



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date **2026-01-15**
Time **09:30 - 12:30**
Location **Microsoft Teams Meeting**

Digital, Data and Innovation Committee Meeting

HDD_Digital, Data and Innovation Committee
NHS Wales

Agenda - 15 January 2026

1 Governance and Risk

09:30, 15 min

1.1 Welcome and Apologies

09:45, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

1.2 Declarations of Interests

09:45, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

1.3 Minutes and Matters Arising from the meeting held on 07 October 2025

09:45, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

1.4 Table of Actions from the meeting held on 07 October 2025

09:45, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

2 Digital

09:45, 55 min

2.1 Planning Objectives (PO9) Update Report

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

2.2 Digital Operational Plan

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

2.3 Digital Strategic Plan

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

2.4 Digital Partner Update

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

2.5 Patient Services Centre

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

2.6 Proposal for the Introduction of Ambient AI into HDdUHB

10:40, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

3 Research and Innovation

10:40, 30 min

3.1 Research and Innovation Sub-Committee (RISC) 3A's Update

11:10, 0 min

Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

3.2 Research & Development (R&D) Annual Framework Update

11:10, 0 min

Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

3.3 University Partnership Arrangements Update

11:10, 0 min

Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

3.4 Trittech Business Plan

11:10, 0 min

Prof. Chris Hopkins (Hywel Dda UHB - Head of Innovation & Trittech Institute • Research and Development)

Break

11:10, 10 min

4 Data

11:20, 30 min

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

11:50, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

4.2 Data Protection Impact Assessment Assurance Report

11:50, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

4.3 Information Governance Training Update

11:50, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

5 Impact and Outcomes

11:50, 20 min

5.1 Update on Impact of Flow System

12:10, 0 min

Anthony Tracey (Hywel Dda UHB - Digital Director)

5.2 Analytical and Modelling Work including Presentation

12:10, 0 min

Gareth Jenkins (Hywel Dda UHB - Head of Data Science)

6 For Assurance

12:10, 10 min

6.1 Assurance and Risk Report

12:20, 0 min

Huw Thomas (Hywel Dda UHB - Director of Finance)

7 For Information

12:20, 0 min

7.1 DDIC Workplan 2025/26

12:20, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

8

Any Other Business

12:20, 10 min

Maynard Davies (Hywel Dda UHB - Independent Member)

9

Date and Time of next meeting

12:30, 0 min

Maynard Davies (Hywel Dda UHB - Independent Member)

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1 - Governance and Risk

1.1

09:45, 0 Mins

1.1 - Welcome and Apologies

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

Professor Chris Hopkins, Sarah Harraway

1.2

09:45, 0 Mins

1.2 - Declarations of Interests

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

| For assurance

1.3

09:45, 0 Mins

1.3 - Minutes and Matters Arising from the meeting held on 07 October 2025

Maynard Davies
(Hywel Dda UHB -
Independent
Member)

| For approval

Attachments

1.3 - 2025-10-07 - Digital, Data and Innovation Committee Meeting - Minutes.docx

MINUTES OF THE DIGITAL, DATA AND INNOVATION COMMITTEE MEETING

Date of Meeting: **Tuesday 07 October 2025**
Venue: **Ystwyth Board Room and Microsoft Teams Meeting**

Present: Mr Maynard Davies, Independent Member (Committee Chair)
Mrs Chantal Patel, Independent Member (Committee Vice-Chair)
Ms Sarah Harraway, Independent Member
Mr Winston Weir, Independent Member

In Attendance: Mr Huw Thomas, Executive Director of Finance
Mr Lee Davies, Executive Director of Strategy and Planning
Dr Leighton Phillips, Director of Research, Innovation and Value)
Mrs Joanne Wilson, Director of Corporate Governance/Board Secretary
Dr June Picton, AMD Professional Standards/Deputy Caldicott
Guardian, Associate Medical Director for Professional Standards
Dr Anthony (Tony) Smith, Consultant Anaesthetist
Mr Gavin Jones, Head of Digital Operations
Ms Carolyn Williams, Head of Digital Innovation & Transformation
Mr Gareth Beynon, Head of Information Services
Ms Claire Evans, Committee Services Officer (minutes)

Minutes Ref.	Item	Action
DDIC (25)51	Welcome and Apologies	
	The Chair welcomed members to the meeting.	
	Apologies for absence were received from:	
	- Mrs Eleanor Marks, Vice-Chair, Hywel Dda University Health Board - Mr Mark Henwood, Executive Medical Director - Mr Anthony Tracey, Director of Digital	
DDIC (25)52	Declarations of Interests	
	No declarations of interest were made	
DDIC (25)53	Minutes and Matters Arising from the meeting held on 22 July 2025	
	The Minutes from the meeting held on 22 July 2025 were approved as an accurate record.	

Decision:

The Committee APPROVED the minutes of the meeting held on 22 July 2025.

DDIC
(25)54

Table of Actions from the meeting held on 22 July 2025

Updates were provided on the following outstanding actions:

- *DDIC(25)07 Digital Strategic Plan:* Mr Huw Thomas will follow up with Mrs Sharon Daniel to resolve how the adoption of digital systems in clinical settings are being incorporated within Board Member Patient Safety walkabouts.
- *DDIC(25)34 Digital Operational Plan:* an update on the Digital Operational Plan will be presented to the next Digital, Data and Innovation Committee (DDIC) meeting in January 2026.
- *DDIC(25)44 Assurance on Governance Arrangements:* an update on the implementation date for Welsh Health Circular (WHC) 03-22: Further extending the use of Blueteq in secondary care, will be provided at the next DDIC meeting in January 2026.
- *DDIC(25)46 Business Cases:* Mrs Joanne Wilson confirmed that all business cases should be presented to formal Committee before going to Board. In response to Mr Thomas' comments regarding appropriate submission timings, **Mrs Wilson requested that Mr Anthony Tracey develop a timeline for scheduling business cases. This timeline will require agreement to ensure its alignment with the governance process and timely submission to DDIC and Board.** AT

All other actions from the DDIC meeting held on 22 July 2025 were Complete.

DDIC
(25)55

Information Governance Sub-Committee (IGSC) 3A's Update and IGSC Annual Report

3As Update

The Information Governance Sub-Committee (IGSC) 3As update report alerted Members of the DDIC to the condition of the local record storage facility, which requires improvements. Mr Thomas explained that he has visited the facility and reported that it is unsuitable for record storage. A business case will be developed to justify the need for an alternative location. Mr Thomas suggested a suitable site in Dafen, Llanelli. Work is ongoing to define storage requirements with the medical records team; it was also noted that the team will transfer to Mr Thomas' remit.

Mr Thomas outlined that the records are managed centrally, however the team are dispersed over various sites. Work is underway to identify records for disposal. A number of records previously retained for the blood borne inquiry, have now exceeded their retention period and can be removed. A scanner has now been delivered to facilitate the creation of electronic records.

Mrs Patel commented that the review is scheduled for inclusion in the 2026/27 Digital Operation Plan and questioned whether this timeline is too long. In response, Mr Thomas advised that it is a complex issue and will require significant time to address properly.

Following a challenge from Mrs Wilson, it was agreed that the matter should be classified as an advisory rather than an alert, as there is currently no action required from the Committee.

Mr Winston Weir raised a number of queries, particularly the age of the records, the expected timescale for changing the facility, whether other facilities could be used in the short-term and the number of back-dated records. He also expressed concern over the timescale to produce a business case. In response, Mr Thomas explained given that the largest cost burden would be transportation of records, it is important to ensure the transfer is only undertaken once. The number of appropriate storage units currently available is quite limited, with suitable premises being scoped with the Property Team. With the desire to digitise, it is essential for the records to be stored in close proximity to facilities with scanners, to reduce regular transfer of documents.

Mr Weir suggested that if a report aims to alert the Committee to a risk, it should also be added to the risk register to ensure appropriate leads are assigned people are responsible for mitigation.

Mr Thomas agreed to **progress the business case for records storage facilities as a priority, ensuring Mr Weir's queries are included.** **AT**

It was noted that not all primary care records fall within the Health Board's remit and have now been largely digitalised.

Mrs Wilson highlighted that the Health Board is bound by a lease on the local record storage facility, which affects the timescales.

The Committee were ASSURED on this item.

Annual Report

No further discussion was made on the IGSC annual report.

The Committee were ASSURED on this item.

Decision:

The Committee:

- NOTED the Information Governance Sub-Committee 3A's Report and RECEIVED ASSURANCE from the actions and oversight of the Sub-Committee.
- RECEIVED ASSURANCE from the Information Governance Sub-Committee Annual Report and ACKNOWLEDGED the work of the Sub-Committee

Mr Weir highlighted that a key priority of the Information Governance (IG) workplan is to increase IG training compliance above 80%. He advised that efforts should aim for compliance in the 90% range and be monitored closely. In order to provide an assurance, Mr Thomas confirmed that ongoing efforts will continue to improve training compliance.

Dr Picton noted that medical staff have lowered compliance rates, despite the IG team working closely with directorates to improve them. She added that staff face challenges accessing training via ESR. Although the Digital Team has developed an alternative training package, it does not cover the Caldicott Principles, which she will need to address with staff.

Responding to Mrs Patel's query about embedding IG training into staff requirements, Mr Thomas explained that focus has mainly been on managing change rather than developing a comprehensive training programme for the evolving Health Board. He noted that this will require further discussion with the Organisational Development (OD) Team. Following the agreement for an OD representative to join DDIC, this matter could be included in the induction discussion between Mr Thomas and the OD representative.

A verbal update on how IG training is being embedded in staff training requirements, would be presented to the next DDIC meeting. AT

Mr Thomas thanked the IGSC and IG team in particular for their excellent work and sound judgement. Mr Maynard Davies agreed and added his appreciation.

The Committee were ASSURED on this item.

Decision:

The Committee RECEIVED ASSURANCE on the IG Assurance Report included within Appendix 1 and acknowledge the work of the Information Governance Sub-Committee.

DDIC
(25)57

Data Quality Deep Dive

Introducing the data quality deep dive report Mr Gareth Beynon explained that the Digital Team is developing governance processes for data quality. This includes creating a data usability matrix to score and assess data quality levels.

Following data quality deep dives conducted with multidisciplinary teams, reports are produced and returned to services outlining a number of recommendations. The aim is to build relationships with services in order to improve data quality.

In response to Mrs Patel's query, Mr Beynon explained that the matrix does not align with the complaints system. It focuses on quality and does not triangulate with the complaints process.

Mrs Patel noted that similar issues were raised by the Listening and Learning Sub-Committee. Mr Beynon outlined that work is ongoing to

improve patient identification in Emergency Departments which is complicated by changes in patient details, such as address or identity.

Mr Weir enquired whether a league table exists to compare departmental data accuracy. Mr Beynon explained that while comparable outputs are available for similar areas, differences in data requirements prevent cross-department comparisons. He noted this is an initial step with plans for continuous improvement.

Mr Thomas noted that an internal audit review had taken place in January 2025 which provided assurance on data quality.

Ms Sarah Harraway commented that a scoring system would be very helpful to Board meetings.

Mr Thomas stated that in a previous DDIC meeting Mr Anthony Tracey had discussed the possibility of adding quality 'kitemarks' to documentation. **Mr Thomas recommended adding this to the Data Quality Deep Dive Workplan.** **AT**

Mr Maynard Davies highlighted that despite extensive discussions on Artificial Intelligence (AI), its effectiveness depends on high-quality underlying data. He also added that this topic is rarely discussed at Board level.

Mr Thomas thanked Mr Beynon and his team for their work in detecting controls.

The Committee were ASSURED on this item.

Decision:

The Committee:

- RECEIVED ASSURANCE regarding the ongoing Data Quality Deep Dives
- NOTED the continuation of the Data Quality Deep Dives, along with the structured methodology being applied to support their delivery. These deep dives remain a key component of the Health Board's approach to improving data integrity, and their consistent application ensures a robust and repeatable process for identifying and addressing data quality issues.

DDIC
(25)58

Analytical and Modelling Work

The report on Analytical and Modelling Work was submitted for information only due to the unavailability of a reporting officer at the meeting.

Mr Thomas highlighted the significant volume of packages listed in the report and suggested Mr Gareth Jenkins could meet with Independent Members individually to discuss in detail.

There is a gap in managing the change process of this work. Without an effective change management approach, the expected benefits will not be realised. Concerns were raised that the process was not being managed as effectively as it could be.

A number of queries were raised by Members.

- We need to consider how to prioritise limited resources.
- The role of the patient voice needs to be clearly defined.
- It's not enough to ask the question; we must ensure the answers are accurate and meaningful.
- We are engaging with PhD students and the education sector, however there is potential to go further.
- Governance is essential to ensure questions remain relevant, pertinent, and aligned with the work undertaken.
- We should explore how to use our resources more effectively for prevention and public health.
- A clear set of evaluation metrics is needed to review the impact of our work.

It was agreed that an updated report on Analytical and Modelling Work, incorporating the requested information, would be presented to the next DDIC meeting.

AT

DDIC
(25)59

Digital Strategic Plan

Ms Carolyn Williams introduced the digital strategic plan report.

Mr Thomas recognised that patient experience could be improved and highlighted an opportunity to develop a Patient Service Centre call centre) where clinicians would have access to the relevant data. However, he questioned whether this would provide good value or simply become expensive call centre. At this stage the report seeks to gauge support from Independent Members.

Ms Harraway noted the lack of co-production relating to patient facing services, and stressed the need to hear patients' voices to avoid creating services that do not meet their needs. As 10% of the public lack digital access, face-to-face options must remain. Ms Williams commented that further stakeholder engagement was required.

Mr Thomas confirmed that he had discussed with Mrs Sharon Daniel the need to prioritise patient experience, and also engaged with the Royal National Institute of Blind People (RNIB).

Mrs Wilson queried the timescales and whether the proposal would be ready for submission to the Board in January 2026. Mr Maynard Davies reminded Members that, as stated in the first DDIC meeting, he did not want timing constraints to hinder progress given the Committees quarterly schedule and suggested holding an extraordinary DDIC meeting, if required to discuss this item.

Mr Thomas agreed to review the timescales for the Digital Strategic Plan with Mrs Wilson, Lee Davies, Mr Maynard Davies and Mr Anthony Tracey to assess the feasibility of its submission to DDIC and Board in January 2026.

**HT/LD/
MD/AT**

Mr Maynard Davies observed that the report did not address the need for physical infrastructure to support one to one, face-to-face patient interactions.

Mr Thomas emphasised the importance of considering what is required, noting that this work involves multiple components, a significant programme of change and a clearly defined plan.

The Committee were ASSURED on this item.

Decision:

The Committee RECEIVED ASSURANCE from the proposed approach to the Patient Services Centre and Patient Relationship Management Tool.

DDIC
(25)60

Mini Proposal on the Use of AI Scribes

This item was deferred to the next DDIC meeting.

DDIC
(25)61

In Year Delivery of Programmes - Digital Operational Plan

Mr Gavin Jones introduced a report on In Year Delivery - Digital Operational Plan. The report outlined the status of a number of key digital system programmes, with the following noted:

- Radiology Deployment: the implementation of this programme has been delayed; however, it is expected to go live in December 2025. All issues have now been resolved.
- Laboratory Information Management System (LIMS) Deployment: this programme remains very challenging. The team is working alongside Swansea Bay University Health Board (SBUHB). Work is also underway on migrating data with tranche one beginning next week. Tranche four however remains an area of concern.
Electronic Prescribing and Medicines Administration (ePMA): the team is working with CGI and a revised roadmap is being developed.
- Patient Flow/eObservations: work is progressing at pace, with testing underway and any defects being addressed. Training materials are being finalised, and the system is scheduled to go live in November 2025.
- Hybrid Print and Post: the Digital Team is working with the Data Science Teams regarding hybrid and digital communications. The Post Hub enables patients to confirm rebook or cancel appointments and request preferences, such as language or large print. Delays in postal delivery, due to Royal Mail changes have highlighted the need for improved reminders. The Hybrid Mail system addresses this by sending text reminders, even if letters are delayed. Reducing reliance costly first class mail remains a priority.
- Maternity System (BadgerNet): implementation of this programme is progressing well.
- Eye Care System (OpenEyes): work is ongoing with SBUHB and the system has now gone live.
- Switchboard Modernisation: work continues on this complex programme.

- **Paging Replacement:** the Digital Team aims to replace the current systems by mid-February 2026.
- **Telecoms Modernisation:** British Telecomm will switch off current telephone lines by the end of 2026. All acute sites will be moved to digital telephone systems prior to this date.

Ms Williams explained that midwives are leading the rollout of the new maternity system, and have raised concerns about digital inclusion, as some patients lack digital access. In response, Mr Maynard Davies noted that a number of mobile providers offer free data to support individuals experiencing digital poverty.

Mr Weir queried the RAG status and whether the programmes accounted for both quantitative and qualitative benefit realisation, Mr Thomas clarified that the RAG status reflects progress against delivery timelines, not the achievement of outcomes.

The Committee were ASSURED on this item.

Decision:

The Committee NOTED the In Year Delivery - Digital Operational Plan 2025/2026 Update.

DDIC
(25)62

Digital Partner Update

Mr Thomas reported that the Health Board's relationship with CGI was maturing.

The Committee were ASSURED on this item.

Decision:

The Committee NOTED the content of the Digital Partner Update report.

DDIC
(25)63

Digital leadership with Allied Health Professionals and Health Scientists

Dr Tony Smith introduced a report on the role and importance of digital leadership amongst Allied Health Professionals (AHPs) and Health Scientists.

Dr Smith informed the Committee that the Chief Nursing information Officer post was currently being advertised. This has highlighted a gap in the areas on Allied Health Professionals and Health Scientists, with no advocates for those professions within the Informatics sphere.

The report advocated introducing two new part time roles, Chief Allied Health Professional Information Officer (CAIO) and a Chief Health Scientist Information Officer (CHSIO).

Mr Thomas provided assurance that the cost of the additional roles would be met from the existing team budget and confirmed that the report does not seek approval for additional funding. The advertisement will be

published externally, however, it is acknowledged that external candidates are less likely to apply for part time positions.

Mrs Wilson advised that the wording of the recommendation section of the report should be reconsidered moving forward as the Committee is seeking assurance that consideration has been given to a representation from Allied Health Professionals and agreed it through the management structure.

Mrs Wilson also noted the report refers to a clinical digital group, however it does not set out the reporting structure.

Dr Smith responded that the clinical digital group would support the Digital Steering Group and agreed to discuss further with Mrs Wilson outside of the meeting.

The Committee were ASSURED on this item.

Decision:

The Committee:

- SUPPORTED the principle of the expansion of the clinical digital leadership to include allied health professionals and health scientists. All being within existing budgets.
- SUPPORTED the establishment of a Clinical Digital Scrutiny and Assurance Group.

DDIC
(25)64

**Digital Innovation & Transformation Benefits Realisation Report
2024/25**

Mrs Williams introduced a report setting out the key elements of the benefits realisation methodology adopted within Digital Services. Although still its early stages, the report provides an insight into the Digital Team's expected benefits over the course of the year.

While this report has provided assurance on the queries raised earlier in the meeting, Mr Weir emphasised the importance of keeping the Committee informed of any further slippage and its potential impact.

Mr Maynard Davies noted that an internal audit conducted last year received a substantial rating, the highest achieved to date. He praised the comprehensive nature of the report and acknowledged the small size of the Digital Inclusion Team and the significant workload they are managing.

It was agreed to forward plan a deep dive on Digital Inclusion to a future DDIC meeting.

AT

Ms Harraway expressed concern over a decline clinical users accessing digital health records. Ms Williams suggested the drop may follow earlier promotional activity and noted that communications work is needed. She added that establishing a Scanning Group is within the Health Records Team, should help increase engagement.

Mr Thomas added that once scanners are in place, this would reduce time searching for records, with assurance that the system can also search for records which have been mis-filed.

The Committee were ASSURED on this item.

Decision:

The Committee:

- RECEIVED ASSURANCE on progress made within the programme made to date, the risk mitigation actions in place, and the ongoing commitment to maximising the value and impact of digital investment.
- RECEIVED ASSURANCE on the Benefits Realisation Report for 2024/25.

DDIC
(25)65

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

Dr Leighton Phillips introduced the Research and Innovation Sub-Committee (RISC) 3As report, along with requested details on commercial research and enabling digital/ data research. The digital research report outlines opportunities, while the Strategy sets actions to widen access. It was noted that Mr Tracey has scheduled sessions with both teams during November 2025 to explore these opportunities.

In response to Mr Maynard Davies' question of what the Committee could recommend to Executives to improve future research opportunities, Dr Phillips advised that securing additional funding would increase the possibility of accepting commercial trails.

Mr Maynard Davies noted that recruitment can be influenced by the availability of research opportunities. Dr Phillips highlighted the need to support clinical academics with protected time for research to attract and retain staff. Mr Thomas suggested the Executive Team may need to consider how best to support those opportunities.

The Committee were ASSURED on this item.

Decision:

The Committee:

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

DDIC
(25)66

Assurance and Risk Report

Mr Lee Davies left the meeting.

The Assurance and Risk Report outlined 2 corporate risks and 9 operational risks. Risk 1352 - *Risk of business disruption and delays in patient care due to a cyber-attack* remains high, and would be further discussed In-Committee. It was noted that Operational risks were currently being managed.

The report highlights key emerging risk themes and notes that the use of CGI has shifted from a being a digital risk to an organisational risk.

The audits and inspections section of the report highlights that IT infrastructure is being tracked. It was also noted that medicines management on acute hospitals is dependent on the Data Protection Act.

In relation to Welsh Health Circulars, ambient voice technology is not currently being used. The Ministerial Direction is being managed through the rollout of new technology.

Ms Harraway raised concerns regarding the extent of digital change across the organisation, noting its impact on multiple teams. She emphasised the need to consider organisational culture, capacity and resources for embedding long-term change, as highlighted in several reports. She suggested that should be articulated on the risk register.

Ms Williams highlighted concerns about change fatigue, noting that when planning or deploying initiatives, focus should be balanced across areas to allow for adjustment. There has been recent investment in Change Officers whose role is to consider lessons learned. No specific risks are currently listed, however, the next 12 months will be a challenging one for the organisation. The Digital Inclusion Team is actively engaged in identifying upcoming risks, which will be added to the register as each project progresses.

Mrs Wilson noted that numerous other changes are underway across the Health Board and highlighted a risk relating to digital inclusion, which is reported to the People, Organisational Development and Culture Committee (PODCC). She advised that if a specific risk is required, it can be escalated through PODCC or DDIC, however stressed the importance of avoiding duplication.

Mr Thomas stated this reiterates the importance of including an OD representative as a Member of DDIC.

The Committee were ASSURED on this item.

Decision:

The Committee:

Risk Management:

- RECEIVED ASSURANCE that identified controls are in place and working effectively;
- RECEIVED ASSURANCE that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports:

- RECEIVED ASSURANCE from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

Welsh Health Circulars:

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

Ministerial Directions:

- RECEIVED ASSURANCE that the Health Board is compliant with the NSIs (MDs) issued by Welsh Government.
- CHALLENGED where assurances are inadequate Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).

DDIC
(25)67

National and Regional Landscape

Mr Thomas introduced the National and Regional Landscape Report which outlined collaborative processes for developing regional transformation, with the planning process divided into four phases.

Dr Phillips suggested including research into the regional plan and offered to provide information from a regional perspective.

Mr Maynard Davies noted the importance of ensuring views of this Committee are reflected in Joint-Committees.

Mrs Wilson sought clarification on the governance and reporting structure of an AI Sub-Committee referenced in the report. Mr Thomas suggested that it might operate at a regional level and agreed to discuss the governance with Mrs Wilson outside of the meeting.

To engage with Mrs Joanne Wilson regarding the governance arrangements of sub-committees/groups such as the AI Sub-Committee to ensure the appropriate and effective reporting structures are established.

AT/HT

The Committee were ASSURED on this item.

Decision:

The Committee:

- SUPPORTED the phased approach to developing a regional digital transformation approach, ensuring alignment with national priorities and local needs.
- SUPPORTED governance structures, including the Regional Digital Steering Group and thematic working groups, to drive collaboration and accountability.
- SUPPORTED the advancement of AI as a strategic enabler by establishing an AI Oversight Sub-Committee, defining governance standards, and prioritising pilot use cases.

DDIC
(25)68

Policies for Approval

There are no policies for approval.

DDIC
(25)69

Artificial Intelligence and the Welsh Language Regulatory Policy Statement

The report outlined that AI systems such as ChatGPT did not perform well through the medium of Welsh, which is a challenge for bilingual AI provision.

DDIC
(25)70

DDIC Workplan 2025/26

The DDIC workplan for 2025/26 was circulated for information.

DDIC
(25)71

Any Other Business

No other business was discussed.

DDIC
(25)72

Date and time of next meeting

9.30am-12.30pm Thursday 15 January 2026

1.4

09:45, 0 Mins

1.4 - Table of Actions from the meeting held on
07 October 2025

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

| For approval

Attachments

1.4 DDIC Table of Actions 07.10.25 for 15 January 2026 meeting.docx

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

07 October 2025

TABLE OF ACTIONS/ TABL GWEITHREDOEDD

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress
DDIC(25)03	22.04.25	DDIC Terms of Reference	To liaise with Lisa Gostling on the merits of adding a representative from Workforce/Organisational Development to the DDIC Membership. To identify a suitable Workforce/Organisational Development representative to join the DDIC Membership	HT LG	~~31 May 25~~ ~~29 Aug 25~~ 17 Dec 25	Complete: Attendance at the committee will form part of the remit and objectives of the interim Assistant Director of Organisational Development once appointed.
DDIC(25)07	22.04.25	Digital Strategic Plan	To liaise with Sharon Daniel regarding incorporating within Board Member Patient Safety walkabouts how digital systems are being adopted in clinical settings.	HT	~~31 May 25~~ ~~29 Aug 25~~ 17 Dec 25	In Progress: Raised with Sharon Daniel on 13 May 2025. Update: Huw Thomas will contact Sharon Daniel to continue discussions and achieve a resolution.
DDIC(25)34	22.07.25	Digital Operational Plan	To explore AI accountability and governance and to establish appropriate frameworks and arrangements.	HT/AT	~~29 Aug 25~~ 17 Dec 25	Complete: An update is on the agenda for the January 2026 DDIC meeting.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress
DDIC(25)44	22.07.25	Assurance and Risk Report	To contact Rhian Bond to obtain an implementation date for Welsh Health Circular 03-22: Further extending the use of Blueteq in secondary care	AT	~~29 Aug 25~~ 17 Dec 25	In Progress: Currently working through the deployment and implementation plan. Update: Contact made but no response received. Will contact Rhian Bond. Update will be brought to the January DDIC meeting.
DDIC(25)46	22.07.25	Business Cases	To discuss with the Chair whether DDIC or IC-DDIC is the most appropriate meeting for discussing business cases.	AT	29 Aug 25	Complete: Mrs Joanne Wilson confirmed that all business cases should be submitted to full Committee meetings before onward submission to Board.
DDIC(25)54	07.10.25	Table of Actions from the meeting held on 22 April 2025	To develop a timeline for scheduling business cases and liaise with Mrs Joanne Wilson to align the governance process, to ensure timely submission to DDIC and Board.	AT	17.12.25	In Progress: Meeting scheduled with JW on 12.01.26.
DDIC(25)55	07.10.25	Information Governance Sub-Committee (IGSC) 3A's Update and IGSC Annual Report	To progress the business case for records storage facilities, as a priority, ensuring all requested information is incorporated.	AT/HT	17.12.25	In Progress: Issues to be addressed through the annual planning cycle 2026/2027.
DDIC(25)56	07.10.25	Information Governance Assurance Report	To bring an update to the next DDIC meeting on how IG training is being embedded in staff training requirements.	AT	17.12.25	Complete: On the agenda for the January DDIC meeting.
DDIC(25)57	07.10.25	Data Quality Deep Dive	To add quality kitemarks for documents to the Data Quality Deep Dive Workplan	AT	~~17.12.25~~ 14.04.2026	In Progress: Update to be provided to 14 April 2026 DDIC.

Minute No.	Meeting Date	Subject	Action	Lead	Timescale	Progress
DDIC(25)58	07.10.25	Analytical and Modelling Work	To present a further update on Analytical and Modelling Work to the next DDIC meeting, ensuring all requested information is incorporated.	AT	17.12.25	Complete: On the agenda for the January DDIC meeting.
DDIC(25)59	07.10.25	Digital Strategic Plan, Including Business Plans	To arrange a meeting with Mrs Joanne Wilson to review the timescales for Digital Strategic Plan and assess the feasibility of its submission to Board in January 2026. If required, schedule an Extraordinary DDIC to facilitate discussion and approval.	HT/LD/MD/AT	17.12.25	In Progress: Meeting scheduled with JW on 13.01.26.
DDIC(25)64	07.10.25	Digital Innovation & Transformation Benefits Realisation Report 2024/25	To present a deep dive report on Digital Inclusion to a future DDIC meeting.	AT	17.12.25	Complete: On the agenda for the January DDIC meeting.
DDIC(25)67	07.10.25	National and Regional Landscape	To engage with Mrs Joanne Wilson regarding the governance arrangements of sub-committees/groups such as the AI sub-Committee to ensure the appropriate and effective reporting structures are established.	AT/HT	17.12.25	Complete: To be discussed at January DDIC meeting.

Key: HT: Huw Thomas AT: Anthony Tracey LD: Lee Davies MD: Maynard Davies

2 - Digital

2.1

10:40, 0 Mins

2.1 - Planning Objectives (PO9) Update Report

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

| For discussion

Attachments

[2.1 - Planning Objectives \(PO9\) Update Report - Highlight Reports - Digita~.pptx](#)

Planning Objective: Planning Objective PO9

Executive Lead: Huw Thomas, Executive Director of Finance

Reporting Period: Quarter 3

Overall status: On-track

Rationale for overall status (please provide a brief summary of current progress indicating any key highlights or potential barriers to delivery)

Whilst the HDdUHB continues to make significant progress in its digital transformation journey, the deployment of national and local foundational digital systems remains a complex and evolving challenge. These programmes are critical to supporting clinical care, operational efficiency, and the delivery of strategic objectives aligned with national digital health priorities. Whilst some programmes are noting delays, they are within project tolerances.

Progress against planned outcomes / trajectories / milestones (please provide SPC/data charts and an explanation of any variances):

Please see table below

Activities completed in previous reporting period

- Readiness for ePMA
- Readiness for Digital Maternity and Open Eyes
- Phase 1 rollout of Patient Flow and eObservations
- Radiology (RISP) rollout
- First draft of proposal for Patient Services Centre
- Capital Projects (Picton Terrace, Pentre Awel, Sexual Assault Referral Centre (SARC), Bronglais Hospital (BGH) Chemotherapy Day Unit (CDU)
- Decommission of Biztalk
- Operational Improvements (Introduction of Nutanix, Office 2016 decommission, Citrix software upgrades)

Activities planned for next milestone and reporting period

- Further adoption of Laboratory Information System (LIMS)
- Continue with the implementation of patient flow/eObservations
- Development of a proposal for a centre of excellence for Data

Any other Comments

Matters for information:

Risks to delivery: Capacity with the operational teams, and the business change required. We are now looking at additional support

Any other comments:

Programme	Risk of Delivery Level:	
Radiology Deployment	Risk of Delivery Level: Low This risk has been assessed as <i>Low</i> . The programme has been delivered; however, a small number of residual issues remain to be addressed. These matters are minor in nature and do not impact operational functionality.	
Laboratory Information Management System (LIMS) Deployment	Risk of Delivery Level: High The risk has been assessed as <i>High</i> due to the ongoing fluidity of the deployment plan. Every effort is being made, both nationally and locally, to ensure the programme is delivered within the required timescales and that further delays are avoided.	
Electronic Prescribing and Medicines Administration (ePMA)	Risk of Delivery Level: Low / Medium The risk is assessed as <i>low to medium</i> due to the current progress in deployment and the presence of an agreed implementation plan. However, operational concerns remain around user adoption, system configuration, and assurance of clinical safety, which require ongoing monitoring and support.	
Patient Flow / eObservations	Risk of Delivery Level: Low / Medium Phase 1 has been delivered, and the programme is now looking to complete Phase 2 of patient flow and begin the readiness work for eObservations	
Hybrid Print and Post	Risk of Delivery Level: Low / Medium The risk is assessed as <i>low to medium</i> based on data quality issues, incomplete patient contact information, postal delays for short-notice appointments, inconsistent process adherence and potential resistance to change. Mitigation requires improved data governance, staff training, and maintaining alternative communication channels for patients.	
Maternity System (BadgerNet)	Risk of Delivery Level: Medium The risk is assessed as <i>medium</i> but contingent on closing supplier documentation items, securing integration timelines, protecting training and clinical engagement capacity, and tightening programme-level governance with national partners.	
Eye Care System (OpenEyes)	Risk of Delivery Level: Medium The risk is assessed as <i>medium</i> based on the timescales of implementation by 31 March 2026 . Progress at Swansea Bay UHB provides a workable blueprint, but HDdUHB's delivery still hinges on near-term design choices (notably prescribing), recruitment, and national dependencies (hosting, interfaces, and electronic referral systems).	

Programme	Risk of Delivery Level:	
Switchboard Modernisation	Risk of Delivery Level: Medium The risk is assessed as <i>medium</i> based delivery is exposed to near-term risks around rota standardisation and training, infrastructure resilience (power / rooms / Reinforced Autoclaved Aerated Concrete (RAAC) interfaces and maintaining 24/7 operational continuity during phased cutover across sites.	
Paging Replacement	Risk of Delivery Level: Medium The risk is assessed as <i>medium</i> as successful delivery hinges on tight sequencing with switchboard and alarms modernisation, estates readiness (power/rooms), supplier lead-times, and a zero-harm cutover plan that preserves emergency cascades throughout.	
Telecomms Modernisation	Risk of Delivery Level: Low The risk is assessed as <i>Low</i> as all sites have been migrated onto the new telephony system. Work is continuing on rolling out the softphone approach.	

2.2

10:40, 0 Mins

2.2 - Digital Operational Plan

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

| For discussion

Attachments

[2.2 -DDIC - Operational Plan - Delivery Dates - Jan 2026 \(AT, needs HT\).docx](#)



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:	Digital Operational Plan Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

Pwrpas yr Adroddiad (dewiswch fel yn addas) Purpose of the Report (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA SBAR REPORT
<u>Sefyllfa / Situation</u> The purpose of this paper is to present the Digital, Data and Innovation Committee (DDIC) with an update on timelines for the 2025/26 Digital Operational Plan, which represents the next phase of our digital transformation journey. This plan aims to strengthen our digital infrastructure, improve patient engagement, and maintain full compliance with regulatory standards.
<u>Cefndir / Background</u> Effective prioritisation of digital projects is critical to ensure that limited resources such as, funding, technical expertise, and staff time, are allocated to initiatives that deliver the greatest value. In today's complex digital landscape, organisations must make strategic decisions that align projects with corporate objectives, regulatory obligations, and user expectations. Prioritisation also plays a key role in risk management by focusing attention on essential systems that safeguard operational safety and continuity. However, this process presents significant challenges. Balancing competing stakeholder interests, managing resource limitations, and adapting to shifting priorities driven by external pressures or emerging technologies can make decision-making difficult. Without clear and consistent criteria, prioritisation risks becoming subjective or influenced by politics. Despite these obstacles, adopting a structured and transparent approach is essential to ensure that digital transformation efforts remain impactful, resilient, and sustainable.
<u>Asesiad / Assessment</u> Project / Programme List Output Following a detailed analysis of the "Must Do" projects from the uploaded project list, the initiatives have been logically grouped into four implementation phases. This phased approach enables structured delivery, supports effective resource planning, and ensures alignment with both strategic objectives and operational priorities.

- **Phase 1: Foundational Infrastructure and Compliance**

These projects are critical for maintaining system security, operational continuity, and regulatory compliance. They form the backbone of the digital environment and must be prioritised for immediate action.

Project	Proposed Timeline	Project Status	
		Oct 25	Dec 25
Cyber Security – Audit Findings	April 2026		
Microsoft Enterprise Agreement Renewal	June 2026		
Cyber Resilient Unit Audit	September 2025		
Integration Layer & Application Programming Interface	August 2025		
Biztalk Decommissioning	December 2025		
Telecomms Modernisation – Phase 1	July 2026		
Wireless Application Protocol (WAP) Replacement	Begun – Nov 25 (18-month programme)		
Switchboard Alarm Digitisation	Begun – May 2025 - 24-month programme		
Paging Replacement	Contract Awarded – September 2025 – 12-month programme for delivery		
Laboratory Information Management System Replacement	June 2026		
Urgent and Emergency Care UEC Transformation Work (Planning the Unscheduled Care)	Ongoing		
Radiology Informatics System Programme (RISP)	December 2025		
Integrated Performance Assurance Report (IPAR)	On-going		
Patient Flow – Phase 1 – Partial Functionality	November 2025		
Patient Flow – Phase 2 – Full Functionality	May 2026		
eObservations – Phase 1 - Manual Entry	June 2026		
eObservations – Phase 2 - Full Electronic	September 2026		
Switchboard Modernisation	Linked to the Switchboard Alarm Digitisation		
Implementation of a Maternity System (BadgerNet)	March 2026		
Implementation of an Eye Care System (OpenEyes)	March 2026		

- **Phase 2: Core Service Enablement and Access**

These projects support essential service delivery and user access. While not as urgent as Phase 1, these are key to ensuring smooth operations and improved clinical workflows.

Project	Proposed Timeline	Project Status	
		Oct 25	Dec 25
Pyxis Upgrade	September 2025		
Citrix Hardware Replacement	December 2025		
Audit Wales Response	July 2026		
ePMA	May 2026 – March 2027		
PPH - MIU	October 2025		
Virtual Ward – remote monitoring H@H integration	March 2026		
UEC report rationalisation	August 2025		

Phase 3: Targets enhancements that improve efficiency, integration, and user Experience

Project	Proposed Timeline	Project Status	
		Oct 25	Dec 25
Single Sign On	September 2025		
Carmarthen Hwb	October 2025		
Picton Terrace	December 2025		
Community Networks – Llandovery	December 2025		
Planned Care Transformation Work (Waiting List Management)	March 2026		
Dashboards	Ongoing		
Information Services Data Platform Migration	February 2026		
Digital Response	Summer 2026		
Forcepoint / iBOSS	June 2025		
Pentre Awel	August 2025		
Community Networks – Llys Steffan	October 2025		
Community Networks – Elizabeth Williams	January 2026		
CCTV Installation	March 2026		
Optimisation of Legacy / Existing Clinical Systems	Ongoing		
AI Commission	February 2026		
Centre of Excellence - Data Analytics	March 2026		

Key:

Delivered	
Progressing Ahead of Schedule	
On Schedule	
Slightly Delayed (Within Acceptable Limits)	
At Risk – Mitigation Required	

Summary

The Digital Operational Plan for 2025/26 marks a significant step in our digital transformation journey. By prioritising high-value projects and applying a structured implementation approach, the plan aims to strengthen digital infrastructure, enhance patient engagement, and ensure regulatory compliance. However, not all initiatives are progressing as scheduled. Some projects have experienced delays due to resource constraints, competing priorities, and the complexity of integration. These challenges highlight the importance of agile planning, proactive risk management, and ongoing reassessment to maintain momentum. Despite these pressures, the plan remains a critical framework for delivering a more efficient, responsive, and digitally enabled healthcare system.

Argymhelliad / Recommendation

The Committee are requested to:

- **NOTE** the Digital Operational Plan update and the projected timelines for 2025/2026 and in future years.

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

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.2 That the organisation is discharging its responsibilities with regard to the quality and integrity; safety, security and appropriate access and use of information and data, to support health improvement and the provision of high-quality healthcare.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial and service impacts of the digital plan are evident in the substantial investments made and the

	significant improvements in service delivery. These efforts reflect our commitment to creating a modernised, patient-centred system of care that aligns with national digital standards and local healthcare priorities. Each of the tranches, and projects will be subject to further business cases.
Ansawdd / Gofal Claf: Quality / Patient Care:	The digital plan will bring about substantial improvements in the quality of care and patient outcomes. By leveraging advanced digital technologies, we have created a more efficient, safe, and patient-centred healthcare system that aligns with our commitment to delivering high-quality care to our communities.
Gweithlu: Workforce:	The digital plan has significantly transformed our workforce by enhancing productivity, fostering skills development, and improving overall well-being and engagement. These efforts reflect our commitment to creating a modernised, efficient, and supportive work environment that aligns with our strategic goals and enhances the quality of care we provide.
Risg: Risk:	The digital plan carries several risks, proactive risk management and mitigation strategies are in place to address these challenges. By continuously monitoring and managing these risks, the organisation aims to ensure the successful implementation of the digital plan and the achievement of its strategic objectives.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The successful execution of the digital plan can greatly enhance our organisations reputation as a leader in digital innovation within the healthcare sector. By integrating advanced digital tools and platforms, we demonstrate our commitment to improving patient care, operational efficiency, and data security. This proactive approach can attract positive media coverage, bolster public trust, and strengthen relationships with stakeholders, including patients, staff, and partners. The digital plan's emphasis on enhancing service delivery and patient outcomes aligns with our mission to provide high-quality, value-based healthcare, further solidifying our reputation as a forward-thinking and patient-centred organisation.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	All business cases / projects will be subject to an equality assessment

2.3

10:40, 0 Mins

2.3 - Digital Strategic Plan

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

| For discussion

Attachments

[2.3 - DDIC - Strategic Plan Jan 2026 \(AT, needs HT\).docx](#)



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:	Digital Strategic Plan
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA

SBAR REPORT

Sefyllfa / Situation

The primary purpose of this document is to provide the Digital, Data and Innovation Committee (DDIC) with a comprehensive overview of the future foundational digital systems required to support the operational plans and strategic objectives of Hywel Dda University Health Board (HDdUHB). It outlines the vision, approach, and roadmap for digital transformation over the next five years and beyond, ensuring alignment with the Health & Care Strategy, “A Healthier Mid and West Wales: Our future generations living well.”

The document aims to:

- Set out the strategic direction for digital investment and transformation, building on lessons learned since the 2020 Digital Response.
- Identify the core digital capabilities and systems necessary to deliver integrated, patient-centred, and data-driven care.
- Address the challenges posed by demographic changes, climate imperatives, and rapid technological advancement.
- Present a phased roadmap for implementing digital solutions that improve patient outcomes, enhance operational efficiency, and support workforce development.
- Ensure that digital adoption is embedded as a cultural and organisational priority, not just a technical one.
- Engage stakeholders across HDdUHB, including staff and the public, in shaping the next iteration of the digital strategy.

In summary, the document serves as a strategic guide for HDdUHB’s digital journey, ensuring that digital transformation is purposeful, sustainable, and responsive to the evolving needs of the population and the health and care system.

Cefndir / Background

The Digital Response published in 2020, 20-yearated the future strategic vision for investment in digital services for the next five years, in order to meet the priorities outlined within our Health & Care Strategy, ‘A Healthier Mid and West Wales: Our future generations living well’ approved

by the Board in November 2018, and the 20 year vision for population health outcomes set out in our Health and Wellbeing Framework, 'Future Generations: Living Well'.

Having a strategic response to the health board's requirements provided clarity and forward momentum for digital transformation to help meet the strategic vision of working together to drive excellence in care for patients and communities. Key focus areas included:

- Integration with the partners to take forward the digital programmes and related population health initiatives.
- Unlocking the power of information to improve decision making at the point of care.
- Exploiting digital technologies to deliver patient centred solutions in neighbourhoods and communities.
- Keeping patient and service user's information safe, secure and up to date, and only using this data with appropriate governance and controls.
- Improving organisational digital maturity and user digital literacy to maximise the benefits of digital technologies.
- Delivering digital services which will be paper-free at the point-of-care.

Over the last four years we have made significant strides towards this vision, and we are now identifying future foundational systems that will enable to continue this journey over the next five years and beyond.

Asesiad / Assessment

Redrafting of the Digital Response

The Digital Response, initially published in 2020, landed during the COVID-19 pandemic, which necessitated immediate adjustments to the strategic direction of the HDdUHB digital plans. Some long-term strategic initiatives were temporarily shelved to prioritise the rapid rollout of Microsoft 365 tools, ensuring that the health board could respond effectively to the urgent needs of the pandemic. However, this period also provided valuable lessons and insights that have informed the redrafting of the Digital Response. The revised plan will incorporate these learnings and addresses newly identified key requirements that will enable digital service improvement and transformation across various directorates and communities.

Approach

The approach to redrafting the Digital Response will involve a comprehensive assessment of HDdUHB's digital needs and opportunities. This includes identifying areas where digital technologies can drive service improvement and transformation, such as enhancing decision-making at the point of care, delivering patient-centred solutions, and improving organisational digital maturity. The revised plan will emphasise the integration of digital programs with partners, ensuring that patient and service user information is kept safe, secure, and up to date with appropriate governance and controls. Additionally, the approach will focus on maximising the benefits of digital technologies by improving user digital literacy and delivering paper-free digital services at the point of care. By adopting this strategic approach, the health board aims to continue its journey towards digital excellence over the next five years and beyond.

Strategic

We have developed our thinking on Digital as detailed in the following text. Digital is the means by which we all interact with each other and with everything around us. In healthcare, using digital technology, citizens and patients will be able to receive and share information online about their health and well-being, communicate by audio, video, secure email and messaging, and participate in peer-to-peer patient support groups, in trials, and in health and care decision-

making with their clinicians. Health and care teams will use digital technology to become more data-driven and evidence-based, with a robust and ever-expanding decision-support capability.

Our digital vision continues to be ambitious, presenting the need for changing the culture through transformation enabled by digital combined with an opportunity for accelerated delivery and a focus on collaboration with our partners in Health and Social Care. The intent is to shape collective mindset and decision making rather than to prescribe products or platforms. In a society that is rapidly embracing and adopting technology, such as Artificial Intelligence (AI) the NHS cannot stand still. Our digital vision outlines how we intend to integrate digital solutions into every patient interaction and how, through clinical leadership, we will use these to improve the quality of care and experience of our patients and support our workforce providing safe and efficient tools.

We are in the process of reframing our Digital Response, however the four pillars previously outlined are still the cornerstone of the digital transformation approach for HDdUHB.

- 1) **Citizen engagement**, allowing a citizen or carer to have a single digital front door through which to access and interact with health and care services. This will allow citizens and their carers to manage their own condition, receive tailored and personal information and interact with services.
- 2) **Health and care co-ordination and collaboration**, ensuring that colleagues across health and care services have access to data, schedules and actionable work. This will allow colleagues to refer, request and track patients and service users across services; collaborate across the system and access the right information at the right time.
- 3) **Digital operations and control centre**, supporting new models of care through scaled remote monitoring, availability of resources and regional case and system management. This will allow us to release and direct scarce resources to deliver services appropriately; supporting the direction of the right care at the right time with the right resources; and establish a foundational element of integrated health and care delivery.
- 4) **Regional data fabric**, supporting the integration and interoperability and improving data sharing through an integrated health and care record. This will allow us to drive insight into service delivery and population health; direct improved service outcomes; and create a bridge between current and new solutions for improving health and care across our region.

Progress Towards Foundational Clinical Systems: Digital as a Driver and Enabler

Digital transformation has been at the heart of our progress towards establishing foundational clinical systems across HDdUHB. Recognising the critical role that digital plays in modern healthcare, we have made it a central driver for change, shaping our strategy, guiding our investments, and accelerating the adoption of new ways of working.

Over the past year, our digital programme has delivered significant progress in modernising and consolidating our core clinical platforms. A key achievement has been the development of the thinking towards a unified digital health record, designed to bring together data from primary, secondary, and community care into a single, accessible view. This integration is fundamental to improving continuity of care, reducing duplication, and enabling clinicians to make informed decisions quickly and safely.

Alongside this, we have introduced electronic patient flow and electronic observation systems, which are already transforming how clinical teams manage patient journeys and monitor vital signs. Looking ahead, the planned implementation of electronic prescribing in 2026 will complete a suite of foundational tools that underpin safe, efficient, and digitally enabled care delivery.

These developments are not just incremental improvements; they represent the building blocks of a truly digital health board. By creating a connected ecosystem of clinical systems, we are accelerating our ability to reimagine how care is delivered, optimise workflows, and harness data for better outcomes. This work positions us to move beyond digitisation towards innovation, where technology actively shapes the future of patient care across our organisation.

This integration, powered by digital solutions, is reducing fragmentation and providing clinicians with a comprehensive, real-time view of patient information at the point of care. The digitisation of key clinical workflows, such as electronic prescribing, order communications, and results reporting, is now embedded in daily practice, improving efficiency and patient safety.

Current Future Demands affecting Digital.

Health and care services within our health board are entering a period of unprecedented change. We are operating at the crossroads of major demographic, environmental, and technological shifts that will redefine how care is delivered and experienced. These forces are not abstract, they are already shaping the expectations of patients, the workflows of clinicians, and the resilience of our systems.

Over the next two decades, we face three interconnected transitions:

- **Demographic pressures**, driven by a rapidly aging population and increasing complexity of health needs.
- **Climate imperatives**, as we work toward ambitious sustainability targets while ensuring continuity of care.
- **Digital acceleration**, with emerging technologies transforming clinical practice, patient engagement, and operational efficiency.

This section explores how these transitions intersect and how systems thinking, combined with digital megatrends, can be harnessed to meet these challenges head-on. By understanding the interplay between these forces and identifying key leverage points, we can design a health and care ecosystem that is future-ready, adaptive, and resilient, one that not only responds to change but actively shapes it for the benefit of our communities.

Demographic and Climate Transitions: A Dual Challenge for Health and Care

Our health and care system is entering a period of profound transformation, shaped by two powerful and interconnected forces: demographic change and climate imperatives. These transitions will define the next two decades and require us to rethink how we deliver care, allocate resources, and build resilience.

On the demographic front, the challenge is clear. By 2044, the baby boomer generation will reach peak life expectancy, driving a sharp rise in the number of people aged over 85—up by nearly 80% in some communities such as Pembrokeshire. This surge begins well before the peak, accelerating in the early 2030s. At the same time, the working-age population will decline significantly, with areas like Ceredigion projected to see a reduction of more than 10%. This imbalance between rising care needs and shrinking workforce creates a demographic care deficit that demands a step change in productivity and innovative supply-side solutions. These pressures are already visible today, with increasing multimorbidity, complex frailty, and chronic conditions intensifying demand per person. Without a fundamental redesign of how we sense need, allocate resources, and support self-management, these trends will compound year on year.

Alongside this, the climate transition introduces equally profound challenges. Current policy commits us to reducing net carbon emissions by 63% by 2030, 89% by 2040, and achieving net zero by 2050. While early progress has been encouraging, the next phase will require

transformational change. Large-scale renewable energy projects, such as floating offshore generation in the Celtic Sea and associated transmission infrastructure in Carmarthenshire, will reshape our regional energy landscape. Homes will become more efficient and interconnected through insulation, heat pumps, and solar technologies, while transport systems adapt to electric vehicles. At the same time, we must prepare for the realities of a changing climate, warmer, wetter winters and hotter, drier summers, bringing more frequent extremes that will impact health and care demand.

Together, these transitions represent both risk and opportunity. They compel us to adopt systems thinking and leverage digital innovation to create an adaptive, resilient health and care ecosystem, one that not only responds to change but actively shapes it for the benefit of our communities.

Future Challenges

The digital transition is the opportunity to address, at least partly, the challenges posed to health and care over the coming 20 years. Over the coming decade we can expect at least five of these digital megatrends to accelerate:

- Artificial intelligence (AI) to become more pervasive into every layer of systems and processes. Generative AI will move from text and image reasoning to multimodal, including video and voice. Agentic AI will create autonomous digital workers acting across systems. Adaptive or Edge AI will increasingly operate on-device as personal computing power continues to increase. Neurosymbolic or Explainable AI will combine reasoning with learning for decisions which will move beyond the black-box and create greater transparency in our interactions.
- Quantum and advanced computing will become widely available. A traditional computer uses 'bits,' which are either 0 or 1 to calculate. A quantum computer uses quantum bits 'qubits' which can be 0, 1 or both. This superposition allows many possible solutions to be determined simultaneously; and probabilities determine the correct solution. Google, for example, in 2019 conducted an experiment using quantum computing which took 200 seconds to complete, a task which would have taken the Summit Supercomputer 10,000 years.
- Connectivity and the internet of everything. Transitions from 4G to 5G and on to 6G will reduce latency, increase bandwidth, and allow any object to become a data node. It will allow spatial computing, merging the digital and physical through augmented reality, virtual reality, holographic and sensors. Real time models could then be created at scale: we may all have a personal digital twin or have a system digital twin. Global coverage and resilience will be enabled through satellite communication, providing greater resilience to data collection.
- Infrastructure. Mesh computing will replace centralised models. We will need to transition from cyber controls to quantum security (cyber controls could easily be overcome by malign quantum actors). This will require a zero-trust approach, where every device, user and application are continually authenticated. Data will be transferred using blockchain technology to provide tamper-evident audit trails for data transfers.
- Interface. Increasingly ambient computing will mean that tech fades into the environment and responds to our voices, our gestures, our context. Extended reality will merge augmented and virtual reality with the real world. Wearables, even implantables, will continuously collect biometric information. We may even transition to brain-computer interfaces.

While these trends offer significant opportunities, our ability to benefit from them is currently constrained by the underlying condition of our digital estate. Legacy platforms, fragmented data flows and limited interoperability create friction that reduces the impact of even well-designed

innovations. The megatrends described above must be understood in relation to this starting point. Our priority is not to chase the most advanced technologies but to build the foundations that allow us to absorb these trends safely and at pace.

These megatrends will themselves result in a multitude of enabling trends which will both increase the expectations of our citizens, and the opportunities for the health and care sector.

Developing the roadmap – “From Vision to Action”

To deliver this, we must undertake digitally enabled transformation, redesigning care models, empowering our workforce, and activating our population through the intelligent, ethical, and effective use of digital technology and data. This means going beyond the digitisation of existing processes to build an intelligence-led, learning health and care system that connects people, services, and insights.

Our transformation must be approached in phases, ensuring that each stage builds upon the foundations of the previous. No amount of innovation can succeed without the underlying infrastructure, data, and digital capabilities in place to support it. This means prioritising establishing robust architecture, shared standards, reliable infrastructure, and a digitally confident workforce before scaling more advanced solutions.

Our first stage requires us to standardise the way we work, our clinical workflows, care protocols, documentation and data capture, bringing a new consistency to pathways and administrative processes. While digitising our current service model is essential, it is only the first step. We must then look beyond this and reimagine and rearchitect how care is delivered from reactionary to where proactive, participatory, personalised and preventative care becomes the norm.

We also recognise that currently many patients have limited access to their health data or the tools to manage their conditions; our vision is to empower individuals with access, personalised care plans, and connected technologies.

Looking to the future, we envision a system where individuals can view and contribute to their health records, have personalised interactive and responsive care plans, access high quality digital therapeutics, monitor their conditions with connected technologies (such as wearables), and share data with their care teams to support better, more responsive care.

By maximising the use of data including predictive analytics and taking an intelligence led, risk-based approach with a focus on prevention, we will enable a shift towards precision health which uses data and insights to tailor care, prevention, and interventions to individuals based on their unique risk factors, behaviours and needs. This will optimise resources, enable earlier interventions, reduce the burden of avoidable illnesses and help people stay healthier longer.

The roadmap also recognises that the future of health care is deeply connected with social care, public health, and community support. We will work to strengthen these connections digitally, enabling integrated, person-centred journeys across the system.

Success requires a profound cultural shift, reshaping mindsets, practices and ways of working across our entire system. Without this transformation, even the best technologies and investments will fall short of their potential.

With this roadmap we are building towards that more personalised, equitable, and sustainable health and care system for the future, one where the people of mid and west Wales are supported to live longer, healthier, and more independent lives.

We will build a future where data is ubiquitous, connected, and trusted, and use real-time insights to achieve the ambition of “better data, better care, better lives”. We will mature towards an environment where we harness AI and advanced analytics to turn information into action, predicting needs and personalising care and use data to power every decision be it clinical, operational or strategic.

Moving to a Capabilities Approach in Digital Transformation

Digital transformation is no longer about implementing isolated technologies or chasing the latest trends; it is about building sustainable capabilities that align with the organisation’s strategic objectives. A capabilities-based approach focuses on developing the skills, processes, and platforms that enable the business to adapt and thrive in a rapidly changing environment. Rather than viewing digital initiatives as one-off projects, this approach embeds digital thinking into the core of the organisation, ensuring long-term resilience and agility.

By linking digital capabilities directly to business needs, organisations can prioritise investments that deliver measurable outcomes. For example, instead of deploying a new analytics tool simply because it is innovative, the focus shifts to building a data capability that supports better clinical decision-making, operational efficiency, and patient experience. This alignment ensures that technology serves as an enabler of strategic goals rather than a standalone solution.

A capabilities based approach also emphasises scalability and interoperability. In healthcare, for instance, creating a robust digital capability means ensuring systems can share data seamlessly across departments and with external partners. This not only improves care coordination but also supports compliance and governance requirements. The result is a digital ecosystem that grows with the organisation’s needs rather than becoming fragmented over time.

Finally, adopting this approach fosters a culture of continuous improvement. Capabilities are not static; they evolve as business priorities shift and technology advances. By embedding capability development into the transformation roadmap, organisations can remain agile, respond to emerging challenges and leverage new opportunities without starting from scratch each time.

Core Capabilities as the Foundation

Digital transformation succeeds when it is built on a foundation of core capabilities rather than isolated technology projects. Core capabilities represent the essential organisational strengths—spanning people, processes, data, and platforms, that enable a consistent delivery of business outcomes. This approach shifts the focus from “what systems do we buy?” to “what abilities do we require to achieve our strategic goals?” By defining and investing in these capabilities, organisations create a scalable, interoperable, and future-ready digital ecosystem that directly supports priorities such as improving patient care, enhancing operational efficiency, and ensuring financial sustainability. In short, a capabilities-based approach ensures that digital investment is purposeful, outcome-driven, and adaptable to changing needs. The following core capabilities will form the foundation of our health board’s digital plan. Together with our digital design principles, they will serve as the cornerstone of our transformation journey.

- **Health Information & Data:** Stores comprehensive patient info (vitals, allergies, history, social determinants) in one place.
- **Result Management:** Manages laboratory results, imaging, and reports, making them quickly accessible to all providers.
- **Order Management:** Digitally creates and manages orders for prescriptions, laboratory diagnostics, and referrals, reducing errors.

- **Decision Support:** Provides alerts for drug interactions, reminders for screenings, and evidence-based guidelines.
- **Electronic Communication & Connectivity:** Facilitates secure messaging and information exchange between providers and patients.
- **Patient Support:** Offers portals for patients to access records, educational materials, and self-monitoring tools.
- **Administrative Processes:** Streamlines hospital admissions, scheduling, booking, and reporting functions.
- **Reporting & Population Health:** Tracks health trends, manages chronic diseases, and supports public health initiatives.

Proposed Roadmap for Digital Transformation

Our digital transformation roadmap is designed to provide a clear, structured path for delivering meaningful change across the HDdUHB. Built around four strategic pillars, outlined above, the roadmap translates vision into action through ten previously agreed focused workstreams. Each workstream represents a critical capability area, ensuring that investments are aligned with business priorities such as improving patient outcomes, enhancing staff experience, and driving financial sustainability. This phased approach enables us to deliver early wins, scale proven solutions, and embed continuous improvement, creating a digital ecosystem that is resilient, interoperable and future-ready.

To ensure we deliver the right things at the right time, our roadmap is grounded in a proven framework used to manage transformation over time. It helps us to plan for the future while delivering meaningful improvements in the present.

The model ensures that our efforts are sequenced, prioritised, and resourced in a way that allows each tranche to overlap, reinforce, and build on the one before.

Whilst distinct in focus, the tranches are not strictly linear; activities from different tranches may run in parallel, but always with a clear understanding of what we must do *now* to enable what comes *next*.

The table below illustrates how this approach applies to our digital and data transformation:

Tranche	Focus	Timeframe	Purpose	Programme
Tranche 1:	Establishing the foundations	2026–2027	Fix the basics: modernise infrastructure, close critical gaps including critical systems, improve data quality, and prepare the organisation for the Acute and Community Hospital for a digital record.	• Finalise Phase 2 of Patient Flow • eObs Rollout • ED Replacement • Digital Response Redesign • AI adoption
Tranche 2:	Deployment a modern digital health record	2027–2028	Connect care: roll out our Acute and Community digital health record as the anchor for integrated, real-time, patient-centred care across settings.	• Readiness Patient Services Centre • Deploy Patient Services Centre – Phase 1 • Patient Relationship Management (PRM) • Real Time Data Management
Tranche 3:	Unlocking intelligence, innovation, and proactive care models	2028–2029	Optimise and personalise use data, automation, further AI and citizen-generated inputs to redesign care and drive sustainable system change.	• Hospital at home • Virtual Wards • Removal of Shadow IT • Improved Patient engagement platforms • Employee wellbeing • Workforce and Asset Scheduling and Tracking

At the foundation of our approach lies the essential “business as usual” activities. These include ensuring robust benefits realisation and tracking, driving continuous improvements in business change and promoting effective user adoption across all initiatives.

Security remains paramount, every action we take will be underpinned by strong cybersecurity measures and adherence to information governance standards, safeguarding our systems and data at all times.

In parallel, the Digital Team will continue to deliver a range of in-flight projects, manage capital refurbishments, and support ongoing operational priorities. These efforts will ensure that while we innovate and transform, we maintain stability and resilience in our digital infrastructure.

Appendix A provides a high-level plan for the coming three years

Conclusion

The Digital Strategic Plan sets out a clear and ambitious roadmap for transforming health and care delivery across HDdUHB. Building on the progress made since the original Digital Response in 2020, the plan recognises the need to move beyond technology implementation towards a culture of digital adoption, capability-building, and continuous improvement. By focusing on four strategic pillars; citizen engagement, care coordination, digital operations, and regional data integration, the plan aims to create a connected, resilient, and future-ready digital ecosystem.

The phased approach outlined in the roadmap ensures that foundational infrastructure and digital literacy are prioritised, enabling the safe and effective adoption of advanced technologies such as AI, real-time data management, and integrated digital health records. The plan also acknowledges the significant demographic, environmental, and technological changes facing the region, and positions digital transformation as a key enabler for addressing these challenges.

Ultimately, the successful delivery of this plan will depend on strong leadership, stakeholder engagement, and a relentless focus on outcomes, improving patient care, supporting the workforce and ensuring financial and operational sustainability. By embedding digital thinking into every aspect of the organisation, HDdUHB is well-placed to deliver high-quality, equitable, and sustainable healthcare for the communities of mid and west Wales, both now and in the future.

Argymhelliad / Recommendation

The Committee are requested to:

- **NOTE** the proposed approach to the Digital Strategic Plan
- **NOTE** that the final Digital Strategic Plan will be developed over the next five months, ensuring comprehensive stakeholder engagement with both staff and the public to incorporate all those perspectives into the next version of the plan.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

2.1.1 That the direction, development and delivery of the Digital Strategic Plan is to drive continuous

	improvement and support digitally enabled health care through a digitally enabled workforce to achieve the objectives of the Health Board's Annual Plan/Integrated Medium-Term Plan (IMTP).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	9 Digital plan All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:

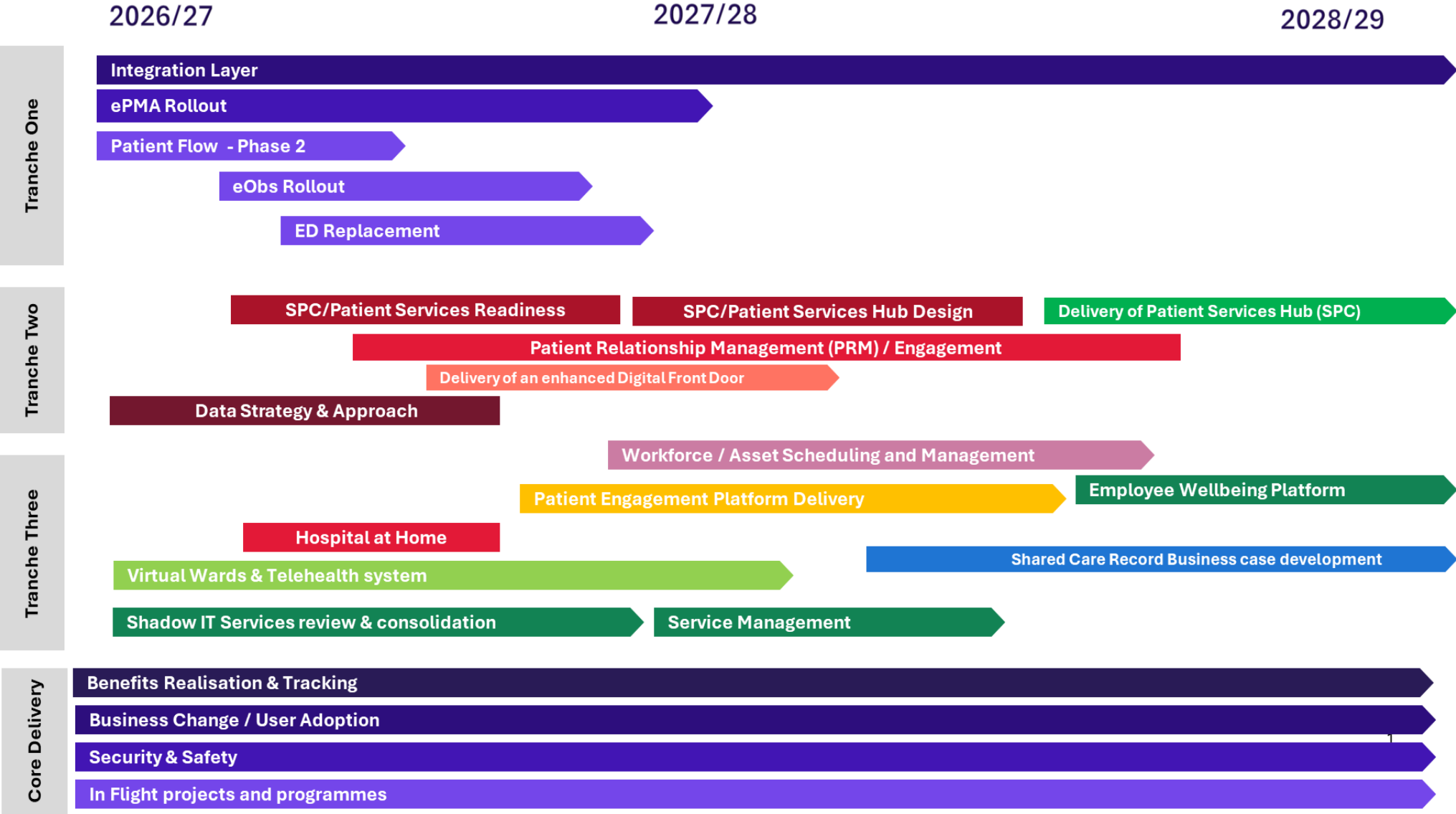
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termiau: Glossary of Terms:	Contained within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)

Ariannol / Gwerth am Arian: Financial / Service:	The financial and service impacts of the digital plan are evident in the substantial investments made and the significant improvements in service delivery. These efforts

	reflect our commitment to creating a modernised, patient-centred system of care that aligns with national digital standards and local healthcare priorities. Each of the tranches, and projects will be subject to further business cases.
Ansawdd / Gofal Claf: Quality / Patient Care:	The digital plan will bring about substantial improvements in the quality of care and patient outcomes. By leveraging advanced digital technologies, we have created a more efficient, safe, and patient-centred healthcare system, that aligns with our commitment to delivering high-quality care to our communities.
Gweithlu: Workforce:	The digital plan has significantly transformed our workforce by enhancing productivity, fostering skills development, and improving overall well-being and engagement. These efforts reflect our commitment to creating a modernised, efficient, and supportive work environment that aligns with our strategic goals and enhances the quality of care we provide.
Risg: Risk:	The digital plan carries several risks, proactive risk management and mitigation strategies are in place to address these challenges. By continuously monitoring and managing these risks, the organisation aims to ensure the successful implementation of the digital plan and the achievement of its strategic objectives.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The successful execution of the digital plan can greatly enhance our organisations reputation as a leader in digital innovation within the healthcare sector. By integrating advanced digital tools and platforms, we demonstrate our commitment to improving patient care, operational efficiency, and data security. This proactive approach can attract positive media coverage, bolster public trust, and strengthen relationships with stakeholders, including patients, staff, and partners. The digital plan's emphasis on enhancing service delivery and patient outcomes aligns with our mission to provide high-quality, value-based healthcare, further solidifying our reputation as a forward-thinking and patient-centred organisation.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	All business cases / projects will be subject to an equality assessment

Appendix A - Transformation Programmes: High-Level Three-Year Roadmap



2.4

10:40, 0 Mins

2.4 - Digital Partner Update

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

| For assurance

Attachments

2.4 - DDIC - Digital Partner Update - Jan 2026 v1 (No financials) (AT, ne~.docx



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:	Digital Strategic Partner Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Digital, Data and Innovation Committee (DDIC) an update on the digital strategic partner to support its digital transformation initiatives. This report outlines the spending and impact of the digital partner in line with Board-approved programmes.

Cefndir / Background

Working with our new strategic partner CGI, we are in the process of accelerating the project plans towards deployment, as well as developing the technical integration layer required to deploy the foundational systems in line with the timescales previously outlined to the Executive Team. The digital transformation initiatives are part of Hywel Dda University Health Board's (HDdUHB's) strategic plan to enhance patient care and operational efficiency through technology.

In addition to those listed above, HDdUHB has also invested in various digital programmes aimed at improving patient care pathways, data accessibility, and patient safety. These programmes include the Hybrid Print and Post, and Digitalisation of Records, which are part of the broader strategy to digitise healthcare services.

Overall, these digital transformation initiatives are designed to modernise healthcare delivery, improve operational efficiency, and enhance patient care through the strategic use of technology.

Asesiad / Assessment

Partnership Charter

At our last meeting, we discussed the importance of demonstrating how we are operating as an intelligent client in our partnership with CGI, ensuring that both parties derive maximum value from the relationship. In response, we have been collaborating closely with CGI to develop a formal "Partnership Charter" that sets out our shared approach and commitments.

The Partnership Charter between CGI and HDdUHB will set out the ten-year strategic collaboration aimed at transforming healthcare services across mid and west Wales. The vision is to enable HDdUHB to become a fully digitally enabled health board, empowering excellence in care for patients and communities. This long-term partnership is designed to leverage digital innovation, enhance operational efficiency, and deliver patient-centered healthcare solutions.

The partnership establishes CGI as the Digital Partner for HDdUHB, with a focus on delivering innovative, sustainable, and impactful digital solutions. The guiding principles underpinning this relationship include collaboration, innovation, transparency, accountability, patient-centricity, and simplicity. Both organisations commit to fostering a culture of mutual respect, open communication, and teamwork, ensuring that all initiatives prioritise the well-being and experience of patients.

The Partnership Charter outlines a broad scope of collaboration, covering digital transformation initiatives, data integration and analytics, training and capacity building, innovation projects, cybersecurity, and social value. The partnership aims to co-create and deliver technology solutions that improve healthcare delivery, optimise operational efficiency, and contribute to the local economy by putting people at the heart of partnership activities.

Roles and responsibilities will be clearly defined, with CGI providing technical expertise, programme management, and ongoing transformation governance, while HDdUHB sets strategic objectives, facilitates access to data and stakeholders, and ensures organisational readiness. The governance structure includes monthly executive steering groups and weekly project updates, supported by robust reporting, risk management, and escalation protocols. Key artefacts such as programme definition documents, plans, blueprints, and benefits realisation plans are used to ensure alignment and transparency.

The Partnership Charter emphasises shared values, such as partnership, quality, integrity, respect, and outlines expected behaviours including openness, professionalism, cooperation, and continuous improvement. Success is measured through periodic reviews, satisfaction surveys, and formal assessments against agreed principles and behaviours. Both parties are committed to resolving differences through discussion and negotiation, making efficient use of resources, and providing early warnings of any issues that could impact shared objectives. This structured approach ensures that the partnership remains dynamic, responsive, and aligned with the evolving needs of the Health Board and the communities it serves.

Proposals requested

Following the latest meeting, we have committed an additional £825k across several work packages previously highlighted to the committee.

To support ongoing digital transformation and ensure alignment with strategic objectives, a number of new proposals have been requested for detailed scoping. These proposals are designed to address emerging needs, optimise service delivery, and maximise the benefits of future investment. The following are those proposals that are under development:

- **A review of artificial intelligence (AI)** across the region will identify key opportunities for development and areas where adoption can be accelerated. This assessment will provide a strategic overview of current capabilities, highlight best practices, and recommend priority areas for investment and implementation to maximise the benefits of AI for regional healthcare services.

- **Workforce Proposal – Digital:** The workforce proposal aims to strengthen digital capability across the organisation by investing in targeted training, upskilling, and support for staff at all levels. By equipping the workforce with the necessary digital skills and confidence, the proposal will enable staff to fully engage with new technologies, drive innovation, and adapt to evolving service needs. This approach supports a culture of continuous improvement, enhances staff wellbeing and retention, and ensures the organisation is well positioned to maximise the benefits of digital transformation.
- **Business Change Support** - Effective business change support is essential to ensure the successful adoption and realisation of benefits from digital transformation initiatives. This proposal focuses on providing structured change management, stakeholder engagement, and communication strategies to help staff adapt to new ways of working. By supporting teams through the transition, addressing concerns, and building digital confidence, business change support will maximise the impact of digital investments, minimise disruption, and foster a culture of continuous improvement across the organisation.
- **Accelerating Digital and Cyber Operations:** - To support the organisation's digital transformation, we are prioritising the acceleration of key digital operations initiatives. This includes advancing our migration to Azure Cloud Services, enhancing system integration capabilities, and completing the deployment of Windows 10 across the estate. These actions will strengthen our digital infrastructure, improve security and interoperability, and ensure staff have access to modern, reliable technology to deliver high-quality care and services.

Overall, the work packages assigned to CGI encompass a wide range of responsibilities, from technical integration and programme management to stakeholder engagement and supplier discussions. The costs associated with these packages are justified by the anticipated benefits and the strategic importance of the digital transformation initiatives.

Argymhelliad / Recommendation

The Committee are requested to consider:

- **RECEIVE ASSURANCE** from the content of the Digital Strategic Partner Update Report.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.1.1 Seek assurance on the direction, development and delivery of the Health Board's digital, data and information governance strategies to drive change and transformation in line with the Health Board's Annual Plan/Integrated Medium Term Plan (IMTP) that will support modernisation through the use of information, data and digital technology.

3.1.2 Seek assurance on the direction, development and delivery of the Health Board's research and innovation strategies to drive change and transformation in line with the Health Board's Annual Plan/Integrated Medium Term Plan (IMTP).

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Included within the main body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Not Applicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Value cases will be assessed for each individual business cases prior to utilising the supplier. A wider strategic benefit will be that the healthcare systems will be more efficient, processes are faster, and wasteful processes can be decreased or eliminated supporting longer-term sustainability for the HDdUHB.

Ansawdd / Gofal Claf: Quality / Patient Care:	The implementation of the transformation and digital enablement plan, will provide the following positive impact on quality and patient care: • Patient safety increased - Increased timeliness and availability of relevant clinical information decreased transcription errors and therefore decreased risk to patients' safety • Positive patient outcomes increased - Easy access increases speed and of diagnosis, patient care, treatment plan and onward referrals. • Patient confidence increased - The availability and targeting of accurate and relevant information at the point of contact • Reducing delay, improving waiting times and access to treatment
Gweithlu: Workforce:	Having a modern digital system, will attract and retain the workforce within HDdUHB. A key component of this work is the assessment of operational readiness for organisational and digital change and the digital roadmap required and recommended service redesign principles for a whole system approach, which will enable the change the workforce urgently need. As part of the transformation plan there will be a change management, service redesign and digital enablement programme designed to co-produce and design services for people through a professional integrated and upskilled workforce across health and care.
Risg: Risk:	Without the necessary investment in transformation and digital there is a risk that the current complex system will become even slower stifling innovation that the HDdUHB has progressed and urgently needs.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The ambitious transformation and digital enablement plan will progress the HDdUHB forward to becoming a fully integrated digital organisation propelling HDdUHB to become the first system-wide digital exemplar within NHS Wales.
Gyfrinachedd: Privacy:	At the centre of the transformation and digital enablement plan is inclusivity, and the requirement to ensure that staff, patients, and the people of our region are included in the development of any service with strong information governance and cyber security.
Cydraddoldeb: Equality:	Not applicable

2.5 - Patient Services Centre

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

*** Financially sensitive elements of this paper to be discussed at IC-DDIC and have been provided in a separate paper.

| For approval

Attachments

[2.5 - SBAR Patient Services Centre - Jan 2026 v3 \(AT, HT\).docx](#)

[2.5 \(a\) - Hywel Dda Patient Service Centre Business Case v0.1 \(without Fina~.pdf](#)

[2.5 - PSC - Option 1 - Full EqlA v1.0.docx](#)

[2.5 - PSC - Option 2 - Full EqlA v1.0.docx](#)

[2.5 - PSC - Option 3 - Full EqlA v1.0.docx](#)

[2.5 - PSC - Option 4 - Full EqlA v1.0.docx](#)



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
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

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.

Long-list summary



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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-managing 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 Termiau: 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

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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 development¹. 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.

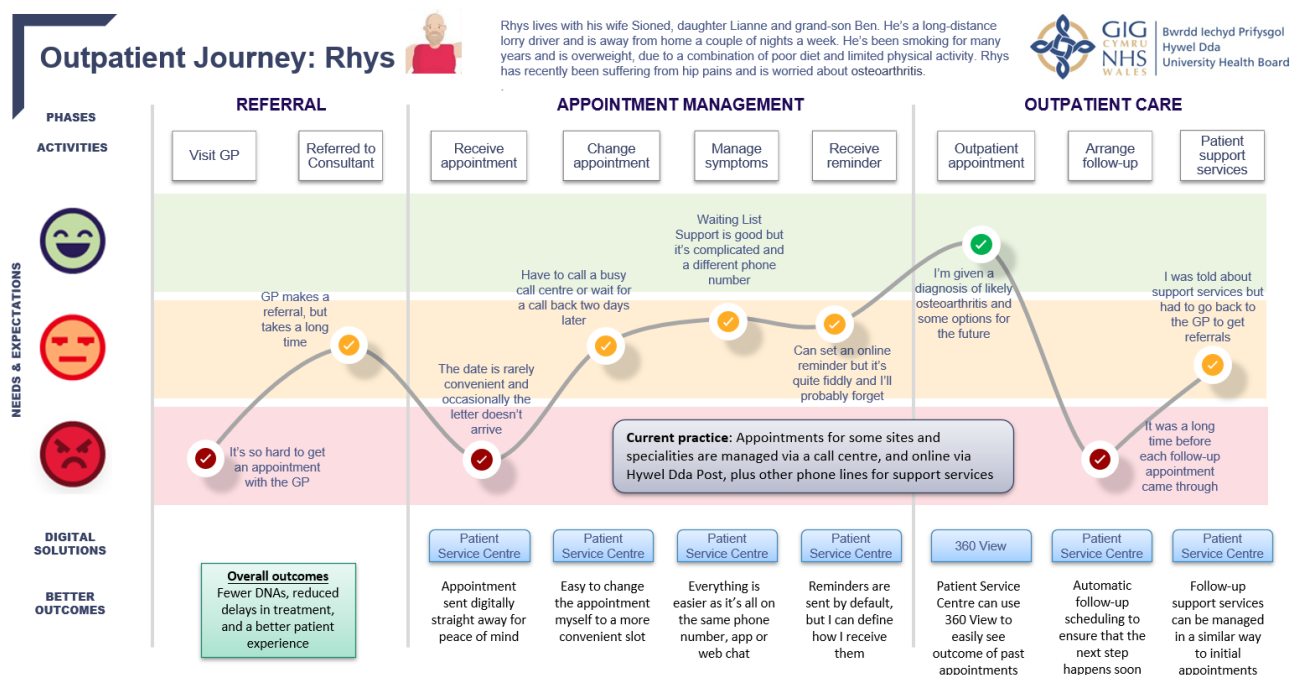


Figure 1 - Outpatient journey

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.

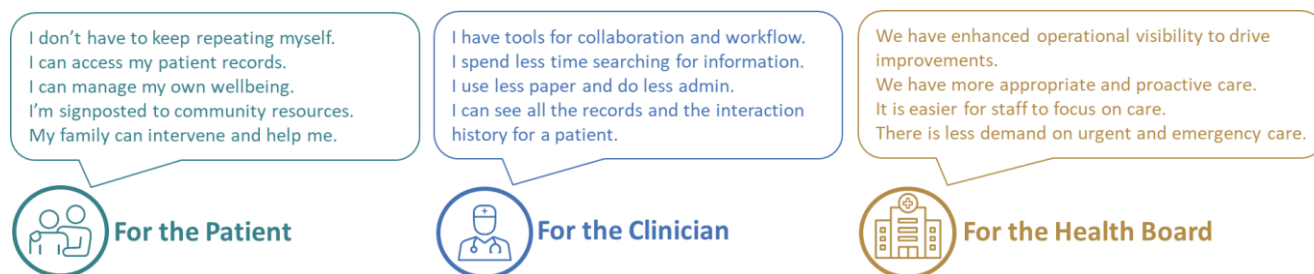


Figure 2 – Vision statements

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.

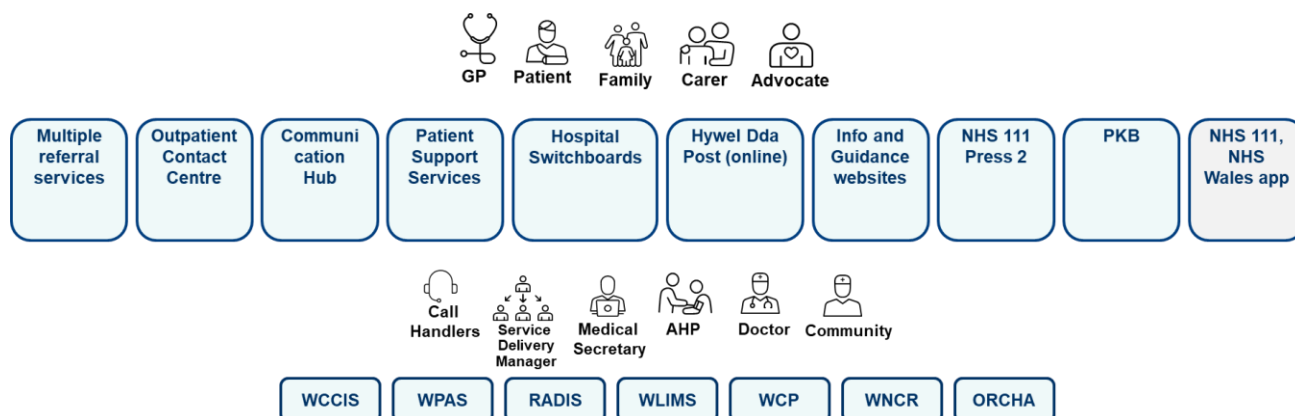


Figure 3 – Existing arrangements

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.

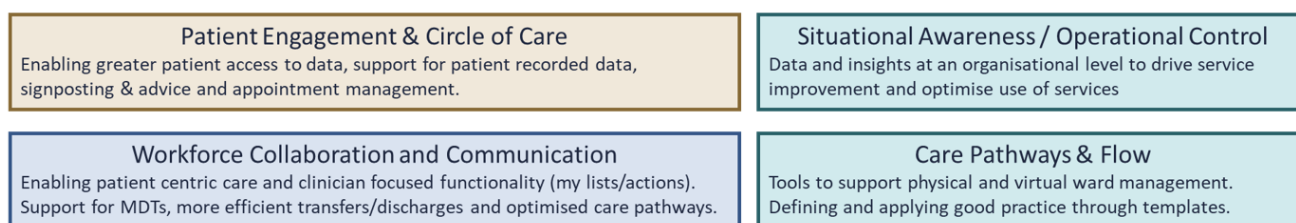


Figure 4 – Regional Health and Care capability model

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

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	Workforce
	- Appointment management - Dynamic appointment scheduling - Alerts, reminders and notifications - Multi-channel engagement	- Single View of a Person - Actionable insight and decision support - Triage and prioritise referrals - Alerts and notifications - Video and Chat guidance and consultation
	Awareness	Flow
	Patient tracking and dashboards	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	Flow
	- Patient tracking and dashboards - Advanced analytics and visualisation	- 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).

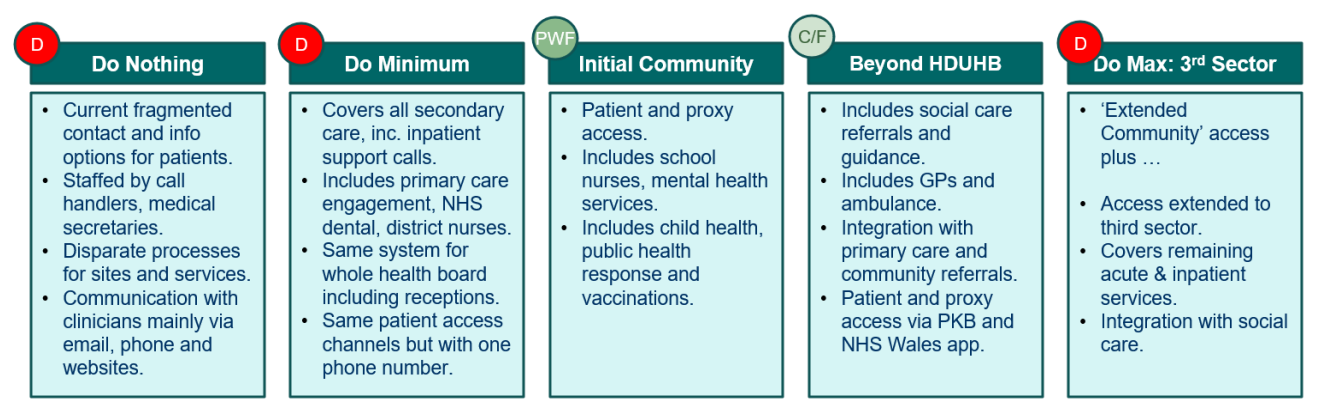


Figure 5 – Long-list Scope options

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.

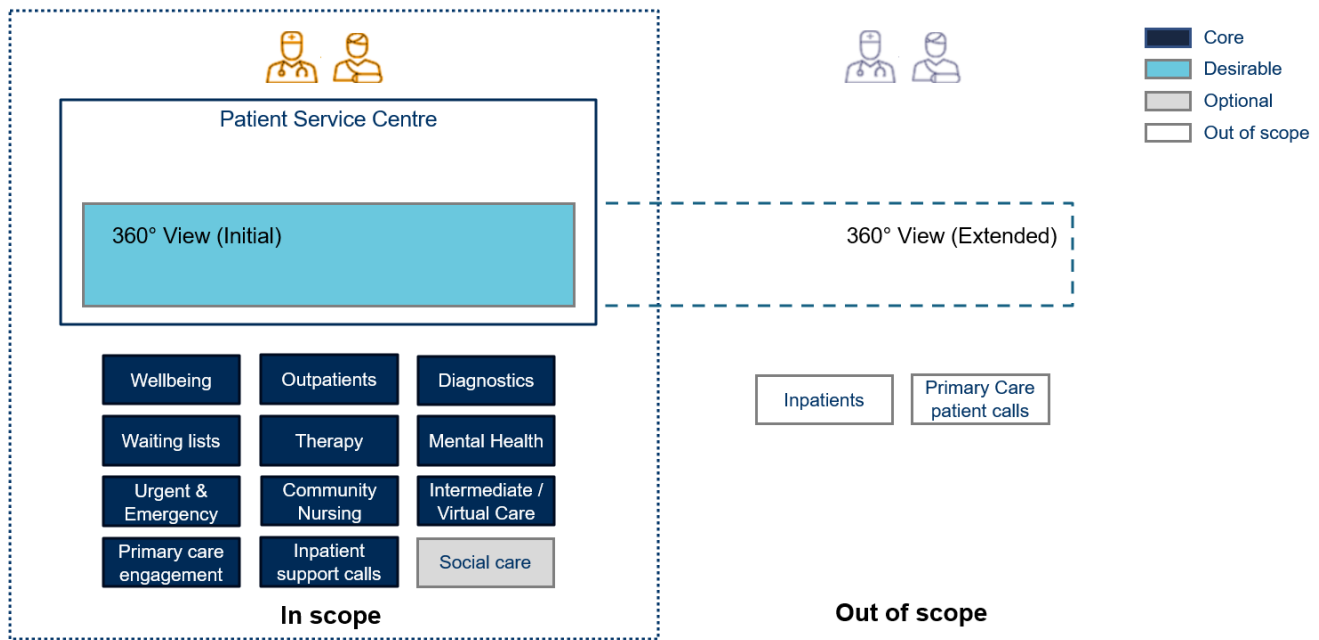


Figure 6 – Scope of health board service

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 than 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.

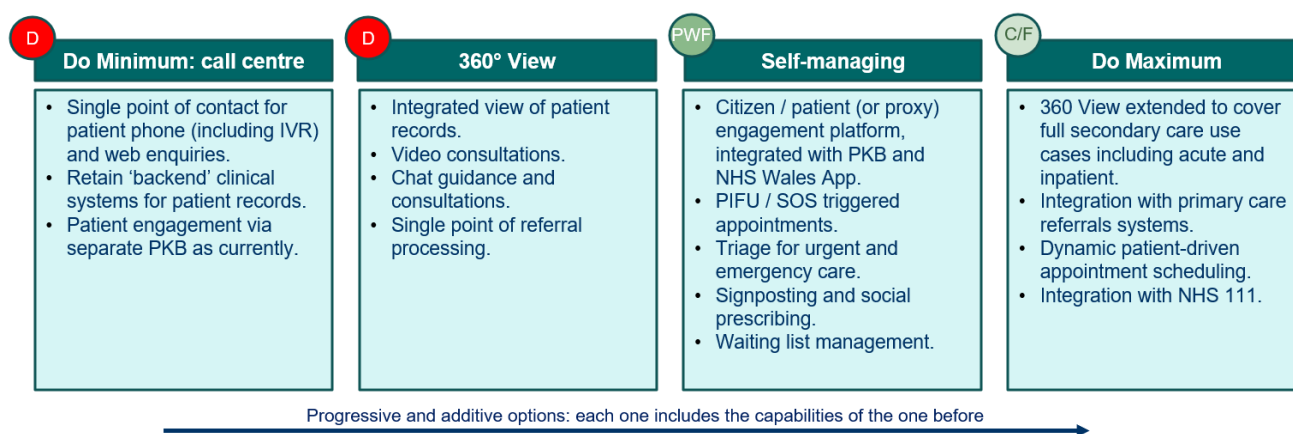


Figure 7 – Long-list Service Solution options

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.

	Buy			Build	
	D DHCW + call centre	C/F DHCW + PKB + call centre	C/F Product + DHCW + PKB + call centre	C/F Platform + DHCW	D Develop + call centre
Overview	Suite of products managed and supported by DHCW, able to share data across Wales.	Suite of products managed and supported by DHCW, able to share data across Wales. Linked to PKB.	Extend current products to cover a broader internal 360 View of patients: able to integrate and add more modules.	Low-code platforms for core functionality, with applications built on top. Some have built-in support for health care.	Development based on frameworks, standards and some commodity components, alongside a call centre solution.
Examples	WPAS, WCP, WNCR, SMR + Netcall	WPAS, WCP, WNCR, SMR + Netcall + PKB	Aldicion, Better + Netcall	Salesforce, Service Now	Bespoke development + Netcall
Key Strength	Provides consistency and visibility across other Health Boards.	Provides consistency and visibility across other Health Boards.	Provides a repeatable solution and builds on the current modules used.	Provides flexibility and enables development speed and quality.	Provides a highly flexible approach.
Size	Small	Small	Medium	Medium	Large
Integration	Small	Small	Medium	Medium	Medium
Timescale	Medium	Medium	Small	Small	Large

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.

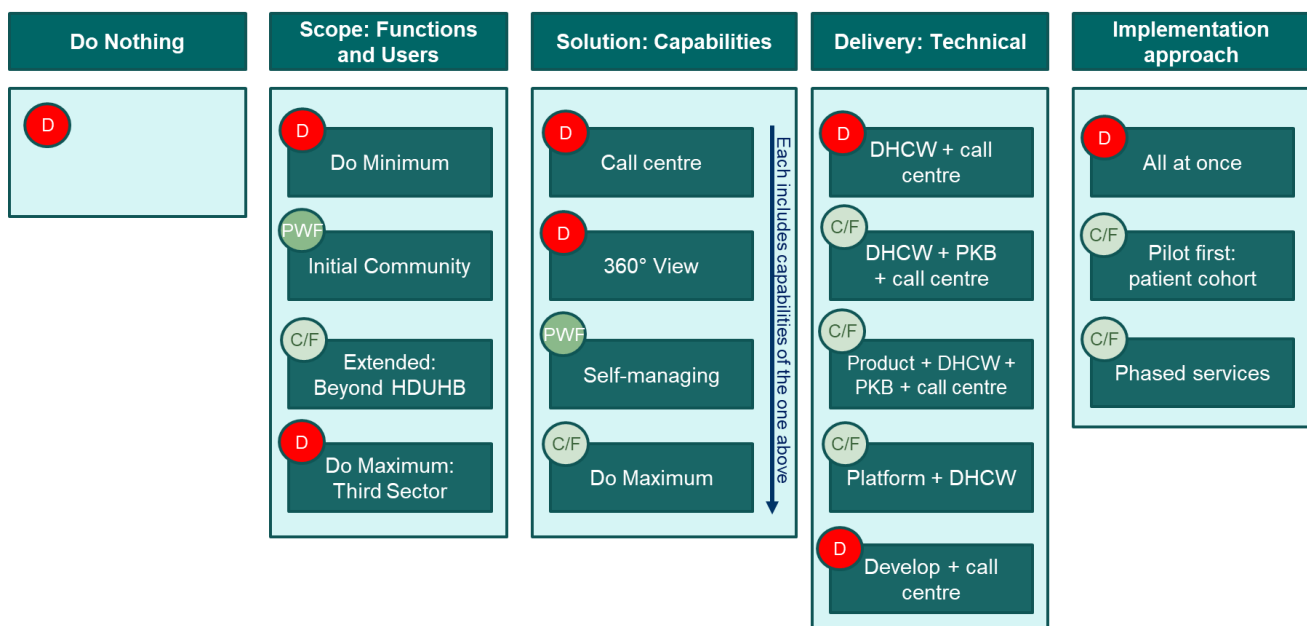


Figure 9 – Long-list options summary

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-managing 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	HUHB plus initial community	HUHB plus initial community	HUHB plus initial community	Extended Beyond HUHB
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:

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

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 , 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:

Proposed Solution Architecture for Hywel Dda Patient Service Centre - 2025

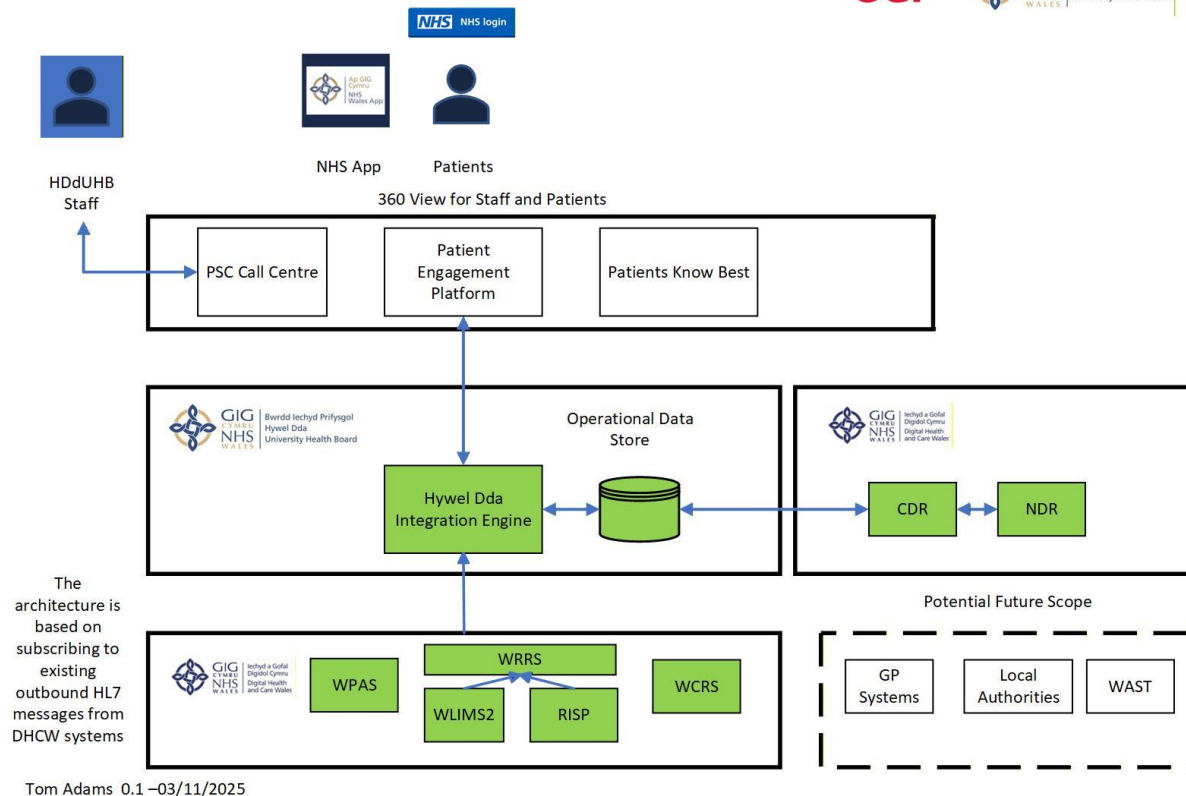


Figure 10 - Logical solution architecture

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 is 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.

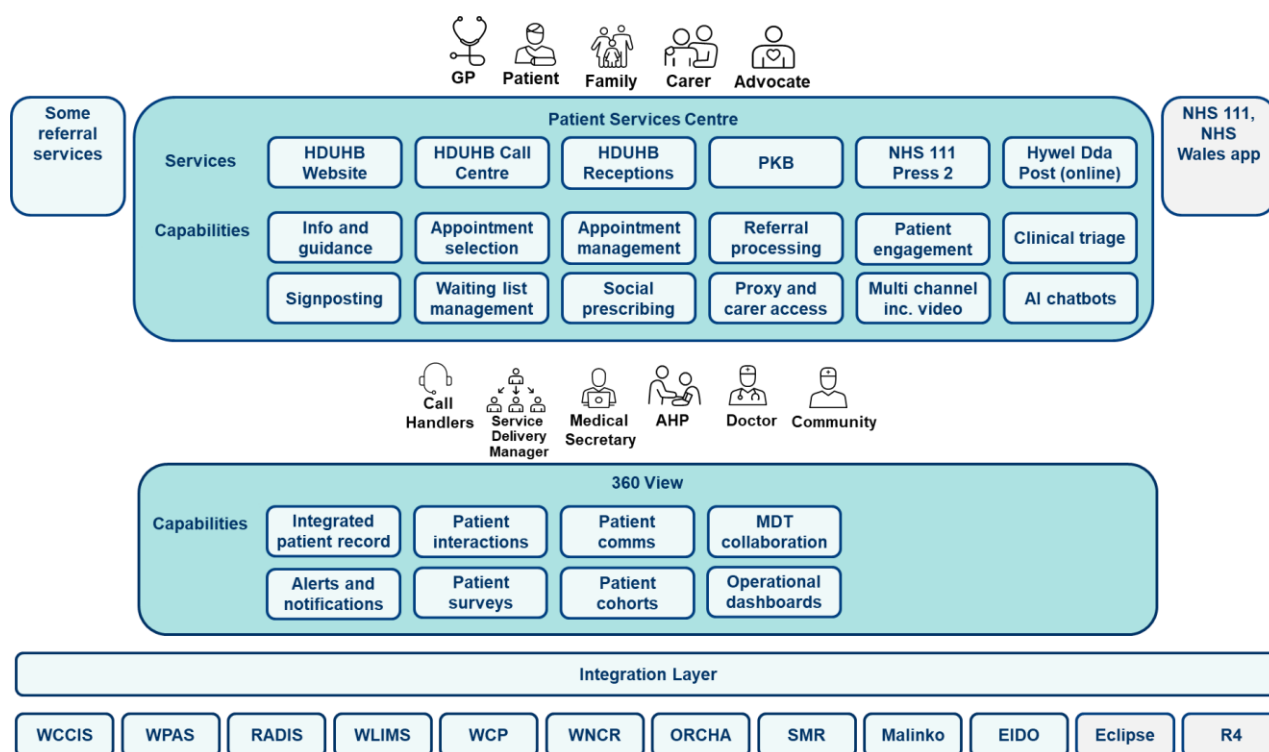


Figure 11 – Likely service requirements

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 be 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:

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

Cost component	Option 0 Do nothing	Option 1 Do minimum	Option 2 Less ambitious	Option 3 Preferred way forward (Baseline)	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).

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

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

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 2025³, 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.

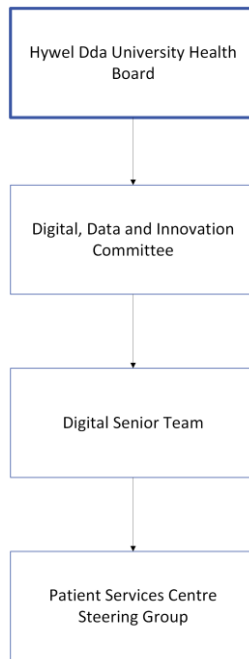


Figure 12 – Internal HDdUHB Governance Structure

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	M5	M6	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									

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.

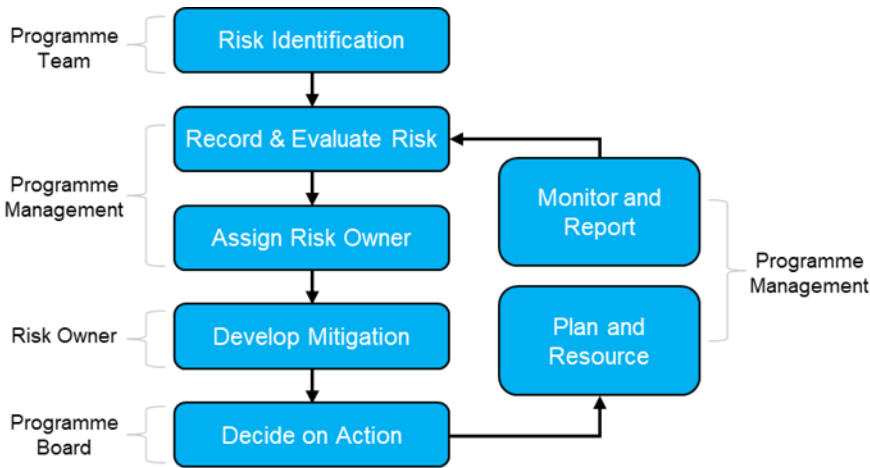


Figure 14 – Risk management approach

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 world⁴, 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.

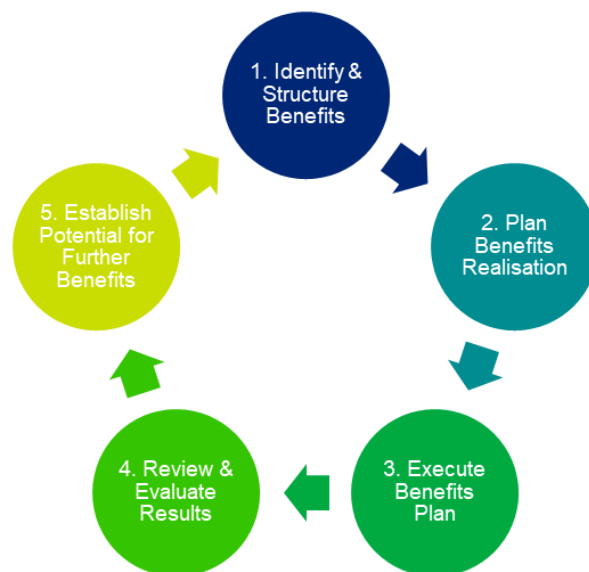


Figure 15 – Benefit management approach

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	

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 Complaints 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 scores⁷. 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 Warmesley	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 Duszyńska	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 – 17/09/2025
- 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 Warmesley – 29/10/2025
- Engagement with representatives from Llais – 18/11/2025
- Options Analysis Outcome Workshop – 05/12/2025

Appendix B Regional Health 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.

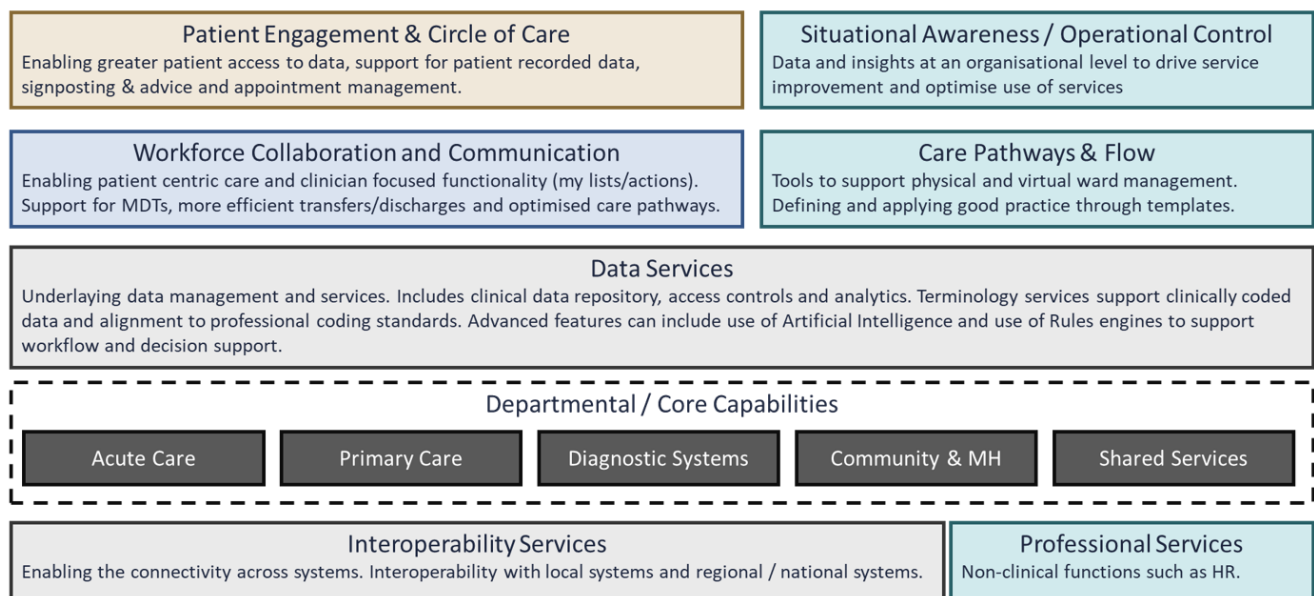


Figure 16 – Capability groups

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.

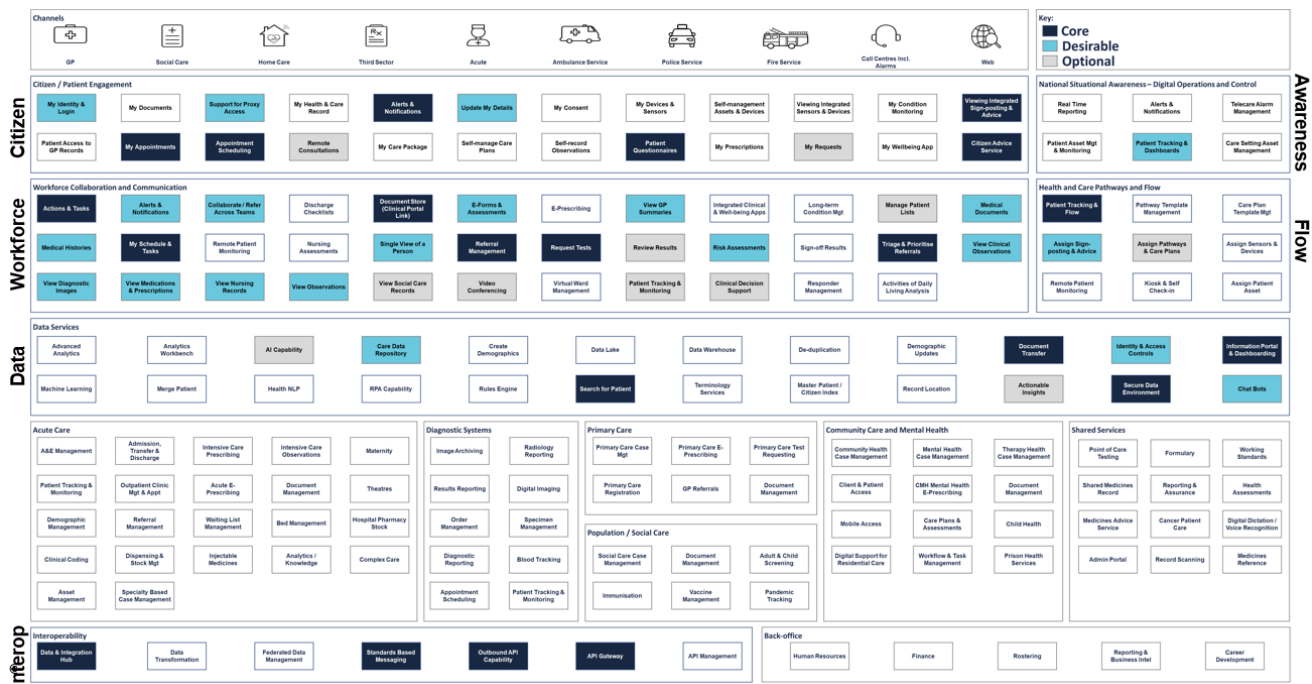


Figure 17 – Detailed capabilities

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 $9 \div (9+6) = 60\%$ and for Benefit B would be $6 \div (9+6) = 40\%$.
- 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 $9 \div (9+6) = 60\%$ and for Benefit B would be $6 \div (9+6) = 40\%$.
- 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).



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

Hywel Dda University Health Board Equality Impact Assessment (EqlA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqlA)?

An EqlA 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 EqlA, or if applicable an EqlA 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 EqlA or EqlA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqlA 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

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

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 EqlA and inform the D&I team.

Support

For further support please visit the [EqlA 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 Negative No Impact	X X
Guidance Remove population data if not relevant to EqIA and upload relevant data.	Population Data										Summary 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)
	County	Carms		Cere		Pembs		Total			
	Age	value	%	value	%	value	%	value	%		
	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						

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

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.	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.				
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.	<table border="1"> <thead> <tr> <th data-bbox="367 858 1317 890">Negative Impact</th> <th data-bbox="1321 858 2186 890">Opportunities for improvement / mitigation</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 893 1317 1426"> • 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 data-bbox="1321 893 2186 1426"> • 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> </tbody> </table>	Negative Impact	Opportunities for improvement / mitigation	• 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.	• 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.
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		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.		

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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.		

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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.									

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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	<table border="1"> <tr> <td data-bbox="360 1061 1317 1406"> 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 data-bbox="1321 1061 2190 1406"> 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>	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.
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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	

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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.		

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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.		

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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.		

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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: <u>Armed-Forces-Covenant-duty-statutory-guidance</u>					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.						

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identified data gaps in the future.			
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.	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.		
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.	<table border="1"> <tr> <td data-bbox="360 858 1317 1305"> 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 data-bbox="1321 858 2190 1305"> 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> </table>	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.	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.
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Provide a summary of the positive	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.		

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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

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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								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)	
		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		

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.

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

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.

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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 • 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	

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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 <table border="1"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <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> </tbody> </table> People, population and community - Office for National Statistics (ons.gov.uk)			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
Area	Percentage of people who can speak Welsh												
Carmarthenshire	53.3												
Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
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.												

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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	<table border="1"> <tr> <td data-bbox="367 1201 1314 1433"> Negative Impact • Risk of delayed response if rostering doesn't ensure coverage </td><td data-bbox="1314 1201 2192 1433"> Opportunities for improvement / mitigation • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh. </td></tr> </table>	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.
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.		

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

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

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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 EqlA 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 will 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.

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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 occurring.
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.

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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

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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.

	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 EqlA will be completed when an Option has been confirmed.				

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Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqlA 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 EqlA and if required provided guidance.

EqlA 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
EqlA 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 EqlA 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 EqlA 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 EqlA and inform the D&I team.

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Hywel Dda University Health Board Equality Impact Assessment (EqlA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqlA)?

An EqlA 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 EqlA, or if applicable an EqlA 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 EqlA or EqlA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqlA 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

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

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 EqlA and inform the D&I team.

Support

For further support please visit the [EqlA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

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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.

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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

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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 Negative No Impact	X X
Guidance Remove population data if not relevant to EqIA and upload relevant data.	Population Data										Summary 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)
	County	Carms		Cere		Pembs		Total			
	Age	value	%	value	%	value	%	value	%		
	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		

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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	

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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							

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

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.	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.				
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.	<table border="1"> <thead> <tr> <th data-bbox="367 853 1314 890">Negative Impact</th> <th data-bbox="1319 853 2192 890">Opportunities for improvement / mitigation</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 893 1314 1431"> • 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 data-bbox="1319 893 2192 1431"> • 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> </tbody> </table>	Negative Impact	Opportunities for improvement / mitigation	• 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.	• 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
Negative Impact	Opportunities for improvement / mitigation				
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	• 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	

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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 EqlA 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 EqlA 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.								

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

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	<table> <tr> <td data-bbox="365 1066 1317 1399"> 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 data-bbox="1317 1066 2192 1399"> 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>	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.
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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 EqlA 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.		

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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 EqlA 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: <u>Armed-Forces-Covenant-duty-statutory-guidance</u>					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.					

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

identified data gaps in the future.			
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.	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.		
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.	<table border="1"> <tr> <td data-bbox="360 857 1317 1305"> 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 data-bbox="1321 857 2190 1305"> 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> </table>	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.	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.
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Provide a summary of the positive	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.		

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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

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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																																																						
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Guidance Remove population data if not relevant to EqIA.	Population Data <table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="8">County</th> </tr> <tr> <th colspan="2">Carms</th> <th colspan="2">Ceredigion</th> <th colspan="2">Pembs</th> <th colspan="2">Hywel Dda</th> </tr> <tr> <th>Economic Factor</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> <th>Value</th> <th>%</th> <th>Total value</th> <th>%</th> </tr> </thead> <tbody> <tr> <td>Economically active – In employment (this includes full time students)</td> <td>81,952</td> <td>52.7</td> <td>30,119</td> <td>49.1</td> <td>52,765</td> <td>51.5</td> <td>164,836</td> <td>51.1</td> </tr> <tr> <td>Economically active - Unemployed</td> <td>3,922</td> <td>2.5</td> <td>1,845</td> <td>3</td> <td>2,769</td> <td>2.7</td> <td>8,536</td> <td>2.73</td> </tr> <tr> <td>Economically inactive</td> <td>69,613</td> <td>44.8</td> <td>29,428</td> <td>47.9</td> <td>47,017</td> <td>45.8</td> <td>146,058</td> <td>46.16</td> </tr> </tbody> </table>									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)	
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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.																																																														

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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.

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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 • 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	

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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 <table border="1" data-bbox="371 903 1187 1139"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <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> </tbody> </table> People, population and community - Office for National Statistics (ons.gov.uk)			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
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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.												

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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	<table border="1"> <tr> <td data-bbox="365 1198 1314 1433"> Negative Impact • Risk of delayed response if rostering doesn't ensure coverage </td><td data-bbox="1314 1198 2192 1433"> Opportunities for improvement / mitigation • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh. </td></tr> </table>	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.
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.		

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

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

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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?

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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 will 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.

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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 occurring.
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

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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 EqlA will be completed when an Option has been confirmed.				

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Section 6: Authorisation

Ensure that the details for the person completing, as well as the person authorising/owning the EqlA 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 EqlA and if required provided guidance.

EqlA 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
EqlA 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 EqlA 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 EqlA 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 EqlA and inform the D&I team.

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Hywel Dda University Health Board Equality Impact Assessment (EqlA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqlA)?

An EqlA 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 EqlA, or if applicable an EqlA 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 EqlA or EqlA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqlA 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

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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 EqlA and inform the D&I team.

Support

For further support please visit the [EqlA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

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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.

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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

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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 Negative No Impact	X X
Guidance Remove population data if not relevant to EqIA and upload relevant data.	Population Data										Summary 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)
	County	Carms		Cere		Pembs		Total			
	Age	value	%	value	%	value	%	value	%		
	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		

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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	

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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				

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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.	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.				
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.	<table border="1"> <thead> <tr> <th data-bbox="367 853 1314 890">Negative Impact</th> <th data-bbox="1319 853 2192 890">Opportunities for improvement / mitigation</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 893 1314 1431"> • 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 data-bbox="1319 893 2192 1431"> • 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> </tbody> </table>	Negative Impact	Opportunities for improvement / mitigation	• 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.	• 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
Negative Impact	Opportunities for improvement / mitigation				
• 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.	• 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				

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	• 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	

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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.		

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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 EqlA 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.		

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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.									

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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	<table> <tr> <td data-bbox="365 1066 1314 1399"> 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 data-bbox="1314 1066 2192 1399"> 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>	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.
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.		

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

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 EqlA 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 EqlA 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 EqlA 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: <u>Armed-Forces-Covenant-duty-statutory-guidance</u>					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.						

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

identified data gaps in the future.		
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.	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.	
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 • 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.	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.
Provide a summary of the positive	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.	

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

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

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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								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)	
		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		

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.

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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.

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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 • 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	

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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 <table border="1" data-bbox="371 903 1187 1139"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <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> </tbody> </table> People, population and community - Office for National Statistics (ons.gov.uk)			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
Area	Percentage of people who can speak Welsh												
Carmarthenshire	53.3												
Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
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.												

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

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	<table border="1"> <tr> <td data-bbox="365 1198 1317 1433"> Negative Impact • Risk of delayed response if rostering doesn't ensure coverage </td><td data-bbox="1317 1198 2192 1433"> Opportunities for improvement / mitigation • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh. </td></tr> </table>	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.
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.		

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

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 will 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 occurring.
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

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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 EqlA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqlA 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 EqlA 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 EqlA and if required provided guidance.

EqlA 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
EqlA 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 EqlA 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 EqlA 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 EqlA and inform the D&I team.

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

Hywel Dda University Health Board Equality Impact Assessment (EqlA)

Director and Directorate	Digital
Service Area	Innovation & Transformation

What is an Equality Impact Assessment (EqlA)?

An EqlA 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 EqlA, or if applicable an EqlA 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 EqlA or EqlA Screening is monitored as part of the Health Boards escalation process, and forms part of the Quality Impact Assessment process. An EqlA 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

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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 EqlA and inform the D&I team.

Support

For further support please visit the [EqlA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

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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.

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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

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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 Negative No Impact	X X
Guidance Remove population data if not relevant to EqIA and upload relevant data.	Population Data										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)
	County	Carms		Cere		Pembs		Total		Summary	
	Age	value	%	value	%	value	%	value	%		
	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		

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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	

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	• 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

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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							

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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.	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.				
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.	<table border="1"> <thead> <tr> <th data-bbox="367 858 1314 890">Negative Impact</th> <th data-bbox="1319 858 2192 890">Opportunities for improvement / mitigation</th> </tr> </thead> <tbody> <tr> <td data-bbox="367 893 1314 1431"> • 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 data-bbox="1319 893 2192 1431"> • 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> </tbody> </table>	Negative Impact	Opportunities for improvement / mitigation	• 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.	• 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
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	• 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.	

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

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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.		

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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.		

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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.		

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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.								

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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	<table> <tr> <td data-bbox="365 1066 1314 1399"> 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 data-bbox="1314 1066 2192 1399"> 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>	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.
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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	

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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.		

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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 EqlA 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: <u>Armed-Forces-Covenant-duty-statutory-guidance</u>					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.					

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identified data gaps in the future.			
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.	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.		
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.	<table border="1"> <tr> <td data-bbox="360 857 1317 1406"> 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 data-bbox="1321 857 2190 1406"> 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>	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.	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
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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

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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																																																														
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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.

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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 • 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	

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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 <table border="1"> <thead> <tr> <th>Area</th> <th>Percentage of people who can speak Welsh</th> </tr> </thead> <tbody> <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> </tbody> </table> People, population and community - Office for National Statistics (ons.gov.uk)			Area	Percentage of people who can speak Welsh	Carmarthenshire	53.3	Pembrokeshire	25.2	Ceredigion	56.4	Hywel Dda	45
Area	Percentage of people who can speak Welsh												
Carmarthenshire	53.3												
Pembrokeshire	25.2												
Ceredigion	56.4												
Hywel Dda	45												
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.												

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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	<table border="1"> <tr> <td data-bbox="365 1198 1314 1433"> Negative Impact • Risk of delayed response if rostering doesn't ensure coverage </td><td data-bbox="1314 1198 2192 1433"> Opportunities for improvement / mitigation • Single contact centre may support improvements in rostering sufficient number of staff that can converse in Welsh. </td></tr> </table>	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.
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.		

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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

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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 EqlA 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?

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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 will 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.

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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 occurring.
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 EqlA will be completed when an Option has been confirmed.				

Please note - All white boxes within this EqlA 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 EqlA 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 EqlA and if required provided guidance.

EqlA 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
EqlA 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 EqlA 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 EqlA 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 EqlA and inform the D&I team.

2.6

10:40, 0 Mins

2.6 - Proposal for the Introduction of Ambient AI into HDdUHB

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

Proposal on the use of AI Scribes.

| For approval

Attachments

[2.6 - DDIC - SBAR Ambient AI - Jan 2026 \(AT, needs HT\).docx](#)



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:	Proposal for the Introduction of Ambient AI into HDdUHB
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

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 a proposal regarding the use of Ambient Artificial Intelligence (AI) in the health board. HDdUHB is experiencing significant clinical documentation pressures, contributing to clinician burnout, reduced capacity, and inefficiencies in patient care. Ambient Artificial Intelligence (AI) — often termed AI scribes — can listen to clinician–patient conversations and generate draft clinical notes for clinician review. This technology is increasingly used across healthcare systems and shows potential to reduce administrative workload.

The Committee is asked to consider a proposal to run controlled pilots of Ambient AI within the HDdUHB.

Cefndir / Background

Across the NHS, heavy documentation remains a significant challenge, particularly in primary and outpatient care. New NHS guidance sets out the key requirements for safely introducing ambient scribing technology, including a clinical safety case (DCB0160), a Data Protection Impact Assessment, information governance compliance, and confirmation of the appropriate regulatory status where the Medicines and Healthcare products Regulatory Agency (MHRA) rules apply.

International experience shows that Ambient AI can reduce after-hours documentation, improve the quality of clinical notes, and support clinician wellbeing when used with mandatory human oversight. More than 400 organisations have already adopted these tools, demonstrating growing maturity and confidence in the technology.

Asesiad / Assessment

Strategic Rationale

Introducing Ambient AI within HDdUHB directly addresses long-standing documentation pressures that contribute to clinician burnout and reduce overall workforce capacity. Evidence from multicentre studies and real-world trials shows that AI-enabled ambient scribing can

substantially cut after-hours documentation and cognitive load, with noticeable reductions in burnout emerging within 30–84 days of use. This indicates strong potential to improve wellbeing and support retention in high-demand areas such as primary care and outpatient services.

Case studies also demonstrate consistent time savings per consultation and higher-quality, more complete clinical notes. Most users report improved documentation quality and an average saving of around five minutes per encounter, helping to support safer care and more accurate coding.

Benefits

Ambient AI delivers benefits across multiple levels, including clinician wellbeing, patient experience, operational performance, documentation quality, and broader strategic goals. Evidence from large multicentre studies shows meaningful reductions in burnout and after-hours work, with some evaluations reporting improvements in wellbeing within the first one to three months of use. These reductions are supported by pragmatic trials demonstrating daily time savings of around 30 minutes when clinicians use ambient scribing tools with human review.

Patients also consistently report a better experience when clinicians can fully focus on them rather than on typing. Studies highlight noticeable improvements in perceived clinician presence, with some clinicians describing a renewed sense of satisfaction as administrative demands ease.

Operationally, the time saved per consultation can lead to faster completion of notes, improved clinic flow, and reduced backlogs. Some organisations have reported increases in the number of patients seen and early signs of positive financial impact, although independent reviews recommend careful, site specific measurement to validate any return on investment. Ambient AI also strengthens documentation quality by producing more complete and structured notes, and by automating outputs such as letters, referrals, and after visit summaries. These capabilities support consistency across services and improve coding and analytical value. Strategically, the technology aligns with the HDdUHBs ambitions for improved data quality, cloud-based infrastructure, and adherence to recognised evidence and assurance frameworks such as the National Institute for Health and Care Excellence (NICE) Evidence Standards Framework.

Risks

Ambient AI offers significant potential but requires careful and disciplined risk management across clinical safety, information governance, regulation, ethics, technical reliability, and programme delivery. Key to safe implementation is recognising that transcription or summarisation errors — such as omissions, misinterpretations or occasional inaccuracies — can affect clinical records, particularly in specialist settings. To minimise these risks, NHS guidance emphasises a strong human in the loop model, supported by formal safety cases, hazard logs, and ongoing monitoring throughout deployment.

Information governance is another major consideration, as the technology relies on processing sensitive voice and health data. Robust Data Protection Impact Assessment (DPIAs), clear legal bases for processing, transparent patient communication, and strict controls preventing vendors from re-using identifiable data are essential to maintaining compliance and protecting patient trust. Regulatory assurance is also vital. Ambient AI summarisation functions often fall under MHRA Class I, requiring suppliers to demonstrate appropriate conformity and lifecycle monitoring. Organisations must avoid non-compliant solutions and ensure that regulatory obligations are met from pilot through to scale.

Ethical and equity concerns include the risk of reduced accuracy for certain accents or languages, potential bias in model outputs, and the influence of “automation bias” on clinical decision making. Local pilots must therefore evaluate performance across Welsh and English, monitor for disparities, and ensure transparency and ongoing oversight in line with World Health Organisation (WHO) guidance.

From a technical perspective, performance can vary in noisy or fast-paced environments, speaker diarisation may occasionally misattribute dialogue, and integration issues can disrupt workflows. This underscores the need for a structured vendor comparison, realistic testing in local settings, and reliable fallback options such as dictation or manual templates. Finally, programme risks include variability in adoption, change fatigue, and uncertainty around financial benefits. National bodies recommend that organisations set clear objectives, measure outcomes rigorously, and follow a pilot-first approach with defined success criteria before progressing to wider rollout.

Proposed Outcomes of Pilot

We anticipate benefits across clinical, operational, documentation, and strategic areas, which will be tested through controlled pilots aligned to NICE’s Evidence Standards Framework. Clinically, the main expected outcome is reduced burnout and workload, with improvements in patient experience as clinicians become more present during consultations.

Operational gains should include time saved per encounter, faster completion of notes, and potential increases in service capacity. While other organisations have reported higher patient throughput and early financial benefits, these will need careful local measurement. Documentation quality is expected to improve through more complete, consistent notes and automated outputs such as referrals and after visit summaries, supported by continued human review to ensure safety.

Strategically, successful pilots would demonstrate responsible AI use and support wider digital priorities, including cloud adoption, open standards, and strengthened data quality. Outcomes will be measured through wellbeing indicators, time use studies, documentation audits, patient feedback, incident monitoring, and economic analysis to build a credible evidence base for future decisions.

Functional Capabilities (in scope)

1. Encounter Capture & Transcription
 - Secure audio capture of in person and virtual consultations; real-time or near-real-time transcription, with speaker identification (clinician vs. patient).
2. Clinical Summarisation & Note Drafting
 - Generation of draft notes aligned to specialty templates (e.g., Simple Objective Assessment Process(SOAP), problem oriented notes) and HDdUHB conventions, including histories, examination findings, impressions, and plans.
3. Letters, Referrals, and Discharge Summaries
 - Automated drafting of referral letters and patient facing summaries using the same encounter data, with style customisation and clinician approval before dispatch or filing
4. Template & Style Customisation
 - Clinician configurable note styles (concise versus detailed; bulleted versus prose), terminology preferences, and pronoun handling—improving adoption and reducing editing time.

Clinical Contexts (initial scope for Hywel Dda UHB)

- Primary Care (GP): high-volume conversational encounters benefit from ambient documentation; evidence indicates meaningful reductions in burnout and after hours work in ambulatory settings.
- Outpatient Specialties: to be confirmed; pilots will calibrate templates and measure accuracy and time savings.
- Optional Allied Health: physiotherapy or speech & language therapy for longer, narrative rich notes; requires specialty tuned vocabularies and template design.

Rationale for these contexts is supported by multicentre and pragmatic trials showing burnout reductions and documentation time savings in ambulatory care, as well as case studies from health systems using ambient scribe solutions.

Out of Scope (Phase 1 pilots)

- Autonomous clinical decision making: the AI will not independently diagnose, adjust medications, or create management plans. Any suggestion content must be considered non-directive and subject to clinician judgement and approval.
- Write back: drafts cannot be committed without clinician review; this is central to clinical safety and liability mitigation.

Proposed Implementation Roadmap (Appendix A)

Phase 0 — Market scan & readiness (4–6 weeks)

- **Activities:**
 - Requirements definition (specialties, languages, templates, mobile versus desktop).
 - Vendor communication for the pilot
 - Architecture & integration design aligned to Digital Health and Care Wales (DHCW) platforms
 - Draft safety case; initiate DPIA; prepare patient communications.

Phase 1 — Controlled pilots (12–16 weeks)

- **Sites:** 3–4 services (GP, AHP and Planned Care).
- **Scale:** ~20–40 clinicians; 1,500–3,000 encounters.
- **Model:** human-in-the-loop note review; standardised templates; dual workflows (ambient AI vs usual care) for comparative measurement.

Phase 2 — Evaluation & business case (6–8 weeks)

- **Deliverables:** pilot report mapped to clinical effectiveness, usability, economic analysis, IG/regulatory assurance summary, scale-up plan with investment options

Phase 3 — Phased scale-up (6–12 months)

- **Approach:** specialty waves; change champions; peer coaching; in-product style customisation; continuous monitoring dashboards; quarterly governance reviews.

Recommended approach: run 3–4 controlled pilots across primary care and outpatient specialties; adopt a “human-in-the-loop” review model; meet UK GDPR/ICO expectations; use NICE’s Evidence Standards Framework for digital technologies to evaluate value; and proceed to phased scale-up contingent on verified benefits, safety, and affordability.

Financial Impact

- Pilot costs (3–4 sites, ~30 users, 4–6 months)
 - Licences/subscriptions (ambient AI scribe): £60k–£100k (depends on vendor and volume).
 - Training & change: £5k–£10k.

Conclusion

The introduction of Ambient AI presents a timely and evidence based opportunity for HDdUHB to address longstanding clinical documentation pressures that impact clinician wellbeing, operational efficiency, and the quality of patient care. By adopting a controlled pilot approach with strong clinical governance, human oversight, and robust evaluation, the health board can safely assess the technology's potential to improve documentation quality, reduce administrative burden, and enhance the patient and clinician experience. Subject to positive pilot outcomes, Ambient AI could form a key component of the organisation's wider digital transformation agenda, supporting sustainable workforce practices and improved service delivery.

Argymhelliad / Recommendation

The Committee are requested to:

- **ENDORSE** the proposed pilots and associated investment to enable a structured, responsible, and informed assessment of this emerging technology.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.1 That the direction, development and delivery of the Digital Strategic Plan is to drive continuous improvement and support digitally enabled health care through a digitally enabled workforce to achieve the objectives of the Health Board's Annual Plan/Integrated Medium-Term Plan (IMTP).
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

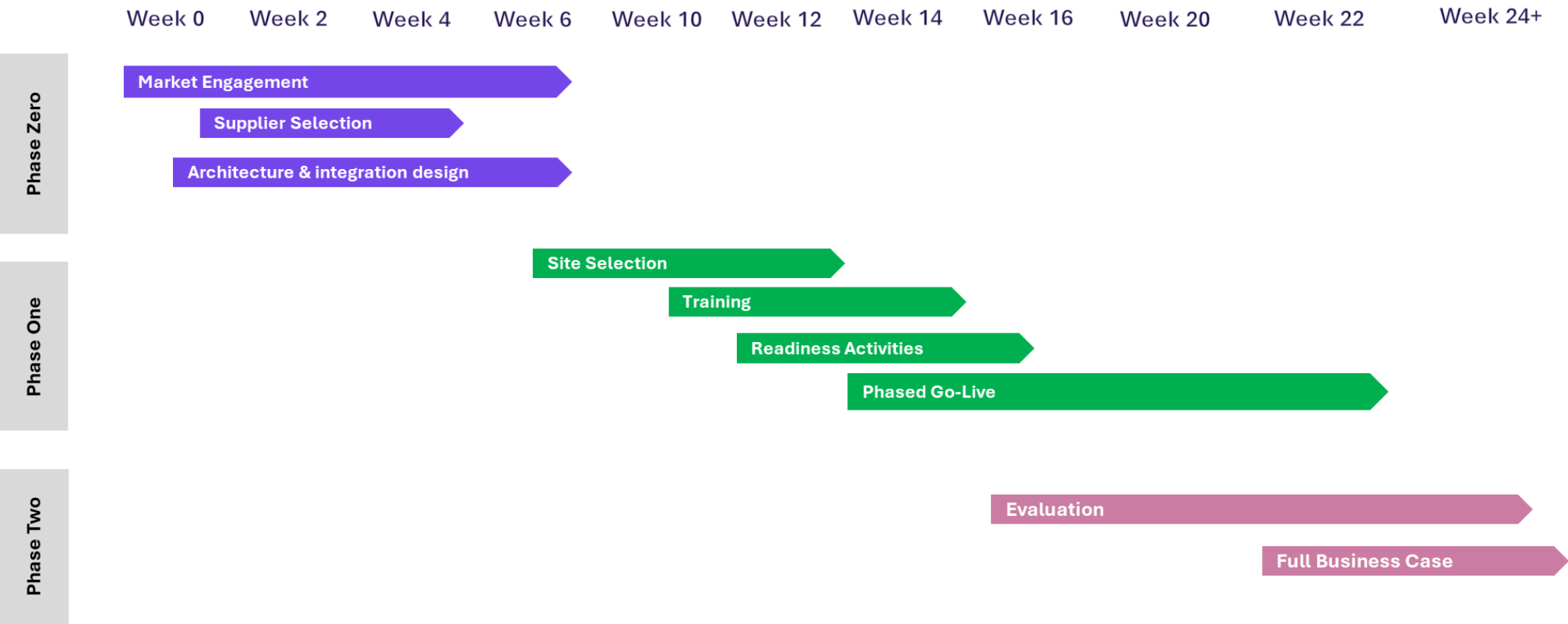
Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Included within the main body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Information Governance Sub-Committee (IGSC)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial impact of AI use within the health board includes both significant initial investments and potential long-term savings, from an efficiency and cash releasing perspective.
Ansawdd / Gofal Claf: Quality / Patient Care:	The use of AI within the health board has a profound impact on quality and patient care. Internally, AI enhances service delivery, reduces clinician workloads, and improves patient outcomes through continuous observation and effective management of conditions. Externally, AI fosters innovative medical treatments, enhances clinical workflows, and ensures equitable and transparent patient care
Gweithlu: Workforce:	The use of AI within the HDdUHB has a significant impact on the workforce. Internally, AI initiatives focus on educating and upskilling the workforce, automating content creation, and maintaining data quality for informed decision-making. Externally, AI addresses workforce shortages, enhances diagnostic accuracy, and improves treatment planning, ultimately leading to a more efficient and effective healthcare workforce.
Risg: Risk:	Outlined within the paper
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The use of AI within the Health Board has a significant impact on its reputation. Internally, the adoption of trusted AI frameworks, robust data protection measures, and ethical clinical practices ensures transparency, trust, and compliance with regulatory standards. Externally, aligning with best practices in AI transparency, informed consent, and health equity can further enhance the Health Board's reputation as a leader in ethical and innovative healthcare
Gyfrinachedd: Privacy:	Not applicable

**Cydraddoldeb:
Equality:**

This will be included within the review, and will be a crucial element of the outputs

Ambient AI – Simplified Roadmap



3 - Research and Innovation

3.1

11:10, 0 Mins

3.1 - Research and Innovation Sub-Committee
(RISC) 3A's Update

*Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and
Value)*

| For assurance

Attachments

[3.1 RISC 3As Update Report DDIC Jan 2026 \(CT, LP, MH\).docx](#)

COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R RESEARCH & INNOVATION SUB-COMMITTEE (R&ISC))

Date of last meeting/ Dyddiad y cyfarfod diwethaf:

10 December 2025 (Extraordinary Research & Innovation Sub-Committee (R&ISC))

18 December 2025 (R&ISC)

Quoracy/ Cworwm: Met on both occasions

Report by/ Adroddiad gan: Mark Henwood, Chair

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

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

The Research and Innovation Sub-Committee (R&ISC) have no matters they wish to **alert** to members of the Digital, Data and Innovation Committee (DDIC).

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

The Research and Innovation Sub-Committee have no matters that they wish to **advise** members of the DDIC of.

Assure³ (to note)/ **Sicrhau** (i nodi)

Research and Innovation Sub-Committee wishes to assure members of the DDIC, that they:

- Received assurance from the financial position for Research and Development (R&D), with a plan to cover the shortfall within the Medical Directorate.
- Received assurance from the performance within the R&D delivery and support functions, recognising a continued positive recruitment figure to date for 2025/26. Members also noted the recent success that HDdUHB R&D were the first site in the UK to recruit to two commercial research studies. This positive news has been shared with Health and Care Research Wales (HCRW) and reported to Welsh Government (WG).

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

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

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

- Noted the Research and Innovation (R&I) Strategic Plan 2025-30 annual assessment against the national HCRW research framework, with progress on the accompanying objectives accepted.
- Received assurance from the activities of the Research Quality and Sponsorship Group (RQSG).
- Noted the intent from WG to audit NHS organisations on their compliance with Research Delivery Funding grant award. R&D will undertake minor actions to address the four categories, with no concerns raised against current compliance.
- Noted the progress against the commitments for each university partner, as well as updates on activity.
- Received assurance from the TriTech and Innovation (T&I) financial position and activity report.
- Received assurance from the T&I progress against the business plan and were informed that Key Performance Indicator (KPI) relating to Intellectual Property 9 (IP)) was not met, due to recent contracted projects not including new IP. The revised TriTech Business Plan 2026-31 was presented and discussed at the extraordinary R&ISC meeting on 10 December 2025. Members responded positively and approved the Plan.
- Received assurance from the progress on development of the Centre for Social Innovation (CfSI) at University of Wales Trinity Saint David (UWTSD).
- The Pentre Awel project has experienced further delays and expected occupancy for Research and Innovation is likely quarter 3 of 2026/27. As such, an extension to the lease at Dura Park, Llanelli has been requested.

Review of Risks/ Adolygiad o Risgiau

The Research and Development (R&D) Risk Register was discussed, and members were advised that the target score for the remaining risk (1492 – Risk to research delivery funding) will be formally reviewed and will likely increase due to the continued financial shortfall. Alternative sources of finance are being utilised to cover the overspend and a wider financial projection for the next three years is being undertaken, which will inform a further review, or consideration to close the risk. Monitoring of this risk continues through the R&D Leadership Group.

Members noted an emerging risk in relation to the Health Board (HB) Information Governance (IG). IG is a crucial aspect of R&D in developing our own (sponsored) studies and in the development or purchase of new ways of working e.g. software applications, however significant delays have been experienced and therefore highlighted at the R&D Leadership Group to explore the issue further. The Director of Research, Innovation and Value and the Executive Medical Director have initiated conversations with relevant colleagues to facilitate a resolution.

The R&ISC also reviewed the two TriTech and Innovation risks that are aligned to it. There was no change to the score for risk 1511 (regulatory climate). Risk 1508 (lack of wider organisation support) increased from 6 to 12 in light of the emerging risk arising from significant delays in digital support for projects. These delays are impacting approval timelines which in turn create financial exposure and threaten delivery against agreed milestones.

Recommendation/ Argymhelliad

The Committee is asked to:

- **Take assurance** from the items that the Sub- Committee is providing assurance on

Date of next meeting/ Dyddiad y cyfarfod nesaf: 02 March 2026

Agenda, papers and minutes are available on request.

3.2

11:10, 0 Mins

3.2 - Research & Development (R&D) Annual Framework Update

***Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and
Value)***

| For assurance

Attachments

[3.2 RD Framework Update DDIC Jan 2026 \(CT, LP, MH\).docx](#)

[3.2 Appendix 1 - RD Framework Update DDIC Jan 2026 - \(additional\).docx](#)



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:	Research & Development (R&D) Annual Framework Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mr Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leighton Phillips, Director of Research, Innovation & Value

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

An overview of annual progress against the national Health Care Research Wales (HCRW) research framework - Research matters – What excellence looks like in NHS Wales (hereinafter referred to as ‘the framework’. The Digital, Data and Innovation Committee (DDIC) are asked to take assurance from the progress update.

Cefndir / Background

The NHS Research and Development Framework, published in July 2023 by the Welsh Government and Health and Care Research Wales, sets out a clear vision for embedding research as a core function within health and social care services in Wales. It emphasises that research is not an optional activity and is instead a statutory duty under the Health and Social Care Act 2020. The framework aims to ensure that research drives evidence-based care, improves health outcomes, and reduces inequalities, positioning Wales as a globally recognised leader in health and care research.

The document highlights the importance of integrating research into everyday NHS service delivery. This means that health boards and trusts must treat research as a fundamental component of planning and quality improvement, rather than an add-on. Building capacity and capability is a central theme, with commitments to strengthen infrastructure, develop research careers, and enable staff participation. Public and patient involvement is also prioritised, ensuring that research is inclusive, transparent, and co-produced with communities.

Collaboration with partners such as the National Institute for Health and Care Research (NIHR), academia, and industry is encouraged to maximize impact and innovation. Governance and accountability are key elements of the framework. NHS organisations are expected to demonstrate leadership in research through board-level oversight, clear reporting mechanisms, and integration of research objectives into organisational strategies. The framework sets out expectations for monitoring performance and ensuring that resources are allocated to support research activity. Strategic priorities include fostering a culture of continuous improvement, leveraging digital innovation and secure data environments, and addressing health inequalities. The framework also draws lessons from the COVID-19

pandemic, where Wales delivered 125 studies and involved over 60,000 participants, showcasing the benefits of a strong research infrastructure.

For NHS organisations, the implications are significant. Health boards must embed research into service planning, support staff involvement, and align local strategies with national priorities. This requires active engagement with research networks, investment in workforce development, and commitment to governance standards. By doing so, HCRW and the Welsh Government state that organisations will not only meet statutory obligations, they will also contribute to improving patient outcomes and position Wales as a leader in health and care research.

The People, Organisational Development, and Culture Committee (PODCC) received an update on the framework on 17 August 2023 and were advised that the first review of Hywel Dda University Health Board's (HDdUHB's) adherence with the framework would be assessed at an annual review meeting on 17 October 2023. The R&ISC received a paper setting out HDdUHB's position on 11 September 2023. The assessment found the organisation to be in a strong position, with a number of the framework's key features already embedded through the 2021–2024 Research and Innovation Strategy. Governance, leadership, and partnership working were highlighted as particular strengths, and regular reporting mechanisms are in place to ensure ongoing compliance and improvement.

The assessment also identified areas for further development, notably the need to strengthen public engagement with the research strategy and to better integrate R&D into staff appraisal processes. These areas were reported as priorities for the coming year, especially as the organisation prepares to refresh its R&D strategy. Overall, the self-assessment reflects a culture of continuous improvement. While many framework features are well established, the report to R&ISC recognised that some aspects—such as fostering a culture of research excellence—are ongoing endeavours rather than endpoints. The R&ISC were advised that the findings would inform both the annual review with HCRW and the next phase of strategic planning for research and innovation within HDdUHB. The annual review went well and there has not been a subsequent review of progress against the framework.

With the new HDdUHB Research and Innovation Strategic Plan now in place, and significant progress made since the 2023 assessment, it was considered timely to assess the current position against the framework, in advance of future WG reviews.

Asesiad / Assessment

An assessment of performance against the framework pillars is provided at Appendix 1. In summary, it highlights that HDdUHB's new Research and Innovation Strategy (2025–2030) has been formally adopted, with clear alignment to national and UK-wide research priorities and is actively monitored through regular leadership meetings and governance structures. Research and Innovation (R&I) is fully integrated into the organisation's planning cycles and enjoys strong board-level commitment, with dedicated executive leadership and independent member champions ensuring research remains a strategic priority.

Partnership and collaboration are well established, with refreshed agreements in place with university partners and active engagement with public sector organisations, industry, and advisory boards. The Board has invested in research support infrastructure, including new clinical research facilities and enhanced digital collaboration, and continues to develop capacity through dedicated research support teams and ongoing staff development. Financial management is robust, with transparent reporting and successful efforts to secure both core and external funding, although challenges remain in fully covering core staffing costs.

Workforce development remains an ongoing area of focus, with efforts to attract, retain, and develop research-active staff, though the need to carve out more protected research time within job plans is acknowledged as a continuing challenge. Public involvement and participation are embedded at the study level, and the Board is working to further strengthen strategic engagement with communities. Communications and engagement activities have been expanded, leveraging both internal and national networks to raise the profile of R&I.

Finally, HDdUHB is committed to open access publishing, evidence-based practice, and ensuring that research informs service redesign and delivers societal value. While a number of framework pillars are well established, the assessment recognises that continuous improvement is needed—particularly in public engagement and workforce capacity—to fully realise the vision of research excellence across all aspects of health and care delivery. It should be noted that HDdUHB has been able to achieve this progress due to leveraging its TriTech and Innovation and Value Based Health Care (VBHC) divisions alongside R&D. There are restrictions to HCRW funding, which would make achieving the pillars of the framework challenging without being able to leverage these wider forms of support. With capacity restrictions it is also necessary to prioritise activities and full adherence to the pillars of the framework should be considered an ongoing endeavour rather than a one-off event.

Argymhelliad / Recommendation

To **TAKE ASSURANCE** in the annual assessment of performance against the national Health Care Research Wales (HCRW) NHS framework.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.1.4 That the organisation is discharging its functions and meeting its responsibilities with regards to research and innovation activity carried out within the organisation.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	4. Learning, improvement and research
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable

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:	N/A
Rhestr Termiau: Glossary of Terms:	Detailed within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	R&D Leadership Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	N/A
Ansawdd / Gofal Claf: Quality / Patient Care:	Detailed within report
Gweithlu: Workforce:	N/A
Risg: Risk:	N/A
Cyfreithiol: Legal:	N/A

Enw Da: Reputational:	No negative impact anticipated
Gyfrinachedd: Privacy:	N/A
Cydraddoldeb: Equality:	N/A

3.2 - Research & Development (R&D) Annual Framework Update

Appendix One

Adherence with 'Research matters What excellence looks like in NHS Wales'

Framework Pillar	Hywel Dda UHB adherence
Strategy: Supportive Organisations: 1.1. Have clear vision for research and ambitious R&D strategies, with aligned implementation plans and continuous progress monitoring. Strategies will: • be coproduced with the public and key stakeholders to ensure they are patient/ public centred • outline a clear vision • demonstrate a clear connection to wider organisational strategies and service plans • demonstrate alignment with the opportunities presented by national and UK wide R&D strategies • be signed off by the Board, alongside a time bound	1.1 New Research and Innovation Strategy (2025-2030) signed off by Board in March 2025, formally launched in June 2025 and showcased at an event at the Pentre Awel scheme 16 October 2025. Second regional showcase on 31 October. Strategic plan and launch process addresses all adjacent actions. 1.2 Progress against the strategy, and research performance is reported through bi-monthly R&D Leadership Group meetings and quarterly Research & Innovation Sub-Committee governance structures. 1.3 R&I sit within the Medical Directorate and strategic aims are reflected in the annual planning cycle /IMTP.

implementation plan • be widely promoted to staff and the public. 1.2. Demonstrate a clear connection between their strategy and implementation plans and key local and national indicators for research performance. 1.3. Ensure R&D has full representation and visibility within the NHS organisations Integrated Medium-Term Plan (IMTP).	
2. Governance and Leadership Supportive organisations: 2.1. Demonstrate clear board commitment to research, with evidence of members contributing to agenda setting, assessing performance, and impact. 2.2. Appoint an independent board member/ champion for research, to act as an ambassador and to champion R&D at the board and across the organisation. 2.3. Support research at all levels by raising awareness among NHS directors, executives, deputies, senior and operational managers to	2.1 Quarterly reports on Research and Innovation are provided to the Board through the Digital, Data, and Innovation Committee. The reports detail performance and impact. 2.2 An Independent Board Member had been appointed as R&D research and innovation champion and sits on the Research and Innovation Sub Committee (R&ISC) and Digital, Data and Innovation Committee (DDIC). 2.3 As above (2.2) as well as dedicated communications and annual R&I Conference (Research & Innovation in Health & Life Sciences Conference 16.10.2025).

secure commitment and by promoting research through existing committee structures. 2.4. Have a dedicated Executive Lead for research and a dedicated R&D Director, who have dedicated time to oversee the R&D strategy and provide strategic leadership. 2.5. Have a dedicated committee wired into the NHS organisation’s governance where research is frequently discussed, with representatives from across the organisation and public members, to plan, oversee and report on research. 2.6. Annually report on progress against the organisation’s R&D strategy, including reporting progress for a public facing audience for example, through a public facing annual report outlining R&D activities and income	2.4 Dedicated Executive Lead (Mr Mark Henwood) and R&I Director (Dr Leighton Phillips) in place. Executive lead chairs Research and Innovation Sub Committee meeting. 2.5 R&ISC and DDIC terms of reference are available on request. Both include representatives from across the organisation. A separate stakeholder advisory committee, with public representatives, exists and receives periodic research and innovation updates, with an opportunity to contribute to priorities moving forward. 2.6 R&D annual report and progress against the “Research Matters – What excellence looks like in the NHS” Framework (HCRW/WG 2023) submitted through above committee structures March/April annually.
3. Partnership and Collaboration Supportive organisations: 3.1. Establish strong interdisciplinary working within the organisation between departments and specialisms; across primary, secondary and	3.1 R&D sits within the Medical Directorate under the Director for Research, Innovation and Value with direct responsibility for University Partnerships with 3 partner institutions. This provides a unique connection with colleagues leading innovation and value-based healthcare as well as meaningful collaborative links with the wider organisation and a range of faculties within the Universities.

community care; and evidenced connections across research, training and education, service improvement and innovation.

3.2. Establish cross-sector partnerships across Wales, the UK and internationally to increase the reach, level and impact of research. Specifically, there will be evidence of alignment of vision, joint R&D strategies, memorandums of understanding, deliverable plans and regular progress reviews with:

- Higher education providers, collaborating to maintain integrated partnership working between the NHS and academia including, where relevant, as part of the research and development pillar for University Health Board status
- Research agencies and funders (including research councils and third sector organisations)
- Public sector organisations, by working across organisational boundaries and adopting flexible approaches to enable easier movement of staff. This may include working with other NHS organisations, Digital Health and Care Wales, Health Education and Improvement Wales, and the Regional Innovation and Improvement Coordination Hubs.
- Life science companies and representative bodies as part of Wales and UK wide industry collaboration plans, whilst developing efficient systems to support commercial research.

3.2 Refreshed Memorandum of Understandings signed with all 3 partner Universities (Swansea University, Aberystwyth University and University of Wales Trinity St Davids) in 2025 setting out our strategic priorities for the next 5 years. Several jointly funded posts exist currently; clinical academic, clinical scientists, health economists and honorary professorial appointments across all 3 institutions. In respect of other public service organisations, a Centre for Social Innovation has been established, offering wider opportunities for research and innovation collaborations. In relation to life science partnerships, recent success through the Voluntary Pricing Agreement for Branded Medications and Growth research and innovation funding has strengthened existing and opened new commercial research partnerships.

3.3 The Research and Innovation Director, Head of Research, and Head of TriTech are well represented on national and international research and innovation advisory arrangements. For example, the Director sits on the Commercial Research Wales Delivery Board.

3.3. Establish partnerships with external expert advisory boards and key international opinion leaders to bring fresh insight and perspective; act as critical friends and collaborative partners; and help NHS researchers to benchmark against internationally leading research within their fields.	
4. Research Support Supportive organisations have: 4.1. R&D offices and/or departments to support researcher development, research governance and the set-up, delivery, and quality assurance associated with studies. 4.2. Support for research within departments and directorates including support for staff time and NHS support services for research such as radiology, pathology, pharmacy, finance, and workforce and organisational development (W&OD). 4.3. The ability to assess organisational capacity and capability to undertake research so that studies can be hosted or sponsored. 4.4. Access to well-equipped physical and digital library services, where staff can access information on research outcomes to inform best practice.	4.1 We have appointed 2 new assistant heads in 2025 each leading a distinct part of R&D. Chris Tattersall has direct responsibility for Research Support (Research development, governance, set-up and quality assurance) and Research Delivery (participant recruitment). We continue to support 4 Clinical Research Centres based at each of the district general hospitals. 4.2 R&D continue to fund wider support services for research within Hywel Dda in pathology, pharmacy and finance. Radiology support for R&D is limited in terms of capacity and wider solutions are being explored through HCRW's national task and finish group as well as accessing ILS2 as part of our University Partnership arrangements. Digital enablement is a new area of focus. 4.3 We have a research study set-up team with 3 staff members led by Chris Tattersall. Our study set-up times are

4.5. Access to suitable space, facilities, and equipment for the conduct of research, with ongoing development enabled through the organisation's facilities and estates strategy. 4.6. An effective and efficient Information Management & Information Technology (IM&IT) infrastructure and systems to support research, with evidenced alignment to organisational digital strategies and national strategies, including those produced by Health and Care Research Wales for example supporting data and software that adheres to the FAIR (Findable, Accessible, Interoperable, and Reusable) principles to allow full repeatability, reproducibility, and reuse. 4.7. Processes in place to contribute to the availability of health data for research purposes, increasing data resources for secure access data via trusted research environments and supporting more diverse research enabled by data driven services. 4.8. A commitment to embracing emerging technologies and to research enabled by data and digital tools, leveraging the strength of NHS Wales and UK health data assets to allow for more high-quality research to be developed and delivered, whilst adhering to data protection obligations in relation to conducting research.	efficient and have been commended by HCRW in a recent annual performance review (10.11.2025) 4.4 We have Library facilities online and at each of our district general hospitals. 4.5 Over the last year we have invested in fit for purpose Clinical Research Facilities at Withybush Hospital Haverfordwest and upgraded our facilities in Prince Philip Hospital in Llanelli. We now have a rolling programme to maintain facilities at each of the district general hospitals 4.6 Closer collaboration with our digital colleagues has been enabled through the creation of the Digital, Data and Information Committee which brings together research, innovation and digital/IT for the first time within the organisation's governance structures. 4.7 & 4.8 In July 2025, Hywel Dda UHB published a five-year Strategic Plan for Research and Innovation. The plan sets out a vision for high-quality and impactful research and innovation, which improves services and health outcomes for communities, patients, and staff. The actions contained within the plan to improve access included developing research and innovation capability and capacity in other corporate departments (e.g. digital services, leadership and

	management practice), primary care and public health. One of the early priorities of the plan, now supported by the establishment of the new Digital, Data and Innovation Committee, is to assess how the R&I and Digital Departments could work together to support research and innovation into new digital and data technologies. Through meaningful relationships with public services, communities, universities and industry Hywel Dda is currently exploring ways to accelerate our digital research and innovation ambitions.
5. Research delivery Supportive organisations: 5.1. Implement UK and Wales wide research delivery support programmes in partnership with the Health and Care Research Wales. 5.2. Adopt One Wales approaches (where Welsh organisations operate as a national collective) to research delivery to enable streamlining, reduce duplication and consistency across Wales including national approaches for research approvals, rapid study setup and delivery. 5.3. Strategically manage the NHS organisation's research portfolio, to lead and participate in a wide range of research, capitalising on local	5.1 – 5.6 We have a dedicated team of research delivery and support staff who actively engage with HCRW and identify suitable studies for adoption in Hywel Dda. We align with Health board and population health priorities, have a rapid study set up process and research delivery capability across all counties. Study set up and recruitment to time and target (the national KPI) is monitored weekly at Research Delivery Meetings, alternate months at R&D Delivery Leadership Team and Research & Development Leadership Group meetings and quarterly at R&ISC. We also meet HCRW for regular

strengths and research groups, organisational priorities and research capacity and capability. 5.4. Support research with high policy relevance which aligns with priorities at a national and regional level, and the NHS organisation's local population health needs. 5.5. Set realistic study delivery targets, ensure research delivery to time and target as agreed with sponsors and monitor the performance of individual studies, ensuring study management data is accurately recorded and monitored frequently. 5.6. Regularly review the organisation's track record in research delivery across the portfolio, understanding the context with local intelligence and benchmarking with UK peers.	performance management meetings. Studies slow to recruit or failing to meet the recruitment target set are discussed weekly and appropriate action plans put in place to meet the target where possible.
6. Finance Supportive organisations: 6.1. Secure adequate funding from Health and Care Research Wales to establish a sustainable R&D function covering research development and delivery and manage the funding transparently, in line with the Health and Care Research Wales R&D Finance Policy. 6.2. Include R&D within the organisation's financial strategies and plans. 6.3. Have financial plans for R&D with good forecasting, timely invoicing, and proportionate risk management.	6.1 The Research Delivery Funding awarded to Hywel Dda in 2025/2026 was £1,081,673. Core staffing costs £1,398,567 which leaves us with an underlying deficit of £316,894. This is being managed through an OCP and external income generation, which has included a substantial commercial research funding award. Ongoing discussions with HCRW are aiming to arrive at a more sustainable solution

6.4. Have a commitment to generate research income for non-commercial studies (i.e. from research funders, research councils and third sector organisations) and commercial studies (i.e. from industry partners) to facilitate capacity building. 6.5. Help existing and prospective researchers secure grants from a wide range of funding sources to advance their studies leading to high quality and impactful outcomes and peer-reviewed international journal publications. 6.6. Ensure financial support is provided to advise on and monitor all costs relating to commercial and non-commercial research.	6.2 & 6.3 & 6.6 R&D financial position is reported for scrutiny monthly to HCRW/WG through face-to-face meeting, bi-monthly to R&D Leadership Group and quarterly through the R&ISC. We fund a finance assistant who manages invoicing and R&D income as per the NHS R&D Funding Policy. 6.4 A successful bid to WG/HCRW for monies to increase our commercial research in both respiratory and metabolic specialisms has positively enhanced both our commercial research infrastructure and portfolio this year. A successful collaboration with Roche has also enabled us to open 2 commercial gastroenterology studies at Bronglais Hospital. 6.5 The researcher support function within the Health Board is funded by research income and supports staff from all professional groups to apply for grants and research awards. We currently have 6 staff with dedicated research time awards, greatly supported by a researcher development function.
7. NHS Workforce Capacity and Capability Supportive organisations:	7.1. Hywel Dda UHB has a strategic workforce group, which the Head of R&D is a member of. Several steps are being taken

7.1. Promote R&D in the organisation's W&OD strategy to facilitate research and recognise the benefits of being a research supportive NHS organisation in attracting talented staff.

7.2. Deliver NHS workforce plans where research is a key component which will include plans to:

- raise awareness of research and research careers through a variety of mechanisms to attract more people into research careers, whilst providing role variety, job enhancement and facilitating staff retention (e.g. through staff induction and mandatory training).
- build research capacity and capability for all staff by supporting the professional development of research knowledge and skills (e.g. through PADRs, mentoring, and signposting to national training opportunities provided through Health and Care Research Wales and other training providers across Wales and the UK).
- ensure that all NHS staff have the opportunity to support research by including research in all NHS job descriptions and have protected time for research for NHS staff through job planning and PADRs.
- maintain support for research in the NHS workforce during times of clinical crises such as urgent public health emergencies and winter pressures, where research activity should be focussed toward the clinical needs.
- enhance research delivery capacity amongst the workforce, including the capability to support clinical trials, ensuring good

by this group to attract and retain the best staff in West Wales, with the benefits of R,D,&I being increasingly understood.

7.2. Hywel Dda UHB funds a small researcher development unit on a cost recovery basis, which works hard to secure internal and external support for research interested staff. This has resulted in several staff, spanning professions, being awards funding to advance their research careers. Like most organisations, the bigger challenge has been carving out time within existing job and work plans for research within existing directorate budgets. While there are examples in some areas of this happening, service pressures means that this is not as widespread as the ambition conveyed within the recent research ad innovation strategic plan. This will be a priority over the coming strategic planning period.

clinical governance and best practice. o adopt national policies enabling agile regional and national mobilisation of the R&D workforce across NHS organisation boundaries and adopt flexible approaches to staff contracts with partner organisations to promote cross-organisational working. • facilitate access to support for staff at all levels who wish to undertake research, advising on how to navigate the R&D environment and signposting to internal and external sources of information (e.g. on funding streams, protocol development, writing funding applications, statistical support, research design and methods). • explore opportunities for investment in joint clinical academic roles in specialties and disciplines aligned to local and national plans, in partnership with universities.	
8. Public Involvement and Participation Supportive organisations: 8.1. Have an evidenced commitment to proactive public involvement and participation in the development and delivery of research studies where the public’s experience is valued and where they can play a variety of roles adding significant value to research e.g. strategy development, setting research priorities, study steering group member,	Section 8.1 – 8.8. There is considerable overlap between this section and section 9. PPI happens more proactively at a research study by study basis, where it is easier to convene meaningful and formative engagement with public and community representative. Many of the steps within the adjacent column are undertaken as research funding applications are worked through. At a strategic level, the Department for Research, Innovation and Value is leaning into the Health Board wide participatory mechanisms.

as a research participant and in shaping plans to share the findings of research.

8.2. Allocate sufficient budget to public involvement, ensuring that public contributors are acknowledged and recognised for their time, lived experience and contribution, in the form of monetary payment or other methods of reward and recognition in line with best practice guidelines.

8.3. Ensure that all research supported by the NHS organisation is people centred, supporting research to make it easier for patients, service users and members of the public to access research of relevance to them and be involved in its design, learning directly from public experience.

8.4. Adopt the national approach to promote research opportunities to staff and the public, including working in partnership with key stakeholders such as third sector organisations to promote research opportunities to communities of people with lived experiences; and signpost access to the organisations and NHS Wales' research portfolio to enhance participation.

8.5. Ensure that the public involved in the NHS organisation's research represents the population it serves with equality, diversity and inclusion being key drivers, and develop flexible approaches to involvement to

enable inclusive representation e.g. addressing barriers to involvement and participation through language barriers and literacy levels etc. 8.6. Adopt the UK Standards for Public Involvement, enabling good practice in public involvement. 8.7. Facilitate access to national training on public involvement for research active staff, to raise awareness on how to effectively involve the public in research. 8.8. Have active representation on the Health and Care Research Wales Public Involvement Alliance.	
9. Communications and Engagement Supportive organisations: 9.1. Include research in the NHS organisation's communications and engagement plans to demonstrate the value and importance of research, celebrating successes and raising the profile amongst staff and the public. 9.2. Adopt the national approach to communications and engagement for research in Wales to ensure there is clear and consistent messaging. 9.3. Have active representation at the Health and Care Research Wales Communications Alliance.	9.1 Substantial work has been undertaken with the communications team, including press releases to coincide with the strategic plan launch, support with events, and ongoing social media input. One off funding awards have also been profiled through communication materials, including recent investments in supporting commercial respiratory research. 9.2, 9.3, 9.6. Hywel Dda UHB works closely with the HCRW communications network to enhance new stories about research and innovation activities. 9.4. The recently formed Centre for Social Innovation is offering new research partnership opportunities with third sector

9.4. Develop plans to raise awareness of the importance of research among local diverse communities, collaborating with researchers and ensuring proactive engagement with underrepresented groups, including working in partnership with third sector organisations and their local communities. 9.5. Include research in the NHS organisation's equality, diversity and inclusion plans with a strong commitment to active engagement with specific groups to address health inequalities through research. 9.6. Adopt national research campaigns and link local research with national Health and Care Research Wales research to maximise impact.	organisations and local communities. In addition, the Department for Research, Innovation and Value continues to support research across the organisation in areas including 'Arts in Health' and 'Biophilic' healthcare design. All of this is possible outside the HCRW research funding allocation. Individual research groups (e.g. women's health) will also have their own engagement mechanisms to formulate research questions.
10. Research Impact Supportive organisations: 10.1. Have a commitment to open access publishing for research findings, including a commitment to ensure that researchers follow the open access policies of those funding their work, to ensure that research outcomes are freely available and encourage the use of research findings. 10.2. Have systems in place to enable research from Wales, the UK and beyond to influence practice and service delivery on an ongoing basis to improve and enhance the quality of services.	10.1. Hywel Dda UHB has a strong commitment to open access publishing. 10.2. There is a commitment to ensuring evidence-based practice, supported by strong relationships between R&D and wider functions of the medical directorate, including effective clinical practice. 10.3. While HCRW funding cannot be utilised to support research relating to service re-design, Hywel Dda UHB benefits

10.3. Develop plans to ensure research is supported during service redesign and informs the design of new models of service delivery based on outcomes from national, UK wide and international research. 10.4. Work with Health and Care Research Wales to develop mechanisms for measuring the economic and societal value associated with research and its impact.	from the capacity that its VBHC team and the TriTech Institute are able to offer. 10.4. Hywel Dda UHB is contributing to the national work being undertaken to understand the wider economic and societal benefits of research and development.

Appendix One

Adherence with ‘Research matters What excellence looks like in NHS Wales’

Framework Pillar	Hywel Dda UHB adherence
Strategy: ve organisations: 1.1. Have clear vision for research and ambitious R&D strategies, with aligned implementation plans and continuous progress monitoring. Strategies will:	1.1 New Research and Innovation Strategy (2025-2030) signed off by Board in March 2025, formally launched in June 2025 and showcased at an event at the Pentre Awel scheme 16 October 2025. Second regional showcase on 31 October. Strategic plan and launch process addresses all adjacent actions.

• be coproduced with the public and key stakeholders to ensure they are patient/ public centred • outline a clear vision • demonstrate a clear connection to wider organisational strategies and service plans • demonstrate alignment with the opportunities presented by national and UK wide R&D strategies • be signed off by the Board, alongside a time bound implementation plan • be widely promoted to staff and the public. 1.2. Demonstrate a clear connection between their strategy and implementation plans and key local and national indicators for research performance. 1.3. Ensure R&D has full representation and visibility within the NHS organisations Integrated Medium-Term Plan (IMTP).	1.2 Progress against the strategy, and research performance is reported through bi-monthly R&D Leadership Group meetings and quarterly Research & Innovation Sub-Committee governance structures. 1.3 R&I sit within the Medical Directorate and strategic aims are reflected in the annual planning cycle /IMTP.
2. Governance and Leadership Supportive organisations:	2.1 Quarterly reports on Research and Innovation are provided to the Board through the Digital, Data, and Innovation Committee. The reports detail performance and impact. 2.2 An Independent Board Member had been appointed as R&D research and innovation champion and sits on the

2.1. Demonstrate clear board commitment to research, with evidence of members contributing to agenda setting, assessing performance, and impact. 2.2. Appoint an independent board member/ champion for research, to act as an ambassador and to champion R&D at the board and across the organisation. 2.3. Support research at all levels by raising awareness among NHS directors, executives, deputies, senior and operational managers to secure commitment and by promoting research through existing committee structures. 2.4. Have a dedicated Executive Lead for research and a dedicated R&D Director, who have dedicated time to oversee the R&D strategy and provide strategic leadership. 2.5. Have a dedicated committee wired into the NHS organisation's governance where research is frequently discussed, with representatives from across the organisation and public members, to plan, oversee and report on research. 2.6. Annually report on progress against the organisation's R&D strategy, including reporting progress for a public facing audience for example, through a public facing annual report outlining R&D activities and income	Research and Innovation Sub Committee (R&ISC) and Digital, Data and Innovation Committee (DDIC). 2.3 As above (2.2) as well as dedicated communications and annual R&I Conference (Research & Innovation in Health & Life Sciences Conference 16.10.2025). 2.4 Dedicated Executive Lead (Mr Mark Henwood) and R&I Director (Dr Leighton Phillips) in place. Executive lead chairs Research and Innovation Sub Committee meeting. 2.5 R&ISC and DDIC terms of reference are available on request. Both include representatives from across the organisation. A separate stakeholder advisory committee, with public representatives, exists and receives periodic research and innovation updates, with an opportunity to contribute to priorities moving forward. 2.6 R&D annual report and progress against the "Research Matters – What excellence looks like in the NHS" Framework (HCRW/WG 2023) submitted through above committee structures March/April annually.

3. Partnership and Collaboration Supportive organisations: 3.1. Establish strong interdisciplinary working within the organisation between departments and specialisms; across primary, secondary and community care; and evidenced connections across research, training and education, service improvement and innovation. 3.2. Establish cross-sector partnerships across Wales, the UK and internationally to increase the reach, level and impact of research. Specifically, there will be evidence of alignment of vision, joint R&D strategies, memorandums of understanding, deliverable plans and regular progress reviews with: • Higher education providers, collaborating to maintain integrated partnership working between the NHS and academia including, where relevant, as part of the research and development pillar for University Health Board status • Research agencies and funders (including research councils and third sector organisations) • Public sector organisations, by working across organisational boundaries and adopting flexible approaches to enable easier	3.1 R&D sits within the Medical Directorate under the Director for Research, Innovation and Value with direct responsibility for University Partnerships with 3 partner institutions. This provides a unique connection with colleagues leading innovation and value-based healthcare as well as meaningful collaborative links with the wider organisation and a range of faculties within the Universities. 3.2 Refreshed Memorandum of Understandings signed with all 3 partner Universities (Swansea University, Aberystwyth University and University of Wales Trinity St Davids) in 2025 setting out our strategic priorities for the next 5 years. Several jointly funded posts exist currently; clinical academic, clinical scientists, health economists and honorary professorial appointments across all 3 institutions. In respect of other public service organisations, a Centre for Social Innovation has been established, offering wider opportunities for research and innovation collaborations. In relation to life science partnerships, recent success through the Voluntary Pricing Agreement for Branded Medications and Growth research and innovation funding has strengthened existing and opened new commercial research partnerships.

movement of staff. This may include working with other NHS organisations, Digital Health and Care Wales, Health Education and Improvement Wales, and the Regional Innovation and Improvement Coordination Hubs. Life science companies and representative bodies as part of Wales and UK wide industry collaboration plans, whilst developing efficient systems to support commercial research. 3.3. Establish partnerships with external expert advisory boards and key international opinion leaders to bring fresh insight and perspective; act as critical friends and collaborative partners; and help NHS researchers to benchmark against internationally leading research within their fields.	3.3 The Research and Innovation Director, Head of Research, and Head of TriTech are well represented on national and international research and innovation advisory arrangements. For example, the Director sits on the Commercial Research Wales Delivery Board.
4. Research Support Supportive organisations have: 4.1. R&D offices and/or departments to support researcher development, research governance and the set-up, delivery, and quality assurance associated with studies. 4.2. Support for research within departments and directorates including support for staff time and NHS support services for research such as radiology, pathology, pharmacy, finance, and workforce and organisational development (W&OD).	4.1 We have appointed 2 new assistant heads in 2025 each leading a distinct part of R&D. Chris Tattersall has direct responsibility for Research Support (Research development, governance, set-up and quality assurance) and Research Delivery (participant recruitment). We continue to support 4 Clinical Research Centres based at each of the district general hospitals. 4.2 R&D continue to fund wider support services for research within Hywel Dda in pathology, pharmacy and finance. Radiology support for R&D is limited in terms of capacity and

4.3. The ability to assess organisational capacity and capability to undertake research so that studies can be hosted or sponsored. 4.4. Access to well-equipped physical and digital library services, where staff can access information on research outcomes to inform best practice. 4.5. Access to suitable space, facilities, and equipment for the conduct of research, with ongoing development enabled through the organisation's facilities and estates strategy. 4.6. An effective and efficient Information Management & Information Technology (IM&IT) infrastructure and systems to support research, with evidenced alignment to organisational digital strategies and national strategies, including those produced by Health and Care Research Wales for example supporting data and software that adheres to the FAIR (Findable, Accessible, Interoperable, and Reusable) principles to allow full repeatability, reproducibility, and reuse. 4.7. Processes in place to contribute to the availability of health data for research purposes, increasing data resources for secure access data via trusted research environments and supporting more diverse research enabled by data driven services. 4.8. A commitment to embracing emerging technologies and to research enabled by data and digital tools, leveraging the strength of NHS Wales and UK health data assets to allow for more high-quality research to be	wider solutions are being explored through HCRW's national task and finish group as well as accessing ILS2 as part of our University Partnership arrangements. Digital enablement is a new area of focus. 4.3 We have a research study set-up team with 3 staff members led by Chris Tattersall. Our study set-up times are efficient and have been commended by HCRW in a recent annual performance review (10.11.2025) 4.4 We have Library facilities online and at each of our district general hospitals. 4.5 Over the last year we have invested in fit for purpose Clinical Research Facilities at Withybush Hospital Haverfordwest and upgraded our facilities in Prince Philip Hospital in Llanelli. We now have a rolling programme to maintain facilities at each of the district general hospitals 4.6 Closer collaboration with our digital colleagues has been enabled through the creation of the Digital, Data and Information Committee which brings together research, innovation and digital/IT for the first time within the organisation's governance structures. 4.7 & 4.8 In July 2025, Hywel Dda UHB published a five-year Strategic Plan for Research and Innovation. The plan sets out a

developed and delivered, whilst adhering to data protection obligations in relation to conducting research.	vision for high-quality and impactful research and innovation, which improves services and health outcomes for communities, patients, and staff. The actions contained within the plan to improve access included developing research and innovation capability and capacity in other corporate departments (e.g. digital services, leadership and management practice), primary care and public health. One of the early priorities of the plan, now supported by the establishment of the new Digital, Data and Innovation Committee, is to assess how the R&I and Digital Departments could work together to support research and innovation into new digital and data technologies. Through meaningful relationships with public services, communities, universities and industry Hywel Dda is currently exploring ways to accelerate our digital research and innovation ambitions.
5. Research delivery Supportive organisations: 5.1. Implement UK and Wales wide research delivery support programmes in partnership with the Health and Care Research Wales. 5.2. Adopt One Wales approaches (where Welsh organisations operate as a national collective) to research delivery to enable streamlining,	5.1 – 5.6 We have a dedicated team of research delivery and support staff who actively engage with HCRW and identify suitable studies for adoption in Hywel Dda. We align with Health board and population health priorities, have a rapid

reduce duplication and consistency across Wales including national approaches for research approvals, rapid study setup and delivery. 5.3. Strategically manage the NHS organisation's research portfolio, to lead and participate in a wide range of research, capitalising on local strengths and research groups, organisational priorities and research capacity and capability. 5.4. Support research with high policy relevance which aligns with priorities at a national and regional level, and the NHS organisation's local population health needs. 5.5. Set realistic study delivery targets, ensure research delivery to time and target as agreed with sponsors and monitor the performance of individual studies, ensuring study management data is accurately recorded and monitored frequently. 5.6. Regularly review the organisation's track record in research delivery across the portfolio, understanding the context with local intelligence and benchmarking with UK peers.	study set up process and research delivery capability across all counties. Study set up and recruitment to time and target (the national KPI) is monitored weekly at Research Delivery Meetings, alternate months at R&D Delivery Leadership Team and Research & Development Leadership Group meetings and quarterly at R&ISC. We also meet HCRW for regular performance management meetings. Studies slow to recruit or failing to meet the recruitment target set are discussed weekly and appropriate action plans put in place to meet the target where possible.
6. Finance Supportive organisations: 6.1. Secure adequate funding from Health and Care Research Wales to establish a sustainable R&D function covering research development and delivery and manage the funding transparently, in line with the Health and Care Research Wales R&D Finance Policy.	6.1 The Research Delivery Funding awarded to Hywel Dda in 2025/2026 was £1,081,673. Core staffing costs £1,398,567 which leaves us with an underlying deficit of £316,894. This is being managed through an OCP and external income

6.2. Include R&D within the organisation's financial strategies and plans. 6.3. Have financial plans for R&D with good forecasting, timely invoicing, and proportionate risk management. 6.4. Have a commitment to generate research income for non-commercial studies (i.e. from research funders, research councils and third sector organisations) and commercial studies (i.e. from industry partners) to facilitate capacity building. 6.5. Help existing and prospective researchers secure grants from a wide range of funding sources to advance their studies leading to high quality and impactful outcomes and peer-reviewed international journal publications. 6.6. Ensure financial support is provided to advise on and monitor all costs relating to commercial and non-commercial research.	generation, which has included a substantial commercial research funding award. Ongoing discussions with HCRW are aiming to arrive at a more sustainable solution 6.2 & 6.3 & 6.6 R&D financial position is reported for scrutiny monthly to HCRW/WG through face-to-face meeting, bi-monthly to R&D Leadership Group and quarterly through the R&ISC. We fund a finance assistant who manages invoicing and R&D income as per the NHS R&D Funding Policy. 6.4 A successful bid to WG/HCRW for monies to increase our commercial research in both respiratory and metabolic specialisms has positively enhanced both our commercial research infrastructure and portfolio this year. A successful collaboration with Roche has also enabled us to open 2 commercial gastroenterology studies at Bronglais Hospital. 6.5 The researcher support function within the Health Board is funded by research income and supports staff from all professional groups to apply for grants and research awards. We currently have 6 staff with dedicated research time awards, greatly supported by a researcher development function.
7. NHS Workforce Capacity and Capability	

Supportive organisations:

7.1. Promote R&D in the organisation's W&OD strategy to facilitate research and recognise the benefits of being a research supportive NHS organisation in attracting talented staff.

7.2. Deliver NHS workforce plans where research is a key component which will include plans to:

- raise awareness of research and research careers through a variety of mechanisms to attract more people into research careers, whilst providing role variety, job enhancement and facilitating staff retention (e.g. through staff induction and mandatory training).
- build research capacity and capability for all staff by supporting the professional development of research knowledge and skills (e.g. through PADRs, mentoring, and signposting to national training opportunities provided through Health and Care Research Wales and other training providers across Wales and the UK).
- ensure that all NHS staff have the opportunity to support research by including research in all NHS job descriptions and have protected time for research for NHS staff through job planning and PADRs.
- maintain support for research in the NHS workforce during times of clinical crises such as urgent public health emergencies and winter pressures, where research activity should be focussed toward the clinical needs.

7.1. Hywel Dda UHB has a strategic workforce group, which the Head of R&D is a member of. Several steps are being taken by this group to attract and retain the best staff in West Wales, with the benefits of R,D,&I being increasingly understood.

7.2. Hywel Dda UHB funds a small researcher development unit on a cost recovery basis, which works hard to secure internal and external support for research interested staff. This has resulted in several staff, spanning professions, being awards funding to advance their research careers. Like most organisations, the bigger challenge has been carving out time within existing job and work plans for research within existing directorate budgets. While there are examples in some areas of this happening, service pressures means that this is not as widespread as the ambition conveyed within the recent research ad innovation strategic plan. This will be a priority over the coming strategic planning period.

• enhance research delivery capacity amongst the workforce, including the capability to support clinical trials, ensuring good clinical governance and best practice. o adopt national policies enabling agile regional and national mobilisation of the R&D workforce across NHS organisation boundaries and adopt flexible approaches to staff contracts with partner organisations to promote cross-organisational working. • facilitate access to support for staff at all levels who wish to undertake research, advising on how to navigate the R&D environment and signposting to internal and external sources of information (e.g. on funding streams, protocol development, writing funding applications, statistical support, research design and methods). • explore opportunities for investment in joint clinical academic roles in specialties and disciplines aligned to local and national plans, in partnership with universities.	
8. Public Involvement and Participation Supportive organisations: 8.1. Have an evidenced commitment to proactive public involvement and participation in the development and delivery of research studies where the public’s experience is valued and where they can play a variety of roles adding significant value to research e.g. strategy development, setting research priorities, study steering group member,	Section 8.1 – 8.8. There is considerable overlap between this section and section 9. PPI happens more proactively at a research study by study basis, where it is easier to convene meaningful and formative engagement with public and community representative. Many of the steps within the adjacent column are undertaken as research funding applications are worked through. At a strategic level, the

as a research participant and in shaping plans to share the findings of research. 8.2. Allocate sufficient budget to public involvement, ensuring that public contributors are acknowledged and recognised for their time, lived experience and contribution, in the form of monetary payment or other methods of reward and recognition in line with best practice guidelines. 8.3. Ensure that all research supported by the NHS organisation is people centred, supporting research to make it easier for patients, service users and members of the public to access research of relevance to them and be involved in its design, learning directly from public experience. 8.4. Adopt the national approach to promote research opportunities to staff and the public, including working in partnership with key stakeholders such as third sector organisations to promote research opportunities to communities of people with lived experiences; and signpost access to the organisations and NHS Wales’ research portfolio to enhance participation. 8.5. Ensure that the public involved in the NHS organisation’s research represents the population it serves with equality, diversity and inclusion being key drivers, and develop flexible approaches to involvement to	Department for Research, Innovation and Value is leaning into the Health Board wide participatory mechanisms.

enable inclusive representation e.g. addressing barriers to involvement and participation through language barriers and literacy levels etc. 8.6. Adopt the UK Standards for Public Involvement, enabling good practice in public involvement. 8.7. Facilitate access to national training on public involvement for research active staff, to raise awareness on how to effectively involve the public in research. 8.8. Have active representation on the Health and Care Research Wales Public Involvement Alliance.	
9. Communications and Engagement Supportive organisations: 9.1. Include research in the NHS organisation's communications and engagement plans to demonstrate the value and importance of research, celebrating successes and raising the profile amongst staff and the public. 9.2. Adopt the national approach to communications and engagement for research in Wales to ensure there is clear and consistent messaging. 9.3. Have active representation at the Health and Care Research Wales Communications Alliance.	9.1 Substantial work has been undertaken with the communications team, including press releases to coincide with the strategic plan launch, support with events, and ongoing social media input. One off funding awards have also been profiled through communication materials, including recent investments in supporting commercial respiratory research. 9.2, 9.3, 9.6. Hywel Dda UHB works closely with the HCRW communications network to enhance new stories about research and innovation activities. 9.4. The recently formed Centre for Social Innovation is offering new research partnership opportunities with third sector

9.4. Develop plans to raise awareness of the importance of research among local diverse communities, collaborating with researchers and ensuring proactive engagement with underrepresented groups, including working in partnership with third sector organisations and their local communities. 9.5. Include research in the NHS organisation's equality, diversity and inclusion plans with a strong commitment to active engagement with specific groups to address health inequalities through research. 9.6. Adopt national research campaigns and link local research with national Health and Care Research Wales research to maximise impact.	organisations and local communities. In addition, the Department for Research, Innovation and Value continues to support research across the organisation in areas including 'Arts in Health' and 'Biophilic' healthcare design. All of this is possible outside the HCRW research funding allocation. Individual research groups (e.g. women's health) will also have their own engagement mechanisms to formulate research questions.
10. Research Impact Supportive organisations: 10.1. Have a commitment to open access publishing for research findings, including a commitment to ensure that researchers follow the open access policies of those funding their work, to ensure that research outcomes are freely available and encourage the use of research findings. 10.2. Have systems in place to enable research from Wales, the UK and beyond to influence practice and service delivery on an ongoing basis to improve and enhance the quality of services.	10.1. Hywel Dda UHB has a strong commitment to open access publishing. 10.2. There is a commitment to ensuring evidence-based practice, supported by strong relationships between R&D and wider functions of the medical directorate, including effective clinical practice. 10.3. While HCRW funding cannot be utilised to support research relating to service re-design, Hywel Dda UHB benefits

10.3. Develop plans to ensure research is supported during service redesign and informs the design of new models of service delivery based on outcomes from national, UK wide and international research. 10.4. Work with Health and Care Research Wales to develop mechanisms for measuring the economic and societal value associated with research and its impact.	from the capacity that its VBHC team and the TriTech Institute are able to offer. 10.4. Hywel Dda UHB is contributing to the national work being undertaken to understand the wider economic and societal benefits of research and development.

3.3

11:10, 0 Mins

3.3 - University Partnership Arrangements Update

***Leighton Phillips
(Hywel Dda UHB -
Director Research,
Innovation and
Value)***

| For assurance

Attachments

3.3 DDIC SBAR University Partnership Update January 2026 (CT, MH approved ~.docx



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:	University Partnership Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Dr Leighton Phillips, Director of Research, Innovation, and Value

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

To provide an update of university partnership activity for assurance.

Cefndir / Background

In order to maintain its 'University Health Board' designation, Hywel Dda University Health Board (HDdUHB) is required to demonstrate continuous improvement in collaborative working with its university partners. University designation represents a commitment on behalf of HDdUHB to ensure that university activity is demonstrably improving the quality of care, improving patient outcomes, and enhancing the reputation of the Health Board to attract people to work in Wales.

On an annual basis, HDdUHB is required by the Welsh Government to provide evidence of purposeful university partnership activity, with examples of how this is improving services and benefitting our population and to set out our plans for the next 12 months aligning to the Integrated Medium plans. There are three themes against which we are required to report our activity: Research and Development; Innovation; and Workforce, Training, and Education.

Given the importance HDdUHB attaches to university status, partnership activities are reflected in its planning objectives, particularly those relating to research, innovation, and workforce, however, university partnership can be useful to advancing many of the HDdUHB's ambitions, in areas including engineering, building design, law, management, and ecology.

The focus on the university partnership arrangements driven corporately is not to keep track of every area of activity being advanced between universities and the health board; rather, it is to ensure that a limited number of priorities receive the corporate focus and energy they deserve.

As members were advised at the inaugural Digital, Data and Innovation Committee (DDIC) in April 2025, work had commenced to refresh and re-invigorate our university partnership arrangements with our regionally based Higher Education Institutions (HEIs):

- Aberystwyth University;

- Swansea University; and
- University of Wales Trinity St David.

This paper sets out progress made and early plans and priorities with each partner for the next 12 months.

Asesiad / Assessment

The new Research and Innovation Strategic Plan (2025-2030) was published in June 2025 and formally launched at an event at Pentre Awel on 16 October 2025.

The Strategic Plan committed to improving the alignment and reciprocity between current university partners and HDdUHB's research and innovation plans. The Strategic Plan included a commitment to refreshing collaboration agreements with each university partner and developing an improved way of managing bilateral and multilateral partnerships. It also contained a commitment to agree a maximum of three long term research and innovation goals with each university partner, strongly aligned to their plans.

New agreements, in the form of Memoranda of Understanding (MoUs), are now in place with all regionally based HEIs. The MoUs were signed at Joint Executive Team meetings, led by the Chief Executive of HDdUHB and Vice-Chancellors of the respective HEIs on the following dates:

- 23rd June 2025 – Aberystwyth University.
- 9th July 2025 – Swansea University.
- 12th September – University of Wales Trinity St Davids.

The MoUs are broad in scope, allowing HDdUHB to collaborate with HEIs in a wide range of areas as documented within Appendix 1.

At the Joint Executive Team meetings, achievements were recognised, and discussions took place about potential long-term research and innovation goals. The Director of Research, Innovation and Value has held follow up discussions with all HEIs and the collaborative areas of interest included:

- The Social Model for Health and Wellbeing and supporting community-based research and innovation, including maximising the opportunities associated with existing research studies including the Local Policy and Innovation Partnership.
- Collaboration in support of the National Network for Innovation in Sport and Health (NNISH).
- Maximising the opportunities associated with the Centre for Social Innovation, and its early priorities, which include community health and wellbeing workers and advancing biophilic design principles.
- Deepening partnership activity in respect of AI, optimising its potential benefits, guided by core principles and regulatory frameworks designed to protect patients and maintain trust.
- Working together to strengthen regional approaches to research and innovation, leveraging the translational research capabilities known to exist in West Wales and building on the recent cardiovascular disease project.
- Widening the reach of research and innovation partnership activity into disciplines and faculties of potential relevance to HDdUHB but have received limited exploration to date.

These areas will be further explored and honed with university partners between now and the end of the 2025/26 financial year, with projects and work programmes for delivery during 2026/27.

In addition to this activity, all university partners were brought together for the first time under the leadership of the Medical Directors of HDdUHB and Swansea Bay UHB on 31 October 2025 at Pentre Awel. This meeting served to share the Research and Innovation priorities of both Health Boards and the three university partners collectively and was beneficial to the identification of new collaborative areas and something that all partners wished to continue.

In relation to ongoing monitoring of these activities and routine engagement with the HEIs, the following has been determined:

- The Medical Director of HDdUHB, alongside Executive colleagues, will convene an annual review meeting with each HEI partner to review progress against the long-term goals and in-year priorities. These will be known as annual bilateral university partnership meetings. The first will take place between March – May 2026 and will achieve final agreement of the long-term priority areas with each HEI.
- The annual regional R&I summit, involving all university partners, will be repeated in 2026/27. This will be known as the annual trilateral university partnership meeting.
- The Director of Research, Innovation, and Value will continue to have Bi-lateral meeting with each University partner at a Pro Vice-Chancellor/Dean level, focused on project activity, twice a year.
- The Chief Executive has instigated bi-annual meetings with the Vice-Chancellors of each Institution.

A further update on University Partnership activities will be presented to DDIC at the July 2026 meeting.

Argymhelliad / Recommendation

The DDIC is asked to:

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

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.16 Seek assurance that the university partnership arrangements are operating effectively and continue to protect the Health Board's 'university' designated status.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality	7. All apply

Quality and Engagement Act (sharepoint.com)	
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not Applicable
Rhestr Termiau: Glossary of Terms:	Not Applicable
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Research and Innovation Sub Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable.
Ansawdd / Gofal Claf: Quality / Patient Care:	Project partnerships have the potential to improve care quality. Potential benefits will be considered on a case-by-case basis.
Gweithlu: Workforce:	University partnerships offer the potential of joint and honorary posts, which alongside the positive impact of

	research and innovation can support recruitment and retention.
Risg: Risk:	Not Applicable
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	University partnership activities have the potential to reflect positively on HDdUHB.
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Appendix 1 – Potential Areas for Collaboration

Research and Development, with examples including:

Use of specialist facilities

Clinical and non-clinical trial sponsorship Collaborative research projects

Developing and managing an active trial portfolio, spanning health and social care

Knowledge mobilisation, including approaches to ensure research is leading to quantifiable impact Research income capture

Enterprise and Innovation, with examples including:

University, Health Board, and Industry collaborations

New device and technology development

Managing joint innovation assets, through intellectual property and commercialisation Shared services

Consultancy

Innovation income capture, particularly taking advantage of post Brexit opportunities

Workforce, Education, and Training, with examples including:

Managed placement activities in clinical and non-clinical settings Honorary posts

Fellowships and studentships

Managed graduate and undergraduate training opportunities
New educational programme developments
Joint posts
Continuing professional development
Workforce planning and commissioning, linked to national processes, including those overseen by Health Education and Improvement Wales

3.4

11:10, 0 Mins

3.4 - Tritech Business Plan

***Prof. Chris Hopkins
(Hywel Dda UHB -
Head of Innovation &
Tritech Institute •
Research and
Development)***

| For approval

Attachments

[3.4 SBAR TriTech Business Plan 2026-31 DDIC 15.01.25 PUBLIC \(CT, LP, MH\).docx](#)

[3.4 HD049264 - TRITECH BUSINESS PLAN 25-26 - PUBLIC v4 \(CT, LP, MH\).pdf](#)

[3.4 Tritech Business Plan - EqlA Screening form SIGNED.pdf](#)



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:	TriTech Institute Business Plan 2026-31
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Professor Chris Hopkins, Consultant Clinical Scientist, Head of Tritech and Innovation Dr Leighton Phillips, Director of Research, Innovation and Value

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

Following Formal Executive Team approval on 19 November 2025, and agreement from the Research & Innovation Sub-Committee (R&ISC) on 10 December 2025 to progress the TriTech Institute Business Plan (2026–2031) through the HDdUHB's governance and assurance framework, the Business Plan is now being presented to the Digital Data and Innovation Committee (DDIC) for assurance, prior to its consideration by the Public Board on 26th March 2026.

Cefndir / Background

The TriTech Institute (hereafter referred to as “the Institute”) was established by HDdUHB in 2021 to support healthcare technology development, research, and innovation. Its inception sought to sustain the interdisciplinary collaboration between the Research and Development (R&D) department, clinical engineering, and clinical services that had emerged during the COVID-19 pandemic, with the overarching aim of supporting evidence collection for those innovations that could enhance patient outcomes. The Institute was formally launched by the Permanent Secretary of the Welsh Government in November 2021.

As the current business plan approaches its conclusion in 2025/26, the development of a new business plan has been initiated for the period 2026–2031, informed by the following:

an independent peer review, which involved a multidisciplinary team (NHS, biopharmaceutical and medical technology) interviewing stakeholders to identify organisational strengths, challenges, and areas for improvement.

an assessment of financial performance over the past four and a half years undertaken by the Finance directorate, which has also been involved in several facilitated discussions to set out a financial strategy and plan for the next five years. The Institute has consistently delivered a year-on-year surplus relative to its cost recovery targets and, more significantly, has demonstrated an enduring commitment to evidence-

generation while actively supporting clinical teams in the adoption and integration of innovative practices.

a comprehensive assessment of key performance indicators and a market assessment.

- an overall assessment of key successes (2020/21-2024/25), which has included:
 - Support for 111 projects, all in a financially sustainable manner
 - Support provided to 29 clinical leads, 37 academic collaborations, and 6 local businesses. Clinical teams frequently highlight the enabling nature of the Institute's approach and its contribution to innovation adoption.
 - Recognition through awards including MediWales, CSO England, and NHS Wales accolades
 - 42 outputs comprising publications, posters, and conference presentations
 - Support for local companies and public sector organisations.
 - Creating high quality scientific jobs: eight substantive staff, four fixed-term staff, and three HEIW-funded Clinical Scientist trainees
- several team development sessions, with a focus on understanding how the structure and working practices could be enhanced to optimise the delivery of the proposed TriTech Institute's objectives going forward.

It is also important to state that the business plan is built upon four years of operational experience. During this period, the business model has been refined and tested, governance structures have been developed and consolidated, a skilled team has been recruited, and multiple contracts and partnerships have been successfully delivered.

The resulting business plan is included at Appendix 1. Commercially sensitive information, including appendices, have been redacted from the plan. The Digital, Data, and Innovation Committee will have to opportunity to consider an unredacted version during its 'in-committee' meeting.

Asesiad / Assessment

The business plan is structured into the following sections:

- Current Organisation Details
- Market Analysis & The TriTech Institute's Positioning
- Situational Analysis
- Strategy & Implementation
- Organisation, Management Team & Governance
- Financial Plan & Projections

Many sections of the business plan are reflective of a business-as-usual approach. The key changes set out within the business plan include:

- A revised Marketing, Advertising and Communications Plan. The plan serves as a broad framework and will be supplemented with an internally focused approach.
- A revised Financial Plan, which requests an increase to the cost recovery targets in 2026/27, 2027/28, and 2028/29 before holding steady for the remainder of the plan. These would enable a modest increase in establishment, enabling the proposed increases to activity levels and associated income in line with the financial strategy and investment plan. To ensure a measured approach to financial risk, at this point, the Executive Team was only asked to approve the 2026/27 increase and the principle of a 'stage gate' approach to agreeing further increases to the cost recovery target.

- An Internal Commissioning Approach. All the TriTech Institute's projects, regardless of funding source, are only selected if they offer the potential to contribute to the health and wellbeing of the population of south west Wales. However, the work undertaken through this business plan has demonstrated the potential for the TriTech Institute to re-balance its portfolio to enable it to be more responsive to internal direct commissions. This might include an evaluation of a new process or pathway of care or supporting the introduction of a proven innovation. The business plan sets an approach for operating internal commissioning.
- New Key Performance Indicators (KPIs). The KPIs seek to maintain the high quality and financial performance of the past four and a half years, with the addition of other indicators to respond to feedback received during the plan development process. An indicator has been added to ensure that the TriTech Institute strengthens the way in which it supports the wider planning objectives of HDdUHB.

Formal Executive Team approved the Business Plan on 19 November 2025, subject to:

- Compliance of the branding and communications plan with Welsh Language standards. Revisions have been made to the plan.
- Market engagement. While not relating to the drafting of the document, Executives were keen for the TriTech Institute team to examine the HDdUHB's annual plan to identify opportunities for collaborative projects with existing external industry partners in aligned areas of opportunity. The KPIs have been amended to reflect annual alignment with the HDdUHB's planning priorities.
- Strengthen Welsh policy context. A section on '*A Healthier Wales*' has been added to the plan, including referencing its recent refresh and priorities for primary care innovation. The national public health priorities have been added to the plan emphasising the importance of tackling the wider social determinants of health and wellbeing.
- Internal commissioning. Executives approved the principle of internal commissioning and asked for further work on the practicalities associated with operationalising the approach. Greater clarity has been added to the plan, and the practicalities will now be worked through.
- A confirmation of current impact and the level of ambition. Specifically, Executives asked whether the full potential of the plan was being realised. Subsequent review of the Business Plan has led the TriTech Institute team to conclude that it balances ambition with delivery and the reputation associated with the same. However, targets will be kept under continuous review and Executives will be appraised of opportunities for further growth and development throughout the course of delivery.
- Executives asked whether the TriTech team could explore the further leverage of partnerships to respond to key opportunities and challenges for the organisation. An advisory group arrangement has been described.

The R&ISC received and considered the plan on 10 December 2025 and were assured of its content. R&ISC members commended the TriTech and Innovation Division for the TriTech Institute's achievements and considered the plan to be thorough and comprehensive. No amendments were required. R&ISC members made the following observations:

- The role of the TriTech Institute undertaking internally commissioned projects was welcomed, particularly those that support HDdUHB with its strategy refresh and Clinical Services Plan (CSP). However, members of the R&ISC thought it important to ensure the TriTech Institute team continued to have the capacity to work on externally commissioned work and remained relevant to commercial partners;
- The approach to succession planning and building a resilient team was welcomed;

- R&ISC members questioned whether the TriTech Institute had considered employing a business development lead. Members were advised that there is provision for business development capacity in the second year of the business plan, subject to performance targets being met. The approach to business development would seek to leverage the TriTech Institutes delivery track record and the competence of the team.
- The balance between ambition and deliverability was recognised. Members of the R&ISC appreciated there were limits to how much financial risk the TriTech Institute could take on and that the current plan seemed well measured.

Argymhelliad / Recommendation

- The Digital Data and Innovation Committee to receive **ASSURANCE** from the TriTech Institute's Business Plan for the period 2026–2031 and **APPROVE** for onward submission to Public Board on 26 March 2026.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.4 Seek assurance on the development of the Health Board's strategies and plans for maintaining the trust of patients and public through its arrangements for research and innovation, and handling and using information, including personal information, safely and securely, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales. 3.1.5 Review and scrutinise business cases, and associated revenue implications, 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:	N/A
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)	3. Data to knowledge 4. Learning, improvement and research 1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	2. Healthier communities 3. Great care 4. Positive futures

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	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives 2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS 8. Transform our communities through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Peer review of the TriTech Institute (February 2025) Financial analysis of the TriTech Institute (September 2025) All other evidence detailed within the business plan.
Rhestr Termiau: Glossary of Terms:	N/A
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	TriTech and Innovation Group Formal Executive Team Research and Innovation Sub Committee.

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	An assessment of financial performance over the past four and a half years has been completed by the Finance Directorate, along with financial projections for the next five years. These have been incorporated into the plan.
Ansawdd / Gofal Claf: Quality / Patient Care:	The business plan highlights the overall Quality Management System approach for the TriTech Institute. Project plans, including quality considerations, are put in place on a project-by-project basis.
Gweithlu: Workforce:	Future staffing impacts are considered as part of the business plan. If the business plan is approved, appointments will be made in line with Hywel Dda UHB policies and procedures.

Risg: Risk:	The main risks associated with the business plan are the inability to generate sufficient income to cover the operating costs. As the TriTech Institute is an existing entity, this risk is monitored and mitigated through the TriTech Institute's risk register, with the support of the Finance Directorate and regular reports into the TriTech and Innovation Group and Research and Innovation Sub Committee.
Cyfreithiol: Legal:	The NHS (Wales) Act 2006, as amended by the 2014 Act, references the following: Part 11, Chapter 4: Power to raise money • Applies to a Local Health Board, NHS Trust or Special Health Authority. • Has power to engage in activities intended to stimulate the giving (whether on trust or otherwise) of money or other property to: • assist the body in providing or improving any services or any facilities or accommodation which is or are, or will be, provided as part of the health service, or • assist it in connection with its functions with respect to research. • Subject to any directions of WMs excluding specified descriptions of activity, the activities authorised include: • public appeals or collections • competitions • entertainments • bazaars • sales of produce or other goods, and • other similar activities. • The activities may involve the use of land, premises or other property held by or for the benefit of the body exercising the power. All contracts are reviewed by Legal and Risk on a case-by-case basis.
Enw Da: Reputational:	The TriTech Institute is supporting innovation within Hywel Dda UHB and as such offers the opportunity to reflect positively on the organisation. The negative reputational impact would occur in the event of poor management of projects or failure to deliver key performance indicators. A robust approach to governance has therefore been described within the business plan.

Gyfrinachedd: Privacy:	Not applicable.
Cydraddoldeb: Equality:	Yes, EqlA screening undertaken. Full EqlA not undertaken as not required



TRITECH

Sefydliad | Institute

Hywel Dda University Health Board

TriTech Institute Business Plan 2026 - 31

Version XX / XX / XXXX

Commercial in Confidence



Document purpose:

Planning, resources, and governance

Publication date:

XX / XX / XXXX

Target audience:

Hywel Dda University Health Board (Hywel Dda UHB) internal stakeholders

Commercially sensitive information, a summarised version will be shared with external stakeholders when appropriate.

Commissioning Director:

Mr Mark Henwood, Executive Medical Director

Description:

To set out the scope, objectives and mission statement, the financial breakdown, quality and safety standards, key performance indicators, and governance of the TriTech Institute up to 2031

Contact:

Prof. Chris Hopkins & Dr Leighton Philips
Tritech and Innovation
Medical Directorate
Hywel Dda UHB



Who We Are

In 2021 the TriTech Institute was launched. We are a team based in a bespoke facility within the Hywel Dda University Health Board comprising of industry-leading engineers, scientists, and clinicians.

Our Institute

Here at the TriTech Institute, we support the development of healthcare solutions on a local, national, and global level offering designers and manufacturers a single point of access to the NHS through a collaborative and agile approach.

What We Offer

The team's advanced skills in clinical and research design are combined with technical engineering expertise to manage the whole innovative pathway from early unmet need, through to concept design, prototyping, clinical testing, and evaluative research.

Our Services

We provide specific services and solutions for clinical engineering, research and innovation, and value-based healthcare, and can also support with grant writing and submission.

Executive Summary

1.0 Current Organisation Details

- 1.1 National Context
- 1.2 Hywel Dda University Health Board (HDUHB) Context
- 1.3 Mission, Vision & Values
- 1.4 Governance & Structure
- 1.5 Products & Services
- 1.6 Customers
- 1.7 Financial

2.0 Market Analysis & The TriTech Institute’s Positioning

- 2.1 Industry/Sector Overview
- 2.2 Market Sector in Wales
- 2.3 The TriTech Institute Positioning
- 2.4 Alignment with Strategic Policy Priorities
- 2.5 Sustainability and the Green Agenda

3.0 Strategy & Implementation

- 3.2.1 Products and Services (Product)
- 3.2.2 Marketing, Advertising, and Communications (Promotion)
- 3.2.3 Location (Place)
- 3.2.4 The TriTech Position in the Market (Position)
- 3.2.5 The Team (People)
- 3.2.6 Customer/Project Journey (Process)

4.0 Organisation, Management Team & Governance

- 4.1 Organisation Design
- 4.2 Governance
- 4.3 Organisation Chart
- 4.4 Organisation Culture
- 4.5 Continuous improvement
- 4.6 Quality and Safety Standards
- 4.7 ISO 13485
- 4.8 Risk Register

5.0 Financial Plan & Projections

- 5.1 Summary Financial Position
- 5.2 Financial Control
- 5.3 Internal Commissioning
- 5.4 Current and Future Resource Planning and Investment
- 5.5 New Key Performance Indicators

6.0 Conclusion

Executive Summary: The TriTech Institute Strategic Plan 2026–2031

Purpose and Scope

The *TriTech Institute Business Plan 2026–2031* outlines the strategic, operational, and financial framework through which Hywel Dda University Health Board (HDUHB) will advance innovation-led transformation. The plan establishes how the TriTech Institute will translate innovation into measurable impact, generating real-world evidence (RWE), to support teams in embedding prevention and digital innovation across HDUHB and NHS Wales. It defines the mission, governance, market position, and resourcing model required to sustain the Institute’s contribution to population health, system efficiency, and economic growth across Wales.

Strategic Context

Operating within the framework of the *Well-being of Future Generations (Wales) Act 2015*, *Wales Innovates (2023)*, and the *Health and Care Research Wales (HCRW) Plan (2022)*, the TriTech Institute is aligned with both national and UK priorities, including *A Healthier Wales* and *NHS England’s Fit for the Future 10-Year Plan*. These strategies collectively promote prevention, digital transformation, and community-based models of care. The TriTech Institute serves as an NHS-embedded translational research and innovation partner, leveraging HDUHB’s population profile as a testbed for new pathways and evidence-led adoption.

Organisational Position

Five years since inception, the TriTech Institute has evolved from a MedTech evaluation hub into a multidisciplinary centre of excellence for innovation to impact – accelerating evidence and value creation within the NHS to enhance insights, and outcomes for patients, healthcare providers, and industry partners. Its portfolio spans collaborations with global biopharmaceutical companies, national charities, Med-Tech, and European consortia. The planned relocation to

the Pentre Awel development will create a world-class base integrating research, innovation, and enterprise to drive cross-sector collaboration.

Market and Policy Alignment

Market analysis identifies sustained growth in MedTech, AI-enabled diagnostics, and digital health, with the UK smart medical devices market forecast to reach GBP 7.8 billion by 2030. The Institute’s positioning responds to key trends, including:

- Rising demand for evaluative research of innovations.
- Regulatory evolution under the soon to be launched MHRA Med Tech Regulations.
- National momentum in AI integration and automation.
- Increased focus and investment in prevention and sustainability.

The TriTech Institute’s NHS affiliation and evidence expertise uniquely positions it to act as a system enabler bridging innovation, evaluative research, and adoption.

Situational and Market Analyses

The PESTEL, Porter’s Five Forces, and TOWS analyses completed in preparing this business plan highlight four dominant imperatives:

- Escalating the need for robust **RWE and Value-Based Healthcare (VBHC)** evidence.
- Securing regulatory and assurance frameworks for safe **digital/AI deployment**.
- Overcoming structural and procurement barriers to **scaling innovation**.
- Capturing system-level gains from **preventative, pathway-oriented innovation**.

The TriTech Institute differentiates itself through its **NHS-embedded status, multidisciplinary expertise**, and **agile governance**, allowing rapid translation of evidence into operational change.

Governance and Delivery

The TriTech Institute operates within HDUHB’s Research and Innovation governance framework, reporting through the **TriTech and Innovation Group (TIG)** to the **Research and Innovation Sub-Committee (R&ISC)** and ultimately to the Board via the **Digital, Data and Innovation Committee**. This ensures transparency, quality, and alignment with HDUHB’s strategic objectives. The operational excellence of the TriTech Institute is underpinned by ISO 13485 compliance, enhanced data governance, and robust risk management.

People and Resources

To sustain growth and delivery, the business plan seeks a modest investment in the TriTech Institute’s staffing establishment. This business plan proposes a phased approach to recruitment for key roles in areas including health economics, quality management systems, computation, and grant applications. These roles have been identified through a candid assessment with the current team, a thorough peer review and by considering future market opportunities. They will enhance capability in evaluative research, quality assurance, and partnership development.

Partnerships and Ecosystem

The TriTech Institute is positioned within Wales’ collaborative life sciences ecosystem, engaging with **Life Sciences Hub Wales, Health Technology Wales, Bevan Commission, Assistive Technologies Innovation Centre (ATiC)**, and **Swansea University’s Health Technology Centre (HTC)**. These partnerships enable co-creation, evaluative research, and scaling of innovation aligned to national priorities and the Wales Innovates strategy.

Performance, KPIs, and Impact

The new Key Performance Indicators (KPIs) for the TriTech Institute are designed to provide a comprehensive and outcome-oriented framework for measuring success across four interrelated strategic principles. Collectively, these principles align the Institute’s operational performance with its mission to deliver high-quality research and innovation that directly

supports the priorities of **Hywel Dda University Health Board (H DUHB)** and the wider NHS Wales innovation ecosystem. In summary the KPIs are:

Excellence in Quality, Timeliness, and Stakeholder Engagement	KPI 1 – Timely Project Delivery: Achieve ≥95% on-time project completion, supported by milestone tracking and proactive risk management.
	KPI 2 – Quality and Stakeholder Engagement: Implement a formal post-project feedback process achieving ≥80% stakeholder response rates, ensuring systematic learning and quality assurance.
Effective Use of Resources	KPI 3 – Yearly Net Zero (or Better) Financial Position: Maintain at least a break-even position annually, through rigorous budget monitoring, financial dashboards, and monthly variance reviews.
Alignment with HDUHB Strategic Imperatives	KPI 4 – On agreement of the priorities, the TriTech Institute cost recovery target is reduced by the combined value of the projects internally commissioned by 20% of the establishment costs.
Strategic Engagement, Communication, and Dissemination	KPI 5 – Effective Communication and Dissemination: Deliver a minimum of six internal communications or engagement events and four external dissemination outputs annually; embed patient and public involvement (PPI) across all projects; and achieve >90% collaborator satisfaction and recommendation rates.

By embedding these KPIs within its governance and reporting structure, the TriTech Institute will strengthen its role as a **trusted, evidence-driven innovation partner**, ensuring measurable benefits for patients, the healthcare system, and industry collaborators alike.

Financial Plan

Operating under a **cost-recovery model**, the Institute has maintained fiscal sustainability and exceeded income generation targets annually since 2021. The financial strategy focuses on a balanced diversification across the portfolio and seeks to continue to build upon

strengths (e.g. evaluative research) and identify new opportunities, including digital innovation and developing an internal commissioning approach. This strategy will ensure continued alignment with HDUHB’s *Research and Innovation Strategic Plan 2025–2030*, while safeguarding quality and growth within agreed financial envelopes.

Conclusions and Recommendations

The *TriTech Institute Business Plan 2026–2031* represents a maturing, evidence-driven strategy to consolidate the Institute’s role as a leading NHS innovation and evaluation centre.

1.0 Current Organisation Details

1.1 National Context

The TriTech Institute operates in the ever-evolving field of health and care research and innovation. It is therefore important to set out the policy and strategic context, to which the TriTech Institute contributes and benefits from. A brief overview of key legislation, strategies and policies follow.

The Well-being of Future Generations Act

The Well-being of Future Generations (Wales) Act 2015 remains central to public sector priorities, embedding the need to improve social, cultural, environmental, and economic well-being. It compels public bodies to act with a focus on long-term impacts, preventative action, integrated working, and community collaboration.

Recent guidance, including the Continuous Learning and Improvement Plan (2023–2025), reaffirms the Act as the central organising principle for decision-making in Walesⁱ. For the TriTech Institute, the Act reinforces a duty to drive innovation that supports more sustainable, resilient, and equitable healthcare solutions.

Wales Innovates: Creating a Stronger, Fairer, Greener Wales

At the time of writing the previous business plan (2021-2025), the Welsh Government had

i. Source: gov.wales

Through its mission to convert Innovation to Impact, the TriTech Institute will continue to drive real-world evidence generation, accelerate technology adoption, and deliver system-wide value for the benefit of the health and wellbeing of the population of South West Wales.

Innovation to Impact – Accelerating evidence and value creation within the NHS to enhance insights, impact, and outcomes for patients, healthcare providers, and industry partners.

committed to developing a new integrated Innovation Strategy for Wales, and in 2023, it launched *Wales Innovates*, the new national Innovation Strategy. The Strategy sets missions across four areas—education, economy, health and well-being, and climate and nature—with a strong emphasis on public value and inclusive innovationⁱ.

The strategy guides the next phase of innovation policy, reinforcing collaboration across sectors and highlighting the role of institutions like the TriTech Institute in addressing national priorities through translational research, evaluative research, and strategic advice for healthcare innovations.

Health and Care Research Wales (HCRW) Plan (2022)

The launch of the *Health and Care Research Wales (HCRW) Plan (2022)* sets out how Welsh Government will promote, support, and oversee health and social care research. The plan focuses on four central aims, associated activities, and defines the financial and operational environment for research functions across NHS organisations.

Building on this, a new *NHS Research and Development Framework (2023)*, established clear expectations and standards for research within NHS Wales. This framework underlines the need for quality, transparency, and the integration of research activity into routine healthcare delivery.

In parallel, the Welsh Government has refreshed its overarching health strategy, A Healthier Wales, introducing stronger research and development planning objectives. It has also published targeted initiatives focusing on commercial research growth and enhanced cancer research programmes, signalling a push towards greater economic value from research activities and improved patient outcomes in priority disease areasⁱⁱ.

Review (2023) into Commercial Clinical Trials in the UK

The Lord O’Shaughnessy Review (2023) into Commercial Clinical Trials and the launch of the VPAG Investment Programme (2024) have unlocked new funding and reforms to increase commercial trials activity. In parallel, innovation policy in England has advanced, with Roland Sinker CBE setting out the Innovation Ecosystem Programme (IEP), building on the *Life Sciences Vision, Accelerated Access Review, and Lord Darzi’s work*. These initiatives provide a stronger platform for the TriTech Institute to contribute to national priorities in health innovation and evaluative researchⁱⁱ.

Fit for the Future: 10-Year Health Plan for England

The newly published 10-Year Health Plan for England represents a transformative vision for the NHS, placing research and innovation at the heart of its future. Central to the plan are three radical shifts: moving care from hospitals to communities, transitioning from analogue to digital systems, and pivoting from reactive treatment to proactive prevention. These shifts are underpinned by a bold innovation strategy that aims to make the NHS the most AI-enabled health system in the world.

The plan envisions a future where genomics, robotics, wearables, and predictive analytics are embedded into everyday care, enabling earlier diagnosis, personalised treatment, and more efficient service delivery.

For research and innovation, this means a significant expansion of infrastructure and capability. The National Institute for Health and Care Research (NIHR) is set to play a pivotal

role by accelerating clinical trials, embedding research into routine care, and supporting AI-driven health screening. The Health Research Authority (HRA) is also streamlining regulatory processes to reduce clinical trial setup times to 150 days, while championing public involvement in research. The plan also commits to integrating research opportunities into the NHS App, allowing patients to be proactively matched with relevant trials. This ecosystem approach—linking NHS services, academia, industry, and patients—aims to position the UK as a global leader in health innovation, with the NHS not just benefiting from innovation, but actively driving it.

While the TriTech Institute operates in Wales, the influence of the UK Government on research and innovation funding streams and organisations means that this wider context is inevitably relevant to this business plan.

Health Innovation System in Wales

The **Life Sciences Hub Wales** has driven industry partnerships and launched targeted programmes, including a new **Cancer Mission**. The **Bevan Commission’s Foundations for the Future Model of Health** and Care and the **Together for Change** work in West Wales have expanded the concept of innovation to include both technical and social approaches. Organisations such as **MediWales** and **ABPI Cymru** continue to play vital roles in connecting the latest health innovations with the NHS, further enhancing the national innovation ecosystem.



The TriTech Institute’s Role in the National Landscape

Reflecting its values - Professional, Cutting-edge, Innovative, Personable, and Agile - the TriTech Institute continues to advance healthcare innovation within this national context. As outlined on its websiteⁱⁱⁱ, the TriTech Institute drives innovation to impact – accelerating evidence and value creation within the NHS to enhance insights, impact, and outcomes for patients, healthcare providers, and industry partners, aligning with NHS Wales’ drive for Value-Based healthcare. Working closely with life science industries, universities, and healthcare providers, the TriTech Institute enables sustainable innovation that improves outcomes for patients, communities, and the environment.

The TriTech Institute’s Contribution to National Well-being Goals

The TriTech Institute plays an important role in advancing the National Well-being Goals of Wales, as outlined in the Well-being of Future Generations (Wales) Act 2015. The TriTech Institute’s contributions to these goals is summarised as follows:

1. A Healthier Wales

The TriTech Institute supports this goal by:

- Conducting translational research and real-world evaluations of healthcare innovations to ensure they are effective and safe.
- Collaborating with NHS Wales and life sciences partners to improve patient outcomes through evidence-based healthcare solutions.

2. A More Equal Wales

The TriTech Institute fosters inclusive innovation by working with diverse stakeholders, including universities, healthcare professionals, and industry, to ensure that new technologies benefit all communities.

3. A Prosperous Wales

By accelerating the adoption of cutting-edge health technologies, the TriTech Institute contributes to economic growth and job creation in the Welsh life sciences sector.

iii. www.tritech.nhs.wales

Its support for startups and SMEs through innovation challenges and co-applying for grants to help stimulate local enterprise.

4. A Wales of Cohesive Communities

The TriTech Institute’s collaborative model strengthens ties between healthcare providers, academia, and industry, promoting community-based innovation and shared learning.

5. A Resilient Wales

Through its focus on sustainable healthcare innovation, the TriTech Institute helps build a system that can adapt to future challenges, including public health crises and environmental pressures, as evidenced through recent EU collaborative projects.

6. A Globally Responsible Wales

The TriTech Institute aligns with global health and sustainability goals by promoting innovations that are not only effective locally but also scalable and impactful globally.

7. A Wales of Vibrant Culture and Thriving Welsh Language

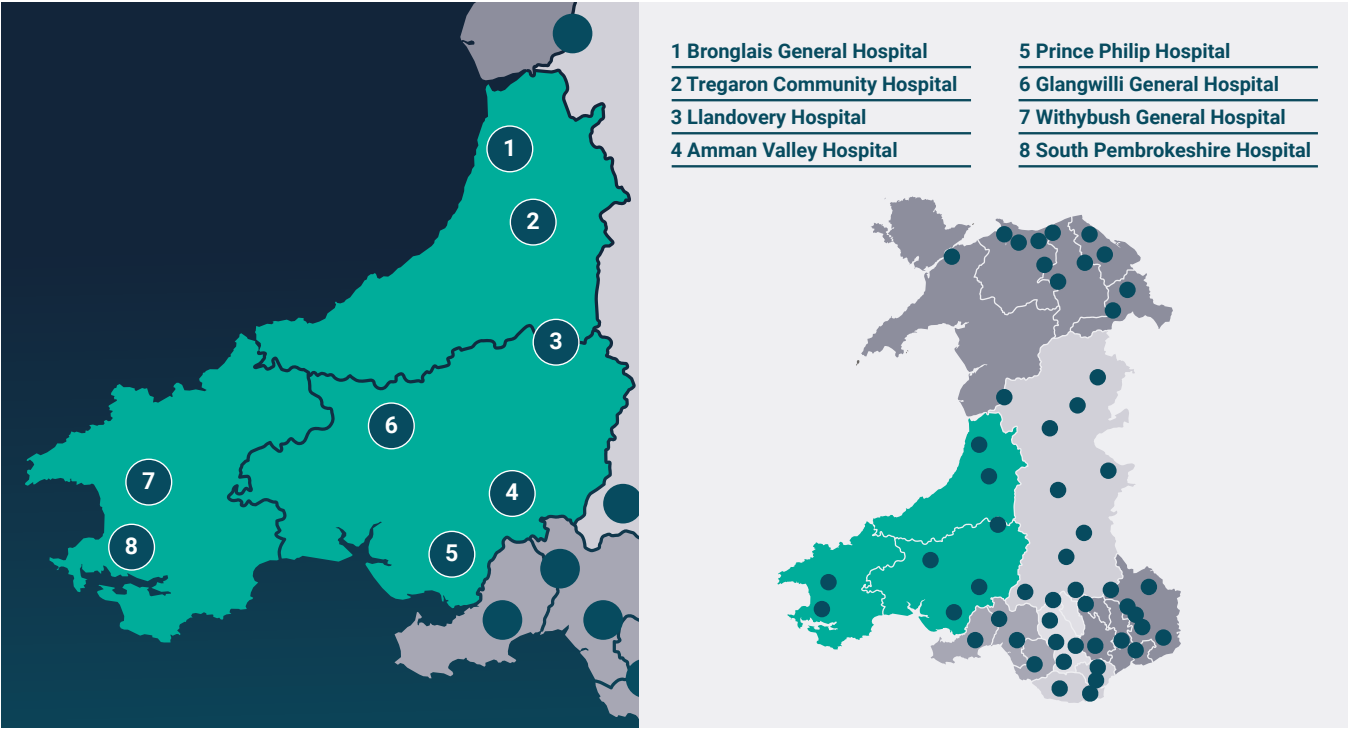
While this is not a primary focus, the TriTech Institute supports bilingual communication and engagement, contributing to the cultural fabric of Wales.

Through its services and partnerships, the TriTech Institute is positioned to continue as a contributor to the vision of a *stronger, fairer, and greener Wales*, fully supporting the ambitions of both the *Well-being of Future Generations Act* and *Wales Innovates*.

1.2 Hywel Dda University Health Board (H DUHB) Context

Hywel Dda University Health Board (H DUHB) provides healthcare services to a population of approximately 389,000 people across Carmarthenshire, Ceredigion, Pembrokeshire, and borders of Powys. It delivers Acute, Primary, Community, Mental Health, and Learning Disability services within General and Community Hospitals, Health Centres, GPs, Dentists, Pharmacists, Optometrists, and other sites^{iv}.

ii. Source: Research and Innovation Strategic Plan 2025-2030.



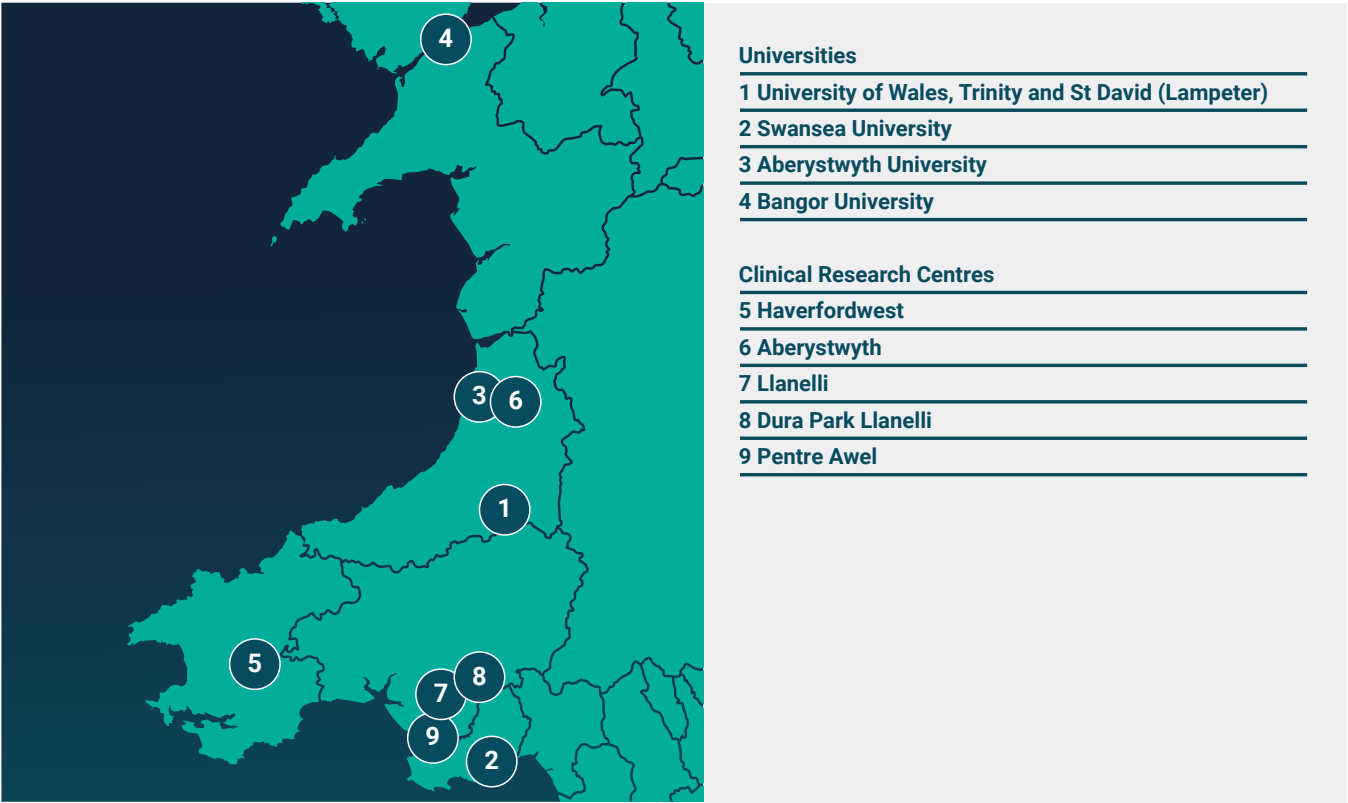
HDUHB’s long-term strategy, A Healthier Mid and West Wales: Our future generations living well^{iv}, remains central to its transformation ambitions. The strategy (likely to undergo a refresh, but not major alterations) sets out a vision for delivering excellent, accessible clinical services, while reaffirming the health board’s commitment to promoting well-being, prevention, and early intervention. Any updates would also afford the Health Board the opportunity to: refresh its strategic objectives; focus on digital, population health, the social model for health & wellbeing and providing more care in the community; re-consider the infrastructure options, and sequencing, in support of this vision; assess the role of each of the acute sites and the configuration of services to provide resilient and high-quality services from within the existing hospital network; consider opportunities for regional working, and strengthen the relationship with the wider community to co-produce and co-deliver a future model of health care^v.

HDUHB recently launched a comprehensive public consultation on its Clinical Services Plan, aiming to reshape how nine key healthcare services are delivered across Carmarthenshire, Ceredigion, and Pembrokeshire. The consultation, which

ran from 29 May to 31 August 2025, invited feedback from staff, patients, and the wider community on proposed changes to services including critical care, dermatology, emergency general surgery, endoscopy, ophthalmology, orthopaedics, radiology, stroke, and urology. The consultation also explored the future roles of acute hospitals such as Glangwili, Prince Philip, Bronglais, and Witherbush, recognising the interdependencies between services and the need for integrated planning.

Research and innovation, including that supported by the TriTech Institute, are critical to the success of HDUHB’s Clinical Services Plan, particularly as the organisation seeks to address longstanding challenges such as service fragility, workforce pressures, and post-pandemic recovery. Embedding research into clinical practice can help generate evidence for new models of care, evaluate service redesigns, and ensure that changes are both effective and sustainable. Innovation, meanwhile, offers opportunities to harness digital tools, remote monitoring, and AI-driven diagnostics to improve access, reduce waiting times, and personalise treatment pathways.

iv. Source: hduhb.nhs.wales
v. The full plan can be found at: <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/>
vi. Source: Research and Innovation Strategic Plan 2025-2030



Research and innovation have become firmly embedded within HDUHB’s operations. The Research and Innovation Department supports staff and local residents to participate in a wide range of health and social care research studies, spanning areas such as cancer, respiratory disease, cardiovascular disease, musculoskeletal health, gastrointestinal disorders, and ophthalmology. The infrastructure supporting this includes three dedicated Clinical Research Centres, and the TriTech Institute, soon to be based at Pentre Awel.

Pentre Awel is a landmark development in Llanelli, bringing together business, health, innovation, and learning on a single, world-class site. As the first project of its kind in Wales, it offers state-of-the-art facilities for life sciences, med-tech, research, and community health, creating a dynamic environment for collaboration and growth. It represents a bold investment in the region’s future—bridging economic development with health and well-being. For further information about the TriTech Institute and Pentre Awel, please go to section 4.2.4 Location.

HDUHB maintains strong collaborations with higher education institutions, including University of Wales Trinity Saint David, Swansea

vii. Sources: hduhb.nhs.wales, tritech.nhs.wales

University, and Aberystwyth University, and has established formal partnerships with Cardiff and Bangor Universities to further strengthen its research and innovation ecosystem.

HDUHB Research and Innovation Strategy

The newly created Research and Innovation Strategic Plan 2025-2030 (**Appendix 1**) has recently been published and sets out a fresh commitment to delivering high quality and impactful research and innovation in support of *A Healthier Mid and West Wales Strategy*.

Its vision is: *to deliver high quality and impactful research and innovation, improving services and health outcomes for our communities, patients and staff; by focusing on three key areas:*

- Access and Impact: Improve access to high quality research and innovation that improves services, health and wellbeing.
- Environment and Culture: Create an environment and culture that develops and enables competent and empowered researchers and innovators to flourish.
- Partnerships: Develop and sustain partnerships that maximise and accelerate research and innovation access and impact.

The TriTech Institute plays a fundamental role in delivering this strategy in terms of implementation decisions and monitoring, developing new capabilities, and evaluative research. Specific commitments within the new Strategic Plan pertaining to the TriTech Institute are:

- Increasing commercial research and innovation through the TriTech Institute at HDUHB and in collaboration with the Joint Clinical Research Facility at Swansea University and Swansea Bay UHB;
- Further developing the TriTech Institute in support of medical technology, clinical pathway and innovation strategies, plans and associated initiatives, including those being evaluated by Health Technology Wales and considered by the Life Science Hub Wales;
- Developing the TriTech Institute as a centre of excellence for evaluative research, including implementation science aligned with national and international strategic developments.

1.3 Mission, Vision & Values

Mission

The TriTech Institute’s mission is to translate innovation into impact – accelerating evidence and value creation within the NHS to enhance insights, impact, and outcomes for patients, healthcare providers, and industry partners. The TriTech Institute offers a single point of access to Health & Social Care in Wales with academic experts, a national clinical NHS testbed, and provides an agile and efficient approach.

Vision

To accelerate evidence and value creation within the NHS to enhance insights, impact and outcomes for patients, healthcare providers and industry partners.

Values

The TriTech Institute embodies the following attributes in everything it does:

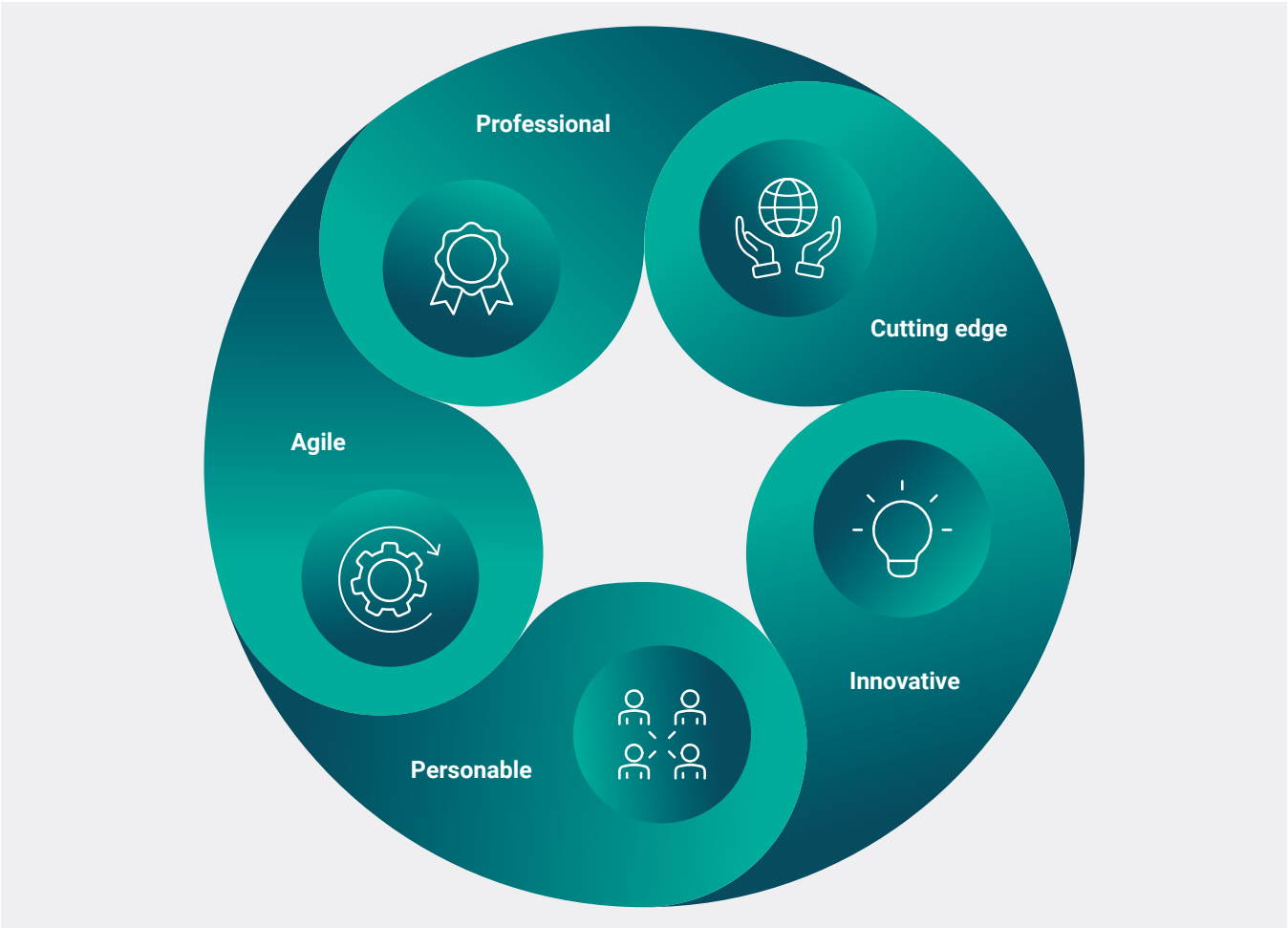
Professional: Value-Based Health Care and Health Economic evidence-based approaches, providing a single point of access to the NHS in Wales. The TriTech Institute holds itself to account for delivering services that meet and exceed the expectations of its customers and stakeholders.

Cutting edge: The TriTech Institute’s work is grounded in translational research and real-world evidence, driving forward promptly with decisiveness to achieve high customer satisfaction. Its services are designed to be both swift and effective, ensuring it stays at the forefront of healthcare innovation.

Innovative: The TriTech Institute’s team is composed of highly skilled clinical scientists, researchers, engineers, data scientists, nurses, pharmacists, and doctors. It is committed to being innovative, forward-thinking, and progressive, ensuring that solutions are market ready.

Personable: Partnerships are central to the mission of the TriTech Institute. Its team is ethical and personable, dedicated to building long-lasting relationships. It believes in the power of collaboration and strive to create meaningful connections in all our endeavours.

Agile: The TriTech Institute embodies agility, demonstrating high responsiveness and the ability to adapt approaches for industry partners while upholding strong governance frameworks.



Unique Selling Point: Innovation to Impact

The TriTech Institute’s USP **is translating Innovation into Impact. It does this through its vision of accelerating evidence and value creation within the NHS to enhance insights, impact, and outcomes for patients, healthcare providers, and industry partners.**

Having a clear USP is essential to differentiate the TriTech Institute within the evolving health innovation landscape, offering a strong identity that resonates with stakeholders across the NHS, academia, and industry. The TriTech Institute will actively use this USP to frame its service offer, drive strategic partnerships, guide communications, and focus operational delivery, ensuring that every project fulfils the promise in its USP.

“Working with TriTech has been an outstanding experience. Their professional and methodological evidence-based approach, combined with a deep strategic awareness of NHS Wales, ensures that projects are delivered efficiently

and effectively. Their practical ability to navigate the complexities of the NHS system, while fostering strong collaborations with commercial partners, sets them apart. Their expertise has been invaluable in driving successful outcomes across the healthcare landscape.”

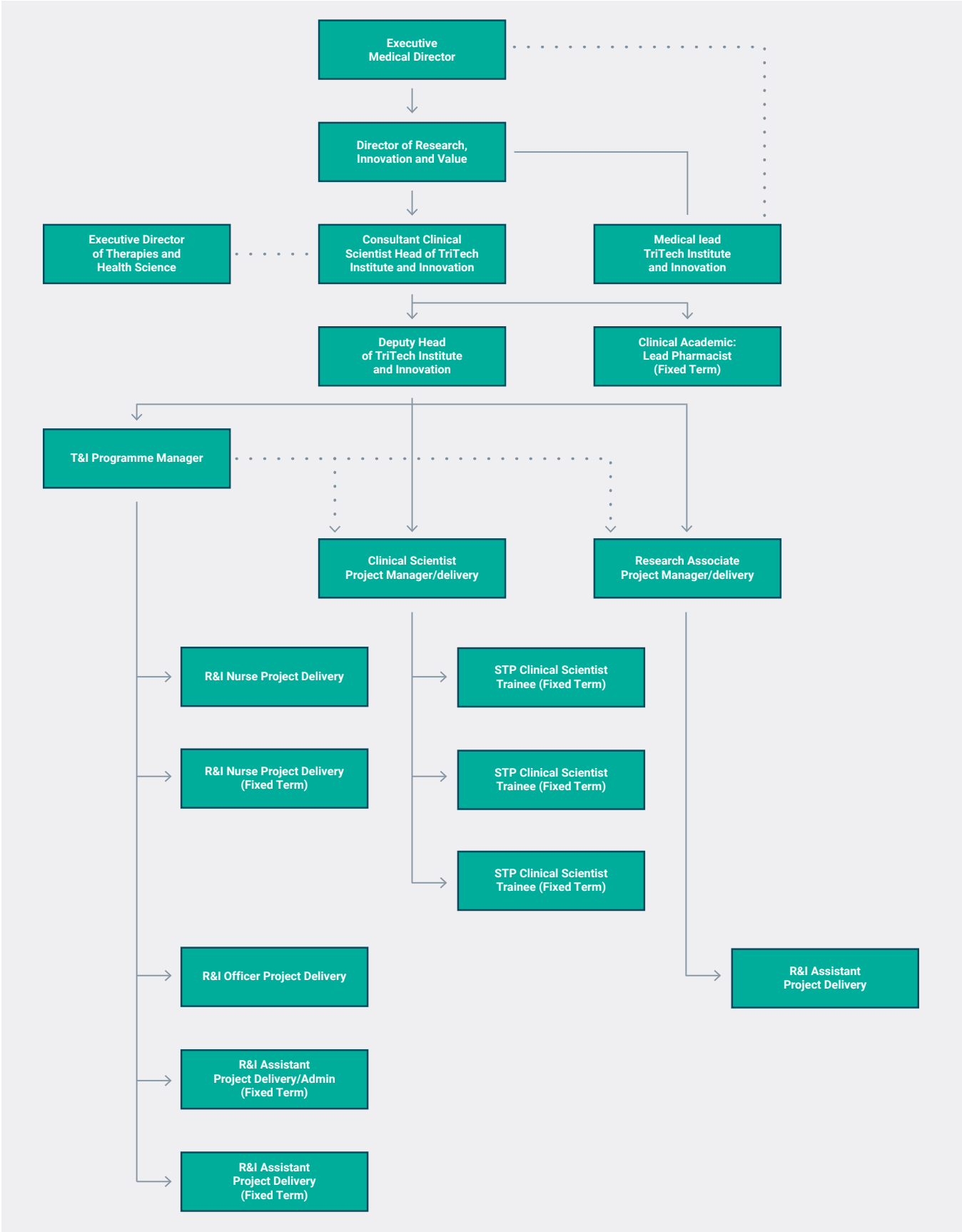
Suzanne Rankin, Chief Executive Officer, Cardiff and Vale University Health Board

1.4 Governance & Structure

The activities of the TriTech Institute are governed by the TriTech and Innovation Group, which is a subgroup of the Research and Innovation Sub Committee. The Research and Innovation Sub-Committee reports to the Digital, Data and Innovation Committee, ensuring strong oversight, transparency, and alignment with Board priorities. The TriTech Institute submits quarterly financial, governance, performance, and risk updates to the Research and Innovation Sub-Committee, helping to drive continuous improvement and informed decision-making.



Further details about the TriTech Institute’s governance arrangements and responsibilities are set out in its Terms of Reference (pages 63-65 of this business plan). The reporting and accountability structure is illustrated in Section 5.3. In addition to its core governance arrangements, The TriTech Institute also reports through the Medical Devices Group (MDG), a specialist group operating under the Quality & Safety Intelligence Group, further strengthening clinical and operational governance.



1.5 Products & Services

The TriTech Institute collaborates with the life science sector, other health bodies, and various Higher Education Institutions (HEIs) across Wales and the UK. Its team of clinical scientists, researchers, engineers, data scientists, nurses, pharmacists and doctors conduct translational research and evaluative research on a wide range of healthcare innovations.

This enables the TriTech Institute to provide dedicated support for industry, academia, and NHS stakeholders to navigate their way through the healthcare innovation landscape, while delivering improved impact and outcomes for those served by HDUHB.

To further embed innovation within the organisation, the TriTech Institute also supports HDUHB’s strategic priorities and planning objectives through an internal commissioning approach. By working closely with clinical, operational, and corporate teams, the TriTech Institute identifies and co-develops real-world evidence to support innovation opportunities that address local system challenges, improve patient outcomes, and enhance service sustainability. This proactive approach ensures that innovation is not only externally sourced but also internally cultivated, enabling the health board to deliver on its ambition for a learning, adaptive, and value-driven healthcare system. This is an area the TriTech Institute is keen to upon, to ensure it maximises the benefits delivered to the population it serves. The specific services offered are now described.

1.5.1 Translational Research

The TriTech Institute supports the translation of health technologies and innovations into practical clinical solutions. The TriTech Institute offers coordinated access to clinical and research infrastructure across NHS Wales, acting as a single point of contact for life science companies and other people and organisations interested in translational research. Specific services include:

- Innovation pathway management, including needs assessment, concept design, prototyping, and clinical validation

- Product translation support, facilitating the integration of new technologies into live healthcare environments
- Specialist advice in regulatory compliance and health economic analysis
- Working closely with the Research and Innovation team and Health and Care Research Wales, to coordinate multi-site evaluative research activity under a unified framework (One Site for Wales approach)

This work aligns closely with national priorities on innovation adoption, health system integration, and Value-Based healthcare.

1.5.2 Evaluative Research

The TriTech Institute’s evaluative research team provides robust evidence of clinical effectiveness, economic value, and patient experience associated with innovative healthcare solutions. The team employs internationally recognised patient-reported outcome and experience measures (PROMs and PREMs), combined with advanced health economics modelling. Specific services include:

- Evaluative research of innovative technologies aligned with Value-Based Health Care (VBHC) principles.
- Outcome and costing analysis to inform procurement, adoption, and spread decisions
- Bespoke evaluative research design tailored to the needs of NHS partners and industry collaborators.

This service plays a vital role in ensuring that innovation investments are evidence-based and directly linked to patient and system benefit.

1.5.3 Advisory Services

The TriTech Institute also offers strategic advice and consultancy to support organisations navigating the regulatory, research, and innovation landscape. Drawing on the team’s diverse expertise in clinical research, regulatory science, and innovation policy, the TriTech Institute provides:

- Support with research study design, regulatory frameworks, and clinical trial setup

- Advice and input on funding applications, including grant writing and project planning
- Evaluative research strategy design, research delivery models, and pathways to innovation adoption
- Strategic insights for commercial developers to align innovation with NHS priorities

The TriTech Institute’s trusted position within the NHS and strong academic partnerships underpin its role as a leading centre of excellence in health innovation and applied research across Wales.

1.6 Customers

The TriTech Institute has local, regional, national, and international customers and partners, with a growing portfolio of high-profile clients across the life sciences and health technology sectors. While the team continues to support SMEs and regional innovators, its customers have included global biopharmaceutical companies.

The TriTech Institute’s expertise in evaluative research has positioned it as a trusted delivery partner on major UK and European research programmes, as well as a collaborator on NHS transformation initiatives. The breadth of current projects – from AI-enabled diagnostics and advanced therapeutics to pathway redesign – reflects the TriTech Institute’s expanding influence and ability to generate robust evidence for innovation adoption at scale.

The examples in the diagram below are presented to demonstrate the scope and nature of work undertaken within TriTech.

Much of the TriTech Institute’s activity has been generated through inbound enquiries and the strength of its existing relationships, supported by strong associations with the NHS and the reputational credibility this affords. The NHS affiliation continues to play a central role in fostering trust, retention, and long-term collaboration.

While recognising the value of this organic growth model, this business plan outlines a proactive approach to broadening the customer base, geographic reach and strategic partnerships, whilst building a more diverse project portfolio. It sets out clear objectives to support targeted growth, strategic outreach, and

service development aligned with both HDUHB & NHS Wales priorities and industry needs.

The TriTech Institute’s embedded position within a Welsh University Health Board offers unique value to partners, providing direct access to clinicians, patients, and operational insight. This continues to strengthen its market position, offering a distinctive blend of credibility, accessibility, and real-world relevance for health and care innovation partners.

A full list of The TriTech Institute customers, with a brief project overview/case study can be found at **Appendix 2**.

“ We collaborated with TriTech and the HDUHB as a test site for our Test, Evidence, Transition Programme. The team were impressive in their approach to gathering evidence to enhance the impact of their novel prostate cancer diagnostic pathway, ultimately aiming to improve outcomes for patients.”

Naser Turabi, Director of Evidence and Implementation, Cancer Research UK

1.7 Financial

Financial Sustainability and Operating Model

An independent analysis undertaken by the Finance Directorate confirms that the TriTech Institute continues to operate under a cost-recovery financial model. This approach has enabled the TriTech Institute to maintain financial sustainability while delivering value across its research and innovation portfolio. Notably, the TriTech Institute has exceeded its business plan targets in each of the past four fiscal years (2021/22 through 2024/25). Projections for the current financial year (2025/26), which marks the fifth year of operation, indicate a balanced financial position is expected to be achieved.

It should be noted that where financial surpluses have been generated, it is because the same relates to contracted commercial projects, which spanned financial year, rather than income that could be deployed for other purposes.

Financial snapshot: The distribution of income lines by organisation / type is shown in the following table:

Overall	2021/22 (£k)	2022/23 (£k)	2023/24 (£k)	2024/25 (£k)
Total income	£514	£862	£1,726	£1,501
Cost of operating	£506	£546	£1,322	£1,284
Surplus	£7	£317	£405	£217

2.0 Market Analysis & The TriTech Institute’s Positioning

2.1 Industry/Sector Overview

Innovation in health and care continues to evolve rapidly, encompassing far more than just medical devices and healthcare technologies. The TriTech Institute operates at the intersection of health service innovation, digital transformation, and real-world evidence generation—supporting not only the development and evaluative research of new technologies but also the redesign of care pathways, systems, and services to improve patient outcomes and organisational efficiency.

While medical devices remain a significant area of focus, the TriTech Institute’s remit includes supporting innovations in diagnostics, digital health, value-based healthcare, AI and data-driven tools, and service improvement. This wider scope reflects a growing need for integrated, system-level solutions that respond to population health challenges and sustainability pressures within the NHS.

In line with the previous business planning period, the TriTech Institute continues to use the Medicines and Healthcare products Regulatory Agency (MHRA) definition of medical devices, which includes:

“Any instrument, apparatus, appliance, material or other article, whether used alone or in combination, including the software necessary for its proper application, intended by the manufacturer to be used for human beings for the purpose of:

- *Diagnosis, prevention, monitoring, treatment or alleviation of disease;*

- *Diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap;*
- *Investigation, replacement or modification of the anatomy or of a physiological process;*
- *Control of conception; and*
- *Which does not achieve its principal intended action in or on the human body by pharmacological, immunological or metabolic means, but which may be assisted in its function by such means.”*

This definition serves as a useful foundation, but the TriTech Institute’s work goes beyond products—it includes evaluating and supporting innovations in clinical pathways, digital platforms, and new models of care. These efforts aim to embed innovation into the heart of the health system, not only improving technologies but also rethinking how care is delivered across primary, secondary, and community settings.

The Medical Technology Market

Medical technologies remain a vital asset to the NHS, playing a central role in diagnosis, treatment, and patient outcomes. Continued innovation in this sector brings clear benefits: new clinical techniques, improved outcomes, shorter hospital stays, and more efficient service delivery. For health systems, these developments can also enable increased patient throughput and cost savings.

To realise these benefits fully, a strategic and evidence-based approach to technology acquisition is essential. This includes aligning procurement with user needs and ensuring consistent evaluative research. However, formal business planning processes for medical technologies are not consistently in place across Welsh health boards. While NHS organisations are required to produce Integrated Medium-Term Plans (IMTPs) under the NHS Wales Planning Framework 2024–2027, the degree to which these plans incorporate structured medical technology acquisition varies—often due to differences in local capacity and access to robust evaluative research evidence^{viii}.

In response to these challenges, the Welsh Government has introduced the Health Services (Provider Selection Regime) (Wales) Regulations 2025 to modernise procurement and enable more flexible, innovation-friendly processes. However, its full impact on planning consistency across health boards is still emerging.

The TriTech Institute helps address these system gaps by conducting evaluative research that generate practical insights into technology implementation. These assessments explore user experience, service impact, and associated costs, supporting HDUHB and NHS Wales in making informed decisions about innovation adoption and contributing to broader system learning across Wales.

Digital Innovation, Pathway Redesign, and System-Level Change

While medical technologies remain a core focus, the TriTech Institute increasingly works with the digital directorate to support digital innovation and AI, going beyond physical devices. The rapid growth of AI-enabled tools, remote monitoring technologies, and digital platforms has opened new possibilities for proactive care, pathway optimisation, and improved system efficiency. The TriTech Institute plays a key role in assessing the value and impact of these digital innovations in real-world settings—ensuring they are evidence-based, scalable, and aligned with clinical needs.

In parallel, the TriTech Institute is working with

partners to support more generative innovation—helping to co-design and evaluate entirely new models of care. This includes supporting pathway redesign, value-based healthcare programmes, and cross-sector initiatives that address health inequalities and population-level outcomes. These broader contributions position the TriTech Institute as a system enabler, supporting HDUHB and the wider NHS in translating bold innovation into measurable impact.

Prevention and Upstream Innovation

The TriTech Institute is increasingly contributing to upstream innovation—working earlier in the care continuum to prevent illness, rather than responding only at the point of treatment. This reflects a national shift towards proactive care models and aligns with NHS Wales’ ambitions to reduce avoidable harm and improve long-term population health outcomes.

The TriTech Institute’s collaboration with global bio-pharmaceutical company Amgen on the Predict and Prevent cardiovascular disease project exemplifies this strategic pivot. By identifying high-risk patient cohorts earlier, developing tailored intervention pathways, and applying real-world evidence to improve lipid and blood pressure management, the project is enabling meaningful change before critical events like heart attacks or strokes occur.

This preventative focus allows the TriTech Institute to support innovations that enhance clinical outcomes while also relieving pressure on overstretched services. By combining data insights with service redesign, the TriTech Institute is helping health systems move beyond reactive care—demonstrating the value of investing in prevention to achieve both health and economic impact.

Market Insights

The UK medical technology sector continues to demonstrate robust growth. In 2023, the global medical devices market was valued at approximately \$518 billion, with projections indicating it could reach nearly \$886 billion by 2030.

This growth is driven by factors such as the increasing prevalence of chronic diseases and the rising demand for innovative medical solutions^{ix}.

In 2024, the UK’s smart medical devices market generated revenue of approximately USD 4.75 billion and is projected to reach USD 10.57 billion by 2030, growing at a compound annual growth rate (CAGR) of 14.4% from 2025 to 2030^x.

The UK remains a significant player in this global market, with its medical technology exports valued at around £10 billion in 2023. The sector comprises approximately 6,630 businesses, employing over 268,000 individuals, and is characterised by a high proportion of small and medium-sized enterprises (SMEs), which account for 85% of the companies^{xi}.

Key trends influencing the sector include the integration of artificial intelligence in diagnostics¹, the expansion of telemedicine services², and the development of wearable health technologies³. These advancements are reshaping patient care and creating new opportunities for innovation and collaboration within the healthcare industry.

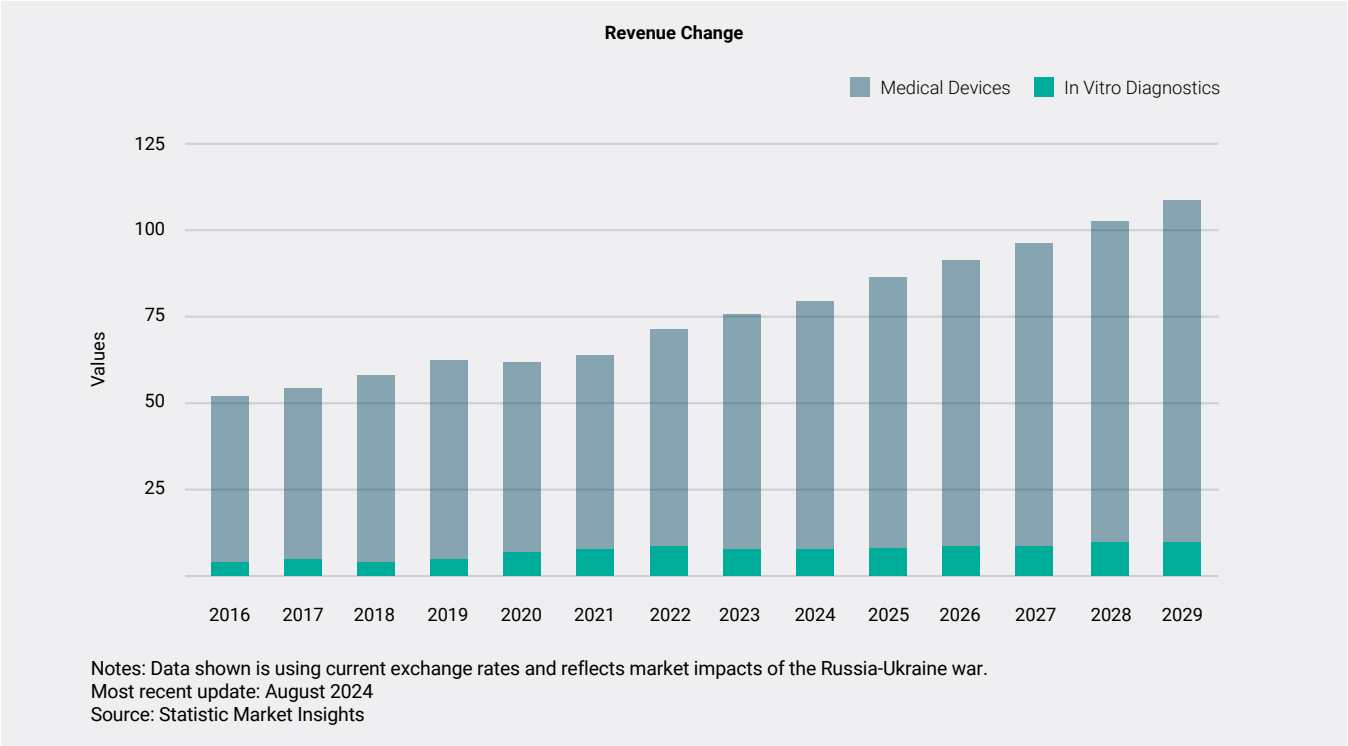
1. IMARC Group (2024). UK Medical Devices Market Report^{xii}.

- 2. Grand View Research (2024). UK Smart Medical Devices Market Outlook^{xiii}.
- 3. BioSpace (2024). UK Digital Health Market Forecast^{xiv}.

Medical Technology - United Kingdom

Key themes include:

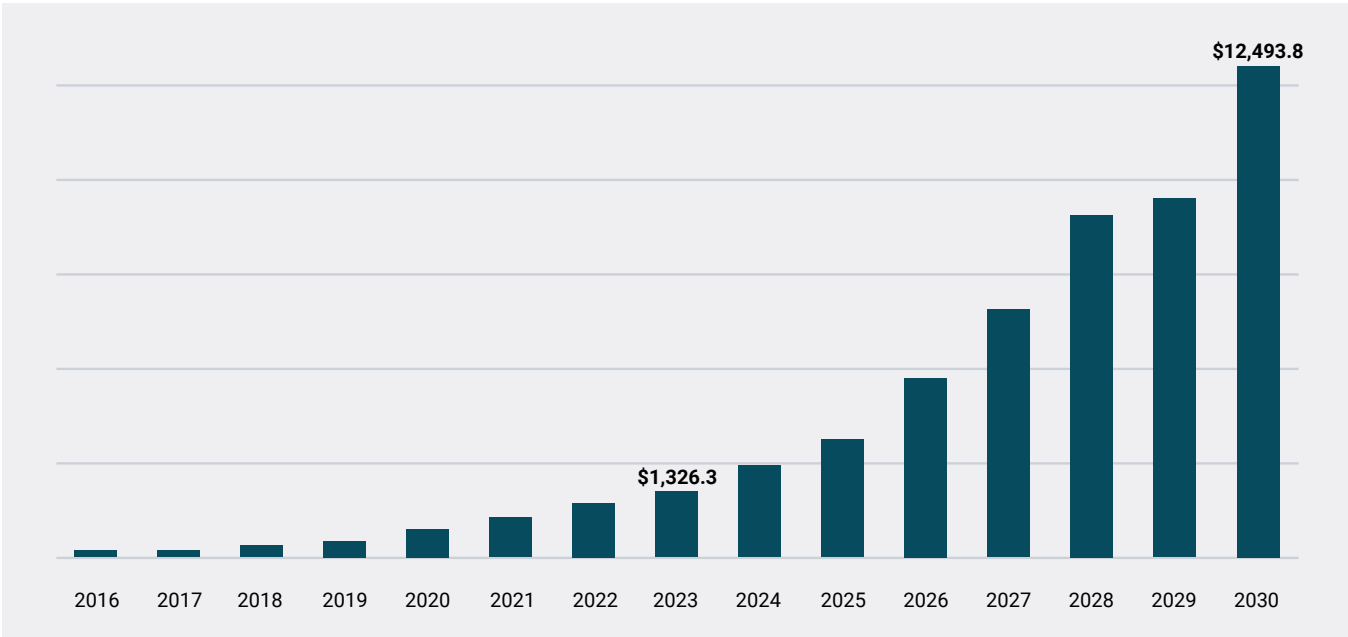
- The projected revenue in the Medical Technology market in the United Kingdom is expected to reach £16.97bn in 2025.
- Among the various markets within the market, Medical Devices is the largest, with a projected market volume of £15.51bn in 2025.
- Looking ahead, the revenue is anticipated to demonstrate an annual growth rate of 6.35% (CAGR 2025-2029), resulting in a market volume of £21.25bn by 2029.
- When compared globally, the United States is expected to generate the highest revenue, amounting to £171.84bn in 2025.
- The United Kingdom is at the forefront of medical technology innovation, with a strong focus on developing advanced healthcare solutions for patient care.



viii. Source: NHS Wales Planning Framework 2024–2027, www.gov.wales/sites/default/files/publications/2024-03/nhs-planning-framework-2024-to-2027.pdf
ix. Source: www.gov.wales/health-service-procurement-statutory-guidance

x. Source: www.proclinical.com/blogs/2024-10/top-10-medical-device-companies-in-the-world-in-2024
xi. Source: www.grandviewresearch.com/horizon/outlook/smart-medical-devices-market/uk
xii. Source: www.thetimes.com/business-money/companies/article/its-all-up-in-the-air-the-science-of-exporting-to-america-qw9ftxq9m
xiii. Source: <https://www.imarcgroup.com/>
xiv. Source: <https://www.grandviewresearch.com/>
xv. Source: <https://www.biospace.com/>

The Impact of AI on the UK Medical Devices and Pharma Markets



AI Powered Medical Devices & Diagnostics

Key trends include:

- **Substantial Growth:** The UK’s healthcare AI sector is projected to grow from USD 1.33 billion in 2023 to USD 12.49 billion by 2030, with a staggering annual growth rate of 37.8%^{xvi}.
- **Imaging Innovation:** AI-driven imaging tools are also surging—UK revenues rose from USD 51.7 million in 2022 to USD 603.1 million by 2030, driven by deep learning and NLP applications in diagnostics^{xviii}.
- **Medical Device Integration:** Globally, the AI-enabled medical devices market is expected to increase from USD 10.1 billion in 2024 to USD 35.5 billion by 2029, growing at a 29.9% CAGR.

2. **Operational Efficiency** – AI tools are not just diagnostic; they also support clinical workflows (e.g., AI scribes transcribing consultations), enabling providers to do more with less^{xv}.
3. **National Momentum** – UK government and NHS targets include embedding robotics and AI in 1 in 8 procedures by 2035, with funding plans tied to adoption of these technologies^{xiv}. In September 2025, the UK secured substantial AI investments from major US tech firms including **Microsoft, Google, Nvidia, OpenAI, and Salesforce**, marking a pivotal moment in its ambition to become a global AI superpower. Microsoft alone pledged **\$30 billion** to build the UK’s largest supercomputer and expand its AI infrastructure, while Google announced a **£5 billion** investment focused on data centres and research through DeepMind.

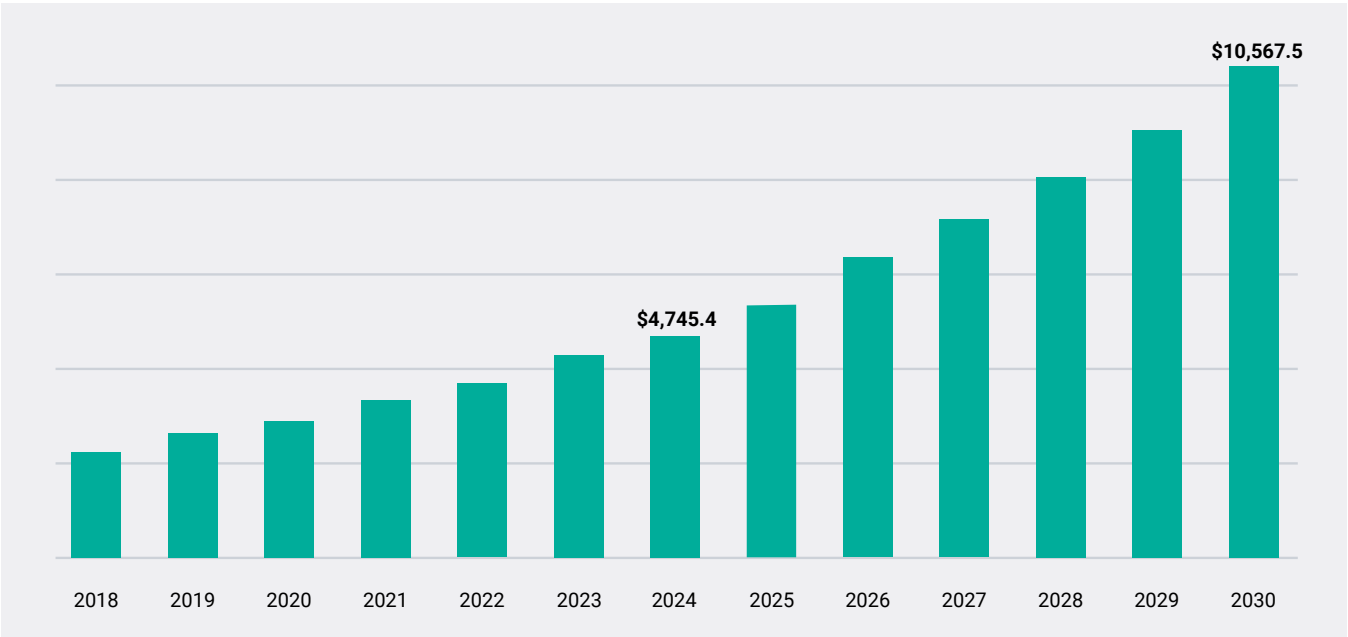
Relevance of AI

There are several areas where AI is now mattering more than ever before:

1. **Diagnostic Acceleration** – AI is helping reduce scan backlog and improve early detection. For instance, the NHS trial of the “Edith” AI model in breast screening is helping reduce wait times for hundreds of thousands of women^{xiv}.

xvi. www.grandviewresearch.com/horizon/outlook/ai-in-healthcare-market/uk?utm_source=chatgpt.com
xvii. www.grandviewresearch.com/horizon/outlook/ai-in-medical-imaging-market/uk?utm_source=chatgpt.com
xviii. www.ft.com
xix. www.ft.com/content/5c356658-6db4-47c1-940b-b2e3cf3a51f3?utm_source=chatgpt.com

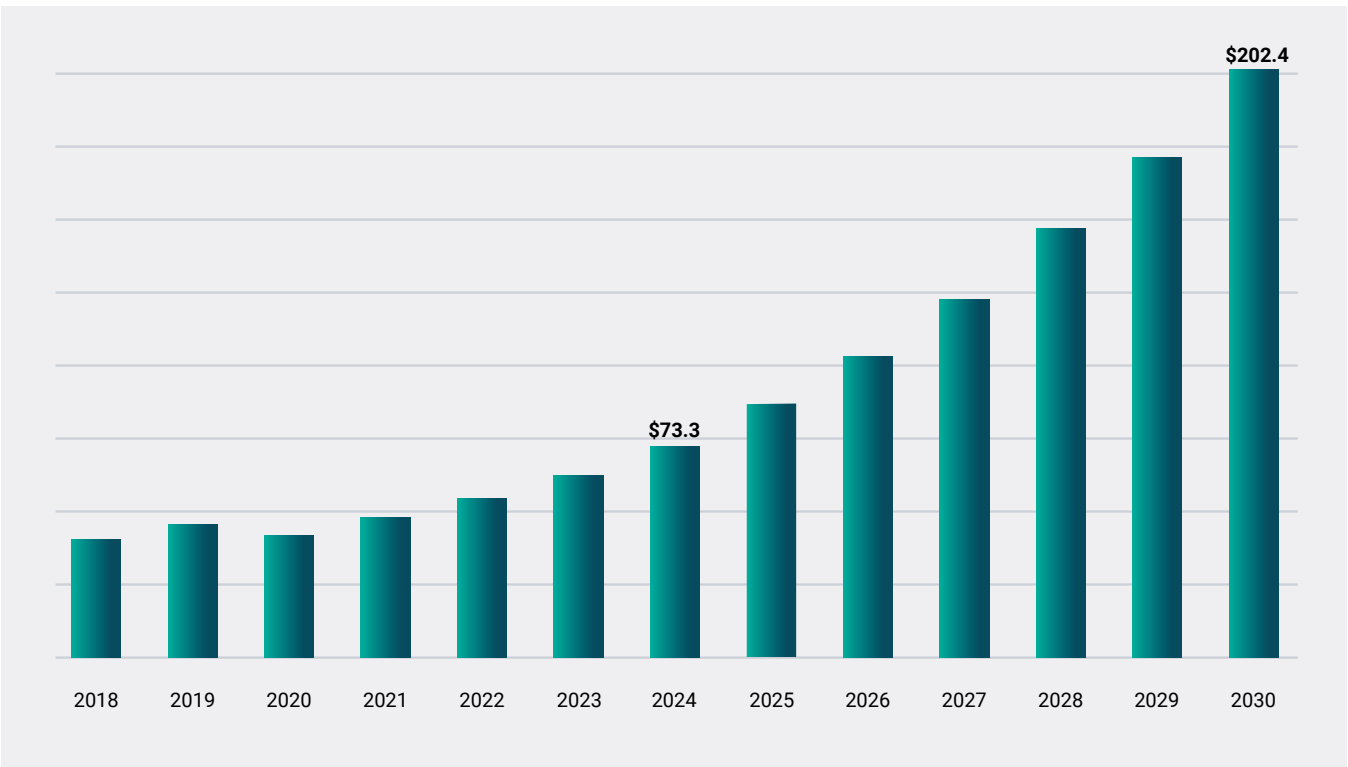
UK Smart Medical Devices Market Size & Outlook, 2024-2030



UK smart medical devices market highlights^{xvi}

- The UK smart medical devices market generated a revenue of USD \$ 4,745.4 million in 2024 and is expected to reach USD 10,567.5 million by 2030.
- The UK market is expected to grow at a CAGR of 14.4% from 2025 to 2030.
- In terms of segment, therapeutic devices was the largest revenue generating product type in 2024.
- Therapeutic Devices is the most lucrative product type segment registering the fastest growth during the forecast period.

UK Reprocessed Medical Devices Market Size & Outlook



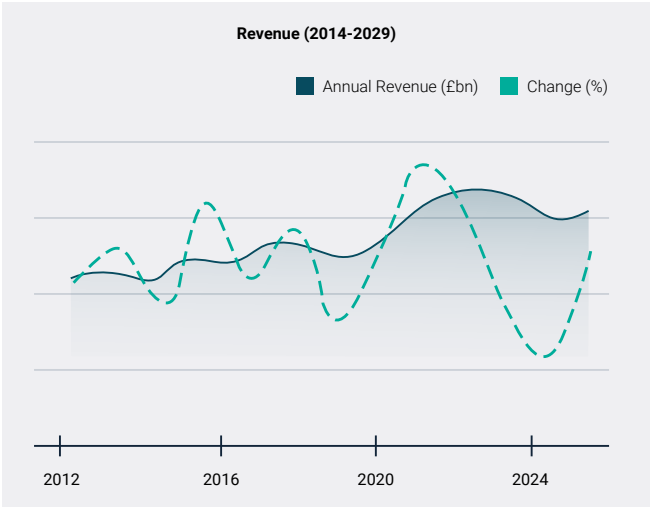
xx. Source: www.grandviewresearch.com/horizon/outlook/smart-medical-devices-market/uk

Reprocessed medical devices are single use or disposable medical devices that have been cleaned, disinfected, sterilised, and tested so they can be safely reused. The market highlights include:

- The market generated a revenue of USD 73.4 million in 2024 and is expected to reach USD 202.4 million by 2030.
- The market is expected to grow at a CAGR of 18.5% from 2025 to 2030.
- In terms of segment, cardiovascular was the largest revenue generating product type in 2024.
- Cardiovascular is the most lucrative product type segment registering the fastest growth during the forecast period.

The importance to the TriTech Institute is in presenting an opportunity for it to support companies understand cost savings, environmental impact, and safety associated with reprocessed devices^{xxi}.

Medical & Dental Instrument Manufacturing in the UK (2014–2029)



The industry revenue associated with medical and dental instrument manufacturing in the UK has grown at a CAGR of 0.3 % over the past five years, to reach an estimated £7.8bn in 2025^{xxii}.

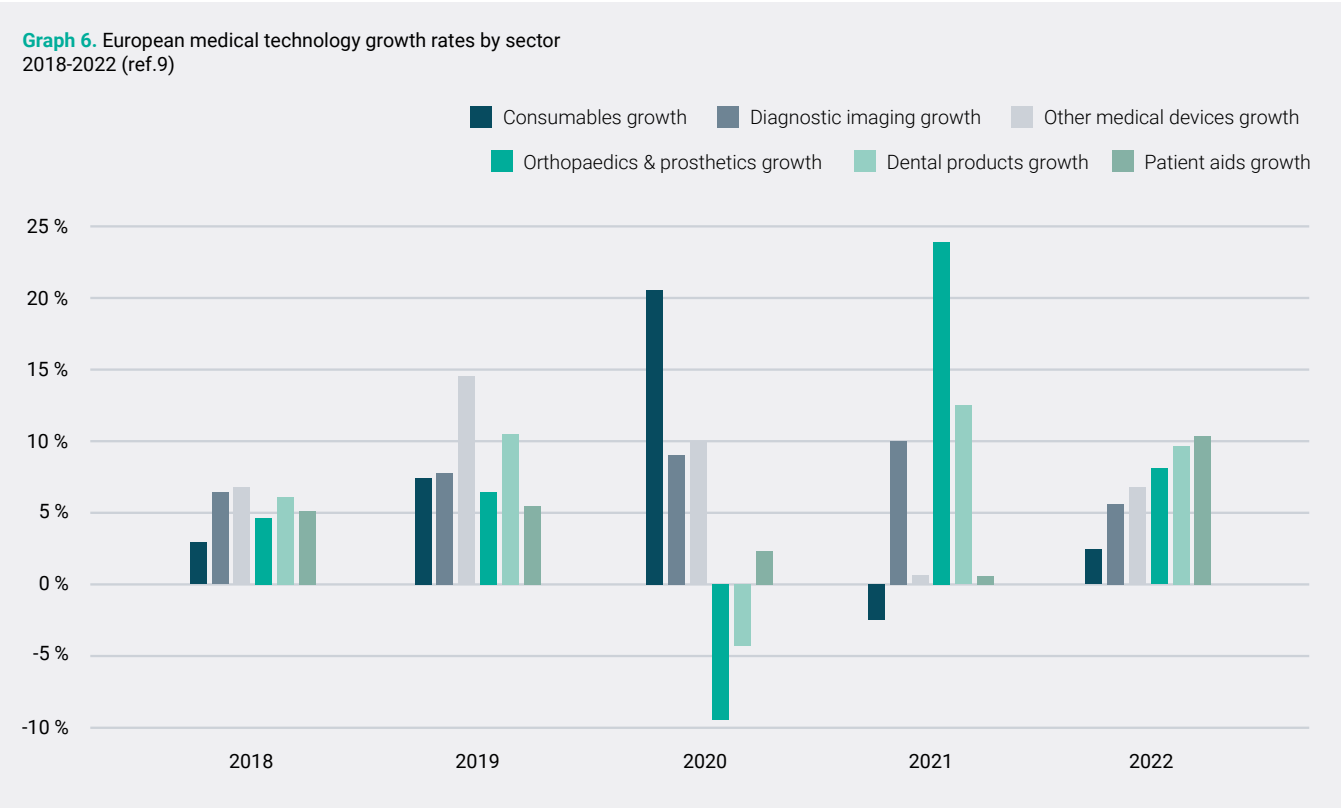
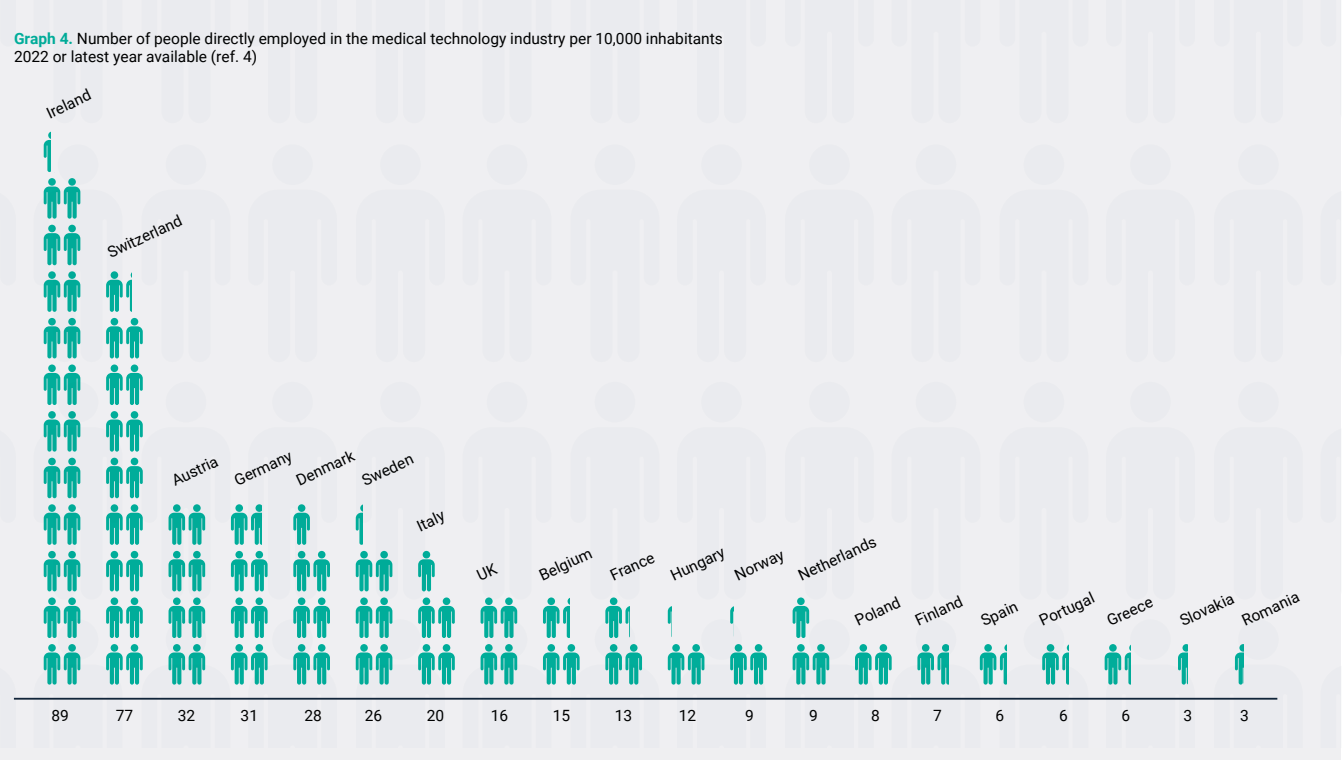
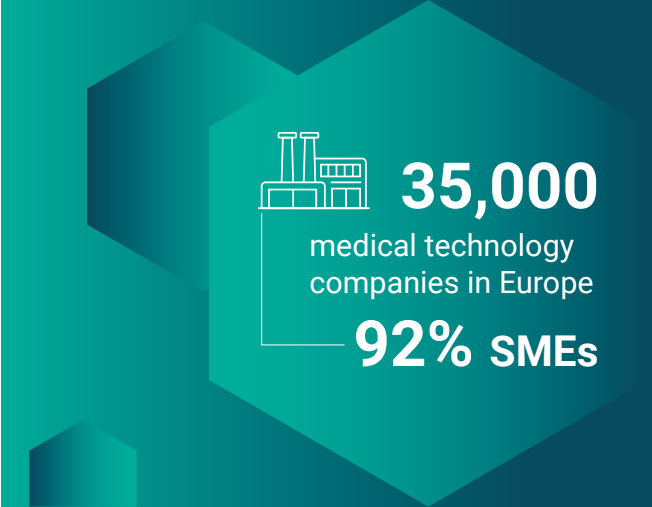
European Medical Technology Market Overview

While the TriTech Institute’s operations are rooted in the Welsh NHS, its strategic vision and partnerships, particularly through Horizon Europe-funded collaborations position it firmly within the broader European innovation ecosystem.

Understanding Europe-wide market dynamics is essential to ensure TriTech Institute’s work remains competitive, informed, and aligned with emerging trends across the continent.

The European medical technology sector is a key driver of innovation, investment, and health system transformation. With over 34,000 MedTech companies, predominantly SMEs, contributing to a €160 billion market, Europe represents a vibrant and evolving landscape.

The following graphs highlight key trends in areas such as regulatory frameworks, R&D intensity, market growth, and export strength providing essential context for the TriTech Institute’s ongoing efforts to scale impact, attract partners, and shape the future of health innovation.



xxi. www.grandviewresearch.com/horizon/outlook/reprocessed-medical-devices-market/uk
xxii. www.ibisworld.com/united-kingdom/industry/medical-dental-instrument-manufacturing/2140/



Statista Opinion – Medical Technology (Summarised)^{xxiii}

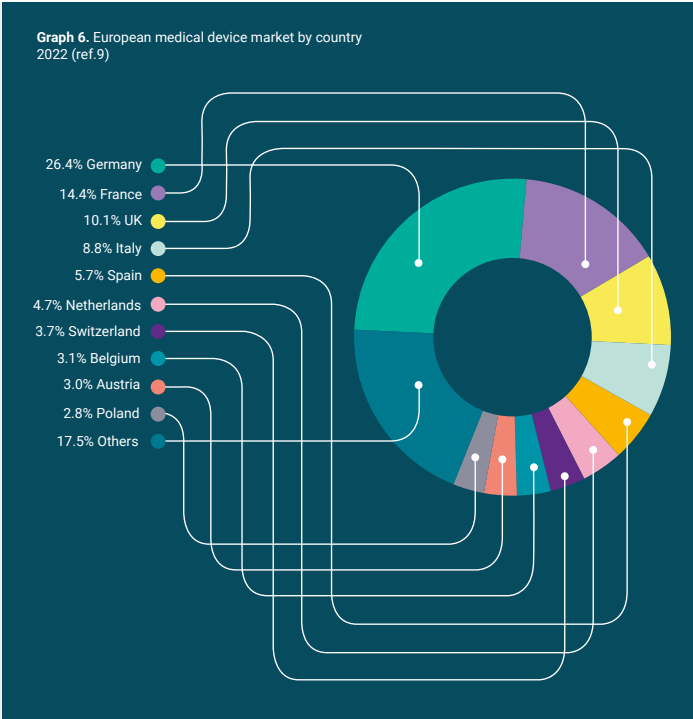
The UK MedTech market is growing, underpinned by NHS demand for solutions that improve outcomes and efficiency. Buyers increasingly favour user-friendly, cost-effective technologies and digital tools that enable care closer to home. A strong R&D base, skilled workforce and supportive regulation sustain investment, while an ageing population drives continued need.

Key takeaways

- **Customer demand:** Clear preference for innovations that are easy to use, affordable, and demonstrably improve diagnosis, treatment and workflow; rising interest in telehealth and remote monitoring.
- **Technology trends:** Rapid adoption of AI/ML across diagnostics, surgery and monitoring; COVID-accelerated shift to virtual care models persists.
- **NHS effect:** The NHS’ purchasing power and digital priorities strongly shape adoption and reimbursement, creating a favourable route to scale for proven solutions.
- **Macro drivers:** UK strengths in R&D and talent, plus demographic pressures (ageing, chronic disease), continue to fuel market growth.

xxiii. www.statista.com/outlook/hmo/medical-technology/united-kingdom?currency=GBP#revenue

xxiv. www.statista.com/outlook/hmo/pharmaceuticals/united-kingdom?currency=GBP#revenue



Statista Opinion – Pharmaceuticals (Summarised)^{xxiv}

The UK pharma market continues to grow, anchored by a strong science base, skilled workforce and sustained NHS demand. Buyers are moving toward precision/personalised medicine and therapies that demonstrate clear outcome gains, with parallel consumer interest in natural/plant-based options.

Key takeaways

- **Customer demand:** Rising preference for targeted, personalised treatments with measurable benefits; niche growth in natural/alternative remedies.
- **Industry structure:** Mix of global multinationals and a vibrant SME ecosystem, reinforced by leading universities and research institutes driving pipeline innovation.
- **Operating context:** Post-Brexit adjustments persist, but the UK remains attractive due to R&D strength; the NHS provides a large, stable route-to-market for proven therapies.
- **Macro drivers:** Government life-sciences investment, an ageing population and high chronic disease burden continue to fuel medium-term growth.

Real-World Evidence and Value-Based Health Care

There is growing demand across the NHS and the life sciences sector for robust **Real-World Evidence (RWE)** and outcome-focused innovation. As systems shift toward **Value-Based Health Care (VBHC)**, decision-makers are prioritising technologies that can demonstrate measurable benefits, both in terms of patient outcomes and system-level efficiency.

This shift presents a clear opportunity for organisations like the TriTech Institute, which specialises in evaluative research, outcome analysis, and health economics. The TriTech Institute’s ability to provide independent, NHS-aligned evidence gives both healthcare providers and innovators the insight they need to inform procurement, adoption, and scale. With the increasing complexity of the innovation landscape, the TriTech Institute’s services are becoming essential to help NHS organisations de-risk adoption and ensure that technology investments are delivering real, measurable value.

Regulation

Carrying over from the previous business planning period, **regulation remains an important consideration** in the health technology landscape. While the Medicines and Healthcare Products Regulatory Agency (MHRA) continues to oversee medical device and technology standards in the UK, the environment is evolving, particularly following post-Brexit regulatory divergence and international harmonisation efforts. The number of organisations offering paid regulatory consultancy has grown, but for many SMEs, the regulatory pathway into the NHS still presents a barrier due to its perceived complexity and cost.

The TriTech Institute’s experience working within NHS systems continues to offer value to companies navigating these challenges. Its ability to advise on the regulatory landscape particularly in the context of NHS adoption, clinical investigation setup, and health technology assessments remains a sought-after service for innovators with limited in-house expertise. While no longer the sole driver of demand, regulatory guidance remains a key part of the TriTech Institute’s broader service offer.

“There is an appetite for exactly what TriTech is putting out there as a service”

Gwyn Tudor, Health Technology Innovation Specialist, MediWales

2.2 Market Sector in Wales

The Life Sciences Ecosystem in Wales

Wales continues to foster a strong and collaborative life sciences ecosystem, with a network of national and regional organisations playing a key role in driving innovation, evaluation, and adoption of new health technologies. Key partners include:

Life Sciences Hub Wales

A national organisation working to accelerate the development and adoption of innovative solutions to support better health and well-being. The Hub acts as a bridge between industry and the NHS, providing strategic support to address system challenges and stimulate economic growth across the life sciences sector.

Health Technology Wales (HTW)

Established to provide a strategic, national approach to the appraisal and adoption of non-medicine health technologies. HTW evaluates the clinical and cost-effectiveness of technologies and publishes guidance for use across Wales. It supports evidence-informed decision-making and works closely with health boards, including collaborations with The TriTech Institute on evaluative research.

Assistive Technologies Innovation Centre (ATiC), UWTSd

ATiC brings expertise in user-centred design, motion capture, prototyping, and experience evaluation. The centre supports early-stage innovation and has an established partnership with The TriTech Institute, including joint appointments and collaborative research projects.

Healthcare Technology Centre (HTC), Swansea University

HTC provides research and enterprise support for translating health innovations into scalable solutions. With strengths in data science and high-spec labs, it complements the TriTech Institute’s evaluative research expertise and has worked jointly on multiple innovation projects.

MediWales

An independent, member-led network supporting life sciences, bringing together industry, academia, and clinical partners. MediWales creates business opportunities, supports trade development, and connects its members with NHS expertise and innovation needs.

Health and Care Research Wales (HCRW)

Funded by Welsh Government, HCRW supports research across NHS Wales and its partners. It enables research into services, treatments, and technologies that improve care and outcomes. The TriTech Institute collaborates with HCRW via HDUHB’s R&D team to support high-quality study design and delivery.

National Imaging Academy Wales (NIAW)

The NIAW is a flagship radiology training and innovation facility supporting the adoption of AI and advanced diagnostic technologies.

Additional Key Organisations in Wales’ Life Sciences Sector

Public Health Wales

An NHS Trust established in 2009, Public Health Wales aims to protect and improve health and wellbeing in Wales. It plays a pivotal role in health protection, healthcare improvement, and health advisory services.

Cardiff University

As a member of the Russell Group, Cardiff University is a leading research institution in Wales, with significant contributions to biomedical and life sciences research.

Swansea University Medical School

Ranked among the top medical schools in the UK, it collaborates closely with government, industry, and the NHS, focusing on research areas like nanotechnology, health informatics, and life sciences. It also houses the Health Technology Centre.

Performance and Productivity Unit (formerly NHS Executive)

The Performance and Productivity Unit leads the national strategic direction for NHS Wales, overseeing quality improvement, innovation, and service transformation. It works closely with health boards, trusts, and partners to embed research and innovation into everyday practice.

Bangor University

A research-led institution with strengths in health and behavioural sciences, Bangor University supports innovation through its clinical trials unit and partnerships with local health boards, particularly in North and Mid Wales.

University of South Wales

Home to the Welsh Institute of Health and Social Care, USW delivers applied research and innovation in health technologies, professional practice, and service delivery—often in partnership with NHS and industry stakeholders.

Cardiff Metropolitan University

With expertise in biomedical sciences, product design, and digital health, Cardiff Met fosters interdisciplinary innovation, particularly through its School of Sport and Health Sciences and Centre for Health, Activity and Wellbeing Research.

“Thank you for the incredible effort you’ve put into this grant application. It’s incredible how quick and delightful an experience it’s been collaborating on this project with TriTech.”

Arshia Gratiot, Eupnoos

2.3 The TriTech Institute Achievements and Positioning

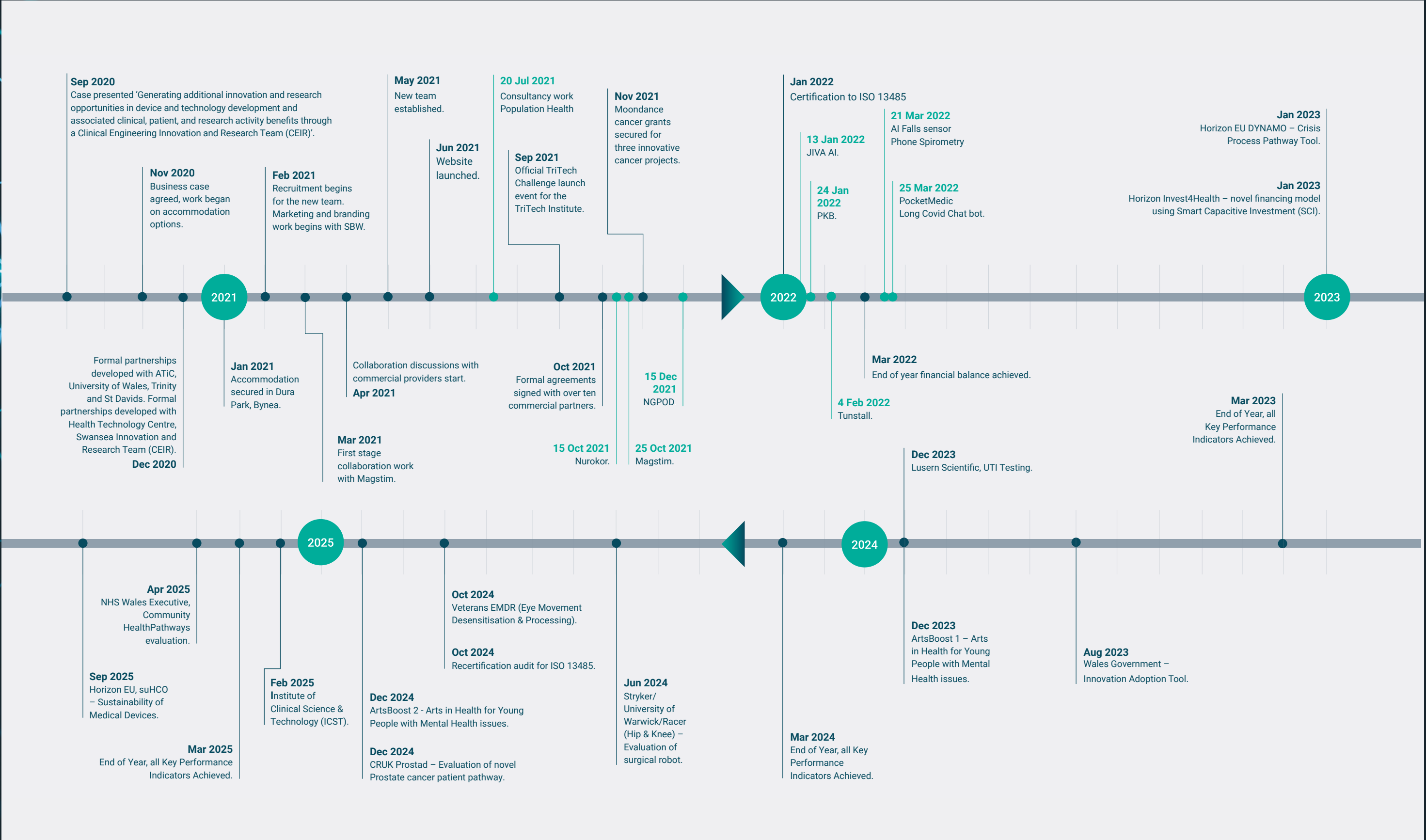
Now five years on from its formation,, the TriTech Institute has established itself as a leading hub for healthcare innovation in Wales. Evolving from its original role as a collaborative space for Med-Tech and R&D, the TriTech Institute now operates as a fully integrated service, supporting the evaluative research, translation, and adoption of health technologies across the NHS and industry. Having moved beyond its initial set-up phase, the

TriTech Institute is now focused on consolidating its impact and scaling its activity. Its growing portfolio of projects, partnerships, and sector recognition places it in a strong position to shape the future of innovation-led service improvement within HDUHB and the wider Welsh health system.

This new business plan sets out the next phase of The TriTech Institute’s development building on solid foundations to deliver sustainable growth, increased influence, and greater value across the health and care landscape.



The timeline below highlights the key milestones in the period from 2020 to 2025.



Expanding on The TriTech Institute's Position and Achievements

The TriTech Institute's strategic position within HDUHB is further reinforced by the **scale, diversity, and impact** of the projects it has delivered and committed to. The diagram below illustrates the **high-level achievements** that reflect The TriTech Institute's growing influence, operational maturity, and capability as a driver of innovation across the region.

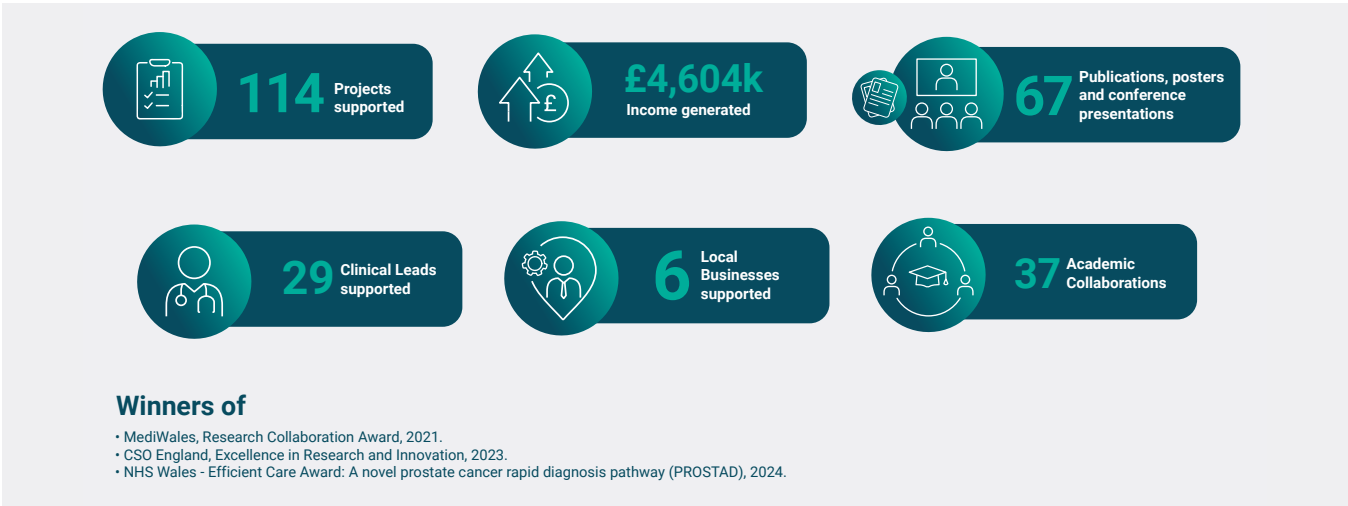
Since its inception, The TriTech Institute has:

- **Supported 114 innovation projects**, spanning translational research, evaluative research, and strategic advisory services.
- **Generated over £4.6 million in income**, with a further **£662,000 forecast for 2025/26**, demonstrating strong financial stewardship and the ability to attract external investment.
- Contributed to **67 academic outputs**, including peer-reviewed publications, conference presentations, and posters highlighting its role in knowledge generation and dissemination.

- **Enabled 29 clinical leaders** to engage in innovation, embedding a culture of research and improvement within frontline services.
- **Collaborated with 37 academic institutions**, strengthening its role as a bridge between research and practice.
- **Supported 6 local businesses**, contributing to regional economic development and the wider innovation ecosystem.

The TriTech Institute's excellence has also been recognised through multiple national awards, details can be found in 'Awards' section below.

These achievements collectively demonstrate the TriTech Institute's increasing capability to deliver high-impact, value-driven innovation that supports both organisational transformation and broader system goals.



Collaborations



CASE STUDIES

The TriTech Institute has collaborated with health boards, industry, and academic partners across Wales and beyond to deliver a diverse portfolio of projects over the last planning period. These have ranged from early feasibility studies and evaluative research through to national pilots and EU-wide programmes.

A full collection of case studies is available on our website^{xxv}, and a selection is summarised in the following table, with full detail provided in **Appendix 2 – Clients and Case Studies**.



xxv. www.tritech.nhs.wales/case-studies/

Project	Partners	Period	Focus / Outcome
NGPOD Nasogastric Tube Device	HDUHB, SBUHB, NGPOD	May–Aug 2022	Evaluated safety and usability of a novel NG tube placement device. Showed 94% placement success, reduced X-ray use, improved efficiency; highlighted training/cultural adoption needs.
Technology Enabled Care (TEC) – Heart Failure	Delta Wellbeing, Tunstall	Jun 2021–Oct 2022	Remote monitoring of 232 patients reduced hospital stays (50%) and increased virtual outpatient use. Strong patient satisfaction; scalability to COPD/diabetes flagged.
AI for Prostate Cancer (JivaRDX)	Moondance, JIVA.AI	Nov 2021–May 2023	AI tool achieved 77% sensitivity, 65% specificity. Potential to reduce radiologist workload; further refinement needed for regulatory readiness.
UTI Point-of-Care Testing	Llusern Scientific	Sep 2022–Apr 2023	Evaluated molecular POC UTI test. Potential to cut antibiotic use; cost vs workflow integration issues noted; promising for out-of-hours/remote use.
Learning Lab – CVD Risk	HDUHB, SBUHB, Swansea Uni, Amgen	Aug 2022–ongoing	Data-driven programme to improve CVD care. Early results: reduced lipids, BP, weight. Supports national rollout strategy for high-risk patients.
Diabetes Prevention Programme	HDUHB	Jan 2023–Mar 2024	542 participants. Improved BMI, BP, wellbeing. Aligns with NHS Wales prevention goals; scalable with more long-term data.
DiaSole for Diabetic Foot Ulcers	Kaydiar, ConvaTec, WWIC	Sep 2022–Sep 2024	Early findings: reduced ulcer area/depth, no adverse skin effects. Improves mobility and patient comfort; potential cost-effective alternative to casts.
Robotic Arthroplasty Trials (RACER Hip & Knee)	NIHR, UHCW, Stryker, HDUHB	2023–2024 (ongoing)	Supporting the R&D team. Evaluating robotic-assisted hip/knee replacements. Early impacts: surgical precision, learning opportunities. Supports national NHS evidence base. Specifically, to support the R&D Division with the study.
DYNAMO EU Consortium	7 EU partners, incl. HDUHB	Jan 2023–Feb 2026	Dynamic modelling for system resilience. Focus on crisis preparedness, pathway redesign, EU-wide adoption potential.
PROSTAD Prostate Cancer Pathway	CRUK, HDUHB, Swansea Uni	Oct 2022–Dec 2023	Pilot cut diagnostic delays (MRI wait down 10 days, biopsy 24 days). Award-winning; blueprint for wider rollout.
DanceWell – Arts on Prescription	HDUHB Arts, Tywi Taf GP Cluster, ACW	Oct 2022–Dec 2023	Dance intervention for chronic illness/frailty. Reported better mood, confidence, reduced isolation. Informs wider creative health strategy.

Collectively, these projects demonstrate TriTech Institute’s role in enabling evaluative research, accelerating adoption, and supporting system-wide innovation.

AWARDS

The TriTech Institute has been recognised with several industry and NHS awards and commendations for its innovative contributions to healthcare:

MediWales Innovation Award (2021): The TriTech Institute, in collaboration with Bond Digital Health, won the Health and Social Care Research Partnership with Industry Award for developing the COPD Pal app. This digital tool empowers patients to manage their chronic obstructive pulmonary disease (COPD) by logging symptoms, feelings, and medications, leading to improved patient confidence and reduced hospital visits^{xxii}.

Chief Scientific Officer's Excellence in Healthcare Science Award (2022): Professor Chris Hopkins, Head of Innovation and the TriTech Institute at HDUHB, received the Research and Innovation Award at the NHS Chief Scientific Officer’s Excellence in Healthcare Science Awards. This accolade recognises groundbreaking scientific work and strong collaborations that make a real difference in patient care^{xxiii}.

Innovate Awards Finalist (2022): The TriTech Institute was selected as a finalist in the ‘Innovative Health System of the Year’ category at the Innovate Awards, highlighting its impressive and inspirational work in health system innovation^{xxiv}.

NHS Wales Awards (2024): The TriTech Institute’s PROSTAD (Prostate Cancer Rapid Diagnosis Pathway) project was recognised with the Efficient Care Award at the NHS Wales Awards. This initiative significantly reduced the average time from referral to diagnosis by 28 days, enhancing patient-centred care through streamlined clinical pathways and AI-powered diagnostic tools^{xxv}.

Royal College of GPs - Annual Conference 2024 (Liverpool): The TriTech Institute was recognised at the Royal College of General Practitioners (RCGP) Annual Conference 2024 in Liverpool, where the “DanceWell – Seated & Gentle Dance on Prescription in West Wales” project won the Best Innovation Poster award^{xxvi}.

“It’s great to see this project coming to a conclusion. It’s been great working with TriTech Institute on this. We’ve had a few hurdles to get over given the ongoing COVID-19 situation, but thanks to the TriTech team the delays have been minimal.”

Marcus Ineson, NGPOD

2.4 Alignment with Strategic Policy Priorities

Positioning TriTech Institute within National and Local Contexts

Operating within the framework of the Wellbeing of Future Generations (Wales) Act 2015, Wales Innovates (2023), and the Health and Care Research Wales (HCRW) Plan (2022), the TriTech Institute is aligned with both national and UK priorities, including A Healthier Wales and NHS England’s Fit for the Future 10-Year Plan. These strategies collectively promote prevention, digital transformation, and community-based models of care. The TriTech Institute serves as an NHS-embedded translational research and innovation partner, leveraging HDUHB’s population profile as a testbed for new pathways and evidence-led adoption.

On 3 July 2025, the UK Government officially published **“Fit for the Future”**, NHS England’s new 10-Year Health Plan. The strategy outlines three major shifts that will shape the future of healthcare: a move from hospital to community, analogue to digital, and treatment to prevention. While The TriTech Institute operates within NHS Wales, its strategic focus, capabilities, and active project portfolio strongly reflect and, in many cases, anticipate these national priorities.

The TriTech Institute’s work with partners such as Amgen on the *Predict and Prevent Cardiovascular Disease Programme* exemplifies this forward shift towards proactive care, enabling earlier detection and intervention to prevent acute episodes such as heart attacks and strokes. Similarly, projects with AstraZeneca on asthma pathways and the CRUK-funded prostate cancer optimisation work demonstrate how TriTech Institute supports

xxvi. www.healthandcareresearchwales.org/about/news/hywel-dda-university-health-board-partnership-wins-mediwales-award-2021
xxvii. www.llanellistandard.com/cso-excellence-in-science-award-win-for-professor-hopkins/
xxviii. www.tritech.nhs.wales/innovate-awards-tritech-institute-finalist/
xxix. www.hduhb.nhs.wales/news/press-releases/pioneers-from-hywel-dda-recognised-in-shortlist-for-cancer-awards
xxx. www.wahwn.cymru/uploads/resources/DanceWellv3.pdf

integrated, evidence-based redesign of care services in line with national health reform.

Within the Welsh NHS context, we will champion innovation in primary care by supporting new models of service delivery, digital solutions, and collaborative approaches that enhance access and patient experience. This commitment aligns with national priorities set out in A Healthier Wales and the Public Health Wales strategic framework, which emphasize the need to tackle the wider social determinants of health, such as housing, education, employment, and community resilience. By embedding these principles into our planning, we aim to reduce health inequalities and improve wellbeing across our communities.

The TriTech Institute’s emphasis on real-world evidence generation, digital innovation, and service pathway transformation supports broader goals around health equity, system efficiency, and population outcomes. As NHS England rolls out bold changes in digital health and community care models, the TriTech Institute stands ready as a collaborative and future-aligned partner.

Supporting HDUHB Objectives

The TriTech Institute will continue to play a central role in delivering against the strategic objectives of HDUHB, acting as both a delivery partner and system enabler across priority areas:

- PO1: Happy, healthy workforce (e.g. through innovation in staff wellbeing tools and inclusive design).
- PO2: Financial recovery (the TriTech Institute will continue to assess the value of health innovations, include their cost and the outcomes delivered)).
- PO3: Urgent and emergency care transformation (e.g. evaluative research of new care models).
- PO4: Planned care, diagnostics, and cancer (e.g. digital diagnostics and pathway redesign).
- PO5: Mental health and CAMHS (e.g. digital therapeutics and service evaluation).
- PO6: Clinical services plan (e.g. innovation pipeline alignment).
- PO7: Primary and community strategy (e.g. collaboration with Primary Care Academy).
- PO8: Estates plans (e.g. evaluating

technologies that enable care to be delivered closer to home thereby placing less reliance on pressurised hospital facilities).

- PO9: Digital plans (e.g. AI, data science, and digital health evaluations).
- PO10: Population health (e.g. innovation addressing health inequalities and prevention).

2.5 Sustainability and the Green Agenda

The TriTech Institute is increasingly aligning its innovation strategy with the NHS’s wider commitment to environmental sustainability. As the NHS Wales Decarbonisation Strategic Delivery Plan and Greener NHS initiatives gain traction, the TriTech Institute recognises the need to ensure that the technologies, pathways, and service models it supports not only improve outcomes but also contribute to reducing environmental impact. For example, this could include evaluating lower-carbon digital alternatives to traditional service delivery, supporting the adoption of remote monitoring solutions to reduce unnecessary travel, or contributing to the evidence base around reprocessed medical devices.

By embedding sustainability considerations into technology evaluations and procurement guidance, the TriTech Institute ensures innovations are aligned with **both clinical impact and carbon-conscious decision-making**.

It also makes sense to focus on this from a growth perspective, as the **UK reprocessed medical devices market** is projected to grow, with cardiovascular reprocessing leading the way. The TriTech Institute’s evidence-led approach can play a vital role in supporting NHS Wales to assess, adopt, and scale green innovations that deliver *clinical, economic and environmental* benefits.



3.0 Strategy & Implementation

3.1.1 Products and Services (Product)

Structured Around the 5 I’s: Aligned with The TriTech Institute’s Core Values

The TriTech Institute delivers a unique and agile portfolio of services that combines scientific rigour, health system insight, and close industry collaboration. To communicate the depth of its offering, The TriTech Institute frames its product strategy through the 5 I’s, a lens that emphasises customer connection and value creation grounded in its **core organisational values**.

Impact

The TriTech Institute’s work drives measurable change across health and care systems. From reducing waiting times in cancer diagnostics to enabling earlier cardiovascular interventions, every project is designed to deliver real-world value. Backed by **Value-Based Healthcare** and **health economic evaluation**, the TriTech Institute ensures its innovations are clinically meaningful, financially justifiable, and system-ready.

Value Lens: Professional, Cutting Edge

Influence

The TriTech Institute is a trusted partner to global life sciences companies, SMEs, and NHS leaders. It has the ability to produce robust evidence and insight, has *influenced procurement decisions, national policy discussions, and clinical adoption strategies*. Collaborations with organisations like Amgen, AstraZeneca, and Cancer Research UK showcase its reach—and the confidence leading partners place in the TriTech Institute’s expertise.

Value Lens: Professional, Innovative

Intimacy

The TriTech Institute doesn’t simply deliver projects. It builds long-term partnerships. Its team of clinicians, scientists and innovators invest deeply in understanding customer challenges, enabling *tailored solutions* and support. Clients return for multi-phase programmes because they trust the people *behind the product*, not just the service.

Value Lens: Personable, Professional

Interaction

The TriTech Institute fosters dynamic and transparent interaction throughout each project lifecycle. Whether this is through co-design sessions, joint project boards, or interactive workshops, engagement is two-way, continuous, and adaptive. By embedding **agile, responsive** practices into its operating model, the TriTech Institute ensures solutions stay relevant—even as project parameters evolve.

Value Lens: Agility, Personable

Involvement

Clients are not passive recipients they are co-creators. The TriTech Institute invites partners into the heart of the innovation process, from defining research questions to interpreting evaluative research data. This level of involvement strengthens ownership, sharpens outcomes, and creates innovations that are *fit for context, fit for people, and fit for purpose*.

Value Lens: Innovative, Agility

3.1.2 Marketing, Advertising, and Communications (Promotion)

Several actions are being advanced to support a better understanding of the TriTech Institute and develop a pipeline of projects. To support this, the TriTech Institute has committed a dedicated marketing budget to advance its promotional and strategic communications activity. This investment covers the creation of high-quality branded materials, event assets, website promotion, and professional video content. The overall aim is to elevate the TriTech Institute’s visibility across key audiences and clearly communicate its evolving role and value within the health innovation landscape. The rest of this section highlights the specific marketing and promotional activities that are planned or underway.

Strategy Film

A micro-documentary film is currently in production to coincide with the launch of the new Research and Innovation Strategy. The film captures the journey of the TriTech Institute,

including where it began, what it has achieved, and where it is heading next. Filming is taking place across various sites and includes contributions from internal and external stakeholders, industry and academic partners and patients. Once released, the film will serve as a powerful storytelling tool to articulate the TriTech Institute's impact and ambition to a wider audience.

NHS Confed Conference

The TriTech Institute had a dedicated presence at the NHS Confed Conference in Manchester in June 2025. For this event, bespoke marketing materials and stand adornments were developed to reflect the refreshed brand and messaging. This conference was a key opportunity for The TriTech Institute to engage with senior health and care leaders, raise awareness of its service offer, and forge new connections across the wider innovation ecosystem.

The TriTech Institute Website

The TriTech Institute's website has undergone a full redesign, featuring a new look and feel, as well as refreshed content. The updated site offers improved navigation, clearer messaging, and a more compelling representation of the TriTech Institute's services, case studies, and strategic priorities.

The website will serve as a hub for future promotional activity, including the launch of the strategy film.

Social Media Approach

The TriTech Institute has shifted away from general social media promotion in favour of more targeted digital outreach. The current approach includes Google Search and geo-targeted advertising, as well as a stronger focus on LinkedIn as the primary channel for professional engagement. Experimentation through the previous planning period highlighted LinkedIn has worked well.

The TriTech Institute is also exploring promotional opportunities via respected sector publications and platforms, such as New Scientist and the British Medical Journal, to increase reach among clinical and academic audiences.

Partnerships, Stakeholders, and Reputation

Developing strong, purposeful partnerships remains central to the TriTech Institute's strategy and is critical to delivering the objectives set out in this business plan. Building on a foundation of trusted relationships across academia, industry, and the wider NHS, the TriTech Institute continues to focus on creating shared value that benefits both the population of West Wales and the broader innovation ecosystem.

Partnerships allow the TriTech Institute to draw on a diverse range of expertise, infrastructure, and insight maximising resources and supporting the timely, high-quality delivery of its services.

As the organisation grows in reach and capability, protecting and enhancing its reputation is a key priority. The TriTech Institute aims to be recognised not only as an integral part of HDUHB's research and innovation infrastructure, but also as a gold-standard partner for life sciences innovation across Wales and beyond.

Exhibitions and Trade Shows

There are a number of exhibitions and trade shows that present valuable opportunities for The TriTech Institute to raise its profile and build strategic relationships. The TriTech Institute's attendance at previous exhibitions has been valuable and will continue to form a key part of our promotion strategy. Attendance may take the form of delegate participation, collaborative presence alongside a partner, or a standalone exhibition space. Many of these events are supported by high-quality conference programmes, providing an ideal platform for networking, thought leadership, and showcasing the TriTech Institute's work to potential collaborators and customers.

3.1.3 Location (Place)

The TriTech Institute's location in West Wales continues to offer unique advantages for healthcare innovation. As part of HDUHB, the TriTech Institute operates within a health system that covers a geographically broad and demographically diverse population spanning urban centres and deeply rural communities. This diversity makes it an

ideal real-world testbed for health and care innovation, reflecting the broader challenges and opportunities seen across Wales and the UK.

Wales also benefits from strong national infrastructure supporting inward investment and innovation in life sciences. Organisations such as Life Sciences Hub Wales, Business Wales, and MediWales help foster a thriving MedTech ecosystem, while national and regional economic strategies including the Swansea Bay City Deal and the Mid Wales Growth Deal provide a supportive policy and investment environment. This makes the region increasingly attractive to entrepreneurs, academics, and international investors looking to collaborate, test, and scale new health technologies^{xxvii}.

Early in 2026, the TriTech Institute will relocate to a new, purpose-built facility at Pentre Awel, Llanelli a transformational development set to become a flagship site for integrated health, care, and innovation in Wales. Pentre Awel is the first development of its kind in the country, bringing together research, life science innovation, education, rehabilitation, and community well-being under one roof.

Developed as part of the Swansea Bay City Deal, the site is designed to foster collaboration between the NHS, academia, business, and the public.

At Pentre Awel, the TriTech Institute will be co-located with universities, industry partners, and innovation-focused SMEs, with access to high-quality clinical research infrastructure and digitally enabled rehabilitation environments. The new space will support the TriTech Institute's growth, enabling it to scale its evaluative research and innovation services, attract new partners, and play an even more visible role in Wales' health innovation ecosystem.

In addition to its enhanced physical presence, the TriTech Institute's base at Pentre Awel will offer improved opportunities for community engagement, multi-disciplinary research, and cross-sector collaboration all vital for driving the development and adoption of technologies that improve health outcomes and system performance.

3.1.4 The TriTech Position in the Market (Position)

The situational analysis confirms that the TriTech Institute continues to occupy a leading position across multiple areas of operation, with particularly strong performance in evaluative research and growing recognition in research and advisory services. Strategic diversification since the last business planning cycle has improved resilience, broadened income streams, and deepened sector engagement.

The combination of NHS embedding, academic collaboration, and agility continues to provide a distinct market advantage. The TriTech Institute's strong reputation both as an organisation and through its individual team members underpins its ability to lead, influence, and deliver within a highly specialised and competitive innovation landscape. With a maturing offer and a strong foundation in place, the TriTech Institute is well-positioned to consolidate its market lead and expand its national and international reach in the short to medium term.

3.1.5 The Team (People)

The TriTech Institute has cultivated a highly skilled, respected, and motivated team, recognised for its ability to collaborate effectively across the NHS, with clinical colleagues, industry partners, academic institutions, and patients. The people behind the TriTech Institute are central to its growing reputation, and their collective expertise is driving forward a culture of innovation, evidence generation, and meaningful impact.

Now entering a new phase of growth, the team is increasingly focused on consolidating its role as a leader in health technology evaluative research and innovation across Wales and beyond. With the upcoming move to Pentre Awel, there will be greater opportunities for integrated working, cross-sector collaboration, and the expansion of specialist capabilities. As the TriTech Institute scales, so too will the need for strong succession planning, skills development, and leadership that ensures continuity and ambition in equal measure.

Many members of the team are already delivering substantial projects aligned with their areas of

xxxi. www.growingmidwales.co.uk/article/10701/Mid-Wales-Growth-Deal

clinical and technical expertise, contributing to a distinctive model that blends innovation delivery with frontline insight. Continued investment in people will be essential to sustaining momentum.

The plan includes provision for increased resourcing in line with project growth, ensuring the team remains agile, well-

supported, and equipped to deliver the next stage of the TriTech Institute's evolution.

"Truly innovative health technologies offer us the potential to have a positive powerful impact upon our patients, health system, and staff, thereby transforming healthcare for the future..."

Chief Executive, HDUHB

4.0 Organisation, Management Team & Governance

This section outlines the operational model for TriTech, including its management structure, approach to governance, quality assurance processes, and risk management.

4.1 Organisation Design

The TriTech Institute is overseen by a Sub Group of the Research and Innovation Sub Committee, which provides strategic leadership, steers the organisation's progress against its key objectives, monitors key issues, risks, and financial performance.

The sub group is called the TriTech & Innovation Group, which meets bi-monthly to review project pipelines and ensure all initiatives reflect the broader priorities and values of HDUHB.

The sub group is supported by an experienced Operational Team made up of research staff, scientists, and delivery leads who manage day-to-day activity across projects.

The membership of the TriTech & Innovation Group:

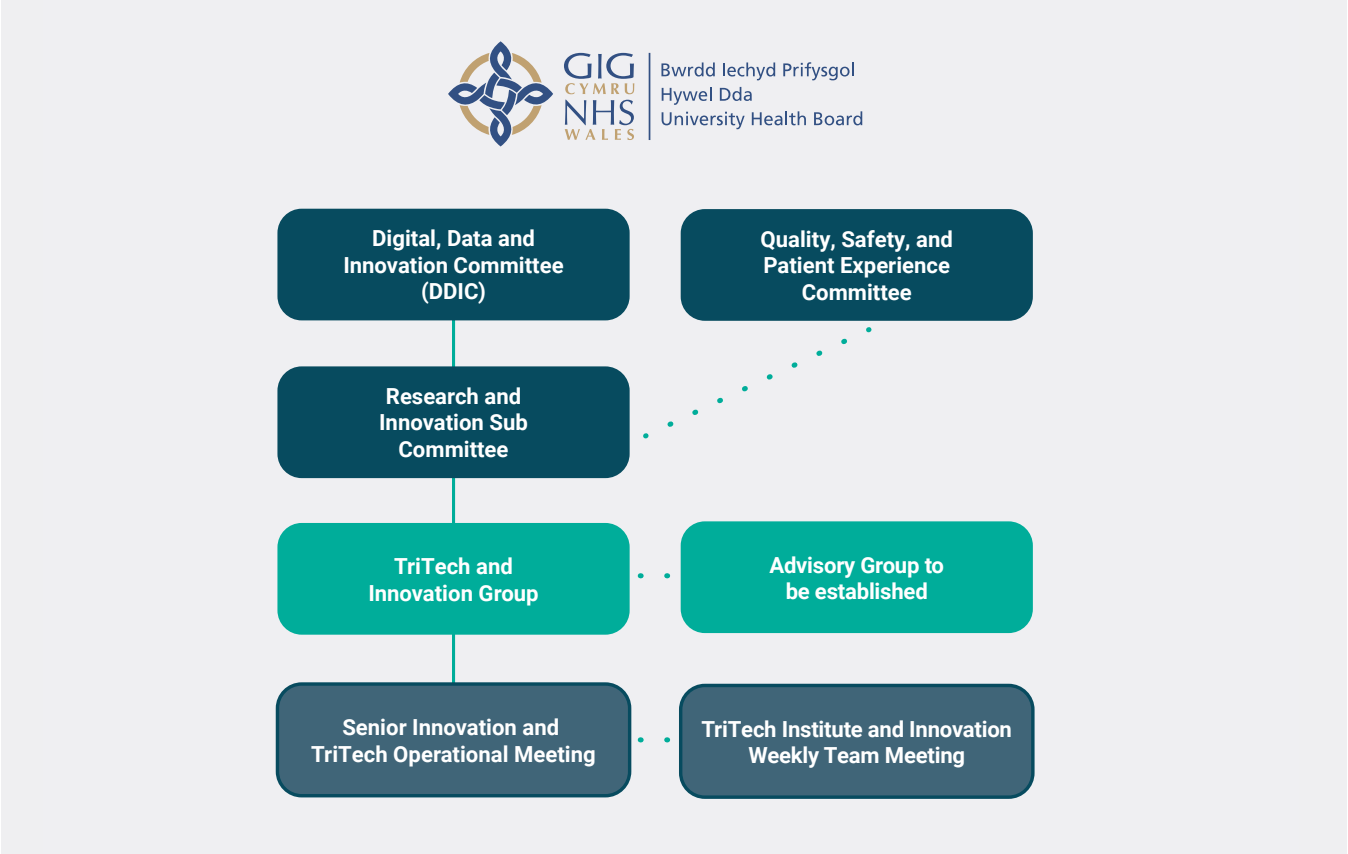
- Director of Research, Innovation, and University Partnerships (Chair)
- Consultant Clinical Scientist, Head of TriTech Institute and Innovation (Vice-Chair)
- Clinical Director Research & Development
- Clinical Lead, TriTech Institute and Innovation
- Head of Research and Development
- Deputy Head of TriTech Institute and Innovation
- TriTech Institute and Innovation Programme Manager
- Head of Value Based Health Care

- Finance Business Partner
- Blood Sciences Service Manager
- Life Science Hub Representative
- Lead Pharmacist (Cardiac Services)
- University Partnership Advisor UWTSD (co-opted expert advisors)
- University Partnership Advisor SU (co-opted expert advisors)
- Secretarial Support
- Specialist support as required

Purpose

The TriTech and Innovation Group plays a vital role in ensuring that HDUHB is actively engaged in the development and adoption of high-quality healthcare technologies and innovations. It provides assurance to the Research and Innovation Sub-Committee through regular reporting, demonstrating that its responsibilities are being met with regard to both the quantity and quality of innovation activity taking place within HDUHB. This includes oversight of new technology developments and ensuring that all associated work is delivered safely and to a high standard.

Beyond oversight, the TriTech and Innovation Group is also responsible for making strategic decisions that enable meaningful, evidence-based innovation to flourish. Its remit includes taking action to foster a culture of innovation, building organisational capacity, and encouraging involvement in projects that improve outcomes and deliver measurable impact for patients and services. By doing so, the Group plays a central role in shaping the future of health technology innovation across HDUHB.



Responsibilities

The responsibilities of the TriTech and Innovation Group are to:

- Ensure compliance with all relevant frameworks, UK Clinical Investigations and other Regulations (transposed into UK law from European Union Directives) and reporting requirements are in place and functioning appropriately.
- Respond to any issues arising from relevant internal review or audit, or inspections carried out by external regulatory authorities.
- Oversee the development of the TriTech and Innovation Division's strategy, operational plan, and other relevant documents in line with local and national priorities and guidance, for sign off by the Board after scrutiny from the Research and Innovation Sub-committee.
- Oversee the TriTech Institute and Innovation budget, ensuring it is being spent in accordance with health board policies and procedures.
- Oversee progress of the TriTech and Innovation Division against the objectives of the operational plan. Identify risks to the achievement of the operational plan that need to be escalated to the Research and Innovation Sub-committee meeting.

- Provide strategic oversight of action plans that have been developed by the TriTech Institute and Innovation team to address operational problems.
- Review and approve reports for relevant internal groups.
- Agree the information submitted to relevant organisations.
- Develop strategic partnerships with Higher Education Institutions and other external organisations critical to the delivery of the operational plan.
- Review and approve specific standard operating procedures for the TriTech and Innovation Division, which are not currently held or governed by another system or body within HDUHB.
- Review and, as appropriate, give final approval for the TriTech and Innovation Division to commit to entering legally binding agreements for projects / collaborations, in accordance with the health board's scheme of delegation, policies and procedures.

Reporting

- The TriTech & Innovation Group contributes to the integration of good governance across the organisation, ensuring that all sources of

assurance are incorporated into the TriTech & Innovation overall risk and assurance framework.

- The TriTech & Innovation Group establishes task and finish groups to carry out specific aspects of its business on its behalf. The TriTech & Innovation Group receives an update following each task & finish group's meeting detailing the business undertaken on its behalf.
- The TriTech & Innovation Group:
 - o Reports quarterly and on a timely basis to the Research and Innovation Sub-committee.
 - o Brings to the sub-committee's specific attention any significant matters under consideration by the TriTech & Innovation Group.
- Ensures appropriate escalation arrangements are in place to alert the Medical Director of any urgent/critical matters that may compromise patient care and affect the operation and/ or reputation of the Department.

Frequency of Meetings

- The TriTech & Innovation Group will meets bi-monthly.
- Extraordinary meetings are convened when necessary and at the discretion of the Chair of the TriTech and Innovation Group

4.2 Governance

The TriTech and Innovation Division operates within a well-defined governance structure, as set out by HDUHB. Full details of this structure are available in the health board's suite of policies and written control documents, published on its website. Internally, the TriTech Institute follows a clear project governance process to manage how initiatives progress through the organisation.

The Senior Management Team continues to review and refine governance processes to ensure they remain effective and adaptable across different sectors, service areas, and partner organisations.

4.3 Organisation Chart

The TriTech Institute has maintained a stable organisational structure throughout its current operational period, which has effectively supported the delivery of its strategic objectives

and programme activities. This continuity has contributed to operational efficiency and alignment with institutional goals. The current organisation structure is detailed within 1.4 Governance and Structure.

The core of this organisational structure has remained unchanged from the last business plan. Where changes have taken place, they have been made to respond to lessons from operating the TriTech and Innovation Division. These have included strengthening the commercial research offer, building internal capacity, supporting national strategic priorities, and embedding research and innovation into governance and operations - to ensure the Institute confidently moves forward into its next phase of consolidation and growth. All changes have been actioned in accordance with health board policies and procedures.

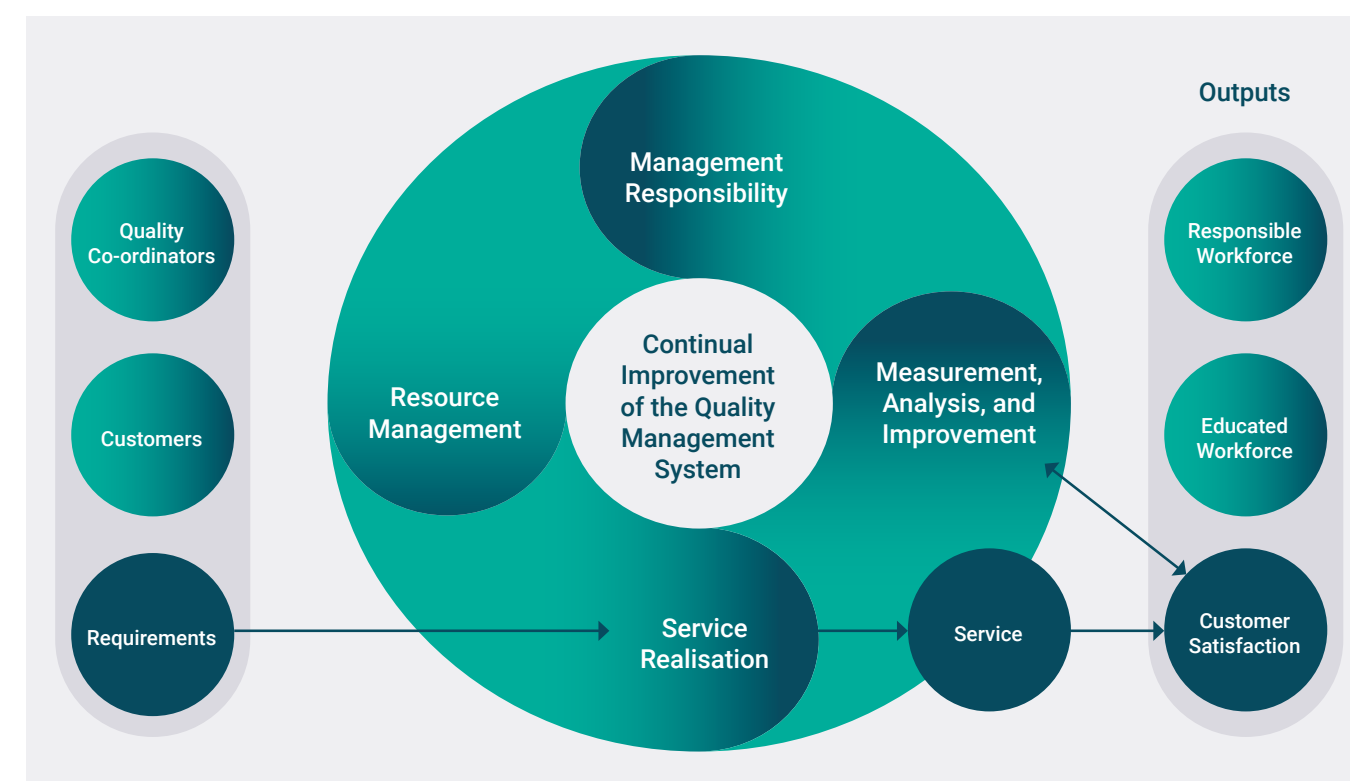
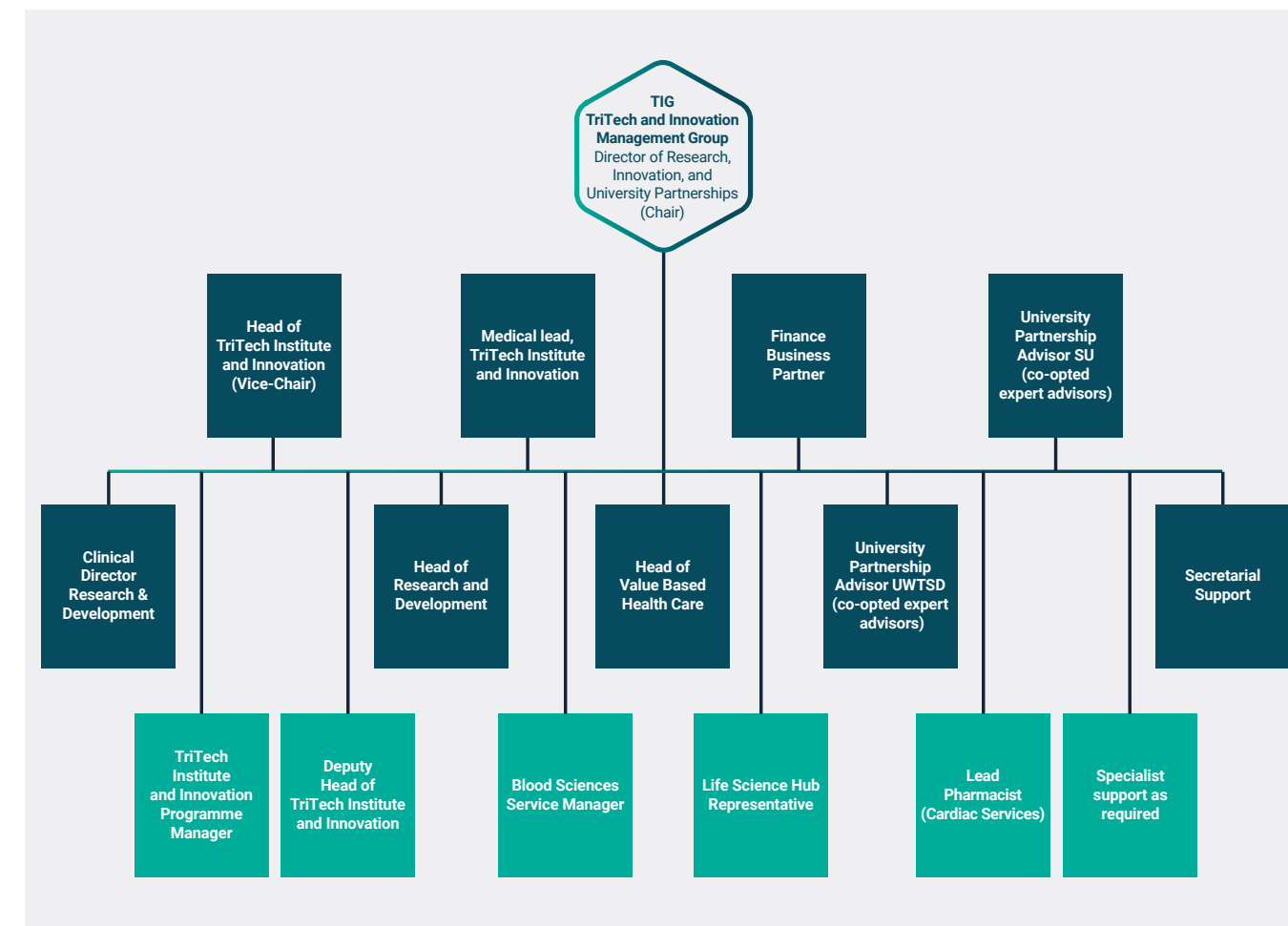
4.4 Organisation Culture

HDUHB fosters a culture of openness, engagement, and innovation, where all members of the workforce are encouraged to contribute ideas and drive change. This culture is underpinned by clear, supportive leadership at all levels, with a strong emphasis on clinical leadership and meaningful staff engagement.

The TriTech Institute reflects and builds on this organisational philosophy. Its culture is defined by its mission, vision, and values, which place collaboration, professionalism, agility, and innovation at the core of its work (See section 1.3 Mission, Vision & Values). These principles are further detailed in the TriTech Institute's Brand Guidelines (**Appendix 3**) and are embedded across its partnerships, services, and internal practices.

"it's been an absolute pleasure to work with you and the team."

Mark Girvan, Managing Director, Streamliners.



4.5 Continuous improvement

Our mission, vision, purpose, and values are embedded across all aspects of the TriTech Institute's operations. They serve not only as guiding principles but as drivers of continuous improvement, shaping our approach to recruitment, retention, appraisal, and day-to-day working practices. By fostering a culture of reflection, learning, and adaptation, these values translate into a consistent set of behaviours that support innovation, accountability, and excellence across the organisation.

4.6 Quality and Safety Standards

The TriTech Institute operates under a suite of quality management documents. Central to this is a Quality Management System (QMS) manual, currently in use, which has been specifically developed to meet the requirements of ISO 13485:2016 the international standard for medical device quality management systems.

This ensures that the TriTech Institute maintains high standards of regulatory compliance, operational consistency, and continuous quality improvement across all innovation activities.

4.7 Project Level Governance

All potential projects are subjected to the TriTech Institute's scoping and feasibility assessment. This includes the TriTech and Innovation Team evaluating the innovation's readiness, regulatory requirements, and practical implementation considerations within NHS settings. The background associated with potential collaborators (e.g. universities or industry partners) is also assessed and the project's fit with one of TriTech Institute's service categories (research, evaluation, advice) is considered.

If the project involves a new clinical procedure or clinical research, it must go through HDUHB's relevant governance processes, including review by the Effective Clinical Practice Advisory Panel or research approval pathways, including sponsorship group. This ensures patient safety, ethical compliance, and alignment with appropriate clinical standards. The TriTech Institute supports this process by coordinating necessary documentation and approvals.

In the case of Innovation projects and research of a non-clinical nature, the TriTech and Innovation Group (TIG) will ultimately review and decide whether it should proceed. TIG ensures the proposal aligns with HDUHB's innovation strategy and prioritizes projects based on population need, potential impact, and available resources. TIG may approve the project, request further development, or suggest alternative approval pathways.

Once approved by TIG, TriTech and Innovation division formalizes the project through agreements and commissioning, such as SLAs or MoUs. Intellectual property and legal matters are managed in collaboration with NWSSP Legal & Risk.

The TriTech and Innovation team then oversees project delivery, ensuring compliance with standards like ISO 13485, and monitors progress through data collection, analysis, and reporting.

Please see Appendix 6 for a copy of Research, Evaluation and Advice Decisions Process Map.

4.7 ISO 13485

ISO 13485 is an internationally recognised standard that outlines the requirements for a quality management system specific to medical devices. The current version, ISO 13485:2016, includes a 2021 amendment that introduces annexes mapping the standard's clauses to the requirements of the European Medical Devices Regulation (MDR) and the In Vitro Diagnostic Regulation (IVDR). This alignment helps organisations ensure regulatory compliance while maintaining high standards of safety, quality, and performance in medical device development and delivery.

To enhance the utilisation of our service offer, we will pursue a strategic expansion of collaborative activities with university partners, early-stage industry enterprises, and recognised innovation leaders. This approach will be underpinned by our specialised expertise in regulatory compliance and quality management systems, with particular emphasis on ISO 13485:2016, which aligns with the UK and European Medical Devices Regulations and In Vitro Diagnostic Regulation (IVDR).

Through the provision of targeted support, including regulatory advisory services, co-

designed innovation projects, and capacity-building workshops we aim to facilitate the development of safe, high-quality, and compliant medical technologies. These initiatives will be tailored to the specific needs of academic research teams and emerging businesses, thereby contributing to a more integrated and resilient innovation ecosystem.

4.8 Risk Register

The risks for the TriTech Institute are recorded within a risk register. The TriTech Institute's risk register provides an agreed record of the significant risks that have been identified through a risk assessment process and serves as a record of the control activities that are currently undertaken. It also provides a record of the additional actions

that are proposed to improve control of particular risks, including responsibility and timescales for the implementation of those intended controls. In order for risk management to be effective and make a significant contribution to the team, the risk register is a document that drives changes and improvements. The risk register is reviewed at the TriTech and Innovation Group and is also considered by the Research and Innovation Sub Committee for assurance. There are also risk registers for individual projects, which are routinely reviewed at weekly team meetings, where consideration is given to whether risks need to be escalated to the higher-level risk register.

Further details about the HDUHB Risk Management Strategy and Policy can be found on the UHB website.

Please see **Appendix 4** for Risk Register.

5.0 Financial Plan & Projections

5.1 Summary Financial Position

The TriTech Institute has delivered a financial surplus during the period 2021/22 to 2024/25, as summarised in the table below:

Overall	2021/22 (£k)	2022/23 (£k)	2023/24 (£k)	2024/25 (£k)
Total income	£514	£862	£1,726	£1,501
Cost of operating	£506	£546	£1,322	£1,284
Surplus	£7	£317	£405	£217

Summary Financial Projections

The financial projections demonstrate that evaluative research is the main source of income, reinforcing a strategic dependency on activities associated with the same. Research also plays a meaningful role in the overall financial model. Forecasts over the forthcoming five-year period incorporate both projected income and operational expenditures, including the planned introduction of new posts at defined intervals. Importantly, the timing and nature of these posts will remain flexible and subject to adjustment in response to evolving service needs and emerging income opportunities.

These projections are structured to achieve a balanced net zero financial position annually, thereby supporting long-term fiscal sustainability. The total projected return for the period from 2026/27 to 2030/31 is derived from the financial outlook for 2025/26.

The same level of project income has been assumed, while secondment income has been reduced to reflect the conclusion of secondments between 2023 and 2025. Inflationary adjustments have been applied to both annual income and operating costs for each financial year.

Additionally, where new post appointments have been considered, income growth of 12-17% pa is anticipated between 2026/27 and 2028/29. This reflects the expected impact of increased capacity and project delivery. If this growth fails to materialise during 2026/27, the investment in posts during 2027/28 will not be made. From 2029/30, a steady state of income and expenditure is assumed, with increases in line with inflationary pressures.

In summary, the financial model aims to provide a realistic scenario based on current commitments, anticipated staffing changes, external funding and internal commissioning. The initial ask of Hywel Dda UHB in respect of this business plan is to underwrite the additional income generation risk of £91,721 in 2026/27 to cover a modest increase in establishment.

5.2 Financial Control

The rationale underpinning all financial models within the TriTech Institute is informed by the need for public bodies to adhere to state aid regulations, which are designed to prevent the distortion of competition through the inappropriate use of public resources. In this context, it is essential that services provided, particularly those involving collaboration with external or commercial partners are delivered on a full cost recovery basis. This ensures that public funding is not inadvertently used to subsidise activities that could confer a competitive advantage, thereby maintaining compliance with legal and regulatory obligations. Unlike private entities, public sector organisations must navigate complex funding and governance frameworks, and the adoption of a transparent, equitable cost structure is critical to safeguarding both financial integrity and strategic alignment.

The model therefore reflects a commitment to responsible public sector innovation, balancing service delivery with regulatory compliance. The ability to apply overhead charges to projects varies by sector, directly influencing each project's potential to generate a financial surplus. Where modifications have occurred, whether in staffing levels, role definitions, or the timing of appointments, these have been undertaken in accordance with established HDUHB governance protocols and organisational policy frameworks.

The rationale for such adjustments reflects the dynamic nature of service requirements, strategic priorities, and emerging income opportunities, ensuring that resource deployment remains both responsive and aligned with operational objectives. All changes have been subject to rigorous procedural oversight, including formal review and approval processes, thereby upholding principles of transparency, accountability, and regulatory compliance.

5.3 Internal Commissioning

All the TriTech Institute's projects, regardless of funding source, are only selected if they offer the potential to contribute to the health and wellbeing of the population of South West Wales. However, the work undertaken through this business plan has demonstrated the potential for the TriTech Institute to re-balance its portfolio to enable it to be more responsive to internal direct commissions.

This might include an evaluative research of a new process or pathway of care or supporting the introduction of a proven innovation.

In order to do this, it is proposed that on an annual basis, the TriTech Institute ringfences 20% of its capacity (defined as 20% of its established costs) to support clinical care group priorities. Practically, this would involve:

- Criteria defined by executives in the October of the year preceding when the internal commissioning will take place. This would align to the annual planning cycle.
- An internal call for project ideas issued in November.
- TriTech Institute scope the project ideas with the delivery team, with proposals costed. The internal cost recovery rate will be applied, without the application of oncosts.
- Costed proposals considered by an internal prioritisation panel, chaired by an Executive, with recommendations ratified by all Executives.
- Projects will then be entered into the TriTech portfolio for the subsequent year, for delivery within the same year.
- The TriTech Institute cost recovery target is reduced by the combined value of the projects internally commissioned.

If the TriTech Institute delivers a genuine surplus during the year of the internally commissioned projects, the surplus will offset the cost of project delivery. However, if a surplus is not delivered, it is proposed that the the costs associated with the projects will be covered by the Hywel Dda University Health Board.

5.4 Current and Future Resource Planning and Investment

Current Resource Planning and Investment

Given the current strategic priorities and financial considerations, it is both appropriate and necessary to re-evaluate the existing staffing structure to determine whether current roles remain optimally aligned with operational requirements and future service delivery objectives. This review has explored the potential for transitioning existing roles into newly proposed positions, as well as identifying the need for additional roles where appropriate.

Such adjustments aim to enhance functional alignment and operational efficiency, while also contributing to the mitigation of financial risk through more targeted and effective resource deployment. All proposed changes have been considered within the context of organisational governance and policy, ensuring that any structural modifications are both justified and compliant.

Future Resource Planning and Investment

To sustain growth and deliver against the expanded scope of services outlined in this business plan, several opportunities for developing the current workforce and infrastructure have been identified.

Acting on these will ensure the organisation can meet rising demand, maintain quality, and continue operating at pace in areas such as evaluative research, digital innovation, and pathway redesign. Costed proposals for additional posts and associated support functions have been developed to inform future investment decisions and align resource growth with strategic priorities.

We will adopt a flexible approach to fixed-term appointments over the next five years, aligning these roles with emerging project opportunities and new income streams. This strategy ensures we can respond dynamically to innovation needs while maintaining financial sustainability.

The structure arising from these investments is illustrated in the next page. This would represent the entirety of the establishment in 28/29, if all income generation targets are met.

5.5 New Key Performance Indicators

The New Key Performance Indicators (KPIs) for the TriTech Institute are structured around four strategic principles that collectively define and measure the Institute's success in delivering research and innovation aligned with organisational priorities.

Principle 1&2: Excellence in Quality, Timeliness and Stakeholder Engagement

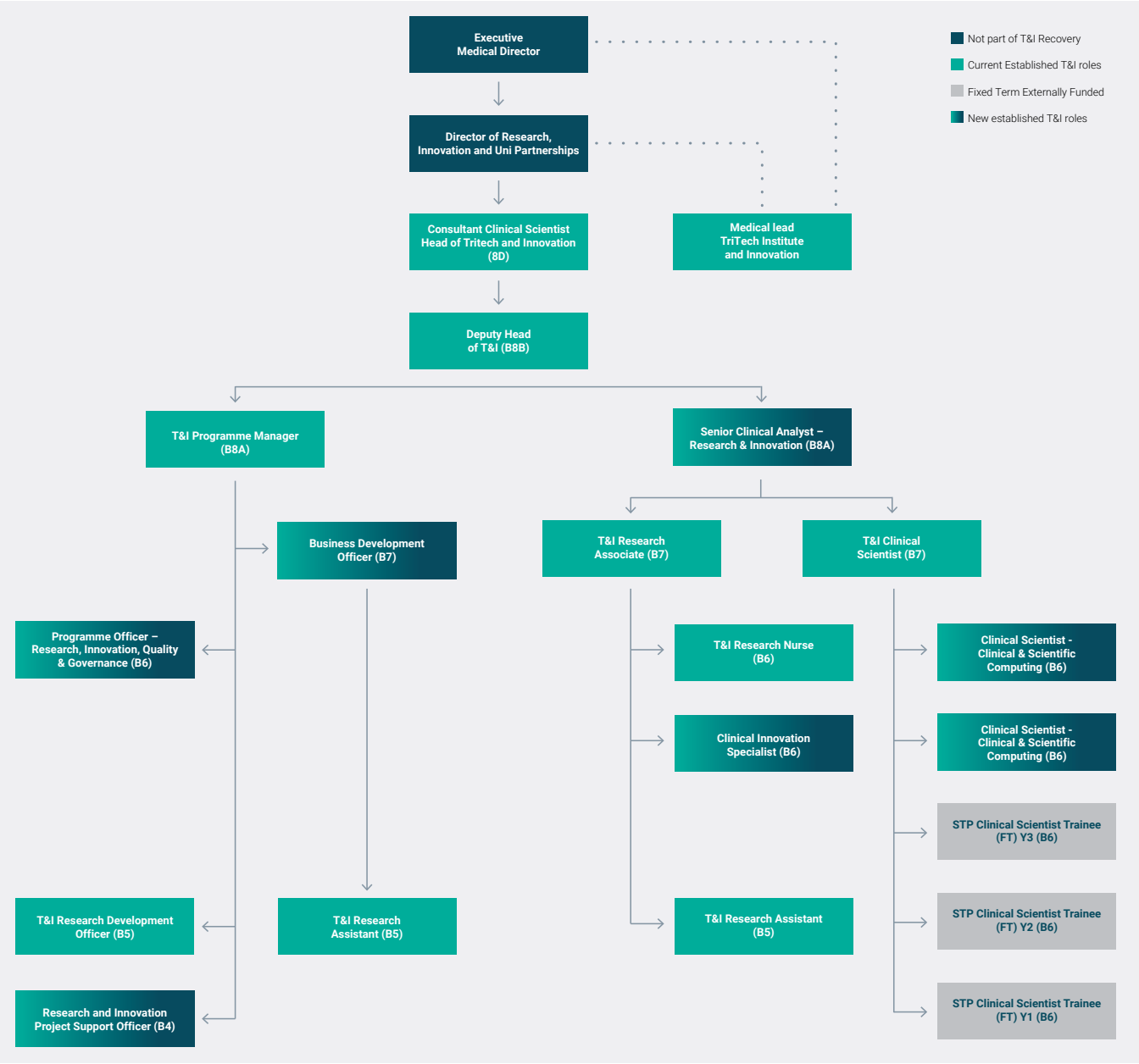
A foundational principle of the TriTech Institute is the delivery of high-quality, timely research and innovation projects in collaboration with internal stakeholders across HDUHB and external academic and industry partners. This principle encompasses two interdependent dimensions: the effective execution of projects and the systematic engagement of stakeholders through structured feedback mechanisms.

The TriTech Institute's operational model is underpinned by robust project governance, performance monitoring, and stakeholder engagement frameworks. Projects are managed to meet defined contractual obligations, quality standards, and agreed timelines, with proactive risk management to mitigate delays and reputational risks. Equally, stakeholder feedback is embedded as a core evaluative practice, enabling continuous improvement, organisational learning, and the refinement of collaborative processes. Together, these practices ensure that The TriTech Institute maintains credibility, fosters trust-based partnerships, and delivers sustained impact within the research and innovation ecosystem.

Key Performance Indicators (KPIs)

KPI 1 – Timely Project Delivery

- Specific: Ensure all research and innovation projects are delivered within agreed timelines or formally revised schedules, agreed with commissioners, through structured planning and regular progress tracking.
- Measurable: Achieve ≥95% on-time delivery across all active projects within our control by monitoring milestone completion rates.



- Achievable: Implement routine reviews with project leads.
- Relevant: Supports HDUHB's commitment to efficient delivery and enhances reputation and stakeholder confidence.
- Time-bound: Launch the tracking system within three months of business plan approval; achieve target by March 31, 2026, and annually thereafter.

KPI 2 – Quality and Stakeholder Engagement

- Specific: Implement a structured feedback process to capture stakeholder insights within two weeks of project completion.
- Measurable: Achieve ≥80% response rate from identified stakeholders per project; analyse

feedback using a standardised framework.

- Achievable: Use digital survey tools (e.g., Microsoft Forms or Qualtrics) with automated reminders.
- Relevant: Enhances continuous improvement and informs future project planning.
- Time-bound: Launch feedback process by March 31 2026; apply to 100% of completed projects by March 31, 2027, and annually thereafter.

Principle 3: Effective use of resources

The TriTech Institute operates under a cost recovery financial model within HDUHB, governed by an annual budget that encompasses staffing expenditures and non-pay miscellaneous operational costs. A fundamental aspect of this

model is the recovery of incurred costs through direct financial contributions from internal and external partners and collaborators, as well as through competitive grant funding. The strategic objective is to achieve the minimum of a financially neutral position at the end of each fiscal year and ideally a position that allows re-investment in wider health board service innovations and research priorities. It should be noted that all the TriTech Institute's project will make wider financial contributions to the health board by, for example, securing investment into service developments, improving efficiency or affording the 'head space' to work on early intervention and prevention.

To support the delivery of its financial objective, The TriTech Institute employs robust financial planning and monitoring processes, ensuring that project budgets are aligned with funding sources and that expenditure remains within approved limits. Failure to achieve cost neutrality would result in an unsustainable financial burden on HDUHB, potentially compromising The TriTech Institute's operational viability and its capacity to deliver future research and innovation activities. Inadequacies in costing methodologies can also result in a misalignment between team capacity and the work required to deliver financial balance.

A combination of these factors means that financial sustainability is embedded as a core principle within The TriTech Institute's governance framework.

KPI 3 – A yearly net zero (or better) financial position

- Specific: Monitor and manage the TriTech Institute's finances to ensure a minimum breakeven position by the end of each financial year.
- Measurable: Track yearly budget vs. actual spend and revenue (or cost savings) for the TriTech Institute, achieving a net financial position of zero or better by the close of the HDUHB financial year.
- Achievable: Using a financial tracker/dashboard and conduct monthly reviews with project leads and finance teams to identify variances and take corrective actions.
- Relevant: Supports HDUHB's goal of financially sustainable innovation and ensures responsible use of resources across the programme.

- Time-bound: Launch financial planning and monitoring tools within 3 months of business plan approval, and achieve break-even outcomes for 100% of projects closing annually thereafter.

Within the Welsh NHS context, we will champion innovation in primary care by supporting new models of service delivery, digital solutions, and collaborative approaches that enhance access and patient experience. This commitment aligns with national priorities set out in A Healthier Wales and the Public Health Wales strategic framework, which emphasize the need to tackle the wider social determinants of health, such as housing, education, employment, and community resilience. By embedding these principles into our planning, we aim to reduce health inequalities and improve wellbeing across our communities.

Principle 4: Aligning with the Strategic Imperatives of the HDUHB

A critical component of the TriTech Institute's strategic approach is the alignment of its research and innovation activities with the planning objectives of HDUHB. This alignment ensures that the TriTech Institute's initiatives directly contribute to addressing the organisation's most pressing challenges and deliver measurable impact for the populations and communities served within the HDUHB region. By embedding HDUHB's strategic priorities into project selection and development processes, the TriTech Institute maximises the relevance and utility of its outputs.

Failure to align the TriTech Institute's activities with HDUHB's planning objectives risks diminishing the value of its contributions, potentially resulting in limited organisational benefit and reduced return on investment. To mitigate this, the TriTech Institute employs a structured alignment framework, including regular strategic reviews, stakeholder consultations, and impact assessments, to ensure that its portfolio remains responsive to evolving organisational needs. This approach reinforces The TriTech Institute's role as a catalyst for system-wide improvement and ensures that innovation efforts are both purposeful and contextually grounded.

KPI 4 – On agreement of the priorities, the TriTech Institute cost recovery target is reduced by the combined value of the projects internally commissioned by 20% of the establishment costs.

- **Specific:** Ensure all projects supported by the TriTech Institute align to HDUHB planning objectives and 20% of the established staff are working on internally commissioned projects.
- **Measurable:** Review project agreement forms to ensure all projects align to HDUHB planning objectives and 20% of project income arising from internally instigated and funded projects.
- **Achievable:** All project applications to complete the HDUHB strategic alignment section in their proposal. Financial trackers used to determine proportion of internally instigated and funded projects.
- **Relevant:** Supports the HBUHB system-wide agenda
- **Time-bound:** Internal commissioning framework launched within three months of business plan being agreed (i.e., with quarterly updates thereafter).

Principle 5: Strategic Engagement, Communication and Dissemination

Strategic engagement and communication are essential to ensuring the visibility and continued success of the TriTech Institute. To support the development and sustainability of its research and innovation portfolio, the TriTech Institute must actively engage with both existing and prospective stakeholders, partners, and collaborators, internally within HDUHB and externally across academic, industry, and public sectors. Equally important is the communication and dissemination of project outcomes and findings to wider audiences, facilitating knowledge transfer and promoting the practical application of research and project insights.

To follow this principle, the TriTech Institute will implement a comprehensive communication and engagement strategy that includes regular stakeholder updates, targeted outreach campaigns, and structured dissemination activities such as publications, presentations, and digital media outputs. The absence of such a strategy would risk limiting the visibility and impact of TriTech Institute's work, reducing the likelihood of research findings being translated into practice, and potentially constraining future project opportunities due to diminished stakeholder awareness and engagement.

A measurable objective within this framework is to deliver quarterly communications outputs and ensure that 100% of completed projects include a documented dissemination plan and stakeholder feedback mechanism. This approach reinforces TriTech Institute's commitment to transparency, collaboration, and the strategic advancement of innovation within HDUHB and beyond.

KPI 5 – Effective Communication, Engagement, and Dissemination

- **Specific:** Enhance visibility and impact of innovation projects by actively communicating outcomes through internal channels, external platforms (e.g., journals, conferences, public events), and academic collaborations. Enhance trust in the TriTech Institute as a preferred delivery partner.
- **Measureable:** Four core measures are planned but further will follow the communications and engagement plan:
 1. Deliver a minimum of 6 internal communications (e.g., newsletters, intranet updates)/engagement events (e.g., away days, webinars) annually within HDUHB
 2. Deliver a minimum of 4 external outputs (e.g. journal articles, conference presentations, public engagement events) annually
 3. Demonstrate Patient and Public Involvement (PPI) involvement across all research and innovation projects where appropriate.
 4. through a question as part of KPI 2, demonstrate that >90% of clients and collaborators would recommend the TriTech Institute to other organisations.
- **Achievable:** A communications and engagement plan and the target measures can be achieved without additional resources. The approach will be to leverage existing networks, cohost events and co-author publications, thereby maximising capacity.
- **Relevant:** Supports HDDUHB strategic goals by promoting innovation, fostering knowledge exchange, and strengthening partnerships across clinical, academic, and public domains.
- **Time-bound:** Launch the communications and collaboration plan within three months of this business plan being approved, with quarterly progress reviews and a final impact summary by April 2026 and annually thereafter.

6.0 Conclusion

Over the next five years, the TriTech Institute will convert innovation to impact by focusing on four investable offers: **Digital & AI Assurance, Prevention & Pathway Optimisation, Procurement-ready Evidence, and Collaborative R&D.** This focus aligns directly with national policy in Wales, read-across to NHS England's prevention/digital shift, and HDUHB's priorities—moving us upstream, accelerating safe adoption, and hard-wiring value into routine care.

The TriTech Institute starts from a position of strength: a five-year track record, diversified income with c.£4.6m generated to date and further forecast in-year, a growing portfolio with global biopharma and national partners, and a credible testbed across Hywel Dda. Case studies in CVD, prostate cancer, TEC, AI diagnostics and surgical trials evidence The TriTech Institute's approach: co-design, evaluate, implement, and scale.

Delivery will be driven by three core disciplines:

First, governance and assurance: TIG R&ISC oversight, standardised evaluative research, adoption playbooks, and enhanced data, AI and QMS capability.

Second, people and place: phased resourcing (Health Economist/Data Analyst, QMS Lead, Computational Clinical Scientist, Portfolio PM, Bid/Grant Writer) to protect quality and throughput, alongside activating Pentre Awel as a partnership hub.

Third, engagement: targeted industry and academic outreach, stronger internal advocacy, and clear articulation of our USP to convert pipeline into adoption.

Risks are known and actively managed: system capacity and procurement variation (mitigated by adoption playbooks and PSR-aligned value cases), digital/AI assurance needs (mitigated by QMS/NICE-ESF alignment and post-deployment monitoring), and team resilience (mitigated by phased hiring and succession planning). KPIs will track outcomes and experience, adoption and spread, system value (VBHC), pipeline conversion, and risk/quality—reported quarterly to give clear line-of-sight from investment to benefit.

The ask of Hywel Dda UHB is proportionate and targeted. Approving the four-offer business plan, authorising the phased resource plan and non-pay lines, and reaffirming governance will allow TriTech to meet demand, de-risk adoption for the system, and deliver measurable patient and financial benefits at pace.

In short: the context is favourable, the demand signal is strong, and the route to value is clear. With this plan approved, the TriTech Institute is positioned to lead Wales—and contribute nationally—in turning evidence into outcomes, at scale.



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Equality Impact Assessment (EqIA) Screening Template

When to complete an EqIA Screening

An EqIA Screening Template must be completed when reviewing, changing and developing procedures/ proposals/ projects/ policies. This is a first step and is used to consider whether there are any negative impacts that may arise.

Purpose of an EqIA Screening Template

The purpose of this short exercise is to ensure that you have shown appropriate due regard when considering the impact for people with protected characteristics in your decision making. The screening process is designed to help you consider the circumstances and to inform evidence-based decisions.

If the proposal is of a significant nature and it is apparent from the outset that a full EqIA will be required, then it is not necessary to complete this Screening Template, you can proceed to complete the full [EqIA](#).

If no negative impacts are identified following completion of the EqIA screening then it is not necessary to undertake a full EqIA however, the decision and justification must be clearly recorded in this document.

On completion of the Screening Template:

- Ensure that all the white boxes within the screening are completed.
- Ensure that the Procedure/ Project/ Proposal/ Policy owner has signed and dated the Screening Template.
- Send a copy of the completed template along with the related policy or project proposal to Inclusion.hdd@wales.nhs.uk for the Diversity & Inclusion Team to review.
- Each Screening Template will be reviewed by the Diversity & Inclusion Team and feedback will be provided to the Procedure/ Project/ Proposal/ Policy owner. This may include recommendations for further action to inform robust decision-making.

Support

For further support please visit the [EqIA Sharepoint](#) or contact:

Email: Inclusion.hdd@wales.nhs.uk

Tel: 01554 899055

Director and Directorate	Mr Mark Henwood, Medical Directorate
Service Area	Tritech and Innovation

Title of Procedure, Project, Proposal, Policy being screened:	TriTech Institute Business Plan 2026-31

Description of the Procedure/ Project/ Proposal/ Policy being screened (including key aims and objectives)

As the current business plan approaches its conclusion in 2025/26, the development of a new business plan has been initiated for the period 2026–2031

The business plan is structured into the following sections:

- Current Organisation Details
- Market Analysis & The TriTech Institute's Positioning
- Situational Analysis
- Strategy & Implementation
- Organisation, Management Team & Governance
- Financial Plan & Projections

Executive approval is required of the entire business plan.

Evidence considered (including staff and population data, relevant research, expert and community knowledge etc.)

An independent peer review, which involved a multidisciplinary team (NHS, biopharmaceutical and medical technology) interviewing stakeholders to identify organisational strengths, challenges, and areas for improvement. The findings of this review were presented to the Executive Team on 23 July 2025 and included the need for a clearer USP, sustainability plans, and furthering of the applied research ambitions of the Institute. In response, the Executive Team asked for the business plan to:

- show clear alignment with the health board's organisational priorities and planning objectives;
- incorporate a costed assessment of workforce requirements; and
- set out a communications approach that enhances internal visibility, fosters stronger links with internal arrangements (e.g. primary care academy), and the contribution made to health board priorities.

An assessment of financial performance over the past four and a half years undertaken by the finance directorate, which has also been involved in several facilitated discussions to set out a financial strategy and plan for the next five years. The Institute has consistently delivered a year-on-year surplus relative to its cost recovery targets and, more significantly, has demonstrated an enduring commitment to evidence generation while actively supporting clinical teams in the adoption and integration of innovative practices.

- a comprehensive assessment of key performance indicators and a market assessment supported by the marketing company SBW. SBW also supported the development of the Institute's last business plan (2021-2026) and have convened several facilitated workshops to inform future KPIs in view of market opportunities;
- an overall assessment of key successes (2020/21-2024/25), which has included:
 - £4.63M income generated across 111 projects.
 - Support provided to 29 clinical leads, 37 academic collaborations, and 6 local businesses. Clinical teams frequently highlight the enabling nature of the Institute's approach and its contribution to innovation adoption.
 - Recognition through awards including MediWales, CSO England, and NHS Wales accolades.
 - 42 outputs comprising publications, posters, and conference presentations.
 - Support for local companies and public sector organisations.
 - Creating high quality scientific jobs: 8 substantive staff, 4 fixed-term staff, and 3 HEIW-funded Clinical Scientist trainees.
- several team development sessions, with a focus on understanding how the structure and working practices could be enhanced to optimise the delivery of the proposed TriTech Institute's objectives going forward.

Assess which protected characteristics will potentially be affected by the proposal in the table below (please ✓ the relevant box to confirm positive, negative or no impact).

If at any point a negative impact has been identified (actual or potential), you do not need to proceed with the completion of this form, as a full EqlA must be undertaken: [Equality Impact Assessments \(EqlAs\) \(sharepoint.com\)](https://sharepoint.com)

Age				
Is it likely to affect older and younger people in different ways or affect one age group and not another?				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified: The justifications below apply to all protected characteristics. Commissioned projects - Our activities are primarily evaluative and situated within a research context. As such, the work is designed to generate short-term insights rather than deliver sustained, long-term impact. The purpose is to assess effectiveness, usability, and outcomes within a defined timeframe, rather than to implement permanent service changes. In conducting this evaluation, we will adhere strictly to established research governance and ethical standards, including the completion of an Equality Impact Assessment (EqlA) in line with research protocols. This ensures that the study is inclusive, transparent, and compliant with all relevant regulatory and ethical requirements. Marketing, advertising and communication – ensuring that all marketing, advertising and comms (depending on the messages, target audiences) is inclusive, such as being bilingual, using inclusive language, targeting underrepresented communities, not using gendered language, using accessible formats etc. We work with a Cardiff-based marketing agency that is also commissioned by the Welsh Government. They take all of these factors into account when delivering their services.				

Disability				
Is it likely to affect those with a physical disability, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes?				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Gender Reassignment				
Is it likely to affect those who either:				
- Have undergone, intend to undergo or are currently undergoing gender reassignment. - Do not intend to undergo medical treatment but wish to live in a different gender from their gender at birth				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Marriage / Civil Partnership				
Under the Equality Act, the characteristic of Marriage and Civil Partnerships is only protected in the workplace/ employment.				
Is it likely to affect those who are married or in a Civil Partnership? This means someone who is legally married or in a civil partnership.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Pregnancy and Maternity				
Is it likely to affect those who are pregnant or have recently had a baby? Maternity covers the period of 26 weeks after having a baby, whether or not they are on Maternity Leave.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Race / Ethnicity				
Is it likely to affect people of a different race, nationality, colour, culture or ethnic origin including non-English / Welsh speakers, Gypsies/Travellers, asylum seekers and migrant workers?				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Religion or Belief				
Is it likely to affect people who have a religion or belief? The term 'religion' includes a religious or philosophical belief.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒

Justification of impact identified:				
Sex Is it likely to affect people who are mostly male or female. Where it applies to both equally does it affect one differently to the other?				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Sexual Orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or either.				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Armed Forces Community Consider whether this impacts on members of the Armed Forces and their families, whose health needs may be impacted long after they have left the Armed Forces and returned to civilian life. Also consider their unique experiences when accessing and using day-to-day public and private services compared to the general population. It could be through 'unfamiliarity with civilian life, or frequent moves around the country and the subsequent difficulties in maintaining support networks, for example, members of the Armed Forces can find accessing such goods and services challenging.' For a comprehensive guide to the Armed Forces Covenant Duty and supporting resource please see: Armed-Forces-Covenant-duty-statutory-guidance				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
Socio Economic Duty Consider those on low income, economically inactive, unemployed or unable to work due to ill-health. Also consider people living in areas known to exhibit poor economic and/or health indicators and individuals who are unable to access services and facilities. Food / fuel poverty and personal or household debt should also be considered. For a comprehensive guide to the Socio-Economic Duty in Wales and supporting resources please see: more-equal-wales-socio-economic-duty				
Positive Impact	☐	Negative Impact	☐	No Impact ☒
Justification of impact identified:				
We actively contribute to supporting local businesses and strengthening the regional economy. This includes collaborating with Welsh-based partners, and ensuring that our projects create opportunities for local enterprises to participate in innovation and research activities.				
Welsh Language Is it likely to impact on opportunities for people to use the Welsh language? The Welsh language should be treated no less favourably than the English language.				

Positive Impact		Negative Impact		No Impact	☒
Justification of impact identified:					

If a negative impact has been identified, you are not required to complete this form as a full EqIA must be undertaken. A full EqIA template and guidance can be found on the following link: [Equality Impact Assessments \(EqIAs\) \(sharepoint.com\)](#)

Screening Completed by:	Name	Chris Hopkins
	Title	Professor
	Contact details	Chris.I.hopkins@wales.nhs.uk
	Date	4 th November 2025
Screening Authorised by: (Directorate level owner of the procedures/ proposals/ projects/ policy)	Name	Leighton Phillips
	Title	Professor
	Contact details	Leighton.Phillips2@wales.nhs.uk
	Date	4 th November 2025
Guidance has been provided by Diversity & Inclusion Team:	Name	Helen Sullivan
	Title	Head of Partnerships, Diversity and Inclusion
	Contact details	Helen.sullivan@wales.nhs.uk
	Date	5/11/2025
Diversity and Inclusion Team additional Comments:		

Please note: The D&I team will save a copy of the completed form for reference. If any changes are made after the date of review, it is the directorate's responsibility to update the EqIA and inform the D&I team.

4 - Data

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

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

IGSC have scrutinised and are requesting that DDIC approve their findings. (IGSC was not quorate.)

| For approval

Attachments

[4.1 - DDIC- IGSC Sub-Committee \(3As\) - Jan 2026 V2 \(AT, needs HT\).docx](#)

[4.1 - 282-Network Security Policy.v4 1.docx](#)

[4.1 - 319 - Disposal of Digital Equipment Policy.v4.docx](#)

[4.1 - 422 - Consumer Device Policy.V4 1.docx](#)



INFORMATION GOVERNANCE SUB-COMMITTEE COMMITTEE UPDATE REPORT

Date of last meeting: 26 November 2025

Quoracy: Unmet 26 November 2025

Report by: Anthony Tracey, Digital Director, Chair

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert (may require discussion)

Information Governance Sub-Committee wishes to **alert** members of the Digital, Data and Innovation Committee that:

- Although Information Governance training compliance is above 85%, some departments still require improvement, which will be addressed through the Mandatory Training Group.

Advise (to monitor)

Information Governance Sub-Committee wishes to **advise** members of the Digital, Data and Innovation Committee that:

- Due to IGSC not being quorate, the Sub-Committee scrutinised extensions to the All-Wales IG policies (listed below) and also Health Board for DDIC to approve:
 - 836 - All Wales Information Governance Policy
 - 837 - All Wales Information Security Policy
 - 494 - All Wales Email Use Policy
 - 495 - All Wales Internet Usage Policy
 - 282 - Network Security Policy
 - 319 - Disposal of Digital Assets Policy
 - 422 - Consumer Device Policy

Assure (to note)

Information Governance Sub-Committee wishes to **assure** members of the Digital, Data and Innovation Committee.

- Compliance with Information Governance training has risen from 77% to 85.3%, marking the first time the Health Board has successfully achieved the national benchmark.

Review of Risks

The Sub-Committee reviewed the risks which are aligned to them. As part of its review, the Sub-Committee considered the status of each risk, and the current score was deemed in tolerance.

Sharing of learning

Not applicable

Recommendation

The Committee is asked to:

- **APPROVE** the extensions to the All-Wales IG policies (836,837,494 and 495).
- **APPROVE**; 282 Network Security Policy, 319 Disposal of Digital Assets Policy and 422 Consumer Device Policy.
- **NOTE** the items that the Committee is advising them of.
- **TAKE ASSURANCE** from the items that the Committee is assuring them of.

Network Security Policy

Policy information

Policy number: 282

Classification: Corporate

Supersedes: Previous versions

Version number: 4.0 Draft

Date of Equality Impact Assessment:

Approval information

Approved by:

Date of approval:

Date made active:

Review date:

Summary of document:

This policy states the network security requirements for the Health Board

Scope:

This policy applies to all users of the Health Board's digital networks.

To be read in conjunction with:

[837 - AW Information Security Policy](#) – opens in a new tab

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

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

Patient information:

Owning group:

Information Governance Sub-Committee [Click or tap to enter a date.](#)

Executive Director job title:

Director of Finance

Reviews and updates:

1 – new policy 26.6.2012

2 – revised 29.3.2016

3 – full review 28.2.2023

Keywords

Network, security, access, computing

Glossary of terms

None

Keypoints:

To ensure the security, integrity and availability of the Health Board's digital networks used to support our clinical and administrative services.

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INTRODUCTION

This document defines the computer network security policy for Hywel Dda University Health Board and this policy applies to all business functions and information contained on the network, the physical environment and relevant people who support the network.

It sets out the policy for the protection of the confidentiality, integrity, and availability of the network as well as security responsibilities for ensuring the security of our networks.

The network for the purpose of this policy is a collection of communication equipment such as servers, computers and printers which are connected using our local and wide area networks.

POLICY STATEMENT

The overall Network Security Policy for the Health Board is described below.

The Health Board's information network will be available when needed, can be accessed only by legitimate users and devices, and will contain complete and accurate information. The network must also be able to withstand or recover from threats to its availability, integrity, and confidentiality. To satisfy this the Health Board will undertake the following: -

- Protect all hardware, software, and information assets under its control. This will be achieved by implementing a set of well-balanced technical and non-technical measures.
- Provide both effective and cost-effective protection that is commensurate with the risks to its network assets.
- Implement the Network Security Policy in a consistent, timely and cost-effective manner.
- Where relevant comply with the legal, regulatory, and internal policy requirements.

If a user is found to have breached this policy, they may be subject to the Health Board's [disciplinary procedure](#). – opens in a new tab.

If a user does not understand the implications of this policy or how it may apply to them, they should seek advice from the Health Board's Network or Cyber Security Team.

SCOPE

This policy applies to all networks within Hywel Dda Health Board both wired and wireless used for: -

- The storage, sharing and transmission of non-clinical data and images
- The storage, sharing and transmission of clinical data and images
- Printing or scanning non-clinical or clinical data or images
- The provision of Internet systems for receiving, sending, and storing non-clinical or clinical data or images

AIMS

The aim of this policy is to provide assurance through relevant controls and procedures that our networks are secure and the information on them is kept confidential.

OBJECTIVES

The objectives to be achieved by this policy are: -

- Suitable controls exist to secure our networks.
- Ensure all those accessing and managing the network understand their roles and responsibilities.
- Ensure suitable procedures are in place.

Risk Assessments

Hywel Dda University Health Board will carry out security risk assessment(s) in relation to all aspects of the network that are used to support business processes. The risk assessment will identify the appropriate security countermeasures necessary to protect against possible breaches in confidentiality, integrity, and availability.

Formal risk assessments will be conducted in line with Health Boards Risk Assurance Framework.

Physical and Environmental Security

The following Physical and Environmental security mechanisms will be employed: -

- Network computer equipment will be housed in a controlled and secure environment that is monitored for temperature, humidity, and power supply issues.
- Critical network equipment will be housed in dedicated secure areas protected by physical locks and access control mechanisms.
- The Head of Digital Operations is responsible for ensuring the suitability of these security measures.
- Network equipment will be protected from power supply failures.
- Critical network equipment will be protected by intruder alarms and fire suppression systems.
- Various technical controls will be in place to secure the network including security patching, firewalls, and network admission control.
- All visitors to secure and critical network areas must be authorised by the Head of Digital Infrastructure.
- The Head of Digital Infrastructure will ensure that all relevant digital employees are made aware of procedures for visitors and those visitors are escorted when necessary.

Access Control to the Network

Entry to secure areas housing critical or sensitive network equipment will be restricted to those whose job requires it. Ordinarily, such access is supervised but there may be occasions when trusted engineers may require unsupervised access. The Head of Digital Infrastructure will maintain and periodically review a list of those with unsupervised access. Access to these areas will be restricted by appropriate controls.

Access to the network will be via secure methods and authentication against our directory service. Remote access to the network will conform to the Health Board's [Mobile Working Policy](#) – opens in a new tab.

There must be a formal, documented user registration and de-registration procedure for access to the network. All users on the network will have their own individual user identification and password and are ensuring their password is kept confidential. Users must ensure that they protect the network from unauthorised access. They must log off the network when finished working and workstations must be locked if a workstation is left unattended.

User access rights will be immediately removed or reviewed for those users who have left the Health Board or changed jobs.

Any device connecting to the corporate network must comply with the Health Board's Managed security requirements which include domain membership, Endpoint Detection and Response, Secure Web Gateway, and patching procedures. Devices that do not meet these requirements are not permitted to connect to the corporate network.

Clinical devices and Internet of Things (IoT) equipment connecting to the network must be placed in a segregated virtual network to ensure they are protected from the wider network and have controlled access control lists.

Requests for New Devices to Access the Network

Any department that has a need to connect new IoT or IoMT corporate devices to the corporate network must request formally via the Digital Services portal, Device Connectivity Request. The Cyber Security Team will need to review any new devices prior to connection. Departments must request this before procuring any new devices to ensure they meet the Health Boards security standards. Any devices that are procured without Digital Services approval may require significant network re-configuration to ensure they can be added securely which will incur additional costs.

Third Party Access to the Network

If external third-party owned devices require access to the corporate network this will be allowed only once the third party has provided assurances of their security posture of the organisation and device to the cyber security team where possible the free public and patient guest Wi-Fi service should be used ("Hywel Dda Public").

All third-party access to the corporate network must be logged and access to Hywel Dda Health Board's systems must be always audited.

Third party users must have an Active Directory account created for them for the duration of their stay with appropriate permissions and will not use generic accounts or service accounts.

Any department that has a need to connect new third-party owned devices to the corporate network must request formally via the Digital Services portal, Device Connectivity Request.

All third remote access by external third parties must be approved following the Code of Connection process and must utilise Hywel Dda approved remote access methods.

Physical access by 3rd parties to network equipment locations (Server Rooms, Communication Rooms, Cabinets etc) must be approved by Digital Services. 3rd parties must be supervised when physically working in these areas to maintain system security.

Network Monitoring

The Hywel Dda corporate network is monitored by an Armis network discovery tool. This monitors all devices connected to the network and provides a status of the device's vulnerabilities. New devices that are connected to the network are automatically reported to the Cyber Team via Armis. If a formal request to connect the device has not been received prior to connection, the Cyber Team reserve the right to block the device until an appropriate security review has been conducted.

External Network Connections

Any external network connections must only be through approved access methodologies and managed by the Digital Services department to ensure they can be appropriately secured and monitored.

Any connections not formally approved may put the Health Board at risk by disconnection from the Public Sector Broadband Aggregated Network (PSBA)

Personally Owned Devices

Under no circumstances should personally owned devices be connected to the corporate network. This includes plugging them into any network sockets located on walls throughout the estate, or attempting to connect them to corporate Wi-Fis (i.e. Hywel Dda or Hywel Dda Corporate).

Personally owned devices are only permitted to be connected to the available guests Wi-Fi networks available through the estates (i.e. _Hywel Dda Public)

Maintenance Agreements

The Head of Digital Operations will ensure that maintenance contracts are maintained and periodically reviewed for all network equipment. All contract details will constitute part of the Digital Department's Configuration Management Database.

Operating Procedures

Documented Security Operating Procedures will be created for the network that reflects this policy and changes to these procedures must be authorised by the Head of Digital Infrastructure.

Change Control

Any changes proposed to the network must consider the security of the network.

Changes must be in line with the Hywel Dda change control procedure and must be reviewed by the Digital Change Advisory Board and approved by the Head of Digital Infrastructure.

As part of acceptance testing of all new network systems the Cyber Security Manager will undertake security tests to ensure compliance with this policy.

Security Monitoring

The network will be monitored for potential security breaches and automated alerts will be generated to highlight potential issues.

All potential security breaches must be reported to the Cyber Security Team using the Digital Portal. The Cyber Security Manager is responsible for auditing the network to ensure it meets agreed security standards.

RESPONSIBILITIES

Proper definitions of roles and responsibilities are essential to assure compliance with this Policy. In summary these are: -

Users

The health Board will ensure that all users of the network are provided with the necessary security guidance, awareness, and where appropriate training to discharge their security responsibilities.

All users of the network must be made aware of the contents and implications of the network security policy and that irresponsible or improper actions by users may result in disciplinary actions(s).

All users should safeguard hardware, software and information in their care and prevent the introduction of malicious software onto the organisation's digital systems.

They also have an obligation to report on any suspected or actual breaches in security.

Digital Operations

Digital Operations will be responsible for: -

Management of our network equipmentManage our network security including that of the Wireless LAN and any external connections not a part of the PSBA network.

- Be responsible for Disaster Recovery and Business Continuity Plans and for the testing of those plans.
- Provide support to users in gaining access to the network and their use of services provided over the network.
- Periodic penetration testing to ensure the security of our networks.

Head of Digital Operations

Will be responsible for implementing an effective framework for the management of network security and ensure the production of all relevant security documentation, security operating procedures and contingency plans reflecting the requirements of this policy.

Head of Digital Infrastructure

Will be responsible for the implementation of effective security countermeasures contacting the Cyber Security Manager when incidents or alerts have been reported that may affect the security of the Health Board's networks.

Responsible for ensuring all network components will have effective configuration management procedures in place in line with the Hywel Dda Configuration Management Procedure.

Cyber Security Manager

The Cyber Security Manager will be responsible for: -

- Will be responsible for the mandating of effective security countermeasures.
- Acting as a central point of contact for cyber security within the organisation.
- Assisting in the updating of this policy and related policies for approval by the Information Governance Sub-Committee.
- Produce organisational standards, procedures, and guidance on cyber security matters.
- Liaise with external organisations on cyber security matters, including representing the organisation on the national Operational Security Service Management Board and associated sub-groups managed by Digital Health & Care Wales (DHCW).
- Advising the Head of Digital Operations on cyber security breaches and recommended actions.
- Encouraging, monitoring, and checking compliance with this policy.
- Promoting awareness and providing guidance on this policy.
- Creating, maintaining, and giving guidance on and overseeing the implementation of network security.

Line Manager's Responsibilities

Ensuring all employees are made aware of their security responsibilities as indicated in this policy.

TRAINING

All staff will be required to have appropriate information governance training which will include guidance on network security.

IMPLEMENTATION

All staff must adhere to this policy and failure to follow these policies may lead to disciplinary action being taken. This policy will be disseminated through global email and through periodic Information Governance training.

Disposal of Digital Assets Policy

Policy information

Policy number: 319

Classification: Corporate

Supersedes: Previous versions

Version number: 4

Date of Equality Impact Assessment:

Approval information

Approved by:

Date of approval:

Date made active:

Review date:

Summary of document:

The purpose of this policy is to outline the steps that need to be taken to ensure that all digital equipment is disposed of in the appropriate manner in terms of confidentiality and Waste Electrical and Electronic Equipment (WEEE) legislation and regulations.

Scope:

This policy covers the disposal of all digital equipment in particular the disposal of any computer related equipment computer media, audio tapes and removable media.

The policy applies to all materials which contain confidential information for example: paper records, photographs, computer media and audio tapes

To be read in conjunction with:

[183 - Information Security Policy](#) – opens in new tab

[275 - Secure Transfer of Personal Information](#) – opens in new tab

[494 - All Wales E-mail Policy](#) – opens in new tab

[281 - Mobile Working Policy](#) – opens in new tab

[282 - ICT Security Policy](#) – opens in new tab

Patient information:

Not applicable

Owning group: IGSC

Executive Director job title: Director of Finance

Reviews and updates:

- 1 – new policy 28.1.2023
- 2 – revised policy 26.6.2018
- 3 – revised policy 28.2.2023

Keywords

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

Glossary of terms

ICT – Information and Communication Technology

PC – Personal Computer

WEEE – Waste Electrical and Electronic Equipment

PAT – Portable Appliance Test

Health Board – Hywel Dda University Health Board

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Introduction

The Health Board has a duty of care to ensure that the disposal of digital equipment, especially those with disks or removable media containing information and data is undertaken with due care and attention. If any files contain personal or other sensitive or confidential data, then special care must be taken to ensure that this information cannot be accessed by anyone. There have been high profile cases where this care has not been adequately exercised; the Data Protection Act/General Data Protection Regulations 2018 or any subsequent legislation to the same effect requires that these issues are given serious consideration.

In addition, there are obligations that must be met for any person receiving the equipment in relation to its electrical safety that may represent a continuing liability or environmental implications in disposing of computer equipment.

Scope

This policy covers the disposal of digital equipment, in particular: -

- The disposal of any computer related equipment. This includes Servers, connected medical devices Personal Computers (desktop or laptop), mobile devices (tablets, smartphones), mobile phones, printers, scanners, and any other peripheral devices such as memory sticks.
- The policy applies to all materials which contain confidential information for example computer media and audio tapes.

This policy links to the Health Boards policies covering - Confidentiality, Data Protection, Records Management, and Information Security. Together these policies form an integral part of the Health Boards approach to Information Governance and Cyber Security.

Aim

The aim of this policy is to outline the steps that need to be taken to ensure that all digital equipment is disposed of in the appropriate manner in terms of confidentiality and Waste Electrical and Electronic Equipment (WEEE) legislation and regulations.

Objectives

The aims of this policy will be achieved through: -

- Effective communication with Health Board employees so they are aware of the procedures to follow.
- Digital department procedures to cover the effective disposal of equipment.

Definitions

Hardware

By its own nature digital equipment is constantly evolving and this can therefore become a very broad category making it impossible to list every single item or group of items within this policy document; however physical assets can be summarised as follows: -

- Desktop Devices
 - PC or Workstation
 - A Laptop, Tablet Computer or digital mobile device including Apple and Android devices
 - Telephones
- Data Centre Components
 - Servers, Storage systems, Power Distribution Units
 - Backup Devices, Backup appliances, Magnetic Tapes
- Local or standalone Devices
 - Printer, Scanner, Multi Function Device (MFD)
 - Security equipment (e.g. CCTV, Door Entry system)
- Network attached equipment
 - Printers, Scanners, MFDs
 - Medical Devices
 - Network Switches, Routers, Firewalls
 - Security equipment (e.g. CCTV, Door Entry systems)
 - Access Control systems such as card swipe systems
- Mobile devices (Cellular / WiFi connections)
 - Smart Phone
 - Smart Tablet
 - DECT Phones and their infrastructure equipment
 - Cellular infrastructure equipment
 - WiFi infrastructure equipment

Software

Providing a complete list of applications used by Hywel Dda University Health Board is not feasible, and detailing all acceptable uses for each application would be an extensive process. However, the software can be summarised as follows. :-

- Desktop Software – all applications and related data loaded onto a Desktop or Laptop computer.
- Server Software – all applications and related data loaded onto a server.
- Hosted Solution – all applications and related data (owned by the Health Board) hosted off site either in the National Data Centres or in a third-party provided Data Centres.
- Software as a Service – all applications and related data hosted in public cloud services such as Microsoft Azure and Amazon Web Services.

Electronic Data

Electronic Data can be summarised as follows: -

- CD's / DVD's
- Backup Tapes
- Memory Sticks
- Videos

Disposal of Digital Equipment Procedure

The Digital Operations department will assess whether equipment is redundant for its original use. This will be following discussion with the system owner and/or departmental manager. The disposal of Digital equipment procedures will cover all Health Board Equipment.

Equipment Disposal

Upon request an assessment will be made on the equipment by digital operations staff. Where possible equipment will be redeployed throughout the Health Board or offered to other NHS Wales organisations via the WarpIT portal.

Regardless of the path the equipment has taken there are only three reasons for disposing of equipment, they are as follows: -

- Redundant (fully functioning / not functioning)
- Broken (reasons known / reasons unknown)
- End of Life / Support and hence a Cyber Security Risk

Generally, Digital equipment will reach its natural end of life when it is between five and seven years old, however there are likely to be some exceptional circumstances where equipment becomes redundant mid-term due to specific machines (PCs and Laptops) needing to run specialised software where the specification of the machines has been exceeded.

In all instances an assessment (triage) must be undertaken to determine the validity of disposal of the equipment and to ensure authorisation is granted for the removal of the equipment from the asset system.

Where equipment is determined to be redundant an assessment will be made to determine whether the equipment can be used for digital inclusion.

Redundant Equipment

This is equipment that is no longer fit for purpose and is incapable of running the standard software deployed at the time. Typically, this will be the equipment that is five years of age or older. Redundant equipment that is not working will be disposed.

Broken Equipment

This is equipment that is not working and is out of warranty. Broken equipment that cannot be repaired will be disposed. It is also possible that broken equipment that can be repaired will be disposed when the cost of repair is greater than, equal to or just less than the cost of replacement. It may also be where the cost of repair is financially inappropriate, such as equipment which is nearing five years old is therefore due to be replaced soon.

End of Life

This is equipment which may be functioning correctly but has reached its end of life and is no longer supported by the manufacturer. Such equipment may no longer receive security updates or pose a risk to the Digital Operations of the Health Board. In such circumstances the equipment may be disposed of and replaced as required from available funds.

Disposal Method

In all instances all Health Board owned equipment will be disposed via the Digital Services approved scheme.

However, for redundant functioning equipment owned by the Health Board, it would be appropriate for this equipment to be reused in another suitable scenario or broken down as spares for other units that may yet have a small element of life within them. If no spares can be claimed from the unit, then it will be disposed.

Under absolutely no circumstances can any computer equipment be directly sold (or given) to any individual or other organisation. The procedure contained within Appendix A must be followed for all equipment and under no circumstances should any computer equipment be disposed of via undesignated skips, recycling centres or landfill.

All equipment disposals will be undertaken within current and future Waste Electrical Equipment (WEEE) legislation. However, Digital Services reserves the right to review this arrangement, with prior notification, as more equipment falls within the WEEE directive.

When re-deploying equipment, the Digital Operations Department will, if required, arrange for all equipment that does not have an up-to-date Portable Appliance Test (PAT) certificate to be tested prior to redeployment by the Estates Department.

Digital Inclusion

Where equipment is determined to be redundant an assessment will be made to determine whether the equipment can be used to support the Health Board's digital inclusion agenda. If so, the equipment will be securely wiped and provided for use by the digital inclusion team in our local communities to help improve digital accessibility and digital skills.

Media Destruction

Media, which is no longer required (or has passed its effective reuse period), should be dealt with as outlined below.

All media including CD-ROM's, DVD's, Hard Drives, USB memory keys and tapes will be dealt with by the Digital Services approved scheme and will be shredded and therefore destroyed using industry standard equipment.

Incidents

It is the responsibility of ward / department / unit managers to report incidents. Advice and guidance regarding confidential waste or record storage can be sought from the Head of Medical Records.

The Health Boards Risk Incident Reporting Procedures, DATIX, and security incidents must be followed, and the investigation / action accurately documented.

Responsibilities

Proper definitions of roles and responsibilities are essential to assure compliance with this Policy. In summary these are.

Executive Directors

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

Executive Directors must: -

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

Digital Services

Digital Services are responsible for: -

- For assessing whether the equipment could be suitably redeployed in another department or used for digital inclusion.
- Before disposal Digital Services will confirm with the user that no data is held locally which needs to be retained.
- In the event of such data being discovered then the data will be copied for safe storage and security onto network file storage.
- The equipment maybe dismantled and used for spare part purposes. In this case the hard disk will be erased to a complete and unrecoverable state.
- If any equipment is un-repairable or has no other useful life it will be disposed of, and the hard disk will be physically destroyed.
- After disposal Digital Services will record disposal on the relevant asset register, including the reason and method of disposal and which technician undertook the task.
- Physical disposal of assets must adhere to WEEE Regulations and ensure that disposal is both secure and environmentally responsible.

Line Managers

Managers are responsible for ensuring that all their staff have read and understood this policy. They must ensure that staff work in compliance with this policy and other appropriate legislation and Health Board policies.

Inform the Digital Service Desk of any digital equipment which require disposal.

All Staff

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

Staff must: -

- Confirm to their line manager that they understand this policy and their responsibility for the protection and security of the Health Board information they access.

- Be responsible for ensuring that unauthorised individuals are not able to see any confidential Health Board information or access Health Board systems.
- Should staff become aware that a breach of confidential information has taken place the Health Boards Information Governance incident response process should be followed immediately.

Consumer Device Policy

(Smartphones / Tablets)

Policy information

Policy number: 422

Classification: Corporate

Supersedes: Previous versions

Version number: 4

Date of Equality Impact Assessment:

Approval information

Sustainable Resources Committee

Date of approval:

Date made active:

Review date:

Summary of document:

This policy defines the roles and responsibilities, objectives and policy statements relating to the use of smart phones or tablets to access Hywel Dda University Health Board (Health Board) data or IT systems.

Scope:

The policy relates to any staff member (or manages a staff member) who uses a Health Board corporate smartphone or tablet, or their own smartphone or tablet to access Health Board IT services.

To be read in conjunction with:

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

[281 - Mobile Working Policy](#) – opens in a new tab

[494 – All Email Policy](#) – opens in a new tab

[495 – All Wales Internet Access and Usage Policy](#) – opens in a new tab

[320 – Acceptable use of information and communication technology policy](#) – opens in a new tab

Owning group: IGSC

Executive Director job title: Director of Finance

Reviews and updates:

1 – new policy 28.4.2015

2 – updated 28.08.2018

3 – full review 28.2.2023

4- updated 27.10.2025

Keywords

Information, Digital, Mobile Working, COBE, BYOD, Tablet, Smartphone, IT, ICT, Apple, Android

Glossary of terms

MDM	Mobile Device Management, software that provides features that enables a device to be used in a secure manner.
COBE	Corporate Owned Business Only, corporate issued devices that must only be used for business purposes.
BYOD	Bring Your Own Device
GDPR	General Data Protection Regulations
ICT	Information & Communication Technologies
Jail Broken	Apple device that has been modified to install apps and make configuration changes not authorised by Apple.
Rooted	Android device where access has been given to modify the software on the device to make unauthorised changes.
WPAS	Welsh Patient Administration System.
Health Board	Hywel Dda University Health Board

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Introduction

The Health Board has the goal to enable greater flexibility to allow the use of Smartphones and Tablets to access health board data and applications. These could be both corporately owned devices (Corporate Owned, Business Only - COBE) and personally owned devices (Bring Your Own Device – BYOD).

This policy will therefore use the terms BYOD and COBE throughout and are clarified below: -

- BYOD – refers to Bring Your Own Device and is the scenario where a health board employee chooses to use their own smartphone or tablet to access health board information and systems.
- COBE – refers to Corporate Owned Business Only and is the scenario where the health board has purchased a smartphone or tablet for the use by the employee whilst undertaking Health Board business. These devices should only be used for business use only.

This will allow you to access: -

- Your work emails
- Your work calendars
- Your work contacts
- A secure work web browser (Access to internal web sites)
- Access to OneDrive
- Microsoft Teams
- Other O365 applications (e.g. Viva Engage)
- Citrix based applications
- Public applications available in App Stores which maybe of relevant to your role
- Private applications which might be developed in the future by Hywel Dda and/or its partners.

The use of portable devices and mobile platforms is now commonplace in our personal lives and during the pandemic the use of these technologies in the NHS has grown considerably. The adoption of tablets and smartphones has the potential to deliver many benefits to health board staff especially those which are mobile.

This mobile device use however poses a substantial risk in that devices may be lost, damaged, or stolen, potentially resulting in loss or inappropriate disclosure of data. When using mobile devices, the risks of working in an unprotected environment must be considered and mitigated where possible using appropriate security systems and the procedures outlined in this policy.

It is noted that some staff may use their own device for work business outside of this scheme, all staff are reminded that it is not permitted to use consumer applications such as WhatsApp, Dropbox and Snapchat etc. for the transfer of Person Identifiable Information (PII) or confidential Health Board information. These activities could result in a breach of the Data Protection Act / General Data Protection Regulations or any subsequent legislation to the same effect and enforcement activities against the Health Board and disciplinary procedures against the individual.

Policy Statement

To utilise any of these services to access corporate data and applications, all users of the service will need to understand the following terms and conditions. There is no registration required for the BYOD scheme and it is available to all staff once they have setup Microsoft Multi-Factor Authentication (MFA).

All users of this service will fully comply with corporate policies on appropriate mobile phone, e-mail, and internet usage. These can be found on the Health Board's Intranet or Internet site.

All users of the service must familiarise themselves with the corporate Information Governance policies and ensure they are adhered to.

- All staff will need to register for Microsoft Multi-Factor authentication and either use the app on the smartphone / tablet, receive SMS messages or automated phone calls.
- All users of this service will need to adhere to the security policies of the health board ensuring safe access to corporate data and applications.
- A security application will provide the health board with the ability to lock down and secure the device such as enforcing a password and encrypting the device on COBE devices. No applications are installed on personal devices using the BYOD scheme.
- Policies enforced on your device are aimed at managing corporate data and applications, your personal information on COBE devices will not be affected.
- Policies on COBE which are corporately owned will be aimed at managing the device and whilst personal information can be stored on these devices it is done so at your own risk and digital will not be able to recover any personal information lost.
- You will keep your password / passcode secret and not allow anybody else to access the information. Where possible use biometric authentication such as your thumb print where the device supports this.
- Should you lose or have your BYOD device stolen you will need to report this to Digital immediately so that we can revoke access to corporate data remotely. It will be the user's responsibility to report the theft of the device to the authorities.
- Should you lose or have your COBE device stolen you will need to report this to digital immediately so that we can wipe the device remotely. The Health Board will then report the theft of the device to the relevant individuals in the health board.
- In the unlikely event that personal data on the BYOD device is affected or lost, the Health Board will not be held responsible or liable for any damages or compensation. Any personal data on the COBE device will be lost if the device is stolen or lost as the device will be wiped completely.
- You accept that the Health Board will not be liable for any charges relating to the handset hardware, tariff, insurance, call, or data charges incurred when using BYOD devices.
- You accept that the Health Board offers no support or maintenance for the phone/tablet and it is your responsibility to maintain or repair it as and when required for BYOD devices. COBE will be fully supported by the Digital Service Desk.
- No cloud services should be used to store health board data such as Apple's iCloud, GoogleDrive and Dropbox. Separate services are available to enable data to be shared with third parties or for home access. Please contact the Digital Service Desk to access these.
- Under no circumstances should PII data relating to patients be stored directly onto devices. Data should remain in the relevant application and service for that data. I.e WPAS/ WCP etc.

Failure to adhere to these protocols will result in the withdrawal of the service.

Scope

All staff that are part of the scheme or manage staff that are part of the scheme needs to adhere to this policy.

Aim

The aims of this policy are:

- To ensure that the Health Board complies with its legal obligations against the Data Protection Act including UK GDPR (2018) and the Network & Information System Regulations (2018).
- To promote the safe and secure use of mobile equipment in support of the clinical and operational work of Hywel Dda University Health Board.
- To provide a secure working environment for personnel working remotely on corporate / public wireless networks and 4G/5G mobile connections.
- To ensure that resources provided to staff are not misused.
- To ensure that the security of mobile systems and the information they contain is not compromised in any way.

The policy applies to all full-time and part-time employees of the Health Board, Independent Members, contracted third parties (including agency staff), students/trainees, bank staff, staff on secondment and other staff on placement with Hywel Dda University.

Objectives

The Health Board's approved method of enabling the required security is through Microsoft Intune which is part of the Microsoft 365 suite of productivity tools.

Mobile phones and similar devices used for application / data access must have a security PIN number, passcode enabled, or biometric security such as fingerprint / facial recognition.

Patient identifiable information (PII) or other confidential Health Board data must not be stored permanently on mobile devices or media. Where possible information should be transferred to the Health Board's systems and deleted from the device as soon as possible.

All devices will be enrolled onto the system using the vendor's current enterprise deployment method such as Apple Deployment Enrolment Programme or Android Enterprise.

Service Policy

Applying for the Service

Please use the online form to access the COBE scheme. Your manager will need to approve this spend and provide Digital with a cost code.

All users have automatic access to the BYOD scheme and it is personal preference whether a member of staff chooses to use or not.

Acceptable Use

- The Health Board defines acceptable business use as activities that directly or indirectly support the services within the Health Board.
- Acceptable use for Internet and E-mail use is available in the relevant existing policies.
- For BYOD the Health Board defines acceptable personal use on company time as reasonable and limited personal communication. Policies will ensure Health Board data cannot be shared outside of corporate apps such as Outlook.
- COBE devices may not be used at any time to: -
 - Store or transmit illicit materials.
 - Harass others, particularly on the grounds of any protected characteristic as defined in the Equality Act 2010.
 - Engage in outside business activities.
- A list of applications will be maintained and these maybe pushed directly to the device on registration.
- COBE will have policies applied to ensure a disallow list of applications and internet sites are maintained so that these cannot be used on health board devices.
- Employees may use their own mobile device to access the following Health Board resources: email, calendars, contacts, documents, websites, Microsoft 365 applications and other approved applications.
- The Health Board has a zero-tolerance policy for texting or emailing while driving.
- Staff must not allow unauthorised individuals access to Corporate systems and data via their COBE and BYOD.

Working Abroad

- Calls on Hywel Dda mobile phones are blocked by default outside of the UK. Requests to use a Health Board mobile phone outside of the UK should be submitted to the IT Service Desk at least 10 days before travel. Each request will be reviewed on a case-by-case basis. Users are required to keep call and data to a minimum to perform business function, to keep charging costs as low as possible.

Devices and Support

- Smartphones including iPhone and Android are allowed to use this service.
- Tablets including iPad, Windows and Android are allowed to use this service.
- Health Board app issues are supported by Digital Services; employees should contact the device manufacturer or their carrier for operating system or hardware-related issues for BYOD devices.
- NO "jail broken" or rooted devices are allowed and will be automatically rejected and will not connect to the service.

After a licence is purchased and a user account is setup on the system you will be sent instructions on how to add your device to the service.

- Microsoft Outlook
 - Email – you will have access to work email and lookup users from the directory.
 - Calender – access to your work appointments
- Task Management
 - Microsoft To Do and Microsoft Planner

- Microsoft Teams
- Secure web browser (Microsoft Edge) – this will allow access to work SharePoint sites e.g., the Intranet.
- Access to work files and the ability to create docs (using Word, PowerPoint, Excel etc.).
- Please note there are limitations with the degree of functionality of internal applications. This relates to how the application has been designed to function in a traditional PC/Laptop environment with larger screens. If you still wish to access applications via Citrix (HDDVAPPS) such as WPAS, you can do but in the knowledge that full functionality may not be available and navigation may be difficult.

Responsibilities

Reimbursement

- The Health Board will not reimburse the employee for a percentage of the cost of the BYOD device.
- The Health Board will not reimburse the employee for data changes on BYOD devices.

Security

- For BOYD devices the following is employed:
 - conditional access policies are in place to protect Health Board data
 - staff must use Microsoft Authenticator to access Health Board data
- For COBE devices the following is employed:
 - To prevent unauthorized access, devices must be password protected using the features of the device.
 - The device will lock itself if it's idle for five minutes.
 - After 11 failed login attempts, the device will lock. Contact the Digital Service Desk to regain access.
 - The minimum password length is 6 characters and must be complex.
 - Password expiry is 90 days.
 - Internet protection
- Rooted (Android) or jailbroken (iOS) devices are strictly forbidden from accessing the service and are blocked by default.
- Employees are automatically prevented from downloading, installing, and using any app that does not appear on Health Boards list of approved apps on COBE devices
- For COBE the device may be remotely wiped if 1) the device is lost, 2) the employee terminates his or her employment, 3) ICT detects a data or policy breach, a virus or similar threat to the security of the Health Boards data and technology infrastructure.
- For BYOD the users account will be removed from the license group therefore removing access to health board data and applications, personal data will not be affected.

Data Security

The device is fully encrypted and all data in transit to and from the device is fully encrypted. The device integrity and authenticity are continually checked for any security risks and immediately blocked if detected.

Should you lose your device, or you must inform the Digital Service Desk immediately and we will remove access. This will NOT interfere with any personal data of the device for BYOD devices. If you forget your password after 10 attempts, it will delete the corporate device and all work data within it. Digital Services do not have sight of the password and cannot recover it

Risk / Liabilities / Disclaimers

- The Health Board can accept no liability for the loss of any private information held on a BYOD or COBE device such as documents and photos.
- While Digital Services will take every precaution to prevent the employee's personal data from being lost it is the employees responsibility to take additional precautions, such as backing up your personal device using the iCloud for example.
- The health board reserves the right to disconnect devices or disable services without notification.
- Lost or stolen devices must be reported to the Health Board immediately. Employees are responsible for notifying their mobile carrier immediately upon loss of a BYOD device. A self-service portal will also be available for employees to disable their own devices if required.
- The employee is expected to always use his or her devices in an ethical manner and adhere to the Health Boards [320 - acceptable use policy](#). – opens in a new tab.
- The employee is personally liable for all costs associated with his or her BYOD device.
- The employee assumes full liability for risks including, but not limited to, the partial or complete loss of company and personal data due to an operating system crash, errors, bugs, viruses, malware, and/or other software or hardware failures, or programming errors that render the device unusable.
- The Health board reserves the right to take appropriate disciplinary action for noncompliance with this policy.

Roles & Responsibilities

Directors

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

Directors must: -

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

Line Managers

Managers are responsible for ensuring that all their staff have read and understood this policy prior to authorising mobile computing arrangements. They must ensure that staff work in compliance with this policy and other appropriate legislation and Health Board policies. This includes the responsibility for ensuring that risk assessments are or have been carried out and that suitable controls are put in place and remain in place to either eradicate or minimise any identified risks to the security of Health Board information.

Line managers **must** inform the Digital Service Desk when a member of staff leaves the Health Board or changes role.

All Staff

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

Staff shall inform their manager if they have any concerns about any issues that would constitute an information risk. This covers not only risks to resources or confidentiality of data, but also personal risk, risk to others and risk to the Health Boards reputation.

Staff need to confirm to their line manager that they understand this policy and their responsibility for the protection and security of the Health Board information they access.

Health Board information must only be used for Health Board related purposes in connection with Health Board work.

Staff are responsible for ensuring that unauthorised individuals are not able to see any confidential Health Board information or access Health Board systems.

Users of information will: -

- Keep usage to a minimum in public areas.
- Only use information off-site/at home for work related purposes.
- Ensure security of information within the home.
- Not send patient identifiable or confidential data to home (internet) e-mail addresses.

Digital Services

- Fulfil requests to access the scheme.
- Provide advice and direction on the use of this scheme.
- Ensure adequate security controls are implemented in support of this policy.
- Provide reports on usage of the scheme and retire inactive devices from the service.

4.2

11:50, 0 Mins

4.2 - Data Protection Impact Assessment Assurance Report

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

| For assurance

Attachments

4.2 - DDIC - DPIA Update - Jan 2026 (AT, HT).docx



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:	Data Protection Impact Assessment Assurance Report
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This report provides an overview of the progress made in managing Data Protection Impact Assessments (DPIAs) during the current financial year. It details the volume of DPIAs reviewed and completed by the Information Governance Team, highlights key trends, and outlines any emerging issues or areas for improvement. The purpose of this report is to demonstrate compliance with data protection requirements and to ensure transparency in how privacy risks are being assessed and mitigated across the organisation.

Cefndir / Background

A DPIA is a structured process designed to identify, assess, and mitigate risks to personal data before implementing new projects, systems, or processes. DPIAs help ensure that privacy considerations are embedded into the design and delivery of services, reducing the likelihood of data breaches or non-compliance with data protection legislation. They are particularly important when introducing technologies or workflows that involve large-scale processing of personal data, special category data, or innovative uses of information.

Under the UK General Data Protection Regulation (UK GDPR), organisations are legally required to carry out a Data Protection Impact Assessment (DPIA), also referred to as a Data Privacy Impact Assessment, when introducing significant changes or new methods of processing personal data. This requirement applies particularly to activities that present a high risk to individuals' rights and freedoms, such as the processing of personal and special category data within the health sector.

Current data protection legislation places strong emphasis on accountability and the protection of individual information rights. Patients and service users have a reasonable expectation that their privacy and confidentiality will be respected at all times, both during the provision of care and beyond. Meeting these expectations is fundamental to maintaining trust and compliance.

For these reasons, it is essential that any new initiative, system, or process involving personal data is assessed for its potential impact on privacy. A DPIA provides a systematic and

structured approach to identifying risks, evaluating their severity, and implementing appropriate safeguards. By embedding DPIAs into project planning and decision-making, organisations can ensure that privacy considerations are addressed proactively rather than reactively, reducing the likelihood of breaches and supporting compliance with legal and ethical obligations.

Failure to complete DPIAs when required can result in regulatory action, reputational harm, and financial penalties. As such, DPIAs are an essential mechanism for ensuring compliance and safeguarding patient trust within the health board. While this process is critical, it may occasionally introduce delays to project completion due to the need for thorough risk assessment and mitigation.

Asesiad / Assessment

Challenges

The DPIA process, while essential for compliance, presents several operational challenges that impact both project timelines and the workload of the IG Team. One of the most significant issues is the late submission of DPIAs, which often occurs at advanced stages of project development. This limits the opportunity for early risk identification and mitigation, forcing the IG team to work under tight deadlines and increasing the likelihood of delays to implementation.

Another recurring challenge is the quality and completeness of initial DPIA drafts. Many submissions lack critical details such as data flows, technical security measures, or third-party arrangements. This results in multiple rounds of clarification and revision, placing additional strain on IG resources and extending review times.

The IG Team also experience limited awareness among project leads and service areas regarding when a DPIA is required and the level of detail expected. This knowledge gap contributes to inconsistent submissions and delays, as teams often underestimate the complexity of the process.

Resource constraints within the IG Team compound these issues. The growing volume of DPIAs, driven by digital transformation initiatives and new service models, has significantly increased demand for reviews. With finite capacity, the team must balance competing priorities, which can lead to bottlenecks.

Finally, projects involving external providers introduce further complexity. Obtaining timely input and assurance from third-party suppliers can be challenging, particularly when contractual arrangements do not clearly define responsibilities for DPIA completion. These dependencies often result in prolonged review cycles and uncertainty around compliance.

Future Reporting

For future reporting, it is proposed that the category currently listed as 'In Progress' will be broken down into more detailed sub-categories to provide greater visibility of where each DPIA sits within the process. This enhanced reporting will improve transparency and allow the Information Governance Sub-Committee (IGSC) to monitor progress more effectively.

Suggested sub-headings include:

- IG Awaiting Initial Draft – DPIA has been requested but not yet received from the service or project team.
- With IG for Review – Initial draft submitted and under review by the IG Team.
- With Service/Provider for Comment/Revision – DPIA returned to the originating team for clarification or amendments following IG review.
- On Hold – DPIA paused due to project delays, dependency issues, or awaiting further information.

Introducing these sub-categories will enable clearer tracking of DPIA workflow stages, highlight potential bottlenecks, and support timely completion of assessments.

Benefits of Sub-Categorisation

Introducing sub-categories within the 'In Progress' status provides significant advantages for reporting and operational oversight. By breaking down this broad category into specific stages, such as "IG Awaiting Initial Draft," "With IG for Review," "With Service/Provider for Comment," and "On Hold," the organisation gains much greater clarity on the progress of each DPIA. Appendix 1 provides a comprehensive list of all subcategories, detailing not only the classification of each DPIA but also the associated level of complexity. It further outlines the degree of involvement required from the IG Team at each stage, helping to clarify resource needs and responsibilities for successful completion.

Firstly, transparency is improved, as stakeholders can see exactly where each DPIA sits within the workflow. This level of detail helps the IGSC monitor progress more effectively and identify any areas of concern.

Secondly, monitoring and accountability are enhanced. Sub-categorisation makes it easier to pinpoint bottlenecks and delays. For example, if a large number of DPIAs are awaiting initial drafts, this signals a need for earlier engagement with project teams.

Another key benefit is better resource planning. Understanding which stage DPIAs are in allows the IG Team to allocate resources more efficiently. If several DPIAs are under review, additional capacity can be deployed to avoid delays.

Sub-categorisation also supports timely completion by enabling proactive intervention when issues arise. This reduces the risk of last-minute compliance problems that could impact project timelines. In addition, communication improves because the sub-categories provide a common language for project teams and IG staff. Status updates become clearer, and next steps are easier to explain.

Finally, over time, this approach generates data-driven insights. Reporting on these sub-categories will highlight patterns, such as which stages typically take longest, informing process improvements and targeted training.

Addressing Challenges Going Forward

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

- **Early Engagement and Expanded Training**

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

- **Improved Submission Quality**

Improve our guidance and templates to project teams to ensure DPIA drafts include all

necessary details, such as data flows, technical controls, and third-party arrangements. This will reduce the need for multiple review cycles and improve efficiency.

- **Enhanced Tracking and Visibility**

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

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

- **Resource Planning and Capacity Management**

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

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

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

- **Strengthened Third-Party Governance**

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

Number of DPIAs Completed and In Progress

During the current financial year, the IG Team has managed a total of 130 DPIAs up to Quarter three, reflecting the continued demand for privacy risk assessments across the organisation. Of these:

- **Completed DPIAs:** 64 – These assessments have been fully reviewed, approved, and signed off, ensuring compliance prior to project implementation.
- **In Progress DPIAs:** 31 – These are currently undergoing review or awaiting further information. For future reporting, this category will be broken down into sub-stages such as:
 - *Awaiting Initial Draft from Service*
 - *Under IG Review*
 - *Returned to Service for Amendments*
 - *On Hold due to Project Dependencies*

This breakdown will provide greater transparency and allow IGSC to monitor progress more effectively. It will also help identify bottlenecks and support timely intervention where necessary. This also shows that 73% of all DPIAs are either completed or currently in progress, while the remaining cases fall under the low-level enquiry category and have not yet been started.

The table provides further detail on the number of DPIAs received by the IG Team.

As at Quarter 3	Enquiry	Level 1	Level 2	Level 3	Total	%
DPIA Level (Completed)	30	6	19	9	64	49%
DPIA Level (In Progress)	1	3	16	11	31	24%
DPIA Level (On Hold)	0	0	0	0	0	0%
DPIA Level (Not Started)	28	4	1	2	35	27%
Total	59	13	36	22	130	

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

Summary

This report has provided a comprehensive overview of the management and progress of DPIAs within Hywel Dda University Health Board (HDdUHB) during the current financial year. The report has highlighted both the achievements and the ongoing challenges faced in the DPIA process. Notably, the increasing volume and complexity of DPIAs reflect the health board's commitment to embedding privacy considerations into digital transformation and service innovation. However, challenges such as late submissions, incomplete information, limited awareness among project leads, resource constraints, and dependencies on external providers have impacted the efficiency and timeliness of DPIA completion.

To address these challenges, the IG Team has set out a series of targeted actions, including enhanced training and early engagement, improved guidance and templates, the development of a DPIA tracking dashboard with sub-categorisation, and strengthened resource planning and third-party governance. These measures are designed to improve transparency, accountability, and responsiveness, ensuring that DPIAs are completed promptly and to a high standard.

In conclusion, HDdUHB remains committed to upholding the highest standards of data protection and information governance. By continuously refining the DPIA process and investing in staff awareness and resources, the organisation will further strengthen its compliance posture, safeguard patient trust, and support the safe and effective delivery of care in an increasingly digital environment.

Argymhelliad / Recommendation

The Committee are requested to:

- **TAKE ASSURANCE** that the Information Governance (IG) Team has clear plans in place to enhance both transparency and responsiveness in the DPIA process. These improvements include the development of a DPIA tracking dashboard. Collectively, these measures will provide greater visibility of progress, reduce delays, and ensure that those requesting IG support receive timely updates and guidance.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.3 Seek assurance that the digital, data and information governance implications and risks arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners are considered and mitigated. 3.1.6 Seek assurance that there is a robust information governance and security framework within the UHB and encourage a strong information governance and security culture across the organisation. 3.1.7 Seek assurance that the Health Board is meeting its responsibilities with regard to the General Data Protection Regulations, the Freedom of Information Act, Caldicott Principles, Records Management, Clinical Coding, Information Sharing, national Information Governance policies and the Information Commissioner's Office guidance. 3.1.8 Seek assurance of the Health Board's compliance against relevant statutory requirements, internal and external standards and assessment criteria, via the Information Governance Toolkit, Cyber Assessment Framework (CAF) any other relevant requirements / assessments, and audits, inspections and reviews, including the implementation of Audit Wales, Health Inspectorate Wales and Internal Audit recommendations.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply

Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termau: Glossary of Terms:	Included within the main body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Information Governance Sub-Committee (IGSC)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Failure to comply with data protection legislation could result in a monetary fine or penalty.
Ansawdd / Gofal Claf: Quality / Patient Care:	Poor practice around information governance in relation to poor understanding and a lack of training for staff has a direct impact on the quality of patient care.
Gweithlu: Workforce:	Ensuring that all HDdUHB staff have the required information and training to assist them in complying with Information Governance and data quality principles, including confidentiality
Risg: Risk:	Failure to comply with data protection legislation will result in poor IG practices being in place throughout HDdUHB . It may also lead to investigations by the Information Commissioner's Office and could result in a monetary fine or penalty.
Cyfreithiol: Legal:	Failure to comply with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018, the Freedom of Information Act 2000 and the common law duty of confidentiality will result in HDdUHB not being fully compliant with data protection legislation
Enw Da: Reputational:	A lack of trust by patients in the HDUHB's ability to safeguard their information may dissuade people from providing information that is essential to providing them with quality care.
Gyfrinachedd: Privacy:	Privacy is very important within HDdUHB and the impact on the individual's privacy should be considered at each stage
Cydraddoldeb: Equality:	All personal data should be managed appropriately and in the same manner across the HDdUHB

Appendix A – DPIA Category

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

Sub-Categories

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

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

4.3

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4.3 - Information Governance Training Update

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

| For assurance

Attachments

[4.3 - DDIC - Information Governance Training Update - Jan 2026 \(AT, HT\).docx](#)



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:	Information Governance Training Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, Digital Director

Pwrpas yr Adroddiad (dewiswch fel yn addas)

Purpose of the Report (select as appropriate)

Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to provide the Digital, Data and Innovation Committee (DDIC) with an update on the Hywel Dda University Health Board's (HDdUHB's) ongoing efforts to improve compliance with mandatory Information Governance (IG), Records Management (RM), and Cyber Security training. These areas are fundamental to ensuring the confidentiality, integrity, and availability of patient and organisational information, as well as safeguarding against increasing cyber threats.

This paper outlines the current compliance position, highlights key challenges impacting training uptake, and details the actions being implemented to address these gaps. It also sets out the strategic importance of achieving full compliance, both to meet statutory and regulatory obligations and to support the Health Board's wider digital transformation agenda. By strengthening staff awareness and adherence to best practices, HDdUHB aims to reduce risk exposure, maintain public trust, and enhance operational resilience.

Cefndir / Background

IG, RM, and Cyber Security training are critical components of maintaining the confidentiality, integrity, and availability of patient and organisational data within HDdUHB. Compliance with these mandatory training requirements ensures that staff understand their responsibilities in safeguarding sensitive information, adhering to legal and regulatory frameworks, and mitigating risks associated with cyber threats.

Recent internal audits and compliance reports have highlighted variability in training completion rates across departments, with some areas falling below the health board's target thresholds. This poses potential risks, including data breaches, non-compliance with statutory obligations such as the Data Protection Act (DPA) 2018 and UK General Data Protection Regulation (GDPR), and increased vulnerability to cyber-attacks. Furthermore, the growing reliance on digital systems and remote working has amplified the need for robust cyber awareness and adherence to best practices in RM.

Improving compliance is not only a regulatory requirement, it is also a strategic priority to protect patient trust, maintain operational resilience, and support the health board's digital transformation objectives. Addressing gaps in training uptake will require a coordinated approach involving clear accountability, enhanced monitoring, and targeted interventions to engage staff and embed a culture of information security.

Asesiad / Assessment

Current Compliance Position

The IG Team has implemented targeted actions to improve compliance with mandatory IG, RM, and Cyber Security training across HDdUHB. As part of this approach, IG has been actively contacting staff and their managers who have not yet completed the required training.

- **Previous Position:** Before direct engagement began, the overall compliance rate stood at **77%**.
- **Current Position:** Following these interventions, compliance has increased to **85%**, meeting the **national target of 85%**.

The table below highlights the percentages per staff group.

Data as at 30.11.2025

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS CSTF Information Governance (Wales) - 2 Years	12,411	1,241	1,050	84.63%

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	431	431	377	87.47%
Additional Clinical Services	2,584	2,584	2,233	86.42%
Administrative and Clerical	2,482	2,482	2,227	89.73%
Allied Health Professionals	888	888	758	85.36%
Estates and Ancillary	1,017	1,017	795	78.17%
Healthcare Scientists	214	214	182	85.05%
Medical and Dental	802	802	448	55.86%
Nursing and Midwifery Registered	3,993	3,993	3,484	87.25%

Actions Taken to Improve Compliance

To address gaps in mandatory training completion, the IG Team has implemented a comprehensive approach focused on communication, accountability, and escalation. The team began by directly engaging with staff who had not completed their training and their line managers, reinforcing the importance of compliance for patient safety, legal obligations, and cyber resilience. These communications provided clear instructions and deadlines to encourage timely completion.

Department-specific interventions have also been introduced.

- Within the Estates Department, multiple email reminders were sent to managers, accompanied by lists of non-compliant staff to enable targeted follow-up. This proactive engagement has resulted in a significant improvement, with compliance increasing from 58% in April to 78% currently.
- In the Medical Directorate, all non-compliant staff were contacted in July, followed by direct engagement with Service Delivery Managers in September 2025 to reinforce accountability. Additional escalation included communications issued on behalf of the Caldicott Guardian, emphasising the requirement for completion by the end of September 2025. These actions have led to a modest improvement in compliance, rising from 43% to 56%, although further progress is needed.

To maintain momentum, compliance data is now monitored more frequently, with regular updates shared at directorate level to sustain focus. Escalation to senior managers has been used where compliance remains low, ensuring visibility and prioritisation at leadership level. Alongside these measures, messaging has emphasised the link between training compliance and patient safety, data protection, and cyber security, aiming to embed a culture of responsibility across the HDdUHB. Plans are also underway to integrate compliance reminders into routine staff communications and performance reviews to support sustained improvement.

Key Challenges Contributing to Low Compliance

Despite targeted interventions, several systemic and operational factors continue to impact compliance with mandatory IG, RM, and Cyber Security training across HDdUHB:

- **Operational Pressures and Competing Priorities**
Clinical and administrative teams experience significant workload pressures, which often result in mandatory training being deprioritised. Staff working in high-demand environments struggle to allocate time for e-learning modules, particularly during periods of service escalation.
- **Accessibility and Technical Limitations**
A proportion of staff experience difficulties accessing training platforms due to limited IT resources, shared devices, or connectivity issues in certain locations. These challenges are more pronounced for community-based staff and those without regular access to health board systems.
- **Awareness and Engagement**
Although mandatory training requirements are communicated, there is inconsistent understanding of the importance of IG and Cyber Security in safeguarding patient data and organisational resilience. This lack of awareness can lead to low motivation and delayed completion.
- **Staff Turnover and Workforce Dynamics**
High levels of staff turnover, combined with the onboarding of temporary, locum, and agency staff, create a continuous cycle of non-compliance. These staff groups are not always fully integrated into compliance monitoring processes, which further compounds the issue.
- **System Limitations and Reporting Gaps**
Current compliance tracking relies heavily on manual reporting and email reminders, which can delay escalation and reduce visibility of real-time progress. This limits the ability to target interventions effectively and creates administrative burden.
- **Cultural and Behavioural Factors**
In some areas, mandatory training is perceived as a procedural requirement rather than a critical component of professional responsibility. Changing this perception requires sustained leadership engagement and cultural reinforcement across all directorates.

Approach to Addressing Compliance Challenges

The Digital Team recognises the systemic and operational barriers impacting compliance and has developed a targeted action plan to address these challenges effectively. The approach focuses on improving accessibility, strengthening accountability, and embedding a culture of information security across all staff groups.

- **Enhancing Accessibility and Technical Support**
We will work to ensure training platforms are fully accessible, including providing alternative access routes for staff without regular IT availability. Additional guidance and technical support will be offered to resolve login and connectivity issues promptly.
- **Leadership Engagement and Accountability**
Directorate leads and senior managers will receive regular compliance reports to

maintain visibility and prioritisation. Non-compliance will be escalated through established governance channels, ensuring accountability at all levels.

- **Streamlining Monitoring and Reporting**

Automated compliance dashboards will be introduced to provide real-time visibility of training completion rates. This will reduce reliance on manual reporting and enable targeted interventions where compliance remains low.

- **Cultural and Behavioural Change**

Communications will emphasise the link between training and patient safety, data protection, and cyber resilience. Mandatory training will be positioned as a core professional responsibility rather than a procedural requirement, supported by leadership messaging and staff engagement campaigns.

- **Flexible Learning Options**

We will explore the introduction of shorter, modular training formats and mobile-friendly access, to accommodate staff with limited time or IT resources, reducing barriers to completion.

Timelines and Measurable Targets

To ensure accountability and sustained improvement, the following timelines and performance indicators have been established:

Short-Term (0–3 Months) (January 2026 – April 2026)

- **Action:** Continue targeted engagement with non-compliant staff and managers, supported by escalation to directorate leads.
- **Target:** Maintain overall compliance above **85%** and achieve a minimum of **80%** compliance in all directorates.
- **Monitoring:** Weekly compliance reports shared with senior managers.

Medium-Term (3–6 Months) (April 2026 – July 2026)

- **Action:** Implement automated compliance dashboards and integrate reminders into staff communication channels.
- **Target:** Achieve **90% overall compliance** and reduce directorate variance to less than **5%**.
- **Monitoring:** performance is reviewed at Information Governance Sub-Committee.

Long-Term (6–12 Months) (July 2026 – January 2027)

- **Action:** Embed compliance into induction processes for all new starters, including temporary and agency staff, and introduce flexible learning options.
- **Target:** Sustain compliance at **93% or above** across all staff groups.
- **Monitoring:** Quarterly reporting to DDIC and Information Governance Sub-Committee.

Key Performance Indicators (KPIs):

- Percentage of staff completing mandatory training within required timeframe.
- Reduction in the number of directorates below compliance threshold.
- Time taken to achieve compliance for new starters.

Summary

This report has outlined the current position regarding compliance with mandatory IG, RM, and Cyber Security training across HDdUHB. While overall compliance has improved from **77% to 85.32%**, meeting the national target, significant variation remains across directorates, with some areas still below acceptable thresholds. Key challenges include operational pressures, limited IT access, awareness gaps, workforce turnover, and cultural perceptions of training as a low priority.

Targeted actions have already delivered measurable improvements, including direct engagement with staff and managers, escalation to senior leadership, and enhanced monitoring. However, sustaining progress and achieving full compliance will require a strategic approach that addresses systemic barriers and embeds training as a core professional responsibility.

Improving compliance is critical to safeguarding patient data, meeting statutory obligations, and reducing cyber risk. The Health Board is committed to tackling the identified challenges through a structured action plan focused on accessibility, accountability, cultural change, and process automation. Clear timelines and measurable targets have been established, aiming for **90% compliance within six months** and **95% compliance within twelve months**, supported by robust monitoring and leadership engagement.

Achieving these objectives will not only ensure regulatory compliance but also strengthen organisational resilience and public trust in HDdUHB's ability to protect sensitive information.

Argymhelliad / Recommendation

The Committee are requested to:

- **TAKE ASSURANCE** on the actions being implemented to address gaps with Information Governance Training.

Amcanion: (rhaid cwblhau)

Objectives: (must be completed)

Committee ToR Reference:

Cyfeirnod Cylch Gorchwyl y Pwyllgor:

3.1.3 Seek assurance that the digital, data and information governance implications and risks arising from the development of the Health Board's corporate strategies and plans or those of its stakeholders and partners are considered and mitigated.

3.1.6 Seek assurance that there is a robust information governance and security framework within the UHB and encourage a strong information governance and security culture across the organisation.

3.1.7 Seek assurance that the Health Board is meeting its responsibilities with regard to the General Data Protection Regulations, the Freedom of Information Act, Caldicott Principles, Records Management, Clinical Coding, Information Sharing, national Information Governance policies and the Information Commissioner's Office guidance.

3.1.8 Seek assurance of the Health Board's compliance against relevant statutory requirements, internal and external standards and assessment criteria, via the Information Governance Toolkit, Cyber Assessment Framework (CAF) any other relevant requirements / assessments, and audits, inspections and reviews, including the implementation of Audit Wales, Health Inspectorate Wales and Internal Audit recommendations.

Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	All Planning Objectives Apply
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Not applicable
Rhestr Termiau: Glossary of Terms:	Included within the main body of the report
Partion / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Information Governance Sub-Committee

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Improving compliance with mandatory Information Governance, Records Management, and Cyber Security training has direct financial and service benefits for the Health Board. By increasing staff awareness and adherence to best practices, the organisation reduces the risk of costly data breaches, regulatory penalties, and operational disruptions. Enhanced compliance supports

	more efficient service delivery, protects patient data, and strengthens organisational resilience against cyber threats. Investment in training and monitoring systems is offset by the long-term savings from avoided incidents and improved public trust, ensuring value for money and safeguarding the Health Board's reputation and service quality.
Ansawdd / Gofal Claf: Quality / Patient Care:	Improved compliance with mandatory Information Governance, Records Management, and Cyber Security training directly enhances the quality and safety of patient care. By ensuring staff understand their responsibilities in safeguarding sensitive information, the health board reduces the risk of data breaches and protects patient confidentiality. Strengthened information governance supports clinical effectiveness, maintains public trust, and underpins safe, reliable service delivery. Embedding a culture of information security is essential for maintaining high standards of care and supporting the health board's commitment to patient safety and quality improvement.
Gweithlu: Workforce:	Raising compliance with mandatory Information Governance, Records Management, and Cyber Security training strengthens workforce capability and accountability. Improved training uptake ensures all staff are equipped with the knowledge to protect sensitive information and respond to cyber risks, reducing the likelihood of human error. Targeted interventions and leadership engagement foster a culture of responsibility and continuous improvement, supporting staff confidence and professional development. Addressing barriers to training access and completion also helps integrate new, temporary, and agency staff, promoting consistency and resilience across the workforce.
Risg: Risk:	Strengthening compliance with mandatory Information Governance, Records Management, and Cyber Security training significantly reduces organisational risk. Improved staff awareness and adherence to best practices lower the likelihood of data breaches, regulatory non-compliance, and cyber incidents. Proactive monitoring and targeted interventions help address vulnerabilities, ensuring risks are identified and mitigated promptly. This approach protects patient data, maintains operational continuity, and safeguards the health board's reputation against potential threats.
Cyfreithiol: Legal:	Achieving and sustaining high compliance with mandatory Information Governance, Records Management, and Cyber Security training ensures the health board meets its statutory and regulatory obligations, including the Data Protection Act 2018 and UK GDPR. Improved staff awareness reduces the risk of legal breaches, regulatory penalties, and enforcement actions. Proactive training and monitoring demonstrate the organisation's commitment to legal compliance and accountability, protecting both

	patients and the health board from potential legal consequences.
Enw Da: Reputational:	Maintaining high compliance with mandatory Information Governance, Records Management, and Cyber Security training is essential to protecting the health board's reputation. Effective training reduces the risk of data breaches and incidents that could undermine public trust and confidence. Demonstrating a proactive approach to information security and regulatory compliance reassures patients, partners, and stakeholders of the organisation's commitment to safeguarding sensitive information and upholding professional standards.
Gyfrinachedd: Privacy:	Achieving high compliance with mandatory Information Governance, Records Management, and Cyber Security training is essential for protecting the privacy of patient and organisational data. Improved staff awareness and adherence to best practices minimise the risk of unauthorised access, data loss, or breaches. This proactive approach upholds individuals' rights to privacy, ensures compliance with legal and regulatory requirements, and reinforces public trust in the health board's ability to safeguard sensitive information.
Cydraddoldeb: Equality:	Not applicable

5 - Impact and Outcomes

5.1

12:10, 0 Mins

5.1 - Update on Impact of Flow System

Anthony Tracey
(Hywel Dda UHB -
Digital Director)

| For discussion

Attachments

5.1 - DDIC Patient Flow Update Jan 26 (AT, HT).pptx

- **Digital, Data and Innovation Committee
(DDIC)**

- Update on Patient Flow rollout

First Phase 1a includes – All Acute Adults ward, Mental Health & Maternity

Functionality

- Admissions,
- Internal referrals (Therapies 5 pathways)
- Bed management and occupancy
- Transfer management,
- Discharge planning
- Patient flags and alerts,
- System pressure dashboard,
- Patient Record View
- Reporting

Integration

WPAS (demographics, wait list / TCI, ADT)



Training

Training method

Via teams (group sessions) and 1-2-1 for those hard to reach / difficulty attending. Q&A, access to resources post training.

Target groups

Ward Administrators (inc users of Frontier)
Clinical Site Managers
Nursing / Ward managers
Navigators
Operational Managers

Training schedule

Over four weeks over 1200 staff trained (training team ten application support) also supporting on the ground.
Training takes place during day and evening
Different sessions provided depending on role and access requirements.

To date:

95 % Clinical site Managers trained across all Acute sites
69 % Ward administrators
65 % overall more to do, but continuing to train

Go live support

From 08.30 – 22:00pm
then on call overnight
through to morning.

Weekend working

Attendance at all physical sites

Bed meetings

Ward rounds

Walk around with clinical site managers

Sitting with Ward administrators

Demonstrating and encouraging use of Interactive Whiteboards (EWB).

Clinical conversations with informatic nursing team

Plus all members of the Application Support team plus majority of DI & T Team

Snags & Issues

Microsoft Update to EWB

An update removed the interactive whiteboard keyboard – not just for HDdUHB but all organisations absorbing the update. Our Desktop Team and integration lead worked through night to rebuild one from scratch.

Key individuals had not attended training

We accessed rota information to help identify when staff were next on shift and targeted communication / 1-2-1 support to encourage use of the system / attendance at training..

WPAS not updated with Admissions, transfers, discharges

Continuation of an existing issue where patient location details / position in the care pathway is not updated promptly. This is amplified in eFlow as the system relies on this information. WPAS is still our patient Spine and supports Welsh Nursing Care Record (WNCR), Welsh Clinical Portal (WCP) etc. Communication circulated to heads of nursing, system GM's, training sessions will include this reminder as well as face to face discussions with staff across the organisation.

Location	No. of Wards	R2G Updated within 24 hours	% of wards updating
Bronglais Hospital	8	6	75%
Glangwili Hospital	22	18	81%
Prince Philip Hospital	11	11	100%
Withybush Hospital	11	10	90%
Grand Total	52	45	86%

R2G: Red to Green (patient status)

How are we doing?

What's next on the list?

- ▶ **Phase 1b – Manual eObs** (Delivery alpha phase: Towy ward): Go late Jan 26

Functionality - Manual recording of observations re NEWS2 and Sepsis, soft alerting

Integration - Nil

- ▶ **Phase 1c - eObs extended (further assessments and rollout to additional wards)**

Functionality - Manual recording of observations re Maternity Early Warning System (MEWS) and Paediatric Early Warning System (PEWS), hard alerting and direct messaging

Integration - Nil

- ▶ **Phase 2 – eObs with device integration**

Functionality - Inpatient spot monitoring, clinical noting and task management, resource assignation.

Integration - Monitoring devices (demographics, observations)

- ▶ **Phase 3 - results integration and application context launch**

Functionality - *ePMA, Picture Archiving Communication System (PACS) context launches*

Integration - *ePMA (demographics, ADT (incl. discharge meds), allergies), WLIMS (pathology orders, results), RIS (radiology orders, appts, reports)*

What else? ..

Operational requirements

- ▶ Installation of further Electronic White Boards and estates works to install
- ▶ Wireless Access Points replacement to ensure connectivity
- ▶ Purchase and distribution of mobile devices
- ▶ Design and implement network & assurance effectively for vital signs monitoring
- ▶ Strengthen and Improve Business Continuity estate

Phasing of benefits realisation

Reporting Schedule – draft!

Reporting Schedule – draft!																							
		eFlow - Go Live		eObs - Pilot						2025/26 Q4				2026/27 Q1				2026/27 Q2				2026/27 Q3	
Benefit REF	Benefit Title	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27					
EOBS-IPO-001a	Reduced risk of harm due to a reduction in hospital based cardiac arrests	-	-	-	-	-	Y	-	-	Y	-	-	Y	-	-	Y	-	Y					
EOBS-IPO-001b	Reduced risk of harm due to a reduction in hospital acquired infections	-	-	-	-	-	Y	-	-	Y	-	-	Y	-	-	Y	-	Y					
EOBS-IPO-002	Reduced risk of errors (e.g. due to more regular, accurate observations)	-	-	-	-	-	Y	-	-	Y	-	-	Y	-	-	Y	-	Y					
EOBS-IPO-003	Reduced unplanned admissions to critical care units from eOBS-equipped wards	-	-	-	-	-	Y	-	-	Y	-	-	Y	-	-	Y	-	Y					
EOBS-IPO-004	Increased # of observations completed on time	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EOBS-ISE-005	Increased confidence resulting in improved decision making	-	-	-	-	-	-	-	-	Y	-	-	-	-	-	-	-	Y					
EOBS-IE-006	Reduced manual admin work and removal of duplication of effort	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EOBS-PE-007	Reduced complaints and improved brand image due to better patient care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Y					
EOBS-OB-008	Reduced litigation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	Y					
EFLOW-IPE-001	Increased time to care for patients	-	-	-	-	-	-	-	-	Y	-	-	-	-	-	-	-	Y					
EFLOW-ISE-002	Reduced stress levels	-	-	-	-	-	-	-	-	Y	-	-	-	-	-	-	-	Y					
EFLOW-ISE-003	Improved communication between staff members and across departments	-	-	-	-	-	-	-	-	Y	-	-	-	-	-	-	-	Y					
EFLOW-IE-004	Improved handovers and quicker discharges / Reduced handover time	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-005	Reduced avg. time until seen by doctor in A&E	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-006	Reduced time an ambulance waits outside of the hospital	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-007	Quicker response times for ambulances	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-008	Reduction in staff time wasted due to not being able to access real time patient information or bed state information	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-009	Reduced avg. length of hospital stay per patient	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
EFLOW-IE-010	Reduced cancelled surgeries due to better bed management	-	-	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					

Continuously learning...

- Lessons learned
- Reflections
- Feedback
- Floorwalking log
- Celebrating small wins
- Motivating the team
- Motivating staff
- Business change and analysis to target improvement in usage and compliance

- **Recommendation:**
- The Committee is asked to **note** the update on the Patient Flow rollout

5.2

12:10, 0 Mins

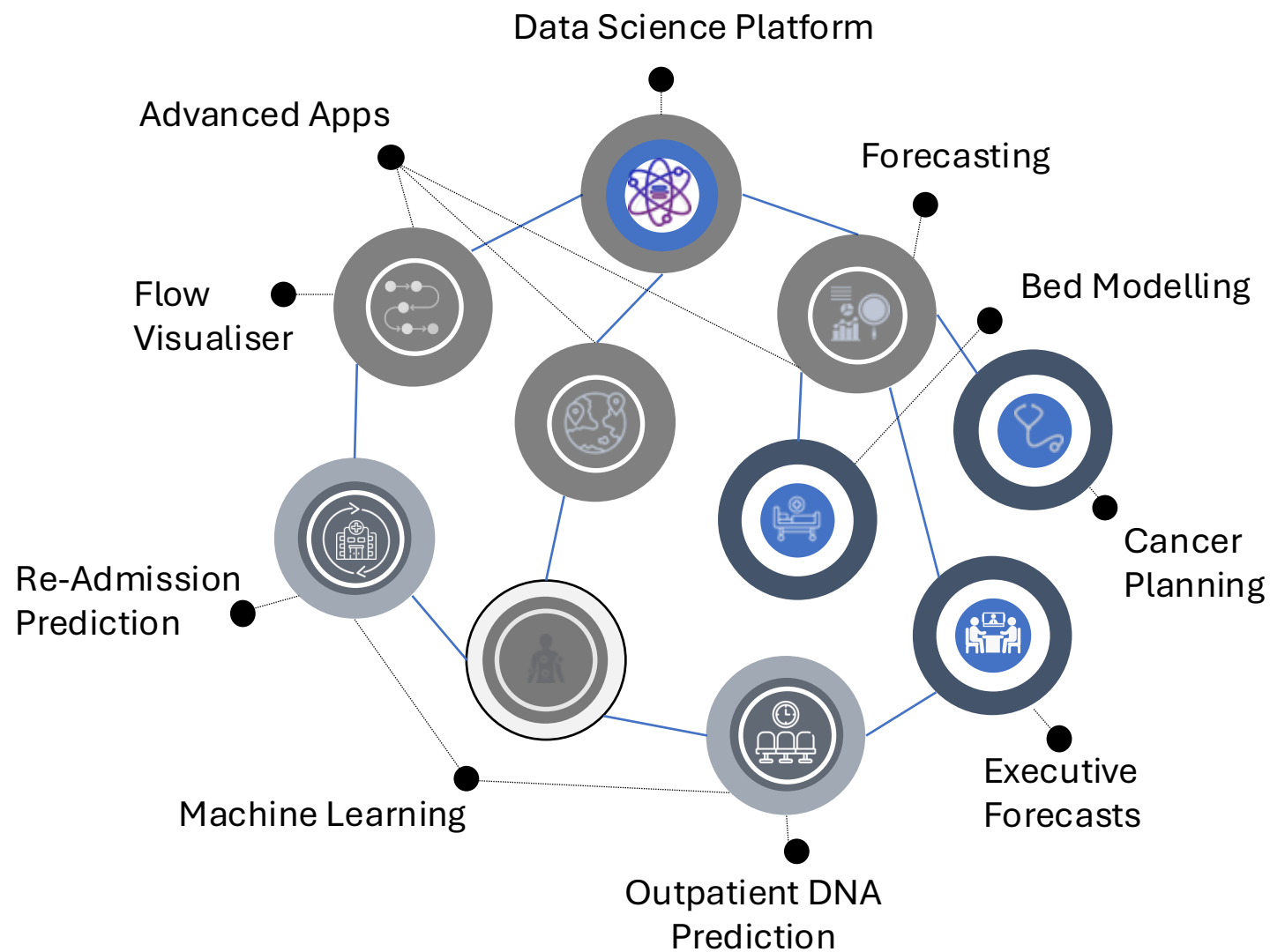
5.2 - Analytical and Modelling Work including Presentation

Gareth Jenkins
(Hywel Dda UHB -
Head of Data
Science)

| For discussion

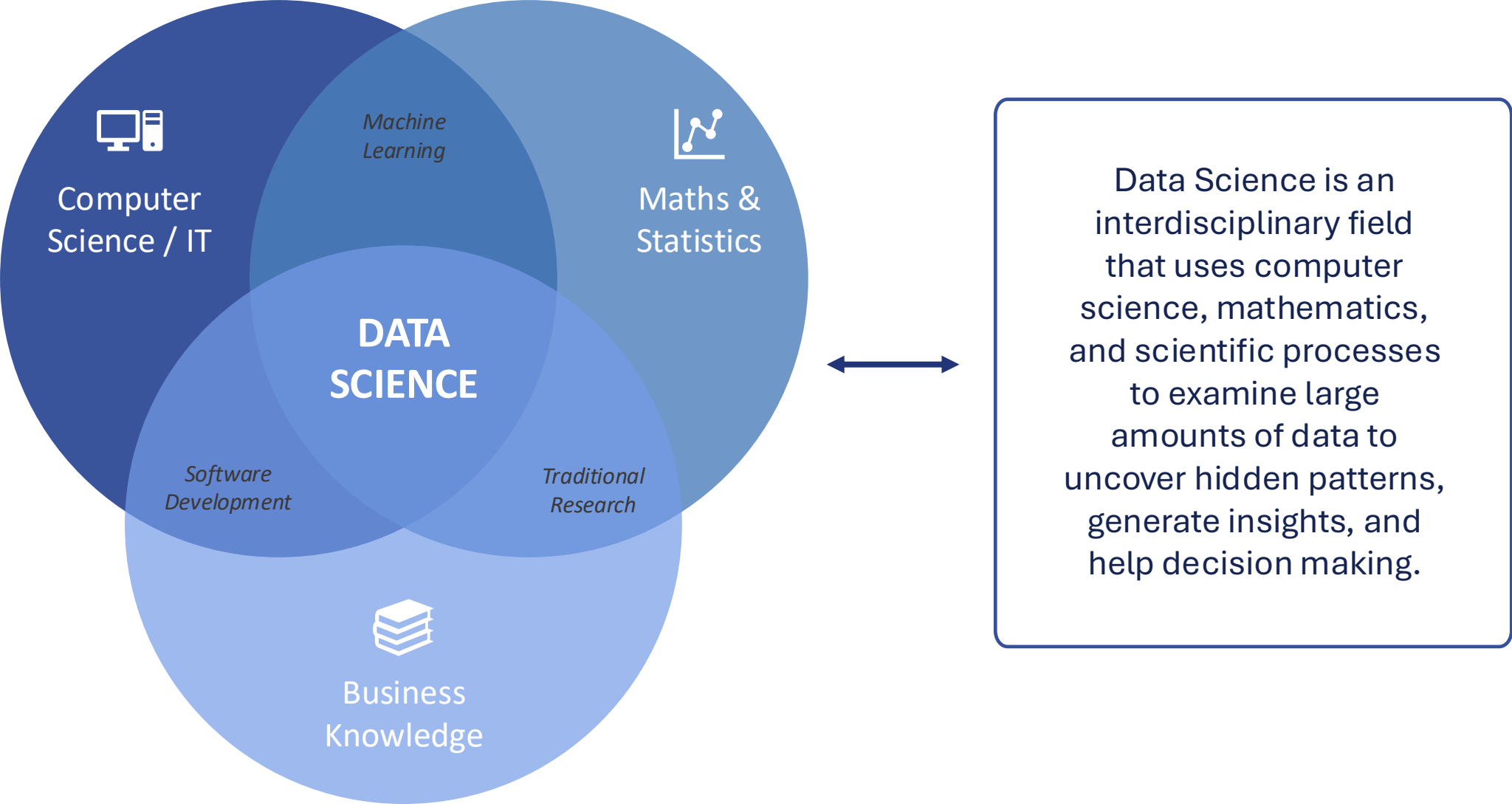
Attachments

5.2(a) - DDIC Analytical and Modelling Work (AT, HT).pptx



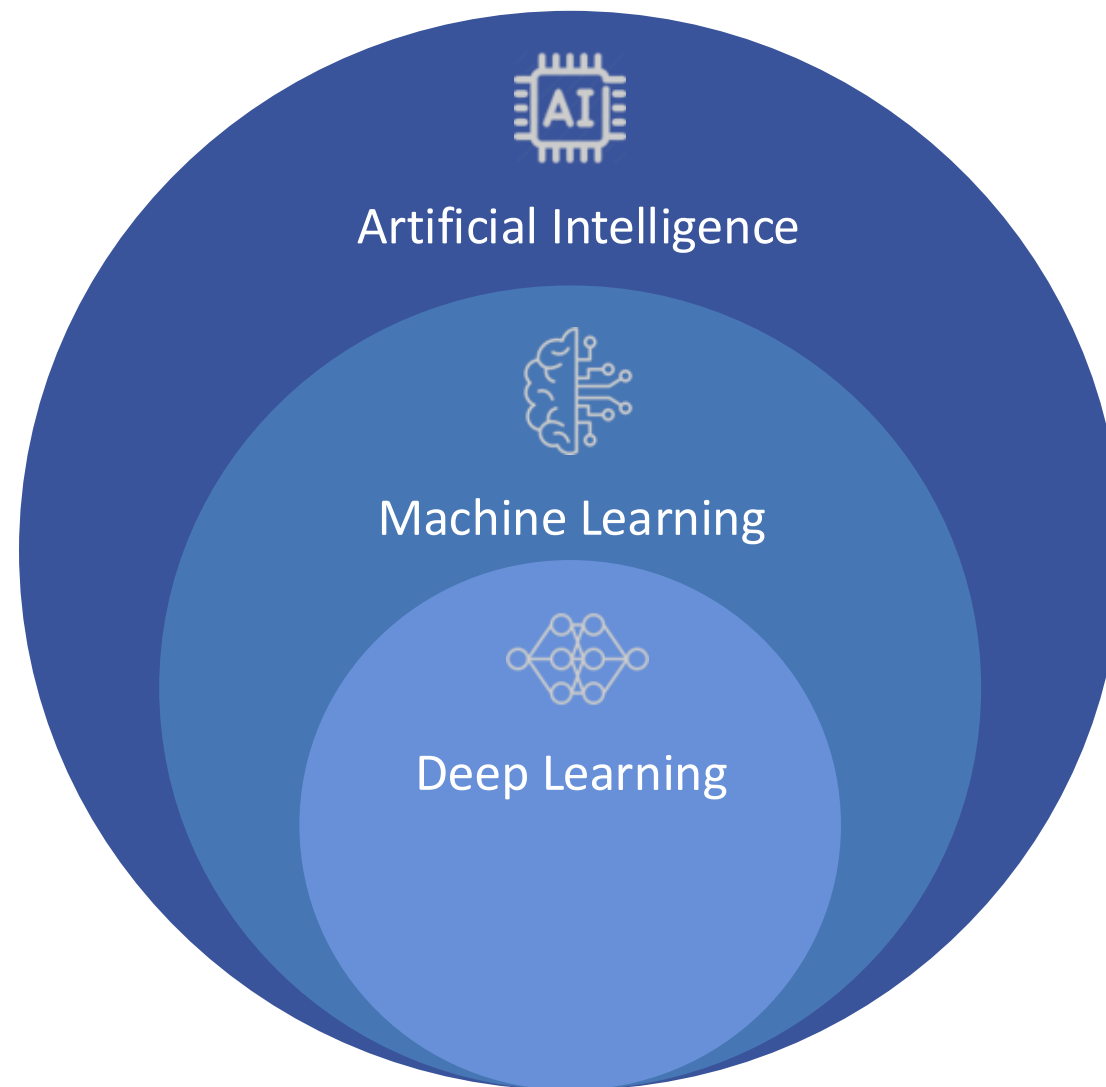
ANALYTICAL & MODELLING WORK - DATA SCIENCE

WHAT IS DATA SCIENCE?



WHAT IS AI?

Artificial Intelligence (AI)
is any technology that
imitates human
intelligence or performs
human tasks.



DATA SCIENCE

AI

To support high quality decision-making for clinical, operational, and strategic services by discovering and communicating the meaningful patterns in big data using data science techniques.



01

SCIENTIFIC

Work must be evidence based, with transparent and reproducible methods.

02

PROBLEM DRIVEN

Data science is useless if addressing the wrong question.

03

COLLABORATION

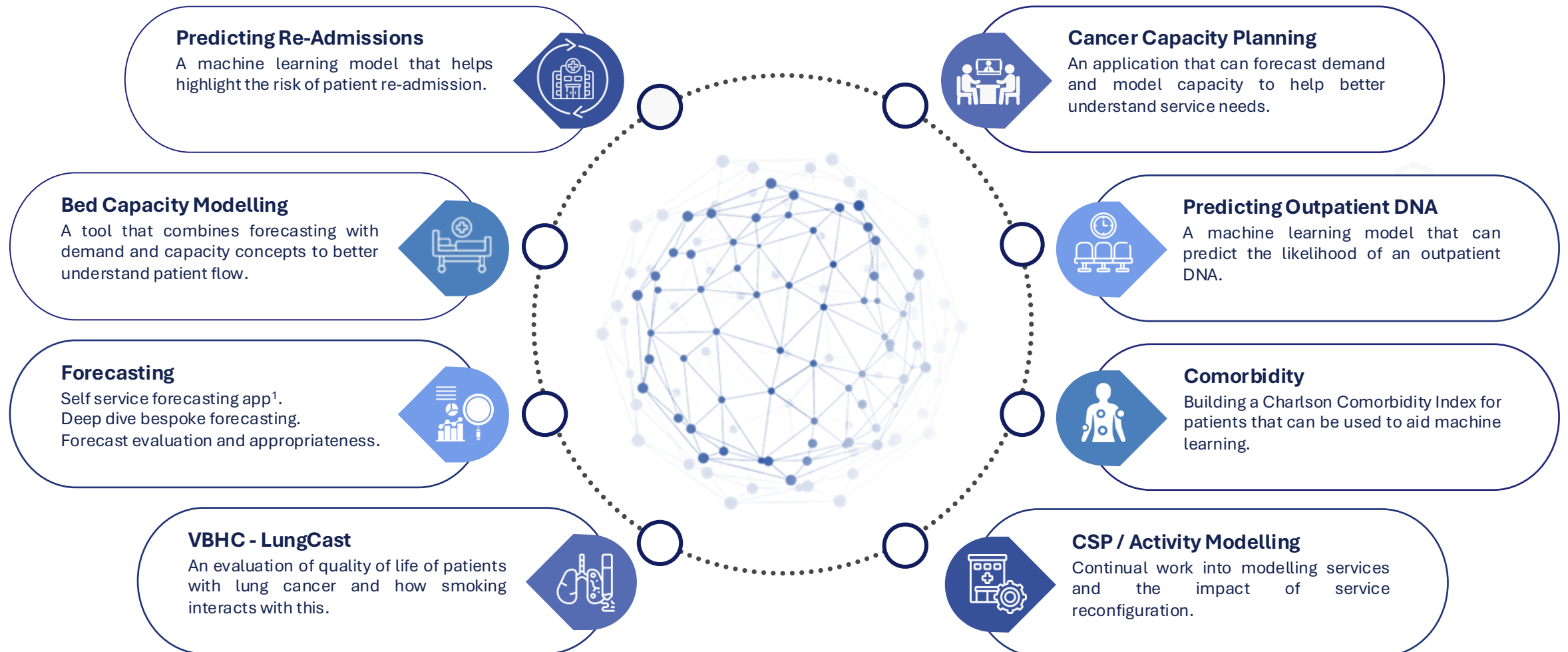
Data science will achieve little if the decision-making processes are not designed to embrace it.

04

COMMUNICATION

Complex ideas need to be explained simply. Simple ideas mustn't be over complicated.

EXAMPLES FROM DIGITAL SERVICES



UNIVERSITY PARTNERSHIPS



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CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board



+



Swansea University
Prifysgol Abertawe

+



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Joint Post

Hywel Dda and Aberystwyth University support a joint post in Health Data Science. This unique and innovative approach embeds cutting edge academic skills within the Health Board.

Dr Praboda Rajapaksha² has significant expertise in AI and Data Science and is currently developing a patient / digital twin framework for Hywel Dda. A first for NHS Wales.

PhD Student

Hywel Dda is sponsoring a PhD student in Swansea University via a partnership to enhance human interaction via data driven systems³.

Megan Morgan is building upon the forecasting work already in Hywel Dda. She is researching whether it is possible to predict the likely categories/presentations arriving at Emergency Department (ED).

Collaboration

Working with all the local universities has fostered many connections enabling the potential for mutual benefit.

Digital Service and the Data Science Team are recognised as being progressive and innovative in the field of data science and AI. Through these connections Hywel Dda is advancing AI through continued collaboration with universities.

REFERENCES



GIG
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1. <https://7a201srvhat0006.cymru.nhs.uk/DataScience/>
2. <https://www.aber.ac.uk/en/cs/staff-profiles/listing/profile/prr16/#teaching>
3. <https://www.swansea.ac.uk/computational-foundry/epsrc-centre-for-doctoral-training/>

Recommendation:



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- The Committee is asked to **note** the update on the Analytical & Modelling Work - Data Science

6 - For Assurance

6.1

12:20, 0 Mins

6.1 - Assurance and Risk Report

**Huw Thomas (Hywel
Dda UHB - Director
of Finance)**

| For assurance

Attachments

[6.1 DDIC PublicGovernance Arrangements Jan 2026 \(RW, JW, AT HT\).pptx](#)

[6.1 Appendix 1 - DDIC -Corporate Risk 2079 Public \(RW\).pdf](#)

[6.1 Appendix 2 - DDIC Operational Risk Register - Dec 25 \(RW\).pdf](#)

[6.1 Appendix 3- Overdue Audit and Inspection Recommendations \(RW\).pdf](#)



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Assurance and Risk Report

Digital, Data and Innovation Committee – 15 January 2026

Situation



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This report provides the Digital, Data and Innovation Committee (DDIC) with the current status of the risks, audits and inspections recommendations, Welsh Health Circulars (WHCs) and Ministerial Directions (MDs) within its remit. The Committee is asked to seek assurance from the Lead Executive Directors that risks are being managed effectively, and that recommendations from audit and inspections, WHCs and MDs are being implemented by the Health Board.

Principal Risks:
0

Corporate Risks:
2
(1 In-committee)

Operational Risks
9
(4 reportable)

Audit and Inspection
Reports
7
(4 In-committee)

Welsh Health Circulars
2

Ministerial Directions
1

Risk Management - Overview



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Effective risk management requires a 'monitoring and review' structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

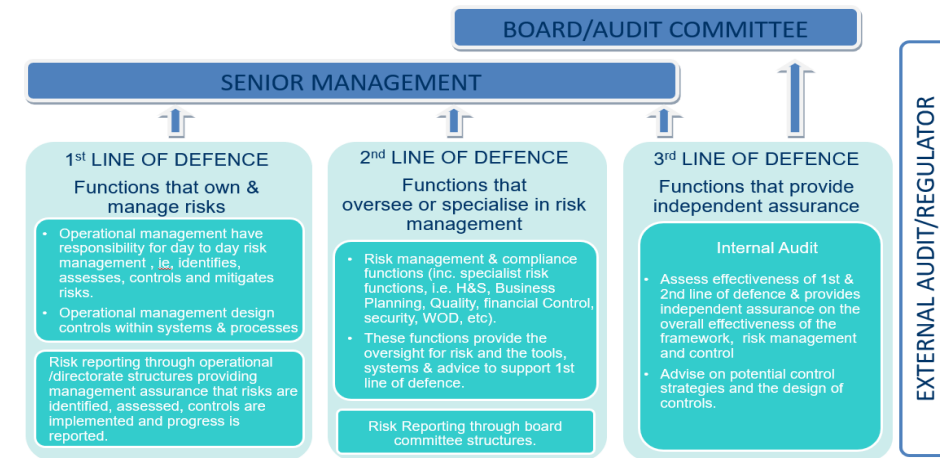
HDdUHB's risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either Principal, Corporate or Operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted "Three Lines of Defence" model to ensure the appropriate responsibility is allocated for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group (CCG) or Executive Function (hereto referred to as "Functions"), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board's Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (e.g. where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the 'acceptance' of risks that cannot be brought within risk appetite.



Corporate Risks Assigned to DDIC



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Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

These risks have been identified by individual Directors via a top down and bottom-up approach and are either:

- Associated with the delivery of the Health Board objectives; or
- Escalated operational risks that are of significant concern and require corporate oversight and management.

There are two risks currently aligned to DDIC (out of the 23 that are currently on the CRR).

Due to the sensitive nature of risk '1988 – Risk of prolonged outage following cyber-attack caused by insufficient measures to recover', the detail is being reported to in-committee to provide discussion and assurance. Risk 1988 supersedes the previous Corporate risk '1352 - Risk of business disruption and delays in patient care due to a cyber-attack'.

The following slide provides a summary of the reportable corporate risks aligned to DDIC. The Risk Register attached at Appendix 1, provides full detail of the risk, including control measures in place, a risk action plan to further manage and mitigate the risk, an expected date to achieve the noted Target Risk Score, and sources of assurance.

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
Impact ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2079 (→)	
Major 4				1988 (NEW)	
Moderate 3					
Minor 2					
Negligible 1					

Corporate Risks assigned to DDIC



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Risk Reference & Title	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS
2079 – Risk of loss of Pathology services across the Health Board due to delayed implementation of Laboratory Information Management System (LIMS)	Chief Operating Officer	20 → (Reviewed 19/12/2025)	5 →	01/04/2026 31/08/2026
1988 - Risk of prolonged outage following cyber-attack caused by insufficient measures to recover	Executive Director of Finance	12 NEW (Reviewed 28/11/2025)	4 →	30/12/2026 31/12/2027
Rationale for Current Risk Score of Risk 2079			Rationale for Target Risk Score of Risk 2079	
The impact of loss of service would be considerable. Pathology is crucial for diagnosis and treatment of patient conditions and ultimately the loss of service could lead to catastrophic patient outcomes. User Acceptance Testing (UAT) began on a system which was not built and integrated, leading to inefficient and repetitive testing, there is a lack of Health Board resource to support the volume of testing and validation subsequently required. The project plan milestones have consistently not been met by Digital Health and Care Wales (DHCW) and there is significant build, configuration and testing work to be completed to provide a safe, functional and reliable minimal viable product by the end of the year. The delay affects the pace and scale of pathology service transformation as set out in the HDUHB Annual Plan 2025/26. The December LIMS 2.0 Programme Board acknowledged that the original timescales for delivery by March 2026 are no longer achievable. The revised plan anticipates delivery commencing in January 2026, with completion extending beyond March 2026; however, a definitive completion date has not yet been confirmed. Additionally, the Programme Board has advised that no further funding will be available beyond March 2026. The current national system (TCL2016) is provided by InterSystems on Digital Health and Care Wales (DHCW) hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in August 2026.			The reduction of the current risk score to the target risk score is reliant on Digital Health Care Wales (DHCW) and the wider system finding a robust mitigation plan and financial support to manage the risks of compressing the timescales or staying on end of life hardware and software until the system can be implemented. On risk review in September 2025, the expected date to achieve the Target Risk Score (TRS) was amended from January 2026 to April 2026. On risk review in November 2025 the expected date to achieve the TRS was extended further to August 2026 as discussed in the LIMS Programme Board.	

Operational Risks assigned to DDIC

Nine operational risks on Datix have been aligned to DDIC which are all within review date. Reporting of these risks is currently under review by the risk lead.

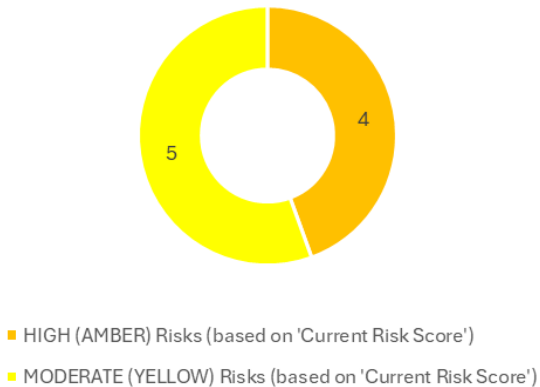
Of these, four have been identified as reportable to DDIC based on the following criteria:

- DDIC has been selected by the risk lead as the ‘Assuring Committee’ on Datix;
- Risks have been identified at operational level (previously Service and Directorate level) on Datix risk module;
- The current risk score is ‘extreme’ or ‘high’; and
- The current risk score is either equal to or exceeds the target risk score.

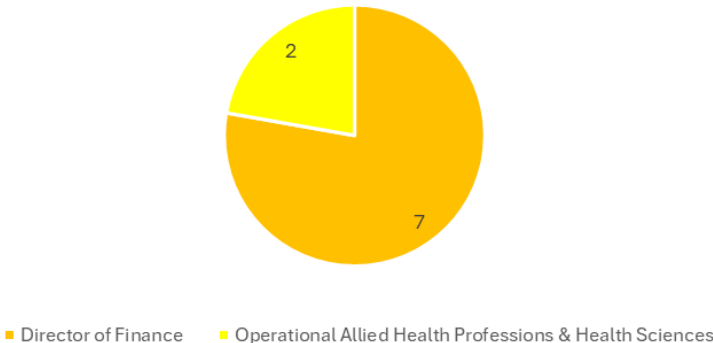
The following slides summarise the operational risks currently aligned to DDIC. The Risk Register attached at Appendix 2, provides full detail of each risk, including control measures in place and the risk action plan to further manage and mitigate the risk.

Total Number of Open Risks meeting criteria for reporting	4
New Risks since last reported to DDIC	2
Closed Risks since last reported to DDIC	0
Risks no longer reportable to DDIC	2
Increase in Risk Score since last reported to DDIC →	0
Decrease in Risk Score since last reported to DDIC ↓	0
No Change in Risk Score since last reported to DDIC →	2
EXTREME (RED) Risks (based on ‘Current Risk Score’)	0
HIGH (AMBER) Risks (based on ‘Current Risk Score’)	4

Current Level of Risks assigned to DDIC



Risks split out by Clinical Care Group/Executive Function



Target Risk Score



Operational Risks Reportable to DDIC



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Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score*	Target Risk Score	Expected Date to Achieve Target Risk Score	Date of last risk review
1535 - Risk of unresponsiveness and limitations in Digital Transformation projects due to limited funding	Finance	Executive Director of Finance	9 ↓	9 →	31/03/2026	18/12/2025
1719 - Risk of loss of Radiology services across the Health Board from 31 March 2025 due to delayed implementation of Radiology Informatics System Procurement (RISP)	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	10 →	10 →	31/03/2026	24/11/2025
1480 - Risk of losing touch with National Work programmes and not meeting statutory reporting obligations due to capacity**	Finance	Executive Director of Finance	9 (NEW)	3 →	31/10/2025	23/07/2025
2222 - There is a risk that acute Occupational Therapy (OT) referrals will be missed by acute OT teams due to implementation of new systems	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	9 (NEW)	6	01/01/2026	27/11/2025

*any movement in the current risk score since the risk was previously reported to DDIC is denoted by the arrow under the current risk score.

** Risk 1480 realigned to DDIC from Information Governance Sub Committee (IGSC).

Operational risks no longer reportable to DDIC since previous report

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Rationale
2029 - Risk of harm to patients and insufficient clinical governance in digital systems	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	Risk re-aligned to IGSC
1676 - Risk of lack of communications in or out of the Health Board due to UK PSTN telephone network switch off in 2025	Director of Finance	Director of Finance	Current risk score reduced to moderate therefore does not meet reporting criteria for DDIC.

Operational Risks assigned to DDIC sub committees



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The Research & Innovation Sub Committee (RISC) and Information Governance Sub Committee (IGSC) report to DDIC, with current risk reports provided as below:

Research & Innovation Sub Committee (RISC)

A risk report for Research & Innovation risks, and a separate risk report for Tri Tech risks, are provided quarterly to RISC. All three operational risks (which includes those with a moderate current risk score) are reported, last reported to RISC in December 2025.

Information Governance Sub Committee (IGSC)

IGSC meet on a bi-monthly basis, with a risk report provided to every other meeting. The criteria for reportable risks is the same as outlined for DDIC.

IGSC currently have 12 reportable risks, last reported to IGSC in November 2025.

The following risk themes are aligned to IGSC to receive assurance in relation to the process of management oversight, with subject matter experts receiving the themed risk registers on a bi-monthly basis:

- Information & Data Capture
- Information Governance
- Cyber Security

Risk owners can allocate themes to their risks, which allows the health board to share risk information on specific areas with relevant experts as part of the second line of defence. Risk themes provide assurance that a holistic approach to risk management is undertaken and enables the health board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

The following risk themes are currently aligned to DDIC:

Themed Risk Register	Recipients	Date of last report
Capital-Digital	Head of Capital Planning, Digital Director, Head of Digital Operations, Capital Programme Manager Planning, Head of Digital Business & Engagement	28/11/2025
Digital Transformation	Digital Director, Head of Digital Operations, Head of Digital Innovation & Transformation, Head of Digital Business & Engagement	03/11/2025
ICT (Information and Communications Technology)	Digital Director, Head of Digital Operations, Head of Digital Business & Engagement, Cyber Security Manager	11/12/2025

These ‘themes’ are included on Datix and shared with the appropriate team leaders on a bi-monthly basis to improve the ‘oversight’ of risks by specialist areas and functions within the Health Board, to provide guidance to those responsible for managing risk and develop/improve organisational controls, i.e., policies, procedures, systems, processes, to reduce the risk to the Health Board.

Service leads receive a notification when risks with a ‘theme’ are entered on the Datix Risk Module. On review of the risk registers, theme leads identify any risks which may require further support, and the relevant risk owner and/or service is then contacted for further discussion when required.

The Sub-Committee’s role in respect of these themed risks is to receive assurance in terms of the management oversight of these, i.e., that advice has been provided to the management lead where appropriate on the management of the risk, as well assuring that any themes/trends have been picked up and addressed e.g., form part of work plans, training, etc.

Audits and Inspections - Overview



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HDdUHB remains in Targeted Intervention (TI) (Level 4) status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the health board has been de-escalated for 'Governance' from Enhanced Monitoring (Level 3) to Level 1 (Routine Arrangements), the Health Board must continue to meet the set criteria:

- Evidence that all recommendations from the Royal Colleges / Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan; and
- Demonstrate a prompt response to any HIW inspections, concerns, incidents, never-events, coroners requests and regulation 28s – *which has replaced the previous criteria of 'Effective response from the Health Board to external reports and reviews including those from Audit Wales, the Ombudsman, Royal Colleges and HIW resulting in sustainable improvements.'*
- The Board acts on, and addresses appropriately, concerns raised through NHS regulators such as HIW.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked via the **AMaT (Audit Management and Tracking)** system, with progress updated by relevant service leads against each recommendation and evidence required to be uploaded to demonstrate implementation.



AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored using a categorisation system based on performance against original completion dates, with several new categories introduced since the previous meeting (shown on the next slide).

Recommendations that have exceeded original timescales, along with the management responses, completion dates and barriers to implementation as provided by the lead officer on AMAT are included in **Appendix 3**.

Audit & Inspections – New tracker statuses



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There are seven open reports aligned to DDIC to enable them to undertake the following responsibility set out in their Terms of Reference:

3.1.8 Seek assurance of the Health Board's compliance against relevant statutory requirements, internal and external standards and assessment criteria, via the Information Governance Toolkit, Cyber Assessment Framework (CAF) any other relevant requirements or assessments, and audits, inspections and reviews, including the implementation of Audit Wales, Health Inspectorate Wales and Internal Audit recommendations.

Each recommendation raised within audit and inspection reports are assigned a status category. Since the previous report to DDIC, three new status categories have been introduced to provide enhanced analysis on the progress being made in implementing recommendations. Definitions for these new categories are included in the table below. The number of recommendations noted in the table below include those reported via the DDIC In-Committee meeting.

Status Category	Definition	Number of recommendations
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.	8
Unable to Complete (NEW)	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision (NEW)	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.	4
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	0
Complete Pending Formal Approval (NEW)	The Service / Function have completed the recommendation and currently awaiting formal approval to close.	1
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	34

Audits and Inspection Reports assigned to DDIC



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The table below provides a summary of 3 of the 7 reports aligned to DDIC. **Appendix 3** contains details of the overdue recommendations.

Date of report	Report issued by	Report Title	Report Assurance Rating	Clinical Care Group/ Executive Function	Lead Director	Original Completion Date	Revised Completion Date	Number of recommendations in original report	Overdue	In Progress	Complete	Complete Pending Formal Approval	Reliant on External Factors	Pending Decision	Unable to Complete	Any Barriers to Completion Noted?
Jun-15	Audit Wales	Medicines Management in Acute Hospitals	N/A	Medical Director	Medical Director	Apr-16	Sep-22 Nov-22 Mar-23 Mar-25 Mar-26 Apr-26	19	1	0	17	1	0	0	0	n/a - Electronic Prescribing & Medicines Administration (ePMA) system funding now received
Oct-22	Internal Audit	IT Infrastructure	Reasonable	Director of Finance	Director of Finance	Mar-24	Mar-24 Jul-24 Dec-24 Apr-26	6	1	0	5	0	0	0	0	Funding for Contract Manager post to be approved to allow remaining recommendation to be progressed.
Jan-25	Internal Audit	Data Quality Final Internal Audit Report 2024/25	Limited	Director of Finance	Director of Finance	Aug-25	Oct-25 Jan-26	4	1	0	3	0	0	0	0	n/a

**Overdue recommendations in the above table have revised implementation dates provided.*

Due to their sensitive nature the following four reports are presented via in-committee to provide discussion and assurance:

- Internal Audit Technical Resilience Final Report
- NHS Wales Cyber Resilience Unit Cyber Assessment Framework Report March 2024
- NHS Wales Cyber Resilience Unit Cyber Security Assurance Report September 2024
- NHS Wales Cyber Resilience Unit Cyber Security Assurance Report Hywel Dda University Health Board September 2025

Implementation of Welsh Health Circulars (WHCs)



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There are two open WHCs aligned to DDIC as at December 2025.

All WHCs are managed via the Audit Management and Tracking system (AMaT), which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each Welsh Health Circular (WHC) is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of December 2025, and the number completed since the previous report. To provide a more accurate reflection of WHC progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are included in the table below.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	1
Unable to Complete (NEW)	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision (NEW)	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The WHC is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1
Complete Pending Formal Approval (NEW)	The Service / Function have completed the WHC and are currently awaiting formal approval to close.	0
Complete	The WHC has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	0

Oversight of the delivery of WHCs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of WHCs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

Welsh Health Circulars assigned to DDIC (1 of 2)



WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	RAG Status	Associated risk (if applicable)	Barriers to implementation
032-22: Further extending the use of Blueteq in secondary care	21/03/23	Primary Care, Community Strategy & Long Term Care	Executive Medical Director	April 2024 N/K	External	N/A	See progress update below

Progress update

Progress continues on the national rollout of Blueteq. The All-Wales Blueteq Steering Group, supported by the All-Wales Therapeutics and Toxicology Centre (AWTTC), is finalising several drug-specific forms, with Rheumatology and Weight Management forms nearing completion (noting delays due to technical issues) and multiple additional forms for other therapeutic areas currently in development. The Health Board continues to support and contribute towards the development of these forms.

Once forms are available, implementation within our Health Board will consider operational workflows, clinical engagement and data capture requirements. While Blueteq supports governance and appropriate use of high-cost medicines, it is not primarily a pharmacy system, and its integration should reflect broader clinical and service-level workflows. Given the scale and complexity of implementation, additional resource may be required to proactively plan and coordinate the rollout across services.

While no formal timeline has been confirmed, Q4 of 2025/26 has been suggested as a feasible starting point, subject to national progress and local capacity.

Welsh Health Circulars assigned to DDIC (2 of 2)



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WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	RAG Status	Associated risk (if applicable)	Barriers to implementation
034-25: Implementation of the Planned Care Referrals DSCN (DSCN 2024/11)	01/10/25	Executive Director of Finance	Executive Director of Finance	TBC	Overdue	N/K	N/K
Progress update							
RAG status of report currently as overdue due to requiring UHB implementation date from the Digital Function. Once received the WHC status will be amended to 'In Progress'.							

Implementation of Ministerial Directions (MDs)



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Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, HDdUHB has a duty to provide assurance of compliance with the MDs. As MDs potentially form part of the process of how the Health Board delivers its services, DDIC will receive a regular assurance report on compliance

There is one MD aligned to DDIC as at December 2025, all of which have been noted as complete.

Each MD is assigned a status category. The table below outlines the definition of each category, the number of MDs assigned to each as of December 2025. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report. Definitions for these new categories are also included in the table.

Status Category	Definition	Number of MDs
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Overdue	The MD is behind schedule to the timescale provided by the Lead officer or as stipulated in the MD, or a plan (with date for implementation) is not yet in place.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1
Pending Decision (NEW)	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests. Committee updates will detail whether the MD is overdue or not whilst decision pending.	0
Unable to Complete (NEW)	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Complete Pending Formal Approval (NEW)	The Service / Function have completed the MD and are currently awaiting formal approval to close.	0
Complete	The MD has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.	0

Oversight of the delivery of MDs has been included in new Clinical Care Group (CCG) Terms of Reference, with the requirement to escalate appropriately instances of non-compliance.

The timely implementation of MDs is included within the Governance domain of the Health Board's internal escalation framework, with services escalated in instances of non-compliance.

Ministerial Directions assigned to DDIC



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MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	RAG Status	Associated risk (if applicable)	Barriers to implementation
<u>WG23-08: Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023</u>	24/03/23	Primary Care, Community Strategy & Long Term Care	Executive Medical Director	April 2024 N/K	External	N/A	<i>See progress update below</i>

Progress update

Implementation of this MD is aligned to Welsh Health Circular 032-22 - “Further extending the use of Blueteq in secondary care” (see slide 18) which is also aligned to DDIC. The All-Wales Blueteq Steering Group, supported by the All-Wales Therapeutics and Toxicology Centre (AWTTC), is finalising several drug-specific forms and our Health Board continues to support and contribute towards the development of these forms.

The Health Board continues to engage with AWTTC to ensure readiness for implementation and is actively contributing to the development of drug-specific forms. A start date to begin implementation of Q4 2025/26 has been suggested but not formally confirmed (subject to national progress and local capacity).

The Committee is requested, in relation to the areas presented in this paper, to:

Risk Management

- **RECEIVE ASSURANCE** that identified controls are in place and working effectively;
- **RECEIVE ASSURANCE** that all planned actions are credible and deliverable, and in line with agreed plans, and will be implemented within stated timescales and will reduce risks further and/or mitigate the impact should risks materialise.

Audits, Inspections and Regulatory Reports

- **RECEIVE ASSURANCE** from the lead Executive Director or Supporting Officer on the management of recommendations raised in audit, inspection and regulatory reports within their area of responsibility, particularly in respect of confirming the full implementation of recommendations, any barriers to delivery and subsequent impacts of non/late delivery, and assurance that the risks associated with these are being managed effectively.

Welsh Health Circulars

- **RECEIVE ASSURANCE**, or otherwise, from the lead Executive Director or Supporting Officer on the management of WHCs within their area of responsibility, particularly in respect of understanding when the WHC will be delivered, any barriers to delivery, impacts of non/late delivery and assurance that the risks associated with these are being managed effectively.

Ministerial Directions

- **RECEIVE ASSURANCE** that the Health Board is compliant with the NSIs (MDs) issued by Welsh Government; and
- **CHALLENGE** where assurances are inadequate Acts of Parliament, Acts of Senedd Cymru, Assembly Measures and Assembly Acts enable Welsh Ministers to develop more detailed legislation, known as secondary or subordinate legislation, usually by means of Statutory Instruments (SI).



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND



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CORPORATE RISK REGISTER SUMMARY DECEMBER 2025

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Dec-25	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score
2079	Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Carruthers, Andrew	Service/Business interruption/disruption	4×5=20	4×5=20	→	1×5=5	31/08/2026

RISK SCORING MATRIX

Likelihood x Impact = Risk Score					
Likelihood	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency - How often might it/does it happen? (how many times will the adverse consequence being assessed actually be realised?)	This will probably never happen/recur (except in very exceptional circumstances).	Do not expect it to happen/recur but it is possible that it may do so.	It might happen or recur occasionally.	It might happen or recur occasionally.	It will undoubtedly happen/recur, possibly frequently.
	Not expected to occur for years.*	Expected to occur at least annually.*	Expected to occur at least monthly.*	Expected to occur at least weekly.*	Expected to occur at least daily.*
* time-framed descriptors of frequency					
Probability - Will it happen or not? (what is the chance the adverse consequence will occur in a given reference period?)	(0-5%*)	(5-25%*)	(25-75%*)	(75-95%*)	(>95%*)
*used to assign a probability score for risks related to time-limited or one off projects or business objectives.					
Risk Impact Domains	Negligible - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Safety of Patients, Staff or Public	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention.	Moderate injury requiring professional intervention.	Major injury leading to long-term incapacity/disability.	Incident leading to death.
	No time off work.	Requiring time off work for >3 days	Requiring time off work for 4-14 days.	Requiring time off work for >14 days.	Multiple permanent injuries or irreversible health effects.
		Increase in length of hospital stay by 1-3 days.	Increase in length of hospital stay by 4-15 days. Agency reportable incident. An event which impacts on a small number of patients.	Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects.	An event which impacts on a large number of patients.
Quality, Complaints or Audit	Peripheral element of treatment or service suboptimal.	Overall treatment or service suboptimal.	Treatment or service has significantly reduced effectiveness.	Non-compliance with national standards with significant risk to patients if unresolved.	Totally unacceptable level or quality of treatment/service.
	Informal complaint/inquiry.	Formal complaint.	Formal complaint -	Multiple complaints/ independent review.	Gross failure of patient safety if findings not acted on.
		Local resolution.	Escalation.	Low achievement of performance/delivery requirements.	Inquest/ombudsman inquiry.
		Single failure to meet internal standards.	Repeated failure to meet internal standards.	Critical report.	Gross failure to meet national standards/performance requirements.
		Minor implications for patient safety if unresolved. Reduced performance if unresolved.	Major patient safety implications if findings are not acted on.		

CORPORATE RISK REGISTER SUMMARY DECEMBER 2025

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
			Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty. Improvement notices.	Prosecution. Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				Critical report.	Severely critical report.
Adverse Publicity or Reputation	Rumours.	Local media coverage – short-term reduction in public confidence. Elements of public expectation not being met.	Local media coverage – long-term reduction in public confidence.	National media coverage with <3 days service well below reasonable public expectation.	National media coverage with >3 days service well below reasonable public expectation. AMs concerned (questions in the Assembly).
	Potential for public concern.				Total loss of public confidence.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national 10–25 per cent over project budget. Schedule slippage. Key objectives not met.	Incident leading >25 per cent over project budget. Schedule slippage. Key objectives not met.
Finance including Claims	Small loss.	Loss of 0.1–0.25 per cent of budget.	Loss of 0.25–0.5 per cent of budget.	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget.	Non-delivery of key objective/ Loss of >1 per cent of budget.
	Risk of claim remote.	Claim less than £10,000.	Claim(s) between £10,000 and £100,000.	Claim(s) between £100,000 and £1 million.	Failure to meet specification/ slippage Claim(s) >£1 million.
Service or Business interruption or disruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours.	Loss/interruption of >1 day.	Loss/interruption of >1 week.	Permanent loss of service or facility.
		Some disruption manageable by altered operational routine.	Disruption to a number of operational areas within a location and possible flow onto other locations.	All operational areas of a location compromised. Other locations may be affected.	Total shutdown of operations.
Environmental	Minimal or no impact on the environment.	Minor impact on environment.	Moderate impact on environment.	Major impact on environment.	Catastrophic/critical impact on environment.
Health Equity	Minimal or no impact on our attempts to improve health equity	Minor impact on our attempts to improve health equity or low level of certainty on the impact we are having on health equity	Moderate impact on our attempts to improve health equity or a lack of sufficient information that would demonstrate this. Indications that we are not having a positive impact on health improvement or health equity	Major impact on our attempts to improve health equity. Validated data suggesting that we are not improving the health of the most disadvantaged in our population whilst clearly supporting the least disadvantaged. Validated data suggesting we are having no impact on health improvement or health equity.	Validated data clearly demonstrating a disproportionate widening of health inequalities or a negative impact on health improvement and/or health equity.

RISK MATRIX

	LIKELIHOOD →				
IMPACT ↓	RARE	UNLIKELY	POSSIBLE	LIKELY	ALMOST CERTAIN
	1	2	3	4	5
CATASTROPHIC 5	5	10	15	20	25
MAJOR 4	4	8	12	16	20
MODERATE 3	3	6	9	12	15
MINOR 2	2	4	6	8	10
NEGLIGIBLE 1	1	2	3	4	5

RISK ASSESSMENT - FREQUENCY OF REVIEW

RISK SCORED	DEFINITION	ACTION REQUIRED (GUIDE ONLY)	MINIMUM REVIEW FREQUENCY
15-25	Extreme	Unacceptable. Immediate action must be taken to manage the risk. Control measures should be put into place which will have an effect of reducing the impact of an event or the likelihood of an event occurring. A number of control measures may be required.	This type of risk is considered extreme and should be reviewed and progress on actions updated, at least monthly.
8-12	High	Very unlikely to be acceptable. Significant resources may have to be allocated to reduce the risk. Urgent action should be taken. A number of control measures may be required.	This type of risk is considered high and should be reviewed and progress on actions updated at least bi-monthly.
4-6	Moderate	Not normally acceptable. Efforts should be made to reduce risk, providing this is not disproportionate. Establish more precisely the likelihood & harm as a basis for determining the need for improved measures.	This type of risk is considered moderate and should be reviewed and progress on actions updated at least every six months.
1-3	Low	Risks at this level may be acceptable. If not acceptable, existing controls should be monitored & reviewed. No further action or additional controls are required.	This type of risk is considered low risk and should be reviewed and progress on actions updated at least annually.

Assurance Key:

3 Lines of Defence (Assurance)		
1st Line	Business Management	Tends to be detailed assurance but lack independence
2nd Line	Corporate Oversight	Less detailed but slightly more independent
3rd Line	Independent Assurance	Often less detail but truly independent

Key - Assurance Required		<i>NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you</i>
	Detailed review of relevant information	
	Medium level review	
	Cursory or narrow scope of review	

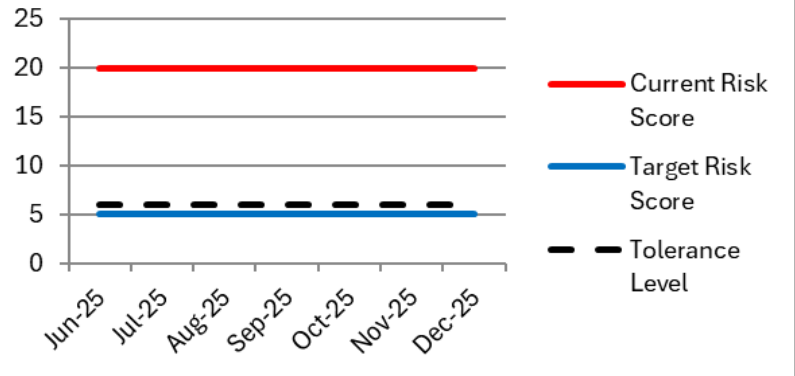
Key - Control RAG rating	
LOW	Significant concerns over the adequacy/effectiveness of the controls in place in proportion to the risks
MEDIUM	Some areas of concern over the adequacy/effectiveness of the controls in place in proportion to the risks
HIGH	Controls in place assessed as adequate/effective and in proportion to the risk
INSUFFICIENT	Insufficient information at present to judge the adequacy/effectiveness of the controls

Date Risk Identified:	Nov-24
Strategic Objective:	

Executive Director Owner:	Carruthers, Andrew	Date of Review:	Dec-25
Lead Committee:	Digital, Data and Innovation Committee	Date of Next Review:	Jan-26

Risk ID:	2079	Corporate Risk Description:	There is a risk of loss of Pathology services across the Health Board from 31st August 2026 affecting a wide range of services across primary, community and secondary care including urgent and emergency care. This is caused by the potential inability of Digital Health Care Wales (DHCW) and the contracted supplier to provide a functional, reliable and safe system to enable Health Board approval and mobilisation before funding ceases to support the LIMS Programme at the end of March 2026 and the hardware becomes end of life in August 2026. The System Build milestone is 12 months behind schedule and a significant volume of work is outstanding to provide a safe minimal viable product. This could lead to an impact/affect on a total loss of service resulting in potential serious harm to patients. The financial implications would be significant, this would include £53k for Telepath and £2-9m for hardware upgrade, these costs are indicative and yet to be confirmed by DHCW via a contingency plan. It would also detrimentally impact on the Health Board's ability to meet Ministerial priorities and targets including a significant proportion of diagnostic turn around and referral to treatment times. It would have an adverse impact on the reputation of the Health Board, and render it liable to increased complaints, litigation and scrutiny from external regulators, Welsh and UK governments. Outsourcing would be a difficult and costly approach and would need to be outside of Wales as this is a national concern. A year of contingency would be circa £4m
Does this risk link to any Directorate (operational) risks?			1526, 1352

Risk Rating:(Likelihood x Impact)	
Domain:	Service/Business interruption/disruption
Inherent Risk Score (L x I):	5×5=25
Current Risk Score (L x I):	4×5=20
Target Risk Score (L x I):	1×5=5
Expected Date To Achieve TRS:	31/08/2026
Trend: 	



Rationale for CURRENT Risk Score:

The impact of loss of service would be considerable, Pathology is crucial for diagnosis and treatment of patient conditions and ultimately the loss of service could lead to catastrophic patient outcomes.

User Acceptance Testing (UAT) began on a system which was not built and integrated, leading to inefficient and repetitive testing, there is a lack of Health Board resource to support the volume of testing and validation subsequently required. The project plan milestones have consistently not been met by DHCW and there is significant build, configuration and testing work to be completed to provide a safe, functional and reliable minimal viable product by the end of the year. The delay affects the pace and scale of pathology service transformation as set out in the HDUHB Annual Plan 25/26.

The December LIMS 2.0 Programme Board acknowledged that the original timescales for delivery by March 2026 are no longer achievable. The revised plan anticipates delivery commencing in January 2026, with completion extending beyond March 2026; however, a definitive completion date has not yet been confirmed. Additionally, the Programme Board has advised that no further funding will be available beyond March 2026.

The current national system (TCL2016) is provided by InterSystems on Digital Health and Care Wales (DHCW) hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in Aug 2026

Rationale for TARGET Risk Score:

The reduction of the current risk score to the target risk score is reliant on DHCW and the wider system finding a robust mitigation plan and financial support to manage the risks of compressing the timescales or staying on end of life hardware and software until the system can be implemented.

On risk review in September 2025, the expected date to achieve the TRS was amended from January 2026 to April 2026.

On risk review in November 2025 the expected date to achieve the TRS was extended further to August 2026 as discussed in the LIMS Programme Board.

Key CONTROLS Currently in Place: (The existing controls and processes in place to manage the risk)	Gaps in CONTROLS				
	Identified Gaps in Controls : (Where one or more of the key controls on which the organisation is relying is not effective, or we do not have evidence that the controls are working)	How and when the Gap in control be addressed	By Who	By When	Progress
Project plans in place both locally and nationally, they are monitored monthly. Local concerns are escalated to programme board. The Health Board have also raised concerns directly to the SRO. Project teams in place both locally and nationally, both meet weekly. Weekly meetings scheduled: HDU/SBU Leads, Technical Delivery and Testing Progress Regional Risks, Assumption, Issues and Decisions (RAID) Log is updated weekly and discussed monthly in the regional programme board including representatives from DHCW and InterSystems. Governance process are in place, Hywel Dda have raised and escalated the risk to LIMS 2.0 Programme board and direct to the national SRO on multiple occasions including in Feb 2025 with a proposal of an alternative plan. A joint all Wales Health Board letter to the SRO on 7th April 2025 led to agreement that the project plan needs to be re-set. Local contingency plans are in place for short term LIMS downtime.	No national contingency plan in place after 31st March 2026 A local contingency plan is in place but will only enable continuity for up to 5 days. More long term contingencies would involve reliance on supplier middleware solutions and outsourcing for histology. Lack of resource to complete the build and configuration by DHCW and InterSystems; lack of resource to complete the volume of testing and validation currently required to meet current timescales. Ineffective and incomplete user acceptance testing as the system is not functional and reliable. Blood transfusion (BT) legacy data unavailable due to inaccuracies on upload, therefore BT testing cannot be	All Health Boards to work alongside DHCW and ISC to approve a national contingency plan, including extension of hardware and software provision for current system with costs and mechanisms to enact.	Jones*, Dylan	Completed	DHCW presented the current position to Health Board CEOs on 8th April and they have requested a detailed, costed, contingency plan is developed by DHCW and ISC for review by Health Boards. 28/05/2025 - No contingency plan agreed at last LIMS Programme Board. Revised plan and costings to be provided by next programme board. 26/06/2025 - Mitigation plan agreed in June Programme Board, changing from HB deployment to discipline deployment with Microbiology commencing in July and the final discipline (Blood transfusion) going live in Jan 2026. National contingency plan inc costings has been submitted to Health Board CEOs via DHCW.

CORPORATE RISK REGISTER SUMMARY DECEMBER 2025

	completed and the service will not meet regulatory compliance via the Medicines and Healthcare products Regulatory Authority (MHRA). 26/06/2025 - Draft national contingency plan circulated to Health Board CEOs but not yet agreed. Additional funding will be required to support contingency plan, extending implementation into early 2026. 17/07/2025 - LIMS Programme Board wrote to CEOs requesting approval for the new service by service mitigation plan. The proposal will take the programme into 2026 and consequently will have financial impact. DoD has circulated summary paper of proposal to execs, waiting CEO decision.	Review local contingency action plan and duration.	Jones*, Dylan	Completed	Short term contingency includes use of middle-ware and paper based processes which is not viable for more than 5 days. 28/05/2025 - Local Business Continuity Plan already established and captured in Pathology BCP SOP (found on QPulse) Long term would be to prioritise urgent samples to be done manually and outsource all others to English laboratories. This would be logistically difficult and involve manual transcribing of results into WCP requiring significant staff resource, training and testing. This is practically not a viable option.
	26/09/2025 - All Health Boards have agreed with extension of mitigation plan to March 2026. Currently we have timelines for tranche 1,2 (Cell Path go live - Nov 25) and 3 (Micro Go Live - Jan 26) but yet to determine timelines for tranche 4,5 (Blood Science and Transfusion) 28/11/2025 - Further delays with Tranche 1 and 2 (go live now likely in Jan 26). This will push the programme beyond March 26.	To review staff resourcing to support testing requirements	Jones*, Dylan	Completed	There has been no agreed funding from the programme to support overtime in 2025/26. Review has highlighted increased staff resource requirements are 4 Biomedical Scientists (Only Agency BMS likely to be available) for 6 months. £39k x 4 - £156,000 DHCW has explored the possibility of hiring an external resource company and will work with Health Boards on the approach in May/June. 28/05/2025 - On going. DHCW continue to explore resource opt 28/08/2025 - Blood Transfusion BMS appointed on a fixed term/ part time basis to support legacy data and UAT testing.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls)	Latest Papers (Committee & date)	Gaps in ASSURANCES				
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance Current Level			Identified Gaps in Assurance:	How are the Gaps in ASSURANCE will be addressed Further action necessary to address the gaps	By Who	By When	Progress
All Wales Project Timelines	Pathology Strategy Group	1st			CCG Q&S Committee 16-07-2025 - Pathology Mitigation Paper submitted by DoD.					
	Quality And Safety	2nd								
	LIMS 2.0 National Programme Board	3rd								
	Regular Communication with DHCW	2nd								

DDIC Risk Register

Date: December 2025

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1535	Director of Finance	Digital	Digital	Thomas, Huw -	Tracey, Anthony	Williams, Carolyn	Williams, Carolyn	07-Nov-22	There is a risk of that digital transformation programmes that could potentially enable improved patient care, patient outcomes and staff experience will be limited in pace and scope of delivery or may not progress at all. This is caused by there being limited funding for digital transformation which often requires investment. Conflicting priorities in the HDUHB and at Welsh Government level will make the next few years very challenging. This will lead to an impact/affect on our ability to deliver at pace and as planned, resulting in our ability to respond to the demands of our patients and services and an ability to meet targets such as RTT, 6 Goals, Cancer Pathway targets etc Risk location, Health Board wide.	Digital Transformation Roadmap to illustrate the planned project delivery in place and reviewed annually. Exec and board members are familiar with our digital transformation ambition and priorities. Proposed projects are costed and illustrate a ROI with a benefits realisation plan. Projects are submitted via the Digital Delivery Framework to ensure they are aligned with our strategic and planning objectives. New project approach being rolled out to ensure that business requests are prioritised and assessed appropriately to make the most of our limited resources.	Business objectives/projects	3	3	9	The current risk score reflects the importance of planning and prioritising however, due to funding cuts in the public sector and the fact that HDUHB remains in targeted intervention, it is still likely that some projects will not be supported due to limited funding.	Publish an update to the Digital Response	Tracey, Anthony	Completed	The Digital Enablement Plan (which went to Board in November 2023 and going back to Board in March 2024 for contract approval) which will bring in resources to help address this issue. Work continues to improve how we highlight to colleagues across the UHB the limited resources of Digital services which has enabled prioritisation of projects. Governance routes to support Business cases has been agreed however an update to the digital strategy is required to reflect the procurement of the strategic partner. Now that the strategic partner has been appointed, this can inform the ambition	Digital, Data and Innovation Committee	3	3	9	The work with the strategic partner has provided support for the implementation of the current projects and work is progressing well.	Treat	18-Feb-26

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Publish and share the DI&T delivery roadmap.	Williams, Carolyn	Completed	Timescales and project delivery are dependent on the outcome of the Board's approval of the Digital Enablement Plan and 2 Business Cases (going to Board in March and May 2024 respectively). The roadmap has been updated for Feb 25 and is being shared with directorates during strategic meetings as well as the Digital Programme Group on a monthly basis. Strategic partner procurement is now completed -awaiting sign off from Board Nov 2024. This will feed into the digital strategy , which the DI&T roadmap is a component. Roadmap - plan on a page provided and conversations around the structure and content being discussed.							
																Publish a refreshed Digital Response	Tracey, Anthony	30/06/2025 31/12/2025	Update at next review							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1719	Operational Allied Health Professions & Health Sciences	AHP&HS: Radiology	AHP&HS: Radiology	Carruthers, Andrew	Quarrie, Sara	Roberts-Davies, Gail	Roberts-Davies, Gail	19-Jun-23	There is a risk of loss of Radiology services across the Health Board from 31 August 2026. This is caused by the delayed implementation of the All Wales Radiology Information Systems Procurement (RISP) programme, with the existing contract with Fuji ceasing prior to the implementation of the All Wales solution. This could be exacerbated by delays in the roll-out of the All Wales solution across other Health Boards in Wales. This will lead to an impact/affect on a total loss of services being delivered by the Radiology directorate across the Health Board and the loss of all radiology data held for patients, resulting in potential harm to patients, the inability to undertake diagnostic assessments, a detriment to the Health Board's ability to achieve ministerial priorities and targets. This will also have an adverse impact on the reputation of the Health Board, and render it liable to increased complaints, litigation and scrutiny from external regulators. There are also financial implications, with the current contract due to expire 31 August 2026. Risk location, Health Board wide.	Hywel Dda have initiated a new project board, with members attending from both Radiology and Digital Services and TORs in place Health Board attendance by colleagues from Radiology and Digital Services at monthly All Wales RISP programme meetings, hosted by Digital Health and Care Wales (DHCW) ensuring the Health Board stays informed of the All Wales position which may have an impact on Hywel Dda's contract and timelines Regular communication with senior colleagues in Finance All Wales Deployment order agreed	Service/Business interruption/disruption	2	5	10	The Radiology Information Systems Procurement (RISP) project is a Wales wide project and therefore Hywel Dda UHB timelines will be affected by any time delays accrued within the other Health Boards with implementation dates before Hywel Dda UHB. A contract extension has been obtained with Fuji to cover the period until 31st August 2026. It is anticipated that the new RISP system will be functional by September 2025 (this date has slipped from the original date of 30th June 2025)- as such, contingencies are in place to mitigate the risk to ensure continued service delivery. Due to revised dates, this now allows for the dual running of both systems. The likelihood rating of this risk has been reduced from 4 to 2 given the developments with contract negotiations providing additional contingency. Nov 25 - Go live date is 1/12/26 - target risk score has been reached. risk to be closed after go live date.	To prepare and present a paper for August SRC In-Committee, highlighting revised options since the matter was presented at July 2023 Board Complete preparatory work (informatics and implementation plan) for our Health Board, with continued attendance at RISP meetings to monitor progress of other Health Boards and learn from delays encountered to avoid repeating errors before stable operations achieved. Appoint to a fixed term pathways project manager to manage the pathways and centralised booking work Confirmation received that the go live date for RISP has been delayed until 24/10/25	Roberts-Davies, Gail Roberts-Davies, Gail Procter, Sarah Procter, Sarah	Completed Completed Completed 04/11/2025 31/12/2025	Paper has been prepared and presented, and outcomes of discussions at SRC In-Committee inform future actions for this risk and further update to Board in September 2023. Regular meetings occurring at present three times per week. This action has now changed in light of the intended work with the Digital team and potentially CGI. Additional RISP budget would be used to fund WTE via the Digital Team Go live date delayed til 1st Dec by Philips.	Digital, Data and Innovation Committee	2	5	10	Once contracts have been agreed and renegotiated, this will reduce the likelihood of this risk occurring, with sufficient contingencies in place to manage any delays encountered by the project whilst being implemented.	Treat	24-Nov-25

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
1480	Director of Finance	Digital	Digital: Information Services	Thomas, Huw -	Tracey, Anthony	Beynon, Gareth	Beynon, Gareth	20-Sep-22	There is a risk of of losing touch with national work programmes and not being able to meet our statutory obligations to report to Welsh Government and Digital Health and Care Wales This is caused by the quantity of different work programmes currently underway by Welsh Government and Digital Health and Care Wales that requires input from local Information Services along side local initiatives. This will lead to an impact/affect on the Health Board of not implementing these programmes effectively or not being able to feed into the work programmes during the development phase due to inconsistent attendance and involvement, and not being in a position to report on the requirements made locally or nationally Risk location, Health Board wide.	Appropriate individuals remain as members of the groups and on the various distribution lists even if attendance is difficult or conflicts with local priorities. Ensure that any national requests for local intelligence or feedback are addressed and responded to in a timely manner.	Statutory duty/inspections	3	3	9	Too many national programmes of work underway as well as the work going on locally make attendance and involvement in all difficult. Going forward this is becoming increasingly problematic. Some rationalisation on membership has been undertaken to alleviate meeting fatigue Appointments have been made that will support the releasing of key staff in time to be closer involved with some national work programmes. Domain changed from 'Business disruption' to 'Statutory Duty' and Impact increased from 2 to 3 to reflect current situation. Further national groups	Review current workloads of staff that could be streamlined, combined or stopped in an attempt to release staff time to attend and work on national requirements	Beynon, Gareth	Completed	Addition	Digital, Data and Innovation Committee	1	3	3	Improvement made following recruitment, but meeting target score will be dependent on the successful candidate being backfilled via the recruitment process	Treat	23-Jul-25

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date							
															are being developed to address strategic direction set by Welsh Government, concerns raised nationally about the number of meetings being asked of Information Health Board teams to contribute to these groups and local priorities when they are either not aligned or at similar levels of maturity. Unable to stretch the team further with regards to number of meetings and workstreams that need input from us nationally. Discussions taken place outside of national meetings in an attempt to keep pace with the requirements Job description being developed to strengthen appropriate area of structure in a attempt to support this situation.	Ensure that any national requests for local intelligence or feedback are addressed and responded to in a timely manner	Beynon, Gareth	Completed	Ongoing														
															Position appointed to awaiting recruitment process to on-board individual Position filled and successful candidate has started in role, progress is being made with redistribution of workload but need to backfill as successful candidate was internal.	Develop job description to support this important work area within Information Services,	Beynon, Gareth	Completed	Job description developed and matched														

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive Function	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
2222	Operational Allied Health Professions & Health Sciences	Allied Health Professions and Health Sciences	AHP&HS: Occupational Therapy	Carruthers, Andrew	Quarrie, Sara	Adams, Jon	Davies, Carol-Anne	12-Nov-25	There is a risk of that acute occupational therapy referrals will be missed being received or delayed in being received by the acute OT teams due to the new e-obs e-flow system being implemented without explicit indication within the training sessions that existing referral pathways for occupational therapy will remain in place until local agreements are established. This is caused by The implementation of an new e-flow e-obs system across the acute sites which has not yet been updated with the occupational therapy changes required. Although the digital team have stated in correspondence with the service that existing referral pathways will exist and any changes will need to be made locally this is not explicitly being highlighted in the training which could lead to ward staff sending referral via the e-flow e-obs dashboard which therapy teams wont be aware of. This will lead to an impact/affect on An increase in duplication of work for acute occupational therapy teams and it could result in a delay to referrals being accessed if the teams are needing to check 2 systems and it could result in referrals being missed. Risk location, Bronglais General Hospital, Glangwili General Hospital, Prince Philip Hospital, Withybush General Hospital.	Occupational Therapy staff attending training sessions to learn how to access the system Escalating concerns to digital project managers Referrals to Occupational Therapy via Miyer Flow app can be seen by the MDT and oversight of referrals that have not been progressed will be monitored by the MDT	Safety - Patient, Staff or Public	3	3	9	new system changes are a significant change from current established referral systems leading to OT referral being sent via multiple routes causing confusion and duplication until new systems and processes established Raise concerns with digital team and request that it is reinforced during E-Obs E-flow roll out training sessions that existing referral pathways remain in place until changes are agreed Occupational Therapy Service Representative attend Miya Referrals Implementation meeting on Monday 17/11 to discuss current risk and mitigations that can be put in place Occupational Therapy Service to review service processes for receiving referrals and monitor existing referral pathways and new referral pathways via the Miyer Flow system the interim during implementation to mitigate risk of referrals being missed occupational Therapy Service to monitor implementation and review in 4 weeks with digital team any snags identified Occupational Therapy Service to monitor snags with referral processes and other issues during implementation of Miyer Flow system and report back to strategy group Acute Occupational Therapy staff to attend Miyer Flow System Training	Adams, Jon	Completed	Email sent on 13/11 to Caryl Jones highlighting current risk	Digital, Data and Innovation Committee	2	3	6	Once local systems and processes have been established it is anticipated that this risk will be managed		27-Nov-25	

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function	Clinical Service Sub-Group / Executive	Executive Director	Clinical Care Group Director / Executive	Clinical Service Group Lead / Executive Function	Clinical Service Sub-Group Lead / Executive	Date risk Identified	Risk Statement	Existing Control Measures Currently in Place	Domain	Current Likelihood	Current Impact	Current Risk Score	Rationale for Current Risk Score	Additional Risk Action Required	By Whom	By When	Progress Update on Risk Actions	Lead Committee	Target Likelihood	Target Impact	Target Risk Score (tolerable score)	Rationale for Target Risk Score	Detailed Risk Decision	Review date
																Digital team to reinforce during training sessions for roll out of Myer Flow system that existing referral processes for Occupational Therapy remain in place until agreed otherwise.	Williams, Carolyn	Completed	message to be reinforced during training sessions.							
																Where a new referral is submitted via the Myer Flow system only and existing referral pathways are not used then the referral will be rejected until a local agreement has been reached and any change in referral process has been agreed.	Darby, Katie	31/12/2025	Site teams to action							

Appendix 3- Overdue Audit and Inspection Recommendations

Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	RAG Status
Medicines Management in Acute Hospitals	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Owain Williams	Jun-16	N/K ~~Mar-25~~ ~~Mar-26~~ Apr-26	Overdue
IT Infrastructure	HUHB-2223-24_003	Medium	R3. Suppliers should be monitored regularly, at annual review points, to ensure all contractual obligations, including claimed standards and accreditations for themselves and their staff are being maintained.	This recommendation is being picked up as part of the supply chain security workstream of our cyber programme where assurances will be sought at contract award and annual renewal of their standards and accreditations.	Cyber Security Manager	Jul-23	~~Jul-23~~ ~~Oct-23~~ Apr-26	Overdue
Data Quality Final Internal Audit Report 2024/25	HU-2425-28_004	Medium	R4. Information / Intelligence Strategy The health board does not currently have a formal information / intelligence strategy that outlines not only what the organisation aims to achieve with data but also how it intends to collect, manage, analyse and apply that data effectively to ensure a coordinated and systematic approach to utilising intelligence across teams and services. This absence impacts the ability to align efforts, prioritise key areas and effectively use data for decision-making.	The Digital Response requires refreshing, and "data" will be a key element to be document. As part of the data management and analytics plan, we will look to expand how the organisation will use this information to make informed decisions and create machine learning (ML) or generative artificial intelligence (AI)	Anthony Tracey	Aug-25	~~Oct-25~~ Jan-26	Overdue

7 - For Information

7.1

12:20, 0 Mins

7.1 - DDIC Workplan 2025/26

Maynard Davies
(Hywel Dda UHB -
Independent
Member)

| For information

Attachments

[7.1 - DDIC Work Programme 2025-26 v2 \(For Information\).docx](#)

DIGITAL, DATA AND INNOVATION COMMITTEE WORK PLAN APRIL 2025 – MARCH 2026

Currently, Digital, Data and Innovation Committee (DDIC) meets quarterly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2025 – March 2026.

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	22 Apr 2025	22 Jul 2025	7 Oct 2025	15 Jan 2026	21 Apr 2026
Governance and Risk							
Welcome and Apologies	Chair	All	✓	✓	✓	✓	
Declarations of Interests	Chair	CSO	✓	✓	✓	✓	
Minutes from previous meeting	Chair	CSO		✓	✓	✓	
Matters Arising (not on agenda)	Chair	All		✓	✓	✓	
Table of Actions (ToAs)	Chair	CSO		✓	✓	✓	
DDIC Terms of Reference (TORs) Review (12.1)	Chair	JW	✓				✓
DDIC Annual Report (10.4.1)	Chair	CSO					✓
Self-Assessment of Committee Effectiveness: Outcome Report (10.5)	Chair	JW					✓
Assurance and Risk Report: combined report including: - Corporate Risks Assigned to DDIC (3.1.20) - Operational Risks Assigned to DDIC (3.1.20) - Internal and External Audit Reports (3.1.8) - Monitoring of Ministerial Directions - Monitoring of Welsh Health Circulars (WHCs)	HT	RW	✓ V	✓	✓	✓	✓
National and Regional Landscape	HT	HT		D	✓		
Digital							
Digital Context Report	HT	AT	✓				
Digital Strategic Plan (2.1.1 & 3.1.1) (PO9)	HT	AT	✓	✓	✓	✓	
Digital Annual Plan (PO9)	HT	AT	✓				
Summary of Progress against Board Approved Business Cases	HT	AT	✓				
Digital Partner Update	HT	AT	✓	✓	✓	✓	
Recommendations of Patient Flow and E-Obs	HT	AT		✓			

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	22 Apr 2025	22 Jul 2025	7 Oct 2025	15 Jan 2026	21 Apr 2026
RISP – Radiology Informatics System Programme	HT	AT		✓	✓		
• RISP – Feedback on how the system is working							
LIMS – Laboratory Information Management System	HT	AT		✓			
Cyber Security Updates incl CAF compliance (3.1.8 & 10) – In-Committee	HT	AT	✓	✓	✓	✓	
Digital Operation Plan	HT	AT	✓			✓	
Digital Inclusion (from SRC workplan) Deep Dive	HT	AT		✓		?	?
Planning Objective (PO) Update Report (3.1.18)	HT	DW		✓		✓	✓
Proposal of Ambient AI within the Health Board	HT	DW		✓			
• Mini proposal on the use of AI Scribes					D	✓	
Digital leadership with Allied Health Professionals and Health Scientists (action from DDIC 22/4/25)	HT	AT			✓		
Digital Innovation & Transformation Benefits Realisation Report 2024/25	HT	AT			✓		
In Year Delivery of Programmes	HT	AT			✓		
Data							
Data Context Report	HT	AT	✓				
Current use of AI	HT	AT	✓				
Information Governance Sub-Committee (IGSC) 3A's update (10.3)	AT		✓	✓	✓	✓	
IGSC Workplan (3.1.24)	AT		✓				✓
IGSC Annual Report (10.4.1)	AT		D	D	✓		✓
Annual Review IGSC TORs (10.3)	AT		✓				✓
Data Quality Report (3.1.9)	AT			✓			
• Data Quality Deep Dive					✓		
Data Protection Impact Assessment Assurance Report (3.1.11)	HT	AT				✓	
Information Governance Assurance Report (2.1.3, 3.1.6,7 & 8)	HT	AT		D	✓	✓V	
• IG Training							
Analytical and Modelling Work	HT	AT			✓	✓	
Research and Innovation							

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	22 Apr 2025	22 Jul 2025	7 Oct 2025	15 Jan 2026	21 Apr 2026
Research and Innovation Context Report	LP	CH/SH	✓				
Research and Innovation Sub-Committee (RISC) 3A's update (10.3)	LP	CH/SH	✓	✓	✓	✓	
• Update on commercial research delivery	LP	SH			✓		
• Update on support embedding R&I in the health board	LP	SH				✓	
• Update on oncology research trials	LP	SH				✓	
Annual Review RISC TORs (10.3)	LP	CH	✓				✓
RISC Workplan (3.1.24)	LP	CH	✓				✓
Research & Development Implementation of the NHS Framework and Strategic Plan (10.4.1)	LP	CH	✓	✓			✓
Research and Development Framework Annual Update	MH	CH/SH				✓	
Commercialisation of Research, Innovation (Tritech Business Plan and KPI Monitoring for Tritech Institute) (3.1.17)	LP	CH/SH				✓	
TriTech Peer Review Report	LP	CH		✓			
TriTech Business Plan	LP	CH				IC	
Research & Innovation Annual Report (3.1.15)	LP	CH/SH	✓				
University Partnership Arrangements Update (3.1.16)	LP	CH/SH	✓			✓	
Research Project Presentation							✓
For Approval							
Policies (as required) (3.1.24)	HT	HT	✓	✓	✓	✓	✓
Business Cases (as and when required for scrutiny before onward ratification at Board) (3.1.5)	HT	AT		✓	✓	✓	✓
• Draft Business Case on single point of contact, patient service centre and possibly CRMPRM consultation					✓		
Administration							
Agenda setting meeting with Chair & Exec Lead (at least 6 weeks before the meeting)	CSO	N/A	✓	✓	✓	✓	
Draft agenda to go to Executive Team	CSO	N/A	✓	✓	✓	✓	

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	22 Apr 2025	22 Jul 2025	7 Oct 2025	15 Jan 2026	21 Apr 2026
Call for papers (at least 6 weeks before the meeting to receive papers at least 14 days before the meeting)	CSO	N/A	✓	✓	✓	✓	
Disseminate agenda/papers 7 days prior to meeting	CSO	N/A	✓	✓	✓	✓	
Issue a draft TOA within two days of the meeting	CSO	N/A	✓	✓	✓	✓	
Circulate minutes and TOA to the Lead Director within 7 days of meeting	CSO	N/A	✓	✓	✓	✓	
Issue minutes and TOA to Members (including the Committee Chair) following Lead Director review	CSO	N/A	✓	✓	✓	✓	

Chair: Maynard Davies **Vice Chair:** Chantal Patel **Lead Executive:** Huw Thomas

HT	Huw Thomas	JW	Joanne Wilson	MH	Mark Henwood	AT	Anthony Tracey
RW	Rachel Williams	DW	Daniel Warm	SA	Shaun Ayres	LP	Leighton Phillips
CH	Chris Hopkins	SH	Sally Hore	CSO	Committee Services Officer	D	Deferred
V	Verbal						

8 - Any Other Business

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

9 - Date and Time of next meeting

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

9.30am-12.30pm Tuesday 21 April 2026