Cofnodion heb eu cymeradwyo o'r Pwyllgor Digidol, Data ac Arloesi/
Unapproved Minutes of the Digital, Data and Innovation Committee

Date of Meeting:	**09:00, Tuesday 21 July 2026**
Venue:	**Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Present:
Mr Maynard Davies, Independent Member (Chair)
Ms Chantal Patel, Independent Member (Vice Chair)
Mr Winston Weir, Independent Member
Ms Sarah Harroway, Independent Member

In Attendance:
Mr Anthony Tracey, Digital Director deputising for Mr Huw Thomas, Executive Director of Finance
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Ms June Picton, Associate Medical Director for Professional Standards
Dr Leighton Phillips, Director of Research, Innovation and Value
Dr Eiry Edmunds, deputy Medical Director deputising for Mr Mark Henwood, Executive Medical Director
Dr Daniel Warm, Head of Planning deputising for Mr Lee Davies, Executive Director of Strategy and Planning
Ms Charlotte Wilmshurst, Assistant Director of Assurance and Risk
Ms Jo Bradburn, Deputy Director of Allied Health Professions
Ms Anna Harries, Chief Nursing Information Officer
Ms Corinna Lloyd-Jones, Interim Assistant Director of Organisation Development
Dr Anthony Smith, Consultant Anaesthetist
Ms Helen Tench, Assistant Head of Research Delivery (observing)
Mrs Helen Mitchell, Committee Services Officer (minutes)

Items DDIC(26)117, DDIC(26)121
Mr Gareth Beynon, Head of Information Services

Items DDIC(26)120, DDIC(26)121
Mr Gareth Jenkins, Head of Data Science

Item DDIC(26)121
Ms Tracy Price, Head of Performance

Items DDIC(26)124, DDIC(26)126
Ms Carolyn Williams, Head of Digital Transformation & Programmes Digital Services

Item DDIC(26)132
Mr Chris Tattersall, Assistant Head of Research Support

Minutes Ref.	Item	Action

DDIC(26)113 Welcome and Apologies

Mr Maynard Davies welcomed Members to the meeting and advised that one report was still awaiting completion of the Executive review process. Consequently, any associated recommendations may be subject to further Executive consideration. The Committee also noted that several of these matters would be considered in more detail at the Extraordinary Digital, Data and Innovation Committee (DDIC) meeting scheduled for 4 September 2026.

Apologies were received from:

- Mr Huw Thomas, Executive Director of Finance
- Mr Lee Davies, Executive Director of Strategy and Planning
- Mr Mark Henwood, Executive Medical Director

DDIC(26)114 Declarations of Interests

Board Member DOI Register

Mr Davies declared an interest in the University Partnership item arising from his role at Swansea University, while clarifying that he was not involved in the matters under discussion.

Ms Chantal Patel also declared a Swansea University-related interest already recorded in the register.

DDIC(26)115 Minutes and Matters Arising from the meeting held on 21 April 2026

The minutes of the DDIC meeting held on 21 April 2026 were **APPROVED**.

DDIC(26)116 Table of Actions from the meeting held on 21 April 2026

All actions from the meeting on 21 April 2026 were noted as complete.

In response to a query regarding mandatory training compliance being enforced prior to study leave approval, Mr Anthony Tracey confirmed that Board policy requires managers not to approve study leave where mandatory training remains outstanding, although operational consistency may vary. Ms Corinna Lloyd-Jones added that the control is active within Workforce and Organisational Development and cited a recent case in which a study leave request had been returned until mandatory training compliance improved.

DDIC(26)117 Data Quality Report

Mr Gareth Beynon joined the meeting.

Mr Tracey presented the Data Quality Report indicating that this is the next step in embedding a more systematic approach to data quality across Hywel Dda University Health Board (HDdUHB). Mr Gareth Beynon explained that the work has been progressing for approximately 18 months and is intended to move the discussion beyond a simple judgement of whether data is good or bad. The proposed model combines deep dives, escalation routes through IGSC and other governance groups, a prioritisation matrix, and a data usability score so that recipients can judge whether a dataset is fit for a particular purpose.

Mr Beynon reported that progress had been slower on the usability scoring element because the team has had to prioritise patient identification issues across a growing number of connected systems, including Hybrid Print and Post, Patient Flow, Electronic Observations (EObs), Electronic Prescribing and Medicines Administration (ePMA) and Digital Maternity Solutions. He advised that the growing number of demographic data feeds has increased the complexity of maintaining alignment of patient information across systems. Against that background, the team is developing an abridged Outpatient score as the first end-to-end test case, with separate scoring for accuracy, completeness and timeliness. The intention is to publish the score alongside the relevant dataset, supported by an Iris-branded kite mark signalling a robust source and reduced reliance on manual intervention.

Ms Patel enquired whether the framework remained a work in progress and sought clarity on how accuracy would be defined. Mr Tracey confirmed that the methodology remains iterative rather than fixed, and Mr Beynon indicated that accuracy depends on the dataset and on which trusted benchmark is available, such as comparison against clinical letters or national standards. Capacity was also explored, and Mr Beynon acknowledged that with limited capacity, the work had been deliberately structured into manageable components so that findings remain sufficiently current to support operational improvement.

Mr Winston Weir enquired whether future models could take account of the proposed score so that poor-quality data would trigger an explicit caveat rather than being treated as reliable by default. Mr Tracey indicated data quality was one of the reasons for moving towards a more structured score. In response to a query from Ms Sarah Harraway on a timeline for the Outpatient pilot, Mr Beynon indicated that the intention is to present the pilot to the upcoming IGSC meeting. Ms Harraway emphasised that improvements in data quality must be accompanied by enhanced data literacy, ensuring that decision-makers understand what the score represents and can interpret data appropriately, rather than simply receiving additional dashboards.

It was noted that, while the report referred to a general data quality risk, it did not clearly link the identified issues to specific entries within the risk register. Mr Tracey agreed to liaise with Ms Charlotte Wilmshurst to ensure that the relevant data quality risks were appropriately reflected and aligned within the Risk Register. **AT**

Decision:
The Committee:

- **RECEIVED ASSURANCE** regarding the ongoing data quality deep dives and the continued refinement of the data quality methodology to support assurance. These activities remain a key element of the Health Board's approach to strengthening data integrity, and their consistent application provides a robust, systematic, and repeatable process for identifying, monitoring, and addressing data quality issues.

DDIC(26)118 Data Protection Impact Assessment Assurance Report

Mr Tracey presented the Data Protection Impact Assessment (DPIA) Assurance Report, highlighting the significant increase in demand for DPIAs and related assessments. He explained that the team was moving towards a more proportionate, risk-based approach, ensuring that higher-risk initiatives continued to receive the greatest level of scrutiny whilst enabling lower-risk assessments to be progressed more efficiently. This reflected the need to balance organisational safety with the timely delivery of service improvement and transformation initiatives.

Mr Tracey noted that DPIAs form part of a wider assurance framework encompassing information governance, cyber assurance and clinical safety. He emphasised that the key challenge was balancing increased throughput with the need to maintain appropriate controls and safeguards, whilst ensuring that assurance arrangements remained proportionate to the risks involved.

Dr Leighton Phillips advised that the Research and Innovation Sub-Committee (RISC) was streamlining processes and increasing capacity through revised documentation, improved triage arrangements and the exploration of Artificial Intelligence (AI)-supported drafting for lower-risk elements of assessments. Mr Tracey emphasised that AI would support drafting only, with based with, human review, professional judgement, and formal sign-off remaining integral to the process.

Whilst legislative changes within the data protection landscape had provided greater flexibility in relation to wording and questioning, Mr Tracey confirmed that they had not materially altered the overall direction of travel. He noted that the organisation was not experiencing breaches as a consequence of DPIAs not being completed, although incidents involving external organisations and suppliers continued to require management. The principal challenge remained one of capacity and ensuring that assurance arrangements could keep pace with growing organisational demand.

In response to Ms Patel's query regarding whether the increasing volume of requests reflected a broader organisational capacity gap, Mr Tracey advised that process redesign, revised documentation and selective AI support were being pursued as the immediate response. Whilst acknowledging that demand would require ongoing monitoring, Mrs Jo Wilson indicated that increasing establishment numbers was not currently an available option for HDdUHB. Consequently, efforts were focused on maximising existing resources and directing available capacity towards areas of greatest risk.

Dr Phillips highlighted the importance of the issue from a research and innovation perspective, noting that delays in assurance processes could impede research activity, service development and innovation. However, he recognised the equally significant risks associated with progressing projects without appropriate consideration of information governance, cyber security and clinical safety implications. Members agreed that the key challenge was achieving an appropriate balance between safety and pace, ensuring that assurance processes enabled innovation whilst continuing to protect patients, staff and the organisation.

In response to a query from Mr Davies regarding standardisation across NHS Wales, Mr Tracey advised that discussions were underway through the All-Wales Information Governance Manager Group regarding the development of a national DPIA template. He noted that where systems had already been implemented elsewhere in Wales, elements of previous assessments could potentially be reused, whilst retaining local review and sign-off arrangements to ensure that the Health Board's own risk profile and operating environment were fully considered.

The Committee acknowledged the work being undertaken to develop a more proportionate and sustainable approach to DPIAs and recognised the continuing risk that delays in assessment processes could affect future innovation and research activity if demand continued to outstrip capacity. Mr Tracey agreed to liaise with Dr Phillips and Ms Wilmshurst to further consider the organisational risks associated with the DPIA backlog, including the potential impact on future innovation and research activity. **AT**

<u>Decision</u>:
The Committee:

- **RECEIVED ASSURANCE** that the key issues are understood and that improvement actions are underway to strengthen early engagement, improve submission quality, enhance tracking and visibility, support prioritisation of high-risk Data Protection Impact Assessments (DPIAs) and strengthen third-party accountability.
- **NOTED** the progress update provided in relation to the management of DPIAs, including the current position on completed, in progress, on hold and not yet started assessments.
- **NOTED** the ongoing challenges affecting timely completion, particularly capacity pressures within the IG Team, increasing demand, variable submission quality and dependencies on service areas and third-party providers.

DDIC(26)119 Information Governance Sub-Committee (IGSC) 3As Update

Mr Tracey presented the IGSC 3As Update Report, highlighting that several policies had completed due process and were being submitted for approval.

Mr Davies referenced improved cyber security training completion, commending the increase to 84.87% and requesting that thanks be conveyed, particularly in relation to medical and dental engagement. Strong progress in clinical coding was also recognised, with

completeness at 99.2%, noted as the best position among Health Boards excluding Velindre NHS Trust.

In response to an enquiry regarding how learning points identified by IGSC were being disseminated across the Health Board, Mr Tracey indicated that this was done through Global communications, Viva, the Medical Director's newsletter, the Information Governance newsletter, and the support of the Digital Inclusion Team when working directly with staff. He added that breaking cyber training into shorter segments, rather than expecting staff to complete a single long session, had helped improve take-up.

Ms June Picton outlined the current pressure regarding approximately 400 Subject Access Requests (SARs) received each month, a backlog of over 1400 outstanding requests, and between 20 and 25 complaints each week regarding delays, indicating that complaints handling was consuming time that would otherwise be used to process the requests. Emphasising that the team was validating the backlog because some cases may be duplicate submissions, Mr Tracey was also considering how the new Electronic Discovery Reference Model (EDRM) solution could assist by improving retrieval and redaction processes.

Mr Tracey also recognised that the removal of charges for SARs has contributed to higher demand and that requests can involve external parties such as police and solicitors, adding further complexity to the workload The Committee acknowledged the challenges experienced by the team and agreed that these risks should remain visible within future reporting.

During discussion of information governance assurance arrangements, members agreed that a DPIA Deep Dive would be beneficial and requested that this be scheduled for the next Committee meeting. **AT**

Decision:
The Committee:

- **APPROVED** the following policies:
  - 191 - Health Records Management Strategy.
  - 192 - Health Records Management Policy.
  - 193 - Health Records Retention Policy.
  - 240 - IT Procurement Policy.
- **NOTED** the items that the Sub-Committee advised them of.
- **RECIEVED ASURANCE** from the items that the Sub-Committee assured them of.

DDIC(26)120 Review of Organisational AI Readiness

Mr Gareth Jenkins joined the meeting.

Mr Tracey presented the Review of Organisational AI Readiness Report as an early DDIC update on an AI readiness assessment completed with support from the Health Board's digital partner, CGI. Members noted that the report had not yet completed Executive review and that both the recommendations and governance implications would require further consideration before the Committee could take a final position. Mr Gareth

Jenkins explained that the report represented a condensed version of a more detailed assessment which considered stakeholder perspectives, existing documentation, current governance arrangements and the organisation's readiness to adopt AI safely and effectively.

Mr Jenkins advised that the assessment focussed less on the technical capabilities of AI and more on governance, controls and organisational readiness. He highlighted a spectrum of AI use ranging from relatively controlled applications already in use within Digital Services to more widely available tools such as Microsoft Copilot, noting a substantial unstructured middle ground where staff could encounter a growing number of externally marketed AI products. The principal conclusion of the assessment was therefore that clearer governance arrangements, defined accountabilities and a dedicated oversight structure would be required to support safe and consistent adoption across the organisation.

The Committee strongly supported the emphasis on governance but requested greater clarity regarding risk appetite, accountability and operational scope. Mr Tracey agreed to liaise with Ms Wilmshurst regarding the identification and management of AI-related organisational risks. **AT**

Mr Weir emphasised that future AI governance arrangements should not be limited to technical specialists and suggested the establishment of a dedicated AI Panel or similar oversight mechanism. He stressed that such a group would require Clinical Executive oversight and should include operational and patient representation to ensure a broad range of perspectives informed decision-making. Given the increasing influence of AI on how patients access information and interpret advice, he also highlighted the need for a programme of staff education and awareness, supported by clear protocols and guidance to promote safe and consistent use. The Committee agreed that effective governance should be viewed as an enabler rather than a barrier to innovation, providing the assurance, guardrails and confidence necessary to support AI adoption responsibly.

Ms Patel sought clarity regarding responsibility for monitoring "shadow AI" and requested a clear statement defining the scope of AI governance across clinical, administrative and educational applications. Mr Jenkins advised that existing digital controls prevented the use of non-approved tools on Health Board systems, whilst acknowledging that the use of personal devices presented a wider behavioural and educational challenge.

Members also highlighted the importance of clinical safety, strategic prioritisation and proportionate safeguards. Dr Daniel Warm noted the need to ensure that clinically relevant AI capabilities were appropriately reflected within clinical safety cases, whilst Ms Harraway emphasised the importance of focusing effort on areas where AI could deliver genuine strategic benefit rather than treating AI as a solution to every operational challenge. Mr Tracey advised that distinct governance pathways would likely be required for clinical, administrative and other AI applications, underpinned by appropriate human oversight, clear guardrails and visibility of approved solutions. He added that, whilst formal governance

arrangements remained under development, preparatory work could continue in parallel to ensure the organisation was well positioned to respond.

Mr Davies reinforced the scale and complexity of the challenge, highlighting Medicines and Healthcare products Regulatory Agency (MHRA) considerations relating to clinical AI, alongside associated cyber security, information governance and data protection risks. He stressed that AI was not an end in itself and that successful deployment would depend upon robust governance, high-quality data and clearly defined use cases.

As the report had not yet completed Executive scrutiny, the Committee did not endorse the proposed governance arrangements or implementation plan at this stage. Instead, it noted the assessment, supported the continuation of work through the Executive governance route and requested a more detailed follow-up report in six months' time following completion of the Executive review process. **AT**

Decision:
The Committee:

- **NOTED** the findings of the AI Readiness Assessment, including that HDdUHB has emerging AI readiness, strong foundations and clear opportunities to expand the safe and responsible use of AI, but is not yet operating at scale.
- **RECEIVED ASSURANCE** from the progress already made through the data science function, Copilot adoption, existing information governance arrangements, data quality activity and wider organisational engagement in AI opportunities.
- **DID NOT ENDORSE** the proposed five priority areas as the strategic framework for a coordinated programme of work to support safe, scalable and responsible AI adoption across HDdUHB, covering AI governance, enablement and adoption, data and platform strategy, tooling and funding, and the development of reusable delivery patterns.
- **DID NOT APPROVE** the establishment of an AI Governance Group, or equivalent governance route, with clear Terms of Reference, decision rights, assurance requirements and reporting arrangements into the Digital, Data and Innovation Committee.
- **NOTED** that an implementation plan is being developed setting out governance products, approved tool guidance, data and platform requirements, capacity implications, training and awareness activity, milestones and a reporting cycle, with a progress update presented to a future meeting of the Committee.

DDIC(26)121 Extracting Insight from Data

Ms Tracy Price joined the meeting.

Mr Tracey introduced the Extracting Insight from Data report, outlining HDdUHB's three-year approach to strengthening its use of data and analytics. He advised that the Health Board increasing demand, growing clinical complexity, financial and workforce pressures, and inconsistent access to modern digital tools, make effective use of data critical to

organisational improvement and informed decision-making. Developed in response to these challenges and the requirements of Targeted Intervention, Phase 1 of the Data Blueprint aims to strengthen data quality, governance, integration and analytical capability to support stronger assurance and evidence-based decision-making.

Mr Jenkins presented the blueprint as the first phase in a longer journey towards becoming a genuinely data-enabled organisation, noting that Executive members had been engaged in its development and that staff feedback had informed eight key aims:

- **Aim 1:** Strengthen and improve data quality: Ensure our data is complete, accurate, reliable, relevant and timely
- **Aim 2:** Central storage of our key data: Health and social care data stored in the Health Board's data platform on the cloud
- **Aim 3:** Develop a network of skilled analysts: To support services in identifying where improvements need to be made
- **Aim 4:** Data products accessible to all relevant staff: Access to appropriate data and information in a timely and appropriate manner
- **Aim 5:** Make data more available for the public: Be more open and transparent with people who use our services
- **Aim 6:** Using data to improve productivity and efficiency: Data is essential for identifying areas of potential waste across our services
- **Aim 7:** Enhance our data science tools and skills: Data science gives us greater power to help improve patient outcomes and productivity
- **Aim 8:** Leverage data for artificial intelligence (AI): Sound data is essential to ensure AI produces meaningful results.

Mr Davies described the report as a strategic enabler rather than a technical exercise. In welcoming the report, Ms Harraway challenged the Committee to be clear about what was meant by "insight", prompting a discussion on the distinction between data, information, intelligence and actionable insight. Ms Harraway suggested that insight can be understood as a previously unknown truth from which action follows, while Mr Davies described it in terms of understanding why something happens rather than simply reporting that it happened.

Dr Warm emphasised the need to use insight as a practical planning tool, particularly where services must improve through better use of existing resources rather than additional investment. Ms Lloyd-Jones drew parallels with workforce data, where information is often available however, translating it into meaningful insight remains challenging. Mr Tracey highlighted data literacy as a key enabling theme within the blueprint and advised that related work was already underway through programmes such as Equip and Leap, although a broader organisational offer would be required.

The Committee acknowledged that analytical capability exists across the organisation and discussed the importance of greater consistency in analytical approaches. Mr Tracey advised that consideration was being given to the development of a data analytics centre of excellence,

incorporating common standards, training and methodologies to support robust, triangulated analysis and interpretation. Strong support was also expressed for regional and national collaboration with partners including Swansea Bay University Health Board (SBUHB) and Digital Health and Care Wales (DHCW).

The Committee requested that future updates include practical examples demonstrating how improved use of data and insight has influenced clinical practice, operational performance or outcomes.

Ms Price left the meeting.

Decision:
The Committee:

- **ENDORSED** the phased, capabilities-led approach set out in the blueprint, as the strategic direction for developing the Health Board's data, analytics and AI capability, recognising the need to strengthen data quality, analytical capacity, data literacy, access to trusted information and the effective use of advanced analytics and artificial intelligence.
- **NOTED** the development of the Turning Data into Insight 2025-2028 blueprint as the first phase of the Health Board's journey towards becoming a data-enabled organisation.
- **NOTED** that progress updates, including delivery milestones, risks, benefits realisation and areas requiring Committee support or escalation, are presented to the Digital, Data and Innovation Committee at appropriate intervals.

DDIC(26)122 Digital Strategic Plan

Mr Tracey presented the Digital Strategic Plan, indicating that the Health Board is now working through the sequencing of a roadmap covering 87 projects over the next three years. Dr Anthony Smith highlighted several live deployments already underway, including ePMA on Ward 9 at Prince Philip Hospital (PPH), eObs in the Padarn Ward at Glangwili Hospital (GGH) and the Maternity Electronic Health Record, demonstrating that the Strategic Plan had moved from design into delivery.

Dr Smith outlined the developing model for clinical leadership in digital transformation, describing a three-tier structure comprising Chief Clinical Information Officer roles at the strategic level, a wider tier of Clinical Informatics Practitioners and Fellows beneath them, and a network of Digital Champions and super users providing support at a local level. He advised that the model was intended to embed clinical informatics within governance, programme delivery and assurance arrangements rather than relying on an external advisory function. Clinical safety was described as an integral component of programme development and implementation, embedded within Working Groups, Programme Boards and project delivery from the outset rather than being viewed as a final-stage sign-off requirement.

In response to a query from Ms Patel regarding organisational resilience and the extent to which the model relied on a small number of key individuals, Ms Anna Harries advised that roles had been designed to

avoid over-specialisation and support resilience across the team. However, she noted that a number of posts remained programme-funded and temporary in nature, limiting long-term stability despite the significant expertise being developed.

Ms Harries emphasised the importance of demonstrating to staff that clinical informatics and digital leadership roles are visible, valued and represent genuine career opportunities within the organisation. She indicated that the establishment of more permanent roles would provide the structure and stability required to create a core team of experienced staff that could subsequently be expanded to support future programmes and additional projects as the digital agenda develops. Dr Smith added that the ambition was to establish a genuine career pathway through which staff could progress from Tier 2 positions into senior informatics leadership roles, thereby reducing single points of failure and strengthening succession planning.

In response to Ms Jo Bradburn's enquiry regarding how the model would support both strategic delivery and the development of digital capability across the wider clinical workforce, Ms Harries advised that visible implementation activity was already generating interest amongst clinicians, who could see the impact and value of these roles in practice. However, she noted that opportunities for wider development remained limited. Dr Smith indicated that Wales currently lacked a well-established formal training route comparable to the former NHS Digital Academy model and suggested that national workforce development arrangements would need to mature if HDdUHB was to sustain and scale this capability over the longer term.

The Committee supported the overall direction of travel and regarded clinically led transformation as fundamental to the successful delivery of the Digital Strategic Plan. Members recognised the progress being made in embedding clinical leadership and clinical safety within digital programmes, whilst noting that permanent organisational structures, clearer workforce planning and sustainable career pathways would be required if the current momentum was to be maintained over the longer term.

Decision:
The Committee:

- **RECEIVED ASSURANCE** on the updated direction of travel for the Digital Strategic Plan and the strengthened focus on clinical leadership, clinical safety and professional accountability as core requirements for digital transformation the shift toward a more disciplined, prioritised and assurance-led delivery model.

DDIC(26)123 Planning Goal 5: People First, Digital Always

Mr Tracey presented the Planning Goal 5: People First, Digital Always report, highlighting that Patient Flow is now live across 1,200 beds, eObs has been implemented and ePMA is underway. Progress was also reported across the wider Strategic Plan, Electronic Document and Records Management System (EDRMS), business cases, and the data-to-insight blueprint. He emphasised that the programmes interdependent

workstreams are progressing rapidly and delivering mutually reinforcing benefits.

Ms Harraway enquired whether the organisation had identified the key factors underpinning a successful implementation and whether lessons learned were being systematically incorporated into future planning. In response, Mr Tracey described a readiness-led approach that includes ward-level assessments of equipment, digital maturity and staff preparedness prior to implementation. He noted that lessons learned from the Patient Flow rollout had a more disciplined approach to ePMA, with significantly higher staff training completion rates required before deployment.

Mr Tracey also confirmed that post-implementation review is included as part of the model. Alongside formal lessons learned reviews, HDdUHB is exploring the use of adoption software to provide insight into how deployed systems actually are being used in practice, identify variations in uptake, and inform targeted support where required.

The Committee acknowledged that successful deployment depends on a combination of organisational readiness, disciplined implementation, effective adoption support and continuous learning, rather than the achievement of a technical go-live alone.

Decision:
The Committee:

- **NOTED** the Planning Goal 5: People First, Digital Always update.

DDIC(26)124 Digital Inclusion

Ms Carolyn Williams joined the meeting.

Mr Tracey introduced the Digital Inclusion update, summarising the current position against the team's eight-pillar approach. He indicated that the team has made strong progress despite very limited staffing, with a major focus on staff readiness because of the scale of digital deployment activity already underway. He also noted growing work with communities, supported by funding to work with the University of Wales Trinity Saint David (UWTSD) on digital divide research that should deepen understanding of local need beyond the workforce.

Highlighting work already in progress through the Regional Digital Inclusion Steering Group, partnership with Local Authorities and the third sector, accessibility engagement including the Royal National Institute for the Blind (RNIB), the development of a digital awareness toolkit, and active support from digital inclusion champions. Ms Williams indicated that there are approximately 300 champions across the organisation and that the Team, comprising two members and one temporary member of staff, is currently supporting 56 teams, with around 76 referrals arising from digital readiness work. A recent engagement event in Carmarthen had been well received and had helped increase awareness and understanding of the programme across the organisation.

Ms Harraway welcomed the breadth of the work and requested that future reporting provides clear evidence of the impact and benefits being realised. Ms Williams advised that a benefits realisation plan and supporting dashboard are already in place, tracking changes in confidence levels following intervention, and suggested that this evidence could be reflected more explicitly in future reporting.

Ms Harraway emphasised the importance of evidencing long-term impact in harder-to-reach communities. Ms Williams noted that, although this cannot be captured directly, third sector partners may be better placed to evidence community impact, supported by ongoing digital divide research.

In response to Mr Weir's query regarding gaps in champion coverage and the extent to which digital inclusion is linked with other governance areas such as information governance and wider digital engagement, Ms Williams indicated there are still areas where managerial engagement is limited. Mr Tracey added that there may be value in exploring whether lower compliance in some areas correlates with digital inclusion needs, especially where broader policy and training requirements are concerned; and agreed to triangulate information governance against digital inclusion deficit. Ms Lloyd-Jones framed this in workforce planning terms, emphasising that the organisation must align capability, capacity and future demand rather than relying on further staffing growth. **AT**

Ms Williams also highlighted practical support through group sessions, one-to-one engagement, skills development pathways and proactive walkarounds to assist staff in becoming more confident with new technologies.

The Committee strongly supported the work and recognised it as critical to safe and equitable digital transformation, while also acknowledging that the scale of ambition remains greater than the current dedicated resource.

Decision:
The Committee:

- **RECEIVED ASSURANCE** on the progress made in embedding of digital inclusion across the Health Board, including actions to improve the Digital Readiness approach, Champions Network, Skills and Confidence Development Pathway and targeted support for teams.

DDIC(26)125 Digital Partner Update

Mr Tracey provided a brief update on the organisation's arrangements with CGI as digital partner. He explained that fuller discussion was being reserved for the Extraordinary DDIC meeting on 4 September 2026, where the matter would be examined in greater depth. For the current meeting, he emphasised that work to develop the digital services partnership remains ongoing and that no additional expenditure had been committed to CGI since the last Committee meeting.

Decision:

The Committee:

- **RECEIVED ASSURANCE** that the Digital Partner arrangements, the continued use of CGI to support Board-approved digital transformation activity and Digital Services Partnership remain subject to appropriate governance, financial scrutiny and approval processes, with no new expenditure or additional financial commitment incurred since the last reporting period.

DDIC(26)126 Electronic Document and Records Management System **Re-procurement (Document Management System)**

Ms Williams presented the EDRMS Re-procurement report, describing it as the organisation's digital filing cabinet for scanned records. She explained that the current contract with Civica for the Cito system runs only until March 2027 and that the procurement exercise had therefore commenced sufficiently early to allow for transition. Around 450,000 documents have already been scanned into the current system, making continuity and migration planning especially important.

Ms Williams indicated that the procurement had been completed in accordance with established NHS Wales procurement processes, working in partnership with NHS Wales Shared Services Partnership (NWSSP) procurement; and included a methodology developed with input from colleagues across the organisation. A transition plan is in place with the incumbent supplier, and the matter remains commercially sensitive because the process is still within the standstill period. The Committee was also reminded that the business case had already completed finance governance processes and would still proceed to Board.

The Committee supported the proposed approach, noting that failure to complete the transition before March 2027 would represent a significant operational risk and should continue to be closely monitored.

Decision:
The Committee:

- **ENDORSED** the proposed procurement approach.
- **SUPPORTED** the continuation of the programme to ensure a safe and seamless transition to the new contract, with no disruption to clinical and operational services.
- **NOTED** the progress of the EDRMS procurement exercise and the outcome of the tender process.

DDIC(26)127 Research and Innovation Sub-Committee (RISC) 3A's Update

Dr Phillips presented the Research and Innovation Sub-Committee (RISC) 3A's Update for the meeting held on 8 June 2026, indicating that the balance of reporting is usually weighted towards assurance, however that two advisory points had been escalated on this occasion. The first related to DPIA and information governance delays affecting research and innovation projects, a matter discussed earlier in the meeting. Dr Phillips indicated that, if the proposed process changes are promptly implemented, this advisory point may return to a more assured position.

The second advisory concerned an emerging financial pressure within the research and development function. Dr Phillips emphasised that the department has not overspent during his seven years in post and that the current issue relates to an unexpected pressure in the 2026/2027 position, particularly in relation to the Welsh Government (WG) allocation supporting the portfolio and staffing model. He advised that a possible route to mitigation would be the use of commercial research income, and for that reason he described the issue as something to monitor rather than a cause for concern.

Ms Patel noted that the issue had already been raised directly with WG colleagues and that the discussion had been constructive. Dr Phillips confirmed that the relationship is positive and collaborative, which may assist in addressing the pressure.

Decision:
The Committee:

- **NOTED** the items the Sub-Committee is advising them of
- **RECEIVED ASSURANCE** from the items that the Sub-Committee is providing assurance on.

DDIC(26)128 Strategic Plan Progress Update

Dr Phillips presented the Research and Innovation Strategic Plan Progress Update Report, indicating that it was intended to provide a clear line of sight between the recently published Research and Innovation Strategic Plan and practical delivery. He emphasised that the report covered approximately six months of implementation, as the Strategic Plan had not been published until October 2025. In that context, he described overall progress as encouraging, with 35 of the 38 actions rated either green or amber.

Dr Phillips explained that amber ratings were being used deliberately as an indication of constructive self-challenge rather than failure. In several areas, the team thought that progress could have been accelerated further or delivered more comprehensively, despite remaining broadly on track. Three actions were identified as no longer being actively progressed and had been included transparently within the report to provide clarity regarding delivery against the Strategic Plan.

In response to a query regarding which, amber-rated actions required the greatest attention, Dr Phillips highlighted regional research and innovation work, particularly access to oncology studies, where progress remained dependent upon collaboration with SBUHB due to existing service configurations. He also identified broader evaluative work through TriTech and Innovation as an area where organisational pressures could affect the pace at which opportunities could be progressed. Nevertheless, he reported a number of positive developments, including the prospect of additional WG support and a generally favourable national policy environment.

The Committee, welcoming the progress made during the early stages of implementation and, whilst recognising that some areas would require

continued focus and partnership working, were assured by the positive overall direction of travel.

Decision:
The Committee **RECEIVED ASSURANCE** from:

- The work undertaken to deliver the Strategic Plan in 2025/26; and
- The work planned for 2026/27, including the actions that will be discontinued.

DDIC(26)129 University Partnership Arrangements Update

Dr Phillips presented the University Partnership Arrangements Update Report outlining engagement with the University of Wales Trinity Saint David (UWTSD), Swansea and Aberystwyth Universities. He emphasised that the report focussed on the additional value and opportunities arising from structured partnership discussions, rather than routine liaison activity, commitments and collaborative initiatives that would be less likely to arise through day-to-day interactions alone.

He outlined constructive discussions with Aberystwyth University and the UWTSD, highlighting opportunities across education, workforce, enterprise and research. Dr Phillips noted that, following a delay at Swansea University's request, the partnership meeting took place on 10 July, with an update to be presented at the next Committee meeting. Early themes from that discussion included nursing education, graduate entry medicine, research collaboration and enterprise opportunities.

Mr Davies welcomed the progress and highlighted the reinvigoration of the Centre for Community Health at Aberystwyth through £5m of funding to strengthen engagement with rural communities. Dr Phillips advised that the University was connecting this work to wider place-based research exploring how services and communities interact in rural settings. He also highlighted a programme led by Professor Michael Phillips which was strengthening links between the Health Board, staff and students.

The Committee considered this a valuable opportunity that aligned strongly with the Health Board's rural context and would support workforce development, research and innovation, while strengthening links between education, research and service delivery across the region.

Decision:
The Committee:

- **RECEIVED ASSURANCE** from the report on progress in university partnership activities.

DDIC(26)130 DEFERRED: Update on Impact of Flow System

DDIC(26)131 Assurance and Risk Report

Ms Wilmshurst presented the Assurance and Risk Report, noting that principal risks will now be reported in a form more closely aligned to Board reporting. She highlighted that one corporate risk had increased to 25 and that the report also included operational risks and the usual assurance items. The Committee acknowledged that several earlier

discussions during the meeting suggested that additional risks, or stronger articulation of existing risks, may also be required in future reports.

Concerns were raised regarding the risk attached to the national Laboratory Information Management System (LIMS) 2 programme. Mr Tracey clarified that this is an All-Wales issue rather than one unique to the Health Board, agreeing that it remained a material concern because of key dependencies, delivery milestones and the need to maintain a safe and effective information management system. The risk was therefore recognised as appropriately rated at 25.

The Committee also considered the EDRMS transition risk, noting that the current supplier arrangement runs only until March 2027 and that successful transition before then is essential. Mr Tracey confirmed that weekly meetings are now in place on LIMS2 and that standstill and transition arrangements are being closely managed for EDRMS.

The Committee queried whether the significance of the LIMS2 position was sufficiently visible at Board level. Mr Tracey agreed to ensure that the issue was reflected in the relevant upward reporting with appropriate context. **AT**

Decision:
The Committee, in relation to the areas presented in this paper, to:
Risk Management

- **RECEIVED ASSURANCE** that the principal risks have been refreshed, aligned to the relevant Committee, and will be reported to the Board in July; and
- **RECEIVED ASSURANCE** that there are processes in place to oversee corporate and operational risks to ensure these are being managed effectively. Audits, Inspections and Regulatory Reports
- **RECEIVED ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

Welsh Health Circulars

- **RECEIVED ASSURANCE,** or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively. Ministerial Directions
- **RECEIVED ASSURANCE** that the Health Board is compliant with the MDs issued by Welsh Government.

DDIC(26)132 Research & Development Finance Policy

Mr Chris Tattersall joined the meeting.

Dr Phillips presented the Research and Development Finance Policy, explaining that it is largely shaped by WG requirements, reflecting the national framework under which the organisation receives just over £1m each year for this area. He advised that the revised policy contains no significant changes from the previous version, although local amendments had been incorporated during development to ensure its continued practicality and operational effectiveness.

The Committee sought assurance that the organisation could comply with the policy as drafted. Dr Phillips confirmed that it could, and the policy was supported accordingly.

Decision:
The Committee:

- **APPROVED** adoption by HDdUHB of the NHS Wales Research & Innovation Finance Policy 2026.

DDIC(26)133 DDIC Workplan 2026/27

The Committee noted the DDIC workplan for 2026 to 2027.

DDIC(26)134 Any Other Business

No additional business was considered.

DDIC(26)135 Date and Time of next meeting

Friday 4 September 2026, 13:00 – 15:00

Tuesday 20 October 2026, 09.30 - 12.30