GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 25th November 2024 **Agenda item:** *4.1*

Quality Governance Performance Report Quarter 2(1st July – 30th September) 2024/2025	
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Approval/Scrutiny route:	Business Executive Team – 6.11.24 Angela Cook, Assistant Director of Quality and Nursing

Purpose

The Quality Governance Report provides the Quality Safety & Improvement Committee (QSIC) with an overview of quality governance within Public Health Wales for the period Quarter 2 (1st July to 30th September 2024). It incorporates the two domains of a quality management system; quality assurance and quality improvement. Quality control is provided within the Integrated Performance Report, which contains quality measures at organisational level. The report provides specific updates and assurance on:

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

- The work of the Infection Prevention Control Group

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

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

The Committee is asked to:

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

Link to Public Health Wales Strategic Plan

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

This report contributes to the following:

Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives
Strategic Priority/Well-being Objective	Choose an item.
Strategic Priority/Well-being Objective	Choose an item.

Summary impact analysis	
Equality and Health Impact Assessment	No Equality and Health Impact Assessment is required. 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 (Incident, complaint Section (page 7).

- 541 incidents were reported during Quarter 2, investigated and remedial actions identified. Of these, 16 were initially reported as moderate harm or above.
- 1 Nationally Reported incident and 1 Early Warning Report were submitted this quarter.
- As of 1 July 2024, there are 66 incidents on Datix with an 'open' status of more than 30 working days.

Safeguarding of Adults & Children at risk (page 22)

- 13 safeguarding incidents were raised at PHW sites with varying themes behind those safeguarding reports.
- Safeguarding training compliance continues to improve and remains above the Welsh Government target of 85%.
- There is 1 safeguarding risk on the corporate risk register which relates to Disclosing and Barring (DBS) checks within PHW.

Infection Prevention & Control (page 26)

- There were 21 IPC incidents reported in Quarter 2. 2 moderate harms were reported and remain under investigation with the remaining incidents assessed as no or low harm.
- Compliance with Cleaning standards within some Screening services has raised some concerns, and further actions are being put in place to address these.
- IPC level 1 and 2 training levels have improved since the last quarter and is now above the Welsh Government targe.

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 13)

- 11 Early Resolution complaints were received in Quarter 2 and 13 formal complaints.
- 64% of the early resolution complaints were resolved within 2 working days target. All 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 19)

The Quality and Clinical Audit Interim Report for 2024-25 is being presented to QSIC at the same time as this report for assurance for progress against the plan. The Quality and Clinical Audit Team have engaged with all areas undertaking audit to evaluate progress against the draft plan and an update is included in this report.

Safety Alerts Management (page 16)

- 46 alerts were received in Quarter 2, of which 3 of which required the action of disseminating for information.

Do we provide person centred services?

By person centred we mean our services meet the needs of the people we work with and for to ensure that their preferences, needs, and values are considered and guide decision-making.

Compliments (page 15)

- 135 Compliments were received this quarter of which 'Beyond the level of care expected or anticipated' was the highest recorded compliment category with 62.96%.

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

1. Purpose / situation

The purpose of this report is to provide information on quality performance during Quarter 2 2024-25 and provide updates from Public Health Wales governance subgroups to provide assurance for the following areas of work:

- Putting Things Right
- Claims Management
- Alerts Management
- Quality and Clinical Audit
- Infection Prevention Control
- Safeguarding

This report supports the achievement of quality through the following:

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

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

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

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

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

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

2. Putting Things Right

2.1 Nationally Reportable Incidents/Early Warnings/Never Events

Number in Quarter	Q3 Oct – Dec 23	Q4 Jan – Mar 24	Q1 Apr – Jun 24	Q2 Jul - Sep 24
Nationally Reportable Incidents reported to NHS Executive	1	0	1	1
Early Warning reports submitted to Welsh Government	0	0	2	1
Early Warning reports submitted and subsequently upgraded by Welsh Government to a Nationally Reportable Incident	0	0	0	0
Never Events	0	0	0	0

One **Early Warning** Incident and one **Nationally Reportable Incident** were reported by Diabetic Eye Screening Wales in July 2024. This incident was reported following a review of participants who had initially been excluded from the programme screening register as they were either medically unfit to attend or did not have a diagnosis of diabetes. It came to light that some of the people on this list had subsequently been re-referred back into the programme and had been marked as duplicate referrals and therefore not added to the screening list. A total of 115 participants who were now eligible for screening and not been invited. Since this issue was identified all the people affected are being offered a screening appointment. Of those who have now received retinal screening no harm has been identified to date.

Incident Management

Incidents

During Quarter 2, a total of 541 incidents were reported. This is an increase from the 465 reported in Quarter 2 of 2023/2024.
The below table indicates the number of moderate harm or above incidents recorded for each quarter.

	Moderate	Severe	Catastrophic/ Death
Quarter 3 (Oct – Dec 23)	1	0	0
Quarter 4 (Jan – Mar 24)	3	0	0
Quarter 1 (Apr – Jun 24)	23 (17 downgraded, 6 ongoing investigation)	1 (downgraded to no harm)	0
Quarter 2 (Jul -Sep 24)	16 (12 downgraded, 2 ongoing investigation)	0	0

Previously the PTR team would review the initial level of harm associated with the incident and amend if appropriate the indicated harm level, however, as of 1 April the level of harm initially reported has not been amended by the PTR Team.
This process has been changed and the harm level remains unchanged until the investigation is complete. This allows for more accurate reporting and supports the PTR team to identify areas for further learning and ensure the appropriate levels of harm are reported.

The most frequently reported incident categories are displayed in Chart 1 below:

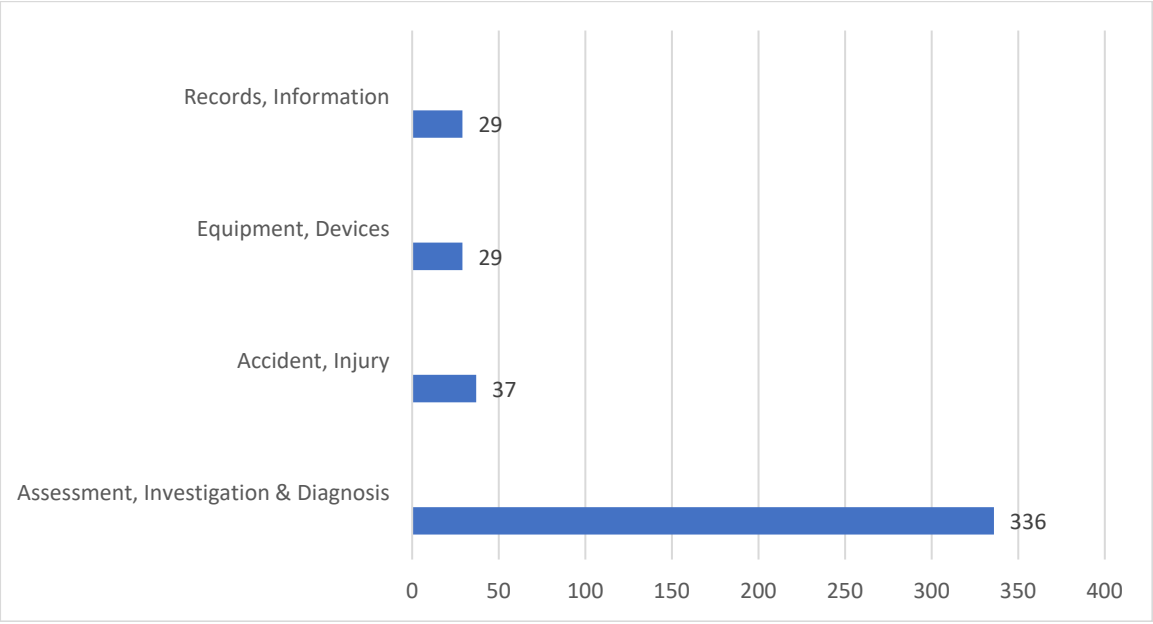


Table 1. Frequently reported incident categories

'Records, Information' has featured as a new frequently reported category this quarter, replacing 'Communication; that was reported in Quarter 1. 48% of these incidents have been reported by Diabetic Eye Screening Wales and commonly relate to incorrect information being documented on a participants record.

Chart 2 below indicates the highest five 'Assessment, Investigation, Diagnosis' subcategories reported for all Directorates compared with the numbers reported in Quarter 1 2024/2025.

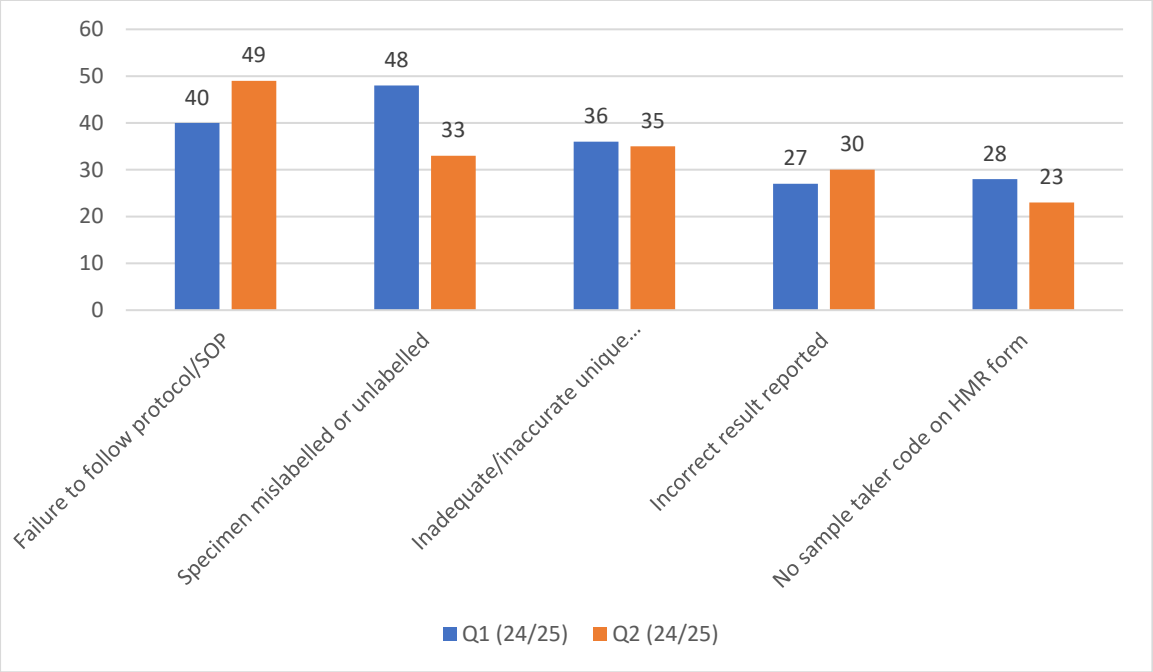


Table 2. Top five categories for subcategories

The highest reported subcategory has changed during this Quarter, from 'Specimen mislabelled or unlabelled' to 'Failure to follow protocol/SOP' being reported the most frequently to. 49 incidents have been reported under this category during this quarter, an increase of 9 compared to the 40 reported in Quarter 1. 24 (49%) incidents occurred in Diabetic Eye Screening Wales and 22 (45%) in Microbiology and 3(6%) in Cervical Screening Wales.

The second highest subcategory is 'Inadequate/Inaccurate unique identifiers' with 35 incidents reported during the quarter in this category. 34 (97%) of these incidents occurred within Cervical Screening Wales and 1 (3%) within Microbiology.

There has been an improvement this quarter in the number of incidents being reported within the category of 'Specimen mislabelled or unlabelled' equating to 34% reduction in this incident category by Cervical Screening Wales.

Open Incidents

As of 1 October 2024, there are a total of 66 overdue reported incidents within Datix that have an 'open' status of more than 30 working days. The highest number of open incidents are currently within Cervical Screening Wales (38), followed by Microbiology (11) and Diabetic Eye Screening Wales (7).

Chart 3 below shows the progression of overdue incidents throughout Quarter 1 and 2.

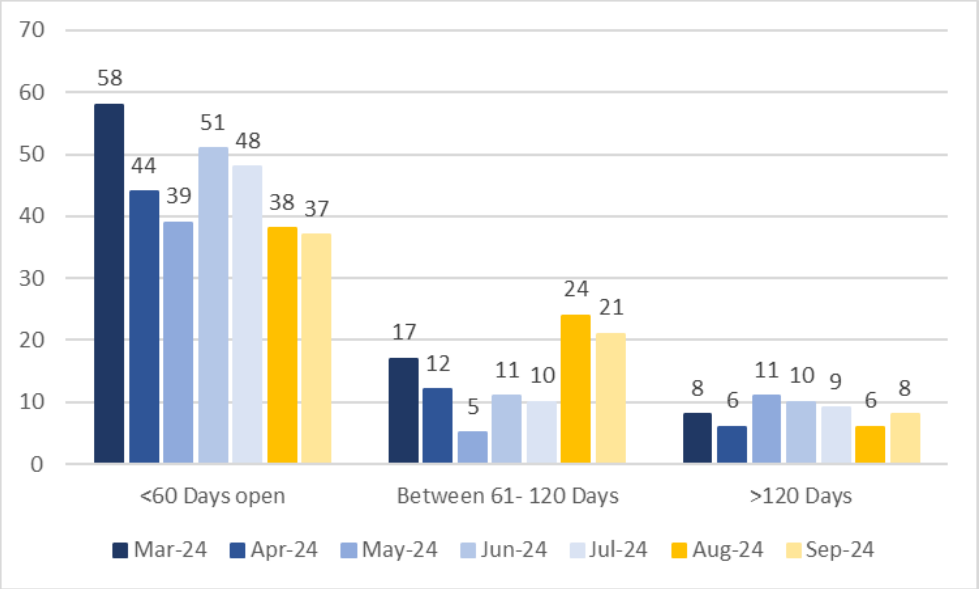


Chart 3. Overdue incident progression

Of the 66 overdue incidents, 8 (12%) have been open for more than 120 working days, with the oldest being open for 414 working days. This incident relates to an error within the Cervical Screening Information Management System (CSIMS) which has been investigated with digital services who are currently implementing a number of bug fixes within CSIMS and a bulk data amendment is ongoing. Cervical Screening Wales are meeting with Digital Services on a frequent basis to ensure this incident investigation is progressed and completed as soon as possible.

21 incidents (32%) have been open between 60 and 120 working days and 37 (56%) have been open for less than 60 working days.

Overdue incidents continue to be an area of concern and targeted work continues to improve this. Open incident data is supplied weekly to Datix leads for each service area and now also includes Directorate senior staff and business leads to support closure management with real time learning. In addition to this service areas receive notifications of incidents when they are at 20-29 days in attempt to prevent the incidents missing their closure date and becoming overdue.

The Executive Director for QNAHPs has been working with the PTR team and incident management teams to facilitate improvements in incident closure rates and will include a revised escalation process.

Incident Reporting and Management Training

During Quarter 2, Level 1 Datix incident reporting training has been delivered to 63 members of staff. 41% of Public Health Wales have now undertaken this training and increasing uptake of this remains a priority.
It should be noted that Datix training is not mandatory for PHW staff however all staff are encouraged to attend, with new starters being specifically targeted. Monthly training sessions are available to all staff throughout the organisation along with bespoke sessions with individual teams and divisions arranged as required.

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

2.2 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.

3 new Redress case were received in Quarter 2. 1 within Cervical Screening Wales and relates to the misinterpretation of a cytology slide. Causation is yet to be determined due to ongoing investigations from independent experts, and 2 in Breast Test Wales relating to misinterpretation of mammograms.

2.4 Complaints Management

Early Resolution Complaints (Informal)
Public Health Wales endeavours to deal with any complaints received by way of early resolution wherever possible.

11 Early Resolution complaints were received in Quarter 2. This is a large reduction on the 29 received during Quarter 1. 64% (7) of these complaints were resolved within the Putting Things Right target of two working days. 36% (4) were resolved outside of the target, but as soon as reasonably practical.

Delays occurred because either staff were unable to contact the complainant during the required timeframes, consent was not received in the required timeframe, or the investigator required further information prior to contacting the complainant to proceed.

The below chart indicates the service areas where Early Resolution complaints have been received during Quarter 2 and provides Quarter 1 (2024-2025) data for comparison.

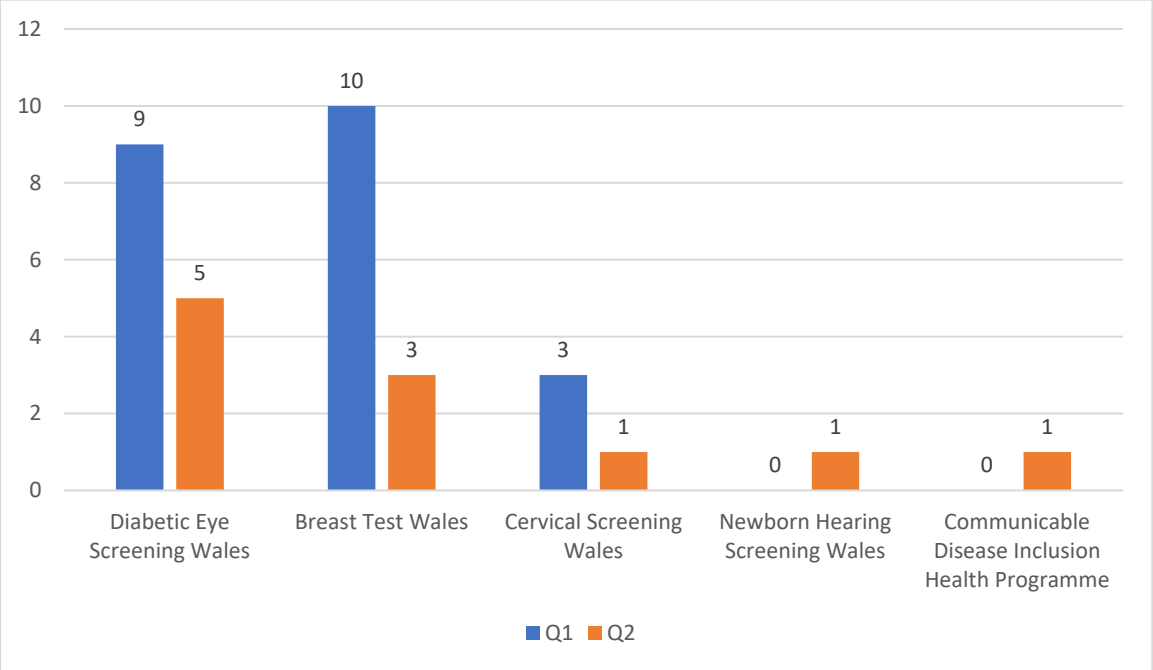


Table 3. Early Resolution Complaints by Area.

It should be noted that there has been a noticeable reduction in complaints received in Quarter 2 within some of the screening services, namely Diabetic Eye Screening Wales and Breast Test Wales.

Diabetic Eye Screening and Breast Test Wales continue to receive the highest volume of Early Resolution complaints.

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

- Communication Issues – (2)
- Appointments - (2)
- Access (To Services) – (1)
- Attitude and Behaviour – (2)
- Clinical Treatment/Assessment – (2)
- Environment/Facilities – (1)
- Equality – (1)

A review of these Early Resolutions complaints did not identify any additional learning.

Formal Complaints

During Quarter 2, 13 formal complaints were received, an increase of 3 compared to the previous Quarter.

The below table demonstrates the percentage of complaints responded to within target of 30 working days in this quarter.

Month	Number of Complaints	Acknowledged within 5 w/d	Responded to within 30 w/d
July 2024	5	100%	100%
August 2024	5	80%	80%
September 2024	3	100%	N/A (Not yet due for response)

12 of the 13 formal complaints received this Quarter were acknowledged within the 5 working day target.

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

Formal complaints received during Quarter 2 related to the following areas:

- Breast Test Wales **(5)**
- Bowel Screening Wales **(3)**
- Diabetic Eye Screening Wales **(3)**
- Cervical Screening Wales **(1)**
- Microbiology **(1)**

The formal complaint themes were recorded as follows:

- Communication Issues **(8)**
- Clinical Treatment/Assessment **(2)**
- Confidentiality **(1)**
- Access (To Services) **(1)**
- Environment/Facilities **(1)**

Of the 13 formal complaints received, 8 related to communication issues and is an increase of 5 on last quarter.
One complaint related to Bowel Screening Wales where in the last quarter 3 complaints related to their policy of not accepting Colonoscopy reports which have been performed in the private sector and quality standards.

As a result, the programme had agreed to undertake a policy review of this position and will notify the complainant of the outcome once this has been completed.

A further example of improvement and change in practice as a result of one of the above formal complaints is detailed below:

- Diabetic Eye Screening Wales (DESW) received a complaint from a participant who raised concerns regarding appropriate communication where a referral and care with Ophthalmology is indicated post screening. As a result, DESW has: -

1. Established a task and finish group to review result letters prioritising the letter template that has received adverse feedback.
2. The programmes GP letter has been reviewed and was shared at an event with the Behavioural Science unit. As a result, the letter is being updated and will subsequently include the email details of the DESW clinical team along with DESW website details for further information.

2.6 Duty of Candour

Duty of Candour (DoC) regulations have been in effect in Wales since April 2023. There has been 2 new Duty of Candour case identified during Quarter 2.

Breast Test Wales triggered the DoC from an interval cancer review where moderate harm was identified following identification of mis- interpreted mammograms.

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

The other ongoing Duty of Candour case (reported in Quarter 2 September 2023). This is a combined DOC case CVUHB who are the lead reporter and investigator. The case pertains to samples that had tested positive since May 2023 for a rare organism, and which had not been acted upon. PHW did not recognise the significance of the rare result and missed opportunities to inform requesting clinicians of the clinically significant results. PHW has provided its report and are awaiting C&V UHB to provide their report. The case is now with the coroner for inquest.

2.7 Compliments

During Quarter 2, 135 compliments were reported via the Civica system by PHW staff. This is a slight reduction compared to the previous quarter (154). The recently introduced 'Your Feedback' pages on the public facing website also received 11 compliments however only 1 related to PHW services with the remaining 10 being Health Board related. This is a new method for leaving direct feedback rather than being reliant on staff inputting the data and it is anticipated that more people will start to use this new facility in the coming months to provide feedback on our services.
The new page can be found at - [Feedback and Complaints - Public Health Wales (nhs.wales)]

The Compliment themes received for this Quarter are categorised as follows:

Available Answers	Responses
Beyond the level of care expected or anticipated	85
Communication	3
Environment	0
Being listening to	2
Feeling understood	2
Dignity and respect	3
Going the extra mile	11
Demonstrating empathy	2
General thank you to staff	27
Professional and caring manner	12
General service compliment	9
Quality of training	3
Other, please specify:	2
Total	**135**

'Beyond the level of care expected or anticipated' continues to be the highest reason for a compliment to be left, with 85 reported compliments this quarter. This is followed by 'General thank you to staff' (27) and 'Professional and caring manner' (12). Most compliments are received via the website or via email with the majority relating to the Screening Division as listed below,

- Screening Division 117 compliments
- Microbiology 18 compliments

2.8 Service User Experience

All Screening programmes now have local People's Experience surveys available and are all different stages of this rollout. Promotional material in development to encourage completion includes flyers, posters, along with changes to screening websites to include a 'feedback page'. In addition, amendments to results letters so that a request for feedback and a link to the survey is incorporated is also being progressed.

Furthermore, the Lead for Service User Experience is working with the Improvement and Innovation Hub and other internal stakeholders to pilot SMS (text) feedback requests which adopts a more proactive approach to collecting feedback. The initial pilot phase of this project will be with Diabetic Eye Screening and will involve the use of SMS text starting in November 2024.

3.0 Safety Alerts and Notices Management

Public Health Wales has a management system for the distribution, ongoing management, monitoring, and appropriate record keeping of Safety alerts / safety notices that it receives. Reporting of Alerts is by exception.

A total of **46** alerts were received by Public Health Wales during the reporting period 1 July – 30 September 2024, **3** of which required action to be taken. The primary theme of the applicable alerts in Quarter 2 were for Public Health Patient Safety Alerts. All alerts received were disseminated to the organisation within 6/24/48 hours of receipt as required by the policy and procedure.

PHW receives alerts via multiple channels which has the potential to affect the timely management of these. As a result, improvement work is required to ensure the most effective system for alert management. Currently engagement activity is taking place with key internal stakeholders to streamline current processes, and where possible to ensure a single point of entry and distribution. This should avoid duplication and delays in required actions.

The Once for Wales Concerns Management System has developed a module for Safety Alerts which will support the recording, dissemination, and assurance of compliance. The module is still being tested by two Health Boards at present with a view to going live across NHS Wales on the 1 April 2025. Public Health Wales has identified technical issues within the module and will only use some of its functionality until these are resolved.

Whilst we await the new Safety Alert module the PTR team will continue to work with the Records Management team to ensure we are maximising our use of the SharePoint functionalities to manage the Safety Alerts that come into PHW.

Table 1. Total Number of Alerts Received and Actions Taken.

Type of Alert	Number received	Number requiring action. (Covid 19)	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action taken
Pharmaceutical Alert	19	0	0			
Medical Device Alert	2	0	0			
Medical Device (Information)	0	0	0			
Patient Safety Notice/Alert	1	0	0			
Medicine Shortages	20	0	0			
Estates and Facilities Alert	1	0	0			
High Voltage Alert	0	0	0			
Public Health Alert	3	0	3	**Heat Health Advice** **Mpox Brief** **RSV Vaccination Programme**	24/07/2024 19/08/2024 23/08/2024	Shared with Health Protection & Office of the Medical Director. Shared with Health Protection & Office of the Medical Director. Shared with Health Protection, Office of the Medical Director, QNAHPs and Chief Executive.
Totals	**46**	**0**	**3**			

Table 2. Alerts by Division

Type of Alert	Number received	Number requiring action (Covid 19)	Number requiring action (other)	Subject Matter	Date Received and Actioned	Action Taken
Health & Wellbeing	**0**	**0**	**0**			
Knowledge	**0**	**0**	**0**			
Policy and International Health	**0**	**0**	**0**			
QNAHPs	**1***	**0**	**1***	**Heat Health Advice**	24/07/2024	Alert shared with QNAHPs. *The same alert was shared with Micro/Health Protection
Operations & Finance	**0**	**0**	**0**			
People & OD	**0**	**0**	**0**			
Screening	**0**	**0**	**0**			
Micro/Health Protection	**3***	**0**	**3***	**Heat Health Advice** **Mpox Brief** **RSV Vaccination Programme**	24/07/2024 19/08/2024 23/08/2024	All three requiring action were shared with Health Protection & Office of the Medical Director. *One of these three alerts was also shared with QNAHPs.
Estates	**0**	**0**	**0**			
Not Applicable	**43**	**0**	**0**			
Totals	**46**	**0**	**3**			

4.0 Quality and Clinical Audit

Public Health Wales (PHW) has a prioritised audit programme that relates to both local and national priorities, with the overall aim of improving patient/service user outcomes. The priorities reflect a combination of both local and national audits which are listed in the table below (Table 1):

Type of Audit	Number
National Audits	7
Audits identified as a result of risks	6
National Institute of Clinical Excellence (NICE)Guidance (including Technology Appraisals, Interventional Procedures and Guidelines)	0
Local Policy Audits Care Pathways/Local Guidelines Audits	54 (6 of which are linked with risk, as above) *NB Increased from 51 at start of reporting year

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

A clinical audit programme should:

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

4.1 Quarter 2 Update against plan.

The 2024-25 Plan initially included 7 external audits and 51 internal audits and was approved in July 2024. During Quarter 1 and Quarter 2 a further 3 audits were identified and added to the annual plan, bringing the total number to 54.
Figures 1 and 2 below, summarise the status of these audits:

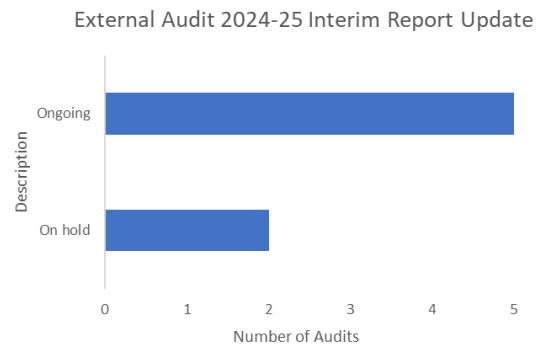


Figure 1: External Audit Activity

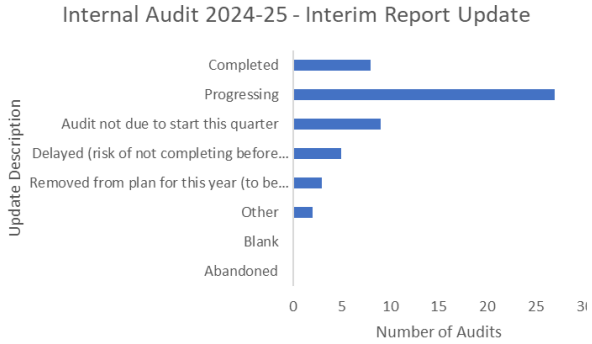


Figure 2: Internal Audit Activity

Full analysis of audit activity is contained within the interim report. Key highlights to note are:

a. 3 audits have been added to the Plan since approval in Jul 2024.
b. 4 audits have been delayed with plans in place for 3 to be completed by the end of the reporting year and one dependent staffing to complete before the end of the year.
c. There has been a request for 3 audits to be removed. Please see analysis below:

Programme	**Audit**	**Priority level**	**Summary**	**Potential Risks associated with withdrawal**
Bowel Screening Wales	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	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.

			BSW 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	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	Re-audit of Referrals for Diagnostic Hearing Assessment Following Automated Auditory Brainstem Response (AABR) Screening		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.

4.2 Digital Audit Platform

Recurrent funding to procure a Digital Audit Platform was approved by Business Executive Team in Quarter 1. This type of system has been recommended in external audit reports to assist Public Health Wales in all aspects of assurance in relation to Quality and Clinical Audit activity conducted across the organisation. Work was undertaken in conjunction with Data, Knowledge and Research Directorate and key personnel from the wider organisation to develop a needs assessment for the required platform. Approval was given by the Digital Data and Design Authority on 2 September 2024 to proceed with procurement.

The Quality and Nursing Directorate have been working closely with colleagues from Public Health Wales Cyber Security Team and NHS Shared Services Procurement Team to develop the complete technical specification requirements. Business leads are in communication with Procurement to move forward with the tender process. It is anticipated that a system will be available for implementation by Quarter 4.

4.3. Audit Training

An in-house 'Introduction to Audit' training session was facilitated by the Quality and Clinical Audit Team in September 2024. Participant feedback from the session

was positive with most staff initially identifying little to some knowledge of audit at the beginning of the session. Following the 2-hour training, feedback suggested that all staff had improved their knowledge to moderate up to extremely knowledgeable, with all training objectives being met.

Further training to take place:

a. 2 October 2024 – The Audit Cycle. Cancelled due to staff absence. In-house training session. Rearranged for 11 December 2024.

b. 19 November 2024 – Refresher training for those who have previously undertaken the 'Clinical Audit Masterclass' provided by Clinical Audit Support Centre. 20 spaces.

c. 22 January 2025 – Clinical Audit Masterclass provided by Clinical Audit Support Centre. 10 spaces.

d. February and March 2025 – In-house training for Introduction to Audit and The Audit Cycle, dates TBC.

5.0 Safeguarding Group Report

Safeguarding Group Report
The purpose of this section is to provide an update on the work of the Corporate Safeguarding Group, and safeguarding activity in Quarter 2, 2024-25.

This quarter's meeting was held on 8th October 2024. The agenda included:

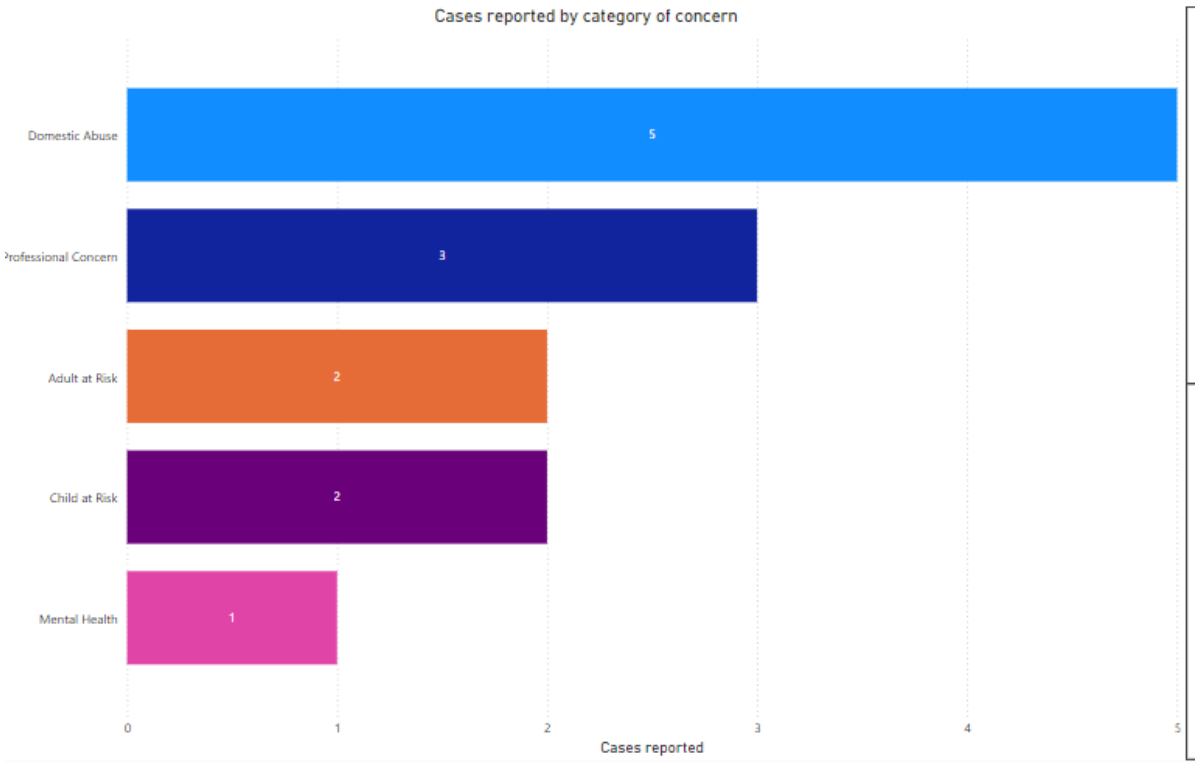
- Safeguarding incidents, referrals and themes reported using the newly developed Power BI Safeguarding Dashboard
- Directorate and divisional updates from safeguarding incidents and learning
- The group's Terms of Reference were reviewed agreed and approved.
- Presentation and review of the Safeguarding Risk Register
- Presentation and oversight of the Safeguarding Maturity Matrix for self-assessment and identified improvements for 2024-25.
- A review of Safeguarding Training Compliance figures and improved compliance rates noted, and areas identified for further targeted support.
- A review of compliance figures for Disclosure and Barring Service checks for newly appointed employees in Quarter 2
- Discussion pertaining to the implementation of the 'Once for Wales' Datix Safeguarding module for advice, support and reporting.
- An update from the National Safeguarding Service, including shared learning from Safeguarding Reviews and identified improvement workstreams along with emerging national and local safeguarding issues.

- A Presentation from Louise Mann Interim Director of the National Safeguarding Service on Sexual Safety.

5.1 Safeguarding Incidents

During quarter 2, 13 Safeguarding incidents were reported and the graph below details these by Directorate. As the largest directorate, Health Protection and Screening reported the most safeguarding concerns/incidents which is to be expected as the directorate with most public facing services. The overall number of safeguarding incidents reported by PHW staff remains small compared to the wider context of NHS Wales.
Domestic abuse was the highest reported theme of incident. Through Datix Safeguarding incident reporting review 2 missed opportunities, to undertake a targeted enquiry were identified whereby indicators of domestic abuse and sexual violence were disclosed by a Breast test Wales participant but the Violence Against Women Domestic Abuse and Sexual Violence pathway was not followed at the time. As a result of this incident, it has become apparent that staff awareness and confidence to comply with Ask and Act needs attention and is now an area of focused attention. To date Group 2 VAWDASV training in person has been delivered to BTW staff. In addition, a range of resources to help improve understanding of the need to signpost victims of VAWDASV to the Live Fear Free helpline has been provided.

The graph below highlights the types of safeguarding concern.



5.2 Safeguarding Training

All staff are required to complete level 1 safeguarding training and certain staff groups are required to complete a higher level of training dependent on their roles.

Overall organizational compliance for quarter 2 against a Welsh Government target of 85% is as follows:

- Level 1 Safeguarding Adult training is at 92%
- Level 1 Safeguarding Children training is at 92%

- Level 2 Adult Safeguarding training is at 92%
- Level 2 Safeguarding Children training is at 91%

Both level 1 and level 2 safeguarding training compliance rates have improved since the last quarter following targeted support from managers.

In addition to the required mandatory eLearning training, 29 employees have attended the virtual delivery of the Group 2 Ask and Act, Violence Against Women, Domestic Abuse and Sexual Violence training this quarter. This has led to the overall compliance rate improving from 69% to 75% this quarter. To improve further, However this remains below the required target of 85% and so managers continue to be informed of staff who are out of date and for these staff to be booked and released to so the training.

5.3 Key Safeguarding Risks & Issues

There is one safeguarding risk which committee should note.

Risk 1656 - DBS (Disclosure and Barring Service) checks

Risk Description
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.

Risk Cause
Whilst this is not a legal requirement, best practice indicates that Disclosure and Barring Service renewal checks are carried out on employees, further to the initial check that is undertaken at recruitment.

Risk Effect

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.

Significant work has progressed with the work with the appointment of a Disclosure and Barring compliance officer who has commenced the organisational wide review compliance with DBS checks. Several mitigations are in place to reduce the risk. In addition, a briefing and appraisal paper has been written to discuss the risks and cost analysis to implement regular DBS renewal checks for relevant PHW employees. This will be presented to the People and Organisational Committee on the 21st October 2024.

Improvements as a result of Learning

Following a review of the safeguarding incidents and the missed opportunities to implement ASK and ACT at the time of disclosure, the group endorsed the plan to implement an improvement project targeting screening programmes. The aim is to strengthen professional curiosity and build staff confidence in dealing with participants presenting with Domestic Abuse at screening appointments.

6.0 Infection Prevention and Control (IPAC) Report

The purpose of this section is to provide an update on the work of the Infection Control Group. The group met on 10th October 2024 to review quarter 2 data. Areas of particular focus included:

- Presentation and review of the IPC Risk Register
- An update on the national IPC Assurance Framework
- A review of IPC Training compliance figures and improving compliance and areas for targeted support
- A review of progress made against identified IPC issues, namely ventilation and decontamination compliance.
- An update regarding the cleaning contract procurement
- An update on the IPC corporate IPC role
- To receive and discuss divisional IPC Updates
- To receive an update from the National Infection Prevention and Control Service sharing learning and areas for improvement at local and national level.
- Noting of IPC safety notices and associated actions.

6.1 IPC-related incidents

There have been 21 incidents reported in Quarter 2 of which 2 were reported as moderate harm and remain under investigation.

Category	Number of Incidents	Division where it occurred	Risk Level	Approval Status
Cleanliness	2	Diabetic Eye Screening/NHS Executive	1 x Low 1 x None	1 x Closed 1 x Management Review/Make it Safe Plus
Contact with Needles or medical sharps	2	Microbiology	2 x Low	2 x Closed
Contact with or exposure to hazardous substance	14	Microbiology	8 x Low 4 x None 2 x Moderate	12 x Closed 2 x Under investigation
Environmental Cleaning (Process and procedures)	2	DESW	2 x None	1 x Closed 1 x Management Review/Make it Safe Plus
Hand Hygiene	1	DESW	1 x Low	1 x Closed

Both moderate incidents were reported within Microbiology and related to staff exposure to hazardous substances.

One incident involved inappropriate transportation of a high-risk sample that was handled by two members of staff. Following the initial moderate harm report, the level of harm has now been downgraded to low harm by the Incident Manager.

The other incident related to a smear of blood identified on a sample request form from a high-risk patient. There is a joint investigation into this incident with Hywel Dda University Health Board which is ongoing.

Both incidents were reviewed by the PTR Team and Legal Support Manager upon report of the moderate harm.

6.2 IPC Mandatory Training Compliance

Overall IPC training compliance for both level 1 and level 2 has improved this quarter following targeted intervention by managers.

IPC level 1 training is now reported at 91.5% against a Welsh Government target of 85%.

IPC level 2 training has increased from 80.0% in the previous quarter to 91.2% compliance this Quarter, a significant improvement.

Areas still requiring improvement were discussed and noted for IPC level 1 as Corporate/Board staff, health protection division and SPRs.

For IPC level 2 areas for further improvement include certain Screening teams, 1 microbiology laboratory, and Policy and International Health teams. Managers support will be enlisted to target these specific areas during the next few months.

In addition to the required mandatory training, additional IPC training has been delivered to Screening Services staff who are nominated as IPC link workers. Sessions covered environmental auditing and additional IPC roles and responsibilities.

Aseptic Non-Touch Technique Assessment and Training is also on an upward trajectory with assessment compliance improved from 88% to 76% this quarter.

6.3 IPC Risk Register

The IPC risk register was reviewed and agreed as accurate.

It will be reviewed again in the quarter 3 meeting, but it is worth noting that Risk ID 1501 which relates to the corporate IPC role being a single post holder continues to

be an issue with mitigation in place with the Healthcare Associated infection, Antimicrobial Resistance & Prescribing Programme (HARP) team who are now responsible for this position and currently supporting until a replacement post holder can be found. The post is out to recruitment.

6.4 IPC Policies and Procedures

2 Procedures were approved by the group at the meeting.

- Outbreak Management Procedure
- Decontamination of Mobile devices /Electronic tablets used by the public.

Key Risks and Issues Identified

Since the start of 2024, concerns have been highlighted at the IPC group and to QSIC regarding 2 aspects of decontamination practice in Screening Services. The first relates to compliance with the new decontamination standards for biopsy probes within Breast Test Wales programme with delays to achieving full compliance resulting from the identification of inadequate mechanical ventilation within the clinical areas.

A Task and Finish Group was subsequently set up to support and progress remedial work to the ventilation system and all units are now fully operational within Breast Test Wales, with the maintenance of these units now being managed by the PHW Facilities team.

In addition, since the last meeting Breast Test Wales has successfully procured and trained staff in the use of Ultraviolet cabinets which will achieve high level disinfection with traceability functionality. These will be operational imminently.

A further Task and Finish group remains active to support targeted improvements to provide the assurance required for clinical environments against infection prevention and control standards.

A further area of concern regarding decontamination practices relates to the endoscopy decontamination facilities at the Glan Clwyd hospital. Bowel Screening Wales continue to work with Betsi Cadwaladr University Health Board and PHW Corporate teams to find a longer-term solution for the decontamination unit and the required IPC assurance as a commissioned service. Capital funding has now been agreed from WG for BCUHB to improve the facilities to deliver the required decontamination standards.

3. 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:

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