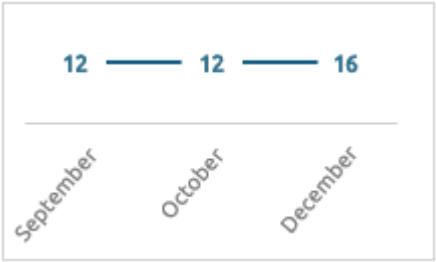
<table>
<tr><th>Risk Reference and Link to Strategic Priority</th><th colspan="2">Risk Description</th></tr>
<tr><td>SRR3

Strategic Priority 5

“Delivering excellent public health services to protect the public and maximise population health outcomes.”</td><td colspan="2">There is a risk that:
We fail to deliver our contribution to excellent public health services in population health screening, infection, health protection and emergency response.

Caused by:
1. Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.
2. Inability to maintain capacity and capability of the specialist workforce.
3. Absence of innovation and continuous quality improvement.
4. Exceedance in unplanned activities arising from unexpected acute threats to health.

Resulting in: Poor quality and unsafe services, sub-optimal population health outcomes for population screening and health threats, and a breach of legal duties on Civil Contingencies and Duty of Quality.</td></tr>
<tr><td>Executive Director Sponsor</td><td colspan="2">National Director of Screening and Health Protection Services/Medical Director</td></tr>
<tr><td>Assuring Committee</td><td colspan="2">Quality, Safety and Improvement Committee</td></tr>
<tr><td>Trend</td><td>Current Position of Risk Including Risk Appetite and Risk Decision</td><td>Position Statement – Executive Director Update</td></tr>
<tr><td> 
</td><td><table><tr><td>Open</td><td>PHW is open to consider all potential options, subject to continued application and/or establishment of controls recognising that there could be a high risk of exposure.</td></tr></table>
Current Score = 16
Target Score = 6
Risk Appetite Level Applied = Open, therefore, now outside tolerance level.</td><td>The risk score has been increased from 12 to 16 following BET review to reflect heightened organisational exposure arising from the recent Sexual Health Service incident. The screening performance risks remain. The score will be reduced when sustained improvement and assurance are evidenced.</td></tr>
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		For this cycle only, SRR3 includes additional context to support assurance on three strategic service risks with current challenges: Breast Test Wales (BTW), Bowel Screening Wales (BSW), and Health Protection Sexual Health. Operational risks and actions (e.g., Out-of-Hours, Environmental Public Health and programme delivery) are managed via the Corporate Risk Register (CRR) and are not duplicated here. As stability is restored, SRR3 will revert to a more strategic, high-level focus. Additional system fragility themes—including Sexual Health, Environmental Public Health, organisational financial and change capacity—are now reflected explicitly in the internal control framework. **Screening Services Performance** Risks remain within key national screening programmes (Breast, Bowel and Diabetic Eye), reflecting ongoing population-level performance challenges and system dependencies. Strategic trajectories are being developed and will be overseen through HPSS DMT and QSIC. Detailed operational recovery activity is monitored via programme governance and the Corporate Risk Register. A. **Bowel Screening** - Risks remain due to system and diagnostic pathway

		dependencies across Health Boards. Executive-level engagement continues to support a whole-system approach to recovery, with operational improvement activity overseen through programme governance. **B.** **Diabetic Eye Screening -** Risk persists as the programme undergoes transformation to improve sustainability, equity and resilience. Oversight of the transformation programme is maintained through DMT and QSIC, with operational delivery and pathway redesign managed via programme governance. **C.** **Breast Screening -** Risks remain in meeting national assessment standards. Improvement activity continues alongside the Breast Test Wales Review, with high-level expectations for recovery and pathway resilience overseen at Directorate and Executive level. Detailed operational actions are monitored through programme and directorate governance and shared with BET and the Board via private routes. **Health Protection System Fragility:** Areas of system fragility are evident across elements of Health Protection, reflecting sustained demand pressures, workforce constraints and key external dependencies. Strategic trajectories for

		strengthening resilience and improving governance are being developed. A. **Sexual Health:** Recent incidents have highlighted underlying governance and system weaknesses requiring strengthened oversight at a strategic level. Operational recovery plans are held separately and overseen through divisional governance and the CRR. B. **Environmental Public Health – UKHSA Withdrawal:** While the existing Memorandum of Understanding between Public Health Wales, Welsh Government and UKHSA underpins elements of specialist Environmental Public Health collaboration, it does not include provision for daily operational duty desk support. UKHSA's historical contribution to this function was provided on a goodwill/custom and practice basis. UKHSA's decision to withdraw from this discretionary support creates a strategic resilience risk for Wales. Transitional arrangements remain in place while revised service schedules and future support models are agreed. These system fragilities collectively contribute to the current risk position and are being addressed through strengthened governance, clearer

		escalation routes, and enhanced performance oversight. **Business and Digital Transformation** Public Health Wales is taking a prioritised, whole-organisation approach to digital transformation, as agreed through the 2025/26 IMTP process. This reflects the principle that digital improvements must be delivered alongside business process transformation, and that organisational capacity to manage change is finite across both service and digital teams. Our move toward a components-based model reinforces this shared approach, with HPSS and RDD jointly enabling the business-led and digital changes needed to support sustainable performance improvement. Digital enablement priorities relevant to this risk are governed through the DDDA portfolio, with strategic delivery risks reported to BET and KRIC. HPSS and RDD continue to work closely on the organisation's agreed priority programmes—including the Digital Health Protection Programme, secure genomics data transition to the Cloud, lung cancer screening delivery, sexual health case management development, and migration of analytical and surveillance functions to the National Data Resource.

		Work is underway to assess and address remaining system gaps, including the requirements for screening transformation. In the short term, opportunities to strengthen performance through targeted digital improvements will be explored where these can be delivered without delaying essential longer-term transformation. **Workforce Capacity and Capability** 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. **Emergency Preparedness and Unplanned Activity** Learning from Exercise Pegasus (December 2025), upcoming internal exercises and the COVID-19 Inquiry modules will inform strengthened emergency planning assumptions. Preparedness performance indicators are being defined to demonstrate increased resilience to acute threats and unplanned activity.

Internal System of Controls – Linked to 'Caused By' section of Risk Description and Source of Assurance [1] **C1:** Weakness in clinical governance, clinical and administrative systems and digital processes, service planning and operational delivery.			
Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
C1.1	Development, implementation, and maintenance of emergency and business continuity arrangements, including participation in EPRR training and exercises, alongside debriefing and implementing lessons identified from incidents and outbreaks.	• PHW Emergency Response Plan (V3.2) • PHW Countermeasures Protocol • PHW Business Continuity Arrangements. • Communicable Disease Plan for Wales • PHW Annual Assurance Return to Welsh Government on EPRR • Work with partners to locally, regionally and nationally to continually review, update, train for and exercise multi-agency plans and procedures for emergencies. **NB.** This is via Local Resilience Fora (LRF), Wales Resilience Partnership, Wales Resilience Forum and the 4 Nations Public Health (PH) Emergency Preparedness, Resilience & Response (EPRR) Group.	• Annually reviewed, tested by exercise, with written assurance to Board. • Reviewed biennially, tested by exercise. • Annually reviewed by Directorate with assurance via Emergency Preparedness Resilience and Response (EPRR) Group Meetings (Quarterly) reported to Board. • Reviewed biennially, tested by exercise in conjunction with Health Protection • Annually produced, with approval from EPRR Group, HPSS DMT, BET, QSIC & Board. • Schedules for meeting, training, testing and exercising vary. For further detail, please contact phw.eprr@wales.nhs.uk
C1.2	Development and utilisation of policies and procedures to enable effective and efficient service delivery, including clinical and non-	• Comprehensive suite of organisational policies and procedures. • HPSS directorate and divisional policies and standard operating procedures	• Corporate Policy and Control Document Reviews via Leadership Team. • Regular Clinical Audits undertaken against Standard Operating Procedures, policies &

[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.

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Control Reference	**Internal Control**	**Internal Sources of Assurance**	**How/When is it monitored?**
	clinical *Standard Operating Procedures and Protocols*.	aligned where relevant to clinical and operational delivery standards and agreements. • Population Screening Programmes delivered in line with UK National Screening Committee recommendations and as approved by the Wales Screening Committee and Welsh Government Policy. • HPSS laboratory systems accredited to ISO 15189:2022, with re-validation required yearly.	NICE Guidance. Clinical audits undertaken on outcomes e.g. Cervical Screening Wales audit of all cervical cancers in Wales. Health Inspectorate Wales routine inspections. Clinical review and also specifically inspection of IR(ME)R regulations in Breast Screening Programme (radiation regulations) • UKAS inspections and resulting accreditation guarantees the highest levels of impartiality and competence through the continuous assessment processes including walkarounds.
C1.3	Variation / risk-based prioritised approach to directorate delivery assurance.	• Cross directorate operational delivery reporting. • Action plans with appropriate tracking and trajectories, spotlight sessions and reports to HPSS Divisional SMT's, DMT QSIC. • Annual clinical audit programme based on risk and variation • Thematic Analysis of NRIs, EWN and Claims. • Result of Peer review programme/quality walks	• 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

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?**
		• Safety culture and open incident reporting processes, compliance with PTR regulations and Duty of Quality Health & Care Standards	screening programmes and recovery trajectories. (SH)
C1.4	An HPSS programmatic approach to benchmarking, reviewing and improving corporate and business operational systems and processes within the directorate supported by corporate enabling functions using the Duty of Quality Health & Care Standards to fully operationalise a quality management system.	• Excellent operations programme scope • Excellent operations delivery dashboard • Range of diagnostic / review reports • Deliver quality improvements against the quality priorities identified against the Duty of Annual Report & Quality Standards Self-assessment /QOF • Service User Feedback	• Monthly DMT update reporting • Reports into corporate committees and Board • Internal audit reports on programme projects
C1.5	HPSS adoption of the PHW Clinical Governance Framework and the divisional systems of quality monitoring aligned to delivery context and mandated or quality standards and enablers building a safety culture and learning culture	• PHW Clinical Governance Framework • Divisional Quality Lead resources • Divisional Quality reports and action plans • 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

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?**
			• Development of a new Organisation wide clinical governance meeting to provide Trust wide view and assurance • QUOG with strengthened TOR (to be finalised Feb 26)
C1.6	Delivery of agreed future digital transformation needs aligned with strategic priorities and service user and operational needs aligned to the Duty of Quality standards and digital standards	• Delivery of PHW's digital routemap • Comprehensive mapping document of HPSS user requirements • HPSS delivery of future service transformation vision. • Inclusions in 10 year strategic capital plan • Service user feedback and engagement	• Project/Programme boards for specific initiatives (e.g. Health Protection Digital replacement programme) • Monitored through delivery of the digital portfolio and reported to BET and KRIC
C1.7	Strategic oversight of screening programme performance with high-level governance and assurance arrangements in place to oversee performance and population-level risks associated with the national screening programmes.	• Monthly screening performance dashboards (strategic indicators only) • DMT and QSIC oversight reports • Welsh Government oversight of national screening standards • Internal Audit of Screening Services (strategic recommendations) • Executive reporting on strategic dependencies, including diagnostics and workforce	• Monthly strategic performance review (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)	• Monthly divisional SMT and DMT reporting • After-action reviews following incidents • Monitoring via risk registers and escalation logs

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?**
		• Incident reporting and trend analysis	• Quarterly updates to QSIC
C.1.11	HPSS financial management for directorate-level financial governance and alignment between operational plans and financial capability.	• Monthly financial performance reports (M1–M12) • Savings Plan monitoring • Mid-Year Review and year-end position reports • Finance Business Partner oversight • Directorate risk registers financial entries	• Monthly DMT and finance review meetings • Quarterly reporting to QSIC/Board • Regular savings plan tracking cycles • In year variance management process • Annual financial planning and budget risk review
C1.12	Strengthened programme and change-management oversight across the Directorate.	• Programme Oversight Team reporting • IMTP alignment and prioritisation decisions • Workforce and leadership capacity reviews • Coordination with enabling functions (Finance, Digital, POD, Strategy & Planning). • Improvement programme milestone reporting • 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 • Organisatsional 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	**December 2025:** Exercise PEGASUS concluded. Lessons Identified from debrief being finalised. Outputs to be considered by the Pandemic Preparedness T&F group when finalising the Pandemic Response Arrangements for PHW. **October 2025:** All work on track. DRAFT 04 produced and being utilised to support PHW participation in Exercise PEGASUS.

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	**December 2025:** Re-establishing bi-monthly meeting between HPSS & RDD Execs to ensure strategic alignment with PHW's digital and data strategy October 2025: Organisation portfolio reporting processes have been changed and HPSS are in discussions with RDD to understand the implications and Impact August 2025: It has been agreed with Research Data and Digital on the need to amalgamate actions to mitigate risk will, over time, be managed in one space to ensure a

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**
						joined up approach. Further work on mapping of all digital projects/activities continues. Preliminary mapping of major project alignment to Digital governance structures in place.
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		**December 2025** Trajectories in development; dependency mapping with Health Boards underway.
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		**December 2025** CEO-to-CEO meetings completed; Health Board action themes identified; national performance overview being built.

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**
AP1.7c	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		**December 2025** Review conclusions pending; preparatory improvement activity ongoing.
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		**December 2025** Clinic models piloted; technology change evaluation expected Feb 2026.
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	**December 2025** Revised reporting incorporated into deep dive and being aligned with QSIC expectations

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	**December 2025:** Paper submitted to BET regarding approach to professions. **October 2025:** Collaboration started with NQIG in relation to carry out a joint TNA across professions and utilising previous retention survey questionnaire for HCPC regulated professions.
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	Mar 26	**December 2025:** Responding to HEIW review of the PH specialist training scheme. **October 2025:** Paper delayed to obtain POD input in relation to the job families work they are undertaking –

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**
				of Medical Director		additional content added – paper will be progressed.
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 Business / Workforce Development Manager - Office of Medical Director	Mar 26	**December 2025**: Joint working with POD, NQIG and L&D Leads to determine first draft of commissioning requirements for end of Jan 26. **October 2025:** Meeting held with HEIW relating to the Education Commissioning process determining future improvements. OMD continues to be part of the L&D Leads Group for PHW specifically feeding into education commissioning.

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	**December 2025:** Route maps being embedded in IMTP development process for HPSS. Engagement with Strategy & Planning re; embedding priority across organisation and all process. **October 2025:** Final updates to the routemap are being undertaken in light of BET conversation. Discussion regarding links with IMTPs outside HPSS are ongoing to ensure a wider adoption.
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	Deputy National Director Health Protection and	March 2026	**December 2025:** Continuing to explore RDD's offer in assessment of impact. Initiated reporting 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**
			activity is meeting innovation and improvement needs	Screening Services		R&D activities to HPSS DMT. **October 2025:** Currently liaising with RDD on providing additional insight from their feedback surveys.
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	**December 2025:** Continuing to explore RDD's offer in assessment of impact. Initiated reporting of R&D activities to HPSS DMT. **October 2025:** We continue to explore with relevant leads how we can develop a 'do once and reuse' approach to reporting of research activity and consider reporting routes within the directorate.

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**

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	**December 2025:** PHW Exercise PEGASUS Phase 02 & 03 evaluations via internal debrief, and formal exercise evaluation provided to Exercise Control Team in UK Government. Engagement also in National exercise Debrief programme. Lessons to be considered in the development of PHW Pandemic Response Arrangements. **October 2025:** PHW Exercise PEGASUS Phase 01 evaluation via internal debrief,

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**
						and formal exercise evaluation provided to Exercise Control Team in UK Government. Exercise Control evaluators to monitor Phase 2 and Phase 3 play.
AP 4.2	Strengthen strategic oversight of pathway resilience across national screening programmes ensuring risks arising from unplanned activity and wider system dependencies are identified, escalated and addressed through established governance routes.	• Improved visibility of emerging screening system risks. • Evidence of enhanced pathway resilience across national screening programmes • Strengthened workforce sustainability indicators at a strategic level. • Digital capabilities aligned with strategic assurance requirements	• Maintains organisational resilience to unplanned activity affecting screening performance and population outcomes. • Strengthens the organisation's resilience to variation in screening demand and wider system pressures. • Provides assurance that screening pathways remain stable and that risks are escalated effectively.	Director Screening Division		**December 2025:** Pathway resilience work continues across regions, with risks in meeting assessment standards escalated through established Health Board and Executive routes. Strategic oversight remains focused on addressing system and workforce dependencies, with operational improvements monitored through programme governance.

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**
			• Supports sustained compliance with national screening standards			Bowel Screening: Risks arising from system and diagnostic pathway dependencies continue to be overseen through Executive-level engagement with Health Boards. A whole-system approach to addressing these dependencies is in development, with detailed operational recovery activity monitored through programme governance and the Corporate Risk Register. Diabetic Eye Screening - Strategic transformation of the programme continues,

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**
						focused on strengthening capacity, equity and resilience. Oversight is maintained through DMT and QSIC, while detailed operational testing is undertaken. October 2025 • Issues escalated to executive level as appropriate- Workforce development and training ongoing • Digital initiatives and pathway reviews progressing