
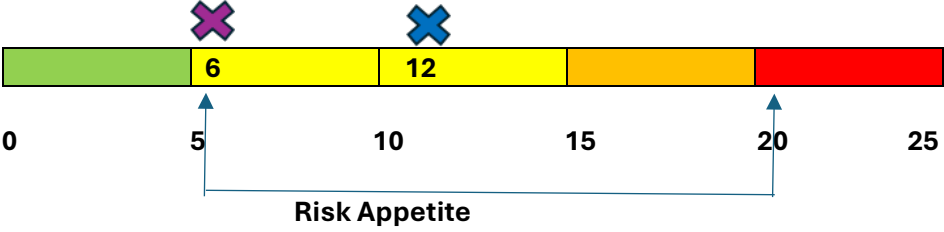


Risk Reference and Link to Strategic Priority	Risk Description			
<p>SRR3</p> <p>Strategic Priority 5</p> <p>“Delivering excellent public health services to protect the public and maximise population health outcomes.”</p>	<p>There is a risk that: We fail to deliver our contribution to excellent public health services in population health screening, infection, health protection and emergency response.</p> <p>Caused by:</p> <ol style="list-style-type: none"> 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. <p>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.</p>			
Executive Director Sponsor	National Director of Screening and Health Protection Services/Medical Director			
Assuring Committee	Quality, Safety and Improvement Committee			
Trend	Current Position of Risk Including Risk Appetite and Risk Decision	Position Statement – Executive Director Update		
 <p>Risk Score</p> <p>9 (JUNE) 9 (JULY) 12 (AUGUST)</p>	<table border="1" data-bbox="584 991 1491 1142"> <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>  <p>0 5 10 15 20 25</p> <p>Risk Appetite</p>	Open	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.	<p>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. This has been escalated to health boards and Chief executive level discussions to agree short- and long-term improvements will conclude in September.</p>
Open	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.			

 = **Current Score**
 = **Target Score**

Optimisation and transformation of Diabetic Eye Screening continue to develop a sustainable delivery model. Several digital developments are ongoing to support service delivery.

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, taking an end-to-end pathway approach will be carried out during 2025.

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.

Looking ahead to September to October, the EPRR team has been preparing for Exercise Pegasus to ensure that there is

		<p>sufficient capacity to respond to the demands of the exercise play.</p> <p>In light of the overall position around performance, the current risk score has been escalated to 12 from 9, increasing the ‘likelihood’ score.</p>
--	--	--

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.	<ul style="list-style-type: none"> • 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- 	<ul style="list-style-type: none"> • 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.

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?
		<p>agency plans and procedures for emergencies.</p> <p>NB. This is via Local Resilience Fora (LRF), Wales Resilience Partnership, Wales Resilience Forum and the 4 Nations Public Health (PH) Emergency Preparedness, Resilience & Response (EPRR) Group.</p>	<ul style="list-style-type: none"> Schedules for meeting, training, testing and exercising vary. For further detail, please contact phw.epr@wales.nhs.uk
C1.2	Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-clinical <i>Standard Operating Procedures and Protocols</i> .	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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

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?
			assessment processes including walkarounds.
C1.3	Variation / risk-based prioritised approach to directorate delivery assurance.	<ul style="list-style-type: none"> • Cross directorate operational delivery reporting. • Action plans with appropriate tracking and trajectories , spotlight sessions and reports to HPSS Divisional SMT’s, DMT QSIC. • Annual clinical audit programme based on risk and variation • Thematic Analysis of NRIs, EWN and Claims • Result of Peer review programme/quality walks • Safety culture and open incident reporting processes, compliance with PTR regulations and Duty of Quality Health & Care Standards 	<ul style="list-style-type: none"> • Performance management with monthly quality monitoring at HPSS Divisional SMT’s on key performance indicators and quality metrics. Focused monthly performance monitoring at HPSS DMT with reporting and insights to PHW Board. • Rolling monthly programme at HPSS DMT / SMT monitoring via quality & performance reporting through governance structures of PHW to QSIC & Board • Reports to divisional SMT’s and QSIC • Monthly Quality performance reviews with Health Boards on their aspects of delivery of screening programmes and recovery trajectories . (SH)
C1.4	An HPSS programmatic approach to benchmarking, reviewing and improving	<ul style="list-style-type: none"> • Excellent operations programme scope 	<ul style="list-style-type: none"> • Monthly DMT update reporting

Internal System of Controls – Linked to ‘Caused By’ section of Risk Description and Source of Assurance ¹			
C1: Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	Internal Control	Internal Sources of Assurance	How/When is it monitored?
	corporate and business operational systems and processes within the directorate supported by corporate enabling functions using the Duty of Quality Health & Care Standards to fully operationalise a quality management system.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Medical, Nursing & Midwifery, HCPC, Allied Health Professional and Multi-Disciplinary Staff Revalidation process and annual audit • Medical Job Planning Process • MYC CPD planning and career professional conversations • Numbers of staff participation in clinical supervision • Mentorship/Preceptorship programmes in place • Nursing Senedd attendance • Nursing & Midwifery Leads attendance and information cascade 	<ul style="list-style-type: none"> • 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 • 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	<ul style="list-style-type: none"> • Divisional level workforce plans in development • Use of career pathway tools 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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

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?
			<ul style="list-style-type: none"> • Number of staff achieving promotions • Equality & Diversity Annual Report /Workforce reports • Nursing & Midwifery retention plan
C2.4	Extensive people development opportunities to maintain and expand knowledge, skills and competency	<ul style="list-style-type: none"> • Training attendance records • Developing and maintaining of staff competency framework and staff Training Needs Assessments (TNA) • Workforce reports 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Via POD assurance processes • OMD and NQIG student programmes/opportunities 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 24/7 Resilient EPRR On Call Service Standard Operating Procedure. 	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> Exceedance reports and protocols with agreed criteria for escalation and response management Weekly HP issue summary produced 	<ul style="list-style-type: none"> 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	<p>August 2025: Work progressing well – currently working on DRAFT 03 of the Pandemic Response Arrangements for PHW.</p> <p>Exercise ANADL to be confirmed in the October EPBC group meeting.</p> <p>February 2025: Work ongoing via the Internal Pandemic Preparedness subgroup. Terms of reference agreed, workstream leads identified and key actions for delivery agreed.</p>
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	Tom Fowler/Michelle Battlemuch	Q4; 2025/26	<p>August 2025: It has been agreed with Research Data and Digital on the need to amalgamate actions to mitigate risk will, over</p>

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
			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.			<p>time, be managed in one space to ensure a joined up approach. Further work on mapping of all digital projects/activities continues.</p> <p>Preliminary mapping of major project alignment to Digital governance structures in place.</p>

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	August 2025: Recent discussions with POD in relation to the work linking with the job families project. BET paper being finalised

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
						<p>outlining proposals for agreement.</p> <p>Initial discussions with Nursing and Midwifery professional leads</p>
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	<p>August 2025: Paper drafted and will be progressed through the relevant committees proposing future placements (similar to Nursing/Midwifery) for AHPs.</p> <p>HEIW have produced plan, paper being drafted for consideration and agreement by BET to engage.</p>
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	<p>August 2025: Debrief session being arranged to review and improve PHW's future understanding and response for HEIW's annual education</p>

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
						<p>commissioning requirements.</p> <p>Annual commissioning recently completed – allocation confirmation due May 25.</p>

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	<p>August 2025: An updated route map by the central team has been proposed. An updated version is being developed.</p> <p>A draft route map has been developed and submitted centrally.</p>
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	Tom Fowler	March 2026	<p>August 2025: A proposed pilot model has been developed – existing data sources</p>

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
			assurance that research activity is meeting innovation and improvement needs			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	August 2025: A pilot proposed model has been developed – existing data sources 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	Measurement of efficacy will become relevant if	By undertaken a review to identify potential further	Tom Fowler/Huw Williams	March 2026	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
	<p>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.</p>	<p>further actions are identified to mitigate this risk</p>	<p>risk mitigation activities. Impact/mitigation will only occur if additional actions are identified</p>			<p>evaluation of organisation role in Pandemic exercises (see risk AP1.1)</p>