Agenda item 5.6.1 Strategic Risk 3

<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><td>Trend</td><td>Current Position of Risk Including Risk Appetite and Risk Decision</td><td>Position Statement – Executive Director Update</td></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>The risk score remains at 16 and is likely to be revised downwards as the Sexual Health Test and Post Incident has been closed, reverting to business as usual. However, performance of the Breast screening 3 week waits for assessment, and 4 week waits for bowel screening colonoscopy remain significantly off target.

Following closure of the Sexual Health incident, a series of debriefs will take place to identify learning regarding the management of the incident. A chair</td></tr>
</table>

		has been identified for the Independent External review and a panel convened to carry out the review, A draft report is due in October and a final report in January 2027. Strong governance arrangements are in place for the ongoing management of the service. The operational response to health protection incidents, particularly fires of long duration, have tested the resilience of the Environmental Public Health and EPRR teams. Work is ongoing to ensure resilience in the Environmental Public Health team following the withdrawal of UKHSA support to the team. The capacity in the Health Protection Response team has improved following the return of staff from planned and unplanned absence. 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 and a final report will be shared, followed by a period of engagement with the programme team. 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 in EPRR training and exercises, alongside debriefing and implementing lessons identified from incidents and outbreaks.	• PHW Emergency Response Plan (V4) • PHW Pandemic Response Arrangements (V1) • PHW Countermeasures Protocol • PHW Business Continuity Arrangements. • Communicable Disease Plan for Wales • PHW Annual Assurance Return to Welsh Government on EPRR	• Annually reviewed, tested by exercise, with written assurance to Board. • Reviewed biennially, tested by exercise. • Annually reviewed by Directorate with assurance via Emergency Preparedness Resilience and Response (EPRR) Group Meetings (Quarterly) reported to Board. • Reviewed biennially, tested by exercise in conjunction with Health Protection

[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.

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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?**
		• 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.	• Annually produced, with approval from EPRR Group, HPSS DMT, BET, QSIC & Board. • Schedules for meeting, training, testing and exercising vary. For further detail, please contact phw.eprr@wales.nhs.uk
C1.2	Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-clinical *Standard Operating Procedures and Protocols*.	• Comprehensive suite of organisational policies and procedures. • HPSS directorate and divisional policies and standard operating procedures aligned where relevant to clinical and operational delivery standards and agreements. • Population Screening Programmes delivered in line with UK National Screening Committee recommendations and as approved by the Wales Screening Committee and Welsh Government Policy. • HPSS laboratory systems accredited to ISO 15189:2022, with re-validation required yearly.	• 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) • UKAS inspections and resulting accreditation guarantees the highest levels of impartiality and competence through the continuous assessment processes including walkarounds.

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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?**
C1.3	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 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.	• Excellent operations programme scope • Excellent operations delivery dashboard • Range of diagnostic / review reports • Deliver quality improvements against the quality priorities identified against the Duty of Annual Report & Quality Standards Self-assessment /QOF	• Monthly DMT update reporting • Reports into corporate committees and Board • Internal audit reports on programme projects

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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?**
		• Service User Feedback	
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 the Duty of Quality standards and digital standards	• Delivery of PHW's digital routemap • Comprehensive mapping document of HPSS user requirements • HPSS delivery of future service transformation vision. • Inclusions in 10 year strategic capital plan • Service user feedback and engagement	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme) • 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	• Monthly screening performance dashboards (strategic indicators only)	• Monthly strategic performance review (DMT/QSIC)

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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?**
	assurance arrangements in place to oversee performance and population-level risks associated with the national screening programmes.	• 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	• 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 • Mid-Year Review and year-end position reports • Finance Business Partner oversight • Directorate risk registers financial entries	• Monthly DMT and finance review meetings • Quarterly reporting to QSIC/Board • Regular savings plan tracking cycles • In year variance management process • Annual financial planning and budget risk review

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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?**
C1.12	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-	• Annual Report to POD COM / QSIC

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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?**
		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	• 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

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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

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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

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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	**August 2026:** Closed? **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). **February 2026:** Exercise PEGASUS debrief report finalised, recommendations incorporated into Pandemic Response Arrangements for

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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.			PHW, to be showcased at Exercise Anadl on 5th March.
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	**~~Aug~~ust 2026** A cross-functional HPSS and RDD group has been established to improve IMTP and procurement planning, addressing identified gaps in visibility and coordination through enhanced processes, standardised documentation, and earlier engagement. The group is also reviewing upcoming work to identify digital upgrades with significant resource or financial impacts, escalating risks where required. **June 2026:**

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Conversation 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. **February 2026:** Bi-monthly Exec meeting between HPSS & RDD initiated, scoping of areas of focus for the Exec meeting underway. Full impact of changes to organisational approach to portfolio reporting still under assessment.

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
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		**August 2026** Three separate trajectories have been developed for each of the improvement plans and included in the reporting. Improvement plan updates have been reviewed by the Business Executive Team (BET) and will be submitted to the Board for consideration. **June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an additional Exec led listening exercise undertaken

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						April 2026 Improvement recovery plans being updated monthly with work to be undertaken to develop the appropriate recovery trajectories to include in the plans. **February 2026:** Improvement Implementation plans developed for KPI that not meeting timeliness standard. Timelines of recovery detailed.
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		**August 2026** Improvement plan updates have been reviewed by the Business Executive Team (BET) and will be submitted to the Board for consideration. To strengthen system oversight and

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**
						assurance, the Chief Executive has agreed to write to each Health Board regarding current pathway performance and the assurance arrangements in place for pathways subject to improvement plans. **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 .

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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 has 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 Breast Test Wales,

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						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. **February 2026:** CEO follow-up correspondence has been issued in relation to agreed action plans. We are now establishing a single, centralised process for

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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**
						review, monitoring, and reporting of progress to the Directorate Management Team of improvement plans for the BTW, BCS and DESW.
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		**August 2026** Responses to the Breast Test Wales Service Review consultation including additional stakeholder engagement and factual accuracy checks are currently being reviewed and incorporated into the final report. **June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an

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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 has 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. This Programme will be

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**
						supported by cross-organisational governance and resourcing, with an immediate focus on prioritised improvement actions **February 2026:** The in-depth analysis of the Breast Test Wales (BTW) Review has been completed. The consolidated report will be considered by BET on 04.03.26 to obtain initial executive feedback and agreement on next steps.
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		**August 2026** The DESW improvement plan with trajectories have been reviewed by the Business Executive Team (BET) and will be

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						submitted to the Board for consideration. **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 cancel some clinics due to staff sickness. **April 2026** Extension of contract for use of Tenovus mobile agreed for 3 months to maintain

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**
						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. **February 2026:** Additional mobile clinics in March to target backlog areas. Two new clinic models have been piloted successfully and will be implemented March and April 2026. Evaluation of new technology and modified usage of eye drops now expected to be in April and May 2026.
AP1.7e	Enhance strategic screening assurance reporting into DMT/QSIC, enabling clearer oversight	• Quality of reporting • Assurance ratings at QSIC	Improves organisational oversight, enables earlier action, and strengthens Board assurance on risk mitigation effectiveness.	Head of Directorate Business Operations	Q4 2025/26	**August 2026** Improvement Plan updates have been reviewed by DMT, BET and submitted to the

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	of risk movement and escalation	• Improved visibility of early warning indicators		Head of Operations Screening Division		Board for consideration. Regular submission to BET of working plan documents agreed for information. **June 2026:** Updated QSIC report incorporating specific Board feedback submitted. Proposed DMT governance structure under consideration to 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

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Programme and SRO/Lead agreed and will report monthly to DMT and BET. **February 2026:** Report reviewed at QSIC, work is ongoing.
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	**August 2026 :** At the Executive Oversight Meeting on the 4 August it was agreed that pending sign off of the Hepatitis C closure report, the incident would stand down with all remaining actions being transferred into Health Protection Business as Usual Governance process. The IMT is expected to meet and close the incident on 7 August. A plan has been developed to deliver that remaining

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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.						
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						improvement actions, and assurance against delivery of the plan will be monitored by HP SMT, HPSS DMT and BET in line with normal governance processes. **June 2026:** SRG and SHIG has now stood down. Service management structure is being refined with clear governance around accountability, 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

Agenda item 5.6.1 Strategic Risk 3

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.						
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						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. Digital improvements underway, and BPAG to stand up and implements best practice guidance and appropriate skillset **February 2026:** Incident Management Team and sub-groups in place to co-ordinate the necessary actions to mitigate the risks.

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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	**August 2026** Cross directorate activity review presented to DLT. Next steps under consideration **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 training and development function which is being scoped. **February 2026:** Paper approved by BET, work to commence on

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						retention and TNA activities.
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	**August 2026** Joint working taking place with NQIG and HEIW. Contact made with HEIs and work started to identify requirements of placements. **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. **February 2026:** Paper approved by BET, working group to be established with support from HEIW

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**
						and NQIG to establish and embed student placement opportunities for AHPs.
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 Business / Workforce Development Manager - Office of Medical Director	Mar 26	**August 2026** No update on outcome of education commissioning, update as per AP2.1 **June 2026:** No update on outcome of education commissioning, update as per AP2.1 **April 2026** No update on outcome of educational commissioning submission, however this work is being scoped under the cross-directorate training and development function project. **February 2026**

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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**
						Education commissioning requirements submitted by deadline – awaiting final approval due at end of March 26.

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	**August 2026** Model of reporting to KRIC on the strategic priority being developed to offer enabling functions space to report relevant updates. IMTP objective setting process still in development to better reflect strategic priority. **June 2026:** Preparation for 27/28 IMTP setting process underway, to include a

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
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						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 IMTP process and how to further embed Routemap being initiated for next year IMTP setting process **February 2026:** Work continues within the IMTP setting space to ensure route maps are fully embedded. An assessment undertaken as part of IMTP setting activity has identified where route map aims are not explicitly reflected in IMTP objectives, this

Gaps in Assurance / Action Plans for the cause C3 Absence of innovation and continuous quality improvement.						
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						is due to them primarily being delivered through BAU activity or via other organisational programmes. A cross-organisation workshop held on 28 January 2026 explored how excellence is defined within the 2035 enabling objectives. A follow-up session in April will focus on how colleagues can support delivery of these objectives and inform future IMTP planning.
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	**August 2026** Cross directorate review presented to DLT – awaiting next steps decision if research will be prioritised. **June 2026:**

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						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. **February 2026:** Pilot drafts of standard metrics on academic impact from existing academic databases is being explored. A model of gathering internal impact is being considered and how this can link with RDD's offer, with the intent to prose a pilot. We are also exploring RDD's existing processes to assess the impact of our

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						epidemiological reports.
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	**August 2026** Cross directorate review presented to DLT – awaiting next steps decision if research will be prioritised. **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. **February 2026:** Pilot drafts of standard metrics on academic impact from existing

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						academic databases is being explored. A model of gathering internal impact is being considered and how this can link with RDD's offer, with the intent to prose a pilot. We are also exploring RDD's existing processes to assess the impact of our epidemiological reports.

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	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	March 2026	**August 2026** ~~Closed~~? **June 2026:** Request Closure. Ongoing BAU Management **April 2026:** V1 of the PHW Pandemic Response Arrangements complete, currently

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Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	and gaps also apply to this risk scenario. This process will identify further areas of risk mitigation.			Resilience and Response		awaiting approval at BET and Board (May & June respectively). **February 2026:** Exercise PEGASUS debrief report finalised; and C19 Lookback Series published. Lessons from both incorporated into Pandemic Response Arrangements for PHW, and the PHW Emergency Response Plan.
AP 4.2	Strengthen strategic oversight of pathway resilience across national screening programmes ensuring risks arising from unplanned activity and wider system dependencies are identified, escalated and addressed through established governance routes.	• Improved visibility of emerging screening system risks. • Evidence of enhanced pathway resilience across national screening programmes • Strengthened workforce sustainability indicators at a strategic level.	• Maintains organisational resilience to unplanned activity affecting screening performance and population outcomes. • Strengthens the organisation's resilience to variation in screening demand and wider system pressures.	Director Screening Division		**August 2026** Working improvement plans with trajectories now being shared with BET and Board on an ongoing basis. **June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
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		• Digital capabilities aligned with strategic assurance requirements	• Provides assurance that screening pathways remain stable and that risks are escalated effectively. • Supports sustained compliance with national screening standards			recommendations 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

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						recovering national 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, system-wide 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

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						sustainable, equitable improvement. 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. **February 2026:** Improvement implementation plans have been developed and are being

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						implemented and monitored for the three main areas of improvement on timeliness of screening pathway that is focussed. Deep dive on Screening at QSIC on 24 February with deep dive presentation and detailed papers on Breast Screening, Bowel Screening and Diabetic Eye Screening focused on timeliness performance specific areas. Letter of escalation to BCU CEO on assessment pathway in BCU sent with CEO meeting arranged for 10 March. CEO letters sent to Health Boards for follow up of recovery plans for Bowel

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						Screening Colonoscopy waiting times. Breast Screening Programme has initiated Performance Improvement group to take improvement plan forward. Bowel Screening has initiated Screening Colonoscopy Improvement Project to identify options to strengthen core screening colonoscopy capacity and improve the resilience of the screening endoscopy services across Wales. Representatives from across all health boards and partner organisations to contribute to project Input from clinical

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						leads, Screening Colonoscopists, operational managers, Lead SSPs, senior nurses and colleagues with an interest in service improvement. Your support to nominate representatives is valued. Diabetic Eye Screening managing improvement plan through project group and transformation programme structure.