



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	2026-07-21
Time	09:00 - 12:00
Location	Microsoft Teams Meeting; HDD Picton - Dolau Cothi

Digital, Data and Innovation Committee

Digital, Data and Innovation Committee
NHS Wales

Table of contents

2026-07-21 09:00 - 12:00

1 - Governance	6
1.1 - Welcome and Apologies	7
1.2 - Declarations of Interests	8
1.3 - Minutes and Matters Arising from the meeting held on 21 April 2026	9
Attachments	
1.3 2026-04-21 - Digital, Data and Innovation Committee - Minutes	10
1.4 - Table of Actions from the meeting held on 21 April 2026	22
Attachments	
1.4 DDIC Action Tracker 21 04 2026 FINAL	23
2 - Data	25
2.1 - Data Quality Report	26
Attachments	
2.1 DDIC - Data Quality Deep Dive	27
2.2 - Data Protection Impact Assessment Assurance Report	34
Attachments	
2.2 - DDIC - DPIA Update - July 2026	35
2.3 - Information Governance Sub-Committee (IGSC) 3A's Update	45
Attachments	
2.3.1 - 3As Update Report DDIC - IGSC July 2026	46
2.3.2 Attach 12a 191 - Health Records Management Strategy- v5 DRAFT (1)	49
2.3.3 Attach 12b 192 - Health Records Management Policy.V5 DRAFT (1)	58
2.3.4 Attach 12c 193 - Retention Destruction Policy final 2026 (1)	70
2.3.5 Attach 12d -240-ITProcurementProcedure-v4 draft (3) (1)	78
2.3.6 Attach 12e - Policy 320 - Acceptable use of Digital Services Policy v4 draf~	88
2.3.7 Attach 12f 250-IQA Policy_20260622	97

2.4 - Review of Organisational AI Readiness	110
Attachments	
2.4.1 DDIC SBAR - AI Readiness Assessment	111
2.4.2 Hywel Dda AI Readiness final report v1.0	120
2.5 - Extracting insight from data	195
Attachments	
2.5.1 DDIC SBAR - Data blueprint - July 2026	196
2.5.2 - DDIC Turning Data into Insight - 2025 to 2028	203
3 - Digital	231
3.1 - Digital Strategic Plan	232
Attachments	
3.1.1 - DDIC - Strategic Plan July 2026	233
3.1.2 DDIC - Clinical leadership strategy	240
3.2 - Planning Goal 5: People First, Digital Always	253
Attachments	
3.2 Planning Goal 5 People First, Digital Always)	254
3.3 - Digital Inclusion	256
Attachments	
3.3 - DDIC Digital Inclusion SBAR July 2025	257
3.4 - Digital Partner Update	265
Attachments	
3.4 - DDIC - Digital Partner Update - July 2026	266
3.5 - EDRS Re-procurement (Document Management System)	272
Attachments	
3.5 - DDIC EDRMS procurement June 2026	273
4 - Research and Innovation	279
4.1 - Research and Innovation Sub-Committee (RISC) 3A's Update	280
Attachments	
4.1 Committee Update (3As) RISC July 2026	281
4.2 - Strategic Plan Progress Update	285
Attachments	
4.2 DDIC SBAR Strategy Update July 2026	286

4.3 - University Partnership Arrangements Update	315
Attachments	
4.3 DDIC SBAR University Partnerships July 2026	316
5 - Impact and Outcomes	323
5.1 - Update on Impact of Flow System	324
Attachments	
DDIC Presentation eflow eObs update July 2026	325
6 - For Assurance	336
6.1 - Assurance and Risk Report	337
Attachments	
6.1.1 DDIC Public Governance Arrangements - July 2026 DRAFT	338
6.1.2 Appendix 1 - DDIC CRR (public)	364
6.1.3 Appendix 2 - Operational Risk Register (Public)	374
6.1.4 Appendix 3 - Overdue Audit and Inspection Recommendations	377
7 - For Approval	378
7.1 - Research & Development Finance Policy	379
Attachments	
7.1.1 R_D Finance Policy DDIC SBAR	380
7.1.2 HDUHB R_D Finance Policy 2026	384
7.1.3 1395 Equality Impact Assessment	408
8 - For Information	414
8.1 - DDIC Workplan 2026/27	415
Attachments	
8.1 DDIC Work Programme 2026-27 FINAL	416
9 - Any Other Business	421
10 - Date and Time of next meeting	422
11 - In-Committee Session	423

1 - Governance

1.1

09:05, 0 Mins

1.1 - Welcome and Apologies

Maynard Davies
(Hywel Dda UHB -
Independent Member)

Apologies

Huw Thomas - Anthony Tracey deputising

Lee Davies - Dan Warm deputising

Mark Henwood - Eiry Edmunds deputising

Jo Wilson - Charlotte Wilmshurst deputising

1.2

09:05, 0 Mins

1.2 - Declarations of Interests

***Maynard Davies
(Hywel Dda UHB -
Independent Member)***

[HDdUHB Register of Board Members Interests 2026-27](#)

| For assurance

1.3

09:05, 0 Mins

1.3 - Minutes and Matters Arising from the meeting held on 21 April 2026

*Maynard Davies
(Hywel Dda UHB -
Independent Member)*

| For approval

Attachments

[1.3 2026-04-21 - Digital, Data and Innovation Committee - Minutes.pdf](#)

MINUTES OF THE Digital, Data and Innovation Committee MEETING

Date of Meeting: **9:30 AM, Tuesday 21 April 2026**
Venue: **Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Present: Chantal Patel, Independent Member (Vice Chair)
Winston Weir, Independent Member

In Attendance: Anthony Tracey, Digital Director
Huw Thomas, Executive Director of Finance
Joanne Wilson, Director of Corporate Governance/Board Secretary
June Picton, Associate Medical Director for Professional Standards
Lee Davies, Executive Director of Strategy and Planning
Leighton Phillips, Director of Research, Innovation and Value
Mark Henwood, Executive Medical Director
Anna Harries, Chief Nursing Information Officer
Sara Quarrie, Service Director for Allied Health Professions and Health Sciences (part)
Ruth Poynting, Committee Services Officer (minutes)

Apologies: Maynard Davies, Independent Member (Chair)
Sarah Harraway, Independent Member
Corinna Lloyd-Jones, Interim Assistant Director of Organisation Development

Minutes Ref.	Item	Action
DDIC(26)94	Welcome and Apologies Ms Chantal Patel welcomed all to the meeting and apologies were noted as above.	
DDIC(26)95	Declarations of Interests Board Member DOI Register Ms Patel declared that although she is employed by Swansea University, which has links to research and innovation activity for the Health Board, she has no direct involvement in this work and plays no role in decision making in this area.	
DDIC(26)96	Minutes and Matters Arising from the Meeting Held on 15 January 2026 Dr Leighton Phillips noted that the minutes record the action for Dr Phillips and Mr Huw Thomas to meet with Mr Gareth Cross as complete. This	

meeting has not yet taken place; however, a date has now been scheduled.

Subject to the above amendment, the minutes were accepted as an accurate record.

Mr Winston Weir requested further information on the Executive Team discussions regarding the introduction of ambient Artificial Intelligence (AI) into the Health Board, particularly regarding patient consent and ethical considerations. Mr Thomas advised that a paper had been taken to the Executive Team, who were supportive and recognised the need for robust consent arrangements during any trial period, noting that ambient AI use cases are increasingly emerging across the UK and becoming more mainstream.

Mr Anthony Tracey added that ambient AI is currently being piloted within neurodivergence services with consent managed through engagement with parents and carers. Wider rollout of these services would require additional informed consent measures such as visible communications.

Mr Weir highlighted the importance of the ethics process, emphasising the need for assurance that the consent was appropriately captured and that any issues raised were given due consideration.

Mr Tracey confirmed that the work had been presented to the Ethics Panel and acknowledged that potential risk of error. He advised that, as a mitigation, clinicians have been asked to review the transcripts prior to sign off.

Mr Thomas advised that there was supporting evidence from social care and highlighted that the approach enabled clinicians to focus on the individual, rather than on note-taking, resulting in improved quality of discussions. Mr Tracey added that this had delivered a time saving of at least 30 minutes per patient.

Mr Tracey clarified that current transcription tools require each person to identify themselves at the start of each session from which the AI will recognise their voice.

In response to a query from Ms Patel, Mr Tracey confirmed that legal responsibility remains with the clinician who signs off the documentation, once it has been captured. Ms Joanne Wilson and Mr Tracey agreed to seek further legal advice.

JW,
AT

Decision: The Committee APPROVED the Minutes of the Previous Meeting.

DDIC(26)97 **Table of Actions from the meeting held on 15 January 2026**

DDIC(25)57: Mr Tracey advised the Committee that the proposal to potentially introduce quality kitemarks for documents into the Data Quality Deep Dive Workplan would be presented to the July 2026 meeting as part of a wider data update.

Decision: The Committee NOTED the Table of Actions.

DDIC(26)98 **Digital, Data and Innovation Committee (DDIC) Terms of Reference**

Ms Wilson presented two proposed changes to the Terms of Reference (ToR), reflecting updated terminology, and sought the Committee's approval. Mr Weir commented that the ToR provided a comprehensive set of operational requirements and that the update was timely.

Decision: The Committee APPROVED the Digital, Data and Innovation Committee's Terms of Reference (version 3) for onward ratification by the Board on 28 May 2026.

DDIC(26)99 **Digital, Data and Innovation Committee (DDIC) Annual Report**

Ms Wilson advised the Committee that Mr Maynard Davies had prepared the Chair's Summary and that the report is produced annually to track the Committee's progress.

Mr Weir commented that, in its first year, the Committee had made a positive start and recognised the progress achieved, while indicating that he would welcome greater coverage of the Radiology Informatics System Programme (RISP).

Mr Thomas believed that the report was a comprehensive assessment however would welcome more coverage of regional working. In response, Ms Wilson queried whether this could lead to duplication with the Regional Joint Committee, while acknowledging that there may be an opportunity to link the work of the two committees where appropriate.

Decision: The Committee APPROVED the Digital, Data and Innovation Committee (DDIC) Annual Report

DDIC(26)100 **Digital, Data and Innovation Committee (DDIC) Self Assessment Report**

Ms Wilson presented the Committee's Self-Assessment, which had been completed in line with the Standing Orders. Overall scores were high, with the assessment highlighting areas of strong performance, particularly in relation to chairing and reporting to Board. Ms Wilson noted that there was scope for the Committee to place greater emphasis on strategic thinking and to avoid becoming overly focused on operational detail, concluding that this represented a positive start.

Mr Weir stated that, while it had been a strong start, further work was required to strengthen the culture, particularly in relation to embedding digital innovation. He emphasised the importance of clear line of sight between digital initiatives and their impact on health services. Mr Thomas acknowledged these points and suggested that, as the strategy develops, appropriate processes would be embedded to support such initiatives.

Decision: The Committee CONSIDERED the outputs from the Committee Self-Assessment process and AGREED the actions identified to further improve Committee effectiveness

The Committee received the risk report, which outlined two corporate risks, including one to be considered In Committee, and seven operational risks, three of which were also In Committee.

Mr Weir commended the quality of the risk presentation and sought assurance that all relevant risks were captured, highlighting that a number of elements within the Digital Operational Plan were rated red. He also raised specific concerns regarding the Electronic Staff Record (ESR), the Single Point of Access, TriTech-related risks, and sought assurance that these were appropriately reflected within the overall risk profile. Ms Wilson advised that risks were escalated to the Committee only where they met the threshold for high or above scores, with some issues appropriately managed at directorate level. She further explained that risks relating to ESR sat within the remit of the People, Organisational Development and Culture (PODCC) Committee, given their direct link to staffing matters.

Mr Weir queried whether an overarching data quality risk should be identified given the recommendations made. Ms Wilson advised that this had not yet emerged as a theme. Mr Tracey further noted that the forthcoming DDIC deep dive on data quality would provide an opportunity to explore this further.

In relation to TriTech, Mr Weir highlighted risks around funding, communications and engagement, and questioned whether these were sufficient. Dr Phillips explained that there were two formal risks relating to changes in the regulatory environment and clarified the distinction between matters within the organisation's control and those that formally met the definition of a risk. He noted that the Research & Innovation Sub-Committee escalate concerns where it considered that issues were not being adequately managed.

Mr Weir concluded by suggesting that there was an opportunity for the organisation to strengthen its approach and questioned whether there was sufficient assurance that CGI was optimising all aspects of delivery.

Ms Patel queried whether patient risk was explicitly taken into account within the risk reporting process. Ms Sara Quarrie explained that risks were scored using a risk matrix that considered multiple domains, including patient safety, patient experience, workforce and staff experience. She noted that individual risks often spanned several domains, with emphasis placed on the most prominent, typically patient safety and care, followed by staff wellbeing.

Mr Weir raised concerns regarding audit recommendations relating to data quality, querying whether these remained outstanding or require reassessment, given that target dates had been moved on multiple occasions. In response, Mr Tracey advised that this matter would be reported back to the July 2026 meeting and confirmed that an approach had been developed in consultation with relevant areas across the Health Board.

Decision: The Committee RECEIVED ASSURANCE of the robustness of arrangements for risk management, the effective management and implementation of audit, inspection and regulatory recommendations, the oversight of Welsh Health Circulars, and compliance with Ministerial Directions.

DDIC(26)102 **Research and Innovation Sub-Committee (RISC) 3As update, RISC ToRs and RISC Annual Report**

Dr Phillips presented updates on the 3As report, the Terms of Reference and the Annual Report for the Research and Innovation Sub-Committee.

In relation to the 3As, he highlighted that the one advisory item concerning Information Governance cyber clearances for Research & Innovation (R&I) projects had been resolved, with plans to ensure future capacity and avoid delays.

Dr Phillips confirmed adherence to the framework previously presented to the Committee, including the 2026 position. He noted that correspondence had been received from Welsh Government requesting a comparative analysis, and as such an additional column had been included to show what had been reported previously.

He also provided a high-level overview of work to support equitable access to cancer studies across South West Wales. This included a systematic, clinically led assessment, accepted across organisations, aimed at improving diagnostic access.

The updated RISC Terms of Reference were presented and approved by the Committee.

Dr Phillips confirmed that assurance had been received that clinical trials are taking place across all hospitals. He highlighted Pentre Awel as a key and exciting development in community-based research and innovation. While there had been some delays, the programme is now back on track, with occupation anticipated shortly.

Mr Weir challenged whether risks related to Trittech and wider organisational support should be escalated. In response, Dr Phillips acknowledged that the system is always under pressure, however outlined progress made to overcome existing constraints. He explained that work is underway to reduce the risk score from 12, with the aim of fully mitigating the risk over time, supported by improvements in cyber processes.

Dr Phillips confirmed that communications and engagement have improved, whilst noting ongoing pressures on communications teams. A short film on innovation is due to be released shortly.

Mr Weir sought clarification on whether endorsement of the associated oncology costs was being requested. Dr Phillips confirmed the item was for noting only, providing assurance that costing work had been undertaken and that the issue is being actively prioritised by the department.

Welsh Government (WG) has planned an audit of NHS organisations' compliance with Research Delivery Funding and Healthcare Research Wales (HCRW) Research & Development finance policy, with feedback due to be provided on 7 May 2026. Mr Thomas expressed concern regarding the implications of this audit, emphasising the importance of fully understanding the HCRW requirements and any potential risks arising. He also stressed the need to ensure that the outcomes are appropriately and transparently reported to the Board, and suggested that this matter should first be escalated and considered through the Executive Team.

Ms Patel highlighted that while current levels of trials and innovation activity are appropriate, limited workforce capacity remains a key constraint given the limited staffing model. This introduces fragility, particularly in the context of potential reductions in funding or changes in market conditions.

She also noted that, unlike larger centres such as Cardiff, consolidation is not feasible due to the four-site model, as this would negatively impact access to studies.

Decision: The Committee APPROVED the Research and Innovation Sub-Committee Terms of Reference.

Decision: The Committee RECEIVED ASSURANCE by the Update Report, while noting the implications of HCRW actions.

DDIC(26)103 **Research Project Presentation**

Dr Phillips introduced Mr Daniel Harris and Dr Helen Tench, who presented on current initiatives relating to commercial trials activity.

Dr Tench provided an overview of commercial trials work at Bronglais Hospital. She outlined inflammatory bowel disease (IBD), including colitis and Crohn's disease, noting that approximately 30,000 people in the UK are affected, with diagnoses continuing to rise. She described the significant impact of Crohn's disease on patients' physical and mental health, treatment challenges, and the fact that surgery is often required.

Dr Tench highlighted Hywel Dda's involvement in HCRW global trials, including work with Pfizer, comprising 12 UK sites. Despite having a small IBD clinical team, Hywel Dda was ambitious in taking on the studies and achieved notable success.

R&D within Hywel Dda University Health Board (HDdUHB) is recognised as having the fastest set-up times in Wales, being the first site to open and the first in the UK to recruit patients across one study for each disease area. Significant achievements included establishing Hywel Dda as a trusted and preferred research partner, including with Roche, supported by efficient delivery, strong patient–clinician relationships, and a positive, supportive R&D and clinical culture. The availability of research-naïve patients was noted as a further strength, enabling effective recruitment outcomes.

Mr Weir queried whether, in addition to the drug-based elements of the trial, diet and lifestyle factors were being considered, and whether any positive outcomes had been observed to date. In response Mr Thomas advised that patients are closely monitored, including their lifestyle habits, however it is too early to draw conclusions or share data. Following the initial study phase, patients will have access to the drug, including those currently on placebo, providing immediate access thereafter.

In response to a query from Ms Patel regarding risk, Mr Thomas confirmed that Roche bears the risk, with legal contracts in place with patients.

Mr Harris delivered the second presentation outlining the ongoing work to improve outcomes in Atherosclerotic Cardiovascular Disease (ASCVD), noting that effective management of blood pressure and related risk factors remains one of the most cost-effective interventions in healthcare.

A collaborative project with Swansea University utilising the SAIL databank has enabled analysis of patient data against clinical guidance and the development of a novel risk prediction tool to support decision-making. This has supported identification of high-risk patients and cohorts for targeted intervention at population level.

Data indicates a 14% increase in ASCVD prevalence, consistent with wider trends, including rising diabetes rates. Treatment gaps remain, particularly in lipid-lowering therapy, with 2022 data showing lower rates across all groups with those diagnosed with Peripheral Artery Disease (PAD), the highest risk cohort, being particularly affected.

A Phase 2 pilot across both HDdUHB and Swansea Bay University Health Board (SBUHB), delivered by pharmacists with cardiology support, has demonstrated effective risk reduction, particularly in secondary prevention cohorts. The programme has enabled a more proactive approach to patient management.

A business case is now being developed for a Pathfinder project to support further scale-up.

Mr Weir queried whether greater emphasis should be placed on early intervention rather than treatment of an established disease. In response Mr Harris reiterated the importance of community-based delivery and cautioned against expanding screening before current management arrangements are optimised.

Mr Henwood noted that the SAIL databank is valuable in identifying high-risk populations. While prevention remains the preferred approach, the current work is focused on patients who already require treatment. Initial scale-up will target high-risk cohorts, with scope to expand to programme to other disease areas over time.

Decision: The Committee NOTED the progress against the two research initiatives.

DDIC(26)104 **Information Governance Sub-Committee (IGSC) 3A's update, IGSC Terms of Reference and IGSC Annual Report**

Mr Tracey reported continued improvements in assurance and steady progress within the IGSC, alongside completion of the annual training review.

Ms Wilson advised that she was content with the Terms of Reference, highlighting the removal of the requirement for an Independent Member within the quorum. While noting it remains beneficial to have independent representation, it was agreed this is not essential for quoracy.

Mr Weir queried how quoracy could be improved. Ms Wilson responded that a Vice Chair is in place to support attendance and continuity. Ms Picton added that meetings are scheduled well in advance and should enable members to plan accordingly to maintain quoracy.

Decision: The Committee APPROVED the Information Governance Sub-Committee ToRs, APPROVED 174 Reuse of Public Sector Information Policy (Appendix 2), NOTED the items the Sub-Committee is advising them of and TOOK ASSURANCE from the items that the Sub-Committee is providing assurance on

DDIC(26)105 **Digital Operation Plan**

Mr Tracey presented a reflective update of the past year, highlighting key issues, mitigating actions, and notable achievements. He noted that it had been a particularly busy period, with significant progress made in rolling out core digital systems.

Key successes included implementation of patient flow systems, completion of the digital maternity system within the past two weeks, delivery of approximately half of the Laboratory Information Management System (LIMS) programme, and progress in radiology systems. Improvements in cyber security resilience and compliance were also noted.

The seven priority areas are:

- LIMS – work is ongoing, with progress reported though Executive Team meetings.
- Switchboard modernisation – this is a longstanding programme, with a focus on introducing an alarm monitoring system; procurement is underway following withdrawal of a previous supplier.
- OpenEyes (Ophthalmology) – rollout of this has been delayed, with delivery now anticipated in June/July 2026.
- Single Sign-On (SSO) – a solution has been implemented in Accident & Emergency, with further rollout being explored, including prescribing.
- Planned Care Transformation – work is underway with CGI to enhance systems, with further updates expected within 2–3 months.
- Strategic response – further development is underway, with an update planned for September 2026.

Mr Tracey noted that this progress places the organisation in a strong position for future Electronic Health Record development, with foundational clinical systems now well established. He added that the Health Board is currently the only one in Wales to have patient flow systems implemented across all sites.

Mr Thomas thanked Mr Tracey and the team for their work over the past year, noting that further positive change is anticipated. Dr Anna Harries echoed this from a maternity perspective, highlighting the positive impact of the BadgerNet system and improved support.

Mr Weir queried the number of red-rated areas within the plan. Mr Tracey advised that these reflect capacity pressures and deliberate prioritisation decisions, with some areas deprioritised to enable delivery of higher-priority programmes.

Mr Weir raised concerns following a recent hospital visit that patient records were not being utilised optimally, presenting potential data and information governance risks. He queried whether similar issues existed within Hospital at Home services. Mr Tracey confirmed that community services remain predominantly paper based. A procurement process is underway for a new community system, which will enable continuation notes to be accessible for visiting and school nurses.

Mr Tracey explained that the patient flow system and wider technology infrastructure support operational oversight, including control centre monitoring. He noted that these systems are designed to capture technical and physiological data rather than day-to-day clinical record-keeping.

Mr Weir queried the availability of funding for Single Sign-On (SSO) and whether this could be escalated. Mr Tracey advised that capital bids have been submitted to Welsh Government; however, costs have increased significantly. Work is ongoing to assess whether the current supplier remains the most cost-effective option, with an All-Wales approach also being considered.

In response to queries from Mr Weir on the provision of Closed-Circuit Television (CCTV), Mr Tracey confirmed that legacy systems across sites are being consolidated into a single remotely accessible digital solution. Ms Wilson advised that further discussion should take place outside the meeting as CCTV falls under the remit of the Health and Safety Committee (HSC).

Mr Tracey confirmed that key clinical systems have both digital and operational leadership, supported by clinical and operational leads. It was emphasised that all systems will continue to have appropriate clinical and operational ownership in place.

Decision: The Committee NOTED the update on progress relating to the Digital Operational Plan.

Mr Tracey advised that work is underway to refresh the digital response, incorporating learning from 2025. The updated approach will be more focused, aligning to a targeted three-year strategy and planning framework, and is scheduled to be presented to the Committee in September 2026. He added that the Communications Team will engage with patients and other stakeholders to help shape the approach.

Mr Weir welcomed the approach, particularly the strategic pillars, however stressed the need for clearer articulation for patients and carers and stronger alignment with wider Health Board strategies, suggesting further discussions take place at Strategy and Planning Committee (SPC) and at Board Seminar. Mr Tracey clarified this is not a standalone strategy, however a response to the overarching strategy, incorporating patient, carer, and staff perspectives, including the use of patient personas to illustrate impact.

Mr Thomas highlighted feedback from a recent all-staff meeting, noting the need for clearer communication on how new digital systems impact day-to-day roles. Mr Weir supported this, emphasising the importance of demonstrating tangible benefits to staff to build confidence, engagement, and optimism.

Ms Patel sought clarification on the proposed role of CGI and its implications for the Health Board. Mr Tracey advised that CGI would provide strengthened support, particularly offering expert input to enhance delivery. He noted that the organisation is increasingly using CGI to maximise existing resources and capability.

Mr Lee Davies highlighted the need to align the refreshed digital approach with the four overarching strategic objectives, suggesting this mapping should add clarity. He also noted that strategic planning should clearly define priorities, including what will not be progressed, and proposed further discussion within forums such as A Healthier Mid and West Wales (AHMWW).

Mr Thomas highlighted the interface between DDIC and the Regional Joint Committee, noting that both HDdUHB and SBUHB are developing digital strategies from differing starting points and with varying risk appetites.

Decision: The Committee RECEIVED ASSURANCE from the direction of travel of the Digital Strategic Plan and the shift to a phased, capabilities-led delivery model while noting the learning from work undertaken during 2025 and acknowledging that delivery will continue to be underpinned by strong benefits realisation, cyber security, information governance, and clinical leadership

DDIC(26)107 **Closure of Planning Objective (PO) and Confirmation of new Planning Goals**

Mr Tracey presented the year end position, confirming sign-off of 2025/26 objectives.

There were no additional comments, and the Committee were assured of the position.

Decision: The Committee RECEIVED ASSURANCE from the Closure of Planning Objective (PO) and Confirmation of new Planning Goals that 2025/26 can be characterised as a credible and necessary consolidation year.

DDIC(26)108 **Digital Partner Update**

Mr Tracey advised that a Partnership Charter with CGI is being developed, with a focus on performance management and ensuring value for money. Significant funding has been provided to CGI, including Welsh Government allocations to deliver projects on behalf of NHS Wales, with the partnership providing the flexibility to respond to these opportunities.

Ms Patel sought assurance on how value from the CGI partnership is being tracked. Mr Thomas confirmed that assurance is provided through established processes with CGI. However, he noted that this has also highlighted weaknesses in contract scrutiny across other suppliers, with further work underway through the Finance and Performance Committee (FPC) to strengthen arrangements.

Mr Tracey also reported that an AI readiness assessment is underway, with a report expected within the next four weeks. This work includes a review of current AI activity across the Health Board, identification of development opportunities, and an assessment of governance arrangements. A desktop review has commenced, with stakeholder interviews planned over the coming weeks. Findings are expected to be presented at the July 2026 meeting.

Mr Weir queried whether current governance structures are sufficient, particularly the role of the monthly executive steering groups. Mr Thomas advised that governance is supported by regular engagement with CGI, including weekly meetings involving himself and Mr Tracey, alongside procurement and commercial oversight. Ms Wilson added that she also meets with procurement and CGI where governance matters arise.

Dr Phillips highlighted the opportunity for the Health Board to make greater use of CGI's Innovation Centre activity, noting that CGI has five UK centres focused on key service and policy areas. He suggested this be explored further through development of the Partnership Charter.

Decision: The Committee RECEIVED ASSURANCE on the content of the Digital Partner Update report and the Digital Charter approach.

DDIC(26)109 **DDIC Workplan 2025/26**

There were no comments on the Workplan.

DDIC(26)110 **Microsoft Enterprise Agreement Renewal**

Included within the [Procurement Report](#) presented to the March 2026 Public Board meeting.

Mr Thomas noted that this was presented to the Board first due to the timing of the report. Scrutiny and approval were received at Board level.

DDIC(26)111 **Digital Access**

The report was noted.

DDIC(26)112 **Any Other Business**

No other business was discussed.

Date and time of next meeting

09:30-12:30, Tuesday 21 July 2026

1.4

09:05, 0 Mins

1.4 - Table of Actions from the meeting held on 21 April 2026

Maynard Davies
(Hywel Dda UHB -
Independent Member)

| For information

Attachments

1.4 DDIC Action Tracker 21 04 2026 FINAL.pdf

DIGITAL, DATA AND INNOVATION COMMITTEE (DDIC)/ PWYLLGOR DIGIDOL, DATA AC ARLOESI
21/04/2026

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AT-Anthony Tracey; JW-Joanne Wilson

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
07/10/2025	DDIC(25)55	The Information Governance Sub-Committee 3As report to DDIC alerted members to the condition of the record storage facility. As part of this discussion Mr Thomas advised the business case would be completed. • To progress the business case for records storage facilities, as a priority, ensuring all requested information is incorporated.	AT	21/04/2026	Complete This has been achieved through current resources and communication has been made with Clinical Executives to advise of the consequences.
07/10/2025	DDIC(25)57	As part of the data quality discussion, Mr Thomas stated that in a previous DDIC meeting Mr Anthony Tracey had discussed the possibility of adding quality 'kitemarks' to documentation. • To add quality kitemarks for documents to the Data Quality Deep Dive Workplan	AT	21/04/2026	Complete Included within the July 2026 DDIC Agenda around Data Quality
15/01/2026	DDIC(26)86	Information Governance Sub Committee (IGSC) 3A's update • A discussion to be held regarding IGSC quoracy issues.	AT	21/04/2026	Complete A review of the IGSC TORs will be undertaken to remove the Independent member from being part of quorum recognising the attendance is in an observer/scrutiny. This was followed by a discussion with the relevant Independent Member regarding Committee attendance.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
15/01/2026	DDIC(26)88	Information Governance Training Update • To explore whether study leave should not be able to be undertaken without mandatory training being in place first, this would be work for PODCC to investigate	JW	21/04/2026	Complete The Executive Director of Workforce and OD has confirmed that mandatory training should be at 100% compliance before Managers grant study leave. It was agreed this matter did not need to be a substantive item of the PODCC due to the operational nature of the matter.
21/04/2026	DDIC(26)96	Minutes and Matters Arising from the Meeting Held on 15 January 2026 • To seek legal advice on Clinical ownership of AI recorded patient notes.	AT	21/07/2026	Complete We have engaged with the NHS Wales Shared Services Partnership (NWSPP) Legal Team, who have reaffirmed their commitment to supporting Hywel Dda UHB in developing a robust and defensible approach to Artificial Intelligence. This ongoing partnership will focus on key legal considerations, including liability, clinical and organisational accountability, the management of potential claims, and the broader ethical implications of AI adoption. Their expertise will help ensure that our AI strategy is underpinned by appropriate governance, legal assurance, and ethical principles, enabling innovation to be progressed in a safe, compliant and responsible manner.

2 - Data

2.1

09:05, 10 Mins

2.1 - Data Quality Report

*Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Gareth Beynon
(Hywel Dda UHB -
Head of Information
Services)*

| For assurance

Attachments

2.1 DDIC - Data Quality Deep Dive.pdf



Pwyllgor Digidol, Data ac Arloesi/ Digital, Data and Innovation Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 JULY 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Data Quality Deep Dive
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Gareth Beynon, Head of Information Services

**Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)**

Er Sicrwydd/ For Assurance

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Digital, Data and Innovation Committee (DDIC) with an updated overview and assurance regarding the ongoing data quality deep dives. It references the methodologies, governance processes, and analytical frameworks employed to assess, monitor, and improve data quality across key digital systems. This paper also highlights progress made to date and identifies areas of concern and opportunities for improvement.

Cefndir / Background

High-quality data is fundamental to the effective delivery of healthcare services. In a clinical and operational environment, data must be accurate, timely, and fit for purpose to support informed decision-making, which directly contributes to improved patient outcomes, enhanced safety, and overall well-being.

Robust data quality is also essential for the production of reliable management information, enabling the Health Board to operate efficiently and make best use of its resources. Whether supporting strategic planning, performance monitoring, or service improvement, data underpins every aspect of organisational intelligence and accountability.

Poor data quality can have far-reaching consequences. It can undermine clinical decision-making, distort performance reporting, and lead to inefficient use of resources. In some cases, particularly with national datasets, data quality directly affects how the Health Board's performance is represented against Welsh Government targets, with implications for public accountability and funding.

Maintaining high standards of data quality is therefore not just a technical or operational concern, it is a strategic imperative that supports the Health Board's mission to deliver safe, effective, and person-centred care.

Asesiad / Assessment

The [update](#) provided to the DDIC in October 2025 included an overview of the following established processes and methodologies:

- Deep Dive work plan;
- Escalation process;
- Data usability matrix;
- Prioritisation matrix.

Positive progress has been made to embed the data quality process and usability matrix into the organisation's datasets, however progress has been slower than anticipated due to capacity limitations. The team is having to prioritise the investigation of, and where necessary corrective action relating to, patient identification issues. This is becoming increasingly complex with the introduction of new patient-facing applications, including Hybrid Print & Post solutions, Electronic Patient Flow, Electronic Observations, Electronic Prescribing and Medicines Administration, and Digital Maternity Cymru.

To progress the data usability matrix methodology, the team plans to carry out an abridged data quality deep dive into outpatient activity to test and refine the approach. The outpatient dataset has been selected because it is sufficiently large, spans most secondary care services, and is complex enough to provide an appropriate use case.

The usability matrix is intended to provide a more nuanced assessment of data quality than a simple binary judgement and to help users determine whether data is fit for specific use cases. For example, users who are looking purely at the number of outpatient appointments may not be overly concerned that some specific data items may be inaccurate, or that a number of data items may not accurately reflect the appointment and may instead be more concerned that the dataset being used is complete.

The matrix focuses on three data quality parameters and provides a score out of five based on percentage or time against each parameter.

Score	Accuracy (%)	Completeness (%)	Timeliness	
			Live Data (mins)	Other Data
1	0 - 19	0 - 19	120 +	7 days +
2	20 - 49	20 - 49	60 - 120	3 to 6 days
3	50 - 79	50 - 79	30 - 59	48 - 72 hrs
4	80 - 94	80 - 94	5 - 30	24 - 48 hrs
5	95 +	95 +	Live - 5	Within 24 hrs

Accuracy (%) - Definition – *Accuracy is the quality or state of being true, correct, or exact.*

The deep dive will compare the information captured on the Welsh Patient Administration System's (WPAS) Outpatient module with the detail in the clinical letter dictated by the clinician. The number of inaccuracies identified in the sample will be used to calculate a percentage value, which in turn corresponds to a score.

Completeness (%) - Definition – *The state or condition of having all the necessary or appropriate parts.*

The scope of the deep dive will identify all key data items that should be captured in the WPAS Outpatient module. The number of data items not captured will be used to calculate the percentage, which in turn corresponds to a score.

Timeliness (hrs) - Definition – *The fact or quality of being done or occurring at a favourable or useful time.*

The scope of the deep dive will determine whether the analysis is based on near real-time/live data entry or post-event data entry. The sample will identify the time taken to enter 95% of the required data onto WPAS. The score will be based on the time range the value falls between. For example, 95% of activity entered by 27.2 hours = 4.

Once a score has been derived for each parameter, the intention is to introduce a three-part usability score for the outpatient dataset.

		*example scores			
Application	Dataset/Theme/Module	Accuracy	Completeness	Timeliness	Review Date
WPAS	Outpatient Activity	5	1	3	Jul-26

The detail will be available to analysts when accessing the Outpatient dataset through the Information Services Data Platform, supporting decisions around usability for their specific use case.

Kitemark

Assurance is key when making decisions, especially when using large amounts of data that have been prepared and published into dashboards and other business intelligence outputs. The Information Services Team is developing a kitemark with the intention of providing assurance to users of the Information Reporting Intelligence System (IRIS), so that both the quality of the data and the robustness of the dashboard are suitable for use.



The kitemark brings together the usability score and assurance that the dashboard retrieves data from the data platform, is updated automatically through routine processes, and aligns with approved data standards and definitions.

The kitemark intends to make a distinction between dashboards that have robust end-to-end processes and automation built in and dashboards that rely on manual intervention to update base spreadsheets and data sources. While manually maintained datasets may still be fit for purpose, Information Services cannot fully guarantee that they are consistently up to date, sourced directly from a digital applications, or aligned with appropriate data standards and definitions.

This becomes more prevalent as more dashboards are hosted on Incident Response Improvement System (IRIS) that are managed and updated by teams outside Information Services. The IRIS ambition is to become the Health Board's starting point for organisational business intelligence tools, while ensuring that the data surfaced through it does not unintentionally mislead users with potentially outdated dashboards or outputs that have not been updated for a number of months due to a breakdown in a manual refresh process. The Information Services Team will continue to work with and support other dashboard developers to ensure their dashboards mature to the point where the kitemark can be applied, providing further assurance and governance to the work of developers and analysts outside of the Digital Team.

Conclusion

The development of the data quality deep dive methodology, usability matrix and IRIS kitemark represents an important step in strengthening organisational assurance around the quality, reliability and appropriate use of data. While progress has been constrained by capacity and the need to prioritise patient identification issues, the approach described in this report provides a clear framework for identifying data quality risks, improving confidence in reporting outputs and supporting safer, more informed decision-making across the Health Board.

The proposed abridged outpatient deep dive will provide a practical test case for the methodology and will support further refinement before wider application to other priority datasets. Continued development of the kitemark will also help distinguish between assured, automated and standards-based reporting outputs and those that require further improvement, thereby improving transparency for users of IRIS and strengthening governance across business intelligence activity.

Next Steps

- Complete the abridged data quality deep dive into outpatient activity, using the agreed accuracy, completeness and timeliness measures.
- Review the findings from the Outpatient Deep Dive and refine the usability matrix methodology where required.
- Develop a clear process for surfacing usability scores through the Information Services Data Platform so analysts can understand the suitability of datasets for specific purposes.
- Continue development and testing of the IRIS kitemark, including criteria relating to data source, automation, refresh frequency, approved definitions and governance standards.
- Engage with dashboard developers and service teams outside Information Services to support improvement of reporting outputs and readiness for future kitemark application.
- Provide a further update to the Digital, Data and Innovation Committee once the outpatient deep dive has been completed and the methodology has been reviewed.

Argymhelliad / Recommendation

The Committee is requested to **RECEIVE 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.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.1 Seek assurance on the direction, development and delivery of the Health Board's digital, data and information governance strategies to drive change and transformation in line with the Health Board's Annual Plan/Integrated Medium Term Plan (IMTP) that will support modernisation through the use of information, data and digital technology.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
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)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Incomplete or missing data can lead to significant errors in the calculation of financial cost returns, potentially resulting in inaccurate projections, flawed budgeting decisions, and misinformed strategic planning. This can undermine financial reporting integrity and affect overall organisational performance.
Ansawdd / Gofal Claf: Quality / Patient Care:	Poor quality data can lead to the misidentification of patients, which poses serious risks to safety and care continuity. Additionally, service changes may be implemented based on incomplete or inaccurate information, preventing healthcare providers from gaining a full and accurate understanding of patient needs and system performance. This can compromise decision-making, resource allocation, and the overall effectiveness of healthcare delivery.
Gweithlu: Workforce:	Poor data quality can lead to inaccurate workforce planning, misallocation of staff, and ineffective deployment of resources. This can result in increased workload pressures, reduced staff morale, and compromised service delivery, ultimately affecting both employee well-being and organisational performance.
Tegwch Iechyd: Health Equity:	Not applicable.
Risg: Risk:	The accuracy of Welsh costing returns, which rely heavily on derived Healthcare Resource Groupings (HRGs), is critical for informed financial planning and service evaluation. Inaccurate or incomplete HRG data could undermine the effectiveness of clinical service reconfigurations, potentially preventing the University Health Board (UHB) from achieving its strategic objectives to enhance patient care.
Cyfreithiol: Legal:	Not applicable.

Enw Da: Reputational:	Poor data quality can hinder the ability to meet key Delivery Targets set by the Welsh Government, leading to potential reputational damage for the organisation. Inaccurate or incomplete data undermines performance reporting, erodes stakeholder confidence, and may result in increased scrutiny or loss of public trust.
Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Not applicable.

2.2

09:15, 10 Mins

2.2 - Data Protection Impact Assessment Assurance Report

*Anthony Tracey
(Hywel Dda UHB -
Digital Director)*

| For assurance

Attachments

[2.2 - DDIC - DPIA Update - July 2026.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Data Protection Impact Assessment Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology

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 a progress update on the management of Data Protection Impact Assessments (DPIAs) during the current financial year, including the volume completed, the number currently in progress, and the steps being taken to improve oversight of the process. It highlights positive progress in embedding DPIAs within project and service change activity, while also recognising the operational challenges that continue to affect timely completion.

These include late submissions, variable quality of initial drafts, increasing demand on Information Governance (IG) capacity, and dependencies on service areas and third-party providers. The report sets out the actions being taken to improve transparency, strengthen early engagement, and provide clearer assurance on how privacy risks are being identified, managed and mitigated across the organisation.

Cefndir / Background

DPIAs are a key element of the Health Board's IG framework. They provide a structured way of identifying and managing privacy risks before new projects, systems, services or changes to existing processes are implemented. This is particularly important where proposals involve the processing of personal data, special category data, new technologies, data sharing, or changes to the way patient and staff information is collected, used or stored.

Under the UK General Data Protection Regulation (UK GDPR), organisations are required to complete a DPIA where processing is likely to result in a high risk to individuals' rights and freedoms. Within a healthcare setting, this requirement is especially relevant because of the sensitivity of the information held by the Health Board and the potential impact on patients, service users and staff if information is not handled appropriately.

The DPIA process supports the principle of privacy by design and default by ensuring that information risks are considered at the earliest possible stage. It also helps project and service teams to understand their responsibilities, document the lawful basis for processing, assess

data flows, identify security and confidentiality risks, and agree appropriate mitigations before implementation.

Effective completion of DPIAs provides assurance that the Health Board is taking a proactive and proportionate approach to data protection compliance. It also supports transparency, strengthens accountability, and helps maintain public confidence that personal information is being managed safely, lawfully and ethically.

The increasing pace of digital transformation, service redesign and third-party system use has increased the volume and complexity of DPIAs requiring review. While this demonstrates greater awareness of IG requirements, it also places additional demand on the IG Team and can create challenges where assessments are submitted late, lack sufficient detail, or depend on information from service areas or external providers.

Asesiad / Assessment

This section provides an update on the areas previously highlighted to the Committee, including the challenges affecting the timely completion of DPIAs, the actions being taken to strengthen the process, and the current position in relation to the number of DPIAs completed, in progress, on hold or not yet started. It is intended to provide assurance on progress since the previous [update](#), while also setting out the further improvements planned to increase transparency, improve workflow management and support earlier engagement with services and project teams.

Challenges

The key challenges associated with the DPIA process have previously been reported to the Committee. In summary, these relate to late submissions, variable quality and completeness of initial drafts, limited awareness of when a DPIA is required, capacity pressures within the IG Team, and dependencies on service areas and third-party providers. These issues continue to influence the timeliness of completion and are being addressed through the improvement actions set out below.

Addressing Challenges Going Forward

To strengthen the DPIA process and reduce the operational pressures currently experienced by the IG Team, a series of targeted actions will be implemented:

- **Early Engagement and Expanded Training**

We plan to enhance our IG training by incorporating a dedicated DPIA awareness module for project managers and service leads. This will ensure DPIAs are initiated at the earliest stage of project planning, reducing last-minute submissions and enabling proactive risk management. In addition, we will review and update our digital project proposal form to include mandatory checks, ensuring that no project is added to the work plan without prior approval from both IG and Cyber Security teams. These changes aim to improve compliance rates, strengthen governance, and embed privacy considerations into the project lifecycle from the outset.

Progress: Since the previous report to the Committee, work has progressed to address the challenges identified in the DPIA process. This has included strengthening early engagement with project and service teams (Targeted Training has been delivered to Project Managers), reviewing how DPIAs are identified through digital project initiation routes, and developing clearer workflow categories to improve reporting and transparency. Further work is underway to improve guidance, refine templates, and introduce more structured tracking of DPIAs through each stage of the process.

- **Improved Submission Quality**

Improve our guidance and templates to project teams to ensure DPIA drafts include all necessary details, such as data flows, technical controls, and third-party arrangements. This will reduce the need for multiple review cycles and improve efficiency.

***Progress:** Work has commenced to improve the quality and completeness of DPIA submissions. This includes reviewing the current guidance and templates provided to project teams to ensure that key information is captured at the point of submission, including data flows, technical controls, third-party arrangements and proposed mitigations. This is intended to reduce the number of review cycles required and support more timely completion of DPIAs. Discussions have taken place with national IG leads on developing a national DPIA template. While this work has progressed, not all organisations have adopted the template and there remains some uncertainty about national-level approval. HDdUHB has agreed to test and use the national template and is currently doing so alongside several other organisations across Wales.*

- **Enhanced Tracking and Visibility**

To strengthen oversight and improve efficiency, we will develop a DPIA tracking dashboard that provides real-time visibility of progress at each stage of the assessment process. This dashboard will incorporate sub-categorisation of all DPIAs currently marked as “In Progress,” breaking them down into specific workflow stages such as “IG Awaiting Initial Draft,” “With IG for Review,” “With Service/Provider for Comment,” and “On Hold.”

This enhanced level of detail will deliver several benefits. It will improve transparency for the Information Governance Sub-Committee (IGSC) and for service areas that have requested IG support, ensuring they can clearly see where their DPIA sits in the process. It will also help identify bottlenecks and delays, enabling timely intervention and better resource allocation. Ultimately, this approach will support more efficient DPIA completion, reduce compliance risks, and foster stronger collaboration between IG and project teams.

***Progress:** Work has progressed to improve tracking and visibility of DPIAs through the development of clearer workflow categories. DPIAs currently recorded as “In Progress” are being broken down into more specific stages, including those awaiting an initial draft, with IG for review, with service or third-party providers for comment, with Cyber Security, on hold, or awaiting senior sign-off. This will support more transparent reporting to the IGSC and improve the ability to identify delays, bottlenecks and areas requiring escalation.*

- **Resource Planning and Capacity Management**

The IG Team will undertake a comprehensive review of resource allocation to ensure capacity aligns with the growing demand for DPIA support. This review will include an assessment of current workloads, identification of peak periods, and evaluation of options to strengthen resilience during times of high activity.

Potential measures include introducing temporary support arrangements, to alleviate pressure during critical phases. Additionally, prioritisation protocols will be established to ensure that high-risk projects and those with significant compliance implications receive expedited attention.

By implementing these strategies, the IG Team aims to maintain service quality, reduce delays, and ensure that DPIAs are completed promptly without compromising the thoroughness of risk assessments. This proactive approach will help safeguard compliance and support the organisation's commitment to data protection and patient trust.

Progress: *Limited progress has been made to review IG capacity against current and forecast DPIA demand. This will include considering workload pressures, identifying areas where DPIA activity can be prioritised according to risk, and ensuring higher-risk projects receive appropriate focus. Further consideration is being given to resilience arrangements where demand exceeds available capacity, with escalation routes to be used where delays may affect delivery timescales or compliance assurance.*

Consideration should be given to allocating dedicated resource to support Research and Development activity. A number of proposals are being submitted, including initiatives linked to TriTech and other research projects, and additional support would help improve the timeliness of DPIA review and completion. It may also be appropriate to explore whether CGI could provide further support in this area to help manage incoming requests more effectively.

- **Strengthened Third-Party Governance**

Future contracts with external providers will include clear clauses defining DPIA responsibilities and timelines. This will improve accountability and reduce delays caused by dependency on third-party input.

Progress: *Limited progress has been made in strengthening third-party governance within the DPIA process. Work is ongoing to improve contract terms and conditions so that supplier responsibilities for data protection, information security, DPIA support and timely provision of information are clearly defined. This will support greater assurance that personal data is managed safely, that suppliers comply with the Health Board's requirements, and that appropriate routes for escalation or recourse are available where contractual or compliance expectations are not met.*

Summary

Overall, progress has been made in addressing the challenges previously reported to the Committee, particularly in relation to improving early engagement, strengthening DPIA workflow visibility, and reviewing the quality of submissions. However, progress has been slower than expected due to ongoing capacity pressures within the IG Team and the increasing volume and complexity of DPIA requests. The current position demonstrates that the improvement actions remain appropriate, with further work required to embed them consistently and to ensure that the pace of delivery is sustainable.

Going forward, the Health Board would like to move to a more proactive and transparent DPIA process, with clearer expectations for services and project teams, improved supplier engagement, better tracking of each stage of the process, and more effective prioritisation of high-risk work. This will support greater assurance to the Committee that privacy risks are being identified and managed appropriately, while recognising that delivery will need to be aligned to available capacity and organisational priorities.

Number of DPIAs Completed and In Progress

The table below provides an overview of the DPIAs received by the IG Team during the reporting period, showing the current position across completed, in progress, on hold and not yet started assessments. This information is intended to provide the Committee with greater

visibility of demand, throughput and the level of work still requiring review or further action. It also supports the wider assessment that, while progress continues to be made, the volume and complexity of DPIA activity remains a key factor affecting overall timescales and capacity.

2025/2026	Enquiry	Level 1	Level 2	Level 3	Total
DPIA Level (Completed)	54	8	27	11	100
DPIA Level (In Progress)	7	2	20	20	49
DPIA Level (On Hold)	6	0	0	0	6
DPIA Level (Not Started)	36	3	2	1	42
Total	103	13	49	32	197

The volume of DPIAs this year reflects the organisation's commitment to embedding privacy considerations into all new initiatives, particularly in response to increased digital transformation and data-sharing requirements.

Conclusion

In conclusion, the Health Board continues to make progress in strengthening the DPIA process and embedding privacy considerations within project and service change activity. However, progress has been slower than expected due to ongoing capacity pressures, increasing demand and the complexity of some assessments. The actions described in this report remain appropriate and are intended to improve early engagement, submission quality, tracking, prioritisation and third-party accountability. While further work is required to fully embed these improvements, the Committee can take assurance that the key challenges are understood, improvement activity is underway, and the DPIA process continues to support the identification and management of IG risks.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE 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.
- **NOTE** 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;
- **NOTE** 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;

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Seek assurance that the digital, data and IG implications and risks arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners are considered and mitigated. 3.1.6 Seek assurance that there is a robust IG and security framework within the Health Board and
--	---

	encourage a strong IG and security culture across the organisation. 3.1.7 Seek assurance that the Health Board is meeting its responsibilities with regard to the General Data Protection Regulations, the Freedom of Information Act, Caldicott Principles, Records Management, Clinical Coding, Information Sharing, national IG policies and the Information Commissioner's Office guidance. 3.1.8 Seek assurance of the Health Board's compliance against relevant statutory requirements, internal and external standards and assessment criteria, via the IG Toolkit, Cyber Assessment Framework (CAF) any other relevant requirements / assessments, and audits, inspections and reviews, including the implementation of Audit Wales, Health Inspectorate Wales and Internal Audit recommendations.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termiau:	Included within the main body of the report

Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Information Governance Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no direct financial implications arising from this report. However, failure to complete DPIAs appropriately may expose the Health Board to regulatory action, financial penalties, remediation costs, or delays to projects and service changes. Strengthening the DPIA process will support better planning, reduce rework and improve value for money through earlier identification of IG requirements.
Ansawdd / Gofal Claf: Quality / Patient Care:	Effective DPIA completion supports safe, lawful and appropriate use of patient and staff information. By identifying privacy, confidentiality and information security risks at an early stage, the DPIA process helps protect patients, support service quality and maintain confidence in digitally enabled care. Delays or incomplete assessments may increase the risk of privacy issues being identified late in project delivery.
Gweithlu: Workforce:	The report identifies continued capacity pressures within the IG team and the need for clearer expectations across services and project teams. Improved guidance, training and earlier engagement will support staff to understand when a DPIA is required, improve the quality of submissions and reduce avoidable rework.
Risg: Risk:	The main risks relate to delayed completion of DPIAs, variable submission quality, limited capacity, and reliance on third-party information. These risks may affect the Health Board's ability to evidence compliance and provide timely assurance that privacy risks are being identified and mitigated. The improvement actions described in the report are intended to strengthen controls and reduce residual risk.
Cyfreithiol: Legal:	DPIAs are a key requirement under UK GDPR where processing is likely to result in a high risk to individuals' rights and freedoms. Strengthening the DPIA process supports compliance with UK GDPR, the Data Protection Act 2018, the common law duty of confidentiality and relevant IG standards. Failure to complete DPIAs appropriately may increase the likelihood of regulatory scrutiny or non-compliance.
Enw Da: Reputational:	Public and staff confidence depends on the Health Board demonstrating that personal information is managed safely, lawfully and transparently. Weaknesses or delays in the DPIA process could affect confidence in the organisation's ability to protect information, particularly

	where new digital systems, data sharing or third-party arrangements are involved.
Gyfrinachedd: Privacy:	The DPIA process directly supports privacy by design and default by ensuring that privacy risks are considered before new processing begins or existing processing changes. The actions outlined in the report will improve the Health Board's ability to identify risks, agree mitigations and provide assurance that personal information is being protected appropriately.
Cydraddoldeb: Equality:	No specific equality impacts have been identified from this report. However, consistent application of the DPIA process helps ensure that personal information is managed fairly, lawfully and transparently across all services and population groups. Where relevant, DPIAs should consider whether data processing may have differential impacts on individuals or groups.

Appendix A – DPIA Category

Level of DPIA	Description
DPIA	Enquiries.
DPIA Level 1	Review of DPIA Screening Questions to assess whether DPIA is required.
DPIA Level 2	Minimal Risks to PII; where a Level 3 – Mandatory / Full DPIA is not required. The IG Team will review the processing (i.e., Section A of the DPIA is completed), identify any risks, make recommendations, and record the required approval.
DPIA Level 3	Mandatory / Full DPIA or Review of External DPIA.

Sub-Categories

Category/Current Position	Description
Enquiry	Includes: sending Link to the online Screening Questions, sending the DPIA Template, determining whether Digital approval has been granted (if required) or providing advice (including meetings). No DPIA or immediate follow up required.
Review of External DPIA	For instance, review of DPIA from an organisation with whom the Health Board will be working in collaboration. To be recorded and updated in the same way as all Level 3 DPIAs.
In Progress - Awaiting Initial Draft	Under discussion as to whether DPIA is required or awaiting department to provide the IG Team with initial draft / screening questions. Those where the Information Asset Register has identified the requirement for completion of retrospective DPIAs.
In Progress - On Hold	The Service has advised that they are not in a position to progress the implementation or Digital Services has advised that the requirement is unable to progress at this time e.g., lack of contract or capacity for implementation.
In Progress - With Service/ Third Party	With the service lead for Review/Comment.
In Progress - With IG	With the IG team lead for Review/Comment.
In Progress - With Cyber Security	Cloud Assessment to be reviewed and assured by the Cyber Security team.
In Progress - DPO Review	IG Managers have developed the DPIA and the IG Risks have been highlighted to the DPO for consideration.
In Progress - For Sign off from Senior Information Risk Owner (SIRO) or Caldicott Guardian (CG)	IG Risks have been highlighted to the Deputy SIRO for Consideration / Review / Sign Off IG Risks have been highlighted to the Deputy Caldicott Guardian for Consideration / Review / Sign Off

Finalised and Signed Off - DPO / IG Team	Finalised by the IG Team and Data Protection Officer
Finalised and Signed Off - Caldicott Guardian (CG)	Finalised by the IG Team and Signed Off by CG
Finalised and Signed Off - Senior Information Risk Owner (SIRO)	Finalised by the IG Team and Signed Off by SIRO
Finalised and Signed Off - SIRO and CG	Finalised by the IG Team and Signed Off by CG and SIRO
Not Required	No PII discovered during Screening questions. Following review of the Screening Questions or initial review of the DPIA, IG has determined that the processing does not require a DPIA.
Withdrawn	Where the Directorate/Service has withdrawn the need for a DPIA e.g., they have decided not to proceed with the processing in question, or the processing has been addressed at a national level.

2.3 - Information Governance Sub-Committee (IGSC) 3A's Update

*Anthony Tracey
(Hywel Dda UHB -
Digital Director)*

| For approval

Attachments

[2.3.1 - 3As Update Report DDIC - IGSC July 2026.pdf](#)

[2.3.2 Attach 12a 191 - Health Records Management Strategy- v5 DRAFT \(1\).pdf](#)

[2.3.3 Attach 12b 192 - Health Records Management Policy.V5 DRAFT \(1\).pdf](#)

[2.3.4 Attach 12c 193 - Retention Destruction Policy final 2026 \(1\).pdf](#)

[2.3.5 Attach 12d -240-ITProcurementProcedure-v4 draft \(3\) \(1\).pdf](#)

[2.3.6 Attach 12e - Policy 320 - Acceptable use of Digital Services Policy v4 draf~.pdf](#)

[2.3.7 Attach 12f 250-IQA Policy 20260622.pdf](#)



COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R INFORMATION GOVERNANCE SUB-COMMITTEE COMMITTEE / IS- BWYLLGOR LLYWODRAETHU GWYBODAETH

Date of last meeting/ Dyddiad y cyfarfod diwethaf: 23 June 2026

Quoracy/ Cworwm: Not Quorate

Report by/ Adroddiad gan: Anthony Tracey, Digital Director

KEY DISCUSSION POINTS AND MATTERS FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert¹ (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Information Governance Sub-Committee wish to note that there are no matters to **alert** members of the Digital Data and Innovation Committee (DDIC).

Advise² (to monitor)/ **Cynghori** (i fonitro)

The Information Governance Sub-Committee wishes to advise members of the DDIC that:

Overall compliance with mandatory Information Governance, Records Management and Cyber Security training has improved from 77% to 84.87%; however, the Health Board remains below the national target of 85%. Medical and Dental staff continue to be the lowest compliant staff group despite targeted interventions. The Sub-Committee will continue to monitor compliance and provide further updates.

The Welsh Government Records Management Code of Practice remains under review. Internal organisational changes within Welsh Government have delayed publication of the final version. Health Board policies have therefore been developed against the current interim version and may require review once the final national document is issued.

Due to IGSC not being quorate, the Sub-Committee scrutinised and supported the progression of the following policies and strategies to DDIC for approval:

- 191 - Health Records Management Strategy.
- 192 - Health Records Management Policy.
- 193 - Health Records Retention Policy.
- 240 - IT Procurement Policy.
- 320 - Acceptable Use of Digital Services Policy.

¹ There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

² There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

- Information Quality Assurance Policy.

The Sub-Committee was assured that these documents had undergone organisational consultation and relevant amendments had been incorporated.

Assure³ (to note)/ Sicrhau (i nodi)

The Information Governance Sub-Committee wishes to assure members of the DDIC that:

Information Governance Performance

The Sub-Committee received assurance through regular reports covering:

- Information Governance (IG) activity and performance.
- Data Protection Impact Assessments (DPIAs).
- Information Asset Register reviews.
- IG audit programme.
- Caldicott Guardian activity.
- IG compliance monitoring.

Clinical Coding Performance

Clinical Coding achieved:

- 99.3% completeness for 2025/26.
- Performance above the national completeness target.
- Continued achievement of coding accuracy standards.

The Sub-Committee recognised the significant achievement by the Clinical Coding Team and received assurance regarding ongoing improvement activity.

National and Local Governance Groups

The Sub-Committee received updates from:

- Information Governance Managers Advisory Group (IGMAG).
- Health Records Managers Advisory Group (HRMAG).
- Caldicott Guardian Group.
- Information Asset Owners Group.
- Cyber Security Assurance Group.

The updates provided assurance regarding ongoing governance arrangements, records management developments and cyber security activities across Wales.

Review of Risks/ Adolygiad o Risgiau

There were no updates to the risks that require updating to the Committee.

Sharing of learning/ Rhannu dysgu

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

The Sub-Committee recommends sharing the following learning across the Health Board:

- Artificial Intelligence (AI) assisted phishing attacks are becoming increasingly sophisticated and may closely resemble legitimate communications. Staff should remain vigilant and report suspicious emails immediately.
- Cyber awareness campaigns and phishing reporting continue to improve organisational resilience.
- IG audit activity will now include questions relating to the use of AI in both clinical and administrative settings.
- Information Asset Registers have been amended to include a specific field relating to AI usage to strengthen oversight of emerging technologies.

Recommendation/ Argymhelliad

The DDIC is asked to:

- **Approve** the following policies:
 - 191 - Health Records Management Strategy.
 - 192 - Health Records Management Policy.
 - 193 - Health Records Retention Policy.
 - 240 - IT Procurement Policy.
 - 320 - Acceptable Use of Digital Services Policy.
- **Note** the items that the Sub-Committee is advising them of.
- **Receive Assurance** from the e items that the Sub-Committee is assuring them of.

Date of next meeting/ Dyddiad y cyfarfod nesaf: 28 July 2026

Agenda, papers and minutes are available on request.

Health Records Management Strategy

DRAFT

Policy information

Policy number: 191

Classification: Corporate

Supersedes: Previous Version

Version number: 5

Date of Equality Impact Assessment:

Approval information

Approved by:

Date of approval:

Date made active:

Review date:

Summary of document:

This strategy addresses the principles and practice for managing health records within Hywel Dda University Health Board.

Scope:

This strategy has been written to provide an overarching framework of professional advice and guidance for all Hywel Dda University Health Board staff, to ensure compliance with all legal requirements for the maintenance, storage and provision and security of records. The strategy defines standards for improving the quality, availability and effectiveness of records management activities. This strategy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

To be read in conjunction with:

[\[192\] – Health Records Management Policy](#) – opens in a new tab

[\[193\] – Retention and Destruction of Records Policy](#) – opens in a new tab

[\[249\] – Access to Health Records Policy](#) – opens in a new tab

[\[172\] – Confidentiality Policy](#) – opens in a new tab

[\[836\] – All Wales Information Governance Policy](#) – opens in a new tab

[\[837\] – All Wales Information Security Policy](#) – opens in a new tab

[\[347\] – Corporate Records Management Policy](#) – opens in a new tab

Patient information:

Owning group: IGSC

Executive Director job title: Director of Operations

Reviews and updates:

- 1 New policy September 2012
- 2 Full review 23.2.2016
- 3 DPA update 26.6.2018
- 4 Full review
- 5 – full review

Keywords

Health Records, Records Management

Glossary of terms

Records management - is that “field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposal of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records”.

A record - A health record is “one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual”. Anything that contains information that has been created or gathered as a result of any aspect of the work of NHS employees.

Data Protection Act 2018 - The Data Protection Act 2018 is a United Kingdom Act of Parliament which updates data protection laws in the UK. It is a national law which complements the European Union's General Data Protection Regulation and replaces the Data Protection Act 1998.

Information Security - The protection of information and information systems from unauthorised access, use, disclosure, disruption, modification, or destruction in order to provide confidentiality, integrity, and availability.

Public Records Act 1958 - The Public Records Act 1958 is an Act of the Parliament of the United Kingdom forming the main legislation governing public records in the United Kingdom.

Contents

Policy information..... 1

Approval information 1

Introduction 4

Scope..... 4

Aim..... 5

Objectives 5

Responsibility and Accountability 6

Standards of Records Management 6

Training 9

DRAFT

Introduction

This strategy addresses the principles and practice for managing health records within Hywel Dda University Health Board (HDUHB). The organisation uses a hybrid of computer and paper records to support patient processes and patient care and the strategy establishes how all patient records will be managed. Health Records management is about the proper content, control, security, storage and ultimate destruction of records. Records created and held by HDUHB as part of its functions, are public records under the Public Records Act 1958. The Public Records Act 1958 requires that there is a systematic and planned approach to the management of records within an organisation.

Effective management of healthcare services can only be achieved if there are appropriate health records management policies and processes in place. Health records management falls within the remit of the Health Records service. The aim of the health records service is to ensure that procedures are in place to bring together the health professional and accurate, relevant patient information/documentation at the correct time and place, to support patient care. Records management is a key component of the health records service and an expert professional field. The correct creation, management and maintenance of the health record provides the communication tool between the health professional and the patient.

The strategy details the aims, aspirations and targets of what we want to achieve with our health records management programmes and provides direction within the organisation. The Board, Executive Team, senior management and all who work for the organisation have responsibilities to ensure that information is handled appropriately and functions are performed in line with the required records management standards, ensuring the accuracy and availability of records for patient care.

The strategy will be updated as required to include future developments such as updated health records management guidance, to reflect technological changes such as the introduction of scanning services and the possible migration to an electronic patient record or changes in legislation.

This strategy is based on the requirements of the Records Management Code of Practice for Health and Social Care. This document covers management of all types of NHS health records throughout their lifecycle, from their creation and use, to their final disposal. This strategy should be read in conjunction with other HDUHB policies e.g. HDUHB Health Records Management Policy, Retention and Destruction Policy, Access to Health Records Policy etc and also the Data Protection Act.

Scope

This strategy has been written to provide an overarching framework of professional advice and guidance for all Hywel Dda University Health Board staff, to ensure compliance with all legal requirements for the maintenance, storage and provision and security of records. The strategy defines standards for improving the quality, availability and effectiveness of records management activities. The strategy clearly identifies all critical elements of effective records management and identifies key individuals within HDUHB and their obligation to ensure records are managed in accordance with legal requirements and both national and local standards.

This strategy relates to all clinical operational records held in any format by the HDUHB. Within the strategy the terms 'Health Record', 'Patient Record' and 'Case record' are synonymous and include:

- Records of patients treated by HDUHB including health and care records
- Records of private patients treated on NHS premises
- Records of patients treated on behalf of the NHS in the private healthcare sector

Health Records may be held in many formats, for example:

- Personal health records (electronic, microfilmed, scanned images & paper based)
- Theatre Registers and all other registers that may be kept
- X-ray and imaging reports, output and images
- Photographs, slides and any digital images
- Audio and video tapes, cassettes
- Digitised images/Digital Records (scanned)
- Emails
- Text messages (SMS)

This list is not exhaustive.

This strategy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

Aim

The aim of the Health Records Management Strategy is to provide an overarching framework for current records management activities and initiatives, as well as any new ones recommended in the future. The Strategy will ensure there is:

- a systematic and planned approach to health records management covering health records from creation to disposal.
- efficiency and best value for money through improvements in the quality and flow of information, and greater co-ordination of health records and storage systems.
- compliance and delivery with statutory and legislative requirements.
- awareness of the importance of health records management and the need for responsibility and accountability at all levels.
- appropriate archiving of non-current health records.
- improve data quality to ensure accuracy and consistency.
- provide assurance around governance, confidentiality and data protection.

Objectives

The objectives of the strategy is to define an agreed approach for improving the quality, availability and effective use of records in the HDUHB and provide a strategic framework for all records management processes and procedures. This will enable overall coordination of all records management activities and ensure alignment with the HDUHB's business model. The key objectives associated with the strategy is improved patient safety and quality of care with the deliverable benefits being:

- the improved maintenance of the history of patient care and better communication and information sharing between care providers and patients
- greater efficiencies from the improved management of clinical functions
- reduced duplication of effort
- greater accountability and corporate governance
- reduction in litigation costs through improved patient safety and ability to defend against claims
- compliance with legislation and best practice record standards.

Responsibility and Accountability

There should be a clear chain of management, accountability and responsibility for all records created and utilised within the HDUHB. The Chief Executive has overall accountability for ensuring that records management operates appropriately and a duty to make arrangements for the adequate resourcing and safekeeping of all HDUHB records. The Chief Executive may delegate responsibility for records management arrangements within the organisation to a designated Executive, who is responsible for ensuring appropriate mechanisms are in place to support service delivery and continuity. The Medical Director has particular responsibilities for patient records as the Caldicott Guardian of the HDUHB.

The health records manager has strategic and operational accountability for the creation, retrieval, storage, archiving and disposal of all health records within the HDUHB. The HDUHB has in place a documented [191 - Health Records Management Policy](#) and [193 - Retention and Destruction Policy](#) – opens in a new tab - and detailed documented procedures, to support the life span of a health record from creation to disposal.

All staff should be aware of their individual responsibility and accountability in the creation, management, storage and access to all HDUHB records. More detailed information in regards specific HDUHB roles and responsibilities can be found in the [191 - Health Records Management Policy](#) – opens in a new tab.

Standards of Records Management

The Health Records Management Strategy comprises of the following key elements.

Record Quality

The Health Records Management Strategy aims to provide assurance that policies and procedures are in place to ensure that the patient and health professional, together with accurate, relevant, reliable patient information and documentation are available at the correct time and place to support effective and safe patient care. HDUHB records should be accurate and complete, in order to facilitate audit and fulfil the HDUHB's responsibilities and protect its legal and other rights.

Records should show proof of their validity and authenticity so that any evidence derived from them is clearly credible and authoritative. Records should be retained securely and should only be shared or merged where appropriate. The [192 - Health Records Management Policy](#) – opens in a new tab- and appendix of policies and procedures provide further detail specifically on standards for the management of health records. Health records are managed in accordance with the standards detailed in the introduction of this strategy.

Management

All health records are subject to the standards and legislation detailed in this strategy and the HDUHB is responsible for ensuring that health records are managed accordingly. Record-keeping systems should be easy to understand, clear, and efficient in terms of minimising staff time and optimising the use of space for storage. The [192 - Health Records Management Policy](#) – opens in a new tab - details

procedures for the storage, retrieval, archiving and disposal of each record type. This strategy is in accordance with the Welsh Records Management Code of Practice for Health and Social Care.

There should be a consistent approach to records management across the HDUHB, which should be in line with external guidance. The HDUHB is responsible for ensuring that adequate resources are made available to support effective records management, including making adequate provision for records growth and technological developments which enable records to be stored or transferred to other media. Investment in the move from paper to electronic records will become critical and will support improved patient care and service delivery not only within the health records service but across the entire HDUHB.

Security

The HDUHB provides systems which maintain appropriate confidentiality, security and integrity for all health records including their storage and use. Records must be kept securely to protect the confidentiality and authenticity of their contents and to provide further evidence of their validity in the event of a legal challenge. No person identifiable information should be stored, transferred or accessed unless absolutely necessary.

Health records in any format are highly confidential documents and the HDUHB is responsible for ensuring that adequate physical controls are put in place to ensure the security and confidentiality of all patient identifiable information, whether they are held manually (physically) or on computer (electronically). Other relevant policies and procedures are documented, including the [837 All Wales Information Security Policy](#) – opens in a new tab - and they should be utilised in conjunction with local departmental procedures.

Access

Access is a key part of any records management strategy. Fast, efficient access to records unlocks the information and knowledge they contain. There should be clear and efficient access for employees and others who have a legitimate right of access to HDUHB records. Access to all patient identifiable information is on a strict need to know basis in accordance with the Caldicott principles, Data Protection Act 2018, General Data Protection Regulation, Information Governance Standards and various codes of professional conduct. Health Records Policies, including the [249 Access to Health Records Policy](#) – opens in a new tab - and supporting procedures governing access to patient identifiable information all comply with and are in accordance with these principles.

The public has rights of access to all information held by the HDUHB, unless that information is covered by an exemption. Not only must records be maintained appropriately, when it is necessary to pass them to another user or stakeholder, care must also be taken to ensure that they are dispatched in a manner suitable to the content of the records. All managers are responsible for ensuring that there is an appropriate system for tracking and retrieving records when requested legitimately and that non-legitimate requests for records are declined.

Health records and associated clinical information are released to patients, their representatives and legal bodies in accordance with relevant and current legislation, including:

- Access to Health Records Act 1990
- Data Protection Act 2018
- General Data Protection Regulation (UK GDPR)

This list is not exhaustive.

The Health Records Manager is responsible for the processing and release of clinical information in accordance with the [249 Access to Health Records Policy](#) – opens in a new tab - and documented procedures.

Retention and Disposal

Retention is the holding of records after their creation in readiness for operational use. It is a fundamental requirement that all the HDUHB records are retained for a minimum period for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the HDUHB's business and clinical functions. The Records Management Code of Practice for Health and Social Care establishes the minimum retention periods for a number of records and these requirements are reflected in the [193 Retention and Destruction Policy](#) – opens in a new tab.

When considering how long to retain a record staff should first note any legal or HDUHB requirement. Records should be retained for the identified minimum requirements and storage in excess of the specified retention period is undesirable. During the retention period appropriate arrangements must be made for the safe storage and effective security of the record and considerations should be given to the storage medium (electronic or paper). Records no longer needed for operational or any other use should be destroyed. It is particularly important that the disposal of records, which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed, is undertaken in accordance with clearly established policies and always through confidential processes.

Legislation

This strategy is based on current legal and statutory obligations and best practice and processes for records management. The Strategy also takes into account the recommendations and standards set by:

- Public Records Act 1958;
- Medical Reports Act 1988;
- The Computer Misuse Act 1990;
- Access to Health Records Act 1990;
- Data Protection Act 2018;
- Human Rights Act 2000;
- Freedom of Information Act
- Welsh Assembly Government (Ministerial Letters, Circulars and Policies);
- Caldicott: Principles into Practice;
- Information Sharing Protocols - Wales Accord on the Sharing of Personal Information
- Data accreditation and data quality

The strategy will be updated as required to include future developments such as updated health records management guidance, updates to statutory legislation, policies, protocols, Acts, etc and to reflect technological changes.

Risk Management and Patient Safety

Systems, policies, procedures and processes are in place to ensure that any risks to the record or the patient as a result of record issues, are identified, assessed and managed according to best practice.

Audit

This Health Records Management Strategy will be audited accordingly based on compliance against the aims, objectives and responsibilities outlined within the [192 - Health Records Management Policy](#) – opens in a new tab.

Training

As the volume and complexity of clinical information increases, we demand the highest standards of performance in the way it is gathered, recorded, stored and transmitted. These requirements are set out in the Introduction of this strategy and throughout the document. Implementation of the strategy, within the HDUHB will put in place explicit guidance on legal and ethical responsibilities for all NHS staff involved with the creation, maintenance and ongoing management of health records. By utilising appropriately referenced publications, the Strategy will ensure compliance with legislation, nationally recognised standards and best practice.

Ongoing workforce education plays a major part in preparing NHS staff to deliver effective, high quality services. There are numerous reasons for providing education and training in information handling, including maintenance and improvement of services, respect to patients as well as the need to comply with legislation in respect of data collection, storage and use. Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. The Health Records service is able to support awareness sessions or bespoke sessions as and when required to increase the awareness of individual staff responsibilities in regards records management. Self-learning modules are available to all staff through the HDUHB's intranet and ESR application.

Health Records Management Policy

DRAFT

Policy information

Policy number: 192

Classification: Corporate

Supersedes: Previous Version

Version number: 5

Date of Equality Impact Assessment:

Approval information

Approved by:

Date of approval:

Date made active:

Review date:

Summary of document:

This policy sets out best practice for the creation, utilisation, retention and destruction of health records within Hywel Dda University Health Board (H DUHB).

Scope:

This policy has been written to provide advice and guidance for all Hywel Dda University Health Board staff dealing with operational records management issues on a daily basis. The Policy highlights the standards that should be attained by all staff when utilising records from creation until final disposal. This policy applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

To be read in conjunction with:

[\[192\] – Health Records Management Policy](#) – opens in a new tab

[\[193\] – Retention and Destruction of Records Policy](#) – opens in a new tab

[\[249\] – Access to Health Records Policy](#) – opens in a new tab

[\[172\] – Confidentiality Policy](#) – opens in a new tab

[\[836\] – All Wales Information Governance Policy](#) – opens in a new tab

[\[837\] – All Wales Information Security Policy](#) – opens in a new tab

[\[347\] – Corporate Records Management Policy](#) – opens in a new tab

Patient information:

Owning group: IGSC

Executive Director job title: Director of Operations

- Reviews and updates:
- 1 New policy September 2012
 - 2 Full review 23.2.2016
 - 3 DPA update 26.6.2018
 - 4 Full review 27.6.2023

Keywords
Health Records, Records Management

Glossary of terms
Records management - is that “field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposal of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records”.

A record - A health record is “one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual”. Anything that contains information that has been created or gathered as a result of any aspect of the work of NHS employees.

Data Protection Act 2018 - The Data Protection Act 2018 is a United Kingdom Act of Parliament which updates data protection laws in the UK. It is a national law which complements the European Union's General Data Protection Regulation and replaces the Data Protection Act 1998.

Public Records Act 1958 - The Public Records Act 1958 is an Act of the Parliament of the United Kingdom forming the main legislation governing public records in the United Kingdom.

Subject Access Request – Individuals have the right to access and receive a copy of their personal data, and other supplementary information. This is commonly referred to as a subject access request or 'SAR'. Individuals can make SARs verbally or in writing, including via social media.

Data Protection Impact Assessment – Describes a process designed to identify risks arising out of the processing of personal data and to minimise these risks as far and as early as possible. DPIAs are important tools for negating risk, and for demonstrating compliance with the GDPR.

Contents

Policy information.....	1
Approval information	1

Introduction 4

Scope..... 4

Aim..... 4

Objectives 5

Health Records Resource 6

Roles and Responsibilities 6

Legal and Professional Obligations..... 9

Health Records Lifecycle 9

Training12

Introduction

Hywel Dda University Health Board (HDUHB) will conduct its responsibilities for records management in accordance with relevant legislative requirements of the European Parliament, the United Kingdom and Welsh Government. HDUHB will also comply with any decisions or guidance issued by Welsh Government.

Health Records form an integral part of the clinical recollection of HDUHB, providing evidence of decisions, the rationale for decisions and supporting the HDDUB daily functions and operations. As contemporaneous records they form the basis for the organisations accountability for clinical care. Health records are also essential to protect the rights of patients, staff and members of the public who have dealings with the HDUHB. Health Records support consistency, continuity and efficiency and help the Board to deliver services to our patients in a consistent and equitable way.

Health Records management is about the proper content, control, security, storage and ultimate destruction of records. Records created and held by HDUHB as part of its functions, are public records under the Public Records Act 1958. The Public Records Act 1958 requires that there is a systematic and planned approach to the management of records within an organisation. Moving forward, the effectiveness, safety, care and efficient management of healthcare services, depends on the right information being available to the right people, at the right time. This can only be achieved if there are effective health records management policies and processes in place.

The Board, Executive Team, senior management and all who work for the organisation have responsibilities to ensure that information is handled appropriately and is not retained unnecessarily beyond its life cycle. We also have a responsibility to ensure the accuracy of records and to be able to identify and locate information that is critical for current decision making and available when required for patient care.

This document should be read in conjunction with other HDUHB policies e.g. HDUHB [191 Health Records Management Strategy](#), [193 - Retention and Destruction Policy](#), [249 - Access to Health Records Policy](#) – all open in a new tab - etc and also the Data Protection Act.

Scope

This policy has been written to provide advice and guidance for all Hywel Dda University Health Board staff dealing with operational records management issues on a daily basis. The policy highlights the standards that should be attained by all staff when utilising records from creation until final disposal. This policy applies to all permanent, temporary or contracted staff employed by HDUHB (including Executive and Non – Executive Directors).

Aim

The aim of this Health Records Policy is to ensure that procedures are in place to bring together the health professionals and accurate, relevant and reliable patient documentation, at the correct time and place to support patient care. In achieving this aim, HDUHB employees should fulfil statutory and other legal requirements, ensuring patient safety and safe custody and confidentiality of patient information at all times.

The Health Records Management policy applies to all health records and personal information collated in relation to clinical activities and patient care. As the HDUHB utilises a hybrid of both paper and

electronic records to support clinical processes this policy and the agreed standards of records management will fully apply to both formats. The policy sets out best practice for the creation, utilisation, retention and disposal of health records. It applies to all health records regardless of format, of all types and in all locations where they are used to:

- to support patient care and the continuity of care
- to support evidence based clinical practice
- to assist clinical and other types of audits
- to support improvements in clinical effectiveness through research and support archival functions by taking account of the historical importance of material and the needs of future research
- to support the day-to-day business which underpins the delivery of care
- to support sound administrative and managerial decision making as part of the knowledge base for the NHS services
- to support patient choice and control over treatment and services designed around patients
- to meet legal requirements including requests from patients under subject access provisions of the Data Protection Act

Objectives

The objective of this policy is to ensure that health records management is applied consistently across the HDUHB and draws on best practice, as well as ensuring that our services meet the legal, professional and individual responsibilities associated with record keeping. It is designed to provide the staff who create, hold and utilise the health record in the course of their duties with their obligations and expectations and help to increase the confidentiality, integrity and availability of the health record.

The policy relates to all health records which are created carrying out the HDUHB business and captured in any readable form, providing evidence of the patient care delivered. The policy provides all HDUHB staff with clear guidance and standards to attain on a daily basis and robust assurance that health records management systems are able to ensure that:

- **health records are available when needed** – from which the HDUHB is able to form a reconstruction of activities or events that have taken place
- **health records can be accessed** – health records and the information contained within them can be located and displayed in a way which is consistent with the records initial use and that the current version is identified where multiple volumes exist;
- **health records can be interpreted** – the context of the record can be interpreted; who created or added to the health record and when, during which business process, and how the health record is related to other health records
- **health records can be trusted** – the health record reliably represents the information that was actually used in or created by the business process, and the record integrity and authenticity can be demonstrated;
- **health records can be maintained through time** – the qualities of availability, accessibility, interpretation and trustworthiness can be maintained for as long as the health record is needed, perhaps permanently despite changes of format;

- **health records are secure** – from unauthorised and inadvertent alteration and erasure. Access and disclosure are properly controlled and audit trails will track all use and changes to ensure that health records are held in a robust format;
- **health records are retained and disposed of appropriately** – using consistent documented retention and disposal procedures which include provision of appraisal and permanent preservation for health records with archival value;
- **staff are trained** – all staff within the organisation are made aware of their responsibilities for health record keeping and management.

Health Records Resource

Records are a valuable resource because of the information they contain. Information is only useful if it is correctly recorded in the first place, is regularly updated and is easily accessible when it is needed. Information is essential to the delivery of high quality healthcare and effective records management. The records and formats will include (but is not limited to):

- Records of patients treated by HDUHB including health and care records
- Records of private patients treated on NHS premises
- Records of patients treated on behalf of the NHS in the private healthcare sector
- Adult Service user records where there is integration with health services e.g. jointly held records

This list is not exhaustive.

A health record is everything (paper or electronic) that contains information which has been created or gathered as a result of any aspect of the delivery of patient care, including (but not limited to):

- Personal health records (electronic, microfilmed, scanned images & paper based)
- Theatre Registers and all other registers that may be kept
- X-ray and imaging reports, output and images
- Photographs, slides and any digital images
- Audio and video tapes, cassettes
- Digitised images/Digital Records (scanned)
- Emails
- Text messages (SMS)

This list is not exhaustive.

Roles and Responsibilities

All health and care employees are responsible for managing records appropriately. Health records management must provide a focus for all types of records, in any format to be managed from their creation to ultimate disposal. The health record management function must have clear responsibilities and accountability throughout the HDUHB.

Chief Executive

The Chief Executive has overall accountability and responsibility for ensuring that health record management operates correctly and legally within the HDUHB. The CEO may delegate responsibility for management and organisation of the health records services to the Caldicott Guardian or another Director who will be responsible for ensuring that appropriate mechanisms are in place to support service delivery and continuity.

Caldicott Guardian/SIRO

The Caldicott Guardian/SIRO are responsible for protecting the confidentiality of service user information. The Caldicott Guardian/SIRO have strategic roles which involve representing and championing information governance requirements and particular responsibility for reflecting patients' interest regarding the use of patient identifiable information.

The Caldicott Guardian has responsibility for:

- Ensuring the HDUHB is fulfilling all legal obligations in managing patients' health records
- Agreeing and reviewing internal protocols governing the protection and use of patient identifiable information by HDUHB staff
- Agreeing and reviewing protocols governing the disclosure of patient information across organisational boundaries e.g. with social services and other partner organisations, contributing to the local provision of care (WASPI)
- Developing the HDUHB security and confidentiality policies through the clinical and information governance frameworks
- Representing confidentiality requirements and issues to the HDUHB, advising on annual improvement plans and agreeing and presenting outcome reports

The SIRO is responsible for:

- Fostering a culture for protecting and using data
- Provides a focal point for managing information, risk and incidents
- Is concerned with the management of all information assets
- Acts as an advocate for information risk on the Board and provides written advice to the Accounting Officer on the content of their annual governance statement in regard to information risk

Executive Directors

All Executive Directors are responsible for implementing records management arrangements at Directorate level through the relevant committees and meeting forums and overseeing a programme of record management activities, in accordance with this policy.

Digital Director

The Digital Director is responsible for ensuring that regulations are in place to maintain the security of all electronically stored information, outlining the security responsibilities of management and staff. The Director is also responsible for the management of electronic/digital systems.

Information Governance Sub Committee

The Information Governance Sub Committee is responsible for ensuring that the Health Records Management Policy is implemented through its endorsement and approval and will take a lead role in its obligation to ensure robust records management arrangements are implemented across the HDUHB.

Head of Information Governance

The Head of Information Governance is the designated management advisor for the HDUHB and has responsibility for ensuring that the HDUHB complies with the developments in national guidance relating to information governance. They will have a responsibility to provide any specialised advice or guidance to other service areas as required and maintain an Information Asset register, which can be utilised for records management arrangements.

Health Records Manager

The Health Records Manager has professional responsibility and accountability for the overall development and maintenance of health records management practices within the organisation and for ensuring that related policies and procedures conform to the latest legislation and standards on data protection, UK GDPR, confidentiality and health records practice. They will have a responsibility to provide specialised leadership, guidance, advice and support in regards records management arrangements and processes within the HDUHB. They have responsibility for overseeing, directing and coordinating the day to day management of operational matters within the Health Records Service including the provision of patient records for inpatient, outpatient and day case attendances. They are responsible for ensuring that the release of all patient clinical information for data Subject Access Requests (SARs) and provision of records for medico-legal purposes is in accordance with the legislation.

Information Asset Owners & Information Asset Administrators

Information Asset Owners (IAO's) will delegate responsibility to Information Asset Administrators (IAA's), whose remit will also include responsibility for health record management arrangements within their service. The IAO's will ensure that the policy is implemented within their service areas and robust records management arrangements are in operation.

Professional Staff Groups

Professional staff groups must ensure that they maintain factual, clear, concise and unambiguous records to provide credible and authoritative evidence of services delivered. They must ensure that all contact with service users, carers or other relevant individuals is systematically recorded in keeping with agreed standards. Ensure that no action or omission on their part or within their sphere of responsibility is detrimental to the interests, condition or safety of service users, staff or the HDUHB and that records are always documented with a view that they can potentially be disclosed and read by the service user/patient.

Employees

All NHS employees and staff are responsible for any health records which they create or use. This responsibility is established and defined by the law and any records created by an employee are public records. All HDUHB staff, whether clinical or administrative, have an individual responsibility for records management and for the correct creation, use and retention of records in line with their job roles. Staff must ensure that they keep appropriate records of their work and manage those records in keeping with this policy and with any supporting policies or guidance subsequently produced.

Everyone working for or within the NHS who records, handles, stores or otherwise comes across patient information has a personal common law duty of confidence to patients and to his or her employer. The duty of confidence continues even after the death of the patient or after the employee or contractor has left the NHS. All staff must ensure that all confidential, patient identifiable information is retained in the appropriate records management system. Staff have a duty to read and understand the content of this policy and a Breach of this policy will mean that the HDUHB is not safeguarding information entrusted to it, which could render the HDUHB liable to prosecution. It is therefore essential that staff within the organisation with responsibility for record management comply with the policy or they may be subject to disciplinary procedures.

Legal and Professional Obligations

All health and care employees are responsible for managing records appropriately. Records must be managed in accordance with the law. All NHS Health Records are public records under the Public Records Act. The HDUHB will take actions as necessary to comply with legal and professional obligations such as:

- Public Records Act 1958 and Local Government Act 1972
- Freedom of Information Act 2000
- Records Management Code of Practice for Health and Social Care 2022
- UK GDPR and Data Protection Act 2018
- Access to Health Records Act 1990
- The Common Law Duty of Confidentiality
- Health and Social Act 2008
- Limitation Act 1980 and Consumer Protection Act 1987
- Caldicott: Principles into Practice
- Any new legislation affecting health records management as it arises

Health and care professionals also have professional responsibilities for example complying with the **record keeping standards** as set out by registrant bodies.

Health Records Lifecycle

Health records are confidential documents and should be clearly identifiable, accessible and retrievable. They should be authentic, meaningful, authoritative and adequate for their purpose and correctly reflect what was communicated, decided or done. They should be unalterable and after an action has occurred nothing from the health record should be deleted or altered. Information added to an existing hard copy health record should be signed and dated. Health records systems should be secure and their creation, management, storage and disposal should comply with current legislation.

Creation

A comprehensive health record is created and maintained for every patient attending health services to provide an up to date and chronological account of the patient's care.

- Patient demographic data for each registration should be recorded on the master patient index of the patient administration or departmental system
- The minimum patient demographic data should include: surname, forename, sex, date of birth, home address, postcode, NHS and or PAS/departmental number
- The organisation should use the NHS number as the main patient identifier and a partial validation tool
- Where there is more than one local identifier or case record per patient, a system is in place to ensure that the existence of all other health records is known
- The paper health record has a standard case record folder constructed of robust material which can withstand handling and transport and has secure anchorage points to protect against loss or damage to documentation
- There is a designated area within the health record for health professionals to record actual or suspected clinical alerts or risk factors

- There is a locally agreed format for the filing of the information in the health record which facilitates ease of access to all clinical information. Clear instructions regarding the order of filing is contained within the folder
- Machine generated reports and recordings such as CTG, ECG and laboratory reports are stored securely within the case note folder
- All electronic systems are password protected and passwords are changed at regular intervals. An audit trail of access, amendments or updates is available and reports can be taken from the system

Storage

Health record storage areas should provide a safe working environment with secure storage that allows health records to be retrieved as and when required. These areas should only be accessible to authorised staff and should conform to agreed standards e.g. BS 5454 to protect records from damp, fire, flood and chemical contamination.

- Health records storage areas and office accommodation should conform to all current legislation and guidance regarding health and safety
- Risk assessments are undertaken in line with the risk management strategy
- Racking, where this is in use, is stable and of strong enough construction to support the weight of the health records and mostly complies with current health and safety regulations
- There are safety step ladders and stools appropriate to the number of staff employed and to the size of the different storage areas
- The staff are trained in the manual handling procedures associated with the library areas
- Equipment within the department conforms to the appropriate legislation and equipment checks are conducted when necessary
- Access to the libraries is restricted to authorised personnel. The keys/access codes/swipes to areas that are locked are made available to staff to facilitate the retrieval of health records during the out-of-hours service
- The health records areas should be capable of accommodating the current needs and annual growth of health records
- Health records must be stored securely when in clinical areas, offices and arrangements made within these areas to allow retrieval of records when required

Management of Records (onsite & offsite)

Maintaining the health record is vital to patient care. The health records service has well defined procedures and systems in operation for the ongoing management of the health record from initiation to final disposal in accordance with legislation.

- Whenever possible, separate areas are maintained for current and non-current health records in use within the organisation;
- There are documented procedures for the safe storage and retrieval of health records;
- There are documented procedures for the tracking of records within the organisation and audit is used to highlight any issues that arise as a result of non compliance
- There is a documented procedure for the splitting of fat folders and cross referencing of the volumes. Closed volumes are suitably labelled.
- There is a documented procedure relating to the return of the patient held record when an episode of care is complete.

- The responsibility for the filing of loose documentation rests with the staff who generate the information.
- There are agreed processes and identified staff responsible for the filing of loose documentation.
- Each person who uses and adds to the record has the responsibility to maintain the record and file any information into the appropriate section and format. This is part of the overall record keeping standards of the organisation.
- Health records staff will routinely split large folders or provide a new folder if the outer cover is not of a good standard.
- There are documented procedures for the transportation of health records both within and outside of the HDUHB.
- There are documented procedures for the handling of subject access and Access to Health Records requests with clear responsibility for responding by fully trained, dedicated staff who process requests in accordance with the law;
- There are documented procedures for the retention, archiving and destruction of health records in accordance with national guidelines. The method of destruction ensures that confidentiality is maintained at all times.
- There is a set of performance indicators which demonstrate the efficiency of the health records service which include health record availability, incorrectly tracked records, SAR's compliance etc
- Offsite records requires that there is a full inventory of the records that are held offsite
- Retention periods require to be assigned to each record held offsite
- Evidence is obtained of secure disposal of records and information
- A Data Protection Impact Assessment (DPIA) must be conducted if moving records to an offsite storage contractor and the Health Records service contacted for advice and guidance on the factors to be taken into consideration prior to removal of records to an offsite store.

Creation and Maintenance of Patient Healthcare Records

The HDUHB uses the Welsh Patient Administration system (WPAS) to create a patient record. HDUHB policies and procedures specify clear standards that should be used by all staff involved in maintaining the patient record.

Wherever possible all patient information should be centrally held as part of the main patient record. However the HDUHB acknowledges that in some circumstances it may be practical to generate or hold local patient records, for example emergency attendances. Where there are locally held patient records, all staff involved in the creation, use and/or management of these records should also ensure they meet the required standards and ensure that the record types are recorded on the Information Asset Register.

The Health Records Department are responsible for identifying main clinical records for retention or destruction and will apply the retention schedules as stipulated in the HDUHB [193 - Retention and Destruction Policy](#) – opens in a new tab - and supported by the Record Management Code of Practice.

Tracking and Retrieval of Records

The movement and location of records should be controlled to ensure that a record can be easily retrieved at any time, that any outstanding issues can be dealt with and that there is an auditable trail of record transactions.

The HDUHB utilises the Welsh Patient Admin System **Intelligent Tracking** facility to monitor and records the movement of the main patient healthcare record within the organisation (paper). The objectives of this policy are to:

- Ensure all health records are tracked on WPAS
- Ensure the location of all health records are known at all times
- Establish and maintain standards for the use of health records
- Reduce the risk of health records not being available for patient consultations, subject access requests and legal requirements

Archiving and Disposal of Health Records

There is a detailed and agreed policy on the retention, destruction and/or archiving of health records, which operates in accordance with the Welsh Records Management Code of Practice. It is particularly important that the disposal of records, which is defined as the point in their lifecycle when they are either transferred to an archive or destroyed, is undertaken in accordance with clearly established policies.

It is a fundamental requirement that all the HDUHB records are retained for a minimum period for legal, operational, research and safety reasons. The length of time for retaining records will depend on the type of record and its importance to the HDUHB business and clinical functions. The HDUHB has a retention schedule which is set out in the HDUHB [193 - Retention and Destruction Policy](#) – opens in a new tab. Records destroyed shall be recorded on WPAS. Destruction of eligible records shall be completed annually with archived records indicating the year for destruction, which will enable those pending destruction to be identified. Any decision to retain/destroy records outside of the periods specified will be approved and fully documented.

The Health Records Manager and Health Records Management team can offer advice on the requirements and procedure for dealing with the disposal of all records at this stage in the lifecycle.

Training

While some aspects of Information Governance is covered in the HDUHB Corporate Induction for all staff, it is expected that local induction arrangements will cover the specific roles and responsibilities of staff in relation to the lifecycle of records. All staff employed by the NHS in Wales will receive information on their personal responsibilities for record keeping in contracts of employment. This includes the creation, use, storage, security and confidentiality of health records. The mandatory training on Information Governance also includes elements of records management standards.

Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. The Health Records service is able to support awareness sessions or bespoke sessions as and when required to increase the awareness of individual staff responsibilities in regards records management. Self-learning modules are available to all staff through the HDUHB's intranet and ESR application.

Retention and Destruction of Records

Policy (Including Health Records)

Policy information

Policy number: 193

Classification: Corporate

Supersedes: Previous versions

Version number: 5

Date of Equality Impact Assessment: 27th January 2026

Approval information

Approved by: Digital Data and Innovation Committee

Date made active:

Review date:

Summary of document:

This policy states our commitment to meet the required standards and legal obligations for the storage, retention and destruction of records, highlighting staff roles and responsibilities

Scope:

This policy has been written as guidance for Hywel Dda University Health Board in dealing with the legal retention and destruction timescales for all clinical and non-clinical records and ensuring information is processed and disposed of in accordance with the Data Protection Act /General Data Protection Regulations 2018 or any subsequent legislation to the same effect. Staff working for the Health Board must make every effort to comply with this policy and applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

To be read in conjunction with:

[\[191\] – Health Records Management Strategy](#) – opens in a new tab

[\[192\] – Health Management Policy](#) – opens in a new tab

Records Management Code of Practice for Health and Social Care 2022

[\[172\] – Confidentiality Policy](#) – opens in a new tab

[\[836\] – All Wales Information Governance Policy](#) – opens in a new tab

[\[347\] – Corporate Records Management Policy](#) – opens in a new tab

[\[224\] – Information Classification Policy](#) – opens in a new tab

[\[837\] – All Wales Information Security Policy](#) – opens in a new tab

Patient information:

Owning group: IGSC

Executive Director job title: Director of Digital

Reviews and updates:

- 1 New ;policy September 2012
- 2 Full review 23.2.2016
- 3 DPA update 26.6.2018
- 4 Full review 28.2.2023
- 5 Correction to the Records Management Code of Practice for Health and Social Care, published by the Welsh Government, retention period for sealed contracts changed from 6 years to 12 years

Keywords: Retention and destruction, health records

Glossary of terms

Records management - is that “field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and [disposal] of records, including processes for capturing and maintaining evidence of and information about business activities and transactions in the form of records”. ISO 15489-1: 2016 Information and documentation – Records Management “Records management is about controlling the organisation’s records to ensure authenticity, reliability, integrity and usability”.

Retention Schedule - is a document setting out what records the Health Board holds and how long they will be retained before disposal. It can also be used to set out what needs to happen to records at various different stages of their lifecycle to ensure that they are stored efficiently.

A record - A health record is “*one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection with the care of that individual*”. Anything that contains information that has been created or gathered as a result of any aspect of the work of NHS employees

Data Protection Legislation – the term Data Protection Legislation means all applicable laws, regulations and regulatory rules which govern the processing of personal data including (i) the Data Protection Act 2018, Regulation (EU) 2016/679 the UK General Data Protection Regulation (UK GDPR), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (as amended) and any subsequent legislation enacted and duly in force from time to time relating to the processing of Personal Data; and (ii) all guidance and / or codes of practice issued from time to time by the Information Commissioner or relevant government department, and any relevant rulings from time to time of the Information Commissioner or of the Courts of England and Wales relating to the processing of Personal Data.

Contents

Policy information..... 1

Approval information 1

Introduction 4

Policy Statement..... 4

Scope of policy..... 4

Aim..... 5

Objectives 5

What is a Record 5

Retention..... 6

Destruction..... 6

Legislation..... 7

Responsibilities 7

Training 8

Retention Timescales 8

Introduction

The Public Records Act 1958 requires that there is a systematic and planned approach to the management of records within an organisation. NHS organisations have a statutory duty to make arrangements for the creation, safekeeping and eventual disposal of all such records, which ensures that the Health Board has access to reliable information. Records are a valuable resource because of the information they contain and the Health Board needs to maintain information in a manner that effectively serves its own business needs, those of the patient and to dispose of the information efficiently when no longer required.

High quality information underpins the delivery of high quality evidence based healthcare and many other key service deliverables. Information has most value when it is accurate, up to date and accessible when needed. An effective records management service ensures that all records and information is appropriately managed in line with legal requirements and is available whenever and wherever there is a justified need for that information, in whatever form of media it is required.

The key statutory requirement for compliance with records management principles is the Data Protection Act 2018 / UK General Data Protection Regulation or any subsequent legislation to the same effect. It provides a broad framework of general standards that have to be met and considered in conjunction with other legal obligations. The Acts regulate the processing of personal data, held both manually and on computer. It applies to personal information generally, not just to health records.

Policy Statement

This policy complies with the Welsh Government National Guidance: Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records.

The Code is a guide to use in relation to the practice of managing records. It is relevant to organisations working within, or under contract to, the NHS in Wales and provides a framework for consistent and effective records management based on established standards and current legislation. It includes guidelines on topics such as legal, professional, organisational and individual responsibilities when managing records. It also advises on how to design and implement a records management systems including advice on organising, storing, retaining and deleting records. It applies to all records regardless of the media they are held on.

This Code replaces the previous guidance: WHC 2000 (71): For the record – Managing Records in NHS Trusts and Health Authorities.

Individual members of staff are responsible for any records they create or use and all organisations and managers need to enable staff to conform to this policy and the standards of the code.

Scope of policy

This policy is provided to Hywel Dda University Health Board to deal with the legal retention and destruction timescales for all clinical and non-clinical records and ensuring information is processed and disposed of in accordance with the Data Protection Legislation or any subsequent legislation to the same effect.

Staff working for the Health Board must make every effort to comply with this policy and it applies to all permanent, temporary or contracted staff employed by Hywel Dda University Health Board (including Executive and Non – Executive Directors).

Aim

The policy will provide a framework within the Health Board to ensure compliance with Welsh Government National Guidance: Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records.

The Health Board has an individual responsibility to retain all records securely, in line with legal timeframes. The aim of the policy is to ensure that retention periods for health records are maintained in accordance with Statute law. The policy will underpin all operational procedures and provide assurance and assistance to staff in terms of activities connected with the retention and destruction of records.

Objectives

The objectives of the policy are to provide all Health Board staff with clear guidance and standards to attain on a daily basis and provide robust assurance in regards the retention and destruction of sensitive and confidential patient information. The policy will ensure:

- All records are only retained for the minimum and legal timescales.
- Clearly appraised, validated and culled in line with guidance and best practice.
- Provide assurance that only relevant and appropriate records are destroyed.
- All records are destroyed in a confidential manner.
- Provide simplistic reference points for staff to identify retention periods for both clinical and non clinical records.
- Used as a service guide for all areas to comply with retention periods.
- Utilised as a guide for effective working and storage management.

What is a Record

There are a couple of definitions of a record, which are useful to highlight.

The ISO standard ISO 15489 – 1:2016 defines a record as:

- Information created, received and maintained as evidence and as an asset by an organisation or person, in pursuance of legal obligations or in the transaction of business.

Section 205 of the Data Protection Act 2018 defines a health record as a record which:

- Consists of data concerning health.
- Has been made by or on behalf of a health professional in connection with the diagnosis, care or treatment of the individual to whom it relates.

Records Management applies to any material that holds information gathered as part of the work undertaken in the NHS. A health record can be anything that contains information and has been gathered and created as a result of any aspect of the work of NHS employees – including management consultant agency or bank/agency staff. It will include decisions which relate to the physical and mental health of an individual which has been made by or on behalf of a health professional. A corporate record is any record relating to the business function of the organisation which is not considered a health record.

There will be a wide range of record formats and that will include both physical and digital records. Only relevant records that are utilised by Hywel Dda staff to undertake their daily duties, should be managed through this policy and in line with the guidance provided in Appendix ii and iii of the Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records. A link to the Code of Practice is provided in the retention timescales section below.

Retention

Access to the health record is essential to the delivery of effective patient care. Patient health records must therefore be retained securely for the whole period that the patient is receiving active treatment and must be easily retrievable internally, from offsite storage or digitally, whenever they are required by a clinician.

Corporate records also need to be easily retrievable and securely retained throughout their lifecycle to enable day to day business function to be conducted and evidenced.

It is important to note that the Health Board no longer uses external/non Health Board storage providers/facilities and any storage requirements should be discussed with both the Health Records Manager and the Information Governance Service. In emergency circumstances only approved Third Party Providers should be used.

This policy details the legal minimum recommended periods for the retention and destruction of records. Health Board staff will be responsible for complying with the minimum retention periods and providing assurances that retention timescales are being applied and adhered to, following the conclusion of treatment. The recommended minimum retention periods apply to both paper and digital records.

Destruction

All organisations have a responsibility to dispose of records at the end of their lifecycle, which is usually at the end of the retention period. Normally an appraisal will be completed, to decide what to do with the records, once their business need has ceased and the minimum retention period has been reached. Paper records selected for destruction and can be destroyed either in-house or under contract with an approved provider. If an external provider is used, the health organisation is responsible for ensuring the chosen provider meets the necessary requirements.

A record should be maintained and preserved confirming the destruction of records, showing their reference, description and date of destruction, so that the organisation is aware of those records that have been destroyed and are therefore no longer available. Disposal schedules would constitute the basis of such a record.

All health records falling into the category of being selected for destruction will be destroyed after meeting relevant criteria, such as:

- All retention categories have been complied with
- Records will be identified either by manual or digital methodology
- All Hywel Dda University Health Board systems have been checked for most recent activity
- Records will be physically checked to ensure that there are no entries relating to a later date
- Records will be marked as destroyed on the relevant computer systems on which details of the patient records are held e.g. Welsh Patient Administration System (WPAS)

- Records for destruction will be destroyed in accordance with the appropriate Confidential Waste Process.
- All corporate records should be reviewed at the end of their retention schedule (laid out in Records Management Code of Practice for Health and Social Care – A guide to the management of health and care records). The disposal outcome should be reviewed by the Information Asset Owner and the Senior Corporate Records Management Officer. The Senior Corporate Records Management Officer will work with teams to arrange the transport of records identified for transfer to an archive. Records for destruction will be destroyed in accordance with the appropriate Confidential Waste Process.

Legislation

This policy and the guidelines provided take into account and must be applied in conjunction with the laws relating to confidentiality, data protection, the patient's rights of access to their health records and the staff's duty of care to patients to make proper records. The Health Board and Managers within services must ensure staff are also aware and familiar with such laws, guidance and governance principles.

Responsibilities

Records management should be recognised as a specific corporate responsibility within every organisation. It should provide a managerial focus for records of all types, in all formats throughout their lifecycle, from creation through to ultimate disposal. The records management function should have clear responsibilities and objectives and be adequately resourced to achieve them.

The Chief Executive has overall accountability for ensuring the effective implementation of this policy and ensuring records are retained securely and disposed of in a timely and confidential manner, in accordance with the identified legal guidance and information governance standards. The Chief Executive may delegate responsibility for management and organisation of retention and destruction service to a designated Executive/Caldicott Guardian who is responsible for ensuring appropriate mechanisms are in place to support service delivery and continuity.

The Health Records manager has professional and operational responsibility for the security, retention and destruction of health records ensuring practices within the organisation are managed in accordance with legal timescales and that related policies and procedures conform to the latest legislation and standards. The Health Records Manager is accountable for ensuring only appropriate records are destroyed and for reviewing destruction processes to maintain confidentiality at all times.

The Senior Corporate Records Management Officer has professional and operational responsibility for the secure retention and destruction of the Health Boards corporate records and ensuring these records are managed in accordance with legal timeframes. The Senior Corporate Records Management Officer is responsible for ensuring only appropriate records are destroyed and all inquiries regarding the destruction of corporate records, must be directed to Information Governance Team and any destruction authorised by the Senior Corporate Records Management Officer.

All Health Board staff have an individual responsibility for the records they create and use. All staff must ensure all records and patient information, which is extremely confidential is destroyed by utilising the confidential waste process available to them and in line with Health Board standards.

Training

All staff employed by the NHS in Wales will receive information on their personal responsibilities for record keeping in contracts of employment. This includes the creation, use, storage, security and confidentiality of health records. Appropriate training will be given to all health records staff on the systems used to maintain records and these will meet local and national standards. All new employees to NHS organisations in Wales will be given basic records practice training as part of the induction process.

Professional standards of record keeping are governed by the associated Royal Colleges. These standards should form part of the professional practice review.

Training in the specifics of confidentiality and data protection will be identified through the agreed Information Governance training sessions.

Retention Timescales

Retention timescales can vary quite significantly across the various record types. It is essential that staff only review retention timescales associated with the record types they utilise within their roles and responsibilities within the Health Board. Retention guidance is provided in Appendix ii and iii of the [Records Management Code of Practice for Health and Social Care](#) (opens in a new tab) – A guide to the management of health and care records and information for all Health Board staff on nationally agreed retention guidelines .

Digital Procurement and Requests Procedure

DRAFT

Policy information

Policy number: 240

Classification: Corporate

Supersedes: Previous versions (previously named Informatics Procurement & Request Procedure)

Version number: 4

Date of Equality Impact Assessment:

Approval information

Approved by: Digital Data and Innovation Committee

Date of approval:

Date made active:

Review date:

Summary of document:

Hywel Dda University Health Board is committed to ensuring all Digital purchases align with both local and national strategies and that they represent value for money to public funds.

This procedure sets out a series of steps to follow to ensure all Digital purchases meet the requirements above and satisfy both the technical infrastructure and security requirements of the Health Board.

The procedures in this document are to be followed to ensure all requests for new Digital projects follow the correct governance and assurance arrangements before being committed into the Digital Operational Plan.

Scope:

This procedure covers everyone that is employed by Hywel Dda University Health Board who may request Digital services. The definition of Digital includes the following services: -

- Telecommunications (Telephones, paging and mobiles).
- Desktop Equipment (PC's, printers, scanners, projectors, and other peripherals).
- Mobile Equipment (Tablets, Android / Apple devices, carts).
- Medical equipment which connects to the Health Board network or includes software which needs to be assessed from an Information Governance / Cyber Security perspective.

- Audio-Visual equipment.
- Equipment to support health & safety assessments in relation to the use of display screen equipment regulations.
- Office moves and refurbishments.
- New Builds.
- Requests for new Digital Services.

To be read in conjunction with:

[Digital Health Strategy](#) (opens in a new tab)

[837 – All Wales Information Security Policy](#) (opens in a new tab)

[Health Board's Standing Financial Instructions](#) (opens in a new tab)

[Standing Orders](#) (opens in a new tab)

[Capital Investment Procedure](#) (opens in a new tab)

[Our Digital Response](#)

Owning group: Information Governance Sub-Committee

Executive Director job title: Director of Finance

Reviews and updates:

Version 1 – new policy 6.9.2011

Version 2 – revised and amended 26.2.2017

Version 3 – full three yearly review 25.4.2023

Version 4 – full review

Keywords: Digital procurement procedure

Glossary of terms

DHCW – Digital Health and Care Wales

DCP - Discretionary Capital Programme

ICT – Information & Communications Technology

Contents

Policy information..... 1

Approval information 1

1. Aim 4

2. Objectives..... 4

3. Scope 4

4. Procurement of Standard Digital Equipment 4

5. Procedure for Adhoc Departmental Moves..... 6

6. New Digital Project Approval Procedure..... 6

7. Determining the Priorities for a Project..... 7

8. Responsibilities 7

9. Training 8

Appendix A – Digital Requesting and Project Approval Flowchart..... 9

1. Aim

It is the responsibility of the Digital Senior Management Team to oversee the implementation of the Digital Strategy, including commissioning additional developments and resources as required. This document sets out the method by which Digital and System procurements, new Digital projects, adhoc departmental moves and changes as well as enhancements to existing systems will be approved, allocated resources, and ensuring that appropriate governance and assurance is sought.

The procedure for gaining approval for Digital initiatives is dependent on the context of the project. If the project is: -

- **Procurement of standard ICT equipment** (purchasing of standard hardware, software, mobile phones / smartphones, and peripherals such as printers and scanners) should follow the “Procurement of Digital Equipment” procedure outlined in section 4.
- **Adhoc departmental moves and changes** should follow the ‘Adhoc Departmental Moves’ procedure outlined in section 5.
- **Digital project approval** (New Digital projects, new builds, major refurbishments, and upgrades/enhancements to existing systems) should follow the “Digital Project Approval” procedure outlined in section 6.

This procedure should be read in conjunction with the Health Board’s Standing Financial Instructions, Standing Orders, the Policy for Procurement and Life Cycle Management of Equipment and where relevant, the Capital Investment Manual.

Templates and electronic links for the submission of projects are provided in the ICT Forms Library on the Health Board’s Intranet site or through requests to the Informatics Service Desk.

Any project which may impinge on National Strategy may need to be submitted to the relevant Digital Health and Care Wales (DHCW) governance committees.

2. Objectives

The main objective of this procedure is to ensure employees of the Health Board are aware of the procedure to follow when requesting Digital equipment, software, services and new projects.

3. Scope

This procedure covers everyone that is employed by Hywel Dda University Health Board who may request Digital services.

4. Procurement of Standard Digital Equipment

This covers the purchase of all Digital standard hardware, software, peripherals (scanners, printers etc.) and mobile phones in addition to related professional services. This procedure does not include purchases which are part of an already approved capital programme, business case or DHCW funded projects.

Advice from Digital Services should also be sought where network attached equipment is being procured. This includes medical devices, laboratory analysers, security systems and CCTV.

All Digital equipment purchases will conform to Digital Services specifications and will be authorised prior to ordering by the Digital procurement team.

All Digital purchases should be channelled through Digital Services, if bypassed any Digital purchases should be clearly identifiable by Procurement who will forward such requisitions to the Head of Digital Operations to ensure that the processes in this procedure are followed.

Replacement Programme

When equipment is assessed as being “end of life” it will be replaced under the replacement programme subject to available funding levels. This will include but is not restricted to PCs, printers, scanners, servers, network devices, infrastructure components, software and telecommunications (including mobile phones).

The replacement programme is funded from the Health Board’s Discretionary Capital Programme (DCP) and will be managed by Digital Services. This does not exclude the funding of replacement equipment from departmental budgets (if less than £250) and Charitable Funds as required in line with the Health Board’s standing financial instructions.

New Equipment

The procurement of new Digital equipment will be from departmental budgets following approval and providing it doesn’t fall under the remit of the “New Digital Project” procedure requirements.

It is important to note that items over £250 in value and connected to the network are classed as capital assets (not revenue) and as such can only be funded from the Health Boards capital allocations and local charitable funds. This will include many pieces of Digital equipment including high end printers, PC’s, laptops and tablets.

All requests for software packages, computer hardware, peripherals (scanners, printers etc.) or network / telecommunication services should be made by completion of the request forms via the Digital Services Portal which is available under the “Request a service” link:

[Welcome to the Digital Services Portal](#) (opens in a new tab)

All sections in the form require completion for the procurement to progress and once received Digital Services will process in line with local procedures. The request must be authorised by the responsible officer (e.g. budget holder or service manager) and a notification will be received via Microsoft Teams to approve or deny the request.

Any request “deemed” as non-standard will be forwarded to the Head of Digital Operations for consideration and may fall under the remit of the “New Digital Project Approval” procedure as outlined in Section 8.

External Funding

Occasionally the Health Board will receive external funding which is placed into ring fenced budgets (Welsh Government R&D for example), requests utilising these monies will be managed as per this procedure and Digital Services will discuss with Finance on a case-by-case basis the funding arrangements and any revenue / capital transfers.

5. Procedure for Adhoc Departmental Moves

This section outlines the procedure that will be followed to gain approval for Digital to support departmental moves / changes and office moves. The scope includes Health Board employees requiring: -

- New data points for network access.
- New telephone points, handsets, and numbers.
- Moving of extension numbers between locations.
- Move of Digital equipment (PC's / Printers etc.) between locations.

It is important that Digital Services should be engaged as soon as possible using the process below to ensure any associated works can be scheduled in and completed prior to any staff moving offices.

All requests for departmental moves should be made by completion of the relevant electronic form on the Digital Services Portal. The link to the form is also provided below: -

[Adhoc Network Moves and Changes : Hywel Dda University Health Board \(wales.nhs.uk\)](#) (opens in a new tab)

All sections in the form require completion for Digital Services to process and once received the request will be completed in line with local procedures. The request must be authorised by the responsible officer (e.g., budget holder or service manager) and a notification will be received via Microsoft Teams to approve or deny the request.

On receiving the request Digital Services will review and respond to the requester when the work can be completed and details of any associated costs. If the number of resources required by Digital is extensive then the "New Digital Project Approval" will be followed.

Once the budget holder has approved the work, Digital Services will complete a schedule for completion and any moves and changes requested which don't follow this procedure will be potentially rejected.

6. New Digital Project Approval Procedure

This section outlines the procedure that will be followed to gain approval and funding for a new Digital project which would be added to the Digital Operational Plan. Examples of such new projects include: -

- New builds or refurbishments of Health Board property which have a Digital element.
- Requests for upgrades to existing systems.
- Requests for new Digital system or service.
- Any requests received through the "Standard Digital Equipment Procedure" where the Head of Digital Operations determines it needs to follow the formal approval process.

Any such requests must be via the online request form available on the Digital Services Intranet Pages:

[Digital Project / Support Request](#) (opens in a new tab)

More information on the Health Boards Digital Response and framework can be found below:

[Delivering the Digital Response](#) (opens in a new tab)

The Digital project proposal once submitted will be discussed by the Digital Services Senior Management Team for consideration, prioritisation and acceptance.

If approved by the Digital Senior Team and the project has already been funded and approved by the relevant assurance committee the project will have a priority set, be scheduled and have resources allocated by the digital delivery team. If there is a conflict in priorities these will be considered and deconflicted at the Digital Service Programme Group, based on business impact and funding.

If no funding / approval has been approved, then the request will be deferred to the Digital Programmes Group as required for consideration.

Further information regarding the priority of digital project can be found in the [Digital Response](#) document.

7. Determining the Priorities for a Project

The following criteria will be used by the Digital Senior Team in assessing what priority should be given when approving and progressing projects: -

- The priority in this area / activity in the Health Board's IMTP.
- The project's time constraint.
- The potential savings that would be lost or additional cost incurred if the project was delayed.
- The resources required and any conflicts with other projects.
- Other projects / activities / initiatives dependent on the completion of this project.
- Any external influences on the project's implementation date.
- Risks incurred or changed by the implementation.
- The project's fit with national strategies if relevant.

8. Responsibilities

Head of Digital Operations

The Head of Digital Operations shall have overall responsibility for the implementation of this procedure and will delegate responsibility to ensure appropriate departmental procedures are in place to aid its implementation.

The Head of Digital Operations will escalate any issues as appropriate to the Digital Director.

Digital Senior Team

All members of the Digital Senior Team will be made aware of this procedure to ensure they are aware of their roles and responsibilities in the approval process for Digital projects.

NHS Wales Shared Services Partnership

The NHS Wales Shared Services Partnership will be required to be aware of this procedure to ensure any requisitions they receive for Digital related equipment is not processed unless this procedure has been followed (where requisitions are not received through designated Digital requestors).

Director of Estates

The Director of Estates will be responsible for dissemination of this procedure to relevant Estates staff to ensure it is considered when planning new builds and refurbishments of Health Board property.

Executive Directors / County Directors / Service Delivery Managers

Will be required to be aware of this procedure to ensure Digital implications are considered when planning service change, new projects, and new services.

Information Asset Owners

Information Asset Owners will be responsible for considering this procedure when planning any system upgrades or enhancements with 3rd party suppliers.

Heads of Department / Budget Holders

Will be required to be aware of this procedure to ensure it is followed when requesting Digital services.

9. Training

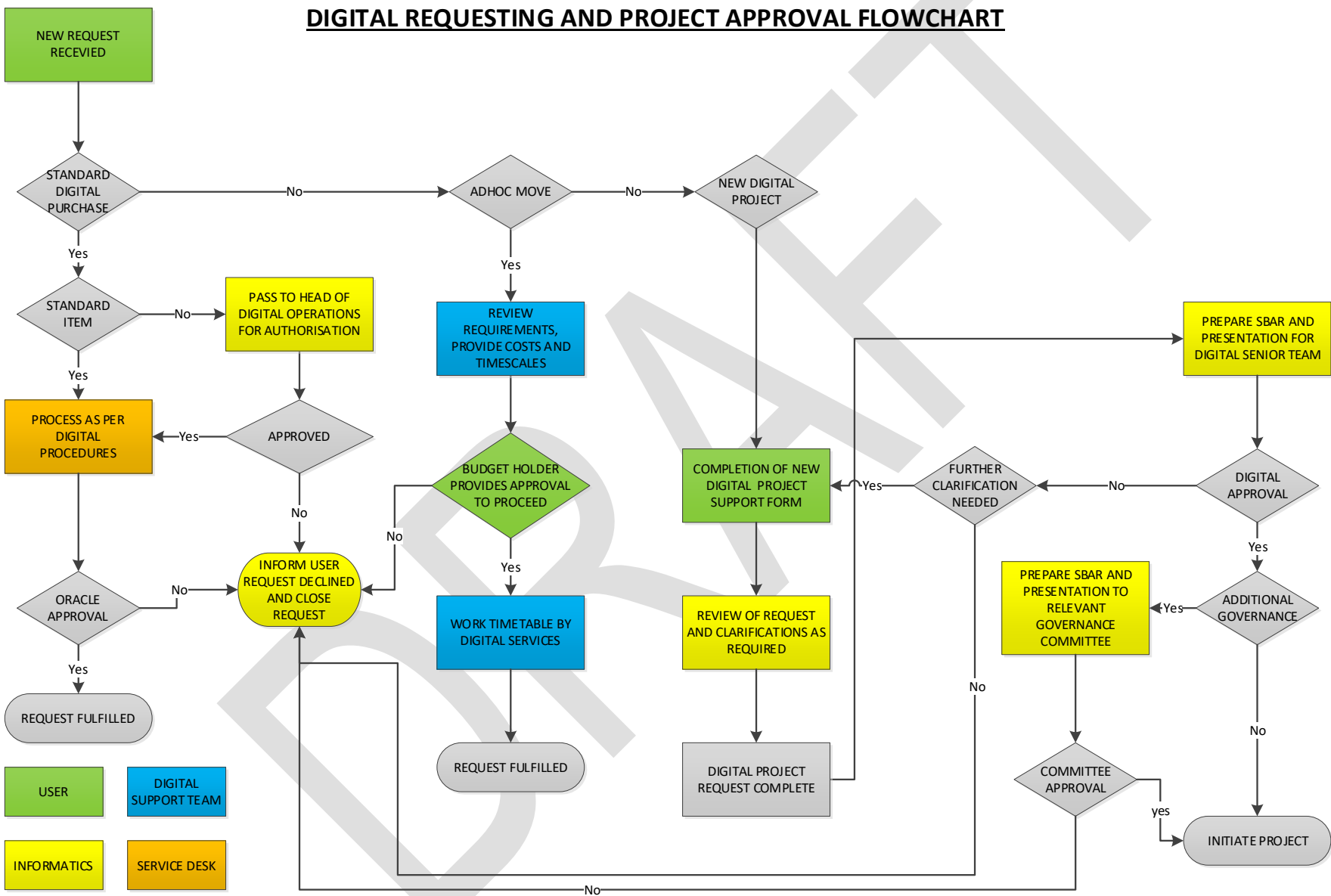
All staff will be made aware of this procedure through a communications plan and availability to view on the Health Board Intranet site.

Awareness will also be promoted by the Digital Service Desk when requests are received and through membership of the relevant governance groups of the Health Board.

Targeted communications will also be undertaken to the groups identified in the Responsibilities Section.

Support will be provided by Digital Services Department as required to support Health Board staff in ensuring they meet the requirements of this procedure.

Appendix A – Digital Requesting and Project Approval Flowchart



DRAFT

Acceptable Use of Digital Services Policy

DRAFT

Policy information

Policy number: 320
Classification: Corporate
Supersedes: Previous versions
Version number: 4
Date of Equality Impact Assessment:

Approval information

Approved by: Digital Data and Innovation Committee
Date of approval:
Date made active:
Review date:

Summary of document:

This policy outlines standards for the appropriate and inappropriate use of Health Board digital systems and networks. It clarifies permitted activities, including personal use; identifies prohibited actions, such as personal use during working hours and accessing indecent, obscene, or offensive material; and details the consequences for violating these guidelines.

The policy describes how the Health Board has established systems to track users and their activity, as well as measures that block access to indecent, obscene, or offensive content. It also states that any violations will be addressed promptly and according to disciplinary procedures when appropriate.

Scope:

This policy applies to all employees of the Health Board, volunteers, other NHS and health organisations, and other contracted staff; having the facility to use the Health Board's e-mail and internet services, plus anyone granted access to the Health Board network whilst engaged in work for the Health Board at any Health Board occupied location, and/or on any Health Board owned or Health Board approved computer asset.

This policy applies to all users of Digital Services in relation to:

- The use of digital equipment.
- The use of digital communication tools.
- Digital systems connected directly or remotely to the Health Board NHS managed network or used on the Health Board's premises.

To be read in conjunction with other Digital Policies and Procedures.

[201 – AW Disciplinary Policy](#) – opens in a new tab

Owning group: Information Governance Sub-Committee

Executive Director job title: Director of Finance

Reviews and updates:

Version 1 – new policy 28.91.2013

Version 2 – revised and amended 21.5.2018

Version 3 – full review

Version 4 – full review

Keywords

Information, Personal Data, Personal Information, Informatics, Transfer of Information, Mobile Working, Information Technology, Acceptable Use of Digital Equipment, ICT.

Glossary of terms

DHCW – Digital Health and Care Wales

DCP - Discretionary Capital Programme

ICT – Information & Communications Technology

Contents

Policy information..... 1

Approval information 1

Aim..... 4

Objectives 4

Scope..... 4

Becoming and Authorised User 4

Acceptable Use..... 5

Unacceptable Use..... 5

The Use of the Organisations Name 6

Unintentional Breaches of Digital Security 7

Acceptable Network and System Usage 7

Responsibilities 7

Training 9

Aim

The aim of this policy is to ensure all users of Health Board services do so in a safe and secure manner ensuring compliance with relevant legislation.

Objectives

The objectives of this policy are to: -

- Clarify Health Board policy regarding acceptable and unacceptable use of Digital services, and Health Board network access.
- Reduce or avoid security threats by increasing awareness and disseminating good practice.
- Cease the copying/distribution of copyrighted materials.
- Encourage effective use of Health Board resources.
- Protect the Health Board against potential liability.

Scope

This policy applies to all employees of the Health Board, volunteers, other NHS and health organisations, and other contracted staff; having the facility to use the Health Board's e-mail and internet services, plus anyone granted access to the Health Board network whilst engaged in work for the Health Board at any Health Board occupied location, and/or on any Health Board owned or Health Board approved computer asset.

This policy applies to all users of Digital Services in relation to:

- The use of digital equipment.
- The use of digital communication tools.
- Digital systems connected directly or remotely to the Health Board NHS managed network or used on the Health Board's premises.

Becoming an Authorised User

Every member of staff or contractor who requires access to Digital systems must complete the relevant online form available on the [Digital Services Portal](#) to request an account with the necessary access to Digital systems. If the account is approved by their line manager, the user will be set-up with a username and password by the Digital Service Desk.

In the unlikely event of the application being turned down, the staff or contractor will be contacted to communicate the reasons for rejection. Access to Digital systems will only be through the following means:

- Health Board NHS managed network which is protected by perimeter firewalls, anti-virus software and content filters.
- Authorised remote access using Cisco Anyconnect, Citrix Gateway, or Microsoft Office 365.

Acceptable Use

Access to Digital systems is primarily for business related purposes. Personal use is permitted provided this does not interfere with the performance of your duties, those of other staff or contractors or the business of the Health Board in general. Personal access to Digital systems can be limited or denied by your manager. Staff and contractors must act in accordance with Health Board Policy.

However, there can be no expectation of the privacy of personal e-mails. In certain circumstances and following the processes contained in the Information Commissioner's code of practice on staff data, the organisation may, in a proportionate manner, view personal e-mails as legislation or the Health Board's Disciplinary procedures permit. In such circumstances, the Regulation of Investigatory Powers Act (2000) and the Lawful Business Practices Regulations (2000) confirms that the organisation's responsibilities may prevail over a member of staff's individual rights to confidentiality of correspondence. The Health Board reserves the right in these circumstances to view the content of an individual's mailbox.

Unacceptable Use

This policy sets the common minimum standards for the acceptable use of Digital systems and services. Set out below are examples of activities and uses which are specifically excluded. The list is not comprehensive and is divided into two sections ("Unacceptable" and "Forbidden") to help highlight the most serious activities. The consequences of undertaking any of the activities listed below (or other instances) will be determined through the normal disciplinary procedures. All such activities are serious and are likely to be viewed as misconduct. It is likely that undertaking a forbidden activity, or repeating an unacceptable activity, will be viewed as gross misconduct.

Any unacceptable use will be reported as per the Information Governance incident procedure, and it is the responsibility of the investigating officer to ensure that the matter is dealt with in line with current Information Governance and Digital policies and procedures. This may result in a full enquiry that could result in disciplinary action being taken and access of the staff or contractor involved may be suspended pending the enquiry conclusion at which point it may be terminated.

Unacceptable use of Digital systems provided by the Health Board are shown below:

- Spending more than permitted amounts of working time making personal use of the internet, e-mail, and other Digital Systems and services.
- Transmitting, downloading or storing any material such that this infringes the copyright of the owner.
- Purchasing goods or services or entering any contract via the Internet or any other Digital system on behalf of the Health Board without the necessary authority and not in accordance with the Health Board's standing financial instructions.
- Business advertisements or trading, i.e., sale of any goods purchased with the sole intention of making a profit.
- Using an unauthorised electronic communication mechanism for the transmission to a third party of personal identifiable data or confidential material concerning the activities of the Health Board.
- Using unauthorised external email accounts for Health Board activities such as Outlook.com or icloud.com.
- Using cloud-based services where Health Board confidential data or person identifiable information could be stored outside of the European Union or European Economic Area.

- Unauthorised redistribution of email.
- Sending or forwarding spam emails.
- Making your Cymru or any other system username and password (also known as a 'user account') available for other people to use on your behalf.
- Accessing another individual's data, Digital systems, or service without appropriate authorisation.
- Deliberately creating, storing, or transmitting information which infringes the Data Protection Act/General Data Protection Regulations 2018 or any subsequent legislation to the same effect.
- Knowingly allowing the use of Health Board's Digital resources by unauthorised third parties.
- Disabling, altering bypassing, or circumventing any measures put in place by the Health Board to maintain the safe and secure operation of Digital systems and services.
- Failing to follow Health Board advice on how to protect, store, transmit, share, and access sensitive information.
- Failing to purchase and dispose of Digital systems and services in line with Health Board policies.
- To load software / apps for which no legitimate licence is held or software / apps that are unapproved.
- Unauthorised removal or relocation of hardware, software, documentation, or media associated with the Health Board's Digital systems.

Forbidden uses of Digital systems provided by the Health Board are shown below:

- Using another person's identity to appear to be someone else.
- Attempting to gain or facilitate unauthorised access to a computer system or information.
- Attempting to or deliberately corrupting, destroying, or denying access to another user's e-mail, data files, information, Digital system, or service.
- Deliberately accessing, viewing, receiving, downloading, sending, or storing material:
 - with pornographic, offensive, obscene, or indecent content.
 - related to criminal skills or terrorist activities.
 - that promote or encourage discrimination, racism, or intolerance.
 - that facilitates illegal activity in the UK or the host country.
 - that is illegal in the UK or the host country.
 - that is defamatory, threatening, harassing, offensive or abusive.
 - that will, or is likely to, bring the Health Board and its staff into disrepute.
 - that is known to be infected with a virus, worm, Trojan or any form of malicious software or code; that infringes the privacy and data protection rights of individuals.
 - that could endanger the health and safety of any other individual.

The Use of the Organisations Name

If staff or contractors join an Internet forum, they are expected to conduct themselves in an honest and professional manner. Individuals are responsible for what they write and should be always courteous and inoffensive. Staff and contractors are reminded to carefully consider whether to contribute to an Internet forum. Unless currently authorised to do so, staff and contractors are not permitted to write or present views on behalf of the Health Board. For example, staff and contractors cannot join an Internet forum in the name of the Health Board, nor can they design a web site and publish it under the name of the Health Board.

Staff and contractors are also reminded to carefully consider whether to distribute or publish their Health Board e-mail address (such as when registering on third-party websites) as this may lead to the staff or contractors mailbox being targeted by spam (commercial unsolicited e-mail) and phishing (fraudulent e-mails designed to aid identity theft) attacks or the Health Board's systems being subject to attacks designed to prevent legitimate access and cause general disruption (Denial of Service).

E-mails sent using the Health Boards e-mail system include the organisations name and may be held to represent the Health Board and its values. In exchanges of e-mails, staff could accidentally tarnish the image of the Health Board and this policy aims to assist with the understanding of e-mail good practice to avoid this. Use of Digital systems in such a way as to expose the Health Board to risk of claims for defamation is prohibited.

Unintentional Breaches of Digital Security

If staff or contractors find themselves unintentionally viewing material, which may be inappropriate, they must make all reasonable attempts to close the application concerned immediately and inform the Digital Service Desk. A note of this unintentional access will be recorded, and any content filtering rules modified where necessary to ensure that further unintentional access does not take place.

Acceptable Network and System Usage

It is the responsibility of all users to ensure that they adhere to the guidelines laid down in this policy. Before a new user can be allocated an account, they must have signed, understood and agreed to the terms of this policy, indicating that they are aware of their responsibilities. A record of which will be retained by the Informatics Department.

The instructions contained in the policy are special restrictions in force with regard to the Health Board related computer systems and network and, are clarifications or additions to the normal security measures in force within the Health Board. All usual security precautions must be taken in addition to these specific requirements.

Responsibilities

Executive Directors

Executive Directors are responsible for the management of risk within their control and in particular are responsible for ensuring their staff are aware of the risks identified within this policy and take responsible action to mitigate them.

Executive Directors must: -

- Ensure procedures are in place within their sphere of responsibility to enable the identification and assessment of risks, including staff training and awareness to mitigate the risks.

Digital Services

Digital Services will be responsible for maintaining the hardware and software components of the Digital and communications infrastructure and, implementing all necessary technical and physical security controls; in summary the department will: -

- Ensure the availability of Digital services and their supporting infrastructure.

- Managing the security and integrity of data, via anti-virus, mail content, web filtering and content, and anti-spam products.
- Managing and monitoring the e-mail quarantine area and releasing appropriate messages.
- Reporting non-compliance to this policy and other security violations via the Health Board risk management procedure.
- Maintaining technical and engineering safeguards in accordance with this Policy and according to the allocated resources.
- Advise Executive Directors and Line Managers on matters relating to Information security.

Heads of Department / Line Managers

- Ensure all staff read, understand, and abide by this policy and any associated policies.
- Ensure that awareness to this policy is highlighted at their local induction programme.
- Monitoring staff compliance to the policy.
- Monitoring staff time spent on personal use of Digital services and systems.
- Instigating further investigations arising out of suspected misuse.
- Investigation and follow up of misuse in accordance with the Health Board's [201 – All Wales Disciplinary Policy](#) (opens in a new tab).
- Reporting non-compliance to this policy and other security violations via the Health Board risk management procedure.
- Ensure the Digital Service Desk is made aware of new starters, users changing roles and leavers of the Health Board using the appropriate electronic forms on the Digital Services Portal.

All Staff

All staff, permanent, temporary, or contracted, must be aware of their own individual responsibilities for the maintenance of confidentiality, data protection, and information security management and information quality and understand they are required to comply with this policy. Failure to comply with this policy may result in disciplinary action being taken.

Staff and contractors who are authorised to access Digital systems have a responsibility to ensure that any usage conforms to policy and legislation relating to Digital security, confidentiality, and data protection.

Digital systems are a business tool that should be treated like any other tool in the workplace. Staff and contractors should be aware that their manager and colleagues may need to gain access to an individual's Digital systems under certain circumstances. Staff and contractors are therefore advised to carefully consider the use of Health Board provided Digital systems for personal use.

Digital systems are a shared resource, and each user has responsibility to learn how to use them appropriately.

Staff must:-

- Comply with this policy and associated guidelines.
- Reporting non-compliance to this policy and other security violations via the Health Board risk management procedure.

Training

All staff will be made aware of this procedure through a communications plan and availability to view on the Health Board Intranet site.

Targeted communications will also be undertaken to the groups identified in the Responsibilities Section.

Support will be provided by Digital Services Department as required to support Health Board staff in ensuring they meet the requirements of this policy.

Information Quality Assurance Policy

Policy information

Policy number: 250

Classification: Corporate

Supersedes: previous versions

Version number: 4

Date of Equality Impact Assessment: 25.02.2026

Approval information

Approved by: Digital Data & Innovation Committee DDIC

Date of approval:

Date made active:

Review date:

Summary of document:

This document is written to provide information on the Policy for ensuring Information Assurance across the Health Board.

Scope:

All Staff, across all areas relating to patient information.

To be read in conjunction with:

[837 – Information security policy](#) – opens in a new tab

[275 – Secure transfer of personal information policy](#) – opens in a new tab

[494 – All Wales email use policy](#) – opens in a new tab

[281 – Mobile working policy](#) – opens in a new tab

[282 – Network security Policy](#) – opens in a new tab

[836 – All Wales Information Governance policy](#) – opens in a new tab

Owning group: Information Governance Sub-Committee

Executive Director job title: Executive Director of Finance

Reviews and updates:

Full review

Keywords; Data Quality, Information, Assurance, Data

Glossary of terms ; IQA – Information Quality Assurance

Contents

Introduction	3
Policy statement.....	3
Scope.....	4
Aim.....	4
Objectives	4
Policy	5
Why does the quality of information matter?.....	5
Causes of poor information quality	6
Electronic Records and Information Quality.....	6
Information Quality Assurance through Information Governance	6
Definition of Data Quality	6
The Six Dimensions of Data Quality	7
What is Information Quality Assurance (IQA)	8
Procedures	8
Measurement of Data Quality	8
Local Data Quality Procedures	9
Failure to Maintain Data Quality	9
Training.....	10
Monitoring.....	10
Responsibilities	10
Chief Executive.....	10
Executive Director of Finance.....	10
Caldicott Guardian	11
Senior Information Risk Officer.....	11
Digital Director	11
Head of Information Services	11
Clinical Coding Manager via the Data Quality Improvement manager.....	11
Departmental Data Quality Leads.....	11
Information Asset/System Owners.....	12
Information Governance Sub-Committee	12
Data Quality Steering Group.....	12
Audit Committee	13
Employees.....	13

Introduction

Good quality information underpins sound decision making at every level in the NHS and most importantly contributes to the improvement of health care. This document outlines the LHBs policy for improving the quality of information in the Health Board. Major drivers include:

- The national service frameworks
- Quality & outcomes assessment in patient care
- The requirements of Service Line Reporting
- Pressure from clinical communities and Ministers to produce high quality information on the quality of care;
- The inability of the LHB to properly monitor quality of service and clinical outcomes.

The starting point of this policy is the recognition that efforts to secure quality must be directed appropriately and that this should start with patient data collected for clinical and operational purposes. Whilst this policy is equally applicable to all information collected and used by the LHB, the initial focus is on information used to support clinical care. Information Quality needs to be addressed within existing working practices and work plans, such as those required to comply with the Information Governance Toolkit rather than as a standalone initiative, though it does need to be managed in a focused way. In particular, the policy seeks to build on two key initiatives:

- I. The recognition of, and the drive to reduce, 'adverse health events'
- II. The modern approach to error prevention and risk management

'Data quality' is a term that has often been used in the past as if it were interchangeable with information quality, but it is actually a more limited term. Data quality relates to the building blocks of information, i.e. data items. Until data is assembled and interpreted it is not information. Considerable attention has also been focused upon readily measurable aspects of data quality, namely the validity and completeness of data items, whilst harder to measure but perhaps more important aspects in the context of overall information quality, such as accuracy, have been neglected. Data quality is an important component of information quality but there are other components that influence just how useful the information is to a particular user.

Policy statement

This policy provides a framework for Information Quality Assurance (IQA). It also outlines the roles and responsibilities of key roles within the organisation to ensure that the information quality policy is realised.

The tools, techniques and interventions that can lead to improved information quality, the options for their deployment and the process of learning from outcomes, are the elements of the IQA framework. The key application of the framework is the development of IQA templates to support specific work areas and/or information flows. The framework will evolve as our understanding improves, both centrally and locally,

The policy reinforces basic principles, namely that:

- High quality clinical information underpins high quality clinical care;
- Information should be captured once only;
- Information should be accurate and complete the first time it is recorded;
- Information for management purposes should be, wherever practicable, derived from the information collected to support care.

Scope

For use in all areas; by all Staff; for use for all patient information

All authorised staff involved in the collection of data are responsible for accurate and timely records to ensure that Health Board information is correct and available. This is required to ensure seamless care from teams within the Health Board and to enable the Health Board to accurately report activity. This Policy is intended to be a comprehensive guide to all staff involved in managing data associated with Clinical Information Systems both electronic and manual.

The purpose of this policy is to set out the strategic direction for further developing information assurance capability and effectively embedding an Information Assurance culture across the Health Board.

This policy describes the measures that all the Health Board's information systems must implement to achieve appropriate levels of quality in normal operation.

The policy supports the eHealth Policy and aims to guide improvement in three broad areas: availability, integrity and confidentiality.

Confidentiality: We protect information from unauthorised disclosure and ensure that we only hold information that we need and have a right to retain

Integrity: We ensure that the data we hold is correct, current, & can only be modified by authorised users with clear audit trails

Availability: We ensure that the data needed is there when its needed

Aim

The aim of this document is to:

- Define the organisational structures within which data quality is managed, monitored, reported and improved.
- Outline main responsibilities and accountabilities, together with the appropriate reporting mechanisms for providing feedback
- Confirm Health Board policies and procedures relating to data quality
- Allocate responsibility for reviewing, updating and amending such documents, with an established timetable and monitoring system, ensuring compliance with written policies and procedures

Objectives

The aim of this document will be achieved by the following objectives:

- Mandate the use of validated NHS Numbers as the unique identifier on all patient records

- Ensure compliance with data standards and all legal obligations
- Create a framework within which information quality issues can feed into training programmes, to address any recurrent problems
- Raise awareness of information quality issues with clinical and nursing staff, and ensure that information systems meet clinical needs.
- Compliance with Freedom of Information legislation, which substantially increases the public visibility of information quality issues.

Policy

Why does the quality of information matter?

High quality information is vital to safe and effective patient care and for this purpose 100% accuracy 100% of the time must be the goal. The model of care is changing and broadening to rely upon interdisciplinary care pathways and clinical networks that transcend organisational boundaries. Information is increasingly used in new and different ways, in a range of different settings, underpinning the continuity and quality of care, for example information provided through forecasting and machine learning models are only as good as the underlying data they have learnt from. These developments create pressure to improve the quality and standardisation of existing information collections but also lead to new and greater demands for information to be made available to different users.

Poor quality information impacts directly upon each and every use made of that information. For example:

- In clinical care, poor quality information may:
 - o result in patients being harmed or distressed
 - o undermine the Health Board clinicians place in recorded information
- In disease surveillance, poor quality information may:
 - o undermine the validity of conclusions drawn
 - o obscure facts and put the public at risk
- In medical research, poor quality information may:
 - o undermine the credibility of evidence based care
 - o cause the validity of findings to be questioned
- In health service management, poor quality information may:
 - o prevent understanding of best clinical practice
 - o result in resources being poorly targeted

Clinical audit and governance processes require that clinical practice be monitored and reviewed and the performance management of clinicians is receiving increased attention. All this activity is dependent upon the availability of high quality information. High quality information should be produced as part of the routine daily activity within a hospital, or other healthcare setting.

Causes of poor information quality

Poor information quality may be due to errors in systems design, the way the information is processed or the way it is interpreted or a combination of all 3. Whilst error is not the sole cause of poor information quality it is by far the most significant. The prevention, and where this fails, detection and correction of error, is a key goal of the Information Quality Assurance Policy.

Poor information quality may be due to errors in systems design, the way the information is processed or the way it is interpreted. Errors will be taken seriously within the Health Board and with the use of DATIX the Health Board will be able to assess the numbers of adverse events and also the lessons learnt from such occurrences. These lessons will form part of the workplan for Information Quality Assurance within the Health Board.

Most errors can be attributed to faulty systems, unhelpful processes and poor training and guidance for staff. This policy therefore needs to be set within a programme of work that seeks to improve organisational performance across a wide range of traditionally distinct disciplines.

Electronic Records and Information Quality

Over recent years attempts have been made to introduce universal electronic medical records. Through the National Programmes in the NHS there is now a centrally driven concerted effort to have an electronic record for every patient.

Amongst the benefits electronic records bring is the potential for a fundamental improvement in information quality. However, without agreed standards for recording and exchanging health data, computerisation can significantly increase the risk of poor quality data leading to misinterpretation and adverse events. Equally, the skills to effectively capture information, manipulate data, present data meaningfully and realise the benefit from improved information quality must be developed and effectively supported.

Information Quality Assurance through Information Governance

It has become clear that whilst data, information, quality, information quality and data quality are all frequently used terms, there is no general agreement on definitions.

Whilst this policy is unlikely to resolve this, in order to avoid confusion and unhelpful debate it is necessary to clarify the way that these terms are used here and to set them within the, perhaps less familiar, concepts of information governance and information quality assurance.

Data; Facts, readings, measurements – items that are essentially ‘value free’

Information; Data that has been interpreted or to which commentary has been added by a user for a purpose, making it ‘value-laden’.

Quality (has two aspects); i. The characteristics that meet user needs and thereby provide user satisfaction. li. The absence of deficiencies that result in user dissatisfaction.

Definition of Data Quality

According to J.M. Juran (1951), data are of high quality “if they are fit for their intended uses in operations, decision making and planning.” Alternatively, data is deemed of high quality if it correctly represents the real-world construct to which it refers. Within an organisation, acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business

intelligence reporting. Data quality is affected by the way the data is entered, stored, analysed, managed and reported.

Consideration of information and data quality are made more complex by the general agreement that there are a number of different aspects to information/data quality but no clear agreement as to what these are. When assessing data within any dataset, it is important to acknowledge that there are several dimensions to its quality, all of which impact on the usability of the information it represents. These can be summarised as follows:

The Six Dimensions of Data Quality

Data quality in essence is the foundations of information. The six dimensions of data quality are defined as:

- **Timeliness:** Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions.
- **Completeness:** Data requirements will be clearly specified and based upon the information needs of the organisation and data collection processes matched to these requirements.
- **Accuracy:** Data should be sufficiently accurate for its intended purposes and captured as close to the point of activity as possible.
- **Consistency:** Data will reflect stable and consistent data collection processes across collection points and over time. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods.
- **Precision:** Data captured will be relevant to the purposes for which it is used, capable of evolving to reflect changing needs. Quality assurance and feedback processes are needed to ensure the quality of such data.
- **Validity:** Data will be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions.

When addressing the issue of data quality, it is common for only one or two of these dimensions to be taken into account. However, to gain a full understanding of the quality of data, all of the above dimensions need to be considered as a whole, even if this is not always done at the same time.

The dimensions arguably increase in complexity and detail as one moves from examining the basic dimensions focussed on whether the data is valid and submitted on time, to whether the data actually paints an accurate and consistent picture of the activity it represents.

As it is not always possible, for a variety of reasons, to adhere to all the principles in every case, a judgement must be made by each information Asset Owner to the relative importance of individual data items. This will depend on the intrinsic nature of the data, as well as the use to which the application is put. High priority items could include important clinical details such as allergies, chronic disease factors or current medication. Other examples might include identification data, financial transactions, etc. However, lower priority items should not be considered as optional for data collection (unless defined as such), merely that the consequences of being unable to collect the data are less serious.

What is Information Quality Assurance (IQA)

Information quality assurance is a cycle process that aims to assess performance and deliver improvement. Improvements relate both to the quality of the information but also, a means of developing and reinforcing an information quality culture, to improve compliance with information quality standards. In line with the approach adopted for broader information governance, these standards relate to:

- a) The management of Information Quality
- b) The requirements for systems that process information
- c) Organisational processes and working practices
- d) The training and guidance that should be provided to staff

IQA requires the assessment of compliance with information quality standards and an assessment of outcomes in terms of improved information quality. A generic model of information quality with standards, guidelines and measurement tools is necessary. Whilst the assessment of compliance against information quality standards is relatively straightforward – attainment levels are either achieved or they are not – the measurement of information quality is more complicated. On the one hand information quality can be measured with subjective perceptions (qualitative) from information users. On the other hand there are approaches developed on the basis of quantitative characteristics such as completeness and accuracy.

IQA proposes a measuring system for information quality that assesses both qualitative and quantitative aspects in the context of key information pathways.

Procedures

The complex nature of patient data: the volume, circulation, confidentiality requirements, legal obligations and associated administrative and management issues makes it essential that procedures are in place which will ensure that the patient and the Health Board are protected from risk. The Health Board is committed to ensuring that procedures are in place to minimise risk and provide an efficient and effective information service through access to high quality patient data.

Measurement of Data Quality

The assessment of whether data quality is of sufficiently high standard is dependent on the data in question and the purpose for which it is collected and utilised. Typical measures may include the following:

- All mandatory data collection is complete, accurate and up to date
- Manual data is readable and stored in a structured filing system
- Duplication of records is minimised
- Data is collected in accordance with documented procedures and guidelines meeting national/local standards
- Percentage of completed and valid coded data regularly monitored
- Random audits on data for accuracy, timeliness and completeness

A scoring mechanism will be used to benchmark certain systems and modules against each other in an attempt to provide information asset owners and secondary users of the data a picture of the data quality of the datasets they are using.

Local Data Quality Procedures

All local procedures should comply with and/or map back to national data standards and coding and will be subject to control processes within the Health Board as well as to external scrutiny.

Each information system must implement well documented and clearly understood local data quality procedures with a view to ensuring that high level of data quality is maintained at all times.

It is the responsibility of the relevant named Information Asset Owner to ensure that local data quality procedures are produced and maintained and monitored. Manual recording of data is not excluded from this process.

Procedures should assess levels of risk associated with different data items, identifying high priority data items and noting the consequences of missing data.

Procedures must specify where applicable what enforcement mechanisms are available to ensure adherence.

Data quality procedures should be reviewed on a regular basis to ensure that they still meet the business requirements of the Health Board.

Regular auditing against local internal targets to monitor data quality compliance, and clear processes on handling poor data quality outcomes to ensure improvement.

Where data errors and/or corruption of data are identified, clear processes must be in place to identify implications and immediate correction of such data.

In certain circumstances, systems may have specific resources allocated for the maintenance of data quality. Local data quality procedures must specify under what circumstances those resources should be used.

Failure to Maintain Data Quality

All instances of failure to maintain adequate data quality in Health Boards systems (for example, by entering incorrect data) will be dealt with as follows:

- First Instance – The individual responsible for the data quality failure will be contacted to inform them of the error and will be offered further training.
- Second Instance – The individual responsible for the data quality failure and their Line Manager will be contacted to inform them of the error and the individual will be notified that they will need to attend further training. A support process will be developed around the individual along with a monitoring and validating routine of the individual's data entry.
- Third Instance – The individual responsible for the data quality failure and their Line Manager will be contacted to inform them of the error. Access to the relevant information system will be reviewed for the individual concerned until they have successfully completed further training and further adjusted working practices to minimise future errors.

- Fourth and Subsequent Instances – The individual responsible for the data quality failure and their General Manager will be contacted to inform them of the error. The Divisional Manager will be expected to consider initiating the Health Board's Capability Procedure to deal with the inability of the individual to maintain adequate data quality.

Training

Training of staff in data quality awareness, security and confidentiality issues, and use in electronic systems is a cornerstone of promoting data quality across the Health Board.

1. Established processes will enable training needs to be linked to any issues highlighted during data validation, to ensure common errors in data recording are eliminated at both individual and group level
2. Comprehensive training records will be kept to ensure progress can be demonstrated, and to assist in recall of staff in the future, including user evaluation feedback to monitor the effectiveness of the training programmes available
3. Training documentation will include a section on security and confidentiality, and will provide guidance over relevant data definitions and the importance of validating, correctly classifying and recording activity information
4. Training in understanding and utilising information should also be provided for the Health Board's decision makers
5. All staff will be provided with appropriate and relevant training before they are issued with access to the electronic systems

Monitoring

The Health Board will, as a matter of routine, monitor performance by collecting and processing data according to nationally defined standards and provide appropriate feedback to all staff.

Internal data quality spot checks and local audits are undertaken by the Data Quality Improvement Manager. The Health Board will put in place mechanisms to ensure there is feedback to the individual divisions where necessary, on data quality issues and of any remedial actions that may be needed to improve the quality of the data.

Responsibilities

Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring the health board has appropriate WCDs in place. These WCDs must comply with legislation, meet mandatory requirements, and provide services that are safe, evidenced-based and sustainable.

Executive Director of Finance

Formal responsibility for Data Quality lies with the Executive Director of Finance who is responsible for reporting on data quality to the Board.

Caldicott Guardian

The Health Board's Caldicott Guardian has a responsibility for reflecting service users' interests regarding the use of patient identifiable information and is responsible for ensuring patient identifiable information is shared in an appropriate and secure manner.

Senior Information Risk Officer

The accountable director for the policy is the Senior Information Risk Officer (SIRO). The SIRO takes ownership of the Health Board's information risk policy and acts as an advocate for information risk on the Board. The SIRO works closely with Information Asset Owners to ensure Health Board information systems are fit for purpose.

Digital Director

The Digital Director has delegated professional responsibility for information assurance and data quality within the Health Board. They are also responsible for the Data Quality Team and their annual programme of work, clinical information systems and the reporting of management information. They act as an advocate for Data Quality and is responsible for reporting on Data Quality to the Executive Director of Finance.

Head of Information Services

The Head of Information Services has delegated responsibility for the management of data quality across the Health Board. Key roles will be the promotion of data quality and include:

- Providing direction and responsibility for the Data Assurance Lead
- Highlighting the importance of data quality at Management Team, Operational Services Managers meetings and other relevant committees and groups

Data Assurance Lead via the Data Quality Improvement manager

The Data Assurance Lead via the Data Quality Improvement Manager is directly responsible to the Head of Information Services for the day-to-day management of data quality across the Health Board.

- Ensuring the quality of data produced meets the requirements of the Health Board and ensuring sufficient mechanisms are in place to ensure this happens
- Developing a culture where there is an appreciation of the importance of high standards of data quality across all relevant staff groups, involved in the production and collation of data
- Ensures that through increased confidence in the quality of data reports and analyses of the data, they can be relied upon for use in better management and clinical decision making
- Provide all relevant staff with sufficient guidance and appropriate training to ensure data is collected in a consistent and accurate manner, ensuring training is updated as required
- Establish a departmental/unit data quality group to identify and address data quality issues which feeds into Health Board wide groups such as Information Asset Owners group, Transformation Working Groups, Directorate meetings etc

Departmental Data Quality Leads

Health Board Managers have a responsibility for ensuring that staff working for them:

- Record accurate and complete data in a timely manner
- Are aware of their responsibilities with regard to checking and updating any inaccuracies and missing data items in service user records

- Address any data quality issues as soon as possible and escalate appropriately
- Ensure all local procedures are documented and updated regularly and are available to all staff
- Ensure all staff are familiar with and adhere to current legislation, Health Board and local policies, procedures etc.
- Ensure all staff meet the Health Board's Data Quality Standards
- Monitor staff competencies and training needs and ensure staff attend appropriate training including refresher as appropriate for both clinical information systems and record keeping/data quality.
- Ensure staff deal with data in a secure and confidential way to comply with Information Governance standards.

Information Asset/System Owners

IAO's have responsibility for the quality of the data held within their systems. This will be achieved by setting data quality standards for the systems and routinely measuring performance against those standards. Where the standard is not being achieved, it is the responsibility of the Information Asset Owner to put in place an action plan to address. Where this requires Health Board wide action, the IAO will be supported by the Assistant Director of Informatics to ensure that the action plan is agreed and implemented at the appropriate level within the Health Board.

For each information system in the Health Board, there is a named person who is ultimately accountable for the quality of information held in that system. This register of system responsibilities, informed by the Information Asset Register, will be monitored and updated on a routine basis. In accordance with the Policy, the named individual will be responsible for:

- Reviewing policies and procedures and ensuring they are kept up to date in line with system changes
- Ensuring compliance with written policies and procedures – via spot check, and rolling programmes of audit
- Ensuring staff receive adequate training in the use of the system
- Monitoring and communicating error rates – informed via the System Administrators own localised Data Quality regime
- These responsibilities should be explicitly identified in the job descriptions for these posts and should form part of the post holder's Appraisal and Development Review.

Information Governance Sub-Committee

The Information Governance Committee is responsible for monitoring the outcomes of the Data Quality Steering Group Audits, Action Plan etc

Data Quality Steering Group

The Data Quality Steering Group will meet on a quarterly basis and is accountable to the Information Governance Sub-Committee.

The group is made up of representatives that have responsibility within their division to cascade relevant information to staff and to report any data quality issues as appropriate to the attention of

divisional managers or to the Data Quality Steering Group as appropriate, to implement measures to address them, ensure the Data Quality Policy is followed locally, Participate in audits etc. as requested by the Steering Group.

The group has overall responsibility for the implementation of this policy and the Data Quality work plan; it will manage and monitor the Data Quality Report, audit reports and action plans and feedback to the Information Governance Sub-Committee. It is the responsibility of the Divisions to ensure representation and attendance at the steering Group and to participate in audits as appropriate.

The Data Quality Steering Group will oversee and monitor the progress of this policy and the annual Data Quality Action Plans.

Audit Committee

The Audit Committee receives assurance in respect of data quality from Internal and External Audit

Employees

All Health Board staff including clinicians and administrative staff, who collect and record data both manually or on the Health Board clinical information systems must:

- Ensure timely, accurate and complete recording of data in service user records
- Update any inaccuracies and/or missing data in service user records
- Address any data quality issues as soon as possible and escalate appropriately
- Be aware of and comply with legislation, Health Board and local procedures etc.
- Ensure they meet the Health Board's Data Quality Standards
- Monitor own competencies and access training where necessary both for clinical information systems and record keeping/data quality
- Ensure all data is dealt with in a secure and confidential way to comply with Information Governance standards.

2.4

09:35, 10 Mins

2.4 - Review of Organisational AI Readiness

*Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Gareth Jenkins
(Hywel Dda UHB -
Head of Data Science)*

| For assurance

Attachments

[2.4.1 DDIC SBAR - AI Readiness Assessment.pdf](#)

[2.4.2 Hywel Dda AI Readiness final report v1.0.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Review of Organisational Artificial Intelligence (AI) Readiness
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Gareth Jenkins, Head of Data Science

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

DRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides assurance to the Committee on Hywel Dda University Health Board's (HDdUHB) current level of organisational Artificial Intelligence (AI) readiness, together with recommendations, based on the independent assessment undertaken with CGI.

The Committee is asked to receive assurance on the progress made to date, the maturity of current arrangements, and the identified priorities required to enable safe, scalable and responsible AI adoption across the organisation.

Cefndir / Background

CGI undertook a comprehensive AI Readiness Assessment to evaluate HDdUHB's ability to adopt and scale AI across clinical, operational and corporate functions.

The assessment:

- Reviewed AI readiness across **six core pillars** (governance, people, data, models/assets, platforms, monitoring)
- Drew on:
 - Stakeholder interviews
 - Organisation-wide survey data
 - Existing documentation and live initiatives

The purpose was to:

- Understand the **current state of AI capability**
- Identify **risks and gaps**
- Define **practical next steps for safe and scalable adoption**

Asesiad / Assessment

Overall Position

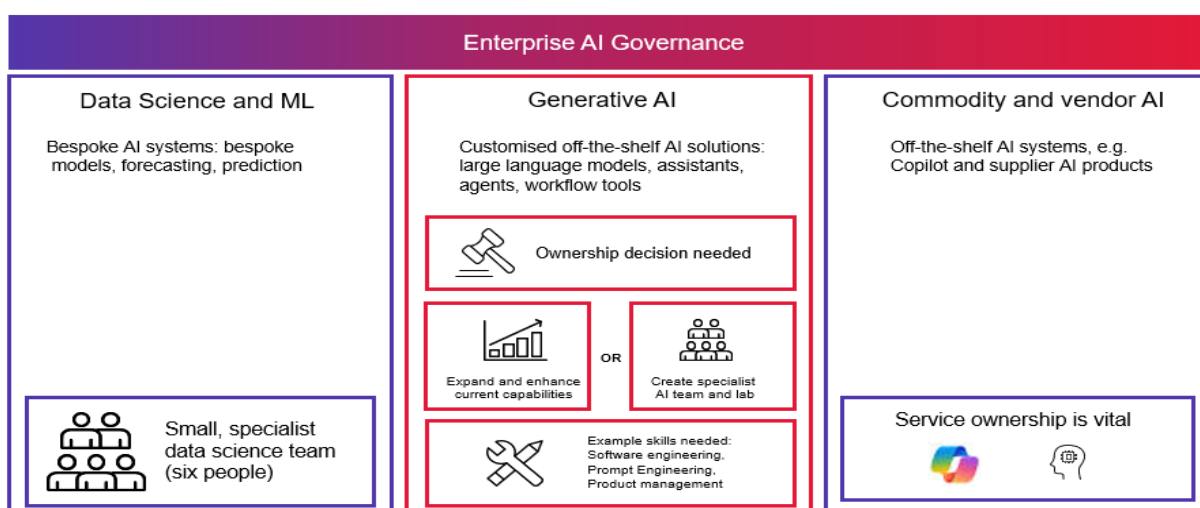
The assessment concludes that HDdUHB has demonstrated emerging AI readiness, although this has not yet scaled across the organisation. Strong foundations are in place; however coordinated development and implementation are required to support enterprise-wide adoption. The evidence shows strong appetite for AI, active Copilot use and visible experimentation across administrative, clinical, operational and analytical areas. A separate workstream focussed on Shadow IT has identified use of several cloud-based AI tools. HDdUHB has important foundations in place to build on, including data quality activity, an information asset register, platform investment, Information Governance (IG) and an established data science function. The data science function and initial rollout of Copilot provide foundations at each end of the AI spectrum.

Appendix 1 provides the full report of the AI Assessment. It is intended to support the recommendations outlined within this paper by providing additional detail and assurance regarding the scope, implementation considerations, and anticipated outcomes of the proposal. The content within the appendix should be considered alongside the main report when reviewing the proposed next steps and decision points.

The opportunity is to establish a comprehensive approach to AI governance and oversight across the organisation, ensuring that all forms of AI are appropriately considered. Current AI adoption outside the Data Science function remains at an early-stage and has yet to be scaled, with activity largely focused on productivity tools and localised areas of experimentation. The next step is to align the data, platform, tool and governance landscape, so it is clear where different types of AI activity should occur, where assets should reside and how they transfer from idea to supported use at scale. The overall direction is to build on existing foundations, make AI activity visible to the right people, strengthen data quality for AI use, clarify approved tools, refine platform roles and identify priority use cases to create reusable delivery patterns.

Hywel Dda and the AI Spectrum

Hywel Dda has emerging activity across the AI spectrum, but custom generative AI remains the least clearly owned area. This will need clearer ownership, capability and governance as use cases develop.



CGI identified five key areas to prioritise that would safely integrate AI into the organisation. These areas take into account the parallel workstreams CGI are already working on with HDdUHB. Investment in governance, resources and user adoption will be required. Although these streams can be approached individually, logistically it would make more sense to group

them together as a program of work. Funding is potentially available from partners such as Microsoft to offset some costs.

Five Priorities for HDdUHB

The five priorities below provide a practical route from HDdUHB's current position of emerging AI readiness towards safe, scalable and responsible organisational adoption. They reflect the need to move beyond isolated experimentation by strengthening governance, improving visibility of AI activity, building staff confidence and capability, clarifying the data and platform foundations, and focusing early delivery on a small number of high-value use cases. Taken together, these priorities should be treated as a coordinated programme of work rather than separate initiatives, ensuring that AI adoption is aligned to organisational objectives, supported by appropriate controls, and able to deliver measurable benefits for patients, staff and services:

1. **AI Governance Foundations** - Implement AI principles, policy and the appropriate guardrails to enable responsible and scalable deployment.
2. **AI Enablement / Adoption** - Create a dedicated AI team responsible for building solutions, establishing staff training and fostering AI awareness.
3. **Data & Platform Strategy** - Clarify the data, content and platform foundations needed to support priority AI use cases.
4. **AI Tooling and Funding** - Optimise value from existing AI tooling, including Copilot, and leverage AI Vendor funding opportunities. Eradicate areas of shadow AI.
5. **Scaling Efficiently and Effectively** - Build priority AI use cases with reusable components (Radiology AI use cases in progress), to create repeatable and modular patterns.

Recommendations for HDdUHB

The recommendations below translate the findings of the AI Readiness Assessment into practical actions for HDdUHB. They are intended to strengthen organisational oversight, make current and future AI activity visible, clarify the safe and approved use of tools, and ensure that early priority use cases are selected and delivered in a way that creates reusable patterns for wider adoption. The recommendations also recognise that AI adoption must be supported by clear governance, robust data foundations, staff confidence and defined routes from idea, to pilot, to scaled implementation.

- **Make AI activity visible to the right people:** align the information asset register with data science tracking, Copilot, vendor AI and foundational AI use cases so the AI Governance Group has clear oversight.
- **Build on existing governance processes:** enhance Responsible AI principles, policy scope, approval routes and assurance expectations so AI can be managed consistently. This includes those identified for Copilot.
- **Strengthen data quality for AI use:** build on existing data quality work to make source, ownership, metadata, known limitations and suitability visible for priority AI use cases.
- **Prioritise a small number of use cases:** agree the highest-value opportunities, define success measures, and use them to tighten working patterns from idea to pilot and wider adoption decision.

- **Clarify approved tools and safe use:** make it clear which AI tools can be used, what they can be used for, what data boundaries apply and where staff should go for guidance.
- **Refine the platform and tool landscape:** agree what Databricks, Microsoft, Posit, Copilot, other vendor tools and existing data platforms are each used for, including boundaries and hand-offs.
- **Build reusable patterns from early work:** utilise priority use cases, including radiology where appropriate, to create repeatable approaches for data checks, evaluation, approvals, release, monitoring and feedback.

Implications and Risks

The assessment highlights that the principal risk for HDdUHB is not AI adoption itself, rather it is the potential for AI activity to develop in an uncoordinated manner without appropriate organisational oversight, clinical assurance, IG, data quality controls or approved mechanisms for scaling effective solutions. In the absence of a clear governance framework and visible pipeline of AI activity, there is a risk that local experimentation, supplier-led functionality and productivity tools are adopted inconsistently, creating variation in practice, uncertainty for staff, avoidable duplication and gaps in accountability. This could expose the organisation to data protection, cyber security, clinical safety, equality, legal and reputational risks, while also limiting the ability to realise the anticipated benefits of AI in improved productivity, decision support, patient flow, quality and service sustainability:

- Data protection and security risks (particularly where governance and classification are immature)
- Inconsistent or unsafe AI usage across departments
- Failure to realise value at scale due to fragmented approaches
- Reputational and clinical risk if AI is implemented without sufficient oversight and assurance

Conclusion and Next Steps

The assessment confirms that HDdUHB has a clear opportunity to build on its existing AI foundations, including the data science function, active Copilot use, emerging clinical and operational interest, and established IG and data quality arrangements. However, AI adoption has not yet been scaled across the organisation and there is a need to transition from isolated experimentation to a coordinated, well governed and benefits-led approach. This will require stronger oversight, clearer approved mechanisms for AI use, improved visibility of current activity, defined data and platform foundations, and sufficient capacity to support safe adoption. The proposed next steps are therefore intended to provide a structured route from current readiness to controlled implementation, ensuring that AI is adopted in a way that is safe, clinically assured, legally compliant, operationally useful and aligned to organisational priorities.

AI Readiness Assessment – Proposed Next Steps and Delivery Plan

The AI Readiness Assessment identified that HDdUHB has strong foundations and several emerging areas of AI activity but requires a more coordinated, governed and benefits-led approach to support safe scaling across the organisation. The recommended next phase is therefore focused on establishing governance, creating organisational visibility, enabling safe adoption and developing the supporting data and technology foundations:

- Establish an AI Governance Group, or equivalent governance route, with clear Terms of Reference, decision rights and reporting arrangements into the Digital, Data and Innovation Committee.

- Create a visible pipeline of current and proposed AI activity, bringing together data science work, Copilot adoption, vendor-enabled AI, shadow AI findings and priority clinical, operational and corporate use cases.
- Define and communicate approved AI tools, safe-use principles, data boundaries and escalation routes so staff understand what can be used, for what purpose and with what safeguards.
- Agree a small number of high-value priority use cases, including where appropriate radiology and productivity-focused opportunities, with clear success measures, clinical safety requirements, IG requirements and benefits realisation plans.
- Clarify the data and platform architecture needed to support AI, including the role of existing Microsoft, Databricks, Posit, vendor and data science environments, and the hand-offs between them.
- Develop an implementation plan that sets out the required capacity, governance products, training and awareness activity, delivery milestones and reporting cycle, with a progress update presented to the Committee.

Proposed Phasing

Phase 1 – Foundations (Months 1–3)

- Establish AI Governance Group.
- Approve Terms of Reference and reporting arrangements.
- Create AI activity register and pipeline.
- Publish interim AI guidance.
- Commence awareness and training programme.
- Define architecture principles and governance products.

Phase 2 – Prioritisation and Control (Months 4–6)

- Prioritise initial AI use cases.
- Complete architecture blueprint.
- Implement assurance and approval processes.
- Baseline benefits and success measures.
- Confirm funding and resource requirements.

Phase 3 – Delivery and Scaling (Months 7–12)

- Deliver priority use cases.
- Monitor benefits, safety and compliance.
- Refine governance arrangements based on experience.
- Produce AI Roadmap.
- Report progress and outcomes through DDIC.

Argymhelliad / Recommendation

The Committee is requested to:

- **NOTE** 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.
- **RECEIVE 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.
- **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.

- **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.
- **NOTE** 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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.1 That the direction, development and delivery of the Digital Strategic Plan is to drive continuous improvement and support digitally enabled health care through a digitally enabled workforce to achieve the objectives of the Health Board's Annual Plan/Integrated Medium-Term Plan (IMTP). 3.1.19 Seek assurance on delivery against all Planning Goals aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, scrutinising and supporting and endorsing plans and programmes developed to deliver the Committee's objectives.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
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 : (<i>complete for strategic change and/or significant service changes</i>)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Hywel Dda AI Readiness final report v1.0
Rhestr Termiau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no immediate financial or capital commitments arising directly from this assurance paper. However, delivery of the proposed AI readiness priorities is likely to require further consideration of capacity, governance support, training, platform use, tooling and potential supplier or partner funding opportunities. Value for money will need to be assessed through prioritised use cases, clear benefits realisation plans and avoidance of duplicated or uncoordinated AI investment.
Ansawdd / Gofal Claf: Quality / Patient Care:	The report supports quality and patient care by setting out the governance, assurance and data foundations required for safe AI adoption. Potential benefits include improved productivity, decision support, patient flow, quality improvement and service sustainability. Any clinical AI use case will require appropriate clinical safety assessment, information governance review, evaluation, monitoring and clear accountability before wider implementation.

Gweithlu: Workforce:	The workforce impact is primarily related to capability, confidence and capacity. AI adoption will require staff awareness, training, clear safe-use guidance and access to approved tools. There may also be a need for dedicated capacity to support governance, evaluation, implementation and benefits realisation. The report does not propose workforce reductions; rather, it identifies opportunities to support staff productivity and reduce avoidable administrative burden where AI is safely applied.
Tegwch lechyd: Health Equity:	Potential health equity impacts have been considered at a strategic level. AI has the potential to improve access, consistency and service responsiveness, but may also introduce or amplify bias if data quality, population representation, evaluation and monitoring are not adequately addressed. Equity considerations should therefore be built into prioritisation, design, testing and ongoing monitoring of each AI use case. • Potential impacts on health equity have been considered: Yes, at strategic level. • An equity-focused health impact assessment has not been undertaken at this stage; this should be considered for individual AI use cases where there is potential impact on access, outcomes or experience.
Risg: Risk:	The key risks are uncoordinated AI adoption, inconsistent safe-use practice, unclear accountability, immature governance, data protection exposure, cyber security risk, clinical safety risk, equality risk and failure to realise benefits at scale. The proposed mitigations are to establish clear AI governance, create a visible AI activity pipeline, define approved tools and data boundaries, strengthen data quality controls, prioritise use cases, and report progress and assurance through the Digital, Data and Innovation Committee.
Cyfreithiol: Legal:	There are no immediate legal impacts arising from this assurance paper. Legal considerations will need to be addressed as part of individual AI use cases, particularly in relation to data protection, information governance, procurement, intellectual property, clinical safety, transparency, accountability and compliance with relevant legislation and national guidance.
Enw Da: Reputational:	There is potential reputational benefit if Hywel Dda adopts AI in a safe, transparent and benefits-led way, demonstrating responsible innovation and improved support for services. Conversely, ungoverned or poorly assured AI use could create reputational risk, particularly where it affects patient care, privacy, fairness, staff confidence or public trust. The governance and assurance

	approach proposed in the report is intended to mitigate this risk.
Gyfrinachedd: Privacy:	Privacy and confidentiality are central considerations for AI adoption. The report identifies the need for approved tools, clear data boundaries, visible oversight of AI activity, alignment with information asset management, and robust information governance review. Any use of personal, confidential or sensitive data in AI tools must be subject to appropriate assessment, controls, security safeguards and ongoing monitoring.
Cydraddoldeb: Equality:	Equality impacts have been considered at a strategic level. AI adoption has the potential to improve consistency and access, but may also create differential impacts if underlying data, model design, implementation or monitoring do not adequately account for protected characteristics and population diversity. Equality considerations should therefore be assessed for individual AI use cases as part of governance, approval and evaluation. • Equality Impact Assessment (EqIA) screening has not been undertaken for this assurance paper; it should be completed for individual AI use cases where implementation may affect access, experience, outcomes, staff groups or protected characteristics.

AI Readiness Assessment

Hywel Dda
June 2026



Contents

Page	Section
3	Executive Summary
6	Why and How we Arrived at These Findings
12	Approach
16	Conclusions and Roadmap
19	Responsible AI at Hywel Dda
28	AI Readiness: Technical Pillars
37	Microsoft Copilot Readiness
45	User Research
56	Acknowledgements
58	Appendix

Executive Summary

Introduction

CGI worked with Hywel Dda to assess its current AI readiness and identify practical next steps for safe and scalable adoption

The core question for this assessment was:

What capabilities does Hywel Dda already have to support AI development and use in clinician/patient focussed areas, and what needs to be done to further integrate AI into the organisation safely and with confidence?

- CGI identified five key areas to prioritise in order to safely integrate AI into the organisation.
- They take into account the parallel workstreams CGI are already working on with Hywel Dda.
- It is clear that investment in governance, resources and user adoption will be required.
- Although they can be approached individually, logistically it would make more sense to group them together as a program of work. N.B. Funding is potentially available from partners such as Microsoft to offset some costs.
- The Roadmap slide (18) identifies the items to work on now, in the near term and further down the line.

Five key priorities for Hywel Dda

AI Readiness Assessment

01

AI Governance foundations

Implement AI principles, policy and the appropriate guardrails to enable responsible and scalable deployment.

02

AI Enablement / Adoption

Create a dedicated AI team responsible for building solutions, establishing staff training and fostering AI awareness.

03

Data & platform strategy

Clarify the data, content and platform foundations needed to support priority AI use cases.

04

AI tooling/Funding

Optimise value from existing AI tooling, including Copilot, and leverage AI Vendor funding opportunities. Eradicate areas of shadow AI.

05

Scaling Efficiently & Effectively

Build priority AI use cases with reusable components*, to create repeatable and modular patterns.

* Radiology AI Use Cases in flight

Enterprise AI success depends on aligning business priorities with scalable technology foundations.

Why and How we Arrived at These Findings

Why AI Readiness is an important enabler for Hywel Dda

Many organisations are focusing on adopting AI without realising full value
Employees are adopting AI fast and bringing it to work if its not provided



88% of organisations reported regular AI use in 2025

McKinsey – State of AI, 2025

60% not yet realising material benefits

BCG – Widening AI Value Gap, 2025



43% increase in AI incidents reported globally since 2024

Stanford AI Index, 2026

Data privacy and patient confidentiality remain top worries, with up to 57% of healthcare leaders citing security concerns.

McKinsey Generative AI in Healthcare, 2026



78% of knowledge workers bringing own AI tools to work

Microsoft – Work Trend Index, 2024

78% of healthcare staff are entirely unaware of the HIPAA risks they introduce via shadow AI.

Healthcarediver – Shadow AI Report, 2026

Summary



CGI assessed Hywel Dda's **current AI readiness** across six pillars, drawing on stakeholder interviews, an organisation-wide survey and available internal documentation.



The evidence shows **strong appetite for AI**, active Copilot use and visible experimentation across administrative, clinical, operational and analytical areas. A separate workstream focussed on **Shadow IT** has identified use of several cloud-based AI tools



Hywel Dda has **important foundations in place to build on**, including data quality activity, an information asset register, platform investment, AI Governance and an established data science function.



The data science function and initial rollout of Copilot provide foundations at each end of the AI spectrum. The opportunity is to make sure **all types of AI** are covered, with data science overview and AI governance oversight.



Current AI use outside of Data Science remains **early-stage and not yet scaled**, with activity mainly focused on productivity support and pockets of experimentation.



The next step is to **align the data, platform, tool and governance landscape**, so it is clear where different types of AI activity should happen, where assets should reside and how they move from idea to supported use at scale.



The overall direction is to build on existing foundations, make AI activity visible to the right people, strengthen data quality for AI use, clarify approved tools, refine platform roles and identify priority use cases to create **reusable delivery patterns**.



CGI's engagement with Hywel Dda on AI-assisted radiology and data integration work provides **focused areas for further exploration** that could help connect readiness findings with practical delivery activity as AI adoption moves forward.

* Microsoft offer funding options related to AI/copilot readiness, governance, adoption and deployment.

Key Findings



AI readiness is emerging, not yet scaled: high awareness and appetite are clear, with current use mainly focused on productivity and administrative support, alongside pockets of clinical, operational and analytical experimentation.



Key elements of Responsible AI and AI Governance still emerging: requiring further policy, oversight, assurance, and compliance processes to manage AI risks effectively across Hywel Dda.



Need to connect technical foundations: Hywel Dda has data, analytics, data science, Copilot, platform and governance components, but not yet a consistent route for AI ideas, vendor tools and priority use cases to move into supported use at scale.



Clearer guidance needed on approved tools: survey and interview evidence show awareness and use of Copilot and other AI tools, while staff still need clearer guidance on available tools, permitted use, data boundaries and access.



People enablement will shape adoption: staff appetite is positive, but survey evidence shows strong demand for formal training, approved tools, written guidance and ongoing support.

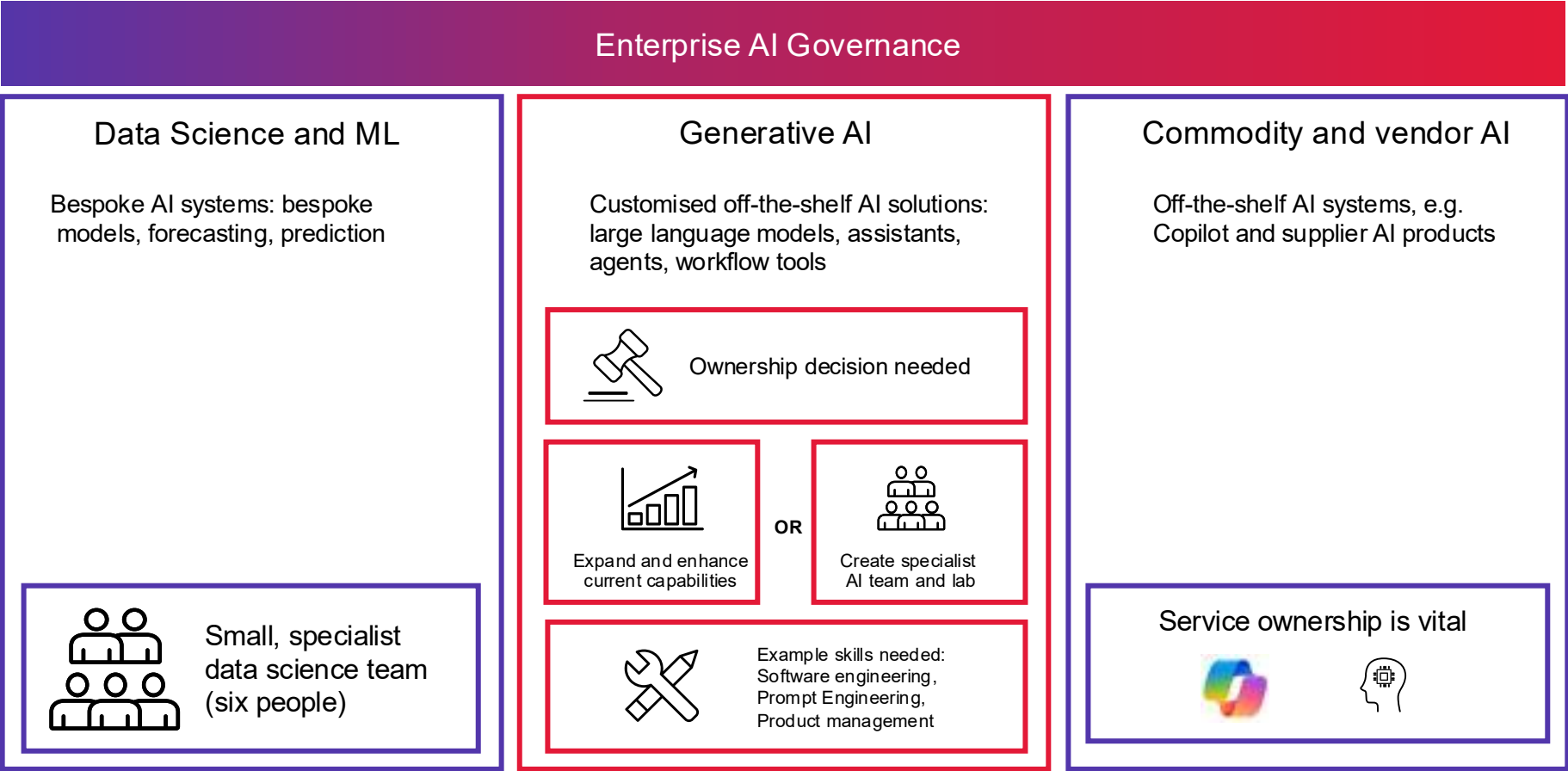


Radiology is a focused opportunity: the use cases being explored with CGI could provide a practical route to test value, controls and delivery patterns before wider adoption decisions.

These key findings are an enabler to the key recommendations

Hywel Dda and the AI Spectrum

Hywel Dda has emerging activity across the AI spectrum, but custom generative AI remains the least clearly owned area. This will need clearer ownership, capability and governance as use cases develop.



Key Recommendations



Make AI activity visible to the right people: align the information asset register with data science tracking, Copilot, vendor AI and foundational AI use cases so the AI governance board has clear oversight.



Build on existing governance processes: enhance Responsible AI principles, policy scope, approval routes and assurance expectations so AI can be managed consistently. This includes those identified for Copilot.



Strengthen data quality for AI use: build on existing data quality work to make source, ownership, metadata, known limitations and suitability visible for priority AI use cases.



Prioritise a small number of use cases: agree the highest-value opportunities, define success measures, and use them to tighten working patterns from idea to pilot and wider adoption decision.



Clarify approved tools and safe use: make it clear which AI tools can be used, what they can be used for, what data boundaries apply and where staff should go for guidance.



Refine the platform and tool landscape: agree what Databricks, Microsoft, Posit, Copilot, other vendor tools and existing data platforms are each used for, including boundaries and hand-offs.



Build reusable patterns from early work: utilise priority use cases, including radiology where appropriate, to create repeatable approaches for data checks, evaluation, approvals, release, monitoring and feedback.

* Envisioning Workshop Funding is available from Microsoft

Approach

Assessment Scope and Approach

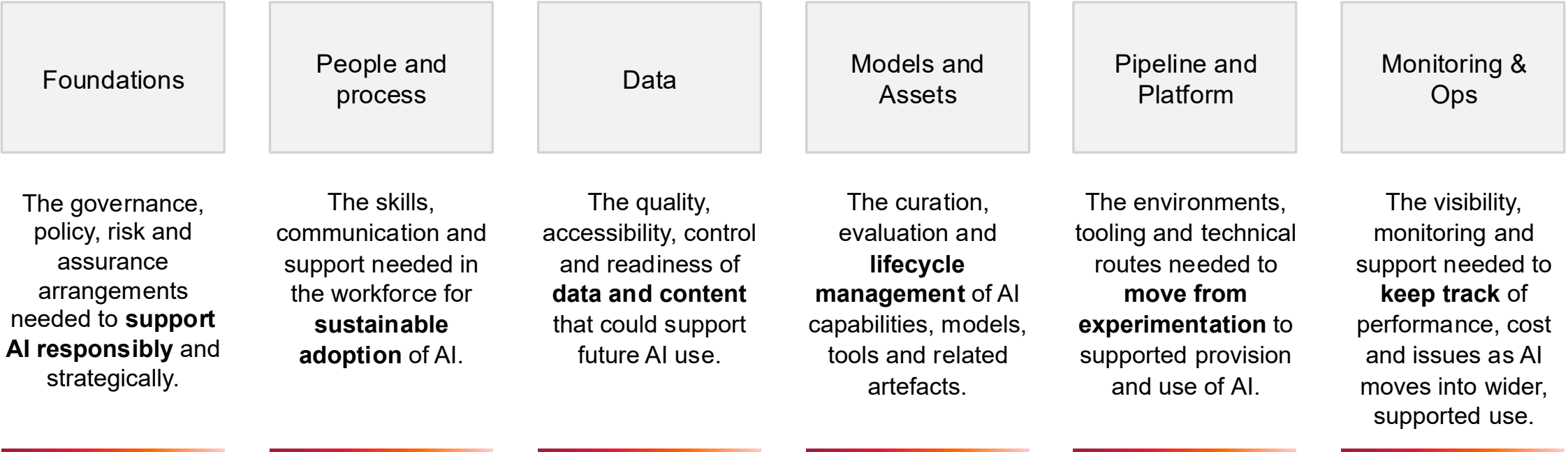
The assessment was structured across six key areas (AI readiness pillars) and drew on three main evidence sources:

- 21 stakeholder interviews across technical, governance, clinical, operational and people-focused roles
- A 16-question organisation-wide survey, issued to over 14,000 employees and completed by 433 respondents
- Available internal documents and artefacts relating to AI, governance, delivery and current initiatives

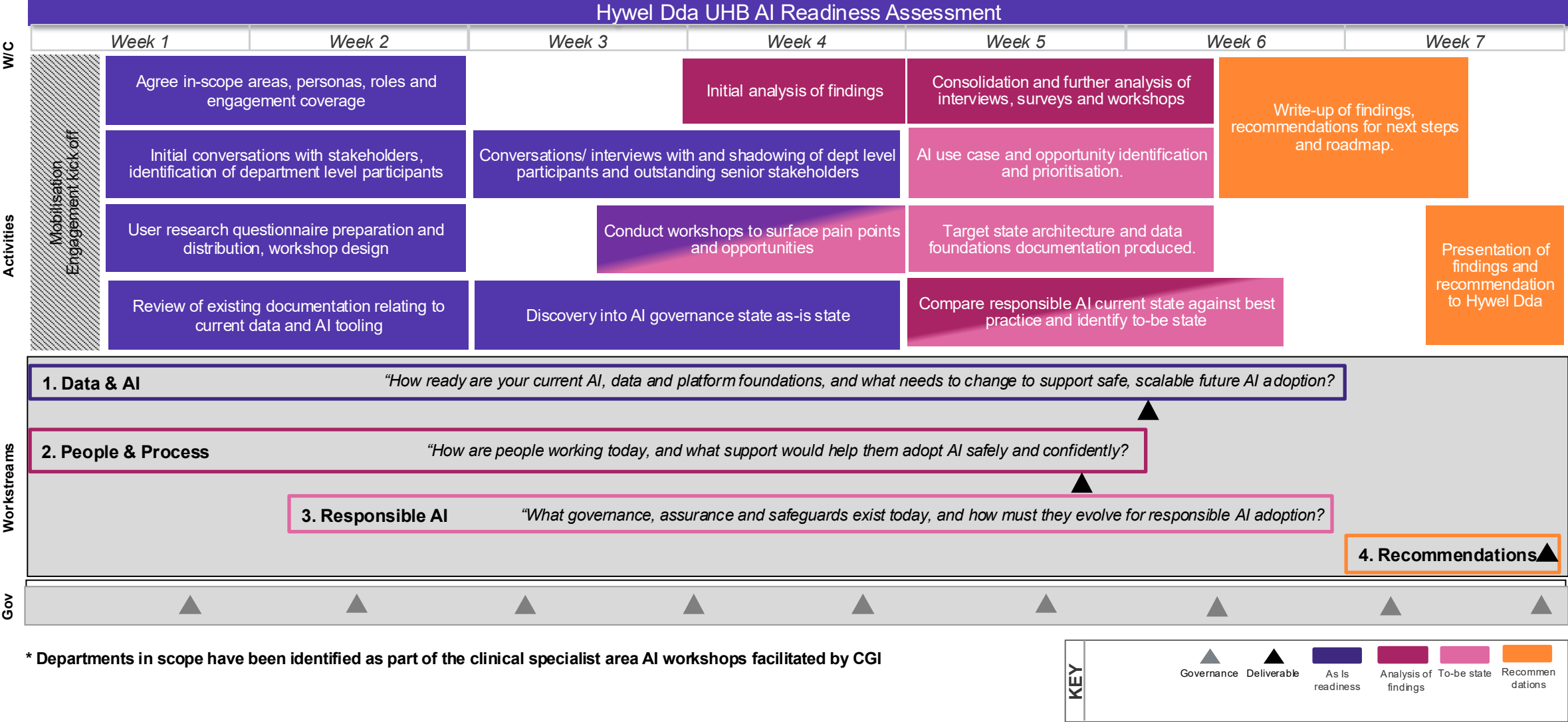
Note : Access to M365 was not available to enable deeper analysis of its current usage

AI Readiness Pillars

Six areas were used to frame Hywel Dda’s current AI readiness and identify practical next steps



Plan on a Page: AI Readiness Assessment



Conclusions & Roadmap

Conclusions

AI is being effectively used in small specialist teams. To meet the broader User Appetite and gain authority-wide benefits more training, control and documentation is required around Data, Architecture, Tools and Process

We recommend the next step is to develop your AI Governance foundations further, including:

- ❖ establishing the AI Governance Board,
- ❖ creating AI principles,
- ❖ issuing interim AI guidance, followed by a dedicated AI policy and
- ❖ rolling out staff AI Awareness training.

From there, Hywel Dda can select an AI use case to explore further and move onto the wider AI Roadmap.

AI Roadmap

AI READINESS PILLARS	INITIAL	NEXT	BEYOND
DATA	Define priority AI use cases - Identify data sources required - Analyse data for suitability and readiness	Sandbox with route to live in mind - Curate data required for proving use cases - Map future data requirements for use cases	Operationalise data controls - Determine path for quality, access and lineage - Promote high quality, reusable data products
AI MODELS & ASSETS	Ensure asset register is future proof - Ensure fields for all potential information - Link to the models and assets in situ	Test register alongside development - Develop use cases as Proof of Concepts - Use POCs to refine register fields	Curate assets beyond POC - Apply release gates and model cards - Ensure promoted assets are registered
PLATFORM & PIPELINE	Clarify platform roles - Map the AI capabilities of all available platforms - Design environments for development and prod	Build delivery patterns - Determine path to live for POCs - Build CI/CD pipelines	Harden route to live - Package pipelines with CI/CD controls - Set rollback and support ownership
MONITORING & OPS	Define baseline and monitoring requirements - Forecast expected cost and usage - Agree AI-specific metrics and logging to capture	Build monitoring and logging - Build logging into the POCs as a first pass - Ensure monitoring is visible and actionable	Run live service controls - Track defined metrics - Monitor and act where necessary
FOUNDATIONS Responsible AI	Define Responsible AI at Hywel Dda - Agree AI principles and publish AI guidance - AI awareness training for staff	Responsible AI in action - Refine AI risk management and escalation - Review AI compliance	AI Assurance - Review audit processes - Plan for monitoring and reporting
PEOPLE & PROCESS	Plan communications and assign owners Define how people stay informed and involved	Human in the loop - Subject Matter Experts input into POCs - Keep the workforce informed	Embed into BAU - Communicate progress or change regularly - Ensure user feedback is considered

Responsible AI at Hywel Dda

Enterprise-level

Key headlines for Responsible AI and AI Governance

1

Priority: Essential foundations

Critical to get AI Principles, interim AI guidance and mandatory 'AI Awareness' training out to provide clarity for Hywel Dda staff.

2

Update existing processes

Review and update existing Governance processes to make sure they include AI risk identification and management.

3

Assess compliance

Look at AI considerations for Hywel Dda and any new requirements that might need to be included for suppliers of tools with AI features.

4

Develop AI assurance further

Refine structures and processes for monitoring, auditing and reporting on AI systems and organisational AI Governance processes.

AI is powerful but it
does need to be
used **thoughtfully.**



We need to consider:

**People, regulations,
global standards,
sustainability, and
AI risk management.**

With the right
governance, we can
innovate with confidence.



AI Governance Board

Effective AI Governance needs a **holistic overview** across ethical, legal, operational and societal aspects. Focusing on only one at a time can mean **vital opportunities** for innovation and risk management are missed. An AI Governance Board ensures this holistic overview happens.

Benefit: Robust, long-term structure that will provide a solid foundation as AI use grows within Hywel Dda, compared to alternative approaches.



AI Governance Board members:

- * Director of Digital (Anthony Tracey)
- * Head of Information Governance (Patrycja Duszynska)
- * Head of Digital Operations (Gavin Jones)
- * Other members (e.g. Clinical Safety team, Caldicott Guardian, Risk and Assurance team members)

Ways of working:

AI Governance Board meets regularly to own AI Governance and progress the tasks in the framework. Chaired by Director of Digital, unless delegated.



1) Make it clear: What does Responsible AI mean for Hywel Dda?

Current status	Next steps	Responsible
AI principles	- Existing values: https://hduhb.nhs.wales/healthcare/services-and-teams/our-values/ - Get AI Board input on what Hywel Dda's AI principles should be - Get Executive sponsorship - Who needs to be considered and/or who needs to test the principles? Operations – especially Cybersecurity, Information Governance, Clinical safety (CNO, CIO, clinical safety forums), Caldicott Guardian, Risk and Assurance team.	Director of Digital (Anthony Tracey, Executive Lead).
AI policy	- N/A - Define what's included under 'AI' at Hywel Dda - Issue interim best practice guide for staff as priority, and then write, approve and publish the new AI policy for staff. - Identify process for reviewing AI policy annually (e.g. take to relevant Board, go to consultation, then take to executive group). - Signpost to other resources for changing info (e.g. list of approved tools) - Refer to other related policies - both All-Wales and local policies.	Director of Digital (Anthony Tracey, Executive Lead).
Staff training	- Microsoft Copilot training exists (365 Centre of Excellence – not mandated) - Microsoft Copilot guidance exists - Compliance platform – have some training on AI - Establish mandatory 'AI Awareness' training for staff (e.g. 30 mins). - Link to the AI policy and Acceptable Use policy in the training - Consider tiers of learning - who only needs general 'AI Awareness' training and who needs additional, more detailed responsible use training (e.g. building AI systems, clinical use) - Clarity about what AI is, and broadly, traditional AI vs. generative AI. Use in business processes vs. clinician use.	Director of Digital (Anthony Tracey, Executive Lead).

2) Put it into action: Responsible AI at Hywel Dda

Current status	Next steps	Responsible
AI risk management	- Information Asset Register exists (review process is quite slow). - Clinical sign-off process for AI systems in clinical use – they map the risks. - Ethics Panel for general reviews - IT Digital Project Request Form - cannot install software without liaising with Information Gov. and Security. - Automated Decision Making question in DPIA, and data use and model use with AI.	- Update existing Information Asset Register and Governance processes to cover AI risks. Include AI impact assessment questions. - Clarify mandatory process for AI tool or feature approval – all tools must be approved before use (even ‘free’ online ones). - Check if any further AI-specific questions need to be added to Data Protection Impact Assessments (DPIA) and Security Assurance questionnaires. - Include process for updating AI systems, and phasing them out safely (especially clinical ones). - Establish future requirements for Responsible AI in the AI development lifecycle
Risk escalation	General incident response process - all incidents inc. IT incidents (Cyber investigation, Welsh Gov, and Comms team would coordinate)	Director of Digital (Anthony Tracey, Executive Lead).
Compliance	- Examples of AI incidents are clearly outlined, staff are clear on how this works, and crisis communications process would kick in - Identify any contingencies for AI systems or tools (e.g. if one fails or goes down, what happens next?)	Incident management and crisis management team
Compliance	- Plan to look at considerations - ISO 27001 is required for suppliers, as is ISO 9000.	- Clarity on where EU AI Act, GDPR applies for suppliers of tools or systems with AI features. - Look at which AI global standards apply and if it needs to be introduced for Hywel Dda or as a supplier question – e.g. ISO 42001, NIST AI Risk Management Framework.

3) Show we're doing Responsible AI well: Checking it's working

Current status	Next steps	Responsible	
Audits	• Currently dealing with pilots • Information Governance – do internal audits. • Have audits for other aspects of Governance.	• Look at whether any further AI points / processes need to be added to existing internal audits (i.e. align with AI risk management and impact assessments) • Bring in experts to audit AI systems regularly (e.g. for bias or explainability) and/or audit Governance processes. • Consider AI Governance external audit, aligned with ISO 42001 on AI Management Systems.	• Head of Information Governance (Patrycja Duszynska)
Monitoring	• Plan to monitor AI systems/tools and organisational AI Governance processes	• Identify what you need to monitor (e.g. how many AI systems in use, how many people have taken training). • Monitor regulatory changes and enforcement. • What tools/systems/data do you need to be able to monitor AI use and/or AI Governance processes?	• Director of Digital (Anthony Tracey, Executive Lead).
Reporting	• Plan to report AI systems/tools and organisational AI processes • Reports are currently regulations/legislation-driven	• Identify what you need to report on, who needs to be informed (internally and externally) and to what level of detail (e.g. credit usage and cost, sustainability) • Look at what Hywel Dda needs to be able to report (e.g. specific systems or dashboards).	• Digital Data Innovation Committee Chair

AI Readiness: Technical Pillars

**Data,
Models and Assets,
Pipeline and Platform,
Monitoring and Ops**

Data Pillar

AI depends on data and content that are suitable, accessible and controlled for the intended use.

What this means

- Traditional ML needs structured data that is stable, trusted and well understood.
- Foundational AI, RAG and agents rely more heavily on documents, content, prompts and organisational knowledge.
- Vendor and commodity AI still need clear controls over local inputs, permissions, outputs and operational use.

Why it matters

- Data quality, ownership, sensitivity and context shape whether AI outputs can be trusted.
- Clear controls help AI systems operate safely, consistently and within agreed permissions.
- Data issues can create clinical, operational, privacy or reputational risk if they are carried into AI workflows.

Data Themes

Five themes used to assess whether Hywel Dda’s data and content can support useful, repeatable AI delivery.

Theme	Current status	Evidence signal	Next steps
Structured data for traditional ML and prediction	Structured data already supports reporting, analytics and some data science, but AI reuse depends on clearer metadata, quality and ownership.	SQL Server warehouse, Power BI reporting and data science activity provide a useful base, but the warehouse has grown organically and some datasets are scoped or duplicated.	Start with defining priority AI use cases. Record source, meaning, owner, refresh pattern, quality limits and historic recording issues for required datasets.
Unstructured content for generative AI	Documents, spreadsheets, SharePoint, Teams and shared folders are widely used, but priority knowledge sources are not yet mapped for AI use.	Key organisational content is spread across multiple document and collaboration stores.	Identify high-value knowledge domains. Record ownership, permissions, sensitivity, retention and update process before wider AI use.
Data quality, metadata and meaning	Data quality work exists, but AI-specific checks for meaning, completeness, history and suitability need to be made explicit.	Data quality worklists, SQL reports and patient-data quality activity already exist, but known issues are not always captured in a way that supports AI reuse.	Define a proportionate AI data check for early use cases. Capture known limitations and historic data issues.
Ownership, sensitivity and approval routes	Ownership, permitted use and approval routes are not consistently visible across systems and content stores.	Ownership and control visibility still depend on local knowledge in some areas.	Align data ownership and sensitivity information with existing asset, DPIA and information governance routes.
Operational and reusable data access	Databricks, Microsoft, Posit and the CGI / Hywel Dda integration-layer project all have roles to clarify for AI use.	Databricks is a strategic direction, the current warehouse supports reporting, Posit supports data science delivery, and the integration-layer work is a parallel route that needs clear positioning.	Assess platform roles and avoid duplicated routes. Define how priority AI use cases should access data and content.

Models and Assets Pillar

AI use becomes more repeatable when models and related assets are visible, tested, owned and controlled.

What this means

- AI assets include models, agents, RAG implementations, configured vendor tools and other AI-enabled capabilities.
- Artefacts are the specific items linked to an AI asset, such as prompts, model files, evaluation evidence and configuration records.
- Traditional ML, foundational AI and vendor AI need different validation and lifecycle controls.

Why it matters

- Hywel Dda needs to know what AI assets exist, what they do and where they are being used.
- Changes to prompts, models, data or configurations can change how an AI asset behaves.
- Lifecycle information helps teams move deliberately from idea to pilot, operational use and review.

AI Models And AI Assets Themes

Five themes used to assess whether Hywel Dda can manage AI models and assets through their lifecycle.

Theme	Current status	Evidence signal	Next steps
AI asset ownership and lifecycle control	AI activity spans data science, pilots, vendor tools and research-linked work. The lifecycle view needs to be consistent as possible across these routes.	The AI application form and related governance material provide a starting point for recording AI use cases and oversight needs. R&D routes, clinical safety routes and data science work already provide partial lifecycle controls.	Use the information asset register as the lifecycle view for material AI assets, from exploration to operational use.
AI asset visibility, registry and versioning	An information asset register exists, and the data science function also tracks related work.	Existing register activity, project tracking and data science work provide starting points, but artefacts such as prompts, notebooks, models, evaluation evidence and configuration records need consistent links.	Use the register as a current snapshot of AI assets and their linked artefacts. Align it with data science tracking of AI solutions rather than creating a separate competing inventory.
Use-case definition and value through the lifecycle	Demand exists for AI-enabled insight, prediction and support. The route from idea to operational use needs to be clearer.	AI ideas and pilots are emerging across predictive, vendor and clinical productivity use cases.	Apply a consistent use-case route covering problem, user, value, risk, data need, evaluation approach and intended operating model.
Evaluation and validation by AI type	Different AI patterns need different evaluation, including performance, explainability, grounding and user review.	Research and pilot activity uses expert feedback, but evaluation criteria are not yet consistent across AI types.	Define proportionate evaluation expectations for traditional ML, foundational AI, RAG, agents and vendor AI.
Guardrailed experimentation and vendor AI control	Staff and services are interested in AI tools and vendor products. The route from experimentation to managed use needs to stay clear.	Demand exists for clinical productivity tools and vendor AI, alongside emerging governance routes.	Apply consistent technical evaluation, asset visibility and review evidence to vendor and internally developed AI.

Pipeline And Platform Pillar

AI needs a clear technical route from exploration to tested, supported use

What this means

- Pipelines move data, code, configuration and artefacts through build, test, release and support.
- Platforms provide the environments, tools, integrations and controls that those pipelines run on.
- The route will differ for traditional ML, foundational AI, Copilot agents, vendor AI and BI-enabled use cases.

Why it matters

- AI delivery is harder to repeat if teams rely on local scripts, one-off environments or manual handovers.
- Platform choices should aim reduce duplication across Databricks, Microsoft, Posit and integration-layer work.
- Release and rollback routes help teams understand what changed, what it depended on and how to recover.

Pipeline And Platform Themes

Five themes used to assess whether Hywel Dda can move AI from experimentation to repeatable delivery. Visualisation of Current State Architecture & Target State Architecture can be found in the appendix.

Theme	Current status	Evidence signal	Next steps
Platform roles and delivery routes	Databricks, Microsoft, Posit, SQL Server and the CGI / Hywel Dda integration-layer project all have potential roles in AI delivery.	Databricks is a strategic direction, SQL Server and Power BI already support reporting, Posit supports data science outputs, and integration-layer work is in flight as a parallel project.	Assess platform roles against defined priority AI use cases. Agree where each platform should be used and where duplication should be avoided.
Development and runtime environments	Current capability includes SQL jobs, stored procedures, Python/Linux environments and BI workspaces. The production route for AI is less clear.	Data science delivery uses a defined technical environment, while some reporting and quality routines use warehouse SQL and Excel/Power BI patterns. Databricks progress depends on Azure/platform readiness.	Distinguish exploration, pilot and operational environments. Use priority use cases to define minimum environment expectations.
Reusable delivery patterns	Reusable patterns for ingestion, validation, masking, retrieval, prompts, evaluation and monitoring are not yet joined up as a standard approach.	Current work includes SQL reporting routines, data quality worklists, Posit-hosted analytical products, research validation, and emerging platform direction.	Build reusable patterns through early AI use cases, starting with data access, validation, permissions, evaluation and monitoring.
Deployment, release and rollback control	Source control, release management and environment separation appear uneven across current data, BI, data science and experimental AI routes.	Code and artefact management have been recognised during interviews as areas for improvement.	Define a lightweight release route for AI-related data products, models, agents and dashboards, including return-to-known-state expectations.
Artefact and dependency management	Prompts, retrieval indexes, datasets, notebooks, models, evaluations and configurations will need to be traceable as AI use grows.	Evidence points to many artefact types already emerging: notebooks, code, dashboards, reports, prompts, generated outputs, model work and documentation.	Link key technical artefacts to the relevant information asset record so changes, dependencies and evaluation evidence remain traceable.

Monitoring And Operations Pillar

AI needs clear monitoring, support and review once it moves beyond experimentation

What this means

- Monitoring covers use, quality, value, cost, issues and ongoing performance.
- Traditional ML may need drift and accuracy checks; foundational AI may need output, grounding and user feedback checks.
- Operational support covers ownership, incident routes, defect handling and review cycles.

Why it matters

- AI can change over time as data, prompts, models, users and suppliers change.
- Benefits, usage and issues need to be visible after pilot, not only during approval.
- Existing monitoring patterns can be reused, but AI-specific signals need to be taken into account.

Monitoring And Operations Themes For AI Use

Five themes used to assess whether Hywel Dda can keep AI use measurable, supportable and under review.

Theme	Current status	Evidence signal	Next steps
Business validation and value tracking	AI ideas and pilots are emerging, but value measures are not yet consistently visible across the lifecycle.	Existing performance reporting uses dashboards, escalation summaries and review patterns.	Use existing reporting practice to define baseline, expected benefit and review points for priority AI use cases.
AI-specific monitoring by type	Current monitoring strengths are strongest around reporting and data quality, not yet AI outputs, model drift or grounding quality.	Data quality worklists, operational reports and performance dashboards provide useful monitoring patterns, but live AI monitoring evidence is limited.	Define proportionate monitoring expectations for traditional ML, foundational AI, RAG, agents and vendor AI. Include data quality, output quality and human feedback where relevant.
Cost, usage and adoption monitoring	Wider AI adoption will create new cost, usage and value questions, especially for licensed tools and platform services.	Copilot and other AI routes are visible, but benefits and usage evidence need to be connected to decisions.	Track usage, cost and adoption for priority AI tools and forecast before wider rollout or scale-up.
Operational support and ownership	Live AI use needs named business, technical and operational ownership, linked to the AI asset view.	Existing governance and data quality routes show ownership can be made visible where processes require it.	Link operational ownership, review cycle and support route to each material AI asset. Make support expectations explicit before pilot-to-live transition.
Technical issue and defect management	AI-related technical issues need to connect to existing service, data, platform and supplier routes.	Responsible AI work covers incident response; technical readiness needs clear hand-offs into those routes.	Map AI-related defects, data issues and supplier issues to existing reporting, triage and escalation routes.

Microsoft Copilot Readiness

Where we are, the risk that matters, and what we recommend

Copilot Readiness Summary

CGI advisory assessment across the dimensions of Copilot readiness. Overall position: **conditionally ready**. The platform and the appetite are in place; the controls are not yet, so scale should follow the governance, not precede it.

Readiness dimension	Status	Basis (verified figures)
Adoption and demand	ESTABLISHED	97% of paid users active in 90 days; median 144 prompts; strong staff-survey appetite
Foundational governance	DEVELOPING	Information Governance sign-off and a platform Data Protection Impact Assessment (DPIA) in place; no Copilot Acceptable Use Policy, DPIA, Application Form or approval gate
Information protection	ATTENTION REQUIRED	8 sensitivity labels defined but 0 applied; the Copilot Data Loss Prevention policy(DLP) is in test mode, not enforcing
Data access and oversharing	ATTENTION REQUIRED	External sharing on for 15,002 of 16,087(DHCW –Tenant Level) inactive sites (93%); Restricted Content Discovery(RCD) review begun, output pending
Identity and access	DEVELOPING	Conditional Access broadly enforced (124 policies); privileged access largely standing (tenant-level, DHCW)
Copilot Studio and agents	ATTENTION REQUIRED	105 agents, 99 without a recorded owner, 64 in unmanaged environments; no approval gate or catalogue
Monitoring and assurance	DEVELOPING	Audit and Copilot interaction monitoring available; assurance model still maturing

Established in place and operating. **Developing** partially in place, or evidence incomplete. **Attention required** not yet in place, or a material gap.

Reflects CGI's assessment confidence from the evidence reviewed, not a formal compliance benchmark. The basis column cites measured figures from the DHCW tenant reports.

Copilot licensing and adoption

Three distinct Copilot capabilities are in use, with different licensing and reach. Adoption of the paid assistant is high, and appetite to expand is strong.

Microsoft 365 Copilot Chat	Microsoft 365 Copilot	Copilot Studio
<i>Free, included tier</i>	<i>Paid, 120 licences</i>	<i>Agents, separate licence</i>
▪ Web-grounded chat available through Microsoft 365 licensing	▪ Productivity assistant in Word, Excel, Teams and Outlook ▪ 120 licences, individually assigned ▪ 97% active in 90 days; median 144 prompts	▪ Low-code agent-building platform ▪ 105 agents already built ▪ Licensed separately; seat count not in the reports

DHCW reporting identified approximately 120 Microsoft 365 Copilot licences, high levels of active usage, and an established Copilot Studio estate.
Sources: DHCW reports R-01, R-02 (23 May 2026) and R-13; the staff survey; the Digital Operations interview.

Copilot adoption is ahead of formal governance

EXISTING FOUNDATIONS

- M365 platform signed off by Information Governance
- Platform-level DPIA and Microsoft agreements in place
- Public consumer AI tools are restricted
- Copilot enabled following platform-level assurance
- Conditional Access broadly enforced within the DHCW tenant

GOVERNANCE PRIORITIES

- Copilot license application and assessment process
- Confirm whether a Copilot-specific DPIA is required
- AI risk classification approach and Acceptable Use Policy for Copilot
- Approval and review process for deployment of Agents
- Extend existing governance controls to cover Copilot Agents
- Review and agree Copilot DLP approach

The assessment found that governance foundations are already in place. The next step is extending these existing controls, processes and oversight arrangements to Copilot agents and future AI capabilities.

Some governance and security controls operate at DHCW tenant level and require joint ownership.

The risk that matters most

Copilot surfaces information user can already access. Where information classification is limited and sharing practices have not yet been fully reviewed, Content may be surfaced more widely than intended.



Permissions are inherited

Copilot creates no additional/new access. It reflects what a user can already open across SharePoint, Teams, Outlook and OneDrive.

Information Classification remains Limited

Eight sensitivity labels are defined but none are applied, so 0% of content is classified to guide what Copilot surfaces.

Oversharing risk requires review

External sharing is enabled on 15,002 of 16,087 inactive SharePoint sites (93%), increasing the importance of implementing a retention policy, information classification and access governance.

This is primarily an information governance and access management challenge rather than a technology issue.

Copilot Studio: Current Agents Landscape

Agent development is already occurring across the organisation. Copilot Studio is open to all licensed users, with no approval step and no catalogue. This is a Hywel Dda (HDD-scoped) view; agents owned by DHCW and other NHS Wales bodies are not included.

105



Agents already built

99



No recorded owner

64



Unmanaged environments

55



Production

GOVERNANCE STATE

- Available to licensed users
- No approval gate before publishing
- No formal catalogue or register identified
- Agents inherit the builder's access

AGENT DISTRIBUTION

- 30 Hywel Dda environments (HDD-scoped)
- 73 agents within single solution (Portal Booking)
- 55 production agents
- 45 in sandbox

DHCW Tenant report R-13 and Copilot Studio Agent inventory. Most Agents currently have no recorded owner, and many are deployed outside managed environments.

Copilot Studio: establishing governance

The aim is not to stop agent-building, but to put light, clear guardrails around it so it can continue safely.

CONTROL THE RISK

- **Approval gate** no agent reaches production without a defined approval and risk check.
- **Catalogue and ownership** a register of every agent, each with a named, accountable owner.
- **Lifecycle and review** test-and-release discipline; retire stale or ownerless agents on a schedule.
- **Control the Risk** assessment and classification before deployment

ENABLE SAFELY

- **Environment strategy** managed environments and clear rules on who can build where, agreed with DHCW.
- **Data guardrails and Access controls** Data guardrails and access controls aligned to agreed governance policies.
- **Monitoring ,Reporting and Operational oversight** to support ongoing governance and assurance .

Some controls operate at DHCW tenant level. Clarifying the Hywel Dda and DHCW responsibility model is a key first step .

A practical way forward

Move quickly, but safely

Stabilise & Govern

- Copilot AUP within the AI governance framework
- Formalise the License Application Form/official request process and DPIA
- Review SharePoint permissions and inactive sites/content that can be archived, begin labelling
- Copilot Studio approval gate and catalogue
- Clarify Hywel Dda and DHCW responsibilities for Copilot governance and controls

Enable & Scale safely

- Controlled adoption with clear criteria
- Establish ownership and visibility of AI solutions
- Support and oversight arrangements
- Monitoring and assurance
- Structured evaluation route for new tools

Optimise & Mature

- Benefits realisation and outcome measurement
- Scale approved, governed use cases
- AI operations, monitoring and support
- Periodic governance, risk and assurance reviews
- Continuous improvement

User Research

Internal

Page 164

Purpose of the User Research

Working with CGI, Hywel Dda has undertaken an AI Readiness Assessment as part of its wider digital transformation programme to understand how AI can be adopted safely, effectively, and responsibly across the organisation.

This user research was conducted to establish a high-level organisational baseline of AI readiness from a user and stakeholder perspective, helping to identify:

-
- Current awareness and usage of AI tools
 - Confidence, capability, and digital readiness
 - Barriers to adoption and organisational challenges
 - Perceptions of trust, governance, and risk
 - Emerging opportunities and areas of value for AI adoption

The research aimed to complement the wider technical readiness assessment by exploring the people, operational, and organisational factors that may influence future AI adoption across Hywel Dda.

Research Methods & Observations

Participant outreach

We aimed to gather insight from a range of different stakeholders across multiple departments and roles.

The Survey was successful in capturing this diverse range, but 1:1 interview participation was lower, due to non-responsive contacts and busy schedules.

As a result, findings were largely dependent on the Survey results which may not represent the full range of perspectives across all departments within Hywel Dda.

Who provided the feedback

Survey results have shown that 50 respondents (17%) were from Managers. The remaining respondents are from varied roles and departments.

Some departments had a lower response rate, such as Diagnostics and Planned & Emergency Care. Encouraging participation from these departments could ensure a higher response rate in the future.

Survey responses

The digital Survey was live from the 29th April and closed on the 11th May. During this period, it received a total of 433 responses.

The Survey exceeding the expected 1% response rate and was closer to 3%. Maximising the number of responses is crucial for ensuring a representative and diverse sample.

Readiness Position: User & Organisational perspective

Strengths

- + High organisational awareness of AI
- + Positive appetite for AI
- + Existing experimentation
- + Emerging use cases

Challenges

- Governance immaturity
- Uneven capability and confidence
- Inconsistent adoption
- Lack of guidance/training

Hywel Dda demonstrates emerging AI readiness through strong awareness and growing interest in AI adoption. However, governance, capability and organisational support gaps currently limit scalable and consistent adoption.

According to the user research outcomes there is stronger evidence of interest and emerging appetite for AI adoption than there is outright resistance to AI itself. However, establishing strong AI Governance and building trust will act as core enablers to future AI adoption

Current AI Awareness & Usage

The survey findings suggest Hywel Dda has a **growing awareness** and **early adoption** of AI across the organisation, but **usage maturity** and **confidence** remain **inconsistent** across teams and roles. Survey data shows that AI is currently being used primarily for **low-risk productivity** and **administrative support** rather than embedded operational or clinical transformation.

Some teams and individuals are already **experimenting** with AI tools and **identifying opportunities** for use, while others have **limited exposure**, **low confidence**, or **uncertainty** around how AI could be applied to their role or area of work.

Current organisational understanding of AI is largely centred around **assistive**, **administrative** and **supportive** use cases rather than transformational automation.

High awareness but inconsistent adoption

- **402** respondents had heard of Microsoft Copilot and **392** had heard of ChatGPT or similar tools, indicating strong organisational awareness of AI technologies.

However, **AI usage maturity** remains inconsistent:

- **94** respondents reported using AI **daily** or **multiple times a day**
- **109** respondents reported using it **a few times a week**
- **121** respondents reported **never** using AI at work

AI use is currently focused on low-risk productivity support

The most common use cases were:

- summarising information (**230** respondents)
- drafting emails/documents (**191** respondents)
- administrative tasks (**152** respondents)

Confidence, Skills & Capability Readiness

The findings suggest that while many staff are **digitally confident** in their current systems, confidence in using AI specifically is **inconsistent** and still in **development** across the organisation.

Barriers to adoption include appear to relate less to resistance toward AI itself and more **to gaps in knowledge**, the need for **structured training**, governance **clarity**, and organisational **support**.

While there is evidence of **adoption** and **interest** in AI tools, levels of **confidence**, **understanding**, and **practical experience** **vary** significantly across teams and roles.

AI confidence is lower than general confidence

- **193** respondents reported being somewhat confident and **110** reported being very confident using **digital systems**.
- Compared to **130** respondents being somewhat confident and **47** being very confident using **AI tools** at work. .

Organisational confidence in AI adoption is mixed

- **44** respondents reported they were **not confident at all** in using AI tools
- **182** respondents were unsure what AI tools were available
- **148 respondents** identified lack of guidance/policy as a barrier

Training and enablement are major readiness gaps

The biggest barriers identified were:

- Lack of knowledge/training (**207** respondents)
- Uncertainty around available tools (**182** respondents)
- Concerns about data privacy/security (**150** respondents)
- Lack of guidance and policy (**148** respondents)

Governance, Trust & Risk Awareness

The findings suggest that **governance, trust, and risk awareness** are **significant factors** influencing AI readiness across Hywel Dda.

Data privacy and security concerns emerged as particularly significant themes throughout both the survey and stakeholder interviews. Concerns were raised around the handling of **sensitive information, reliability** of public AI tools, and the **potential risks** associated with using AI without **appropriate safeguards** or oversight.

Clearer communication around **approved tools, governance processes, security expectations**, and **safe usage guardrails** will likely be important in building organisational confidence and enabling more consistent AI adoption moving forward

Data privacy and security and major concerns

The most reported concerns relating to AI usage were:

- Data privacy/security concerns (**193** respondents)
- Lack of accuracy or reliability (**266** respondents)
- Accountability and who is responsible (**120** respondents)
- Patient safety and clinical risk (**84** respondents)

Governance awareness appears limited

Survey responses suggest many staff are unclear about approved AI usage, organisational policy, governance processes and what tools are permitted.

- **182** respondents reported they are unsure what AI tools are available to them
- **165** respondents were unsure of whether they currently have a Microsoft Copilot license
- **220** respondents reported little or no clear guidance to AI usage at Hywel Dda

Governance, Trust & Risk Awareness

Trust in AI across Hywel Dda is currently **cautious** and **conditional** rather than fully established. While many staff recognise the potential value of AI and are already using AI tools to support productivity and administrative tasks, there are **significant concerns** around **governance, reliability, accountability, and safe usage**.

Our findings suggest that **governance** and **assurance** will be **critical enablers** of future AI adoption within Hywel Dda. Building trust is likely to depend on establishing **clear organisational policies, approved toolsets, structured evaluation processes**, and **visible governance mechanisms** that allow staff to use AI safely and confidently within defined boundaries.

Trust in AI outputs is mixed

The most reported concerns relating to AI usage were:

- **181** respondents felt neutral about how much they would trust AI to support their work
- **156** respondents reported they mostly trust AI to support their work

However, building trust is still a necessity to moving towards AI adoption as:

- **109** respondents reported a lack of trust in AI outputs preventing them from using AI more in their role

Concerns were raised around:

- Accuracy and reliability
- Bias
- Overreliance on AI
- The need for human oversight/Accountability

Interview participants commonly described AI as useful for support tasks but not yet trusted for critical decision making without validation

Operational & Technical Readiness

Operational and technical readiness for AI adoption across Hywel Dda is **still developing** and remains **inconsistent** across the organisation.

While there is evidence of **growing experimentation** and practical AI usage, support structures are not yet fully established to provide staff with the knowledge of what tools they **can and can't use**, or what specific AI tooling is available to them.

Many who do have an awareness of the AI technologies in use across the organisation face **difficulty** with finding the **time to experiment** and **develop AI proficiency** and understand where it could be applied to their work and roles.

Survey responses highlighted uncertainty around available AI tooling

- **182** respondents said they were unsure what AI tools were available to them
- **165** respondents were unsure whether they had a Microsoft Copilot license
- **77** respondents reported they did not have access to Copilot

Survey results combined with interview discussions also suggested that there is **fragmented use** across departments, **uncertainty** around **approved tools**, and varying levels of **access to AI technologies**.

Time and capacity constraints contribute to adoption barriers

Operational pressures were identified as a challenge:

- **133** respondents said they do not have enough time to explore or learn AI tools

Interview participants also referenced **workload pressures** and **limited time** for experimentation **restrict AI learning and adoption**, particularly in Clinical and high-pressure service areas.

Organisational Culture & Change Readiness

Organisational sentiment towards AI is **generally positive** with staff largely viewing AI as a **supportive tool** for **improving efficiency** rather than replacing key activities or roles.

Our findings reinforced the view that the organisation's primary readiness gap is not access to technology itself as experimentation is already apparent, and **appetite for AI already exists**.

The broader capability required is to **develop mature governance, improve AI literacy and visibility**, and **support staff to build confidence** in implementing AI.

Staff interest in AI adoption is generally positive

- **76** respondents rated AI as **Extremely** valuable
- **88** respondents rated AI as **Very** valuable
- **87** of respondents rated AI as **Moderately** valuable
- **88** of respondents rated AI as **Not at all** valuable

It's important to note that some lower value perceptions may reflect users who have had limited exposure or opportunity to use AI, rather than solely negative experiences with AI itself.

Staff want Structured Support & Organisational Enablement

The most requested were:

- Formal training sessions (**305** respondents)
- Access to approved AI tools (**266** respondents)
- Written guidance and policies (**225** respondents)
- Ongoing support/Helpdesk (**208** respondents)

Opportunities & Potential Value Areas

Staff across Hywel Dda already recognise practical opportunities where AI could support **efficiency, reduce administrative burden, and improve access** to information.

Current perceptions of value are largely centred around **productivity enhancement** and **operational support** using Copilot or ChatGPT, rather than fully transformational or autonomous AI use cases.

However, certain departments and clinical services are already exploring more **advanced, workflow-specific AI capabilities**, which shows evidence of **meaningful AI opportunities** for AI-enabled improvement that targets operational and clinical workflows.

Administrative burden reduction is a large area for opportunity

There appears to be strong organisational appetite for AI solutions that reduce administrative pressures. This interest exists across both Clinical and Corporate functions with many respondents describing AI as being most useful for:

- Reducing manual administrative work
- Summarising large amounts of information
- Supporting documentation
- Improving productivity in day-to-day tasks

Clinical & Operational AI use cases are evident

Although prevalence was lower, staff show awareness and use of Clinical based tools then demonstrate opportunity for AI implementation in the future beyond tools that are solely dedicated to administrative support

- **72** respondents have heard of the AI Scribing tool
- **57** respondents have heard of the AI Diagnostic tool
- **22** respondents have heard of the AI Pathology tool
- **Totalling 15% of respondents overall**

Confidential

Acknowledgements

Stakeholder Acknowledgement

We would like to thank the following Hywel Dda colleagues for sharing their time, experience and insight during the AI Readiness Assessment.

Contributor	Role
Anthony Tracey	Digital Director
Gareth Beynon	Head of Information Services
Chris James	Head of Data Development
Gareth Jenkins	Head of Data Science
Patrycja Duszynska	Head of Information Governance
Gavin Jones	Head of Digital Operations
Claire Langdridge	Data Quality Improvement Manager
Tracy Price	Head of Performance
Leighton Phillips	Director Research, Innovation and Value
Anthony Smith	Consultant Anaesthetist / CCIO
Paula Goode	Service Director for Planned and Specialist Care
Dana Scott	Director of Midwifery and Professional Governance for Women and Children
Olwen Morgan	Assistant Director of Nursing
Ihab Abbasi	Associate Medical Director, Planned and Specialist Care
Michelle James	Head of Resourcing and Utilisation
Sarah Barnes	Workforce Manager: Systems and Workforce Intelligence
Tracy Walmsley	Assistant Director of People Planning
Nicola Henwood	People Programme Manager
Megan Morgan	PhD Student / Research-Linked Data Science
Praboda Rajapaksha	Lecturer in Data Science / Researcher
Gareth Skye	Business and Governance Manager

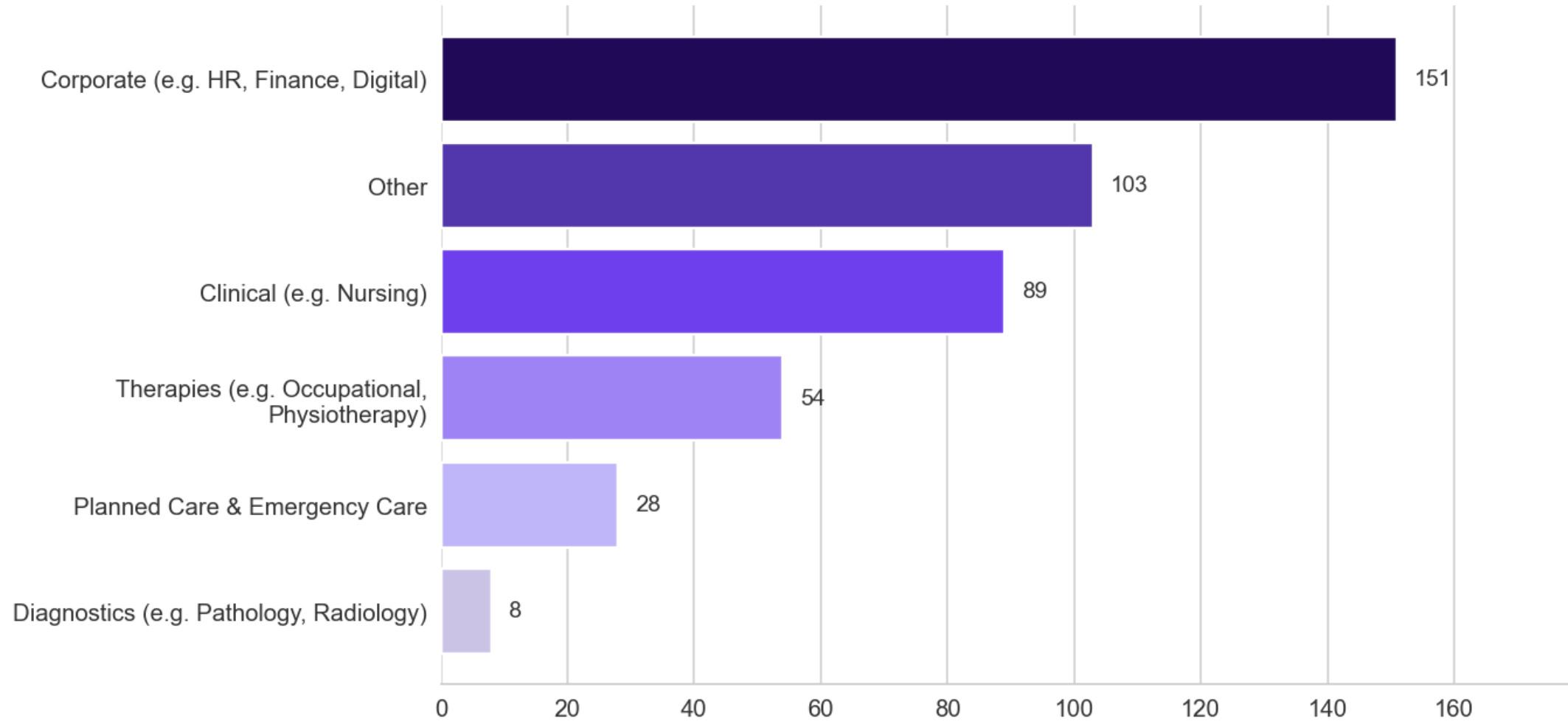
Appendix

Supplementary material

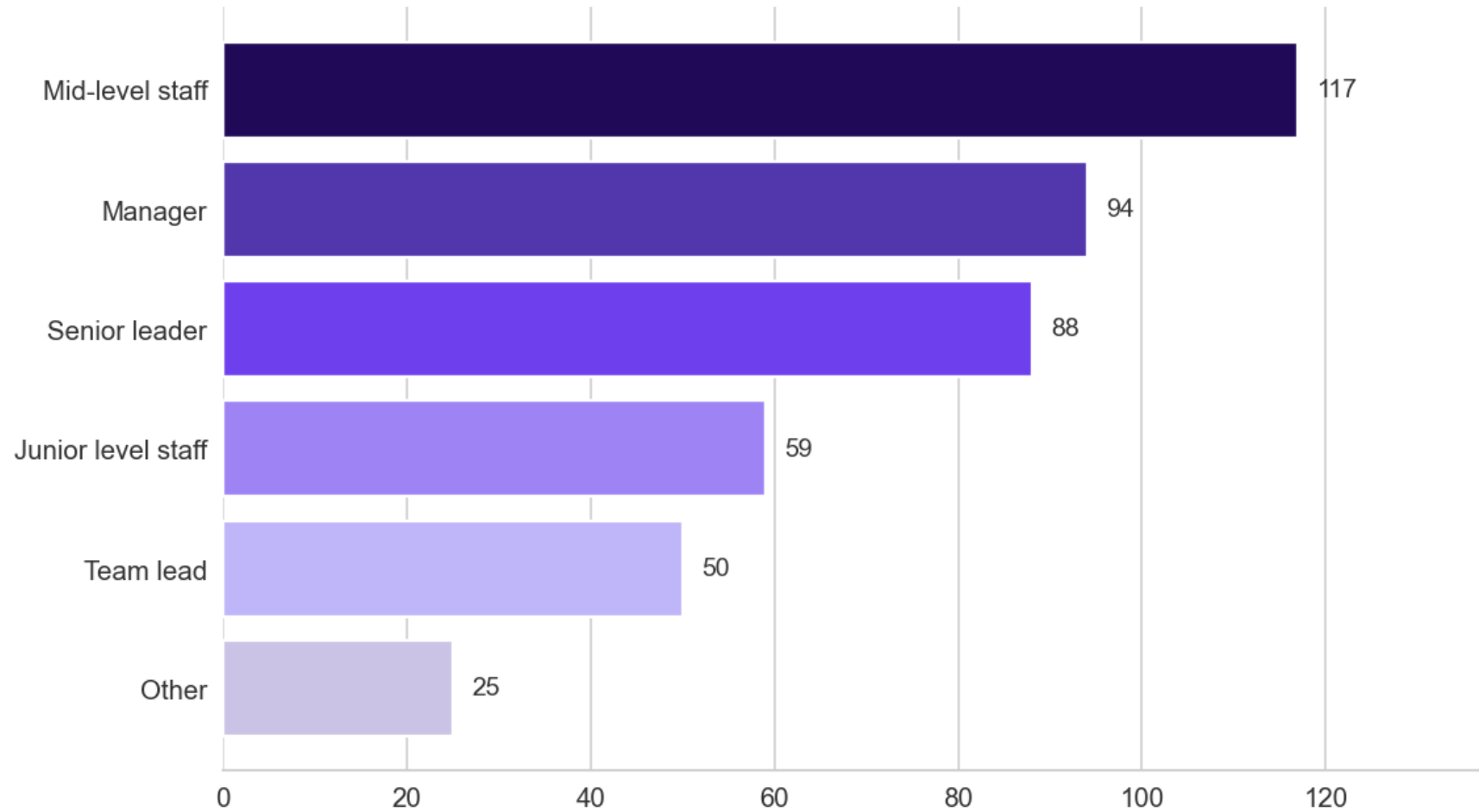
Questionnaire results



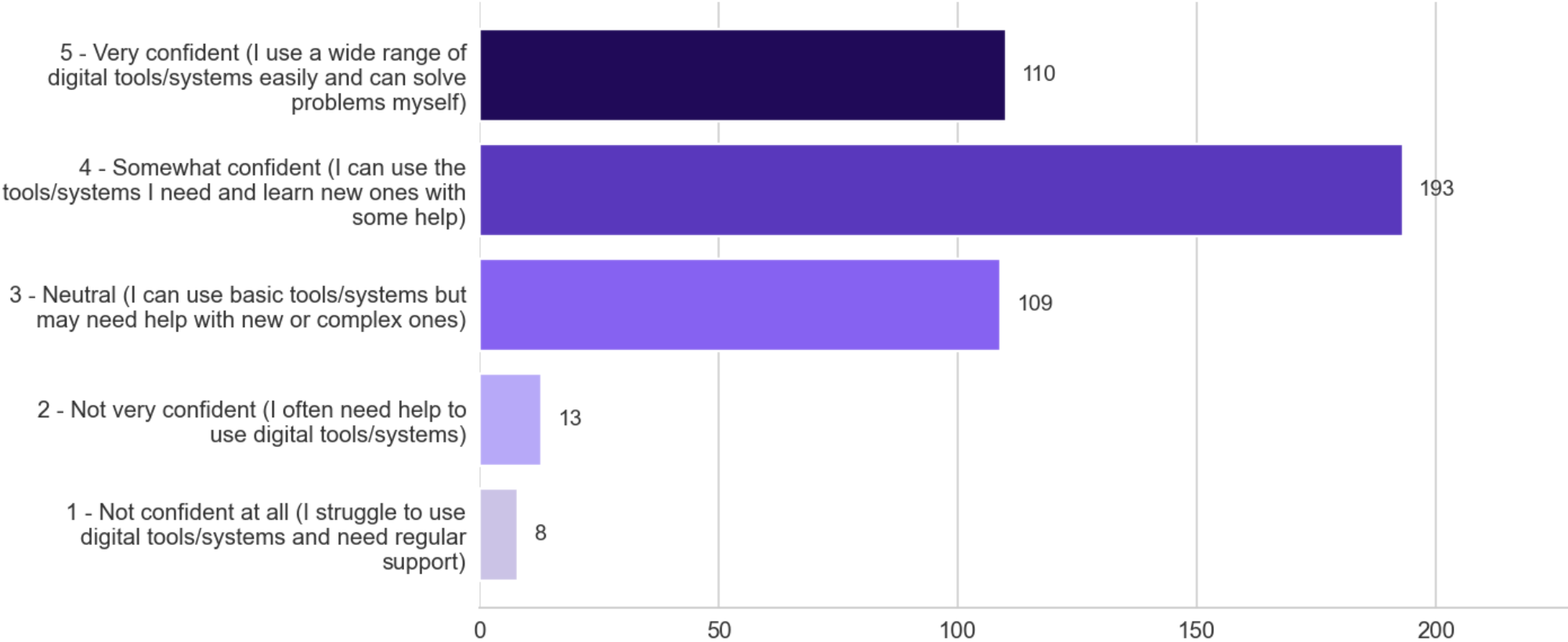
Which Area Do You Work In?



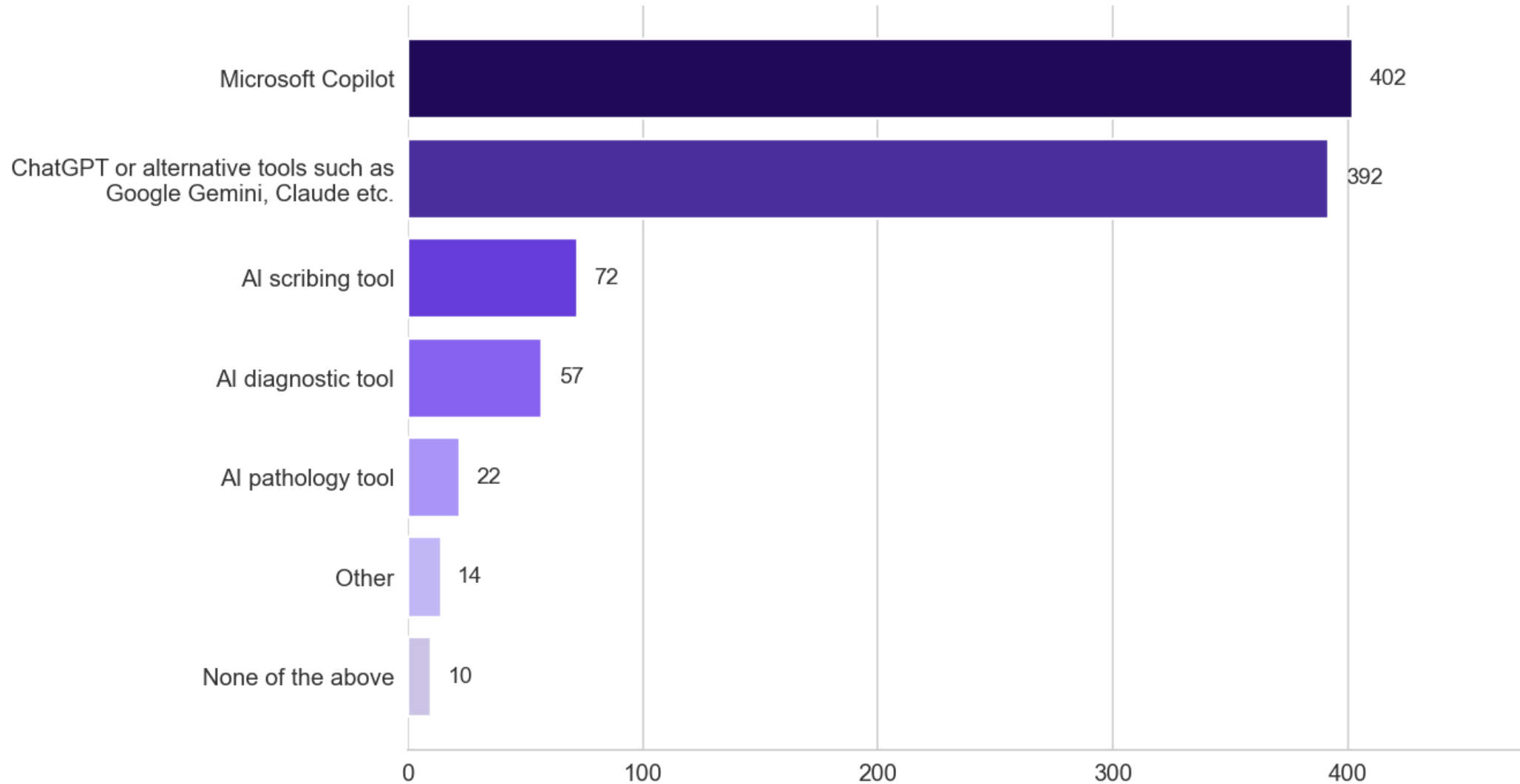
What Is Your Role Level?



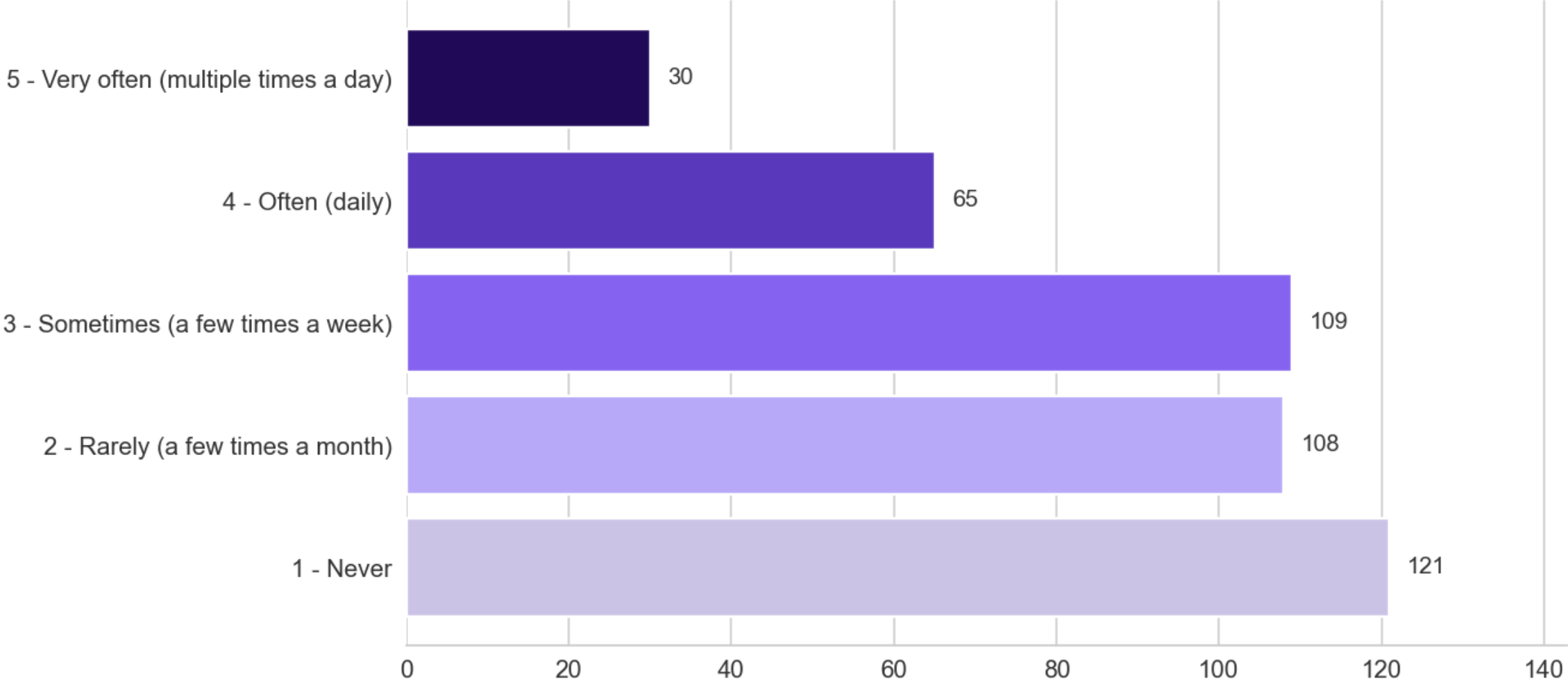
How Confident Do You Feel Using Digital Tools And Systems Required For Your Day-To-Day Work?



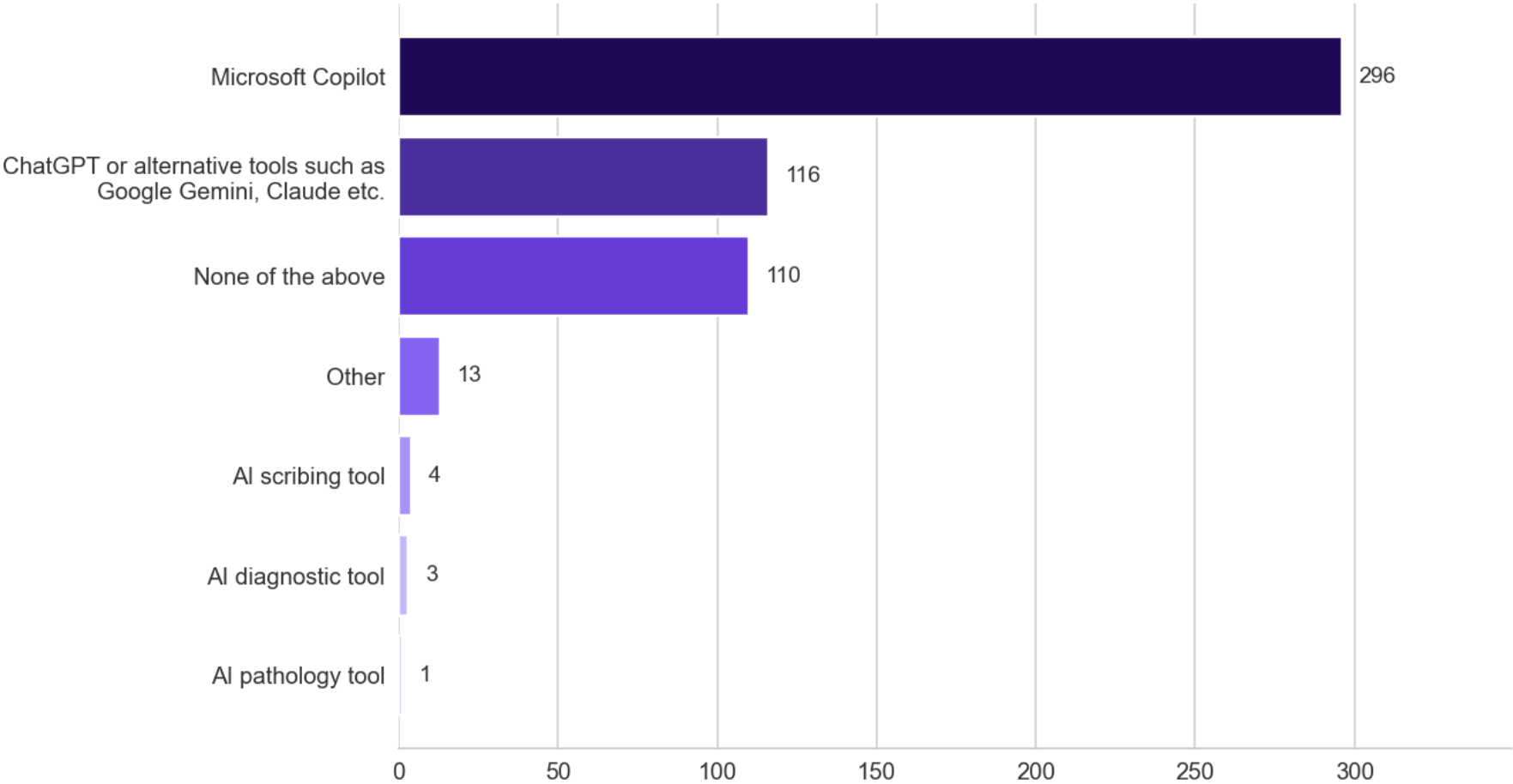
Which Of These AI Tools Have You Heard Of?



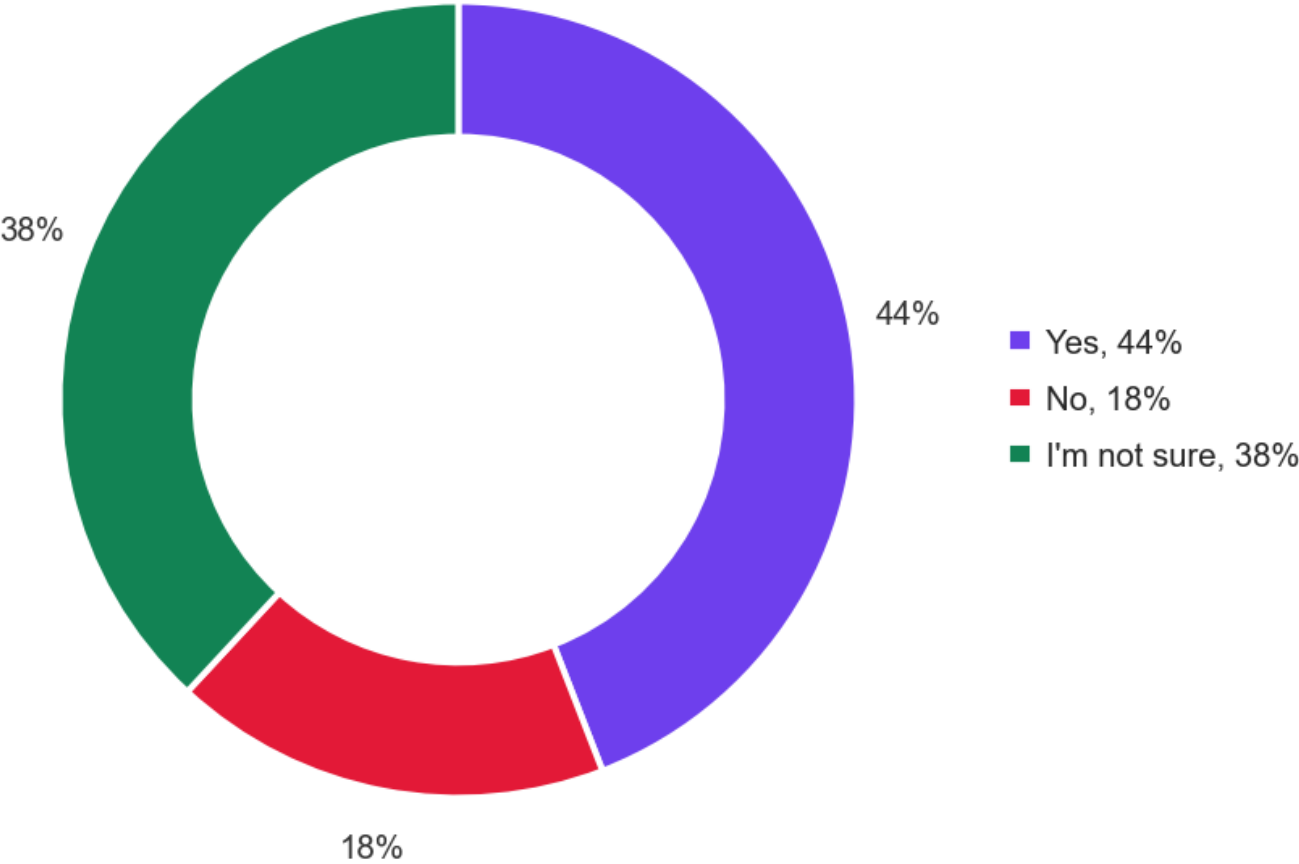
How Often Do You Use AI For Work?



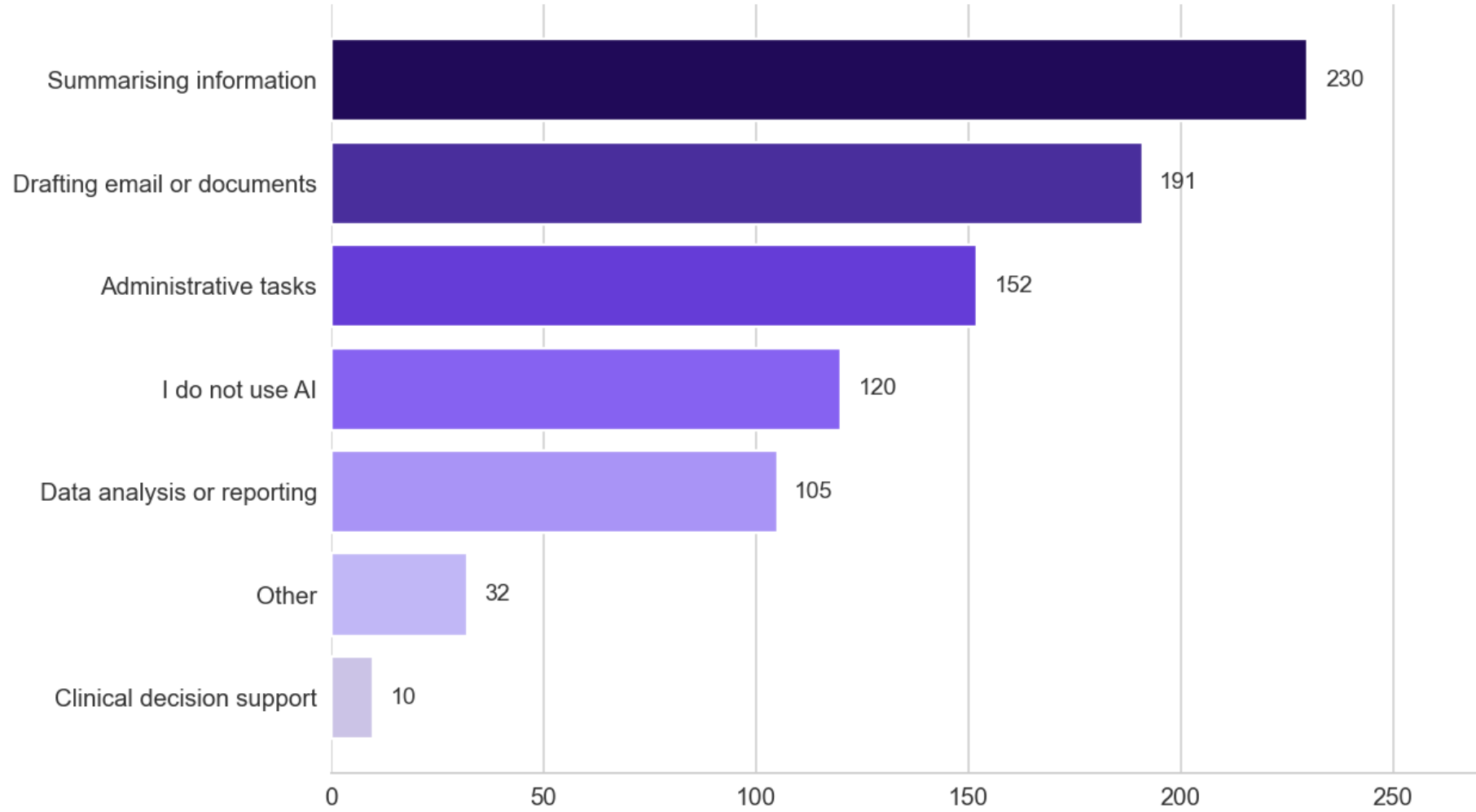
What AI Tool(s) Do You Use?



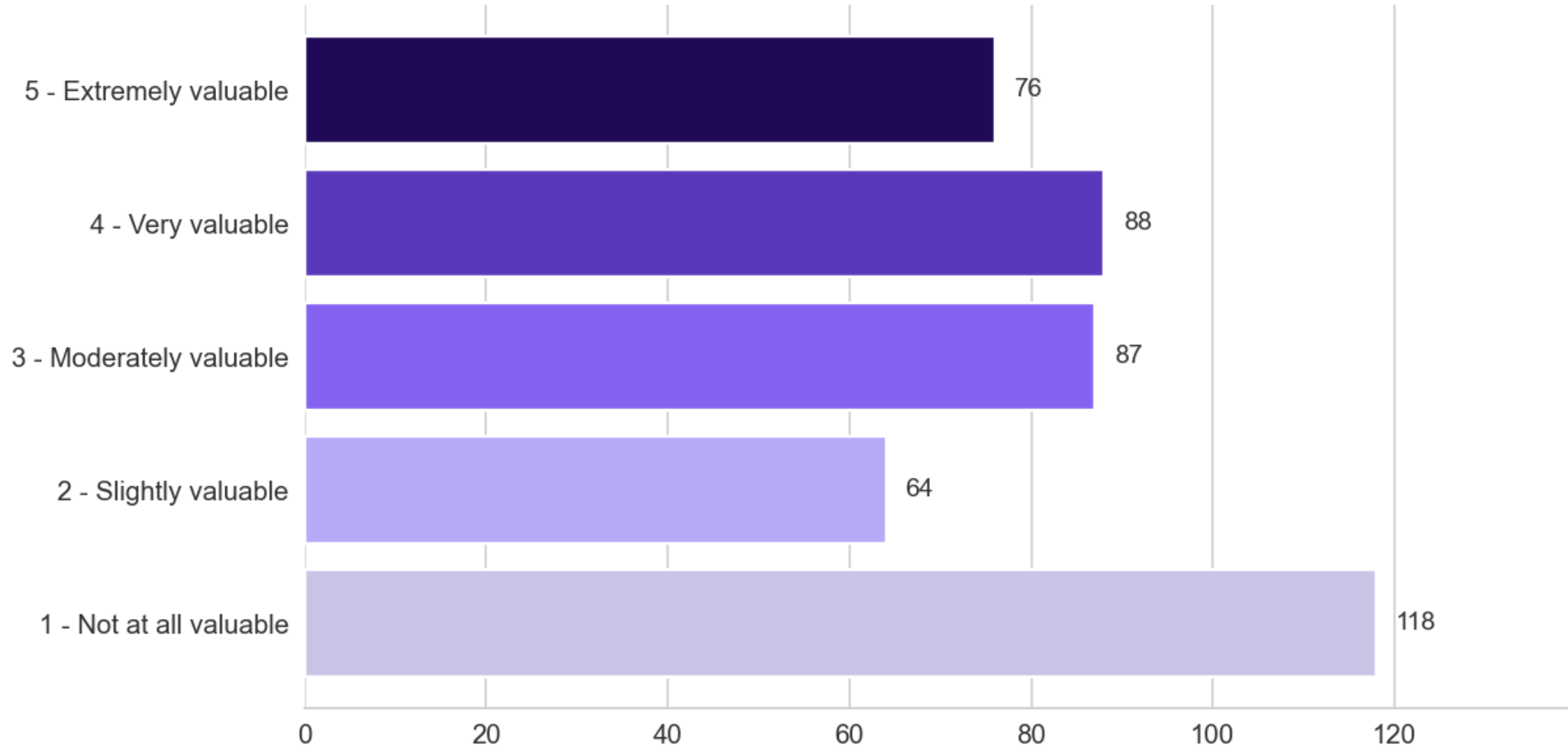
Do You Have A Co-Pilot Licence Provided By Hywel Dda?



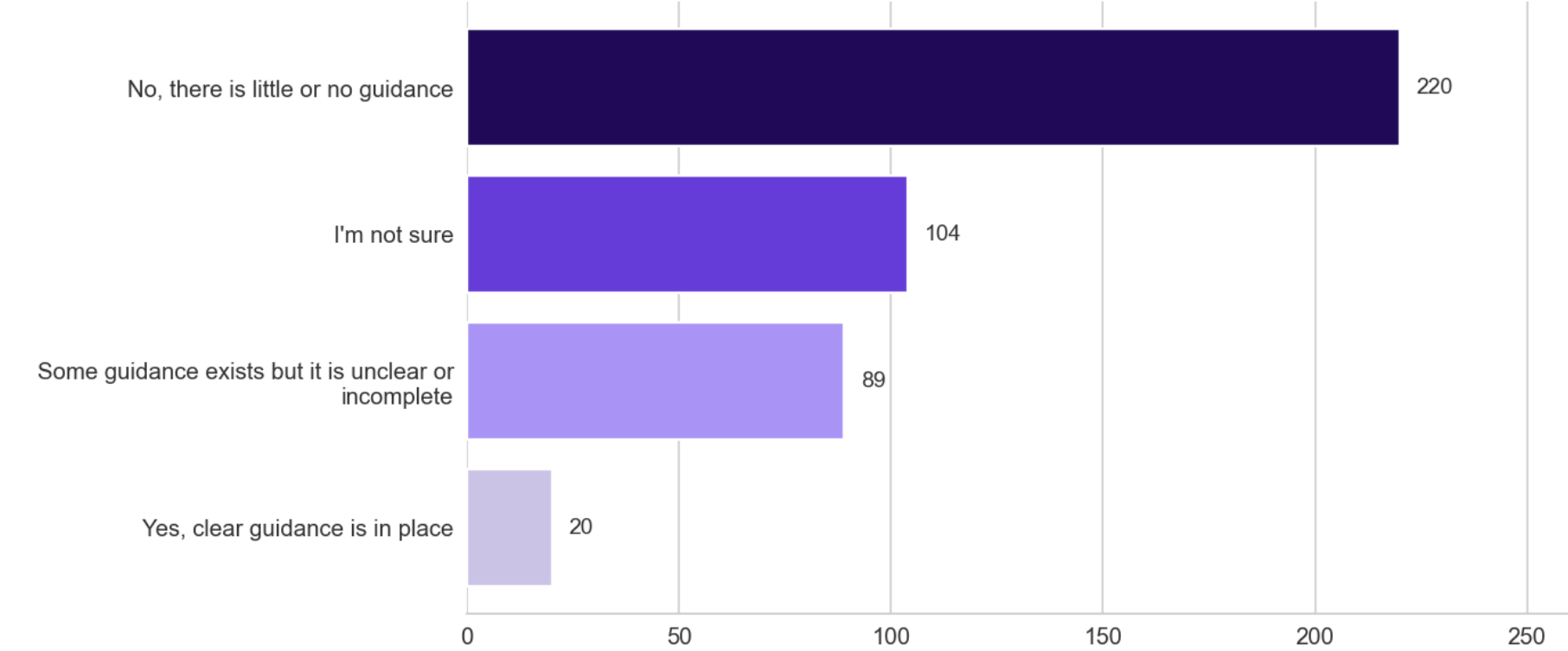
What Do You Use AI For?



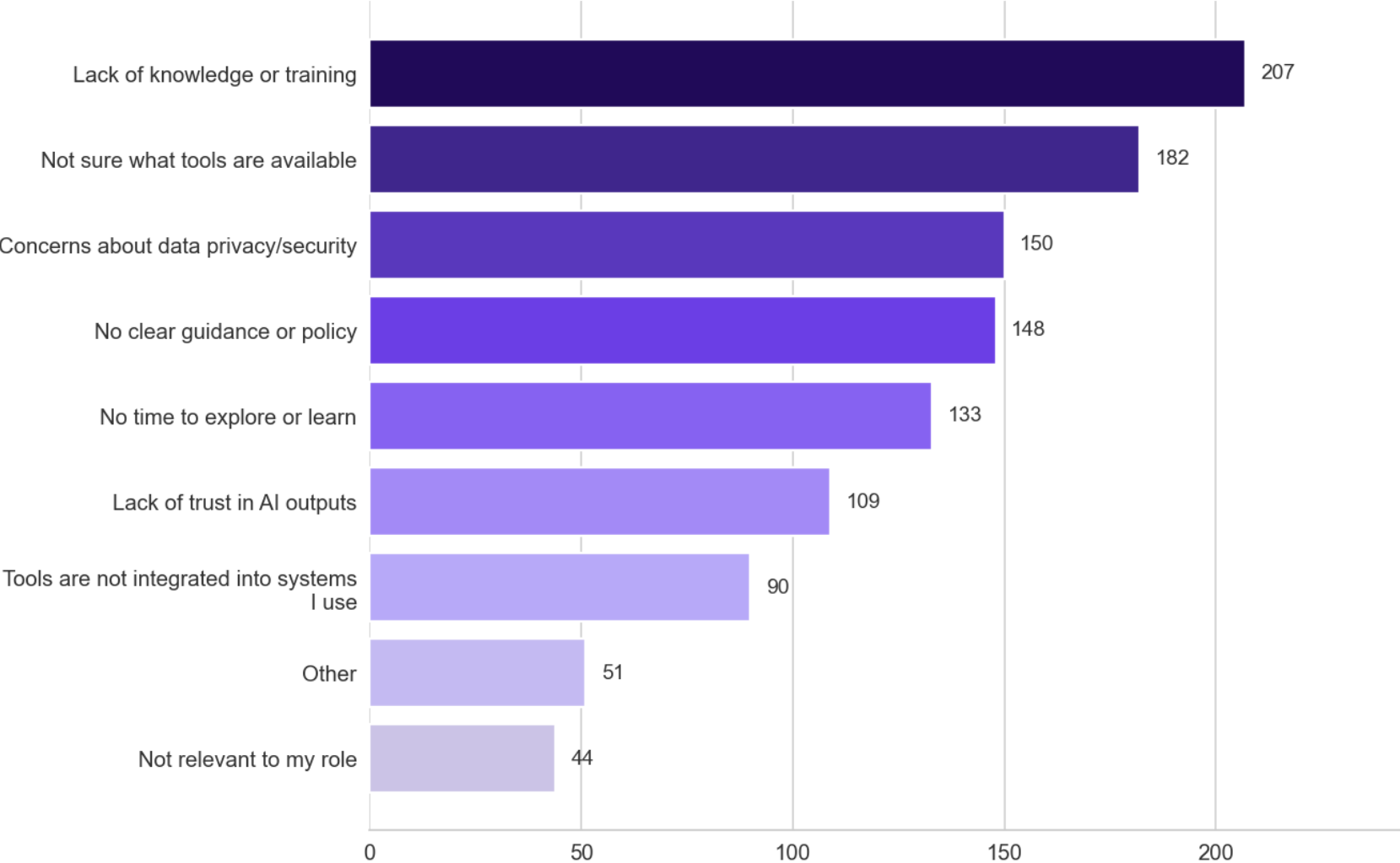
How Valuable/Useful Has AI Been In Your Work So Far?



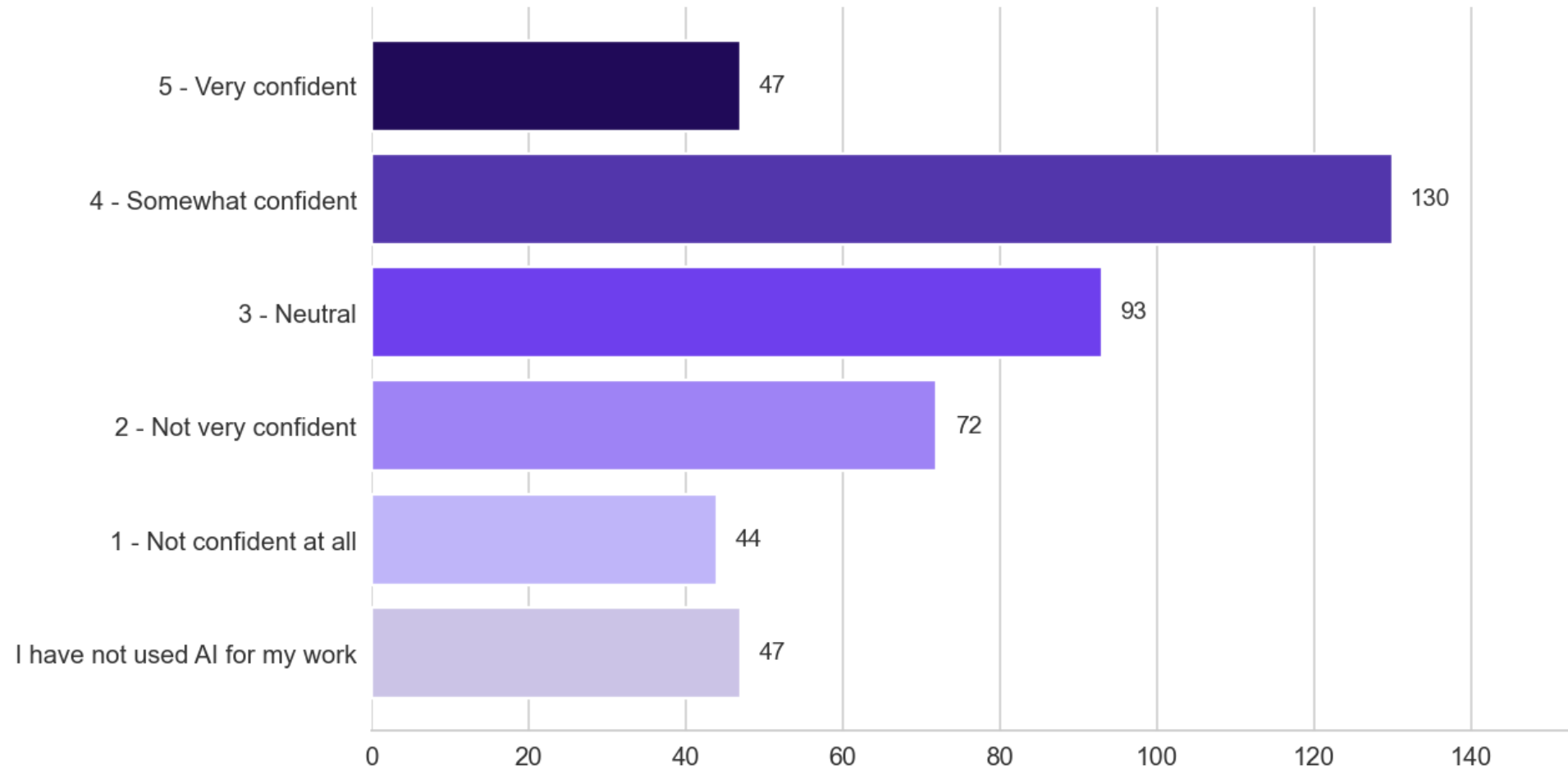
Do You Feel Your Organisation Provides Clear Guidance On How AI Can Be Used Safely And Appropriately In Your Role?



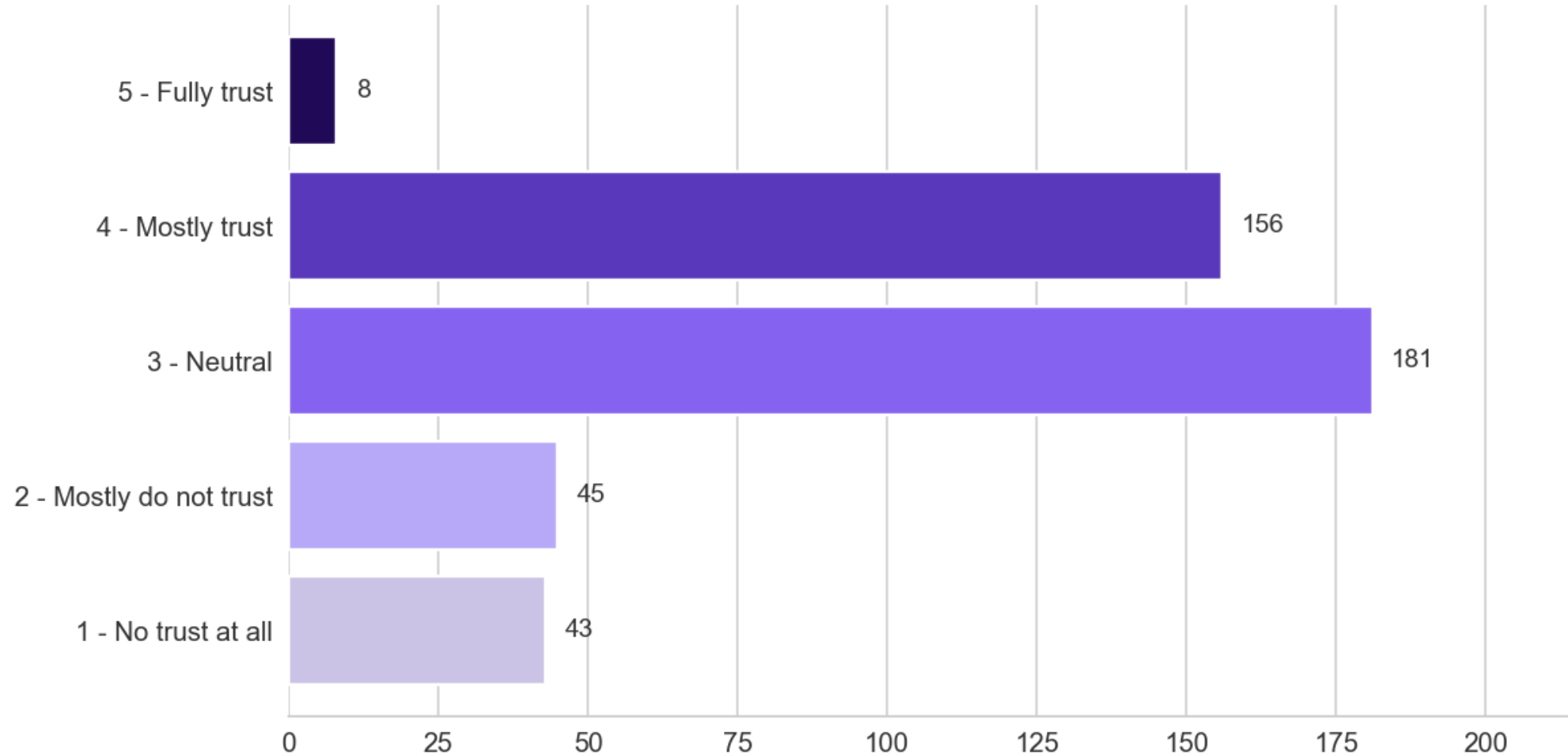
What Prevents You From Using AI More In Your Role?



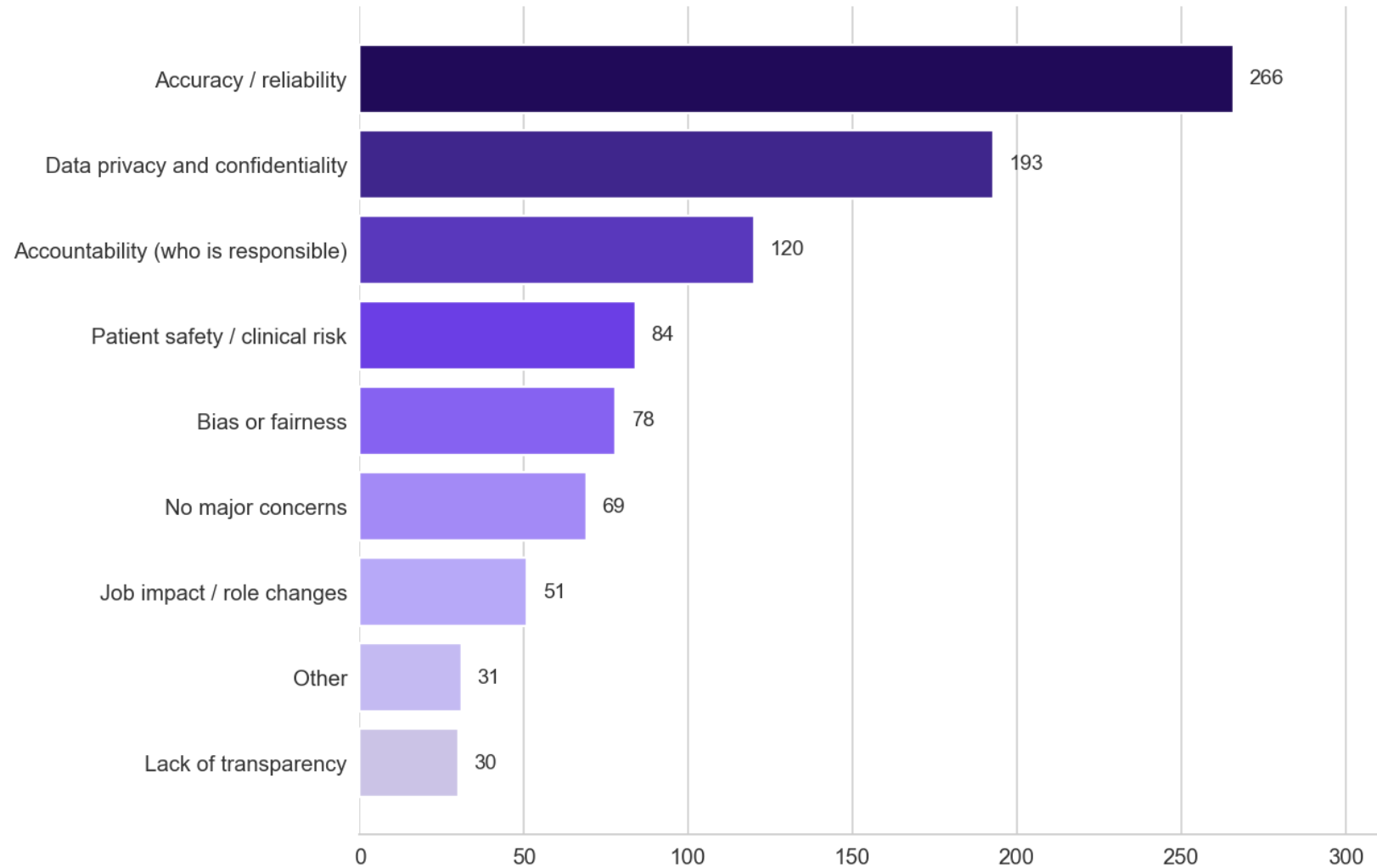
How Confident Do You Feel In Your Ability To Use AI Tools At Work?



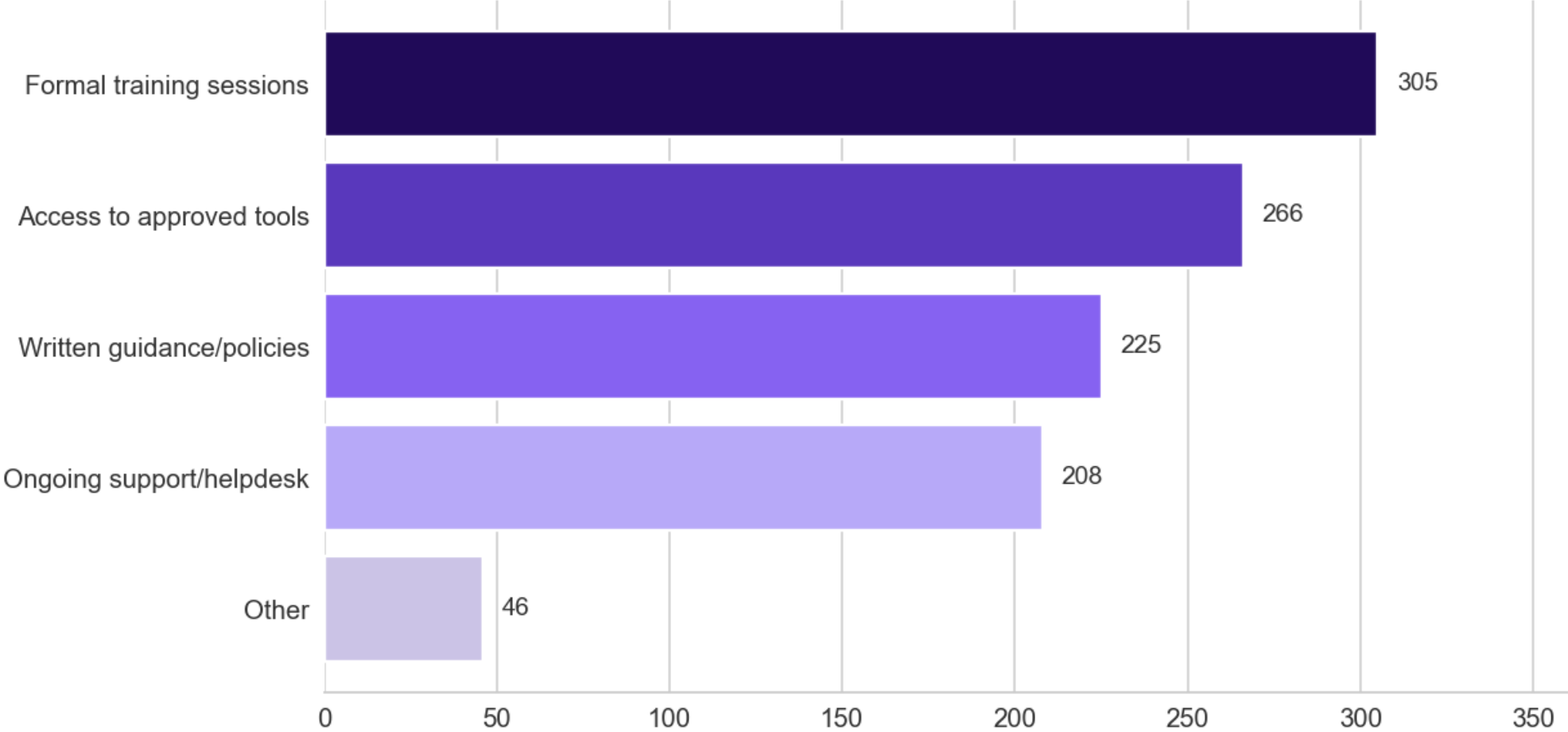
How Much Would You Trust AI To Support Your Work?



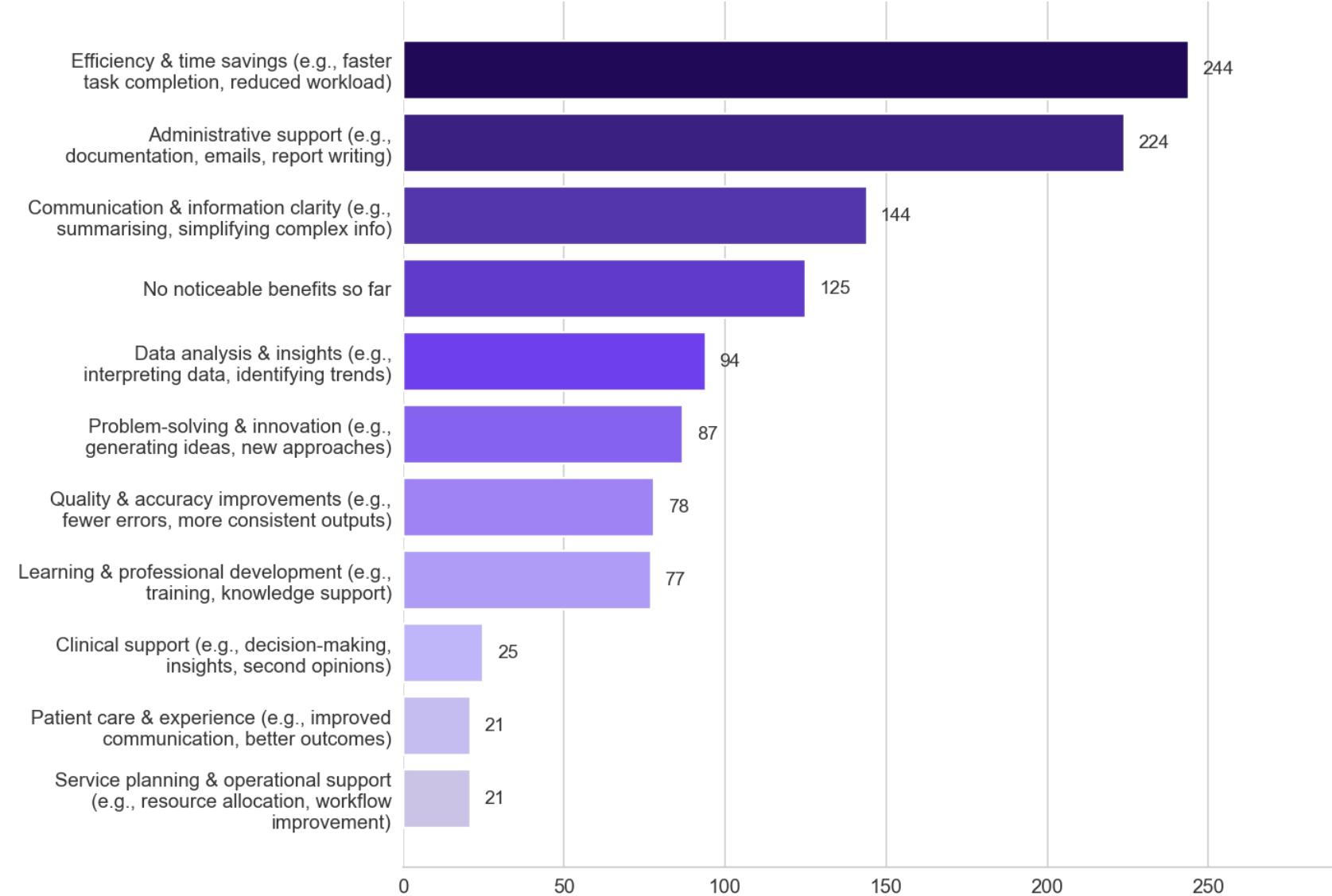
What Is Your Main Concern About AI Being Used In Work? (Select Up To 3)



What Type Of Support Would Help You Use AI Effectively In Your Role? (Select All That Apply)



What Have Been The Main Benefits To Using AI In Your Work So Far?



2.5 - Extracting insight from data

*Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Gareth Beynon
(Hywel Dda UHB -
Head of Information
Services), Gareth
Jenkins (Hywel Dda
UHB - Head of Data
Science), Tracy Price
(Hywel Dda UHB -
Head of Performance)*

| For information

Attachments

[2.5.1 DDIC SBAR - Data blueprint - July 2026.pdf](#)

[2.5.2 - DDIC Turning Data into Insight - 2025 to 2028.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Turning Data into Insight 2025-2028
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Gareth Beynon, Head of Information Services Gareth Jenkins, Head of Data Science Tracy Price, Head of Performance

Pwrpas yr Adroddiad (dewiswch fel yn addas)
Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

Our Health Board faces significant challenges including (but not limited to) rising demand, increasing clinical complexity, financial pressure, workforce fragility and variable access to modern digital tools. These pressures make it more important than ever that every decision we make is supported by robust evidence and effective use of our data. Our current data landscape is fragmented: data quality is variable, analysts are stretched, systems do not always integrate, with staff struggling to access the information they need and advanced analytics are being used inconsistently. Phase 1 of our data blueprint aims to begin to address this gap by strengthening our foundation, increasing our analytical capacity and embracing new technologies.

The blueprint has been developed in response to both the immediate operational pressures facing the Health Board and the longer-term requirement to build sustainable digital, data and analytical capability. It provides a structured first phase for improving how data is collected, governed, connected, analysed and used to support decision-making. This is particularly important in the context of Targeted Intervention (TI), where the organisation must demonstrate stronger grip, improved assurance, clearer prioritisation and evidence-based improvement across quality, performance, finance, workforce and population health.

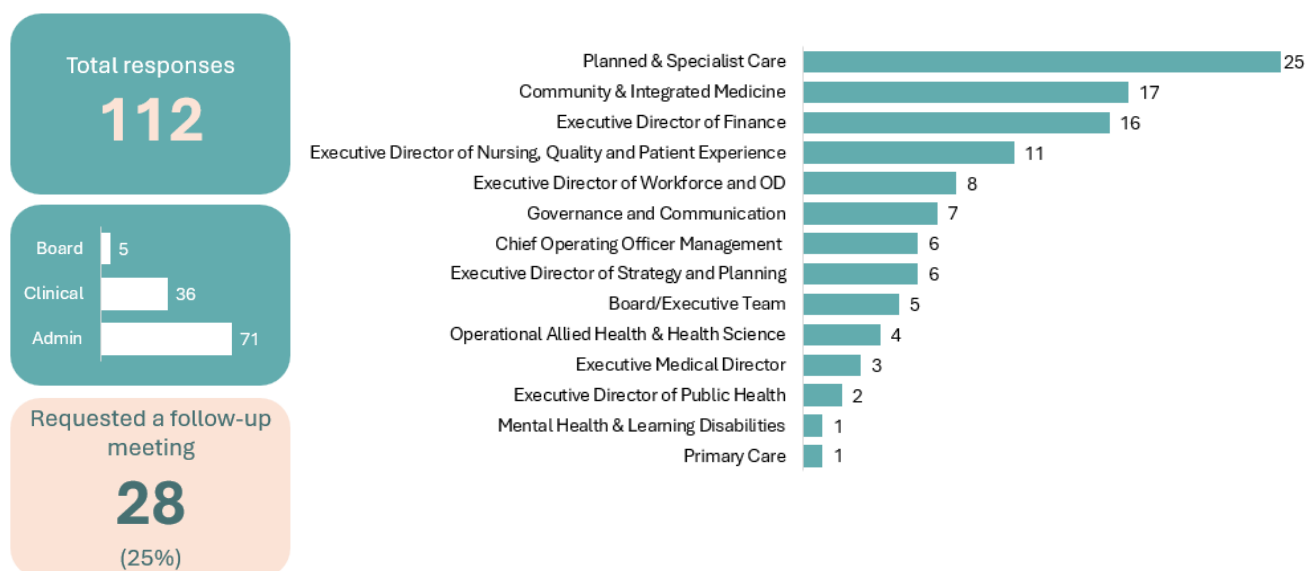
Cefndir / Background

Hywel Dda University Health Board (HDdUHB) aspires to become a data-enabled organisation where individuals at every level have timely, trusted information that empowers better decisions for our patients, staff and communities. Our ambition is to shift from a Health Board that uses data to one that is powered by data: proactive, insight-driven, and always learning.

A series of 14 one-to-one meetings were held with Executive Team members and key individuals nominated within their teams, to obtain a high-level overview of the key data requirements across each function. Views were also sought from Welsh Government to provide an external perspective. The themes emerging from these discussions informed the development of a staff survey, which was made available to all Health Board staff. Responses were received from a broad range of staff groups and Health Board functions.

This engagement confirmed a consistent message: staff and leaders recognise the value of data, however access, confidence, consistency and capacity remain variable. The blueprint therefore focuses on practical foundations rather than abstract ambition. It seeks to strengthen data quality, create a trusted data platform, improve access to self-service reporting, develop the analytical workforce, increase data literacy and enable safe use of advanced analytics and artificial intelligence. The document also aligns with the Health Board's wider digital enablement ambitions, including the need to improve integration, support a single version of the truth, reduce duplication and ensure insight is available to those making operational, clinical and strategic decisions.

Data survey responses



Asesiad / Assessment

Data is a key enabler to the Health Board achieving its purpose, vision and objectives. The current position is that data is split across multiple systems, with duplication, inconsistency and variation in how information is defined and used. Analysts are working hard to support services, although capacity is limited and demand for deeper insight is increasing. Existing products such as IRIS and the “Our” dashboard suite provide an important foundation, however further work is required to standardise access, expand coverage, improve real-time intelligence and ensure staff can use the information confidently. Without this foundation, the organisation will continue to experience avoidable duplication, inconsistent reporting, limited foresight and reduced ability to evidence improvement.

In 2024, the Health Board was placed into TI, the highest level of escalation short of Welsh Government intervening directly in the management of the organisation. High quality data will be a key enabler in supporting better informed decision making and driving the improvements required to improve performance and outcomes.

Why is having a data blueprint important to us?

A clear digital and data blueprint is essential if the Health Board is to deliver its overall Strategy and respond effectively to the challenges facing health and care. HDdUHB is operating in a context of rising demand, increasing clinical complexity, financial pressure, workforce fragility, health inequalities and variable access to modern digital tools. These pressures mean that the organisation must be able to make timely, evidence-based decisions, understand variation, prioritise resources, improve productivity and demonstrate measurable improvement for patients, staff and communities. Digital and data capability is therefore not a supporting technical function; it is a core enabler of strategic delivery.

The Health Board's Strategy depends on its ability to provide safe, sustainable, high-quality and accessible services, support population health, reduce inequalities, improve experience and outcomes, and use public resources responsibly. A digital and data blueprint provides the route map for how information, technology, analytics, governance and workforce capability will support those ambitions. It helps ensure that digital investment is purposeful, aligned to clinical and operational priorities, and focused on the outcomes that matter most: better care, improved flow, stronger assurance, reduced duplication, greater transparency and more effective planning.

The current data landscape remains fragmented: data quality is variable, analysts are stretched, systems do not always integrate, with staff struggling to access the information they need and advanced analytics are used inconsistently. Without a coherent blueprint, the organisation risks continuing to make decisions from inconsistent information, duplicating effort, missing opportunities to improve productivity and being unable to evidence progress against its strategic objectives. Phase 1 of the Turning Data into Insight blueprint therefore begins to address this gap by strengthening the foundations required to become a data-enabled organisation.

There are many ways the organisation will benefit from being a data-enabled organisation, some of which are listed below:

- Staff can access the right data, at the right time, in the right form, wherever they work.
- Leaders make decisions with confidence, supported by consistent, high-quality, real-time information.
- Clinicians have intelligence at the point of care, not retrospective reports.
- Analysts form a connected and capable network, working with modern tools and shared standards.
- Our systems speak to each other, with a single version of the truth for all secondary usage.
- Advanced analytics, forecasting and AI become an expected part of how we design services, plan capacity and improve outcomes.
- The public can easily understand our performance, and we operate with transparency and accountability.

To achieve this, we recognise that becoming a data-enabled organisation is a journey, not an event. Our 2025–2028 blueprint is Phase 1 of that journey, building the essential foundations that allow us to think, plan and act differently.

What are we aiming to do in Phase 1 of our data blueprint?

Phase 1 of the data blueprint focuses on building the core foundations needed to make better use of data across the Health Board. It translates the strategic ambition described above into a practical programme of work, setting out the priority capabilities that need to be strengthened over the next three years. These aims are intended to address the current challenges of fragmented systems, variable data quality, limited analytical capacity and inconsistent access to insight, while also creating the conditions for more advanced use of data science, artificial

intelligence, transparency and population-level planning. The Phase 1 aims therefore provide a clear route from our current position to a more consistent, trusted and data-enabled way of working. We have therefore identified eight aims and an enabler in our 2025-2028 data blueprint:

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.
Enabler: Increase data literacy Help our staff to further develop their skills to accurately interpret and use data to make informed decisions	

Delivery of the blueprint will also support the Health Board's ability to triangulate information across quality, safety, operational performance, workforce, finance and population health. This will help teams move from retrospective reporting towards earlier identification of risk, demand, variation and opportunities for improvement. It will also provide the conditions required for responsible use of data science and artificial intelligence, recognising that these approaches are only safe and meaningful where data is accurate, well-governed, explainable and used for a clearly defined purpose.

The expected benefits of Phase 1 are therefore both practical and strategic. Practically, it will improve access to trusted information, reduce duplication, strengthen data quality and support staff to interpret and act on insight. Strategically, it will help the Health Board build the capability required to support TI improvement, annual planning, Value-Based Healthcare (VBHC), population health, productivity, public transparency and future digital transformation. Endorsement of the document will provide a clear mandate to progress this work as the first phase of a longer-term journey towards becoming a data-enabled organisation.

Argymhelliad / Recommendation

The Committee are requested to consider:

- **ENDORSE** 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.
- **NOTE** 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.
- **NOTE** 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.

mcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.1 That the direction, development and delivery of the Digital Strategic Plan is to drive continuous improvement and support digitally enabled health care through a digitally enabled workforce to achieve the objectives of the Health Board's Annual Plan/Integrated Medium-Term Plan (IMTP).
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Data is an enabler for most risks on our risk register
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)	7. All Apply

A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Range of Health Board and Welsh Government staff, across various functions, staff groups and bands
Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	Contained within the body of the report

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The blueprint supports better informed decision-making, improved prioritisation and more effective use of resources. It will help identify unwarranted variation, duplication, inefficiency and opportunities for productivity improvement. There are no immediate financial commitments arising from this report; any future investment requirements will be subject to the appropriate business case, prioritisation and approval processes.
Ansawdd / Gofal Claf: Quality / Patient Care:	The blueprint will strengthen the use of key metrics and data sources to triangulate quality, safety, outcomes, experience and performance information. This will support earlier identification of risk, unwarranted variation and areas requiring improvement, enabling services to make more evidence-based decisions for patients and communities.
Gweithlu: Workforce:	The blueprint will support development of the analytical workforce through improved networking, shared standards, modern tools and clearer prioritisation. It will also promote wider data literacy across clinical, operational and corporate teams so that staff are better able to interpret and use information in their day-to-day roles.
Tegwch Iechyd: Health Equity:	Improved access to timely, consistent and population-level data will support better understanding of variation, inequality and the needs of different communities. This will help inform service planning, targeted intervention and decisions aimed at reducing inequities in access, experience and outcomes.
Risg: Risk:	Key risks relate to delivery capacity, prioritisation, data quality, system integration, information governance, cyber security and dependency on national data architecture including the National Data Resource. These risks will need to be managed through clear

	governance, phased delivery, appropriate technical assurance and regular reporting to the Digital, Data and Innovation Committee.
Cyfreithiol: Legal:	No direct legal implications arise from endorsement of the blueprint. Delivery will need to comply with all relevant legal, information governance, data protection, clinical safety, procurement and cyber security requirements. Any specific work package with legal implications will be assessed through the appropriate governance route.
Enw Da: Reputational:	There is a positive reputational opportunity if the Health Board can demonstrate improved transparency, assurance and evidence-based improvement through better use of data. There is a reputational risk if expectations are not managed, delivery is delayed, or insight is not trusted due to poor data quality or inconsistent definitions.
Gyfrinachedd: Privacy:	All aims and work packages will be undertaken in accordance with data protection, confidentiality and IG requirements. Privacy by design will be applied, with appropriate controls for access, purpose, retention, minimisation and security. Data Protection Impact Assessments will be completed where required.
Cydraddoldeb: Equality:	The blueprint is expected to have a positive equality impact by improving access to consistent information and supporting better understanding of variation across population groups and services. Each work package will consider whether an Equality Impact Assessment is required and will take appropriate action to mitigate any identified adverse impacts.

Digital, Data and Innovation Committee

21 July 2026

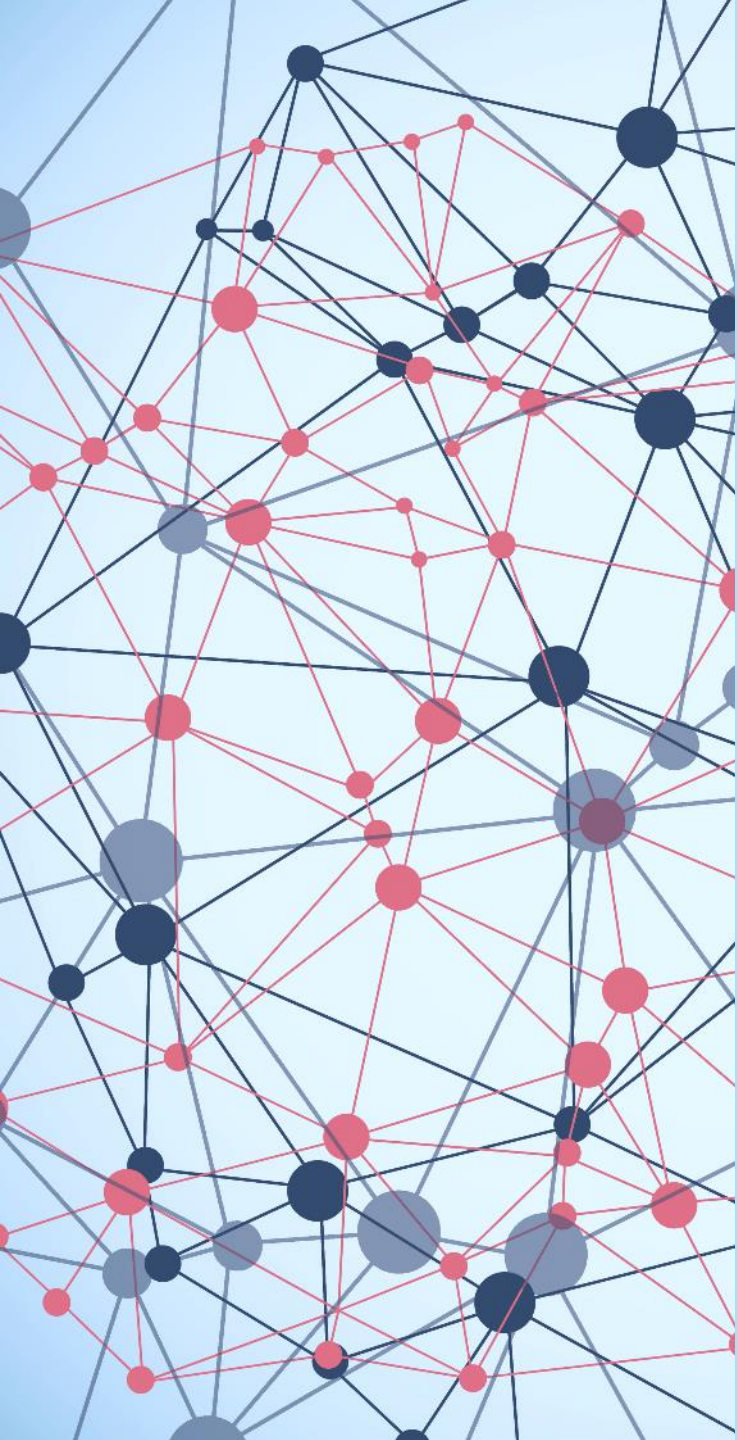


Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Turning Data into Insight

Phase 1: strengthening our
foundation, increasing our
analytical capacity and embracing
new technologies

2025-2028



Contents

Our ambition

Our journey

Our aims overview

Our starting position

Information governance: enabling safe use of data

Aim 1: Strengthen and improve data quality

Aim 2: Central storage of our key data

Aim 3: Develop a network of skilled analysts

Aim 4: Data products accessible to all relevant staff

Aim 5: Make data more available for the public

Aim 6: Using data to improve productivity and efficiency

Aim 7: Enhance our data science tools and skills

Aim 8: Leverage data for artificial intelligence (AI)

Enabler: Increase data literacy

How our data aims support our 2026/27 Annual Plan

Progress made

Developing our approach for 2028 onwards

Benefits and measuring success

Our ambition

Hywel Dda University Health Board (HDdUHB) aspires to become a fully data-enabled organisation — one where people at every level have timely, trusted information that empowers better decisions for our patients, staff and communities. Our ambition is to shift from a Health Board that uses data to one that is powered by data: proactive, insight-driven, and always learning.



Our vision

To enable staff across HDdUHB to use data as an asset for decision making and driving forward improvements:

- Strengthening **oversight** through clear accountability and reliable performance monitoring
- Generating **insight** that supports evidence-based decisions, service improvement and better outcomes
- Building **foresight** by anticipating future risks, opportunities and demand so that leaders can plan proactively, innovate with confidence and create sustainable value.

This means

- Staff can access the right data, at the right time, in the right form, wherever they work.
- Leaders make decisions with confidence, supported by consistent, high-quality, real-time information.
- Clinicians have intelligence at the point of care, not retrospective reports.
- Analysts form a connected and capable network, working with modern tools and shared standards.
- Our systems speak to each other, with a single version of the truth for all secondary usage.
- Advanced analytics, forecasting and AI become an expected part of how we design services, plan capacity and improve outcomes.
- The public can easily understand our performance, and we operate with transparency and accountability.

Our journey

We recognise that becoming a data-enabled organisation is a journey, not an event. Our 2025–2028 blueprint is Phase 1 of that journey, building the essential foundations that allow us to think, plan and act differently.

Why we need a data-enabling plan now

In 2024, the Health Board was placed into Targeted Intervention (TI), the highest level of escalation before Welsh Government step in and take over management of the organisation. Data is going to be a key enabler to help us make better informed decisions to drive forward improvements.

HDdUHB faces significant challenges: rising demand, increasing clinical complexity, financial pressure, workforce fragility and variable access to modern digital tools. These pressures make it more important than ever that every decision we take is supported by robust evidence and effective use of our data.

But today, our data landscape is fragmented. Data quality is variable. Analysts are stretched. Systems do not always integrate. Many staff struggle to access the information they need, and advanced analytics are used inconsistently. This blueprint addresses that gap directly.

Where we are today

- Data is split across systems, with duplication and inconsistency
- Analysts are working hard but with limited capacity to support deep insight
- Data literacy varies across teams
- Data products are useful but not standardised
- Advanced analytics and AI are emerging but not embedded

By 2028 we want to be

- Operating from a single, trusted data platform
- Delivering real-time operational intelligence
- Empowering staff with easy-to-use, consistent data products
- Running a strong analytical network with shared standards
- Embedding predictive and prescriptive analytics into decision making
- Using AI safely and ethically
- Readily sharing insights with our patients and communities

Our aims overview

We have identified eight aims in our 2025-2028 data blueprint that will help us work towards our aim:

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)	Transformative opportunity to reduce administrative burden, accelerate detection in critical pathways, and streamline patient access and staff workflows

These eight aims are underpinned by a key enabler for our staff:



Our starting position: staff

as at 30 September 2025

The Health Board has three data teams, all managed within the Digital directorate: Information Services, Data Science Team and the Performance Team. Combined functions for these teams include:

Data collection

- Data standards
- Data quality
- Clinical coding
- Application support

Data processing

- Data engineering

Data analytics and insights

- Business intelligence
- Corporate reporting
- Ad hoc information requests
- Performance reporting
- Performance improvement

Data-driven actions

- Advanced analytics
- Data science

The three Data teams will work closely with the Health Board's Information Governance Team to ensure our data is used safely (see page nine for further details).

Some other directorates across the Health Board also have staff with analysis as part or all their role. A network has been developed to bring together all Health Board staff with an interest in analytics to share new developments, tips and ideas.

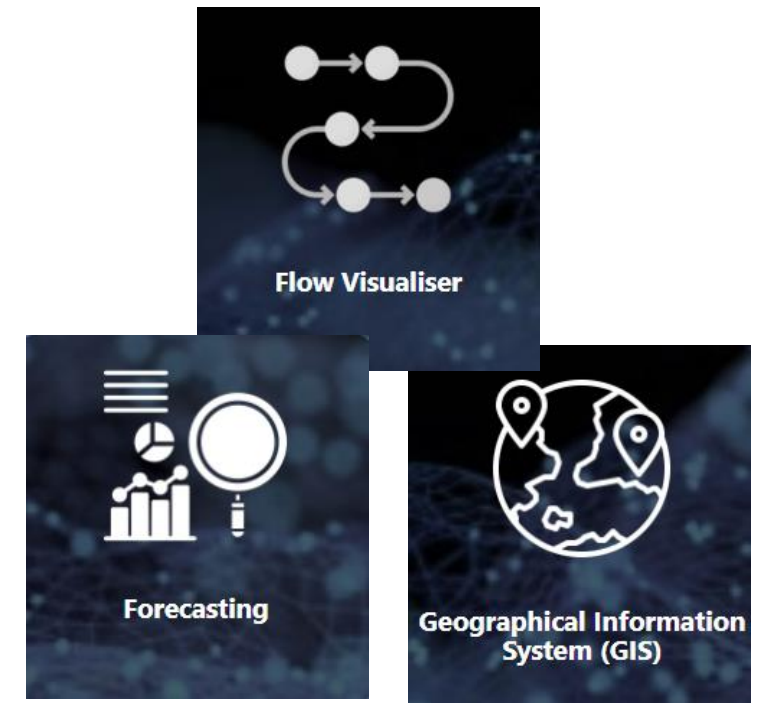


Our starting position: tools and products

as at 30 September 2025

Our existing tools and products

- Information Reporting Intelligence System ([IRIS \(cloud version\)](#)) is the landing page for any self-service reporting output made available at Health Board level by the Digital Data teams. IRIS consists of a suite of Power BI dashboards. It can be accessed by all Health Board staff via a desktop icon, MS Teams or mobile devices.
- [Data Science Platform](#) – includes Flow Visualiser, Geographic Insights and Forecasts modules
- Tool for predicting did not attend (DNAs) for Ophthalmology
- Tool for predicting re-admissions
- Demand and capacity prototype for cancer services
- [Our Improving Together Framework](#) - sets out our approach to embedding data driven performance improvement at all levels of the Health Board
- [Integrated Performance Assurance Report dashboard](#) – updated monthly for Board/Committee and made available to the public via our internet site.
- We are developing a [series of 'Our' dashboards](#) to provide staff, Board/Committees with easier access to key data. Currently available:
 - Our Performance – provides all staff with easy access to data for the 'must dos' e.g. management of incidents, complaints, risks, staff sickness, mandatory training, agency use, finance, procurement, vacancies, turnover.
 - Our Safety – triangulates key quality and safety metrics to determine potential safety hotspots.
 - Our Activity – includes clinical and operational activity metrics.
 - Our Productivity – includes metrics relating to productivity and efficiency of our services.



Information Governance: enabling safe use of data

Strong governance means we can move faster, share more insight, and innovate safely.

Why is information governance important?

Good information governance lets us use data confidently:

- Ensures data is used lawfully, fairly and securely
- Protects patients, staff and public trust
- Allows data to be shared, linked and analysed safely
- Enables self-service, advanced analytics and AI without increasing risk

Embedding information governance

Information governance underpins every aim and work package:

- Clear data ownership and standards
- Appropriate access based on roles
- Safe secondary use of data
- Ethical use of AI aligned to national NHS principles

Our approach

- Governance is designed in, not bolted on
- Rules are clear, proportionate and practical
- Staff are supported with guidance and training
- Fully aligned with national NHS and regulatory requirements





Our aims and enabler

Aim 1

Strengthen and improve data quality

Ensure our data is complete, accurate, reliable, relevant and timely.



Why is this important to us?

- Data collection is the foundation element for any organisation that has an ambition to become truly data driven.
- Without assurances around the quality and usability of the data organisations are at risk of making poor decisions based on the data available to them.
- Having access to good quality data will enable us to make better decisions to improve patient care.
- Data collection must comply with information governance laws and principles.

What is HDdUHB going to do?

- Embed data quality within our Improving Together sessions.
- Seek opportunities through existing training programmes to develop a communication plan to further educate staff on the importance of data quality and the role that each individual plays in ensuring the data is captured as timely, accurately and consistently as possible within the digital applications.
- Develop a data quality matrix to help staff easily assess the robustness and limitations of each data source.
- Data quality deep dives and develop an escalation process to ensure data quality ownership at the service level.
- Ensure we are making effective and consistent use of available applications to support end users to deliver direct patient care and support decision-making processes.
- Clinically code “everything” to support the understanding of what resources are used through each patient interaction.

Aim 2

Central storage of our key data

Health and social care data stored in the Health Board's data platform on the cloud. This will enable easier access to key data sources for staff and better-informed decision making.



Why is this important to us?

- Data will be held centrally and not in silos, making it more accessible i.e. the data will be stored once and used by many.
- There will be one version of the truth.
- We will be able to link data sources, triangulate our data and look for concerning insights / good practice.
- Security access restrictions can be applied where needed.
- Data can be used for dashboard developments.
- The data platform has the processing power to undertake highly complex queries.
- Access to non-traditional health data (e.g. social care) would provide greater insight for all patient care and a 360 degree view for decision making.

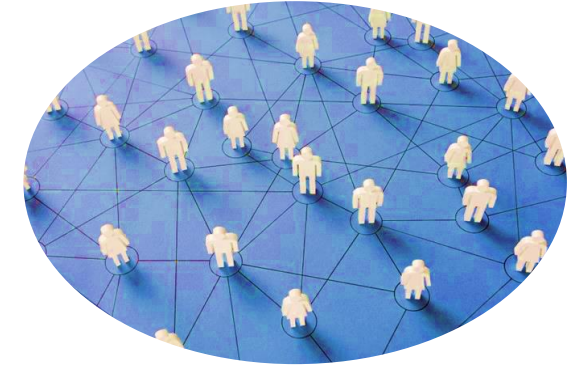
What are Hywel Dda going to do?

- Produce a business case with a proposal to develop a data platform to support the single version of the truth across all outputs. This migration intends to bring all organisational data into one space to support triangulation and decision making. This includes community and primary care data
- Develop a catalogue of data sources and indicators available via the data platform, that can be accessed by all approved Health Board staff.
- Establish real time feeds from our key systems to our data platform to source all data in a timelier manner i.e. transactional, clinical, patient generated, workforce, quality and safety, socio-economic. This will also include commissioning data i.e. data for our residents treated in hospitals outside of HDdUHB.
- Liaise with Local Authorities and third sector to identify key care data sets to be added to the data platform.
- Maximise the data opportunities from the electronic health record and investigate other potential options for data linkage (links to Aim 7).
- Ensure alignment and engagement of the local data platform to the opportunities being made available nationally via the National Data Resource and Care Data repository.

Aim 3

Develop a network of skilled analysts

To support services in identifying where improvements need to be made to benefit patients, staff and the HDdUHB resident population.



Why is this important to us?

- We have analytical capacity to process ad hoc requests for data and requests for data science development work. However, our analytical capacity to support services to look for data insights is very limited.
- Data insights are key to help us identify challenges to drive forward improvements.
- Some Health Board analysts are the only analyst working within a directorate. This can cause issues with quality checking outputs, business continuity if the analyst is not available and limited development opportunities for these analysts.
- To help ensure the work of our analysts is as accurate and efficient as it can be, we want to ensure all analysts are skilled to a minimum standard in key areas. Examples include but are not limited to core datasets, data quality, data visualisation, Excel, SQL, information governance.

What is HDdUHB going to do?

- Develop a business case with a proposal to increase analytical skills and capacity to support services to look for data insights to drive forward improvements.
- Scope and agree a core set of skills/training to be achieved by all analysts.
- Develop a data visualisation guide for staff.
- Develop a programming guide(s) for Health Board analysts.
- Investigate ways to enhance the existing analyst network (CEDA) to give analysts outside of Digital opportunities to be involved in larger data projects and to provide all staff with more training and learning options. Job shadowing should also be considered to help with potential business continuity risks.
- Provide clear guidance and templates for staff on accessing analytical support.
- Develop a matrix for prioritising data requests.
- Develop and make available to staff, data dictionaries for key data

Aim 4

Data products accessible to all relevant staff

Provide decisions makers across all levels and teams in the Health Board access to appropriate data and information in a timely and appropriate manner



Why is this important to us?

- Giving staff easy access to reliable data will help them to make better informed decisions.
- Users must have the ability to interrogate data to truly understand their services and allow triangulation of appropriate data sources to determine possible route cause analysis.
- Reduce duplication and time spent by service leads and corporate teams gathering data to prepare reports for Groups, Committees and Board meetings.

What are Hywel Dda going to do?

- Further develop the Information Reporting Intelligence System to be the launch point for clinical, organisational and population data, with links to national resources and outputs from other directorates (outside Digital), IRIS will also be an access point for analysts across the organisation to access key datasets and tools.
- A dataset kite mark will be developed using the data quality scoring matrix, to ensure everyone is clear on the appropriateness of the data for their specific use.
- Provide staff with an accessible catalogue of available products that will be easy to navigate.
- Develop products for patient outcomes, population health, business continuity plans, audits and inspections, health and safety and commissioning.
- Where applicable and appropriate, provide access to real time data (links to Aim 3).
- Ensure any new applications procured has a reporting element to make data accessible.
- Embed the new Our Improving Together Framework across the Health Board, with data available at all levels to drive forward improvements.
- Extend the Our Safety dashboard to triangulate additional data to get a better overview of patient experience and potential safety hotspots.

Aim 5

Make data more available for the public

Be more open and transparent with people who use our services.



Why is this important to us?

- Provide easy access to common questions for the general public e.g. how long will I wait for my operation, how long is the current wait in Accident and Emergency (A&E). Waiting for healthcare can be a worrying time for patients. Providing easily accessible answers to the most asked questions may help to alleviate some concerns.
- In response to the Health Board being escalated by Welsh Government to Targeted Intervention, the Board has been reviewing its effectiveness. One of the areas identified for improvement is providing the public with easier access to data.
- Qualitative data can provide us with key insights, helping us to identify issues to address to ensure our services are safe and meet the needs of our patients and the HDdUHB population.

What is HDdUHB going to do?

- Link with services across the Health Board to gather a summary of the data patients most commonly request.
- Consult with a patient representative group on the summary list of potential data to be made routinely available to the public.
- Make the agreed data items routinely available via our internet site. Data should be updated monthly wherever possible.
- Build in annual checkpoints with the patient representative group to review if the data being provided is still fit for purpose.
- Where available, direct requestors to already published national figures.
- Review Freedom of Information (FOI) requests to understand frequently asked questions from the public relating to data.
- Review our qualitative data to look for themes of areas for improvement e.g. complaints, patient feedback, consultation responses.

Aim 6

Using data to improve productivity and efficiency

Data is essential for identifying areas of potential waste across our services



Why is this important to us?

- The NHS is in a challenging financial climate. Therefore, it is more important than ever to ensure that any waste is identified and steps are taken to reduce or eliminate it.
- Demands and advances for healthcare are continuously evolving. It is important we keep track of these to determine if we can be more productive or efficient in the services we provide.
- Comprehensive demand and capacity planning is essential to enable service leads to set improvement trajectories to help achieve national and local targets.
- Referral patterns for secondary care (both planned and emergency) can vary greatly by GP practice. It is important that this data is made available so that any outliers can be investigated and action taken where needed.

What is HDdUHB going to do?

- Co-develop with clinicians and service leads tools to enable Health Board staff to undertake robust demand and capacity planning.
- Cascade demand and capacity tools and training to service leads.
- Develop a dashboard of key productivity and efficiency metrics.
- Develop a tool or dashboard to highlight areas of clinical variation.
- Develop a tool or dashboard to highlight variation by GP practice for secondary care services.
- Explore how we can use our data to show an end-to-end pathway view of our services and the value services offer.
- Align clinical outputs to Getting It Right First Time (GIRFT) metrics and national audits.
- Use benchmarking tools to highlight opportunities for improvement aligned to best in class and exemplars.

Aim 7

Enhance our data science tools and skills

Data science gives us greater power to help improve patient outcomes and productivity



Why is this important to us?

- Data driven transformation will only be achieved when we move beyond traditional data analytics and insights. These typically use single data sets to understand what has happened. To properly benefit from AI and Data Science, Big Data needs to be utilised.
- Big Data will combine multiple and large data sets that are normally difficult to interpret. Data science can transparently handle Big Data, providing prescriptive analytics. The power this brings is that it not only anticipates what will happen and when, but also why it will happen.
- Example benefits of data science:
 - Understand the likelihood of a patient outcome
 - Assess meaningful choices that can be taken to mitigate or improve a patient pathway
 - Can help with accurate forecasting and contribute to the development of the Health Board's plan.

What are Hywel Dda going to do?

- Embed our tools into the day-to-day work of the services to support understanding of expectation on services through forecasting and modelling.
- Develop models to evaluate and inform major planning decisions against a wide range of uncertain long term future scenarios.
- Develop a tool to predict the likely numbers of patients expected in our emergency departments.
- Produce robust forecasting and tracking of metrics for the Health Board's Annual Plan.
- Look for opportunities to maximise the use of Big Data (links to Aim 3).
- Investigate the population health of our workforce.
- Optimise our off-pathway patients.
- Extend our use of geographical intelligence tools.

Aim 8

Leverage data for artificial intelligence (AI)

Sound data is essential to ensure AI produces meaningful results.



Why is this important to us?

- AI represents a transformative opportunity for the Health Board, with the potential to reduce administrative burden, accelerate detection in critical pathways, and streamline patient access and staff workflows.
- People need confidence that their data is protected and used for public benefit.
- AI tools are only as reliable as the data, rules and decisions behind them.
- Secondary-use data can support earlier insight, service planning and population health.
- Clear safeguards help teams use data in ways that are lawful, fair and transparent.

What is HDdUHB going to do?

- Commission an AI readiness assessment to be undertaken for HDdUHB.
- A review of current and potential AI uses that rely on Health Board data.
- Look for opportunities to automate data collection and reduce manual effort.
- Make sure the data we collect is high quality, so people can trust that AI tools use the best available information to produce reliable insights and forecasts.
- Ensure each AI project has a clear use case and purpose, with approvals and accountable owners.
- Collaborate with clinicians, data teams, patients and public voices as work develops.
- Consider linking with the private sector and academia to identify other AI tools and opportunities.
- Ongoing monitoring of benefits, risks and unintended impacts.

Enabler

Increase data literacy across the Health Board

Help our staff further develop skills to accurately interpret and use data to make informed decisions



Why is this important to us?

- Data is a key enabler to the Health Board achieving its purpose, vision and objectives.
- Increasing data literacy will help all staff to review data for patterns to help ask the right questions and connect data points to derive meaningful insights.
- The data insights can be actioned to help drive forward improvements for our patients, staff and people living within the HDdUHB area.
- Improving our clinician's understanding of our data and trends will help inform decision making for our patients e.g. if Patient Reported Outcome Measure (PROM) scores are declining, preventative action can be taken were appropriate to do so.

What is HDdUHB going to do?

- Develop and deliver a data awareness training session for Health Board managers.
- Develop and deliver a data awareness training session for quality improvement leads and trainees.
- Develop a data literacy foundation course for all staff.
- Develop training for staff on the importance of undertaking robust demand and capacity planning and how to use the tools and resources that will be developed in Aim 6.
- Develop a narrative repository to enhance access to our qualitative data, help us identify themes and improve efficiency for report writing for our Board, Committees and Groups.
- Support the identification of themes and potential areas for concern within the qualitative data provided by our patients.
- All staff will be required to use the available data tools, seeking training if needed to ensure the tools are utilised effectively.

How our data aims support our 2026/27 Annual Plan



How our data aims support our 2026/27 Annual Plan

Data is a key enabler for achieving the eight planning goals within our Annual Plan for 2026/27. The table below indicates where each of our eight data aims can support these planning goals.

Planning goals	Aim 1 Data quality	Aim 2 Data storage	Aim 3 Analysts	Aim 4 Data for staff	Aim 5 Data for public	Aim 6 Productivity	Aim 7 Data science	Aim 8 Data for AI
1. Healthy, thriving teams	✓	✓	✓	✓		✓	✓	✓
2. Customer service excellence	✓	✓		✓	✓	✓	✓	✓
3. 20Four7 population health	✓	✓	✓	✓	✓	✓	✓	✓
4. Community by design	✓	✓	✓	✓	✓	✓	✓	✓
5. People first, digital always	✓	✓	✓	✓	✓	✓	✓	✓
6. Safe, timely, high-quality care	✓	✓	✓	✓	✓	✓	✓	✓
7. Future-orientated	✓	✓	✓	✓	✓	✓	✓	✓
8. Fit-for-purpose, modern facilities and services	✓	✓	✓	✓	✓	✓	✓	✓



Progress made

Work has started on many of the work packages identified within each of our eight aims and enabler. Below are some key areas to highlight:

Aim 1: Strengthen and improve data quality

- Undertaken a baseline data quality audit for key performance datasets
- Data quality is a key component of the training sessions delivered as part of our Leaders Empowered to Achieve Their Potential (LEAP) and Enabling Quality Improvement in Practice (EQIIP) programmes
- Data quality methodology established to manage escalation, and data usability matrix
- Programme of Data Quality Roadshows established

Aim 3: Develop a network of skilled analysts

- Three new analysts appointed as joint posts between operational and corporate teams
- Draft SQL programming guide prepared for Health Board analysts

Aim 2: Central storage of our key data

- Foundations of a data platform developed, ensuring robust auditing and sign off from Cyber Security colleagues
- Large areas of secondary care data available in existing data platform, with a work programme to gain additional key datasets established. Including primary care and Local Authority opportunities

Aim 4: Data products accessible to all relevant staff

- Our Performance and Our Safety dashboards strengthened and embedded across the organisation to support performance improvement
- Our Actions dashboard and trackers developed to track actions for our Board, Committee, Executive Team and related Subgroups
- Phase 1 of the Our Population Health dashboard has been published and is facilitating better understanding of patterns in health and wellbeing.
- The Health and Safety dashboard (Phase 1) is available to staff and includes metrics relating to health and safety incidents, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) and training.
- Development of a kite mark and usability score underway to provide assurance on the data and published output to consumers

Aim 5: Make data more available for the public

- Complete - Link with services across the Health Board to gather a summary of the data patients most commonly request

Aim 7: Enhance our data science tools and skills

- PhD research is underway to develop models to evaluate and inform major planning decisions against a wide range of uncertain long term future scenarios
- PhD research to predict the types of Emergency Department (ED) presentation is nearing completion for end of 2026
- Trends and forecasts were produced for the 2026/27 Annual Plan
- A geographic dashboard showing workforce population health has been developed

Aim 6: Using data to improve productivity and efficiency

- Phase 1 of the Our Productivity dashboard has been published and provides some productivity metrics to assess delivery trends and potential areas to improve efficiency
- A capacity planning tool for cancer services has already been developed
- Work is underway to support our therapy and radiology services with demand and capacity planning

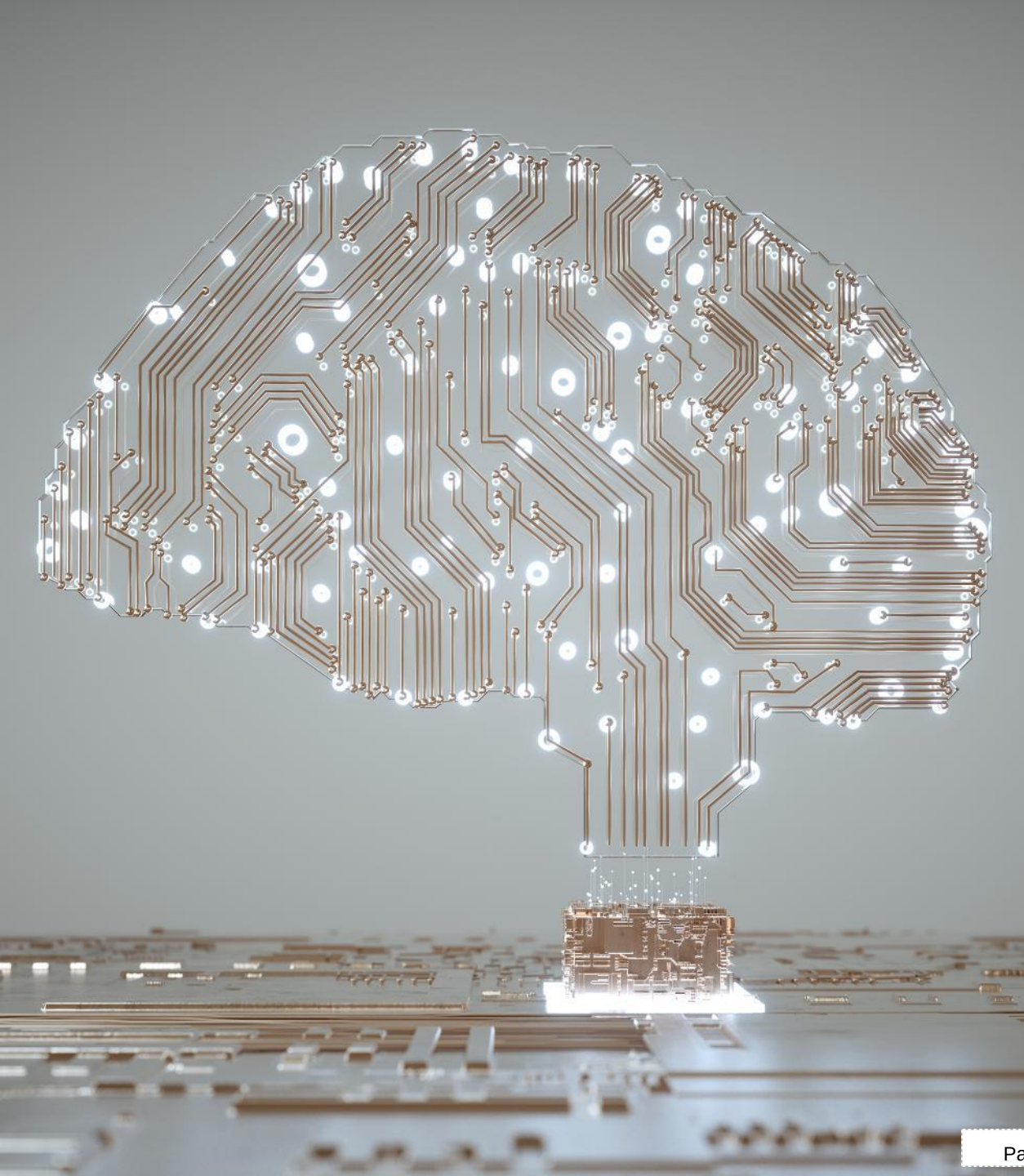
Aim 8: Artificial Intelligence (AI)

- An AI readiness assessment has been completed by CGI Inc

Enabler: Increase data literacy

- Complete - develop and deliver a data awareness training session for Health Board managers – session being delivered as part of our LEAP programme
- Complete - develop and deliver a data awareness training session for quality improvement leads and trainees – session being delivered within EQliP
- Therapy heads of service have been trained on the NHS England demand and capacity tool

Next steps and benefits



Developing *Turning Data into Insight* for 2028 onwards

The pace of change in the data space is rapid; we will continue to look to improve. As mentioned in the introduction section, this is Phase 1 of our blueprint which is focusing on strengthening our foundation, increasing our analytical capacity and embracing new technologies. There are continuous advancements in technology, tools and techniques for data that we need to be open to.

Throughout the lifetime of this blueprint, we will undertake an annual review to ensure it remains fit for purpose and make updates where necessary. In 2027/28, we will prepare our next 3-year data blueprint for 2028-2031 to continue to build on the strong foundations we will have in place. To help us ensure we meet our vision of strengthening oversight, generating insight and building foresight, we will be continuously mindful of these needs:

- Strengthening the foundations - data governance, quality, security, infrastructure
- Data enablement and integration - integration, accessibility, analytics tools, literacy, automation
- Data innovation and value realisation - innovation, advanced analytics, new products, partnerships, measurement, prevention



Benefits and measuring success

Expected benefits

By delivering the aims and workstreams outlined in this blueprint, we aim to:

- Strengthen our foundation by making data more meaningful and accessible for staff
- Increase data literacy across the Health Board
- Increase our analytical capacity
- Support staff to make decisions based on sound data
- Embrace new technologies to help drive forward improvements
- Achieve better outcomes for our patients
- Reduce waste
- Provide the public with data for commonly asked questions
- Improve demand and capacity planning within our services
- Strengthen data governance, security, confidentiality and compliance with Information Governance laws and principles

How will we measure success?

We will use the following metrics to track our progress and success:

- Number of aim workstreams completed within agreed timeframes
- Number of data sources added to the data platform
- Usage statistics for our dashboards
- Number of staff trained through data literacy foundation, EQliP and LEAP
- Number of analysts
- Number of training opportunities for our analysts
- Gather qualitative feedback from staff on the progress made
- Number of views of the data made available to the public
- Progress made for the Health Board's key improvement metrics (via IPAR)

Value is also important to us. Using the value-based health care approach, we will develop a value scorecard to track improvements across the organisation e.g. faster decision making, improved pathways, reduced waste.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3 - Digital

3.1

09:55, 10 Mins

3.1 - Digital Strategic Plan

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

Including:
Patient Services Centre Update
Proposal of Ambient AI within the Health Board

| For assurance

Attachments

[3.1.1 - DDIC - Strategic Plan July 2026.pdf](#)

[3.1.2 DDIC - Clinical leadership strategy.pdf](#)

PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Strategic Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Anthony Smith, Chief Clinical Information Officer Anna Harries, Chief Nursing Information Officer

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

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> This paper provides the Digital, Data and Innovation Committee (DDIC) with an update on the direction of travel of the Health Board's Digital Strategic Plan.
<u>Cefndir / Background</u> Since the last substantive update to the DDIC, the Digital Strategic Plan has continued to mature from a high-level statement of ambition into a more structured, deliverable and capability-led programme of work. The Committee has previously considered the need to move beyond individual technology deployments and to position digital, data and technology as an enabling infrastructure for service transformation, clinical safety, productivity, access and sustainability. The current direction of travel builds on that position and reflects the learning from recent DDIC discussions, delivery experience during 2025, and the developing programme priorities for 2026/27. The main change since the last DDIC meeting is that the Plan has been reframed around delivery confidence: clarifying what must be done first, what can safely be accelerated, and where activity needs to be paused, reset or re-sequenced because the necessary clinical, operational, data or architectural foundations are not yet sufficiently mature. This approach also responds to the Committee's previous emphasis on clearer timescales, benefits realisation, assurance over business case sequencing, AI accountability and governance, and stronger links between digital investment and measurable improvement.
<u>Asesiad / Assessment</u> Direction of Travel of the Digital Strategy

Since the last DDIC meeting, the direction of the Digital Strategic Plan has become more deliberately focused on disciplined execution, prioritisation and assurance. The work has moved away from describing a broad portfolio of digital ambition and toward defining a sequenced delivery model that can be governed, resourced and measured. This is important because the Health Board is operating in a context of significant operational pressure, financial constraint, workforce fragility and rising expectations for digital-enabled improvement. The Plan therefore needs to demonstrate not only what the Health Board intends to do, but why specific priorities have been selected, how dependencies will be managed, and how the Committee can be assured that delivery is realistic.

Key developments since the last DDIC meeting

- **Clearer sequencing:** the roadmap has been strengthened to distinguish foundational work, enabling capabilities and later-stage innovation, ensuring that advanced analytics, AI, automation and integrated records are progressed only where data, governance and operational readiness are sufficient.
- **Greater focus on delivery assurance:** work is being progressed to improve the scheduling of business cases, clarify governance routes and ensure that DDIC and Board scrutiny are aligned to key decisions and investment points.
- **Stronger emphasis on benefits realisation:** the Plan is being shaped around measurable outcomes including patient safety, flow, productivity, access, workforce experience, cyber resilience, information governance and value for money.
- **Improved clarity on partnership support:** the proposed role of CGI Inc has been refined as targeted specialist support to strengthen architecture, integration, delivery assurance and programme capacity, while maintaining Health Board ownership and accountability.

What has changed in practice

The most significant practical change is that the Digital Strategic Plan is now being used as a framework for prioritisation, not simply as a description of digital ambition. This means that programmes are being assessed against strategic fit, readiness, benefit, risk and dependency. Where initiatives support core foundations, such as integration, data quality, cyber resilience, clinical records, patient flow, electronic prescribing, digital access and information governance, they are being prioritised because they create the conditions for wider transformation. Where initiatives rely on mature data, stable architecture, consistent pathways or significant workforce adoption, they are being sequenced carefully to avoid creating avoidable complexity or unfunded recurrent pressure.

This approach has also strengthened the link between digital delivery and wider organisational change. The plan recognises that the benefits from digital investment will not be realised through technology deployment alone. They require operational ownership, clinical leadership, pathway redesign, workforce engagement, data discipline and sustained change management. As a result, the direction of travel now places greater emphasis on embedding digital into service planning, clinical governance, performance improvement and benefits tracking.

Current areas of strategic focus

- **Digital foundations:** strengthening infrastructure, cyber resilience, information governance, integration capability and supplier assurance.
- **Clinical digital maturity:** continuing progress toward a more integrated digital health record, electronic prescribing readiness, digital maternity, patient flow, electronic observations (eObs) and safer clinical workflows.

- **Data and intelligence:** developing the data blueprint, improving data quality, strengthening analytical capacity and creating the foundations for real-time insight and population health intelligence.
- **Access and patient-facing services:** progressing the single digital front door, Patient Services Centre approach and better digital access to services, while recognising the need to address digital inclusion.
- **AI and innovation governance:** developing appropriate accountability, clinical safety, information governance and ethical oversight arrangements before wider deployment of AI-enabled use cases.

Greater Clinical Leadership in Digital Transformation

Clinical Leadership in Digital Transformation presentation sets out a proposed clinical informatics model for the Health Board, it describes how clinical leadership will be embedded across digital transformation activity rather than applied retrospectively. The model is built around a three-tier clinical informatics structure and a Clinical Information Office, ensuring that medical, nursing, midwifery, allied health professional, pharmacy, health science and clinical digital fellow roles contribute to strategic direction, clinical governance, digital safety, professional standards, system design, usability, adoption and benefits realisation.

A central theme of the presentation is that clinical safety must be embedded from the outset of digital change. The proposed model positions the Chief Clinical Information Officer and Chief Nursing Information Officer as joint Clinical Safety Officers, supported by a wider clinical informatics team trained in clinical safety, with concurrent development of clinical safety cases and hazard logs as part of delivery. This strengthens assurance that digital programmes are clinically led, safety-focused and aligned to the Health Board's wider governance arrangements.

The presentation also confirms that the Clinical Information Office will provide clinical digital input at every level of governance, integrate with existing clinical leadership structures and represent the Health Board in regional and national digital strategy, safety standards and supplier governance. This will be important as the Digital Strategic Plan moves from strategy into implementation, ensuring that major programmes are shaped by clinical priorities, workforce adoption, professional accountability and patient safety considerations.

The model is aligned to key national and local policy drivers, including A Healthier Mid and West Wales (AHMWW) Strategy, the Health Board's refreshed strategy, the National Clinical Framework for Wales, the Strategic Vision for Nursing and Midwifery in Wales, the Digital Strategy for Wales, DCB0160 clinical risk management requirements and the emerging National Patient Safety Plan for NHS Wales. Overall, the presentation reinforces that greater clinical leadership is a critical enabler for the Digital Strategic Plan, supporting safer implementation, stronger adoption, clearer accountability and a more sustainable digitally enabled workforce.

What will change

The immediate change will be a move from clinical engagement as a project activity to clinical leadership as a core delivery requirement. Digital programmes will be expected to demonstrate clear clinical ownership, agreed professional input, active safety oversight and evidence that workflows have been designed with the people who will use them. This will strengthen the link between digital investment, operational improvement and patient safety, and will give the Executive Team and Independent Members greater assurance that programmes are not simply

technically deliverable, but clinically adoptable, safe and capable of releasing measurable benefit.

Next steps

The next phase will focus on moving from a proposed clinical leadership model to a practical engagement and delivery approach, supporting the completion and delivery of the Digital Strategy by September 2026. This will include confirming the clinical leadership roles required across the Digital Strategic Plan, clarifying the responsibilities of the Clinical Information Office, and agreeing the method for building clinical input into programme governance, business case development, supplier engagement, pathway design, implementation planning and benefits realisation. This will ensure clinical engagement is not dependent on individual programmes seeking input at a late stage but becomes a standard expectation for all significant digital change.

A structured Clinical Engagement Plan will be developed to identify the priority programmes requiring enhanced clinical leadership, the professional groups that need to be involved, and the routes through which clinical views will be captured and acted upon. Early focus will be placed on major areas of digital delivery including electronic health records, prescribing, patient flow, digital maternity, clinical documentation, AI-enabled solutions and data-driven improvement. Engagement will be aligned with existing clinical governance and operational forums to avoid duplication, while ensuring that clinical risks, usability issues, workflow implications and adoption requirements are visible at the right level.

To support implementation, the Health Board will establish a clearer network of clinical digital champions and subject matter experts, linked to the Chief Clinical Information Officer, Chief Nursing Information Officer and wider clinical informatics roles. This network will support two-way communication between programmes and frontline teams, help test assumptions, inform system design, support training and adoption, and escalate barriers where clinical engagement or operational readiness is insufficient. The approach will also help develop future clinical informatics capability across the organisation.

Progress will be monitored through programme governance and reported through the appropriate digital and clinical assurance routes. Measures of success will include evidence of clinical input into business cases and design decisions, completion of clinical safety documentation, active participation in programme boards or working groups, adoption readiness assessments, feedback from clinical users, and demonstrable links between clinical engagement and benefits realisation.

Conclusion

In conclusion, the Digital Strategic Plan is moving from a broad statement of ambition to a more disciplined, prioritised and assurance-led delivery model. The direction of travel is now focused on strengthening the foundations required for sustainable digital transformation, sequencing delivery around organisational readiness, and ensuring that investment is linked to measurable improvements in safety, access, productivity, workforce experience and value. This approach recognises that successful digital transformation is not achieved through technology deployment alone, but through clinical leadership, operational ownership, robust data, clear governance and sustained change management.

The strengthened focus on clinical leadership is a key enabler of this next phase. Embedding clinical input, clinical safety and professional accountability into programme governance will

provide greater assurance that digital change is clinically meaningful, operationally adoptable and capable of delivering benefits for patients, staff and the wider system. The Committee is therefore asked to receive assurance that the Digital Strategic Plan is being refined into a more deliverable programme of work, while recognising that continued prioritisation, sequencing, benefits tracking and clinical engagement will be essential to successful implementation.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE 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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.1 That the direction, development and delivery of the Digital Strategic Plan is to drive continuous improvement and support digitally enabled health care through a digitally enabled workforce to achieve the objectives of the Health Board's Annual Plan/Integrated Medium-Term Plan (IMTP).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	5. People First, Digital Always

Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
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)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial and service impacts of the digital plan are evident in the substantial investments made and the significant improvements in service delivery. These efforts reflect our commitment to creating a modernised, patient-centered system of care that aligns with national digital standards and local healthcare priorities. Each of the trenches, and projects will be subject to further business cases.
Ansawdd / Gofal Claf: Quality / Patient Care:	The digital plan will bring about substantial improvements in the quality of care and patient outcomes. By leveraging advanced digital technologies, we have created a more efficient, safe, and patient-centered healthcare system

	that aligns with our commitment to delivering high-quality care to our communities.
Gweithlu: Workforce:	The digital plan has significantly transformed our workforce by enhancing productivity, fostering skills development, and improving overall well-being and engagement. These efforts reflect our commitment to creating a modernised, efficient, and supportive work environment that aligns with our strategic goals and enhances the quality of care we provide
Risg: Risk:	The digital plan carries several risks, proactive risk management and mitigation strategies are in place to address these challenges. By continuously monitoring and managing these risks, the organisation aims to ensure the successful implementation of the digital plan and the achievement of its strategic objectives.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The successful execution of the digital plan can greatly enhance our organisations reputation as a leader in digital innovation within the healthcare sector. By integrating advanced digital tools and platforms, we demonstrate our commitment to improving patient care, operational efficiency, and data security. This proactive approach can attract positive media coverage, bolster public trust, and strengthen relationships with stakeholders, including patients, staff, and partners. The digital plan's emphasis on enhancing service delivery and patient outcomes aligns with our mission to provide high-quality, value-based healthcare, further solidifying our reputation as a forward-thinking and patient-centered organisation.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	All business cases / projects will be subject to an equality assessment

Digital, Data and Innovation Committee

21 July 2026

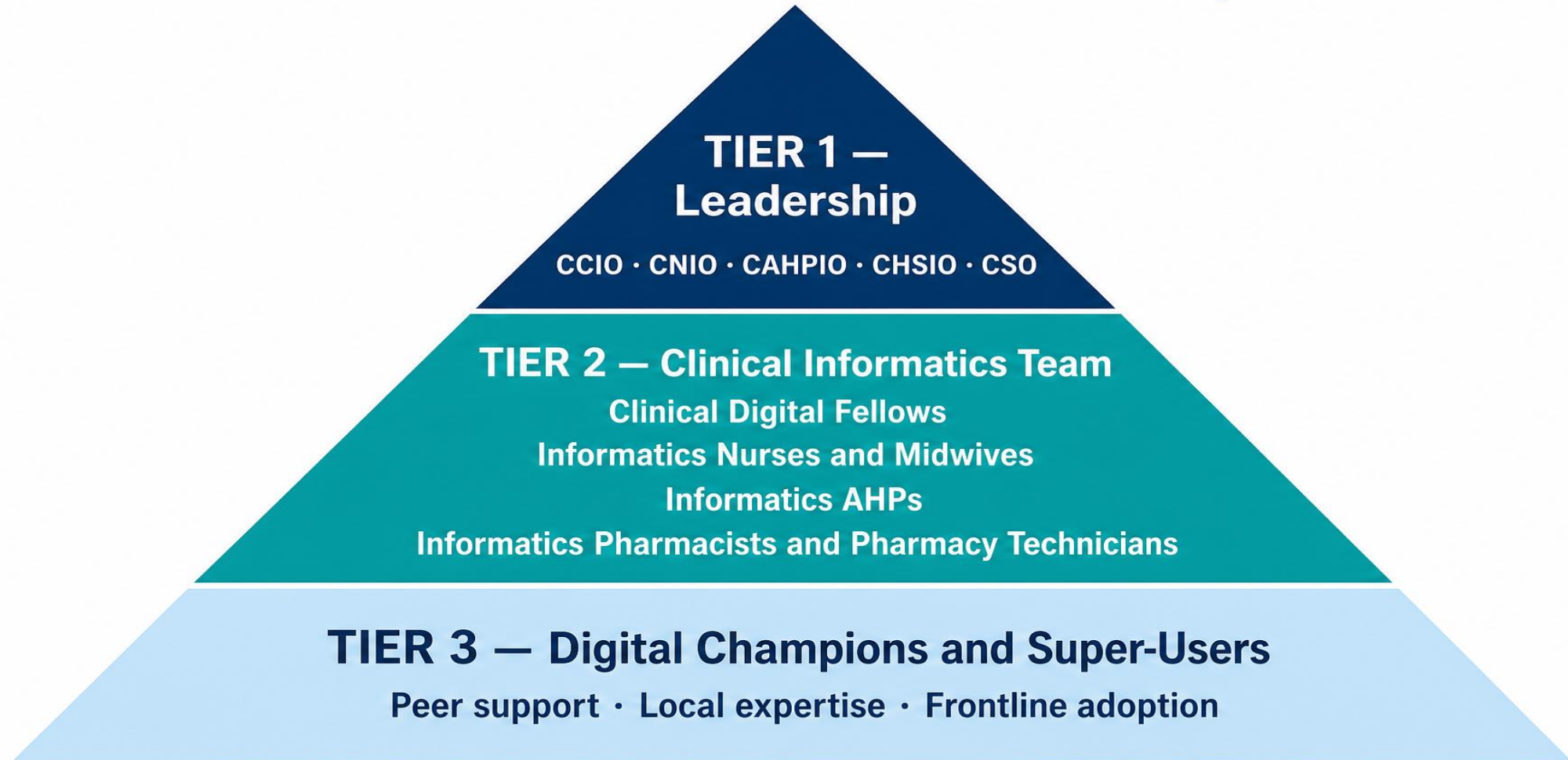
Clinical Leadership in Digital Transformation

A Vision for Hywel Dda University Health Board

Pobl yn gyntaf, digidol drwy'r amser
People first, digital always

Clinical Information Office · June 2026

Clinical Informatics Leadership Model



The Clinical Informatics Team



Role	Shared Responsibility	Specific Focus
CCIO	Strategic direction for clinical digital programmes Clinical governance and oversight Digital safety accountability National and regional representation	Medical informatics strategy; professional standards for digital medical practice; jointly serves as Clinical Safety Officer (CSO)
CNIO		Nursing & midwifery informatics strategy; professional standards for digital nursing and midwifery practice; jointly serves as Clinical Safety Officer (CSO)
CAHPIO		AHP informatics strategy; therapy-specific digital standards; cross-professional digital adoption
CHSIO		Health science informatics strategy; scientific data governance; laboratory and diagnostic digital standards
Clinical Digital Fellows	Clinical engagement Concurrent development of clinical safety case and hazard log Professional representation and advocacy	Programme clinical leadership, system design and configuration, clinical adoption leadership, future leaders pipeline
Informatics Nurses & Midwives		Workflow design, bedside system usability, training, adoption support, workforce digital readiness
Informatics AHPs		Therapy-specific digital expertise, usability testing, adoption support
Pharmacists & Pharmacy Technicians		Prescribing safety, CDS rules, medicines workflows, dm+d database maintenance

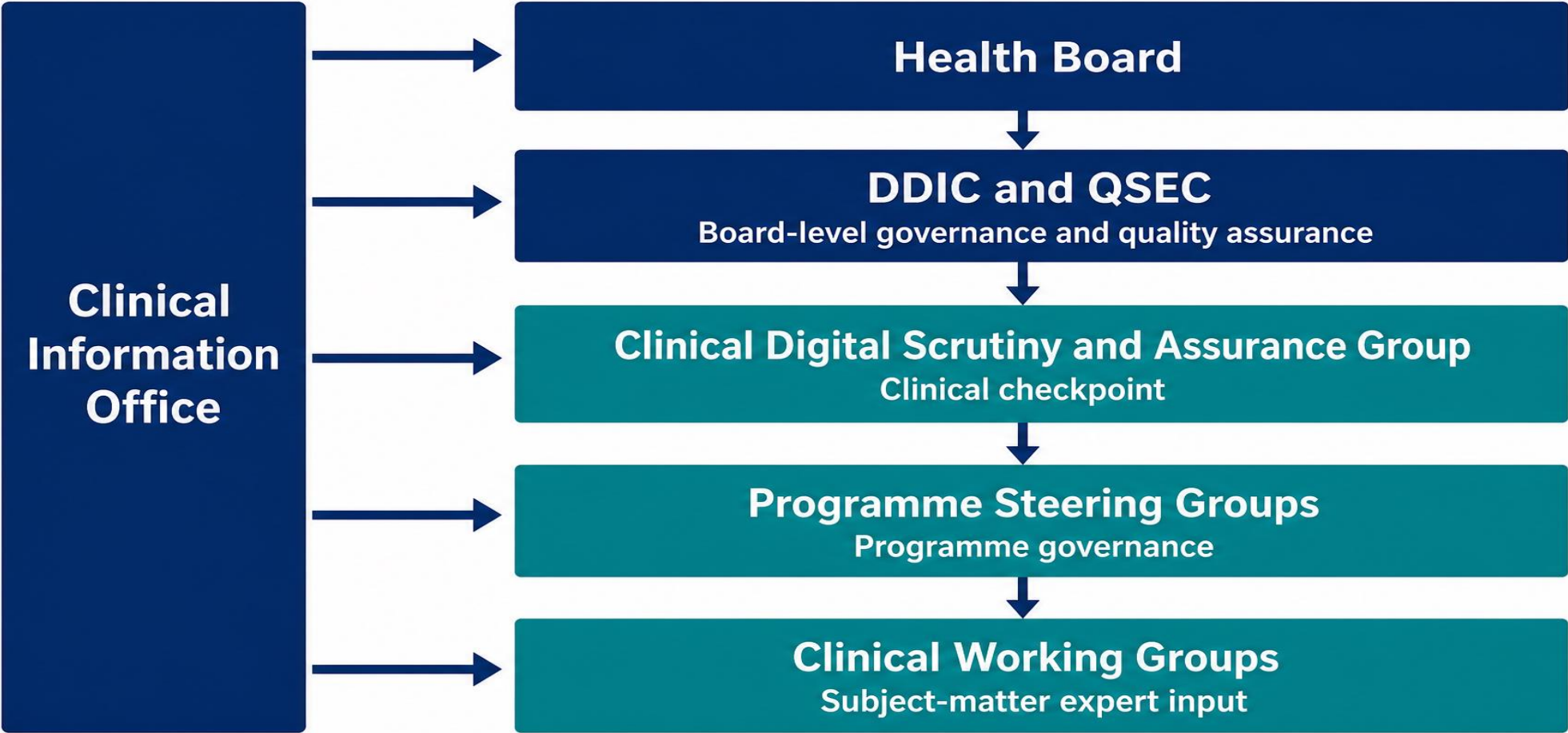
All team members share collective responsibility for implementing with safety in mind and the concurrent development of the clinical safety case and hazard log.

Clinical Safety – Embedded, Not Bolted On



Every team member is trained in clinical safety. The CSOs (CCIO and CNIO jointly) provide cross-programme safety governance.

Clinical Digital Governance Structure



The Clinical Information Office provides clinical digital input at every governance level.

Clinical Information Office

Clinical Information Office



CCIO and CNIO are jointly the Clinical Safety Officers



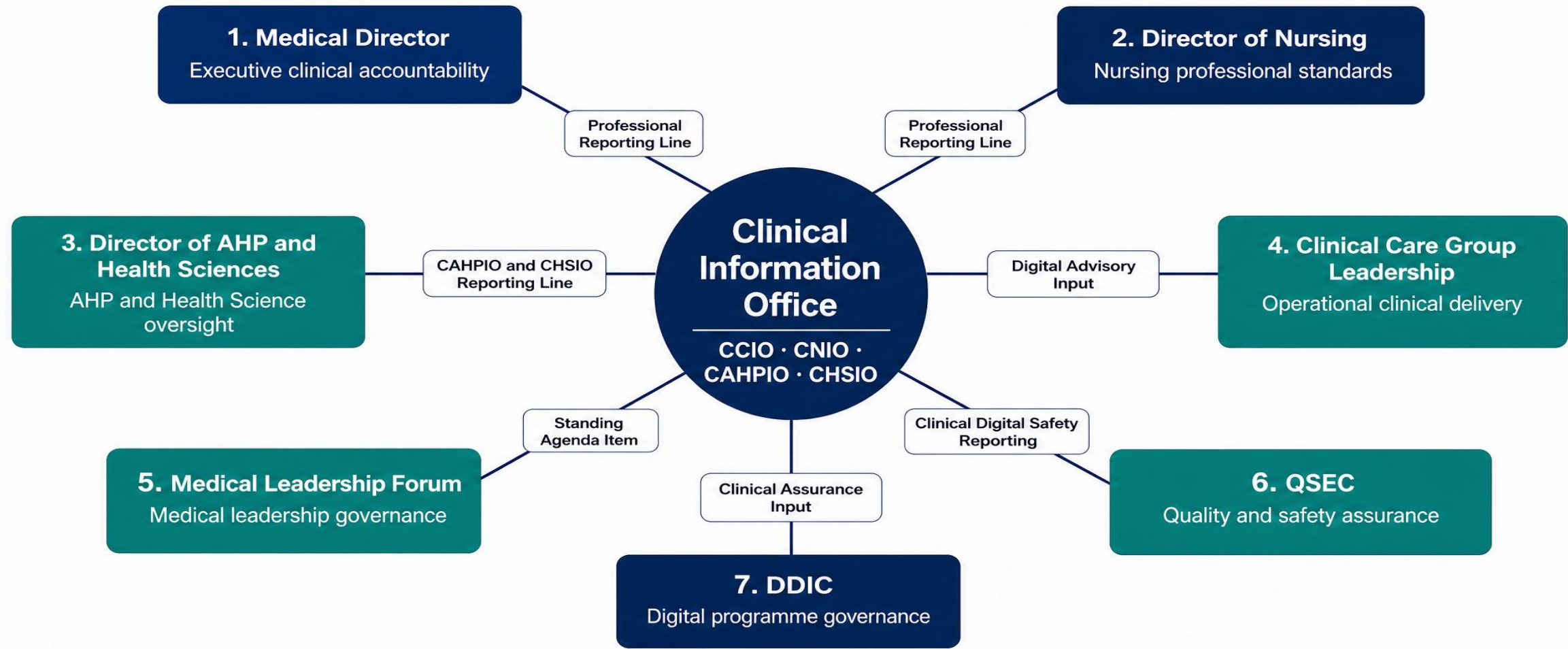
Clinical Informatics Team

- Clinical Digital Fellows
- Informatics Nurses and Midwives
- Informatics AHPs
- Informatics Pharmacists and Pharmacy Technicians

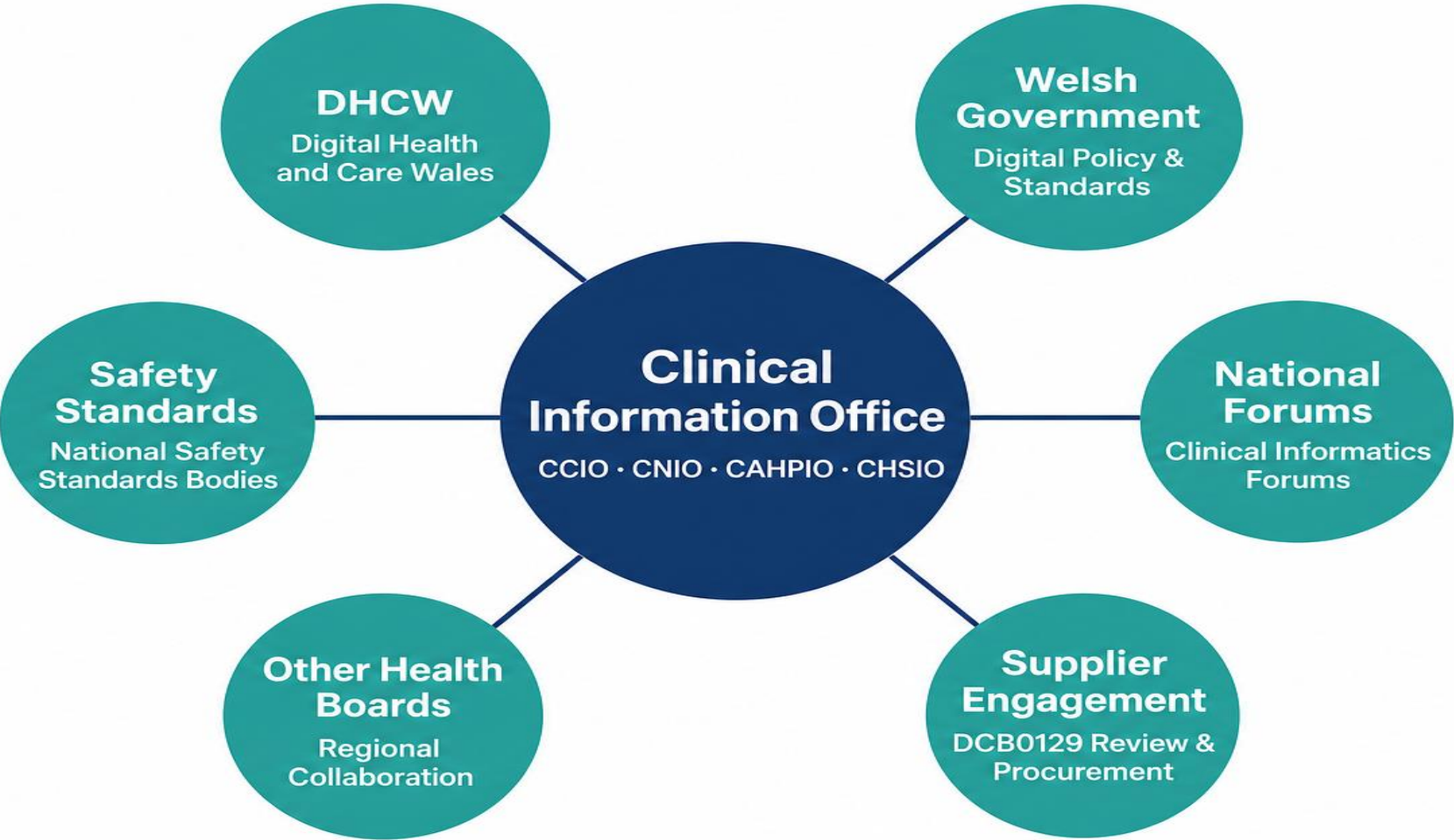


All team members share collective responsibility for clinical safety

Integration with Existing Clinical Leadership



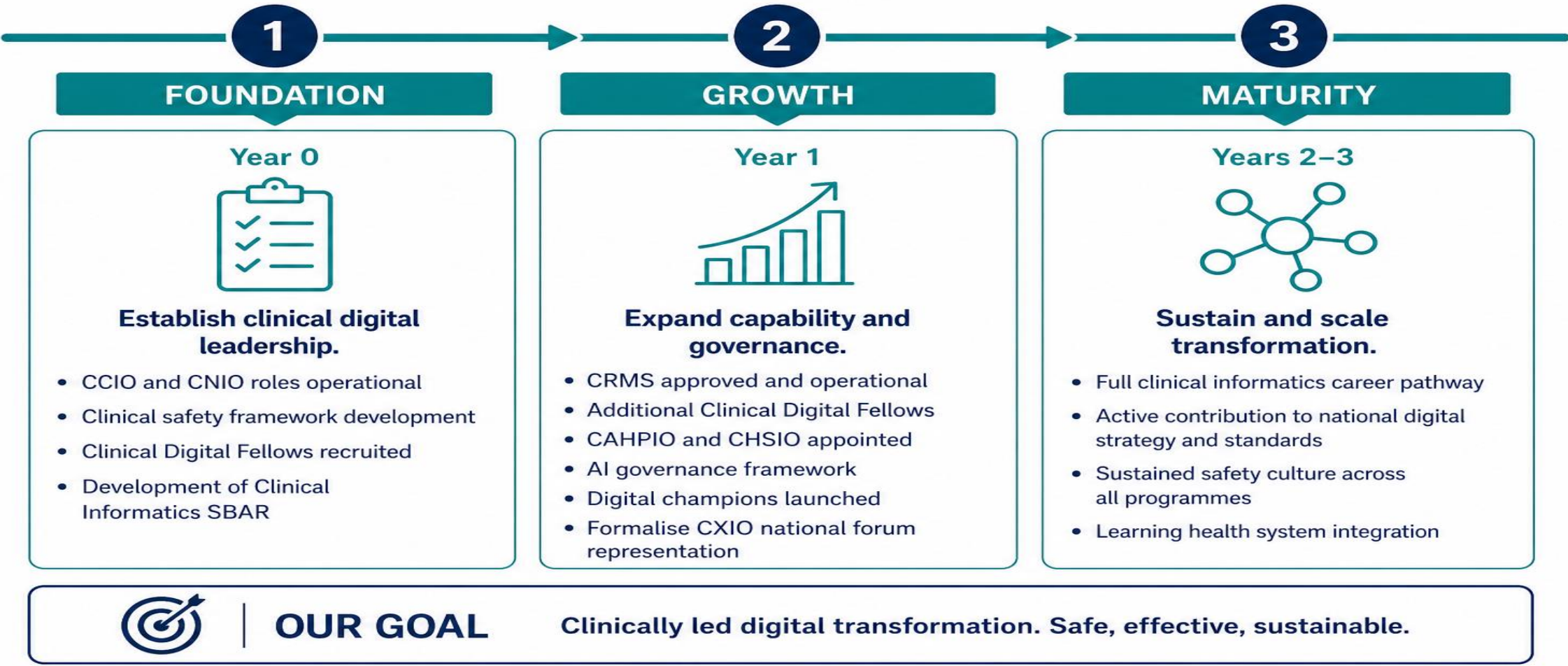
External & National Engagement



Chief Information Officers represent the Health Board in national and regional digital strategy, safety standards, and supplier governance.

Clinical Informatics Maturity Roadmap

A three-phase journey toward clinically led digital transformation.



Policy Alignment

Policy	Requirement	How This Model Delivers
A Healthier Wales (2018)	Quadruple Aim — motivated, sustainable workforce	Clinical informatics as a career strand
Hywel Dda Refreshed Strategy: A Healthier Mid and West Wales (2024)	Goal 5: People First, Digital Always — digital as a design principle	Clinical leadership at every touchpoint of care
National Clinical Framework for Wales (2021)	Learning health system; “documents are not data”	Structured data, clinical governance, data-to-insight cycle
Strategic Vision for Nursing & Midwifery in Wales (2025)	Theme 05: Digital and technological fluency across nursing	CNIO, informatics nurses and midwives
Digital Strategy for Wales (2021)	Mission 3: Digital skills for public service workforce	Clinical safety training, champions network
DCB0160 (2018)	Clinical risk management for deployed systems	Embedded safety, clinical safety-trained team
National Patient Safety Plan for NHS Wales (2026)	QMS approach to patient safety; national clinical governance framework	CSO function, embedded safety culture, hazard log governance

Digital: transforming care, clinically led.

**Pobl yn gyntaf, digidol drwy'r amser.
People first, digital always.**



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3.2

10:05, 10 Mins

3.2 - Planning Goal 5: People First, Digital Always

*Anthony Tracey
(Hywel Dda UHB -
Digital Director)*

Including delivery plan and assurance on any milestones met to date

| For assurance

Attachments

[3.2 Planning Goal 5 People First, Digital Always\).pdf](#)

Planning Goal 5: People First, Digital Always

Executive Lead: Huw Thomas, Executive Director of Finance

Reporting Period: Quarter 1

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Since March 2026, Digital has focused on delivering tangible improvements to patient care and staff experience through the deployment of key clinical systems (BadgerNet, Miya Flow, electronic observations (eObs) and Electronic Prescribing and Medicines Administration ePMA)), strengthening digital governance and workforce capability, advancing AI and data innovation, modernising clinical electronic records management, and establishing a clear strategic roadmap for long-term digital transformation. Collectively, these initiatives support the Health Board’s ambition of delivering safer, more connected and person-centred services through a **People First. Digital Always** approach.

Progress against planned outcomes / trajectories / milestones:

Please see table below

Activities completed in previous reporting period

- Enhanced **Miya Patient Flow**, introducing digital referrals, Digital Home Ward improvements and patient journey functionality to support flow, discharge and operational management
- Progressed rollout of **eObs**, reducing reliance on paper-based processes
- Advanced the **ePMA** programme to improve medication safety, prescribing accuracy and clinical efficiency.
- Matured the **Digital Strategic Plan** into a structured, capability-led roadmap aligned to organisational priorities and benefit realisation.
- Progressed procurement of a new **Electronic Document and Records Management System (EDRMS)** to improve access to patient information and support a paper-light organisation.
- Developed the Health Board’s **Data Strategy (“Turning Data into Insight”)**,

Activities planned for next milestone and reporting period

- Established an **AI and innovation framework**
- Expanded **digital workforce capability** through digital skills development, workforce readiness activity and adoption support.
- Progressed the **Miya Emergency Department Module**, supporting the future transformation of urgent and emergency care pathways.
- Advanced the Health Board’s **Data Strategy (“Turning Data into Insight”)**, strengthening the use of information and analytics to support decision-making and service improvement.

Any other Comments

Matters for information:

Risks to delivery: Capacity with the operational teams, and the business change required. We are now looking at additional support

Any other comments:

Objective Summary

Overview

Goal 5 – People First, Digital Always: To use digital, data and technology to improve outcomes and experiences for patients and staff, ensuring that all digital transformation is person-centred, clinically led, safe, inclusive and focused on delivering sustainable improvements in quality, access, productivity and population health

Key themes associated with the objective include:

- Designing digital services around the needs of patients, carers and staff.
- Increasing access to digital tools and information to support better care and experience.
- Developing digital skills, confidence and literacy across the workforce.
- Embedding digital adoption as a cultural and organisational priority rather than simply an IT programme.
- Ensuring strong information governance, clinical safety and ethical use of digital technologies, including AI.
- Supporting the move towards integrated digital health records, paper-light working and digitally enabled care pathways.

3.3

10:15, 10 Mins

3.3 - Digital Inclusion

***Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Carolyn Williams
(Hywel Dda UHB -
Head of Digital
Transformation &
Programmes)***

| For assurance

Attachments

[3.3 - DDIC Digital Inclusion SBAR July 2025.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Inclusion
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Carolyn Williams, Head of Digital Innovation & Transformation

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 an update on the Digital Inclusion Programme, highlighting progress to date and ongoing efforts to support digital projects. The Digital Inclusion Support Service plays a vital role in preparing the workforce for digital transformation across the Health Board as new systems such as Electronic Prescribing and Medicines Administration (ePMA), Electronic Patient Flow (e-Flow), and Electronic Observations (e-Obs) are introduced where emphasis is placed on the staff's need for basic and essential digital skills and confidence to use digital effectively. Without this readiness, the full benefits of these systems, such as improved patient care, streamlined workflows, and better data, cannot be realised.

The Digital Inclusion Service addresses this by offering:

- A referral process to help individuals access tailored digital support
- Resources for self-directed learning to empower staff in building digital skills
- Digital skills assessments to identify individual and team needs
- Tailored training and one-to-one support to build confidence
- Ongoing guidance to support digital adoption

This support is essential to ensure that all staff can engage with digital systems confidently and consistently, enabling the Health Board to meet its strategic goals.

Cefndir / Background

Hywel Dda University Health Board's (HDdUHB) Digital Inclusion Programme supports a coordinated approach to digital inclusion across the organisation and its partners. It aligns with the Health Board's digital response and focuses on:

- Embedding digital inclusion in daily workforce activities
- Supporting new digital programmes and population health initiatives
- Empowering patients through digital engagement
- Developing community-based digital support opportunities
- Improving digital literacy and digital health literacy to maximise technology benefits and support health and wellbeing

Launched in May 2023, the Digital Inclusion Support Service plays a key role in preparing the workforce for digital transformation. Digital inclusion ensures everyone can access and benefit from digital tools, helping to reduce inequalities and support safe, effective, person-centred care.

The service is delivered by a dedicated team working closely with internal departments and external partners, including Digital Communities Wales. Their collaborative approach ensures digital inclusion is embedded across the organisation and wider community.

To further support and strengthen the foundation of the service and improve digital capability, the programme has now introduced a Digital Readiness approach and a Digital Skills and Confidence Development Pathway, aligned with national frameworks, to promote continuous digital development across all levels

The Digital Skills and Confidence Development Pathway provide the support required to build capability at all levels and support continuous digital learning. The Team Digital Skills and Confidence Readiness Framework supports leaders to guide their teams through the digital changes ahead.

Asesiad / Assessment

The Digital Inclusion Programme has made positive and sustained progress against the Health Board's planning goal and the eight identified pillars. Since its establishment, the programme has developed from an initial support offer into a more mature, structured and proactive service that is increasingly embedded within digital transformation activity across the organisation. The journey to date demonstrates clear improvement in how digital inclusion is understood, promoted and applied, with stronger links now established between workforce readiness, patient engagement, accessibility, community partnership and successful digital adoption.

The Digital Inclusion Support Service continues to provide targeted, personalised support to staff who are digitally excluded or lack confidence, helping to reduce capability gaps, improve equitable access to development opportunities, and build the confidence required for staff to engage positively with new digital ways of working.

The following section summarises progress against the eight agreed pillars, demonstrating how the programme has developed from early engagement and awareness-raising into a broader, more embedded approach that supports workforce capability, patient engagement, accessibility, community partnerships and digital adoption across the Health Board.

Pillar 1 – Recognise Digital Access and Skills as a Social Determinant of Health

- The Digital Inclusion Manager provides regular updates at the Professional Nursing Forum, engaging Ward Managers across all sites to raise awareness, share resources, and address digital barriers and offer a point of contact and link to the larger digital innovation and transformation team.
- Welsh Government has confirmed and allocated funding, in partnership with the University of Wales Trinity Saint David (UWTSD), to develop the Digital Divide research project for the region. This initiative aims to provide a deeper understanding of community needs and commenced on 1 August 2025.

Pillar 2 – Co-Design Digital Health Services

- The Digital Inclusion Team supports the co-design of digital health services across HDdUHB, working with digital project teams to embed digital inclusion from the start.

- The Digital Inclusion Manager represents HDdUHB on the Digital Health and Care Wales (DHCW) NHS Wales App Patient and Public Assurance Group.
- The team collaborates with stakeholders such as Royal National Institute of the Blind (RNIB) to ensure usability and accessibility of new systems and strives to ensure that digital inclusion is considered in all engagement and development activities.
- The Regional Digital Inclusion Steering Group, developed to bring stakeholders and key partners together across the region, continues to grow in strength and influence, with new stakeholders joining and identifying funding opportunities for community-based digital inclusion projects and accessing information from our health service that contributes and supports patient engagement and community engagement.

Pillar 3 – Improve Digital Health Literacy in the Population

- Collaboration with Ceredigion County Council's Independent Living Hub is progressing well with positive steps. Joint efforts are focused on enhancing digital skills and confidence among service users.
- Through ongoing engagement, a new **Digital Inclusion Alliance Group** has been developed in partnership with Ceredigion County Council, bringing together key stakeholders and providers to explore support needs and develop digital inclusion opportunities across the county.

Pillar 4 – Develop 'Digital Health Hubs' to Improve Inclusion

- The Digital Inclusion Team has been asked to offer advice and guidance on incorporating digital inclusion activity into the development of an Independent Living Centre with Pembrokeshire County Council.
- Digital Inclusion input will help ensure the hub provides appropriate access, support, and opportunities for individuals to build digital skills and confidence.
- This collaboration aims to create a space that supports inclusive digital engagement and meets the needs of the local population.

Pillar 5 – Build Trust and Relationships with Poorly Served Groups

- A strong partnership with the RNIB is helping improve accessibility for people with sight loss, particularly in projects such as Hybrid Print and Post.
- The team is supporting departments and teams working with patients to help identify and signpost individuals who may benefit from digital support.
- Patients are directed to local community-based opportunities that can help them build digital skills and confidence.
- Collaboration with the Benefits Realisation Manager is ensuring that communication and change management strategies are embedded into digital project rollouts.

Pillar 6 – Harness the Benefits of Digital for Health and Wellbeing

- Digital projects are regularly shared at Regional Steering Group meetings, encouraging stakeholder engagement and wider dissemination.
- Positive feedback from staff highlights the impact of digital inclusion support:

"Just wanted to feedback how helpful and insightful I have found previous sessions and that I will be sharing some of the resources I have learnt about at my next team meeting..."

"Your support was invaluable ... the wider issues we had are beyond your team's support."

"Presented in a really friendly way using easy to understand language so I didn't get left behind!"

“Following assessment, I realised my skills were better than I had realised, and confidence was more of the issue.”

“We now have a more efficient way of working within the team.”

Pillar 7 – Improve digital skills in the health and care workforce

Digital Inclusion Champions Network

- The network continues to grow, with Champions playing a vital role in supporting peers, promoting digital change, and embedding inclusion into everyday practice. Efforts are underway to expand the network, particularly in clinical areas to strengthen sustainability and address barriers to engagement.
- Understanding and addressing barriers to engagement will remain a key priority to ensure long-term sustainability.

Building Digital Readiness and Capability

- Engaging departments to identify Digital Inclusion Champions who support digital adoption and peer learning.
- Piloting the Digital Readiness Manager’s Toolkit to help teams assess preparedness and access targeted support.
- Developed the Digital Skills and Confidence Development Pathway, offering a structured, inclusive framework aligned with national standards.

Key focus areas of the pathway include:

- Core digital competency domains (e.g., communication, collaboration, problem solving) Skill levels from beginner to expert to support personalised development.
- Assessment tools such as internal audits, Health Education and Improvement Wales (HEIW) self-evaluation, and a management checklist
- Learning resources including internal training, self-learning, and digital induction for new starters.
- Working to embed digital capability into the Performance Appraisal and Development Review (PADR) process as a formal objective (awaiting confirmation).

Pillar 8 – Embed Digital Inclusion in Health, Care, and Wellbeing Strategies

- Significant progress has already been made in engaging pilot areas, and priority teams with the rollout of e-Obs and Patient Flow across the Health Board through the Digital Readiness approach.
- A pilot of the Digital Readiness Manager’s Toolkit has already been launched, enabling team leaders to assess digital preparedness, identify gaps, and access targeted support from the Digital Inclusion team.
- The Digital Readiness Checklist continues to support a management-led approach to embedding digital capability within teams.
- The Digital Inclusion Manager is working with the Head of Digital Business and Engagement to include a Digital Capability and Confidence section within the PADR process. This is currently under review, with confirmation awaited on embedding it as a formal objective.
- The Digital Inclusion Manager and Head of Digital Business and Engagement continue to work closely with Learning and Development to explore opportunities of developing further digital skills development training opportunities within the Health Board’s learning and development catalogue.
- Work continues to raise awareness of digital accessibility, including device functionality and assistive applications, to support both staff and patients.

Mitigating Risks to Digital Project Rollout from Low Digital Readiness

Low levels of digital readiness present a material risk to the successful rollout of digital projects across the Health Board. Where staff do not have the confidence, skills, access or support required to use new digital systems effectively, there is a risk of delayed implementation, inconsistent adoption, increased pressure on operational teams, reduced productivity during transition, and limited realisation of the intended benefits. This is particularly important as major digital programmes such as ePMA, e-Obs, e-Flow and patient-facing digital services require staff to engage with new ways of working safely and consistently. If these risks are not proactively managed, the Health Board may not fully achieve the anticipated improvements in patient safety, care quality, workflow efficiency, data quality, and patient and staff experience. To reduce the risk of delays, low adoption or uneven implementation arising from limited staff digital skills and confidence, the following actions are in place:

- **Digital Readiness Toolkit** - Supports managers in assessing team preparedness and identifying capability gaps early.
- **Digital Inclusion Champions** - Champions embedded in teams promote digital engagement and peer support, with a focus on expanding into clinical areas.
- **Digital Skills and Confidence Development Pathway** - A structured framework aligned with national standards to support skill development across all roles.
- **Targeted Training and Induction** - Tailored training, self-learning resources, and a digital induction for new starters address specific needs.
- **PADR Integration (Pending)** - Plans to embed digital capability objectives into the PADR process to support long-term workforce development.
- **Collaborative Engagement** - Working with internal teams and informatic nurses to ensure inclusive, accessible digital solutions.
- **Proactive Walkarounds** - Direct engagement with less digitally engaged teams and non-engaging teams to understand barriers, offer support, and identify Digital Inclusion Champions.

Conclusion

The Digital Inclusion Programme has made clear and sustained progress in developing a more structured, proactive and embedded approach to supporting digital inclusion across the Health Board. The programme has moved beyond initial awareness-raising and individual support to a broader model that is increasingly aligned with workforce readiness, patient engagement, accessibility, community partnership and digital transformation delivery. Through the Digital Inclusion Support Service, Digital Readiness approach, Champions Network, Skills and Confidence Development Pathway and strengthened partnership working, the Health Board is building the capability and confidence required to support safe, consistent and inclusive adoption of digital services.

While further work is required to fully embed digital capability within routine workforce development, service planning and project implementation, the progress to date provides a strong foundation for continued improvement. Maintaining this focus will help reduce the risks associated with low digital readiness, strengthen adoption of new systems, and ensure that staff, patients and communities are better able to benefit from digital innovation in a way that is equitable, accessible and sustainable.

Argymhelliad / Recommendation

The Committee is asked to:

- **RECEIVE ASSURANCE** on the progress made in embedding of digital inclusion across the Health Board, including actions to improve the Digital Readiness approach,

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.11 Seek assurance on delivery against all Planning Goals aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	7. All apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	5. People First, Digital Always
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant : (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)	7. All Apply

A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	
--	--

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Contained within the Report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	There are no immediate additional financial implications arising from this report. The Digital Inclusion Programme supports value for money by improving digital confidence, reducing barriers to adoption, supporting benefits realisation from existing and planned digital investments, and helping ensure that new systems are used effectively and consistently across services.
Ansawdd / Gofal Claf: Quality / Patient Care:	Digital inclusion supports quality and patient care by helping staff and patients access, understand and use digital services confidently. Improved digital readiness will support safer and more consistent adoption of systems such as ePMA, e-Obs, e-Flow and patient-facing digital services, contributing to improved communication, patient experience, data quality, workflow efficiency and care delivery.
Gweithlu: Workforce:	The programme has a positive workforce impact by supporting staff to develop the skills, confidence and capability required to engage with new digital ways of working. The Digital Inclusion Support Service, Champions Network, Digital Readiness Toolkit and Skills and Confidence Development Pathway provide structured support for teams, helping reduce variation in digital capability and supporting a more confident, inclusive and digitally enabled workforce.
Risg: Risk:	The principal risk is that low digital readiness could delay implementation, reduce adoption, increase operational pressure and limit benefits realisation from digital programmes. This is being mitigated through the Digital Readiness approach, targeted support, Digital Inclusion

	Champions, training resources, partnership working and continued engagement with teams and services.
Cyfreithiol: Legal:	There are no specific legal implications arising from this report. The programme supports wider statutory and organisational responsibilities relating to accessibility, inclusion, equitable access to services and safe implementation of digital change.
Enw Da: Reputational:	The programme has a positive reputational impact by demonstrating that the Health Board is taking an inclusive, proactive and person-centred approach to digital transformation. Supporting staff, patients and communities to access and use digital services confidently will help strengthen trust, reduce exclusion and reinforce the Health Board's commitment to equitable and accessible care.
Gyfrinachedd: Privacy:	There are no direct privacy implications arising from this report. Any future digital inclusion activity involving personal information will continue to be managed in line with information governance, data protection and confidentiality requirements.
Cydraddoldeb: Equality:	Digital inclusion has a positive equality impact by helping reduce barriers for staff, patients and communities who may be digitally excluded or lack confidence in using digital services. The programme supports equitable access, accessibility, inclusive engagement and targeted support for groups who may otherwise be disadvantaged by digital transformation.

3.4

10:25, 10 Mins

3.4 - Digital Partner Update

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

| For assurance

Attachments

[3.4 - DDIC - Digital Partner Update - July 2026.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Partner Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Digital, Data and Innovation Committee (DDIC) with an update on the digital partner to support its digital transformation initiatives. This report outlines the spending and impact of the digital partner in line with Board-approved programmes.

Cefndir / Background

Working with our new strategic partner (CGI Inc) we are in the process of accelerating the project plans towards deployment, as well as developing the technical integration layer required to deploy the foundational systems in line with the timescales previously outlined to the Executive Team. The digital transformation initiatives are part of Hywel Dda University Health Board's (HDdUHB's) strategic plan to enhance patient care and operational efficiency through technology.

In addition to those listed above, HDdUHB has also invested in various digital programmes aimed at improving patient care pathways, data accessibility, and patient safety. These programmes include the Hybrid Print and Post, and Digitalisation of Records, which are part of the broader strategy to digitise healthcare services.

Overall, these digital transformation initiatives are designed to modernise healthcare delivery, improve operational efficiency, and enhance patient care through the strategic use of technology.

Asesiad / Assessment

Digital Service Partnership

Under the Digital Services Partnership, the Health Board is continuing to explore with CGI Inc the potential development of a managed service operating model supporting both the stabilisation of core digital services and the acceleration of digitally enabled transformation. This work is being considered within the wider strategic partnership framework and is focused

on understanding how a future operating model could provide greater service reliability, clearer accountability, improved supplier and service management, and additional capacity to support priority transformation programmes.

The emerging proposal is being shaped around a rolling three-year transformation and service improvement cycle, with an initial emphasis on safe transition, baseline assessment, service stabilisation, and early delivery of measurable value. Areas under consideration include service desk and end-user computing support, application performance management, supplier control, cyber resilience, data and integration foundations, AI productivity, patient flow and command centre capability, and support for care closer to home. The intent is to move from reactive operational pressure towards a more stable, evidence-led and value-measured delivery model.

The NHS Wales Shared Services Partnership (NWSSP) element of this work is being considered as part of the wider partnership operating model, rather than as a single transfer of responsibility. The Partnership Charter describes a range of potential delivery options, including services retained fully by HDdUHB, blended services led by the Health Board with CGI Inc support, blended services where CGI Inc has delegated delivery responsibility, and services that could be delivered externally by CGI Inc while HDdUHB retains governance, accountability and decision-making. This provides a framework for assessing where shared service arrangements may add value, where Health Board capability must be retained, and where a more blended model could improve resilience, consistency and pace of delivery.

The current exploration is therefore focused on identifying which services, capabilities or functions could benefit from a NWSSP approach, including opportunities to standardise processes, strengthen supplier management, improve service performance, reduce duplication, and provide access to specialist capacity that may not be sustainable to maintain in full internally. Any future model would need to be carefully designed to ensure clear boundaries between retained Health Board responsibilities and partner-delivered activity, with defined service levels, performance measures, clinical safety, information governance, cyber security, workforce implications, financial controls and exit arrangements. This approach is intended to support a more resilient and value-led digital operating model, while ensuring that strategic control and accountability remain with the Health Board.

This work remains at the discovery, options appraisal and business case development stage. It is intended to inform future Executive Team, DDIC, Strategy and Performance Committee (SPC) and Board consideration, rather than representing an approved change in scope or financial commitment at this stage. Any progression to a managed service arrangement would require a clear articulation of retained Health Board responsibilities, CGI responsibilities, service levels, performance measures, benefits realisation, financial implications, transition risks, workforce impacts and exit arrangements.

Expenditure

Since the last reporting period, no new expenditure has been committed, and no additional financial commitments have been entered into in respect of the digital partner arrangements. All activity undertaken during this period has remained within the scope of previously approved programmes, existing contractual arrangements and agreed financial governance controls. Any future requirement to extend scope, increase expenditure or commit additional funding will be subject to the appropriate business case, financial scrutiny and approval route before any commitment is made.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE 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.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Seek assurance that the digital, data and information governance implications and risks arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners are considered and mitigated.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer Iechyd a Llesiant: (wedi'i gwblhau ar gyfer newid strategol a/neu newidiadau sylweddol i wasanaethau)	7. All Apply

A Social Model for Health and Wellbeing : (complete for strategic change and/or significant service changes)	
--	--

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Included within the main body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Sustainable Resources Committee Executive Team

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Value cases will be assessed for each individual business cases prior to utilising the supplier. A wider strategic benefit will be that the healthcare systems will be more efficient, processes are faster, and wasteful processes can be decreased or eliminated supporting longer-term sustainability for the health board.
Ansawdd / Gofal Claf: Quality / Patient Care:	The implementation of the transformation and digital enablement plan, will provide the following positive impact on quality and patient care: • Patient safety increased - Increased timeliness and availability of relevant clinical information decreased transcription errors and decreases risk to patients' safety • Positive patient outcomes increased - Easy access increases speed and of diagnosis, care, treatment plan and onward referral • Patient confidence increased - The availability and targeting of accurate and relevant information at the point of contact • Reducing delay, improving waiting times and access to treatment
Gweithlu: Workforce:	Having a modern digital system, will attract and retain the workforce within the Health Board. A key component of this work is the assessment of operational readiness for organisational and digital change, the digital roadmap required and recommended service redesign principles for a whole system approach, which will enable the change the workforce urgently need. As part of the transformation plan there will be a change management, service redesign

	and digital enablement programme designed to co-produce and design services for people through a professional integrated and upskilled workforce across health and care.
Risg: Risk:	Without the necessary investment in transformation and digital there is a risk that the current complex system will become even slower stifling innovation that the Health Board has progressed and urgently needs.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The ambitious transformation and digital enablement plan will progress the Health Board forward to becoming a fully integrated digital organisation, and propelling Hywel Dda to become the first system-wide digital exemplar within NHS Wales.
Gyfrinachedd: Privacy:	At the centre of the transformation and digital enablement plan is inclusivity, and the requirement to ensure that staff, patients, and the people of our region are included in the development of any service with strong information governance and cyber security.
Cydraddoldeb: Equality:	Not applicable

3.5

10:35, 10 Mins

3.5 - EDRS Re-procurement (Document Management System)

***Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Carolyn Williams
(Hywel Dda UHB -
Head of Digital
Transformation &
Programmes)***

| For approval

Attachments

3.5 - DDIC EDRMS procurement June 2026.pdf



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	EDRMS (Document Management System) re-procurement
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Director of Digital, Data and Technology Carolyn Williams, Head of Digital Transformation & Programmes

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this report is to provide the Committee with an update on the procurement of the Electronic Document and Records Management System (EDRMS). This update outlines the procurement process undertaken and the outcome of this exercise, ensuring the Digital, Data and Innovation Committee (DDIC) has clear oversight of the forthcoming contract award and the associated financials.

The Committee is asked to note the progress to date, endorse the procurement outcome and support the continuation of the programme to ensure a seamless transition to the new contract with no disruption to service.

Cefndir / Background

The Health Board is progressing the procurement of an EDRMS as a key enabler of its wider digital transformation programme. This programme aims to transition from paper-based records to a digital, integrated health record, addressing current challenges including the management of approximately 1.5 million paper records, delays in accessing information across multiple sites, and inefficiencies associated with physical record storage and retrieval.

The implementation of a modern EDRMS is critical to ensuring that clinical information is available at the point of care, improving patient safety, supporting timely decision-making, and enabling more efficient and coordinated services across the Health Board.

The initiative aligns with both local and national strategic priorities, including the Health Board's Digital Response and long-term strategy, A Healthier Mid and West Wales (AHMWW), as well as wider NHS Wales ambitions to achieve digital maturity and integrated care.

The move to a paper-light organisation will support improved patient outcomes, enhanced clinician access to records anytime and anywhere, and greater operational efficiency, while

also ensuring compliance with information governance, data protection, and regulatory requirements.

The Health Board is currently operating with an EDRMS provided by Civica (Cito), which supports the storage of digitised patient records following the completion of the large-scale back-scanning programme in January 2026. However, the transition to a fully embedded digital records model remains incomplete, as “day forward” scanning (the process of digitising new records at the point of creation) has not yet commenced, creating a risk of reverting to hybrid paper/digital processes and limiting the full realisation of benefits. With the existing contract due to expire in March 2027, a managed procurement and transition to a new solution is required, including the safe migration of over 435,000 digitised records and the establishment of a sustainable long-term platform.

There are several organisational risks associated with the current position. These include:

- the risk of service disruption if transition timelines are not achieved
- ongoing reliance on paper processes impacting clinical efficiency
- challenges in ensuring consistent access to patient information across multiple sites

There is also a risk to patient safety and quality of care if information is not readily available at the point of need, alongside operational inefficiencies linked to manual record handling and storage.

The EDRMS programme is expected to deliver measurable improvements, including increased accessibility of records (24/7 access across sites), reduction in paper handling and storage costs, and improved clinician productivity through faster retrieval of patient information.

The evidence base to inform decision-making is drawn from the completed scanning programme, system testing, and national and local digital strategy alignment, all of which demonstrate that progressing to a fully integrated, paper-light model is essential to achieving improved patient outcomes, operational efficiency, and long-term sustainability.

Re-procurement of the EDRMS commenced in January 2026 to ensure continuity beyond the current contractual term, avoid any break in service provision and compliance with record management requirements.

Timeline of key procurement activity:

- Invitation to Tender (ITT) published – April 2026
- Evaluation complete – May 2026
- Contract award – September 2026
- Transition period and new contract mobilisation ahead of April 2027

The current contract is due to expire on 31 March 2027, and the awarded supplier will be expected to commence implementation on 1 September 2026 with the view of completing successfully within seven months by 1 April 2027.

Procurement has now reached the award stage; however, the process remains subject to the mandatory standstill period which limits the disclosure of commercially sensitive information at this time.

This contract presents a key pillar to an integrated Digital Health Record (DHR), with long term intentions towards accessibility for both clinicians and patients and is the foundation that all our other clinical solutions will be built upon. It will allow clinicians to share patient information from multiple locations to both support and expedite decision making and provide better quality care.

The key drivers for the EDRMS solution stem from the Health Boards' overall goals and objectives:

- Better Patient Care - Digital records will provide a complete picture for patient records enabling faster diagnoses, prevent the duplication of tests or entering information and provide an important contribution to enable integrated care,
- Access Anytime/Anywhere - The provision of simultaneous 24/7 access to clinicians, to patient health records, irrespective of location across Health Board premises by removing the human element of document management,
- Patient Safety - Digital records will provide complete, up-to-date patient information so that clinicians' decisions are fully informed to ensure the highest quality care is provided,
- Operational Effectiveness – Benefits which will help the Health Board to operate more efficiently, saving time on bureaucratic processes,
- Reduction in operational costs associated with the storage and retrieval of paper records.

Asesiad / Assessment

The procurement of the EDRMS has been undertaken in accordance with established NHS Wales procurement processes, working in partnership with NHS Wales Shared Services Partnership (NWSSP) procurement.

The tender has been delivered through a structured governance process, including the development of a comprehensive specification, aligned evaluation criteria and formal tender publication. Procurement timelines and approvals have been planned in line with organisational and national requirements.

A multidisciplinary evaluation approach has been applied, with input from digital, information governance and operational stakeholders to ensure that both technical and service requirements are fully reflected. Evaluation activities included the review of supplier submissions, structured scoring against defined criteria and demonstration assessments, all of which ensured a robust and transparent selection process.

- The London Procurement Partnership (LPP) Framework for Digital Document Solutions under Lot 6 EDRMS was utilised for this requirement.
- Up to 14 pre-qualified suppliers were invited to participate and following evaluation of the written submissions, the highest scoring suppliers were shortlisted, with the top three progressing to the demonstration stage.
- Evaluation was undertaken using a robust, predefined scoring methodology, incorporating assessment of technical compliance, quality, and commercial response. This included detailed review of supplier proposals against the Health Board's specification, demonstration assessments, and input from a multidisciplinary panel including digital, information governance and operational stakeholders.

The procurement process has been designed to ensure fairness, transparency and compliance with relevant procurement regulations. Key milestones, including tender publication, evaluation and contract award are subject to organisational governance and scrutiny.

Argymhelliad / Recommendation

The Committee is asked to:

- **ENDORSE** the proposed procurement approach.

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

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.2 That the organisation is discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information and data, to support health improvement and the provision of high-quality healthcare.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	5. People First, Digital Always 7. Future Orientated 8. Fit for Purpose, Modern Facilities and Services
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	1. Deliver plans that increase our contribution to a sustainable, low carbon future 2. Strengthen resilience by planning for and adapting to climate change
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)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable

Rhestr Termiau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Non-Pay Group 17 June 2026

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The procurement process has identified a preferred supplier that represents best value for money, having achieved the highest overall score across quality and commercial evaluation criteria. The transition from paper-based records to a digital EDRMS is expected to reduce costs associated with storage, retrieval, and manual handling, while improving operational efficiency across services. The procurement ensures continuity beyond the current contract expiry and supports a sustainable, long-term digital solution. Full financial details remain subject to the procurement standstill period and will be confirmed following contract award.
Ansawdd / Gofal Claf: Quality / Patient Care:	The implementation of an EDRMS will improve the quality of care by ensuring timely access to accurate and complete patient records at the point of care. This will support more informed clinical decision-making, reduce delays associated with physical record retrieval, and minimise the risk of missing or incomplete information. The system also strengthens governance through audit trails and secure access controls, supporting safer and more reliable management of patient information.
Gweithlu: Workforce:	The move to a digital document management system will reduce the administrative burden associated with paper records, including storage, transportation, and manual retrieval. This will release staff time, enabling a greater focus on direct patient care and value-added activities. The procurement includes requirements for supplier-led training and support to ensure staff are equipped to adopt and utilise the system effectively.
Tegwch Iechyd: Health Equity:	The EDRMS supports equitable access to patient information by ensuring records are available digitally across all sites, reducing variation in access between locations. This will support more consistent care delivery regardless of geography and contribute to reducing inequalities in access to timely information within a largely rural health board population.

Risg: Risk:	The procurement process mitigates risks associated with the expiry of the current EDRMS contract by establishing a clear timeline for contract award and transition. A structured and compliant procurement approach has ensured a fair and transparent selection process. Residual risks relate to system implementation and transition, which will be managed through detailed mobilisation planning to ensure continuity of service and minimise disruption.
Cyfreithiol: Legal:	The procurement has been undertaken in accordance with Public Contracts Regulations and NHS Wales procurement processes, in partnership with NWSSP Procurement. The use of an established framework and structured evaluation approach ensures compliance with legal and regulatory requirements, including transparency, fairness and equal treatment of suppliers.
Enw Da: Reputational:	Delivering a compliant and transparent procurement process strengthens organisational reputation and demonstrates effective governance. The successful implementation of an EDRMS will support the Health Board's digital transformation ambitions and improve service delivery, reinforcing public and stakeholder confidence in the organisation's ability to modernise and manage patient information effectively.
Gyfrinachedd: Privacy:	The EDRMS solution includes robust information governance controls, including secure access, audit trails, and compliance with data protection requirements. This supports the safe and appropriate handling of patient data, ensuring confidentiality, integrity and traceability of electronic records throughout their lifecycle.
Cydraddoldeb: Equality:	The move to a digital EDRMS supports equality by improving consistency in access to patient information across services and locations. This ensures that all patients benefit from timely and coordinated care, regardless of where they receive treatment. The system also supports compliance with organisational and statutory equality duties through improved standardisation of processes and information access.

4 - Research and Innovation

4.1

10:55, 10 Mins

4.1 - Research and Innovation Sub-Committee
(RISC) 3A's Update

*Eiry Edmunds (Hywel
Dda UHB - Deputy
Medical Director),
Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and Value)*

| For assurance

Attachments

4.1 Committee Update (3As) R ISC July 2026.pdf



COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R PWYLLGOR

RESEARCH AND INNOVATION COMMITTEE/ CYFARFOD IS- BWYLLGOR YMCHWIL AC ARLOESI

Date of last meeting/ Dyddiad y cyfarfod diwethaf/: 8 June 2026

Quoracy/ Cworwm/: Met

Report by/ Adroddiad gan:

Mark Henwood, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING/ PWYNTIAU TRAFOD ALLWEDDOL A MATERION I'W HUWCHGYFEIRIO O'R DRAFODAETH YN Y CYFARFOD:

Alert¹ (may require discussion)/ **Rhybuddio** (efallai y bydd angen trafodaeth)

The Research and Innovation Sub-Committee (R&ISC) have no matters they wish to **alert** to members of the Digital, Data and Innovation Committee.

Advise² (to monitor)/ **Cynghori** (i fonitro)

The Research and Innovation Sub-Committee wish to **advise** members of the Digital, Data and Innovation Committee that:

- Whilst assurance was received on the 2025/26 financial close report, further work is required on both the Research & Development (R&D) and Transformation & Innovation (T&I) financial positions for 2026/27 to determine a robust financial forecast. The risk registers for both Divisions will be reviewed in view of this work, notably the R&D risk, which considers the financial position in relation to the establishment level.
- Delays continue to be experienced by the TriTech and Innovation Team in respect of Digital Clearances. These affect both national and local services and appear to reflect the volume of requests being managed. Without resolution, the Innovation Team is likely to lose contracts for projects that could bring about patient and public benefits.
- The update on the R&D Risk Register highlighted concerns associated with Research Delivery Funding allocations, affordability and the sustainability of the establishment. The current risk score may require an increase pending further financial detail and review of mitigating actions.

¹ There is a lack of confidence that any action in place is sufficient to address the issue satisfactorily and/or within the scope of the operational team or executive to resolve. Engagement, action or intervention required.

² There are areas of concern where assurance has been taken on actions in place but requires close monitoring. An early warning of an emerging and potentially serious concern.

- Received assurance from the TriTech and Innovation Finance Report and the 2025/26 year-end financial position, whilst noting that further work is required to finalise the 2026/27 position.
- The update on the TriTech and Innovation Risk Register highlighted concerns relating to regulatory uncertainty and Information Governance delays, with a review of risk scores and mitigating actions underway in light of ongoing impacts on project delivery.

Assure³ (to note)/ Sicrhau (i nodi)

The Research and Innovation Sub-Committee wish to assure members of the Digital, Data and Innovation Committee that they:

- Noted the update on R&D national developments.
- While assurance was received regarding the 2025/26 year-end financial position from the R&D Finance and Establishment Report, the Sub-Committee was not assured regarding the financial sustainability of the 2026/27..
- Received assurance from the R&D and Activity and Performance Reports including delivery against national benchmarks and recognition through nominations for two Moondance Awards, and progress across a range of key projects.
- The Researcher Development Report reflected positive progress in building research capacity and supporting early-stage researchers, with a focus on increasing externally funded studies and regional collaboration.
- Received assurance from the Research Quality and Sponsorship Group report, including completion of the 2025/26 audit programme, planned audits for 2026/27.
- Received assurance from the Commercial Research progress report, including growth in key study areas, delivery against Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) targets and ongoing partnership development.
- The Sub-Committee received the Health and Care Research Wales (HCRW) Finance Policy and approved the localised approach.
- The update on the Cancer Pathways Programme confirmed the completion of the Task and Finish Group and development of implementation plans.
- The update on the Intellectual Property Policy outlined ongoing work to localise the HCRW template and explore alignment with partners across the region.
- The update on Welsh Government requirements highlighted feedback from the annual review and associated actions relating to strategic planning, partnerships, communications and research priorities, alongside ongoing

³ There is confidence that actions are robust and will be sufficient to address the issue or generally operating effectively. Routine monitoring.

discussions regarding Research Delivery Funding (RDF) compliance and primary care research challenges.

- Assurance was received from the Novel Technologies commercialisation update, including the cessation of one commercialisation opportunity due to a company going into liquidation. This presents no financial risk to Hywel Dda University Health Board (HDdUHB) and Aberystwyth University, who was leading the commercialisation, are working to identify alternative partners following the appropriate governance arrangements, which will include HDdUHB at the appropriate point.
- The University Partnerships update highlighted continued progress to strengthen collaborative activity across research, innovation and education.
- Received assurance from the TriTech and Innovation Activity Report, including progress of projects aligned to Health Board priorities, continued delivery against the business plan and ongoing portfolio development, whilst noting sustained demand on capacity.
- The TriTech and Innovation Business Plan performance update provided assurance relating to the delivery of the majority of Key Performance Indicators (KPIs) and positive progress in implementing the new framework.
- The update on TriTech and Innovation outlined national developments, including across Wales collaborative work.
- Received assurance from the Social Innovation report.
- Assurance received from the Research and Innovation Strategic Plan and action plan update, including good overall progress and agreement to the proposed actions for 2026/27.
- The update on Pentre Awel demonstrated continued progress and positive integration within the wider health and wellbeing community.

Review of Risks/ Adolygiad o Risgiau

The Research and Innovation Sub-Committee reviewed the R&D Risk Register and were advised that the ongoing risk relating to RDF remains a concern, with pressures on financial sustainability and establishment. Members noted that the current risk score may require an increase pending further financial clarity and acknowledged that mitigating actions will be informed by a clearer understanding of the 2026/27 position. Monitoring of this risk continues through the R&D Leadership Group.

The Research and Innovation Sub-Committee also reviewed the TriTech and Innovation Risk Register and were advised that risks relating to uncertainty regarding Medicines and Healthcare Products Regulatory Agency (MHRA) regulatory changes and Information Governance delays remain. Members noted that ongoing delays, including those experienced at a national level, are impacting project delivery and timelines.

Sharing of learning/ Rhannu dysgu

Not applicable

Recommendation/ Argymhelliad

The Committee is asked to:



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

- Note the items the Sub-Committee is advising them of
- Receive assurance from the items that the Sub-Committee is providing assurance on
-
-

Date of next meeting/ Dyddiad y cyfarfod nesaf:

14 September 2026

Agenda, papers and minutes are available on request

4.2

11:05, 10 Mins

4.2 - Strategic Plan Progress Update

*Eiry Edmunds (Hywel
Dda UHB - Deputy
Medical Director),
Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and Value)*

| For assurance

Attachments

[4.2 DDIC SBAR Strategy Update July 2026.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Research and Innovation Strategic Plan (2025-2030) Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Leighton Phillips, Director of Research, Innovation and Value

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Digital, Data, and Innovation Committee (DDIC) is asked to note and receive assurance from the work being undertaken to deliver actions arising from Hywel Dda University Health Board's (HDdUHB) Research and Innovation Strategic Plan (2025-2030).

Cefndir / Background

HDdUHB's new Research and Innovation Strategic Plan (2025-2030) was launched in October 2025. It provides a strong basis for achieving the vision to deliver high-quality and impactful research and innovation, improving services and health outcomes for our communities, patients, and staff. The Strategic Plan sets out three high level aims:

- Improving access to high-quality research and innovation that improves services, health and wellbeing.
- Creating an environment and culture that develops and enables competent and empowered researchers and innovators to flourish.
- Developing and sustaining partnerships that maximise and accelerate research and innovation access and impact.

The Strategic Plan has been translated into clear and measurable actions, which are owned by team members from across the Department of Research, Innovation and Value. This report provides an update against an action plan developed to support the delivery of an annual plan for 2025/26. As the Strategic Plan was only launched in October 2026, this reflects approximately six months of delivery activity.

Asesiad / Assessment

The Director of Research, Innovation and Value met with the Heads of Division for Research and Innovation to agree progress against the 2025/26 financial year, and planned implementation actions for the 2026/27 financial year. Progress updates against these actions are attached for information in Appendix 1.

There were 38 implementation actions in 2025/26, with the same number of refined actions identified for 2026/27.

The overall assessment for 2025/26 is summarised in the following table.

Status 2025/2026	Number	Narrative
Complete (Green)	16	While the actions for 2025/26 are complete, this is not to suggest that no further action will be taken. For example, while significant action was taken to support more commercial research, this is an ongoing endeavour, and further action will be taken in 2026/27. To note the progress and the supplementary action that the Department will take during this financial year.
In-progress (Amber)	19	These are actions where reasonable progress has been made however, the full intent of the action has not been realised. In such circumstances, the adjacent column for 2026/27 actions sets out what more will be done to accelerate activity in the given area.
Delayed/Discontinued (Red)	3	While no progress has been made against one action, it remains relevant and will be prioritised for progression during this financial year. Two actions will be discontinued, as they are no longer required.

In summary, progress has been made in respect of >90% of the actions identified. While approximately half of these actions require further work to achieve full delivery, this has been reflected in the 2026/27 work plan, with clear actions and priorities identified. A further progress update will be provided to DDIC in early 2027.

The Research and Innovation Sub Committee received assurance from the update at their meeting on 8 June 2026.

Argymhelliad / Recommendation

The Committee is asked to **RECEIVE 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.

Amcanion: (rhaid cwblhau)
Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	2.1.4 That the organisation is discharging its functions and meeting its responsibilities with regards to research and innovation activity carried out within the organisation.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
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 : (<i>complete for strategic change and/or significant service changes</i>)	7. All Apply

Gwybodaeth Ychwanegol:
Further Information:

Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Detailed within the main report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	R&ISC – 8 June 2026

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Appendix 1 - Research and Innovation Strategic Plan Implementation Actions for 2025/26

Strategic Aim 1: Improve access to high-quality research and innovation that improves services, health and wellbeing

	Actions as contained within the Strategic Plan	Specific Implementation Actions (25-26)	Deadline	Progress against 'in year' action 25/26	Refined Implementation Action/Different Action for 2026/27, including quarterly targets.	Progress against 'in year' action 26/27
Objective - Harness opportunities and investment associated with national initiatives and developments where they align to the strategic plan						
1.1	Increase the number and type of commercial research studies supported.	Targeted action in three areas: 1.Respiratory (Deliver first year of funded proposal) 2.Metabolic medicine (Key appointments made and first six months of delivery) 3.Oncology (report developed and approved)	31 March 2026	Complete	Updated targeted action in three areas: - Respiratory. Deliver year two of VPAG proposal, including catching up on performance from year one. (By Quarter (Q) 4) - Metabolic. Refine plans based on lessons from year one and determine whether sustainability is possible. (By Q4)	

		Separate plans are being developed or implemented for each of these. In addition, we are continuing to support commercial research through delivery teams at each of our hospital sites.			- Oncology. Secure financial commitment to programme team and implement first year actions from report. (By Q2)	
1.2	Work with national research centres to sustain Health and Care Research Wales Faculty awards – connecting to national leads and networks.	To support three people a year to apply for awards through the HCRW faculty scheme, aligned to current or planned research groups and sustainability plans.	31 October 2026 (Progress Review)	Complete	Secure an additional three candidates/applicants, through new researcher development manager. Consider alignment to proposed research groups. (By Q4)	
1.3	Collaborate with National Strategic Clinical Networks on innovation programmes, to improve	To deliver the following through the TriTech Institute: Phase 3 of the Amgen project, working with the new Cardiovascular Disease (CVD) industry group.	CVD: March 2026	Complete - A new CVD prevention pathway has been collaboratively developed with colleagues in	Tritech to provide facilitative and evaluative support for a potential new national CVD pathway. Industry partners have been engaged and aligned to support delivery, including provision of project	

	outcomes, and drive change.	Final reporting of an evaluation of the Health Pathways initiative (by October 2025).	Health Pathways Final Reporting: October 2025	North Wales and Cardiff, strengthening a pan-Wales approach.	management capacity. A meeting with Welsh Government has confirmed support for the initiative and agreement to progress the pathway to the next phase. (By Q2) TriTech to deliver the first phase breathlessness pathway, in accordance with the collaboration agreement and project plan. (By Q4)	
1.4	Further develop the TriTech Institute to support MedTech, clinical pathway, and innovation strategies – connecting with the Life Sciences Hub Wales (LSHW) and Health Technology Wales (HTW).	Deliver the TriTech Business plan, and collaboration agreements/ Memoranda of Understanding (MoUs) with relevant representative partners.	Agreements in place: December 2025	Some progress. Other priorities have taken precedence; however, collaborations and connections continue with LSHW and HTW	2026/27 is likely to be a period of change for national functions as a new administration settles in. We will explore whether formal collaborations are required with the LSHW and HTW in the context of developments at the national scale. Discussions and where relevant plans developed (By Q3).	

Objective - Work with the SBUHB and HDd UHB Joint Committee to advance a regional research and innovation programme						
1.5	Develop clear research and innovation plans for service areas of joint interest and opportunity.	Deliver a plan to widen access to oncology studies across South West Wales. Determine the actions that could be taken regionally in response to the 'predict and prevent' CVD project.	Oncology research plan: October 2025 CVD: October 2025	Complete	We will work regionally to implement the findings of the oncology research plan, setting up and participating in the appropriate governance arrangements. (By Q4) Additional priorities regionally will include: - Support for the CJC in developing the life sciences as a driver for economic development and growth. (By Q2) - Developing a harmonised approach to Intellectual Property (IP) policy and commercialisation (By Q3). - Supporting the Regional Joint Committee (RJC) to describe a vision for regional research,	

					innovation and enterprise. (By Q3 – subject to resources being in place)	
1.6	Increase commercial research and innovation through R&D Departments, the TriTech Institute, and the Joint Clinical Research Facility.	Convene joint Health Board discussions to share current operating models and plans and identify practical ways for working together in respect of regional priorities. Joint Research and Innovation Committee established. In respect of R&D, one early opportunity will be to consider a specific Joint Committee Regional Funding (JCRF) collaboration in respect of metabolic medicine. In respect of TriTech and Innovation, priorities will be determined by the Regional Research and Innovation Group.	Regional Committee: October 2025 Metabolic medicine: October 2025	Some progress – the Regional Committee has been slow to establish, however, there is a growing list of projects as described in adjacent columns 1.5 & 1.6.	The regional priorities for 2026/27 are described at 1.5.	

Objective - Increase Research and Innovation opportunities within HDdUHB						
1.7	Establish thematic groups with meaningful public and patient engagement in research and innovation active areas, acknowledging the need to develop capacity to secure ongoing impact.	To involve HDdUHB's Corporate Public and Patient Involvement Group to determine the best way of engaging around research and innovation. Initial discussion planned for the summer. This will be enhanced by issues specific to public engagement, led by investigators/innovators and supported by the department on an ad hoc basis.	Corporate engagement group: First meeting in August 2026	Some progress – the research development manager left during 2025/26. A new appointment has now been made and we expect the thematic groups to be established.	New research development manager to work with our lead investigators to establish thematic groups in areas including metabolic medicine, women's health research, primary care, and public health. (By Q3)	
1.8	Develop Research and innovation capacity in corporate departments (digital services, leadership, and management practice, primary care,	To work with workforce colleagues to set out what it would take to embed R&I in all job descriptions (JDs) and appraisal processes and prepare clear plan(s) for doing the same. To hold exploratory discussions with digital	Workforce JDs: October 2025 Workforce and digital initial	Some progress engaging workforce resilience colleagues. Some progress with engaging	Evidence of embedding R&I in all JDs by March 2027 Initial discussions with digital held, but capacity remains a constraint.	

	and public health research).	and workforce to develop capacity building plans. To convene a discussion with primary care colleagues about building increased research capacity, based on recent time awards.	discussions: October 2025 Primary care discussion: October 2025	digital colleagues. Practical projects with primary care underway but a strategic discussion necessary.	Determine the merits of a joint research and innovation plan, in the context of the Artificial Intelligence (AI) review, which is due to report in June. (By Q3) A specific research and innovation thematic group to be established with primary care. (By Q2)	
1.9	Support community based social research and innovation to advance the biopsychosocial model of health.	To provide research and innovation input into the Centre for Social Innovation's annual plan, as required, and subject to the necessary resources being available. Obtain clarity on 25/26 plan.	Plan clarity: September 2025	Complete	Implement plan for 2026/27, in line with the version recently agreed by the Oversight Group. (By Q4)	
1.10	Develop the TriTech Institute as a centre of excellence for evaluative research and implementation	Develop and achieve Board approval for the TriTech Business plan no later than the 31 March 2026.	Business plan approved: 31 March 2026.	Complete	Action can now be closed as we move into business as usual and monitor implementation of business plan. Implementation assessment by Q4.	N/A

	science, aligned with national and international strategic developments.					
1.11	Strengthen R&I's contribution to operational challenges, including service fragility, improving quality of care and enhancing health outcomes.	Test an 'internal commissioning' approach for research and innovation. This will be done for at least one area in 2025/26.	One project completed: 31 March 2026.	Complete - New internal commissioning model in place and three projects agreed for 2026/27	Review of implementation of business plan for first year complete by January 2027, to support a case for a competitive bidding round, which is centrally underwritten, in 2027/28. (By Q4)	
1.12	Utilise our Value Based Healthcare (VBHC) assets to support our research and innovation programmes, notably Patient Reported Outcome Measures (PROMs) and	No additional action required at this point. This will be progressed on a 'case by case' basis. As evaluations are scoped and public health priorities worked through. Develop an independent and ongoing form of support for economic	VBHC alignment: ongoing Independent health economics:	Complete	New priorities include ensuring the CVD Risk Service and Community Health Pathways (financially supported by VBHC) are evaluated. (By Q4)	

	costing methodologies (including Republic of Ireland (ROI) as a key public health priority).	evaluation in support of our research and innovation projects.	December 2025			
--	--	--	---------------	--	--	--

Strategic Aim 2: Create an environment and culture that develops and enables competent and empowered researchers and innovators to flourish

	Actions from strategic plan	Specific Implementation Actions (2025-26)	Deadline	Progress against 'in year' action 2025/26	Refined Implementation Action/Different Action for 2026/27	Progress against 'in year' action 26/27
Objective - Developing a dynamic, forward-thinking and enabling department						
2.1	Strengthen communication and engagement across the organisation and raise awareness	This year, we will: - Review and improve the SharePoint site, taking on Board user feedback. - Develop Strategic Plan launch	SharePoint site: March 2026. Strategy Launch in September	Complete	Further develop and improve the SharePoint site for research and innovation. Hold a further regional research and innovation showcase event.	

	through a research and innovation conference and events to celebrate achievements .	materials, including a website and targeted press releases (Respiratory in June and Women's Health in September 2026). - Evolve the TriTech webpage (perhaps landing, directing towards R&D and T&I) covering research and innovation. Conclude phase 2 of the TriTech website re-design.	/October 2025. Supported by a film. Ensure enhanced R&D and TriTech web coverage: October 2025. TriTech second phase by March 2025.		Develop a research and innovation seminar series, where we look to showcase researchers, innovators, and their projects through online and in person seminars. (All by Q4)	
2.2	Enhance researcher development and staff capabilities, including developing Departmental	Review the researcher development capabilities in academia and national functions and develop proposals to better align to the	March 2025.	Some progress – delayed due to the research development manager leaving post.	New researcher development manager to formalise connections with regionally based university partners and develop proposals for increasing our HDdUHB's capacity. (By Q2)	

	staff to become research and innovation leaders.	core researcher development capabilities in HDdUHB. Gain a comprehensive understanding of the capacity that exists in other organisations before determining how best to align to HDdUHB's in house offer, with a report prepared for leadership group.				
2.3	Increase use of facilities, including establishing at Pentre Awel.	Enable a seamless transition of Dura Park based staff to Pentre Awel, including optimising the benefits of being located proximal to other tenants and their staff. Conduct a review of utilisation of other facilities to ensure they remain fit for purpose in view of the	Pentre Awel: Smooth occupation by April 2026 (subject to scheme timelines). Review of R&D facilities: March 2026.	Complete	Secure a fit for purpose clinical space close to the Clinical Research Centre (CRC) at Withybush Hospital (WGH).(By Q4)	

		objectives of this strategic plan.				
2.4	Ensure improved and consistent performance against national and HDdUHB KPIs.	Modify our management reporting to come into line with: 1.The new HCRW reporting requirements aligned to national commercial plan initiative and Tackling Cancer Together Through Research Programme. 2.The new TriTech Business Plan and any emerging national innovation indicators.	As required, throughout the year 2026.	Complete	Deliver the 2026/27 VPAG targets for Respiratory. (By Q4) Advance the recommendations from the Regional Oncology Research Review. (By Q4) Ensure all CRF sites have commercial research activity underway. (By Q4) Monitor delivery against the new TriTech and Innovation business plan KPIs. (Every quarter)	
2.5	Implement TriTech business plan aligned to clinical strategy.	Develop and achieve Board approval for the TriTech Business plan.	31 March 2026	Complete	Deliver and review the Internal Commissioning approach. (Evaluate by Q4) Ensure sustainable staffing structure/arrangement is introduced.	

					Secure one additional industry collaboration. (By Q2)	
2.6	Diversify income sources (e.g. commercial activity, internal commissioning, grants, and longer-term partnerships).	In 2025/26, we will: Generate sufficient investment through our research development function, to ensure ongoing sustainability. This will be through costing into grant applications and a 'top slice' arrangement for the support offered to investigators. Test an internal commissioning approach for TriTech and Innovation.	Both end of the financial year	Complete	To generate £50,000 grants through our researcher development function, ensuring its sustainability. (By Q4) To complete a review of the first year of the internal commissioning approach. (By Q3)	
2.7	Identify and resolve wider barriers to supporting research and innovation,	This will be a rolling programme of work, designed to identify and overcome challenges. The		Some progress engaging service areas, but		

	particularly in enabling services (e.g. digital, Information Governance (IG), pharmacy, radiology).	2025/26 priorities will be: 1.To work with Radiology colleagues to ensure a clear plan for overcoming constraints to supporting research studies and innovation projects. 2.To work with Digital colleagues to co-develop a plan for overcoming any constraints to supporting research studies and innovation projects.	Radiology: Plans and some implementation by March 2026. Digital/IG: Plans and some implementation by March 2026.	challenges remain	While immediate radiology constraints relating to protocol review have been overcome, a long-term solution in respect of building radiology capacity within the organisation will be the 2026/27 priority. (By Q4) Immediate digital constraints have been overcome, but there remains a need for longer term solutions following recent positive engagement with the digital team. Clearances remain slow. (by Q2)	
2.8	Develop an innovation adoption framework with procurement and finance.	Partner in national work underway, which is being supported by the Life Science Hub.	National Innovation Adoption work: March 2026 (in line with national process)	Not advanced – discontinue	National support no longer taking place but work will continue in support of local adoption.	

		Support operational areas to harness innovations that could improve care quality and performance through evidence generation. Evidence generation projects will be scoped and supported on a case-by-case basis.	Operational area support: ad hoc, following scoping.			
2.9	Build capacity to support research and innovation activity relating to the wider social determinants of health and wellbeing.	To hold a workshop with Public Health colleagues to understand the opportunities for supporting research around addressing the wider determinants of health and wellbeing and whether there is an interest in applying for time awards and other funding schemes. To ensure the newly established Centre for Social Innovation	Public health research and innovation workshop: October 2025 Social Innovation Centre: Yr 1 Business Plan	Some progress, notably around the Centre for Social Innovation.	Public health workshop will be progressed in 2026/27, building on recent developments with MacMillan. (By Q4) No further work with Centre for Social Innovation in addition to Business as Usual.	

		within UWTSD is adequately supported by the Departments and joint commitments set out within the business plan for 25/26.	Delivery reviewed in March 2026.			
2.10	Strengthen commercialisation expertise for innovation.	To identify the 'in house' capacity required to support research and innovation commercialisation and set out options for meeting the same. These could include a training and development programme for current staff or partnering with local universities. Develop IP Policy.	Commercialisation Review: December 2025 IP policy: December 2025	Some progress, relating to national developments	New IP policy and implementation guideline to be approved through the policy approval process no later than September 2026. (By Q2/Q3)	
Objective - Developing the next generation of research and innovation leaders						
2.11	Increase number of	Establish a baseline position of those staff	Baseline position:	Some progress,	Establish a baseline position and work with all	

	professionals with time to lead R&I (e.g. clinical academics) – aligned to the new research groups. R&I time might also be incorporated into ‘hard to recruit’ posts to support recruitment.	with dedicated time in their working week to contribute and lead research and innovation. Take a targeted approach to increasing the amount of time available to staff to advance research and innovation in the newly established research groups, starting with respiratory, metabolic disease, and cardiovascular disease.	March 2026 Measurable increases in staff time for Respiratory, Metabolic disease and CVD (innovation) by March 2026.	particularly in respiratory and metabolic medicine	professional groups to address and improve the situation. (By Q4)	
2.12	Consider joint clinical academic posts with SBUHB, where it is likely to improve	To determine clinical leadership of oncology studies following the conclusion of the regional pathways work.	Plan for Oncology, with aligned resourcing: January 2026	Some progress, notably in oncology	Implement the 2026/27 actions relating to the recently completed and approved regional cancer research pathways review. (By Q4)	

	access to R&I as part of a regionalised approach.	To determine whether there is a regional opportunity linked to pharmacy and/or healthcare science.			Keep alive discussions regarding other opportunities for regional joint posts. (Ongoing)	
2.13	Allocate R&I time for wider range of professionals (e.g. public health).	Directly relates to 2.11. No additional actions at this point.	December 2026	Some progress, mentioned previously, however, there is more to do.	Explored throughout 2026/27, through thematic groups. (By Q4)	
Objective - Embed research and innovation into planning, performance, and governance						
2.14	Embed R&I in organisational governance and workforce strategy.	Organisation level governance of Research and Innovation will develop and evolve through the new Committee arrangements. A plan will be developed with workforce and organisational development colleagues to determine how best	New governance: implemented Workforce plan: December 2026.	Some progress, through establishment of new Committee structure.	Establish a robust approach for integrating research and innovation across workforce plans with workforce colleagues. (By Q3)	

		to incorporate into workforce strategic plans. This will also cover point 2.15.				
2.15	Develop researcher development programme aligned to Organisational Development (OD).	Directly relates to 2.14.	December 2026.	Some progress	To be picked up as part of the new researcher development manager's work. (By Q3)	
2.16	Develop an ongoing process of engagement with different professional, clinical and non clinical groups across the organisation, focused on what more can be done to advance	Take strategic plan to all professional groups (nursing, therapies, digital, Human Resources (HR)) across the organisation and support response to the aims within.	March 2026.	Complete	Implement additional actions as agreed with professional groups across the organisation. (By Q4)	

	the aims of the strategy.					
--	---------------------------	--	--	--	--	--

Strategic Aim 3: Develop and Sustain Partnerships that maximise and accelerate research and innovation access and impact

	Actions from strategic plan	Specific Implementation Actions (2025-26)	Deadline	Progress against 'in year' action 2025/26	Refined Implementation Action/Different Action for 2026/27	Progress against 'in year' action 2026/27
Objective - Improve the alignment and reciprocity between current university partners and our research and innovation plans						
3.1	Refresh university collaboration agreements and align goals - 3xmax per partner – far more	Sign new MoUs with all University Partners and hold executive to executive discussions, focused on agreeing strategic priorities for the next one to two years.	September 2025	Complete	Deliver on actions plans for 2026/27. (By Q4)	

	strategic/long term					
Objective – Develop New University Partnerships						
3.2	Create new university partnerships – particularly where there is potential for co-funded posts or an opportunity to advance public health missions	Hold exploratory discussions with other Higher Education Institutions (HEIs), to better understand span of activities and determine whether entering a formal collaboration agreement would be worthwhile. Discussions opened with other institutions.	Two exploratory discussions completed and, if appropriate, plans drawn up: March 2026.	Some progress – extensive discussions with Cardiff Metropolitan, with connections to Pentre Awel	Hold a minimum of one additional exploratory discussion with a HEI in Wales. (By Q4)	
Objective – Develop New Industry Partnerships						
3.3	Enter agreements with City	Hold an exploratory discussion with the Swansea Bay Growth	Swansea Bay City Region	Some progress, through	Understand the opportunity for the Health Board to participate in	

	Region Growth Deal schemes to establish a systematic way of supporting industry	Deal team and if appropriate formulate a collaborative working plan around life science ambitions. Carry out the next phase of work in support of the Pentre Awel Scheme.	(SBCR) Growth Deal: Explore and, if appropriate, agree a plan: December 2025. Complete second phase of Pentre Awel business and innovation project: January 2026.	understanding the regional life sciences landscape.	the regional life science agenda by working closely with the Corporate Joint Committee (CJC). (By Q4)	
3.4	Develop long-term industry collaborations	Enter one long term research and innovation (2 years +)	Transacted agreement:	Some progress	A priority for TriTech and Innovation this year will be to identify one	

	in aligned areas.	collaboration agreement with a commercial partner in an area where it is determined there is an aligned benefit/opportunity.	March 2026.		additional multi year industry partnership in an area of real world evaluation interest. (By Q2)	
3.5	Launch new wave of joint clinical fellowships with industry.	Progress one new industry sponsored innovation fellowship.	March 2026	Not Advanced - discontinue	This is a lower order priority and will be discontinued.	
3.6	Develop innovation skills programme for NHS staff to help them in partnering with industry.	Determine how innovation skills development would operate and be resourced, drawing on national support and advice.	December 2025.	Not advanced - continue	Hold an exploratory discussion with the Innovation Intensive Learning Academy (ILA) and as part of university partnership discussions with University of Wales Trinity Saint David (UWTSD).	
Objective - Strengthen public and community partnership arrangements						

3.7	Collaborate with NHS Wales Executive (now Performance and Improvement Wales) on national R&I projects.	Conclude the Health Pathways Evaluation and identify at least one further area of work in support of NHS Delivery and Performance.	Health Pathways: September 2025 Additional area scoped and contracted: October 2025.	Complete - Health pathways concluded. Breathlessness pathways (additional)	One further area of work will be identified this financial year. (By Q2)	
3.8	Work with public bodies (e.g. Delta Wellbeing, Together for Change).	To reinvigorate discussions with Delta Wellbeing, to determine the value of collaborating on research and innovation programmes.	Scoping discussion: by October 2025.	Some progress, notably with the Pembrokeshire Peninsula	Actively supporting Pembrokeshire Peninsula work. Meeting with Delta Wellbeing will determine whether there are future collaborative opportunities. (By Q3)	
3.9	Support South West Wales Joint	Collaborate with SBUHB to develop new Joint Research and Innovation	First Committee: September 2025.	Some progress, with regional events and early plans	Delivery on the RJC's research and innovation plans for South West Wales. (By Q4)	

	Committee R&I agenda.	Committee and establish early priorities, to include oncology and (likely) CVD.				
3.10	Support Mid Wales Joint Committee R&I initiatives.	Exploratory discussions with Aberystwyth University and Rural Health and Care Wales to determine future collaborative opportunities and how the Health Board can best align.	October 2025	Some progress, notably with Aberystwyth University	Positive recent discussions with Aberystwyth University have resulted in re-engagement with the Centre for Rural Healthcare Studies, with actions to be agreed throughout the year. (By Q2) A meeting with Rural Health and Care Research Wales will take place to determine where collaboration could help both organisations. (By Q3)	

4.3

11:15, 10 Mins

4.3 - University Partnership Arrangements Update

*Eiry Edmunds (Hywel Dda UHB - Deputy Medical Director),
Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)*

| For assurance

Attachments

[4.3 DDIC SBAR University Partnerships July 2026.pdf](#)



PWYLLGOR DIGIDOL, DATA AC ARLOESI
DIGITAL, DATA AND INNOVATION COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 July 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	University Partnership Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Leighton Phillips, Director of Research, Innovation, and Value

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide an update on university partnership activities following recent discussion at the Research and Innovation Sub Committee (R&ISC) meetings on 2 March and 8 June 2026. The Digital, Data and Innovation Committee (DDIC) last considered and received assurance from an update provided on 15 January 2026.

Cefndir / Background

To maintain its 'University Health Board' designation, Hywel Dda University Health Board (HDdUHB) is required to demonstrate continuous improvement in collaborative working with its university partners. University designation represents a commitment on behalf of HDdUHB to ensure that university activity is demonstrably improving the quality of care, improving patient outcomes, and enhancing the reputation of the Health Board to attract people to work in Wales.

On an annual basis, HDdUHB has historically been required by the Welsh Government to provide evidence of purposeful university partnership activity, with examples of how this is improving services and benefitting our population and to set out our plans for the next 12 months aligning to the Integrated Medium-Term Plan (IMTP). The Welsh Government has not scrutinised this for several years, however, HDdUHB still values University Partnership and reports on progress through its governance arrangements.

There are three themes against which university partnership progress is assessed: Research and Development; Innovation; and Workforce, Training, and Education. Key criteria for each, as detailed within Memoranda of Understanding, are set out within Appendix 1.

Given the importance HDdUHB attaches to university status, partnership activities are reflected in its planning objectives, particularly those relating to research, innovation, and workforce, however, university partnership can be useful to advancing many of HDdUHB's ambitions, in areas including engineering, building design, law, management, and ecology.

The focus on the university partnership arrangements driven corporately is not to keep track of every area of activity being advanced between universities and the Health Board; rather, it is to ensure that a limited number of priorities receive the corporate focus and energy they deserve.

The R&ISC has received updates on University Partnership activities and received assurance on 2 March and 8 June 2026.

The update on 2 March 2026 highlighted the commitments set out in the Research and Innovation Strategic Plan (2025–2030) to strengthen alignment and reciprocity with university partners. This included refreshing collaboration agreements, enhancing partnership governance, and working towards a small number of shared, long-term research and innovation priorities with each higher education institution.

Members of the R&ISC were advised on the 2 March 2026 that new Memoranda of Understanding had been agreed with Aberystwyth University, Swansea University, and the University of Wales Trinity Saint David (UWTSD) during 2025. These provide a broad framework for collaboration across research, innovation, education, and service improvement, with emerging areas of shared focus including the Social Model for Health and Wellbeing, innovation in sport and health, ethical AI, and strengthening regional research and innovation capacity.

The report also outlined that these priorities were being developed into structured work plans, supported through bilateral engagement with each partner, taking place in April and May 2026, alongside the continuation of a new whole-system approach, which brought all universities together for the first time in October 2025 to identify opportunities for collective collaboration.

The assessment section sets out the most recent update provided to the R&ISC on 8 June 2026. The R&ISC received assurance from the report, which has been updated to reflect the latest position.

Asesiad / Assessment

Meetings with Aberystwyth University and University of Wales Trinity St David took place on 17 April 2026 to start developing a structured work plan. Unfortunately, the Swansea University meeting was postponed due to operational pressures within the University and will now take place on Friday 10 July 2026. While it has not been possible to finalise plans with all three universities, good progress has been made, and formal agreements are expected to be in place by Quarter (Q) 2 2026/27.

All meetings to date have been Chaired by the Executive Medical Director of HDdUHB and the Pro Vice Chancellor or Faculty Dean of the University. The remainder of this report summarises the discussion and formative plans for Aberystwyth and UWTSD.

Aberystwyth University

The meeting was very well attended, reflecting strong interest across many parts of the university. The meeting had a particular emphasis on aligning strategic priorities, expanding collaborative research activity, and enhancing shared workforce development initiatives aligned to service delivery.

Discussions highlighted a strong track record of joint working, including collaborations in women's health, oncology, and biomarker development, alongside support from TriTech in technology development and commercialisation. Meeting attendees thought the partnership is

increasingly oriented towards shared strategic priorities, including rural health, the Social Model for Health and Wellbeing, food innovation, and digital and AI-enabled approaches to care. The meeting also reflected a shared ambition to deepen collaboration through joint grant activity, improved research infrastructure support, and closer alignment between academic research capabilities and health system needs, particularly in the context of prevention, primary care, and rural service delivery.

Several priorities will be further developed with Aberystwyth University over the next month, including:

- Strengthening joint research development and grant writing capabilities. Specific opportunities included exploring how research development capabilities could be 'pooled'. An aligned opportunity relating to digital was also raised, with an offer for HDdUHB to make greater use of research software engineering capacity and more integrated working between research development functions.
- Being purposeful around several priority research themes, including rural health, food systems and nutrition, the Social Model for Health and Wellbeing, digital and AI innovation, and improving access to research in rural communities.
- Enhancing the translation of research into practice, including development of research screening pathways, remote monitoring approaches, and prevention-focused interventions linked to primary care and population health.
- Strengthening links between research, education, and workforce development, including support for clinical academic pathways, healthcare support worker programmes, and new course development aligned to service needs.
- Building on existing collaboration through TriTech to support medical device development, biomarker commercialisation, and adoption of digital technologies within clinical services.
- Re-establishing the collaboration with the Centre for Rural Health and expanding work on community focused research and service models, including mental health, ageing, and chronic disease management.
- Exploring opportunities for shared use of equipment and facilities, as well as broader resource sharing to support collaborative research and service delivery (e.g. DEXA Scanner and gait analysis treadmill).

A follow up discussion on 30 June 2026 focussed on practical actions and next steps, though some areas progressed in advance of this date.

UWTSD

The UWTSD meeting was well attended by representatives from across the Institution, reflecting strong ongoing commitment to partnership. Discussions reflected a strong intent to move beyond broad collaboration into more structured, and delivery focused partnership arrangements, particularly in areas aligned to workforce transformation and community-based models of care.

Progress updates highlighted active collaboration in areas such as digital inclusion research, development of community health and wellbeing roles through the Centre for Social Innovation, and delivery of accredited professional training programmes. There was a lengthy discussion about further training and research in the field of motor development in children, where outcome data suggests significant improvements in several child development indicators. The discussion also reinforced a shared ambition to better align further education, higher education, and health system workforce needs into a more coherent pipeline, while recognising

that key elements of this alignment - including governance, funding models, and scalability - require further definition.

Several priorities will be further developed with UWTSD, including:

- Exploring how to formalise partnership delivery mechanisms. This could be through the development of a Service Level Agreement to support more responsive and scalable Continuing Professional Development (CPD) and educational collaboration, moving the partnership towards clearer delivery arrangements.
- Refreshing the TriTech Institute collaboration in the context of the new Business Plan.
- Investigating further workforce and educational pathway opportunities. This could include progressing a more integrated pathway from further education through to workforce deployment, aligned to service needs. There was also a keenness to explore Band 2–4 workforce development models.
- Maximising the use of the Centre for Social Innovation to further develop community health and wellbeing roles, in the context of the recent business case and related opportunities in areas including arts and health.
- Exploring research, innovation and training opportunities linked to neurodiversity and early years development. This could include initiating joint work on neurodiversity, alongside scaling motor development training programmes aimed at improving early identification and reducing misdiagnosis in children.
- Expanding accredited professional training programmes and addressing access and cost barriers to ensure wider uptake across the health workforce.
- Further research into digital innovation and inclusion, including continuing collaboration on digital exclusion research, with outputs expected to inform Welsh Government policy.
- Exploring opportunities for infrastructure and place-based collaboration, including new facilities at Pentre Awel and Atriwm, and shared physical infrastructure to support integrated models of health, wellbeing, and activity services.

A follow up meeting took place on 15 May 2026, with a focus on practical next steps. The plans for 2026/27 include establishment of a Collaborative Board to identify and secure joint working opportunities between TriTech and the Assistive Technologies Innovation Centre (ATiC) initiative. In addition, focused work will be undertaken to understand the education and training requirement associated with the Community Health and Wellbeing Workers model being advanced by HDdUHB. While these will be the top priorities, work on other aspects of the partnership will continue.

Plans are advancing around a further pan university partner event, to also include SBUHB, in the Autumn.

A further update will be provided in Q4 2026/27.

Argymhelliad / Recommendation

The Committee is asked to **RECEIVE ASSURANCE** from the report on progress in university partnership activities.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.4 That the organisation is discharging its functions and meeting its responsibilities with regards to research

Committee ToR Reference:	and innovation activity carried out within the organisation.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	All Planning Goals Apply
Hypergyswllt i Amcanion Llesiant HDdUHB 2026 Hyperlink to HDdUHB Well-being Objectives 2026	9. All HDdUHB Well-being Objectives apply
Model Cymdeithasol ar gyfer lechyd 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)	7. All Apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable

Rhestr Termiau: Glossary of Terms:	Detailed within Report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	R&ISC – 8 June 2026

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	Not Applicable
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Appendix 1 – Potential Areas for Collaboration

Research and Development, with examples including:

- Use of specialist facilities
- Clinical and non-clinical trial sponsorship Collaborative research projects
- Developing and managing an active trial portfolio, spanning health and social care
- Knowledge mobilisation, including approaches to ensure research is leading to quantifiable impact Research income capture

Enterprise and Innovation, with examples including:

- University, Health Board, and Industry collaborations
- New device and technology development
- Managing joint innovation assets, through intellectual property and commercialisation Shared services
- Consultancy
- Innovation income capture, particularly taking advantage of post Brexit opportunities

Workforce, Education, and Training, with examples including:

- Managed placement activities in clinical and non-clinical settings
Honorary posts
- Fellowships and studentships
- Managed graduate and undergraduate training opportunities
- New educational programme developments
- Joint posts
- Continuing professional development
- Workforce planning and commissioning, linked to national processes, including those overseen by Health Education and Improvement Wales

5 - Impact and Outcomes

5.1

11:25, 10 Mins

5.1 - Update on Impact of Flow System

***Anthony Tracey
(Hywel Dda UHB -
Digital Director),
Carolyn Williams
(Hywel Dda UHB -
Head of Digital
Transformation &
Programmes)***

| For assurance

Attachments

[DDIC Presentation eflow eObs update July 2026.pdf](#)

Transformation with Digital at the Heart



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Digital, Data and Innovation Committee
eFlow & eObservations Update – Carolyn Williams
July 2026

Purpose

To provide the Digital, Data and Innovation Committee with an overview of progress and benefits realised through the Patient Flow and eObservations programmes since go-live, including:

- Functionality deployed to date.
- Early operational impacts.
- The planned roadmap for remaining Flow, eObs implementations.

Patient Flow & eObs – Current Position



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Patient Flow and eObservations programme is delivering digital capability to improve;

- operational visibility
- patient movement
- clinical handover
- observations recording and escalation across Hywel Dda University Health Board (HDdUHB).

Phase 1A Patient Flow functionality is live, including patient record view, admissions, bed management, occupancy, transfer management and the system pressure dashboard.

Programme is now focused on;

- phased completion of remaining Flow functionality,
- wider deployment of manual-entry eObs and progression towards device-integrated observations.

Manual eObs is live in the beta ward in Glangwili Hospital (GGH), with wider rollout targeted from late July 2026 and completion by October 2026; integrated eObs via Baxter clinical spot monitors is targeted for August 2026.

Patient Flow & eObs – Key Dependencies



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Key dependencies remain around:

- Integrated device delivery
- Remaining eObservations Assessments
- Smart Page
- Test result integrations
- Context launch integrations
- Clinical working group to reach a consensus on the Referrals process and eHandover

Current governance focus is on safe phased deployment, clinical risk management, training, business change and ensuring benefits are realised while managing residual risks through established programme controls.

Patient Flow & eObs Phased Deployment Profile



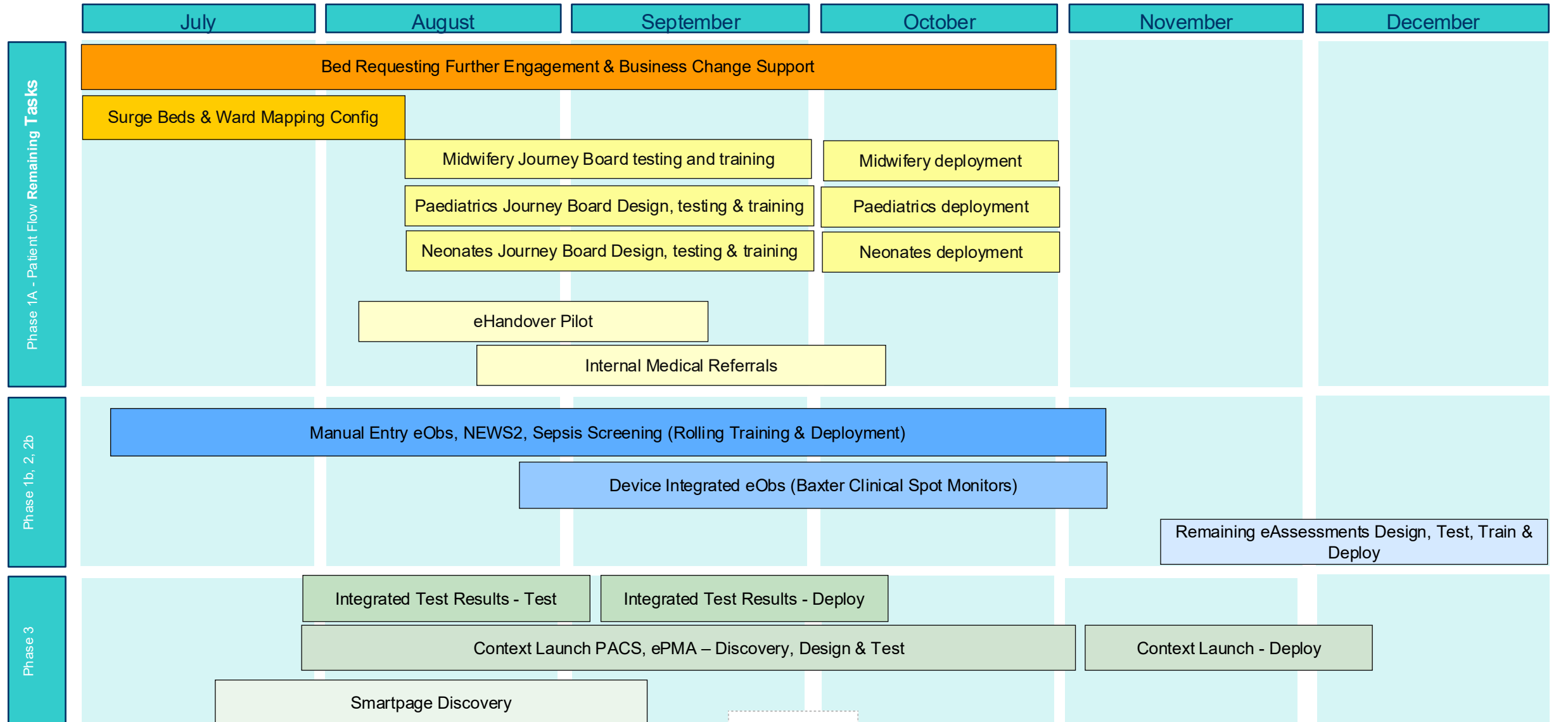
GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Phase	Module	Functionality	Live HDUHB
1A	Patient Flow, Access & Command	Patient Record View, Admissions, Bed Mgt & Occupancy, Transfer Mgt, System Pressure Dashboard	Live December 2025
1A	Patient Flow, Access & Command	Remaining Flow service roll outs, Internal Referrals, Handover	Target pilots Aug 2026
1B	Manual Entry eObs	Manual entry eObs, NEWS2, Sepsis Assessments, Soft Alerts	Live in beta ward. Target commence wider delivery w/c 20/07/26 & close out by October 2026
2	Integrated eObs	Device Integrated Obs (Baxter Clinical Spot Monitors)	Target August 2026 and bring delivery in line with manual entry eObs
2B	Other eObs Assessments	PEWS, MEWS, NEWT, Other eObs Assessments	Awaiting outcome of review on WNCr assessments
3	Smart Page	Hard alerting, direct messaging	In discovery phase, TBC
3	Test Results, Context Launches	Pathology, Radiology, ePMA, PACS,	In Test. Target live by end August 2026
4	ED Module		*Note that ED Deployment Planning is in the process of being developed but is subject to the timely delivery of the above phases

HDUHB Patient Flow & eObs Deployment Plan

2026



Time Saving

- Efficiency: across the health board we will continue to approximately save **23 hours** per day by not duplicating information onto Frontier. Information can be captured live during board rounds (EFLOW-IPE-001)

Emerging Benefits

- Withybush Hospital (WGH) average time from bed request to admission reduced from **17 hours to 13 hours**
- WGH Acute Medical Assessment Unit (AMAU) bed requests are only taking **13 seconds**

“Nice having a snapshot having the wards in one place” – Discharge Liaison Team

“User friendly” – Discharge Liaison Team

“The boards are good because we can see if the patient has had a referral to OT at a click of a button. We don’t have to find a desktop and then log into WPAS” - Physiotherapy

“don’t have to use WPAS as much anymore...everything I need is in Miya” – Discharge Liaison Team

Ref:	Benefit:	Functionality Required:	Timeline:	Progress to date:
EFLOW-IPE-001	Increased time to care for patients	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access	From April 2026 Full realisation: 4-5 years	Efficiency: across the health board we will continue to approximately save 23 hours per day by not duplicating information onto Frontier. Information can be captured live during board rounds.
EFLOW-ISE-002	Reduced stress levels	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access	From April 2026 Full realisation: 4-5 years	Not yet assessed, allowing sufficient time for new processes to embed before evaluating
EFLOW-ISE-003	Improved communication between staff members and across departments	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers	Subject to additional functionalities Full realisation: 4-5 years	
EFLOW-IE-004	Improved handovers and quicker discharges / Reduced handover time	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers	Subject to additional functionalities Full realisation: 4-5 years	
EFLOW-IE-005	Reduced avg. time until seen by doctor in A&E	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations; ED Module	Subject to additional functionalities Full realisation: 5 years	
EFLOW-IE-006	Reduced time an ambulance waits outside of the hospital	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations; ED Module	Subject to additional functionalities Full realisation: 5 years	
EFLOW-IE-007	Quicker response times for ambulances	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations; ED Module	Subject to additional functionalities Full realisation: 5 years	
EFLOW-IE-008	Reduction in staff time wasted due to not being able to access real time patient information or bed state information	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access	From April 2026 Full realisation: 4-5 years	WGH Bed Meeting attendees are stating that Miya is not reducing the time needed to prepare for bed meetings.
EFLOW-IE-009	Reduced avg. length of hospital stay per patient	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Subject to additional functionalities Full realisation: 4-5 years	
EFLOW-IE-010	Reduced cancelled surgeries due to better bed management	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access	From April 2026 Full realisation: 4-5 years	No impact to date



Ref:	Benefit:	Functionality Required:	Timeline:
EOBS-IPO-002	Reduced risk of errors (e.g. due to more regular, accurate observations)	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-IPO-003	Reduced unplanned admissions to critical care units from eOBS-equipped wards	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-IPO-004	Increased # of observations completed on time	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-ISE-005	Increased confidence resulting in improved decision making	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-IE-006	Reduced manual admin work and removal of duplication of effort	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-PE-007	Reduced complaints and improved brand image due to better patient care	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-PE-007	Reduced complaints and improved brand image due to better patient care	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 4-5 years
EOBS-OB-008	Reduced litigation	Admissions; Bed Management; Transfers; Discharge Planning; Command; Access; Referrals; SmartPage; Handovers; eObservations	Following full roll-out of eObservations Full realisation: 7-10 years

Recommendation

The Committee is asked to receive assurance from the progress achieved and the arrangements in place to deliver the remaining phases of the Patient Flow and eObservations programme.



DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

6 - For Assurance

6.1 - Assurance and Risk Report

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

Including:

- Corporate Risks Assigned to DDIC
- Operational Risks Assigned to DDIC
- Internal and External Audit Reports
- Monitoring of Ministerial Directions

Monitoring of Welsh Health Circulars (WHCs)

| For assurance

Attachments

[6.1.1 DDIC Public Governance Arrangements - July 2026 DRAFT.pdf](#)

[6.1.2 Appendix 1 - DDIC CRR \(public\).pdf](#)

[6.1.3 Appendix 2 - Operational Risk Register \(Public\).pdf](#)

[6.1.4 Appendix 3 - Overdue Audit and Inspection Recommendations.pdf](#)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



Assurance and Risk Report

Digital, Data and Innovation Committee – 21 July 2026

This report provides the Digital, Data and Innovation Committee (DDIC) with the status of the principal risks, corporate risks, operational risks, audits and inspections, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) within its remit.

The Committee is asked to seek assurance from the Lead Executive Directors that the principal risks have been refreshed and will be reported to the Board in July, and that there are processes in place to oversee corporate and operational risks to ensure these are being managed effectively, and that WHCs and MDs are being implemented by the Health Board.

Principal Risks:
1

Corporate Risks:
2
(1 In-committee)

Operational Risks
8
(2 In-committee)

Audit and Inspection
Reports
9
(3 In-committee)

Welsh Health Circulars
4

Ministerial Directions
1

Risk Management - Overview



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Health Board's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either principal, corporate or operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (eg where the [risk appetite](#) is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Principal Risks

As a result of the Strategy Refresh, presented to Board in January 2026, the refreshed Board Assurance Framework (BAF) will be reported to Board in July 2026. A review of principal risks has been undertaken as part of the BAF refresh, in addition to the supporting planning goals and outcome measures per the timeline below.



Each principal risk has been aligned to the most relevant Board committee and will be reported via the Assurance and Risk Report to ensure that they are being managed appropriately, taking in to account gaps in control, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Corporate Risks assigned to DDIC

HYWEL DDA RISK HEAT MAP					
	LIKELIHOOD →				
IMPACT ↓	RARE 1	UNLIKELY 2	POSSIBLE 3	LIKELY 4	ALMOST CERTAIN 5
CATASTROPHIC 5					2079
MAJOR 4			1988		
MODERATE 3					
MINOR 2					
NEGLECTIBLE 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

Corporate risks have been aligned to the most appropriate Board level Committee.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Significant escalated operational risks that are of significant concern and require corporate oversight and management.

There are 2 corporate risks currently aligned to DDIC (out of the 24 that are on the CRR at 18 June 2026). Due to the sensitive nature of risk 1988, which relates to Cyber Security, it is reported in-committee to provide discussion and assurance.

The following slides provide a summary of the reportable corporate risks aligned to DDIC. The Risk Register attached at **Appendix 1**, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Corporate Risks assigned to DDIC

Risk Reference & Title	Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2079 – Risk of loss of Pathology services across the Health Board due to delayed implementation of Laboratory Information Management System (LIMS)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20	25 ↑ (Reviewed 26/06/26)	5 →	01/01/26 01/04/26 31/08/26 31/12/26

Rationale for Current Risk Score (CRS)

The impact of loss of service would be considerable. Pathology is crucial for diagnosis and treatment of patient conditions, and ultimately the loss of service could lead to catastrophic patient outcomes. The current national system (TCL2016) is provided by InterSystems on Digital Health and Care Wales (DHCW) hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in August 2026. Programme funding is due to run out at the end of Q2 2026/27.

The likelihood score was increased from 4 to 5 in May 2026 as the delivery of LIMS will not be completed by the end of Quarter 2 2026/27, with a significant financial impact of around £300,000 and contingencies relying on supplier middleware solutions to prevent total loss of Pathology services. The July go-live date is not feasible for Tranches 3 and 4 due to the number of outstanding product fixes. No revised dates have been confirmed, however Microbiology and Blood Science proposed to go live in Q2, with Blood Transfusion extending into Q3.

Rationale for Target Risk Score (TRS)

Achieving the target risk score is reliant on DHCW and the wider system finding a robust mitigation plan and financial support to manage the risks of compressing the timescales or staying on end-of-life hardware and software until the system can be implemented.

Since September 2025, the date for achieving the Target Risk Score (TRS) has been revised several times, with implementation now expected before **December 2026** based on completion of Tranche 5, as reported and discussed with the LIMS Programme Board. The timeline was extended due to delays in completing Tranches 1 and 2, which has delayed full deployment of the new system.

Operational Risks assigned to DDIC



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Of the 8 operational risks aligned to DDIC, 5 have been identified as reportable based on the following criteria:

- DDIC has been selected by the risk lead as the 'Assuring Committee' on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is 'extreme' or 'high'; and
- The current risk score is either equal to or exceeds its target risk score.

Following identification and assessment of risks, each risk is aligned to a specific Health Board committee or sub-committee. Effective risk management requires a 'monitoring and review' structure, ensuring that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

Operational risks are managed within Clinical Care Groups (CCG) and Executive Functions (collectively referred to as "Functions") under the ownership and leadership of individual Executive Directors. Each CCG must establish local arrangements for the review of their Risk Registers, which includes the validation of the information and risk scores, and the prioritisation and identification of solutions to their risks. Each CCG Integrated Governance Group (CCG IGG) is provided with an Assurance and Risk Report, with any issues escalated through the operational directorate governance structure via the 3As Report following each CCG IGG meeting.

The Health Board has formal monitoring and scrutiny mechanisms in place to provide assurance to the Board regarding the effective management of risks. Monthly assessments are made for each Function on their risk management, informing their overall level within the 'Governance' domain as part of the Health Board's internal escalation framework. A key metric in the Health Board's internal escalation process under the Governance domain is how Functions are managing risks in terms of the scale, significance, timeliness and quality, with measures extended from April 2026 to inform internal escalation levels (detailed on the next slide).

The Assurance and Risk Team provide focussed support for those Functions at levels 3 and 4 to aid their de-escalation / recovery and prevent those awarded level 2 status being further escalated. Detail is provided within each report provided and presented at Function governance meetings explaining the reasons behind their escalation status, and suggested actions required to de-escalate (where appropriate). Whilst the four levels within the escalation framework have been agreed, the Executive Team are currently determining processes to support those Functions who may be assessed as being in Level 4. Functions are currently assessed as being either level 1, 2 or 3 pending formalisation of these processes. As at May 2026 month end, Community & Integrated Medicine are at level 3.

Operational Risks assigned to HSC



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Measures to assess against the Governance Domain (risk management) for 2026/27

Level	Criteria
Level 4 – No assurance and insufficient actions / engagement	No plan in place and no engagement, (eg no risk action plans, no expected date to achieve Target Risk Score). Evidence where known risks are not articulated on the function's risk register. No evidence that risks are escalated via CCG management structures where necessary, no engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 3 – No assurance	Lack of evidence that risks are being managed and mitigated within expected timescales, with limited or no qualitative detail included within the risk (eg rationales for risk scores, no progress updates on risk actions.) Evidence where known risks are not articulated on the function's risk register in a timely manner. Less than 80% compliance of risks and risk actions being updated within required timescales Limited evidence that risks are escalated via CCG management structures where necessary, therefore not demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 2 – Limited assurance	Relevant risks articulated on risk registers with action plans in place, but lack of evidence that risks are being managed and mitigated within expected timescales. <i>(eg risk action plans not being implemented within stated action dates, or limited detail behind any date extensions, limited evidence of reduction in current risk score, risks where dates to achieve target risk scores are not being met, poor risk rationales).</i> Between 80% - 89% compliance of risks and risk actions being updated within required timescales Some evidence that risks are escalated via CCG management structures where necessary, demonstrating engagement and the ability for leadership to make informed decisions on prioritisation of resources
Level 1 – Reasonable assurance	Relevant risks articulated on risk registers with action plans in place, and evidence that the function is delivering against these (eg specific and measurable risk action plans, current risk score and target risk score clearly articulated, achieving expected target risk dates) Over 90% compliance of risks and risk actions being updated within required timescales Evidence that risks are escalated via CCG management structures where necessary, demonstrating good engagement and the ability for leadership to make informed decisions on prioritisation of resources

Operational Risks assigned to DDIC

8 operational risks on Datix have been aligned to DDIC, 5 risks of which have been identified as reportable to DDIC based on the following criteria:

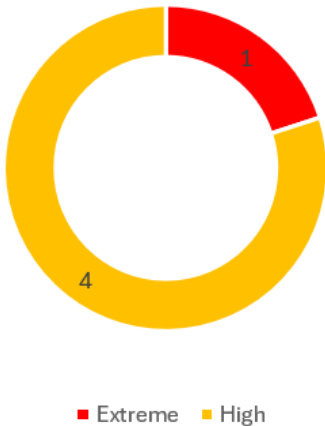
- DDIC has been selected by the risk lead as the ‘Assuring Committee’ on Datix;
- Risks have been identified at operational level on Datix risk module;
- The current risk score is ‘extreme’ or ‘high’; and
- The current risk score is either equal to or exceeds the target risk score.

The following slides summarise the reportable operational risks aligned to DDIC. The Risk Register attached at **Appendix 2**, provides full detail of reportable risks.

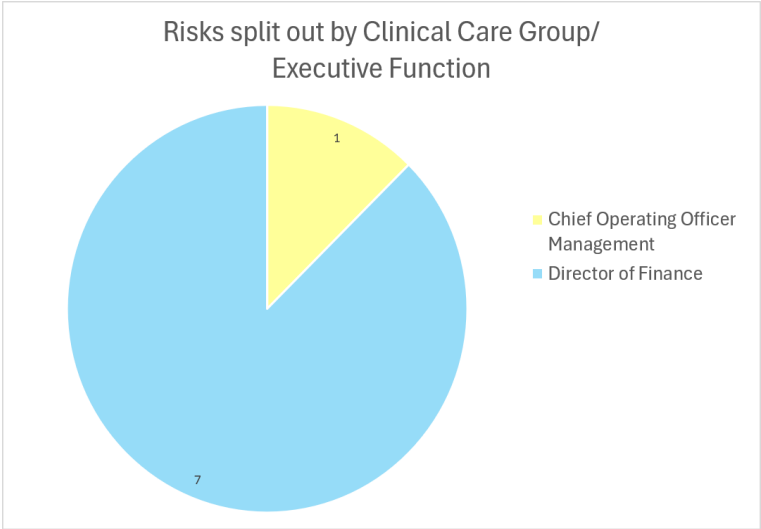
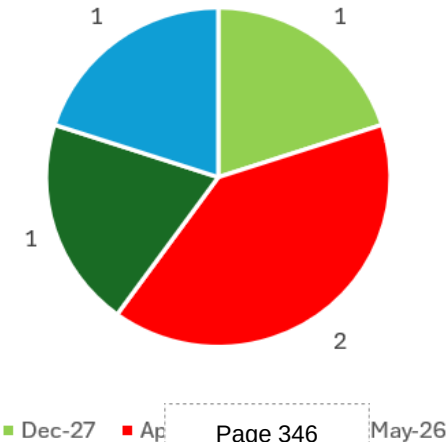
Due to their sensitive nature, 2 risks are being reported to in-committee to provide discussion and assurance.

Risks reported to previous DDIC meeting	3
New risks added / newly reportable risks since last report	3
Risks closed since last report	1
Risks that are no longer reportable	0
Risks with increased Current Risk Score (CRS) since last report	0
Risks with decreased CRS since last report	0
Risks with no change in CRS since last report	2
Total number of risks meeting criteria for current report	5

Current Level of reportable risks assigned to DDIC



Expected Date to Achieve Target Risk Score



Operational Risks assigned to DDIC



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The risks aligned to the Committee highlight that Health Board:

- is reliant on digital infrastructure where replacement / transition / implementation arrangements are not yet fully resolved;
- has insufficient organisational capacity to manage current demands;
- has limited funding affecting the pace and scope of digital transformation programmes; and
- has competing local and national priorities.

The impact of reportable risks include:

- the potential harm to patients due to current record-keeping arrangements;
- the ability to deliver services effectively and efficiently;
- the inability to deliver change at pace, which could negatively impact on the ability to achieve organisational objectives;
- non-compliance with regulatory, statutory and governance requirements.

The operational risk register highlights that risks have consequences beyond individual services, and will require cross-directorate risk action plans to fully address and mitigate. Common actions noted across the risks demonstrate:

- the requirement to invest in and modernise current infrastructures to reduce long-term operational risks;
- the need to increase organisational resilience and preparedness for service disruptions;
- Improving workforce capacity, resilience and availability



New risks added since last report



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
2337 - Risk of not having digital record system from March 2027 due to current digital clinical record system arrangements ceasing	Planned & Specialist Care	Chief Operating Officer	15	4	31/12/27	19/06/26

The Risk Register attached at **Appendix 2**, provides full detail of reportable risks.

Risks closed since last report



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Rationale for risk closure	Date Risk Closed
2222 - There is a risk that acute Occupational Therapy (OT) referrals will be missed by acute OT teams due to implementation of new systems	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	Local systems and processes have been established to mitigate risk.	31/03/26

Risks with no change in CRS



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1535 - Risk of unresponsiveness and limitations in digital transformation projects due to limited funding	Finance	Director of Finance	9	9	31/03/26	27/05/26
1480 - Risk of losing touch with National Work programmes and not meeting statutory reporting obligations due to capacity	Finance	Director of Finance	9	3	31/07/26	05/06/26

The Risk Register attached at **Appendix 2**, provides full detail of reportable risks.

Risk themes (1 of 2)

Risk owners can allocate themes to their risks, which allows the Health Board to share risk information on specific areas with relevant experts as part of the second line of defence. Risk themes are assigned based on any additional impacts or contributory factors, with each theme aligned to the appropriate committee to provide assurance that risks are shared and overseen by subject matter experts within the Health Board. Risk themes provide assurance that a holistic approach to risk management is undertaken and enables the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk. Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board’s control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to DDIC as of 18 June 2026:



Theme	Definition	Number of operational risks	Date themed Risk Register last shared
Capital - Digital	A risk that could occur as a result of a lack of capital funding towards the procurement or development of a specific digital system.	13	14/05/2026
Digital Transformation	A risk related to the strategic adoption of digital technologies that are used to improve processes and productivity, deliver better care and staff experiences, manage business risk, and control costs.	16	14/05/2026
ICT (Information & Communications Technology)	A risk related to any of the organisation's digital networks or information systems that would compromise security, technology dependent tools or processes, assets, operational processes, or the provision of services reliant on these technologies.	23	17/06/2026

Risk themes (2 of 2)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The **Capital - Digital** themed risk register highlights risks across the Health Board which are dependent on resources and capital becoming available to procure a new or alternative digital solution. Many of these risks focus on the potential impact on patients due to the lack of an appropriate Digital record-keeping system, current systems being discontinued or reaching end-of-life, limited system support, and the continued reliance on paper patient records.

Risks aligned to the **Digital Transformation** theme relate to various barriers and limitations of current digital platforms. 75% of these risks were identified over a year ago, reflecting ongoing challenges in delivering digital transformation initiatives and support services within existing resource and capacity constraints.

The majority of operational Clinical Care Groups have one or more risks with an **ICT (Information & Communications Technology)** theme, which require the oversight and technical guidance of 'subject matter experts' within the Digital team. These risks are broad in nature, covering infrastructure limitations (e.g. physical space and ageing estates), communication networks and devices (e.g. telephony and emails) and systems-based risks (risks associated with service-specific digital systems) .

Analysis on risk themes highlight that risks overlap and have several interdependencies, demonstrating that risks should not be viewed in isolation. Mitigation of these risks should be co-ordinated and cross-service action plans developed to address them.



Audits and Inspections - Overview



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations; and
- Develop a prompt response to any HIW unannounced inspections, Audit Wales (AW) and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on AMaT (Audit Management and Tracking), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation, and any barriers to completion clearly noted.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Audits and Inspection Reports – Summary (1 of 2)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The following reports have been assigned to DDIC to enable them to undertake the following responsibility set out in their Terms of Reference:
3.1.20 Seek assurance on the delivery of the requirements arising from the Health Board’s regulators, WG and professional bodies.

Full detail of recommendations that are overdue are included in **Appendix 3**, with details of 4 reports as noted below as reported via in-committee included in the relevant appendices presented to the in-committee due to their sensitive nature.

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jun-15	Audit Wales	Medicines Management in Acute Hospitals	Medical Director	Medical Director	Apr-16	Sep-22 Nov-22 Mar-23 Mar-25 Mar-26 Apr-26 Jul-26	19	1	0	17	1	0	0	0	Delay due to lack of ePMA (now due for implementation by July 2026)
Oct-22	Internal Audit	IT Infrastructure	Finance	Director of Finance	Mar-24	Mar-24 Jul-24 Dec-24 Apr-26 Jul-26 Dec-26	6	1	0	5	0	0	0	0	Funding aligned for the post could not be determined.
Mar-24	NHS Wales Cyber Resilience Unit	Cyber Assessment Framework Report March 2024	Finance	Director of Finance	Jun-26	Jul-26	7	1	1	5	0	0	0	0	Reported via In-Committee
Sep-24	NHS Wales Cyber Resilience Unit	Cyber Security Assurance Report September 2024	Finance	Director of Finance	Dec-25	Dec-26	5	0	0	4	1	0	0	0	Reported via In-Committee

Audits and Inspection Reports – Summary (2 of 2)



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date of report	Report Issued By	Report Title	Clinical Care Group / Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Barriers to Completion
Jan-25	Internal Audit	Data Quality Final Internal Audit Report 2024/25	Finance	Director of Finance	Aug-25	Oct-25 Apr-26 Jul-26	4	1	0	3	0	0	0	0	Postponed due to operational constraints related to the introduction of the eFlow system.
Sep-25	NHS Wales Cyber Resilience Unit	Cyber Security Assurance Report Hywel Dda University Health Board September 2025	Finance	Director of Finance	Feb-26	Dec-26	2	1	0	1	0	0	0	0	Reported via In-Committee
Mar-26	Internal Audit	Shadow IT Final Internal Audit Report 2025/26	Finance	Director of Finance	Dec-26	N/A	3	0	2	0	1	0	0	0	Reported via In-Committee
Apr-26	Audit Wales	Digital Transformation Review	Finance	Director of Finance	Mar-27	N/A	5	0	5	0	0	0	0	0	None noted

Implementation of Welsh Health Circulars



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

All Welsh Health Circulars (WHCs) are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each Welsh Health Circular (WHC) is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of 18 June 2026, and the number completed since the previous report.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	0
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	1
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	3
Complete Pending Formal Approval	The Service / Function have completed the WHC and currently awaiting formal approval to close.	0
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	1

Oversight of the delivery of WHCs has been included in Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.



WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Next steps
011-26: Maternity Reporting Data Set (MRDs) – Data Requirements	01/04/26	Planned & Specialist Care	Chief Operating Officer	April 2029		Advice is currently awaited by the service on how to implement the technical informatic requirements of this WHC.

Welsh Health Circulars Reliant on External Factors



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
032-22: Further extending the use of Blueteq in secondary care	21/03/23	Medical	Medical Director	April 2024 N/K		Progress continues with the national rollout of Blueteq with 57 forms live across a range of specialties. The national Blueteq Steering Group is reviewing the inclusion and exclusion criteria for mandatory form completion, which will inform the future direction of the programme. The Health Board continues to work closely with the All-Wales Therapeutics and Toxicology Centre (AWTTC) to ensure readiness and remains actively involved in the development of drug specific forms. March 2027 is currently anticipated as the potential implementation date, subject to national progress and local capacity considerations. Implementation of this WHC is aligned to Ministerial Direction WG23-08 - <i>“Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023”</i> (see slide 26)
034-25: Implementation of the Planned Care Referrals DSCN (DSCN 2024/11)	25/09/25	Finance	Director of Finance	N/K		The Health Board has partially implemented this WHC but has been unable to provide all required data due to limitations in the functionality of the Welsh Patient Administration System (WPAS). Further updates are awaited to WPAS to ensure full compliance however no date is currently known. The Health Board has not been able to develop a manual workaround which would cause significant duplication and additional risk in the absence of a technical solution being provided by DHCW. Head of Information Services has raised this with NHS Performance & Improvement. This is highlighted in risk 1474 - <i>Risk of missing clinical information and increasing user workloads due to lack of appropriate system integration</i> , which has a current risk score of 8.
002-26: Modernised Outpatient Dataset Phase 2: Planned Care activity.	04/03/26	Finance	Director of Finance	N/K		The Health Board is reliant on DHCW to provide a WPAS upgrade that meets the requirements of this WHC. The Health Board are in discussions with WG around this dependency, but as yet no release notes or indicative dates for User Acceptance Testing (UAT) versions from DHCW single record team have been released to Health Boards to progress this.



WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
011-25: Introduction of The NHS Wales Digital Health Identity Standard for Primary Care (NHS Login)	11/04/25	Primary Care	Chief Operating Officer	17/04/25		WHC for information and cascaded to practices via Shared Services Partnership.

Implementation of Ministerial Directions



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as at 18 June 2026. Definitions of categories are included in the table below.

Status Category	Definition	Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	0
Unable to Complete	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1
Complete Pending Formal Approval	CCG / Function have confirmed compliance with the statutory requirements of the MD, and evidence send to relevant Lead Executive for confirmation.	0
Complete	CCG / Function have confirmed compliance with the statutory requirements of the MD, and receipt of approval to close obtained from Lead Executive.	0

MDs included within this report are based on the following criteria:

3.1.20 Seek assurance on the delivery of the requirements arising from the Health Board's regulators, WG and professional bodies.

Progress updates relating to the implementation of MDs are extracted from the AMAT system.

Ministerial Directions Reliant on External Factors



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
<u>WG23-08: Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023</u>	24/03/23	Medical Director	Medical Director	April 2024 N/K		Implementation of this MD is aligned to Welsh Health Circular 032-22 - <i>“Further extending the use of Blueteq in secondary care”</i> (<u>see slide 23</u>) The Health Board continues to work closely with the All-Wales Therapeutics and Toxicology Centre (AWTTC) to ensure readiness and remains actively involved in the development of drug specific forms. March 2027 is currently anticipated as the potential implementation date, subject to national progress and local capacity considerations.

Recommendations



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

The Committee is requested, in relation to the areas presented in this paper, to: -

Risk Management

- **RECEIVE ASSURANCE** that the principal risks have been refreshed, aligned to the relevant Committee, and will be reported to the Board in July; and
- **RECEIVE 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

- **RECEIVE 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

- **RECEIVE 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

- **RECEIVE ASSURANCE** that the Health Board is compliant with the MDs issued by Welsh Government.





DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Jun-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
2079	Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Carruthers, Andrew	Service/Business interruption/disruption	5×4=20	5×5=25	↑	1×5=5	12/31/2026	Z

RISK SCORING MATRIX

Likelihood x Impact = Risk Score						
		Corporate Risk Description:				
Likelihood	1	2	3	4	5	
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain	
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.	
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*	
	* time-framed descriptors of frequency					
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)	
	*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5	
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.	
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.	
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days.	Increase in length of hospital stay by >15 days.	Mismanagement of patient care with long-term effects.	An event which impacts on a large number of patients.
			Agency reportable incident.	An event which impacts on a small number of patients.		
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.	
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.	
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.	
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.	
		Minor implications for patient safety if unresolved.	Major patient safety implications if findings are not acted on.			
	Reduced performance if unresolved.					

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Executive Director Owner:	Carruthers, Andrew	Date of Review:	May-26
Lead Committee:	Digital, Data and Innovation Committee	Date of Next Review:	Jun-26

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5x5=25
Current Risk Score (L x I):	5x5=25
Target Risk Score (L x I):	1x5=5
Expected Date To Achieve TRS:	12/31/2026
Trend:	↔

Rationale for CURRENT Risk Score:	Rationale for TARGET Risk Score:
The impact of loss of service would be considerable, Pathology is crucial for diagnosis and treatment of patient conditions and ultimately the loss of service could lead to catastrophic patient outcomes. The current national system (TCL2016) is provided by InterSystems on Digital Health and Care Wales (DHCW) hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in Aug 2026. Programme funding is due to run out at the end of Q2 26/27. 22/05/26 - Increased likelihood from 4-5 as there is very little confidence that the delivery of LIMS will be complete by end of Q2, which will have a significant financial impact to each health board.	The reduction of the current risk score to the target risk score is reliant on DHCW and the wider system finding a robust mitigation plan and financial support to manage the risks of compressing the timescales or staying on end of life hardware and software until the system can be implemented. On risk review in September 2025, the expected date to achieve the TRS was amended from January 2026 to April 2026. On risk review in November 2025 the expected date to achieve the TRS was extended further to August 2026 as discussed in the LIMS Programme Board. 24/04/2026 - Tranche 5 scheduled for completion after Aug 26 but prior to 31st Dec 2026.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Project plans in place both locally and nationally, they are monitored monthly. Local concerns are escalated to programme board. The Health Board have also raised concerns directly to the SRO. Project teams in place both locally and nationally, both meet weekly. Weekly meetings scheduled: HDU/SBU Leads, Technical Delivery and Testing Progress Regional Risks, Assumption, Issues and Decisions (RAID) Log is updated weekly and discussed monthly in the regional programme board including representatives from DHCW and InterSystems. Governance process are in place, Hywel Dda have raised and escalated the risk to LIMS 2.0 Programme board and direct to the national SRO on multiple occasions including in Feb 2025 with a proposal of an alternative plan. A joint all Wales Health Board letter to the SRO on 7th April 2025 led to agreement that the project plan needs to be re-set. Local contingency plans are in place for short term LIMS downtime.	Only high level plans in place after tranche 3 go live (microbiology). Awaiting conformation of Tranche 4&5 plans. A local contingency plan is in place but will only enable continuity for up to 5 days. More long term contingencies would involve reliance on supplier middleware solutions. Lack of resource to complete the build and configuration by DHCW and InterSystems; lack of resource to complete the volume of testing and validation currently required to meet current timescales. Ineffective and incomplete user acceptance testing as the system is not functional and reliable. Blood transfusion (RT) legacy data	All Health Boards to work alongside DHCW and ISC to approve a national contingency plan, including extension of hardware and software provision for current system with costs and mechanisms to enact.	Jones*, Dylan	Completed	DHCW presented the current position to Health Board CEOs on 8th April and they have requested a detailed, costed, contingency plan is developed by DHCW and ISC for review by Health Boards. 28/05/2025 - No contingency plan agreed at last LIMS Programme Board. Revised plan and costings to be provided by next programme board. 26/06/2025 - Mitigation plan agreed in June Programme Board, changing from HB deployment to discipline deployment with Microbiology commencing in July and the final discipline (Blood transfusion) going live in Jan 2026. National contingency plan inc costings has been submitted to Health Board CEOs via DHCW.

blood transfusion (BT) legacy data unavailable due to inaccuracies on upload, therefore BT testing cannot be completed and the service will not meet regulatory compliance via the Medicines and Healthcare products Regulatory Authority (MHRA). 26/06/2025 - Draft national contingency plan circulated to Health Board CEOs but not yet agreed. Additional funding will be required to support contingency plan, extending implementation into early 2026. 17/07/2025 - LIMS Programme Board wrote to CEOs requesting approval for the new service by service mitigation plan. The proposal will take the programme into 2026 and consequently will have financial impact. DoD has circulated summary paper of proposal to execs, waiting CEO decision. 26/09/2025 - All Health Boards have agreed with extension of mitigation plan to March 2026. Currently we have timelines for tranche 1,2 (Cell Path go live -Nov 25) and 3 (Micro Go Live - Jan 26) but yet to determine timelines for tranche 4,5 (Blood Science and Transfusion) 28/11/2025 - Further delays with Tranche 1 and 2 (go live now likely in Jan 26). This will push the programme beyond March 26. 27/02/2026 - Gone live with tranche 1&2 (cell Pathology), Tranche 3 scheduled for May 18th. Concerns remain with Blood Science and	Review local contingency action plan and duration.	Jones*, Dylan	Completed	Short term contingency includes use of middle-ware and paper based processes which is not viable for more than 5 days. 28/05/2025 - Local Business Continuity Plan already established and captured in Pathology BCP SOP (found on QPulse) Long term would be to prioritise urgent samples to be done manually and outsource all others to English laboratories. This would be logistically difficult and involve manual transcribing of results into WCP requiring significant staff resource, training and testing. This is practically <u>not a viable option</u>.
	To review staff resourcing to support testing requirements	Jones*, Dylan	Completed	There has been no agreed funding from the programme to support overtime in 2025/26. Review has highlighted increased staff resource requirements are 4 Biomedical Scientists (Only Agency BMS likely to be available) for 6 months. £39k x 4 - £156,000 DHCW has explored the possibility of hiring an external resource company and will work with Health Boards on the approach in May/June. 28/05/2025 - On going. DHCW continue to explore resource opt 28/08/2025 - Blood Transfusion BMS appointed on a fixed term/ part time basis to support legacy data and UAT testing.

Remain with blood services and Transfusion. 24/04/2026 - Delays to Tranche 3 (approx go live 22nd June), May cause further delay to Tranche 4&5. 22/05/2026 - Tranche 3 go live extended again to 20th July 26. The current plans for Tranche 4 is also 20th July and September for Tranche 5. There is increased uncertainty with Tranche 4 and 5 timescales. Extension beyond Q2 will have financial impact on HBs (approx £300,000)	Agree Telepath LIMS extension for Blood Transfusion from Dec 2025 - Dec 2026.	Jones*, Dylan	Completed	Oracle order has been approved. Once confirmation of extension has been received from company, this action can be closed.
	Sign off Tranche 1 and 2 prior to Cell Path Go live (19th Jan 2026)	Jones*, Dylan	Completed	New Action T1 - Dylan signed off on this for Cell Path. T2 - Dylan and Craig signed off on this for Cell Path. All internal approvals were collated via email (and saved as DHCW were having issues with electronic signatures)
	Sign off tranche 3 (Microbiology - Feb 26)	Jones*, Dylan	30/01/2026 30/04/2026 31/05/2026 30/06/2026 31/07/2026	tranche 3 moved to later in 2026
	Understand cost implications associated with extension to programme as a result of missing March deadline. DHCW to collate costs and impact to Health Boards.	Jones*, Dylan	Completed	costings collated and sent to CEO for decision.
	Escalated BT options SBAR to Execs for decision. include financial impact of decision.	Jones*, Dylan	31/03/2026 07/04/2026 30/04/2026 31/05/2026 30/06/2026	SBAR drafted and discussed with CCG and DoD. waiting costings from Dedulas

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance	Required Assurance			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed	By Who	By When	Progress
		(1st, 2nd, 3rd)	Current Level							
All Wales Project Timelines	Pathology Strategy Group	1st			CCG Q&S IG meeting 16-07-2025 - Pathology Mitigation Paper submitted by DoD.					
	Quality And Safety	2nd								
	LIMS 2.0 National Programme Board	3rd								
	Regular Communication with DHCW	2nd								

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
2337	Planned & Specialist Care	Children, Women & Family Health	CW&FH: Health Visiting	Carruthers, Andrew	Goode, Paula	Davies, Nick	Wilson, Liz	29-Apr-26	There is a risk of that there will be no replacement digital platform in place at the end of the Life of WCCIS in March 2027. This is caused by having no identified platform procured to transition over the current patient records which consists of over 27000 in Health visiting. This will lead to an impact/affect on -Incomplete exit and transition arrangements -a dependency on an interim work around, such as paper records, standardised templates. -Safeguarding concerns due to missed, delayed and/or fragmented records -Non - compliance with NMC code record keeping standards -Increased administrative burden -Patient safety -Inability to evidence Programme and service delivery -Insufficient time to train the workforce within a new system -Staff disengagement and burnout Risk location, Health Board wide.	-Information governance and record keeping policies in place -Health Board digital team are exploring replacement systems -Readiness within teams to transition temporary paper records -Exploration of Badgernet within neonatal outreach.	Safety - Patient, Staff or Public	3	5	15	The risk remains scored at 15 as the core issue, the absence of an assured, fully implemented replacement digital clinical record system, has not yet been resolved. The current platform is approaching end-of-life, and reliance on interim workarounds means disruption to the continuity, accessibility or integrity of longitudinal records remains likely during transition. Exploration of Badgernet within the neonatal outreach is in the early stages while Badgernet is becoming embedded as a system. The potential impact remains major because longitudinal records are critical to safeguarding, patient safety, clinical decision-making, statutory compliance, and organisational assurance. Currently WCCIS holds within Health Visiting alone	Source New digital platform system to replace WCCIS Develop Business Continuity plan Exploration of Badgernet within the neonatal outreach team	Tracey, Anthony	30/11/2026	Update at next review Update at next review Update at next review	Digital, Data and Innovation Committee	2	2	4	Once new digital system in place there will still be a risk while training needs are being met and records being transferred. Assurance is required in relation to the storage and access to current digital records once WCCIS is no longer available (after March 2028).	Treat	8-May-26
1480	Director of Finance	Digital	Digital: Information Services	Thomas, Huw -	Tracey, Anthony	Beynon, Gareth	Beynon, Gareth	20-Sep-22	There is a risk of of losing touch with national work programmes and not being able to meet our statutory obligations to report to Welsh Government and Digital Health and Care Wales This is caused by the quantity of different work programmes currently underway by Welsh Government and Digital Health and Care Wales that requires input from local Information Services along side local initiatives. This will lead to an impact/affect on the Health Board of not implementing these programmes effectively or not being able to feed into the work programmes	Appropriate individuals remain as members of the groups and on the various distribution lists even if attendance is difficult or conflicts with local priorities. Ensure that any national requests for local intelligence or feedback are addressed and responded to in a timely manner.	Statutory duty/inspections	3	3	9	Too many national programmes of work underway as well as the work going on locally make attendance and involvement in all difficult. Going forward this is becoming increasingly problematic. Some rationalisation on membership has been undertaken to alleviate meeting fatigue Appointments have been made that will support the releasing of key staff in time to be closer involved with	Review current workloads of staff that could be streamlined, combined or stopped in an attempt to release staff time to attend and work on national requirements	Beynon, Gareth	Completed	Addition	Digital, Data and Innovation Committee	1	3	3	Improvement made following recruitment, but meeting target score will be dependent on the successful candidate being backfilled via the recruitment process	Treat	5-Jun-26

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
									during the development phase due to inconsistent attendance and involvement, and not being in a position to report on the requirements made locally or nationally Risk location, Health Board wide.						some national work programmes. Domain changed from 'Business disruption' to 'Statutory Duty' and Impact increased from 2 to 3 to reflect current situation. Further national groups are being developed to address strategic direction set by Welsh Government, concerns raised nationally about	Ensure that any national requests for local intelligence or feedback are addressed and responded to in a timely manner Develop job description to support this important work area within Information Services, Backfill of posts that have since become vacant following the appointment to other posts	Beynon, Gareth Beynon, Gareth Beynon, Gareth	Completed Completed 29/06/2026-31/07/2026	Ongoing Job description developed and matched Vacancy currently going through the advert and recruitment process							
1535	Director of Finance	Digital	Digital: Transformation	Thomas, Huw -	Tracey, Anthony	Williams, Carolyn	Williams, Carolyn	7-Nov-22	There is a risk of that digital transformation programmes that could potentially enable improved patient care, patient outcomes and staff experience will be limited in pace and scope of delivery or may not progress at all. This is caused by there being limited funding for digital transformation which often requires investment. Conflicting priorities in the HDUHB and at Welsh Government level will make the next few years very challenging. This will lead to an impact/affect on our ability to deliver at pace and as planned, resulting in our ability to respond to the demands of our patients and services and an ability to meet targets such as RTT, 6 Goals, Cancer Pathway targets etc Risk location, Health Board wide.	Digital Transformation Roadmap to illustrate the planned project delivery in place and reviewed annually. Exec and board members are familiar with our digital transformation ambition and priorities. Proposed projects are costed and illustrate a ROI with a benefits realisation plan. Projects are submitted via the Digital Delivery Framework to ensure they are aligned with our strategic and planning objectives. New project approach being rolled out to ensure that business requests are prioritised and assessed appropriately to make the most of our limited resources.	Business objectives/projects	3	3	9	The current risk score reflects the importance of planning and prioritising however, due to funding cuts in the public sector and the fact that HDUHB remains in targeted intervention, it is still likely that some projects will not be supported due to limited funding.	Publish an update to the Digital Response	Tracey, Anthony	Completed	Delivery plan for 2026 has been shared with CGI and DDIC. Updated digital response now due Oct 2026.	Digital, Data and Innovation Committee	3	3	9	The work with the strategic partner has provided support for the implementation of the current projects and work is progressing well. Whilst the development of a Digital response to the Health Board Strategy will provide planning and prioritising, there will always be an element of this risk due to the funding mechanisms from Welsh Government which don't currently allow for long term planning. In addition there may be unidentified 'in year' requests from Welsh Government which need to be implemented and encompassed within existing resources.	Treat	27-May-26

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Publish and share the DI&T delivery roadmap.	Williams, Carolyn	Completed	The roadmap has been updated for Feb 25 and is being shared with directorates during strategic meetings as well as the Digital Programme Group on a monthly basis. Strategic partner procurement is now completed -awaiting sign off from Board Nov 2024. This will feed into the digital strategy , which the DI&T roadmap is a component. Roadmap - plan on a page provided and conversations around the structure updated. Delivery plan for this year shared with CGI and DDIC.							
																Publish a refreshed Digital Response to the Health Board Strategy.	Tracey, Anthony	30/06/2025 28/2/2026 31/05/2026	An operational Digital plan has been drafted for 2026/27 and has been shared with operational and clinical leads. The overall Health Board Digital response (for the next five years) is currently being developed by the Digital Director with input from CGI. Approximate revised date now Oct 2026.							

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	RAG Status
Audit Wales	Medicines Management in Acute Hospitals	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Owain Williams	Jun-16	N/K Mar-25 Mar-26 Apr-26 Jul-26	Overdue
Internal Audit	IT Infrastructure	HUHB-2223-24_003	Medium	R3. Suppliers should be monitored regularly, at annual review points, to ensure all contractual obligations, including claimed standards and accreditations for themselves and their staff are being maintained.	This recommendation is being picked up as part of the supply chain security workstream of our cyber programme where assurances will be sought at contract award and annual renewal of their standards and accreditations.	Daniel Owens	Jul-23	Jul-23 Oct-23 Apr-26 Dec-26	Overdue
Internal Audit	Data Quality Final Internal Audit Report 2024/25	HU-2425-28_004	Medium	R4. Information / Intelligence Strategy The health board does not currently have a formal information / intelligence strategy that outlines not only what the organisation aims to achieve with data but also how it intends to collect, manage, analyse and apply that data effectively to ensure a coordinated and systematic approach to utilising intelligence across teams and services. This absence impacts the ability to align efforts, prioritise key areas and effectively use data for decision-making.	The Digital Response requires refreshing, and "data" will be a key element to be document. As part of the data management and analytics plan, we will look to expand how the organisation will use this information to make informed decisions and create machine learning (ML) or generative artificial intelligence (AI)	Anthony Tracey	Aug-25	Oct-25 Jan-26 Apr-26 Jul-26	Overdue

7 - For Approval

7.1

11:40, 5 Mins

7.1 - Research & Development Finance Policy

***Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and
Value), Chris
Tattersall (Hywel Dda
UHB - Assistant Head
of Research Support)***

| For approval

Attachments

[7.1.1 R_D Finance Policy DDIC SBAR.pdf](#)

[7.1.2 HDUHB R_D Finance Policy 2026.pdf](#)

[7.1.3 1395 Equality Impact Assessment.pdf](#)



Pwyllgor Digidol, Data ac Arloesi/ Digital, Data and Innovation Committee

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 JULY 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	R&D Finance Policy
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Chris Tattersall, Assistant Head of Research Support

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Penderfyniad/ For Decision

ADRODDIAD SCAA SBAR REPORT

Sefyllfa / Situation

The Research & Development (R&D) Finance Policy is a Wales-wide mandated document with some scope for local changes. Following consultation, the final version has now been produced.

Cefndir / Background

The policy Research & Development Finance Policy template from the research division of the Welsh Government - Health and Care Research Wales (HCRW), describes the requirements and systems in place for the costing, management, accountability and distribution of all research related funding and income within all NHS organisations across Wales.

It is one of the NHS organisation's research governance policies, focusing on the costing, management and accountability of all research funding in the NHS organisation.

The Managing Public Money document by HM Treasury sets out the principles of financial probity, transparency and accountability and these are reiterated in the Standing Financial Instructions (SFIs) issued by Welsh Ministers to Health Boards, Trusts and other NHS bodies, using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006.

Asesiad / Assessment

The draft Finance Policy Template has been shared for Health Board wide consultation in late 2025 with no comments received except from R&D. The feedback received from R&D was shared with HCRW, which responded to the comments and incorporated them in the national policy where appropriate.

The updated R&D Finance Policy was issued under a Welsh Health Circular on 12 March 2026 by HCRW.

The final policy with some HCRW approved localisations has been discussed and approved by the R&D Leadership (15/4/2026) Group and the Research & Innovation Sub-Committee (R&ISC) on 8 June 2026.

Argymhelliad / Recommendation

The Committee is asked to **APPROVE** adoption by HDdUHB of the NHS Wales Research & Innovation Finance Policy 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Cyfeirnod Cylch Gorchwyl y Pwyllgor: Committee ToR Reference:	3.1.17 Seek assurance that the commercialisation of research, innovation, related developments are appropriately risk assessed and in accordance with health board duties, policies, and procedures.
Cyfeirnod Cofrestr Risg Datix, Teitl a Sgôr Risg Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Nodau Cynllunio 2026/27 Planning Goals 2026/27	8. Fit for Purpose, Modern Facilities and Services
Hypergyswilt i Amcanion Llesiant HDdUHB 2026	10. Not Applicable

Hyperlink to HDdUHB Well-being Objectives 2026	
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: (<i>complete for strategic change and/or significant service changes</i>)	Not Applicable
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termau: Glossary of Terms:	Within the policy
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y cyfarfod hwn: Parties / Committees consulted prior to this meeting:	R&D Leadership Group 15/4/2026 R&I Sub Committee 8/6/2026

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Hywel Dda Finance department via R&D have commented on the template policy. All comments have been discussed and incorporated as appropriate. This policy will not result in additional expenditure but will be followed in respect of managing the finances of the Department.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Tegwch Iechyd: Health Equity:	An EqIA has been submitted and approved as part of the health board-wide consultation process.
Risg: Risk:	Not Applicable

Cyfreithiol: Legal:	The Managing Public Money document by HM Treasury sets out the principles of financial probity, transparency and accountability and these are reiterated in the Standing Financial Instructions (SFIs) issued by Welsh Ministers to Health Boards, Trusts and other NHS bodies, using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006.
Enw Da: Reputational:	As a Wales-wide mandated policy, non-acceptance would result in reputational damage.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	An EqlA has been submitted and approved as part of the health board-wide consultation process.



Llywodraeth Cymru
Welsh Government



NHS R&D Finance Policy 2026

Version 03; 9 June 2026



Version Control

Version	Summary of Amendments	Issue Date
01	Initial Issue	April 2017
02	Terminology updated to reflect current funding streams and policies. Sections re-ordered to outline the full processes for costing and income management of non-commercial research separately from commercial research. Section 5: Costing Research Studies • Distinction between costing process for lead sites and participating sites for non-commercial studies • Addition of SoECAT to confirm resource requirement at grant application stage. • Explanation of National Contract Value Review (NCVR). • Explanation of the Interactive Costing Template (iCT) and how it calculates direct costs, indirect costs (overheads) and capacity building fee, including application of the updated Market Forces Factor (MFF). Section 6: Funding streams and sources of income associated with research in the NHS • Clearer distinction between non-commercial and commercial funding streams Section 7: Research Accounts • More concise overview of Research Accounts structure Section 8: Management of Research Accounts New section to outline the following: • 8.1 Research Account set-up • 8.2 Account signatories • 8.3 Managing Income and Expenditure through a Research Account • 8.4 Review of a Research account • 8.5 Closure of a Research Account	May 2025



	Section 9: Income Management & Distribution • 9.3 Commercial study income • 9.3.1 Direct Costs Income Distribution • 9.3.2 Indirect Costs Income Distribution • 9.3.3 Capacity Building Income Distribution Income distribution models expanded, consistent with NIHR recommendations, for NHS organisations to outline their adopted approach across cost types. • 9.3.4 Market Forces Factor (MFF) Explanation of increased MFF to cover higher local individual itemised costs, ensuring there is no overall shortfall in funding delivery of a study. Section 10: Invoicing • Updated invoicing process flow diagram, to reference relevant sections. Section 11: Deferred Income Rules: • Updated to strengthen NHS organisations understanding of IFRS15 and their ability to recognise research related income in the appropriate way to allow deferral across financial years. • Explanation that future capacity building is a performance obligation of a commercial research contract (as well as completion of the study) and if unmet at the end of the financial year, can be deferred to the next. • Reference to model Commercial Trials Agreement (mCTA) which includes a financial appendix and accompanying guidance regarding use of funding across financial years. Appendix 1: Worked example of commercial income distribution: • Updated to show the benefits of NCVR and increased MFF for Wales. Appendix 2: Examples of overheads covered by Interactive Costing Tool (iCT) 70% indirect cost rate: • Provided for information, as per NIHR guidance.	
--	---	--



	Section 9.3 Updated Appendix 1 removed as detailed in 9.3 and replaced with Terms and conditions of investigator research accounts. Also examples added. Appendix 2 Examples of Overheads covered by commercial income for service departments.	
--	--	--

Contents

1. Purpose	6
2. Scope	6
3. Policy context.....	6
4. Types of research:.....	8
4.1 Non-commercial Research	8
• Portfolio.....	8
• Non-portfolio	8
4.2 Commercial Research	8
5. Costing Research Studies	8
5.1 Costing Non-Commercial Research	9
5.1.1 Research grant applications	9
5.1.2 Acting as a participating site	9
5.2 Costing Commercial Research	9
5.2.1 National Contract Value Review (NCVR).....	9
6. Funding streams and sources of income associated with research in the NHS	11
6.1 Non-commercial.....	11
6.2 Commercial.....	11
6.3 Other.....	11
7. Research Accounts	12
7.1 R&D Office Research Accounts	12
7.2 Investigator/departmental Research Accounts	12



8.	Management of Research Accounts.....	12
8.1	Research Account Set Up	12
8.2	Account Signatories	13
8.3	Managing Income and Expenditure through a Research Account.....	13
8.4	Review of Research Accounts	13
8.5	Closure of a Research Account	14
9.	Income Management & Distribution.....	14
9.1	Welsh Government Funding.....	14
9.2	Non-commercial study income.....	14
9.3	Commercial study income.....	16
10.	Invoicing	17
11.	Deferred Income Rules.....	19
11.1	International Financial Reporting Standard (IFRS) 15.....	19
11.2	Model Clinical Trial Agreement (mCTA) Financial Appendix.....	20
12.	Savings to the health community.....	20
	Appendix 1 – Terms and conditions of investigator research accounts	22
	Appendix 2 – Examples of Overheads covered by commercial income for service departments.....	23



1. Purpose

This policy describes the requirements and systems in place for the costing, management, accountability and distribution of all research related funding and income within NHS organisations across Wales.

2. Scope

This policy applies to:

- All NHS organisations in Wales
- Non-commercial and commercial research activities
- The following types of income/ funding available:
 - Research delivery funding as provided by Welsh Government quarterly
 - Non-commercial research income
 - Commercial research income
 - Charitable funds donated for research
 - Grant income from research led by the organisation
 - Grant income from research undertaken or hosted by the organisation
 - Wales Commercial research delivery funding (VPAG)

Funding related to service evaluation, service improvement projects, innovation projects and audits are not covered by this policy.

3. Policy context

This policy is one of the NHS organisation's research governance policies, focusing on the costing, management and accountability of all research funding in the NHS organisation.

The Managing Public Money¹ document by HM Treasury sets out the principles of financial probity, transparency and accountability and these are reiterated in the Standing Financial Instructions² (SFIs) issued by Welsh Ministers to Health Boards, Trusts and other NHS bodies, using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006.

These SFIs are 'designed to ensure that the Health Board's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability'. Rules are also set out by the Charity Commission regarding the use of public funds³.

¹ [Managing Public Money May 2023](#)

² [Standing Orders - NHS Wales Shared Services Partnership](#)

³ [Publication scheme - The Charity Commission - GOV.UK](#)



Financial probity and compliance with the law and other relevant rules are as important in research as in any other area of NHS finance and the use of public funds in Wales.

Supporting NHS research yields real benefits for the NHS, its patients, research sponsors and investigators. Ensuring continued success and investment in research is dependent on putting in place effective and efficient funding flow mechanisms which are consistent, fair and transparent.

The management of research related funding and income requires that comprehensive accountability and transparency can be demonstrated in all research undertaken in NHS organisations across Wales.

The principles for meeting patient care costs associated with externally funded research are covered by various policies and guidelines, which are updated from time to time. These include (but not limited to):

- Health Service Guidelines initially issued by the Department of Health in 1997 (HSG (97) 32)
- Welsh Government Guidance: Attributing the costs of health and social care research & development (AcoRD)⁴, which is a set of principles agreed across the UK, building on HSG (97) 32
- Welsh Government commissioned operational guidance document All Wales Support & Delivery Funding - Technical guidance for NHS Organisations & Support & Delivery Centre⁵
- Commercial Research Delivery Framework
- NHS R&D Framework for Research and Developments WHC 2023/026
- UK Policy Framework for Health and Social Care Research⁶
- ICH Harmonised Tripartite Guideline for Good Clinical Practice (CPMP/ICH/135/95)⁷

NHS organisations have a duty to ensure that income from research covers the costs incurred, without calling on routine clinical service or patient care budgets.

NHS organisations need to be able to demonstrate that they are covering costs and managing accounts in accordance with policy and national standards. Through support from Health and Care Research Wales, NHS organisations across Wales have therefore established a rigorous financial management process for research income and expenditure to ensure that NHS organisations:

- allocate expert accounting input into costing and monitoring of finances related to research
- can demonstrate appropriate use of research related income
- can demonstrate how Research and Development (R&D) offices adhere to the Standing Financial Instructions
- maintain and demonstrate financial probity in all matters concerning research governance

⁴[Attributing the costs of health and social care research & development \(AcoRD\)](#)

⁵[All Wales Support & Delivery Funding - Technical guidance for NHS Organisations & Support & Delivery Centre](#)

⁶[UK Policy Framework for Health and Social Care Research](#)

⁷[ICH Harmonised Tripartite Guideline for Good Clinical Practice \(CPMP/ICH/135/95\)](#)



4. Types of research:

There are various funding streams for NHS research, which are categorised into two main funding streams:

- Non-commercial
- Commercial

4.1 Non-commercial Research

These are research studies that are initiated and led by a non-commercial based research sponsor. Within non-commercial research, this will either be portfolio or non-portfolio, details as follow:

- **Portfolio**

These are high quality studies, as determined by their funding source (through open national competition) and peer review, and meet the portfolio eligibility criteria⁸. Examples include studies funded by Welsh Government funding streams (e.g. Integrated Funding Scheme); the National Institute for Health Research (NIHR) or other charity partners like Cancer Research UK (eligible funding streams only). These studies may include collaborative research with a range of funders or partners e.g. industry and charities.

- **Non-portfolio**

These tend to be smaller standalone research projects being conducted as a one off, often with no plans to develop bids for portfolio eligible funders. They do not meet the portfolio eligibility criteria.

4.2 Commercial Research

These are research studies that are initiated and led by an industry-based research sponsor.

5. Costing Research Studies

Researchers must engage with the R&D office at the earliest stage when considering undertaking a research project to ensure that advice and support can be provided on grants, costings and the regulatory requirements.

⁸[portfolio eligibility criteria](#)



5.1 Costing Non-Commercial Research

5.1.1 Research grant applications

When grant applications are being prepared, all planned activities within that research study should be attributed with the use of AcoRD⁹ in order to ensure that the correct funding is being requested from the funder.

For most grant applications, a SoECAT (Schedule of Events Cost Attribution Template)¹⁰ must be completed to identify all planned activities within that research study and determine the cost attribution of each, with the use of AcoRD in order to ensure that the correct funding is being requested from the funder.

5.1.2 Acting as a participating site

Relevant costing template should be completed for each study accordingly. The template should detail the activity and the cost of the non-commercial activity. The model Non-Commercial Agreement (mNCA) or Organisational Information Document (OID) should also detail how payments will be managed.

5.2 Costing Commercial Research

The price to be charged for commercially funded contract research should be at least equal to the full cost as determined by the commercial sponsor, through use of the UK wide commercial Interactive Costing Tool (iCT). All activities over standard care must be covered by the commercial sponsor.

The iCT provides a clear standard methodology to calculate consistent and transparent prices for the resource associated with delivering each commercially funded contract study to support both the Life-Sciences Industry and the NHS minimise setup time related to cost agreement.

Data relating to the single costing methodology is built into iCT, including per-participant costs in addition to standard of care. The methodology identifies Agenda for Change rates for specific bands of NHS staff time representing the direct costs. Any overheads are covered by the indirect cost and capacity building elements. Prices for investigations and costs for service departments supporting research are also included. These values are all localised with the research Market Forces Factor (MFF). Only tasks performed by sites in addition to normal or routine patient care are captured in the iCT.

Further information and support regarding the iCT and the development of its cost structure and values are available on the How the interactive Costing Tool (iCT) calculates the costs of studies at sites¹¹ webpage.

5.2.1 National Contract Value Review (NCVR)

National contract value review (NCVR) is a standardised, national approach to costing for commercially funded contract research, and in October 2024, it became mandatory for all commercial trials in the NHS across the UK.

⁹[AcoRD](#)

¹⁰[SoECAT \(Schedule of Events Cost Attribution Template\)](#)

¹¹[How the interactive Costing Tool \(iCT\) calculates the costs of studies at sites](#)



It creates transparency and streamlines administrative processes by providing the site-level costs as a financial appendix for direct insertion into localised contracts. Local negotiation of contract value is **not permitted**, and all NHS Organisations must use the fixed financial appendix in the clinical trial agreement.

The NCVR process significantly reduces the time it takes to set-up commercial studies in the NHS and the resource required to cost commercial clinical trials, including staff resources, as the activity and cost negotiation is done once by the lead site in the UK rather than at each study site.

NCVR ensures that the NHS costs (direct and indirect) are covered. The type of income and receiving department should be identified in the study review and set-up stage. Where permitted by financial systems, the relevant departments should be identified on invoices to facilitate the flow of funds to the appropriate budget.

NCVR uses the NIHR Interactive Costing Template (iCT) to:

- determine resource requirements for study delivery at a national level
- calculate site-specific prices, ensuring commercial trials are costed correctly and the NHS recovers the costs
- include a site-specific multiplier that considers local MFF and overheads.

A capacity building rate is added to both direct staff time and investigation costs within the NCVR, to maintain, strengthen and grow sustainable research infrastructure, as well as build capacity, retain skills and strengthen eligibility to deliver future research.

The MFF tariff included in the cost of the study provides an adjustment value to accommodate the unavoidable cost differences of providing healthcare across the country.

The finance appendix for UK templated model commercial agreements, developed as part of the NCVR standardised national approach to costing commercial contract research has been mandated as follows:

- The current mandate to use the appropriate UK template agreement without modification
- Site specific prices generated in the iCT will be included in a standard template for the financial appendix of the model agreements and local modification will not be permitted.

There is an NCVR escalation pathway to understand when and how to escalate issues or errors with the NCVR review, or wider NCVR programme. An infogram¹² has been co-created by the four UK nations which provides information on the UK NCVR escalation pathway.

More information on National Contract Value Review can be found on the Health and Care Research Wales website¹³

¹²[NCVR escalation pathway infogram](#)

¹³[Faster costing for commercial research in the UK | Health Care Research Wales](#)



6. Funding streams and sources of income associated with research in the NHS

Funding streams and sources of income are divided into non-commercial and commercial.

6.1 Non-commercial

All NHS organisations in Wales receive research delivery funding quarterly from Welsh Government. The funding is intended to support NHS organisations in delivering their non-commercial research portfolio locally, including funding for research delivery staff time. Funding is provided based on the in-year resource needs of the research studies that are to be delivered (including those in follow-up), with funding directed to where and when those resources are needed and to where and when those costs are incurred.

Income from non-commercial studies covers research cost activities, as defined in the AcoRD Cost Attribution policy guidance (see section 5.1 for more information).

Excess Treatment Costs (ETCs) are funded on a study-by-study basis, from a centralised Welsh Government budget¹⁴.

Centralised support cost funding is available to Powys THB, Public Health Wales and Welsh Ambulance Service on a study-by-study basis.

6.2 Commercial

Income from commercial studies, including overheads and capacity building fees are funded as determined through the NCVR process (as outlined in section 5.2.1 above)

6.3 Other

Programme investment funding including:

- Wales commercial research delivery funding (via the Voluntary Pricing Access and Growth (VPAG) funding allocated to Wales)
- Savings to the NHS and health community
- Charitable funding for research

¹⁴[Make arrangements for support costs and excess treatment costs \(ETCs\) in the NHS and social care | Health Care Research Wales](#)



7. Research Accounts

All commercially sponsored and non-commercial research income, which is not a genuinely charitable donation and relates to the NHS organisation must be held within ring-fenced research accounts on the NHS organisation's central ledger.

7.1 R&D Office Research Accounts

These accounts must hold all R&D funding types previously described in section 6, for investment on an organisation wide basis. Each type of income should be reported under separate subjective codes within the related budget.

7.2 Investigator/departmental Research Accounts

These accounts are intended to hold research related income for individual research active clinical specialties. Where more than one investigator exists for a specialty, all investigators are encouraged to work collaboratively as a consortium, planning income and expenditure, undertaking overall management of their research account. Where the account is departmental, it is expected that investigators departmental leads/support departments work collaboratively as a consortium, planning income and expenditure, undertaking overall management of their research account. See **Appendix 2** for terms and conditions of investigator research accounts.

8. Management of Research Accounts

The set up, management and closure of research accounts should be managed by the R&D office in conjunction with the NHS Finance Department. All income held in a research account is the property of the NHS organisation and is not owned by any individual who may have been involved in securing funding.

8.1 Research Account Set Up

The R&D finance manager and R&D manager are responsible for setting up research accounts on their organisation's general revenue ledger.

To open a research account the NHS finance department need evidence of the funding arrangements. A completed authorised signatory form is required by the finance department to open and activate any type of research account.

The research account budget holders are required to authorise all expenditure from the research accounts and to ensure that the NHS organisation service budget is reimbursed for any research only tests or treatment costs.

Finance departments must maintain a record of all transactions posted to the NHS organisation's ledger and report on a monthly basis to account signatories.

Occasionally, a charitable research grant may be managed via the NHS organisation's charitable accounts systems, where the principles covered by this policy still apply.



The overall budget is the responsibility of the NHS organisation, who will report regularly to the relevant budget holders.

8.2 Account Signatories

Up to three account signatories plus a member of R&D office staff can be assigned to a research account. It is the responsibility of the account signatories to manage the account. One account signatory must be named as the main budget holder. If the main signatory of the research account leaves the NHS organisation the money remains in the control of the NHS organisation.

If the money is linked to a grant, and it has been agreed that control of the grant is transferred to another organisation then this should be arranged by the R&D office in consultation with the finance department.

Money held in research accounts is not the property of the account signatories, and if the money is not linked to a grant, the money must remain at the NHS organisation and new account signatories should be nominated.

8.3 Managing Income and Expenditure through a Research Account

It is the responsibility of all the budget holders to manage the income and expenditure through the research account, support financial forecasting and to ensure that there are sufficient funds to cover the expected outgoings. The NHS finance department should send bi-monthly account statements to assist with this. It is the responsibility of the signatories on the account to review the statements on a bi-monthly basis.

Overspending on budgets is not permitted. The budget holders are responsible for ensuring that projects remain within budget and if not, may be liable for making the necessary arrangements to cover any shortfall.

The management of the financial risks of the project is the responsibility of budget holders. The R&D finance manager should notify the R&D office of any overspend. The R&D office should notify the lead budget holder and request immediate corrective action. Where unsatisfactory responses are received, the matter must be escalated to the department leads and Finance Director.

Expenditure is authorised by the budget holders and in line with current local NHS organisational policies. All expenditure should be in line with the NHS organisation's rules and regulations, policies and procedures.

Invoices are raised through the R&D office and issued through the NHS Finance department. Invoices need to be requested and are not automatically generated.

It is the responsibility of the budget holders to ensure that the invoices are raised in accordance with the contract and the invoice value is correct before the invoice is raised.

8.4 Review of Research Accounts

All research accounts are subject to both internal and external audit review. Only where studies have been approved by the R&D office can they incur expenditure against research accounts.



The signatories are required to provide a plan of expenditure, which is reviewed by the R&D office. If there is no agreed plan the account is considered dormant. If the account is dormant, then the account should be closed and the remaining funded transferred the R&D office accounts to enable future R&D activities, infrastructure or resources.

8.5 Closure of a Research Account

Written confirmation from the sponsor that the study is complete must be obtained by the study clinical team. This is retained on file, as documentary evidence of the closure of the research account and that there is no requirement for funds to be returned.

If the research study is closed and money remains in the account, after all money owed to the NHS organisation for research activities has been paid, then the account should be closed, and money moved to an R&D Office research account, for appropriate re-distribution to support the existing portfolio and individual investigators' spending plans.

9. Income Management & Distribution

Income distribution models are most effective when all income values are transparent to all departments involved through good local accounting allocations, clear distribution rule application and central oversight by the R&D office. The use of research income should be managed and monitored through spending plans which are reviewed and approved centrally by the R&D office. This approach ensures an integrated approach to research development across the NHS organisation.

9.1 Welsh Government Funding

Welsh Government provides several funding streams to support the delivery of commercial and non-commercial research activities. These include:

- Research Delivery Funding
- Wales Commercial Research Delivery Funding
- Excess Treatment Costs
- Centralised Support Costs

The management of these funding streams must adhere to the terms and conditions outlined in the corresponding Welsh Government funding award letters and guidance documents.

9.2 Non-commercial study income

NHS organisations must review the resource requirements of the study and identify any potential sources of income. For example, there may be funding within the research grant to cover the cost of NHS staff time spent in undertaking data collection or reporting associated with the study at each NHS organisation. There are sometimes lump sums provided to the organisation in recognition of the participation of the organisation in the study.



All research income identified from non-commercial studies must be invoiced for in a timely manner, with income distributed to the relevant research accounts.

Non-commercial research income should be paid into research accounts. The only exception to this is if the income covers staff time that has already been paid for by R&D, in which case this will be retained by R&D for re-investment; or if the income is for specific fees and charges.

All grant income should be paid into a study specific cost centre within a research account. This is used to cover all identified costs as detailed within the research grant application and the contract as signed with the grant funder. Where appropriate, at the end of the study, providing that the funding body agrees, any surpluses must be transferred to the R&D Office account and re-distributed to specialty research accounts and used for general research activity, subject to provision of acceptable spending plans.

Where an NHS organisation sponsors a research study, costs for providing sponsorship activities should be charged (e.g. for pharmacovigilance, contract management and study oversight).

The R&D Office will advise if costs for sponsorship related activities are required to be included in grant applications. All sponsor costs should be paid into the R&D Office budget under a specific income line.

Diagrams 1 and 2 below summarise how non-commercial research income (excluding sponsorship fees) is distributed:

Diagram 1: Distribution of income for non-commercial research investigation costs

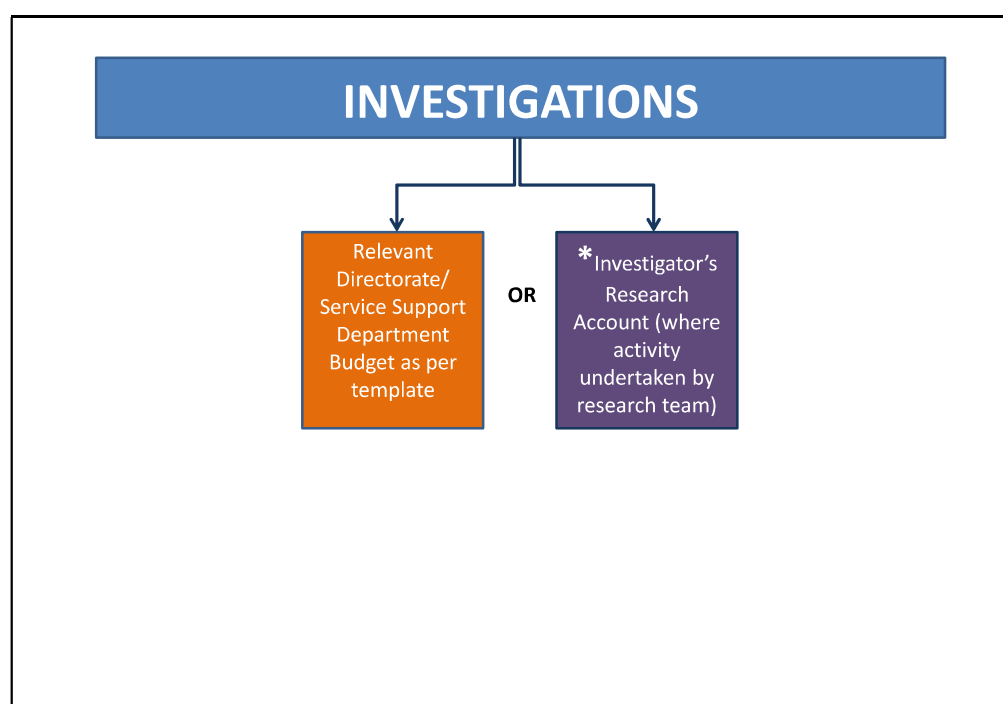
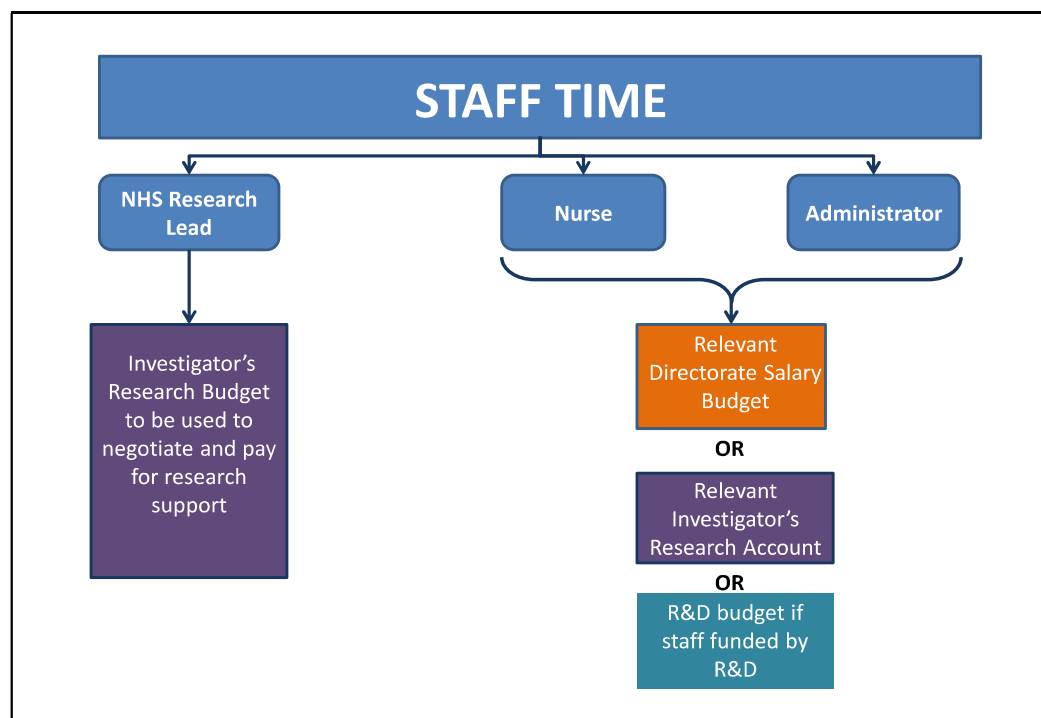




Diagram 2: Distribution of income for non-commercial research staff costs



9.3 Commercial study income

HDULB is fully signed up to the use of the ICT and NCVR.

A simplified income distribution model was tested using a number of commercial studies (observational and interventional) in order to ascertain its accuracy in maintaining an appropriate income compared to the suggested Wales Policy model. The Hywel Dda model (described below) has been in effect since 2020 with no issue and a vastly reduced man-power requirement from R&D/finance in its operation.

Irrespective of how procedure/staff or investigation costs are made up (MFF, Capacity building element etc) they will be distributed using this model. Overall, using this model the service areas and investigators are not underfunded compared to the Wales Policy.

On study confirmation, the R&D office will issue an email detailing the costs to be claimed to the lead research team

Set-up / closedown costs

Full costs will be claimed and retained by R&D in the capacity building account unless specifically for other areas such as pharmacy set-up or investigator training.



Investigations

The full cost of investigations as listed in the iCT will be distributed directly to the areas concerned (including the 'capacity building' element). Any overpayment compared to the Wales Policy is considered appropriate to facilitate a smooth setup/review process and to ensure the service area can accommodate the research and potentially invest in their own research. These funds can be distributed to the service account to fund the procedures directly or split between the service area and their research account. This distribution will be discussed with the service lead in the set-up phase. Also see appendix 2.

Procedure/staff costs

Using the exported Excel file from the iCT the 'Procedures' will be separated between R&D costs (usually classified as 'nursing/manager') and Investigator costs (usually classified as 'medical staff') on a per patient basis. Occasionally there will be some 'nursing/manager' costs allocated to the investigator, if for example there are nurses in the investigators team being utilised, not R&D delivery staff.

Once the percentage split of the final costs per patient has been calculated between R&D and Investigator, this split will be applied to all procedure costs claimed. The percentage will be rounded up to the nearest 5% but only in the benefit of the investigator (may be varied in exceptional circumstances and with the agreement of the R&D Leadership Group).

Scheduled / All Participants						Visit Schedule						Total Activity Cost
Activity	Activity Type	Department	Activity Code	Staff Role	Time Required	Activity Cost	V1	V2	V3	V4	V5	
Informed consent	Procedure	Study Team	NIHR_PRC_001	Nursing/Manager	25	£ 22.08	1					£ 22.08
Informed consent	Procedure	Study Team	NIHR_PRC_001	Medical Staff	5	£ 10.33	1					£ 10.33
Inclusion / exclusion criteria	Procedure	Study Team	N/A	Nursing/Manager	5	£ 4.42	1					£ 4.42
Inclusion / exclusion criteria	Procedure	Study Team	N/A	Medical Staff	5	£ 10.33	1					£ 10.33
CRF/eCRF completion including data transfer and query resolution	Procedure	Study Team	NIHR_PRC_026	Nursing/Manager	60	£ 53.00	1					£ 53.00
CRF/eCRF completion including data transfer and query resolution	Procedure	Study Team	NIHR_PRC_026	Medical Staff	0	£ -	1					£ -
CRF/eCRF completion including data transfer and query resolution	Procedure	Study Team	NIHR_PRC_026	Nursing/Manager	40	£ 35.33		1	1	1	1	£ 141.33
CRF/eCRF completion including data transfer and query resolution	Procedure	Study Team	NIHR_PRC_026	Medical Staff	0	£ -		1	1	1	1	£ -
Review/reporting of participant AEs/SAEs	Procedure	Study Team	NIHR_PRC_027	Nursing/Manager	10	£ 8.83	1	1	1	1	1	£ 44.17
Review/reporting of participant AEs/SAEs	Procedure	Study Team	NIHR_PRC_027	Medical Staff	5	£ 10.33	1	1	1	1	1	£ 51.67
Without Overheads						£ 119.33	£ 54.50	£ 54.50	£ 54.50	£ 54.50	£ 54.50	£ 337.33

The example above shows highlighted 'R&D' per patient procedure income as £265 of the total £337.33. This equates to R&D: 78.558%, Investigator: 21.442%

The split for all procedure costs will therefore be R&D: 75%, Investigator: 25%

10. Invoicing

All invoices or requests to raise an invoice must be sent to the R&D Office. All payments must be made out to the individual NHS organisation and not to individually named accounts or directly to individuals. Failure to follow this process may result in delays, inappropriate or incorrect reimbursement to accounts. Similarly, incomplete and



inaccurate records will be available to auditors and the board, therefore it is critical to ensure that financial transparency, accuracy and probity are always demonstrated.

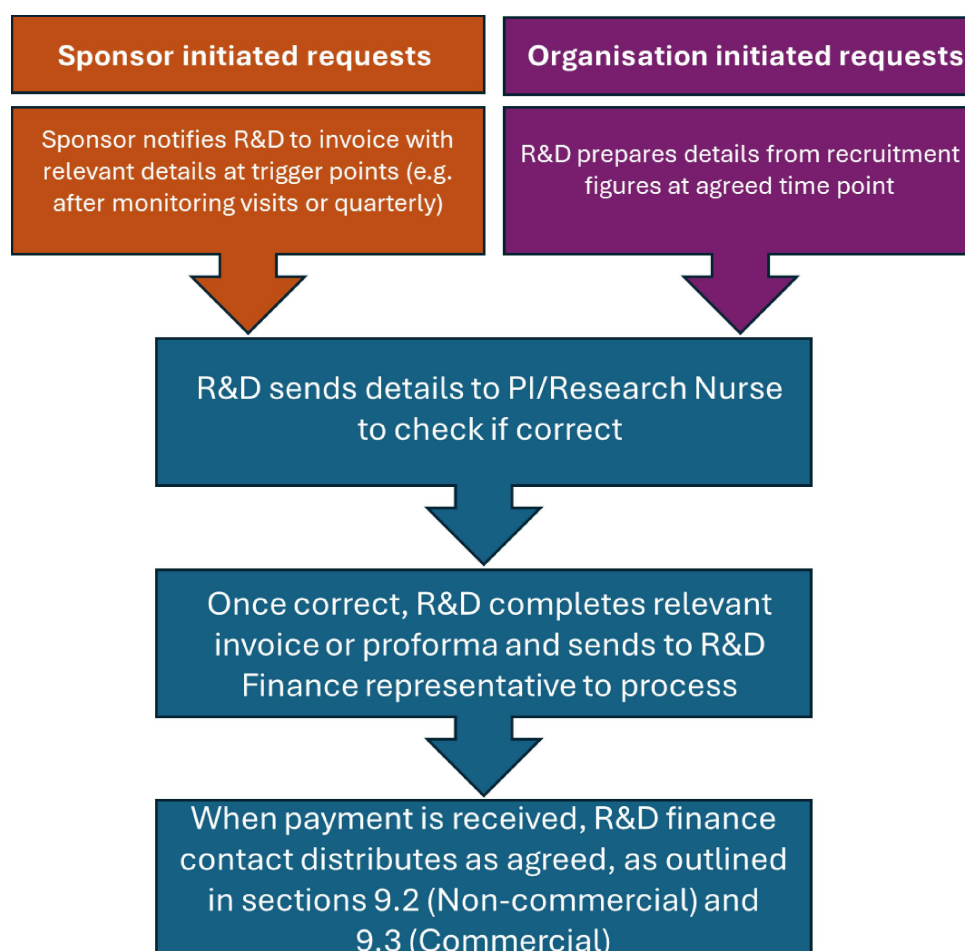
All contracts must stipulate who is responsible for initiating payments, when and how.

Invoicing can be triggered either by a request from the research Sponsor or CRO for commercial studies.

It is preferred that the Sponsor automatically generate payments or to automatically generate a reminder to the organisation to invoice for payment at defined trigger points. However, where automatic invoicing via the Sponsor is not in place, proactive arrangements for invoicing must be undertaken via the R&D Office and through the R&D Finance Manager or Accountant in consultation with the Principal Investigator.

The diagram below summarises the R&D invoicing process:

Diagram 5: R&D invoicing process





11. Deferred Income Rules

Funding/Income from government organisations (Welsh Government, Department of Health, NHS Trusts and Local Teaching or University Health Boards) must not be treated as deferred income. Expenses that have been incurred but are not yet recorded in the accounts at year-end should be accrued and the funding for this expenditure agreed with Welsh Government.

Income relating to commercial trial funding, as calculated via the iCT, can be deferred across financial years if the performance obligation of the commercial contract has not been met provided plans for expenditure are in place to maintain financial management and oversight. Spending plans must be discussed and agreed with the R&D Office and primarily be intended to cover investment in supporting the delivery of studies, including building research capacity.

To support the delivery of studies that remain open beyond the end of the financial year and therefore have an unmet performance obligation associated with study completion, study specific income can be deferred across financial years.

To support the organisation's ability to deliver commercial research at the standard required by commercial research sponsors, capacity building income can be deferred across financial years if there is an unmet performance obligation associated with improving the organisation's capacity and infrastructure to the level required for ongoing high quality commercial research delivery. There is an expectation from commercial research sponsors that capacity building income will be used for this purpose and forms the performance obligation of the capacity building element of a commercial research contract.

11.1 International Financial Reporting Standard (IFRS) 15

IFRS 15 provides the following principles-based 5 step model to be applied to all contracts with customers.

1. Identify the contract(s) with a customer.
2. Identify the performance obligations in the contract.
3. Determine the transaction price.
4. Allocate the transaction price to the performance obligations in the contract.
5. Recognise revenue when (or as) the entity satisfies a performance obligation.

IFRS 15 should not be used as a mechanism to recognise income on a cost accounting basis. The income can be recognised as and when the performance obligations have been completed – for example, study specific agreed research activities have been completed or capacity related improvements achieved. At that point, the NHS organisation should determine an appropriate measure of progress to determine how much revenue should be recognised, in accordance with IFRS 15.



Income from the delivery of commercial contract studies covers the costs of undertaking the activities required and funds the building of the capacity and capability for further research in the NHS.

Income recognition in statutory accounts in respect of commercial contract research must follow IFRS 15. An NHS organisation has a contract to carry out obligations (the research/increased capacity), for a customer for an agreed price. Although Commercial research income is generally received in arrears to pay for activity already completed, it is 'recognised' once the performance obligations have been completed i.e. the end of the study or achievement of increased capacity and not when the asset is transferred to the sponsor.

The income should therefore be recognised as or when the NHS organisation fulfils the performance obligations, not when an invoice is issued. **Funding for commercial contract research can therefore be deferred to future financial years where performance obligations remain outstanding at year-end^{15 16}.**

11.2 Model Clinical Trial Agreement (mCTA) Financial Appendix

As part of the executed mCTA the sponsor acknowledges that the trial site can defer funds paid under this agreement to build research capacity in future financial years. Both parties acknowledge that there is no obligation under this agreement on the trial site to either spend funds paid under the agreement within the same financial year, or to refund the sponsor with any sums not spent within the same financial year.¹⁷

12. Savings to the health community

Participating in research can provide significant and substantial potential savings to the NHS and should be recognised widely as an additional benefit in supporting high quality research. This is a valuable source of 'potential funding' for investment into both research capacity and infrastructure as well as general clinical service provision.

A large proportion of research studies provide free medication or devices which over time can lead to significant cost savings for the NHS organisation whilst the trial is underway. Additionally, other research studies test more effective treatments, which may save costs on existing patient treatment pathways and provide valuable data for use in appraisal by the All-Wales Medicines Strategy Group (AWMSG) or the National Institute for Health and Care Excellence (NICE).

The overall net effect of a research study must be reviewed. Additionally, the organisation is committed to ensuring that information on the overall effect of the whole research portfolio can be demonstrated in terms of cost savings.

NHS organisations are expected to contribute to national Health and Care Research Wales activities to support the collection of data or other information that demonstrates the value of research through the savings made to the NHS.

¹⁵ [NHS England » Managing research finance in the NHS](#)

¹⁶ [Microsoft Word - UK Research Finance Guidance-v1.6](#)

¹⁷ [IRAS Help - Preparing & submitting applications - Templates for supporting documents](#)



Llywodraeth Cymru
Welsh Government





Appendix 1 – Terms and conditions of investigator research accounts

Terms and conditions of investigator research accounts include:

1. Trials income earned from undertaking commercial and non-commercial research studies will be paid into the investigator research accounts (after relevant R&D and support department costs and/or fees have been deducted)
2. The account must be used primarily to support the research agenda within the specialty in accordance with the organisation's overall research objectives and strategy
3. Planned expenditure must never be more than income
4. At the end of each financial year, accounts with accrued income greater than the set threshold must provide spending plans on how investigators intend to use the funding, determined in collaboration with the R&D Office.
5. Spending plans are to be provided on a per annum rolling basis and reviewed by R&D at least 6 monthly. Spending plans must detail outline or planned spending / expenditure against income accrued, plus anticipated new income generated per annum
6. Failure to provide spending plans will result in the accrued income not being reinstated at the start of the new financial year. This income will be put into a general research support fund, managed by the R&D Office.
7. For Investigator research accounts with accrued income at year end less than the organisation's set threshold, provision of spending plans is optional.
8. The threshold will be set by the R&D office in consultation and agreement with the Finance Director
9. Investigator research accounts where there has been no transaction activity, and where there is no plan in place for 2 consecutive financial years will be cleared at year end and any accrued income will be transferred to the general R&D income budget line for investment into the general wider research agenda, unless a request is made to the R&D office providing reasonable explanations
10. Principal investigators should be listed as an authorised signatory against a nominated investigator research account. These authorised signatories are responsible for producing spending plans when requested by the R&D office
11. Failure to provide robust remedial action plans will result in any income accrued at the end of each financial year being defaulted automatically to the R&D general account and will not be reinstated to the investigators research account at the start of the new financial year
12. The R&D Director and Senior Management Team, in conjunction with the Finance Director reserves the right to review and change income thresholds and any other terms and conditions associated with Investigator research accounts at any time, associated with an appropriate notice period before enactment
13. Spending must be discussed with and approved by R&D and priority will be given to expenditure that supports the development and delivery of high-quality research studies

Examples of appropriate spend include:



- Conference attendance – ideally to present findings of a research study undertaken at HDUHB, at local, national and international conferences, including reasonable travel and accommodation costs, poster production costs, but also to network with peers in order to explore potential future research opportunities.
- Promoting research in the department – providing backfill for staff to attend research training courses e.g. Health and Care Research Wales' Foundation in Research Practice course or Good Clinical Practice training, contribution to the wider research endeavour in line with the local NHS R&D Strategy.
- Supporting researchers in the design, set up and delivery of high-quality research studies, e.g.:
 - Undertaking database searches;
 - Performing literature searches;
 - Coordinating and undertaking early feasibility assessments;
 - Developing research questions/proposals;
 - Searching and applying for grant funding;
 - Securing statistical support in order to develop a grant application/research proposal
- Equipment which could be used to support future research in the department (non-capital equipment under £5k including VAT), e.g.:
 - Research fridge/freezer for storage of samples/reagents;
 - Centrifuge for research use;
 - Translation costs for patient and public facing documentation (to meet the requirements of the Welsh Language Act).

Appendix 2 – Examples of Overheads covered by commercial income for service departments.

Indirect costs which are included in the commercial distribution of funds to service areas, provide a representative value for the running costs of conducting a commercial study that are not already covered by the direct costs (i.e. the real cost of carrying out a research activity). These indirect costs include physical aspects such as:

- Heating
- Lighting
- Building maintenance
- Security
- Central finance
- Human resources



- Corporate and strategic management of the organisation (adherence to national processes for corporate oversight offered by the CEO, the finance director, R&D director and others to ensure efficiency and cost savings within the organisation/unit)
- General study oversight and administration, including:
 1. Visit management
 2. Investigator, Nurse and coordinator oversight
 3. Medical records/worksheets setup
 4. Category C and contract amendment activities
 5. Change of Sponsor/CRO administration
 6. Financial management of study - invoice generation for all departments
 7. General maintenance of study related paperwork (excluding data management)
 8. Pre-screening (e.g. note searches) that sites may perform where the CI and Sponsor do not feel it is justified (excluding pre-screening activity where the Sponsor and CI/reviewer feel it is necessary to make the protocol work and results in significant workload for the participating organisation)
 9. Pre-site selection or feasibility tasks
 10. Setup and maintenance of standard NHS finance and IT systems (excluding IT support department setup where additional software installation or quality assurance is required by Sponsor for a study)
 11. Study related communications
 12. Arrangement/attendance at any introduction or qualification meetings
 13. Time spent preparing or attending inspections by regulatory bodies
 14. Medical record retrieval
 15. Internal contracts or paperwork for staff, e.g. honorary contracts or University/Health Board agreements for research staff
 16. Principle Investigator duty of care responsibilities, including investigator review of safety reporting provided by commercial Sponsor, e.g. annual safety reports
 17. Storage space/coordination of equipment/notes

As these costs are already covered within the indirect cost component associated with direct labour activity, the activities listed above should not be added separately to the iCT. Any staff time associated with investigation activities is already included within the investigation cost and therefore should not be charged separately either, e.g. overnight staffing costs are covered in the cost of an overnight stay, ECG nursing and upload time is covered in the cost of an ECG in the tariff data.

Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	Dr Leighton Phillips, Research and Development Division/ Is-adran Ymchwil a Datblygiad
Service Area	Department of Research, Innovation, and VBHC/ Yr Adran Ymchwil, Arloesedd, a GISW

Title of Procedure, Project, Proposal, Policy being screened:	NHS R&D Finance Policy
--	------------------------

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

This policy describes the requirements and systems in place for the costing, management, accountability and distribution of all research related funding and income within NHS organisations across Wales.

It is a Wales-wide Government mandated Policy.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

This policy is one of the NHS organisation's research governance policies, focusing on the costing, management and accountability of all research funding in the NHS organisation. The Managing Public Money document by HM Treasury sets out the principles of financial probity, transparency and accountability and these are reiterated in the Standing Financial Instructions (SFIs) issued by Welsh Ministers to Health Boards, Trusts and other NHS bodies, using powers of direction provided in section 12 (3) of the National Health Service (Wales) Act 2006.

These SFIs are 'designed to ensure that the Health Board's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability'. Rules are also set out by the Charity Commission regarding the use of public funds.

Financial probity and compliance with the law and other relevant rules are as important in research as in any other area of NHS finance and the use of public funds in Wales.

Supporting NHS research yields real benefits for the NHS, its patients, research sponsors and investigators. Ensuring continued success and investment in research is dependent

on putting in place effective and efficient funding flow mechanisms which are consistent, fair and transparent.

The management of research related funding and income requires that comprehensive accountability and transparency can be demonstrated in all research undertaken in NHS organisations across Wales.

The principles for meeting patient care costs associated with externally funded research are covered by various policies and guidelines, which are updated from time to time. These include (but not limited to):

- Health Service Guidelines initially issued by the Department of Health in 1997 (HSG (97) 32)
- Welsh Government Guidance: Attributing the costs of health and social care research & development (AcoRD), which is a set of principles agreed across the UK, building on HSG (97) 32
- Welsh Government commissioned operational guidance document All Wales Support & Delivery Funding - Technical guidance for NHS Organisations & Support & Delivery Centre
- Commercial Research Delivery Framework
- NHS R&D Framework for Research and Developments WHC 2023/026
- UK Policy Framework for Health and Social Care Research
- ICH Harmonised Tripartite Guideline for Good Clinical Practice (CPMP/ICH/135/95)

NHS organisations have a duty to ensure that income from research covers the costs incurred, without calling on routine clinical service or patient care budgets.

NHS organisations need to be able to demonstrate that they are covering costs and managing accounts in accordance with policy and national standards. Through support from Health and Care Research Wales, NHS organisations across Wales have therefore established a rigorous financial management process for research income and expenditure to ensure that NHS organisations:

- allocate expert accounting input into costing and monitoring of finances related to research
- can demonstrate appropriate use of research related income
- can demonstrate how Research and Development (R&D) offices adhere to the Standing Financial Instructions
- maintain and demonstrate financial probity in all matters concerning research governance

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ☐ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken:
[Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](#)

Age					
Is it likely to affect older and younger people in different ways or affect one age group and not another?					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic					
Disability					
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic					
Gender Reassignment					
Is it likely to affect those who either:					
- Have undergone, intend to undergo or are currently undergoing gender reassignment. - Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic					
Marriage / Civil Partnership					
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.					
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic					
Pregnancy and Maternity					
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.					
Positive Impact		Negative Impact		No Impact	x
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic					
Race / Ethnicity					
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?					
Positive Impact		Negative Impact		No Impact	x

Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic				
Religion or Belief				
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic				
Sex				
Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic				
Sexual Orientation				
Whether a person's sexual attraction is towards their own sex, the opposite sex or either.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic				
Armed Forces Community				
Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.'				
For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: Armed-Forces-Covenant-duty-statutory-guidance				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic				
Socio Economic Duty				
Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered.				
For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty				
Positive Impact	☐	Negative Impact	☐	No Impact ☒

Justification of impact identified: This policy ensures the fair and transparent management of research funding and does not have a direct or disproportionate impact on individuals, irrespective of whether they possess a protected characteristic

Welsh Language

Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.

Positive Impact		Negative Impact		No Impact	x
-----------------	--	-----------------	--	-----------	---

Justification of impact identified: There will be no impact on opportunities for participants to use the Welsh language.

If a negative impact has been identified, you are not required to complete this form as a full EqlA must be undertaken. A full EqlA template and guidance can be found on the following link: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](https://sharepoint.com)

Screening Completed by:	Name	Chris Tattersall
	Title	Assistant Head of R&D Support
	Contact details	Hywel Dda Health Board Withybush Hospital Haverfordwest Pembrokeshire SA61 2PZ chris.tattersall@wales.nhs.uk
	Date	09.07.2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Sally Hore
	Title	Head of Research & Development
	Contact details	Sally.hore@wales.nhs.uk
	Date	9.7.25
Guidance has been provided by Diversity & Inclusion Team:	Name	Kylie Daniels
	Title	Senior Diversity and Inclusion Officer
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	16/07/25
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqlA and inform the D&I team.

8 - For Information

8.1

11:45, 0 Mins

8.1 - DDIC Workplan 2026/27

Maynard Davies
(Hywel Dda UHB -
Independent Member)

| For information

Attachments

8.1 DDIC Work Programme 2026-27 FINAL.pdf

DIGITAL, DATA AND INNOVATION COMMITTEE WORK PLAN APRIL 2026 – MARCH 2027

Currently, Digital, Data and Innovation Committee (DDIC) meets quarterly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2026 – March 2027, including standing agenda items (denoted by *).

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	PURPOSE	21 Apr 2026	21 Jul 2026	4 Sept 2026	20 Oct 2026	21 Jan 2027
PAPER DEADLINE					30 June 2026	21 Aug 2026	29 Sept 2026	29 Dec 2026
INTRODUCTIONS								
Welcome and Apologies*	Chair	All	N/A	✓	✓		✓	✓
Declarations of Interests*	Chair	CSO	N/A	✓	✓		✓	✓
GOVERNANCE								
Minutes from previous meeting*	Chair	CSO	Approval	✓	✓		✓	✓
Matters Arising & Table of Actions (ToAs) *	Chair	All	Information	✓	✓		✓	✓
Matters Arising (not on agenda) *	Chair	CSO	N/A	✓	✓		✓	✓
Annual Review of DDIC Terms of Reference (TORs) (12.1)	Chair	JW	Approval	✓				
DDIC Annual Report 2025/26 on Committee's activity for onward submission to the Board (10.4.1)	Chair	CSO	Approval	✓				
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW	Assurance	✓				
Self-Assessment of Committee Effectiveness: 6 month Report	Chair	JW	Assurance				✓	
Assurance and Risk Report: combined report including: - Corporate Risks Assigned to DDIC (3.1.20) - Operational Risks Assigned to DDIC (3.1.20) - Internal and External Audit Reports (3.1.8) - Monitoring of Ministerial Directions Monitoring of Welsh Health Circulars (WHCs)	HT	RW	Assurance	✓	✓		✓	✓
DIGITAL								
Planning Goal 5: People First, Digital Always (3.1.18): - To bring the benefits of digitisation and technological advances into healthcare - Create digital pathways between hospital, community and home - Support our staff with digital tools to deliver safe, effective, quality care - Closure report - General update report	HT	DW	Assurance	✓	✓		✓	✓
Digital Strategic Plan (2.1.1 & 3.1.1) (PO9)	HT	AT	Assurance	✓	✓		✓	✓
Digital Operation Plan	HT	AT	Assurance	✓				✓
Digital Partner Update	HT	AT	Assurance	✓	✓		✓	✓
Summary of Progress Against Board Approved Business Cases	HT	AT	Assurance					
Digital Inclusion	HT	AT	Assurance		✓			
Current use of AI	HT	AT	Information					
In Year Delivery of Programmes	HT	AT	Assurance				✓	
Digital Innovation & Transformation Benefits Realisation Report	HT	AT	Assurance				✓	

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	PURPOSE	21 Apr 2026	21 Jul 2026	4 Sept 2026	20 Oct 2026	21 Jan 2027
PAPER DEADLINE					30 June 2026	21 Aug 2026	29 Sept 2026	29 Dec 2026
2025/26								
RISP – Radiology Informatics System Programme	HT	AT	Assurance					
RISP – Radiology Informatics System Programme: Lessons Learnt	HT	AT	Assurance				✓	
Patient Services Centre Business Case	HT	AT	Recommend, for onward ratification by Board		✓			
Proposal of Ambient AI within the Health Board Proposal on the use of AI Scribes	HT	DW	Information		D		✓	✓
EDRS Re-procurement (Document Management System)	HT	AT	Assurance		✓			
In-Committee EDRS Re-procurement (Document Management System)- Financials	HT	AT	Assurance		✓			
In-Committee Key performance indicators	HT	AT	Assurance				✓	
In-Committee Cyber Security Updates incl CAF compliance (3.1.8 & 10)	HT	AT	Assurance	✓	✓		✓	✓
In-Committee Laboratory Information Management System (LIMS)	HT	AT	Information	✓				
DATA								
IGSC Workplan (3.1.24)	AT	AT	Information	✓				
Annual Review IGSC TORs (10.3)	AT	AT	Approval	✓				
Information Governance Sub-Committee (IGSC) 3A's update (10.3)	AT	AT	Information	✓	✓		✓	✓
IGSC Annual Report (10.4.1)	AT	AT	Approval	✓				
Data Quality Report (3.1.9)	AT		Assurance		✓			
Information Governance Assurance Report (2.1.3, 3.1.6,7 & 8)	HT	AT	Assurance				✓	
Data Protection Impact Assessment Assurance Report (3.1.11)	HT	AT	Assurance					✓
Microsoft Enterprise Agreement Renewal	HT	AT	Approval	✓				
AI Framework	HT	AT	Information		✓			
Digitalisation of Health Records	HT	AT	Assurance				✓	
Extracting Insight From Data	HT	AT	Emdorsement		✓			
RESEARCH AND INNOVATION								
Research & Innovation Annual Report (3.1.15)	LP	CH/SH	Assurance	✓				
Research and Development Framework Annual Update	MH	CH/SH	Assurance	✓				
RISC TORs Annual Review (10.3)	LP	CH	Assurance	✓				
RISC Workplan (3.1.24)	LP	CH	Assurance	✓				
Research and Innovation Sub-Committee (RISC) 3A's update (10.3)	LP	CH/SH	Assurance	✓	✓		✓	✓
Research & Development Implementation of the NHS Framework and Strategic Plan (10.4.1)	LP	CH	Assurance				✓	
Research Project Presentation	LP	SH	Information	✓				
University Partnership Arrangements Update (3.1.16)	LP	CH/SH	Assurance		✓			✓
TriTech Business Plan	LP	CH	Assurance		✓			
Centre for Social Innovation	LP		Assurance				✓	

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	PURPOSE	21 Apr 2026	21 Jul 2026	4 Sept 2026	20 Oct 2026	21 Jan 2027
PAPER DEADLINE					30 June 2026	21 Aug 2026	29 Sept 2026	29 Dec 2026
IMPACT AND OUTCOMES								
Update on Impact of Flow System	HT	AT	Assurance					
Analytical and Modelling Work including Presentation	HT	AT	Assurance					
FOR ASSURANCE								
National and Regional Landscape	HT	HT	Assurance				✓	
FOR APPROVAL								
Policies (as required) (3.1.24)	HT	HT	Approval	✓	✓		✓	✓
R&D Finance Policy	HT				✓			
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.5)								
• EDRMS Re-procurement (Document Management System) (21.07.26)	HT	AT	Recommend, for onward ratification by Board	✓	✓		✓	✓
• Workforce Asset Scheduling-2027/28 OBC (20.10.26)								
MEETING GOVERNANCE								
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	N/A	✓	✓		✓	✓
Draft agenda to go to Executive Team	CSO	N/A	N/A	✓	✓		✓	✓
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	N/A	N/A	✓	✓		✓	✓
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	N/A	✓	✓		✓	✓
Add actions to the Action Tracker within two days of the meeting and send notification to action owners	CSO	N/A	N/A	✓	✓		✓	✓
Circulated minutes to Lead Director within 7 days of the meeting	CSO	N/A	N/A	✓	✓		✓	✓
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	N/A	✓	✓		✓	✓
Produce 3A's Report for Board	CSO	N/A	N/A	✓	✓		✓	✓

Chair: Maynard Davies **Vice Chair:** Chantal Patel **Lead Executive:** Huw Thomas

HT	Huw Thomas	JW	Joanne Wilson	MH	Mark Henwood	AT	Anthony Tracey
RW	Rachel Williams	DW	Daniel Warm	SA	Shaun Ayres	LP	Leighton Phillips
CH	Chris Hopkins	SH	Sally Hore	CSO	Committee Services Officer	D	Deferred

V Verbal

SO	Planning Goals	What we want to achieve (tangible outcomes – how do these align /fit with our current principal risks?	How we expect to deliver this (actions)	Committee Alignment
----	----------------	--	---	---------------------

Thriving Teams	Goal 1 – Healthy, thriving teams <i>Lead – Lisa</i>	- Sustainable workforce in hospitals and communities - Shape organisational culture - To celebrate success and promote innovation	- Creating a positive workforce culture - Delivery of workforce stabilisation programme, in particular applying the approach to medical staff - Implementing the Research and Innovation Strategic Plan (2025 – 2030)	PODCC
	Goal 2 – Customer Service Excellence <i>Lead – Sharon</i>	- To promote a culture of speaking up safely - Promote equality, diversity and inclusion - Provide excellent bilingual services	- Compassionate experiences - Customer service excellence - Community connectedness	QSEC
Healthier Communities	Goal 3 - '20Four7' population health <i>Lead – Ardiana</i>	To reflect population health priorities that build in equality of opportunity and human rights, together with plans to reduce health inequalities	- Strengthen prevention services - Advance population health programmes - Monitor performance	SPC
	Goal 4 - Community by design <i>Lead – Andrew</i>	To ensure that Hywel Dda has a clear vision and strategic direction that secures the long-term sustainability of the organisation, both at local community and wider system levels	Develop and deliver a primary care and community services strategic plan	SPC
Great Care	Goal 5 – People First, Digital Always <i>Lead – Huw</i>	- To bring the benefits of digitisation and technological advances into healthcare - Create digital pathways between hospital, community and home - Support our staff with digital tools to deliver safe, effective, quality care	- Delivery of Digital Strategic Plan - Progress digital, technology and AI adoption	DDIC
	Goal 6 – Safe, timely, high quality care <i>Lead – Andrew</i>	- Ensure patient safety is a priority - Safe and sustainable planned care and community services - Promote high ethical standards - To act as a catalyst for change, providing independent and objective perspectives. This includes having the courage to speak up about any concerns - Improved experiences and outcomes for those using our urgent and emergency care services - Implementation of national Mental Health and Women's Health strategies in Hywel Dda that meet local needs	- Improve patient pathways, embed safety dashboard & remove clinical variation - Promote a way of working that is open, transparent and accountable - Deliver the programme commitments made as part of the Clinical Services Plan and Community by Design strategic delivery plan - Improve efficiency and productivity and reduce waste, harm and variation - Develop and deliver an Urgent and Emergency Care strategic delivery plan to improve standards, in line with the existing strategy, ahead of the new hospital network - Develop and deliver a flexible, open access mental health model in Hywel Dda - Develop and deliver the Women's Health Plan for Wales in Hywel Dda - Implement Hywel Dda's learning disability transformation programme	FPC
Positive Futures	Goal 7 - Future Orientated <i>Lead – Ardiana</i>	- Connected and resilient communities - Establish how we will strengthen how we listen and incorporate the voice of our future generations	- Embed the Principles of Social Model for Health & Wellbeing - Delivering our Decarbonisation Delivery Plan - Encourage collaboration with others	SPC
	Goal 8 - Fit for purpose, modern facilities and services <i>Lead – Lee</i>	- Determine and implement sustainable models for services within the Clinical Services Plan programme - Deliver our Programme Business Case to develop fit for purpose and modern community and hospital facilities	- Provide an addendum to our Programme Business Case to allow us to proceed with the development of community and hospital schemes - Develop the Clinical Services Plan to make changes to services, and consider other services that may need	SPC

			support, to allow us to provide safe and sustainable services for the future	
--	--	--	--	--

9 - Any Other Business

*Maynard Davies
(Hywel Dda UHB -
Independent Member)*

10 - Date and Time of next meeting

Maynard Davies
(Hywel Dda UHB -
Independent Member)

Tuesday 20 October 2026, 9.30am-12.30pm

21 January 2027

11 - In-Committee Session

In accordance with the Committee's Terms of Reference, which permit the Committee to operate an in-committee function for the consideration of sensitive and/or confidential information, the next part of the meeting will be held in private session. Attendance will be restricted to Committee Members and those individuals (or their nominated deputies) identified in the Terms of Reference.

This session will consider the following items:

1. EDRS Re-procurement (Document Management System) - Financial Information
2. Cyber Security Updates incl CAF compliance
3. Assurance and Risk Report

A summary of matters considered will be reported to the next appropriate Committee meeting.