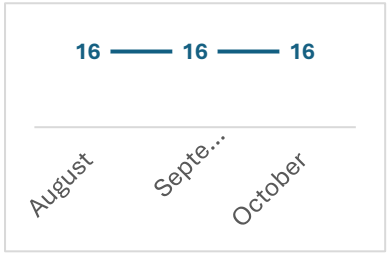
Item 4.2 – Strategic Risk Register
Strategic Risk 3

<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>October 2026 Update:

The risk score remains at 16. While the previous Sexual Health Test and Post Incident had been closed and transitioned into business-as-usual governance, a new incident relating to Hepatitis B testing within the Sexual Health Service has subsequently been identified. In light of this development, it would not be appropriate to reduce the current risk score at this stage. Full assurance cannot be provided until the new incident has been investigated, the associated review and lookback activity has been completed,</td></tr>
</table>

		and the implications for the wider service and its governance have been fully understood. An **Incident Management Team (IMT)** and **Tactical Co-ordination Group (TCG)** have been established to coordinate the response. The IMT is chaired by the Interim Medical Director. Additional senior support has also been put in place for the Sexual Health Service, including interim line management from an experienced former Nursing Director, reporting into the Deputy National Director of Health Protection, Infection and Environment. These arrangements are intended to strengthen immediate operational oversight and provide additional leadership capacity while the response, lookback and improvement work progresses. The **Independent External Review** has also been asked to consider the response to the newly identified issue, including how the issue was not identified earlier and whether there are lessons for the effectiveness of previous scrutiny and assurance arrangements, including at Board level. This should provide an additional and independent assessment of whether existing governance and assurance processes were sufficiently effective and identify any further changes required. The service should therefore **not yet be considered risk-free or fully assured**. A programme of improvement activity is required to reduce the underlying risk, with a number of actions already in progress and some improvements implemented. This includes implementation of relevant best-practice guidance and completion of the actions arising from the incident response, lookback work and external review. The residual risk should be reconsidered once

		this work has progressed sufficiently to provide evidence that improvements have been embedded and are operating effectively. Performance pressures also remain within Screening, with Breast Screening three-week waits for assessment and four-week waits for Bowel Screening colonoscopy remaining significantly off target. Separately, the operational response to Health Protection incidents, particularly prolonged fires, continues to test the resilience of the Environmental Public Health and EPRR teams. Work remains under way to strengthen Environmental Public Health resilience following the withdrawal of UKHSA support. Capacity within the Health Protection Response team has improved following the return of staff from planned and unplanned absence. **AP1.8 Update** Following the previous decision to stand down the Hepatitis C incident and transfer outstanding actions into business-as-usual governance, a **new Sexual Health incident relating to Hepatitis B testing has been identified**. An IMT and TCG have been established to coordinate the response, with strengthened senior leadership and management support put in place for the service. As a consequence, the overall risk **remains at 16 and should not currently be reduced**. The position will need to be reassessed following completion of the new incident investigation, associated lookback and review activity, and consideration of the findings of the Independent External Review. Improvement actions already under way, together with implementation of best-practice guidance and any

		additional actions arising from these reviews, will provide the evidence required to determine whether the underlying risk has been sustainably reduced and whether greater assurance can be provided.

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 • 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	• 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 • 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

[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?**
		Public Health (PH) Emergency Preparedness, Resilience & Response (EPRR) Group.	
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.
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.	• 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.

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?**
		• 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	• Rolling monthly programme at HPSS DMT / SMT monitoring via quality & performance reporting through governance structures of PHW to QSIC & Board • Reports to divisional SMTs and QSIC • Monthly Quality performance reviews with Health Boards on their aspects of delivery of screening programmes and recovery trajectories. (SH) • New Screening performance arrangements being developed as a result of management changes
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 • Service User Feedback	• Monthly DMT update reporting • Reports into corporate committees and Board • 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	• 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)

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?**
		• Contribution to the PHW Duty of Quality reporting and corporate Governance groups • Compliance with quality inspections (e.g. UKAS)	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 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	• Monthly strategic performance review (BET/QSIC) • Quarterly Board reporting through established assurance mechanisms. • Annual reporting to Welsh Government • Escalation through Executive route where strategic risks increase

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?**
		• Improvement plans for BTW, BSW and DESW implemented by the programme with oversight at the Directorate Management Team and reporting to QSIC	
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
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	• 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] **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?**
		• 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	
C1.13	Lift from action bit	•	•

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	• 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),

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?**
		• Nursing & Midwifery Leads attendance and information cascade	
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
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
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,

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?**
			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**
AP1.2	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	Deputy National Director Health Protection and Screening Services Assistant Director of Operations Health Protection	Q4; 2025/26	**October 2026** NQIG representation on HPSS clinical digital safety group to support clinical safety officer from the RDD and workstreams to strengthen clinical involvement in digital systems design **August 2026** A cross-functional HPSS and RDD group

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 clinical safety officers.			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.
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		**October 2026** Monthly reporting for BTW, DESW and BSW is now embedded into Divisional governance cycles, with periodic reporting to the Business Executive Team (BET) and Board.

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**
						August Improvement Trajectories been reviewed by the Business Executive Team (BET) and will be submitted to the Board for consideration. Exercise undertaken 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		**October 2026** Monthly reporting for BTW, DESW and BSW is now embedded into Divisional governance cycles, with periodic reporting to the Business Executive Team (BET) and Board. **August 2026**

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**
						Improvement plan updates have been reviewed by the Business Executive Team (BET) and will be submitted to the Board for consideration.
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		**October 2026** The BTW review consultation period has ended and feedback has been analysed and reported to the Business Executive Team. Final report amendments are currently in-progress. Improvement capacity increased by involving the I&I hub in planning & implementation of recommendations, based upon application of a Quality Management System approach.

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**
						NGIG will be undertaking a review of staff rostering with POD for N&M and staffing levels with screening Head of Nursing. **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.
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		**October 2026** Monthly improvement reporting for DESW is now embedded into Divisional governance cycles, with periodic reporting to the Business Executive Team (BET) and Board.

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**
						Scoping work has commenced to undertake a review of DESW performance reporting and the application of data standards similar to the NHS 'Unified Rules' but in line with National Screening Committee standards. **August 2026** The DESW improvement plan with trajectories have been reviewed by the Business Executive Team (BET) and will be submitted to the Board for consideration.
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	Q4 2025/26	**October 2026** Monthly reporting for BTW, DESW and BSW is now embedded into Divisional governance cycles, with periodic

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**
				Head of Operations Screening Division		reporting to the Business Executive Team (BET) and Board. Planning for the Population Screening and Quality Directorate is underway which includes a governance review and assurance flows from the Division to the Business Executive Team and Board. Weekly safety huddles with NQIG are in place to review incident management, safety issues and concerns to address incident closure rates and improvement actions Quarterly Quality meeting in place with NQIG and Screening programmes to review patient safety and quality related workstreams.

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**
						Quality Dashboard collated by NQIG and presented at Quality Oversight group monthly. Quality Management System approach being applied to performance improvement across screening programmes. **August 2026** Improvement Plan updates have been reviewed by DMT, BET and submitted to the Board for consideration. Regular submission to BET of working plan documents agreed for information.
AP1.8	Strengthen governance and delivery of the Sexual	• Effectiveness of Incident Management Team	Completion of lookback in a timely manner.	Director of Health Protection	Q1 2026/27	**October 2026** Clinical Governance review completed 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**
	Health Test and Post service incident	• Key timely decision-making • Timely actions • Effective stakeholder communication • Alignment of service with best practice	Delivery of a service aligned with best practice.			the service and wider PHW clinical services. Corporate safeguarding nurse in supporting the service 2 days a week to release capacity for redesign work. Senior Nursing support also now in place for the service day to day operations and ensuring legacy actions form the IMTs are completed. Band 7 safeguarding secondment opportunity also being progressed to strengthen safeguarding arrangements. Service reports received quarterly at the safeguarding group. **August 2026 :** At the Executive

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**
						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 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.

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	**October 2026** NQIG model for retention and TNA review to be used and adapted for regulated professions (HCPC registrants) – survey to be launched in November 26. TNA for Nurses & Midwives completed and report drafted. **August 2026** Cross directorate activity review presented to DLT. Next steps under consideration.
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	Mar 26	**October 2026** Survey to identify placement opportunities launched in Oct 26. Discussions being arranged with HEIW and HEIs. NQIG having ongoing discussion with 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**
				Manager - Office of Medical Director		and meeting scheduled for spoke placement with one HEI. Discussions with POD on the development of a robust process to support this. **August 2026** Joint working taking place with NQIG and HEIW. Contact made with HEIs and work started to identify requirements of placements.
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	**October 2026** Joint Strategic & Education Meeting scheduled for 21/9/26 with HEIW and PHW **August 2026** No update on outcome of education commissioning, update as per AP2.1

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		

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	**October 2026** Clinical Governance group created (PHW Wide) with draft TOR in progress. Quality Impact Assessment developed with supporting procedure and process through the QUOG and will be launched in Q3. Review of approach to IMTP development underway in light of organisation changes. **August 2026**

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**
						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.
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	**October 2026** Explicit clarification of research and evaluation activities in the delivery of IMTP have been included in the advice and guidance for the development of new IMTP's for the Directorate **August 2026** Cross directorate review presented to DLT – awaiting next steps decision if

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**
						research will be prioritised.
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	**October 2026** Explicit clarification of research and evaluation activities in the delivery of IMT have been included in the advice and guidance for the development of new IMTP's for the Directorate **August 2026** Cross directorate review presented to DLT – awaiting next steps decision if research will be prioritised.

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**
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. • Digital capabilities aligned with strategic assurance requirements	• 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. • Provides assurance that screening pathways remain stable and that risks are escalated effectively. • Supports sustained compliance with national screening standards	Director Screening Division		**October 2026** Performance against improvement trajectories slightly improved on BTW and BSW but not DESW despite additional capacity and efficiency doe to demand and capacity gap. Evaluation of new cameras complete – design of new model being clinically worked up. **August 2026** Working improvement plans with trajectories now being shared with BET and Board on an ongoing basis across Wales.

SRR3 control-by-control directorate mapping

Control	Current control focus	Proposed ownership	Required update
C1.1	Emergency preparedness, business continuity, training, exercises and lessons from incidents/outbreaks.	**HPIED**	Retain under HPIED. Replace HPSS DMT references with the agreed HPIED governance route and confirm the current versions and approval cycle for EPRR plans.
C1.2	Policies, procedures, SOPs, screening standards and laboratory accreditation.	**Split: HPIED and Population Screening & Quality**	Create separate controls: HPIED for divisional SOPs and ISO 15189 laboratory systems; Population Screening & Quality for screening policy, UK National Screening Committee requirements, audits and IR(ME)R assurance.
C1.3	Risk-based delivery assurance, performance reporting, audit, incidents and screening recovery monitoring.	**Split: HPIED and Population Screening & Quality**	Separate directorate performance and quality-assurance arrangements. Retain screening recovery trajectories and Health Board reviews within Population Screening & Quality; establish equivalent HPIED reporting and escalation routes.
C1.4	HPSS-wide operational improvement and quality-management approach.	**Both, subject to redesign**	Remove the HPSS-wide framing. Each directorate should confirm its own quality-management and operational-improvement control, governance, dashboard and corporate assurance route.
C1.5	Clinical governance framework, divisional quality monitoring and safety and learning culture.	**Both**	Retain as a common corporate framework but describe separate directorate quality leads, reports, inspection regimes and escalation routes. Allocate screening-specific interval cancer reviews and peer visits to Population Screening & Quality; UKAS and clinical-service assurance to the relevant HPIED services.
C1.6	Digital transformation aligned to strategic, operational, user and quality needs.	**Split: HPIED and Population Screening & Quality**	Replace the single HPSS digital portfolio with directorate-specific digital priorities. Retain the Health Protection Digital replacement programme within HPIED and map screening systems and transformation dependencies to Population Screening & Quality.

Control	Current control focus	Proposed ownership	Required update
C1.7	Strategic oversight of national screening programme performance and improvement plans.	**Population Screening & Quality**	Transfer in full. Update DMT references, Executive ownership and assurance flows to reflect the new directorate and its route to BET, QSIC and Board.
C1.8	Governance and assurance of Sexual Health service delivery and incident actions.	**HPIED**	Retain in HPIED. Update divisional and directorate governance references, action ownership and the route for external review and residual incident assurance.
C1.11	Directorate financial governance and alignment of operational plans with financial capacity.	**Both**	Duplicate as a directorate-level control for each new directorate, with separate budgets, savings plans, finance business-partner oversight, risk entries and reporting routes. Correct numbering if controls C1.9 and C1.10 are not intended.
C1.12	Programme and change-management oversight across the directorate.	**Both**	Replace the former single-directorate portfolio with separate HPIED and Population Screening & Quality change portfolios, capacity reviews, IMTP priorities and escalation arrangements.
C1.13	Incomplete placeholder: “Lift from action bit”.	**Decision required**	Do not transfer in its current form. Define the intended control and evidence, allocate it to the appropriate directorate, or delete the placeholder.
C2.1	Professional regulation, revalidation, appraisal, supervision and professional standards.	**Both**	Retain the corporate professional framework but separate directorate assurance. Map specialist scientific and public health professions to HPIED and screening nursing, clinical and programme professions to Population Screening & Quality.
C2.2	Workforce planning aligned to future operational and strategic needs.	**Both**	Require separate directorate workforce plans, capacity indicators, vacancy and pipeline analysis, with distinct risks for HPIED specialist services and screening pathways.
C2.3	Specialist training-provider status, competency standards and career pathways.	**Both, with service-specific elements**	Separate the scientific workforce, NSHCS, IBMS and ISO elements under HPIED from screening-specific competency and development pathways under Population Screening & Quality.

Control	Current control focus	Proposed ownership	Required update
C2.4	People development, competency frameworks and training needs assessment.	**Both**	Retain as parallel directorate controls with separate training needs, competency gaps, development plans and monitoring through each management team.
C2.5	HEIW and higher-education links to develop future workforce pipelines.	**Both**	Retain jointly where corporate relationships are shared, but specify directorate workforce pipelines, placements, professional groups and accountable leads.
C3.1	Horizon scanning for service and technological advances, including procurement and UK screening advice.	**Split: HPIED and Population Screening & Quality**	Assign scientific, infection, environmental and health-protection horizon scanning to HPIED. Assign UK National Screening Committee recommendations and screening innovation to Population Screening & Quality. Retain procurement support across both.
C3.2	Research and development strategy and directorate priorities.	**Both**	Replace HPSS wording with separate directorate research, evaluation and innovation priorities, while retaining links to the corporate research strategy and KRIC.
C3.3	Cross-reference to C1.4, C1.5 and C1.11.	**Both, subject to review**	Review whether this adds a distinct control. If retained, update cross-references after the controls are split and correct any numbering; otherwise remove duplication.
C4.1	Resilient 24/7 EPRR on-call service and Civil Contingencies Act obligations.	**HPIED**	Retain in full within HPIED. Replace HPSS metrics and DMT references with HPIED monitoring and confirm the annual assurance route through BET, QSIC and Board.
C4.2	Surveillance and escalation of infectious and environmental health threats.	**HPIED**	Retain in full within HPIED. Confirm accountable service, escalation criteria, weekly reporting route and links to incident response.