GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales	**Name of Meeting** Quality, Safety and Improvement Committee **Date of Meeting** 10 September 2026 **Agenda item:** 5.6.1

Public Health Wales Strategic Risk Register

Medical Director/ National Director	SR 3
Approval / Scrutiny Route	BET 02/09/2026

Purpose

There is a dual purpose to this paper. Firstly, the Committee is asked to receive the updated Strategic Risk Register for the purpose of scrutiny and challenge, noting the updates to action plans and controls and progressing risk maturity going forward since the last reporting period. This is in line with due diligence, custom and practice alongside the Committee Terms of Reference.

Secondly, the paper provides further assurance over the controls and mitigating actions within Strategic Risk 3 (SR3), as requested by the Chair of the Committee. The report is intended to provide a level of assurance that the mechanisms and controls in place to manage SR3 are appropriate, proportionate and effective. The paper also identifies perceived gaps in assurance and summarises where these gaps are reported, monitored and evaluated across the Health Protection and Screening Services (HPSS) Directorate and to wider governance structures across the organisation.

Following recent structure and reporting changes to Screening Services, this work will also help provide a basis to further assess controls and mitigating actions and to strengthen risk management actions under SR3.

Appendix 1 includes the full risk assessment for strategic risk 3.

Recommendation:

APPROVE	CONSIDER	RECOMMEND	ADOPT	ASSURANCE
☐	☐	☐	☐	☒

The Committee is asked to:

- Take **assurance** that SR3 is being managed appropriately and effectively.

Link to Public Health Wales Strategic Plan

Public Health Wales has an agreed strategic plan, which has identified seven strategic priorities and well-being objectives. This report contributes to the following:	
Strategic Priority/Well-being Objective	All Strategic Priorities/Well-being Objectives

Summary impact analysis	
Equality and Health Impact Assessment	No decision is required.
Risk and Assurance	This submission is the Strategic Risk Register.
Health and Care Standards	This report supports and/or takes into account the Health and Care Quality Standards. All themes
Financial implications	The financial implications of failing to manage risk effectively are significant, both in terms of the potential for loss and also the failure to capitalise on opportunities.
People implications	There are both Corporate and Strategic Risk(s) relating to workforce and organisational development.

1. Introduction

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Following recent structure and reporting changes to Screening Services, this work will also help provide a basis to further assess controls and mitigating actions and to strengthen risk management actions under SR3.We recognise that although this specific request focussed on enhanced assurance related to Screening Services, further review and evaluation of other areas under this risk also need to be undertaken. This will be built into the workplan for the Committee over the course of the remainder of this financial year. In addition to this, Business Executive Team also review and undertaken focussed, deep dives into every Strategic Risk as part of its workplan.

In line with due process and the approach of all Health bodies in Wales, risks are measured against a 5x5 risk scoring matrix:

Risk Scoring Matrix					
Likelihood/ Frequency	Consequence/Impact				
	1. Negligible	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain (91%)	5 (Moderate)	10 (High)	15 (Extreme)	20 (Extreme)	25 (Extreme)
4. Likely (61-90%)	4 (Moderate)	8 (High)	12 (High)	16 (Extreme)	20 (Extreme)
3. Possible (41-60%)	3 (Low)	6 (Moderate)	9 (High)	12 (High)	15 (Extreme)
2. Unlikely (11-40%)	2 (Low)	4 (Moderate)	6 (Moderate)	8 (Moderate)	10 (High)
1. Rare (1-10%)	1 (Low)	2 (Low)	3 (Low)	4 (Moderate)	5 (Moderate)

Organisational risk reporting provides a snapshot of a point in time, and this will continue to be an iterative process. This report outlines the strategic risk position as of **1st August 2026**. In line with the current Risk Management Policy, strategic risks are reviewed and updated every other month, however, the Business Executive Team are asked to acknowledge that the organisational risk profile and landscape is iterative, and work is consistently ongoing to manage the identified strategic risks to the organisation.

2. Risk Appetite Reporting

The risk continues to be managed at 4x4=16 which takes it slightly outside of risk tolerance (which is 3x5=15). However, subject to continued progress of relevant actions and controls, the residual score is anticipated to decrease.

3. Enhanced Assurance - Elements of Controls and Actions for Strategic Risk 3

Following a request from the Chair of Quality Safety & Improvement Committee (QSIC) to provide an enhanced level of assurance over the controls and mitigating actions in respect of Strategic Risk 3 (SR3), the Head of Risk Management met with lead Public Health Consultants in Screening Services to assess the effectiveness of the controls and actions currently being applied to mitigate the likelihood and impact of SR3.

Potential gaps in assurance have also been identified and cross referenced against the current risk assessment for SR3. The following narrative summarises the effectiveness and/or scope for improvement identified in the controls and actions for Screening Services to provide the Committee with assurance that they are being monitored, tested and evaluated consistently and in line with best practice. All relevant updates have been reflected in the 1st August position risk assessment for SR3.

Control 1.2 - Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-clinical *Standard Operating Procedures and Protocols.*

Following learning identified through recent incident investigations, a renewed focus has been placed on assuring consistency of operational processes and compliance with Screening Services Standard Operating Procedures (SOPs) across all screening programmes. Programme teams undertake routine review and updating of SOPs alongside staff training and competency processes to support the consistent delivery of screening pathways. Compliance assurance is provided through operational audits, quality reviews, incident investigations, peer review activity and external assessment processes.

Evidence reviewed to assess the effectiveness of the control includes incident and complaint themes, audit findings, pathway variation, programme performance

indicators, quality assurance visits and recommendations arising from internal and external reviews. Where variation or non-compliance is identified, improvement actions are tracked through programme governance arrangements and monitored through Divisional and Directorate oversight processes.

The control is tested through a combination of routine clinical audit, programme-specific quality assurance activities, external inspections, UKAS accreditation processes (where applicable) and review of incidents and near misses. Recent screening improvement programmes have also strengthened the monitoring of pathway-level performance and operational variation, providing more effective oversight to ensure that procedures are being applied and complied with consistently across Wales.

Control 1.7 - 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.

The effectiveness of this control is evidenced through the establishment of programme-level improvement plans and recovery trajectories for Breast Test Wales (BTW), Bowel Screening Wales (BSW) and Diabetic Eye Screening Wales (DESW). These arrangements have improved oversight of performance variation, enabling earlier escalation and intervention where programmes move off trajectory. Examples include Executive action to address bowel screening colonoscopy capacity, targeted recovery actions for breast screening assessment performance, and transformation activity within DESW to address demand-capacity pressures. The control provides assurance that emerging performance risks are identified, monitored and actively managed through established governance arrangements.
The improvement plans are specifically related to three key metrics and areas of concern in these programmes, namely colonoscopy waiting times in BSW, Coverage in DESW and Assessment Waits in BTW.
A separate group is bringing together a number of issues related to the BTW mobiles into a consolidated improvement piece supported by facilities and others from across the wider organisation.

Action Point 1.7a – Finalise and implement strategic recovery trajectories for national screening programmes.

Recovery trajectories have now been incorporated into the improvement plans for BTW, BSWales and DESW and are monitored through established programme governance and monthly reporting arrangements. The trajectories provide measurable recovery expectations against national standards and key performance indicators and enable early identification of variance and targeted intervention. Examples include BTW recovery trajectories for assessment waits, round length and uptake; the BSW all-Wales trajectory to achieve at least 50% compliance with the

28-day colonoscopy standard by March 2027; and the DESW coverage trajectory linked to delivery of capacity and transformation initiatives.

Action Point 1.7b – Strengthen Executive-level engagement on system-wide dependencies (e.g. diagnostics) to support sustainable screening performance.

Executive engagement has supported stronger system-level ownership of screening recovery plans across Health Boards. For BSW, approval of an all-Wales recovery trajectory, Health Board recovery plans and associated Executive level engagement arrangements have strengthened accountability for delivery. Early evidence of impact is evidenced through all-Wales performance exceeding planned recovery trajectories, with 20.2% compliance against a trajectory of 13.2% and backlog reduction ahead of plan (491 versus 576 participants waiting more than 28 days). Similar Executive level engagement is in place for BTW regarding diagnostic capacity, assessment services and surgical dependencies.

Action Point 1.7c – Provide strategic oversight of the Breast Test Wales Review and ensure alignment of recovery expectations with its recommendations.

The Breast Screening Review is being revised following the 'listening exercise' and remains subject to final sign-off. Whilst awaiting the final report, the associated improvement programme is being implemented and providing strengthened assurance through monthly performance review, governance oversight and delivery against defined improvement domains. These include improvement in assessment timeliness, reading timeliness, round-length recovery, uptake and workforce resilience. Current programme monitoring has improved visibility of risks and dependencies, including workforce pressures, assessment capacity constraints and regional variation, enabling earlier escalation and more targeted mitigation actions.

Action point 1.7d – Ensure strategic assurance of the Diabetic Eye Screening transformation programme.

The DESW transformation programme is focused on improving 12-month coverage through five interconnected objectives: increasing clinic capacity, implementing alternative clinic models, evaluating retinal imaging without routine dilation, expanding the low-risk recall pathway, improving clinic utilisation and strengthening workforce resilience.

Improvement measures include increased appointment capacity, clinic utilisation above 90%, improved programme coverage, increased use of the low risk recall pathway and improved workforce sustainability. Recent progress includes completion of the camera evaluation with 1,445 participants recruited against a target of 1,341, delivery of a 7% increase in programme capacity through new clinic models, and sustained clinic utilisation above 95%. Governance is provided through weekly improvement meetings, monthly Screening Management Team (SMT) reporting and Directorate Management Team (DMT) oversight.

<u>Action Point</u> 1.7e – Enhance strategic screening assurance reporting into DMT/QSIC, enabling clearer oversight of risk movement and escalation.

Whilst longer-term governance arrangements are being considered as part of the wider directorate restructuring, enhanced assurance reporting has already been implemented through the screening improvement governance arrangements. Each programme now reports against defined improvement plans, trajectories, KPIs and programme-level risks through established governance routes to SMT, DMT and Business Executive Team (BET). This has improved visibility of performance variation and recovery progress, enabling more structured oversight and escalation of risk. Interim arrangements will remain in place until the new Directorate structure is fully established.

<u>Action Point</u> 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.

Risks arising from unplanned activity/issues are identified through routine performance monitoring, programme dashboards, improvement plan trajectories, risk registers, incident reporting processes and escalation through governance structures. The screening improvement programmes have strengthened organisational visibility of emerging risks through monthly monitoring of workforce resilience, backlog trajectories, pathway capacity, service fragility and recovery delivery confidence.

Current examples include workforce shortages in BTW, screening colonoscopy capacity pressures and programme delivery risks associated with emerging service demand. Assurance is provided through monthly programme reviews, exception reporting and escalation through Directorate and Executive governance routes, enabling earlier intervention where performance moves off trajectory.

4. Links to the Corporate Risk Register

The Corporate Risk Register (CRR) reflects the most significant operational risks that impact Public Health Wales. The CRR summary table presented within this report is provided to demonstrate the synergy between the management of the Corporate and Strategic risks.

Risk Ref	Risk Description	Risk Cause	Strategic Risk Link
1541	There is a risk of harm to service users and employees within PHW, specifically in relation to vulnerable groups, due to the absence of regular disclosure and barring service checks.	This is caused by the organisation failing to carry out disclosure and barring service renewal checks in additional to the initial check that is undertaken at recruitment (whilst this is not a legal requirement it is best practice)	SR2 SR3
1593	There is a risk that we are unable to demonstrate that the quality standards and the Duty of Quality are embedded in all aspects of PHW business.	This is caused by lack of organisational capacity and capability to operationalise and embed due to competing priorities.	SR1 SR2 SR3 SR4 SR5 SR6
1648	There is a risk that Public Health Wales will lose access to Primary Care data.	This is caused by Audit+ (the current tool) used to gather primary care data being discontinued from July 2024 and there will be no further support of Audit+ from March 2026.	SR1 SR3 SR4 SR5
1678	There is a risk that the organisation will fail to provide sufficient assurance that it is identifying and managing risks effectively through the endorsed Risk Management Procedure and failing to identify themes and trends.	This is caused by inconsistencies in the use of Datix across the organisation, contrary to the approved process.	SR1 SR2 SR3 SR4 SR5 SR6
1758	There is a risk of further service disruption due to excessive dust damaging the detectors of the mammography units on the MBSU's. 1 mobile unit is currently out of service due to this issue. 9 other units could potentially be at risk.	This is caused by dust entering the casing containing the image detector potentially damaging the detector, rendering the machine inoperable.	SR1 SR2 SR3 SR6

1779	There is a risk that we will lose our ability to monitor our impact due to declining survey response rates across many sources of official statistics including the National Survey for Wales, the Annual Population Survey and the Labour Force Survey.	This is caused by declining survey response rates across multiple sources of official statistics.	SR1 SR2 SR3 SR4 SR5 SR6
1946	There is a risk that the organisation will fail to implement a suitable Datix Web replacement that matches the current risk maturity when the system is decommissioned in November 2027	There is no current funding allocated to procure, develop and implement a replacement system and a lack of strategic direction regarding whether a local or national solution is being taken forward. There is also no organisational commitment to supporting this project from a digital perspective.	SR1 SR2 SR3 SR4 SR5 SR6
2076	There is a risk that PHW is unable to meet the legal duties set out in the Equality Act 2010/Public Sector Equality Duty and respond to the needs of the population. It may be unable to enable and demonstrate full compliance with the newly published Accessible Information Standards	This is caused by the lack of an organisational capacity with overall responsibility for Equality Diversity & Inclusion to ensure both a strategic and coordinated approach and associated infrastructure is in place to respond to the needs of the population.	SR1 SR2

2143	There is a risk that we will be unable to deliver an effective long-term sustainable and excellent Environmental Public Health Service to the population of Wales.	- The service is provided by Public Health Wales & Environmental Public Health and the UKHSA, underpinned by an MOU signed in 2013. The MOU was later re-negotiated with UKHSA withdrawing from existing informal arrangements to support front line service provision (can be traced to risk ID 1633; risk materialised). - UKHSA withdrawing from existing informal arrangements to support front line service provision will mean that the Environmental Public Health Service will need to be solely responsible for frontline response both in and out of hours. - Resource capacity issues within the team. 10/02/2026: Further information below: UKHSA has historically provided support to Public Health Wales for the delivery of the duty desk service as a matter of custom and practice. However, no formal or documented arrangements were ever agreed between the two organisations. Following recent developments relating to the revision of arrangements between UKHSA and the devolved administrations, UKHSA colleagues informed Public Health Wales that their frontline support for both in-hours and out-of-hours duty desk provision would cease.	SR1 SR2 SR3
2144	There is a risk that service users may have a clinical procedure undertaken or make decisions on planned care without being fully informed if the All-Wales consent process is not adhered to. This could be from direct service delivery in Public Health Wales or because of national advice & guidance being published by Public Health Wales without taking consent and decision making into consideration.	This is caused by clinicians or Public Health Wales staff potentially not following the latest guidance as detailed in the All-Wales consent and decision-making policy and procedure.	SR3

5. Strategic Risks

A full assessment of Strategic Risk 3 is provided in the attached Strategic Risk Register.

6. Equality Impact Assessment

No decision required.

7. Recommendation

The Committee is asked to:

- Take **assurance** that SR3 is being managed appropriately and effectively.