Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	15 January 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Business Proposal – Patient Service Centre and Patient Relationship Management Tool
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
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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

This report provides the Digital, Data and Innovation Committee (DDIC) with an update on the development of the Outline Business Case (OBC) for the Patient Service Centre (PSC) and Patient Relationship Management Tool.

This update summarises progress to date, undertaken in partnership with CGI, and presents a clear overview of the options appraisal process so that an informed discussion around the preferred way forward can take place.

In summary:
The OBC has been developed to support a proposed investment in a PSC and Patient Relationship Management Tool.
The initiative is driven by clear organisational and system-level imperatives:

- To improve patient access and experience through a single point of contact.
- To enhance operational efficiency and reduce duplication.
- To ensure clinicians have timely, holistic access to patient information.
- To support regional and national digital transformation objectives, including interoperability and data sharing.

Cefndir / Background

A Healthier Mid and West Wales describes the vision to transform healthcare services by achieving the goal of Hywel Dda University Health Board (HDdUHB) in becoming a fully digital health board that drives excellence in care for patients and communities across the region. The Health Board's digitally transformed healthcare vision is to digitise all the events and information that relate to a patient's care into an easily accessible data store that can be shared with partners. In doing so, patients will receive better and safer care as teams will have a clear and more easily understood picture of the patient's health. The creation of a PSC will streamline care and enhance operational efficiency.

Asesiad / Assessment

The current patient service landscape is fragmented, with appointment management, referral coordination, and patient support services handled across multiple channels, systems and teams. This leads to inefficiencies, inconsistent patient experiences and challenges in data management and analysis.

The proposed PSC will centralise functions such as appointment management, information and guidance, referral coordination, follow-up care, patient support services, data management and communication, supported by a comprehensive 360° view of patient information and their interactions with the HDdUHB. This will enable clinicians and staff to access unified patient records, supporting better decision making and care coordination.

Key benefits identified include:

- Reduced missed appointments (Did Not Attends (DNAs)) and cancellations, freeing up clinical capacity and reducing costs.
- Improved staff productivity and ability to focus on patient care.
- Enhanced patient self-service and satisfaction through digital tools.
- Lower administrative burden and postage costs.
- Shorter patient waiting times and improved access to care.
- Reduced carbon footprint through digital-first processes.

During the scoping workshops, aimed at shaping the future direction of the PSC, key stakeholders from HDdUHB and CGI came together to collaboratively define the scope, requirements and strategic context for this project. The primary objective was to develop an options analysis for the PSC and Patient Relationship Management Tool and followed the "*Better Business Cases*" methodology, ensuring a structured approach to determining strategic context, making the case for change, exploring options and identifying critical success factors, benefits, risks and dependencies.

A range of options were considered by the stakeholder group within each of the following five dimensions which collectively formed the long-list:

- **Scope:** Defines the functions and user groups the solution must cover.
- **Service Solution:** Compares capabilities that the solution will deliver.
- **Service Delivery:** Considers whether the business needs are best delivered by a bespoke solution build, or by procuring one of a number of identified Commercial-Off-The-Shelf (COTS) solutions.
- **Implementation:** Selects the preferred rollout approach: pilot in one department, phased by site, or "big-bang" go-live.
- **Funding:** Identifies capital vs. operational expenditure mix: capital licence purchase, subscription fees, managed-service charges, or pay-per-use.

Within each dimension, the identified options were assessed against the Critical Success Factors (CSF) and Spending Objectives for the initiative:

CSF	Description
Strategic fit	The option fits with other HDdUHB strategies + projects

Business need	The option delivers the agreed Investment Objectives
Benefits optimisation (impact)	The options enables the realisation of the benefits that have been agreed
Potential value for money	The option optimises public value (social, economic, and environmental)
Supplier-side capacity	The option is deliverable by vendors in the market
Supplier-side capability	The option delivers the identified and required capabilities
Potential affordability (cost)	The option can be funded from available sources and must be affordable in line with HDdUHB budgets, taking into account the Total Cost of Ownership
Potential achievability (delivery)	The option can be delivered by HDdUHB and can be done so in the required timescale
Potential achievability (risk)	The option is evaluated to be within the risk appetite of HDdUHB

The workshops identified several risks including system resilience, resistance to change, usability and adoption challenges, data integration issues, information governance, clinical risk from incomplete data, cybersecurity threats, misalignment of expectations, and digital exclusion.

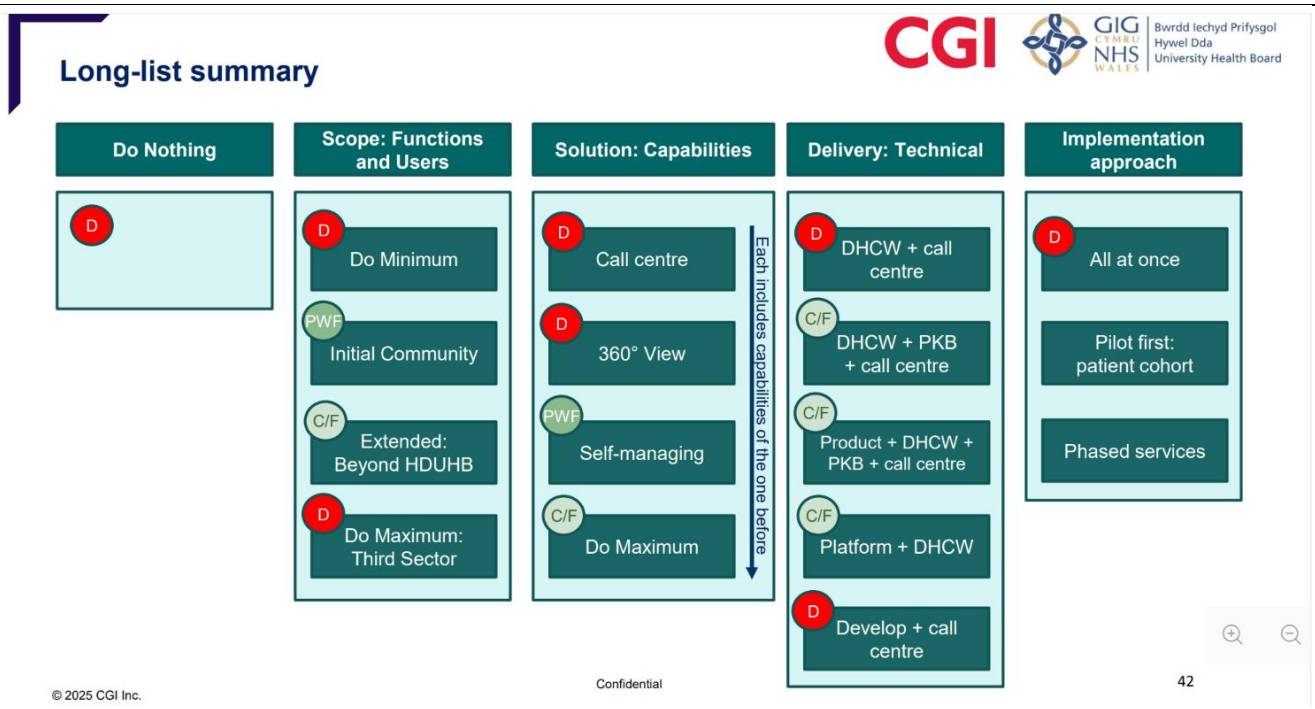
Mitigations include robust technical design, stakeholder engagement, co-design, comprehensive training, adherence to integration standards, clear governance frameworks, and maintaining non-digital access channels.

Success will depend on strategic alignment with local, regional, and national policies, value for money, supplier capability and affordability and achievability within set timescales. The solution must be user-friendly and able to deliver measurable improvements in patient care and operational efficiency, and extendable to future capabilities and services.

Based on the workshop discussions and subsequent evaluation, each long-list option was categorised as one of the following:

- Unrealistic options to be Discounted (D)
- Possible options to be Carried Forward (C/F)
- The option identified as the Preferred Way Forward (PWF) - the ‘solution’ which is considered most likely to optimise value.

A summary of the long-list options and their assessment is provided in the diagram below.



The options that were not discounted on the long list were combined into viable solutions across each of the dimensions to be taken forward for further consideration. This resulted in the following short-list:

- **Option 0: Do Nothing (Business as Usual)**

  This option is included for completeness, and to provide a baseline against which to compare other options.

- **Option 1: Do Minimum**

  The Do Minimum option would create a new single call centre which combines with the Patients Knows Best (PKB) app for patient engagement. An initial 360 View would be provided by augmenting the call centre solution with integrations to current Digital Health and Care Wales (DHCW) systems.

- **Option 2: Less Ambitious Way Forward**

  The Less Ambitious Way Forward would create a single call centre for the Health Board along with a full 360 View and self-manging patient engagement portal by expanding the products used by the health board, extending integration with current DHCW systems and providing full integration with Patients Know Best.
  This encompasses information and guidance for all of secondary care, plus primary care engagement, NHS dental, district and school nurses, community therapies, mental health services (including NHS 11 Press 2), child health, public health response and vaccinations.
  The solution would be phased in over an extended period of time.

- **Option 3: Preferred Way Forward**

  The Preferred Way Forward would use a low-code platform approach to create a solution that combines a single call centre, a 360 View and a patient engagement portal, along with integration with Patients Know Best and current DHCW systems.
  The same capabilities and scope reach are provided as the Less Ambitious Way Forward, but the solution would be deployed in a pilot and then swiftly rolled out across health board services.

- **Option 4: More Ambitious Way Forward**

  The More Ambitious Way Forward would extend the previous option to make use of an external 24x7 call centre while still using the same low-code platform for a 360 View and a patient engagement portal, along with integration with Patients Know Best and current DHCW systems.
  The scope and reach now incorporates services beyond the Health Board such as social care referrals and guidance, GPs, ambulance, and integration with primary care and community referrals.
  The capabilities of the solution would also be extended to include full secondary care use cases for the 360 View including acute and inpatient services, dynamic patient-driven appointment scheduling for all Health Board services, and integration with NHS 111.

The five shortlisted options are summarised in the tables and diagrams below:

Options	Do Nothing	Do Minimum	Less Ambitious Way Forward	Preferred Way Forward	More Ambitious Way Forward
Scope	Current users and access	HDdUHB plus initial community	HDdUHB plus initial community	HDdUHB plus initial community	Extended beyond HDUHB
Solution	Current capabilities and services	Initial 360° View plus PKB for minimal patient engagement	Full 360° View and patient self-management	Full 360° View and patient self-management	Maximum capabilities
Delivery	Current systems	DHCW + PKB + call centre	Product + DHCW + PKB + call centre	Platform (inc. call centre) + DHCW	Platform + DHCW + external 24x7 call centre
Rollout	N/A	Phased over longer time	Phased over longer time	Pilot and then rollout	Pilot and then rollout
Solution components	HDUHB DHCW	PKB HDUHB inc. call centre DHCW	PKB HDUHB inc. call centre Product + DHCW	HDUHB inc. call centre Platform + DHCW	Call centre Beyond HDUHB Platform + DHCW

Further details on each option (other than Do Nothing) are provided in the table below.

Options	Do Minimum	Less Ambitious Way Forward	Preferred Way Forward	More Ambitious Way Forward
Scope	**HDUHB plus Initial Community** • Secondary care, including inpatient support calls. • Primary care engagement, NHS dental, district nurses. • Patient and proxy access (including family, circle of care and advocates). • School nurses, therapy, mental health services (including NHS 11 Press 2). • Child health, public health response and vaccinations.			**Extended Beyond HDdUHB** 'Initial Community' plus: • Social care referrals and guidance. • GPs and ambulance. • Integration with primary care and community referrals. • Patient and proxy access via

				PKB and NHS Wales app.
Solution	**Minimal patient engagement** • Single point of contact for patient phone (including Interactive Voice Recognition (IVR) and web enquiries. • Engagement using PKB and NHS Wales app (not integrated) • Some additional integration with current Patient Flow system	**360° View and Self-Managing patient engagement** • Single point of contact for patients. • Integrated view of patient records. • Video and Chat guidance and consultations. • Single point of referral processing. • Engagement platform, integrated with PKB + NHS Wales App. • Patient Initiated Follow Up (PIFU) / See on Symptom (SOS) triggered appointments. • Patient selected appointments for some services. • Triage for urgent and emergency care. • Signposting and social prescribing. • Waiting list management.		**Maximum capabilities** '360° View and Self-Managing patient engagement' plus: • Full secondary care use cases including acute and inpatient. • Dynamic patient-driven appointment scheduling. • Integration with NHS 111.
Delivery	• One Health Board call centre • PKB • DHCW systems	• One Health Board call centre • Extending current HDUHB products (e.g. Miya) • PKB • DHCW systems	• New platform for 360° View and patient engagement (inc. one Health Board call centre) • PKB • DHCW systems	• External 24x7 call centre • New platform for 360° View and patient engagement • PKB • DHCW systems
Implementation	• Phased over longer time		• Pilot and then rollout	

To inform the decision about which option should be the preferred option going forward, each of the shortlisted options were evaluated by stakeholders from HDdUHB. Stakeholders provided quantitative feedback against the critical success factors, including an assessment of Benefits (from 4.4, Outline Business Case, Appendix 1), Risks (from 4.5, Outline Business Case, Appendix 1) and rough order of magnitude (ROM) costs, and the responses were combined to provide a RAYG (red, amber, yellow, green) value for each option against each of the criteria, where Red indicates the least preferred option for the corresponding criteria, and Green indicates the most preferred. Note that the RAYG values for some of the evaluation criteria, particularly the supplier-side capacity and capability and the solution costings, have been provided by the market assessment conducted by CGI colleagues rather than from the wider stakeholder group.

Note also that these are indicative RAYG values and, particularly those that relate to costings, will continue to be evaluated and refined in the weeks to come.

Critical Success Factor	1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Benefits				
Risks				
Investment Objectives				
Strategic fit				
Potential value for money				
Supplier-side capacity				
Supplier-side capability				
Potential achievability (delivery)				
Costs				

The Outline Business Case is provided in **Appendix 1**.

To summarise:

- Key drivers include reducing missed appointments (currently 6.9% DNA rate), improving patient satisfaction, streamlining workflows, and enhancing data quality. The initiative aligns with national and regional strategies, supports HDdUHB's 10-year vision, and is informed by extensive stakeholder engagement.
- Expected benefits are both quantitative (e.g., reduced DNAs, fewer cancellations, increased staff productivity, and significant cost savings) and qualitative (e.g., improved patient experience, faster access to care, and better data for decision-making).
- Risks have been identified and mitigations planned, including system outages, resistance to change, data integration challenges, and digital exclusion. The programme will be delivered in tranches, with robust governance and ongoing stakeholder engagement.

Next Steps:

To ensure the successful delivery of the Patient Service Centre and 360° View, it is essential to move forward with a clear and structured implementation plan.

The following next steps outline the immediate actions required to progress from proposal to execution, ensuring robust governance, effective stakeholder engagement, and timely realisation of the anticipated benefits. These steps are designed to maintain momentum, manage risks, and provide a strong foundation for the digital transformation journey across HDdUHB.

- Approval of Business Case:
  Seek formal approval from the Board at the January 2026 meeting to proceed with the Patient Service Centre and Patient Customer Relationship Management (CRM)/ Patient Relationship Management (PRM) initiatives as outlined in the proposal.
- Establish Programme Governance:
  Confirm programme governance arrangements, including oversight by the Digital, Data and Innovation Committee (DDIC) and regular reporting mechanisms.
- Detailed Planning and Resourcing:
  Develop a detailed implementation plan, including resource allocation, timelines, and

key milestones for delivery.

- Stakeholder Engagement:
  Continue and expand engagement with patients, clinicians, administrative staff, and external partners to refine requirements and ensure buy-in.
- Procurement and Supplier Selection:
  Initiate procurement processes for technology, integration, and change management partners, ensuring alignment with value for money and capability criteria.
- Technical Design and Integration:
  Begin technical design work, focusing on rapid integration of telephony, CRM, and patient administration systems, and ensuring interoperability with existing platforms.
- Change Management and Training:
  Develop and deliver a comprehensive change management and training programme to support staff adoption and minimise resistance.
- Pilot and Phased Rollout:
  Plan and execute a pilot phase, followed by a phased rollout across HDdUHB, with clear criteria for success and mechanisms for feedback and adjustment.
- Benefits Realisation and Monitoring:
  Establish robust monitoring and evaluation processes to track progress against key performance indicators, manage risks, and ensure delivery of anticipated benefits.
- Ongoing Communication:
  Maintain transparent and regular communication with all stakeholders throughout the implementation process.

Argymhelliad / Recommendation

The Committee are requested to:

- **RECEIVE ASSURANCE** from the proposed approach to the Patient Services Centre and Patient Relationship Management Tool.
- Recommend that Board **APPROVE** the outline business case. This will enable market engagement. A final business case will be brought back to include market tested costs and further detail on benefits before committing expenditure and approving contracts.

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). 3.1.5 Review and scrutinise business cases, and associated revenue implications, relating to digital and research and innovation activities, and ensuring there are robust contracting processes and procedures are in place, prior to Board approval.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable

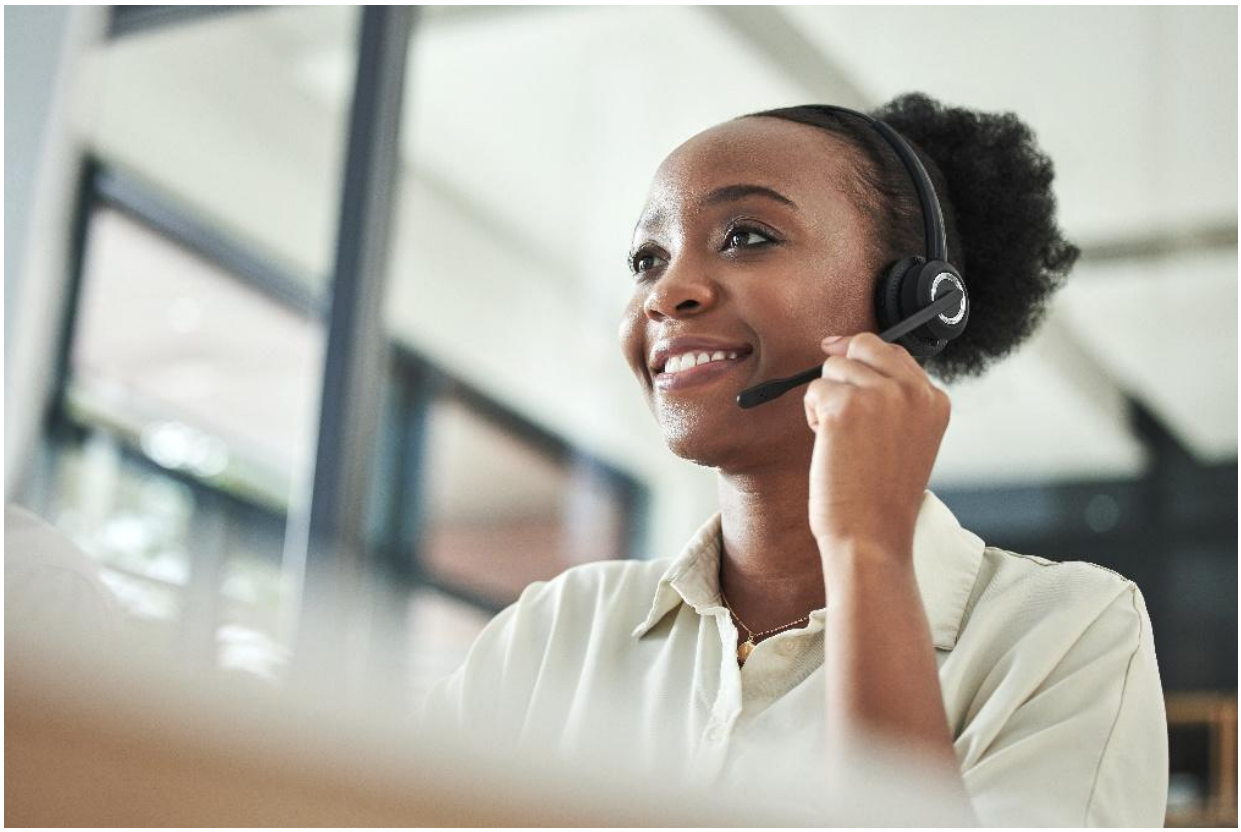
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio 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:	Contained within the report
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:	Executive Team A Healthier Mid and West Wales

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The Patient Service Centre (PSC) and 360° View initiative, as outlined in the HDdUHB business case, is set to deliver a major transformation in patient access and clinical workflow. By centralising patient contact and providing clinicians with a unified, real-time view of patient information, the programme aims to simplify access, reduce duplication, and improve both patient and staff experience. Anticipated service benefits include a significant increase in patient satisfaction, reduced Did Not Attend (DNA) rates, fewer cancellations, and improved operational efficiency—such as faster call handling and the ability to process more referrals per day. These

	improvements are expected to free up staff time for direct patient care and support better clinical decision-making, while also laying the groundwork for future digital integration across the region. Financially, while the initial outlay may be considerable, the business case demonstrates that the investment will drive long-term value through efficiency gains, cost reductions in administration and postage, and improved outcomes that reduce system-wide pressures. The programme is designed to be affordable within the HDdUHB strategic priorities, with funding drawn from a mix of internal and external sources. Robust governance, phased implementation, and a strong focus on change management and digital inclusion are highlighted as essential to realising these benefits and mitigating risks such as resistance to change or digital exclusion.
Ansawdd / Gofal Claf: **Quality / Patient Care:**	The Patient Service Centre and 360° View initiative, as detailed in the HDdUHB business case, is expected to significantly enhance the quality of care and patient experience. By centralising patient contact and providing clinicians with a comprehensive, real-time view of patient information, the programme will streamline access, reduce delays, and ensure patients receive consistent and accurate information. This will lead to higher patient satisfaction, improved safety, and more coordinated care, while also empowering patients to manage their own health through self-service options. Additionally, the initiative will support more efficient and proactive care delivery by reducing administrative burdens, minimising missed appointments, and enabling staff to focus more on direct patient care. Standardised processes and integrated digital tools will help reduce errors and improve communication, ensuring equitable access and continuity of care for all patients, including those with limited digital skills.
Gweithlu: **Workforce:**	By centralising patient contact functions and introducing integrated digital tools, the programme will streamline administrative processes, reduce duplication, and enable staff to work more efficiently. This transformation is expected to free up staff time from manual and repetitive tasks, allowing them to focus more on direct patient care and higher-value activities. The initiative also supports improved staff experience by providing better access to information, clearer workflows, and opportunities for upskilling in digital competencies. Additionally, the programme emphasises change management and digital inclusion to ensure a smooth transition for all staff. Targeted training, early engagement, and support for digital skills development are central to the implementation plan, helping to build confidence and

	capability across the workforce. By reducing administrative burden and improving job satisfaction, the initiative aims to enhance staff recruitment and retention, while fostering a culture of continuous improvement and adaptability within HDdUHB.
Risg: **Risk:**	The Patient Service Centre and 360° View initiative presents risks including staff resistance to change, digital exclusion, integration challenges, and potential service disruption. The business case addresses these with strong mitigation plans—such as phased implementation, stakeholder engagement, and robust technical safeguards—to ensure risks are managed and service quality is maintained throughout delivery.
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	The Patient Service Centre and 360° View initiative is expected to enhance the reputation of HDdUHB by demonstrating a strong commitment to patient-centred care, digital innovation, and service quality. By improving patient access, satisfaction, and outcomes, while also addressing efficiency and equity, the programme positions the Health Board as a leader in modern healthcare delivery and strengthens public and stakeholder confidence.
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable. To follow, requested from AT.



Outline business case: Patient Service Centre and 360° View

Hywel Dda University Health Board

28 Nov 2025

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

CGI

Table of contents

1 Introduction

1.1 Purpose of this document

This document presents the Outline Business Case (OBC) for the proposed investment by Hywel Dda University Health Board (HDdUHB) in the Patient Service Centre and 360° View initiative. This document has been co-created by the Health Board along with CGI in the latter's capacity as the Health Board's Digital Partner.

This business case has been developed in line with the Welsh Government's Five Case Model and HM Treasury Green Book guidance, in order to set out a detailed justification for the preferred option. The document provides a robust basis for investment decision-making and formal approval to proceed to procurement and implementation.

The business case describes the rationale for the proposed investment, and confirms that the PSC and 360° View programme:

- Aligns with the Health Board's strategic objectives and with national NHS Wales digital priorities
- Demonstrates best public value and affordability
- Is deliverable within the governance, technical and workforce capabilities of HDdUHB.

The business case draws on the structured analysis undertaken through a series of workshops, with engagement across clinical, operational, digital and executive stakeholder groups. The OBC establishes the foundations for a Full Business Case (FBC) to progress to procurement and implementation.

1.2 Scope and structure

This Outline Business Case has been developed in accordance with the Five Case Model, the standard adopted by HM Treasury and the Welsh Government for business case development[1]. The model ensures that investment proposals are robust, evidence-based, and aligned with both organisational priorities and public value principles.

The document is structured around the Five Case Model as follows:

- **The Strategic Case** demonstrates the case for change and strategic fit with Hywel Dda University Health Board's objectives and relevant national, regional and local strategies
- **The Economic Case** presents a detailed analysis of the available options and confirms the preferred option offers optimal public value
- **The Commercial Case** outlines the proposed procurement strategy and demonstrates that the preferred option is viable and attractive to the market
- **The Financial Case** sets out the affordability of the proposal and the impact on Hywel Dda's financial position
- **The Management Case** describes the arrangements for successful delivery, including project governance, risk management, benefits realisation, and evaluation.

Together, these cases provide a comprehensive assessment to inform investment decision-making and approval.

[1] https://assets.publishing.service.gov.uk/media/66449468ae748c43d3793bb8/Project_Business_Case_2018.pdf

Case	Purpose	Key Contents
Strategic Case	Demonstrates alignment with policy and organisational priorities and explains why change is needed now.	Background, strategic context, investment objectives, existing arrangements, business needs, benefits and risks, constraints and dependencies.
Economic Case	Identifies the range of options, evaluates them against Critical Success Factors and Investment Objectives, and defines the Preferred Way Forward.	Long list, short list, benefits, risks, cost comparison, preferred option.
Commercial Case	Describes how the preferred solution will be procured and managed contractually.	Procurement strategy, risk allocation, service requirements, key contractual terms.
Financial Case	Sets out the anticipated capital and revenue costs, funding sources and affordability.	Cost assumptions, affordability tests.
Management Case	Defines programme governance, delivery plans and benefits realisation approach.	Implementation plan, risk management, change management, training and evaluation.

Table 1- Document structure

2 Executive Summary

Patient Service Centre and 360° View will simplify patients' access to Hywel Dda, while providing clinicians a complete view of the patient - improving efficiency and outcomes today, and establishing the foundations for regionally integrated care tomorrow.

2.1 Background

This Outline Business Case (OBC) has been developed to support a proposed investment in a Patient Service Centre and 360° View, and builds on the work completed during the earlier options analysis phase, where high-level requirements were assessed and a preferred way forward was identified through structured appraisal.

The initiative is driven by clear organisational and system-level imperatives:

- To improve patient access and experience through a single point of contact
- To enhance operational efficiency and reduce duplication
- To ensure clinicians have access to timely and holistic patient information
- To support regional and national digital transformation objectives, including interoperability and data sharing.

It aligns closely with the strategic ambitions set out by the Health Board in *"A Healthier Mid and West Wales"* [2] and the Digital Response Plan, reinforcing HDdUHB's ambition to become a fully digital health board delivering seamless, person-centred care.

2.2 Key findings

The key findings from the preparation of this business case are summarised as follows:

- **Strategic Fit**: The proposal demonstrates clear alignment with HDdUHB's transformation strategy and with national and regional priorities including the *'A Healthier Mid and West Wales'* strategy, the *Wellbeing Of Future Generations Act* and the *Digital and data strategy for health and social care in Wales*. The proposal supports these by enabling a consistent and integrated patient experience, potential for improved health outcomes, improved digital access to healthcare, a 'shift left' to prevention rather than reactive care, and better utilisation of workforce resources.
- **Benefits**: The investment is expected to deliver several key benefits across patient experience, operational efficiency, cost reduction and patient outcomes. Based on publicly available data relating to similar solutions in use at other health boards and trusts across the UK, some of the benefits realised have included:
    - A 30% increase in patient satisfaction scores
    - Call handling time reduction of ~57 seconds per call
    - A shift to patient self-service of ~30%
    - Productivity gains such as the ability to process 57% more referrals in a day
    - Reduction in hospital cancellations of >11% and patient cancellations of ~4%
    - Reduction in DNAs of >4%

[2] https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/

A detailed breakdown of the identified benefits, along with examples from other NHS organisations implementing similar solutions can be found in section 7.8 (Benefits Management).

- **Preferred Option**: Following detailed options evaluation across scope, capability, delivery and affordability dimensions, the recommended approach is to implement a platform-based solution which combines
    - A centralised Patient Services Centre providing telephony, multi-channel digital, and self-service access for patients and their proxies, covering external queries for all health board services other than primary care, and providing information and guidance, appointment selection and management, patient engagement, signposting, patient engagement, clinical triage, referral processing and waiting list management.
    - A 360° View enabling clinicians to access unified, real-time patient information drawn from HDdUHB and national systems, showing an integrated patient record, a history of patient interactions and communications, and enabling MDT collaboration and management of patient surveys and patient cohorts.
- **Costs and Value**: Indicative budgetary estimates across an assumed five-year period are in the range [redacted]. These will be finalised at Full Business Case (FBC) stage following a procurement exercise. A fuller explanation of the methodology applied to derive these estimates can be found within the Financial Case section.

This Outline Business Case seeks formal approval to proceed to procurement of the preferred solution.

2.3 Next steps

Formal review, endorsement, and approval of this outline business case will follow the appropriate governance process as follows:

- **Internal Assurance and Endorsement**
  Review by the Health Board's internal governance groups, including A Healthier Mid and West Wales programme board, the Hywel Dda Executive Team, the Digital, Data and Innovation Committee (DDIC) and the Full Board.
- **Stakeholder Sign-off**
  Endorsement by key delivery and funding stakeholders, including Senior Responsible Owner (SRO), clinical and digital leads, finance and planning teams, and where appropriate, regional and national partners
- **Submission to Welsh Government**
  Following internal approval, this OBC will be submitted to the Welsh Government for scrutiny and formal approval in line with NHS Wales investment governance arrangements.
- **Gateway Review / Readiness Assessment**
  A Gateway 3 (Investment Decision) review may be required prior to procurement.

These steps are essential to ensure that the investment is properly governed, deliverable, and aligned with organisational and national priorities.

3 Strategic Case

3.1 Background

Hywel Dda University Health Board (HDdUHB) is one of the largest Health Boards in Wales, with 4 acute hospitals and 5 community hospitals totalling approximately 1,200 beds. It serves around 385,000 people across Carmarthenshire, Ceredigion and Pembrokeshire – an area covering nearly a quarter of Wales. 15,000 staff provide a wide range of acute, community, mental health and learning disability services, supported by primary and community care.

Over the past few years, the Health Board has made strong progress with its digital transformation programme, supporting the vision set out in *A Healthier Mid and West Wales.* However, many patient-facing administrative processes are still fragmented and manual. Patients and staff must navigate multiple phone numbers, paper letters and local systems to book appointments, check referrals or get advice. This creates frustration, duplication and inefficiency, and limits our ability to provide a consistent experience and timely care.

The proposed **Patient Service Centre (PSC)** and **360° View** initiatives will tackle these challenges head on. By bringing together all patient contact functions into a single multi-channel hub and supporting staff with a complete, real-time view of each patient's journey, we can improve access, coordination and overall efficiency across the Health Board.

3.2 Strategic Context

The PSC programme has been driven by service pressures and inefficiencies and sits at the heart of the Health Board's Digital Strategic Plan (2025), which is part of the Board's 10-year vision for digital excellence. It aligns with the strategic ambitions set out by:

- **A Healthier Mid and West Wales** – the blueprint for modern health and care services that are safe, sustainable, accessible, kind and digitally enabled.
- **The NHS Wales Digital Transformation Strategy** – supporting national standards and platforms such as the NHS Wales App and *Patients Know Best (PKB).*
- **Welsh Government Digital and Data Strategy for Health and Care** – calling for a more connected, accessible and efficient system.

The PSC will directly contribute to our well-being objectives and planning priorities, creating connected, value-based care, reducing unwarranted variation and supporting staff well-being through simpler ways of working.

3.3 The Case for Change

3.3.1 Current challenges

Patients currently face a complex landscape with multiple contact points and varying processes by site and specialty. Current patient communication and booking processes are fragmented across multiple phone numbers, systems and teams. The Health Board outpatients Did Not Attend (DNA) rate stands at 6.9% – around 21,000 missed appointments a year – and short-notice cancellations remain high. Staff spend valuable time handling calls and paperwork instead of supporting clinical care, and health board data systems (WPAS, WCP, WLIMS, WNCR, RADIS) don't yet speak to each other.

3.3.2 Impact

For patients, this means delays, inconsistent information and lost confidence in the process. For staff, it creates workload pressure, duplication and limited visibility of demand. The result is reduced efficiency and a less equitable service across our region.

3.3.3 Why we must act

The PSC and 360° View will transform how patients interact with the Health Board – simplifying access, standardising service quality and providing clinicians and administrators with the information they need to work smarter and faster.

The diagram below shows an example Patient Journey for a patient called Rhys as he endeavours to get a diagnosis and treatment plan for his hip pains. The journey highlights some of the 'pain points' felt by patients as they try to obtain information and guidance about their appointment or more generally about how to best manage symptoms and improve their wellbeing. It shows how the PSC would help improve the situation for Rhys and help turn more of his journey from a poor Red or Amber experience to a better Green one.

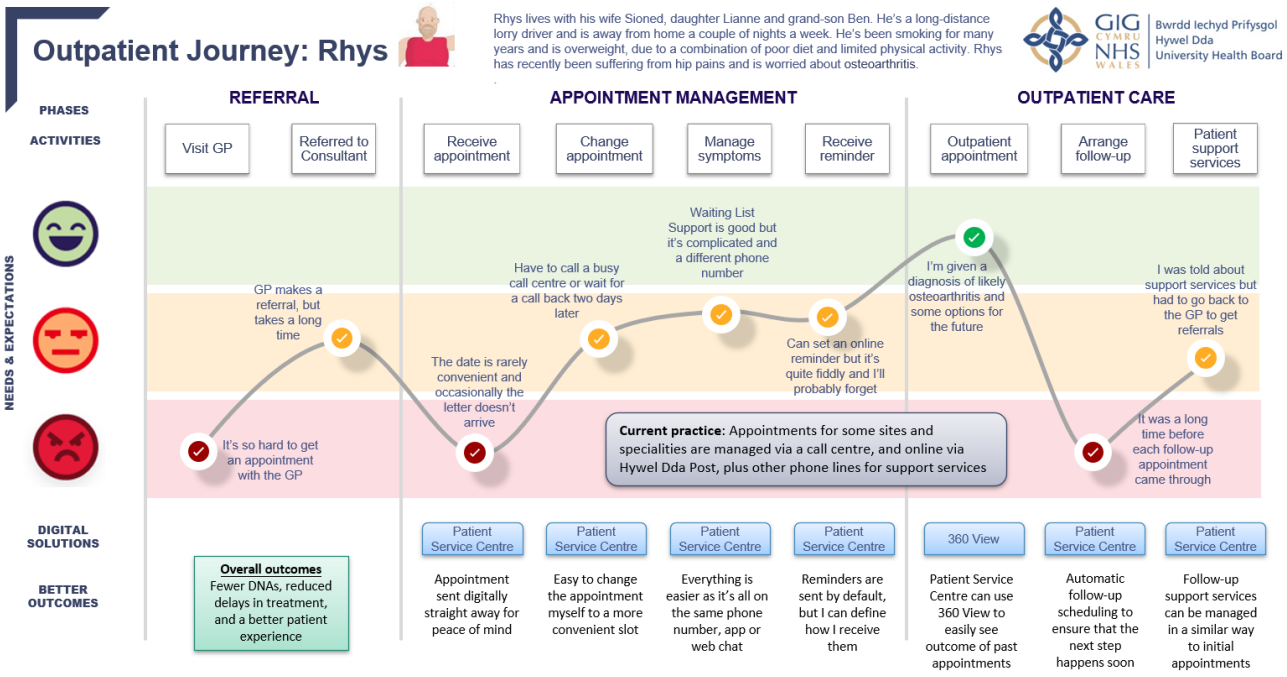


Figure 1 - Outpatient journey

3.3.4 Future Vision

With a PSC and 360° View in place, a future can be imagined where life is better for patients, clinicians and for the health board overall, as described by the vision statements below.

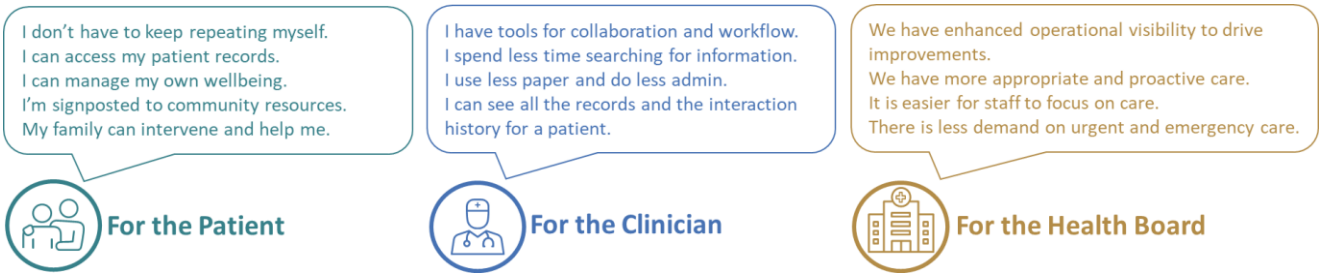


Figure 2 – Vision statements

3.4 Investment objectives

The Health Board has defined five investment objectives that together capture what this programme is seeking to achieve:

Investment Objectives	Goal	How	Measures
1. Improve Effectiveness	Optimise the quality of public services and delivery of agreed outcomes	Enable clinicians and staff to access clear, actionable patient information, supporting better decision-making and improved health outcomes	Improved clinical outcomes, reduced errors, higher patient and staff satisfaction, increased patient self-serve
2. Increase Efficiency	Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery	Streamline appointment management, referral coordination, and patient support through digital automation and centralisation.	Reduced call volumes, faster call resolution, increased staff productivity, lower administrative costs, reduced patient waiting times
3. Enhance Economy	Lower the cost and administrative burden of care through digital automation and increased patient self-service.	Reduce wasted resources from missed appointments, late cancellations, and inefficient processes.	Cost savings from reduced DNAs and cancellations, postage, and administrative effort; improved resource utilisation.
4. Ensure Compliance	Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility.	Implement robust information governance, data protection, and accessibility standards, including Welsh language compliance.	Compliance with NHS and Welsh Government standards, successful audits, no major IG incidents.
5. Support Future Improvement	Enable better data collection, analysis, and reporting to inform ongoing service development and innovation.	Provide a foundation for future digital initiatives (e.g., E-Forms, Virtual Wards) and support continuous improvement.	Enhanced analytics capability, ability to monitor and improve performance, readiness for future digital transformation.

Table 2 - Investment objectives

3.5 Existing arrangements

At present, Hywel Dda University Health Board operates a complex and highly decentralised network of patient-facing contact points. Each hospital, service and specialty manages its own arrangements for appointment booking, referral queries and general information, using a mixture of telephone, post, email and digital tools. The result is a system that has evolved organically rather than by design and which is confusing for patients, inefficient for staff, and difficult to govern consistently.

3.5.1 Telephone and Call-Handling

3.5.1.1 Main Outpatient Contact Centre (Llanelli):

- Handles booking amendments, cancellations and general enquiries for a proportion of outpatient services. Operating hours are typically 8 am–5 pm, Monday to Friday.
- Around 19 staff answer between 300 and 500 calls per day using Netcall's Liberty telephony integrated with the Welsh Patient Administration System (WPAS).
- Coverage does not extend to all specialties, and callers are frequently redirected to local secretaries or other sites.

3.5.1.2 Hospital Switchboards (Glangwili, Bronglais, Prince Philip and Withybush):

- Each site maintains its own switchboard, handling all incoming traffic for wards, clinics and administrative offices.
- These act as general gateways for patients and professionals but are not able to resolve booking queries directly.
- Transfer between sites or departments is common, and performance data are not routinely consolidated.

3.5.1.3 Local Specialty Offices and Secretarial Lines:

- Many outpatient, surgical and diagnostic services continue to manage their own diaries and telephone numbers.
- Clinic secretaries field calls relating to specific consultants or specialties, often using voicemail or manual log sheets.
- The reliance on individual staff knowledge creates single points of failure and little resilience during absence or turnover.

3.5.1.4 Community and Mental Health Services:

- Operate separate call lines managed through local hubs.
- Examples include the Community Nursing Team Hub, mental-health triage numbers, and the Single Point of Contact for learning-disability services.
- These functions are not integrated with hospital scheduling systems or shared telephony.
- NHS 111 Press 2 provides a local 24/7 mental health helpline and receives between 70 and 100 calls per day although around a third of the calls go unanswered. Around 60% of calls relate to wellness and signposting, whereas 5% are crisis calls which are transferred straight away to more suitable services.

3.5.2 Written and Digital Correspondence

3.5.2.1 Traditional Mail:

- Paper letters remain the default for appointment offers, reminders and test results across many services.
- Volumes exceed 1.8 million items annually, incurring high postage and printing costs and delays in communication.

3.5.2.2 Hywel Dda Post (Digital Letter Service):

- Introduced to allow patients to receive letters electronically through a secure web link.
- Adoption varies between 20–40% depending on specialty.
- If a digital letter is not accessed within 72 hours, an automatic paper copy is posted.
- While this reduces some cost, the system is standalone and not integrated with call-handling or reminder processes.

3.5.2.3 Email and Ad-hoc Messaging:

- Many services use generic inboxes or individual staff emails for patient communication.
- These are difficult to monitor and present information-governance risks due to inconsistent processes for verification and record-keeping.

3.5.3 Self-Service and Online Tools

3.5.3.1 Patients Know Best (PKB):

- Available for some services to share clinical correspondence and test results.
- Patient uptake is limited, data is managed by patients rather than integrated with health board systems, and functionality is not uniformly embedded in operational workflows.

3.5.3.2 NHS Wales App:

- Currently offers limited local functionality for Hywel Dda patients beyond national information and COVID-19 services.
- Appointment booking through the app is not yet enabled for the Health Board.

3.5.3.3 Hospital Websites and Forms:

- Provide information about services and contact numbers but do not support transactional services such as booking or re-scheduling appointments.

3.5.4 In-Person and Community Access

- Patients can also make contact by visiting hospital receptions, ward desks or community clinics directly.
- Reception staff answer general enquiries, print letters and assist with way-finding but have no access to real-time appointment systems or patient information.
- Community-based clinics, including therapy and diagnostic centres, maintain their own local booking lists and reception points.

3.5.5 Observations and Implications

- There are more than 200 active contact numbers for patient services across the Health Board, many of which are unpublished or change periodically.
- No single directory or routing logic exists, and patients often experience long hold times or multiple transfers before reaching the correct department.
- Call-handling performance data are fragmented; there is no consolidated view of call volumes, unanswered calls or patient satisfaction.
- Processes for appointment confirmation, reminder and cancellation vary widely, leading to missed appointments and inconsistent follow-up.
- The lack of unified systems prevents staff from sharing workload or providing cross-cover between sites.
- There is limited ability to report on demand, call reasons or trends, making service planning reactive rather than proactive.
- In summary, patients currently interact with HDdUHB through a patchwork of phone lines, paper letters, emails, web pages and in-person visits, none of which provide a single, coherent or predictable experience. For staff, the absence of a central system results in duplicated effort, manual reconciliation and missed opportunities for efficiency. These shortcomings provide a compelling rationale for creating a centralised Patient Service Centre, integrating multi-channel access with a single source of accurate, real-time information.

3.5.6 Conceptual summary

A conceptual summary of the existing arrangements is shown below, providing details of the patient and GP facing services that are currently available and the systems that are used by health board staff to respond to enquiries.

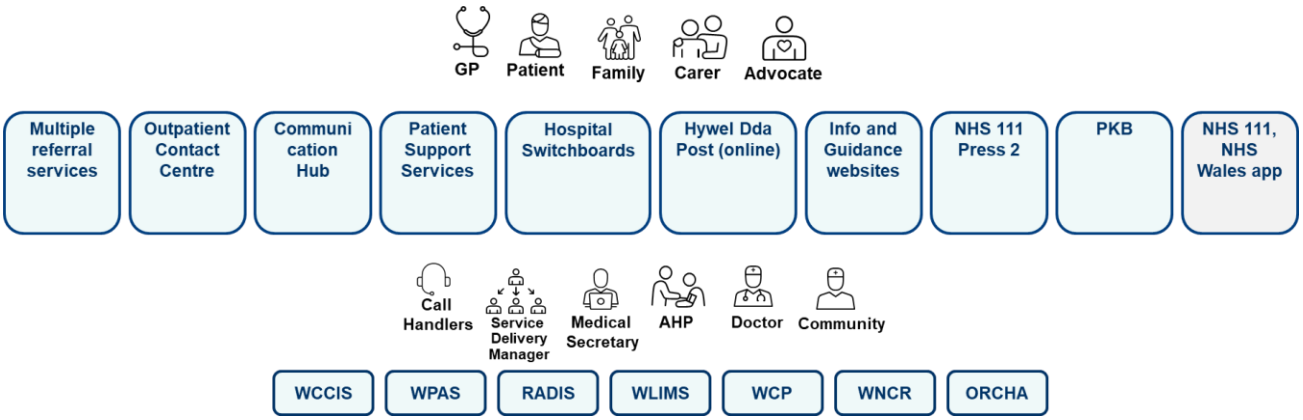


Figure 3 – Existing arrangements

3.6 Business needs (current and future)

Having understood both the investment objectives and the existing arrangements, we can think in a little more detail about the business needs for the Health Board as they pertain to each of the investment objectives.

Those needs can be summarised as follows:

- **Current Needs:** A unified, resilient and scalable mechanism with multi-channel access (phone, web, chat, app) for managing patient interactions, providing accurate information, improving coordination between clinical and administrative teams, and providing data insights for planning and continuous improvement.
- **Future Needs:** The capability to integrate with health and care organisations beyond the Health Board, delivering a single digital front door for patients, supporting regional and national digital initiatives, and providing a platform for clinical staff to manage patient care more easily across the Health Board.

The PSC and 360° View will address these needs by offering an integrated communications and information platform that supports the full lifecycle of patient interactions—from referral to discharge and follow-up.

Each of the investment objectives can be viewed as a statement about the desired future state of the health board, and a gap analysis between the existing arrangements and the desired future state can provide the business needs or capabilities that must form part of the PSC and 360° View.

The analysis has been performed using a Capability Model of Regional Health and Care developed by CGI alongside HDUHB which show the digital capabilities that are required to provide everything that is needed by a fully digital Health Board.

Capabilities fall into high-level groups, four of which are shown below and used to derive the business needs in each of the following tables.

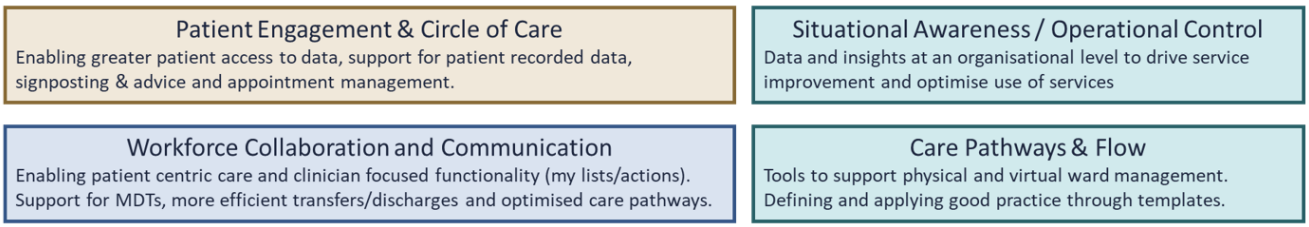


Figure 4 – Regional Health and Care capability model

Note that more details and the full capability model can be found in Appendix C.

Effectiveness: **Optimising safe care**

Description	The PSC will optimise the quality of public services and the delivery of patient outcomes, especially those relating to non-acute care.
Existing Arrangements	Record split across systems Disjointed visibility Limited / no clinical coding Same data recorded in more than one system Limited cross-referencing of patient data Significant use of paper and scanned records Limited alerting and notification Limited visibility of pathway information Limited understanding of latest Health Board interactions
Business Need (Split by capability groups)	**Citizen** • Patient surveys • Signposting and advice • Alerts and notifications **Awareness** • Patient tracking and dashboards **Workforce** • Single View of a Person • Collaboration across teams • Alerts and notifications **Flow** • Patient pathway tracking

***Efficiency:* Simplifying pathways**	
Description	The PSC will simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery
Existing Arrangements	Disjointed services and patient interactions Insufficient waiting list management Difficult for patients to manage appointments Inability for patients to self-select and manage appointments Disparate channels for GP referrals Limited alerting, reminders and notification Limited visibility of pathway information Insufficient patient self-management
Business Need (Split by capability groups)	**Citizen** • Appointment management • Dynamic appointment scheduling • Alerts, reminders and notifications • Access for circle of care and advocates **Awareness** • Patient tracking and dashboards **Workforce** • Single View of a Person • Collaboration across teams • Referral management • Triage and prioritise referrals • Triage for urgent and emergency care • Alerts and notifications **Flow** • Patient pathway tracking • Signposting and social prescribing

***Economy:* Lowering cost of care**	
Description	The PSC will lower the cost and administrative burden of care through digital automation and increased patient self-service.
Existing Arrangements	Missed appointments (DNAs) Cancelled appointments and operations Unnecessary postage Patient waiting times are too high Excessive administrative effort Wasted process steps Non-value patient outcomes Clinicians need more time for patient care

Business Need (Split by capability groups)	**Citizen** • Appointment management • Dynamic appointment scheduling • Alerts, reminders and notifications • Multi-channel engagement **Awareness** • Patient tracking and dashboards	**Workforce** • Single View of a Person • Actionable insight and decision support • Triage and prioritise referrals • Alerts and notifications • Video and Chat guidance and consultation **Flow** • Patient pathway tracking

***Improvement:* Ongoing service development**		
Description	The PSC will enable better data collection, analysis, and reporting to inform ongoing service development, improvement and innovation	
Existing Arrangements	Minimal ability to monitor patient engagement, bottlenecks, process metrics, patient outcomes	Minimal ability to view public health data and information and use that to drive future campaigns
Business Need (Split by capability groups)	**Awareness** • Patient tracking and dashboards • Advanced analytics and visualisation	**Flow** • Patient pathway tracking • Public health cohorting

Table 3 – Investment objectives and capabilities

3.7 Potential scope and service requirements

In order to identify and evaluate potential options that would meet the business needs, a number of assessment dimensions have been considered, including the scope (users, functions and integrations), service requirements (capabilities), service delivery (technical solutions), and service implementation approaches.

3.7.1 Scope and user access

Based on the investment objectives and business needs, and in workshops with the key stakeholder group, the following areas of scope, covering user access and data and system integrations, have been identified. Each item has been marked as one of:

- Core (essential changes without which the project will not be judged a success),
- Desirable (additional changes which the project can potentially justify on a cost/benefit basis),
- Optional (possible changes which the project can potentially justify on a marginal low cost basis) or
- Out of scope (changes which would not be included within the project).

Description	Priority
Establishment of a centralised multi-channel Patient Service Centre accessible via telephone, web, app, email, chat, post, SMS and in-person.	Core
Access via AI chatbot and video	Desirable
Access via email and social media	Optional

Description	Priority
Covering Health Board functions including outpatients, diagnostics, therapy, mental health, urgent and emergency, community nursing, intermediate care, primary care engagement, inpatient support calls	Core
Include GPs and ambulance	Desirable
Include third sector, social care and other external on non-HDUHB services	Optional
Include use of 360° View for managing acute services and inpatients	Out of scope
Include use of PSC for managing Primary Care patient calls	Out of scope
Integration with key Health Board systems including WPAS, WCP, WCRS, WRRS, SMR	Core
Integration with WNCR, WCCIS, RADIS, WLIMS, Malinko (for district nursing), ORCHA, Patients Know Best, NHS Wales App	Desirable
Integration with Eclipse, EIDO, R4 (for community dental)	Optional

Table 4 – Potential scope

3.7.2 Key service requirements

Workshops were held with key stakeholders to discuss and determine what the key requirements and capabilities should be for the PSC and 360° View, and which of them should be classed as Core, Desirable or Optional.

Description	Priority
Single point of contact for patients.	Core
Integrated view of patient records	Core
Appointment booking, rebooking, and cancellation management.	Core
PIFU / SOS triggered appointments	Desirable
Full dynamic patient-driven appointment scheduling	Optional
Dynamic patient-driven appointment scheduling for some services e.g. physio, therapies, community nursing, bloods	Core
Waiting list management	Core
Referral coordination and tracking across services.	Core
Self-referral for some services	Desirable
Information and guidance for patients and carers.	Core
Signposting and social prescribing	Core
Collection of patient feedback and complaint handling.	Core
Reporting and analytics dashboards for demand and capacity.	Core
Triage for emergency & urgent care	Desirable
Follow-Up Care	Desirable
Health education	Core
Crisis management	Core

Table 5 – Key service requirements

3.8 Main benefits and risks

3.8.1 Benefits

Benefits represent the gains made by patients, citizens, clinicians, staff and by the health board overall as a result of outcomes that are enabled by project outputs. For example, the 360° View would provide clinicians with the information that they need in a single place and thereby reduce the time that they spend on finding patient information.

The main benefits to be realised as a result of the PSC and 360° View were discussed by the key stakeholder group and are listed below, and classed as one of:

- Cash releasing: results in cost reductions for the health board
- Non-cash releasing: results in important measurable gains that are not directly cash releasing
- Qualitative: results in important gains that not easily measurable

Benefit ID	Benefit	Beneficiary	Benefit Class
PSC-B001	Reduction in administrative time in managing patient queries as more, and more accurate, information is available to call handlers	Patients, Staff, Health Board	Cash releasing
PSC-B002	Reduction in appointment Did Not Attend (DNA) rates as patients have more control of their appointment timings	Staff, Health Board	Non-cash releasing
PSC-B003	Reduction in call volumes as patients are better able to manage their wellbeing and their pathways	Health Board	Cash releasing
PSC-B004	Reduced cancellations/unused slots as patients prehabilitation is easier to manage and improve	Patients, Staff, Health Board	Non-cash releasing
PSC-B005	Ensuring right place first time for patients as more, and more accurate, information is available to call handlers and patients	Patients	Non-cash releasing
PSC-B006	Increased ability for patients to self-serve via patient engagement features	Patients	Qualitative
PSC-B007	Increase in patient satisfaction as better information is available, less time is wasted, waiting times are lower and more time is spent on care	Patients	Non-cash releasing
PSC-B008	Increased time for patient care as less time is spent on admin tasks and on finding patient information	Patients, Staff	Non-cash releasing
PSC-B009	Improvement in staff recruitment and retention as the experience of working at HDUHB is improved	Staff, Health Board	Cash releasing
PSC-B010	Reduction in associated costs with administrative processes as less time is spent on managing patient queries	Health Board	Cash releasing
PSC-B011	Reduced postage costs as fewer letters are sent to patients and GPs	Health Board	Cash releasing

Benefit ID	Benefit	Beneficiary	Benefit Class
PSC-B012	Reduction in appointment volumes via changed clinical processes e.g. SOS, PIFU	Staff, Health Board	Non-cash releasing
PSC-B013	Reduction of carbon impact as fewer face-to-face appointments are needed	Planet	Non-cash releasing
PSC-B014	Reduction in volume of complaints and litigation as patient satisfaction improves	Health Board	Cash releasing
PSC-B015	Reduction in hospital admissions and A&E attendance as patient are better able to manage their wellbeing and find alternate options, and as patient wellbeing improves	Patients, Staff, Health Board	Non-cash releasing
PSC-B016	Improved clinical outcomes as patient prehabilitation and rehabilitation improves and better decisions are made about patient pathways	Patients, Health Board	Non-cash releasing
PSC-B017	Improved citizen wellbeing as people are empowered to manage their own wellbeing and engage in activities that prevent ill health	Patients	Qualitative
PSC-B018	Reduction in patient waiting times as fewer appointments are cancelled and there are fewer DNAs	Patients, Health Board	Non-cash releasing

Table 6 – Benefits summary

Further detail on the identified benefits and proposed measurements for benefits realisation purposes can be found in section 7.8 (Benefits Management).

Based on publicly available data relating to similar solutions in use at other health boards and trusts across the UK, some of the benefits realised have included:

- A 30% increase in patient satisfaction scores
- Call handling time reduction of ~57 seconds per call
- A shift to patient self-service of ~30%
- Productivity gains such as the ability to process 57% more referrals in a day
- Reduction in hospital cancellations of >11% and patient cancellations of ~4%
- Reduction in DNAs of >4%

The source of these statistics and their relevance to specific benefits identified above can be found in section 7.8 (Benefits Management).

3.8.2 Risks

As with benefits, the key risks to be aware of and their mitigations were discussed by the key stakeholder group and are listed below, and classed as one of:

- **Business risks:** These risks remain with the organisation (100%), cannot be transferred by the organisation and include political and reputational risks.
- **Service risks:** These associated risks fall within the design, build, financing and operational phases of the project and may be shared with the others from outside of the organisation.

- **External risks:** These non-systemic risks affect all society and are not connected directly with the proposal. They are inherently unpredictable and random in nature. They include technological disruption, legislation, general inflation and catastrophic risks.

Description	Mitigation	Category
Resistance to change from clinical and admin teams	Engage stakeholders early, provide clear communication and business change support, co-design processes, deliver comprehensive training	Business
Misalignment of expectations and realised benefits	Ensure rigorous benefit analysis is applied as part of constructing the business case	Business
Bottlenecks from an overwhelmed PSC could lead to delays in response times or missed patient needs.	Establish clear guidelines for the scope of patient enquiries, and ensure that feedback and continual improvement is in place for call handler decision trees	Business
Overlap with other digital initiatives (national or local) could result in duplication or rejection by health board.	Ensure that key stakeholders feed into business case to assess the likelihood of strategic overlap	Business
Information governance or privacy incidents	Develop clear IG framework, Data Protection Impact Assessments (DPIAs), role-based access controls, regular audits	Business
GPs not wishing to work closely with the PSC programme	Early engagement with GP stakeholders to establish outcomes of benefit to GPs and the health board	External
Cybersecurity and privacy breaches as a result of wider data sharing	Apply NHS DSPT & Cyber Essentials standards, regular penetration testing, continuous monitoring, staff cyber awareness training	External
Single point of failure if telephony or platform fails leading to outages	Build resilience into design (cloud-based, failover, redundant lines), test DR/BCP regularly	Service
Poor usability leading to low clinical or citizen adoption	Involve clinicians in design/testing, conduct usability testing, iterative improvements, ongoing training & support	Service
Diversion of finances and resources from other critical areas.	Active involvement of senior health board stakeholders to ensure that finance and resources are focussed on highest priorities	Service
Poor integration of data leading to staff and patient frustration	Use proven integration standards (HL7/FHIR), conduct rigorous testing, phased rollout with feedback loops	Service
Digital exclusion leading to patients struggling to access services or engage with their care	Ensure that suitable channels are retained to provide for those that are unable or unwilling to access digital channels	Service
Clinical risk from incomplete or conflicting data in the unified view	Apply data quality checks, flag conflicts, clinical validation before go-live, ongoing monitoring	Service

Table 7 – Risks identified

3.9 Constraints and dependencies

3.9.1 Constraints

Constraints are the external conditions and agreed parameters within which the programme must be delivered, over which the project has little or no control. These can include policy decisions, ethical and legal considerations, rules and regulations, and timescales within which the project must be delivered. Affordability constraints may include agreed limits on capital and revenue spend.

- Telephony, new solutions and integration with current systems needs to be managed effectively and at pace.
- A central team needs to be staffed and trained with specialty skills and knowledge.
- Peaks and troughs in demand over a 24/7 time period need to be managed in terms of staff rostering and operational procedures.
- Welsh language needs to be provided along with accessibility compliance for all staff and public facing aspects of the service.
- Data quality, provenance and timeliness need to be considered and addressed across all data sources.
- Appropriate governance needs to be put in place to ensure effective and empowered decision making.
- Patient data records need to be managed according to GDPR regulations, with minimal role-based access, and with patient consent where appropriate.
- Legacy paper and scanned records need to be considered given the potential impact to affect the completeness of PSC and 360° View data.

3.9.2 Dependencies

The following have been identified as dependencies outside the scope of the project but upon which the ultimate success of the Patient Services Centre and 360° View is dependent:

- The ability of existing HDdUHB systems (e.g. WCP, WNCR) to be interoperable with the new solution.
- The adoption of consistent processes across departments given the likely business change and need to ensure that processes are consistent.
- The design and implementation of improvements to processes and patient pathways and the corresponding significant clinical change.
- The ability of services and call handlers to provide suitable verbal and written knowledge and information to drive patient self-management.
- HDUHB being a suitable curator and communicator for patient knowledge and guidance.
- The ability and willingness of services outside of HDdUHB direct control (e.g. GPs and social care) to integrate systems, processes and services with the new solution.

4 Economic Case

The Economic Case identifies the range of options that could be considered, evaluates them against the Investment Objectives and a set of Critical Success Factors, and defines the Preferred Way Forward.

4.1 Critical Success Factors

Critical Success Factors (CSFs) are the attributes essential for successful delivery of the project, and are used to appraise the options for the delivery of the project, alongside the investment objectives. The following CSFs have been identified:

CSF	Description
Strategic fit	The option must fit with other HDdUHB strategies + projects
Business need	The option must deliver the agreed Investment Objectives
Benefits optimisation (impact)	The options must enable the realisation of the benefits that have been agreed
Potential value for money	The option must optimise public value (social, economic, and environmental)
Supplier-side capacity	The option must be deliverable by vendors in the market
Supplier-side capability	The option delivers the identified and required capabilities
Potential affordability (cost)	The option can be funded from available sources and must be affordable in line with health board budgets, taking into account the Total Cost of Ownership
Potential achievability (delivery)	The option can be delivered by HDdUHB and can be done so in the required timescale
Potential achievability (risk)	The option is evaluated to be within the risk appetite of the health board

Table 8 – Critical Success Factors

4.2 Long-listed options

A range of options were considered by the key stakeholder group within the following dimensions:

- **Scope:** Defines which functions and user groups the solution must cover
- **Service Solution:** Compares capabilities that the solution will deliver
- **Service Delivery:** Considers whether the business needs are best delivered by a bespoke solution build, or by procuring a Commercial-Off-The-Shelf (COTS) solution
- **Implementation:** Looks at preferred rollout approach: pilot in one department, phased by site, or “big-bang” go-live

Within each dimension, the identified options were assessed by against the Critical Success Factors and Investment Objectives for the initiative.

The outcome of this exercise is summarised in the following sections.

4.2.1 Scope options

The following options were considered for the scope of health board functions and user groups that would access the PSC and 360° View, and weighed against the investment objectives and critical success factors to reach a decision on whether to discount the option (marked as D), carry forward the option to the shortlisting

exercise (marked as C/F) or to mark the option as the preferred way forward for this dimension (marked as PWF).

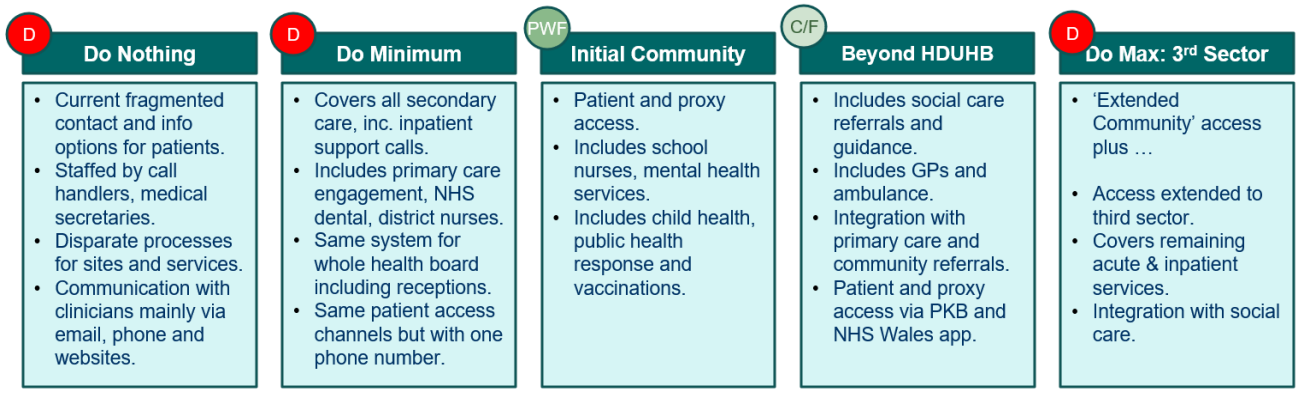


Figure 5 – Long-list Scope options

A representation of health board services and whether they were considered to be in and out of scope is shown in Figure 6, which also shows the relationship between the Patient Services Centre and the 360° View. In particular it shows that whilst the 360° View would initially support the PSC, it should have the capability to be extended as part of a future roadmap to also support inpatient services.

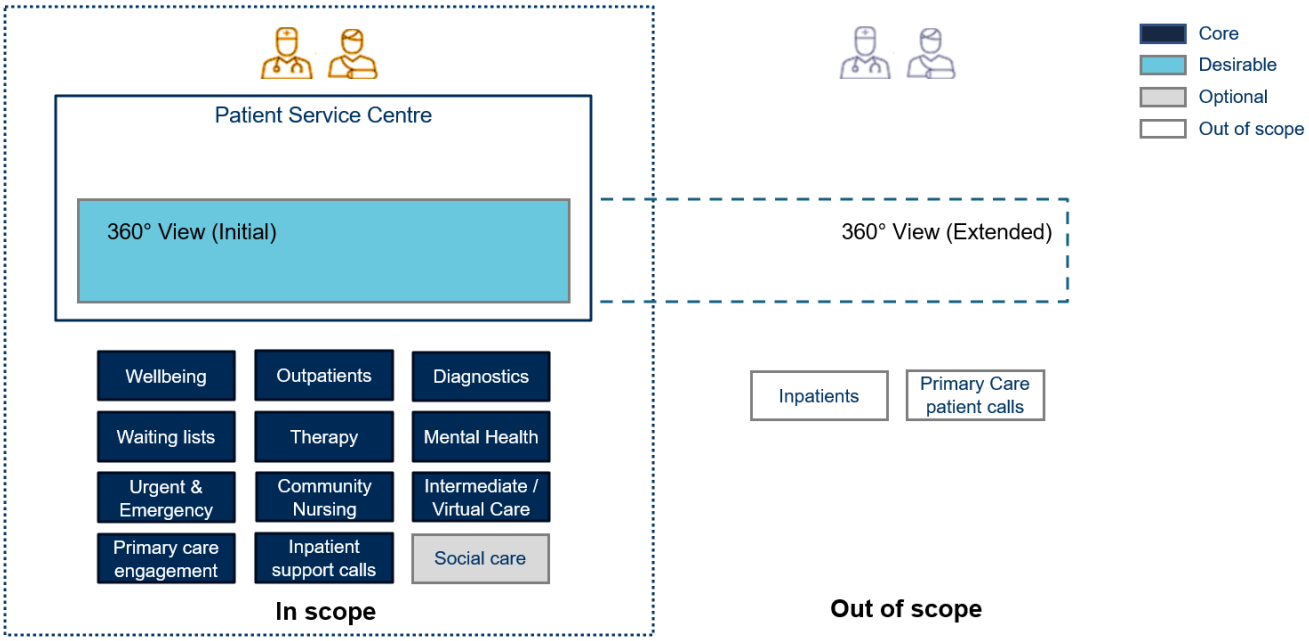


Figure 6 – Scope of health board service

4.2.1.1 Do Nothing

Do Nothing represents the existing arrangement whereby patients experience a fragmented set of contact services and where call handlers are unable to see a full set of information about the patient.

4.2.1.2 Do Minimum

Do Minimum is the set of health board functions and users that would represent the smallest possible set that would still constitute a Patient Services Centre. This includes all secondary care services, including the facility to manage support calls for inpatients. It would also include calls that are used to manage engagement with and questions about primary care services, although not direct patient calls and questions for primary care practitioners. Do Minimum would also include NHS dental and district nursing services. This would provide a single system for the whole Health Board with one phone number but would retain the current access channels.

Do Minimum would include only the Core items in Figure 6 and, as such, it was felt that the Do Minimum option would not be ambitious enough for the health board and was discounted.

4.2.1.3 Initial Community

The Initial Community option adds school nursing and mental health services (including the NHS 111 Press 2 helpline) and provides access for proxy access e.g. for a patient's family, advocate or wider circle of care. Child health, public health response and vaccinations are also included.

This option effectively extends the solution to cover all health board services, was deemed to meet the health board investment objectives and was the agreed Preferred Way Forward.

4.2.1.4 Beyond HdUHB

The Beyond HdUHB option extends the Patient Services Centre to include services outside of the health board direct control such as social care referrals and guidance, patient information relating to GPs and ambulance services, integration with primary care and community referrals, and system integration with Patient Knows Best and the NHS Wales app.

This option would meet the investment objectives in a more significant way but would be more ambitious and carry more delivery risk that the Initial Community option and so was Carried Forward to the shortlist stage rather than being marked as the Preferred Way Forward.

4.2.1.5 Do Maximum

Do Maximum represents the extent of the possibilities that could be achieved with the Patient Services Centre. It incorporates the third sector and full inpatient and acute services, along with full integration with social care.

This option was deemed to be an ambition that the Patient Services Centre project should have in mind but should not seek to achieve initially. The PSC should be built with flexibility and extensibility in mind so that the Do Maximum option could still be achieved in the future.

4.2.2 Service solution options

The Service Solution options relate to the capabilities that should be provided by a PSC and 360° View. In a similar way, the options described below were considered, weighed against the investment objectives and critical success factors and a decision was reached on whether to discount the option, carry it forward or mark the option as the preferred way forward.

The capabilities that were assessed were mentioned in Section 3.6 and are drawn from the Regional Health & Care Capability Model co-developed by CGI and HDdUHB.

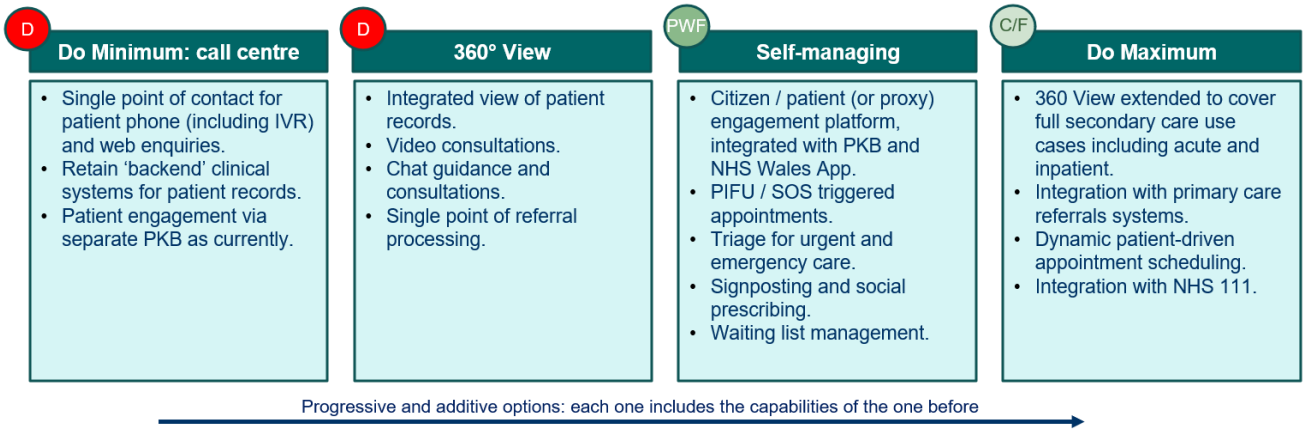


Figure 7 – Long-list Service Solution options

Note that each of the options listed below includes all of the capabilities of the preceding options.

4.2.2.1 Do Minimum: call centre

In the context of capabilities, the Do Minimum option is to implement a single call centre for the health board with no additional systems integration or patient engagement features.

This was discounted as not meeting the health board's ambition or investment objectives.

4.2.2.2 360° View

The 360° View would provide an integrated view of patient records and health board interactions for call handlers and supporting clinical staff, and would incorporate a broader range of channels for patient interactions to obtain information and guidance, including video consultations and advice. It would also allow a single point for referral and care pathway management and tracking.

The 360° View would also provide some improvement in overall operational awareness and control for the health board along with tools for continual improvement.

However, as the additional features for patient engagement are minimal, this option was also discounted as not meeting the health board investment objectives.

Note also that uncertainty remains around how much functionality and use would be retained of health board systems such as WCP and WNCR and how much duplication there would be of 360° View capabilities.

4.2.2.3 Self-managing Citizens

The Self-managing Citizens option provides a rich platform for citizen and patient engagement with the health board built on top of the 360° View and call centre from the earlier options.

This option enables citizens to manage their wellbeing using information and guidance, signposting and social prescribing provided via whichever channels suit them best, including AI -driven chatbots, Patient Knows Best and NHS Wales apps, websites, calls (including IVR) and video, but retaining Relay UK, post and in-person receptions to ensure that citizens do not feel excluded by the digital options available.

Patients would be able to view more of their patient records and manage their appointments, including the ability to trigger PIFU (patient-initiated follow-up) and SOS (see on symptom) appointments and, for some services such as therapies, community and bloods, to select appointment slots directly.

AI-assisted triage for urgent and emergency care would direct patients more effectively to the right services for their situation and free-up capacity in ED and GP services.

Proactive waiting list management would improve the accuracy of waiting lists and make it more likely that patients appear for the right appointments and in the right state of health.

This option aligns strongly with the health board investment objectives and was selected as the Preferred Way Forward.

4.2.2.4 Do Maximum

Do Maximum extends the 360° View to cover the full set of secondary care functions and use cases including acute and inpatient services, and integrates with GP referral systems and with NHS 111 and WAST ambulance systems.

It also extends patient appointment booking to all services.

It was deemed to be an ambition that the health board should be striving for in the future but beyond the scope of this business case and hence was discounted.

4.2.3 Service delivery options

Service Delivery options considered the technical solutions that could be used to deliver a PSC and 360° View. The following options were considered, weighed against investment objectives and critical success factors and a decision was made on whether to discount the option, carry it forward or mark it as the preferred way forward.

The technical options were split into 3 options that would predominantly be bought and configured and 2 options that represent a greater degree of configuration and implementation.

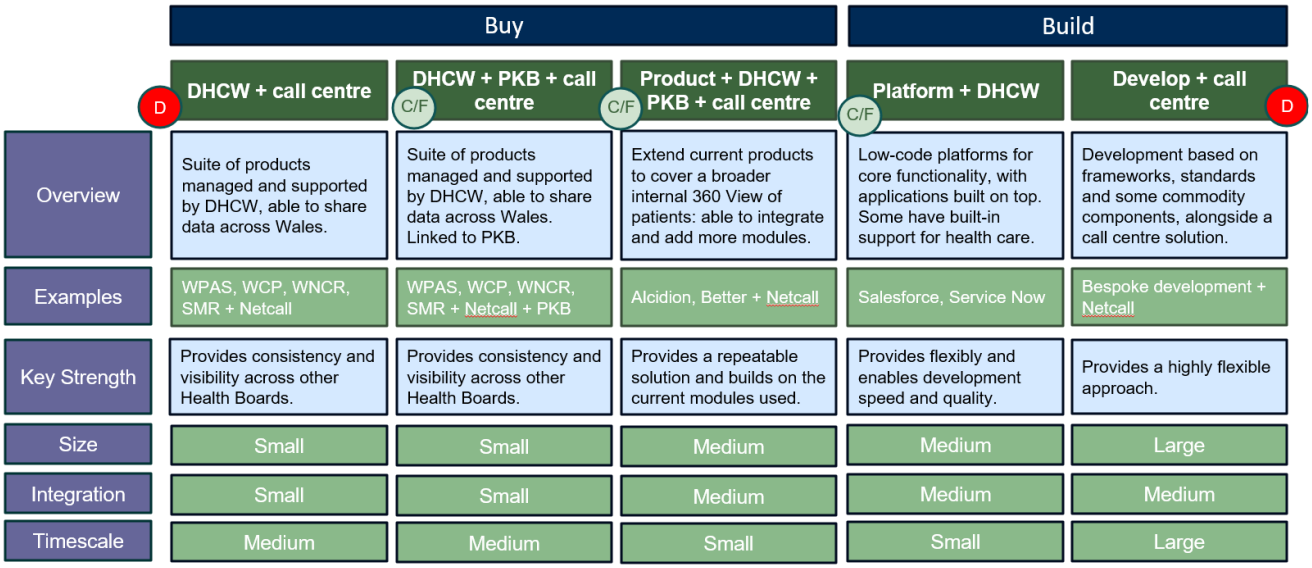


Figure 8 – Long-list Service Delivery options

4.2.3.1 DHCW + call centre

The first option would be to use the current suite of services provided by DHCW to provide the data required by the PSC in a similar manner to existing arrangements, but with a greater level of data integration provided by an expanded Integration Layer. This data would feed into a single call centre solution.

Given that this provides minimal patient engagement and a sub-optimal view of patient records it was deemed to be discounted.

4.2.3.2 DHCW + PKB + call centre

The second option would be to use the current suite of services provided by DHCW to provide the data required by the PSC in a similar manner to existing arrangements, but with a greater level of data integration provided by an expanded Integration Layer including additional integration with Patients Known Best. Patient record data would feed into a single call centre solution.

This option was carried forward on the basis that it provides sufficient patient engagement capabilities with the caveat that the call centre solution would need to provide sufficient capabilities for viewing patient data.

4.2.3.3 Product + DHCW + PKB + call centre

The third option would be to use the current suite of services provided by DHCW to provide the data required by the PSC but to integrate that information via the Integration Layer and surface it in an internal 360° View provided for by a product such as those already being rolled-out by the health board but extended to incorporate additional capabilities. This option would include a separate but fully integrated call centre.

This option was carried forward on the basis that it provides sufficient patient engagement capabilities and contains a full 360° View capability provided by an extended product.

4.2.3.4 Platform + DHCW

The fourth option would be to use the current suite of services provided by DHCW to provide the data required by the PSC but to integrate that information via the Integration Layer and surface it in a new configurable platform to create an internal 360° View. The platform would also incorporate call centre and patient engagement capabilities. Low-code platforms can contain core health and care object models and functionality that can be swiftly configured to provide the health board requirements.

This option was carried forward on the basis that it provides sufficient patient engagement capabilities and contains a full 360° View and call centre capability provided by a new configured platform.

4.2.3.5 Develop + call centre

The final option would be to use the current suite of services provided by DHCW to provide the data required by the PSC but to integrate that information via the Integration Layer and surface it in a new solution developed from scratch to provide the capabilities for a 360° View and for patient engagement.

This option was discounted on the basis that it would be significantly more time consuming and riskier than other options and that the better design pattern is to use best-of-breed solutions provided by the market.

4.2.4 Implementation options

The final dimension of Implementation options considered delivering the PSC and 360° View all at once, using a small patient cohort as a pilot before a swift roll-out, and a phased approach.

Both the pilot and the phased approach were deemed to worthy of carrying forward to shortlisting.

4.2.5 Long list summary

The options considered as part of the long list appraisal can be seen below.

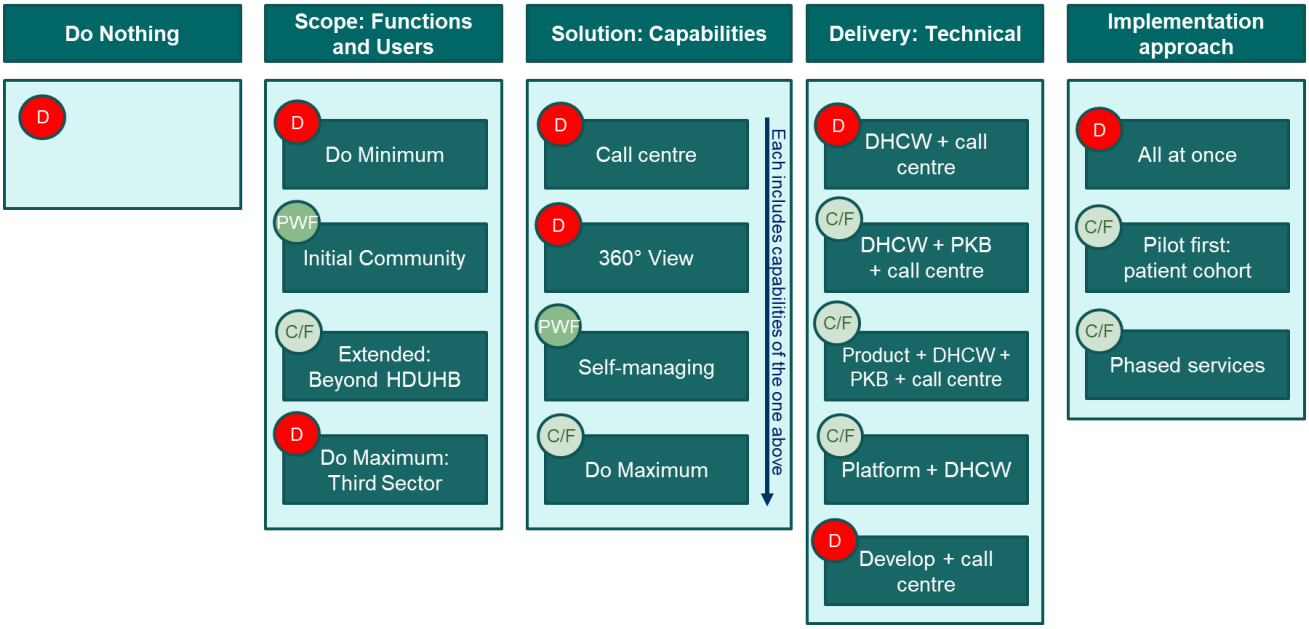


Figure 9 – Long-list options summary

4.3 Shortlisted options

The results of the long list options carried forward from the above evaluation were combined into viable solution options to be carried forward for further consideration. This resulted in the following short-list of options:

- **Option 0: Do Nothing (Business as Usual)**

This option is included for completeness, and to provide a baseline against which to compare other options.

- **Option 1: Do Minimum**

  The Do Minimum option creates a new single call centre which combines with the Patients Knows Best app for patient engagement. An initial 360° View is provided by augmenting the call centre solution with integrations to current DHCW systems.

- **Option 2: Less Ambitious Way Forward**

  The Less Ambitious Way Forward creates a single call centre for the health board along with a full 360° View and self-manging patient engagement portal by expanding the products used by the health board, extending integration with current DHCW systems and providing full integration with Patients Know Best.

  This option reaches all of the Initial Community scope described above touching on all health board services that relate to patients and citizens, although not extending the 360° View to cover inpatient services or services beyond the health board.

  The solution would be phased in over an extended period of time.

- **Option 3: Preferred Way Forward**

  The Preferred Way Forward uses a low-code platform approach to create solution that combines a single call centre, a 360° View and a patient engagement portal, along with integration with Patients Know Best and current DHCW systems.

  The same capabilities and scope reach are provided as the Less Ambitious Way Forward but the solution would be deployed in a pilot and then swiftly rolled out across health board services.

- **Option 4: More Ambitious Way Forward**

  The More Ambitious Way Forward extends the previous option to make use of an external 24x7 call centre but otherwise use the same low-code platform to create the 360° View and a patient engagement portal, along with integration with Patients Know Best and current DHCW systems.

  The scope and reach now incorporate services beyond the health board such as social care referrals and guidance, GPs, ambulance, and integration with primary care and community referrals.

  The capabilities of the solution are also extended to include full secondary care use cases for the 360° View including acute and inpatient services, dynamic patient-driven appointment scheduling for all health board services, and integration with NHS 111.

The five options are summarised in the tables and diagrams below.

Options	0 Do Nothing	1 Do Minimum	2 Less Ambitious Way Forward	3 Preferred Way Forward	4 More Ambitious Way Forward
Scope	Current users and access	HDUHB plus initial community	HDUHB plus initial community	HDUHB plus initial community	Extended Beyond HDUHB
Solution	Current capabilities and services	Initial 360° View and minimal patient engagement (PKB)	Full 360° View and self-managing components	Full 360° View and self-managing components	Maximum capabilities
Delivery	Current systems	DHCW + PKB + call centre	Product + DHCW + PKB + call centre	Platform (inc. call centre) + DHCW	Platform + DHCW + external 24x7 call centre
Implementation	N/A	Phased over longer time	Phased over longer time	Pilot and then rollout	Pilot and then rollout

Options	0 Do Nothing	1 Do Minimum	2 Less Ambitious Way Forward	3 Preferred Way Forward	4 More Ambitious Way Forward
Solution components	HDUHB DHCW	PKB HDUHB inc. call centre DHCW	PKB HDUHB inc. call centre Product + DHCW	HDUHB inc. call centre Platform + DHCW	Call centre Beyond HDUHB Platform + DHCW

Table 9 – Shortlisted options

Further details on each option (other than Do Nothing) are provided in the table below.

Options	1 Do Minimum	2 Less Ambitious Way Forward	3 Preferred Way Forward	4 More Ambitious Way Forward
Scope	**Initial Community** • Secondary care, including inpatient support calls. • Primary care engagement, NHS dental, district nurses. • Patient and proxy access (including family, circle of care and advocates). • School nurses, therapy, mental health services (including NHS 11 Press 2). • Child health, public health response and vaccinations.			**Extended Beyond HDUHB** 'Initial Community' plus: • Social care referrals and guidance. • GPs and ambulance. • Integration with primary care and community referrals. • Patient and proxy access via PKB and NHS Wales app.
Solution	**Minimal patient engagement** • Single point of contact for patient phone (including IVR) and web enquiries. • Engagement using PKB and NHS Wales app (not integrated) • Some additional integration with current Patient Flow system	**360° View and Self-Managing patient engagement** • Single point of contact for patients. • Integrated view of patient records. • Video and Chat guidance and consultations. • Single point of referral processing. • Engagement platform, integrated with PKB + NHS Wales App. • PIFU / SOS triggered appointments. • Patient selected appointments for some services. • Triage for urgent and emergency care. • Signposting and social prescribing. • Waiting list management.		**Maximum capabilities** '360° View and Self-Managing patient engagement' plus: • Full secondary care use cases including acute and inpatient. • Dynamic patient-driven appointment scheduling. • Integration with NHS 111.
Delivery	• One Health Board call centre • PKB	• One Health Board call centre • Extending current HDUHB	• New platform for 360° View and patient engagement (inc.	• External 24x7 call centre • New platform for 360° View and

Options	1 Do Minimum	2 Less Ambitious Way Forward	3 Preferred Way Forward	4 More Ambitious Way Forward
	• DHCW systems	products (e.g. Miya) • PKB • DHCW systems	one Health Board call centre) • PKB • DHCW systems	patient engagement • PKB • DHCW systems
Implementation	• Phased over longer time		• Pilot and then rollout	

Table 10 – Further details on shortlisted option

4.3.1 Assessment of shortlisted options

To inform the decision about which option should be considered to be the Preferred Option going forward, each of the shortlisted options were evaluated against the Critical Success Factors, including an assessment of Benefits (in Section 4.4), Risks (in Section 4.5) and Costs (in Section 4.7), with a summary provided in Section 4.6.

Based on feedback from stakeholders, weightings were applied to the evaluation criteria listed above, because:

- there are multiple success criteria and investment objectives which are not equally important, but the priorities weren't obvious or agreed at the start of the stakeholder workshops
- there are a diverse group of stakeholders (clinical, operational, digital, finance) who may value different outcomes
- we require a weighted scoring framework which supports option evaluation in a transparent way

A detailed explanation of how the total weighed benefit score was calculated can be found in Appendix C.

4.4 Benefits assessment

This section describes the appraisal of the shortlisted options in relation to benefits. It describes the benefits framework employed and presents the results of the appraisal of the shortlisted options against this framework.

The key benefits that are expected to be realised by PSC and 360° View solutions were described in Section 3.8.1. These benefits outline how replacing some or all of the current systems and processes will provide improved value for patients, improved and sustainable operations and help management teams effectively manage demand. Discussions during workshops highlighted the importance of retaining a variety of communication channels to prevent digital exclusion, and ensuring that the PSC technology does not prevent people contacting the health board using low tech options.

Any quantitative benefits will likely be the result of reduction in administrative activities and increased clinical capacity through more efficient processes, leading to better organisational KPIs and better outcomes for patients.

However, at this stage, it is not anticipated the introduction of a PSC and 360° View will enable significant cash-releasing benefits unless the reduction in administrative time (due to reduced call volumes and/or the introduction of operational efficiencies) would also lead to lower staffing costs. Given the current level of demand faced by healthcare staff in the health board, any released capacity is likely to be required to be reinvested in addressing existing constraints in provision of care for patients and to provide service for a wider range of citizens in Mid and West Wales that could make use of the PSC. Once the solution is more fully understood following the procurement it will be possible to provide additional details at FBC stage on the likely benefits realised.

A weighted scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative non-financial benefit. The purpose of this assessment was to understand any differential between shortlisted options in non-monetary terms.

It should be noted that the status quo option was not scored against either benefit or risk. The key factor to consider was whether any of the options introduced additional benefits in comparison to benefits already delivered under existing arrangements. As such, the status quo option would be judged to score zero across all benefit categories.

The scoring of the short-listed options using the benefits evaluation criteria is presented Table 11.

Benefit Type	Benefit	Weighting (%)	Average Score			
			1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Process Improvement	Reduction in administrative time in managing patient queries as more, and more accurate, information is available to call handlers	6.1%	0.8	2.0	3.3	3.8
	Reduction in appointment Did Not Attend (DNA) rates as patients have more control of their appointment timings	6.1%	0.8	2.3	3.3	3.5
	Reduction in call volumes as patients are better able to manage their wellbeing and their pathways	5.7%	0.5	1.8	3.5	3.5
	Ensuring right place first time for patients as more, and more accurate, information is available to call handlers and patients	5.9%	0.5	2.0	3.3	3.8
	Reduced cancellations/unused slots as patients prehabilitation is easier to manage and improve	5.4%	0.5	2.0	3.3	3.5
Patient / Staff Experience	Increased ability for patients to self-serve via patient engagement features	5.9%	0.5	1.8	3.5	4.0
	Increased time for patient care as less time is spent on admin tasks and on finding patient information	5.9%	0.8	2.0	3.3	3.5
	Improvement in staff recruitment and retention as the experience of working at HDUHB is improved	4.6%	0.6	1.4	3.0	2.8
	Increase in patient satisfaction as better information is available, less time is wasted, waiting times are lower and more time is spent on care	6.2%	0.6	1.8	3.6	3.6
Cash Releasing	Reduction in associated costs with administrative processes as less time is spent on managing patient queries	4.7%	0.8	1.8	3.4	3.2
	Reduced postage costs as fewer letters are sent to patients and GPs	4.1%	1.0	1.7	3.3	3.7
Non-cash releasing	Reduction in appointment volumes via changed clinical processes e.g. SOS, PIFU	5.1%	0.8	2.0	3.4	3.6
	Reduction of carbon impact as fewer face-to-face appointments are needed	3.8%	0.8	1.6	3.2	3.2
	Reduction in volume of complaints and litigation as patient satisfaction improves	5.3%	0.6	1.6	3.6	3.2
Strategic Goal	Reduction in hospital admissions and A&E attendance as patient are better able to manage their wellbeing and find alternate options, and as patient wellbeing improves	6.5%	0.6	1.6	3.2	3.2

Benefit Type	Benefit	Weighting (%)	Average Score			
			1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
	Improved clinical outcomes as patient prehabilitation and rehabilitation improves and better decisions are made about patient pathways	6.2%	0.4	1.6	3.2	3.4
	Improved citizen wellbeing as people are empowered to manage their own wellbeing and engage in activities that prevent ill health	6.1%	0.4	1.8	3.4	3.6
	Reduction in patient waiting times as fewer appointments are cancelled and there are fewer DNAs	6.4%	0.6	1.8	3.6	3.4
	Average weighted benefit score	**100%**	**0.7**	**1.9**	**3.2**	**3.5**

Table 11 – Shortlist benefit assessment

Option 4, implementing the More Ambitious Way Forward, received the highest benefit score, reflecting that this solution would result in the biggest efficiency increases and improvements in staff and patient experience, with Option 3 being slightly lower. Table 11 highlights that the perceived potential benefits of Options 1 and 2 are significantly less high. As mentioned above, Option 0, doing nothing, is expected to introduce no additional benefits to HDUHB.

4.5 Risk assessment

This section describes the appraisal of the shortlisted options in relation to risks. It describes the framework employed and presents the results of the appraisal of the shortlisted options against this framework.

The key risks that impact the PSC and 360° View solutions were described in Section 0. A weighting and scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative risk.

It should be noted that the status quo option was not scored against either benefit or risk. The key factor to consider was whether any of the options introduced additional risk in comparison to current risks under existing arrangements. As such, the status quo option would be judged to score zero across all risk categories.

The scoring of the short-listed options using the risk evaluation criteria is presented below. A detailed explanation of how the total weighed score has been calculated can be found in Appendix C.

Category	Description	Weighting (%)	Average score			
			1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Business	Resistance to change from clinical and admin teams	6.6%	4.7	3.8	5.6	6.3
	Misalignment of expectations and realised benefits	6.6%	4.8	5.1	5.6	5.1
	Bottlenecks from an overwhelmed PSC could lead to delays in response times.	8.6%	4.5	4.4	6.2	6.9
	Overlap with other digital initiatives (national or local) could result in duplication or rejection by health board.	8.9%	3.1	4.0	6.9	7.6
	Information governance or privacy incidents	10.0%	2.2	2.6	4.5	5.3
External	Cybersecurity and privacy breaches as a result of wider data sharing	9.0%	1.9	2.6	4.5	5.1
Service	Single point of failure if telephony or platform fails leading to outages	8.3%	3.9	3.9	4.5	5.1

	Poor usability leading to low clinical or citizen adoption	8.3%	4.4	3.9	3.9	4.5
	Diversion of finances and resources from other critical areas.	7.8%	2.6	4.0	5.0	5.0
	Poor integration of data leading to staff and patient frustration	8.3%	3.5	5.0	5.0	6.3
	Digital exclusion leading to patients struggling to access services or engage with their care	8.1%	1.8	2.5	4.5	5.1
	Clinical risk from incomplete or conflicting data in the unified view	9.4%	5.6	5.0	3.8	5.0
	Average weighted risk score	**100%**	**3.5**	**3.9**	**5.0**	**5.6**

Table 12 – Shortlist risks assessment

Option 4, implementing the More Ambitious Way Forward, received the highest risk score, reflecting that this solution would present the most concerns for the health board to consider and mitigate, with Option 3 being slightly lower. Table 12 highlights that the perceived potential risks of Options 1 and 2 are significantly lower. Although Option 0, doing nothing, was not scored, there is still a significantly risk of not addressing the issues currently being faced by patients and the health board as a result of continuing with the existing arrangements.

4.6 Critical Success Factors assessment

Each option has also been assessed against the Investment Objectives and the Critical Success Factors that are not already covered by the Benefit, Risk and Cost assessments.

Investment Objective	Goal	1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
1. Improve Effectiveness	Optimise the quality of public services and delivery of agreed outcomes	0.5	2.0	3.3	4.0
2. Increase Efficiency	Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery	0.8	2.5	3.5	3.5
3. Enhance Economy	Lower the cost and administrative burden of care through digital automation and increased patient self-service.	1.0	2.0	3.3	3.5
4. Ensure Compliance	Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility.	1.3	2.3	3.0	3.3
5. Support Future Improvement	Enable better data collection, analysis, and reporting to inform ongoing service development and innovation.	1.3	2.0	3.0	4.0
	Average scores	**1.0**	**2.2**	**3.2**	**3.7**

Critical Success Factors	Description	1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Strategic fit	How well the option fits with other strategies + projects	**0.7**	**1.3**	**3.0**	**3.7**
Potential value for money	How well the option optimises public value (social, economic, environmental)	**0.3**	**1.7**	**3.3**	**2.3**
Supplier-side capacity	How likely it is that the option can be delivered by the market	**4.0**	**2.0**	**3.0**	**3.0**

Supplier-side capability	How much of the required capabilities are provided by the option	**1.0**	**2.0**	**2.8**	**3.3**
Potential achievability (delivery)	How likely the option is to be delivered by HDUHB	**3.3**	**3.3**	**2.5**	**1.5**

Table 13 – Shortlist assessment of critical success factors

In summary, Option 3 and 4 contribute most towards Investment Objectives, and have the highest scores for strategic fit with the health board's digital roadmap and the value for money to the public, but have the least favourable scores for deliverability.

4.7 Indicative estimates

A full breakdown of the indicative budgetary estimates can be found in section 6.2.2 (Indicative budgetary estimates). The estimates are provided for each option as a range, representing a Total Cost of Ownership (TCO) over a five-year period, with values rounded to the nearest £10K:

Indicative estimate	Option 0 Do nothing	Option 1 Do minimum	Option 2 Less ambitious	Option 3 Preferred way forward	Option 4 More ambitious
Low range		[redacted]	[redacted]	[redacted]	[redacted]
High range		[redacted]	[redacted]	[redacted]	[redacted]

Taking into account the recommendation set out in section 4.8 below (Preferred option) to consider procurement of solutions aligned to both Option 2 and Option 3, the total cost of ownership for the preferred option over a five-year period therefore ranges from [redacted], representing the low range estimate for Option 2 and the high range estimate for Option 3 respectively.

4.8 Preferred option

To inform the decision about which option should be considered to be the Preferred Option going forward, each of the shortlisted options were evaluated by key stakeholders from the Health Board. Stakeholder responses were combined in Table 14 to provide a RAYG (red, amber, yellow, green) value for each option against each of the criteria, where Red indicates the least preferred option for the corresponding criteria, and Green indicates the most preferred. Note that the RAYG values for some of the evaluation criteria, particularly the supplier-side capacity and capability and the solution costings, have been provided by the market assessment conducted by CGI colleagues rather than from the wider stakeholder group.

Note also that these are indicative RAYG values and, particularly those that relate to costings and benefits, will continue to be evaluated and refined in the weeks to come.

Critical Success Factor	1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Benefits	◔	◑	◕	●
Risks	●	◕	◑	◔
Investment Objectives	◔	◑	◕	●

Critical Success Factor	1 Do Minimum	2 Less Ambitious	3 Preferred Way Forward	4 More Ambitious
Strategic fit	◔	◑	◕	●
Potential value for money	◔	◑	●	◕
Supplier-side capacity	●	◑	◕	◕
Supplier-side capability	◔	◑	◕	●
Potential achievability (delivery)	●	●	◑	◔
Costs	●	◕	◑	◔

Table 14 – Shortlist assessment summary

Table 14 implies that, on balance between the various Critical Success Factors that have been assessed, Option 3 is the most likely option to be selected as the Preferred Option for a procurement. However, it is important to consider that Option 2 and Option 3 differ only in their technical solution and speed of rollout. They have the same scope of health board function, user access and data and the same set of capabilities. It is therefore recommended that the procurement for a PSC and 360° View solution be constructed in such a way as to ensure that vendors could respond with solutions which are compliant with either Option 2 or Option 3, rather than restrict the Health Board up-front to a particular technical solution. This will ensure that more suppliers are able to respond, and therefore help ensure the best fit for requirements, and best value for money.

This draft recommendation needs to be reviewed by a number of key governance bodies before it is taken to the full Board for a decision. The thoughts and feedback from the Healthier Mid and West Wales committee, the Health Board Executive Team, and the Digital, Data and Innovation Committee should be sought and represented before finalising any recommendations in this OBC. Importantly, this recommendation should incorporate feedback relating to the Health Board's digital ambitions and appetite for risk.

Note that importantly, procuring a solution aligning to Option 2 or 3 would not preclude the Health Board from scaling this out to Option 4 in the future; whilst it is not recommended to jump straight to this option initially (due to the complexity of organisational and business change) there is value in this as a longer-term objective, both to expand the availability of the contact centre and also as a potential enabler for greater regional collaboration.

4.9 Overview of solution architecture

The anticipated solution (based on Option 3 as an example) will be based on a third-party commercial off the shelf platform solution consisting of the following components:

- A patient engagement platform that provides a 360° View of patient data for Hywel Dda staff with the ability to track and manage patients
- Support for the patient service centre including call handling and management
- Patient access to their own records with sign-posting support, appointment requesting and care plan management
- A set of integrations to DHCW systems including patient administration records, laboratory results and radiology reports and patient documents and the ability to connect and use ongoing DHCW services such as the Clinical Data Repository, integration hub and National Data Resource

Although a confirmed view of the solution architecture will not be known until Full Business Case stage based on agreement of the solution to be procured, it is assumed that this will follow a similar pattern to the logical technical architecture set out below:

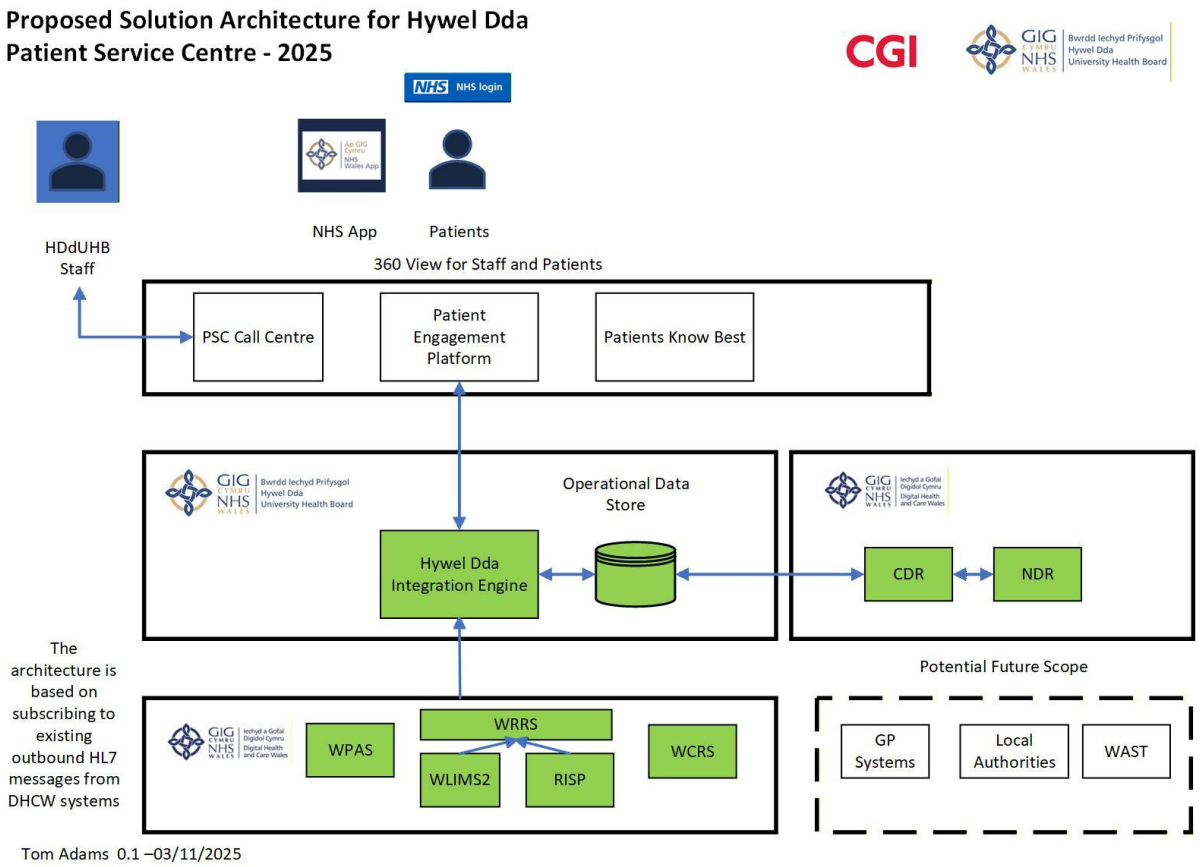


Figure 10 - Logical solution architecture

Some of the key features of the above design are:

- Patient access will be managed via authentication via the NHS App for Wales including links to the Patients Know Best app.
- Data will be published to the DHCW Clinical Data Repository and from there to the National Data Resource. It is anticipated that the DHCW CDR will in time become the primary data store for the Patient Engagement Platform as DHCW shifts services to this platform.
- Role based access controls will ensure that users have the appropriate and controlled access to sensitive patient information.
- The platform will include a range of dashboards and reports to support operational and management reporting.

In line with the Hywel Dda digital strategy, it is anticipated that further integrations will be delivered in the future, including GP system data, local authority social care records, ambulance data from the Welsh Ambulance Service, and remote patient management and connected medical devices for out of hospital care.

The overall principle in vendor selection will be based on providing an enabling platform for the initial scope but also future use cases without the need to procure point solutions. This could build upon the existing investments made by the Health Board in solutions such as Better Meds' ePMA and Alcidion Miya Patient Flow and eObs via new integrations with these solutions.

5 Commercial Case

The Commercial Case outlines the considerations and available strategies that may support the procurement of a Patient Service Centre and 360° View solutions. It provides an assessment of the ability of the market to provide the required solution, the attractiveness of any future deal to potential service providers and details the projects alignment with the commercial strategy of HDdUHB for maximising public value.

This initiative is a cornerstone of the Health Board's digital transformation agenda and aligns with the *A Healthier Mid and West Wales* strategy. Following approval of this Outline Business Case, these considerations should be further developed and detailed in the procurement strategy.

5.1 Procurement Approach

As part of the Commercial Case, a range of procurement approaches are being considered for this proposal, with ongoing dialogue with the HDdUHB Procurement Team. The procurement approach to be adopted is dependent upon the final selection of the preferred option, as part of the Outline Business Case process.

Given the range of options under consideration, from the 'Do Minimum' option, which involves one Health Board call centre with minimal improvements to patient engagement, to the 'Preferred Way Forward', which proposes a platform-based solution with self-managing patient engagement, an integrated view of the patient record and a single point of referral processing, several procurement routes may be applicable. Each option presents distinct commercial implications in terms of supplier engagement, contractual complexity, and market readiness.

The different procurement routes available, when seeking to procure and award contracts, are:

- **Open Tender:** The Open Tender process would involve publishing the Health Board's requirements openly on Sell2Wales and other relevant platforms, inviting all interested suppliers to submit bids. All received bids will be scored against pre-agreed criteria to select the preferred supplier. The advantage of this approach is that it maximises competition and market engagements, whilst encouraging innovative solutions from a broad supplier base. Consideration should be given to increased resource requirements for managing the procurement process and the additional time requirements to support this procurement route.
- **Mini Competition:** A Mini Competition could be conducted under existing framework agreements, if it believed that there are sufficient suppliers on existing frameworks that could deliver the required solution. This approach allows the Health Board to invite a limited number of pre-qualified suppliers to compete for the contract, based on the specific requirements of the Patient Services Centre and 360° View solution. This procurement route would accelerate the procurement process by leveraging pre-established terms and conditions, whilst reducing the administrative burden. Framework terms may constrain flexibility in contract negotiation with this route. A Mini Competition would also require a clear specification to differentiate bids effectively and may restrict market innovation, as it is limited to suppliers on that framework.
- **Direct award through the Digital Partnership framework:** The Digital Partner (CGI) would support the Health Board in evaluating solution providers by running a tender process and then make a recommendation on the best fit for the Health Board's requirements based on responses to this. The Digital Partner would then act as the prime contractor for the project, managing any other solution providers under subcontract. For example, software and telephony solutions providers would be subcontractors in this scenario, whereas the Digital Partner itself would provide overall programme management while also delivering other areas of the overall scope such as systems integration and testing. From the Health Board's perspective, there would only be one contract to manage, which would be with the Digital Partner through the existing framework arrangements.

Following the approval of the Outline Business Case and agreement of the preferred option, the Health Board will determine the most appropriate procurement route for the digital solution, including an assessment of the relative advantages and limitations of pursuing an open competitive process versus procurement through the existing digital partnership arrangement. The evaluation will consider factors such as value for money, timescales, interoperability with existing systems, supplier performance, governance assurance and alignment with national procurement policy. A subsequent recommendation will be presented for formal approval through the relevant governance body.

5.2 Service requirements

At the time of drafting this Outline Business Case, a detailed specification of the required services has not yet been developed. At this stage the procurement scope is envisaged to include the following key components:

- A Patient Services Centre that combines a coherent set of patient-facing services including:
    - A one-stop shop website, call centre and hospital receptions
    - Patients Know Best
    - NHS 111 Press 2
    - Hywel Dda Post

  And provide patient-facing capabilities and channels which cover:
    - Information, guidance, signposting and social prescribing
    - Appointment selection (for some hospital services) and management
    - Referral processing and waiting list management
    - Clinical triage
    - Proxy, circle of care, family and career access
    - Multi-channel including AI chatbots
- A 360° View solution that includes the following capabilities:
    - Integrated patient record and interaction history
    - Patient communications and MDT collaboration
    - Alerts, tasks, workflow and notifications
    - Patient cohorting operational dashboards
    - Patient surveys and assessment scoring
- Solutions that provide a number of important design qualities:
    - Accessibility and usability to mitigate digital exclusion
    - Resilience and security to protect health board operations and patient data
    - Flexibility and adaptability to provide for future roadmaps
    - Compliance to best practice health and care standards
- While compliance with DCB0129 is not currently a legal requirement in Wales, it is considered best practice across NHS organisations. As part of the procurement exercise for the Patient Services Centre platform, Hywel Dda University Health Board will require that the selected supplier demonstrates full DCB0129 compliance. This ensures that clinical safety is embedded throughout the deployment lifecycle and aligns with the Health Board's commitment to robust governance, risk management, and assurance in digital health delivery.

Figure 11 below lays out the various functions, capabilities and services that are likely to be required.

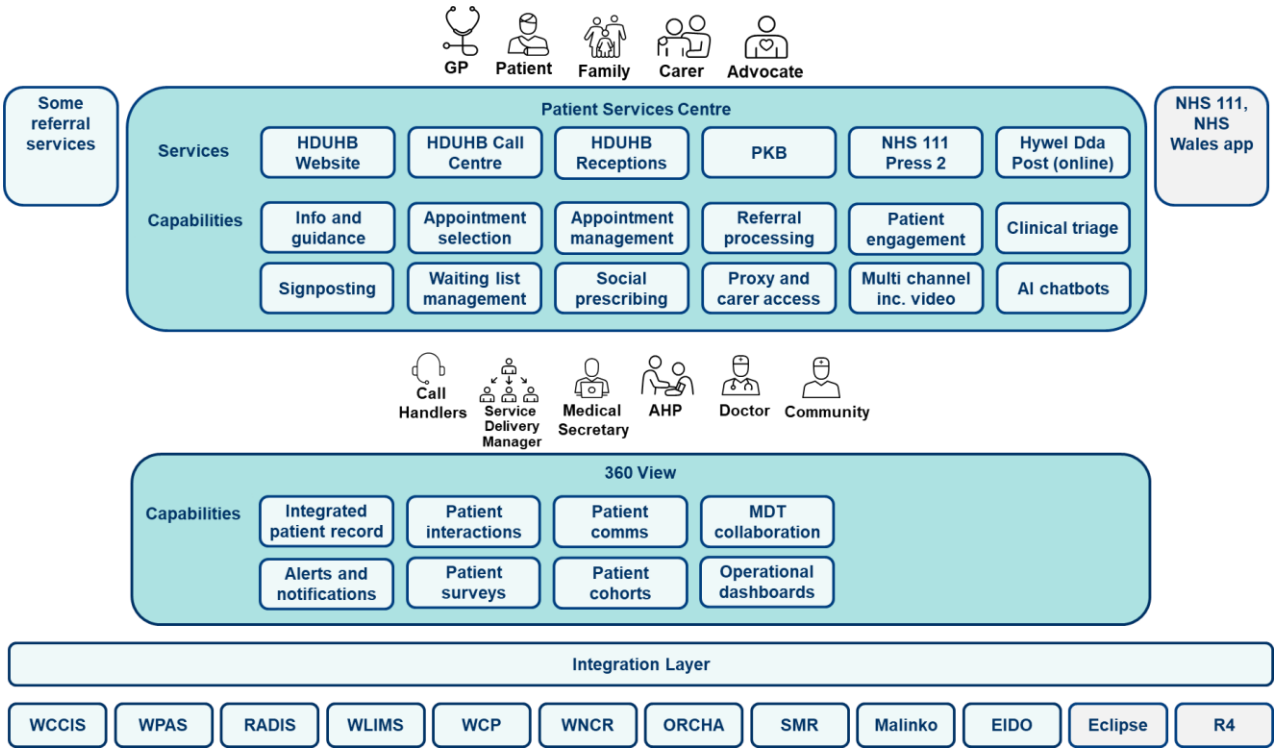


Figure 11 – Likely service requirements

5.3 Personnel Implications

The Patient Services Centre has the potential to deliver transformational change for patient-facing communication, and the implementation of the platform may have significant implications for workforce configuration and role design across Hywel Dda University Health Board.

While the 'Do Minimum' option is likely to result in limited disruption, the 'Preferred Way Forward' introduces a more substantial transformation, including the centralisation of call centre operations and the introduction of new digital roles. This may involve the reallocation or redeployment of existing staff, supported by targeted upskilling to enable effective use of integrated digital tools and workflows.

Whilst one of the options within this paper does consider an external provision of services outside of standard working hours, namely a 24/7 call centre, it is anticipated that employees will not be impacted by the need to apply the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) as no direct transfer of staff is envisaged. A full assessment of the workforce implications for the preferred option will be undertaken once approval has been received by Hywel Dda University Health Board for the Outline Business Case.

In addition, the Organisational Change Policy (OCP) may need to be initiated to manage any changes to roles, responsibilities, or working patterns resulting from the implementation of the PSC platform. Where contractual variations are required, such as adjustments to working hours, job descriptions, or location of work, these will be handled in accordance with the Health Board's HR policies and employment law. Early engagement with staff and trade union representatives will be essential to ensure transparency, mitigate risks, and maintain workforce morale throughout the transition.

5.4 Risk Appointment & Payment Mechanism

The allocation of risk between the Health Board and the supplier, along with the payment mechanisms, will be determined once the most appropriate procurement route has been agreed. These details will be developed during the Full Business Case stage to ensure alignment with contractual obligations, value-for-money principles, and governance requirements.

6 Financial Case

6.1 Financial Assumptions

Financial assumptions have been included in the business case as outlined below.

Accounting Treatment. It has been assumed that any necessary hardware and network upgrades, will be a capital expenditure. Additional services provided by the supplier, as well as the annual support, maintenance and hosting fees and costs for the implementation and BAU team have been treated as revenue expenditure.

Inflation has been included and incorporated into staff costs.

VAT Position. It has been assumed in the cost model that VAT will be payable at the standard rate of 20% on all hardware and infrastructure costs (cloud telephony/CRM implementations), as well as all supplier costs (licence costs, supplier implementation support, and ongoing support). Initial discussions with finance colleagues within HDdUHB suggest the VAT may be recoverable on the costs of the solution and that advice from an external VAT consultant may be necessary to ensure that all potential opportunities for VAT savings are understood. Further clarity on the potential VAT savings will be achieved once a precise cost breakdown is established during the Full Business Case stage.

6.2 Financial Cost

Preliminary estimates have been developed for the Patient Services Centre. These are indicative budgetary estimates which are intended to provide directional guidance rather than precise forecasts.

It is important to note that actual expenditure will vary considerably depending on a range of contextual factors, including but not limited to population size, the current state of digital infrastructure, the scope and complexity of services to be delivered, and the degree of integration required across systems.

The budgetary estimates have been calculated as set out in the following section.

6.2.1 Estimating approach

Given that detailed supplier quotations and technical specifications will not be available until the Full Business Case (FBC) stage, indicative costs for each option have been derived as follows.

Indicative budgetary estimates for Option 3 (platform-based solution) were first developed using the following approach:

- **Product licence (covering patient engagement platform and telephony components):** Initial estimates derived from single health platform vendor's pricing calculator. For this and other product/telephony items, Hywel Dda volumetrics were used to help with sizing, along with some working assumptions on the implementation where necessary
- **Product implementation professional services**: Based on typical configuration, implementation and testing effort for a multi-system deployment of similar scale from vendor's previous experience, along with platform configuration estimate based on CGI's experience of a similar scale project
- **Systems integration (professional services):** Professional services effort for overall systems integration calculated by CGI based on assumed team profile and duration for a typical project of this nature. Interface development tasks within this were based on a 'T-shirt sizing' cost model for interface development, using average integration effort from previous NHS interoperability programmes and adjusted for complexity. Based on assumptions about the number of required interfaces, the known systems landscape and the draft logical architecture as set out elsewhere in this document.
- **Workforce / organisational change plan**: Estimated by HDdUHB based on previous OCP and workforce planning activities carried out within the health board.
- **Procurement costs:** Estimated by HDdUHB based on derived from typical effort for market engagement, tender preparation and evaluation consistent with NHS digital procurement norms.

- **HDUHB project delivery costs:** Estimated by HDdUHB based on previous health-board digital projects, scaled to the expected duration and complexity of the PSC and 360° View implementation. This includes project management, business change, user acceptance testing and other areas.

At this stage in the process all of the estimates should be considered as high level indications. It should also be noted that in terms of the costs external to the Health Board, such as the platform solution and integration costs, these are very rough order of magnitude figures intended to be used to inform budgetary planning, and do not represent formal quotations capable of commercial acceptance.

Indicative estimates for Options 1, 2 and 4 were derived by applying structured scaling from the Option 3 ("Platform") reference case, based on an analogous scaling approach. This approach is often used for cost components that are primarily influenced by the scope or complexity of activity rather than by a quantifiable operational driver, such as professional services effort, systems integration, business change and workforce costs, procurement and delivery management. Using the cost of Option 3 as a baseline, this was then adjusted by proportionate factors reflecting differences in scope and complexity.

Option 4 also includes external call centre annual costs, which were based on an uplift to the Health Board's existing call handling costs (with the figure used here representing the uplift in cost additional to the existing baseline). Whilst there is no readily available benchmark for this, a figure of an additional 30% of cost has been used here for indicative purposes.

VAT has been applied at 20% to any bought-in costs, although as noted in the Financial Case, advice should be sought on how to handle this, with a view to reclaiming this if possible. The exception to this is the external call centre costs for Option 4, based on the assumption that this would be an arrangement with another public sector organisation, which could therefore treated as 'non-business' and outside the scope of VAT (again, specialist advice on this point should be sought at the appropriate time).

Finally, to achieve upper and lower bounds of a likely cost range, these are presented with the original estimates representing the high end, and the lower end being approximately one third lower than this (66% of the original figure). This reflects the uncertainty in the precision of the estimates at this early stage.

The scaling methodologies and ratios applied are shown in the following table:

<table>
<tr><th>Cost component</th><th>Option 0
Do nothing</th><th>Option 1
Do minimum</th><th>Option 2
Less ambitious</th><th>Option 3
Preferred way forward</th><th>Option 4
More ambitious</th></tr>
<tr><td>Systems integrator professional services (platform configuration)</td><td>N/A</td><td rowspan="2">Scaled down technology implementation - 30% of option 3 cost</td><td>Scaled down technology implementation - 60% of option 3 cost</td><td>(Baseline)</td><td rowspan="4">Scaled up technology implementation and workforce change - assumed 50% higher than option 3</td></tr>
<tr><td>Systems integration</td><td>N/A</td><td>30% higher than option 3 as more integration points involved</td><td>(Baseline)</td></tr>
<tr><td>Workforce / Organisational change plan</td><td>N/A</td><td>Lower organisational change but still affects call handlers; 50% of option 3</td><td>Same amount of organisational change as option 3</td><td>(Baseline)</td></tr>
<tr><td>HDUHB project delivery costs</td><td>N/A</td><td>Lower delivery effort as based on existing technology platform with some changes to licencing levels - 30% of option 3</td><td>Same amount of project delivery effort as option 3</td><td>(Baseline)</td></tr>
</table>

Cost component	Option 0 Do nothing	Option 1 Do minimum	Option 2 Less ambitious	Option 3 Preferred way forward	Option 4 More ambitious
Platform and telephony licence and support	N/A	Scaled down technology implementation - 30% of option 3 cost	Scaled down technology implementation - 60% of option 3 cost	(Baseline)	Telephony costs lower than option 3, but potentially cancelled out by higher platform costs due to licencing higher overall number of call handlers - overall assumed same as option 3
Vendor premium support (during implementation and ongoing)	N/A			(Baseline)	Scaled up technology implementation and workforce change - assumed 50% higher than option 3
External call centre annual costs	N/A	N/A	N/A	N/A	Assumed 30% higher than existing HDdUHB call handling costs of [redacted], to account for moving to 24/7 support

Table 15 - Scaling methodologies and ratios

6.2.2 Indicative budgetary estimates

The table below illustrates the indicative budgetary estimates for the project, calculated on the basis set out in the preceding section and inclusive of VAT where applicable. Taking into account the recommendation in section 4.8 (Preferred option) to consider procurement of solutions aligned to both Option 2 and Option 3, the total cost of ownership for the preferred option over a five-year period therefore ranges from [redacted], representing the low range estimate for Option 2 and the high range estimate for Option 3 respectively).

	Capex / Opex	VAT	Option 0 Do nothing	Option 1 Do minimum	Option 2 Less ambitious	Option 3 Preferred way forward	Option 4 More ambitious
Year one - includes implementation period							
Systems integrator professional services (platform configuration)	Capex	Yes		[redacted]	[redacted]	[redacted]	[redacted]
Systems integration	Capex	Yes		[redacted]	[redacted]	[redacted]	[redacted]
Workforce / Organisational change plan	Capex	No		[redacted]	[redacted]	[redacted]	[redacted]
HDUHB project delivery costs	Capex	No		[redacted]	[redacted]	[redacted]	[redacted]
Six months' equivalent of ongoing costs for platform, support and call centre	Capex	Yes		[redacted]	[redacted]	[redacted]	[redacted]
Subsequent years							

	Capex / Opex	VAT	Option 0 Do nothing	Option 1 Do minimum	Option 2 Less ambitious	Option 3 Preferred way forward	Option 4 More ambitious
Platform and telephony licence p.a.	Opex	Yes		[redacted]	[redacted]	[redacted]	[redacted]
Vendor premium support (during implementation and ongoing)	Opex	Yes		[redacted]	[redacted]	[redacted]	[redacted]
External call centre annual costs	Opex	No		[redacted]	[redacted]	[redacted]	[redacted]
Year one total cost				[redacted]	[redacted]	[redacted]	[redacted]
Years two to five annual cost				[redacted]	[redacted]	[redacted]	[redacted]
TCV (five years) - high range				[redacted]	[redacted]	[redacted]	[redacted]
TCV (five years) - low range (assumed 66% of high range cost)				[redacted]	[redacted]	[redacted]	[redacted]

Table 16 - Indicative budgetary estimates

6.3 Affordability

Hywel Dda University Health Board continues to operate in a challenging financial environment. The Board, as its meeting on the 31 July 2025[3], endorsed and approved a revised annual plan [redacted], having made decisions to increase the savings target, defer originally planned investments and recognise changing national funding assumptions. In this context, all new investment proposals must demonstrate not only affordability, but also a clear contribution to long-term financial stability.

The strategic potential of this initiative should not be underestimated. It represents a significant opportunity to transform service delivery and drive long-term value across the region. The proposed Patient Services Centre and 360° View solutions form part of the Health Board's medium-term transformation portfolio, designed to release efficiency gains and reduce reliance on acute hospital settings. The proposed investment is to be funded through a combination of internal and external mechanisms aligned with Hywel Dda University Health Board's strategic priorities and governance framework.

Should the Outline Business Case be accepted, it is envisaged that the proposed solution would generate essential efficiencies and cash-releasing benefits to offset the initial investment, with potential for improved outcomes, enhanced operational efficiency, and broader system-wide benefits.

[3] Hywel Dda University Health Board. (2025). *Financial Report – Board Meeting 25 September 2025*. Available at: https://hduhb.nhs.wales/about-us/your-health-board/board-meetings-2025/board-agenda-and-papers-25-september-2025/board-agenda-and-papers-25-september-2025/9-financial-report-pdf/ [Accessed 5 Nov. 2025]

7 Management Case

This section outlines the proposed governance approach, digital roadmap and high-level implementation plan for the project.

7.1 Governance arrangements

The overall project will be managed by a Programme Lead, who will lead the project team set up in Section 7.1.1 below. The project team will work closely with clinical and operational staff from all sites to ensure that requirements of the solution meet the needs of users.

7.1.1 Project Team

During the first year of the project, the project will be run by an Implementation Team. Once implementation is complete, the Business As Usual (BAU) team will take over.

During the first year, the implementation period, there will be one Project Manager reporting to the Programme Manager, who reports to the Senior Responsible Officer. The table below outlines the full Implementation team.

Role	Description
Senior Responsible Owner	To represent the project at an executive level. To advise on how project needs to meet strategic goals of the organisation. Final escalation point within project governance.
Programme Manager	Overall day-to-day responsibility for project. Managing project managers. Engage and communicate at executive level within Health Board.
Project Manager	Manage daily project activities. Provide Trust wide project co-ordination. Communicate project status issues and events to Trust leadership. Provide leadership to Project Team.
Business Change Officer	Oversee change requirements of the project and assess impact on change plan within the organisation. Support gap analysis, 'as is' process capture and future state process mapping. Deliver Change Action Plan. Support Benefits realisation work as appropriate.
Clinical Safety Officer	Validate clinical risks and issues.
Configuration and Implementation - Clinical Lead	Responsible for providing input into solution design and configuration from a clinical perspective.
Technical Implementation Lead	Responsible for providing input into solution design and configuration from a system administration perspective.
Nursing informatics leads	To provide input into solution design and configuration from a nursing perspective.
Informatics lead	Responsible for ensuring that the solution aligns with clinical informatics standards and supports safe, effective use of patient data.
Application Support Trainers and Acceptance testing support	Responsible for training strategy and approach. Management of trainers. Engagement with operational managers to coordinate and schedule training for operational staff to support business requirements. Sign-off training collateral and localised environment

Role	Description
Cyber lead	Responsible for ensuring compliance with cyber standards and overseeing security risk mitigation during implementation.

Table 17 – Implementation team

The implementation team, outlined in the table above, are the resources required to deploy the systems to support an expected implementation period of 1 year. Given that this technology will be used by frontline staff and directly impact patient care, this is the recommended team size. Using a reduced staffing profile would add to the risk profile by extending timescales and possibly compromising the quality of the delivery and minimise the benefits output.

Note the implementation team will be supported through a collaborative governance approach that will ensure that operational and clinical staff are fully involved in the deployment and delivery planning.

Once implementation is complete, the BAU team will take over. The table below outlines the BAU team which is funded as part of this business case:

Role	Description
Application Support	Responsible for day-to-day support and maintenance of the Patient Service Centre and 360° View applications.
Call Centre Manager	Oversees the operational performance of the Patient Service Centre. Manages staffing, scheduling, and KPIs such as call response times and patient satisfaction.
Service Desk	Provides first-line technical support for PSC and 360° View applications, logging and resolving incidents, and escalating complex issues to Application Support.
Nursing Informatics Lead	Ensures clinical workflows remain aligned with digital systems post-implementation, supports continuous improvement and training.
Senior Clinical Technologist	Oversees technical configuration, system upgrades, and integration maintenance to ensure safe and effective operation.

Table 18 – BAU team

7.1.2 Patient Services Centre Steering Group

The HDdUHB Patient Services Centre Project Team will report into the HDdUHB Patient Services Centre Steering Group that will be established after receiving approval from the Health Board to proceed to Full Business Case development and procurement.

The Steering Group will be chaired by the Senior Responsible Officer for the project to direction and leadership to ensure the safe, effective and efficient delivery of the solution, ensuring engagement and understanding at all levels. The Steering Group will meet on a regular basis and provide oversight and scrutiny of the delivery of the project, including benefits planning, delivery and project assurance. The progress of the delivery of the project will also be reported through the Steering Group.

The Steering Group will report into the Digital Senior Team and upwards governance route through to the Executive Board is outlined in the diagram below.

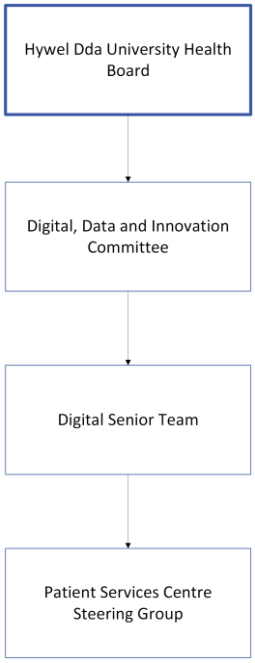


Figure 12 – Internal HDdUHB Governance Structure

7.2 Implementation Plan

The implementation will follow an incremental approach with an initial pilot prior to the solution being rolled out across the health board. Before starting implementation, work to enable integrations will need to be carried out. A high-level illustrative plan is shown below, to be confirmed later at Full Business Case stage based on plans from suppliers.

		Q1			Q2			Q3		
Activity	**Task**	**M1**	**M2**	**M3**	**M4**	**M4**	**M5**	**M7**	**M8**	**M9**
Project Mobilisation	Organisation and Planning									
	Cyber / Safety Engagement									
	Stakeholder Management Plan									
Integration Work	Transactional Messages									
	API Calls									
	Context Launching									
Platform Configuration	Vendor Onboarding / Infrastructure									
	Platform Discovery / Configuration									
	Testing									
Business Change and Readiness	Business Change / Benefits plan									
	Communication and Training									
	Transition to Service									

Go Live

Figure 13 – Implementation plan

7.3 Use of Specialist Advisors

In an effort to ensure that the Patient Services Centre and 360° View project align with the Health Board's wider strategic aims, the Health Board's strategic digital partner, CGI, provided support in the identification of potential solution options to address service needs and supported the development of this outline business case. CGI also provided expert insight into technical feasibility, solution design, and alignment with the wider digital architecture.

To ensure successful delivery of the solution, it is envisaged that ongoing specialist advisory input will be needed from other NHS Wales organisations, for example Digital Health and Care Wales (DHCW) may provide guidance on interoperability and compliance with national digital standards.

Additional expertise will also be drawn from other parts of the Health Board such as clinical advisors, information governance leads, cyber and technical assurance teams, procurement specialists, finance partners, workforce and organisational development colleagues, and patient engagement advisors. Collectively, these advisors will ensure that the subsequent implementation of the solution set out in this business case remains safe, achievable and aligned with Health Board priorities.

7.4 Risk Management

Risk identification and management will be a continual process in the programme to monitor the level of exposure to risk at any point and keep unwanted outcomes to a minimum, particularly given the proximity of these systems to patient care. A risk register has been developed as part of this OBC and is set out in Section 3.8.2. The Project Team will ensure that the following risk processes are in place:

- Up-to-date risks register open to anyone to review. Formal updates will be made by designated individuals only
- All risks will be reviewed regularly by the team, and key risks escalated to the Programme Lead for management by exception
- Significant risks will have mitigation plans developed and will be formally reviewed
- A decision-making process supported by a framework of risk analysis and evaluation
- Processes in place to monitor risk.

The proposed risk management approach is outlined in Figure 13. It will be the responsibility of all team members to identify risks as and when they become aware of them, and to use the risk management processes. These processes ensure that the risks are logged and assigned to owners to manage and continually review the individual risks. The project managers will have a key role in monitoring, reviewing and managing action delivery to mitigate or resolve risks.

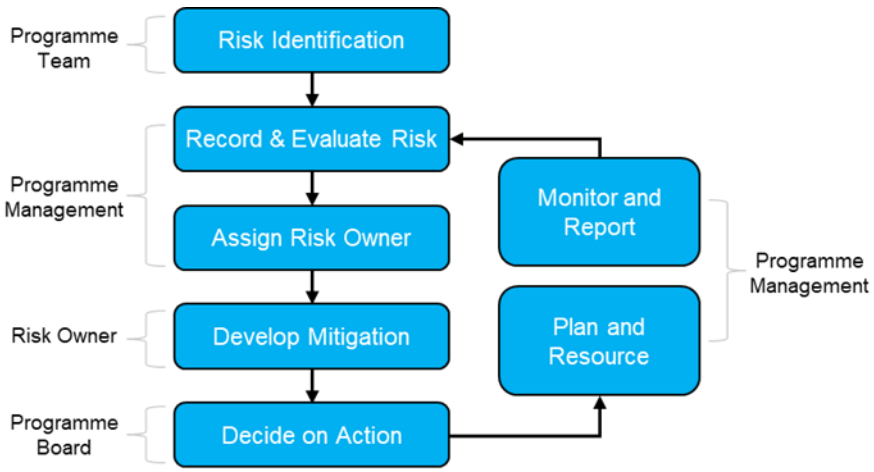


Figure 14 – Risk management approach

7.5 Change Management

The implementation of these solutions is expected to have significant impact on frontline staff, and it will be important to minimise any negative impact during the implementation period.

The current workforce model is fragmented across multiple directorates with no unified workforce plan. There is significant duplication of workstreams and inconsistent processes, with call-handling and administrative functions largely manual and site-specific. From an initial investigation of the current communication landscape

within Hywel Dda University Health Board, it is believed that the following services will be most impacted by the proposed change:

- Hywel Dda Contact Centre
- Communication Hub
- Switchboards
- Patient Advice & Liaison Service (PALS)
- Complaints
- 111 #2 (Mental Health Single Point of Contact).

It is also understood that many specialities provide phone numbers to patients to respond directly to queries, with clinical/medical secretaries and other members of staff carrying out these activities. The future model envisages the centralised of patient-facing contact functions into a single Patient Services Centre, improving communication and delivering efficiencies. To support this endeavour, detailed workforce mapping and planning would need to be undertaken, understanding all parties that are currently undertaking activities in this area, along with the required skill set and role profiles needed for the future service model. Should the preferred option include a real time output for patient's positioning on waiting lists, future workforce planning may consider which role is most suited to providing accurate local information on waiting lists.

The key assumptions underpinning future workforce planning are that baseline workforce numbers will be derived from the existing call-handling and administrative staff across all sites; redeployment and upskilling will be prioritised over external recruitment to retain organisational knowledge and minimise disruption; a significant proportion of staff will require training to operate new systems, reflecting the digital capability uplift needed for the future model; and the Organisational Change Policy (OCP) will be triggered to manage role redesign and location changes, with operational HR involvement essential to ensure compliance and support staff through the transition. No TUPE implications are anticipated, as no direct transfer of staff is envisaged.

Effective change management and visible leadership will be critical to the success of the project in order to:

- Achieve buy-in across stakeholder groups from all sites and departments,
- Gain commitment from users, recognising potential disruption to services and additional effort required during the implementation period,
- Ensure that staff members know that they can communicate any concerns, needs or issues with relevant members of the project team,
- Support the changes in working practices that the new arrangements will require; and
- Realise the benefits of implementing Patient Services Centre and 360° View technology, as outlined in Section 3.8.1.

To ensure effective change management HDdUHB will develop the following:

- Change Management Strategy: to include an assessment of the potential impact of the proposed change on the culture, systems, processes, and people. An underpinning communication strategy for affected disciplines and staff will also need to be defined.
- Change Management Framework: this sets out the organisational structure and personnel required to direct, manage, implement, and evaluate the change, along with details of roles and responsibilities, and to support staff through the change; and
- Change Management Plans: this defines the communication required for the implementation phase.

Furthermore, early engagement will be undertaken with staff and trade unions after acceptance of the Outline Business Case. To support the business change proposal, the team will include a Business Change Officer to oversee change requirements of the project and assess the wider impact on the organisation, as well as local Digital Champions to support engagement and training of clinical and operational staff.

7.6 Digital Inclusion

Digital exclusion continues to be an area of importance locally and nationally and is a clear priority for Welsh Government as services continue to digitalise their ways of working and engaging with the population and as digital continues to be of emphasis. We know from Welsh Government statistics that 4% of Wales continue to be completely excluded from the digital world[4], and a large proportion of the Welsh population still lacking the essential digital skills required including members of the health and care workforce.

HDdUHB is committed to tackling digital exclusion and ensuring that the right opportunities are available to promote and develop the digital skills, confidence and motivation of the workforce, which in turn will naturally cascade into the wider population that HDdUHB serves.

HDdUHB acknowledges that without a fully capable and enabled workforce, the implementation and success of delivering a programme of this calibre will be at risk of not meeting its full potential. HDdUHB is passionate and committed on ensuring that the level of digital skills and confidence of the workforce is understood, and the right support opportunities are available to develop a confident and capable workforce and population for the future. It is important to remember that enhancing the digital skills and confidence of the workforce will support the benefits realisation and objectives of the Patient Services Centre and 360° View project proposed, and also, the wider strategic delivery of the service for the future.

With this in mind, HDdUHB was the first health board in Wales to introduce a digital inclusion support service which focuses on improving the digital skills and confidence of the workforce and aims to:

- Ensure that all staff and volunteers have the opportunity to develop basic digital skills and confidence and take advantage of this opportunity.
- Ensure that digital inclusion principles are embedded into the day-to-day activities of the service and to promote and support the role that digital tools play in managing health and wellbeing.
- Encourage and support staff and volunteers to help others to use technology and have the confidence to develop basic digital skills.

7.6.1 Why is Digital Inclusion of significance?

We know that our staff need to feel comfortable, equipped and competent in using digital solutions. A lack in confidence can create barriers to engagement in digital technology and slow down or even prevent the uptake of such opportunities to deliver care differently. It can also stagnate service transformation and reduce the efficiency that can be gained from changes in our current processes.

Digital inclusion must be positioned as a key enabler for projects such as the Patient Services Centre and 360° View to ensure the success of delivering high-quality care in a modern digital environment and to prepare our workforce for future digital transformation. Engagement with 397 staff between June and November 2025 revealed that 63.7% expressed concerns about their digital skills and 64% about their confidence in using digital technology, while 69% of 130 managers raised concerns about their own and their teams' digital readiness. These findings highlight the critical need to embed digital inclusion support within these projects to drive adoption and sustainability.

7.6.2 Considerations

To support the success of the Patient Services Centre and 360° View project, careful consideration will need to be taken in understanding the readiness of the workforce. It is proposed that the digital inclusion team will work closely with the project implementation team and offer expertise in engaging and understanding the basic digital skills and confidence needs of all relevant staff involved in the roll out of the new digitalised way of working.

[4] Welsh Government (2025). *National Survey for Wales headline results: April 2024 to March 2025* https://www.gov.wales/national-survey-wales-headline-results-april-2024-march-2025-html

It is important that assumptions are not made about the level of digital skills, confidence and motivation among the workforce and to be aware that the reluctance from staff to move from a traditional to digital way of working is a potential reflection of personal barriers, fear and concerns about service quality, job security, as well as organisational and practical issues and a lack of understanding of the benefits that digitalisation can offer.

The key considerations needed from a digital inclusion perspective to support the implementation of the proposed projects are:

- To develop an understanding of the basic digital skills and confidence needs of the staff. This will be essential when developing an implementation plan for the programme to ensure the right support to develop the skills and confidence needs of the workforce are met.
- The workforce confidence and capability in using the device and system proposed within the implementation of the programme, and what support is required to ensure full functional use of the devices by the workforce.
- The accessibility requirements of using digital technology that will support and enhance the workforce to engage with digital comfortably and confidently. Consideration must be given to accessibility needs, if not, this may result in reluctance or barriers to the projects.
- Identifying key collaborators within the HDdUHB that will provide the relevant support beyond the digital inclusion team's remit. This will allow for effective signposting to develop on workforce resilience and empowerment.
- Ensuring that there are ongoing support opportunities available for staff to access pre and post implementation of the Patient Services Centre and 360° View systems and that staff feel confident and are aware of what support is available to them.
- The digital inclusion team will work closely with the project implementation team to ensure that the right support and resources are embedded into the implementation plan for the rollout of the programme. The flexible and proactive approach of the digital inclusion team offers the opportunity for engagement and support to be offered to all services involved within the proposed projects.
- The digital inclusion team will follow the rollout plan developed by the implementation team, ensuring engagement and bespoke support is offered pre rollout of the new systems and will be available to all teams involved across all sites within HDdUHB.
- The digital inclusion team in its nature, is an open and self-referring support opportunity therefore, all staff can and will have the opportunity to continue to access support if and when needed post implementation of the projects.

7.7 Training

The supplier of the solution shall provide quick start guides for the solution along with train the trainer materials as part of the installation and implementation costs. The Application Support team will supplement these materials to make them relevant to Hywel Dda users of the application and identify and document how these systems are expected to work in conjunction with our existing suite of digital applications.

The proposed training approach would follow a tried and tested method of an incremental go-live where a pilot for a select number of specialists will deliver centralised patient-facing communications using the adopted technology. Following the review of the pilot it is anticipated that the pace of further roll out to remaining service areas would increase as lessons are learnt and a rhythm established, with the Health Board taking greater ownership and responsibility of the implementation as the programme progresses.

During all stages of pre implementation, go-live and post go-live, training would be delivered and offered in several methods, face to face, remotely via tools like MS Teams and heavily supplemented by support materials and bespoke user guides for user roles and teams across the Application Support Intranet site and made available to those teams who may not have ready access to the existing platform.

The Application Support team along with clinical informatics nurses will carry out an extensive programme of floor walking before during and after the go-live process for each individual area, ward or team to ensure that any potential operational issues are dealt with the appropriate urgency, and this will continue until there are

assurances that the teams are comfortable and proficient with the new application. This will cover in hours and out of hours teams, ensuring groups such as night shift workers and on-call teams are not disadvantaged.

During the implementation programme there will be a bespoke pathway on the IT helpdesk to ensure calls related to Patient Services Centre and 360° View are given an appropriate priority during the go-live process.

Standard dashboards, outputs and reports will be established and circulated specifically for the go-live period to support the identification of potential data quality issues and hotspots that might require further investigation or investment of time and attention to ensure new processes are adopted and embedded as expected.

Once the solution has been fully implemented and embedded into a business-as-usual model, ongoing training will be offered and provided in line with existing processes for the digitally managed applications.

Implementation into new areas not covered in the original scope of the programme will be managed and prioritised through a product backlog approach. Ensuring maintenance of Hywel Dda data standards and assurance that both local and national recording and reporting requirements are maintained and aligned across the suite of digital applications available to the end user.

7.8 Benefits Management

Section 3.8.1 of this Outline Business Case identifies several benefits to be delivered by the implementation of Patient Services Centre and 360° View solutions.

Prior to implementation, HDdUHB intends to carry out further analysis of current processes in order to develop detailed baseline measures against which to monitor and assess performance and outcomes.

These KPIs should be built into the benefits realisation plan, where owners are assigned to each outcome. A proposed approach for benefits realisation is shown in Figure 15 below.

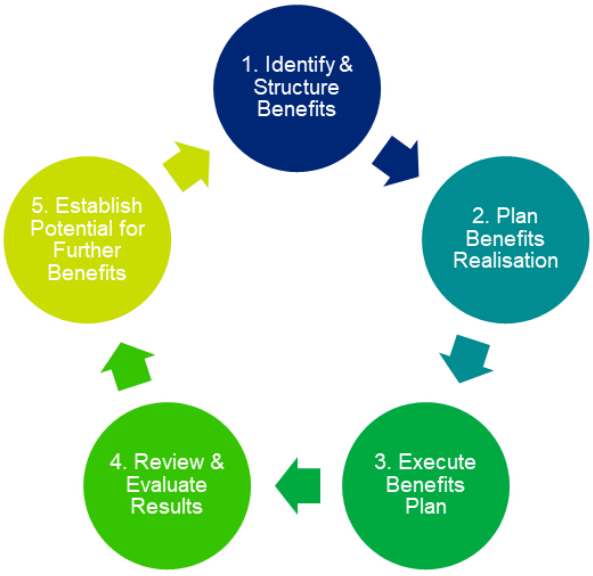


Figure 15 – Benefit management approach

HDdUHB has a dedicated Benefits Realisation Manager within the Digital Team, leading project-specific Business Change Officers. They will lead on assessing whether the benefits outlined in Section 3.8.1 are realised, and work with local teams to manage benefit realisation. As part of their role, they will assign owners to each identified benefit. Note that the preferred supplier may also provide capability to support benefit realisation and measurement.

The learning from other health systems in the UK and abroad who have implemented similar solutions has been supplemented by local consideration of benefits.

A full list of the benefits identified can be found in section 3.8.1 (Benefits). Prior to implementation, HDdUHB intends to carry out further analysis of current practice in order to develop detailed baseline measures for local benefits already identified.

A number of metrics will be further developed to track the delivery of the benefits post implementation. It is recognised that post implementation benefits realisation activities are difficult to resource; however, it will be important to drive value out of the system and have specific metrics tracked and monitored.

It is important to note that which benefits are realised is dependent on the Patient Services Centre capabilities that are implemented and are utilised fully operationally. Several key metrics will need be developed to track the delivery of benefits post implementation. A current view of these is as follows:

Benefit ID	Benefit	Calculation	Data Sources	Notes
PSC-B001	Reduction in administrative time in managing patient queries as more, and more accurate, information is available to call handlers	(Baseline cost per call – New cost per call) × Annual call volume	Time and motion study	Current timings ▪ Contact Centre – 2 mins 43 secs. ▪ Communication Hub – 3 mins 40 secs ▪ 111 #2 – 14 minutes
PSC-B002	Reduction in appointment Did Not Attend (DNA) rates as patients have more control of their appointment timings	(Baseline DNA rate % – New DNA rate %) × Annual appointment volume × Cost per missed appointment	DCHW - Secondary Care Activity Dashboard	Latest annual DNA rate for HDdUHB is 6.9%, with a Health Board target of 5.5%. Imperial PSC pilot: DNAs reduced by >4% [5]
PSC-B003	Reduction in call volumes as patients are better able to manage their wellbeing and their pathways	(Baseline call volume – New call volume)	Telephony system reports Webchat/chatbot analytics	Average inbound call volumes each month for contact centre, communication hub and 111 #2 is 26,202. (PALS, Switchboard and other relevant services to be baselined). Imperial PSC pilot lowered handling cost per call by ~57 seconds per call
PSC-B004	Reduced cancellations/unused slots as patients prehabilitation is easier to manage and improve	(Cancellations before – Cancellations after) × Average cost per appointment	Appointment records (cancellations and DNA data) Finance data on cost per appointment	Imperial PSC pilot: hospital cancellations down >11 %, patient cancellations down ~4 %
PSC-B005	Ensuring right place first time for patients as more, and more accurate, information is available to call handlers and patients	% reduction in misrouted calls	Telephony system reports CRM logs	

5

"New 'choice booking' process on track to help transform outpatient administration" –11 Apr 2025. https://www.imperial.nhs.uk/about-us/news/new-choice-booking-process(Imperial College Healthcare)

Benefit ID	Benefit	Calculation	Data Sources	Notes
PSC-B006	Increased ability for patients to self-serve via patient engagement features	(Agent cost per enquiry – Self-service cost) × Annual volume of self-service enquiries	Workforce data Platform costs and usage logs	~30% callers chose self-service at Medway [6]
PSC-B007	Increase in patient satisfaction as better information is available, less time is wasted, waiting times are lower and more time is spent on care	% change in Patient Experience Satisfaction Score (FFT), % change in complaints volumes	Patient Experience Surveys Compliants Log	Datix Report on the number of complaints relating to communication found that there were 179 unique complaints for the financial year 2024-25, with ~25% relating to cancellation of appointments. According to a webinar between Imperial College Healthcare Trust and Netcall, moving to a PSC resulted in a 30% increase in patient satisfaction scores[7]. Medway reports materially improved access and experience after deployment
PSC-B008	Increased time for patient care as less time is spent on admin tasks and on finding patient information	(New % of clinician time spent on patient care - Baseline % of clinician time spent on patient care)	Workforce data; Time & Motion study	
PSC-B009	Improvement in staff recruitment and retention as the experience of working at HDUHB is improved	Reduction in turnover Improvement in satisfaction scores	Performance Dashboard Staff Survey	According to HDdUHB Performance Dashboard, 12 month rolling staff turnover sat at 7.1% as of 1st October 2025. HDdUHB Performance Dashboard shows elevated vacancy levels with WTE vacancies currently at 1211.1 (Oct '25).
PSC-B010	Reduction in associated costs with administrative processes as less time is spent on managing patient queries	((Calls per agent per day after – Calls per agent per day before) / Calls per agent per day before) × FTE count × Staff cost per FTE	Finance / HR system	Imperial PSC pilot processed 110 vs 70 referrals/day (+57%)

[6] "Medway NHS builds AI-powered contact solution to improve patient experience and resource use" –8 Jul 2025. https://www.pwc.com/gx/en/about/case-studies/medway-nhs-builds-ai-powered-contact-solution.html(PwC)

[7] https://www.datainsightsmarket.com/news/article/case-study-imperial-college-healthcare-nhs-trust-reduces-call-wait-times-with-netcall-11442

Benefit ID	Benefit	Calculation	Data Sources	Notes
PSC-B011	Reduced postage costs as fewer letters are sent to patients and GPs	(Baseline letters – New letters) × Average postage cost	Postal logs	
PSC-B012	Reduction in appointment volumes via changed clinical processes e.g. SOS, PIFU	(Baseline appointments – New appointments)	Datix Reports	
PSC-B013	Reduction of carbon impact as fewer face-to-face appointments are needed	Carbon kg per appointment × Reduction in appointments	Sustainability Reports	
PSC-B014	Reduction in volume of complaints and litigation as patient satisfaction improves	% reduction in complaints related to communication	Datix Report	
PSC-B015	Reduction in hospital admissions and A&E attendance as patient are better able to manage their wellbeing and find alternate options, and as patient wellbeing improves	(Baseline attendance - New attendance)	Iris Reports	
PSC-B016	Improved clinical outcomes as patient prehabilitation and rehabilitation improves and better decisions are made about patient pathways	% improvement in PROMs / PREMs	Annual Reporting	
PSC-B017	Improved citizen wellbeing as people are empowered to manage their own wellbeing and engage in activities that prevent ill health	% improvement in reported wellbeing scores	Public Health Survey	
PSC-B018	Reduction in patient waiting times as fewer appointments are cancelled and there are fewer DNAs	(Baseline waiting time – New waiting time)	RTT (Referral to Treatment) data	

Table 19 – Benefits identified

Appendix A Stakeholders engaged in this exercise

A.1 Hywel Dda stakeholders

Stakeholder name	Role
Anthony Tracey	Digital Director
Tracey Warmsley	Assistant Director of People Planning
Alwena Hughes Moakes	Communications and Engagement Director
Louise O'Connor	Assistant Director for Legal and Patient Support
Carolyn Williams	Head of Digital Innovation & Transformation
Beverly Davies	Strategic Partnership and Inclusion Manager
Mandy Davies	Assistant Director of Nursing & Quality Improvement
Gareth Beynon	Head of Information Services
Gavin Jones	Head of Digital Operations
Sarah Brain	Head of Digital Business & Engagement
John Hackett	Head of Digital Infrastructure
Steven Bennett	Health Records Manager
Rosie Frewin	Senior Services Manager
Daniel Owen	Senior Workforce Manager
Wendy Davies	Project Manager (Workforce Planning)
Kristy Williams	Programme Manager
Enfys Williams	Welsh Language Services Manager
Patrycja Duszynska	Head of Information Governance
Glenys Evans	Communications Hub Facilitator
Rob James	Senior Project Manager
Josh Wood	Assistant Procurement Officer
Elwyn Edwards	Senior Management Accountant
Jeff Bowen	Head of Patient Experience
Joseph Thomas	Clinical Lead

Table 20 – Hywel Dda Stakeholders

A.2 Schedule of Engagements

- Weekly call with Rob James, Senior Digital Project Manager – 15/09/2025 – 22/12/2026
- Weekly Project Team Meeting with Digital Team – 14/08/2025 – 29/01/2026
- Initial Stakeholder Workshop – 11/09/2025
- In-Person Workshop on site – 17/09/205
- Information Governance Workshop – 26/09/2025

- Long List Workshop – 26/09/2025
- Patient Experience Discussion with Louise O’Connor – 01/10/2025
- Options Shortlisting Workshop – 23/10/2025
- Workforce Discussion with Tracey Warmsley – 29/10/2025
- Engagement with representatives from Llais – 18/11/2025
- Options Analysis Outcome Workshop – 05/12/2025

Appendix B Regional Heath and Care Capability Model

CGI and HDUHB have co-created a capability model that covers all of the digital capabilities that a regional health and care organisation such as a Welsh Health Board would need in order to become fully digital.

It consists of two levels of details: capability groups and capabilities.

B.1 Capability Groups

Capability Groups represent high-level collections of capabilities that together address a key part of the organisational, architectural and functional structures that need to be put in place to become a digital health board.

The eight Capability Groups that form the Regional Health and Care Capability Model are described in Figure 16 below.

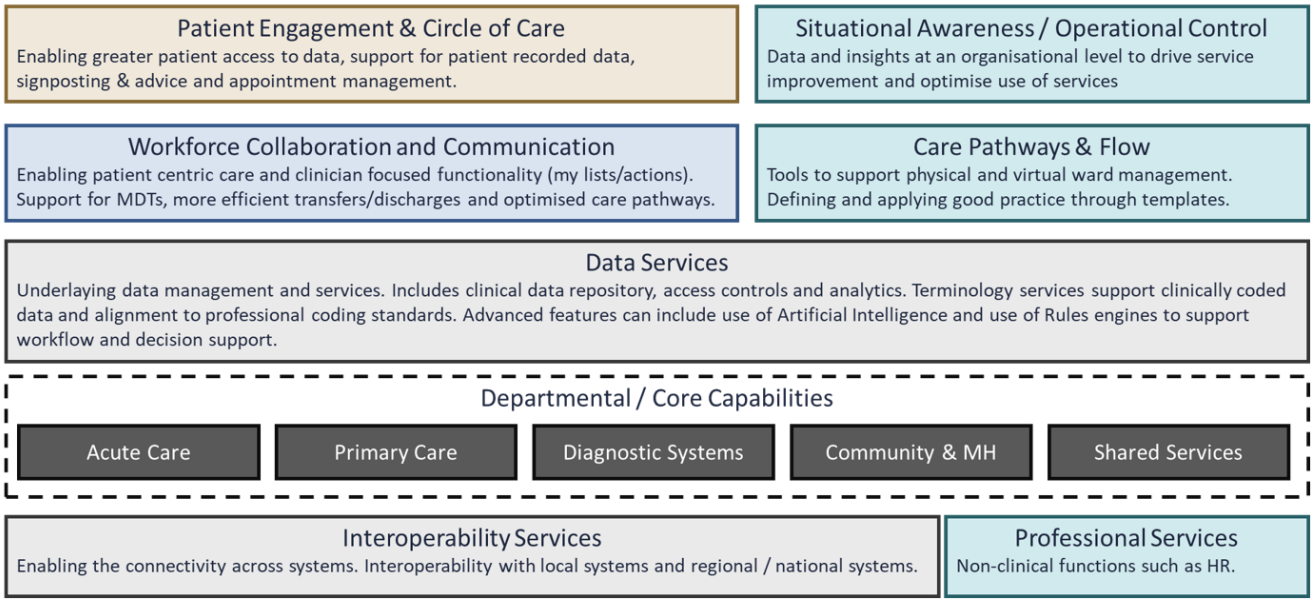


Figure 16 – Capability groups

B.2 Detailed Capabilities

Within each Capability Group there are a number of individual capabilities, each of which can be used to assess either the overall progress of the health board towards full digital capability, or the requirements for new solutions such as the PSC and 360° View.

Figure 17 below shown the detailed capabilities within each Capability Group and indicates which of them were, as part of stakeholder workshops, deemed to be Core, Desired or Optional capabilities for the PSC and 360° View project.

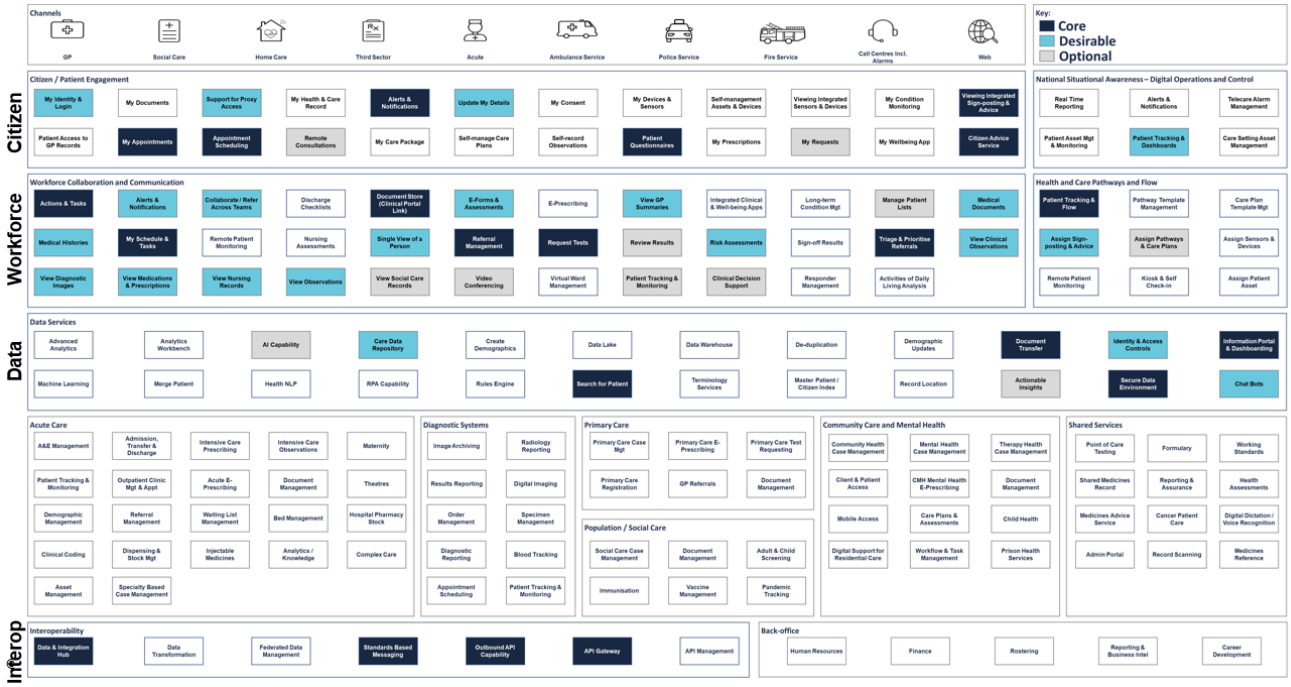


Figure 17 – Detailed capabilities

Appendix C Assessment process for Shortlist options

Each of the shortlisted options were evaluated against Critical Success Factors, including an assessment of Benefits and Risks.

Based on feedback from stakeholders, weightings were applied to the evaluation criteria listed above, as

- there are multiple success criteria and investment objectives which are not equally important, but the priorities weren't obvious or agreed at the start of the stakeholder workshops
- there are a diverse group of stakeholders (clinical, operational, digital, finance) who may value different outcomes
- we require a weighted scoring framework which supports option evaluation in a transparent way

C.1 Benefit assessment

A weighted scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative non-financial benefit as follows:

- Each stakeholder was asked to assign a Relative Importance of 0 to 10 for each benefit to indicate how important they considered each of these to be.
- The Relative Importance values were used to generate a weighted percentage for each benefit.
- For instance, if a Relative Importance of 9 was given to Benefit A and 6 to Benefit B then the weighting for Benefit A would be 9 ÷ (9+6) = 60% and for Benefit B would be 6 ÷ (9+6) = 40%.
- Each stakeholder then assigned an Impact of 0 to 4 for each option according to the degree to which they thought the option would contribute to the realisation of the benefit, where 0 is no benefit and 4 is the most beneficial.
- For each benefit, stakeholder responses were combined by taking an average of everyone's Relative Importance and Impact values.
- A weighted average was calculated across all benefits for each option to give the values shown in Table 11.

It should be noted that the status quo option was not scored. The key factor to consider was whether any of the options introduced additional benefits in comparison to benefits already delivered under existing arrangements. As such, the status quo option would be judged to score zero across all benefit categories.

C.2 Risk assessment

A weighted scoring exercise was undertaken to rank each of the shortlisted options in terms of their relative risk as follows:

- Each stakeholder was asked to assign a Relative Importance of 0 to 10 for each risk to indicate how important they considered each of these to be.
- Note that the risks assessment was optional and applied to risks where stakeholders felt that it is appropriate to provide a score.
- Any Relative Importance value provided were used to generate a weighted percentage for each risk.
- For instance, if a Relative Importance of 9 was given to Benefit A and 6 to Benefit B then the weighting for Benefit A would be 9 ÷ (9+6) = 60% and for Benefit B would be 6 ÷ (9+6) = 40%.
- Each stakeholder then assigned a Likelihood and Impact of 1 to 3 against each risk for each option according to the guidance below
    - Likelihood
        1. The option will introduce no or minimal additional or new risk in this area.
        2. The option will introduce moderate additional or new risk in this area.
        3. The option will introduce a high level of additional or new risk in this area.
    - Impact

1. The risk will have no or minimal negative impact if it occurs.
2. The risk will have moderate negative impact if it occurs.
3. The risk will have a high negative impact if it occurs.

- For each risk where values were provided, stakeholder responses were combined by taking an average of all Relative Importance, Likelihood and Impact values.
- For each risk, the Likelihood was multiplied by the Impact to produce a Risk Score
- A weighted average was calculated across all risks for each option to give the values shown in Table 12.

It should be noted that the status quo option was not scored. The key factor to consider was whether any of the options introduced additional risk in comparison to existing arrangements. As such, the status quo option would be judged to score zero across all risk categories.

C.3 Critical Success Factor assessment

A weighted scoring exercise was undertaken to rank each of the shortlisted options in terms of the Critical Success Factors as follows:

- Each stakeholder was asked to assign an Impact of 0 to 4 for each option according to the degree to which they thought the option would contribute to the achievements of each Investment Objective, where 0 implies that no part of the objective is achieved and 4 is the highest level of achievement.
- For each Investment Objective, stakeholder responses were combined by taking an average of everyone's values.
- An average was calculated across all Investment Objective for each option to give the values shown in Table 13.

It should be noted that the status quo option was not scored as it was judged to score zero across all Investment Objectives.

As similar exercise was carried out by stakeholders for the following Critical Success Factors:

- Strategic fit
- Potential value for money
- Potential achievability (delivery)

The final two Critical Success Factors were assessed by the CGI team using market intelligence:

- Supplier-side capacity
- Supplier-side capability

A summary of the overall assessment process is provided within section 4.8 of this document (see Table 14).

https://hduhb.nhs.wales/

www.cgi.cymru

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqIA)?
An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?
All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?
A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

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 EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	**Title of Procedure, Project, Proposal, Policy being screened.** Patient Services Centre and 360° View (Option 1)
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	The proposal involves the centralisation of functions such as appointment management, information and guidance, referral coordination, follow-up care, patient support services, data management, and communication. The following investment objectives have been identified in the Outline Business Case: • Improve Effectiveness: Optimise the quality of public services and delivery of agreed outcomes by enabling clinicians and staff to access clear, actionable patient information, supporting better decision-making and improved health outcomes. • Improve Efficiency: Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery. • Enhance Economy: Lower the cost and administrative burden of care through digital automation and increased patient self-service. • Ensure Compliance: Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility. • Support Future Improvement: Enable better data collection, analysis, and reporting to inform ongoing service development and innovation. For patients and the public, the Patient Services Centre will provide one phone number to manage all patient queries, utilising an Interactive Voice Response system. It is envisaged that there will also be online capabilities to support public and patient queries, potentially using chatbots and AI tools. The Outline Business Case for this proposal outlines four potential change options. The first being ‘do minimum’ which would be create a new single call centre. Option 2 creates a single call centre for the health board along with a full 360° View and self-manging patient engagement portal by expanding the products used by the health board. Option 3 (Preferred Way Forward) is similar to option 2 for the experience of the patient or public. Option 4 extends the previous option to make use of an external 24x7 call centre.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Rob James, Senior Project Manager
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	- **A Healthier Mid and West Wales Strategy** – the Health Board's blueprint for modern, safe, sustainable, and digitally enabled care. - **Digital Response Plan and Digital Strategic Plan (2025)** – part of the Health Board's 10-year vision for digital excellence. - **Welsh Government Digital and Data Strategy for Health and Care** – calling for a more connected, accessible, and efficient system. - **NHS Wales Digital Transformation Strategy** – supporting national standards and platforms such as NHS Wales App and Patients Know Best. - **Well-being of Future Generations Act** – ensuring sustainable and equitable health services.
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?** (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Population within Hywel Dda University Health Board's geographical region. Patients and/or advocates enquiring about their care are likely to need to engage with the Patient Services Centre. There is potential that those wishing to contact in relation to the care they or a loved one has received may also need to contact the Patient Services Centre. Those members of staff that are involved with responding to patient and public queries, managing patient waiting lists, appointment booking and patient experience are likely to be affected by the proposed changes.
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Staff Training and resistance Confusion for vulnerable patients

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.		X
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		X
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		X
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	X	
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		X
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		X

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert an age breakdown of those affected. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data** Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.
Insert breakdown of staff age in the specific service/ area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the option 1 for the proposal would likely have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Those living within Hywel Dda University Health Board region will all be expected to communicate with the health board via the Patient Services Centre, regardless of age. According to the *National Survey for Wales* 18.5% of people aged 75+ are believed to be digitally excluded. An overreliance on the digital solution to respond to patient queries, could negatively impact this age group within the region. • Individuals who are not digital excluded, yet may have low digital literacy, may become confused if communication on the changes are not effectively communicated.	**Opportunities for improvement / mitigation** • This is being avoided by retaining a phone-based contact centre. It is anticipated that the project will adopt a phased rollout approach with a comprehensive communication strategy to support the change. Physical and digital patient letter templates would need to be updated to ensure single number is available. The health board may also wish to support a public communication campaign. • HDdUHB should seek to ensure that all public-facing digital platforms are updated to reflect the new contact number, including the Health Board website, NHS Wales directories, and Google search results.
Provide a brief summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers slightly improved access and convenience for those of a working age. • **Flexible Working Opportunities:** Limited ability to increase remote working or adjusted hours, subject to service needs, which could benefit older staff seeking work-life balance.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

Insert breakdown of staff with a disability who may be affected

Staff data

<table>
<tr><td>by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Additional considerations for staff with disabilities:
• Accessibility of New Systems: Staff with visual impairments, hearing loss, or motor difficulties may require assistive technologies (screen readers, voice input, high-contrast modes) to use new digital platforms effectively.
• Training Needs: Staff with cognitive or learning disabilities may need tailored training approaches and extended time to adapt to new workflows.
• Physical Relocation Risks: It is not currently anticipated that staff will be physically relocated, as part this proposal, yet if roles are centralised, staff with mobility challenges or reliance on public transport may face barriers in commuting to new locations.
• Flexible Working: Remote working options should be considered for staff with disabilities to reduce physical strain and improve inclusion.
• Mental Health Considerations: Staff with mental health conditions may experience stress during organisational change; proactive support and reasonable adjustments are essential.
• Compliance with Accessible Communication and Information Standards: Systems must allow staff to record and respond to patient accessibility needs accurately.
• Workstation Adaptations: Ensure ergonomic setups and assistive devices are available for staff with physical disabilities if a new environment is adopted.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• The project has considered the potential impact on the existing 111 press 2 service currently in operation. For those seeking support with mental health conditions or in crisis, it is essential that the workforce within the Patient Services Centre has sufficient skills and experience to be able to provide the support needed. It is also important that the service does not exasperate a situation, for example by placing an individual in crisis on hold.
• Patients with hearing loss may face barriers when accessing services via telephone-based systems.

• Patients with speech, cognitive or language-related challenges may require tailored support.</td><td>Opportunities for improvement / mitigation
• It is currently unclear how the Patient Services Centre will work alongside or incorporate current MH support.

• Currently, those with hearing loss experience difficulties accessing information using existing systems in place. Option 1 for proposed call centre solution may not include sufficient integration with British Sign Language (BSL) interpretation services, text relay services and SMS-based communication options, online chat and other alternatives to voice calls.</td></tr>
</table>

		• Use of existing systems under a unified Patient Services Centre may provide some support and staff training can be introduced in inclusive communication techniques.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Option one for Patient Services Centre can deliver some improved access to services and efficiencies in a single contact centre. Due to the usage of existing technologies within HDdUHB, there is a significant reduction in the potential positive impact that the proposal may deliver for those with disabilities. It is anticipated that the PSC will deliver slightly improved access to services through a single contact centre, with potentially longer opening hours, that may support all demographics in society. • **Flexible Working Opportunities:** Some remote working options could be considered for staff with disabilities to reduce physical strain and improve inclusion.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equally for access and service regardless of sexual orientation. Non-gendered language should be used as a default within the contact centre to ensure that those undergoing gender reassignment, or identify as a different gender from their gender at birth, are not misgendered. It is not currently anticipated that staff will be physically relocated as part of this project and therefore, access to any non-gendered facilities that may currently be utilised, will not be withdrawn. Any OCP that may result from this proposal would consider change of line management and how those that may be transitioning would be supported moving forward.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	
		No Impact	X
If you have determined no impact, please provide a brief explanation.	**No Impact** This group relates solely to workplace and employment matters. Any changes to staff roles arising from this policy will not result in differential treatment based on assumptions about their relationship status.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity **Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.**		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** Option one is likely to provide no impact for those who are pregnant or on maternity.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

Additional considerations for staff from different racial, ethnic, or national backgrounds:
Language Barriers: Staff whose first language is not English or Welsh may require additional training and support to use new systems confidently.
Cultural Awareness: Ensure that training materials and communication strategies are culturally sensitive and inclusive.
Translation Support: Staff may need access to translation tools or guidance when assisting patients who speak other languages.
Recruitment and Retention: Diverse staff may bring valuable language skills for patient engagement; ensure these are recognised and utilised.
Equality of Opportunity: Monitor that redeployment or role changes do not disproportionately disadvantage staff from minority ethnic backgrounds.
Training Accessibility: Provide training in multiple formats (written, visual, and verbal) to accommodate varying language proficiency levels.
Anti-Discrimination Measures: Reinforce policies and training to prevent bias or discrimination during organisational change.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</td><td>Negative Impact
Patients who do not speak English or Welsh may experience delays or misunderstandings when accessing the Patient Services Centre.
Communication that is not culturally appropriate or inclusive may reduce trust and engagement among minority ethnic groups.
Groups such as Gypsy, Roma, and Traveller communities, refugees, and asylum seekers may not receive timely</td><td>Opportunities for improvement / mitigation
It is envisaged that processes and training will be in place to ensure that staff are able to access and utilise the Welsh Interpretation and Translation Service (WITS).
Distribute key messages in multiple languages, BSL video, Braille on request, and Easy Read formats.
Use the Community Development Outreach Team to engage hard-to-reach communities through face-to-face sessions, translated materials, and trusted intermediaries.</td></tr>
</table>

relevant negative impact.	information about service changes if communications rely solely on digital channels. • If staff are unfamiliar with WITS (Wales Interpretation and Translation Service) processes, patients may face delays in receiving interpretation support.	• Provide staff training on cultural awareness and inclusive communication to improve patient experience.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers slightly improved access and convenience for all nationalities and ethnicities. • **Community Engagement:** The PSC can work with outreach teams to engage Gypsy, Roma, Traveller communities, refugees, and asylum seekers, ensuring they receive timely information and support.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** The service does not interfere with or restrict religious practices or beliefs. Patients can access services regardless of faith or philosophical belief. The needs of staff with certain religions and beliefs will be considered as part of this project.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** The Patient Services Centre provides equal access and functionality for all genders without bias or differentiation.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equal for access and service regardless of sexual orientation.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider 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**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

According to a Written Question, the Secretary for State for Defence confirmed in 2023 that there are over 500 regular and reserve posts based at Cawdor Barracks (Pembrokeshire). At Cawdor, there are also 148 Service Family Accommodation units.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Should the proposal be progressed, a detailed assessment will be conducted on the affected service areas, including understanding the demographics of the staff involved and whether they are a current reservist or veteran.

Additional considerations for those staff members that are veterans or reservists:
• Required time for training or deployment: Reservists may need time off for annual training or deployment, which could impact rostering in the Patient Services Centre.
• Health Needs: Veterans may have physical and/or mental health needs that require medical appointments and/or adjustments in the workspace.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• Reservists may require time off for training or deployment, creating scheduling and rostering challenges in a centralised Patient Services Centre.
• Active personnel and veterans may be accustomed to existing contact points or direct liaison with specific services. Centralising into a PSC could initially cause confusion or perceived barriers.
• Veterans working in PSC may experience stress during organisational change or in high-pressure call-handling environments.</td><td>Opportunities for improvement / mitigation
• Ensure rostering accommodates reservist training and deployment commitments. Consider hybrid working options where feasible.
• Work with local Armed Forces charities and veteran networks to co-design communication strategies and ensure awareness of PSC changes.

• Provide access to mental health services and peer support networks for veterans and reservists.</td></tr>
<tr><td>Provide a summary of the positive</td><td colspan="2">Positive Impact
• Simplified access: A single, centralised contact number reduces complexity for active personnel and veterans who often move between locations or experience fragmented care pathways.</td></tr>
</table>

impacts you have identified.	• **Opportunity for Outreach:** PSC can collaborate with Armed Forces charities and local networks to improve awareness and engagement, fostering trust and inclusion.
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation 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 resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'least deprived' or as second 'least deprived' in Wales. There are a number of areas identified as being nearer 'most deprived', which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	
Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff experiencing socio-economic deprivation: • Travel and Location Changes: There are no current places to centralise teams physically in one location, so staff who rely on public transport are unlikely to face increased community costs and time. • Flexible Working Needs: The potential ability for staff to work partly remotely may deliver benefits of staff reduced travel costs. • Impact of Shift Changes: Whilst it is currently envisaged that the Patient Service Centre will have increased opening hours, it is not anticipated that HDdUHB staff will be required to work nights to support those services that are only supported in the day currently. • Digital Inclusion: Staff from deprived backgrounds may have limited access to personal devices or broadband, impacting their ability to engage with training or remote work. • Training and Upskilling: Ensure equitable access to training opportunities, including paid time for training, to avoid disadvantaging staff who cannot afford unpaid learning. • Financial Well-being Support: Consider signposting staff to financial advice services and employee assistance programmes during any organisational change.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Staff from deprived backgrounds may lack access to personal devices or reliable internet, limiting their ability to participate in remote working or online training.	**Opportunities for improvement / mitigation** • Ensure access to devices and connectivity for staff who need them and offer on-site facilities for training, if seeking to use more remote working with current systems.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Single, simpler point of access:** A centralised Patient Services Centre (PSC) with one number reduces the “phoning around”, helping people who have limited time, money, or phone credit to resolve queries more quickly.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.	**Positive**	**X**
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:

- Understand spoken Welsh
- Speak Welsh
- Read Welsh
- Write Welsh

Area	Percentage of people who can speak Welsh
Carmarthenshire	53.3
Pembrokeshire	25.2
Ceredigion	56.4
Hywel Dda	45

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those that are affected use the Welsh Language. This data can be

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff regarding Welsh language: • Language Skills Distribution: Staff currently providing patient-facing services may have varying levels of Welsh language proficiency. Some roles may require bilingual capability to meet Welsh Language Standards and patient expectations. • Recruitment and Workforce Planning: If teams are physically centralised, there may be a requirement for redeployment or recruitment of Welsh-speaking staff to ensure compliance and continuity of service. • Training Needs: Staff who are not fluent in Welsh may need access to language training or conversational support to handle basic queries confidently. • Operational Impact: Rostering must ensure Welsh-speaking staff are available during all operating hours to avoid delays for patients requesting service in Welsh. • Monitoring: Workforce data should track Welsh language skills to identify gaps and inform recruitment or training strategies.	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation	**Negative Impact** • Risk of delayed response if rostering doesn't ensure coverage	**Opportunities for improvement / mitigation** • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh.

actions align with the relevant negative impact.		
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Consistent Compliance with Welsh Language Standards:** Centralisation provides an opportunity to ensure Welsh language provision is embedded across all communication channels (phone, web, letters, SMS). When progressing with this proposal, key lessons learnt can be taken from recent changes to the switchboards and the bilingual operations of the communication hub and contact centre.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Additional considerations
In addition to the above protected characteristics please consider impact on the following: • **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)** • **Unpaid Carers** • **Individuals and communities who experience Digital Exclusion** • **Rural and Urban communities**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Intersectionality
It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges. **Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.
Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: an **opportunity/impact score and a likelihood score.** The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores with automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

(Opportunity/impact Score x Likelihood Score = Total Score)

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
Neutral	**0**	Neutral	(Neutral): No effect, either positive or negative.
Negative	**-1**	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

- **To access the scoring table below you will need to double click on the table to open an editable version.**
- **To close the scoring table, you need to click to the side of the table.**
- **The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity* / Impact Rating**	*IIA Matrix		
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative	Positive impact	Neutral impact	Negative impact	Unknown		Opportunity/Impact	Likelihood	Total Score
Age	X		X		* positive rating	3	3	9
					** negative rating	-2	2	-4
Disability	X		X		* positive rating	3	3	9
					** negative rating	-3	2	-6
Gender Reassignment		X			* positive rating			0
					** negative rating			0
Marriage and Civil Partnership		X			* positive rating			0
					** negative rating			0
Pregnancy and Maternity		X			* positive rating			0
					** negative rating			0
Race/Ethnicity or Nationality	X		X		* positive rating	3	3	9
					** negative rating	-2	3	-6
Religion or Belief		X			* Positive rating			0
					** negative rating			0
Sex		X			* positive rating			0
					** negative rating			0
Sexual Orientation		X			* positive rating			0
					** negative rating			0
Armed Forces	X		X		* positive rating	3	3	9
					** negative rating	-3	2	-6
Socio-economic Deprivation	X		X		* positive rating	3	3	9
					** negative rating	-2	2	-4
Welsh Language	X				* positive rating	3	3	9
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	The Patient Services Centre (PSC) proposal will be adopted as part of Hywel Dda UHB's digital transformation strategy. The PSC aligns with strategic objectives to improve access, efficiency, and patient experience.
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	While some negative impacts have been identified, these risks will be mitigated through targeted actions. The overall benefits of improved access, streamlined processes, and enhanced patient engagement outweigh these risks.

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
	This section of the EqIA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqIA are included (ideally these should not be the same person). A member of the Diversity and Inclusion team will add their information to the final section, to show that the Diversity and Inclusion team have had sight of the EqIA and if required provided guidance.

EqIA Completed by:	**Name/s**	Rob James
	Title	Senior Project Manager
	Team / Division	Digital, Innovation & Transformation
	Contact details	Robert.james2@wales.nhs.uk
	Date	02/01/2026
EqIA Authorised by/Owned by: • **Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy** • **Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5**	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
Guidance has been provided by Diversity & Inclusion Team: (to be completed by Diversity and Inclusion team only)	**Name**	Kylie Daniels
	Title	Senior Diversity & Inclusion Officer
	Team	Business, Partnership & Inclusion
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	06/01/2026
Diversity and Inclusion Team additional Comments:	This draft EqIA will need ongoing review and revision throughout the project's progression.	

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 EqIA and inform the D&I team.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqIA)?
An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?
All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?
A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

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 EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	**Title of Procedure, Project, Proposal, Policy being screened.** Patient Services Centre and 360° View (Option 2)
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	The proposal involves the centralisation of functions such as appointment management, information and guidance, referral coordination, follow-up care, patient support services, data management, and communication. The following investment objectives have been identified in the Outline Business Case: • Improve Effectiveness: Optimise the quality of public services and delivery of agreed outcomes by enabling clinicians and staff to access clear, actionable patient information, supporting better decision-making and improved health outcomes. • Improve Efficiency: Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery. • Enhance Economy: Lower the cost and administrative burden of care through digital automation and increased patient self-service. • Ensure Compliance: Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility. • Support Future Improvement: Enable better data collection, analysis, and reporting to inform ongoing service development and innovation. For patients and the public, the Patient Services Centre will provide one phone number to manage all patient queries, utilising an Interactive Voice Response system. It is envisaged that there will also be online capabilities to support public and patient queries, potentially using chatbots and AI tools. The Outline Business Case for this proposal outlines four potential change options. The first being ‘do minimum’ which would be create a new single call centre. Option 2 creates a single call centre for the health board along with a full 360° View and self-manging patient engagement portal by expanding the products used by the health board. Option 3 (Preferred Way Forward) is similar to option 2 for the experience of the patient or public. Option 4 extends the previous option to make use of an external 24x7 call centre.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Rob James, Senior Project Manager
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	- **A Healthier Mid and West Wales Strategy** – the Health Board's blueprint for modern, safe, sustainable, and digitally enabled care. - **Digital Response Plan and Digital Strategic Plan (2025)** – part of the Health Board's 10-year vision for digital excellence. - **Welsh Government Digital and Data Strategy for Health and Care** – calling for a more connected, accessible, and efficient system. - **NHS Wales Digital Transformation Strategy** – supporting national standards and platforms such as NHS Wales App and Patients Know Best. - **Well-being of Future Generations Act** – ensuring sustainable and equitable health services.
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?** (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Population within Hywel Dda University Health Board's geographical region. Patients and/or advocates enquiring about their care are likely to need to engage with the Patient Services Centre. There is potential that those wishing to contact in relation to the care they or a loved one has received may also need to contact the Patient Services Centre. Those members of staff that are involved with responding to patient and public queries, managing patient waiting lists, appointment booking and patient experience are likely to be affected by the proposed changes.
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Staff Training and resistance Confusion for vulnerable patients

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.		X
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		X
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		X
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	X	
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		X
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		X

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Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert an age breakdown of those affected. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data** Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.
Insert breakdown of staff age in the specific service/ area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the option 1 for the proposal would likely have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

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Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Those living within Hywel Dda University Health Board region will all be expected to communicate with the health board via the Patient Services Centre, regardless of age. According to the *National Survey for Wales* 18.5% of people aged 75+ are believed to be digitally excluded. An overreliance on the digital solution to respond to patient queries, could negatively impact this age group within the region. • Individuals who are not digital excluded, yet may have low digital literacy, may become confused if communication on the changes are not effectively communicated.	**Opportunities for improvement / mitigation** • This is being avoided by retaining a phone-based contact centre. It is anticipated that the project will adopt a phased rollout approach with a comprehensive communication strategy to support the change. Physical and digital patient letter templates would need to be updated to ensure single number is available. The health board may also wish to support a public communication campaign. • HDdUHB should seek to ensure that all public-facing digital platforms are updated to reflect the new contact number, including the Health Board website, NHS Wales directories, and Google search results.
Provide a brief summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers improved access and convenience for those of a working age. • **Improved Communication:** For younger, digitally confident patients, online chat and app-based features provide convenience and immediacy. • **Enhanced Autonomy and Self-Management:** Digital tools enable patients to manage appointments, view records, and receive reminders, supporting independence for all ages. • **Flexible Working Opportunities:** Potential for remote working or adjusted hours, subject to service needs, which could benefit older staff seeking work-life balance. • **Skill Development:** Training on new systems provides opportunities for staff to upskill and build confidence in digital technologies. • **Reduced Stress from Fragmented Processes:** Simplified processes and clearer communication channels should reduce instances of staff dealing with challenging behaviour and reduced workload pressure.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

Insert breakdown of staff with a disability who may be affected

Staff data

<table>
<tr><td>by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Additional considerations for staff with disabilities:
Accessibility of New Systems: Staff with visual impairments, hearing loss, or motor difficulties may require assistive technologies (screen readers, voice input, high-contrast modes) to use new digital platforms effectively.
Training Needs: Staff with cognitive or learning disabilities may need tailored training approaches and extended time to adapt to new workflows.
Physical Relocation Risks: It is not currently anticipated that staff will be physically relocated, as part this proposal, yet if roles are centralised, staff with mobility challenges or reliance on public transport may face barriers in commuting to new locations.
Flexible Working: Remote working options should be considered for staff with disabilities to reduce physical strain and improve inclusion.
Mental Health Considerations: Staff with mental health conditions may experience stress during organisational change; proactive support and reasonable adjustments are essential.
Compliance with Accessible Communication and Information Standards: Systems must allow staff to record and respond to patient accessibility needs accurately.
Workstation Adaptations: Ensure ergonomic setups and assistive devices are available for staff with physical disabilities if a new environment is adopted.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
The project has considered the potential impact on the existing 111 press 2 service currently in operation. For those seeking support with mental health conditions or in crisis, it is essential that the workforce within the Patient Services Centre has sufficient skills and experience to be able to provide the support needed. It is also important that the service does not exasperate a situation, for example by placing an individual in crisis on hold.
Patients with hearing loss may face barriers when accessing services via telephone-based systems.
Individuals with visual impairments may encounter difficulties navigating digital interfaces.</td><td>Opportunities for improvement / mitigation
It is currently unclear how the Patient Services Centre will work alongside or incorporate current MH support.
Currently, those with hearing loss experience difficulties accessing information using existing systems in place. Option 1 for proposed call centre solution may not include sufficient integration with British Sign Language (BSL) interpretation services, text relay services and SMS-based communication options, online chat and other alternatives to voice calls.
To mitigate against this, the platform must comply with WCAG 2.2 accessibility standards, support screen</td></tr>
</table>

	• Patients with speech, cognitive or language-related challenges may require tailored support. • Staff with disabilities may struggle with new systems if accessibility features are not embedded or if training is insufficient.	readers and high-contrast modes and offer voice-assisted navigation and adjustable font sizes. • The Patient Services Centre must support proxy access functionality for family members and carers, multi-language support and staff training in inclusive communication techniques. • Full consideration of the impact on individual staff members would need to be considered prior to procuring the solution. We must ensure that any solution contains accessibility features and ergonomic setups and assistive devices should be made available for staff with physical disabilities in any new environment adopted.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** PSC will provide multiple access channels (phone and web), ensuring inclusivity for all patient groups. Clinical staff within the contact centre will improve responsiveness for patients with complex or long-term conditions. • **Enhanced Patient Autonomy:** For those patients seeking autonomy, the self-management tools will support that aim. • **Accessibility Compliance:** Compliance with WCAG 2.2 ensures platforms are usable by individuals with visual, motor, and cognitive impairments (e.g., screen reader compatibility, clear focus indicators, adjustable text size). It is envisaged that the Patient Relationship Management tool will enable staff to record key information about the patient in accordance with the recently published Accessible Communication and Information Standards. • **Flexible Working Opportunities:** Some remote working options could be considered for staff with disabilities to reduce physical strain and improve inclusion.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equally for access and service regardless of sexual orientation. Non-gendered language should be used as a default within the contact centre to ensure that those undergoing gender reassignment, or identify as a different gender from their gender at birth, are not misgendered. It is not currently anticipated that staff will be physically relocated as part of this project and therefore, access to any non-gendered facilities that may currently be utilised, will not be withdrawn. Any OCP that may result from this proposal would consider change of line management and how those that may be transitioning would be supported moving forward.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	
		No Impact	X
If you have determined no impact, please provide a brief explanation.	**No Impact** This group relates solely to workplace and employment matters. Any changes to staff roles arising from this policy will not result in differential treatment based on assumptions about their relationship status.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity **Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.**		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** Option one is likely to provide no impact for those who are pregnant or on maternity.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

Additional considerations for staff from different racial, ethnic, or national backgrounds:
Language Barriers: Staff whose first language is not English or Welsh may require additional training and support to use new systems confidently.
Cultural Awareness: Ensure that training materials and communication strategies are culturally sensitive and inclusive.
Translation Support: Staff may need access to translation tools or guidance when assisting patients who speak other languages.
Recruitment and Retention: Diverse staff may bring valuable language skills for patient engagement; ensure these are recognised and utilised.
Equality of Opportunity: Monitor that redeployment or role changes do not disproportionately disadvantage staff from minority ethnic backgrounds.
Training Accessibility: Provide training in multiple formats (written, visual, and verbal) to accommodate varying language proficiency levels.
Anti-Discrimination Measures: Reinforce policies and training to prevent bias or discrimination during organisational change.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</td><td>Negative Impact
Patients who do not speak English or Welsh may experience delays or misunderstandings when accessing the Patient Services Centre.
Communication that is not culturally appropriate or inclusive may reduce trust and engagement among minority ethnic groups.
Groups such as Gypsy, Roma, and Traveller communities, refugees, and asylum seekers may not receive timely</td><td>Opportunities for improvement / mitigation
It is envisaged that processes and training will be in place to ensure that staff are able to access and utilise the Welsh Interpretation and Translation Service (WITS).
Distribute key messages in multiple languages, BSL video, Braille on request, and Easy Read formats.
Use the Community Development Outreach Team to engage hard-to-reach communities through face-to-face sessions, translated materials, and trusted intermediaries.</td></tr>
</table>

relevant negative impact.	information about service changes if communications rely solely on digital channels. • If staff are unfamiliar with WITS (Wales Interpretation and Translation Service) processes, patients may face delays in receiving interpretation support.	• Provide staff training on cultural awareness and inclusive communication to improve patient experience.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers improved access and convenience for all nationalities and ethnicities. • **Community Engagement:** The PSC can work with outreach teams to engage Gypsy, Roma, Traveller communities, refugees, and asylum seekers, ensuring they receive timely information and support. • **Opportunity for Inclusive Communication:** PSC provides an ability to embed culturally sensitive communication practices across all channels. • **Improved Signposting:** PSC can ensure timely referral to specialist services for patients who speak languages other than English or Welsh. • **Staff Cultural Competence Development:** Training PSC staff on cultural awareness and inclusive communication will improve patient experience and foster trust among diverse communities.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** The service does not interfere with or restrict religious practices or beliefs. Patients can access services regardless of faith or philosophical belief. The needs of staff with certain religions and beliefs will be considered as part of this project.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** The Patient Services Centre provides equal access and functionality for all genders without bias or differentiation.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equal for access and service regardless of sexual orientation.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider 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**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

According to a Written Question, the Secretary for State for Defence confirmed in 2023 that there are over 500 regular and reserve posts based at Cawdor Barracks (Pembrokeshire). At Cawdor, there are also 148 Service Family Accommodation units.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Should the proposal be progressed, a detailed assessment will be conducted on the affected service areas, including understanding the demographics of the staff involved and whether they are a current reservist or veteran.

Additional considerations for those staff members that are veterans or reservists:
• Required time for training or deployment: Reservists may need time off for annual training or deployment, which could impact rostering in the Patient Services Centre.
• Health Needs: Veterans may have physical and/or mental health needs that require medical appointments and/or adjustments in the workspace.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• Reservists may require time off for training or deployment, creating scheduling and rostering challenges in a centralised Patient Services Centre.
• Active personnel and veterans may be accustomed to existing contact points or direct liaison with specific services. Centralising into a PSC could initially cause confusion or perceived barriers.
• Veterans working in PSC may experience stress during organisational change or in high-pressure call-handling environments.</td><td>Opportunities for improvement / mitigation
• Ensure rostering accommodates reservist training and deployment commitments. Consider hybrid working options where feasible.
• Work with local Armed Forces charities and veteran networks to co-design communication strategies and ensure awareness of PSC changes.

• Provide access to mental health services and peer support networks for veterans and reservists.</td></tr>
<tr><td>Provide a summary of the positive</td><td colspan="2">Positive Impact
• Simplified access: A single, centralised contact number reduces complexity for active personnel and veterans who often move between locations or experience fragmented care pathways.</td></tr>
</table>

impacts you have identified.	• **Opportunity for Outreach:** PSC can collaborate with Armed Forces charities and local networks to improve awareness and engagement, fostering trust and inclusion. • **Multi-Channel Flexibility:** PSC offers phone, web, and app-based options, enabling personnel deployed overseas or veterans in rural areas to access services remotely. • **Empowerment through Self-management:** Digital tools will allow individuals, including those managing mental health conditions, to take control of their appointments and access information independently, promoting autonomy and reducing stress.
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation 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 resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'least deprived' or as second 'least deprived' in Wales. There are a number of areas identified as being nearer 'most deprived', which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	
Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff experiencing socio-economic deprivation: • Travel and Location Changes: There are no current places to centralise teams physically in one location, so staff who rely on public transport are unlikely to face increased community costs and time. • Flexible Working Needs: The potential ability for staff to work partly remotely may deliver benefits of staff reduced travel costs. • Impact of Shift Changes: Whilst it is currently envisaged that the Patient Service Centre will have increased opening hours, it is not anticipated that HDdUHB staff will be required to work nights to support those services that are only supported in the day currently. • Digital Inclusion: Staff from deprived backgrounds may have limited access to personal devices or broadband, impacting their ability to engage with training or remote work. • Training and Upskilling: Ensure equitable access to training opportunities, including paid time for training, to avoid disadvantaging staff who cannot afford unpaid learning. • Financial Well-being Support: Consider signposting staff to financial advice services and employee assistance programmes during any organisational change.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • An important feature of the Patient Services Centre is the ability of the patient to access their health record and details through a 'digital front door'. The project has already taken into consideration the potential barriers that may be created if patients were forced to seek answers to their queries solely through a digital application and it is a key reason for utilising the proposed unified contact centre. A recent report by Audit Wales, *Digital inclusion in Wales*, identified that cost of living pressures may force individuals to reflect on the affordability of their current arrangements for internet access. • Staff from deprived backgrounds may lack access to personal devices or reliable internet, limiting their ability to participate in remote working or online training.	**Opportunities for improvement / mitigation** • By retaining our phone-based communication method, patients are not reliant upon personal internet access to seek support from the health board. Consideration has also been given to the ability of patients to contact the health board using telephones. In *Connected Nations: Autumn Update 2022*, it is highlighted that 4% of the geographical area of Wales not having coverage from a telephone operator, with rural Wales being particularly affected. • Ensure access to devices and connectivity for staff who need them and offer on-site facilities for training, if seeking to use more remote working with current systems.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Single, simpler point of access:** A centralised Patient Services Centre (PSC) with one number reduces the "phoning around", helping people who have limited time, money, or phone credit to resolve queries more quickly. • **Reduced missed appointments and wasted journeys:** Proactive reminders, clearer instructions, and easier rescheduling can reduce DNAs and unnecessary travel—benefiting those who would otherwise lose wages or pay extra for transport/childcare. • **Self-service when convenient:** Digital self-management (where appropriate) lets people take action outside working hours, avoiding time off work and associated income loss. • **Reduced personal cost burden:** Where roles allow, hybrid/remote working and consolidated rostering could cut commuting costs, which would be valuable for staff on lower incomes or living in rural areas.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.	**Positive**	**X**
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:

- Understand spoken Welsh
- Speak Welsh
- Read Welsh
- Write Welsh

Area	Percentage of people who can speak Welsh
Carmarthenshire	53.3
Pembrokeshire	25.2
Ceredigion	56.4
Hywel Dda	45

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those that are affected use the Welsh Language. This data can be

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff regarding Welsh language: • Language Skills Distribution: Staff currently providing patient-facing services may have varying levels of Welsh language proficiency. Some roles may require bilingual capability to meet Welsh Language Standards and patient expectations. • Recruitment and Workforce Planning: If teams are physically centralised, there may be a requirement for redeployment or recruitment of Welsh-speaking staff to ensure compliance and continuity of service. • Training Needs: Staff who are not fluent in Welsh may need access to language training or conversational support to handle basic queries confidently. • Operational Impact: Rostering must ensure Welsh-speaking staff are available during all operating hours to avoid delays for patients requesting service in Welsh. • Monitoring: Workforce data should track Welsh language skills to identify gaps and inform recruitment or training strategies.	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation	**Negative Impact** • Risk of delayed response if rostering doesn't ensure coverage	**Opportunities for improvement / mitigation** • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh.

actions align with the relevant negative impact.		
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Consistent Compliance with Welsh Language Standards:** Centralisation provides an opportunity to ensure Welsh language provision is embedded across all communication channels (phone, web, letters, SMS). • **Enhanced Patient Experience:** Patients who prefer to communicate in Welsh will have greater confidence and satisfaction when their language choice is respected and supported. • **Opportunity for Workforce Development:** Staff can access Welsh language training and resources, improving bilingual capability and career development opportunities. When progressing with this proposal, key lessons learnt can be taken from recent changes to the switchboards and the bilingual operations of the communication hub and contact centre.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Additional considerations
In addition to the above protected characteristics please consider impact on the following: • **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)** • **Unpaid Carers** • **Individuals and communities who experience Digital Exclusion** • **Rural and Urban communities**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Intersectionality
It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges. **Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.
Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: an **opportunity/impact score and a likelihood score.** The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores with automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

(Opportunity/impact Score x Likelihood Score = Total Score)

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
Neutral	**0**	Neutral	(Neutral): No effect, either positive or negative.
Negative	**-1**	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

- **To access the scoring table below you will need to double click on the table to open an editable version.**
- **To close the scoring table, you need to click to the side of the table.**
- **The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity* / Impact Rating**	*IIA Matrix		
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative	Positive impact	Neutral impact	Negative impact	Unknown		Opportunity/Impact	Likelihood	Total Score
Age	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Disability	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Gender Reassignment		X			* positive rating			0
					** negative rating			0
Marriage and Civil Partnership		X			* positive rating			0
					** negative rating			0
Pregnancy and Maternity		X			* positive rating			0
					** negative rating			0
Race/Ethnicity or Nationality	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Religion or Belief		X			* Positive rating			0
					** negative rating			0
Sex		X			* positive rating			0
					** negative rating			0
Sexual Orientation		X			* positive rating			0
					** negative rating			0
Armed Forces	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Socio-economic Deprivation	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Welsh Language	X				* positive rating	4	4	16
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	The Patient Services Centre (PSC) proposal will be adopted as part of Hywel Dda UHB's digital transformation strategy. The PSC aligns with strategic objectives to improve access, efficiency, and patient experience.
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	While some negative impacts have been identified, these risks will be mitigated through targeted actions. The overall benefits of improved access, streamlined processes, and enhanced patient engagement outweigh these risks. The PSC will retain non-digital channels (telephone, in-person, postal) and embed inclusive practices to minimize adverse effects.

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
	This section of the EqIA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqIA are included (ideally these should not be the same person). A member of the Diversity and Inclusion team will add their information to the final section, to show that the Diversity and Inclusion team have had sight of the EqIA and if required provided guidance.

EqIA Completed by:	**Name/s**	Rob James
	Title	Senior Project Manager
	Team / Division	Digital, Innovation & Transformation
	Contact details	Robert.james2@wales.nhs.uk
	Date	02/01/2026
EqIA Authorised by/Owned by: • **Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy** • **Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5**	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
Guidance has been provided by Diversity & Inclusion Team: (to be completed by Diversity and Inclusion team only)	**Name**	Kylie Daniels
	Title	Senior Diversity & Inclusion Officer
	Team	Business, Partnership & Inclusion
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	06/01/2026
Diversity and Inclusion Team additional Comments:	This draft EqIA will need ongoing review and revision throughout the project's progression.	

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 EqIA and inform the D&I team.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqIA)?
An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?
All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?
A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

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 EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	**Title of Procedure, Project, Proposal, Policy being screened.** Patient Services Centre and 360° View (Option 3)
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	The proposal involves the centralisation of functions such as appointment management, information and guidance, referral coordination, follow-up care, patient support services, data management, and communication. The following investment objectives have been identified in the Outline Business Case: • Improve Effectiveness: Optimise the quality of public services and delivery of agreed outcomes by enabling clinicians and staff to access clear, actionable patient information, supporting better decision-making and improved health outcomes. • Improve Efficiency: Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery. • Enhance Economy: Lower the cost and administrative burden of care through digital automation and increased patient self-service. • Ensure Compliance: Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility. • Support Future Improvement: Enable better data collection, analysis, and reporting to inform ongoing service development and innovation. For patients and the public, the Patient Services Centre will provide one phone number to manage all patient queries, utilising an Interactive Voice Response system. It is envisaged that there will also be online capabilities to support public and patient queries, potentially using chatbots and AI tools. The Outline Business Case for this proposal outlines four potential change options. The first being ‘do minimum’ which would be create a new single call centre. Option 2 creates a single call centre for the health board along with a full 360° View and self-manging patient engagement portal by expanding the products used by the health board. Option 3 (Preferred Way Forward) is similar to option 2 for the experience of the patient or public. Option 4 extends the previous option to make use of an external 24x7 call centre.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Rob James, Senior Project Manager
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	- **A Healthier Mid and West Wales Strategy** – the Health Board's blueprint for modern, safe, sustainable, and digitally enabled care. - **Digital Response Plan and Digital Strategic Plan (2025)** – part of the Health Board's 10-year vision for digital excellence. - **Welsh Government Digital and Data Strategy for Health and Care** – calling for a more connected, accessible, and efficient system. - **NHS Wales Digital Transformation Strategy** – supporting national standards and platforms such as NHS Wales App and Patients Know Best. - **Well-being of Future Generations Act** – ensuring sustainable and equitable health services.
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?** (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Population within Hywel Dda University Health Board's geographical region. Patients and/or advocates enquiring about their care are likely to need to engage with the Patient Services Centre. There is potential that those wishing to contact in relation to the care they or a loved one has received may also need to contact the Patient Services Centre. Those members of staff that are involved with responding to patient and public queries, managing patient waiting lists, appointment booking and patient experience are likely to be affected by the proposed changes.
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Staff Training and resistance Confusion for vulnerable patients

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.		X
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		X
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		X
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	X	
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		X
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		X

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert an age breakdown of those affected. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data** Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.
Insert breakdown of staff age in the specific service/ area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the option 1 for the proposal would likely have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Those living within Hywel Dda University Health Board region will all be expected to communicate with the health board via the Patient Services Centre, regardless of age. According to the *National Survey for Wales* 18.5% of people aged 75+ are believed to be digitally excluded. An overreliance on the digital solution to respond to patient queries, could negatively impact this age group within the region. • Individuals who are not digital excluded, yet may have low digital literacy, may become confused if communication on the changes are not effectively communicated.	**Opportunities for improvement / mitigation** • This is being avoided by retaining a phone-based contact centre. It is anticipated that the project will adopt a phased rollout approach with a comprehensive communication strategy to support the change. Physical and digital patient letter templates would need to be updated to ensure single number is available. The health board may also wish to support a public communication campaign. • HDdUHB should seek to ensure that all public-facing digital platforms are updated to reflect the new contact number, including the Health Board website, NHS Wales directories, and Google search results.
Provide a brief summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers improved access and convenience for those of a working age. • **Improved Communication:** For younger, digitally confident patients, online chat and app-based features provide convenience and immediacy. • **Enhanced Autonomy and Self-Management:** Digital tools enable patients to manage appointments, view records, and receive reminders, supporting independence for all ages. • **Flexible Working Opportunities:** Potential for remote working or adjusted hours, subject to service needs, which could benefit older staff seeking work-life balance. • **Skill Development:** Training on new systems provides opportunities for staff to upskill and build confidence in digital technologies. • **Reduced Stress from Fragmented Processes:** Simplified processes and clearer communication channels should reduce instances of staff dealing with challenging behaviour and reduced workload pressure.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

Insert breakdown of staff with a disability who may be affected

Staff data

<table>
<tr><td>by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Additional considerations for staff with disabilities:
Accessibility of New Systems: Staff with visual impairments, hearing loss, or motor difficulties may require assistive technologies (screen readers, voice input, high-contrast modes) to use new digital platforms effectively.
Training Needs: Staff with cognitive or learning disabilities may need tailored training approaches and extended time to adapt to new workflows.
Physical Relocation Risks: It is not currently anticipated that staff will be physically relocated, as part this proposal, yet if roles are centralised, staff with mobility challenges or reliance on public transport may face barriers in commuting to new locations.
Flexible Working: Remote working options should be considered for staff with disabilities to reduce physical strain and improve inclusion.
Mental Health Considerations: Staff with mental health conditions may experience stress during organisational change; proactive support and reasonable adjustments are essential.
Compliance with Accessible Communication and Information Standards: Systems must allow staff to record and respond to patient accessibility needs accurately.
Workstation Adaptations: Ensure ergonomic setups and assistive devices are available for staff with physical disabilities if a new environment is adopted.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
The project has considered the potential impact on the existing 111 press 2 service currently in operation. For those seeking support with mental health conditions or in crisis, it is essential that the workforce within the Patient Services Centre has sufficient skills and experience to be able to provide the support needed. It is also important that the service does not exasperate a situation, for example by placing an individual in crisis on hold.
Patients with hearing loss may face barriers when accessing services via telephone-based systems.
Individuals with visual impairments may encounter difficulties navigating digital interfaces.</td><td>Opportunities for improvement / mitigation
It is currently unclear how the Patient Services Centre will work alongside or incorporate current MH support.
Currently, those with hearing loss experience difficulties accessing information using existing systems in place. Option 1 for proposed call centre solution may not include sufficient integration with British Sign Language (BSL) interpretation services, text relay services and SMS-based communication options, online chat and other alternatives to voice calls.
To mitigate against this, the platform must comply with WCAG 2.2 accessibility standards, support screen</td></tr>
</table>

	• Patients with speech, cognitive or language-related challenges may require tailored support. • Staff with disabilities may struggle with new systems if accessibility features are not embedded or if training is insufficient.	readers and high-contrast modes and offer voice-assisted navigation and adjustable font sizes. • The Patient Services Centre must support proxy access functionality for family members and carers, multi-language support and staff training in inclusive communication techniques. • Full consideration of the impact on individual staff members would need to be considered prior to procuring the solution. We must ensure that any solution contains accessibility features and ergonomic setups and assistive devices should be made available for staff with physical disabilities in any new environment adopted.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** PSC will provide multiple access channels (phone and web), ensuring inclusivity for all patient groups. Clinical staff within the contact centre will improve responsiveness for patients with complex or long-term conditions. • **Enhanced Patient Autonomy:** For those patients seeking autonomy, the self-management tools will support that aim. • **Accessibility Compliance:** Compliance with WCAG 2.2 ensures platforms are usable by individuals with visual, motor, and cognitive impairments (e.g., screen reader compatibility, clear focus indicators, adjustable text size). It is envisaged that the Patient Relationship Management tool will enable staff to record key information about the patient in accordance with the recently published Accessible Communication and Information Standards. • **Flexible Working Opportunities:** Some remote working options could be considered for staff with disabilities to reduce physical strain and improve inclusion.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equally for access and service regardless of sexual orientation. Non-gendered language should be used as a default within the contact centre to ensure that those undergoing gender reassignment, or identify as a different gender from their gender at birth, are not misgendered. It is not currently anticipated that staff will be physically relocated as part of this project and therefore, access to any non-gendered facilities that may currently be utilised, will not be withdrawn. Any OCP that may result from this proposal would consider change of line management and how those that may be transitioning would be supported moving forward.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	
		No Impact	X
If you have determined no impact, please provide a brief explanation.	**No Impact** This group relates solely to workplace and employment matters. Any changes to staff roles arising from this policy will not result in differential treatment based on assumptions about their relationship status.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity **Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.**		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** Option one is likely to provide no impact for those who are pregnant or on maternity.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries.

Additional considerations for staff from different racial, ethnic, or national backgrounds:
Language Barriers: Staff whose first language is not English or Welsh may require additional training and support to use new systems confidently.
Cultural Awareness: Ensure that training materials and communication strategies are culturally sensitive and inclusive.
Translation Support: Staff may need access to translation tools or guidance when assisting patients who speak other languages.
Recruitment and Retention: Diverse staff may bring valuable language skills for patient engagement; ensure these are recognised and utilised.
Equality of Opportunity: Monitor that redeployment or role changes do not disproportionately disadvantage staff from minority ethnic backgrounds.
Training Accessibility: Provide training in multiple formats (written, visual, and verbal) to accommodate varying language proficiency levels.
Anti-Discrimination Measures: Reinforce policies and training to prevent bias or discrimination during organisational change.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the</td><td>Negative Impact
Patients who do not speak English or Welsh may experience delays or misunderstandings when accessing the Patient Services Centre.
Communication that is not culturally appropriate or inclusive may reduce trust and engagement among minority ethnic groups.
Groups such as Gypsy, Roma, and Traveller communities, refugees, and asylum seekers may not receive timely</td><td>Opportunities for improvement / mitigation
It is envisaged that processes and training will be in place to ensure that staff are able to access and utilise the Welsh Interpretation and Translation Service (WITS).
Distribute key messages in multiple languages, BSL video, Braille on request, and Easy Read formats.
Use the Community Development Outreach Team to engage hard-to-reach communities through face-to-face sessions, translated materials, and trusted intermediaries.</td></tr>
</table>

relevant negative impact.	information about service changes if communications rely solely on digital channels. • If staff are unfamiliar with WITS (Wales Interpretation and Translation Service) processes, patients may face delays in receiving interpretation support.	• Provide staff training on cultural awareness and inclusive communication to improve patient experience.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with extended opening hours, offers improved access and convenience for all nationalities and ethnicities. • **Community Engagement:** The PSC can work with outreach teams to engage Gypsy, Roma, Traveller communities, refugees, and asylum seekers, ensuring they receive timely information and support. • **Opportunity for Inclusive Communication:** PSC provides an ability to embed culturally sensitive communication practices across all channels. • **Improved Signposting:** PSC can ensure timely referral to specialist services for patients who speak languages other than English or Welsh. • **Staff Cultural Competence Development:** Training PSC staff on cultural awareness and inclusive communication will improve patient experience and foster trust among diverse communities.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** The service does not interfere with or restrict religious practices or beliefs. Patients can access services regardless of faith or philosophical belief. The needs of staff with certain religions and beliefs will be considered as part of this project.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** The Patient Services Centre provides equal access and functionality for all genders without bias or differentiation.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equal for access and service regardless of sexual orientation.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider 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**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

According to a Written Question, the Secretary for State for Defence confirmed in 2023 that there are over 500 regular and reserve posts based at Cawdor Barracks (Pembrokeshire). At Cawdor, there are also 148 Service Family Accommodation units.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Should the proposal be progressed, a detailed assessment will be conducted on the affected service areas, including understanding the demographics of the staff involved and whether they are a current reservist or veteran.

Additional considerations for those staff members that are veterans or reservists:
• Required time for training or deployment: Reservists may need time off for annual training or deployment, which could impact rostering in the Patient Services Centre.
• Health Needs: Veterans may have physical and/or mental health needs that require medical appointments and/or adjustments in the workspace.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• Reservists may require time off for training or deployment, creating scheduling and rostering challenges in a centralised Patient Services Centre.
• Active personnel and veterans may be accustomed to existing contact points or direct liaison with specific services. Centralising into a PSC could initially cause confusion or perceived barriers.
• Veterans working in PSC may experience stress during organisational change or in high-pressure call-handling environments.</td><td>Opportunities for improvement / mitigation
• Ensure rostering accommodates reservist training and deployment commitments. Consider hybrid working options where feasible.
• Work with local Armed Forces charities and veteran networks to co-design communication strategies and ensure awareness of PSC changes.

• Provide access to mental health services and peer support networks for veterans and reservists.</td></tr>
<tr><td>Provide a summary of the positive</td><td colspan="2">Positive Impact
• Simplified access: A single, centralised contact number reduces complexity for active personnel and veterans who often move between locations or experience fragmented care pathways.</td></tr>
</table>

impacts you have identified.	• **Opportunity for Outreach:** PSC can collaborate with Armed Forces charities and local networks to improve awareness and engagement, fostering trust and inclusion. • **Multi-Channel Flexibility:** PSC offers phone, web, and app-based options, enabling personnel deployed overseas or veterans in rural areas to access services remotely. • **Empowerment through Self-management:** Digital tools will allow individuals, including those managing mental health conditions, to take control of their appointments and access information independently, promoting autonomy and reducing stress.
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation 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 resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'least deprived' or as second 'least deprived' in Wales. There are a number of areas identified as being nearer 'most deprived', which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	
Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff experiencing socio-economic deprivation: • Travel and Location Changes: There are no current places to centralise teams physically in one location, so staff who rely on public transport are unlikely to face increased community costs and time. • Flexible Working Needs: The potential ability for staff to work partly remotely may deliver benefits of staff reduced travel costs. • Impact of Shift Changes: Whilst it is currently envisaged that the Patient Service Centre will have increased opening hours, it is not anticipated that HDdUHB staff will be required to work nights to support those services that are only supported in the day currently. • Digital Inclusion: Staff from deprived backgrounds may have limited access to personal devices or broadband, impacting their ability to engage with training or remote work. • Training and Upskilling: Ensure equitable access to training opportunities, including paid time for training, to avoid disadvantaging staff who cannot afford unpaid learning. • Financial Well-being Support: Consider signposting staff to financial advice services and employee assistance programmes during any organisational change.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • An important feature of the Patient Services Centre is the ability of the patient to access their health record and details through a 'digital front door'. The project has already taken into consideration the potential barriers that may be created if patients were forced to seek answers to their queries solely through a digital application and it is a key reason for utilising the proposed unified contact centre. A recent report by Audit Wales, *Digital inclusion in Wales*, identified that cost of living pressures may force individuals to reflect on the affordability of their current arrangements for internet access. • Staff from deprived backgrounds may lack access to personal devices or reliable internet, limiting their ability to participate in remote working or online training.	**Opportunities for improvement / mitigation** • By retaining our phone-based communication method, patients are not reliant upon personal internet access to seek support from the health board. Consideration has also been given to the ability of patients to contact the health board using telephones. In *Connected Nations: Autumn Update 2022*, it is highlighted that 4% of the geographical area of Wales not having coverage from a telephone operator, with rural Wales being particularly affected. • Ensure access to devices and connectivity for staff who need them and offer on-site facilities for training, if seeking to use more remote working with current systems.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Single, simpler point of access:** A centralised Patient Services Centre (PSC) with one number reduces the "phoning around", helping people who have limited time, money, or phone credit to resolve queries more quickly. • **Reduced missed appointments and wasted journeys:** Proactive reminders, clearer instructions, and easier rescheduling can reduce DNAs and unnecessary travel—benefiting those who would otherwise lose wages or pay extra for transport/childcare. • **Self-service when convenient:** Digital self-management (where appropriate) lets people take action outside working hours, avoiding time off work and associated income loss. • **Reduced personal cost burden:** Where roles allow, hybrid/remote working and consolidated rostering could cut commuting costs, which would be valuable for staff on lower incomes or living in rural areas.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Welsh Language Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.	**Positive**	**X**
	Negative	
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:

- Understand spoken Welsh
- Speak Welsh
- Read Welsh
- Write Welsh

Area	Percentage of people who can speak Welsh
Carmarthenshire	53.3
Pembrokeshire	25.2
Ceredigion	56.4
Hywel Dda	45

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those that are affected use the Welsh Language. This data can be

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff regarding Welsh language: • Language Skills Distribution: Staff currently providing patient-facing services may have varying levels of Welsh language proficiency. Some roles may require bilingual capability to meet Welsh Language Standards and patient expectations. • Recruitment and Workforce Planning: If teams are physically centralised, there may be a requirement for redeployment or recruitment of Welsh-speaking staff to ensure compliance and continuity of service. • Training Needs: Staff who are not fluent in Welsh may need access to language training or conversational support to handle basic queries confidently. • Operational Impact: Rostering must ensure Welsh-speaking staff are available during all operating hours to avoid delays for patients requesting service in Welsh. • Monitoring: Workforce data should track Welsh language skills to identify gaps and inform recruitment or training strategies.	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation	**Negative Impact** • Risk of delayed response if rostering doesn't ensure coverage	**Opportunities for improvement / mitigation** • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh.

actions align with the relevant negative impact.		
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Consistent Compliance with Welsh Language Standards:** Centralisation provides an opportunity to ensure Welsh language provision is embedded across all communication channels (phone, web, letters, SMS). • **Enhanced Patient Experience:** Patients who prefer to communicate in Welsh will have greater confidence and satisfaction when their language choice is respected and supported. • **Opportunity for Workforce Development:** Staff can access Welsh language training and resources, improving bilingual capability and career development opportunities. When progressing with this proposal, key lessons learnt can be taken from recent changes to the switchboards and the bilingual operations of the communication hub and contact centre.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Additional considerations
In addition to the above protected characteristics please consider impact on the following: • **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)** • **Unpaid Carers** • **Individuals and communities who experience Digital Exclusion** • **Rural and Urban communities**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Intersectionality
It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges. **Example:** The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.
Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: an **opportunity/impact score and a likelihood score.** The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores with automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

(Opportunity/impact Score x Likelihood Score = Total Score)

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
Neutral	**0**	Neutral	(Neutral): No effect, either positive or negative.
Negative	**-1**	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

- **To access the scoring table below you will need to double click on the table to open an editable version.**
- **To close the scoring table, you need to click to the side of the table.**
- **The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity* / Impact Rating**	*IIA Matrix		
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative	Positive impact	Neutral impact	Negative impact	Unknown		Opportunity/Impact	Likelihood	Total Score
Age	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Disability	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Gender Reassignment		X			* positive rating			0
					** negative rating			0
Marriage and Civil Partnership		X			* positive rating			0
					** negative rating			0
Pregnancy and Maternity		X			* positive rating			0
					** negative rating			0
Race/Ethnicity or Nationality	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Religion or Belief		X			* Positive rating			0
					** negative rating			0
Sex		X			* positive rating			0
					** negative rating			0
Sexual Orientation		X			* positive rating			0
					** negative rating			0
Armed Forces	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Socio-economic Deprivation	X		X		* positive rating	4	4	16
					** negative rating	-3	3	-9
Welsh Language	X				* positive rating	4	4	16
					** negative rating			0

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	The Patient Services Centre (PSC) proposal will be adopted as part of Hywel Dda UHB's digital transformation strategy. The PSC aligns with strategic objectives to improve access, efficiency, and patient experience.
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	While some negative impacts have been identified, these risks will be mitigated through targeted actions. The overall benefits of improved access, streamlined processes, and enhanced patient engagement outweigh these risks. The PSC will retain non-digital channels (telephone, in-person, postal) and embed inclusive practices to minimize adverse effects.

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
	This section of the EqIA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqIA are included (ideally these should not be the same person). A member of the Diversity and Inclusion team will add their information to the final section, to show that the Diversity and Inclusion team have had sight of the EqIA and if required provided guidance.

EqIA Completed by:	**Name/s**	Rob James
	Title	Senior Project Manager
	Team / Division	Digital, Innovation & Transformation
	Contact details	Robert.james2@wales.nhs.uk
	Date	02/01/2026
EqIA Authorised by/Owned by: • **Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy** • **Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5**	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
Guidance has been provided by Diversity & Inclusion Team: (to be completed by Diversity and Inclusion team only)	**Name**	Kylie Daniels
	Title	Senior Diversity & Inclusion Officer
	Team	Business, Partnership & Inclusion
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	06/01/2026
Diversity and Inclusion Team additional Comments:	This draft EqIA will need ongoing review and revision throughout the project's progression.	

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 EqIA and inform the D&I team.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Hywel Dda University Health Board
Equality Impact Assessment (EqIA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqIA)?
An EqIA is a scrutiny tool which is used to ensure that when making decisions related to creating or changing projects, practices and policies, the decisions made are fair and do not discriminate against any protected group defined under the Equality Act 2010.

Why do they have to be completed?
All public authorities in Wales are **legally required** under the Public Sector Equality Duty 2011 to **demonstrate that due regard** has been given in accordance with the Equality Act 2010 with the need to:

- Eliminate discrimination
- Advance equality of opportunity
- Foster good relations

When should they be completed?
A fully completed EqIA, or if applicable an EqIA Screening, must be produced before the Health Board is asked to make decisions about:

- Changes to the way health services are delivered
- The development of a new service
- Clinical or non-clinical policy document/guidance

Completion of an EqIA or EqIA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqIA is a living document and should be regularly reviewed and updated in light of new information, emerging evidence or stakeholder engagement.

It is recognised that certain proposals or decisions will require a wider consideration of potential impacts, particularly those relating to service change or potential major investment. For large scale projects and strategic decisions you will also need to consider

undertaking an Equality and Health Impact Assessment. Please contact the Diversity and Inclusion (D&I) team if you require further clarity.

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 EqIA and inform the D&I team.

Support
For further support please visit the EqIA Sharepoint or contact:
Email: Inclusion.hdd@wales.nhs.uk
Tel: 01554 899055

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 1: Overview

1.	**What are you Equality Impact assessing?**	**Title of Procedure, Project, Proposal, Policy being screened.** Patient Services Centre and 360° View (Option 4)
2.	**Brief Aims and Description of the procedure/ proposal/ project/ policy:**	The proposal involves the centralisation of functions such as appointment management, information and guidance, referral coordination, follow-up care, patient support services, data management, and communication. The following investment objectives have been identified in the Outline Business Case: • Improve Effectiveness: Optimise the quality of public services and delivery of agreed outcomes by enabling clinicians and staff to access clear, actionable patient information, supporting better decision-making and improved health outcomes. • Improve Efficiency: Simplify care pathways, reduce manual and duplicated processes, and enable faster, more accurate service delivery. • Enhance Economy: Lower the cost and administrative burden of care through digital automation and increased patient self-service. • Ensure Compliance: Meet statutory, regulatory, and best practice requirements for data management, privacy, and accessibility. • Support Future Improvement: Enable better data collection, analysis, and reporting to inform ongoing service development and innovation. For patients and the public, the Patient Services Centre will provide one phone number to manage all patient queries, utilising an Interactive Voice Response system. It is envisaged that there will also be online capabilities to support public and patient queries, potentially using chatbots and AI tools. The Outline Business Case for this proposal outlines four potential change options. The first being ‘do minimum’ which would be create a new single call centre. Option 2 creates a single call centre for the health board along with a full 360° View and self-manging patient engagement portal by expanding the products used by the health board. Option 3 (Preferred Way Forward) is similar to option 2 for the experience of the patient or public. Option 4 extends the previous option to make use of an external 24x7 call centre.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

3.	**Who is involved in undertaking this EqIA? (names/job titles)**	Rob James, Senior Project Manager
4.	**Is the procedure/ proposal/ project/ policy related to other policies/ areas of work?**	- **A Healthier Mid and West Wales Strategy** – the Health Board's blueprint for modern, safe, sustainable, and digitally enabled care. - **Digital Response Plan and Digital Strategic Plan (2025)** – part of the Health Board's 10-year vision for digital excellence. - **Welsh Government Digital and Data Strategy for Health and Care** – calling for a more connected, accessible, and efficient system. - **NHS Wales Digital Transformation Strategy** – supporting national standards and platforms such as NHS Wales App and Patients Know Best. - **Well-being of Future Generations Act** – ensuring sustainable and equitable health services.
5.	**Is this a new EqIA or an updated EqIA?**	New ☒ Updated ☐ Date of original or last version of the EqIA: Please give details / explain any amendments.
6.	**Who will be affected by the procedure/ proposal/ project/ policy development?** (Consider staff as well as the population, patients, carers and family members who may be affected to different degrees)	Population within Hywel Dda University Health Board's geographical region. Patients and/or advocates enquiring about their care are likely to need to engage with the Patient Services Centre. There is potential that those wishing to contact in relation to the care they or a loved one has received may also need to contact the Patient Services Centre. Those members of staff that are involved with responding to patient and public queries, managing patient waiting lists, appointment booking and patient experience are likely to be affected by the proposed changes.
7.	**What might help/hinder the success of the procedure/ proposal/ project/ policy?**	Staff Training and resistance Confusion for vulnerable patients

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 2: Human Rights

Human Rights: The Human Rights Act contains 15 Articles (or rights), all of which NHS organisations have a duty to act compatibly with and to respect, protect and fulfil. The 6 rights that are particularly relevant to healthcare are listed below. Depending on the **procedure/ proposal/ project/ policy** you are considering, you may find the examples below helpful in relation to the Articles.		
Consider, is the procedure/ proposal/ project/ policy relevant to:	Yes	No
Article 2: The right to life. **Example**: The protection and promotion of the safety and welfare of patients and staff; issues of patient restraint and control.		X
Article 3: The right not to be tortured or treated in an inhuman or degrading way. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; Issues of patient restraint and control		X
Article 5: The right to liberty **Example**: Issues of patient choice, control, empowerment and independence; issues of patient restraint and control		X
Article 6: The right to a fair trial **Example**: issues of patient choice, control, empowerment and independence	X	
Article 8: The right to respect for private and family life, home and correspondence. **Example**: Issues of dignity and privacy; the protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers; the right of a patient or employee to enjoy their family and/or private life		X
Article 11: The right to freedom of thought, conscience and religion **Example**: The protection and promotion of the safety and welfare of patients and staff; the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travellers		X

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 3: Gathering of Evidence and Assessment of Potential Impact

How will the procedure/ proposal/ project/ policy impact on Age: Is it likely to affect older and younger people in different ways or affect one age group and not another?	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA and upload relevant data.

Population Data

County	Carms		Cere		Pembs		Total		Summary
Age	value	%	value	%	value	%	value	%	All three regions that comprise the Hywel Dda area have seen an increase in the average age of their population between the last two population censuses, Ceredigion (has seen an increase by 5 years to 47), Pembrokeshire (increase by 3 years to 48) and Carmarthenshire (increase by 2 years to 42). People, population and community - Office for National Statistics (ons.gov.uk)
Total: All usual residents	187,897	100	71,474	100	123,360	100	382,731	100.0	
Aged 4 years and under	9,057	4.8	2,709	3.8	5,583	4.5	17,349	4.4	
Aged 5 to 9 years	10,274	5.5	3,288	4.6	6,731	5.5	20,293	5.2	
Aged 10 to 15 years	13,080	7	4,086	5.7	8,495	6.9	25,661	6.5	
Aged 16 to 19 years	7,799	4.2	4,129	5.8	4,889	4	16,817	4.7	
Aged 20 to 24 years	8,820	4.7	6,366	8.9	5,621	4.6	20,807	6.1	
Aged 25 to 34 years	20,692	11	7,107	9.9	12,907	10.5	40,706	10.5	
Aged 35 to 49 years	31,802	16.9	10,145	14.2	19,461	15.8	61,408	15.6	
Aged 50 to 64 years	40,906	21.8	15,256	21.3	27,331	22.2	83,493	21.8	
Aged 65 to 74 years	24,603	13.1	9,942	13.9	17,445	14.1	51,990	13.7	
Aged 75 to 84 years	15,247	8.1	6,097	8.5	10,855	8.8	32,199	8.5	
Aged 85 years and over	5,617	3	2,349	3.3	4,042	3.3	12,008	3.2	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Insert an age breakdown of those affected. This data can be recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	**Patient data** Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.
Insert breakdown of staff age in the specific service/ area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, this proposal is the most ambitious and it may cover GPs, social care, primary and community care, as well as call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Due to the scale of the potential change that may be delivered with option 4, extensive dialogue would be needed to understand the potential services that would be included and the demographics of the staff involved.

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Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • Those living within Hywel Dda University Health Board region will all be expected to communicate with the health board via the Patient Services Centre, regardless of age. According to the *National Survey for Wales* 18.5% of people aged 75+ are believed to be digitally excluded. An overreliance on the digital solution to respond to patient queries, could negatively impact this age group within the region. • Individuals who are not digital excluded, yet may have low digital literacy, may become confused if communication on the changes are not effectively communicated. • As local residents are supported to age well, there is a higher likelihood that additional health needs may accompany that individual. Due to proposed scope, there is a greater risk of conflict with existing national and local systems currently in use within the region. • If PSC's scope extends too wide, there is a risk of duplication or confusion with NHS 111 services, particularly for older patients who may already rely on 111 for out-of-hours advice. This could lead to delays, misdirection, or patients bypassing clinically safe pathways. • Older patients often have multiple conditions managed across different specialties, making them more vulnerable to errors if waiting lists remain fragmented. Introducing self-booking without unified systems could lead to inappropriate appointments, missed follow-ups, or duplication—particularly for those less digitally confident.	**Opportunities for improvement / mitigation** • This is being avoided by retaining a phone-based contact centre. It is anticipated that the project will adopt a phased rollout approach with a comprehensive communication strategy to support the change. Physical and digital patient letter templates would need to be updated to ensure single number is available. The health board may also wish to support a public communication campaign. • HDdUHB should seek to ensure that all public-facing digital platforms are updated to reflect the new contact number, including the Health Board website, NHS Wales directories, and Google search results. • Establish a cross-sector governance group to oversee integration and conduct end-to-end testing before go-live. Implement clear fallback protocols for system conflicts and provide staff training on escalation routes. Monitor interoperability issues post-launch and resolve promptly to protect continuity of care for patients with complex needs. • Define clear service boundaries between PSC and NHS 111 in the operating model and patient communications. Detailed scoping of service provision covered by Patient Service Centre, particular in relation to primary care, would be required. • Deploy an integrated scheduling platform that consolidates waiting lists and applies clinical prioritisation rules. Provide clear, age-friendly guidance and assisted booking support for older patients to prevent misuse and ensure continuity of care.
Provide a brief summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Enabling patients to book, reschedule, or cancel their own appointments offers the greatest degree of flexibility and convenience, reducing missed appointments and improving timely access to care. This autonomy empowers patients to manage their health proactively, supports work-life balance, and can help optimise waiting lists by freeing clinical time for those with the greatest need	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

	• **Improved Communication:** For younger, digitally confident patients, online chat and app-based features provide convenience and immediacy. • **Enhanced Autonomy and Self-Management:** Digital tools enable patients to manage appointments, view records, and receive reminders, supporting independence for all ages. • **Flexible Working Opportunities:** Potential for remote working or adjusted hours, subject to service needs, which could benefit older staff seeking work-life balance. • **Skill Development:** Training on new systems provides opportunities for staff to upskill and build confidence in digital technologies. • **Reduced Stress from Fragmented Processes:** Simplified processes and clearer communication channels should reduce instances of staff dealing with challenging behaviour and reduced workload pressure.
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Disability: Those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carms	Cere	Pembs	Total
Disabled under the Equality Act: Day-to-day activities limited a lot	21225	6686	12522	40463
Disabled under the Equality Act: Day-to-day activities limited a little	21897	8951	14651	45499
Total with a disability	43152	15637	27173	85,963
Total population	187,895	71,474	123,366	382,735
Percentage of population with a disability	23%	22%	22%	22%

People, population and community - Office for National Statistics (ons.gov.uk)

Insert data for those affected. Include data on the disabilities listed above. (The aging population may have significant levels of age-related disabilities.)

If no information is available, please state that here, including how you plan to address any identified data gaps in the future.

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

Insert breakdown of staff with a disability who may be affected

Staff data

<table>
<tr><td>by your specific service/area of work.

If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations.

Additional considerations for staff with disabilities:
• Accessibility of New Systems: Staff with visual impairments, hearing loss, or motor difficulties may require assistive technologies (screen readers, voice input, high-contrast modes) to use new digital platforms effectively.
• Training Needs: Staff with cognitive or learning disabilities may need tailored training approaches and extended time to adapt to new workflows.
• Physical Relocation Risks: It is not currently anticipated that staff will be physically relocated, as part this proposal, yet if roles are centralised, staff with mobility challenges or reliance on public transport may face barriers in commuting to new locations.
• Flexible Working: Remote working options should be considered for staff with disabilities to reduce physical strain and improve inclusion.
• Mental Health Considerations: Staff with mental health conditions may experience stress during organisational change; proactive support and reasonable adjustments are essential.
• Compliance with Accessible Communication and Information Standards: Systems must allow staff to record and respond to patient accessibility needs accurately.
• Workstation Adaptations: Ensure ergonomic setups and assistive devices are available for staff with physical disabilities if a new environment is adopted.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• The project has considered the potential impact on the existing 111 press 2 service currently in operation. For those seeking support with mental health conditions or in crisis, it is essential that the workforce within the Patient Services Centre has sufficient skills and experience to be able to provide the support needed. It is also important that the service does not exasperate a situation, for example by placing an individual in crisis on hold.
• Patients with hearing loss may face barriers when accessing services via telephone-based systems.

• Individuals with visual impairments may encounter difficulties navigating digital interfaces.</td><td>Opportunities for improvement / mitigation
• It is currently unclear how the Patient Services Centre will work alongside or incorporate current MH support.

• Currently, those with hearing loss experience difficulties accessing information using existing systems in place. Option 1 for proposed call centre solution may not include sufficient integration with British Sign Language (BSL) interpretation services, text relay services and SMS-based communication options, online chat and other alternatives to voice calls.
• To mitigate against this, the platform must comply with WCAG 2.2 accessibility standards, support screen</td></tr>
</table>

	• Patients with speech, cognitive or language-related challenges may require tailored support. • Staff with disabilities may struggle with new systems if accessibility features are not embedded or if training is insufficient. • If the potential impact on primary care workflows and accessibility requirements is not fully scoped, patients with existing disabilities could experience barriers to care, such as loss of reasonable adjustments, inaccessible booking processes, or delays in communication.	readers and high-contrast modes and offer voice-assisted navigation and adjustable font sizes. • The Patient Services Centre must support proxy access functionality for family members and carers, multi-language support and staff training in inclusive communication techniques. • Full consideration of the impact on individual staff members would need to be considered prior to procuring the solution. We must ensure that any solution contains accessibility features and ergonomic setups and assistive devices should be made available for staff with physical disabilities in any new environment adopted. • Undertake detailed accessibility scoping with primary care before implementation to identify potential impacts on patients with disabilities. Engage clinicians, patient representatives, and D&I specialists to ensure reasonable adjustments are preserved.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Enabling patients to book, reschedule, or cancel their own appointments offers the greatest degree of flexibility and convenience, reducing missed appointments and improving timely access to care. This autonomy empowers patients to manage their health proactively, supports work-life balance, and can help optimise waiting lists by freeing clinical time for those with the greatest need**.** • **Accessibility Compliance:** Compliance with WCAG 2.2 ensures platforms are usable by individuals with visual, motor, and cognitive impairments (e.g., screen reader compatibility, clear focus indicators, adjustable text size). It is envisaged that the Patient Relationship Management tool will enable staff to record key information about the patient in accordance with the recently published Accessible Communication and Information Standards. • **Flexible Working Opportunities:** Some remote working options could be considered for staff with disabilities to reduce physical strain and improve inclusion.	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Gender Reassignment: Consider the potential impact on individuals who have undergone, intend to undergo or are currently undergoing gender reassignment; and those who do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth.	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equally for access and service regardless of sexual orientation. Non-gendered language should be used as a default within the contact centre to ensure that those undergoing gender reassignment, or identify as a different gender from their gender at birth, are not misgendered. It is not currently anticipated that staff will be physically relocated as part of this project and therefore, access to any non-gendered facilities that may currently be utilised, will not be withdrawn. Any OCP that may result from this proposal would consider change of line management and how those that may be transitioning would be supported moving forward.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Marriage and Civil Partnership		Positive	
		Negative	
		No Impact	X
If you have determined no impact, please provide a brief explanation.	**No Impact** This group relates solely to workplace and employment matters. Any changes to staff roles arising from this policy will not result in differential treatment based on assumptions about their relationship status.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact Pregnancy and Maternity **Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.**		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** Option one is likely to provide no impact for those who are pregnant or on maternity.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy on Race/Ethnicity or Nationality People of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers. Also includes citizenship.	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

County	Carms		Cere		Pembs		Total	
Ethnicity	Value	%	Value	%	Value	%	Value	%
Total: All usual residents	187,898	100	71,473	100	123,359	100	382,730	100
Asian, Asian British or Asian Welsh	2,321	1.2	1,096	1.5	1,159	0.9	4,576	1.2
Black, Black British, Black Welsh, Caribbean or African	455	0.2	366	0.5	244	0.2	1,065	0.3
Mixed or Multiple ethnic groups	1,756	0.9	867	1.2	1,162	0.9	3,785	1
White	182,652	97.2	68,776	96.2	120,375	97.6	371,803	97
Gypsy or Traveller	450	0.2	55	0.08	585	0.5	1,090	0.3
Another ethnic group	714	0.4	368	0.5	419	0.3	1,501	0.4

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert a breakdown of Race / Ethnicity or Nationality of those that are affected.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

identified data gaps in the future.		
Insert breakdown of the Race/Ethnicity or Nationality of the staff affected by your specific service/area of work. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff from different racial, ethnic, or national backgrounds: • Language Barriers: Staff whose first language is not English or Welsh may require additional training and support to use new systems confidently. • Cultural Awareness: Ensure that training materials and communication strategies are culturally sensitive and inclusive. • Translation Support: Staff may need access to translation tools or guidance when assisting patients who speak other languages. • Recruitment and Retention: Diverse staff may bring valuable language skills for patient engagement; ensure these are recognised and utilised. • Equality of Opportunity: Monitor that redeployment or role changes do not disproportionately disadvantage staff from minority ethnic backgrounds. • Training Accessibility: Provide training in multiple formats (written, visual, and verbal) to accommodate varying language proficiency levels. • Anti-Discrimination Measures: Reinforce policies and training to prevent bias or discrimination during organisational change.	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the	**Negative Impact** • Patients who do not speak English or Welsh may experience delays or misunderstandings when accessing the Patient Services Centre. • Communication that is not culturally appropriate or inclusive may reduce trust and engagement among minority ethnic groups. • Groups such as Gypsy, Roma, and Traveller communities, refugees, and asylum seekers may not receive timely	**Opportunities for improvement / mitigation** • It is envisaged that processes and training will be in place to ensure that staff are able to access and utilise the Welsh Interpretation and Translation Service (WITS). • Distribute key messages in multiple languages, BSL video, Braille on request, and Easy Read formats. • Use the Community Development Outreach Team to engage hard-to-reach communities through face-to-face sessions, translated materials, and trusted intermediaries.

relevant negative impact.	information about service changes if communications rely solely on digital channels. • If staff are unfamiliar with WITS (Wales Interpretation and Translation Service) processes, patients may face delays in receiving interpretation support. • If accessibility and language preferences are not interoperable between PSC, GP, and social care systems, patients may repeatedly need to disclose language needs, causing frustration and risk of errors.	• Provide staff training on cultural awareness and inclusive communication to improve patient experience. • Support engagement with impacted communities, via the Community Development Outreach Team (CDOT), to ensure the solution is designed to address this risk, along with considering how data can be shared with primary care partners.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **Improved Access and Convenience:** Increased access to a single call centre, with 24/7 opening hour coverage, offers significantly improved access and convenience for all nationalities and ethnicities. • **Community Engagement:** The PSC can work with outreach teams to engage Gypsy, Roma, Traveller communities, refugees, and asylum seekers, ensuring they receive timely information and support. • **Opportunity for Inclusive Communication:** Digital platforms allow patients to manage appointments and access health information independently in their preferred language, supporting autonomy and reducing reliance on interpreters. • **Improved Signposting:** PSC can ensure timely referral to specialist services for patients who speak languages other than English or Welsh. • **Staff Cultural Competence Development:** Training PSC staff on cultural awareness and inclusive communication will improve patient experience and foster trust among diverse communities.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Religion or Belief (or non-belief) The term 'religion or belief' includes a religious or philosophical belief, including ethical veganism.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** The service does not interfere with or restrict religious practices or beliefs. Patients can access services regardless of faith or philosophical belief. The needs of staff with certain religions and beliefs will be considered as part of this project.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sex Consider whether those affected are mostly male or female and where it applies to both equally does it affect one differently to the other?	**Positive**	
	Negative	
	No Impact	**X**

If you have determined no impact, please provide a brief explanation.	**No Impact** The Patient Services Centre provides equal access and functionality for all genders without bias or differentiation.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.		**Positive**	
		Negative	
		No Impact	**X**
If you have determined no impact, please provide a brief explanation.	**No Impact** This project will provide equal for access and service regardless of sexual orientation.		

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

How will the procedure/ proposal/ project/ policy impact on Armed Forces Consider 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**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	Carmarthenshire (%)	Pembrokeshire (%)	Ceredigion (%)	Hywel Dda (%)
Regular	3.6	4.5	3	3.7
Reserve	0.9	0.9	0.9	0.9
Both	0.2	0.2	0.2	0.2
Total	4.7	5.7	4.1	4.8

People, population and community - Office for National Statistics (ons.gov.uk)

If data is available insert evidence of what proportion of those affected are members of the Armed Forces Community. This data can be recorded in table or free text format.

If no information is available, please state that here, including how you plan to address any

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

According to a Written Question, the Secretary for State for Defence confirmed in 2023 that there are over 500 regular and reserve posts based at Cawdor Barracks (Pembrokeshire). At Cawdor, there are also 148 Service Family Accommodation units.

<table>
<tr><td>identified data gaps in the future.</td><td colspan="2"></td></tr>
<tr><td>Insert data to show the proportion of staff affected by your specific service/area of work that are a member of the Armed Forces community. If no information is available, please state that here including how you plan to address any identified data gaps in the future.</td><td colspan="2">Staff data

It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Should the proposal be progressed, a detailed assessment will be conducted on the affected service areas, including understanding the demographics of the staff involved and whether they are a current reservist or veteran.

Additional considerations for those staff members that are veterans or reservists:
• Required time for training or deployment: Reservists may need time off for annual training or deployment, which could impact rostering in the Patient Services Centre.
• Health Needs: Veterans may have physical and/or mental health needs that require medical appointments and/or adjustments in the workspace.</td></tr>
<tr><td>Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.</td><td>Negative Impact
• Reservists may require time off for training or deployment, creating scheduling and rostering challenges in a centralised Patient Services Centre.
• Active personnel and veterans may be accustomed to existing contact points or direct liaison with specific services. Centralising into a PSC could initially cause confusion or perceived barriers.
• Veterans working in PSC may experience stress during organisational change or in high-pressure call-handling environments.
• Integration with social care, GPs, and ambulance services may create confusion for serving personnel and veterans unfamiliar with new processes.</td><td>Opportunities for improvement / mitigation
• Ensure rostering accommodates reservist training and deployment commitments. Consider hybrid working options where feasible.
• Work with local Armed Forces charities and veteran networks to co-design communication strategies and ensure awareness of PSC changes.

• Provide access to mental health services and peer support networks for veterans and reservists.

• Collaborate with DHCW to ensure integration with national platforms (e.g., NHS Wales App, WITS, Clinical Data Repository) follows best practice and avoids duplication</td></tr>
</table>

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Provide a summary of the positive impacts you have identified.	**Positive Impact** • **24/7 Access to Services:** External call centre operating round-the-clock ensures serving personnel and veterans can access support at any time, accommodating deployments and non-standard working hours. • **Opportunity for Outreach:** PSC can collaborate with Armed Forces charities and local networks to improve awareness and engagement, fostering trust and inclusion. • **Multi-Channel Flexibility:** PSC offers phone, web, and app-based options, enabling personnel deployed overseas or veterans in rural areas to access services remotely. • **Enhanced Self-management Tools:** Digital platforms allow individuals, including those managing mental health conditions, to book, reschedule, and manage appointments independently, promoting autonomy and reducing stress.
If you have determined no impact, please provide a brief explanation.	**No Impact**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Socio-economic Deprivation 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 resource please see: **https://gov.wales/more-equal-wales-socio-economic-duty**	**Positive**	**X**
	Negative	**X**
	No Impact	

Guidance

Remove population data if not relevant to EqIA.

Population Data

	County							
	Carms		Ceredigion		Pembs		Hywel Dda	
Economic Factor	Value	%	Value	%	Value	%	Total value	%
Economically active – In employment (this includes full time students)	81,952	52.7	30,119	49.1	52,765	51.5	164,836	51.1
Economically active - Unemployed	3,922	2.5	1,845	3	2,769	2.7	8,536	2.73
Economically inactive	69,613	44.8	29,428	47.9	47,017	45.8	146,058	46.16

In its vast majority, Carmarthenshire, Pembrokeshire and Ceredigion areas have been ranked 'least deprived' or as second 'least deprived' in Wales. There are a number of areas identified as being nearer 'most deprived', which are concentrated around Pembroke, Pembroke Dock, Milford, Cardigan, Llanelli and Kidwelly.
(Welsh Index of Multiple Deprivation 2019).
Welsh Index of Multiple Deprivation (WIMD) 2019: results report (gov.wales)

If data is available insert evidence of what proportion of those that are affected are experiencing socio-economic deprivation. This data can be recorded in

Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board's boundaries.

table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.	
Insert data to show the proportion of staff affected by your specific service/area of work that are experiencing socio-economic deprivation. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have an impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff experiencing socio-economic deprivation: • Travel and Location Changes: There are no current places to centralise teams physically in one location, so staff who rely on public transport are unlikely to face increased community costs and time. • Flexible Working Needs: The potential ability for staff to work partly remotely may deliver benefits of staff reduced travel costs. • Impact of Shift Changes: Whilst it is currently envisaged that the Patient Service Centre will have increased opening hours, it is not anticipated that HDdUHB staff will be required to work nights to support those services that are only supported in the day currently. • Digital Inclusion: Staff from deprived backgrounds may have limited access to personal devices or broadband, impacting their ability to engage with training or remote work. • Training and Upskilling: Ensure equitable access to training opportunities, including paid time for training, to avoid disadvantaging staff who cannot afford unpaid learning. • Financial Well-being Support: Consider signposting staff to financial advice services and employee assistance programmes during any organisational change.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation actions align with the relevant negative impact.	**Negative Impact** • An important feature of the Patient Services Centre is the ability of the patient to access their health record and details through a 'digital front door'. The project has already taken into consideration the potential barriers that may be created if patients were forced to seek answers to their queries solely through a digital application and it is a key reason for utilising the proposed unified contact centre. A recent report by Audit Wales, *Digital inclusion in Wales*, identified that cost of living pressures may force individuals to reflect on the affordability of their current arrangements for internet access. • Staff from deprived backgrounds may lack access to personal devices or reliable internet, limiting their ability to participate in remote working or online training.	**Opportunities for improvement / mitigation** • By retaining our phone-based communication method, patients are not reliant upon personal internet access to seek support from the health board. Consideration has also been given to the ability of patients to contact the health board using telephones. In *Connected Nations: Autumn Update 2022*, it is highlighted that 4% of the geographical area of Wales not having coverage from a telephone operator, with rural Wales being particularly affected. • Ensure access to devices and connectivity for staff who need them and offer on-site facilities for training, if seeking to use more remote working with current systems.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **24/7 Access to services:** External call centre ensures individuals with limited flexibility due to work or caring responsibilities can access support outside standard hours, reducing barriers for low-income households. • **Reduced missed appointments and wasted journeys:** Proactive reminders, clearer instructions, and easier rescheduling can reduce DNAs and unnecessary travel—benefiting those who would otherwise lose wages or pay extra for transport/childcare. • **Enhanced Outreach:** Ability to collaborate with community organisations and social care services ensures targeted engagement for those in deprived areas, improving awareness and uptake. • **Reduced personal cost burden:** Where roles allow, hybrid/remote working and consolidated rostering could cut commuting costs, which would be valuable for staff on lower incomes or living in rural areas. Multi-channel access (phone, SMS, web) and proactive communication also reduce the need for unnecessary travel, saving costs for those in rural or deprived areas. • **Integration with social care:** Streamlined pathways between health and social care improve access to holistic support for vulnerable individuals, including those experiencing housing or financial insecurity.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

<table>
<tr><td colspan="2">Welsh Language
Please note opportunities for persons to use the Welsh language and treating the Welsh language no less favourably than the English language.</td><td>Positive</td><td>X</td></tr>
<tr><td colspan="2"></td><td>Negative</td><td></td></tr>
<tr><td colspan="2"></td><td>No Impact</td><td></td></tr>
<tr><td>Guidance

Remove population data if not relevant to EqIA.</td><td colspan="3">Population Data

According to Welsh Census 2022 data, it is estimated that 45% of people aged three or older had some level of Welsh language skills. This figure equates to around 172,000 people.

Definition of whether a person has Welsh language skills (as recorded in the Census 2022).

If a person can or does do any of the following:

• Understand spoken Welsh
• Speak Welsh
• Read Welsh
• Write Welsh

<table><tr><th>Area</th><th>Percentage of people who can speak Welsh</th></tr><tr><td>Carmarthenshire</td><td>53.3</td></tr><tr><td>Pembrokeshire</td><td>25.2</td></tr><tr><td>Ceredigion</td><td>56.4</td></tr><tr><td>Hywel Dda</td><td>45</td></tr></table>People, population and community - Office for National Statistics (ons.gov.uk)</td></tr>
<tr><td>If data is available insert evidence of what proportion of those that are affected use the Welsh Language. This data can be</td><td colspan="3">Patient data

Patient data for this project reflects the census data provided above, ensuring inclusion of all those living within the health board’s boundaries.</td></tr>
</table>

recorded in table or free text format. If no information is available, please state that here, including how you plan to address any identified data gaps in the future.		
If data is available insert evidence of what proportion of staff affected by your specific service/area of work use the Welsh Language. This data can be recorded in table or free text format. If no information is available, please state that here including how you plan to address any identified data gaps in the future.	**Staff data** It has yet to be finalised which service areas will be impacted should the proposal be progressed however, the proposal is likely to have a transformational impact on workflows, call handling, administration functions, referral management, and staff and patient expectations. Initial scoping work has considered the potential impact on employees working within contact centre, communication hub, switchboards, mental health single point of contact (111 #2 service), patient experience, PALS, along with medical/clinical secretaries. Additional considerations for staff regarding Welsh language: • Language Skills Distribution: Staff currently providing patient-facing services may have varying levels of Welsh language proficiency. Some roles may require bilingual capability to meet Welsh Language Standards and patient expectations. • Recruitment and Workforce Planning: If teams are physically centralised, there may be a requirement for redeployment or recruitment of Welsh-speaking staff to ensure compliance and continuity of service. • Training Needs: Staff who are not fluent in Welsh may need access to language training or conversational support to handle basic queries confidently. • Operational Impact: Rostering must ensure Welsh-speaking staff are available during all operating hours to avoid delays for patients requesting service in Welsh. • Monitoring: Workforce data should track Welsh language skills to identify gaps and inform recruitment or training strategies.	
Ensure mitigation actions are recorded in line with the negative impact it refers to. Align bullet points so that it is clear which mitigation	**Negative Impact** • Risk of delayed response if rostering doesn't ensure coverage	**Opportunities for improvement / mitigation** • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh.

actions align with the relevant negative impact.	• With an external 24/7 call centre, there is a risk that Welsh-speaking patients may experience delays if sufficient bilingual staff are not available at all times.	• Work with external call centre provider to guarantee Welsh-speaking staff availability 24/7, supported by clear rostering and monitoring.
Provide a summary of the positive impacts you have identified.	**Positive Impact** • **24/7 Bilingual Service:** External call centre operating round-the-clock provides Welsh-speaking patients with access to services at any time, improving equity and compliance. • **Consistent Compliance with Welsh Language Standards:** Centralisation provides an opportunity to ensure Welsh language provision is embedded across all communication channels (phone, web, letters, SMS). • **Enhanced Patient Experience:** Patients who prefer to communicate in Welsh will have greater confidence and satisfaction when their language choice is respected and supported. • **Opportunity for Workforce Development:** Staff can access Welsh language training and resources, improving bilingual capability and career development opportunities. When progressing with this proposal, key lessons learnt can be taken from recent changes to the switchboards and the bilingual operations of the communication hub and contact centre.	
If you have determined no impact, please provide a brief explanation.	**No Impact**	

Additional considerations

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

In addition to the above protected characteristics please consider impact on the following:

- **Vulnerable groups (homeless and vulnerably housed, Gypsy, Roma and Travellers, Refugees, Asylum Seekers)**
- **Unpaid Carers**
- **Individuals and communities who experience Digital Exclusion**
- **Rural and Urban communities**

Intersectionality

It is important to consider breaking the analysis down by more than one protected characteristic. This is often referred to as 'intersectionality'. Many people will have more than one protected characteristic and, certain aspects of who we are, for example, our race, gender, faith and socio-economic status can increase our positive experiences or contribute to negative experiences, made worse by the combined effects of multiple discrimination, barriers and challenges.

Example: The experiences of a Muslim woman will differ from that of a Muslim man and of a non-Muslim woman. An EqIA may separately identify impacts for Muslim people under Religion or Belief and the impacts for men and women under Sex, but it is also important to recognise that the combined impacts could be very different for a Muslim woman compared to a Muslim man or a non-Muslim woman.

Have you identified any specific additional impacts regarding intersectionality e.g., age and sex, disability and sexual orientation?

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 4: Assessment of Scale of Impact

In this scoring section, you need to assign two scores: an **opportunity/impact score and a likelihood score.** The likelihood score represents the probability of the opportunity or impact occurring, while the opportunity/impact score reflects the severity of the opportunity or impact. Once both scores have been recorded, the scores with automatically be multiplied in order to calculate the **Total Score** for each protected characteristic.

(Opportunity/impact Score x Likelihood Score = Total Score)

OPPORTUNITY AND IMPACT			
IMPACT	**SCORE**		**The proposed change is anticipated to lead to the following level of opportunity and/or impact:**
Positive	**5**	Excellence	(Excellence): Outstanding benefits, significant reduction in health inequalities, and major improvements in service delivery and public confidence.
	4	Major	(Major): Long-term improvements, major reduction in health inequalities, and substantial service delivery enhancements.
	3	Moderate	(Moderate): Moderate benefits requiring professional intervention, moderate reduction in health inequalities, and moderate service delivery improvements.
	2	Minor	(Minor): Minor improvements in access, experience, and outcomes, with minor reductions in health inequalities.
	1	Negligible	(Negligible): Negligible improvements in access, experience, and outcomes, with negligible reductions in health inequalities
Neutral	**0**	Neutral	(Neutral): No effect, either positive or negative.
Negative	**-1**	Negligible	(Negligible): Negligible negative impact, minimal injury potential, and negligible negative impacts on service delivery
	-2	Minor	(Minor): Minor negative impact, minor injury potential, and minor negative impacts on service delivery.
	-3	Moderate	(Moderate): Moderate negative impact, moderate injury potential, and moderate negative impacts on service delivery.
	-4	Major	(Major): Major negative impact, major injury potential, and major negative impacts on service delivery.
	-5	Catastrophic	(Catastrophic): Catastrophic negative impact, potential for death or severe injury, and significant negative impacts on service delivery.

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

LIKELIHOOD		
1	Rare	Not expected to occur for years. Will occur in exceptional circumstances.
2	Unlikely	Expected to occur at least annually. Unlikely to occur
3	Possible	Expected to occur at least monthly. Reasonable chance of occuring.
4	Likely	Expected to occur at least weekly. Likely to occur.
5	Almost Certain	Expected to occur at least daily. More than likely to occur.

LIKELIHOOD	OPPORTUNITY						IMPACT				
	5	**4**	**3**	**2**	**1**	**0**	**-1**	**-2**	**-3**	**-4**	**-5**
5	25	20	15	10	5	0	-5	-10	-15	-20	-25
4	20	16	12	8	4	0	-4	-8	-12	-16	-20
3	15	12	9	6	3	0	-3	-6	-9	-12	-15
2	10	8	6	4	2	0	-2	-4	-6	-8	-10
1	5	4	3	2	1	0	-1	-2	-3	-4	-5

CATEGORY			
	Excellent opportunity		Extreme risk
	Good opportunity		High risk
	Moderate opportunity		Moderate risk
	Minor opportunity		Low risk

- **To access the scoring table below you will need to double click on the table to open an editable version.**
- **To close the scoring table, you need to click to the side of the table.**
- **The information you input will remain when you click back on the word document.**

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Area					Opportunity* / Impact Rating**	*IIA Matrix		
Note - you can select more than one box per area if change may have multiple impacts e.g. both positive and negative	Positive impact	Neutral impact	Negative impact	Unknown		Opportunity/Impact	Likelihood	Total Score
Age	X		X		* positive rating	5	4	20
					** negative rating	-4	4	-16
Disability	X		X		* positive rating	5	4	20
					** negative rating	-4	4	-16
Gender Reassignment		X			* positive rating			0
					** negative rating			0
Marriage and Civil Partnership		X			* positive rating			0
					** negative rating			0
Pregnancy and Maternity		X			* positive rating			0
					** negative rating			0
Race/Ethnicity or Nationality	X		X		* positive rating	5	4	20
					** negative rating	-4	4	-16
Religion or Belief		X			* Positive rating			0
					** negative rating			0
Sex		X			* positive rating			0
					** negative rating			0
Sexual Orientation		X			* positive rating			0
					** negative rating			0
Armed Forces	X		X		* positive rating	5	4	20
					** negative rating	-4	4	-16
Socio-economic Deprivation	X		X		* positive rating	5	4	20
					** negative rating	-4	4	-16
Welsh Language	X		X		* positive rating	5	4	20
					** negative rating	-3	3	-9

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Section 5: Outcome and Actions
This section should be used to detail and monitor any actions identified in sections 1-4.

Will the procedure/ proposal/ project/ policy be adopted? **If no, please give reasons and any alternative action(s) agreed.**	The Patient Services Centre (PSC) proposal will be adopted as part of Hywel Dda UHB's digital transformation strategy. The PSC aligns with strategic objectives to improve access, efficiency, and patient experience.
If a negative impact cannot be mitigated and it is proposed that HDUHB move forward with the plan/ project/ proposal regardless, please provide your justification for this.	While some negative impacts have been identified, these risks will be mitigated through targeted actions. The overall benefits of improved access, streamlined processes, and enhanced patient engagement outweigh these risks. The PSC will retain non-digital channels (telephone, in-person, postal) and embed inclusive practices to minimize adverse effects.

	Actions • Some actions have been populated for further elaboration, please delete as appropriate and add any additional actions identified. • Include any remedial changes that have been made to reduce or eliminate the effects of potential or actual negative impact, as well as any arrangements to collect data or undertake further research.	**Assigned to**	**Target Review Date**	**Completion Date**	**Comments/ Update**
	This section of the EqIA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqIA must be completed, please do not leave them blank.

Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqIA are included (ideally these should not be the same person). A member of the Diversity and Inclusion team will add their information to the final section, to show that the Diversity and Inclusion team have had sight of the EqIA and if required provided guidance.

EqIA Completed by:	**Name/s**	Rob James
	Title	Senior Project Manager
	Team / Division	Digital, Innovation & Transformation
	Contact details	Robert.james2@wales.nhs.uk
	Date	02/01/2026
EqIA Authorised by/Owned by: • **Usually the directorate lead would be the owner of the procedure/ proposal/ project/ policy** • **Responsible for the accuracy of the data captured in this EqIA as well as progressing any actions recorded in Section 5**	**Name**	
	Title	
	Team / Division	
	Contact details	
	Date	
Guidance has been provided by Diversity & Inclusion Team: (to be completed by Diversity and Inclusion team only)	**Name**	Kylie Daniels
	Title	Senior Diversity & Inclusion Officer
	Team	Business, Partnership & Inclusion
	Contact details	Kylie.daniels@wales.nhs.uk
	Date	06/01/2026
Diversity and Inclusion Team additional Comments:	This draft EqIA will need ongoing review and revision throughout the project's progression.	

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 EqIA and inform the D&I team.