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)	
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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.

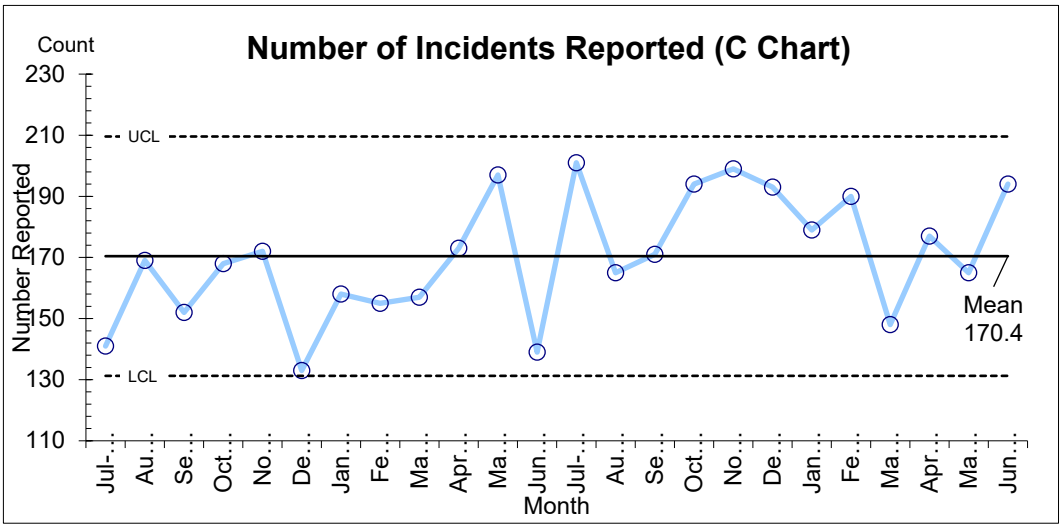
	Moderate Harm- Post investigation	Severe harm- Post investigation	Catastrophic/ Death- Post investigation
Quarter 1 2025/26	1	0	0
Quarter 4 2024/25	1	0	0

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.

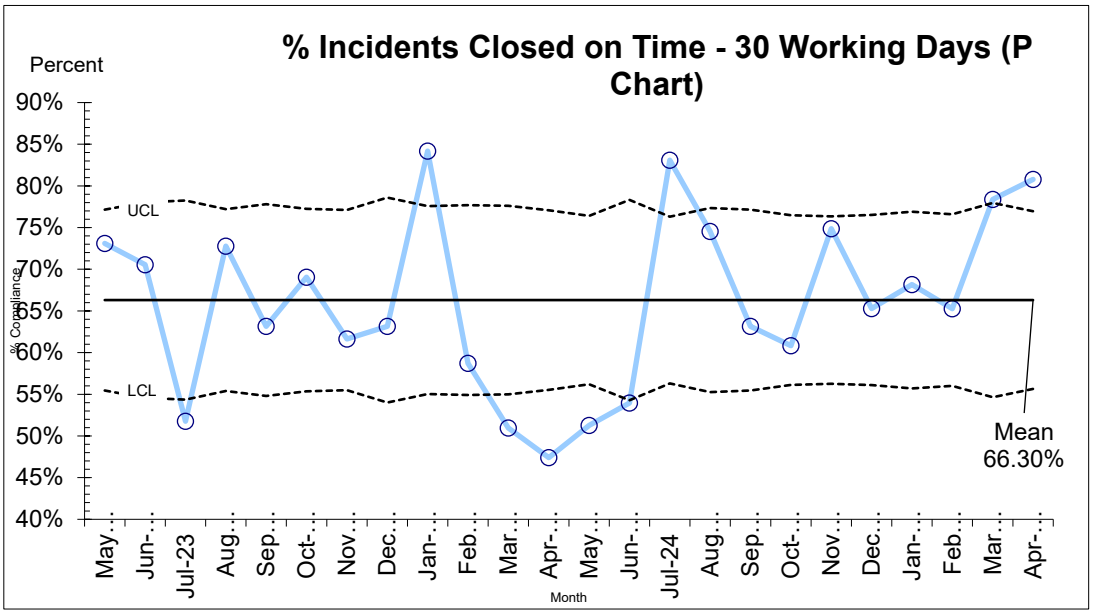
Open Incidents

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

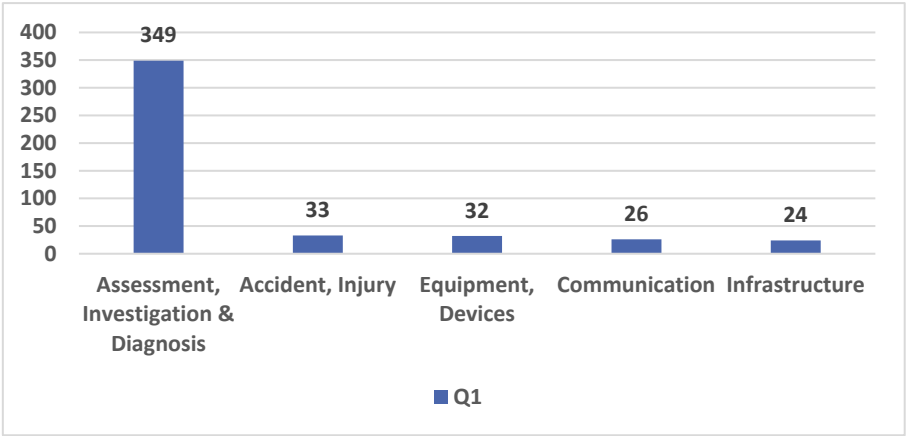


Chart 5. Top 5 incident classifications

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

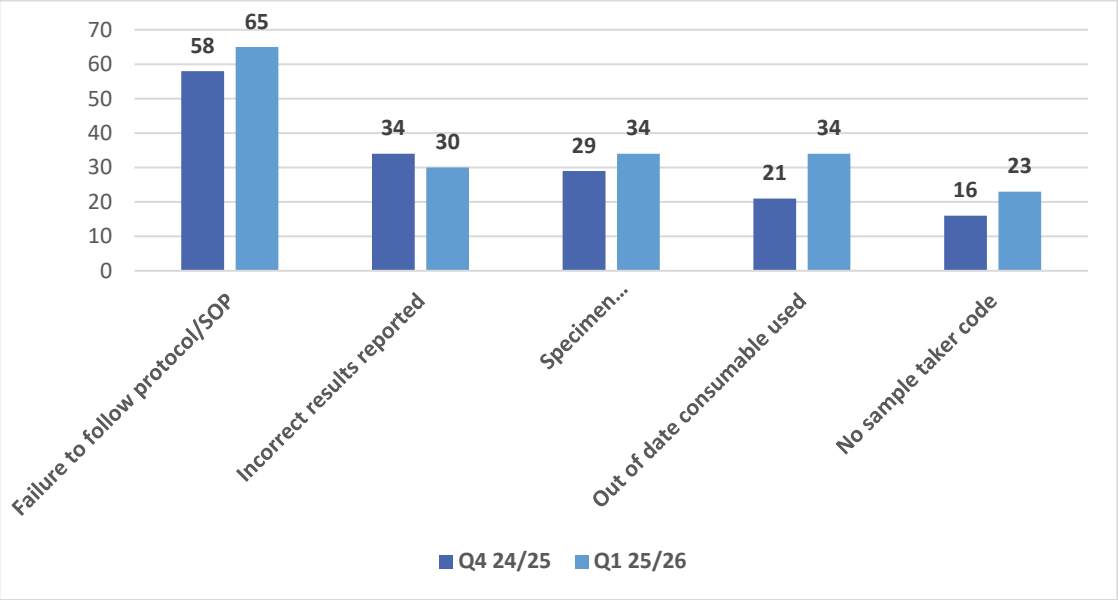


Chart 6. Top 5 sub-categories

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:

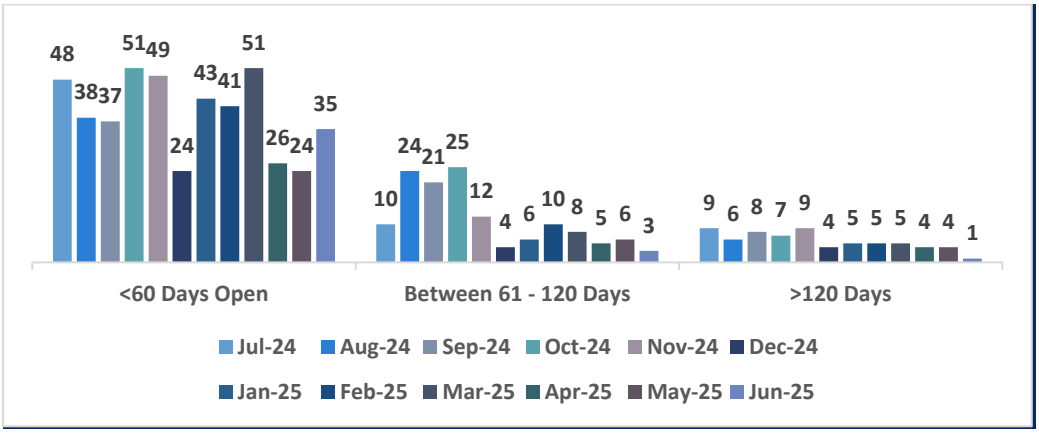
- The Standard Operating Procedure (SOP) has been amended to clearly state that vials may only be used if there is at least 14 days remaining before their expiry date.

- 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.

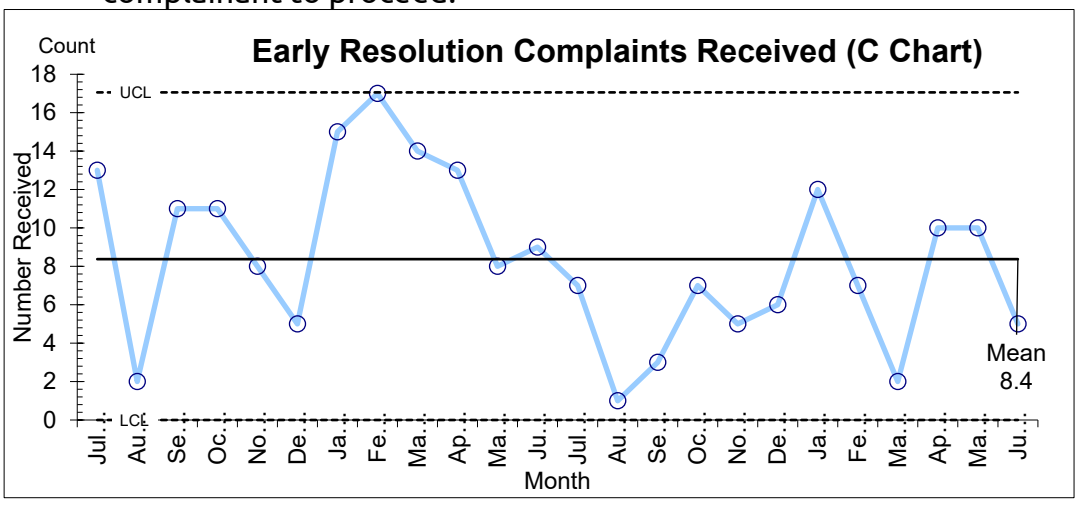
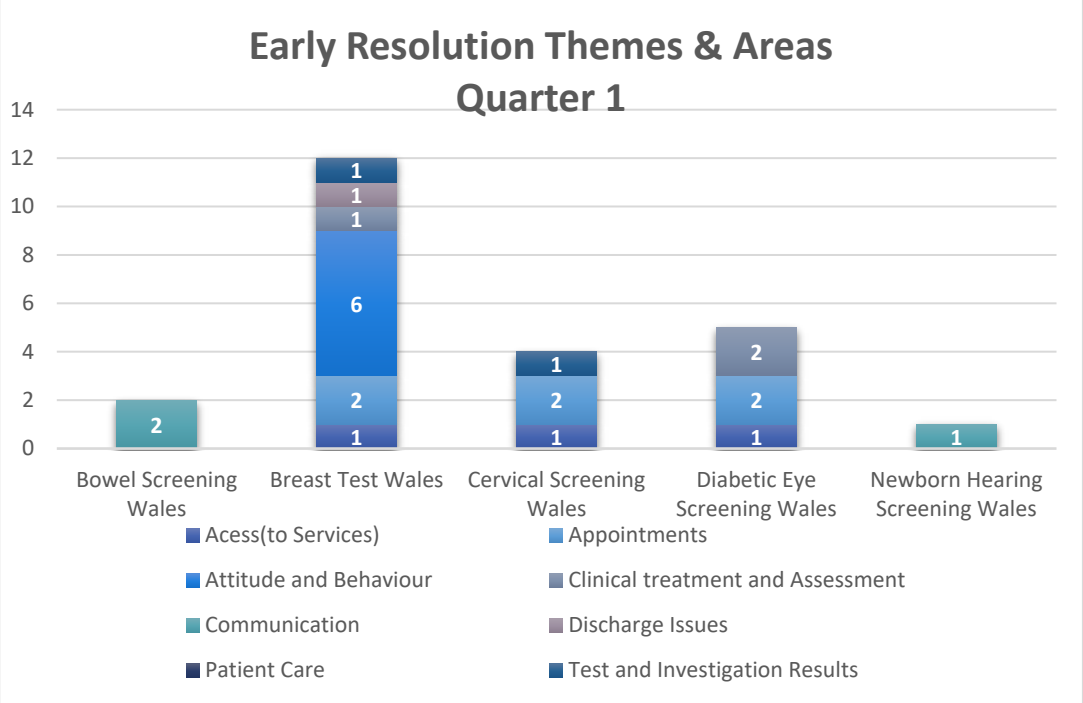
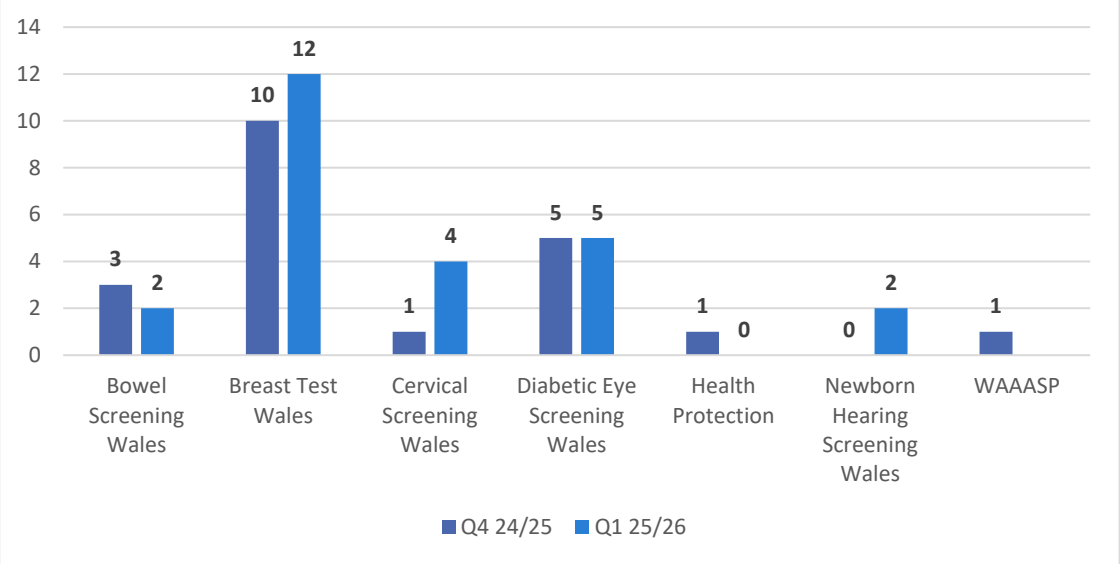


Chart 7. Informal complaints received per Month



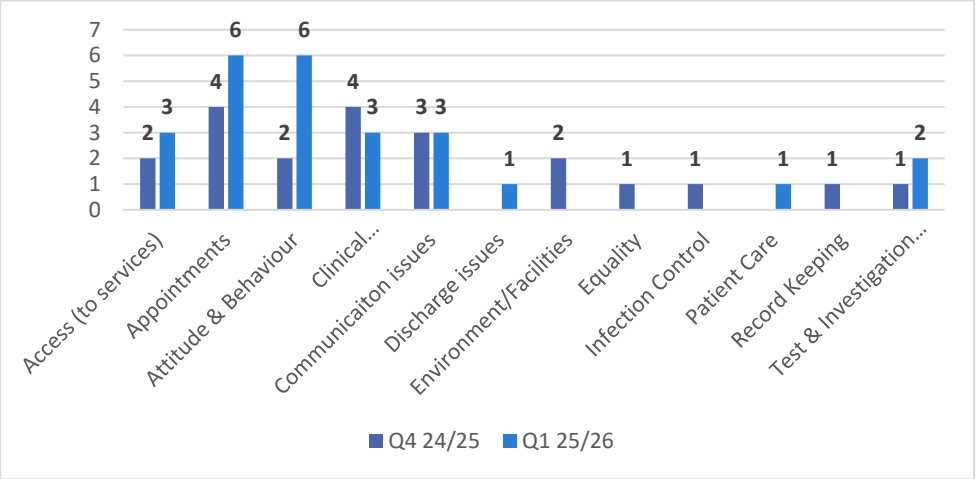
The below chart details the service areas where Early Resolution complaints have been received during each Quarter and provides the previous quarters data for comparison.



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.

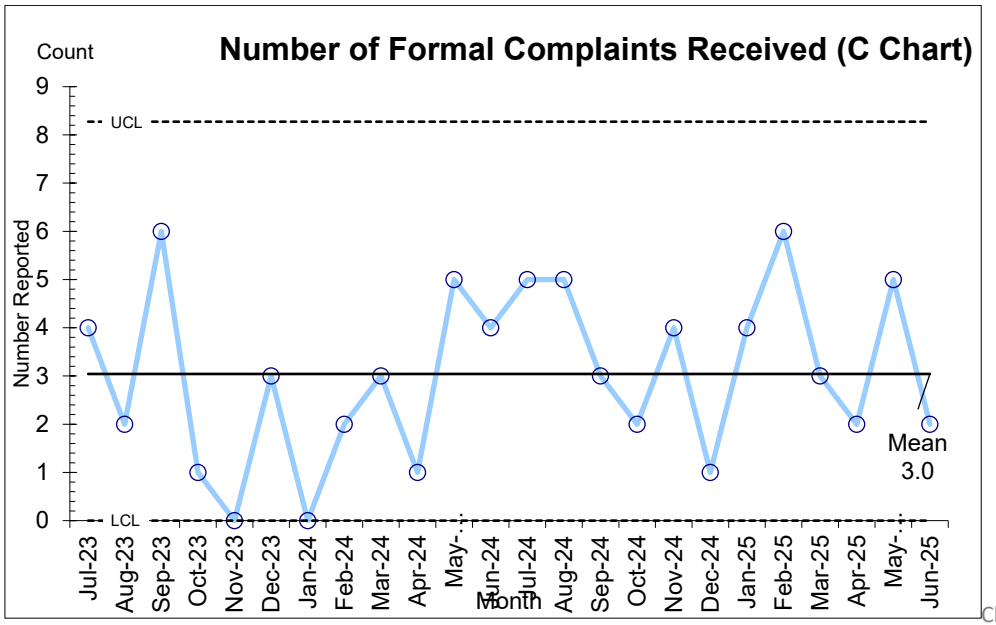
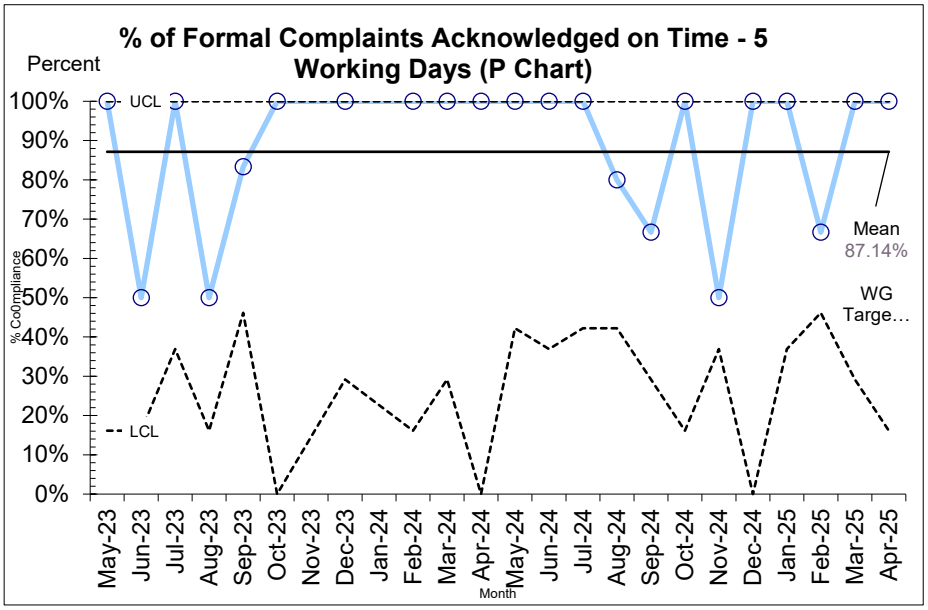
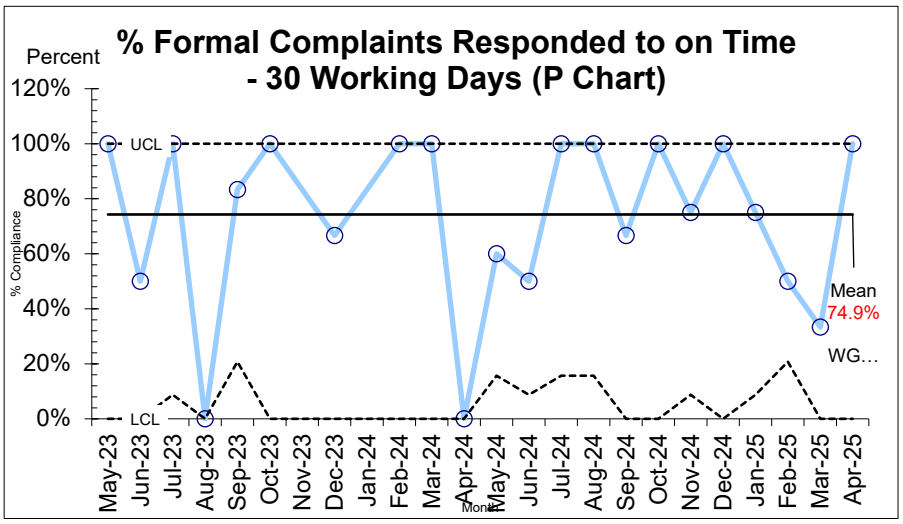


Chart 9.

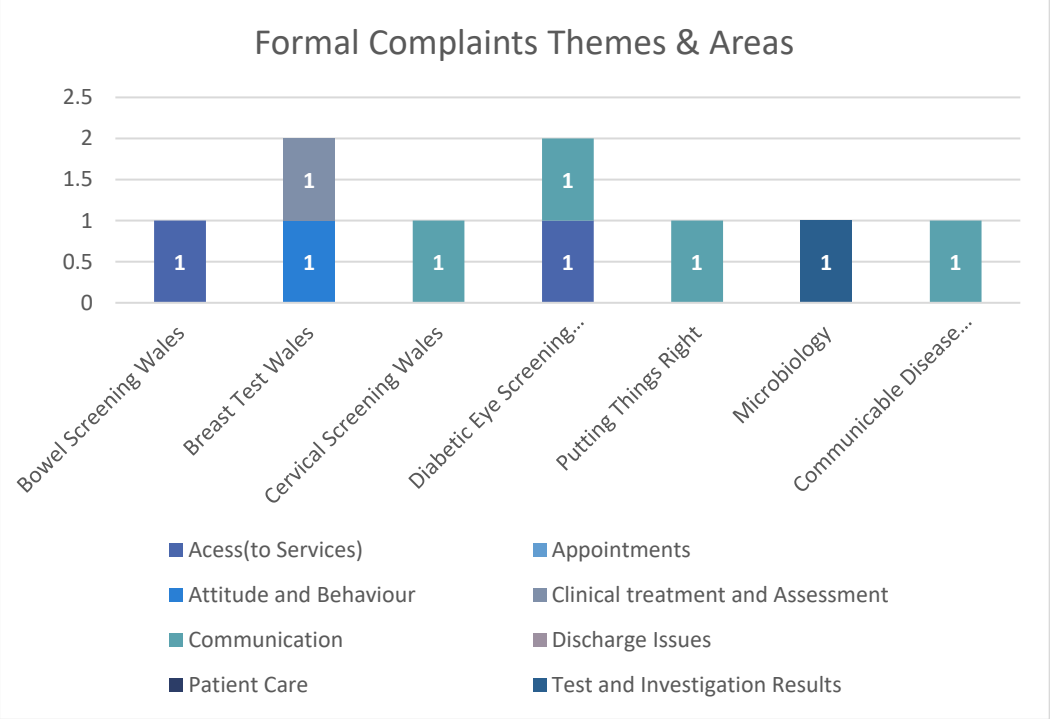
Formal complaints received per month

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

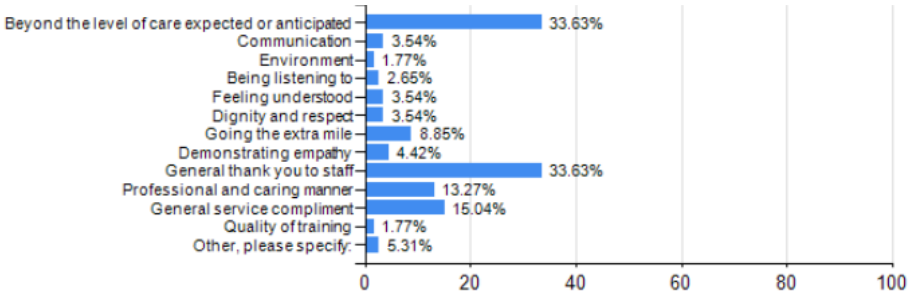
4. Compliments and Service User Experience

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.

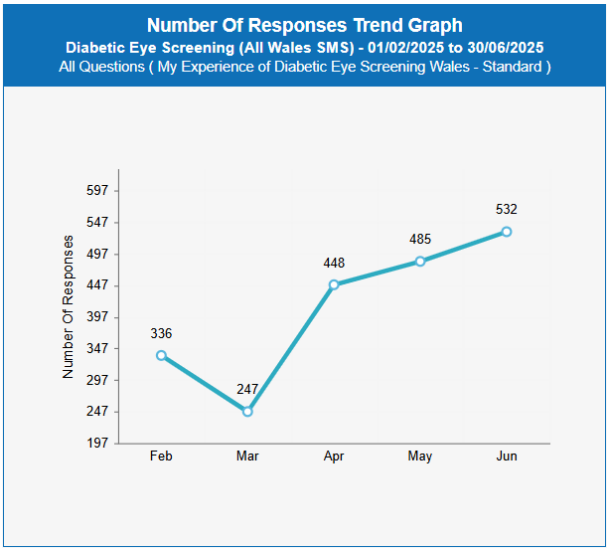
The current operational delivery model for Antenatal and Bloodspot screening poses some challenges in capturing experience and feedback. Conversations between Head of Antenatal Screening and NHS Performance and Improvement are underway on how best to utilise the experience information collated through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

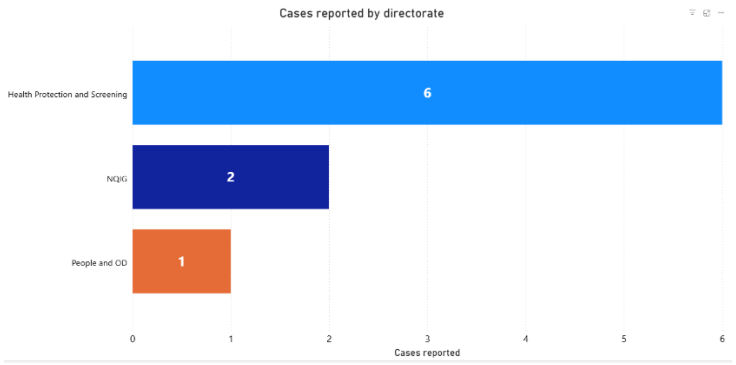


Chart 5.1 Cases Reported by Directorate

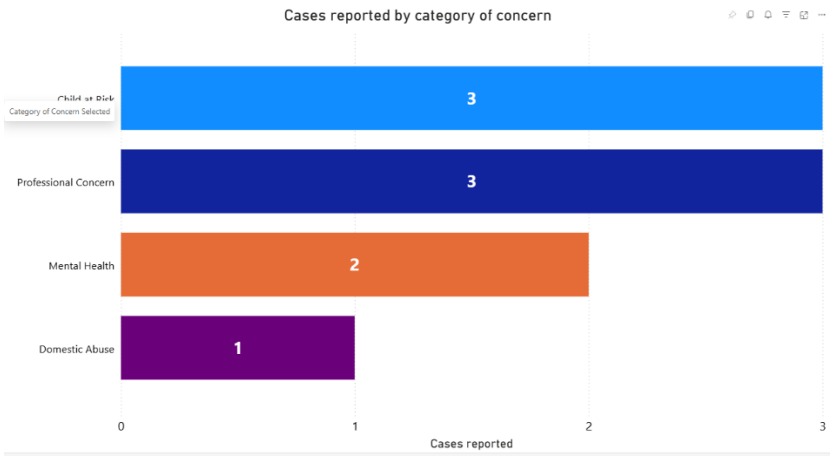


Chart 5.2 Cases reported by category of concern

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.