Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	11 August 2026
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Clinical Care Group Update Report – Operational Allied Health and Health Science
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Andrew Carruthers, Chief Operating Officer
SWYDDOG ADRODD: **REPORTING OFFICER:**	Sara Quarrie, Service Group Director, Allied Health and Health Science Clinical Care Group Angela Bell, Assistant Director of Quality, Safety and Patient Experience, Allied Health and Health Sciences

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/ For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides the Quality, Safety and Experience Committee with assurance from the Allied Health and Health Sciences Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) meetings held between April and June 2026 (Quarter 1 (Q1). The CCG remains focused on improving performance within the Quality and Safety domain, with particular emphasis on current Level 2 performance. This report highlights key trends, identifies areas of improvement and summarises actions being taken to support further progress. It also confirms sustained achievement at Level 1 within the Governance domain, which has been maintained since September 2025.

Cefndir / Background

The CCG has maintained a structured monthly Quality and Safety governance cycle covering risk and assurance, regulatory reports, incidents and Duty of Candour, complaints and patient experience, redress and claims, clinical audit, National Institute for Health and Care Excellence (NICE) and national guidance, mortality reviews, population health, and health and safety. During the quarter, operational governance arrangements also transitioned following internal audit findings, including the standing down of the Integrated Quality, Finance and Performance Delivery Group (IQFPDG) and development of revised Chief Operating Officer (COO)-led delivery arrangements. These arrangements form part of a developing Quality Management System, linking quality planning, quality improvement and quality control through routine review and triangulation of risks, incidents, complaints, audit findings, patient experience and regulatory assurance.

The CCG's assurance position improved across several domains during the quarter.

Governance remained at escalation Level 1; risk review compliance remained above 90%; overdue risk actions reduced from 15% in March to 13% in May; risks past target risk score dates reduced from 28 in March to 7 by May; and business continuity plan compliance improved from 63% to 100% by the end of May 2026. However, several material risks remain, particularly within Radiology, Pathology, Physiotherapy, and Nutrition and Dietetics.

Significant challenges include sustained pressure within Radiology, particularly the non-obstetric ultrasound risk, immediate improvement requirements following the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection at Bronglais Hospital (BGH), and senior leadership fragility.

Pathology risks include Laboratory Information Management System 2 (LIMS2) deployment delays, blood transfusion contingency arrangements, clinical haematology fragility, Withybush Hospital (WGH) microbiology estate pressures, mortuary capacity and Blood Sciences staffing gaps.

Physiotherapy reported escalating Clinical Musculoskeletal Assessment and Treatment Service (CMATS) and musculoskeletal (MSK) waits, acute capacity risks and reduced Carmarthenshire Stroke Early Supported Discharge (ESD) capacity. Nutrition and Dietetics reported ongoing adult weight management and paediatric selective eating fragility.

The Q1 review has been framed using Safe, Timely, Effective, Efficient, Equitable and Person-centred (STEEEP) principles to support the Committee's consideration of safety, timeliness, effectiveness, efficiency, equity, patient outcomes and experience. It concludes with an overview of progress since the previous CCG update in December 2025.

Asesiad / Assessment

The CCG has evidence of active governance, improved business continuity, established complaints management progress and strengthened risk oversight. However, several high-scoring risks remain live, incident investigation timeliness has deteriorated in some areas, and a small number of regulatory actions remain dependent on wider organisational decisions, workforce capacity or capital and estate solutions.

1.1.1. Safe Care

1.1.1.1. Incident Management

Monthly governance 1:1 meeting between Service Leads and a Quality and Patient Safety Business Partner commenced in May 2025 and remain a key mechanism for supporting effective incident management and governance oversight. These dedicated sessions provide protected time to review incident performance, address barriers to progressing investigations, resolve outstanding queries and ensure appropriate actions are implemented. This approach was established to improve the timeliness of incident investigation and closure, while strengthening leadership oversight and promoting a positive culture of incident reporting, learning and continuous improvement. Regular review of performance data enables targeted support to services and monitoring of progress against agreed improvement actions.

Monthly performance trends in incident management are illustrated in Figure 2.

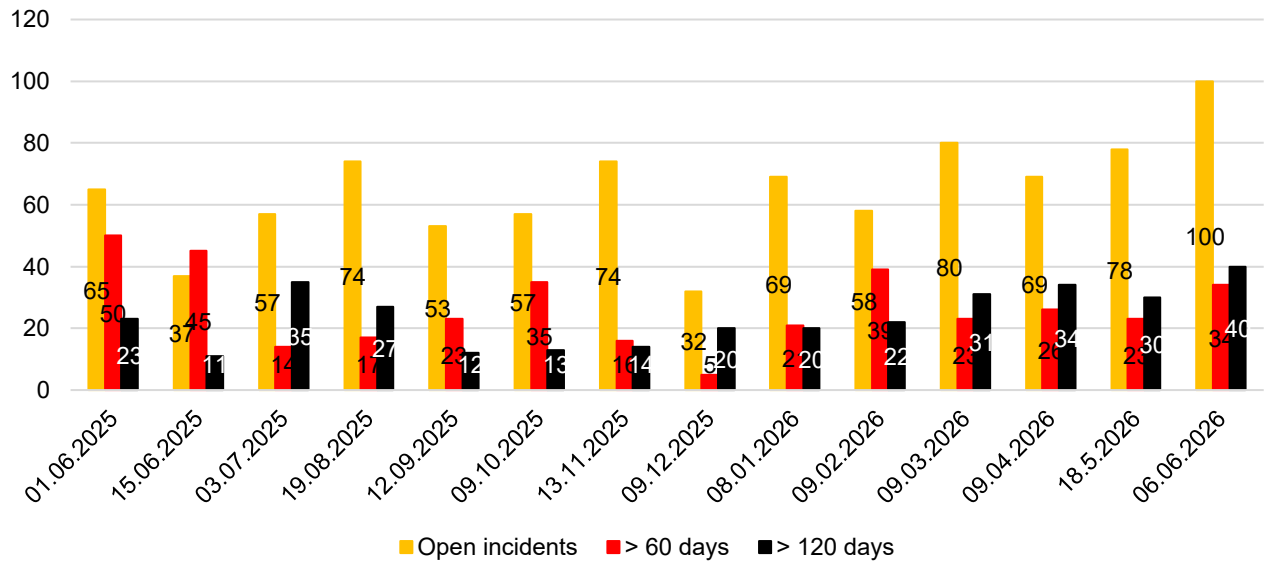

Figure 2 Number of open incidents reported by month- AH & HS CCG - [Data as of 06/06/26]

This structured approach initially delivered a significant reduction in incidents open beyond 60 and 120 days. However, since January 2026, overdue incidents have increased. Two key factors are contributing to this position: leadership capacity within Radiology Services, which affects the ability to complete investigations within required timescales; and a sustained increase in incident reporting.

Monthly incident reporting increased by 16% between November 2025 (n=70) and May 2026 (n=81), reflecting a strengthening safety culture.

Service-level incident data demonstrates alignment between service fragility and timely incident management, with most overdue incidents concentrated in the most operationally challenged services. Radiology holds the largest number of open incidents; however, the reduction in incidents overdue beyond 60 and 120 days indicates improved management of longstanding cases, aligned to focused support from Quality Assurance and Safety Team (QAST) colleagues.

Improvement in Radiology incident management is dependent on stabilising leadership capacity through the current Organisational Change Process. Recruitment to additional leadership roles is expected to commence in autumn, with staffing levels anticipated to improve by March 2027. This is expected to support sustained improvement in incident management during Q 1 and Q2 of 2027/28.

The CCG notes that incident reporting trends remain aligned with the service's established risk profile. Analysis of incident subtypes continues to show that Assessment, Treatment and Diagnosis is the most frequently reported category, with the highest volume of incidents arising within Radiology and Pathology. This reflects the workforce, equipment and infrastructure challenges currently identified within these services. Both services continue to implement mitigating actions within existing resource constraints to manage and reduce associated risks.

Incident reporting levels have risen consistently throughout 2025 and reached their highest level in 2026, as shown in Figure 3 below. Monthly totals peak at approximately 80 incidents. While month-to-month fluctuation is evident, overall reporting activity remains significantly above 2024 levels, before establishment of the CCG model.

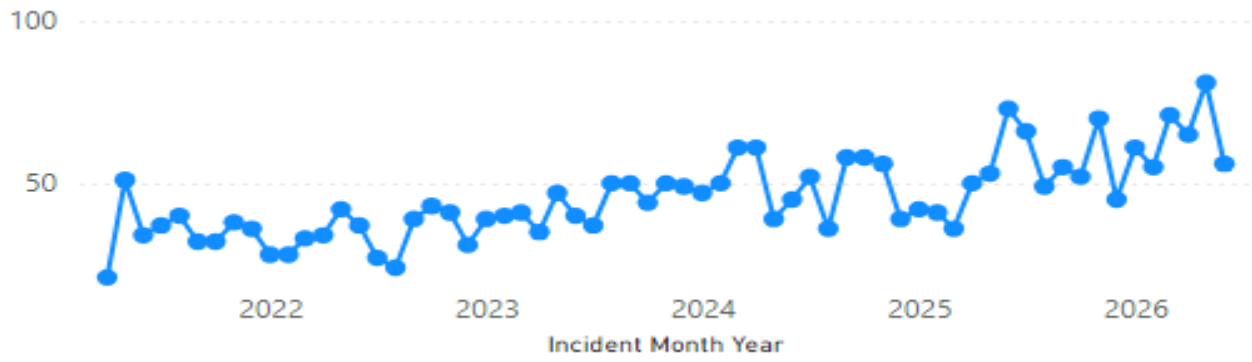

Figure 4 Number of incidents reported by month- AH & HS CCG - Our Performance Dashboard [Data as of 20/07/26]

The increase is likely to reflect a combination of ongoing service pressures, workforce challenges and greater reporting maturity across services. Higher reporting rates indicate improved identification of issues, with sub-categories aligned to known risks and concern themes. Continued monitoring of incident themes, sharing of thematic learning from investigations and timely incident management will provide oversight and support quality improvement.

In summary, incident reporting culture appears active, with no open Nationally Reportable Incidents reported in Q1. However, incident investigation timeliness remains a concern, particularly in Radiology, where sustained improvement is required for longest-open incidents. This is expected to become more achievable following stabilisation of leadership capacity.

1.1.1. Timely

The Clinical Care Group recognises that workforce risks affect timely service provision across several Allied Health and Health Science services. The most significant pressures relate to ultrasound service sustainability, clinical haematology workforce, radiology imaging equipment and infrastructure, and Allied Health Profession service pressures. These pressures result in prolonged waits and delayed access to diagnostics. The resulting patient impacts are summarised below:

Risk	Patient impact	Quality & Safety implication
Sonography workforce risk (ID 797)	Delayed scans	Delayed diagnosis and treatment
Radiology Imaging equipment and infrastructure (ID 684)	Delayed scans	Delayed diagnosis and treatment
Clinical Musculoskeletal Assessment and Treatment Service (CMATS)/musculoskeletal	Delayed assessment	Increased deterioration and complaints

(MSK) waits – physiotherapy (ID 2346/ID 1517)		
Selective eating pathway waits - Nutrition & Dietetics (ID1603)	Delayed intervention	Nutritional and developmental impact
Clinical Haematology Workforce (ID 834)	Delayed assessment	Delays in review, diagnosis, treatment planning

These risks are recorded and monitored through Health Board risk management arrangements, with mitigations in progress. These include separation and refresh of the corporate ultrasound risk, radiology infrastructure replacement schemes, temporary haematology agency workforce alongside workforce planning, annual planning stabilisation funding for radiology capacity and formal consultation on the Radiology Leadership Organisational Change Process.

CCG actions are in progress to maintain and improve timely access where demand continues to exceed available capacity. Services are progressing short-term controls, demand and capacity management, pathway redesign and productivity improvements. Examples include ultrasound pathway diversification, proposed transfer of growth scan activity to a midwifery-led pathway, telephone triage and risk stratification within Physiotherapy, Welsh Patient Administration System (WPAS) diary implementation, and actions to strengthen self-referral information within Podiatry and Surgical Appliances.

While some risk actions remain dependent on external funding, commissioning decisions, capital approval or regional programme delivery, the current position demonstrates active CCG oversight of risks, clear identification of residual gaps and continued escalation through operational governance structures where actions cannot be fully mitigated within existing resources.

1.1.2. Effective

Clinical effectiveness processes are established across the Clinical Care Group, including monthly review of NICE and national guidance, and sharing of clinical audit findings and learning.

1.1.3.1 Clinical Audit

The Clinical Audit Manager has provided an overview of the clinical audit function and programme. This has enabled the CCG to identify the need to strengthen visibility of CCG audit activity and enhance the contribution of Allied Health and Health Sciences to the local clinical audit programme.

Within Adult Speech and Language Therapy (SLT), the ***Acute Stroke SLT Clinical Note Audit*** demonstrated strong compliance with documentation of stroke diagnosis and imaging results, timely referrals, multidisciplinary communication and delivery of evidence-based therapy. Areas for improvement were identified in the use of formal assessments, goal setting, documentation standards, family communication and discharge reporting. The findings provide assurance that key components of the acute stroke SLT pathway are delivered consistently and that governance arrangements are in place to identify and address variation in practice. Actions include service-wide feedback, reinforcement of staff roles and responsibilities, targeted support to the site requiring improvement, ongoing

monitoring through Stroke Lead oversight, and a planned re-audit in August 2026 to assess sustained improvement.

Within Nutrition and Dietetics, an ***Audit of Dose Adjustment for Normal Eating (DAFNE) – Structured Education for People with Type 1 Diabetes*** demonstrated significant clinical benefit, with participants achieving an average reduction of 10.7 mmol/mol in haemoglobin A1c (HbA1c) one year after programme completion. This supports improved diabetes control and reduced risk of complications. The findings also identified the need to increase access to the programme to maximise patient benefit. The results provide assurance that the DAFNE programme delivers sustained improvements in glycaemic control, quality of life and long-term health outcomes for people with Type 1 Diabetes. Actions are focused on continuing initiatives to improve access and maintaining effective audit and data collection processes to support ongoing service improvement and quality assurance.

An Audit of the Process of Care of Patients who Receive Parenteral Nutrition (PN) demonstrated that mandatory clinical monitoring and documentation of PN prescriptions were largely completed, supporting safe and effective care. Consistent biochemical monitoring was also evident, helping to prevent avoidable metabolic complications and optimise clinical outcomes. The findings provide assurance that PN monitoring and prescribing processes are largely embedded and support patient safety, accuracy and continuity of care. Required actions include the development of educational resources and training for all staff involved in PN decision-making and care delivery.

The Podiatry service has continued to progress its clinical audit programme, including the National Diabetes Foot Audit, Patient Record Audit and Clinical Checklist Audit. Completion of the National Diabetes Foot Audit provides assurance of monitoring against national standards. Local audit activity has identified opportunities to strengthen record-keeping standards, with implementation of electronic clinical records addressing legibility issues identified through audit of clinical checklists.

1.1.3.2 Governance

The Clinical Care Group has established service-level governance arrangements to support effective risk management. These arrangements have supported sustained achievement at Level 1 within the Governance domain. Bi-monthly risk review workshops provide a structured process for validating risk assessments, ensuring risk scores are appropriately justified and consistently applied. The workshops also focus on reviewing target risk scores and identifying gaps in existing controls, with mitigating actions put in place to address areas of residual risk.

Sustained effective risk management is illustrated in table 1 below.

Risk overview

Open risks	Risks overdue	% overdue	Open actions	Actions overdue	% overdue
127	10	8%	254	22	9%

Table 1 CCG risk overview [Data as of 20/07/26]

Triangulation of quality metrics from clinical effectiveness processes supports delivery of safe, effective and person-centred services. As a next step, the Clinical Care Group will strengthen links between learning identified through incidents and service risk registers. This will enhance triangulation of intelligence from patient experience, including complaints and incidents, quality assurance, including clinical audit and regulatory inspections, and risk management processes to inform targeted mitigation and improvement actions.

Radiology provides a practical example of effective triangulation of quality intelligence. Findings from a clinical audit of referral quality align with recommendations from Audit Wales *Are Radiology Services Improving?* report (May 2026) and ongoing work with digital partners to develop a digital referral-vetting solution. The system will automate identification of incomplete, inappropriate and duplicate referrals, using the same referral quality standards applied within the clinical audit. This approach links assurance, external review and service improvement activity to support improvements in referral quality patient safety and service efficiency.

In summary, CCG risk management is sustained, and completion of actions arising from audit and inspection improved during Q1, with risk review compliance maintained above 90%. Clinical audit, NICE and mortality oversight are in place, although further development of a proactive CCG clinical audit programme is required.

1.1.3. Equitable

Equity considerations are reflected in several access and capacity risks across the Clinical Care Group, including Physiotherapy (Clinical Musculoskeletal Assessment and Treatment Service (CMATS) and musculoskeletal (MSK)), Adult and Paediatric Speech and Language Therapy, Paediatric Selective Eating, Adult Weight Management, Bone Density Scanning / Dual-energy X-ray Absorptiometry (DXA) and Podiatry services.

The CCG's top equity priorities are Paediatric Selective Eating and Adult Weight Management within Nutrition and Dietetics, and CMATS/MSK waits within Physiotherapy. These areas represent the highest demand and capacity risks and the greatest challenges to delivering equitable access, directly linked to availability of funded workforce.

Paediatric selective eating remains a significant demand and capacity risk, with associated nutritional, developmental and equity impacts. Temporary agency capacity is providing short-term mitigation, while access criteria, triage and referral processes are reviewed. A recurrent workforce solution has been progressed through annual planning.

Adult Weight Management remains a significant risk. Mitigating actions include waiting-list validation, revised referral criteria, patient communications and pathway redesign supported by successful funding through the Obesity Pathway Innovation Programme. These actions are intended to support development of a sustainable service model.

The Physiotherapy Service has maintained active oversight of CMATS and MSK access risks through escalation within Health Board planning processes, development of recovery proposals with Radiology, implementation of alternative triage models and ongoing service redesign aligned to the National MSK Specification. These actions demonstrate a proactive approach to managing risk and mitigating patient impact. However, demand continues to exceed available capacity, and sustainable improvements in access remain dependent on

resolution of underlying workforce and funding challenges. Risks to timely and equitable access therefore remain under close review through established governance arrangements.

Business Continuity Plan compliance improved to 100% by the end of May 2026, strengthening the CCG's ability to maintain safe and sustainable service delivery where locality-based services are affected by known workforce or service fragilities. This supports a more equitable approach to service provision by helping to mitigate variation in access and ensuring service changes and continuity arrangements are managed in a way that minimises unintended impacts on patient experience and outcomes.

1.1.4. Person Centered

1.1.4.1. Patient Stories

Patient stories feature within CCG governance meetings, supported by a schedule to ensure each service shares learning from patient experience. Key themes are summarised and triangulated with complaints, incidents, risks and audit, demonstrating that patient experience intelligence is not reviewed in isolation but informs governance and service improvement activity.

A phlebotomy service patient story demonstrated the value of this approach. Feedback relating to waiting times, perceived fairness of the queuing process and communication prompted a review of service delivery. This resulted in revisions to the service model that improved patient flow and reduced waiting times. Learning was also shared with staff to strengthen communication practices, illustrating how patient feedback and concerns can directly inform service improvement and enhance patient experience.

An Occupational Therapy end-of-life patient story demonstrated the value of collaborative planning, risk management and ethical decision-making, enabling a patient to return home, celebrate a birthday and marry. Learning centred on dignity, fairness, communication and outcomes that matter to patients.

A Physiotherapy patient story demonstrated the value of coordinated multidisciplinary working in the delivery of end-of-life care. Collaborative input from acute and community physiotherapy, respiratory and palliative care teams ensured care was aligned to an advance care plan. Feedback from the family and multidisciplinary team was highly positive, with key learning focused on strengthening communication, staff training and multidisciplinary documentation processes.

Story	Key theme
Phlebotomy experience	Communication and access
Occupational Therapy story	Coordination and responsiveness
Physiotherapy Story	Integrated multidisciplinary care

Theme	Complaints	Incidents	Risks	Audit
Communication	✓	✓		
Access and timeliness	✓	✓	✓	

Coordination of care	✓		✓	✓

1.1.4.2. Complaints

The CCG has maintained monthly deep dives into its longest-open complaints. This approach resulted in a 73% reduction in overdue complaints, from 22 to 5, between September 2025 and April 2026, as shown in Figure 4 below.

Figure - Complaints performance - AH & HS CCG

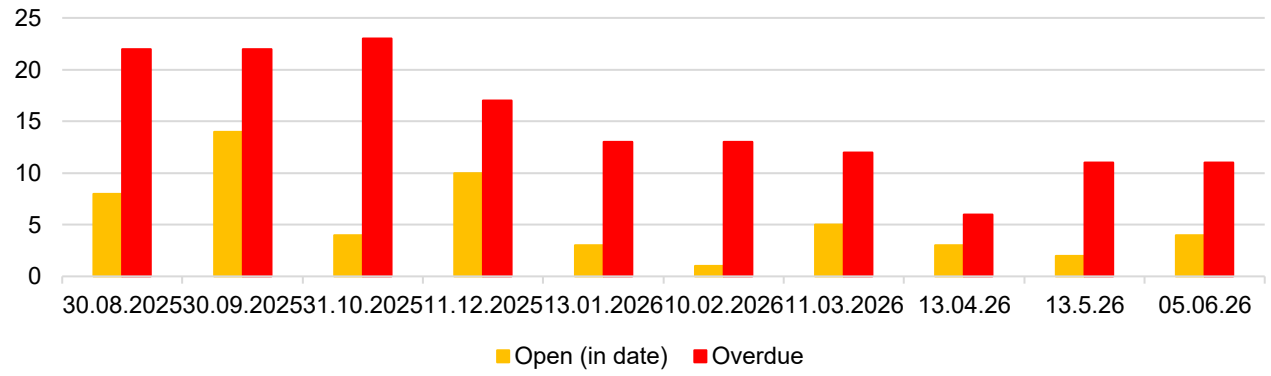

Figure 4 Number of open complaints- AH & HS CCG [Data as of 05/06/26]

Patient experience and complaints oversight continue to support organisational learning and service improvement across the CCG. While several complaints remain overdue, services continue to engage constructively with the process. Monthly deep dives provide oversight of the longest-open complaints and assurance that required actions are progressing. A number of complaints require collaboration across Clinical Care Groups and corporate functions to support comprehensive investigation and shared learning, reflecting the complexity of concerns and the commitment to producing high-quality responses.

The transition to the *Listening to People* approach is expected to reduce the clinical time required to develop complaint responses, enabling greater focus on thematic analysis and triangulation of complaint intelligence with incidents, risks and other quality metrics. Current themes remain aligned to known risks relating to diagnostic capacity and pathway reliability, providing assurance that governance processes are identifying areas of greatest concern and informing improvement activity.

<u>Progress since the previous (QSEC) update</u>

The following summary provides an overview of CCG progress since the previous CCG update in December 2025:

Maintained

- Governance performance sustained at Level 1
- Risk review and risk action compliance maintained

Improved

- Business continuity compliance improved to 100%.

- Overdue complaints reduced by 73%

Requiring continued oversight

- Overdue incidents remain limited by current Radiology capacity, with a plan in place to improve leadership capacity
- Overdue complaints, including complex cross-CCG complaints requiring support from corporate teams
- Risks referenced on page 11 remain under continued oversight, ensuring mitigating actions are aligned to themes identified through lessons learned from incidents.

Argymhelliad / Recommendation

The Committee is asked to:

- Receive assurance from the quality governance arrangements in place within the Allied Health and Health Sciences Clinical Care Group in relation to quality safety and patient experience.
- Note evidence of strengthened governance, improved business continuity compliance, sustained risk oversight and active patient safety governance, while recognising that significant risks remain in relation to the fragility of Radiology, Pathology, Physiotherapy, Nutrition and Dietetics services.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee Terms of Reference (ToR) Reference:	3.1 Provide advice to the Board on the adoption of a set of key indicators of quality of care against which the University Health Board's performance will be regularly assessed and reported on.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Key risks referenced include: Radiology ultrasound corporate risk 797 and non-obstetric ultrasound (NOUS) risk 2336; Pathology Laboratory Information Management System 2 (LIMS2) risks 2079/1526; mortuary capacity risk 1552; Radiology infrastructure risk 684; Physiotherapy Clinical Musculoskeletal Assessment and Treatment Service (CMATS) risk 2024, musculoskeletal (MSK) Referral to Treatment (RTT) risk 1517, acute capacity risk 2145 and Stroke Early Supported Discharge (ESD) risk 2080; Nutrition and Dietetics risks 2169/1661 and 1603; Pathology workforce and estate risks 834, 1309, 838 and 2136; Radiology risks 1706, 1681, 2102, 2131 and 2132.
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Safe care; Timely care; Effective care; Efficient care; Equitable care; Person-centred care.
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Leadership; Culture; Learning, improvement and research; Whole-system perspective; Information and insight.

Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	6. Safe, Timely, High Quality Care
Hyperlink to HDdUHB Well-being Objectives 2026	The report supports the Health Board's well-being objectives by focusing on prevention of harm, timely access, resilient services, learning from experience, workforce sustainability and equitable patient outcomes.
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau) A Social Model for Health and Wellbeing: (*complete for strategic change and/or significant service changes)*	The report identifies access, timeliness and capacity risks
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Quarter 1 (Q1) Allied Health and Health Sciences (AH&HS) Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) agendas and minutes for April, May and June 2026; CCG assurance and risk overview reports; safety dashboard data; incident, complaints, redress and claims reports; service exception reports; Healthcare Inspectorate Wales (HIW), Audit Wales and Internal Audit updates; health and safety reports; business continuity compliance data.
Rhestr Termau: Glossary of Terms:	AH&HS: Allied Health and Health Sciences; CCG: Clinical Care Group; QEC/QSE Committee: Quality, Safety and Experience Committee; STEEEP: Safe, Timely, Effective, Efficient, Equitable and Person-centred; LIMS: Laboratory Information Management System; HIW: Healthcare Inspectorate Wales; IR(ME)R: Ionising Radiation (Medical Exposure) Regulations; NRI: Nationally Reportable Incident; BCP: Business Continuity Plan;

	QIA: Quality Impact Assessment; EqIA: Equality Impact Assessment.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Allied Health and Health Sciences (AH&HS) Clinical Care Group (CCG) Integrated Governance Quality and Safety (IG Q&S) Group; Heads of Service; CCG risk and assurance leads; quality, patient safety, patient experience, redress, complaints, clinical audit, and health and safety representatives. Relevant escalation routes include the Chief Operating Officer (COO) Integrated Operational Delivery Group and CCG Monthly Delivery Group.

Effaith: (rhaid cwblhau) **Impact: (must be completed)**	
Ariannol / Gwerth am Arian: **Financial / Service:**	There are financial and value risks associated with LIMS2 deployment extension costs, adult weight management and paediatric selective eating service fragility, Podiatry non-pay pressures, Radiology infrastructure
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Quality and patient care impacts include delayed access, potential diagnostic delay, incident investigation delays, long waits, fragile diagnostic and laboratory services.
Gweithlu: **Workforce:**	Workforce risks are material across Radiology, Pathology, Physiotherapy, Adult Speech and Language Therapy (SLT), Children's Speech and Language Therapy (SLT), Nutrition and Dietetics, Occupational Therapy (OT) and Podiatry. Key themes include consultant and specialist workforce gaps, sickness absence, maternity leave, recruitment delays, reliance on agency or temporary models, training compliance and leadership fragility.
Tegwch Iechyd: **Health Equity:**	Potential health equity impacts have been considered. The main equity risks relate to differential waiting times, geography, pathway access, diagnostic capacity, workforce-dependent service availability and referral management decisions. A full equity-focused health impact assessment has not been undertaken for this assurance report; individual service changes or decisions will require appropriate Quality Impact Assessment (QIA), Equality Impact Assessment (EqIA) or equity assessment as applicable.
Risg: **Risk:**	The report identifies multiple high and extreme risks currently managed through the CCG risk register and escalation routes. Mitigations include risk review, service SBARs, workforce planning, waiting list validation, escalation to delivery groups, regulatory action plans, business continuity completion, training actions and Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA) processes where service change is proposed.
Cyfreithiol: **Legal:**	There are legal and regulatory considerations relating to Duty of Candour, Welsh Risk Pool requirements, Ionising

	Radiation (Medical Exposure) Regulations (IR(ME)R), Natural Resources Wales (NRW) inspection, Healthcare Inspectorate Wales (HIW) action plans and health and safety legislation.
Enw Da: **Reputational:**	There is reputational risk if regulatory actions, long-open incidents, complaints, redress learning, diagnostic pathway risks, LIMS2 delays, Radiology infrastructure concerns and long waiting times are not demonstrably progressed. Conversely, strengthened governance, transparent escalation and evidence of improvement support organisational assurance.
Gyfrinachedd: **Privacy:**	This report uses aggregated governance information and does not include patient-identifiable information.
Cydraddoldeb: **Equality:**	This is an assurance report and no standalone Equality Impact Assessment (EqIA) has been undertaken. Equality implications arise where service changes are proposed, including pausing referrals, changing service models, workforce redesign or access criteria. Those changes should be supported by relevant Quality Impact Assessment (QIA) / Equality Impact Assessment (EqIA) processes.