Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

CYFARFOD BWRDD PRIFYSGOL IECHYD
UNIVERSITY HEALTH BOARD MEETING

DYDDIAD Y CYFARFOD: DATE OF MEETING:	28 May 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Briefing on Public Health Wales (PHW) Sexual Health Service Incident
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Dr Ardiana Gjini, Executive Director of Public Health
SWYDDOG ADRODD: REPORTING OFFICER:	Bethan Lewis, Assistant Director of Public Health Strategic Business & Operations

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Board with a consolidated, high-level update on the multi-stranded incident affecting the Public Health Wales (PHW) Sexual Health Service, including the national Test and Post (TaP) service. The incident spans safeguarding, patient safety, information governance, and a hepatitis C (HCV) testing omission within a specific testing pathway.

PHW is the accountable organisation for managing the incident and has established enhanced governance, mitigations, and an independent external review. Hywel Dda University Health Board (HDdUHB) has undertaken system actions relevant to its population and geography to support PHW's formal review, to mitigate potential impacts locally, and provide Board assurance regarding safeguarding and blood-borne virus (BBV) follow-up.

Cefndir / Background

In November 2025, PHW identified a number of issues affecting its national Sexual Health Service, including the TaP online and community-based testing pathway. The service provides a significant proportion of sexually transmitted infection (STI) testing across Wales and plays an important role in widening access to sexual health services, particularly for people who may face barriers to traditional clinic-based care.

Following identification of the initial concerns, PHW convened a multi-professional Incident Management Team (IMT) to provide oversight, assess risk, and coordinate mitigation. As understanding of the issues developed, the incident was formally escalated in early 2026, with strengthened executive leadership, enhanced governance arrangements, and parallel improvement activity established across safeguarding, patient safety, and information governance.

The initial areas of concern identified related to:

- Safeguarding, where statutory processes for children, young people, and adults at risk were not consistently met.

- Patient safety, particularly relating to incorrect or delayed communication of test results.
- Information governance, including weaknesses arising from complex and manual data-handling processes.

In February 2026, PHW identified a subsequent and distinct fourth area of concern relating to hepatitis C (HCV) testing within a specific blood testing pathway used by people living with HIV. This finding emerged as part of PHW's ongoing investigation and assurance activity, rather than from the original safeguarding or information governance lines of enquiry.

PHW established that, historically, HCV testing had not been included within this specific pathway in a way that aligned with service user expectation. Upon identification of the issue in late February 2026, PHW took immediate remedial action to correct the testing pathway, to ensure that HCV testing was included going forward, and initiate a structured review of potential impact. This included development of contact and follow-up arrangements, access to repeat testing, and clinical pathways for further assessment where required.

The HCV testing omission was incorporated into the wider incident response framework, with enhanced governance, transparent public communication, Duty of Candour principles applied, and inclusion within the scope of PHW's planned independent external review. Throughout this process, PHW has maintained that continuation of the TaP service, with mitigations in place, presents less risk to population health than suspension, particularly for vulnerable groups.

Asesiad / Assessment

PHW actions to address the four areas of concern

1. Safeguarding

PHW identified that safeguarding processes within the TaP service did not consistently meet statutory requirements. In response, PHW has:

- Implemented immediate changes to prevent circumvention of age and risk screening within the online platform.
- Undertaken retrospective reviews of historic safeguarding disclosures.
- Clarified and strengthened referral pathways to local authorities.
- Established expert input to review safeguarding processes in online sexual health services.
- Introduced enhanced governance and assurance mechanisms for safeguarding oversight.

Health Boards have been engaged as system partners, where local safeguarding duties apply once information is shared.

2. Patient Safety

PHW identified patient safety incidents largely associated with complex and manual result-handling processes. Actions taken include:

- Review and resolution of identified incidents with affected service users.
- Systematic audit activity to provide assurance that further errors have not occurred.
- Redesign of testing algorithms and workflows to reduce manual handling and human error.
- Strengthened quality oversight of the TaP pathway.

3. Information Governance
Information governance concerns arose from manual processing and incomplete risk assessments. PHW actions include:

- Commissioning an Information Governance review.
- Implementing immediate mitigations to reduce the risk of misdirected or inaccurate information.
- Reporting relevant incidents to the Information Commissioner's Office.
- Redesigning processes to move towards automated, safer data flows.
- Strengthening assurance around Data Protection Impact Assessments.

4. Hepatitis C (HCV) testing omission
PHW identified that, historically, HCV testing was not included in a specific blood testing pathway for people living with HIV, contrary to user expectations. Actions taken include:

- Immediate correction of the testing algorithm to include HCV testing.
- A structured lookback exercise to assess potential impact.
- Proactive contact arrangements offering explanation, apology, and repeat testing.
- Establishment of clinical follow-up pathways where required.
- Clear public communications and helpline support.
- Inclusion of this issue within the wider independent external review.

HDdUHB system response

While PHW retains accountability for the incident, HDdUHB has taken specific actions to support assurance, patient safety, and system learning:

- Safeguarding review: completed a review of all relevant safeguarding cases relating to its population for both Phase 1 and Phase 2 cohorts, providing local assurance and identifying no unmet safeguarding actions to date.
- Learning and improvement: committed to sharing any incidental or system learning arising from this review with PHW to support the national improvement programme and external review.
- BBV and HCV testing access: offered hepatitis C testing to anyone living in Mid and West Wales for whom it is the nearest Health Board, ensuring accessible reassurance and follow-up irrespective of previous testing route.
- System readiness: Local BBV and sexual health services have maintained readiness to support re-testing, follow-up, and advice where individuals choose to access local services instead of national pathways.

These actions are intended to support PHW's formal review process and to ensure the population of HDdUHB are appropriately safeguarded and supported.

Argymhelliad / Recommendation

The Board is asked to:

- **NOTE** the consolidated position regarding the PHW Sexual Health Service incident.
- **TAKE ASSURANCE** from the actions undertaken by PHW to address the four identified areas of concern, and Health Board system actions in relation to safeguarding review, BBV testing access, and shared learning.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	1. Safe 2. Timely 3. Effective
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities
Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	PHW incident review briefings.
Rhestr Termau: Glossary of Terms:	As noted within body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	March 2026 In Committee Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct financial implications stated in the report; financial implications of the wider response are supported by PHW.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	Quality/patient care impacts include risk of harm from safeguarding failures, false-positive communications, and failures in confidentiality/data accuracy. Mitigations are in place and the current risk assessment supports continued service delivery with enhanced oversight.
Gweithlu: **Workforce:**	No direct workforce implications stated in the report; however additional capacity is assumed necessary to deliver mitigations while maintaining a safe service.
Risg: **Risk:**	Managed as an enhanced incident with risks recorded on the appropriate risk register by PHW. Key risk controls include strengthened safeguarding pathways, reduced manual processing, algorithm/process redesign, incident reporting, and enhanced governance through SRG/IMT/SHIG.
Cyfreithiol: **Legal:**	Legal considerations include statutory safeguarding duties (children/adults at risk) and data protection obligations. The report also notes relevance of Duty of Quality and Duty of Candour; incidents have been reported to the ICO.
Enw Da: **Reputational:**	Reputational risk is present due to safeguarding and data handling issues and potential media/political interest; PHW issued proactive press statements following confidential stakeholder briefings (24 February 2026).
Gyfrinachedd: **Privacy:**	Privacy/confidentiality impacts relate to misdirected personal data and inaccurate referral letters; mitigations include an IG review, ICO reporting, and process redesign toward automated, robust data transfer.
Cydraddoldeb: **Equality:**	The focus of equality runs throughout the work of the PHW Sexual Health TaP service.