<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR1

Strategic Priority 1, 2, 3 and 4</td><td colspan="2">There is a risk that: We fail to deliver our role to influence a system shift to prevention, reduce health inequalities and address determinants of health.

Caused by:
1. Poor alignment of PHW specialist resources, capabilities and programmes with our long-term strategy
2. Failure to generate the quality of evidence and supporting data to shape our influencing and delivery
3. Insufficient/Ineffective public health advice, evidence and action within our remit
4. Ineffective engagement, advocacy and communication with partners, the public and policymakers
5. Insufficient system leadership and co-ordination with stakeholders and partners
6. Programmes which do not support our population in achieving healthier lives

Resulting in:
We fail to have the impact required to reverse the worsening healthy life expectancy of the population of Wales. Wales fails to close widening gaps in health outcomes between our most and least deprived populations.</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">National Director of Health and Wellbeing</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">Knowledge, Research and Information 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 = 9
Target Score = 6
Risk Appetite Level Applied = Open, therefore, within tolerance level.</td><td>July 2026 Update

Summary
Healthy life expectancy in Wales continues to worsen and PHW action alone will not reverse this without wider public health system change, including collaboration with and action by Health Boards, Local Authorities and the voluntary and community sector. PHW is therefore strengthening controls against SRR1 by:
1. Strengthening delivery and demonstrating impact through the revised IMTP response, with</td></tr>
</table>

		sharper priorities, clearer accountability and a stronger focus on measurable impact. 2. **Building national prevention pathways** to embed prevention across the system. Two examples are OPIP, which brings £8m to develop a bilingual digital obesity pathway for Wales and the hypertension pilot, with around 38,000 people identified with hypertension and treated to target. 3. **Refocusing programmes and resources** across the Health and Wellbeing Directorate so that tobacco, healthy weight, diabetes, physical activity, food systems, community approaches and wider determinants work are better aligned to improving healthy life expectancy and reducing inequalities. 4. **Embedding prevention in the system through Community by Design** by co-leading the prevention and population health management workstream, developing national prevention standards, shaping the national prevention architecture, influencing NHS workforce skills and development framework to embed prevention and creating a practical route for NHS Wales to act earlier and reduce avoidable deterioration. Embedding our Prevention Based Health and Care (PBHC) framework, within the Community by Design prevention work to embed prevention in the health and care system in Wales. **Detail**

		Healthy life expectancy in Wales continues to worsen. The latest ONS data shows that Wales had the largest fall in healthy life expectancy for both males and females between 2019–2021 and 2022–2024. This confirms that SRR1 remains live and that PHW must accelerate action on prevention, inequalities and the wider determinants of health. During June, PHW strengthened the controls against this risk. The revised IMTP response to Welsh Government revised delivery, with sharper priorities, stronger accountability and a more explicit focus on prevention, inequalities, access, system pressures and measurable impact. There is evidence of direct programme impact. The National Quality Improvement Programme for Hypertension has delivered early pilot outcomes, with around 38,000 people identified with hypertension and treated to target. This is a significant prevention gain: better detection and control of high blood pressure will reduce avoidable cardiovascular disease, stroke and premature mortality over time, and the pilot provides a scalable model for using population health management and primary care quality improvement to deliver measurable outcomes. The Healthy Weight Systems and Pathways Programme has secured £8 million through the UK-wide Obesity Pathway Innovation Programme. This will enable development of a bilingual, digitally enabled obesity pathway for Wales. OPIP moves the work from general prevention messaging into a structured pathway model,

		with potential to improve access, reduce variation, strengthen outcomes and build the evidence base for national delivery. Other major prevention programmes are also being sharpened. Tobacco, vaping and nicotine work is supporting health boards to prepare for implementation of the Tobacco and Vapes Act and has provided timely advice to Welsh Government on vaping among children and young people. The All Wales Diabetes Prevention Programme continues to move towards mainstreaming, supported by an updated protocol and work with health boards on sustainable delivery, although financial pressures remain a barrier to universal roll-out. Continued national leadership and coordination of Gwen am Byth, our national oral health improvement programme for older people in Wales has continued to expand its reach across Wales, with strong engagement from care homes and wider health and social care partners. Activity focused on supporting participating homes, delivering staff training, carrying out quality assurance visits, and strengthening partnership working across local health boards. 85% of eligible care homes engaged in the programme (497 homes) training 3,792 care home staff, 866 domiciliary care staff and 1,107 healthcare professionals with links to care homes trained across Wales in 2025/26.

		The Health and Wellbeing Directorate is continuing to review and refocus programmes to improve reach, access, impact and outcomes. Healthy Working Wales and Tobacco Control have already been reviewed and refocused. Further work is bringing together healthy weight, diabetes, physical activity, food systems, community approaches and wider determinants into a more coherent prevention ecosystem, reducing duplication and focusing effort where it can make the greatest contribution to healthy life expectancy and inequalities. Because PHW action alone will not change this, Community by Design is now a key additional control for SRR1. PHW is co-leading the prevention and population health management workstream to make prevention a practical operating model for NHS Wales. During May and June, PHW helped establish programme governance, drafted the initial National Model for Prevention and National Standards for Prevention, defined the first prevention architecture, and convened a number of multi-agency Task and Finish Groups with Welsh Government, NHS Executive, HEIW, DHCW and health boards. This gives NHS Wales a practical route to act earlier, identify risk sooner, target support more effectively and reduce avoidable deterioration. It also creates a mechanism for systematically embedding prevention across primary, community and secondary care, with clearer expectations on workforce, data, delivery and accountability.

		PHW is continuing to develop and strengthen our partnership agreement with the Wales Council for Voluntary Action (WCVA). Being 'partners in prevention' is a key element of this. (see detail below) In addition, PHW's refreshed Young People's Engagement Programme was launched this month, employing 12 young people from across Wales to work alongside us. For more detail on both the PHW-WCVA Partnership Agreement and the Young People's Engagement Programme please progress update on actions below. Overall, the July position demonstrates strengthened controls against SRR1. PHW is aligning resources to priorities, using Community by Design to embed prevention in the health and care system, generating stronger evidence and data, providing timely advice to Welsh Government and NHS Wales, and refocusing programmes towards measurable population impact. PHW action alone will not reverse the decline in healthy life expectancy or close inequalities without wider system change. However, the current position shows that PHW is moving from advocacy and frameworks into standards, delivery architecture, national pathways, programme review and measurable prevention outcomes. **April/May 2026 Update**

		Latest published data shows that for both males and females, in 2022 to 2024, healthy life expectancy decreased compared with 2019 to 2021, with the largest decreases observed in Wales.- Healthy life expectancy, UK - Office for National Statistics. This reinforces the importance and urgency of PHW's work on prevention and health equity. PHW has completed the first phase of its advocacy work and promoted prevention-focused policy messages (e.g., via the Future Generations Commissioner's Report). Significant progress includes: • Launching the first prevention-based framework for health and care • Seconding expertise into Welsh Government to review prevention architecture • Supporting a system-wide assessment of preventive spend • Establishing a Prevention Advisory Group chaired by the CMO The next phase will focus on developing an internal tactical plan that brings together PHW's role in leading and influencing the system-wide shift to prevention, tackling health inequalities, and addressing wider determinants of health. To mitigate the risk, PHW is committed to: • Aligning strategic priorities and specialist capabilities to embed prevention and equity • Generating and mobilising high-quality evidence and data to drive policy and delivery • Providing timely, trusted and impactful public health advice

		• Strengthening engagement and communication with partners, policymakers, the third sector, and the public • Exercising strong system leadership through coordination and collaboration • Designing and delivering inclusive, evidence-based programmes that address the needs of disadvantaged groups It is recognised that influencing a system shift toward prevention alone may not be sufficient to reverse current trends in healthy life expectancy or close the widening health inequalities without wider system change. Health and Wellbeing Directorate continues with reviewing and refreshing programmes of work to ensure we focus on actions which will address healthy life expectancy. A number of programmes including Healthy Working Wales, Mental and Social Wellbeing and Tobacco Control programmes have been reviewed and refocused. The National Quality Improvement Programme for Hypertension has in its first quarter ensured 38,000 people have been identified with hypertension and treated to target.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** 1. Poor alignment of PHW specialist resources, capabilities and programmes with our long-term strategy			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Delivery of Public Health Wales Route Maps and milestones within the Board approved Integrated Medium-Term Plan	• Integrated Performance Report • Programme Deep Dives	• Public Health Wales Board • Public Health Wales Committees • Welsh Government Accountability Meetings • Mid and End of Year Reviews • Health and Wellbeing Directorate Leadership Team • Programme Boards for Wider Determinants of Health; and Climate Change

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Failure to generate the quality of evidence and supporting data to shape our influencing and delivery			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Implementation of Public Health Wales Digital and Data Strategy and ensuring all programmes include built-in evaluation plans with clear metrics and methodologies.	• Public Health Wales Digital and Data Strategy • Research and Development Strategy • Programme Deep Dives • Integrated Performance Report • Contribution to the PHW Duty of Quality reporting	• Digital, Data and Design Authority (DDDA) • DARC Programme Board • Research and Evaluation Strategy Oversight Group • Knowledge, Research and Information Committee • Board and Executive Team Meetings

[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] **C2:** Failure to generate the quality of evidence and supporting data to shape our influencing and delivery			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
			• Health and Wellbeing Directorate Leadership Team

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Insufficient/Ineffective public health advice, evidence and action within our remit			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	Professional standards and registration for Public Health Consultants and Practitioners and system of workforce planning ensuring we have the workforce to meet operational and strategic needs. Extensive people development opportunities to maintain and expand knowledge, skills and competency. Workplans reflect drive to ensure that 1. the organisation and the workforce remains up to date with best evidence and practice on prevention and on relevant areas. 2. The relevant parts of the workforce are skilled and effective at system leadership and advocacy	• Job Planning Process • Registration and revalidation • My Contribution • Training attendance records • Developing and maintaining of staff competency framework and staff Training Needs Assessments (TNA)	• Oversight from OMD • Monitoring of workforce plans by People and OD • Integrated Performance Report reviewed by Board • Training records • Training and development spend monitored through Finance • Annual objective setting and appraisals

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Insufficient/Ineffective public health advice, evidence and action within our remit			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] 1. **C4:** Ineffective engagement, advocacy and communication with partners, the public and policymakers			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Use of multiple communication channels and accessible formats to ensure we meet user needs. Ongoing review of public and third sector engagement activity and metrics, evaluation and quality assurance of engagement activity through our research, campaigns, social marketing activity and website interactions utilising engagement and communications expertise within the organisation. Workplans further develop our ability to nuance approaches to different audiences including policymakers, partners and the public. Public Health Advocacy Programme to support effective organsiational engagement and advocacy with policymakers	• Monthly Communications Report (Publications, Reports and news coverage) • Campaign evaluations • Forward Look (Plan) • WCVA-PHW Partnership Agreement workplan monitoring • Young People's Engagement Programme workplan monitoring Central management of PHW website and PHW social media channels • Editorial planning group • Public health advocacy programme monitoring and evaluation	• Monitoring through Comms Team via a Programme Board • Monitoring of impact of campaigns run by social marketing team in HWB • Joint working between Comms and Health and Well Being Directorate • Campaign Oversight Group and Corporate Comms Playbook (under development) • Media coverage (reach and sentiment) monitored through Communications Team and HWB Social Marketing Team • WCVA-PHW monthly progress meetings • Engagement leads community of practice (under development) • Website metrics • Public Health Advocacy Programme Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C5:** Insufficient system leadership and co-ordination with stakeholders and partners			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C5.1	Strong working relationships with key partners and stakeholders including the third sector, Welsh Government, Directors of Public Health and Public Service Boards Development of joint or shared work plans with Directors of Public Health, HEIW, relevant clinical networks, Community by Design, Sport Wales and Arts Council for Wales are already in place. The PHW-WCVA Partnership Agreement was formerly agreed by both organisations alongside a joint staff launch event in May 2026. MOU agreed with Sport Wales. A Framework for Healthcare Public Health to influence the NHS to shift systematically towards prevention and Early Intervention has been published and is being incorporated into the community by design work The MECC 2 Pack – a training pack to support the workforce become more preventive through use of psychological skills – has been launched and is being disseminated to the system. Multi-agency governance Programme Boards (e.g. Tackling Diabetes Together)	• Memoranda of understanding • Shared work programmes • IMTP	• Board and Executive Team Meetings • Board Committees • Health and Wellbeing Directorate Leadership Team • WCVA/PHW partnership agreement regular check-ins to monitor progress. Progress presented regularly to Board and Executive Team • Engagement leads meetings

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C5:** Insufficient system leadership and co-ordination with stakeholders and partners			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C6:** Programmes which do not support our population in achieving healthier lives			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C6.1	All programmes of work are evidence based, and key milestones are included within the Long-Term Strategy, Route Maps and the Integrated Medium-Term Plan.	• Integrated Performance Report • Programme Evaluations	• Board and Executive Teams • Committee Programme Deep Dives • Health and Wellbeing Directorate Leadership Team • Programme Boards

Gaps in Assurance / Action Plans for the cause C1 Poor alignment of PHW specialist resources, capabilities and programmes with our long-term strategy						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.1	Implementation of agreed Route Maps for priorities 1,2,3 and 4 and ongoing engagement with Welsh	Route maps are required to inform IMTPs going forward which will be monitored	By developing a longer term and more coordinated approach to development and	National Director of Health and Wellbeing	31 March 2027	**July 2026 Update** As part of the Quarter 1 baseline review,

Gaps in Assurance / Action Plans for the cause C1 Poor alignment of PHW specialist resources, capabilities and programmes with our long-term strategy						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	Government to influence provision of resources to PHW and health boards aligned to All-Wales strategies. Review alignment of resources against agreed route maps	Align resources, programmes and delivery plans to the revised IMTP, focusing on prevention, inequalities, access and measurable population impact. Review resource allocation annually against priority outcomes and strategic delivery requirements. Delivery of IMTP milestones; monitoring and review of Routemap Milestones; evidence of resource shifts towards agreed priorities; delivery against performance and outcomes measures.	implementation of innovation and continuous quality improvement in service provision Ensures prioritisation of short-term action is aligned to a longer-term plan to enable change. Strengthening of cross-organisational working to make best use of resource, expertise and stakeholder relationships across the organisation. Ensures specialist resources and programmes are focused on actions most likely to improve healthy life expectancy, reduce inequalities and support system shift to prevention. Review will inform future allocation of resources and prioritisation.	Priority leads	31 March 2027	Public Health Wales is currently reviewing and assessing how resources are deployed across the organisation and aligned to Government priorities and 2026/27 remit letter. This will help support identification of opportunities for optimisation, efficiency and re-prioritisation. This will also support future work to revise and update organisational plans. **April/ May 2026 Update** IMTP agreed by Board for 2026-29. Currently being aligned to the mandate letter received from WG and due to be approved by

Gaps in Assurance / Action Plans for the cause C1 Poor alignment of PHW specialist resources, capabilities and programmes with our long-term strategy						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
		Delivery of strategic objectives				Public Health Wales Board in March 2026.

Gaps in Assurance / Action Plans for the cause C2 Failure to generate the quality of evidence and supporting data to shape our influencing and delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.1	Agreeing a mechanism for balancing evidence and data requests between internal teams (RDD, HI R&E and programme teams) and commissioning external providers where relevant and required (dependant on capacity and skill mix)	Agreed & monitored through Divisional workplans	Coordinating requests ensures alignment with organisational priorities and avoids duplication, which can waste resources and create conflicting outputs. By distributing workload based on capacity and skill mix, you avoid overburdening any one team, ensuring timely delivery of outputs.	National Director of Health and Wellbeing National Director of Research, Data and Digital	31 March 2027	**July 2026 update** Health and Wellbeing Directorate is working closely with the Research, Data and Digital Directorate (RDDD) to strengthen the way we use data, intelligence and evidence to inform decision-making and demonstrate impact. This collaboration is focused on ensuring that programmes are underpinned by robust evidence, have access to the right analytical support, and are able to demonstrate their

Gaps in Assurance / Action Plans for the cause C2 Failure to generate the quality of evidence and supporting data to shape our influencing and delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						contribution to Public Health Wales priorities and Welsh Government outcomes. Work is underway through the DARC programme to support this and also how we can increase data analytical capacity in Health and Wellbeing to support future planned work. **April 2026 update-** As part of the development of the IMTP 2026-2029, ongoing discussions are taking place to understand the data support requirements to deliver our plans and mechanism for commissioning work in the future. This is being undertaken in conjunction with the

Gaps in Assurance / Action Plans for the cause C2 Failure to generate the quality of evidence and supporting data to shape our influencing and delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						DARC programme and move to NDAP.

Gaps in Assurance / Action Plans for the cause C3 Insufficient/Ineffective public health advice, evidence and action within our remit						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.1	Develop capability in system leadership, prevention pathways, population health management, behavioural science and implementation across PHW and key partners. Support Welsh Government, NHS Wales	Workforce capability measures; completion of targeted development programmes; partner feedback; evidence of contribution to prevention standards and pathway implementation.	Strengthens PHW's ability to influence, lead and deliver system-wide prevention and population health improvement.	National Director of Health and Wellbeing National Director Policy and International Health	Ongoing	**July 2026 update** Good progress has been made in strengthening capability for prevention across Public Health Wales and the wider system. Through our Prevention Based Health and Care Framework and our system leadership for the Community by Design programme, PHW is co-leading the prevention and population health

Gaps in Assurance / Action Plans for the cause C3 Insufficient/Ineffective public health advice, evidence and action within our remit						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	and the CMO's work to strengthen prevention.					management workstream, with governance arrangements established, draft National Standards for Prevention and a National Model Architecture for Prevention developed. PHW continues to provide leadership and support to Welsh Government, NHS Wales and the Chief Medical Officer on prevention policy, standards, inequalities and population health management, helping to embed prevention as a practical operating model across the health and care system and strengthening the evidence base for future delivery.

Gaps in Assurance / Action Plans for the cause C3 Insufficient/Ineffective public health advice, evidence and action within our remit						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						April 2026 update- Consultants in Health and Wellbeing continue to access coaching support as part of their development. Change training will be further embedded in 2026-27 Discussions have commenced with Directors of Public Health on development of a public health system workforce plan and internally work has commenced to support development of the practitioner workforce in line with the job families work.

Gaps in Assurance / Action Plans for the cause C4 Ineffective engagement with and communication to partners, the public and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.1	Continue to migrate ancillary websites to new Public Health Wales content management system as part of Web Transformation Programme	Benefits and mechanism for monitoring success and progress have been developed and are monitored through Web Transformation Programme Board	Providing consistent communication methods and channels that comply with relevant standards and regulations will support effective communication to partners, the public and policymakers.	National Director of Health and Wellbeing	31 March 2026	**July 2026 update** Complete. All ancillary sites have now been moved to new content management system as part of Web Transformation Programme. Action to be closed.
	Strengthen engagement, communications and partnership approaches to support adoption of prevention priorities, pathways and wider determinants interventions by policymakers, partners and communities.	Campaign and engagement evaluations; website and digital reach; stakeholder feedback; evidence of use of PHW advice, resources and frameworks.	Improves the effectiveness of PHW's influence and communication, increasing uptake of prevention policies, evidence and interventions.	National Director of Health and Wellbeing	31 March 2027	**April 2026 update-** First set of migrations on schedule - Healthy Weight Healthy You, Help me Quit and Public Health Network Cymru migrations currently in progress completion early May 2026. Further discussions required to take forward developments within these sites as part of Web transformation BAU process.

Gaps in Assurance / Action Plans for the cause C4 Ineffective engagement with and communication to partners, the public and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	Development of a model for engaging with the public and third sector which enables us to have oversight of all engagement activity, share learning and reduce duplication or disjointed approaches	Measures for monitoring success and progress to be developed as part of this work	A strategic and aligned approach to our engagement activity, reducing the risk of over-engagement/engagement fatigue. Transparency of insights from previous engagement activity, improving our ability to be agile and better use community insights in our work. Better use of resources which will increase efficiency	Director of Nursing, Quality and Integrated Governance	Ongoing as part of NQIG workplan	**July 2026 update** A launch event hosted by PHW in May was attended by over 180 colleagues from both PHW and WCVA. As an organisation PHW also had a co-ordinated presence at WCVA's annual conference, Gofod3. A number of teams shared their work and made connections with the voluntary sector through the PHW stall, and PHW hosted two workshops. A PHW consultant spoke at a panel session, and our CEO recorded an interview with WCVA's Chief Executive to be used to promote the partnership. PHW's refreshed Young People's Engagement

Gaps in Assurance / Action Plans for the cause C4 Ineffective engagement with and communication to partners, the public and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Programme was launched this month, bringing 12 young people aged 18-25 together in person in Cardiff for a 2 day induction. Each member of the programme is employed on a bank contract for approximately 6 hours a month. As well as contributing to work across the organisation they will also be supporting the development of a Wales-wide network, to better enable us to engage and hear from existing groups representing young people from across the country. **May 2026** Formally signed partnership agreement with WCVA and staff

Gaps in Assurance / Action Plans for the cause C4 Ineffective engagement with and communication to partners, the public and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						session held 21.5.26 to share aims and how to get involved

Gaps in Assurance / Action Plans for the cause C5: Insufficient system leadership and co-ordination with stakeholders and partners						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP5.1	Co-lead Community by Design prevention and population health management work, including development of prevention standards, prevention architecture and national approach for population health management and data sharing in Wales Strengthening strategic leadership across PHW and HB PH Teams through	Delivery of prevention standards and architecture; partner adoption; implementation milestones achieved; reporting through Community by Design governance arrangements.	Creates a practical mechanism for embedding prevention across NHS Wales and strengthens system leadership,	National Director of Health and Wellbeing	31 March 2028	**July 2026 update** Through Community by Design, Wales has established a national transformation programme focused on delivering care closer to home through prevention, population health management and integrated community services. Key outputs to date include the creation of national governance structures, establishment of three transformation pillars, and the design of a

Gaps in Assurance / Action Plans for the cause C5: Insufficient system leadership and co-ordination with stakeholders and partners						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	collaborative action and network development	Suite of outcome measures in discussion with Welsh Government through the Strategic Programme for Primary Care Route Map and IMTP delivery	Health Care Services and Social Care Services will be able to deliver preventive interventions more systematically and effectively	Interim Health Improvement Directors and Priority leads	Ongoing	community-by-default approach to service planning. Public Health Wales is co-leading the Prevention and Population Health Management pillar and supporting the development of the prevention, data and population health infrastructure required to deliver the programme. **April 2026** We continue to work with the Community by Design workstream and have created draft prevention standards and architecture for the programme.

Gaps in Assurance / Action Plans for the cause C5: Insufficient system leadership and co-ordination with stakeholders and partners						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**

Gaps in Assurance / Action Plans for the cause C6 Programmes which do not support our population in achieving healthier lives						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP6.1	Complete and embed the review and refocus of prevention programmes, ensuring resources are directed towards interventions and pathways with the greatest impact on healthy life expectancy and inequalities.	Outcomes Measurement Framework Integrated Performance Report Evidence of programme reviews informing decisions; outcome measures reported through Board reporting; improvements in reach, uptake, outcomes and reduction in variation.	Ensures programmes contribute demonstrably to healthier lives, improved outcomes and reduced inequalities, maximising impact from available resources.	National Director of Health and Wellbeing	31 March 2028	**July 2026** Ongoing work in Health and Wellbeing to review programmes with a particular focus on assessing impact. This work will continue during quarter 2 and 3 of 2026/27. Service reviews such as in help me Quit have also informed improvement actions which are currently being implemented.

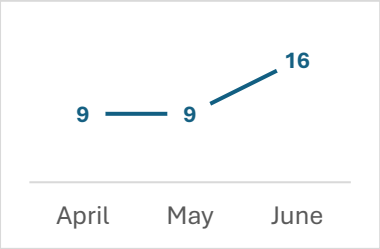
Gaps in Assurance / Action Plans for the cause C6 Programmes which do not support our population in achieving healthier lives						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						April 2026 Health and Wellbeing continue to review their programmes of work. This work will inform future planning and resource allocation. Work is also underway in Health Improvement to develop clusters of programmes to support join up between programmes and more effective and efficient ways of working.

<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR2

Strategic Priority

“Enabler Risk and incorporates all Strategic Priorities.”</td><td colspan="2">There is a risk that: The organisation could experience poor organisational health.

Caused by:
1. Ineffective or inconsistent organisational leadership and governance
2. Lack of progress towards our ideal organisational culture and behavioural expectations
~~3.~~ Inability to effectively engage our people
4. The impact of the lack of integrated and strategic workforce planning on capacity, skills and capability to deliver BAU/IMTP/LTS
5. Ineffective approaches to acknowledging, escalating and managing risks and issues at an organisational level.

Resulting in: poor engagement, diminished ability to deliver strategic priorities, reduced adaptability and innovation, poor attraction, and retention, and erosion of stakeholder confidence.</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">Director of People and Organisational Development</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">People and Organisational Development 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>Willing</td><td>PHW is eager to be innovative and take on a high level of risk, but only in the right circumstances.</td></tr></table>
Current Score = 16
Target Score = 6
Therefore, within risk appetite tolerance level.</td><td>June update:

Since the last update Leadership Team held a deep dive into SR2 to support the Business Executive Team in managing the risk. LT agreed to propose changes to:

• Address duplication with SR5
• Refine and rationalise the causal factors in the risk description
• Strengthen alignment with Corporate Risks so links can be made in future updates and progress with CRs informs the risk score
• Achieve cross organisational engagement on the management of the risk</td></tr>
</table>

		• Consider recent organisational reviews and incidents **After review by the Executive Team and informal discussion at PODCOM, the Risk score has been amended to 4x4 to reflect the current and emerging issues across the organisation in terms of culture, behaviour and SUS incidents. Whilst this means that the score changes to 16, it remains within Risk Appetite (Willing). The Business Executive Team will work with the risk owner over the next reporting period to consider whether, in light of performance indicators and known impact, the appetite for this risk be reduced to Open until controls have become more effective.** The proposed changes are presented below as part of the June update. If the changes are approved the Controls and Action Plans will be revised as part of the next update and in future. An assessment of the Corporate Risk Register (CRR) identified that the following Corporate Risks map to CR2: • CR1593 – Duty of Quality related • CR1678 – Risk Management related • CR2076 – Equality and Inclusion related **Other updates:** Recent reviews and incidents have highlighted the need to strengthen approaches to acknowledging, escalating and managing risks and issues at an organisational level

		and a 5th causal factor has been added to the Risk Description to reflect this. The findings of the BTW Review demonstrate the need to sustain focus on Culture, Behaviour (C2) and Employee Engagement (C3) and this is a core element of the improvement plan which responds to the review. In response to feedback, work has begun to simplify the language we use to talk about Culture and align it with the Being our Best Behavioural Framework that underpins our Values and Cultural Narrative. The aim is to demystify work on Culture and make it accessible. Two additional cohorts have commenced the PHW Leadership and Management Academy programme. The Academy aims to empower line managers to create environments where people and teams can thrive. The 2026-27 Developing People Managers programme has begun and work to develop foundational leadership and management learning to increase leadership and management skills, capability, and confidence which is a proposed IMTP commitment for 2026-27 continues following discussions with SET in June. A Cultural Advocates Network has been established and an Executive Sponsor put in place. In July the Executive team will: • Consider the refresh of the high-level integrated engagement plan, which is one element of this 2026-27 IMTP commitment: 'Refresh the high-level

		integrated engagement plan - using insights from the 2025 NHS Wales Staff Survey and Culture Pulse – to identify cultural priorities, strengthen flexible, equitable ways of working and foster a psychologically safe workplace where every colleague can thrive.' • Meet with the Cultural Advocates Network to discuss their work and how it can be supported by BET.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Ineffective organisational leadership and governance			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	The refreshed Long-Term Strategy, Strategic Priority Route Maps and Integrated Medium-Term Plans (IMTP), provide clear strategic direction and are monitored through regular reporting cycles. Targeted and regular development of the Business Executive Team (BET) to enhance strategic oversight and decision-making.	• BET/Board minutes • IMTP reporting • PODCOM minutes • Internal Audit and Audit Wales reports	• Regular BET/Board meetings • Ongoing IMTP milestone tracking • Regular PODCOM meetings • Annual accountability reporting to Welsh Government

[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:** Ineffective organisational leadership and governance			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	A systemic programme of work which will increase leadership and management skills, capacity and confidence including formal learning. Compliance with Standing Orders, Scheme of Delegation, and Board Etiquette Protocol. Implementation of an organisation-wide Records Management system. Embedding the Duty of Quality and standardised governance practices. Assessment of our organisational approach to equalities work. Embedding the Leadership and Management Academy.		

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Lack of progress towards our ideal organisational culture			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Use of the Organisation Culture Inventory (OCI) to assess progress against cultural priorities. A Cultural Narrative which articulates the desired organisational culture and values, championed by a network of Cultural Advocates across the organisation. Agreement of a strategic and integrated approach to improving staff experience with a focus on embedding behaviours that align with the 'Being Our Best' framework and fostering a psychologically safe and inclusive environment. People Strategy and PS Implementation Plan.	• Staff Survey and OCI results • IMTP reporting	• Employee engagement measures developed in 2024-2025 • Annual staff survey • OCI progress tracking (Culture Pulse survey in Q2 2025/26) • Ongoing IMTP milestone tracking • Mid and end of year review process.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Inability to appropriately engage, develop and enable our people. to deliver our Long-Term Strategy			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	A strategic approach to engagement, and a comprehensive approach to workforce development, underpinned by the People Strategy and Strategic Workforce Planning (SWFP) framework.	• Learning and development records • Staff survey insights • SWFPs • IMTP reporting	• Performance Assurance Reporting • Annual staff survey • Regular review of SWFPs/ workforce actions • Ongoing IMTP milestone tracking

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Inability to appropriately engage, develop and enable our people. to deliver our Long-Term Strategy			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
	Learning and development needs are identified through annual reviews and SWFPs, ensuring alignment with organisational goals. These are supported by a comprehensive learning and development offer. People Strategy implementation plan. Integrated Engagement Action Plan.		

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Lack of adequate capacity or capability to deliver BAU/IMTP/SP route maps and flexibility/ adaptability/ readiness for change			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	The implementation plan for the 'Designed to Deliver' element of the People Strategy Change management support for Tier 1 and 2 organisational change provided by the Programme/Project Management Office and People and OD. Change is delivered in partnership with Trade Unions.	IMTP reporting Change programme boards Local Partnership Forum / Joint Medical and Dental Negotiation Committee minutes Training compliance from PMO Change programmes have benefits realization as a standard reporting outcome.	Ongoing IMTP milestone tracking Regular programme progress reporting Regular partnership working meetings Audit against PMO standards and SOPs Gateway reviews

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Lack of adequate capacity or capability to deliver BAU/IMTP/SP route maps and flexibility/ adaptability/ readiness for change			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
	Learning and development and supporting guidance for change management, as well as support for those going through change. Organisational change work is embedded within the IMTP, designed to enable effective delivery of both business-as-usual and strategic initiatives. PMO provide specific training and support on benefits realisation and how this can be implemented and progressed throughout PHW.		Narrative from staff survey on experience of being part of a change programme.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C5:** Lack of integrated and strategic workforce planning			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C5.1	An established Strategic Workforce Planning (SWFP) process and framework, including clear roles and responsibilities. The framework is designed to align with the timeframe of the Long-Term Strategy.	• SWFPs • IMTP reporting	• Regular review of SWFPs/ workforce actions • Ongoing IMTP milestone tracking

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C5:** Lack of integrated and strategic workforce planning			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
	Integration of the SWFP process and framework with operational and financial planning / Strategic and operational workforce plan as an embedded element of the IMTP process		

Gaps in Assurance / Action Plans for the cause C1						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.4	Standardised approach to Governance and Quality Management / Duty of Quality/ Continue to embed the Quality Oversight Group and Duty of Quality.		Robust, standardised approach to organisational governance			**June 2026 updates:** AP1.1 and 1.2 moved to the Controls section as per the April update. AP1.5 to be discussed at BET in June. A review of the delivery date will follow.
AP1.5	Develop and commence the delivery of foundational leadership and management learning and development to increase leadership and management skills, capability, and confidence.	IMTP milestone reporting Participation rates Evaluation feedback	Builds foundational leadership capability and confidence, supports operational and strategic delivery	Director of People and OD	30 September 2026	**April 2026 updates:** Whilst AP1.1 and 1.2 are complete work to increase leadership and management skills, capacity and confidence will

Gaps in Assurance / Action Plans for the cause C1						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						continue (see new AP1.5). Assurance on AP 1.1 and 1.2 provided to PODCOM in April 2026, these actions will be moved to controls section as part of next update. AP1.4 will be considered at the deep dive with LT in May.

Gaps in Assurance / Action Plans for the cause C2 (Lack of progress towards our ideal organisational culture)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.3	Refresh the high-level integrated engagement plan - using insights from the 2025 NHS Wales Staff Survey and Culture Pulse – to identify cultural priorities, strengthen flexible, equitable ways of working and foster a psychologically safe	People Strategy Implementation Plan IMTP milestone reporting Staff Survey results	Embeds cultural values and supports inclusive organisational development Clear longer-term roadmap for employee experience	Director of People and OD	31 March 2027	**June 2026 updates:** AP2.1 moved to the controls section as per the April update. AP2.3 is on track, will be discussed with BET in July. **April 2026 updates:** AP2.1 complete, will be moved to controls

Gaps in Assurance / Action Plans for the cause C2 (Lack of progress towards our ideal organisational culture)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	workplace where every colleague can thrive.					section as part of next update.

Gaps in Assurance / Action Plans for the cause C3 (Inability to appropriately engage, develop and enable our people to deliver our Long-Term Strategy)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.3	AP1.5 and AP2.3 Implement the Job Families Steering Group, and associated actions agreed by Bet in 2025.26	People Strategy Implementation plan Staff survey scores	Supports career development and workforce planning	Director of People and OD	31 Dec 2026	**June 2026 updates:** AP3.1 and AP3.2 moved to the controls section as per the April update. Next steps for AP3.3 will be discussed at Leadership Team in July. **April 2026 updates:** AP3.1 complete, People Strategy implementation plan now in place, assurance and reporting to PODCOM. AP3.2 complete, assurance provided to PODCOM October 2025. These actions to

Gaps in Assurance / Action Plans for the cause C3 (Inability to appropriately engage, develop and enable our people to deliver our Long-Term Strategy)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						be moved to controls section as part of next update.

Gaps in Assurance / Action Plans for the cause C4 (Lack of adequate capacity or capability to deliver BAU/IMTP/SP route maps and flexibility/ adaptability/ readiness for change)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.2	Provide change management support and learning and development via PMO and POD.	L&D needs analysis/identification of future skills/scarce skills and strategic alignment	Improved capability in the skills to manage change well, and capacity to support organisational change	Directors of People and OD / Finance and Operations	31 March 2026	**June 2026 updates:** AP4.1 moved to the controls section as per the April update. Elements of AP4.2, AP4.5, AP4.6, AP4.7 map to the new SR5 and will be removed as part of the next update to address duplication. AP4.4 is a 2026-27 IMTP commitment and is dependent on WG approval of the IMTP. April 2026 updates: AP4.1 complete, implementation plan in place, action to be moved to the controls section in next update.
AP 4.4	Established a fully integrated planning approach including long-term workforce planning, ensuring future alignment with Strategic Priorities and informing a sustainable skills development programme		Builds organisational capability and adaptability Ensures the organisation has the agility to respond to future challenges.	Director of People and OD	31 Dec 2026	
AP4.6	Ensure DDDA fulfils the role of gatekeeping new change programme proposals	Periodic programme review as per best practice standards.	Driving up standards and providing senior management oversight of capacity and capability.	DDDA Membership	Ongoing	

Gaps in Assurance / Action Plans for the cause C4 (Lack of adequate capacity or capability to deliver BAU/IMTP/SP route maps and flexibility/ adaptability/ readiness for change)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.7	BET/Programme Change Board to provide a structured approach to ensure capability and capacity is assessed before formal agreement and ensure benefits realisation plan links to proposal.	Reports received at the Change Board reflecting the requirements.	Executive/Director oversight and assessment.	Change Board membership and Executive Directors	Ongoing	AP4.2 - a review of the POD change toolkit has been undertaken; more work is needed on further actions to develop skills and support for change – to be discussed at LT deep dive 7 May. Delivery date for AP4.4 to be confirmed in the next update.

Gaps in Assurance / Action Plans for the cause C5: (Lack of integrated and strategic workforce planning)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP5.2	Establish a fully integrated planning approach including long-term workforce planning, ensuring future alignment with Strategic Priorities and informing a sustainable skills development programme.	IMTP milestone reporting Alignment with IMTP, SEP, and strategic priorities	Ensures long-term workforce sustainability and strategic alignment Improves resource efficiency and strategic delivery	Director of People and OD	30 December 2026	**June 2026 updates** AP5.1 moved to the controls section as per the Apri update. AP5.2 is a 2026-27 IMTP commitment and is dependent on WG approval of the IMTP. **April 2026 updates:**

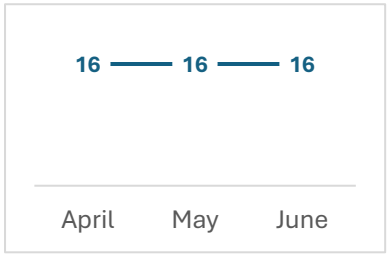
Gaps in Assurance / Action Plans for the cause C5: (Lack of integrated and strategic workforce planning)						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						AP5.1 complete, will be moved to the controls section in the next update. New action added (AP5.2) to reflect 2026-27 IMTP commitments.

<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><th>Trend</th><th>Current Position of Risk Including Risk Appetite and Risk Decision</th><th>Position Statement – Executive Director Update</th></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>June 2026 Update

The risk score remains at 16 as the key areas of concern continue in relation to the Sexual Health Test and Post incident, performance of the Breast screening 3 week waits for assessment, and 4 week waits for bowel screening colonoscopy.

Regarding the Sexual Health incident, work on the lookback exercises and safeguarding concerns is reaching its conclusion. A review of governance</td></tr>
</table>

		arrangements (safeguarding, patient safety, information) has been carried out across all other public facing services with good levels of compliance. The operational response to the hantavirus threat has reduced in intensity, but in light of the emerging ebolavirus threat, the EPRR and HP teams are providing intense support and advice. The Environmental Public Health function has been operating with business continuity arrangements resulting from the withdrawal of UKHSA support to in-hours and out-of-hours response. An interim cover arrangement is in place to continue to provide the service. The Health Protection Response team is also operating in business continuity mode, and short-term arrangements are in place to ensure service continuity. Staffing levels will be restored over the next few weeks. Improvement plans are in place to address performance challenges in Breast Test Wales, Bowel Screening Wales and Diabetic Eye Screening Wales and these are included in Directorate-level controls and reported to QSIC through regular monitoring. Trajectories are being developed to actively monitor performance. Further staff engagement has been carried out following the review of the Breast Test Wales programme.

		We continue to engage with staff following the review of the BTW programme to ensure effective implementation of the recommendations. The HPSS directorate transformation programme is progressing well and workstreams established to improve resilience and learning across divisions will report on their scoping work in June. Workforce resilience remains a key area of focus across Health Protection and Screening Services, with pressures in specialist scientific, bioinformatics and Health Protection functions, and specific challenges in North Wales. Recruitment, training and pipeline development continue to progress. The Directorate is defining workforce capacity indicators to support transparent monitoring of resilience and mitigation effectiveness.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Development, implementation, and maintenance of emergency and business continuity arrangements, including participation	• PHW Emergency Response Plan (V3.2) • PHW Countermeasures Protocol	• Annually reviewed, tested by exercise, with written assurance to 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?**
	in EPRR training and exercises, alongside debriefing and implementing lessons identified from incidents and outbreaks.	• 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 Preparedness, Resilience & Response (EPRR) Group.	• 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
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	• 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)

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?**
		Committee and Welsh Government Policy. • HPSS laboratory systems accredited to ISO 15189:2022, with re-validation required yearly.	• 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. • Annual clinical audit programme based on risk and variation • Thematic Analysis of NRIs, EWN and Claims. • Result of Peer review programme/quality walks • Safety culture and open incident reporting processes, compliance with PTR regulations and Duty of Quality Health & Care Standards	• Performance management with monthly quality monitoring at HPSS Divisional SMT's on key performance indicators and quality metrics. Focused monthly performance monitoring at HPSS DMT with reporting and insights to PHW Board. • Rolling monthly programme at HPSS DMT / SMT monitoring via quality & performance reporting through governance structures of PHW to QSIC & Board • Reports to divisional SMT's and QSIC • Monthly Quality performance reviews with Health Boards on their aspects of delivery of screening programmes and recovery trajectories. (SH)
C1.4	An HPSS programmatic approach to benchmarking, reviewing and improving	• Excellent operations programme scope • Excellent operations delivery dashboard	• Monthly DMT update reporting • Reports into corporate committees and 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?**
	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.	• 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	• 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 • Contribution to the PHW Duty of Quality reporting and corporate Governance groups • Compliance with quality inspections (e.g. UKAS)	• HPSS SMT / DMT reporting • Quality Oversight Group participation and workplan • Corporate reporting (patient / service user experience including incidents, NRI & EWN's complaints, claims and Duty of Candour) Performance monitoring of Interval Cancer reviews • External inspections & Peer Quality Visits • Service User Surveys & associated Improvement plans • Development of a new Organisation wide clinical governance meeting to provide Trust wide view and assurance • QUOG with strengthened TOR (to be finalised Feb 26)
C1.6	Delivery of agreed future digital transformation needs aligned with strategic priorities and service user and operational needs aligned to	• Delivery of PHW's digital routemap • Comprehensive mapping document of HPSS user requirements	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme)

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?**
	the Duty of Quality standards and digital standards	• HPSS delivery of future service transformation vision. • Inclusions in 10 year strategic capital plan • Service user feedback and engagement	• 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 • Improvement plans for BTW, BSW and DESW implemented by the programme with oversight at the Directorate Management Team and reporting to QSIC	• Monthly strategic performance review (DMT/QSIC) • Quarterly Board reporting through established assurance mechanisms. • Annual reporting to Welsh Government • Escalation through Executive route where strategic risks increase
C1.8	Strategic oversight and governance of Sexual Health service delivery, including risk escalation and assurance.	• Incident Management actions and debrief outputs • Divisional governance reports • Quality & safety oversight (clinical governance forums) • Incident reporting and trend analysis	• Monthly divisional SMT and DMT reporting • After-action reviews following incidents • Monitoring via risk registers and escalation logs • Quarterly updates to QSIC
C.1.11	HPSS financial management for directorate-level financial governance and alignment between operational plans and financial capability.	• Monthly financial performance reports (M1–M12) • Savings Plan monitoring	• Monthly DMT and finance review meetings • Quarterly reporting to QSIC/Board • Regular savings plan tracking cycles

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?**
		• Mid-Year Review and year-end position reports • Finance Business Partner oversight • Directorate risk registers financial entries	• 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 • Internal audit outputs related to governance or leadership oversight • Internal audit findings on governance, leadership, or change programme delivery • Transformation programme milestone reporting • Risk register entries relating to delivery capacity or change saturation	• Monthly DMT review of change portfolio capacity and prioritisation • Quarterly reporting to QSIC and Board on transformation progress • Annual IMTP planning cycle • Internal audit follow-up against leadership/governance recommendations • Monthly Delivery Confidence Assessment reporting (Tier 1 & 2 Programmes only) • Assurance report to BET/Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Uphold high professional standards: Professional Regulation – Medical, Nursing & Midwifery, and Multi-Professional Staff	• Medical, Nursing & Midwifery, HCPC, Allied Health Professional and Multi-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	• 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),
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

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Inability to maintain capacity and capability of the specialist workforce.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.4	Extensive people development opportunities to maintain and expand knowledge, skills and competency	• Training attendance records • Developing and maintaining of staff competency framework and staff Training Needs Assessments (TNA) • Workforce reports	• Training and development spend via financial monitoring • Training records • MYC and CPD requests to HEIW • Number of higher level of awards achieved
C2.5	Working with HEIW and developing strategic links with HEI's providers to develop future workforce pipeline	• Via POD assurance processes • OMD and NQIG student programmes/opportunities	• Organisational workforce planning • Number of Student placements PA • Organisational workforce planning including relevant professional workforce planning (e.g. health care science, Nursing and Midwifery, Public Health specialist) • Delivery of the CNO Strategic Vision

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

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3:** Absence of innovation and continuous quality improvement.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.2	Research and development strategy and agreed directorate priorities	• HPSS fully engages in PHW wider research structures which includes an organisation wide research strategy and development of priority areas.	Both specific review of areas of excellent public health service and via PHW wider research structures are reported to the KRIC.
C3.3	See C1.4,1.5 and C1.11		

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Exceedance in unplanned activities arising from unexpected acute threats to health.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Maintenance resilient dedicated 24/7 EPRR On-Call Service which helps to ensure that the organisation meets its statutory obligations under the Civil Contingencies Act 2004 and receives Emergency and Major Incident notifications in a timely manner.	• 24/7 Resilient EPRR On Call Service Standard Operating Procedure.	• Performance monitored monthly via HPSS DMT Metrics, annually reviewed, and reported on via the PHW Annual Assurance Return to Welsh Government on EPRR approved through the EPRR Group, HPSS DMT, BET, Quality, Safety, and Improvement Committee & Board.
C4.2	Extensive system for surveillance of health threats to inform timely and effective response.	• Exceedance reports and protocols with agreed criteria for escalation and response management • Weekly HP issue summary produced	• Weekly circulation to PHW Executives

Gaps in Assurance / Action Plans for the cause C1 Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.1	Develop resilient, coordinated and effective Pandemic Response Arrangements for PHW.	• Arrangements to be validated via an organisation-wide internal desktop exercise.	Align with UK National Respiratory Pandemic Framework (draft) incorporates lessons identified from internal Covid-19 debrief, lookback and reflection processes; as well as recommendations from the UK Covid-19 Module 1 and Module 2 Report. Provides organisational assurance for preparedness. Further Covid 19 Enquiry module reports will be reviewed as and when they are released to assess for both direct and indirect implications following the existing approach used for Module 1 and 2. Review and additional input requested from BET	Deputy National Director Health Protection and Screening Services Head of Emergency Preparedness Resilience and Response	Q4; 2025/26	**June 2026:** Request Closure. Ongoing BAU Management **April 2026:** V1 of the PHW Pandemic Response Arrangements complete, Showcased at Exercise ANADL and currently awaiting approval at BET and Board (May & June respectively).

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**
			and Board for each module.			
AP1.2	Develop digital programme approach to all digital development activity and improved processes for identifying and agreeing digital activity in line with PHW digital and data strategy and DDDA portfolio.	• Timely delivery of digital programmes, and transparency of reporting of programmes.	Substantial digital development is required across a variety of systems, coordination on a portfolio level will enable more coordinated and therefore more effective delivery with HPSS and identification of the most appropriate forum within digital governance structures for action through the utilisation of digital clinical safety officers.	Deputy National Director Health Protection and Screening Services Assistant Director of Operations Health Protection	Q4; 2025/26	**June 2026:** Conversations with RDD are ongoing re Screening Digital priorities and how to improve planning and collaborative working approaches. **April 2026:** In discussion re-impact of Screening improvement activities on capacity and planning.
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		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an additional Exec led

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**
						listening exercise undertaken **April 2026** Improvement recovery plans being updated monthly with work to be undertaken to develop the appropriate recovery trajectories to include in the plans.
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		**June 2026:** As a result of exec engagement Radiology-led clinics in the North BTW Region will now support. Engagement is ongoing re Surgeon capacity in the North due to upcoming surgeon leave and impact MDT capacity.

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**
						For BSW, receipt and feedback on health board recovery plans have been completed, and the BTW Service Delivery and Capacity Management workstream has been tasked with working with health boards to develop a more standardised approach **April 2026** All Screening Division improvement activity will be consolidated within a Screening Improvement Programme, including incident-led actions (e.g. water and dust), performance improvement plans for three priority improvement plans for

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**
						Breast Test Wales, Diabetic Eye Screening Wales and Bowel Screening Wales and the Breast Test Wales service review recommendations. This Programme will be supported by cross organisational governance and resourcing, with an immediate focus on prioritised improvement actions and the development of clear improvement trajectories linked to key performance indicators and outcomes.
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		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations paused while an

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**
						additional Exec led listening exercise undertaken **April 2026** The BTW Service Review dissemination and engagement have now been completed. All Screening Division improvement activity will be consolidated within a Screening Improvement Programme, including incident-led actions (e.g. water and dust), performance improvement plans for three priority improvement plans for Breast Test Wales, Diabetic Eye Screening Wales and Bowel Screening Wales and the Breast Test Wales service review recommendations.

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**
						This Programme will be supported by cross organisational governance and resourcing, with an immediate focus on prioritised improvement actions
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		**June 2026:** DESW improvement plan has been established, with governance and oversight from the programme board, SMT and DMT. The camera evaluation is now in the final week with over 1000 participants taking part so far. The evaluation is on target to meet the sample size requirements though have had to

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**
						cancel some clinics due to staff sickness. **April 2026** Extension of contract for use of Tenovus mobile agreed for 3 months to maintain current clinic capacity. Evaluation of new technology and modified usage of eye drops started 20th April and will run until early June with good uptake by participants to be involved in the study.
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 Head of Operations Screening Division	Q4 2025/26	**June 2026:** Updated QSIC report incorporating specific Board feedback submitted. Proposed DMT governance structure under consideration to

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**
						strengthen assurance process. **April 2026** Board session held in April to discuss Screening Division performance and assurance reporting mechanisms. Governance mechanisms for the Screening Improvement Programme and SRO/Lead agreed and will report monthly to DMT and BET.
AP1.8	Strengthen governance and delivery of the Sexual Health Test and Post service incident	• Effectiveness of Incident Management Team • Key timely decision-making • Timely actions • Effective stakeholder communication • Alignment of service with best practice	Completion of lookback in a timely manner. Delivery of a service aligned with best practice.	Director of Health Protection	Q1 2026/27	**June 2026:** SRG and SHIG has now stood down. Service management structure is being refined with clear governance around accountability,

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**
						responsibility and lines of escalation with assurance report sent to PHW executives on 28 May 2026 **April 2026** Look back of HepC and MDT is now almost complete. Improvement group established and completed interim safe arrangements implementation for safeguarding, and commence scoping of phase 2 Service has reviewed all processes and implemented improvements on mailbox management, condoms processing, and currently looking to streamline test kit management.

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 improvements underway, and BPAG to stand up and implements best practice guidance and appropriate skillset

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	**June 2026:** Scoping has been completed for cross-directorate training and development function, to be presented on 9 June at DMT. **April 2026:** TNA work is a key theme running through the cross-directorate

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**
						training and development function which is being scoped.
AP2.2	Working with HEIW colleagues to broader HEI links offering public health placement opportunities for health professional placements Allied Health professions/Nurses & Midwives	Feedback from participants	This will provide trainees in allied health professions to experience public health placements to support their future careers to promote prevention and healthy lifestyle	Deputy National Director Health Protection and Screening Services Business / Workforce Development Manager - Office of Medical Director	Mar 26	**June 2026:** First T&F meeting due to take place end of June/early July **April 2026** T&F group being set up to include PHW, HEIW and HEI to being to plan. Working with NQIG to align with their student placement process.
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	**June 2026:** No update on outcome of education commissioning, update as per AP2.1 **April 2026** No update on outcome of educational commissioning

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		submission, however this work is being scoped under the cross-directorate training and development function project.

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	**June 2026:** Preparation for 27/28 IMTP setting process underway, to include a greater focus on embedding the routemap. **April 2026** Ongoing engagement with enabling functions to identify how activity supporting the route map aims can be collated. Review of

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**
						IMTP process and how to further embed Routemap being initiated for next year IMTP setting process objectives.
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	**June 2026:** Awaiting outcome of cross directorate way of working review. **April 2026** Research has been included as an area of focus in a cross-directorate ways of working review which will inform future strategy.
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	**June 2026:** Awaiting outcome of cross directorate way of working review. **April 2026** Research has been included as an area of focus in a cross-directorate ways of

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**
						working review which will inform future strategy.

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	Deputy National Director Health Protection and Screening Services Head of Emergency Preparedness Resilience and Response	March 2026 Request Closure. Ongoing BAU Management	**June 2026:** Request Closure. Ongoing BAU Management **April 2026:** V1 of the PHW Pandemic Response Arrangements complete, currently awaiting approval at BET and Board (May & June respectively).
AP 4.2	Strengthen strategic oversight of pathway resilience across national screening programmes ensuring risks arising from unplanned activity and wider system	• Improved visibility of emerging screening system risks. • Evidence of enhanced pathway resilience across national screening programmes	• Maintains organisational resilience to unplanned activity affecting screening performance and population outcomes.	Director Screening Division		**June 2026:** Monitoring ongoing of existing actions. Implementation of BTW review recommendations

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**
	dependencies are identified, escalated and addressed through established governance routes.	• Strengthened workforce sustainability indicators at a strategic level. • Digital capabilities aligned with strategic assurance requirements	• 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			paused while an additional Exec led listening exercise undertaken **April 2026** Improvement plans implemented for Bowel Screening Wales (BSW), Breast Test Wales (BTW) and Diabetic Eye Screening (DESW), with the establishment of the Screening Improvement Programme to enable consolidation of all improvement activity and streamlined governance. The BTW plan sets out a time□bound programme to restore safe, equitable and high□quality breast screening across Wales. It focuses on recovering national

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**
						standards, reducing regional variation, strengthening workforce and infrastructure resilience, improving equity and uptake, and aligning delivery with Breast Screening Service Review. The BSW plan sets out a time limited, systemwide programme to improve access to screening colonoscopy across Wales. It focuses on increasing capacity, addressing workforce constraints, reducing variation, and improving data visibility through collaborative working with health boards and partners, providing a credible route to sustainable, equitable improvement.

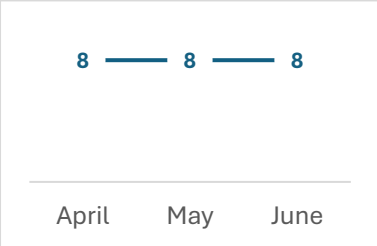
Gaps in Assurance / Action Plans for the cause C4 Exceedance in unplanned activities arising from unexpected acute threats to health.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						The DESW plan sets out an evidence led programme to address demand–capacity imbalance and restore screening coverage across Wales. It focuses on increasing clinic utilisation, redesigning delivery models, testing innovative approaches, strengthening governance and workforce resilience, and providing Board assurance of a sustainable route to equitable, future proof diabetic eye screening.

<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR4

Strategic Priority 6

“Tackling the public health effects of climate change.”</td><td colspan="2">There is a risk that: we fail to effectively mitigate the public health impacts of climate change on the Welsh population

Caused by:
1. Failure to identify and monitor climate change threats to health
2. Failure to effectively inform actions of partner organisations and policymakers so that health is considered as part of their climate action
3. Failure to effectively engage with our population, partner organisations and policymakers
4. Failure to prioritise resources to actions that make a measurable difference to the health of our population
5. Insufficient leadership in Wales to achieve a joined up and aligned system response to climate change.
6. Failure to take co-ordinated actions with partner organisations across the UK 4 Nations and advocate for UK climate policies that protect and promote health

Resulting in: Failure to prevent harm to the health of our population as a result of climate change, resulting in worse health outcomes and widening of health inequalities.</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">National Director of Policy and International Health</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">Knowledge, Research and Information 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 = 8
Target Score = 6
Risk Appetite Level Applied = Open, therefore, within tolerance level.</td><td>There has been increased demand associated with climate-related incidents, including multiple heatwave events and recent wildfires, which have required significant operational response and diverted capacity from proactive to reactive. Highlights of recent heatwave response included early consistent messaging which provided clear instructions for the public and partners, as well as development of a rapid heat period morbidity and mortality surveillance report. In addition, the recent heatwaves have impacted our ability to</td></tr>
</table>

		maintain service delivery, with power outages reported and staff affected by the heat. These challenges will be mapped against our climate risk register to understand what mitigations we are able to make, noting that the challenges in these areas are often in our hosted estates. Learning from the heatwaves is being used to ensure our climate response plan is robust and up to date. We provide strategic leadership through the National Adaptation Board, a subgroup of the Health and Social Care Climate Emergency National Programme Board. We continue to work with partners across the UK and internationally, with UKHSA having proposed an SLA on climate and health. Workforce and organisational capacity pressures have further increased during the reporting period, primarily due to higher levels of sickness absence, creating challenges in maintaining delivery across core programmes of work.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Failure to identify and monitor climate change threats to health			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Climate change and health surveillance system in development, led by CDSC. Active engagement with surveillance partners across the 4 Nations and international system.	Climate Change Surveillance - sub-group of Climate Change Programme Board.	Regular updates from the Surveillance Subgroup to Climate Change Programme Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C2:** Failure to effectively inform actions of partner organisations and policymakers so that health is considered as part of their climate action			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Active engagement and collaboration with partner organisations, including Welsh Government, Future Generations Office and the wider public health system in Wales.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly, and risk is now a standing agenda item.
C2.2	Climate Change is part of our Policy Advocacy Programme priorities	Policy Advocacy Programme Board	Policy Advocacy Programme Board meets monthly to monitor progress and impact. Post election, this is moving to a new phase to reflect new Government priorities.

[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] **C3:** Failure to effectively engage with our population, partner organisations and policymakers			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	Ongoing active engagement and collaboration with the public, partners and policy makers regarding the threat to the public from climate change as part of the workplan.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly, and risk is a standing agenda item.
C3.2	Ongoing collaboration with primary care through Greener Primary Care Team and programme.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly, and risk is a standing agenda item.
C3.3	Climate Change is part of our Policy Advocacy Programme priorities	Policy Advocacy Programme Board	Policy Advocacy Programme Board meets monthly to monitor progress and impact

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C4:** Failure to prioritise resources to actions that make a measurable difference to the health of our population			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Distributive leadership model within PHW aiming to ensure that all colleagues have the skills and time to ensure that climate sensitive practice is part of their day job.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly, and risk is a standing agenda item.
C4.2	Work underway to understand resource allocation to each of the strategic priorities.	Business Executive Team	Business Executive Team meeting

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C5:** Insufficient leadership in Wales to achieve a joined up and aligned system response to climate change.			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C5.1	This is dependent upon broader system recognition in the threat of climate change to health and partners' allocation of sufficient resources. Engagement with Welsh Government and partner organisations through national meetings and working with partner organisations to support a system approach.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly, and risk is a standing agenda item.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C6:** Failure to take co-ordinated actions with partner organisations across the UK 4 Nations and advocate for UK climate policies that protect and promote health			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C6.1	Active engagement with 4 Nation colleagues to ensure that our practice is aligned where feasible and we are learning from others' experiences and advocating for the Welsh population.	Climate Change Programme Board	Climate Change Programme Board meets bi-monthly and risk is a standing agenda item.

Gaps in Assurance / Action Plans for the cause C1 Failure to identify and monitor climate change 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**
AP1.1	Climate change programme board and associated sub-groups have mechanisms in place to ensure that we are actively horizon scanning, monitoring, and taking action on climate related threats to health	Log to capture threats to health developed and monitored by CCPB	Regular identification of the risks and monitoring of our actions to mitigate them.	Sumina Azam and Meng Khaw	Q4 2025-26	July 2026: We are working to map our recent experience of heatwaves against our climate risk assessment and response plan to ensure effective mitigation April 2026: We have developed our Climate Risk Assessment and Response Plan which outline the climate related risks for Public Health Wales, and our plan to manage them.

Gaps in Assurance / Action Plans for the cause C2 Failure to effectively inform actions of partner organisations and policymakers so that health is considered as part of their climate action						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.1	Proactive engagement with policy makers on the climate change agenda	Increased engagement with policy makers and a greater reference to health	Strengthen the relationship between health and climate change in the policy arena	Sumina Azam	Q4 2025-26	July 2026: Engagement with policy makers has recommenced post-election.

Gaps in Assurance / Action Plans for the cause C2 Failure to effectively inform actions of partner organisations and policymakers so that health is considered as part of their climate action						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
		within the climate change agenda				April 2026: The Advocacy Programme is paused for the pre-election period. There are already close working relationships with WG officials on climate change and health. Climate change is a key theme in our Public Health Advocacy Programme.

Gaps in Assurance / Action Plans for the cause C3 Failure to effectively engage with our population, partner organisations and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.1	Review of formal arrangements with key strategic partners, including UKHSA, IANPHI, and NRW	Joint actions / approach on climate and health.	Strengthen opportunities for effective collaboration with joint aims.	Sumina Azam	Q4 2025-26	July 2026: UKHSA are looking to confirm an SLA in relation to work on climate and health. This is currently under review between PHW and WG and presents

Gaps in Assurance / Action Plans for the cause C3 Failure to effectively engage with our population, partner organisations and policymakers						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						both risks and opportunities. April 2026: No further changes

Gaps in Assurance / Action Plans for the cause C4 Failure to prioritise resources to actions that make a measurable difference to the health of our population						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.1	Development of a route map for Strategic Priority 6 (Climate and health) to enable identification of resource requirements for delivery.	Route maps to be reviewed and approved by Executive Team, with resourcing a consideration.	Resource requirements will also enable identification of resource gaps.	Sumina Azam / Rebecca Masters	Q2 2025-26	July 2026: Route map has been completed and delivery plans now being developed to ensure effective delivery aligned to the IMTP and WG mandate. April 2026: This work is on-going in alignment of our Long-Term Strategy and IMTP commitments. High level mapping of resources according to

Gaps in Assurance / Action Plans for the cause C4 Failure to prioritise resources to actions that make a measurable difference to the health of our population						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						Strategic Priority has been undertaken.

Gaps in Assurance / Action Plans for the cause C5: Insufficient leadership in Wales to achieve a joined up and aligned system response to climate change.						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP5.1	Discussions with Welsh Government, and participation in Welsh national climate change meetings to enable system alignment and joined up action to protect health.	Health considered as part of climate action by public bodies.	Participation will enable advocacy for a population health perspective.	Sumina Azam / Rebecca Masters	Q4 2025-26	July 2026: Rebecca Masters now chairs the WG Health and Social Care Climate Emergency National Programme Board – National Adaptation Board, with PHW operating as the organisational sponsor for this workstream. April 2026: No further changes

Gaps in Assurance / Action Plans for the cause C6 Failure to take co-ordinated actions with partner organisations across the UK 4 Nations and advocate for UK climate policies that protect and promote health						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP6.1	Engagement with 4N, FPH, WHO and IANPHI colleagues, along with international organisations regarding the climate and health agenda.	Review of national and international partnership landscape, including regular updates to CCPB	Alignment of work and methods and sharing of good practice.	Sumina Azam / Rebecca Masters	Q4 2025-26	July 2026: Under continuous review to ensure alignment. Rebecca Masters recently chaired a WHO climate adaptation webinar which saw the launch of the WHO Heat Health Adaptation Plans as well as the latest research on adaptation for vulnerable groups – this learning is now being incorporated into our heat response April 2026: Climate change is likely to be a topic for the forthcoming IANPHI meeting to be held in Wales in Q3 2026/7, offering opportunity for

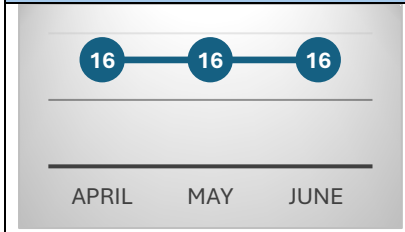
Gaps in Assurance / Action Plans for the cause C6 Failure to take co-ordinated actions with partner organisations across the UK 4 Nations and advocate for UK climate policies that protect and promote health						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						international partnership and collaboration for climate action.

<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR 5

Strategic Priority

“Enabler Risk and incorporates all Strategic Priorities.”</td><td colspan="2">There is a risk that:
Failure to modernise and transform how we provide and deliver our services

Caused by:
• Lack of capability and capacity in leading, managing, delivering and communicating transformational change
• Failure to fully exploit digital and data
• Lack of maturity in benefits realisation from change delivery
• Lack of ability to deliver improvement at pace

Resulting in poorer quality services, outcomes, value and organisational effectiveness</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">Research, Data and Digital</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">Knowledge, Research and Information 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>Willing</td><td>PHW is eager to be innovative and take on a high level of risk, but only in the right circumstance.</td></tr></table>
Current Score = 16
Target Score = 6
Risk Appetite Level Applied = Willing, therefore, within tolerance level.</td><td>It will be a challenge to deliver the current change portfolio given the level of change maturity across the organisation.

We need a clear narrative for strategic and transformational change that helps our staff and stakeholders to understand what we are trying to achieve through our change portfolio, how it will affect them, the overarching benefits we are looking to deliver.

There is currently limited visibility of the cumulative impact of change across the organisation, making it difficult to assess overall change capacity and the</td></tr>
</table>

		impact on staff and services. There is therefore a risk that additional demands could destabilise the existing change portfolio. Managing the scale of change is difficult due to the insufficient leadership capability and capacity for transformation and inconsistent levels of change management experience across the directorates. There is a desire to simply replace what already is in place rather than look at most efficient ways of delivering our services and meeting user needs. There have been some examples of inconsistent adherence to governance processes which compromises appropriate standards being followed. These factors collectively increase the complexity and vulnerabilities of delivering initiatives. Many aspects of the portfolio are dependent on external stakeholders, including DHCW and third-party suppliers. Active management of these relationships is required for successful delivery.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance **C1: Lack of capability and capacity in leading, managing and delivering transformational change**			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Annual Planning Process, including assessment of IMTP feasibility, to include a high level 3–5-year road map for expected delivery	Strategic planning process (including formal approval and change control) covering: • Long Term Strategy • Strategic Priority Routemaps • IMTP, inc assessment of IMTP feasibility • Digital and Data Strategy and Route Map IMTP • Directorate and Divisional level planning • Programme Plans	Portfolio review Change Board BET Board DDDA AIDA
C1.2	Annual planning process including BAU Planning from all directorates to assess delivery feasibility, to include a high-level 3–5-year road map for expected delivery	Directorate Business Leads • Directorate planning of BAU requirements • Directorate procurement forward look • Organisational plan • Digital assurance reporting and Delivery Confidence Assessments • Programme reporting and Delivery Confidence Assessments	• Directorate • DDDA • AIDA • Change Board • BET • Board
C1.3	**Organisational Change Capacity and Demand Management**	• Integrated portfolio dashboard (change demand vs capacity)	• Change Board • BET • Board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance **C1: Lack of capability and capacity in leading, managing and delivering transformational change**			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	• Establish and maintain a single organisational view of all change activity (operate, improve and transform), including assessment of cumulative impact on services, teams and workforce capacity • Formal prioritisation and sequencing of change activity aligned to organisational strategy and available capacity	• Directorate validation of impact on BAU and workforce	
C1.4	Communication of change Develop a clear and compelling narrative that helps staff and stakeholders understand our overarching strategic vision for transformation, how it will support our organisational strategy and what it will mean for staff and stakeholders.	Creation of an organisation strategic objective that aligns with the business need	All enabling functions Change Board BET
C1.5	Digital and Data Strategy and Routemap implemented.	D&D Portfolio – Monthly Delivery Confidence Assessment. Quarterly Assurance papers to BET/KRIC	Change Board BET Board
C1.6	Include resource provision for programme enabling functions as part of the discovery phase of a programme. Enabling functions offer to be developed to provide a more equitable proposition across the portfolio.	Plan to be created Strategic Risk 2 Strategic Risk 2.docx	• Directorate management • Programme Management • Change Management across the whole organisation

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance **C1: Lack of capability and capacity in leading, managing and delivering transformational change**			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.7	**Organisation-wide Change Capability Framework** • Development and implementation of a consistent organisational approach to building change capability across leaders, managers and staff • Defined expectations for leadership behaviours in leading and sustaining change	• Creation of a change capability framework • Leadership development participation and feedback • Staff engagement and change readiness indicators • Change management processes implemented across the organisation successfully	Change Board BET Board
C1.8	Establishment of centralised Business Change expertise in The Research, Digital and Business Transformation Directorate	D&D Portfolio – Monthly Delivery Confidence Assessment. Quarterly Assurance papers to BET/KRIC	Change Board BET Board
C1.9	Commissioning of change: All proposed business change discussed and planned as early as possible with all relevant parts of the organisation through the planning process	• Commissioning of all significant business change (defined as Tier 1 or 2) through Change Board including: ○ Identification and review of pipeline change proposals at Change Board ○ Use of prioritisation criteria to identify the programme tier (1, 2 or 3) ○ Approval of Programme Brief at Change Board required for a new	Change Board BET Board DDDA / AIDA, where required

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance C1: Lack of capability and capacity in leading, managing and delivering transformational change			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
		change programme to be mobilised. ○ Review of monthly Delivery Confidence Assessments by all programmes/ projects on the Change and Digital Portfolios • Assessment of digital feasibility by DDDA required for all programmes that involve digital • Assessment of feasibility by specific Directorates and Divisions, including enabling functions such as Communications, Finance, Digital, Estates and People and OD.	

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] C2: Failure to fully exploit digital and data			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.1	Migration of our data and analysis to the Cloud is being piloted with a view to a full migration of all our analytical resource to the NDR by March 2027	Assurance and Progress reporting	DARC Programme Board Analysis Project Board Data project board

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] C2: Failure to fully exploit digital and data			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C2.2	Small data science team created and beginning to increase the analytical capability with work now carried out on new tools.	Assurance and Progress reporting	AIDA DARC Programme Board Analysis Project Board
C2.3	Ensure agile User Centred Design approach is used in the planning and discovery phase of a digital change programme	User Needs Log User Requirements linked to user needs Programme Specification	Service Users/Owners Programme Board DDDA AIDA
C2.4	R, Python and Power BI established as tools of choice for most new analysis	Assurance reporting	DARC Programme Board DSAB
C2.5	Integration of genomics into our digital and data strategy and delivery routemap has begun.	D&D Portfolio – Monthly Delivery Confidence Assessment. Quarterly Assurance papers to BET/KRIC	DDDA AIDA Digital & Data Portfolio Change Board BET Board
C2.6	**Digital and Data Workforce Capability** -Strategic Workforce Plan in place, aligned to digital and data transformation priorities -Clear identification of current and future digital, data and analytical skills requirements -Defined workforce pipelines including recruitment, apprenticeships and upskilling pathways -Ongoing development of digital and data literacy across all staff, including leadership	**Assurance:** -Workforce metrics (vacancies, time to recruit, retention in key roles) -Skills gap analysis and workforce capability assessments -Uptake and completion of digital and data training programmes -Evidence of increased use of digital tools and data in decision-making	BET Workforce / People & OD governance DDDA / AIDA (for alignment to digital strategy) Strategic Risk 2

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C3: Lack of maturity in benefits realisation from change delivery**			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C3.1	A clear Benefits Realisation Framework is designed, implemented and applied consistently across all change programmes, including: • Defined benefits, baselines and metrics • Named benefit owners within business areas • Tracking of benefits during delivery and post-implementation into BAU	Benefits Framework to include the organisation benefit acceptance rules, named benefit owners, calculation metrics and baseline requirements which must be used by all programmes **Benefits Realisation into BAU** Benefits must be tracked and reported beyond programme closure to demonstrate sustained value **Source of Assurance:** Portfolio reporting of planned vs realised benefits Post-implementation reviews (6–12 months post-delivery)	Programme Boards Benefit Owners Change Board DDDA
C3.2	All change programmes must ensure clinical approval is sought and obtained for any changes that impact clinical systems and / or services, where required	Clinical Governance Group Service Owner Programme Managers	Clinical Governance Group BET Board
C3.3	Discovery of benefits and delivery requirements for each proposed change to be completed prior to the creation of the Business Case	Discovery reports to be submitted to change board. These will identify and quantify key financial benefits of the proposed change and the estimated resource requirement to allow for effective decision making	Programme Lead DDDA/AIDA if digital proposal Change Board BET
Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1]			

C4: Lack of ability to deliver improvement at pace			
Control Reference	**Internal Control**	**Source of Assurance**	**How/When is it monitored?**
C4.1	Identification of the internal resource that is required to complete a programme of change successfully with active collaboration to meet the programme requirements together	Defined change management process Appropriate programme initiation reviews ensuring the right experts are in the room Resource requirements for change programmes to be defined	TBD – Check with all directorates on their current processes
C4.2	Earlier identification of dependencies on DHCW Active management of DHCW delivery for specific programmes eg LIMS.	IMTP Feasibility Assessment Change Portfolio and D&D Portfolio – Monthly Delivery Confidence Assessment. Quarterly Assurance papers to BET/KRIC Monthly planning meetings between PHW DHCW Change Board Assurance report including DCA Reporting against change portfolio programmes	Programme Board Change Board DDDA Dependency identification, mapping and agreement undertaken as part of planning process for internal agreement
C4.3	Earlier and more precise identification of supplier dependencies at programme and portfolio levels	Change Board – analysis of dependencies at portfolio level DDDA – analysis of dependencies at portfolio level Tier 1 and 2 programme plans Digital delivery plans	Programme Board Change Board DDDA Dependency identification, mapping and agreement undertaken as part of planning process for internal agreement

C4.4	Earlier and more precise identification of Local Health Board dependencies at programme and portfolio levels	Change Board – analysis of dependencies at portfolio level DDDA – analysis of dependencies at portfolio level Tier 1 and 2 programme plans Digital delivery plans	Programme Board Change Board DDDA Dependency identification, mapping and agreement undertaken as part of planning process for internal agreement
C4.5	Regular portfolio reviews to be undertaken at an organisation level (every 6 months) to assess the viability of the change portfolio and to ensure all programmes still align with the organisation's strategic goals	Programme delivery timelines Decision turnaround times IMTP Delivery Assessment (6-Monthly) All directorates to review and update plan based on current and planned priorities Change Board – analysis of dependencies at portfolio level DDDA – analysis of dependencies at portfolio level Tier 1 and 2 programme plans Digital delivery plans	Portfolio Review Change Board DDDA Dependency identification, mapping and agreement undertaken as part of IMTP planning process for internal agreement

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.2 & AP2.2	Increase Digital, Cloud, Cyber and Data	Successful recruitment of Cloud	Create capacity and depth of skill to meet	Governance & General Manager	31/12/2025	**June 2026**

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	management technical skills capability into PHW as a result of additional investment.	Engineers, Data Engineers, Developers, Cyber Specialists, Technical Project Managers funded by PHW investment.	deliverables of IMTP/BAU requirements.	– RDDD / Director of PoD		Multiple roles are currently being progressed to support delivery requirements across Lung, DHP and OPIP. However, all posts are being offered as fixed-term contracts and, due to current recruitment restrictions, this is creating operational challenges. There is a significant risk that programme delivery will be affected, as the limited duration and constraints attached to these roles make them less attractive to candidates who have alternative employment options.

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						April 2026 Recruitment activity is underway to fill the Cloud Engineer vacancy following a resignation. The Systems Architect is scheduled to commence in May 2026. NDR funding from DHCW has been paused pending review. This is anticipated to impact Cloud and Data Engineer posts funded through this source, including agency-funded technical specialist roles. Completion date changed due to this update.

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.3	Engage technical agency resource to bridge the gap between recurrent resource commencing in post. This is funded using slippage from investment funding only.	Deliverable are progressing using agency provision. Pay budget balances	Use of agency resource will enable key programmes of work to commence/continue whilst recruitment is ongoing.	Governance & General Manager – RDDD	31/08/2025	**June 2026** Due to pause in NDR funding agency support for Data Engineers roles are required to avoid non delivery digital programmes including DARC. Recruitment is ongoing but this is a significant RDDD cost pressure that could impact break even position. The risk of not doing so impacts deliverables. **April 2026** As per 1.2. Pausing of NDR funding has created a funding gap. One agency Cloud/Data Engineer terminated as a

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						result. There will be impacts to delivery dates due to reduced capacity.
AP1.4	Ensure there is sufficient resource available to support the organisations change portfolio	All organisation programmes resourced with the required team for delivering the change	Provide assurance that change programmes implemented across PHW are being delivered to a high standard.	All enabling functions leads	30-Jun-27	Jun-26: Action expanded to include all change programmes across the organisation.
AP1.5	Ensure there are sufficient programme resource available to support the change	Ensure the programme team has the appropriate team resource available to deliver the programme of change	Ensure the programme team has the appropriate expertise required to deliver the programme	Strategic Programme Lead, RDD Portfolio Lead	30/05/27	May-26: Action Added
AP1.6	Continuing development of and compliance with PHW PPM Standards	Improving compliance with the PPM standards as measured through programme self-assessment.	Provide assurance that change is being delivered well	Standards and Assurance Lead	30/9/26	May 26 – Action added to risk - reported to Change Board that compliance scores are similar to Oct 25.
AP1.7	There is a clear process for appointing SROs to programmes	Relevant SRO candidates for programmes are identified	SROs are identified with sufficient experience and skills to deliver	Standards and Assurance Lead	31/3/27	May-26: Action Added

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
		systematically at programme initiation.	programmes effectively. Consideration will also be given to leaders across the organisation who may bring transferrable skills, or SRO skills across organisational boundaries			
AP1.8	Create and manage a delivery plan for IMTP Milestones – plan over three years considering resource availability and business impact	Review of the delivery plan against organisation priorities to be held regularly (minimum every 6 months)	This will allow successful delivery of change programme without impacting BAU Operations	Strategic Programme Lead, RDD Portfolio Lead		Jun-26: Action Added
AP1.9	Define an appropriate Programme to BAU handover process to embed the change across the intended area of the organisation	Programme Closure Documentation Training Plans Update PPM Standards User /employee feedback Process improvements	Ensure the change programmes are embedded successfully, once complete	Portfolio Lead RDD Service owners/ Service Users, Programme Manager / SRO	31/12/2026	Jun-26 Action added

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP1.10	Develop a change pre-discovery and discovery process that all programmes must complete to assess viability and estimated delivery requirements and benefits of the change	Develop a pre-discovery and discovery approach that all programmes complete to explore the problem space, understand user and business needs, and assess the viability and value of proposed changes. Build a shared understanding of user and organisational needs to inform how change should be shaped and delivered. Ensure the organisation has a clear understanding of the problem, users, and intended outcomes before initiating delivery.	Ensure the organisation understands the needs of the users and the change before initiation	Portfolio Lead RDD Service owners/ Service Users, Programme Manager / SRO	31-Mar-27	Jun-26: Action added
AP1.11	Ensure the change portfolio refresh for 27/28 arrives at a feasible portfolio, taking full	Reviewing the planning process for the change portfolio and providing the	This will allow successful delivery of change programme	Strategic Programme Lead	31/3/28	Proposed new action for SR5

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	account of operate, improve and change activity, in line with good portfolio management practice.	approved process to the organisation to allow for effective change management and understanding Defining and implementing the development of portfolio analysis tools, such as a dashboard to understand change feasibility, in conjunction with the wider planning community	without impacting BAU Operations			
AP1.12	Develop a business case framework for the organisation.	Programmes resourced and delivering successfully	Business case led change	Strategic Programme Lead	9/9/26 (Change Board)	Proposed new action for SR5
AP1.13	Develop and implement a consistent organisational approach to building change capability across	Agreed change management approach for the organisation,	Having change capability in place across the organisation and across all staff grades	Strategy and Planning, People and OD, Communications, Digital	Date tbd	**Jun 2026** No change from last update. **February 2026**

Gaps in Assurance / Action Plans for the cause C1 Lack of capability and capacity in leading, managing and delivering transformational change						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	leaders, managers and staff	Understanding of existing change capability. Learning and development offer defined and implemented	will increase the likelihood of successful change.			Programmes managed by RDD are defining their resources and cost requirements and have appropriate governance measures in place to review any change of scope that may arise within the programme. Any changes of scope are managed through appropriate change management processes within the programme.

Gaps in Assurance / Action Plans for the cause C2 Failure to fully exploit digital and data						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.1	To establish parameters for the efficient and safe use of AI tools across PHW. Providing 'How to' guidance for staff to follow to ensure best practice compliance.	Lack of data breaches reported using approved AI Tools. Efficiencies in time and quality being realised.	PHW will have clear parameters to work to, which should reduce the poor compliance/use of AI capability.	Head of Data Science & Analysis	March 2026 (Check IMTP deliverable)	**June 2026** A plan to mitigate the risks of shadow AI has been approved by the AI Design Authority. This includes training and comms. An AI policy is in the draft stages. The consultation period for generative AI guidance has been completed. **April 2026** Work to create a user guide for guidance, assurance and approval of AI use in PHW has been commissioned by AIDA Guidance on the use pf Generative AI has been completed and is being translated.
AP2.4	Build a Digital and Data Apprenticeship pathway from entry level to degree level	An established career pathway within PHW and partners to 'build and develop' technical capability.	Bring opportunities to school leavers that are non-traditional NHS roles. Established pathways for PHW to be an employer of choice for technical specialities.	Governance & General Manager - RDDD	31/12/2027	**June 2026** There is no additional funding available for apprenticeships currently. It remains an ambition to develop the pathways, but a funding stream needs to be

Gaps in Assurance / Action Plans for the cause C2 Failure to fully exploit digital and data						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						identified to realise this. Delivery date changed to next financial year. **April 2026** No further apprentices added. Work is ongoing subject to funding. Delivery date changed to funding availability.
AP2.5	Maximise the use of M365 tools and/or automation to support internal efficiencies, process improvements and data capture.	DDDA and AIDA sighted on new software being proposed for purchase and assess against current in house paid tools. AIDA will be sighted on AI and Automative tools. Both will be able to drive embed controls. Training for staff on using M365 products from DHCW being promoted.	Utilising and realising the use of M365 suite of tools that are available as part of the tenancy, to drive efficiency and collaboration across the organisation without incurring additional expense.	Head of Digital Services / Head of Data	31/03/2027	**Jul-26** Microsoft Fabric was implemented on 2-Jul-26 which is one of the core M365 Platform upgrades supporting the Power BI platform among other Power Automate tools. **April 2026** Microsoft have introduced a change to the M365 Tools which will be implemented in Jul-26. PHW are working with NHS partners and Microsoft to deliver the change.

Gaps in Assurance / Action Plans for the cause C2 Failure to fully exploit digital and data						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP2.6	Deliver Phase 1 of the AI Programme.	PHW staff know which products to use follow guidance to ensure compliance with good practice for safe, legal and ethical adoption of AI	This will provide clear guidance and safe use of PHW approved AI products.	Head of Data Science & Analysis	31/03/2027	**Jun 26** **This action will be closed as it is now complete.** **April 2026** AI is no longer classified as a programme. Assurance is provided to DDDA and BET via updates on approvals granted. These are documented in the PHW AI Register. Datix incidents are being updated to include AI as a cause.
AP2.7	Treat Corporate Risk 1780 There is a risk that PHW are unable to deliver our digital agenda due to dependencies on national programmes, DHCW and Welsh Government.	Programmes/activities that have a significant dependency on DHCW remain on track, or early warning if breaches are identified.	Clarity is needed on the role of WG and DCHW and that to be cleared documented. Representation has been strengthened and there is commitment to be more aligned, however it remains a gap which may result in under delivery.	Head of Digital Services	31/12/2026	**Jun-26** Decisions made in DHCW over recent months which include decisions on tolls implemented and the pause on review of key national programmes implemented by WG have had an impact on PHW Key programmes, impacting timelines and requiring workarounds to be

Gaps in Assurance / Action Plans for the cause C2 Failure to fully exploit digital and data						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						implemented to maintain delivery. **April 2026** Monthly planning meetings between DHCW and PHW have been established for planning and escalation purposes. PHW have been working with DHCW on a number of escalations regarding DHCW Delays that are impacting the delivery of PHW Programmes and are working through the mitigations together.

Gaps in Assurance / Action Plans for the cause C3 • Lack of maturity in benefits realisation from change delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP3.1	Commence the implementation of	No harm caused as an outcome of new	All new processes will have been assessed against clinical and	Public Health Consultants / Head of	31/03/2027	**June 2026** DCSO work embedded within Digital Health Protection

Gaps in Assurance / Action Plans for the cause C3 • Lack of maturity in benefits realisation from change delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
	Clinical and Digital Safety Standards.	processes being implemented.	digital safety standards to avoid harm as part of the change process. Gaps in assurance will be identified early and mitigations implemented.	service/Head of Digital Services / Digital Clinical Safety Officer		programme with requirement to establish a within programme clinical governance group to provide assurance. DCS training for relevant staff within PHW scheduled for 10 & 11 June 2026. Plans to establish a PHW Clinical Safety Group (we believe to be hosted by the Office of the Medical Director) progressed to draft TORs, however, timelines remain unconfirmed. The DCSO remains a single point of failure within PHW and is working at capacity, currently prioritising two high profile programmes (Digital Health Protection and Lung Cancer Screening). It is anticipated that asks to support Sexual Health Wales programme will emerge soon. Asks to support other screening programmes have been turned down by the DCSO as no current capacity to do so. If resource capacity is not increased there will be a

Gaps in Assurance / Action Plans for the cause C3 • Lack of maturity in benefits realisation from change delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
						need for a transparent mechanism to prioritise the work of the DCSO.
AP3.2	Implement the required actions as detailed under **SRR2**					See SRR2 Updates.
AP3.3	Establish the clinical Governance Group	Clinical Governance Group established Define the clinical governance requirements and metrics.	Provide clinical assurance for all change requirements where clinical approval would be required. Define the ownership and formal acceptance process of any residual clinical risk for the management of services.	Executive Director of Nursing Quality and Integrated Governance and Medical Director.	June 2026	**June 2026** First meeting took place early June 2026. An update will be provided at the next meeting.
AP3.4	Create and manage a benefits framework for the organisation that all change programmes must adhere too	Tangible benefits identified for proposed change programmes and key measures and baselines identified that can clearly assess the impact of the change Benefits will be reported on through Change Board.	Ensure the proposed change will provide adequate tangible benefits for the organisation Implementing a benefits tracking process to ensure benefits are tracked through to completion	Head of Planning, Strategy & Corporate affairs. Strategic Programme Lead, Senior Programme Manager, Programme Design Lead,	9/9/26 (Change Board)	Jun-26: Action Added

Gaps in Assurance / Action Plans for the cause C3 • Lack of maturity in benefits realisation from change delivery						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
		Benefits tracker to manage benefit realisation through programme implementation and BAU	whether that happens during the programme or in BAU	RDD Portfolio Lead		

Gaps in Assurance / Action Plans for the cause C4 • Lack of ability to deliver improvement at pace						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.1	Identification of the internal resource that is required to complete a programme of change successfully with active collaboration to meet the programme requirements together	Ensure the programme is resourced effectively to increase the ability to implement the change successfully	Support the successful delivery of change programmes	All enabling function leads; Comms, RDD, PoD, S&P		**April 2026** Management capacity is being assessed regularly. It remains challenging across the D&D portfolio with the competing demands having to be balanced.

Gaps in Assurance / Action Plans for the cause C4 • Lack of ability to deliver improvement at pace						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
AP4.2	Earlier identification of dependencies on DHCW Active management of DHCW delivery for specific programmes eg LIMS.	Support the mitigation of delays when change programmes include external stakeholders	Support the successful delivery of change programmes	RDD Portfolio Lead,		Jun-26 – Action added
AP4.3	Earlier and more precise identification of supplier dependencies at programme and portfolio levels	Ensure the programme is resourced effectively to increase the ability to implement the change successfully	Support the successful delivery of change programmes	RDD Portfolio Lead, Strategic Programme Lead		Jun-26 – Action added
AP4.4	Earlier and more precise identification of Local Health Board dependencies at programme and portfolio levels	Support the mitigation of delays when change programmes include external stakeholders	Support the successful delivery of change programmes	RDD Portfolio Lead, Strategic Programme Lead		Jun-26 – Action added
AP4.5	Regular portfolio reviews to be undertaken at an organisation level (every 6 months) to assess the viability of the change portfolio and to ensure all programmes still align with the organisation's strategic goals	Ensure the change portfolio continues to align with the organisation's strategic objectives, the delivery of change is still on track and has sufficient resource.	Support the successful delivery of change programmes	RDD Portfolio Lead, Strategic Programme Lead		Jun-26 – Action added

Gaps in Assurance / Action Plans for the cause C4 • Lack of ability to deliver improvement at pace						
Reference	**What Action?**	**How will we measure efficacy?**	**How will this action impact/mitigate the risk?**	**Who is Responsible?**	**By When?**	**Progress**
		Provide the appropriate evidence to the executive team to make informed decisions on the prioritisation of the change portfolio on a frequent basis				