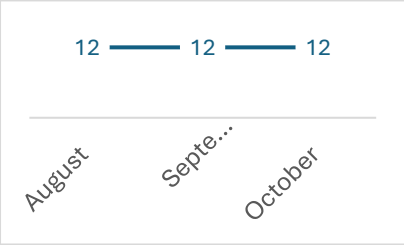
<table>
<tr><td>Risk Reference and Link to Strategic Priority</td><td colspan="2">Risk Description</td></tr>
<tr><td>SRR3

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 = 12
Target Score = 6
Risk Appetite Level Applied = Open, therefore, within tolerance level.</td><td>Work continues to improve operational delivery for services that are not meeting performance targets, particularly for Bowel, Diabetic Eye and Breast screening.
The Bowel screening pathway relies on commissioned providers to carry out further diagnostic tests and the wait times for these are sub-optimal. Meetings have taken place with executives from each Health Board to discuss further mitigations and improvements. Lessons have been identified for implementation.</td></tr>
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		Optimisation and transformation of Diabetic Eye Screening continue to develop a sustainable delivery model. The three-week waiting time for assessments for Breast Screening has not achieved the standard for a long period and the reasons are multi-factorial. In order to identify opportunities to improve excellence, a quality review of the programme has been initiated and will be completed by end 2025. Commitments are made for an internal audit and follow-up of external audits relating to screening services. Workforce capacity across the Health Protection and Screening Services directorate is continuously reviewed, with key mitigations on the health protection and bioinformatics workforce being progressed. The position on screening workforce particularly in North Wales for Breast Test Wales and infection services in North Wales remain key areas of focus to ensure resilient capacity across the clinical team. Work is ongoing to identify priorities for digital support to maintain the delivery of services. As of October 2025, Phase 2 of Exercise Pegasus has been completed, and an initial review has identified lessons to incorporate into future planning assumptions. PHW ensured sufficient resource and input at a local, regional, national and UK-wide level.

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 (V3.2) • 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 Public Health (PH) Emergency	• 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?
		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.	• Performance management with monthly quality monitoring at HPSS Divisional SMT's on key performance indicators and quality

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?
		• 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	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

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
C1.6	HPSS mapping of current and future digital transformation needs aligned with strategic priorities and service user and operational needs aligned to the Duty of Quality standards	• Comprehensive mapping document • Inclusions in 10 year strategic capital plan • Bi Monthly inter directorate DKR and HPSS executive led meeting • Service user feedback and engagement	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme) • Monitored at internal HPSS Programme Meeting • Reporting to HPSS DMT

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

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 • Quarterly reporting of N&M supervision sessions • Pulse/Staff surveys regarding access to CPD
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

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?
			• Equality & Diversity Annual Report /Workforce reports • 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

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

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

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	• Circulated to PHW Executives

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	What Action?	How will we measure efficacy?	How will this action impact/mitigate the risk?	Who is Responsible?	By When?	Progress
AP1.1	Develop resilient, coordinated and effective Pandemic Response Arrangements for PHW.	Arrangements to be validated via an organisation-wide internal desktop exercise.	Align with UK National Respiratory Pandemic Framework (draft) incorporates lessons identified from internal Covid-19 debrief, lookback and reflection processes; as well as recommendations from the UK Covid-19 Module 1 Report. Provides organisational assurance for preparedness.	Huw Williams / Tom Fowler	Q4; 2025/26	October 2025: All work on track. DRAFT 04 produced and being utilised to support PHW participation in Exercise PEGASUS. August 2025: Work progressing well – currently working on DRAFT 03 of the Pandemic Response Arrangements for PHW. Exercise ANADL to be confirmed in the October EPBC group meeting. February 2025: Work ongoing via the Internal Pandemic Preparedness subgroup. Terms of reference agreed, workstream leads identified and key

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
						actions for delivery agreed.
AP1.2	Develop digital programme approach to all digital development activity and improved processes for identifying and agreeing digital activity	Timely delivery of digital 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.	Tom Fowler/Michelle Battlemuch	Q4; 2025/26	October 2025: Organisation portfolio reporting processes have been changed and HPSS are in discussions with RDD to understand the implications and Impact August 2025: It has been agreed with Research Data and Digital on the need to amalgamate actions to mitigate risk will, over time, be managed in one space to ensure a joined up approach. Further work on mapping of all digital projects/activities continues. Preliminary mapping of major project alignment to Digital

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
						governance structures in place.

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	This will either provide assurance that we have a stable, competent workforce or require a set of actions to achieve this	By providing relevant information to determine actions.	Tom Fowler/ Ruth Tofton	Mar 26	October 2025: Collaboration started with NQIG in relation to carry out a joint TNA across professions and utilising previous retention survey questionnaire for HCPC regulated professions. August 2025: Recent discussions with POD in relation to the work linking with the job families project. BET paper being finalised outlining proposals for agreement.

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
						Initial discussions with Nursing and Midwifery professional leads
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	Tom Fowler/ Ruth Tofton	Mar 26	October 2025: Paper delayed to obtain POD input in relation to the job families work they are undertaking – additional content added – paper will be progressed. August 2025: Paper drafted and will be progressed through the relevant committees proposing future placements (similar to Nursing/Midwifery) for AHPs. HEIW have produced plan, paper being drafted for consideration and agreement by BET to engage.

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
AP2.3	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	Tom Fowler/ Eleri Davies/ Ruth Tofton	Mar 26	October 2025: Meeting held with HEIW relating to the Education Commissioning process determining future improvements. OMD continues to be part of the L&D Leads Group for PHW specifically feeding into education commissioning. August 2025: Debrief session being arranged to review and improve PHW's future understanding and response for HEIWs annual education commissioning requirements. Annual commissioning recently completed – allocation confirmation due May 25.

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	Meng Khaw (Exec sponsor) Tom Fowler (priority lead)	Route maps	October 2025: Final updates to the routemap are being undertaken in light of BET conversation. Discussion regarding links with IMTPs outside HPSS are ongoing to ensure a wider adoption. August 2025: An updated route map by the central team has been proposed. An updated version is being developed. A draft route map has been developed and submitted centrally.
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	Tom Fowler	March 2026	October 2025: Currently liaising with RDD on providing additional insight from

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
			activity is meeting innovation and improvement needs			their feedback surveys. August 2025: A proposed pilot model has been developed – existing data sources are being reviewed to consider feasibility of this approach. Initial discussions with Research, Data, Digital on existing metrics collected
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	Tom Fowler	March 2026	October 2025: We continue to explore with relevant leads how we can develop a 'do once and reuse' approach to reporting of research activity and consider reporting routes within the directorate. August 2025: A pilot proposed model has been developed – existing data sources

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
						are being reviewed to consider feasibility of this approach. Forum has been set up for working with key leads

Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	What Action?	How will we measure efficacy?	How will this action impact/mitigate the risk?	Who is Responsible?	By When?	Progress
AP4.1	This risk is predominantly monitored on an ongoing basis via our business continuity planning process. Current controls are considered to provide an appropriate level of risk mitigation. As part of our pandemic planning activity there is an opportunity to consider if lesson learnt and gaps also apply to this risk scenario. This process will identify further areas of risk mitigation.	Measurement of efficacy will become relevant if further actions are identified to mitigate this risk	By undertaken a review to identify potential further risk mitigation activities. Impact/mitigation will only occur if additional actions are identified	Tom Fowler/Huw Williams	March 2026	October 2025: PHW Exercise PEGASUS Phase 01 evaluation via internal debrief, and formal exercise evaluation provided to Exercise Control Team in UK Government. Exercise Control evaluators to monitor Phase 2 and Phase 3 play. August 2025: Planning in place for PHW

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
						evaluation of organisation role in Pandemic exercises (see risk AP1.1)
AP 4.2	Continue to strengthen participant pathways, workforce capacity, and digital transformation across national screening programmes (Bowel, Breast, Diabetic Eye), with a focus on addressing timeliness and service resilience.	• Progress against programme standards and targets • Reduction in waiting times for participant pathway • Improved resilience in specialist roles • Delivery of digital solutions aligned with clinical quality and safety standards	• Supports timely and effective screening delivery • Improves the likelihood of early diagnoses • Maintains compliance with programme standards • Sustains public confidence in screening services	Sharon Hillier		October 2025 • Issues escalated to executive level as appropriate- Workforce development and training ongoing • Digital initiatives and pathway reviews progressing