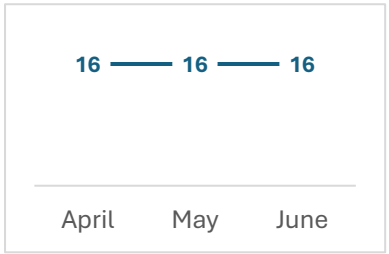
<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR3

Strategic Priority 5

“Delivering excellent public health services to protect the public and maximise population health outcomes.”</td><td colspan="2">There is a risk that:
We fail to deliver our contribution to excellent public health services in population health screening, infection, health protection and emergency response.

Caused by:
1. Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.
2. Inability to maintain capacity and capability of the specialist workforce.
3. Absence of innovation and continuous quality improvement.
4. Exceedance in unplanned activities arising from unexpected acute threats to health.

Resulting in: Poor quality and unsafe services, sub-optimal population health outcomes for population screening and health threats, and a breach of legal duties on Civil Contingencies and Duty of Quality.</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">National Director of Screening and Health Protection Services/Medical Director</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">Quality, Safety and Improvement Committee</td></tr>
<tr><th>Trend</th><th>Current Position of Risk Including Risk Appetite and Risk Decision</th><th>Position Statement – Executive Director Update</th></tr>
<tr><td> 
</td><td><table><tr><td>Open</td><td>PHW is open to consider all potential options, subject to continued application and/or establishment of controls recognising that there could be a high risk of exposure.</td></tr></table>
Current Score = 16
Target Score = 6
Risk Appetite Level Applied = Open, therefore, now outside tolerance level.</td><td>June 2026 Update

The risk score remains at 16 as the key areas of concern continue in relation to the Sexual Health Test and Post incident, performance of the Breast screening 3 week waits for assessment, and 4 week waits for bowel screening colonoscopy.

Regarding the Sexual Health incident, work on the lookback exercises and safeguarding concerns is reaching its conclusion. A review of governance</td></tr>
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		arrangements (safeguarding, patient safety, information) has been carried out across all other public facing services with good levels of compliance. The operational response to the hantavirus threat has reduced in intensity, but in light of the emerging ebolavirus threat, the EPRR and HP teams are providing intense support and advice. The Environmental Public Health function has been operating with business continuity arrangements resulting from the withdrawal of UKHSA support to in-hours and out-of-hours response. An interim cover arrangement is in place to continue to provide the service. The Health Protection Response team is also operating in business continuity mode, and short-term arrangements are in place to ensure service continuity. Staffing levels will be restored over the next few weeks. Improvement plans are in place to address performance challenges in Breast Test Wales, Bowel Screening Wales and Diabetic Eye Screening Wales and these are included in Directorate-level controls and reported to QSIC through regular monitoring. Trajectories are being developed to actively monitor performance. Further staff engagement has been carried out following the review of the Breast Test Wales programme.

		We continue to engage with staff following the review of the BTW programme to ensure effective implementation of the recommendations. The HPSS directorate transformation programme is progressing well and workstreams established to improve resilience and learning across divisions will report on their scoping work in June. Workforce resilience remains a key area of focus across Health Protection and Screening Services, with pressures in specialist scientific, bioinformatics and Health Protection functions, and specific challenges in North Wales. Recruitment, training and pipeline development continue to progress. The Directorate is defining workforce capacity indicators to support transparent monitoring of resilience and mitigation effectiveness.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Development, implementation, and maintenance of emergency and business continuity arrangements, including participation	• PHW Emergency Response Plan (V3.2) • PHW Countermeasures Protocol	• Annually reviewed, tested by exercise, with written assurance to Board.

[1] Three Lines of Defence Model
First – Operational Management control of organisational risks
Second – Risk management and compliance functions, reporting to senior management
Third – Internal audit to provide assurance.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	in EPRR training and exercises, alongside debriefing and implementing lessons identified from incidents and outbreaks.	• PHW Business Continuity Arrangements. • Communicable Disease Plan for Wales • PHW Annual Assurance Return to Welsh Government on EPRR • Work with partners to locally, regionally and nationally to continually review, update, train for and exercise multi-agency plans and procedures for emergencies. **NB.** This is via Local Resilience Fora (LRF), Wales Resilience Partnership, Wales Resilience Forum and the 4 Nations Public Health (PH) Emergency Preparedness, Resilience & Response (EPRR) Group.	• Reviewed biennially, tested by exercise. • Annually reviewed by Directorate with assurance via Emergency Preparedness Resilience and Response (EPRR) Group Meetings (Quarterly) reported to Board. • Reviewed biennially, tested by exercise in conjunction with Health Protection • Annually produced, with approval from EPRR Group, HPSS DMT, BET, QSIC & Board. • Schedules for meeting, training, testing and exercising vary. For further detail, please contact phw.eprr@wales.nhs.uk
C1.2	Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-clinical *Standard Operating Procedures and Protocols*.	• Comprehensive suite of organisational policies and procedures. • HPSS directorate and divisional policies and standard operating procedures aligned where relevant to clinical and operational delivery standards and agreements. • Population Screening Programmes delivered in line with UK National Screening Committee recommendations and as approved by the Wales Screening	• Corporate Policy and Control Document Reviews via Leadership Team. • Regular Clinical Audits undertaken against Standard Operating Procedures, policies & NICE Guidance. Clinical audits undertaken on outcomes e.g. Cervical Screening Wales audit of all cervical cancers in Wales. Health Inspectorate Wales routine inspections. Clinical review and also specifically inspection of IR(ME)R regulations in Breast Screening Programme (radiation regulations)

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
		Committee and Welsh Government Policy. • HPSS laboratory systems accredited to ISO 15189:2022, with re-validation required yearly.	• UKAS inspections and resulting accreditation guarantees the highest levels of impartiality and competence through the continuous assessment processes including walkarounds.
C1.3	Variation / risk-based prioritised approach to directorate delivery assurance.	• Cross directorate operational delivery reporting. • Action plans with appropriate tracking and trajectories, spotlight sessions and reports to HPSS Divisional SMT's, DMT QSIC. • Annual clinical audit programme based on risk and variation • Thematic Analysis of NRIs, EWN and Claims. • Result of Peer review programme/quality walks • Safety culture and open incident reporting processes, compliance with PTR regulations and Duty of Quality Health & Care Standards	• Performance management with monthly quality monitoring at HPSS Divisional SMT's on key performance indicators and quality metrics. Focused monthly performance monitoring at HPSS DMT with reporting and insights to PHW Board. • Rolling monthly programme at HPSS DMT / SMT monitoring via quality & performance reporting through governance structures of PHW to QSIC & Board • Reports to divisional SMT's and QSIC • Monthly Quality performance reviews with Health Boards on their aspects of delivery of screening programmes and recovery trajectories. (SH)
C1.4	An HPSS programmatic approach to benchmarking, reviewing and improving	• Excellent operations programme scope • Excellent operations delivery dashboard	• Monthly DMT update reporting • Reports into corporate committees and Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	corporate and business operational systems and processes within the directorate supported by corporate enabling functions using the Duty of Quality Health & Care Standards to fully operationalise a quality management system.	• Range of diagnostic / review reports • Deliver quality improvements against the quality priorities identified against the Duty of Annual Report & Quality Standards Self-assessment /QOF • Service User Feedback	• Internal audit reports on programme projects
C1.5	HPSS adoption of the PHW Clinical Governance Framework and the divisional systems of quality monitoring aligned to delivery context and mandated or quality standards and enablers building a safety culture and learning culture	• PHW Clinical Governance Framework • Divisional Quality Lead resources • Divisional Quality reports and action plans • Contribution to the PHW Duty of Quality reporting and corporate Governance groups • Compliance with quality inspections (e.g. UKAS)	• HPSS SMT / DMT reporting • Quality Oversight Group participation and workplan • Corporate reporting (patient / service user experience including incidents, NRI & EWN's complaints, claims and Duty of Candour) Performance monitoring of Interval Cancer reviews • External inspections & Peer Quality Visits • Service User Surveys & associated Improvement plans • Development of a new Organisation wide clinical governance meeting to provide Trust wide view and assurance • QUOG with strengthened TOR (to be finalised Feb 26)
C1.6	Delivery of agreed future digital transformation needs aligned with strategic priorities and service user and operational needs aligned to	• Delivery of PHW's digital routemap • Comprehensive mapping document of HPSS user requirements	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme)

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	the Duty of Quality standards and digital standards	• HPSS delivery of future service transformation vision. • Inclusions in 10 year strategic capital plan • Service user feedback and engagement	• Monitored through delivery of the digital portfolio and reported to BET and KRIC
C1.7	Strategic oversight of screening programme performance with high-level governance and assurance arrangements in place to oversee performance and population-level risks associated with the national screening programmes.	• Monthly screening performance dashboards (strategic indicators only) • DMT and QSIC oversight reports • Welsh Government oversight of national screening standards • Internal Audit of Screening Services (strategic recommendations) • Executive reporting on strategic dependencies, including diagnostics and workforce • Improvement plans for BTW, BSW and DESW implemented by the programme with oversight at the Directorate Management Team and reporting to QSIC	• Monthly strategic performance review (DMT/QSIC) • Quarterly Board reporting through established assurance mechanisms. • Annual reporting to Welsh Government • Escalation through Executive route where strategic risks increase
C1.8	Strategic oversight and governance of Sexual Health service delivery, including risk escalation and assurance.	• Incident Management actions and debrief outputs • Divisional governance reports • Quality & safety oversight (clinical governance forums) • Incident reporting and trend analysis	• Monthly divisional SMT and DMT reporting • After-action reviews following incidents • Monitoring via risk registers and escalation logs • Quarterly updates to QSIC
C.1.11	HPSS financial management for directorate-level financial governance and alignment between operational plans and financial capability.	• Monthly financial performance reports (M1–M12) • Savings Plan monitoring	• Monthly DMT and finance review meetings • Quarterly reporting to QSIC/Board • Regular savings plan tracking cycles

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
		• Mid-Year Review and year-end position reports • Finance Business Partner oversight • Directorate risk registers financial entries	• In year variance management process • Annual financial planning and budget risk review
C1.12	Strengthened programme and change-management oversight across the Directorate.	• Programme Oversight Team reporting • IMTP alignment and prioritisation decisions • Workforce and leadership capacity reviews • Coordination with enabling functions (Finance, Digital, POD, Strategy & Planning). • Improvement programme milestone reporting • Internal audit outputs related to governance or leadership oversight • Internal audit findings on governance, leadership, or change programme delivery • Transformation programme milestone reporting • Risk register entries relating to delivery capacity or change saturation	• Monthly DMT review of change portfolio capacity and prioritisation • Quarterly reporting to QSIC and Board on transformation progress • Annual IMTP planning cycle • Internal audit follow-up against leadership/governance recommendations • Monthly Delivery Confidence Assessment reporting (Tier 1 & 2 Programmes only) • Assurance report to BET/Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Uphold high professional standards: Professional Regulation – Medical, Nursing & Midwifery, and Multi-Professional Staff	• Medical, Nursing & Midwifery, HCPC, Allied Health Professional and Multi-Disciplinary Staff Revalidation process and annual audit • Medical Job Planning Process • MYC CPD planning and career professional conversations • Numbers of staff participation in clinical supervision • Mentorship/Preceptorship programmes in place • Nursing Senedd attendance • Nursing & Midwifery Leads attendance and information cascade	• Annual Report to POD COM / QSIC • Oversight by OMD, with assurance reporting via HPSS DMT (or NQIG for Nursing and Midwifery) to BET and Board • HEIW CPD returns • Pulse/Staff surveys regarding access to CPD • Relevant mandatory compliance data (Datix, DoC, Safeguarding, IG) • Professional appraisal structures in place with assurance reporting for relevant professionals (e.g. Consultants),
C2.2	Evolving system of workforce planning aligned to future operational and strategic needs	• Divisional level workforce plans in development • Use of career pathway tools	• POD oversight • Nursing & Midwifery Professional Leads
C2.3	In addition to being an approved specialist training provider there are a range of professional competency standards and associated "pathways" for internal staff development aligned to current and future operational and strategic needs	• Training provider status • Agreed competency standards • Approved professional pathways • NSHCS Training status accreditation with IBMS every 5 years and the • Maintenance of Specialist Scientific workforce skills.	• HEIW contracting, reviews and audits • Workforce development plans • Training completion reporting • External accreditation • Assessed internally every 3 years using defined criteria underpinned by ISO 15189:2022 standards • Number of staff achieving promotions • Equality & Diversity Annual Report /Workforce reports, and Gender Pay Gap • Nursing & Midwifery retention plan

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.4	Extensive people development opportunities to maintain and expand knowledge, skills and competency	• Training attendance records • Developing and maintaining of staff competency framework and staff Training Needs Assessments (TNA) • Workforce reports	• Training and development spend via financial monitoring • Training records • MYC and CPD requests to HEIW • Number of higher level of awards achieved
C2.5	Working with HEIW and developing strategic links with HEI's providers to develop future workforce pipeline	• Via POD assurance processes • OMD and NQIG student programmes/opportunities	• Organisational workforce planning • Number of Student placements PA • Organisational workforce planning including relevant professional workforce planning (e.g. health care science, Nursing and Midwifery, Public Health specialist) • Delivery of the CNO Strategic Vision

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Absence of innovation and continuous quality improvement.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	Specialist / subject area leads and divisional systems for horizon scanning and staying abreast of service and technological advancements.	• Professional leads for scientific areas • Professional Leads for Nursing & Midwifery • Detailed work with procurement specialists to undertake regulated market research to scope and test innovation opportunities/providers • UK National Screening Committee	• Documented Leads • Procurement documentation and reports • Nursing & Professional Leads meeting • Management of NICE Technical appraisals and compliance

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Absence of innovation and continuous quality improvement.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.2	Research and development strategy and agreed directorate priorities	• HPSS fully engages in PHW wider research structures which includes an organisation wide research strategy and development of priority areas.	Both specific review of areas of excellent public health service and via PHW wider research structures are reported to the KRIC.
C3.3	See C1.4,1.5 and C1.11		

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Exceedance in unplanned activities arising from unexpected acute threats to health.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Maintenance resilient dedicated 24/7 EPRR On-Call Service which helps to ensure that the organisation meets its statutory obligations under the Civil Contingencies Act 2004 and receives Emergency and Major Incident notifications in a timely manner.	• 24/7 Resilient EPRR On Call Service Standard Operating Procedure.	• Performance monitored monthly via HPSS DMT Metrics, annually reviewed, and reported on via the PHW Annual Assurance Return to Welsh Government on EPRR approved through the EPRR Group, HPSS DMT, BET, Quality, Safety, and Improvement Committee & Board.
C4.2	Extensive system for surveillance of health threats to inform timely and effective response.	• Exceedance reports and protocols with agreed criteria for escalation and response management • Weekly HP issue summary produced	• Weekly circulation to PHW Executives

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.1	Develop resilient, coordinated and effective Pandemic Response Arrangements for PHW.	• Arrangements to be validated via an organisation-wide internal desktop exercise.	Align with UK National Respiratory Pandemic Framework (draft) incorporates lessons identified from internal Covid-19 debrief, lookback and reflection processes; as well as recommendations from the UK Covid-19 Module 1 and Module 2 Report. Provides organisational assurance for preparedness. Further Covid 19 Enquiry module reports will be reviewed as and when they are released to assess for both direct and indirect implications following the existing approach used for Module 1 and 2. Review and additional input requested from BET	Deputy National Director Health Protection and Screening Services Head of Emergency Preparedness Resilience and Response	Q4; 2025/26	**June 2026:** Request Closure. Ongoing BAU Management **April 2026:** V1 of the PHW Pandemic Response Arrangements complete, Showcased at Exercise ANADL and currently awaiting approval at BET and Board (May & June respectively).

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
			and Board for each module.			
AP1.2	Develop digital programme approach to all digital development activity and improved processes for identifying and agreeing digital activity in line with PHW digital and data strategy and DDDA portfolio.	• Timely delivery of digital programmes, and transparency of reporting of programmes.	Substantial digital development is required across a variety of systems, coordination on a portfolio level will enable more coordinated and therefore more effective delivery with HPSS and identification of the most appropriate forum within digital governance structures for action through the utilisation of digital clinical safety officers.	Deputy National Director Health Protection and Screening Services Assistant Director of Operations Health Protection	Q4; 2025/26	**June 2026:** Conversations with RDD are ongoing re Screening Digital priorities and how to improve planning and collaborative working approaches. **April 2026:** In discussion re-impact of Screening improvement activities on capacity and planning.
AP1.7a	Finalise and implement strategic recovery trajectories for national screening programmes.	• Trajectory delivery against KPIs • Reduction in pathway delays • Trend improvement against programme standards	Provides clarity on expected recovery, enables early detection of slippage, and strengthens assurance that screening services can return to compliant and sustainable performance.	Director Screening Division		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an additional Exec led

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						listening exercise undertaken **April 2026** Improvement recovery plans being updated monthly with work to be undertaken to develop the appropriate recovery trajectories to include in the plans.
AP1.7b	Strengthen executive-level engagement on system-wide dependencies (e.g. diagnostics) to support sustainable screening performance	• Executive to Executive action plan delivery • Improved diagnostic capacity/turnaround • Evidence of reduced bottlenecks in Bowel Screening	Addresses the primary external constraint driving screening underperformance, improving end-to-end pathway flow and reducing delays.	National Director Health Protection and Screening Services		**June 2026:** As a result of exec engagement Radiology-led clinics in the North BTW Region will now support. Engagement is ongoing re Surgeon capacity in the North due to upcoming surgeon leave and impact MDT capacity.

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						For BSW, receipt and feedback on health board recovery plans have been completed, and the BTW Service Delivery and Capacity Management workstream has been tasked with working with health boards to develop a more standardised approach **April 2026** All Screening Division improvement activity will be consolidated within a Screening Improvement Programme, including incident-led actions (e.g. water and dust), performance improvement plans for three priority improvement plans for

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Breast Test Wales, Diabetic Eye Screening Wales and Bowel Screening Wales and the Breast Test Wales service review recommendations. This Programme will be supported by cross organisational governance and resourcing, with an immediate focus on prioritised improvement actions and the development of clear improvement trajectories linked to key performance indicators and outcomes.
AP1.7c	Provide strategic oversight of the Breast Test Wales Review and ensure alignment of recovery expectations with its recommendations.	• Delivery of BTW Review action plan • Improvement in 3-week assessment standard • Workforce resilience metrics (film reader capacity etc.)	Creates system stability in an area with long-standing non-compliance and directly reduces clinical and reputational risk.	National Director Health Protection and Screening Services		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						additional Exec led listening exercise undertaken **April 2026** The BTW Service Review dissemination and engagement have now been completed. All Screening Division improvement activity will be consolidated within a Screening Improvement Programme, including incident-led actions (e.g. water and dust), performance improvement plans for three priority improvement plans for Breast Test Wales, Diabetic Eye Screening Wales and Bowel Screening Wales and the Breast Test Wales service review recommendations.

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						This Programme will be supported by cross organisational governance and resourcing, with an immediate focus on prioritised improvement actions
AP1.7d	Ensure strategic assurance of the Diabetic Eye Screening transformation programme	• Increase in clinic capacity • Reduced variation in timeliness • Finalised sustainable DESW delivery model	Stabilises Diabetic Eye Screening performance, reduces backlog risk, supports equitable access and removes ongoing operational fragility.	Director Screening Division		**June 2026:** DESW improvement plan has been established, with governance and oversight from the programme board, SMT and DMT. The camera evaluation is now in the final week with over 1000 participants taking part so far. The evaluation is on target to meet the sample size requirements though have had to

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						cancel some clinics due to staff sickness. **April 2026** Extension of contract for use of Tenovus mobile agreed for 3 months to maintain current clinic capacity. Evaluation of new technology and modified usage of eye drops started 20th April and will run until early June with good uptake by participants to be involved in the study.
AP1.7e	Enhance strategic screening assurance reporting into DMT/QSIC, enabling clearer oversight of risk movement and escalation	• Quality of reporting • Assurance ratings at QSIC • Improved visibility of early warning indicators	Improves organisational oversight, enables earlier action, and strengthens Board assurance on risk mitigation effectiveness.	Head of Directorate Business Operations Head of Operations Screening Division	Q4 2025/26	**June 2026:** Updated QSIC report incorporating specific Board feedback submitted. Proposed DMT governance structure under consideration to

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						strengthen assurance process. **April 2026** Board session held in April to discuss Screening Division performance and assurance reporting mechanisms. Governance mechanisms for the Screening Improvement Programme and SRO/Lead agreed and will report monthly to DMT and BET.
AP1.8	Strengthen governance and delivery of the Sexual Health Test and Post service incident	• Effectiveness of Incident Management Team • Key timely decision-making • Timely actions • Effective stakeholder communication • Alignment of service with best practice	Completion of lookback in a timely manner. Delivery of a service aligned with best practice.	Director of Health Protection	Q1 2026/27	**June 2026:** SRG and SHIG has now stood down. Service management structure is being refined with clear governance around accountability,

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						responsibility and lines of escalation with assurance report sent to PHW executives on 28 May 2026 **April 2026** Look back of HepC and MDT is now almost complete. Improvement group established and completed interim safe arrangements implementation for safeguarding, and commence scoping of phase 2 Service has reviewed all processes and implemented improvements on mailbox management, condoms processing, and currently looking to streamline test kit management.

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Digital improvements underway, and BPAG to stand up and implements best practice guidance and appropriate skillset

Gaps in Assurance / Action Plans for the cause C2 Inability to maintain capacity and capability of the specialist workforce.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.1	Undertake a broader review relating to retention and TNA of regulated professions	• Provide assurance that that a stable and competent workforce is in place or require development of actions to achieve this.	By providing relevant information to determine actions.	Deputy National Director Health Protection and Screening Services Services Business / Workforce Development Manager - Office of Medical Director	Mar 26	**June 2026:** Scoping has been completed for cross-directorate training and development function, to be presented on 9 June at DMT. **April 2026:** TNA work is a key theme running through the cross-directorate

Gaps in Assurance / Action Plans for the cause C2 Inability to maintain capacity and capability of the specialist workforce.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						training and development function which is being scoped.
AP2.2	Working with HEIW colleagues to broader HEI links offering public health placement opportunities for health professional placements Allied Health professions/Nurses & Midwives	Feedback from participants	This will provide trainees in allied health professions to experience public health placements to support their future careers to promote prevention and healthy lifestyle	Deputy National Director Health Protection and Screening Services Business / Workforce Development Manager - Office of Medical Director	Mar 26	**June 2026:** First T&F meeting due to take place end of June/early July **April 2026** T&F group being set up to include PHW, HEIW and HEI to being to plan. Working with NQIG to align with their student placement process.
AP2.3	Improved involvement by OMD in the education commissioning process, working with POD, NQIG and Divisional L&D Leads	N/A	Improved oversight of education commissioning funding and allocation	Deputy National Director Health Protection and Screening Services Deputy Medical Director and Head of HARP Programme	Mar 26	**June 2026:** No update on outcome of education commissioning, update as per AP2.1 **April 2026** No update on outcome of educational commissioning

Gaps in Assurance / Action Plans for the cause C2 Inability to maintain capacity and capability of the specialist workforce.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
				Business / Workforce Development Manager - Office of Medical Director		submission, however this work is being scoped under the cross-directorate training and development function project.

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.1	Next steps on development and implementation of Route Maps for priority area 'Excellent public health services'	Route maps are required to inform IMTPs going forward which will be monitored through existing approaches	By developing a longer term and more coordinated approach to development and implementation of innovation and continuous quality improvement in service provision	National Director Health Protection and Screening Services (Exec sponsor) Deputy National Director Health Protection and Screening Services (priority lead)	Route maps	**June 2026:** Preparation for 27/28 IMTP setting process underway, to include a greater focus on embedding the routemap. **April 2026** Ongoing engagement with enabling functions to identify how activity supporting the route map aims can be collated. Review of

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						IMTP process and how to further embed Routemap being initiated for next year IMTP setting process objectives.
AP3.2	Development of approach to assess impact of research activity (IMTP Aim)	Via IMTP objective monitoring	Assessment will include service impact in addition to academic impact metrics enabling assurance that research activity is meeting innovation and improvement needs	Deputy National Director Health Protection and Screening Services	March 2026	**June 2026:** Awaiting outcome of cross directorate way of working review. **April 2026** Research has been included as an area of focus in a cross-directorate ways of working review which will inform future strategy.
AP3.2	Development of a Directorate approach to assurance and coordination of research an innovation activities	Via IMTP objective monitoring	HPSS Divisions currently have internal review and assurance processes for research and innovation – a Directorate approach is in development that will enable a more coordinated approach	Deputy National Director Health Protection and Screening Services	March 2026	**June 2026:** Awaiting outcome of cross directorate way of working review. **April 2026** Research has been included as an area of focus in a cross-directorate ways of

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
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						working review which will inform future strategy.

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.1	This risk is predominantly monitored on an ongoing basis via our business continuity planning process. Current controls are considered to provide an appropriate level of risk mitigation. As part of our pandemic planning activity there is an opportunity to consider if lesson learnt and gaps also apply to this risk scenario. This process will identify further areas of risk mitigation.	Measurement of efficacy will become relevant if further actions are identified to mitigate this risk	By undertaken a review to identify potential further risk mitigation activities. Impact/mitigation will only occur if additional actions are identified	Deputy National Director Health Protection and Screening Services Head of Emergency Preparedness Resilience and Response	March 2026 Request Closure. Ongoing BAU Management	**June 2026:** Request Closure. Ongoing BAU Management **April 2026:** V1 of the PHW Pandemic Response Arrangements complete, currently awaiting approval at BET and Board (May & June respectively).
AP 4.2	Strengthen strategic oversight of pathway resilience across national screening programmes ensuring risks arising from unplanned activity and wider system	• Improved visibility of emerging screening system risks. • Evidence of enhanced pathway resilience across national screening programmes	• Maintains organisational resilience to unplanned activity affecting screening performance and population outcomes.	Director Screening Division		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	dependencies are identified, escalated and addressed through established governance routes.	• Strengthened workforce sustainability indicators at a strategic level. • Digital capabilities aligned with strategic assurance requirements	• Strengthens the organisation's resilience to variation in screening demand and wider system pressures. • Provides assurance that screening pathways remain stable and that risks are escalated effectively. • Supports sustained compliance with national screening standards			paused while an additional Exec led listening exercise undertaken **April 2026** Improvement plans implemented for Bowel Screening Wales (BSW), Breast Test Wales (BTW) and Diabetic Eye Screening (DESW), with the establishment of the Screening Improvement Programme to enable consolidation of all improvement activity and streamlined governance. The BTW plan sets out a time□bound programme to restore safe, equitable and high□quality breast screening across Wales. It focuses on recovering national

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						standards, reducing regional variation, strengthening workforce and infrastructure resilience, improving equity and uptake, and aligning delivery with Breast Screening Service Review. The BSW plan sets out a time limited, systemwide programme to improve access to screening colonoscopy across Wales. It focuses on increasing capacity, addressing workforce constraints, reducing variation, and improving data visibility through collaborative working with health boards and partners, providing a credible route to sustainable, equitable improvement.

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						The DESW plan sets out an evidence led programme to address demand–capacity imbalance and restore screening coverage across Wales. It focuses on increasing clinic utilisation, redesigning delivery models, testing innovative approaches, strengthening governance and workforce resilience, and providing Board assurance of a sustainable route to equitable, future proof diabetic eye screening.