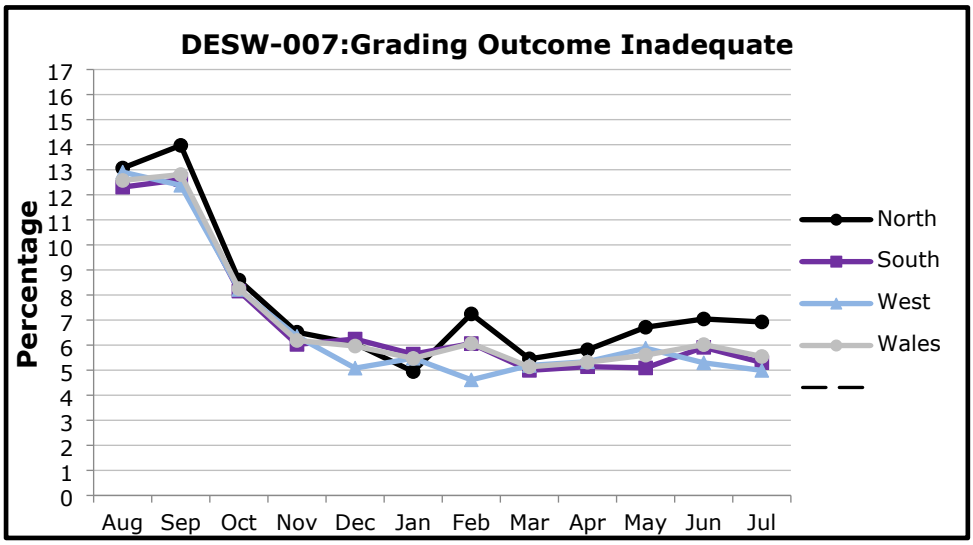
The next step is presentation of detailed and costed modelling work to internal groups and for consideration by Wales Screening Committee for approval of change to both ears clear model for the programme.

3.4 Implementation of replacement cameras Diabetic Eye Screening:

Quality domains. Effective, Efficient, Person-centred

Diabetic Eye Screening Programme implemented an upgraded fundus image capture equipment into the programme on September 24. The aim of the new cameras is to reduce the rate of inadequate retinal images (effectiveness), improve operational efficiency (efficiency) and improve participant experience (person-centred).

Since the introduction of the cameras in September 2024 there has been a reduction in inadequate image capture from 12.8% to 5.5% in July 2025.



The cameras have reduced recall into the programme for repeat images and have reduced referrals into Hospital Eye Services for image capture. The programme is now looking at how to realise the potential benefit of the cameras to take adequate images without the need for pupil dilation with tropicamide eye drops. The camera utilises a new technology that makes use of the retina's reflective properties and as such is capable of capturing colour fundus images without the need to dilate the pupils.

There could be significant benefits to both participants and the programme if tropicamide eye drops are not adminsitered to all participants for pupil dilation and cilary muscle fixation. From a participant's perspective it would reduce the need for the administration of a medicine and potential side effects. From a programme perspective it could offer efficiencies in service delivery (increasing the number of participants seen per clinic due to shorter appointment times) and cost (reducing the amount of tropicamide used). There are also potential wider benefits to participants if tropicamide is not used as their vision will not be impacted and they can return to normal activities immediately.

The implementation of the new cameras provides an opportunity to consider a staged mydriatic approach to diabetic retinopathy screening where tropicamide eye drops are only administered to participants when image capture is not adequate with undilated pupils. DESW are developing with the PHW Evaluation Lead for the Tackling Diabetes Together programme an evaluation framework to determine the safety and effectiveness of image capture in undilated pupils in comparison with dilated pupils.

The evaluation will determine the feasibility, safety, and acceptability of implementing a staged mydriasis protocol in DESW, where retinal images are initially captured without dilation, and dilation is used only when necessary. The primary clinical objective is image quality, with additional secondary objectives to consider the behavioural and clinical implications of adopting a staged mydriatic approach. This service evaluation will inform the development of a standardised, staged mydriatic screening protocol for implementation across all DESW site types (fixed, mobile, outreach).

3. 5 Lung Screening Programme Implementation:

Quality domains: Equitable, Effective. Person-centred

Public Health Wales was commissioned by Welsh Government to scope out a lung cancer screening pathway and to make recommendations as to how the programme could be delivered in Wales. It was initially agreed that an interim report would be provided in March 2025, with a final report in September 2025. Subsequent communications from Welsh Government requested that the interim report contain as much information as possible to inform an early decision on lung cancer screening in Wales.

An interim report was written and following approval from PHW Business Executive Team and Board, was submitted to Welsh Government at the end of March 2025. The interim report outlined the evidence and benefits of lung cancer screening and made a number of recommendations in relation to how a lung cancer screening programme could be delivered in Wales.

On 28th June 2025, Jeremy Miles MS, Cabinet Secretary for Health and Social Care published a written statement introducing a National Lung Screening Programme for Wales, with the first people to be invited in 2027.

'Screening will involve a low dose computed tomography (LDCT) scan of the chest using mobile scanning units to support equitable access for communities in all parts of Wales. We will adopt a phased approach to implementation based on age, starting with the upper age range and gradually reducing it over time'. Implementation will take place in three stages to allow the NHS in Wales to increase capacity to report scans and follow up on the results promptly.'

Welsh Government has confirmed revenue and capital funding for 2025/26 and has detailed that additional capital requirements for 2026-27 onwards will require PHW to submit formal business case(s) to the Welsh Government for scrutiny and further advice to the Cabinet Secretary for Health and Social Care.'

A robust framework and plan with key steps and timelines have been developed to support completion of the business justification case ensuring that all relevant PHW functions have been included. The timescales outlined are for submission to the PHW Board for consideration at meeting on 27th November.

The requirement to complete a business justification case was not included in initial implementation timelines, since feedback from Welsh Government had indicated that approval of the interim report would include all required approvals. The lung screening programme will continue to progress work, but key procurement tasks cannot proceed until capital funding has been approved. Advice has been given to Welsh Government that an

assessment of the impact on the implementation timelines will be made once the business justification case is approved by Welsh Government.

A Programme Assurance Plan has been agreed and sets out the assurance arrangements for the Lung Cancer Screening Programme Implementation Planning Phase. Assurance arrangements for the programme will be carried out in line with the three lines of defence model set out in the PHW Programme Assurance Framework.

The specific assurance objectives are:

- To provide assurance at a project level that products are being produced to a defined level of quality within agreed time and cost parameters (first-line assurance);
- To provide assurance at a programme level that outcomes and benefits are being achieved (second line); and
- To provide assurance at a portfolio level that the programme is delivering the full value and impact forecast set out in the investment case for the programme (third line).

4. Recommendation

The Committee is asked to:

- Take **assurance** that there is progress to working to deliver quality screening programmes in line with delivery of excellent public health services to the population in Wales.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** *4.6*

Health and Safety Report	
Executive lead:	Angela Williams, Interim Executive Director of Operations and Finance
Author:	Neil Desmond, Head of Estate and Health & Safety Scott Thomas, Health & Safety Advisor

Approval/Scrutiny route:	Health and Safety Group – 23/07/25 Business Executive Team – 06/08/25

Purpose
This report provides an update on the health and safety performance for the period of 01 April 2025 – 30 June 2025.

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

The Committee is asked to:

- **Receive assurance** that appropriate measures are in place to monitor compliance and to address areas identified for improvement.
- **Note** that the Business Executive Team approved the Health and Safety Terms of Reference at its meeting on 16th September 2025 (Appendix E).

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	5 - Supporting a sustainable health and care system

Summary impact analysis	
Equality and Health Impact Assessment	Internal report only
Risk and Assurance	The paper details the health and safety risks on Directorate and Divisional risk registers and also includes safety alert notifications. It additionally outlines where gaps have been identified, control measures are being implemented to address issues identified.
Health and Social Care (Quality and Engagement) (Wales) Act	This report supports and/or takes into account the Health and Care Standards for NHS Wales Quality Themes Theme 2 - Safe Care
Financial implications	None identified
People implications	There are no implications for workforce / staff identified

1. Introduction and Purpose

The purpose of section one of this report is to provide an update on the health and safety activities and performance for the period 01 April 2025 to 30 June 2025. The key areas of compliance includes:

- Health and safety incidents reported, and lessons learnt under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)
- Health and safety premise inspection audits
- Health and safety statutory/mandatory training
- Health and safety Corporate Risk Register
- Notifications and alerts
- Health and safety policies and procedures

2. Background

In order for the Health and Safety Group to discharge its responsibilities, it needs to receive assurance that the organisation is effectively managing health and safety. This includes details of any concerns, areas of non-compliance, outstanding actions from relevant health and safety action plans and controls and mitigations are in place.

The Health and Safety Group receives this assurance via this report and exception reports received from the various Directorates/Divisions through the respective Health and Safety leads.

3. Key Highlights

3.1 Three RIDDORs were reported during the Quarter 1 reporting period (01 April 2025 to 30 June 2025). Further information on this can be found in Section 5.

3.2 Significant progress has been made on the findings and actions from the HSE visits over the previous 12 months. A further HSE visits to Bangor is being scheduled in for October 2025. Further information can be found in Section 6 as well as an embedded copy of the Action Tracker.

3.3 There are 16 properties within the organisation's estate portfolio where the responsibility to undertake statutory duties is that of the organisation. These duties include:

- Fire Risk Assessment
- Water Management (Legionella) Risk Assessments
- Electrical Inspection Condition Report (EICR)
- Asbestos survey/re-inspection
- Gas Safety Certification

Currently two sites are falling short of the 100% compliance target in one of the five key areas. Further information can be found in Section 7 and Appendix C.

3.4 All health and safety alerts and notifications received within the reporting period have been reviewed and addressed, with appropriate actions taken where required.

3.5 Further to the completion of the health and safety audits, the Health and Safety Advisor has continued audit review visits at premises to review progress of identified actions and help support premise leads on actions yet to have been completed.

4. Health and Safety Incident Reporting

4.1 Statistics on incident records by directorate

All staff are required to report incidents using the Datix system in accordance with the organisation's policies and procedures. Incidents are monitored to help identify trends, to ensure investigations are undertaken and are concluded identifying the incident cause and any lessons learnt.

From 01 April 2025 to 30 June 2025, we have seen a total of 84 incidents reported, a decrease of 6 incidents on the previous quarter. The total number of reported health and safety incidents is provided with a breakdown by directorate shown in Table 1.

Table 1. Reported health and safety incidents by Directorate

Division	No of incidents Q1
Research, Data and Digital	2
HPSS - Microbiology	37
HPSS - Screening	38
Nursing, Quality & Integrated Governance	1
NHS Performance and Assurance	4
Operations and Finance	2
Total	**84**

All incidents relating to health and safety are notified to the relevant Health and Safety Managers and are followed up to ensure all incidents are investigated correctly and to help identify any trends. Support is provided by the Estates, Facilities and Health & Safety Division as required at an appropriate level of intervention dependant on the nature of the incident.

4.2 Statistics on incident records by classification/category

All incidents reported are classified under the following classifications and categories:

Table 2. Reported health and safety incidents by classification and category

Classification and Category	No of incidents Q1
Accident, Injury	**35**
Burns or scalds	0
Choking	0
Contact or exposure to electricity (electric shock)	0
Contact with needles or medical sharps	1
Contact with object or animal	3
Contact with or exposure to hazardous substance	17
Manual Handling - Non patient/service user handling	2
Manual Handling - Patient/service user handling	0
Patient Injury	2
Road Traffic Collision	0
Slip, trip, or fall	6
Struck against or by an object	4
Behaviour	**3**
Aggressive/threatening behaviour	3
Anti-social behaviour	0
Patient clinically challenging behaviour	0
Equipment, Devices	**33**
Medical devices	14
Non-medical equipment	19
Infection Prevention and Control	**5**
Environmental cleaning (process and procedures)	4
Infection outbreak / period of increased incidence	0
Sterilisation / decontamination of equipment (including vehicles)	0
Hand hygiene	1
Ill Health (work related)	**0**
Ill Health	0
Infrastructure (including staffing, facilities, environment)	**8**
Cleanliness	0
Collection/delivery services	1
Environmental hazards / issues	4

Fire Safety	2
Service Resources	1
Total	**84**

All Incidents from Quarter 1 have been reviewed to ensure the organisation is aware of any possible emerging risk to staff and service users and can continue to enhance our safety performance by ensuring our policies and procedures are fit for purpose and improved where required, as well as identifying any trends in reported incidents so appropriate action can be taken.

Although 30 incidents have been reported under the Equipment, Devices classification, which is over one third of the total reported incidents this quarter, after reviewing the data it has been determined that the majority of these incidents relate to the impact on service delivery across our Screening and Microbiology services and have no health and safety implications. One of these incidents did relate to an Automated External Defibrillator (AED), where the batteries had expired and pads used for defibrillation were out of date. Further to work led by the Estates and Health & Safety Division and the health and safety lead for screening a new process has now been implemented across the organisation to ensure AED's are inspected monthly, with inspection results sent directly to a central database, which allows for improved monitoring of inspections being undertaken and immediate action to be taken for any issues identified with the AED's. This will also allow us to report on the status of AED inspections in future quarterly reports and provide greater reassurance to the organisation on the condition of AED's across the estate.

On reviewing the harm assessment of each incident, 40 were considered no harm, 39 low harm, 4 moderate harm and 1 severe harm. The 1 considered severe harm related to a screener who accidently banged their thumb against a face guard on the x-ray equipment they were utilising at the time. This was considered more severe as the member of staff had pre-existing condition, which resulted in the staff member being off work for over 7 days and therefore was reported as a RIDDOR. Further information on this can found in Section 5 below.

Of the 84 incidents reported during Quarter 1, 65 have been fully investigated and closed, with a further 4 incidents submitted for closure. The remaining 15 incidents are currently still in the investigation or management review stage and will be updated and closed once this has been completed.

Of the incidents reported in the last reporting quarter (Quarter 4), all incidents have been fully investigated and closed.

5. RIDDORs

Three RIDDORs have been reported to the Health and Safety Executive in Quarter 1. A brief outline on the RIDDOR is provided below along with details of any actions taken:

Datix Incident 6518 – Microbiology (Incident Date - 29 April 2025)

Submitted as – Dangerous Occurrence (Release or escape of biological agents)

The Public Health Wales containment level 3 (CL3) was experiencing negative pressure issues so a decision to move to the back-up CL3 in Cytology Ysbyty Glan Clwyd was made. This is usually run at containment level 2 (CL2). There is a conversion checklist which is used to implement the CL3 required controls. During the conversion process the microbiological safety cabinet (MSC) was not already turned on, and the instruction to switch it on was missed. Three samples were processed before it was identified that the MSC was not switched on. The samples were a sputum and pleural fluid which have been screened as negative for the presence of TB and an enteric which was query VTEC/Campylobacter. The Reference laboratory has confirmed that the VTEC was not present.

This is considered a near miss incident in terms of staff exposure and there is no risk of staff developing disease. However, due to the nature of the incident, had a hazard group 3 organism been present, this would have been an exposure, and as such hits the definition to report under RIDDOR Dangerous Occurrences Section 10 Biological agents.

An SBAR has been produced with a number of findings and actions identified, which are currently being worked through by the Microbiology Division.

The HSE have confirmed a site visit is not required, but a letter will be issued, which will be submitted to the Health & Safety Group for review once received.

Datix Incident 6519 – NHS Wales Performance & Improvement (Incident Date - 30 April 2025)

Submitted as – Specified Injury (Bone Fracture)

A member of staff was leaving the office of a property managed by another organisation. They were going down the staircase into the main foyer of the building, at which point they slipped on a wet floor in the foyer whilst stepping off the last step of the stairs. The member of staff was then transported to the nearest

hospital where it was confirmed the member of staff had sustained a left lower leg fracture and soft tissue injury to the left buttock.

Upon further investigation it was confirmed by both the injured staff member and a witness to the event that the floor was wet, which was later confirmed to be due to recent cleaning of the floor from the cleaning company for the building, but no wet floor signage had been put out to warn building occupants that this had taken place.

The landlord for the property was informed about the incident on the 1 April 2025, due to this taking place in a communal area of the building for which they have responsibility for. The landlord was also requested to take immediate action with the contracted cleaning company to ensure they put out adequate signage whenever floor cleaning takes place to ensure staff are aware and can take appropriate precautions to avoid further incidents taking place. No further incidents have occurred since this was reported.

The HSE were informed of the incident on the 1 May 2025. No follow up actions from the HSE have been received to date.

Datix Incident 6780 – Screening Services (Incident Date - 12 June 2025)

Submitted as – Injury preventing the injured person from working for more than 7 days (Superficial Injury to Head)

A member of staff was carrying empty sample bag through the Cervical Screening Laboratory at Magden Park, lost their balance and fell into door frame. After hitting their face against door frame, they then fell to the floor. The member of staff suffered superficial injuries to face and had a nosebleed at the time of the incident. The staff member then attended the local hospital where it was confirmed they had suffered no significant injuries.

A subsequent investigation of the workspace confirmed indoor lighting was at an adequate level. The flooring is of vinyl construction and there are no loose edges or joints observed. The flooring space was free of trip hazards such as trailing cables and no spills of water present. Subsequently, no contributory factors were identified and no changes to procedures or environment have been recommended.

The HSE were informed of the incident on the 23 June 2025. No follow up actions from the HSE have been received to date.

6. Health & Safety Executive Visits

Further to the HSE routine site visits to microbiology laboratories undertaken between 30 July 2024 and January 2025, as part of a schedule of routine site visits, and the issuing of the formal letter from the HSE, the following progress has been made on the findings:

- The letter issued last year with four actions had an original deadline of 6 months but was extended due to difficulties procuring ducting testing. Ducting testing completed and reports submitted by new deadline of 14 July 2025. Awaiting review by HSE and confirmation of satisfaction.

- Current formal letter regarding sealability of network and specifically at WCM (Llandough Hospital) has a deadline of 26 September 2025. Recommended actions are currently progressing. Only risk for completion will be evidence of Memorandum of Understanding with Estates regarding remedial work in response to sealability issues.

Further details on progress of actions can be reviewed in the feedback plan update (**Appendix D**).

A further HSE sites inspection has been provisionally scheduled in for the Bangor Laboratory around 02 October 2025. This will be confirmed in mid-August.

7. Estates Compliance with statutory and regulatory requirements

During the reporting period 01 April 2025 to 30 June 2025 the monitoring and scheduling of compliance has continued to be maintained. There are 16 properties within the organisation's estate portfolio.

Since the last quarterly report one property, River House which accommodates NHS Wales Performance and Improvement has been removed from the PHW estates compliance reporting and going forward will be reported via assurance report from NHS Wales Performance and Improvement. In addition, please note that one site of the 16 reported sites counts as a collective of the BTW Mobile Units. These 16 properties are where the responsibility to undertake statutory duties is that of the organisation. These duties include:

- Fire Risk Assessment – 100% compliant
- Asbestos survey/re-inspection – 100% compliant
- Electrical Inspection Condition Report (EICR) – 100% compliant
- Gas Safety Certification – 100% compliant
- Water Management (Legionella) Risk Assessments – 87% compliant
-

Further details are set out in Appendix C in relation 'Water Management (Legionella) Risk Assessments' compliance.

The rolling programme of compliance checks continues to be adhered to as far as practicable, to ensure that inspections and testing are undertaken at appropriate intervals at all sites that fall under the responsibility of Public Health Wales. Updates on these and their status will continue to be provided to the group on a quarterly basis providing assurance on compliance and highlighting any issues as appropriate.

As a part of the PHW hosting arrangements of the NHS Wales Performance and Improvement (NHS Wales P&I), NHS Wales P&I are responsible for the reporting of their respective compliance with statutory and regulatory requirements to the Health & Safety Group and the Quality, Safety and Improvement Committee of the PHW Board. Compliance with this requirement will be monitored and reported to the Health and Safety Group.

Public Health Wales continues to, despite the introduction of an online assurance check with Health Boards, experience challenges with securing compliance assurance for sites which host Public Health Wales staff. The next scheduled issue of the online compliance confirmation request form to all Health Boards is scheduled for July during the Quarter 2. It is important to note however, that in the absence of compliance returns from health boards an assumption should **not be made**, that the hosted sites are non-compliant with their respective statutory requirements. Relationships with the Health Boards estates functions are established and where specific issues relating to health & safety compliance are identified direct approaches are made to the Health Boards on the specific issue and Health Boards are appropriately responsive. This was evidenced during the reporting period when a member of staff was unwell with Pontiac Fever, and we requested compliance documentation from a Health Board for their water and air conditioning system at a particular site. The Health Board promptly provided all requisite documentation evidencing that all compliance arrangements were in place and that they were operating safe systems in line with statutory and regulatory compliance requirements.

8. Health and Safety Statutory/Mandatory Training

All staff are required to complete a number of statutory and mandatory modules. All directorates are expected as a minimum to attain Welsh Government All Wales compliance target of 85%, with an organisational target of 95%.

The key health and safety statutory/mandatory modules are:

- Fire Safety
- Health and Safety
- Moving and Handling Level 1
- Violence and Aggression A

The organisations compliance status for Quarter 1 is shown in table 2 below. Again, there has been little change in the overall compliance levels for all four training modules across the organisation since the last quarterly report. Currently the overall

compliance for all four areas all four areas meet the Welsh Government target of 85%, however, Fire Safety, Health and Safety and Moving and Handling are still all falling short of the Public Health Wales Target of 95%.

Currently, only Violence and Aggression training is meeting the Public Health Wales target across the whole organisation. As can be seen in the table, only one Directorate (Policy and International Health Directorate) is achieving the Public Health Wales target across all four training areas. However, all Directorates are achieving compliance rates above the Welsh Government target of 85%, which is a significant improvement on previous quarters and has been achieved through engaging with Business Leads in the relevant Directorates to improve compliance rates.

Direction will continue to be provided to staff to ensure training compliance is maintained and in areas that are falling short of Welsh Government and Public Health Wales targets, focused work through Health and Safety Group representatives to highlight non-compliance with those targets to ensure training is undertaken.

Table 2: Health and safety training compliance by Directorate

Directorate	Fire Safety %	Health and Safety %	Manual Handling %	Violence and Aggression %
028 L3 Corporate Directorate	92.31%	92.31%	96.15%	92.31%
028 L3 Health & Wellbeing Directorate	87.86%	91.91%	87.28%	97.69%
028 L3 Health Protection and Screening Services Directorate	88.53%	93.16%	87.93%	97.25%
028 L3 Nursing, Quality and Integrated Governance Directorate	92.16%	98.04%	94.12%	100.00%
028 L3 Operations and Finance Directorate	92.39%	93.48%	94.57%	96.74%
028 L3 People & OD Directorate	93.88%	95.92%	91.84%	97.96%
028 L3 Policy and International Health Directorate	100.00%	97.65%	100.00%	96.47%
028 L3 Research, Data and Digital Directorate	93.30%	97.77%	93.85%	97.77%
Overall Compliance	**89.75%**	**93.80%**	**89.47%**	**97.30%**

Welsh Government target 85%; Public Health Wales target 95%

9. Additional training

9.1 First Aid Training

The Estates and Health & Safety Division continues to work with local premise leads to ensure First Aid Needs Assessments are being completed and regularly reviewed for Public Health Wales premises. These assessments help us ensure we have identified the right level of first aid provision across all Public Health Wales premises and therefore identify the correct training.

As previously reported, an Appointed Person Training Course was procured, and rolled out at sites where this level of provision as a minimum is required. There are currently 34 staff who have been registered for the training, however only 12 of these have completed the training and are compliant. A further 7 have completed the training, but have allowed this to expire, as this course is required to be completed every 12 months and are required to refresh their training. This is being followed up with the relevant individuals as well as the 15 members of staff who have been registered but are yet to start the training.

Where Emergency First Aid at Work trained staff have been identified as a requirement for premises, the Estates and Health & Safety Division continue to work with premise leads to ensure an appropriate training programme is provided for staff who have volunteered for the role and refresher training is provided where required.

Compliance for each premise is also being monitored through the Health & Safety Audit process and review of First Aid Needs Risk Assessments.

9.2 Fire Warden Training

Online training of Fire Wardens continues to be rolled out across the organisation, with 391 staff registered for training, an increase of 24 on the previous reported figures. Currently 205 of those staff have completed the fire warden training (52.4%), an increase of 18 staff members on the previously reported numbers and therefore are able to undertake this role within their designated base. There are a further 113 staff (29%) who have previously completed the training module but have fallen out of compliance due to not completing refresher training. We will continue to contact these staff members to ensure training is refreshed or they are removed from the training if no longer Fire Wardens.

As identified through the Health & Safety Audit process, challenges still continue regarding fire warden provision which meets the requirements for specific premises, and to ensure cover for when fire wardens are hybrid workers and may not always be present at site. Volunteer support from some from some premises are still

outstanding and this continues to be progressed between the Estates and Health & Safety Division and local leads.

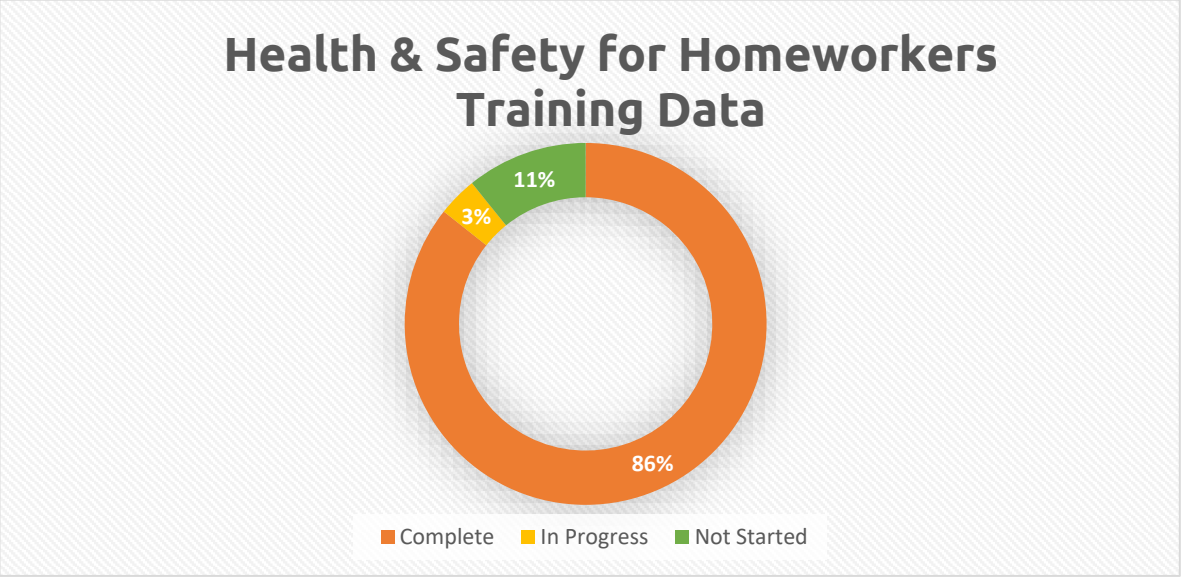
A total of 73 members of staff have been registered for the training and have either yet to start or the training programme is in progress, and this continues to be followed up with those members of staff to ensure training is completed.

The Estates and Health & Safety Division continue to work with Business Leads through the Health & Safety Group to increase training compliance rates and obtain volunteers for premises where gaps exist through lists of staff who regularly attend PHW premises to ensure we are targeting the right staff for the role.

9.3 Health & Safety for Homeworkers Training

Staff working from home are required to undertake accredited online Health & Safety for Homeworkers training to ensure their safety and wellbeing. All issues identified by individuals completing the training and the associated self-assessment are addressed via the provision of specific equipment and guidance on working practices.

A summary of compliance with completion to date is shown below.



As of 16 July 2025, 86% of staff who have been registered for the Health and Safety for Homeworkers training have completed the module, which is a 5% improvement on the previous quarter and now takes us above agreed organisation target of 85% compliance.

As part of the work to improve compliance levels, with the support of the People & Organisational Development Directorate, it is possible to report compliance levels

by Directorate and Division - the following table shows the current picture of compliance levels by Directorate across the organisation:

Directorate	Compliance Rate Q3 (%)
Corporate Directorate	82.6%
Operations and Finance Directorate	90.7%
People & OD Directorate	97.4%
Nursing, Quality and Integrated Governance Directorate	98.1%
Policy, International Health Directorate	100%
Research, Data and Digital Directorate	84.5%
Health & Wellbeing Directorate	87.1%
Health Protection and Screening Services Directorate	84.9%
NHS Wales Performance & Improvement Directorate*	80.5%
TOTAL	**85.6%**

*The NHS Executive now operates as the NHS Wales Performance & Improvement Directorate

For a further detailed breakdown, please refer to **Appendix A**, which details Divisional compliance rates for each Directorate.

As can be seen from the above table, the majority of Directorates are either meeting or close to meeting the organisation target of 85%. Again, some Directorates continue improve compliance rates over the previous quarter, with significant increases from the Operations and Finance Directorate (13.7% improvement), People & OD Directorate (7% improvement), Health Protection and Screening Services (5.8% improvement) and the NHS Executive (6.3% improvement).

However, work still needs to be done by the Health Protection and Screening Services Directorate, Corporate Directorate, Research, Data and Digital Directorate and NHS Wales Performance & Improvement Directorate to raise their compliance levels to the agreed target.

Work will continue with all Directorates, ensuring monthly compliance updates are provided to Business Leads to support individual Directorates in achieving the organisational target and support the organisations total compliance level remains at or above the agreed target.

9.4 Other Health & Safety Related Training

The Disability Awareness and Inclusion training programme provided via online training continues to be rolled out across the Screening Services Division. A total of 416 staff are currently registered for the training programme with 42% of those staff registered having completed the training to date, which is a further increase of

2.5% over the previous quarter. 241 members of staff have yet to complete the training, and the Health & Safety Team will continue to work with Screening to improve this compliance further and ensure regular reminder emails are being sent to staff to complete the training.

10. Health & Safety Audits

The Health and Safety Audit question set is currently being migrated to the AMaT auditing system which will allow us to better track, monitor and report on progress against actions that have been identified. Once this has been completed a new schedule of audits will be developed and carried out. We are currently aiming to begin audits from Quarter 3 onwards. Updates will continue to be provided to the Health & Safety Group at each quarterly meeting.

11. Risk Registers

There are currently 13 open Health and Safety Risks across the organisation. These are held across Directorate and Divisional Risk Registers. The risks are reviewed by the respective Directorates and by the Divisional Senior Management Team at monthly meetings.

The table below summarises the number of health and safety risks currently managed at a Directorate and Divisional level. Please note this covers all new risks reported since the previous report up until 30 June 2025. Since the last report, two new risks have been raised and five risks have been closed (ID 1108, 1501, 1540, 1622 and 1712) following review and the implementation of key controls to reduce the risk to target levels:

Number of open Health and Safety Risks	**13**
Number not meeting target risk score - Tolerate	**5** (ID-1562, 1684, 1706, 1736 and 1808)
Number not meeting target risk score - Treat	**8** (ID-1415, 1551, 1623, 1657, 1720, 1748, 1757 and 1795)
New risks since last Health and Safety Report	**2** (ID-1795 and 1808)

The following table shows the risk profile for all identified open risks:

	Initial	Current	Target
Risk Level			
Low Risk	0	0	7
Moderate Risk	3	7	6
High Risk	7	6	0
Extreme Risk	3	0	0

As can be seen from the above table there are no current extreme risk health & safety risks, as current control measures that have been put in place have downgraded these to high risk.

Details relating to the new risks for the period can be found at **Appendix B**.

12. Policy updates

This section provides a brief update on the current progress of Health & Safety Policies and Procedures currently under review:

Waste Management Policy and Procedure – Both the policy and the procedure have been finalised and are due for publication for consultation in July. Further to which they will be translated and published.

Bomb Threat and Suspicious Packages Procedure - Both the policy and the procedure have been finalised and are due for publication for consultation in July. Further to which they will be translated and published.

Security Procedure - Both the policy and the procedure have been finalised and are due for publication for consultation in July. Further to which they will be translated and published.

13. Alerts and Notifications

The organisation receives a number of alerts under the headings:

- Safety Action Bulletins (SAB)
- Medical Device Alerts (MDA)
- Drug Alerts (DA)
- Chief Medical Officer Alerts (CMO)
- High Voltage Hazard Alerts (HVHA)
- Estates and Facilities Alerts (EFA)

All these alerts are managed by the Quality, Nursing and Allied Professionals Directorate and a report submitted to the Quality and Safety and Improvement Committee for information.

The organisation also receives a number of notifications under the headings:

- Specialist Estates Service Notifications (SESN)
- Publication Notices (PN)

These notifications are sent out directly from NHS Wales Shared Services Specialist Estates Service as Specialist Estates Service Notifications (SESN) and Publication Notices (PN) to the Estates, Safety and Facilities Division. For the reporting period, o**ne** SESNs and **No** Publication Notices have been received:

Date Received	SESN No./ PN No.	SESN Description	Action
19 May 2025	SESN 25/06	2026 Non-domestic (Business Rates) Rating Revaluation	Actioned – PHW Estates has provided confirmation of participation.

14. Summary

The organisation has several processes in place for maintaining and monitoring health and safety compliances so that assurance can be provided, and any gaps identified with the appropriate actions required.

Incidents and RIDDOR's are actively managed, with lessons learned identified and shared.

Processes are in place to monitor policy and procedure reviews and/or development. There are also systems in place to action alerts and notifications as appropriate for the organisation.

15. Recommendation

The Committee is asked to:

- **Receive assurance** that appropriate measures are in place to monitor compliance and to address areas identified for improvement.
- **Note** that the Business Executive Team approved the Health and Safety Terms of Reference at its meeting on 16th September 2025 (Appendix E).

Appendix A

Health & Safety for Homeworkers Training Status by Directorate and Division

Directorate/Division	Compliance Rate Q3 (%)
Corporate Directorate	**82.61%**
Operations and Finance Directorate	**90.70%**
Communications Division	87.50%
Estates, Safety and Facilities Division	90.91%
Finance Division	100.00%
Strategy, Planning & Corporate Affairs Division	77.78%
People & OD Directorate	**97.37%**
Nursing, Quality and Integrated Governance Directorate	**98.08%**
Corporate Division	100.00%
Integrated Governance Division	100.00%
National Safeguarding Division	90.91%
Quality & Nursing Division	100.00%
Policy, International Health Directorate	**100%**
ACE's Hub Division	100.00%
Behavioural Science Division	100.00%
Central Division	100.00%
International Health Division	100.00%
Policy Division	100.00%
Projects Division	100.00%
WHIASU Division	100.00%
Research, Data and Digital Directorate	**84.53%**
RTS/CDR Division	100%
Operations & Management Division	100%
Digital Services Division	62.9%
CARIS/CMP Division	100%
Data Science & Analysis Division	96.97%
Knowledge & Evidence Division	88.24%
Research & Evaluation Division	95.93%
WCISU Division	92.86%

Health & Wellbeing Directorate	**87.10%**
Health Improvement Division	87.04%
HWB Mgt. and Admin Division	89.47%
PCIC Division	85.71%
Health Protection and Screening Services Directorate	**84.99%**
Health Protection Division	96.84%
HPSS Corporate Division	75.00%
Microbiology Division	77.61%
Screening Services Division	80.89%
SPR's Division	92.86%
NHS Executive	**80.53%**
Strategic Programmes for Planned Care Division and Planned Care & Recovery Division	75.68%
Strategic Programmes for Primary Care Division	93.33%
Strategic Programme for Mental Health Division	93.10%
Urgent & Emergency Care Division	28.00%
Quality, Safety and Improvement Division	92.00%
Performance & Assurance Division	72.97%
Networks Division	76.32%
Planning Division	93.75%
Finance Planning & Delivery Division	66.67%
Digital, Technology, Innovation & Value Division	87.30%

Appendix B

New risks reported during Quarter 1

Risk ID-1795 - Microbiology

	Initial	Current	Target
Risk Level	**High Risk**	**High Risk**	**Moderate Risk**

There is a risk that the Class II Microbiological safety cabinets (MSCs) across the network will fail. The age and condition of some of the class II MSCs across the network means that there is a risk of failure. For some there is limited availability of replacement parts due to the age and manufacturing company no longer being in production. The Failure of the MSC during processing could result in staff exposure to hazardous organisms. Additionally, the failure of a Class II MSC within containment level 2 (CL2) would impact the ability of staff to perform aerosolised operations safely and in a timely manner. There is also the additional impact on turnaround times, should samples be required to wait for space in alternative MSC or be rerouted to another laboratory which could result in reputation loss for the organisation.

Key Controls are: There is a maintenance contract in place with Nationwide. With Class II MSCs maintained every 6 months. Additionally, there is a network contingency for work to be rerouted. Network replacement program to monitor condition, reliability and age of MSCs.

Actions being undertaken: The asset register has been updated and MSC's scored based on risk of failure to inform a SON which will be submitting to replace cabinets which are either beyond end of life or with recurring issues. There are 5 hitting this criteria currently. Negotiations are taking place for an asset transfer from Pharmacy which will replace one of the MSCs and are looking to submit a SON for like for like replacement on the other four.

Risk ID-1808 – NHS Wales Performance and Improvement

	Initial	Current	Target
Risk Level	**Extreme Risk**	**High Risk**	**Moderate Risk**

There are an insufficient number of fire wardens to provide cover during opening hours, with a risk of untrained staff entering the building. This has been caused by the reduction of RBU training staff and lack of uptake from other areas for fire warden training. This could result in staff confusion during a fire and a possible risk to life.

Key controls are: Signs displayed with regard to risk of entering the building

Actions being undertaken: Advice has been sought and provided by the Health & Safety Advisor to NHS Wales Performance & Improvement on how to manage an evacuation during a fire if there are no fire wardens available to manage the process. This is currently being reviewed internally to ensure a safe evacuation of premises can take place.

Appendix C

Compliance Summary

Water Management (Legionella) Risk Assessments (LRA): Two premises were out of compliance as of 30 June 2025.

Kimberley House
The LRA was scheduled with WCS for 25/06/25. Unfortunately, staff were not available on site as arranged and the LRA was not carried out.
The LRA was rearranged for 09/07/25 and has now been carried out, with the assistance of screening management staff.

Clwydian House
Schedule date for the LRA was sought from contractor for North Wales in the period of May and June. However, due to contractor availability the earliest available date was 07/07/25 this LRA has now been completed.

Listed in formal letter						
No	**Item/RAG (perceived difficulty)**	**Solution**	**Assigned to**	**Estimated date of completion All to be completed with evidence submitted by february 2025**	**Status/RAG**	**Completed date**
1	Validation of fumigation for emergency spillage in containment level 3	Undertake validation of fumigation procedure. (Requires efficacy study). Obtain quotes for each site and identify priority order to complete.	MP/RR	February 2025 (to complete WCM and have financed plan in place to complete other sites).	Completed review of PO. PO review completed and agreed with Ellab. Credit note to be placed against continuing efficacy studies. Quoting for 5 visits (7 labs). 08.10.24 Quotes received and progressed via KW with timeline for completion. 21.10.24 No feedback on progress. 23.10.24 no progress esclated to KW on monday for feedback to progress. 24.10.24 Funding approved. Meeting requested to schedule tests with Ellab. 08.11.24 Funding approved, waiting for info from procurement as to how to proceed. 14.11.24 Waiting for PO to be produced. 19.11.24 Met with LMB and procurement. currently filling in STA. LF to RAID/Gant. 12.12.24 Requisition raised 300158034. Gant chart created 12.12.24 with LF to identify required steps	21.01.25

Listed in formal letter						
No	**Item/RAG (perceived difficulty)**	**Solution**	**Assigned to**	**Estimated date of completion All to be completed with evidence submitted by february 2025**	**Status/RAG**	**Completed date**
2	Ducting assurance - assurance that ducting is intact particuarly for the Singleton site. Less than 2 years old - UHW x2, Less than 4 years old - GGH, Bangor and WCM main lab. Visually accessible - Aber (drones)WCM ref lab, FW&E, Rhyl and Swansea where located in plant room. (Swansea where placed outside of plant room not accessible to inspect)	Task 1) Determine if SBUHB have access to drone to replicate Aber or alternative solution. Task 2) Review BS 12469 and LEV 5726 Link to No 6 and No 7 for requirements to monitor integrity of ducting. (velocity testing, implantation of smoke above HEPA filter?? Task 3) Engagement with Andy Plume re ports for MSC. Task 4) RA to underpin reasoning of choices	MP/RR	November 2024	Meeting with estates at SBUHB to look at ducting schematic. Pilot velocity test achieved at WCM. Waiting on report to see if hits requirement 08.10.24 Schematics received for Carmarthen. Progrsessing visits on other sites to verify assumed knowledge. Will place in central document for future information. Waiting on NCS to provide velocity report to detrimne suitability of implementation. 09.10.24 Swansea visit completed. 21.10.24 Multiple companies contacted re pressure/leakage testing. No solid progress. Access to roof potential issue. RR writing doc describing ducting. 23.10.24 MP investigating companies able to do leak/pressure testing. Feedback to go through but currently not viable 08.11.24 Doc first draft in situ. Expert to review Swansea for confirmation of approach. RA to be formulated.To be published under MDHSGUID 016 19.11.24 MDRA 038 to be published. Both docs need proofing - time booked 22.11.24 12.12.24 singleton review completed estimated cost of £850 + VAT. Pursuing network evaluation with laboratory air services. New testing added to forward budget. 03.02.25 deadline extended due to procurement times exceeding deadline. STA submitted to procurement. 18.03.25 STA signed, ready to raise requisition. 28.04.25 dates being agreed. deadline extended to accomodate contractor availability - now 27.06.25 16.06.25 deadline extended to cover negative pressure issue repair at Rhyl. Date of potential fix 26.06.25 followed by ducting testing on 30.06.25	14.07.25
3	Complexity of uncontrolled spillage drills - some uncertainty in grey areas found during inspection	Review spillage drills and expand repertoire to increase complexity of scenario.Link with JE/existing scenarios/previous uncontrolled spillages. Identify learning outcomes through template	H&S team	November 2024	time booked - 22.10.24 23.10.24 Reviewd in team meeting 22.10.24. RP leading to integrate feedback and represent plus template on Nov 5th. 08.11.24 meeting to review spillage guidance - mior amendments and then can be published with template form. MDHSGUID 015 and F1	12.11.24
3	Standardisation of spill kits	Task 1)Review requirement of spill kit and standardise for network - publish Task 2) Implement and ensure safe storage	RP	September 2024	Published as MDHS 015F4. Listed as requirement to check contents as part of quarterly audit MDHS 005F3.	13.09.24

Listed in formal letter						
No	**Item/RAG (perceived difficulty)**	**Solution**	**Assigned to**	**Estimated date of completion All to be completed with evidence submitted by february 2025**	**Status/RAG**	**Completed date**
4	Monitoring arangements are not formalised for CL3 - need to identify frequency of checks, what checks are undertaken, by whom, how they are recorded and escalated.	Task 1) Write a policy Task 2) Write a code of practise Task 3) Create annual audit and horizontal auditing system for containment level 3 including templates and guidance (commissioning ans system based Q) Task 4 Cross ref with No 4 for continuity Task 5) Update cross ref docs	H&S team	December 2024	time booked to complete. 21.10.24 Topics of audits to be formalised on 23.10.24 to allow progress. 23.10.24 Reviewed in team meeting 22.10.24 Key topics identified: Management, documentation, equipment and facilities, and training and competency. Breakdown of areas to test completed. Write audits as next tep in conjunctionwith COP and policy 08.11.24 policy reviewed and agreed in first draft. To be proofed by HOO and agreed through SMT. proposed schedue for audit one topic per year. Write audits. 13.11.24 Policy being proofed by JR before dissemination to SMT 19.11.24 out for proofing. 20.11.24 feedback incorporated and distibuted to SMT ready for ratification and feedback in week 4 12.12.24 policy ratified through SMT 28.11.24 as MDHS 024	28.11.24

Other Significant Issues

No	Item/RAG	Site	Status/RAG	Completed date
1	Validation of internal HPV decontamination	All sites - validation per model for typical agent/model agent	Seeking quotes for biological indicators/chemical indicators and incubator appropiate in network. Supplier identified which uses 30-35 degree incubation. RR pursuing. Likely available to purchase through Ellab. 23.10.24 Chemical indicators used by Sandondaf. RR to contact Sanondaf to obtain info. 08.11.24 PO raised. 14.11.24 indicators received. Validation plan to be completed - assigned RP via SB from Quality team 28.04.25 contacted sanondaf - no guidance. make decision on placement of indicators 2.5.25. Write validation plan - RP. 16.06.25 Validation plan agreed. To be implemented. Aber due 17.06.25 17.07.25 validation plan written - awaiting quality check	
2	Autoclave MOU consistency across network	UHW, UHL, Rhyl and Carmarthen.	summary spreadshet compiled of testing/mou status/cost responsibility sent to RH and KW 16.08.24. RH escalating to TC 09.10.24 All MOUS in date except for S.E Region 23.10.24 no change 24.10.24 CVUHB meeting with LC on Nov 27th discussing rehcarges and costings - should move to new SLA and MOU as a result 14.11.24 meeting cancelled, not rearranged as yet 20.11.24 Meeting rearranged 20.12.24 16.06.25 no change in status - MOU in S. E Region outstanding	
3	Competence of staff responsible for CL3 - identify differences in responsibility within CL3 management and monitoring structure between Operational Managers/Departmental H&S leads/Regional H&S leads/H&S management	Network	Review of CL3 competency 16.08.24 by AS and MP. For proofing. Discussed at audit meeting 03.09.24. Out for proofing. 09.10.24 CL3 management competency going live in next week. Draft of H&S Departmental lead competency being proofed. 23.10.24 Draft proofed. Time booked to write Q - 6th Nov. BR to guinea pig 08.11.24 Questions written. Review for non bacti leads and segregate appropriately. Review the training checklist for similar issues. 20.11.24 issues resolved. To be published asap.	14.02.25

Other Significant Issues

No	Item/RAG	Site	Status/RAG	Completed date
4	Risk assessments do not articulate how risk is actualised.	Network	New generic template created 09.08.24 Applied to CL3 by team. Proofing due 23.10.24 time booked to proof on 25.10.24 08.11.24 out for proofing 19.11.24 time booked 25.11.24 to finalise 12.12.24 Reviewed by HSE inspector during Rhyl inspeciton. Feedback given to be implemented. 28.04.25 new template published. All new RA being published on new template. HR RA to be prioritised and others to be changed when up for review. High RA = CL3, VHF, Gas, Autoclaves - RR with reg as required. 16.06.25 CL3 completed and published.	
5	Maintenance arangements are not formalised for critical equipment in the CL3 - need to identify frequency and scope of checks and maintenance, need to identify how reports are formally received, fed back to users in terms of safe/not safe to use and information from contractors is communicated and any issues escalated.	Network	23.10.24 - being amalgamated with monitoring COP	Completed - linked to finding 4 in formal letter 08.11.24
6	Double gloving in containment level 3 - not standardised practise across network	Network	23.10.24 trial across network - use BR/Carrie/everyday staff (Pete). Use engagement sessions for feedback. Write an SBAR - Take it to SMT - MP	
7	Cleaning issues within Containment level 3 - at room and MSC level	Sites inspected	UHW Bacti progressed. Cl3 and intended to CL2 09.10.24 implemented at Singleton at CL3 and CL2 23.10.24 Rhyl implemented. (twice weekly) CL3 and CL2 Bring this to SMT for discussion. 18.03.25 CL3 audit at GGH completed 17.03.25. cleaning discussed with seniors on site. Cleaning schedules to be amended and staff allocated time to complete. 28.04.25 Aberystwyth to complete. 17.07.25 waiting on aber to confirm	

Other Significant Issues

No	Item/RAG	Site	Status/RAG	Completed date
8	MSC practise - decontamination and siting of relevant equipment (is it fit for purpose)	Network	Spot audit. Add to quarterly CL3 audit	Completed 31.10.24
9	Critical indicator lights not working	WCM Ref lab and Singleton	Singleton completed 01.07.24 WCM MR submitted 251442. 16.08.24 LEEC attending site to replace bulb (estates refused to do) 08.11.24 WCM completed 05.11.24	Completed 05.11.24
10	Readability and relevance of emergency instructions in Cl3	WCM and Singleton	Change requests submitted for MDHS 015 and local versions. 08.11.24 MDHS 015 updated to be published 13.11.24. Local versions to be updatedin response.	Completed 05.11.24

Network

No	Item	Site	Solution	Assigned to	Status/RAG	Completed date
1	Permit to work relevance and way being filled in	Network	Task 1)Review permit to work for relevant features and ensure acknowledgement from estates included when fumigating before work commences	RC	for review on 08.11.24 13.12.24 separate ptw for fumigation/sealability/venting processes. Guidance to fill in correctly and the trainign - engagement session?	Forms and guidance completed 29.04.25
2	Ask for written scheme of examination for the autoclaves across the network	Network	Written request for Estates to provide (originally would be provided by manufacturer).		Each autoclave should have a written scheme of examination from the maunfacturer when installed. Need to identify if Estates teams have copies and can they share for records.	
3	Reference PSSR and purpose of each test in autoclave documents	Network	Review of MDHSE 004 autoclave SOP and include		Change request submitted.	
4	Update MDHS 015 CL3 overarching guidance to include risks of fumigation including work place	Network	Update MDHS 015 and local versions with information		Change request submitted.	Completed 08.11.24
5	Expand waste audits to include flow of CL3 to end point. Templates and guidance for each.	Network	Review existing audit and amend as appropriate		Exists as MDHS 021F1. Group with MDHS 022F1 Rebrand as MDHS 014 when written 14.02.25Waste policy being drafted JM 16.06.25 Waste policy ready to publish	Completed 24.04.26
6	In critical equipment log - standards are not correct.	Network	Correct document		Change request submitted	Completed 31.10.24
7	Make decision on use of RPE for uncontrolled spillages	Network	Evidence decision on MDHS 015			23.10.24 No RPE to be used.
8	Critical equipment log – update name and description to reflect full use and refer to exceptions	Network	Review and update		remove embedded doc and update attachment	Completed 31.10.24

Network

No	Item	Site	Solution	Assigned to	Status/RAG	Completed date
9	CL3 guidance missing specific info on centrifuge bucket breakage and how to respond. Transfer	Network	Review and update		Change request submitted	Completed 08.11.24
10	MDHS 015 plus local versions need to identify potential for personal contamination in a	Network	Review and update		Change request submitted	Completed 08.11.24
11	Regional plus management H&S competency needs to identify phileas HPV	Network	Review and update		Reject - technical competncies not included as part of underpinning competency - link through item 13 instead	23.10.24
12	Highlight when to undertake what type of decontamination – HPV Formaldehyde	Network	Review and update		Change request submitted	CL3 guidance completed 08.11.24
13	Description of how training is progressed for H&S roles including timeframes.	Network	Review and update			
14	Appendix 11 – apply network wide MDHS 015 once typos corrected. – mount outside CL3	Network	Review and update		Change request submitted	Completed 08.11.24
15	Review placement of disinfectant in/out of MSC and ensure reflected in documentation as	Network	Review and update MDHS 015 plus local versions		Change request submitted	Completed 08.11.24
16	Review sealability reports and understand impact of non-key controlled	Network	Review with Ellab for context and update MDHS 015 with impact information.		UHL - non key controlled fumigaiton switch identified in sealability report. Review report and ask for clarificaiton from ellab as required. 08.11.24 review has identified issue is a	Completed 13.12.24

Network

No	Item	Site	Solution	Assigned to	Status/RAG	Completed date
17	Refer to autoclave contingency documents in MDHS 015 MDHS 005 and MDHS 014	Network	Review and update		Completed MDHS 015 08.11.24 CR logged for MDHS 005/8 28.04.25 mdhs 015 CR to MDHS 015 to adde MDHSE plan. MDHS 005 needs MDRA 150 adding CR by RC. MDHS 014 is	
18	In audits, significance of non-compliances should be detailed in audit findings – add	Network	Review and update		Change request submitted. 08.11.24 CL3 audit completed. Others to follow	
19	Direct that fumigation requirements from sealability report including where and	Network	Review and update		Change request submitted	Completed 08.11.24
20	Audit guidance doc – create and include details of how MR from audits are tracked and closed	Network	Review and update MDHS 015 plus local versions		link to item 18	
21	Use of bench cote in MSC	Network	Review and update		Review use of bench cote and make a decision update MSC SOP with decision 14.02.25 remove use of bench cote from inside MSC - use kimtech/absorbent	
22	Checking of MSC seals on night doors for fumigation	Network	Add to monitoring checks		Link to Quality team and ask to add to local housekeeping sheets 24.03.25 Regionalto contact quality lead to add onto local housekeeping sheets 28.04.25 NW complete, UHW complete,	
23	daily cleaning of door handles required	Network	Add to monitoring checks		Link to Quality team and ask to add to local housekeeping sheets 24.03.25 Regionalto contact quality lead to add onto local housekeeping sheets 28.04.25 to do	
24	long term look at direct supervision of unregistered staff, how to overcome ?training	Network	Explore options with training team		Need conversation with training team as to whether reasonable ask	

Network

No	Item	Site	Solution	Assigned to	Status/RAG	Completed date
25	VW - Look at changing dynamic RA approach for uncontrolled spillage. - same as	Network		MP	18.03.25 flow chart to be written and added as appendix for display. 28.04.25 flow diagram written - being updated	17.07.25
26	VW-look at how staff trained to identify HG3 agents that are not isolated frequently - how is	Network	Explore options with training team	MP/TP	Initial meeting completed to identify issue. TP to collate info from training team	

No	Item	Solution	Dependancies	Time	Cost	Assigned to	Estimated date of completion	Completed date
1	Quality of remedial sealability work around indicator lights)							

UHL Specific									
No	**Item**	**Solution**	**Dependancies**	**Time**	**Cost**	**Assigned to**	**Status**	**Estimated date of completion**	**Completed date**
1	No UPS maintenance	Purchase a maintenance schedule	Budget Availability of company to undertake 19.11.24 connect with Rhian Rosser about Ups work.	One day	Unknown - obtain quotes Write RA if not to be purchased	RP	no service contract available for size of UPS . Write RA to cover. 24.03.25 email sent to RR. 28.04.25 info sent - awaiting review		
5									
6									

Singleton Specific

No	Item	Solution	Status	Estimated date of completion	Completed date
1	Space in MSC tight	Purchase of smaller equip relevant to number of samples - hotplate, racks	Jm to progress suitable rack solutions 28.4.25 smaller racks purchased	in progress for buying smaller hotplate 16.06.25 racks purchased	
2	electrical circuit bulb blown - formal letter tab duplication				30.07.24
3	Flammable cupboard used for biological storage - relocate?	Remove key and add biohazard sign			Sep-24
4	review lab space to remove clutter	review and remove/purchase as required	shelf fitted in cupboard. Box being emptied. 24.03.25 progressing	In progress	28.04.25
5	consider elbow taps for CL3	review with estates for purchase	24.03.25 JM to submit MR with estate	JM to progress	21.04.25
6	fire signage and eye wash procedure needed in reception	print out and laminate		JM to progress	28.11.24
7	slide holder is open - WCM have closed	purchase similar	24.03.25 - Jm to follow up with BD 28.04.25 received. Check to see if in use	15.11.24 Idenitifed product and sent info to RH LS 16.06.25 ordered	
8	stickers on benches	remove			30.07.24
9	scalpel blades in drawer	remove			30.07.24
10	ceiling sealability - not happy with it, too many seals rather than continuous slab.				

Rhyl

No	Item	Solution	Dependancies	Time	Cost	Assigned to	Status	Estimated date of completion
1	Lack of clarity in instructions to staff about how air handling unit works, with specific ref to how it stops the system from becoming positively pressured.	Update guidance. Clarification to be sought from engineers	Acces to engineers. Time to update guidance			RC	needs to be published.	17.02.25
2	Review spillage procedure to remove reliance on dynamic risk assessment	Update guidance and upskill regional leads to remove reliance on H&S managers	Time to resolve			MP/RR		31.03.25
3	Develop and implement a system to ensure workload only authorised personnel have access to CL3	liaison with HB security to resove. Use of code system (previously inactivated)	security prioiritising the ask			PL/RC/CA	only authorised personnel have access. Controlled by HB security. RC contacts security for new access and leavers. Issues with door not locking after access granted - fixed but potentially need new door.	17.12.24
4	Implement formal system to store schedule 5 organisms	Locked box	Budget/access on oracle					
5	safe storage of flammables - holes in top shelf	buy bunding for shelf or new flammable cupboard or review current storage and streamline	Budget/access on oracle				removed top shelf and limited storage	20.12.24

Completed date
21.02.25
Closed and moved to network tab
14.02.25
11.12.24
14.02.25

Camarthen

No	Item	Solution	Dependancies	Time	Cost	Assigned to	Status	Completed date
1	VW - change keypad code to CL3 reguarly	Log MR with estates to change. Add freq of change to local CMHS 015 and add to CL3 audit schedule to test.				RL and JM	code not changed. Followed up by RL with estates - no feedback. 28.04.25 no further feedback received from estates 16.06.25 no change	
2	VW-look at how staff trained to identify HG3 agents that are not isolated frequently - how is this addressed through competency and training.	Collaboartive moment with TT - TP				MP		Clsoed and moved to network tab
3	VW - Look at changing dynamic RA approach for uncontrolled spillage. - same as Rhyl	Review procedure				MP	Move to network tab	Closed and moved to network tab
4	VW - cease and desist from fumigation at GGH. Ensure no propogated work occurs with HG3 organisms with aerosol transmission pathways. Review network sealability	Send email assuring re GGH - RH. Provide RA to KH by end of month after reviewing network sealability documentation.				RH and MP	RH completed assurance email on 15.01.25. MP to present at SMT week 4. Presentation undertaken and network informed.	15.01.25
5	Ad - add alcohol wipes to spillage kit	Add to spillage kit and change standardised content lis on ipassport				RL and JM	picked up in Cl3 audit - 17.03.25	02.04.25
6	Ad - Remove haz tabs from CL3 (risk of incompatibility during fumigation/disinfection)	Store in CL2				RL		14.01.25
7	Ad - Test out of hours procedure with switchboard	Arrange test of concept				RL	28.04.25 RL followed up with switchboard 16.06.25 no change	
8	Ad - Chemical cupboard shelf is upside down	Turn over				RL		14.01.25

Aberystwyth								
No	**Item**	**Solution**	**Dependancies**	**Time**	**Cost**	**Assigned to**	**Status**	**Completed date**
1	Chemical storage shelf is upside down	Turn it around					24.03.25 - waiting for confirmation from GT	24.03.25
2	Isolate storage box in CL3 needs to have key removed and stored elsewhere, also not referncing where that is on the box	Remove key to office lock box					24.03.25 - waiting for confirmation from GT	24.03.25
3	Remove liquid disinfectant spillage in spill kit and add alcohol wipes instead	Replace with alcohol wipes. Update standardised contents list.					24.03.25 - waiting for confirmation from GT 28.04.25 alcohol wipes added. Need contents list reprinted. JM to do on site 29.04.25	08.05.25

Positive Feedback

Health and Safety resilience has greatly improved
No showstoppers however some issues holding over from improvement notice in 2018 - formal letter
SOPs and guidance clear and well explained
Staff members good - Carrie picked out in UHW.
Confident we are low risk as a network if practise matches paperwork
All documents requested were presented and could be explained.

Req Info

CL3 Item	Specimen reception	Requested records	Autoclaves
Number of HG3 organisms processed in CL3 per month (TB and internal transfers)	what processes present	MSC service and PTW	PSSR - what to do if out of date, how is it organised
Limits of detection	how they know what is high risk	Autoclave validation and PTW	Testing schedule
what MSC are used for which process	do they enter CL3	Autoclave maintenance and PTW	how actions form annual validation are progressed
Is air con sealed and is it tested when room smoke tested?	what disinfectant used	PSSR	what cycles are in use
contents of sharps boxes and are they autoclaved	how specimens transported	Written scheme of examination for autoclaves	what bins/sharps boxes are validated
record of entry and exit to the CL3	how to deal with leaked samples	Sealability report and certificates	is the autoclave validated with a typical load or not
how waste removed from CL3	do they check for leaks	Monitoring and cleaning schedules (filled in)	how the data is recorded and backed up
how autoclave bins prevent spillage	what about leaks outside of bag	Centrifuges servicing	Use of visor, gloves and apron for loading
How many CL3 competent	eye wash present	Anemometer calibration	how fluid is drained off
do they use gloves all the time or only in MSC	first aid response	Magnehelic gauge calibration	how waste is removed - bag colour and waste skip
how are lab coats disposed of	needlestick procedure	MOU for autoclaves	if health board has a compound for storage
use of phones/PCs in CL3		Training records	manual handling
processing of sputum		conversion checklist for CL2 - 3	how the trolley interlocks with the autoclave
centrifuge procedure			how waste is removed and escorted from CL3
room fumigation procedure			how runs are recorded
MSC fumigation procedure			access to override keys
checked cleaning records			cooling cycle
use of sharps in lab			access to plant room - whether kept locked
TB microscopy process			
whether light and fan were independent and how they know MSC is on if light is on			
exaplination of emergency evac			
differences in alarm for outside of neg pressure v emergency evacuation			
o rings and purpose			
MSC cleaning schedule			
daily cleaning schedule			
chair checks			
sample storage			
how to process pleural fluids and enterics			
Schedule 5 storage - how to ensure we are compliant.			
Calibration of heat blocks			
direct supervision of Band 3/4			
safe entry into and exiting CL3			
difference between controlled and uncontrolled spillage			
how to deal with contaminated clothing in uncontrolled spillage			
how MSC airflows work			
how negative pressure is generated			
is there a HVAC system			
is -20 worse than -50 on negative pressure - why			
control of fumigant			

For Information

Health and Safety Group Terms of Reference and Operating Arrangements

Date: 16 September 2025	**Version:** 6

Review Date: Annually

1. Introduction:

Public Health Wales' standing orders provide that *"The Board may and, where directed by the Welsh Government must, appoint Committees either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees".*

In line with part 3 of the Standing Orders and Scheme of Delegation, the Board shall nominate annually a group to be known as the Health and Safety Group.

This Group reports to the Business Executive Team and provides assurance to the Quality, Safety and Improvement Committee.

2. Purpose

The purpose of the Health and Safety Group is to:

- **Advise** and **assure** the Business Executive Team, the Quality, Safety and Improvement Committee, the Board and the Accountable Officer on whether effective arrangements are in place to ensure organisational wide compliance with the Public Health Wales Health and Safety Policy, approve and monitor delivery against the Health and Safety priority action plan and ensure compliance with the relevant Requirements within the Health and Social Care Act Wales.

  This will be achieved by encouraging strong leadership in health and safety, championing the importance of a common sense approach to motivate focus on

core aims distinguishing the risk levels and prioritising the issues identified.

- Where appropriate, the group will **advise** the Business Executive Team, the Quality, Safety and Improvement Committee, the Board and the Accountable Officer on where and how, its Health and Safety management may be strengthened and developed further.

- Approve, on behalf of the Board, relevant, procedures and other written control documents in line with the Corporate Policy, Procedures and other written control documents.

- **Recommend** any relevant Health and Safety Policies to the Quality, Safety and Improvement Committee for approval, and in line with the Corporate Policy, Procedures and other written control documents Procedure

3. Delegated Powers and Authority:

With regard to its role in providing advice to the Business Executive Team and the Quality, Safety and Improvement Committee, the group will comment specifically upon the adequacy of assurance arrangements and processes for the provision of an effective Health and Safety function encompassing:

- Staff and patient/service user health and safety
- Premises health and safety and security
- Personal safety and prevention and management of violence and aggression
- Fire safety
- Risk assessment
- Manual handling
- Health, welfare, hazardous substances, environmental safety.
- Staff healthy lifestyle / health promotion activities.
- Staff health and well-being relating to working practices and working environments.
- Estates compliance – Fire – Asbestos – Legionella – Fixed Wiring – Gas Safety.

The Group will support the Business Executive Team, the Quality, Safety and Improvement Committee and the Board with regard to its responsibilities for Health and Safety:

- approve and monitor implementation of the Health and Safety Action Plan;
- review the robustness of assurances in meeting the Board and the Accountable Officers assurance needs across the whole of the Public Health Wales's' activities,

To achieve this, the Groups programme of work will be designed to provide assurance that:

- objectives set out in the Health and Safety work plan are on target for delivery in line with agreed timescales;
- proactive and reactive Health and Safety plans are in place across the organisation;
- policy and procedure development and implementation is actively pursued and reviewed;
- where appropriate and proportionate, health and safety incident and ill health events are investigated and action taken to mitigate the risk of future harm;
- reports and audits from enforcing agencies and internal sources are considered and acted upon;
- employee health and well-being activities are in place in line with the organisations commitment to be a public health practicing organisation and corporate health standards;
- employee health and safety competence and participation is promoted;
- decisions are based upon valid, accurate, complete and timely data and information.
- to monitor the performance of operational level health and safety groups, recognising and sharing good practice and supporting areas for improvement.

Approve relevant Health and Safety Procedures in line with the Corporate Policy, Procedures and other written control documents Procedure.

Recommend any relevant Health and Safety Policies to the Quality, Safety and Improvement Committee for approval, and in line with the Corporate Policy, Procedures and other written control documents procedures.

4. Sub - Groups

The Group may (subject to the approval of the Business Executive Team) establish sub groups or task and finish groups to carry out on its behalf specific aspects of Group business.

5. Accountability

The group is accountable to the Business Executive Team and the relevant Board Committee via the Executive Director of Operations and Finance.

The Chair will ensure that the Quality, Safety and Improvement Committee and Business Executive Team are provided with updates on of the work programme of the Group, on at least a quarterly basis.

The Group will produce an annual report on the work that has been undertaken which will be presented to the Business Executive Team and the Quality, Safety and Improvement Committee.

The Group Chair will ensure appropriate escalation arrangements are in place to alert the Trust Chief Executive and / or the Quality, Safety and Improvement Committee Chair of any urgent / critical matters that may compromise services / service user provision and affect the operation and / or reputation of Public Health Wales.

6. Membership and Attendees:

6.1 Chair:

Executive Director of Operations and Finance (Executive Lead for Health and Safety)

6.2 Members:

- Head of Estates and Health and Safety (Deputy Chair of the Group)
- Health and Safety Advisor (Professional Lead) Public Health Wales (PHW).
- Health and Safety Lead (Microbiology Division) – Network Health and Safety Manager Microbiology
- Health and Safety Lead (Screening Division) – Governance, Risk, Quality and Health and Safety Manager
- Lead Nurse Infection, Prevention and Control
- Head of Risk Management
- Directorate representatives:
    - Corporate & Board – Board Governance Manager
    - Health Protection – Quality and Systems Officer
    - Health & Wellbeing – Head of Operations/General Manager
    - Nursing, Quality and Integrated Governance – Governance and General Manager
    - People and Organisational Development – Operations Service Manager
    - Policy and International Health - Business Manager
    - Research, Data and Digital – Directorate Governance and General Manager
    - SPR's – Speciality Training Programmes Manager
- Staff side representative/s.

6.3 By invitation:

The Group Chair may extend invitations to appropriate persons to attend Group meetings as required from within or outside the organisation who the Group considers should attend, taking account of the matters under consideration at each meeting.

6.4 Secretariat:

Executive Assistant and Business Support Manager, Operations and Finance Directorate

6.5. Access

The Chair of the Health and Safety Group will be the Executive Lead for Health and Safety.

7. Quorum

At least 4 members one of whom must be the Chair or the Deputy Chair.

8. Frequency of Meetings

Meetings shall be held no less than quarterly and otherwise as the Chair of the group deems necessary.

9. Approval out of Meetings

Where approval for procedures and other written control documents is sought out of the quarterly meeting structure, for example, via email / other electronic process, this will require confirmation of approval from the quorum number listed in section 6 above.

Any procedures approved out of meeting, should then be ratified at the next meeting of the Group.

10. Relationships and accountabilities with the Board and its IPC Group Meeting

The Group must have an effective relationship with the Business Executive Team and the Quality, Safety, and Improvement Committee in order to provide effective reporting and assurance.

The Group must operate within the remit of its role.

Assurance is provided through this scheme of delegation through the Executive Director of Operations and Finance.

11. Review

These terms of reference and operating arrangements shall be reviewed on an annual basis by the Group and recommended to the Business Executive Team for approval.

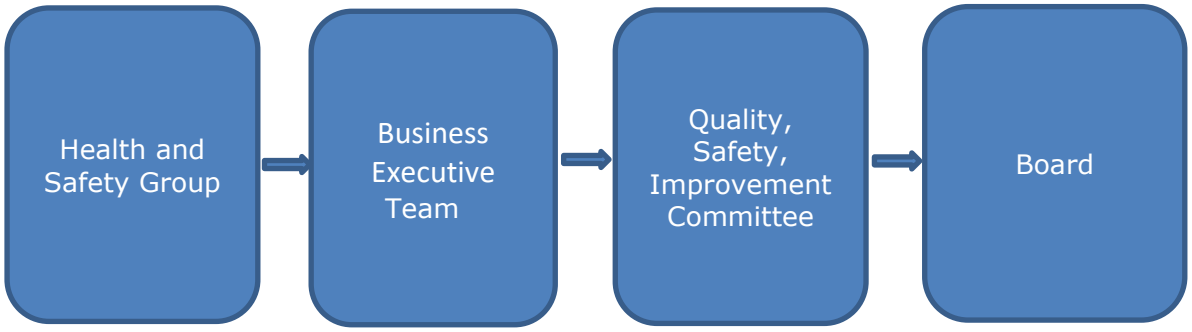
12. Reporting Arrangements

The Group will report to the Business Executive Team and the Quality, Safety and Improvement Committee on a Quarterly basis.

The Group will also produce an Annual Report for assurance, which will be submitted to the Business Executive Team and the Quality Safety and Improvement Committee.

An annual work plan will be submitted the Business Executive Team and the Quality, Safety and Improvement Committee.

13. Flow chart of Governance Arrangements



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Deep Dive: Health & Safety September 23rd 2025

(Neil Desmond – Head of Estates and Health & Safety)

Aim

To provide the committee with an overview of the PHW Health & Safety arrangements and provide assurance on the Health & Safety Management and delivery arrangements.

Summary of presentation

- Health & Safety arrangements in Directorates and how we get assurance from the Directorates.
- Complexity of estates management arrangements.
- Risk and incidents – what are we seeing.
- Regulatory changes etc.
- Links to other groups and sources of assurance
- Areas of good Health & Safety practice
- Learning from HSE / RIDDORs
- Health & Safety Divisional ask of the committee.

Health & Safety

Health & Safety at Work etc. Act 1974

The Health and Safety at Work etc Act 1974 primary piece of legislation covering occupational health and safety in Great Britain. It sets out the general duties which:

- employers have towards employees and members of the public
- employees have to themselves and to each other

1. Provide a safe place of work
2. Provide safe equipment
3. Ensure staff are properly trained
4. Carry out risk assessments
5. Provide proper facilities

Health & Safety across Directorates: Governance and Accountability

The Division has responsibility for ….

- **Scope:** All health and safety related activity across the organisation.
- **Who:** The health and safety of all staff, service users and visitors to our buildings.
- **Requirements:** Ensuring full compliance with statutory and regulatory legislation principally relating to Fire, Water, Gas and Electrical Safety and Asbestos management.
- **Breadth -** The provision of the management of 16 buildings across the Wales and BTW mobile units .
- **Ensures -** Significant Directorate and Divisional liaison and contact / formal and informal – both reactive and proactive.

Governance and Accountability Arrangements

- The Estates and Health & Safety Division reports to the Public Health Wales Health & Safety Group on a quarterly basis. Chaired by the PHW Executive Director of Ops and Finance (Executive lead for Health & Safety).
- Health & Safety Group comprises of all Directorates
- The Health & Safety Group quarterly reporting details;
  - Health and Safety Incidents
  - RIDDORs
  - Estates Compliance
  - Compliance with Health & Safety Statutory/Mandatory training & additional health & safety related training
  - Risk reviews
  - Estates and Facilities Alerts (EFA)
    - Specialist Estates Service Notifications (SESN's) & Publication Notices (PNs)
    - High Voltage Hazard Alerts (HVHA
- Additional reporting via NQIG
  - Alerts and Notifications Safety Action Bulletins (SAB) – reported NQUIG
  - Medical Device Alerts (MDA) / Drug Alerts (DA)/ Chief Medical Officer Alerts (CMO)

Governance and Accountability Arrangements

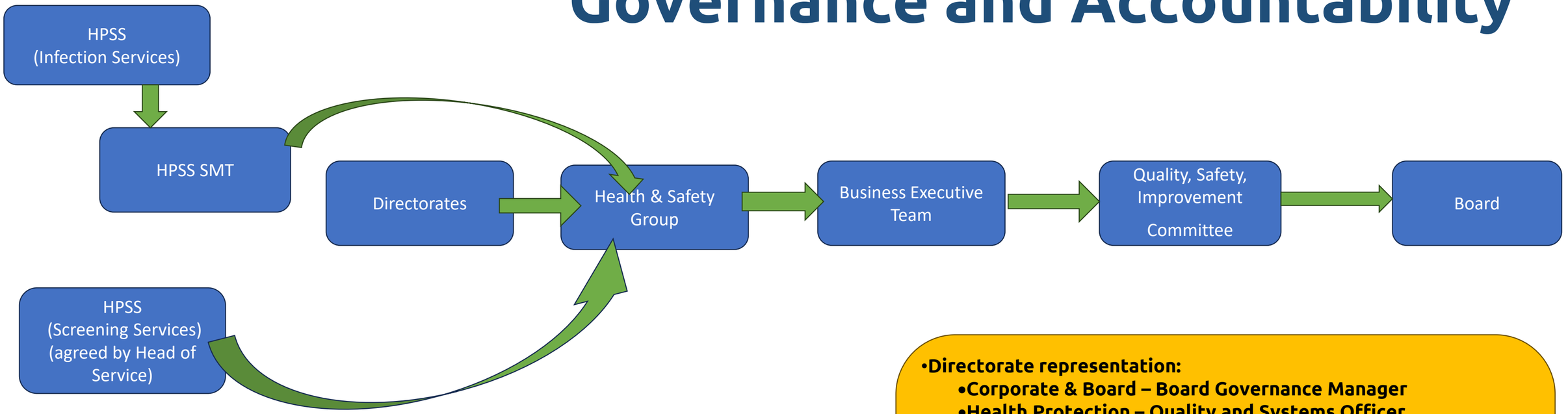
- The group is accountable to the Business Executive Team and the Quality, Safety Improvement Committee via the Executive Director of Operations and Finance.
- Details on updates on the Health & Safety Workplan are provided to the Quality, Safety and Improvement Committee and Business Executive Team on quarterly basis.
- The Group produce an annual report on the work that has been undertaken which is presented to the Business Executive Team and the Quality, Safety and Improvement Committee.
- The Group Chair ensures appropriate escalation arrangements are in place to alert the Trust Chief Executive and / or the Quality, Safety and Improvement Committee Chair of any urgent / critical matters that may compromise services / service user provision and affect the operation and / or reputation of Public Health Wales.

Governance and Accountability

Further linkage to ……

- IP&C Group
- Safeguarding Group
- Decontamination Group
- Waste Management Group
- Radiation Protection Group
- Medical Devices Management Group
- Facilities Group (Trust Water Safety Group / Ventilation/Maintenance/Cleaning / Waste) - Accountable to IP&C)
- Health & Safety Screening Mangers Group
- IMTs

Governance and Accountability



- **Directorate representation:**
  - **Corporate & Board – Board Governance Manager**
  - **Health Protection – Quality and Systems Officer**
  - **Health & Wellbeing – Head of Operations/General Manager**
  - **Nursing, Quality and Integrated Governance – Governance and General Manager**
  - **People and Organisational Development – Operations Service Manager**
  - **Policy and International Health, WHO Collaborating Centre – Business Manager**
  - **Research, Data and Digital – Directorate Governance and General Manager**
  - **SPR's – Specialty Training Programme Manager**

Complexity of Estates management arrangements

- Dispersed and diverse estate
- Incorporates different functions
  - Public facing screening venues (n27)
  - Administrative buildings (n10)
  - Microbiology labs (n12)
  - Hosted organisation NHS P&I (n30)
  - Differing site arrangements for H&S Compliance.
- Owned property/ leased properties/ hosted arrangements with UHBs others (SLAs/ MOU's /MOTO's)
- Challenges: multi tenanted buildings / landlord tenant responsibilities / service contracts management
- Resource -
  - H&S Divisional capacity
  - Screening and Infection services
- Estate condition

Risks and incidents

- Most incidents falling within HPSS
- Infection services Incidents reviewed for four plus year analysis (2021 April 2025) – total of 429 incidents:
  - ➢ Most reported areas –
    - Accident / injury
    - Equipment /devices
    - Contact with hazardous substances
    - Slips trips and falls
- During the 2024 -25 reporting period increased in reporting of incidents.
- Estates, Facilities, Performance Management System - reporting.

Regulatory changes

- All changes notified through agreed internal notification processes
- All changes where applicable to the organisation actioned
- All requirements reported
- Estates and Facilities Alerts (EFA)
  - Specialist Estates Service Notifications (SESN's) & Publication Notices (PNs) High Voltage Hazard Alerts (HVHA)
- Additional reporting via NQIG
  - Alerts and Notifications Safety Action Bulletins (SAB) – reported NQIG
  - Medical Device Alerts (MDA) / Drug Alerts (DA)/ Chief Medical Officer Alerts (CMO)

Areas of good Health & Safety Practice (1)

- Supporting staff to work ***how it works best*** - keeping staff safe
- Commissioning additional targeted Health & Safety training for particular staff
- Health & Safety Culture Survey
- Joined up co-ordinated working
- Health & safety incident management
- Learning from incident reviews
- Learning from RIDDORs – changes to SOPs / staff training
- Proactive risk assessments of activity
- Use of external experts for compliance certification and advice
- Audits: Health & Safety / Access.

Areas of good Health & Safety Practice (2)

Medical devices

- Positive reporting culture – increase in reporting reflects openness.
- Medical Devices Safety Officer role established.

Training compliance

- Directorates above Welsh Government 85% target and most above 90%
- Fire warden and First Aid training improvements
- Working from Home Safely training increasing

Learning from incidents

- Trend analysis
- Shared learning
- Targeted interventions

In conclusion

- Keeping our staff and visitors safe
- Maintaining and meeting Statutory and Regulatory compliance across the estate.
- Supporting and enabling operational service delivery.
- Divisional maturation.

Ask of the Committee……

1. The Committee is asked to take assurance from the presentation on the arrangements in place for ensuring that;

    - Appropriate action is being taken to proactively manage health & safety across the organisation
    - That Health & Safety advice and support is in place for all areas of the wider organisation.
    - That staff are supported to work safely across the organisation.
    - That users of our buildings and services are safe.

2. The committee is asked to receive assurance that appropriate actions are being undertaken to address any issues that arise in a timely and effective way.

3. Ongoing support for the complex estate and compliance challenges.

Any questions……..

GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

Gweithio gyda'n gilydd i greu Cymru iachach

Working together for a healthier Wales

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 30 September 2025 **Agenda item:** *6.1*

Winter/Seasonal Planning	
Executive lead:	Professor KHAW Fu Meng, National Director Health Protection and Screening Services (HPSS), Executive Medical Director
Author:	Dr Tom Fowler, Deputy National Director Health Protection and Screening Services

Approval/Scrutiny route:	HPSS DMT - 08/07/25

Purpose

This paper provides an update to the Quality, Safety and Improvement Committee on Public Health Wales coordinated response to winter planning for 2025/26. Planning for the 2025/26 winter seasons follows work undertaken for the Winter Pressures Summit held in March 2025.

It outlines the organisation's contributions to winter planning, current baseline mapping of winter-related activities, and the proposal to establish a centralised programme to coordinate and enhance visibility of all winter preparedness. The Committee is asked to receive assurance on progress.

Recommendation: (note - to mark an x in the grey box below right click on the mouse, then select "properties", and then select "checked")

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- Take **assurance** that initial activity around winter planning has been initiated in several areas of the organisation, an approach to coordination has been agreed and a programme to oversee this work is under development.

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	1 - Influencing the wider determinants of health
Strategic Priority/Well-being Objective	4 - Delivering excellent public health services
Strategic Priority/Well-being Objective	5 - Supporting a sustainable health and care system

Summary impact analysis	
Equality and Health Impact Assessment	Not Applicable
Risk and Assurance	Not Applicable
Health and Social Care (Quality and Engagement) (Wales) Act	A number of the areas of activity planned have the potential to improve the quality of services, both with PHW and across NHS Wales.
Financial implications	There may be some financial implications identified as plans are further developed. This will be kept under review.
People implications	Not Applicable

1. Purpose / situation

This paper provides an update to the Quality, Safety and Improvement Committee on Public Health Wales' coordinated response to winter planning for 2025/26. Planning for the 2025/26 winter seasons follows work undertaken for the Winter Pressures Summit held in March 2025.

It outlines the organisation's contributions to winter planning, current baseline mapping of winter-related activities, and the proposal to establish a centralised programme to coordinate and enhance visibility of all winter preparedness. The Committee is asked to receive assurance on progress.

2. Background

Winter pressures continue to present significant challenges to the Welsh NHS, with increased demand on urgent and emergency care, higher rates of respiratory infections, and exacerbated health inequalities. In response, Public Health Wales contributed to a national Winter Pressures Summit in March 2025, engaging with partners across the system to identify key preventative and operational priorities. This work aligns with national objectives to reduce avoidable admissions, improve population resilience, and support the Welsh Government's commitments on fuel poverty, vaccination, and infection prevention.

3. Description/Assessment

Public Health Wales has undertaken a cross-organisational review of winter-related activities and identified key activities:

- Warm Homes - The Housing Warmth and Health and Wellbeing programme has provided evidence to Welsh Government on the health impacts of fuel poverty. This includes national surveys, qualitative research, and temperature monitoring in low-

income households. The programme has informed policy updates and contributes to the Fuel Poverty Advisory Panel, with further publications due in 2025–26.

- Falls Prevention - Evidence-based interventions are being scoped, including strength and balance exercises (e.g. “Get Up and Go” guide), home environment reviews, polypharmacy assessments, and third-sector partnerships. These are aimed at reducing emergency admissions, ambulance call-outs, and long-term care needs.

- Immunisation – The Vaccine Preventable Disease Programme is developing a behavioural science-informed strategy to improve uptake, particularly in underperforming GP practices. The focus includes early intervention, targeted messaging, and prioritisation of key groups such as children, pregnant women, and health and social care staff. The RSV programme is also being scaled up, with lessons drawn from high-performing regions like Scotland.

- Behavioural Science Unit is working with the Vaccine Preventable Disease Programme and Welsh Government to support Health Boards and Trusts to embed behavioural science insights into staff flu vaccination approaches and best practice

- Primary Care Division is working with NHS Performance and Improvement to pilot a peer immunisation in nursing and care homes having recognised a lot of staff are not immunised and have difficulty getting to the allocated place yet there are colleagues who are immunising residents. Although this seems like quick win, the benefits of having high rates of immunisation in staff are well documented, the bureaucratic and governance arrangements are not to be underestimated.

- Infection Prevention and Control (IPC) - A refreshed IPC strategy is being implemented, including peer-led audits, updated training, and action cards linked to community prevalence. The aim is to improve compliance, reduce outbreaks, and ensure consistent application of IPC measures across settings.

- Environmental Public Health - Environmental Public Health Team promotes the use of regular appliance checks, CO alarms and knowledge of the symptoms of CO poisoning to reduce winter-related increases in cases of CO poisoning.

- Communicable Disease Surveillance Centre (CDSC) and Vaccine Preventable Disease Programme (VPDP) monitor respiratory and other pathogens and their impact on the healthcare system over the winter period, sharing findings and insights with partners. Additional elements for 2025/6 include:
    - ❖ New surveillance output on respiratory infections in a care home setting to be introduced in advance of the 25/26 season.
    - ❖ Short-term modelling to estimate upcoming impacts on the healthcare system.
    - ❖ Piloting sentinel surveillance in care homes, and auditing of retrospective respiratory outbreak completeness.
    - ❖ CDSC pandemic preparedness cell. Fortnightly meetings and development of a comprehensive epi plan to sit beneath the PHW pandemic preparedness plan, utilising WHO Mosaic surveillance principles and linking with UK nations to identify work carried out at UK level through collaboration.

- Environmental Public Health Team advocates for adaptation efforts to provide warm spaces in the community that will provide safe, warm environments that should contribute to reduced risk of falling and reduced loneliness and isolation. The team also encourages greater adaptation to reduce the health effects of adverse weather events such as floods and storms, as well as supporting the response to such events.

- The Policy and International Health Directorate is updating its report Improving winter health and well-being and reducing winter pressures in Wales: A preventative approach (2019). The report Winter Well-being: shared actions & impact will apply a behavioural science lens to support those already planning and preparing for winter by providing an action-oriented approach with both individual and system-wide interventions.

- The Primary Care Division through the Greener Primary Care Wales Scheme encourages primary care contractors to make plans to protect their patients, staff and premises to ensure quality care and continuity of services in the event of extreme weather conditions through adaptation planning and practice measures.

- The Health Improvement team works to protect and improve physical and mental health and wellbeing across the population and for targeted groups to help reduce the burden of ill-health on the NHS. On-going activities include:
    - Smoking prevention and support to stop through social marketing activities and Help me Quit services. A smoking cessation app is due to be launched and a mass media campaign will run in autumn/winter. Additionally 'Help Me Quit in Hospital' training is to be promoted to healthcare staff to enable them to support smokers during patient interactions.
    - 'Making Every Contact Count' training for health services (and wider organisations) to support positive behaviour change and healthier lifestyles.
    - National Exercise on Referral; a 16 week chronic condition prevention and management programme to increase physical activity in adults at risk of, or with an existing, chronic condition.
    - Promoting mental wellbeing through the Hapus programme, with additional benefits for physical health given the association between better mental wellbeing, improved immune system responses and cardiovascular health and healthy behaviours.
    - Promoting healthy weight and healthier food and activity through Healthy Weight Healthy You.
    - Enhancing weight management pathways to support people to reach and maintain a healthier weight, reducing the risk of health conditions and improving outcomes.

- Promotion of Add To Your Life to patients waiting for treatment to empower patients to improve their health and wellbeing and improve treatment outcomes.
- Healthy Working Wales: Working with and through employers, including NHS trusts, to promote the health and wellbeing of their staff.

- Primary care division continue to work with deep end, clusters and health boards on health inequalities and inclusion health recognising that respiratory disease is one of the biggest drivers of health inequalities and unscheduled admissions and sharing and spreading the actions that can prevent or reduce these.

- Activity is already underway in these different areas. Different routes to impact are being considered with regard to these areas, ranging from directly procured activities such as media campaigns, through to enabling other organisations to effectively deliver interventions to upstream advice to help shape effective policy. For example, the Behavioural Science Unit was asked by NHS Leadership team to support Health Boards and Trusts to embed behavioural science insights into staff flu immunisation plans.

- A baselining assessment of this activity has now been initiated and agreement for a working group to be convened by the Deputy National Director of Health Protection and Screening Services to map out and coordinate between different areas of work.

Risks and Implications:

With a Welsh Government policy focus on addressing winter pressures there is an opportunity to address issues in implementation of public health services and addressing risks e.g.

- Continued variation in vaccine uptake and IPC compliance could undermine system resilience (Health and care Staff and public).
- Fuel poverty and cold homes remain a significant public health risk.

Without central coordination, there is a risk of fragmented delivery and missed opportunities for impact.

Assurance:

The table in Appendix One outlines the planning within the organisation for winter pressures that would be overseen by coordinating group.

Future assurance will be provided through the current scheduled updates to the Committee, including progress against key milestones, impact metrics, and stakeholder engagement outcomes.

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

This work has been put together following the five ways of working, as defined within the sustainable development principle in the Act, in the following ways:

The programme addresses long-term health outcomes by focusing on upstream prevention (e.g. fuel poverty, falls prevention).

Emphasis is placed on reducing avoidable admissions and health deterioration through vaccination, IPC, and community-based interventions.

The programme aligns with national health and social care objectives and supports cross-sector collaboration.

Developed through engagement with internal directorates and external partners including Welsh Government, health boards, and local authorities.

Informed by lived experience research (e.g. housing and warmth studies) and behavioural insights to shape public messaging and service design.

4. Recommendation

The Committee is asked to:

- Take **assurance** that initial activity around winter planning has been initiated in several areas of the organisation, an approach to coordination has been agreed and a programme to oversee this work is under development.

Appendix One

Winter Pressures 2025

HPSS Directorate Operations Team

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
HPSS	HARP	Review of Acute Respiratory Infection (including COVID-19) IPC Guidance and update. Late Summer – early September for the Winter Season. Guidance available on our HARP website: ARI - Acute Respiratory Infections - Public Health Wales.	August - September	Guidance available on HARP website: ARI - Acute Respiratory Infections - Public Health Wales. September: ARI guidance review no planned changes to 2024/5 version.
HPSS	HARP	Provide general IPC Guidance and Support to the NHS in Wales throughout.	Complete	National Infection Prevention and Control Manual for Wales available on our website: NIPCM - Public Health Wales with a version adapted for care homes that include a different use of language.
HPSS	HARP	Contribute to Systems Resilience and Winter Preparedness meetings held by WG.	On-going	Regular attendees at PPE operational group. Update given to WG policy advisor to support plans.
HPSS	HARP	Work closely with NHS Wales Performance and Improvement colleagues to support the	On-going	HCAI DG in place chaired by NHS P&I. CDI reduction safety collaborative learning event 7th October (in person).

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
		quality and delivery agendas, sharing information and collaborating on support to NHS Wales.		
HPSS	HARP	Summer IPC Forum focussed on Winter Pressures / Preparedness.	25th June 25	Complete as per update August 2025.
HPSS	HARP	Webinars arranged for UTI management in care homes / community focussed on managing deteriorating patients / admission avoidance.	September 2025	Series complete.
HPSS	HARP	Working on an advisory note to WG in regard to their preparation of a WHC to NHS Wales with improvement goals for HCAI & AMR, reduction in C. difficile burden and improvements in antimicrobial stewardship all contribute to improved patient flows and support for winter pressures.	On-going	WHC advice given, awaiting WG publication.

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
Operations and Finance	Communications	Integrated, public-facing marketing campaign utilising paid, earned, shared and owned channels to build knowledge of the flu vaccine as the best way to stay protected this winter. The campaign is designed to promote action amongst eligible groups to take up their offer of the vaccine. Campaign will focus primarily on flu but also cover other viruses circulating over winter (RSV, COVID-19).	Campaign will be timed to match vaccination roll out from September to early 2026.	Increasing knowledge of the benefits of vaccination. Motivating those eligible to take up their offer and encourage a commitment to action. Targeted focus on where uptake is less strong means working more closely with communities rather than relying solely on mass-communications.
Operations and Finance	Communications	Marketing activity to promote preventative behaviours to stay well this winter such as handwashing, staying away from others if you have symptoms.	October until February (TBC)	Increasing awareness of what to do to prevent the spread of viruses this winter with the wider impact being a reduction in the spread of respiratory illness and hospitalisation.
RDD + others	Data Science and Analysis	Contribute to updating the	May – November 2025	Updated information and guidance for system

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
		2018 winter health report.		partners, to be published on the website.
NQIG		Roll-out of flu vaccinations to all staff.	Planning commenced in July and programme will go live on 7th October 2025. Communications plan in place and will commence the end of October.	In collaboration with POD, training sessions will be delivered to flu champions to help promote uptake. Insights from VPDP and Behavioural Science have informed strategies to reduce barriers, including offering drop-in clinics and providing digital pharmacy vouchers. These initiatives will be supported by a targeted and appropriate communications approach.
NQIG		Consideration of mask-wearing guidance escalation for both the vulnerable public groups and staff in patient-facing roles.	Autumn in conjunction with the wider NHS Wales system.	Clear guidance on when to trigger guidance on mask-wearing in order for measure to be effective and timely, ensuring it remains easily understandable. Meeting with IPC leads and HARP to review and progress decision making framework for NHS Wales. Also linking with NHSE on similar project. Further work to be undertaken on reviewing the evidence base and gaining a clear understanding of wearing masks in public places, particularly for those more susceptible to respiratory illness. Meeting with PHW comms team to progress how we can integrate mask/face

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
				coverings into the keeping well this winter campaign.
NQIG /HWB	Core group	Exploring opportunities at the prevention end of Falls prevention. Working with WG Policy/6 Goals colleagues.	High level plan implemented from June 2025. For further details on timeline, please see Appendix 1.	We know that what matters to adults with complex needs / older people living with frailty is to remain as well and independent as possible in their own homes and connected to their communities. Our population outcome indicator is therefore considered to be 'healthy days at home' or alternatively 'independent at home'. We are currently unable to systematically measure this outcome across Wales. The following system level indicators are suggested as reasonable proxy indicators and have been a core component of the Care Action Committee for Building Community Capacity since October 2023. Quality outcome measures should also provide us the patient / service user's experience. These system indicators also allow us to monitor how the ICCS at Regional level may be optimising health and social care resource. Process measures should also be monitored that tell us 'how much' and 'how well' components of the system are delivering and subsequently

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
				contributing to impact on the system. Ultimately, we would expect that our system contributes to reducing falls incidence, maintaining independence and avoiding conveyance and admission to hospital. As a minimum we should expect the following with implementation of relevant actions. Update 06/08/25 - Further discussion as a leadership group have agreed the interventions (workstreams for low risk fallers) o Environmental assessments o MECC for FRAT(inc. social prescribers / IAA LA provision / digital technology eg App, routine follow ups with professionals) and onward referral for those 'at risk' for meds mgt review etc via ? Falls / Frailty Nurses in Health Boards o NERS referral increase for

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
				Strength and Balance programmes ○ Public Awareness Campaigns Policy and International health looking at evidence review for this population group, and impact of interventions.
HWB	Help Me Quit	Help Me Quit in Hospital training for staff. Launch of Help Me Quit App. 'Break Its Hold' - launch of new HMQ brand platform and media campaign.	In progress. Work underway, aiming for launch in Q3. Planning underway for launch late Q3.	Increased uptake of support to stop smoking among those at higher risk of/already experiencing health harms. Increased uptake of support to stop smoking.
HWB	NERS	On-going promotion of NERS and support to NERS Co-ordinators Developing proposals to enhance adherence to NERS.	Reviewing evidence (published literature and participant feedback) to inform recommendations. Engagement with NERS Co-ordinators planned for October.	Increased adherence to local 16-week NERS programmes leading to increased likelihood of embedding behaviour change and improved physical health.
HWB	PCD Prevention:	Social Prescribing: - Mixed methods evaluation of holistic	Warm Wales evaluation – April 2025 – March 2026. Financial wellbeing scoping review – completion anticipated by December 2025.	Warm Wales evaluation will enable understanding of impact of intervention on respiratory outcomes. NIHR bid being explored to see if broader outcomes (especially in relation to

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
		Warm Wales intervention. - Social prescribing and financial wellbeing scoping review.		financial wellbeing and mental wellbeing) in line with broad 'social prescribing' approach of WW intervention. Financial wellbeing and social prescribing scoping review will help to increase understanding in Wales of nature of interventions related to social prescribing and financial wellbeing, and position of the current evidence base.
HWB	Greener Primary Care Wales	Provision of a Framework encouraging primary care to take action to protect patients, staff, premises and service delivery.	Continue to update the Framework aligned to policy and national adaptation plans. Collection and sharing of case studies.	Increasing awareness of what primary care can and should do to prepare for adverse weather events. Continuity of primary care service provision.
HWB	Nutrition and Obesity	Review and update HWHY content for maintaining healthier food and activity during winter.	Content review and update content commencing August for completion Nov 25.	Enhance advice to enable and promote healthier behaviours amongst people who are above a healthier weight who are at particular risk of developing health conditions.
Policy and International Health	Specialist Projects	Report on the experiences of low-income households at home during winter including their indoor temperatures experienced and health and well-being.	Autumn release.	This work will help inform sustainable and equitable public health responses to cold homes and the support available to low-income households during winter. Findings will support policy and actions on fuel poverty and healthy housing.

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
Policy and International Health	Behavioural Science Unit	Preventative report on improving winter health and reducing winter pressures being updated.	Early Autumn release.	This refresh of a previous report will apply a behavioural science lens by providing an action-oriented approach for both individual and system-wide interventions.
Policy and International Health	Behavioural Science Unit	Support for Health Boards for staff flu vaccinations.	Awaiting contact points for diary invites.	Session for Health Board contacts to understand some of the barriers and strategies to overcome uptake of staff vaccinations.
HPSS	VPDP	Potential improved agility and quality of surveillance due to new delivery system of flu vaccines.	<u>September</u> • Two and three year olds HB level – w/c 15th September. • School aged HB level data for those using WIS – w/c 15th September. • 65+ and 16y-64y at clinical risk Health HB level data – w/c 29th September. • Occ Health HB level data incl. PHW staff – w/c 29th September. <u>October</u> • First 2025/26 season COVID-19 Weekly report – 6th October. • School aged HB level data for those not using WIS –w/c 13th October. • Full suite of IVOR reports and clinical risk breakdowns – w/c 13th October. • School level reporting for those using WIS – w/c 13th October.	The transfer of data to WIS allows the use of deduplicated data which is captured in real time in the flu surveillance. This will allow: • more accurate reporting of uptake across all providers • reduced reliance on surveys for uptake increasing ability to report • improved reporting on inequalities • contribute to UK estimates on vaccine effectiveness

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
			• Vaccination in pregnant women report – End Oct. • Counts of vaccines given in prisons and to poultry workers – End Oct. <u>November</u> • Report on coverage in homeless populations using SAIL data – date TBC depends on refresh timelines. • Report on coverage in domiciliary carers using SAIL data – date TBC depends on refresh timelines. • Report on coverage in household contacts of the immunocompromised using SAIL data – date TBC depends on refresh timelines and scoping.	
HPSS	Health Protection	Planned work ensuring sufficient surge capacity and business continuity for increased demand. A plan has been developed to manage the increased workload whilst ensuring service continuity is maintained. The	In progress/ on-going	This will allow for an increased number of queries to be dealt with in a timely and safe manner.

Public Health Wales Directorate	Division Programme	Action - What work is being undertaken	Planning - start date to support delivery	Intended Impact
		plan is flexible to response needs and service pressures. It includes service level provisions from Business as Usual - standard acceptable service – minimum acceptable service – below minimum acceptable service. The plan includes surge support from the National Health Protection Surge Team and re-prioritisation of AWARe activity.		

Falls Prevention and Building Community Capacity

Contact: Sue Tranka, CNO, Welsh Government Tracey Cooper, CEO Public Health Wales
Who will present: Rhian Matthews, Professional Advisor Frailty and Integration; Claire Birchall Exec. Director of Nursing Public Health Wales

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Please confirm that in developing the policy/proposal/guidance you have considered Welsh Language, Equality, Sustainable Development, United Nations Convention on the Rights of the Child, any digital technology / ways of working, and socio-economic impacts:

	Confirmed – include a short description of how in the body of the paper, including confirmation that the necessary impact assessments have been completed.
x	Not applicable because: (e.g. internal corporate matter)

Please confirm that in developing the policy/proposal/guidance you have consulted the HSS Policy Forum ahead of EDT:

x	Confirmed – summarise the outcome of the discussion at Policy Forum in the body of the paper, including where you have secured alternative engagement with Policy Forum
	No. Describe in the body of the paper (e.g. internal corporate matter, time critical)

Please state if the paper is for:

x	Discussion
	Decision
	Information

EXECUTIVE DIRECTORS TEAM IS ASKED TO:
List clearly what EDT is asked to do.

	To *agree* a course of action
	To *endorse* a decision
x	To *advise* on an approach
	To *identify* action required
x	To *note* for information

It is essential that all of our polices consider and maximise the contribution to the Wellbeing of Future Generations (Wales) Act 2015. Please set out how your proposed policy meets the five ways of working which are:

- ***Long Term*** – The importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
- ***Prevention*** – How acting to prevent problems occurring or getting worse may help public bodies meet their objectives.
- ***Integration*** – Considering how the public body's wellbeing objectives may impact upon each of the wellbeing goals, on their other objectives, or on the objectives of other public bodies.
- ***Collaboration*** – Acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its wellbeing objectives.
- ***Involvement*** – The importance of involving people with an interest in achieving the wellbeing goals, and ensuring that those people reflect the diversity of the area which the body serves

V0.4 with CB, ST and TC Comments considered

It is essential that all of our health-related polices and decisions consider the Duty of Quality and we can evidence they are made with a view to: a) secure improvements in the quality of health services and b) improve outcomes for the population of Wales. Please set out how your proposed policy has considered the Health and Care Quality Standards 2023.

- ***Safe*** – minimising harm, learning from when things go wrong.
- ***Timely*** – provided in the right place, at the right time and in clinical priority.
- ***Effective*** – evidence-based practice and whole of life pathways
- ***Efficient*** – avoiding waste and getting the best value for money.
- ***Equitable*** – providing everyone with the opportunity for a healthy life.
- ***Person-centred*** – treating people with kindness and respect.
- ***Leadership*** – Clear, focused and fully matured governance, leadership and accountability at all levels is vital in creating a functional quality management system.
- ***Culture and valuing people*** **-** encourage quality and system safety within a supportive, inclusive, and collaborative culture.
- ***Data to knowledge*** – develop understanding of service quality to inform learning, strategic decisions, and guide quality improvement.
- ***Learning, improvement, and research*** – create opportunities for system-wide learning to allow for continuous learning and quality improvement innovation.
- ***Whole-systems perspective*** – learn from quality planning, control, and insurance to improve quality across the healthcare system.
- ***Workforce*** – recruit, retain, develop, and extend roles to ensure enough confident people with the right knowledge and skills can deliver safe care.

PURPOSE

Falls and falls-related injuries for community dwelling individuals are a major public health concern. They are the leading cause of injury related deaths for individuals aged 65 and over and a significant driver of urgent and emergency care demand and associated hospital related pressures.

These incidences frequently lead to a loss of independence and a resultant increased demand for health and social care. For this population, we know that ‘What matters’ is to ‘remain active, independent in their own homes and connected to their communities’. Falls are however preventable and their incidence and prevalence can be reduced.

Appropriately, ‘Falls Prevention’ is therefore a priority area for action across policy and NHS Executive national programmes for 25 / 26 in recognition that optimal management will improve outcomes for the population and enhance system resilience through reducing conveyance and hospital admissions this winter.

Optimal falls prevention management requires a whole system / whole population approach. EDT has previously acknowledged that duplication of efforts exist across national policy and programme areas resulting in diluted impact and conflation on the ground in terms of delivery expectation. Further, EDT recognised that cohesive and coordinated delivery of key actions towards a shared outcome is integral to optimising impact.

V0.4 with CB, ST and TC Comments considered

This paper:

- Defines what is meant by ‘fall’, its incidence and prevalence;
- Presents the case that reducing the risk / incidence of falls and reducing inequalities in Wales would benefit from a population health management approach across the whole system of health, social care and public sector agencies for risk stratified population groups;
- Summarises opportunities and makes recommendations in line with the Building Community Capacity priority to enhance outcomes for this population and build system resilience for Winter 25 / 26

Policy Forum on the 8th May provided an opportunity to discuss the current state in relation to proactive care of older people with complex needs and the need for best practice guidance in this area. The discussion did not explicitly address falls prevention however colleagues endorsed a Proactive Care Framework being integral to improving management of high risk population groups. Policy Forum also acknowledged that Proactive Care of high risk populations was a collective responsibility spanning policy areas and associated national programmes.

BACKGROUND: Falls, Definition, Prevalence and Incidence

Falls are defined as an event where a person unintentionally comes to rest on the ground or a lower level. Such events are not limited to ‘slips and trips’ known as ‘mechanical falls’ but includes intrinsic episodes where an individual has ‘collapsed’ to the floor of unknown origin.

People over the age of 65 are often considered at highest risk of fall. However, falls are not an inevitable part of the ageing process rather, the risk and incidence of falls directly correlates with Frailty and associated progressively complex needs.

Frailty is a long term condition. It describes a state of health whereby body systems gradually lose their biological, physical and mental resilience and individuals are therefore predisposed to sudden changes in function. This includes gait and balance compromise with the person often presenting as having fallen or ‘sudden collapse’. Falls are therefore associated with the ageing process and experienced by older people although not all older people are living with frailty. For instance, 20% of our > 90s population are fit and well. Similarly, younger adults with multi morbidity and associated complex needs may be considered as ‘frail’ and at high risk of fall.

A recent study undertaken by Public Health Wales (PHW) considered peer reviewed literature and specifically the use of a validated eFalls predictor model which stratified the risk of falls for > 65s using GP records in England. Utilising this peer reviewed information it was possible for PHW to provide an indication of falls risk distribution for the >65 population (Table 1. below). Risk in this context was described as the probability of emergency department attendance or hospitalisation with fall / fracture within one year.

Risk of Admission within a Year	Risk Distribution as % of all>65s	% of total >65s
High Risk > 25%	1% >65s are high risk	6% of our >65s fallers
Medium (Rising) Risk 10- 25%	8% >65s are medium risk	29% of our >65s fallers
Low Risk <10%	91% > 65s are low Risk	65% of our >65s fallers

Table 1.

The growth in population of the > 65 year demographic between now and 2035, assuming a constant % of 'high', 'medium' and 'low' risk, is expected to result in greater numbers of people being at risk (Figure 1. below). Similarly, it predicts a 28% increase in admissions relating to falls / fracture (Figure 2.below).

Risk strata	% of 65+ population	2025 pop 65+	2035 pop 65+ (projected)	Increase
High >25% 1y risk	1%	7,059	8,407	1,348
Medium 10-25% 1y risk	8%	56,473	67,253	10,780
Low <10% 1y risk	91%	642,381	765,003	122,622

Example growth of risk strata in Welsh population aged 65+ based on projected growth of the population aged 65+.
Note: Strata proportions very approximate based on data extracted from eFalls paper (Archer et al, 2024).
Source: Archer et al, 2024 and ONS population projections (2022-based; principal projection).

Figure 1.

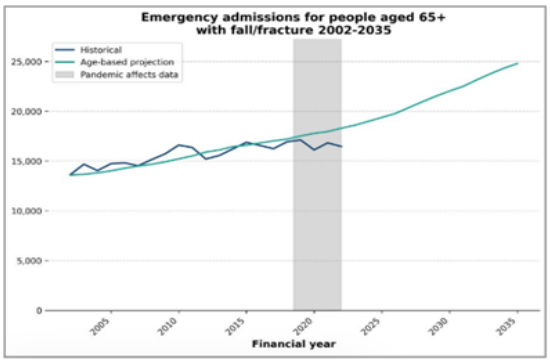

Figure 2.

This growth however is not inevitable and can be mitigated through evidence based interventions to reduce the risk of falls. Given the risk analysis presented in Table 1. above however, a strategy that focuses solely on finding and targeting the 'high risk' stratified population may have a large impact on individuals but a limited impact on total population falls incidence and impact on the system.

The demographic growth is not static, neither is the associated prevalence of frailty (complexity) and demand on our health and care system. A single focus on the 'high risk' is therefore not advocated. Counter effects demand a focus across 'low', 'medium' (rising) and 'high' risk populations simultaneously to engender greatest outcome now and into the future.

ASSESSMENT: Optimal Falls Prevention Management and our Current State

Optimal Falls Prevention and Management

As outlined above, falls are a symptom of frailty, effective management of falls should therefore be tantamount to that of frailty. Frailty however, like other long term conditions such as diabetes, with awareness and optimal management, can be prevented, its onset delayed and progression (including falls incidence) slowed down.

The Integrated Quality Statement (IQS) for Older People living with Frailty Older people and people living with frailty: integrated quality statement | GOV.WALES

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stresses that prevention, proactive and urgent care management of their needs are all integral to reducing the risk and preventing falls. The IQS however recognises that, in terms of effective management 'one size does not fit all'. Our approach and evidence based actions will need to reflect their assessed level of risk, e.g 'low risk', 'rising risk' and 'high risk', to achieve the greatest impact in keeping people healthier, preventing falls and keeping them out of hospital and at home. These actions that are summarised in Table 1. below.

	Low Risk of Falls (91% > 65s)	**Medium Risk of Falls (8% >65s)**	**High Risk Falls (1%)**	***Very High Risk Falls (NB 0.5%)***
Population Descriptor (presence of frailty)	Fit and Well	Mild to Moderate frailty - Simple needs but are progressive in nature Managing with regular support from health professionals No social care needs	Severely Frail Complex fluctuating needs. Regular multi professional coordinated care to manage fluctuating and often urgent needs Mostly eligible social care needs	Very Severely Frail Complex Needs High level dependency on care and support at home / care home residents Multi morbidity Often Palliative
Community Intervention	Universal / Prevention Measures	Proactive Care	Proactive Care, Urgent Response, Step Up Multi Professional and Enhanced Community Care	
Specific Examples of Interventions	Community Falls Awareness Home Safety Checks Keeping Active Nutrition & Bone Health Visual Acuity	Holistic Assessment Future Care Planning / Targeted Effective Interventions Person Centred Goals Proactive Monitoring	Care Coordination / Continuity of Care Early Identification of Decline / Rapid Response to Assessment and Step up Care in Community	

Table 1.

Effective management of frailty, and therefore falls, is wholly dependent on health and social care systems understanding population need and effective resourcing of components of a frailty attuned integrated community care system 'at place' to ensure equitable outcomes for the population and the system. Essential components of a frailty attuned integrated community care system are outlined in Figure 3. below.

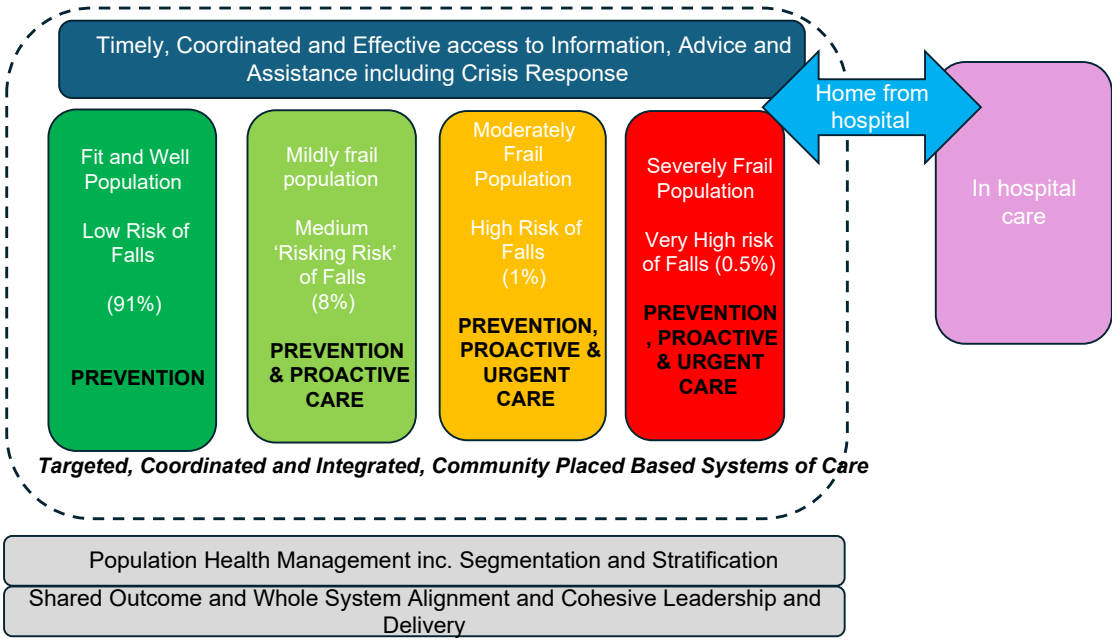


Figure 2. High Level Components of an Integrated Community Care System (Derived from IQS and ICCS Blueprint for Wales, RIF)

Current State

The infographic presented above in Figure 2. offers an organising framework to assess our current state against core components of an effective system that optimises population health management and reduces the risk of adverse outcomes (falls) for our ageing population. This was therefore used to undertake a high level assessment of our current state in preparation for this paper. Please note, while inpatient falls are a recognised challenge to healthcare quality and patient experience, this paper however has not explored inpatient falls prevention strategies. Given that hospital admission itself increases falls risk, the most effective prevention is to avoid admission where possible; an approach that is within the scope of this paper.

The assessment confirmed the breadth of interventions that are being undertaken across our integrated health and social care systems in Wales with reference to managing frailty, reducing falls risk and the effective management of injurious and non-injurious falls in the community.

The interventions are wide ranging with leadership for the initiatives spanning a range of policy and national programme areas many of which have benefited from investment (RIF, Allied Health Professional, Further, Faster, Six Goals Programme and most recently 50 Day Challenge). This activity, and activity that has previously been undertaken that can be reviewed, considered and refreshed should also be recognised.

While there is no doubt that each initiative is grounded in 'best practice' to achieve optimal impact a focus on 2 pillars of improvement is suggested.

Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities

The assessment demonstrated that current focus is disproportionately focused on 'high risk' populations and greater targeted effort is required for 'rising risk' populations

and ‘low risk’ groups. To realise the greatest impact we need a greater focus on prevention and this will be most impactful through community interactions.

Low Risk Populations

Health inequalities significantly influence falls risk and addressing these disparities will be essential. The focus on this population group therefore requires a strong focus on **prevention** and a public health approach which includes building resilience within the community. Such an approach requires system level organisation and multi agency ownership that includes public messaging promoting healthy ageing, active lifestyles and environmental safety. This messaging would benefit from regular public health campaigns particularly seasonal messaging in a manner that engenders community engagement and empowerment. Collaboration with Public Sector Boards and our Social Prescribing model presents us with a significant improvement opportunity. The key for this will be a systematic programme of public awareness and actively engaging with services that connect to people in the community.

A priority action in Quarter 2 (25 / 26) will be to bring together key players such as the Third Sector (eg Age Cymru, Care and Repair), Local Authorities, NHS, Community Housing Cymru and wider public sector organisations (Fire and Rescue) to map current activities, agree a shared approach and a targeted programme that will be delivered collaboratively to reduce duplication and ensure high level of awareness across society. We would anticipate this approach to be endorsed by the Older People’s Commissioner.

Rising Risk and High Risk Populations

Universal preventative approaches outlined above remain integral for these population groups however for ‘rising risk’ and ‘high risk’ population groups their needs have an increasing tendency to fluctuate particularly those who are severely frail many of whom will be benefiting from multiprofessional high volume and frequency care, support and treatment at home and in care homes. Their level of frailty is also likely to be such that their needs could be considered palliative.

Embedding a preventative **proactive care** approach is globally accepted as integral to managing their needs in a manner that enables targeted anticipatory management and early identification of compromise before crisis (such as a fall).

Proactive Care provision has 4 key principles for delivery:

1. **Case Identification (Risk Stratification)**
   ‘Deep dive’ exercises were undertaken with Regional Partnerships earlier this year to better understand their implementation of ‘Identification of the 0.5% most at risk’ (50 Day Challenge Intervention 6). These exercises demonstrated significant variation and inconsistency in scope and approach in relation to stratification. The approach varied from utilising professional judgement to more sophisticated stratification within GP systems using a recognised stratification tool, ‘electronic Frailty Index’ (eFI).

   In terms of scope, broadly there was a recognition that segmentation and stratification required a focus on older people living with frailty and that the ‘high risk’ population group would naturally include those at high risk of falls and should

also provide a focus on those individuals living in care homes and those in receipt of high volume / high frequency care at home. Populations tended to be stratified in 'pockets' such as within Cluster areas with few adopting Pan Cluster approaches for effective proactive management of stratified populations and commissioning integrated services 'at place'.

2. Holistic Multi Professional Assessment

Best practice encompasses the offer of an assessment and subsequent anticipatory care planning (known as Future Care Planning) to all individuals stratified. This assessment should determine 'what matters' to the individual and the risk factors presenting that compromises them achieving this. For this population it should routinely include falls risk assessment.

3. Future Care Planning (FCP)

The holistic assessment should result in an outline plan that sets out how the person and their multi professional team would mitigate risk factors through effective interventions. The plan should also outline how and when the individual should advise escalating needs (at the earliest stage i.e before fall). FCP should provide the basis for proactive monitoring and review of this vulnerable cohorts needs on a regular basis. The 'deep dive' exercises referenced above demonstrated that FCP in Wales has a propensity to focus on assessment and planning for 'end of life wishes' for those with palliative needs. While there is no doubt that this is important for this population group, gaining greater impact on falls prevention will require multiprofessional teams to adopt a purposeful focus on proactively managing the person's wider risk factors and the provision of anticipatory care and effective care coordination by integrated teams at the earliest point of needs escalation.

4. *Care Coordination and Continuity of Care*

The complex needs of this stratified population group demand the provision of timely, integrated and coordinated information, advice and assistance (IAA) that meets their fluctuating needs 7/7 a week at 'neighbourhood' level. This IAA should provide the means to proactively manage high risk cohorts (routinely reviewing FCPs) while responding to escalating needs in a manner that mitigates the need for urgent care in crisis.

There is evidence that primary care and community health services are integrating with Local Authority IAA services however the level of maturity in terms of that integration is inconsistent across Wales. Effective integrated IAA provision enables proportionate response to need by the right service / professional at the right time and reducing urgent care requirement and 'handoffs'.

Positioned correctly, Technology Enabled Care (TEC) and Alarm Receiving Centres (ARCs) can contribute to effective proactive care management and efficient resource utilisation. Across Wales the use of TEC and ARC in the proactive care space is limited.

Implementation of proactive care approaches across all 4 key principles is sub optimal and lacks the maturity, focus and prioritisation of resources afforded to reactive interventions. Consequently, escalating needs all too often result in crisis (fall or

collapse due to physiological compromise), trigger urgent and emergency care response and result in increased demand for finite long term care provision.

A Proactive Care Framework outlining the principles and standards that should be considered by Regional Partners in their planning and service design has recently been endorsed by Policy Forum. This is attached to the report for your reference. The Proactive Care Framework will complement the SPOA for Urgent Care Framework being published by Six Goals Programme and Local Authority Information, Advice and Assistance (IAA) arrangements. A Framework outlining principles for best practice in relation to integrated IAA provision has also been drafted by All Wales Heads of Adult Social Services and Social Care Wales.

Implementing the principles of Proactive Care for high risk population groups as a key component of Building Community Capacity is being overseen by the Strategic Programme for Primary Care as a key action of the Building Community Capacity priority for 25 / 26. The 'Deep Dive' exercise and community data sets / dashboard developed to date will provide the baseline to monitor progress going forward. It is anticipated that the inclusion of 'risk stratification of the 0.5%' utilising eFI in the GMS contract will be valuable both in the short term and in ensuring effective data sharing / data systems are in place to enable national population segmentation and stratification in the future. Implementation of a national Population Segmentation and Stratification Tool for Wales is being led by Data, Digital, Technology, Innovation and Value Team of the NHS Executive.

Given the current immaturity of proactive care approaches, an effective **urgent care** response is integral to ensure that Level one and Level two falls are managed in a manner that ensures appropriate assessment within two hours, a reduction of harm from 'long lies' and the provision of safe alternatives to conveyance and hospital admission where appropriate. National enabling actions relating to improving timeliness of access featured in the NHS Planning Framework for this year set out requirements for Health Boards to to implement Single Points of Access for Urgent Care and seven day a week community falls response services (Framework published in October 2024).

The Six Goals programme is actively supporting Health Boards and partners to deliver the latter through a national implementation group. A dashboard is being developed that will outline:

I. The length of time people wait for ambulance patient handover

II. The length of time people wait in emergency departments before discharge or admission; and

III. Their average length of stay if they are admitted

Health Boards are working with partners on implementation plans towards achievement of outcomes set by UEC policy officials i.e. to reduce ambulance transport of non-injured (level 1) and minor injury / illness (level 2) to emergency departments as well as reduction in admissions.

A high level plan for the 'pillars' is appended providing further detail of those actions that are being progressed that support effective approaches to prevention, proactive

care and urgent care in respect of falls prevention for older people living with frailty and adults living with complexity.

Pillar Two – Shared Outcome and Whole System Alignment and Cohesive Delivery recognising that 'the sum is greater than the parts'.

Building Community Capacity Governance, Monitoring and Reporting

The greatest benefit of the 50 Day Challenge has been acknowledged as engendering effective collaboration across Regional Partnerships in Building Community Capacity across the 10 Best Practice Interventions. Further, in building our Integrated Community Care System (ICCS) the need for better alignment across policy and national programme has been recognised with constructive planning being realised through the ICCS Leadership Group. Revised governance, monitoring and reporting arrangements have been agreed by Ministers to ensure these efforts are sustained and enhance delivery towards a shared outcome. The revised governance is appended to this paper.

It is recognised that, to ensure whole system alignment and cohesive delivery a shared outcome is required.

The Outcome we Want?

We know that what matters to adults with complex needs / older people living with frailty is to remain as well and independent as possible in their own homes and connected to their communities. Our population outcome indicator is therefore considered to be 'healthy days at home' or alternatively 'independent at home'.

We are currently unable to systematically measure this outcome across Wales. The following system level indicators are suggested as reasonable proxy indicators and have been a core component of the Care Action Committee for Building Community Capacity since October 2023. Quality outcome measures should also provide us the patient / service user's experience.

These system indicators also allow us to monitor how the ICCS at Regional level may be optimising health and social care resource. Process measures should also be monitored that tell us 'how much' and 'how well' components of the system are delivering and subsequently contributing to impact on the system.

Ultimately, we would expect that our system contributes to reducing falls incidence, maintaining independence and avoiding conveyance and admission to hospital. As a minimum we should expect the following with implementation of relevant actions.

System Level Indicators	Process Measures	Targets Suggested

Proportionate Long Term Care Commissioning per 100k Reduction in Long Term Care Waits per 100k	Increased referrals to Reablement (Step Up from the Community) Increase District Nursing Capacity	Reduction in emergency transport to hospital (L1 and L2 falls specific) 10% against March 2025 baseline by December and 25% by March 2025
Reduction Emergency Admissions > 75s Reduction in Emergency Admissions LOS > 21 days	Increased referrals to Enhanced Community Care (Step Up from the Community eg Community Falls Crisis response)	Reduction in emergency admissions (L1 and L2 falls specific) 10% against March 2025 baseline by December and 25% by March 2025

A draft outcomes and measures framework is appended to provide some insight to the thinking however this work is in progress and being reviewed and finalised by senior leaders and officials from Welsh Government, NHS Executive, Public Health Wales, Health Boards, Local Authorities and Regional Partnerships.

Recommendations

EDT is asked to:

1. Acknowledge that the greatest impact to reducing the prevalence of falls requires a population health approach of frailty which focuses on prevention and will be most impactful through community interactions for ‘at risk’ populations.
2. Acknowledge that the 0.5% ‘most at risk’ population groups is not currently clearly defined, stratification approaches and population scope is variable and inconsistent nationally, regionally and pan-cluster.
3. Acknowledge that risk stratification is possible through GP systems utilising eFI and can contribute to integrating primary care and community services and effective management of the population
4. Acknowledge that the 0.5% ‘most at risk’ would naturally include individuals at high risk of falls and those residing in care homes and;
5. Agree that management of 0.5% most at risk is ‘one priority’ for 25 / 26 and Building Community Capacity (BCC) plans this Winter will include preventative, proactive and urgent care actions relating to falls, care home management and end of life care (where appropriate);
6. Acknowledge Proactive Care approaches are variable and inconsistent across Wales and would benefit from all Wales guidance outlining principles and standards and;
7. Acknowledge that Outcomes and Measures framework is in development;
8. Acknowledge high level plan outlining key actions attributed to two ‘pillars of improvement’
9. Acknowledge the revised Care Action Committee governance arrangements lend themselves well to providing oversight and seeking assurance on Building Community Capacity (including falls prevention) across policy, national programme and delivery partners

V0.4 with CB, ST and TC Comments considered

V0.4 with CB, ST and TC Comments considered

Appendix One – High Level Plan for Pillars of Improvement

Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities	Action	When	ByWho
Prevention **Low Risk, Rising Risk and High Risk Population Groups** Effective public health approach to the provision of timely targeted and accessible information, advice and assistance for falls prevention	Commission National Falls Task Group to bring together key players such as the Third Sector (eg Age Cymru, Care and Repair), Local Authorities, NHS, Community Housing Cymru and wider public sector organisations (Fire and Rescue) to map current activities, agree a shared approach and a targeted programme that will be delivered collaboratively to reduce duplication and ensure high level of falls prevention awareness across society. Task Force to also consider how Social Prescribing and Local Authority IAA services can support timely and targeted information and advice provision.	September	ICCS Leadership Group
Proactive Care Rising Risk and High Risk Population Groups Case Identification, Holistic Assessment, Future Care Planning, Care Coordination and Continuity of Care	Define 0.5% and its Scope and parameters for approach Publish Proactive Care Framework Issue Comms to Directors Primary Care / Senior Accountable Officers requesting submission BCC Joint Improvement Plans and trajectories Establish Regional Performance Meetings Quarterly IQPD focus on Building Community Capacity Increase use of TEC to proactively manage 'at risk' cohorts Continued focus on use of Telehealth in Enhanced Community Care	End June End June End July End July September TBC TBC	ICCS Leadership Group SPPC SPPC/ 6 Goals ICCSLeadership DDTIV& Leadership Group DDTIV

Cont'd overleaf

V0.4 with CB, ST and TC Comments considered

Pillar One - Population Health Management as a vehicle for prevention and reducing health Inequalities	Action	When	ByWho
Urgent Care Rising Risk and High Risk Population Groups SPOA for Urgent Care and equitable Crisis Response services for falls	Issue SPOA Framework for Urgent Care Improvement Plans submitted by Health Boards outlining implementation timeline Health boards to submit improvement plans for delivery against expected outcomes Monitor implementation through BCC 6 weekly Regional Monthly meetings	End June End July End July July onwards	6 Goals 6 Goals SPPC and Six Goals

V0.4 with CB, ST and TC Comments considered

Pillar Two–Shared Outcome and Whole System Alignment and Cohesive Delivery	Action	When	ByWho
What is the Outcome we Want? How do we measure improvement / What are the Measures?	Agree overarching population and system outcome Agree improvement (process) measures across ICCS components Demand & Capacity Modelling	End June August	ICCS Leadership Group SSID / DDTIV
Compendium of Frameworks or Guidance for 'what success looks like' for ICCS and Building Community Care Capacity priority Maturity Matrix for ICCS would be helpful to benchmark Regional position	Create a repository of Frameworks and guidance documents e.g SPOA Urgent Care, Integrated IAA Community Coordination, Proactive Care, PHM etc Develop and publish a Maturity Matrix for PHM and components of ICCS	End June	ICCS Leadership Group
Delivering the ICCS through PHM requires collective approach across policy and national programmes – reducing disconnect and silos / aligning resource	Collectively known as **Building Community Capacity (BCC)** priority and delivers preventative, proactive and urgent care actions that improve outcomes for people (care closer to home) and the system Winter Plan Alignment to the ambition Approve BCC (ICCS) governance beyond CAC	End June	EDT

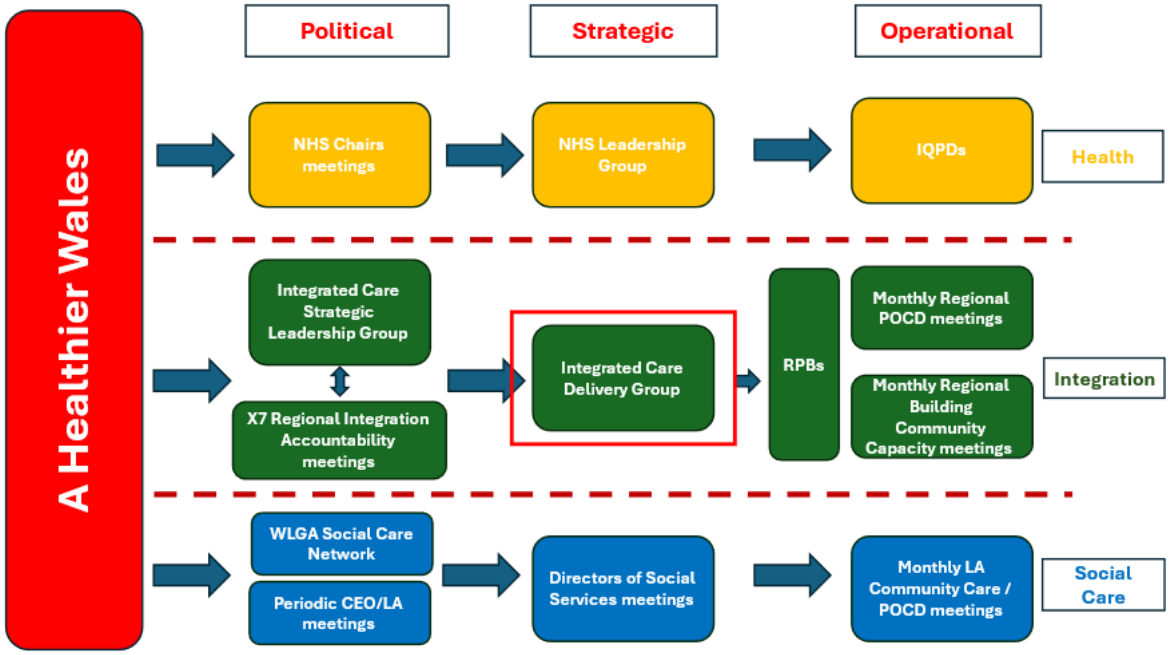
V0.4 with CB, ST and TC Comments considered

Appendix Two DRAFT Outcomes and Measures Framework 'The Outcome we Want'

Population / Quality & Experience	Well and Independent	Improved Patient Experience	Reduced deconditioning in the community				
System Resilience (Proxy for Independent at Home)	Count of People receiving Social Care in the Community per 100k (will increase with demographic)	Count of People waiting for Social Care in the Community per 100k (reduce, stabilise or grow relative to demographic	Reduction Emergency Admissions to Hospital > 75s (Reason Codes Falls / Collapse)	% Emergency Admissions LOS > 21 days	Reduction in Transport to ED for L1 and L2 fallers (10% end December and 25% end March 2026)	Reduction in Admission for L1 and L2 fallers (10% end December and 25% end March 2026) Against March '25 baseline	
System Process Measures	% of individuals identified as being at risk who have been offered holistic assessment and Future Care Planning (Should be 100%)	Number of Future Care Plans in place	District nursing capacity at weekend in at 80% of that of weekday	Increase number of referrals to reablement and enhanced community care (Against March '25 baseline)	% of urgent care response to crisis (falls) responded to within 2 hours during core hours (8am - 8pm 7/7)	Care Home Consult before Conveyance *Measure TBC*	Number of contact assessed in HB SPOA as benefiting from redirection to community service provisions and % that were referred to community pathways with successful outcome *Measure TBC*

V0.4 with CB, ST and TC Comments considered

Appendix Three: Revised Governance, Reporting and Monitoring Structure



V0.4 with CB, ST and TC Comments considered

Quality, Safety and Improvement Committee Work Plan 2025-2026

Category	Item	Exec Lead	Approval Route	Private/ Public	June	Sept	Nov	Feb	Purpose of the report	Cross Cutting Approach: Remitted *(to be populated in year with any referrals to be included in the reporting)*	Cross Committee Theme	Cross Cutting Approach	Assurance Mapping: Board Assurance Map	Why is it on the work plan?
Deep dives	Complaints and Incidents	Executive Director Nursing, Quality, and Information Governance	Exec Lead	Private	✓				Deep dive for assurance. Deep dives provide an holistic overview and a detailed look into a particular area or service covering the following themes : - Performance - Governance Arrangements - Key risks - Improvement approach / Quality Links with Strategic Objectives Forward Look / next steps for the programme of work. Refer to Deep Dive Guidance for content requirements.	None			**Performance** **Risk** **Quality** **Strategic Objectives** **Compliance with Statutory Duties**	These topic areas have been chose, based on timeliness, specific work being undertaken in these areas and cross referenced previous deep dives to ensure the breadth of coverage across the organisation. Once had the deep dive, would then report back to the Committee 6-8 months to update on progress with implementation of the workplan, for assurance.
	Health and Safety	Executive Director Operations and Finance	Exec Lead	Public		✓								
	Lung Cancer Screening	National Director of Health Protection and Screening Services, Executive Medical Director	BET	Public			✓							
	Infection Services		BET	Public				✓						
Clinical Governance	Claims and Redress Report (Private Session)	Executive Director Nursing, Quality, and Information Governance	BET	Private	✓	✓	✓	✓	For assurance that claims are being managed in line with the Claims Management Policy and Procedure.	None			**Clinical Governance / Compliance with Statutory Duties**	Referenced in the Committee TOR: For assurance on the management of the incident...evidence of a culture of reporting and learning lessons with an emphasis on continual improvement, arising from SIs. (ToR 1.7)
	Quality Governance Performance Report		BET	Private/ Public	✓	✓	✓	✓	For assurance on how the organisation has discharged its responsibilities Relating to: IPC Safeguarding Quality and Candor Putting Things Right Quality and Clinical Audit Clinical Governance Framework Implementation					Referenced in the Committee TOR: 1.3 Assurance on effectiveness of quality related frameworks 1.4 Ensuring consistent with Board strategic direction and requirements for NHS Bodies and improvement in standard of quality across the org 1.5 implementation of effective quality management arrangements 1.7 Sources of internal assurance Quality/clinical audit 1.8 assurance on effective arrangements for PTR, IPC, Safeguarding, 1.9 Compliance with the Quality and Engagement Act (Quality and Candour Act)
	Quality Annual Report 2024/25		BET	Public		✓			For oversight, scrutiny and assurance of compliance with the act.					Referenced in the Committee TOR: 1.9 Compliance with Quality Act 1.5 implementation of effective quality management arrangements
	Putting Things Right and Duty of Candour Annual Report 2024/25		BET	Private/ Public	✓				For assurance that there are effective arrangements in place for Putting Things Right, in line with our statutory responsibilities and oversight, assurance of compliance with duty of Quality and Candour Act.					Referenced in the Committee TOR: 1.8 assurance on effective arrangements for PTR, IPC, Safeguarding, 1.9 Compliance with Quality Act
	Quality and Clinical Audit Plan Annual Report 2024/25 and Forward Look 2025/26		LT	Public		✓			To provide the Committee with the Year End report on the Quality and Clinical Audit Plan, for assurance on the progress. And to approve the content of the Quality and Clinical Audit Plan for 2025-26 and the planned approach to the audits for the year.		Clinical Audit - ACGC	Low risk : no current issues identified		TOR: 1.7.1 internal assurance including clinical audit
	Staff Flu vaccination campaign Annual Report 2024/25 and Forward Look 2025/26		BET	Public		✓			The Internal Flu Vaccine Campaign end of year report and for assurance regarding the uptake of influenza vaccinations.		Workforce - PODC	Low risk : no current issues identified		TOR: 1.2 Assurance on systems in place to demonstrate quality services, programmes and functions provided by PHW
	National Safeguarding Service Annual Report 2024/25 and Forward Look 2025/26		BET	Public		✓			For assurance on how the organisation has discharged its National Safeguarding responsibilities on an annual basis	None				TOR: 1.8 assurance on effective arrangements for PTR, IPC, Safeguarding,
Engagement/ Equality	Engagement of our Services	Executive Director Nursing, Quality, and Information Governance	BET	Public			✓		For assurance on the arrangements in place to monitor the voice of the service user and/or the citizen as being central to improving the quality and effectiveness of services, functions and programmes. Demonstration of the CIVICA System. (ToR 1.10)	Equality -discussed at PODC and the need for clarity on how the Committees take collective assurance on the entirety of the Equality agenda.	Equality - PODC	Low risk : issues identified currently needing further review		Referenced in the Committee TOR: 1.10 assurance on arrangements to monitor service user voice
Health Protection	Winter Planning / Seasonal Planning	National Director of Health Protection and Screening Services, Executive Medical Director	Exec Lead	Public		✓	✓	✓	For assurance on the arrangements in place for the management of screening services ensuring the appropriate systems and processes in place that demonstrate quality, safety and effectiveness.	None			Performance / Clinical Governance	Referenced in the Committee TOR: 1.1 Ensuring governance arrangements to ensure provision of high quality and safe public health services and functions
	Emergency Preparedness, Resilience and Response Annual Report 2024		BET	Public	✓				For assurance that the organisation is meeting its statutory requirements in relation to the management of Emergency preparedness, resilience and response.				Compliance with Statutory Duties	Referenced in the Committee TOR: 1.8 effective arrangements...civil contingencies Act
	Medicines Management		Exec Lead	Public			✓		For assurance that there are effective arrangements in place for Medicine Management.				Clinical Governance	Referenced in the Committee TOR: 1.8 Statutory requirements
	Screening Service Update		Exec Lead	Public		✓		✓	For assurance on the arrangements in place for the management of screening services ensuring the appropriate systems and processes in place that demonstrate quality, safety and effectiveness.		Data and Digital - KRIC	Low risk : no current issues identified	Performance Clinical Governance	Referenced in the Committee TOR: 1.1 Governance of HP&SS
Population Health	Population Health Programmes	National Director Health and Wellbeing	Exec Lead	Public			✓		For assurance on the arrangements in place for the management of population health programmes, ensuring the appropriate systems and processes in place that demonstrate quality, safety and effectiveness.		Data and Digital - KRIC	Low risk : no current issues identified	Performance	Referenced in the Committee TOR: 1.1 Governance arrangements of programmes, inc Population Health and Health Improvement Programmes
	Oral Health Update		Exec Lead	Public				✓	For assurance on the arrangements in place for the management of population health programmes, ensuring the appropriate systems and processes in place that demonstrate quality, safety and effectiveness.	None				Referenced in the Committee TOR: 1.1 Governance arrangements of programmes, inc Population Health and Health Improvement Programmes
Health and Safety	Health and Safety Annual Report	Executive Director Operations and Finance	BET	Public	✓				For assurance that appropriate measures are in place to monitor compliance with Health and Safety requirements, and to address areas identified for improvement.		PODC - Workforce	Low risk : no current issues identified	Compliance with Statutory Duties	Referenced in the Committee TOR: 1.8 Statutory requirements
	Health and Safety Quarterly Report		BET	Public	✓	✓	✓	✓						
	Health and Safety Terms of Reference		BET	Public		✓			For assurance that the planned activity for the year fulfils the requirements of the group, as a sub group of the Committee.					
	Health and Safety Work Plan 2025/26		BET	Public	✓				For assurance and assurance, that the planned activity for the year fulfils the requirements of the group, as a sub group of the Committee.					
Managing Risk	Strategic Risk	Executive Director Nursing, Quality, and Information Governance	BET	Public	✓	✓	✓	✓	For assurance that risks within the remit of the Committee are management appropriately.		Risk	Low risk : no current issues identified	Risk	Approach to risk outlined in the Risk Protocol and the BAF
	Corporate Risk Register		LT	Public	✓	✓	✓	✓				Low risk : no current issues identified		
Governance & Accountability	Summary of policies Bi-Annual Update		LT	Public	✓		✓		For assurance on the prioritisation and progress being made to review policies, procedures and other written control documents within the remit of the Committee and to approve any policies and procedures proposed to be removed from the register.				Policy and Governance Documents	Approach to Policies outlined in the Corporate Policies, Procedures and other written control documents Procedure, and the BAF

(Note – this is an indicative work plan, final agenda content will be agreed following discussion with the Chair and the Executive Leads.

Quality, Safety and Improvement Committee Work Plan 2025-2026										Cross Cutting Approach			Assurance Mapping	
Category	**Item**	**Exec Lead**	**Approval Route**	**Private/ Public**	**June**	**Sept**	**Nov**	**Feb**	**Purpose of the report**	**Remitted *(to be populated in year with any referrals to be included in the reporting)***	**Cross Committee Theme**	**Cross Cutting Approach**	**Board Assurance Map**	**Why is it on the work plan?**
	Policies for approval (as required)	Board Secretary and Head of Board Business Unit	LT / BET	Public	✓	✓	✓	✓	To approve policies and procedures within its remit, as outlined in the Policy, Procedure and other written control documents Policy.	None				Approach to Policies outlined in the Corporate Policies, Procedures and other written control documents Procedure, and the BAF
	Committee Annual Report 2025-26		Exec Lead	Public				✓	For recommendation to Board, to provide assurance that the Committee is fulfilling its terms of reference.				Board and Committee	Requirement within each of the Committee TOR to report to Board, and forms part of the assurance to the Board. Also feeds into our Annual Governance Statement.
	Review of Committee Effectiveness		Exec Lead	Public	✓			✓	As part of the overall Board and Committee Performance and Effectiveness review, the Committee will consider the outcomes of the Committee effectiveness survey, and identify any areas of improvement for the following year.					Outlined within the Board Assurance Framework as part of the annual review of effectiveness.
	Committee Terms of Reference Review		BET	Public	✓			✓	For recommendation to Board on any proposed changes to the Committee's Terms of reference (As required under Standing Orders).					Required to be reviewed Annually within Standing Orders
	Committee Work Plan		Exec Lead	Public	✓	✓	✓	✓	For information, and for assurance that the Committee is fulfilling its terms of reference.					Requirement within each of the Committee TOR to report to Board, and forms part of the assurance to the Board. Also feeds into our Annual Governance Statement.
Audit and other Reviews	Audit Action Log Progress Update (within the remit of the Committee)	Board Secretary and Head of Board Business Unit	Exec Lead	Public	✓		✓		Update on the implementation of the management response to the audit, for assurance.		**Audit**	Low risk : no current issues identified	Audit	Approach to Audit outlined in the Audit Protocol and within the BAF.
	Audit Report (as needed)	Relevant Executive Lead	Exec Lead	Public	✓	✓	✓	✓	Where the subject matter of an audit report falls within the remit of one of the other Board Committees, the report is also submitted to that Committee, following consideration at ACGC. (Refer to Audit Protocol). The role of the Remit Committee is to receive the report and to consider the recommendations made in the context of its work plan, and the areas of focus within its remit. Where relevant, the information contained in the reports will then be used to inform discussions of items on the work plan for the Committee.		**Audit**	Low risk : no current issues identified		Approach to Audit outlined in the Audit Protocol and within the BAF.
NHS Wales Performance and Improvement	NHS Executive Governance Compliance Report	NHS Executive	BET	Public	✓	✓	✓	✓	To provide the Committee with assurance on the NHSE Compliance with the following areas: Health and Safety, National Reportable Incident Reporting , Complaints (including PTR if applicable), Claims reporting, DATIX, Safeguarding	None			NHSE Assurance	
	NHS Executive Annual Compliance Statement		BET	Public		✓			To provide the Committee with: Duty of Quality compliance, Duty of Candor compliance, Socio Economic Duty compliance, Wellbeing of Future Generations Act Compliance, Emergency Planning, Clinical Governance					

Changes to the Committee since it was last presented to the Committee are shown in red:

- From October 2025, the approval route for Deep Dives will be BET
- An Extrodinary Committee meeting was held on 26 August 2025 to approve the Duty of Quality Annual Report
- The NHS Executive has been renamed NHS Wales Performance and Improvement

(Note – this is an indicative work plan, final agenda content will be agreed following discussion with the Chair and the Executive Leads.

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 29th September 2025 **Agenda item:** 8

NHS Wales Performance and Improvement – Quality, Safety and Improvement Committee (QSIC) Quarterly Assurance Report (1)

Report Sponsors:	Claire Green, National Director of Financial Planning & Delivery and Responsible Officer Iain Hardcastle, National Director of Networks and Planning
Report Author:	Louise Cooke, Corporate Governance Support Manager
Approval/Scrutiny route:	Approval/scrutiny for NHS Wales Performance and Improvement is via the Senior Leadership Team (SLT). This report was approved at the Monthly Business Meeting on 10/07/25. Business Executive Team – 20/08/25

Purpose

The purpose of this report is to provide a quarterly assurance report to the Quality, Safety and Improvement Committee, on the relevant governance compliance areas as outlined in the NHS Wales Performance and Improvement Assurance Schedule 2025-26.

This report covers the period 1 April 2025 to 30 June 2025 and provides assurance on the following areas.

- Health and Safety Compliance
- National Reportable Incident Reporting compliance
- Complaints (including PTR if applicable) compliance
- Claims reporting
- DATIX compliance
- Safeguarding compliance

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

The Committee is asked to:

Health and Safety

- **Take 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

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

Complaints (including PTR if applicable) compliance

- There have been no complaints received for this period to report to Committee.

Claims reporting (staff and third-party claims)

- **Note 1 claim** received this period and **take assurance** that Claims within the NHS P&I are being appropriate managed.

DATIX compliance

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

Safeguarding compliance

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

Link to Public Health Wales Strategic Plan

Public Health Wales is the Host Organisation for the NHS Wales Performance and Improvement ('the Hosted Unit'). The *Hosting Agreement ('the Agreement') between Public Health Wales (PHW) NHS Trust and The Welsh Ministers* was approved by the PHW Board on 26th January 2023 and took effect from the launch of NHS Wales Performance and Improvement on 1st April 2023.

The Agreement remains extant and, to take account of variations to the Agreement, an Addendum was approved by the PHW Board on 28th March 2024.

Public Health Wales is not responsible or accountable for setting the direction for, or the work programme of, the Hosted Unit or for the delivery/quality or management of work undertaken by the Hosted Unit on behalf of Welsh Government.

Summary impact analysis	
Equality and Health Impact Assessment	A specific Equality and Health Impact Assessment (EHIA) is not required to support of this report.
Risk and Assurance	This report provides assurance on the implementation of the relevant policy and

	Procedures within the NHS Wales P&I, ensuring good governance is maintained.
Health and Social Care (Quality and Engagement) (Wales) Act	This paper supports the Quality themes.
Financial implications	There are no financial implications as a result of this report.
People implications	There are no people implications as a result of this report.

1. Purpose / situation

The purpose of this report is to provide a quarterly assurance report to the Audit and Corporate Governance Committee, on the relevant governance compliance areas as outlined in the NHS P&I Assurance Map.

This report covers the period 1 April 2025 to 30 June 2025 and provides assurance on the following areas.

- Health and Safety Compliance
- National Reportable Incident Reporting compliance
- Complaints (including PTR if applicable) compliance
- Claims reporting
- DATIX compliance
- Safeguarding compliance

The sections below provide a summary of the current status for the areas listed above.

2. Health and Safety

As a Hosted Unit, NHS Wales Performance and Improvement (NHS P&I) operates within appropriate policies established by PHW in support of legislative compliance, and this includes legislation relating to health and safety.

The annual statement of compliance was completed for 2024-25 by the Responsible Officer (RO) for NHS P&I and submitted to PHW at the end of April, in support of the RO, all other SLT Directors complete individual compliance statements for their respective areas. Also, all SLT Directors receive an annual accountability letter from the Deputy Chief Executive of NHS Wales, which includes the requirement to discharge respective responsibilities under the hosting agreement.

During the reporting period there were three health and safety matters recorded as incidents on Datix. Two were related to accident and injury with one reported by PHW under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and one requiring no further action. One related to fire alarm testing and remedial action is in hand.

PHW provided advice on the new tenant operating out of the ground floor at River

House and the related structural changes. There was an outstanding issue with the fire alarm that has been remedied.

Compliance with statutory and mandatory training is reported monthly to the SLT, within a broader People and OD Report provided by PHW POD colleagues. As of **2 July 2025**, compliance for health and safety and related themes was:

Competence Name	Assignment Count	Required	Achieved	Compliance %
Fire Safety - 2 Years	480	480	445	92.71%
Health, Safety and Welfare - 3 Years	480	480	459	95.63%
Moving and Handling - Level 1 - 2 Years	480	480	445	92.71%

In addition to the health and safety modules accessed via ESR and reported via the monthly POD report (as above), arrangements have been made to provide access for staff to the '*Health and Safety for Homeworkers*' training module. With the support of the PHW Health & Safety Advisor, this is being managed with individual divisions to validate staff details and to monitor compliance. A new Induction Working Group will be standardising the approach to new starters across the division which will include this module.

3. National Reportable Incident Reporting compliance

The reporting arrangements outlined in Section 2, apply.

There have been no Nationally reportable incidents reported for this period.

4. Complaints (including PTR if applicable) compliance

The reporting arrangements outlined in Section 2, apply.

There have been no complaints reported for this period.

5. Claims reporting

The reporting arrangements outlined in Section 2, apply. There was one claim submitted during this period to an Employment Tribunal. The claim is being managed in accordance with PHW processes via People and OD and in line with advice from Legal and Risk Services.

6. DATIX compliance

The reporting arrangements outlined in Section 2 apply.

There were seven incidents reported through Datix during this period.

Three were related to Health and Safety as detailed in Section 2, one being related to a breach of confidentiality, one related to loss of equipment and two to cyber security. Support from PHW teams including legal and Digital Health and Care Wales (Cyber) was sought in reviewing the response.

7. Safeguarding compliance

The reporting arrangements outlined in Section 2 apply.

There have been no safeguarding matters reported for this period

Compliance with statutory and mandatory training is reported monthly to the SLT, within a broader People and OD Report provided by PHW POD colleagues. As of **2 July 2025**, compliance for Safeguarding was:

Competence Name	Assignment Count	Required	Achieved	Compliance %
Safeguarding Adults - Level 1 - 3 Years	480	480	444	92.50%
Safeguarding Children - Level 1 - 3 Years	480	480	442	92.08%

There have been no safeguarding concerns raised for this period.

8. Conclusion

The report provides assurance to the Committee that the NHS P&I is meeting the requirements for each of the areas reports.

There are no concerns to bring to the attention of the Committee in any of the areas listed.

9. Recommendation

The Quality, Safety and Improvement Committee is asked to:

Health and Safety

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

National Reportable Incident Reporting compliance

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

Complaints (including PTR if applicable) compliance

- **Note** there have been no complaints received for this period to report to Committee.

Claims reporting

- **Note 1 Claim** received this period and **take assurance** that Claims within the NHS P&I are being appropriately managed.

DATIX compliance

- **Note 7 Incidents** reported on Datix for this period and **take assurance**

that the appropriate process has been followed within the NHS P&I, to manage these incidents.

Safeguarding compliance

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