Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Date	**21/04/2026**
Time	**9:30 AM - 12:30 PM**
Location	**Microsoft Teams Meeting; HDD Picton - Dolau Cothi**

Digital, Data and Innovation Committee

HDD_Digital, Data and Innovation Committee

NHS Wales

Agenda - 21 April 2026

1 Governance and Risk

9:30 AM, 0 min

1.1 Welcome and Apologies

9:30 AM, 0 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.2 Declarations of Interests

9:30 AM, 0 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.3 Minutes and Matters Arising from the Meeting Held on 15 January 2026

9:30 AM, 5 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.4 Table of Actions from the meeting held on 15 January 2026

9:35 AM, 5 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.5 Digital, Data and Innovation Committee (DDIC) Terms of Reference

9:40 AM, 5 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.6 Digital, Data and Innovation Committee (DDIC) Annual Report

9:45 AM, 5 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

1.7 Digital, Data and Innovation Committee (DDIC) Self Assessment Report

9:50 AM, 5 min

1.8 Assurance and Risk Report

9:55 AM, 10 min
Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

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2 Research and Innovation

10:05 AM, 0 min

2.1 Research and Innovation Sub-Committee (RISC) 3A's update, RISC ToRs and RISC Annual Report

10:05 AM, 15 min
Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value)

2.2 Research Project Presentation

10:20 AM, 15 min
Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value), Daniel Harris (Hywel Dda UHB - Lead Pharmacist - Cardiac Services), Helen Tench (Hywel Dda UHB - Assistant Head of Research Delivery)

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3 Data

10:35 AM, 0 min

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

10:35 AM, 15 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

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4 Digital

10:50 AM, 0 min

4.1 Digital Operation Plan

10:50 AM, 15 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

4.2 Digital Strategic Plan (PO9)

11:05 AM, 15 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

4.3 Closure of Planning Objective (PO) and Confirmation of new Planning Goals

11:20 AM, 15 min
Anthony Tracey (Hywel Dda UHB - Digital Director)

4.4 Digital Partner Update

11:35 AM, 10 min
Huw Thomas (Hywel Dda UHB - Director of Finance), Anthony Tracey (Hywel Dda UHB - Digital Director)

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5 For Information

11:45 AM, 5 min

5.1 DDIC Workplan 2025/26

11:50 AM, 0 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

5.2 Microsoft Enterprise Agreement Renewal

11:50 AM, 15 min

5.3 Digital Access

12:05 PM, 15 min

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6 Any Other Business

12:20 PM, 5 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

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7 Date and Time of next meeting

12:25 PM, 0 min
Chantal Patel (Hywel Dda UHB - Independent Board Member)

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21/04/2026 9:30 AM - 12:30 PM

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9:30 AM, 0 Mins

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1 - Governance and Risk

1.1 **9:30 AM, 0 Mins**

1.1 - Welcome and Apologies

Chantal Patel (Hywel Dda UHB - Independent Board Member)

Maynard Davies. (Chantel will Chair.)
Sarah Harraway.

1.2

9:30 AM, 0 Mins

1.2 - Declarations of Interests

Chantal Patel (Hywel Dda UHB - Independent Board Member)

Board Member DOI Register

1.3

9:30 AM, 5 Mins

1.3 - Minutes and Matters Arising from the Meeting Held on 15 January 2026

Chantal Patel (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

2026-01-15 - Digital, Data and Innovation Committee Meeting - Minutes(V2) ~.pdf

MINUTES OF THE HDD_Digital, Data and Innovation Committee MEETING

Date of Meeting: **09:30, Thursday 15 January 2026**
Venue: **Microsoft Teams Meeting**

Present:
Mr Maynard Davies, Independent Member (Committee Chair)
Mrs Chantal Patel, Independent Member (Committee Vice-Chair)
Ms Sarah Harraway, 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 Anthony (Tony) Smith, Consultant Anaesthetist
Mr Anthony Tracey, Director of Digital
y)
Ms Lil Bennett, Senior Clinical Informatics Nurse (acting as deputy for Mrs Lesley Hewer, Head of Nursing)
Mr Gareth Jenkins, Head of Data Science (part)
Ms Meinir Jones, Associate Medical Director, Transformation and Value (observing)
Ms Anna Harries, Chief Nursing Informatics Officer (observing)
Ms Clare Strudwick, Committee Services Officer (minutes)

Minutes Ref.	Item	Action

DDIC(26)73 **Welcome and Apologies**

The Chair welcomed members to the meeting.

Decision:
Apologies for absence were received from:

Professor Chris Hopkins, Head of Innovation & Tritech Institute, Research and Development
Ms Lesley Hewer, Head of Nursing
Mr Mark Henwood, Executive Medical Director
Mr Winston Weir, Independent Member

DDIC(26)74 **Declarations of Interests**

Decision:
No declarations of interest were made.

DDIC(26)75 **Minutes and Matters Arising from the meeting held on 07 October 2025**

The minutes from the meeting held on 7 October 2025 were approved as an accurate record.

Decision:
The Committee **APPROVED** the minutes of the meeting held on 7 October 2025.

DDIC(26)76 **Table of Actions from the meeting held on 07 October 2025**

Decision:
Updates were provided on the following outstanding actions:

DDIC(25)07 Digital Strategic Plan: Mr Huw Thomas reported that he had held discussions with Mrs Sharon Daniel and confirmed this action complete.

DDIC(25)44 Assurance and Risk Report: Mr Anthony Tracey reported discussions with Mrs Rhian Bond are scheduled and an update on the implementation date for Welsh Health Circular (WHC) 03-22: and extending the use of Blueteq in secondary care, will be provided at the next DDIC meeting in April 2026.

DDIC(25)54 Table of Actions from the meeting held on 22 April 2025: Mrs Joanne Wilson confirmed the meeting to develop a timeline for scheduling business cases and to align to the governance process, ensuring timely submission to DDIC and Board, had been postponed and is rescheduled for 16 January 2026.

DDIC(25)55 Information Governance Sub-Committee (IGSC) 3A's Update and IGSC Annual Report. Mr Tracey provided an update on the move from the Llangennech Record Storage Facilities. Formal notice (nine months) has been issued, with the move commencing on 1 February 2026. He noted that remedial work may be required on the Llangennech site, which will create associated cost pressures. A full business case outlining the options will be presented to the Executive Team and DDIC. Mr Tracey confirmed that all records held by external providers have been removed from site and returned. He also outlined the longer-term aspirations are to relocate HDdUHB records, libraries and record storage facilities to one centralised location that is secure and fit for purpose.

DDIC(25)67 National and Regional Landscape: Mr Tracey confirmed a meeting is scheduled for 16 January 2026 with Mrs Joanne Wilson. Action complete.

All other actions from the DDIC meeting held on 7 October 2025 were complete.

DDIC(26)77 **Planning Objectives (PO9) Update Report**

Mr Tracey presented the Planning Objectives (PO9) Update Report, that work around the readiness for Electronic Prescribing and Medicines Administration (EPMA), Digital Maternity and Open Eyes is continuing. Mr Tracey extended his thanks to Ms Lil Bennett and the nursing team for their help with the successful roll out of the Outpatient Flow and radiology programme.

Mr Tracey drew the Committees attention to the Laboratory Information Management System (LIMS) Deployment project as a high-risk potential for NHS Wales, whereby if the project is not rolled out by March 2027, there would be a cost of circa £3M to NHS Wales, with approximately £300,000-£400,000 liability for HDdUHB. Mr Tracy reported negotiations are ongoing with the supplier to reduce costs and that a meeting will be held Thursday 22 January 2026 between CEO's, Directors of Finance and Directors of Digital to discuss an implementation plan which will avoid incurring these costs.

Mr Tracey reported there were time pressures and capacity challenges with regards to the maternity system (BadgerNet).

In response to Mrs Chantal Patel, Mr Tracey confirmed that outcomes and impacts were being tracked at an operational level as part of the readiness and tolerance work undertaken during the five to six month period leading up to project rollout, to ensure a seamless delivery.

Acknowledging that impact and outcomes could be improved, Mr Tracey confirmed that work is undertaken with finance business partners examining operational efficiencies as well as cash releasing benefits. Mr Tracey emphasised the benefits realisation programme was mindful to avoid duplication across projects.

In response to a query from Mr Maynard Davies, Mr Tracey provided an update on the Centre of Excellence for digital analytics, whereby a hub and spoke model is being employed across a collective set of around ninety analysts from the data science team and other teams such as pathology, workforce and finance that can be brought together and co-ordinated by the Executive Team to work on assigned specific pieces of work. Mr Tracey gave the example of demand and capacity work currently being undertaken by this new model of working.

Mr Huw Thomas reported this approach had been tried previously and emphasised the importance of securing full organisational buy in.

Mr Maynard Davies emphasised the tremendous opportunities provided by this work approach, commending the data science work taking place and the need for this to spread through the organisation, rather than existing in isolation as well as the need to develop people in that team further to ensure they can contribute to the wider organisation.

Mr Tracey expressed confidence, noting that the organisation is now in a much stronger position with regards to this way of working and the use of data.

Decision: The committee **DISCUSSED** and **NOTED** the Planning Objectives (PO9) Update Report.

DDIC(26)78 **Digital Operational Plan**

Mr Tracey presented the Digital Operational Plan 2025/2026 highlighting that two areas were a red risk, LIMS and the Single Sign On, which is behind schedule. Mr Tracey reported all other areas had seen tangible progress and were either moving ahead or had been delivered.

In reply to an inquiry from Mrs Patel, Mr Tracey clarified that projects are progressing through phases simultaneously, with separate teams working on readiness and implementation, with support from CGI. Mr Thomas reflected that the usage of the word 'phases' denoted timings and that greater clarity could be provided by reworking the paper and perhaps using 'tranches' or 'stages'. Mr Tracey agreed to revise the paper to improve clarity and will reflect this in future updates to DDIC. **AT**

Mr Tracey confirmed to Mrs Patel that cumulative impact was monitored throughout the project, even if that benefit might not eventuate for nine or twelve months.

Following an inquiry from Mrs Sarah Harraway regarding clarification of timelines reflecting slippage on a project, Mr Tracey agreed to add revised delivery dates into future reports. **AT**

Mr Tracey provided Mr Maynard Davies a update regarding Single Sign On, that the system had been tested in Emergency Departments (ED) and a further programme with Electronic Prescribing and Medicines Administration (EPMA) was being examined, however this was currently on pause as the market is being revisited regarding potential alternative suppliers due to cost concerns.

Mr Tracey summarised to Mr Maynard Davies his main areas of concern over the next few months as LIMS, EPMA and the adoption of technology into the service and the need to avoid business burn out.

Due to the concerns raised, Mr Thomas suggested the LIMS project should be an advise to Board. Mr Maynard Davies agreed that, while he was assured regarding other projects, LIMS required an advisory position due to factors beyond HDdUHB's control, its financial implications and its status as an essential service.

Mr Tracey agreed, subject to CEO approval which he would seek permission for in the LIMS meeting, to present a paper to the next In Committee DDIC (IC-DDIC) to providing an update of the LIMS meeting taking place 22 January 2026. **AT**

Decision: The Committee **NOTED** the Digital Operational Plan update and the projected timelines for 2025/2026 and in future years and agreed to **ADVISE** the Board with regards to LIMS.

DDIC(26)79 **Digital Strategic Plan**

Mr Tracey presented the three-year Digital Strategic Plan, ahead of presentation to a future Board meeting. Initially published in 2020 the Digital Strategic Plan was finalised in 2025 due to the impact of COVID-19. It has been progressed further over the past 18 months to meet the priorities outlined within the Health and Care Strategy, *A Healthier Mid and West Wales: Our future generations living well.* Mr Tracey emphasised the need for public engagement and to look at digital as a driver and enabler with the focus on capabilities rather than thinking about systems.

Mr Tracey identified the key challenges impacting digital as demographic change, climate change and the digital deficit within HDdUHB from a technical, operational and staff perspective.

Mr Thomas recognised the risk of disconnect with Swansea Bay University Health Board (SBUHB), whilst the overall framing is consistent further work is required regarding core capabilities to ensure alignment between health boards.

In reply to a query from Mrs Patel, Mr Tracey clarified the need to ensure HDdUHB has a sufficient digital infrastructure in place to deliver projects, e.g. enough computers and devices on a ward to facilitate roll out. Mr Tracy reported digital deficit is assessed as part of the readiness phase.

Mrs Harraway expressed concern regarding the profound cultural shift required within HDdUHB to ensure the successful implementation of the Digital Strategic Plan, inquiring how such a transformational change could be engendered, the resources required to achieve this and how is work commencing on this challenge.

Mr Tracey reported he is working closely with the Workforce Team and the digital support officer within the Organisational Development (OD) Team and is exploring ways to strengthen the wider inclusion team to better support change. He also acknowledged the challenge of business-change fatigue across the organisation.

Mrs Harraway stated the was a need to recognise the difference between implementation and adoption, regarding culture and acceptance and looking to avoid burnout. Mrs Harraway further reflected on how workforce may look in five years-time compared with its current structure, emphasising that if HDdUHB does not achieve the necessary cultural shift, it risks undermining future successes.

Emphasising the need to design systems that are user centred and co-developed with end users, Mr Thomas reported that the Digital Inclusion Team and CGI have made a positive difference in reducing friction.

Ms Lil Bennett reported that work is ongoing to ensure cultural change and adoption with clinicians, by working with them directly. Furthermore, early work is being undertaken with education providers such as universities, who are training new clinicians to build up digital capability within the workforce.

Dr Leighton Phillips reflected on the need for awareness across three key areas. Firstly, he cautioned that digital enablement could inadvertently worsen health outcomes if HDdUHB attempts to implement change too rapidly. Secondly, he noted that progress will not always be linear, especially as emerging technologies such as quantum computing continue to evolve. Finally, he stressed the importance of distilling important information into clear, accessible communication that can engage and energise both staff and the public supporting the cultural shift required across the organisation.

Mr Tracey acknowledged the potential impact that AI and quantum computing could create a tipping point, expressing his concern that HDdUHB cyber infrastructure could become irrelevant as quantum could be able to crack any security code in minutes.

Mr Tracey outlined the security and safety provided on three fronts by a robust Cyber Team, the Information Governance Team and by building a Clinical Safety Team to provide a cornerstone on making decisions from a safety perspective and to prevent putting harm into the system.

Mr Maynard Davies giving the example of Chat GPT, acknowledged the possibility of disruptive events, however recognised that the public has a demand for change in the NHS and was confident that with the support of the Digital Inclusion Team working together technology could be successfully rolled out to the people who need it.

Mrs Wilson reported from a governance perspective, the need for digital to be aligned with the Healthy Mid and West Wales Group's overarching strategy. Mr Maynard Davies clarified he would be raising this at Strategy and Planning Committee (SPC) the following day.

Mr Lee Davies emphasised the need for culture and staff awareness and knowledge to be linked with the strategy refresh and for this to be communicated through Ms Alwena Hughes-Moakes to the organisation, enabling staff to keep pace with rapid change across digital elements, 24/7 and Community by Design.

Mr Maynard Davies agreed the need to work with the Ms Alwena Hughes-Moakes to engage with staff and the public. In terms of governance and the sequencing of DDIC meetings, Mr Maynard Davies observed the frequency of quarterly meetings should not be a hinderance to progress.

Mr Maynard Davies reflected on a potential dichotomy of pace at Regional Joint Committee (RJC) level between SBUHB and HDdUHB.

Mr Thomas agreed the need to understand and acknowledge this difference in approach to risk and understanding between the two health boards. However, Mr Thomas observed that these are two different statutory organisations and there is a need to be open to different risk appetites between them yet still achieve a consistent overarching vision. Rapid progress made by HDdUHB could provide an opportunity for shared learning with SBUHB through the RJC.

Decision: The Committee
- **NOTED** the proposed approach to the Digital Strategic Plan
- **NOTED** 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.

DDIC(26)79 **Digital Strategic Partner Update**

Mr Tracey reported that HDdUHB is working with CGI to develop a partnership charter and this would enable the Health Board to demonstrate value for money by being an intelligent client. The charter

will clearly define roles and responsibilities between HDdUHB and CGI and to ensure robust governance, Mr Tracey will present the charter to the Committee for approval. **AT**

Mr Tracey reported CGI is conducting a review of AI within HDdUHB, to identify areas where it is currently being used as well as further opportunities moving forward. CGI would provide documentation support around this on a regional basis.

Mr Tracey outlined that CGI had already strengthened the Digital Team by providing additional project and business change managers who supported the work on patient flow and that this enhanced capacity will now be used to accelerate on EPMA and eOBS.

Mr Tracy reported there is a contract in place with CGI to review HDdUHB cyber presence in the Microsoft Azure Cloud environment which will free up the Health Board Cyber Team to address issues rather than constantly monitoring HDdUHB cyber presence.

Mrs Wilson emphasised the need to ensure any contract agreements with CGI as a commercial supplier have received legal advice from Ms Sian-Marie James. **AT**

Mrs Wilson reported a breakdown of the £825,000 spent should be provided in the main open DDIC going forward rather than through IC-DDIC.

Mr Thomas and Mr Tracey confirmed to Mr Maynard Davies that the £825,000 was already contained in the agreed budget.

Mr Thomas reported that Mrs Lisa Gostling, Director of Workforce and Organisational Development/ Deputy Chief Executive Officer had contacted Mr Tracey requesting a meeting to discuss on how best to implement the new HDdUHB replacement Electronic Staff Record system and to examine whether there may be benefits in using the digital partner for this project.

Decision: The Committee **RECEIVED ASSURANCE** from the content of the Digital Strategic Partner Update Report.

DDIC(26)80 **Patient Services Centre**

Mr Tracey reported as detailed in the paper that the Patient Services Centre would provide a single point of contact for patients with HDdUHB. Mr Tracey informed DDIC that the business case had already been for discussion at the Executive Team, with the next stage to present to A Healthier Mid and West Wales Group.

Mr Tracey reported that a draft financial case had been developed to support the business case, although engagement with the wider market, had not yet commenced.

Mr Thomas clarified that administrative transformation would fund the Patient Services Centre and this will prove clinically transformative for HDdUHB.

In reply to Ms Patel's query regarding patient data security, Mr Tracey explained that the telephony based model proposed within the business case would ensure that all interactions are centrally logged and monitored, providing a safer service and more consistent service than the current provision, where patients often need to repeat information across multiple service points. Mr Tracey agreed to clarify the patient data security element in the next version of the business case. **AT**

Mrs Harraway complemented the business case and the aspiration it provided. However, challenged why a decision had been made not to include GP and community services, particularly considering the HDdUHB plan to drive a greater level of activity into community settings. Mrs Harraway emphasised the need for a seamless service for patients and believed not including community care settings provided a disconnect. Mrs Harraway argued that the difficulty of engaging independent GP practices should not deter efforts to do so, as failing to try could lead to fragmented patient pathways.

Mr Tracey acknowledged Mrs Harraway's concerns and agreed to make alterations to the next version of the Patient Services Centre business case to include Primary Care. **AT**

Ms Meinir Jones supported Mrs Harraway's position, highlighting that increasing multi-morbidity is making care coordination ever more challenging. She questioned whether the Imperial College London exemplar referenced in the paper had considered patient experience and stressed that how smoothly a patient is supported through appointments at HDdUHB; without delays or errors significantly shapes both patient and clinician experience. Ms Jones argued that, given ongoing delays linked to independent contractor arrangements, Primary Care should be included in early scoping work, especially as around 90% of patient journeys begin with GP practices.

Mr Tracey confirmed that the Imperial College London exemplar had included patient experience data and agreed the action to share the full details of the Imperial College paper with Ms Jones. **AT**

In answer to Mr Maynard Davies, Mr Tracey reported that work was underway to ensure that there were alignment and connectivity with national projects such as the NHS Wales App, which effectively would provide the front door to this work.

Mr Maynard Davies emphasised the need to bring Primary Care into the project at the appropriate point.

Mrs Wilson suggested that Mr Maynard Davies provide a verbal update to Board regarding the discussions undertaken by Committee and the changes agreed to the business case as a result of Mrs Harraway's comments and the agreement to include Primary Care. **MD**

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

• Recommended that Board **APPROVE** the outline business case subject to an agreement to include Primary Care into the business case at the appropriate point. Approval of the outline business case 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.

DDIC(26)81 **Proposal for the Introduction of Ambient AI into HDdUHB**

Mr Tracey presented the report proposing the introduction of ambient AI's into primary and secondary care. Highlighting the potential risks associated with Ambient AI from a cyber security perspective, Mr Tracey reported there was a need to ensure Ambient AI was seen as a medical device as it would be transcribing clinical discussions, not making medical decisions.

Mr Tracy clarified this would be a pilot in the first instance and that following benefits realisation a full business case would be presented to the Committee to allow rational consideration to be undertaken as to whether this approach should be progressed.

Mr Tracey reported licencing costs for the pilot would be between £60,000 and £100,000 and this would be a cloud hosted product, working with a supplier and CGI over a four-to-six-month period. There would be a need to check bandwidth and wi-fi connectivity at HDdUHB sites, with discussions ongoing with Primary Care Clusters and internally with Outpatients to participate in the pilot as well as other yet to be determined services.

Mr Tony Smith, believed that this was the safest approach, enabling HDdUHB to continue to make progress with this technology, yet balancing the need to be prudent and pilot the technology in a controlled way.

Ms Patel stated she was fully supportive of this pilot approach, requesting clarification on what would be disclosed to patients. In response, Mr Tracey confirmed consent would be required from patients, however as the pilot locations had not yet been agreed, the exact wording had not been finalised. He added that relevant service areas would be engaged to ensure clinical assurance before the wording is completed.

Dr Phillips clarified to the Committee, the consent required would be concerning data protection from an Information Governance perspective, not medical consent as there would be no change to clinical treatment as a result of using Ambient AI.

Dr Phillips reported that the small Business Research Initiative (SBRI) had an imminent deadline to return findings concerning the testing of Ambient AI in the Welsh NHS and that this might provide a useful way forward.

Mr Tracey added that he was also engaged in all-Wales discussions with HEIW regarding the future direction of Ambient AI.

In reply to a query from Mrs Harraway as to whether patient feedback would be gathered as part of the pilot, or whether the pilot had been sense tested with patient groups first, Mr Tracey confirmed the pilot would generate patient feedback.

Mrs Harraway emphasised the need to work with patients in a co-production manner rather than 'doing things' to patients and that if there was an opportunity for patient consultation ahead of the pilot this would be beneficial. The Committee agreed to this approach. **AT**

Mr Thomas reported the Digital Inclusion Team would be supporting with that co-production element, and that the pilot could involve this as part of the first phase of the discussions.

Mr Smith reaffirmed his view that this approach represented the safest way forward, noting that clinicians were highly supportive provided it was implemented in a measured and controlled manner.

Mrs Wilson and Mr Thomas agreed there would be a benefit for this discussion to be presented to Business Executive Team (BET). **AT/HT**

Decision: The Committee **ENDORSED** the proposed pilots and associated investment to enable a structured, responsible, and informed assessment of this emerging technology, subject to the caveat that appropriate co-production steps and consultation with patients be undertaken at the start of the pilot.

DDIC(26)82 **Research and Innovation Sub-Committee (RISC) 3A's Update**

Dr Phillips presented the RISCA 3 A's Update report confirming that there were no matters that to alert or advise DDIC of.

Dr Phillips was pleased to report that HDdUHB and research and development (R&D) were the first site in the UK to recruit to two commercial research studies sponsored by Roche, enabling Irritable Bowel System treatment for patients where all other treatments had proved ineffective. Dr Phillips reported that this positive news had been shared with Health Care Research Wales (HCRW) and Welsh Government (WG).

Dr Phillips updated the Committee that he had noticed a shift in the scrutiny taking place around research and innovation and perhaps this was reflective of a new Chief Medical Officer and a new Scientific and Research Director. Dr Phillips emphasised the increasing importance of the framework update being reported to DDIC and the potential impediments to research and innovation activity contained therein.

No questions were received.

Decision: The Committee **RECIEVED ASSURANCE** on the items that the Committee is providing assurance on.

DDIC(26)83 **Research & Development (R&D) Annual Framework Update**

Mr Phillips presented the Research and Development Annual Framework Update, outlining how R&D is performance managed by WG

through an annual performance review. The framework issued by WG three years ago outlines 10 pillars against which R& D is assessed.

From a personal perspective, Dr Phillips believed that R&D to be performing well in terms of strategy having launched a new strategic direction. Governance and leadership of R&D was equally strong, supported by mature partnerships with industry and universities.

Dr Phillips, giving the example of recruiting patients to trials, considered R&D to have successfully fulfilled research delivery and that communications and engagement had been increased considerably over the past year with assistance from HDdUHB Ms Alwena Hughes Moakes.

Dr Phillips noted that further work was still required to factor in population size and disease burden, and highlighted a discrepancy between the allocation of funding received by HCRW, and the resources needed to adequately support R&D. He and Mr Thomas had met with Mr Gareth Cross (WG) to discuss these concerns and agreed to return to the April 2026 DDIC meeting to provide assurance on the funding position, escalating the matter to Board should concerns remain. **LP/HT**

Dr Philips emphasised the need to ensure from a Workforce perspective, R&D is embedded at the core of a high-quality impactful service, to enable retention and recruitment of staff. Dr Phillips acknowledged the difficulties arising from the length of time to see an impact of a trial when making a case for more investment.

Mr Thomas asked whether, taking SBUHB as an example there was an opportunity to benchmark HDdUHB R&D provision against other research functions regionally, across Wales and more broadly across the UK, in order to better understand the organisations relative strengths and areas for improvement.

Dr Phillips considered this would be possible from a learning point of view rather than from a performance perspective and foresaw WG pooling knowledge in future. Giving the example of Oncology, in particular uncommon cancers where patients travelled to SBUHB for treatment, Dr Phillips reported regional insights in certain areas would be important.

Mr Maynard Davies agreed it was vital to ensure HDdUHB received a fair share of research money with R&D becoming increasingly important as population changed.

Decision: The Committee **RECEIVED ASSURANCE** in the annual assessment of performance against the national Health Care Research Wales (HCRW) NHS framework.

DDIC(26)84 **University Partnership Arrangements Update**

Dr Phillips reported that progress was being made in three main areas; firstly R&D activity partnering with universities, secondly enterprise and innovation activity supporting the commercialisation of devices,

technologies and drug discoveries and finally learning and teaching workforce resulting in staff and organisation development.

Dr Phillips reported Memorandums of Understanding agreements (MOU's) are in place with all universities and that meetings have been held with each partnership organisation to crystalise plans for the 2026/2027 financial year.

Mr Thomas reflected on the need to convey the opportunity of partnership more broadly internally to ensure HDdUHB is slicker in the way it collaborates with partnerships. A paper setting out the opportunities that research and innovation presents to the organisation and setting out the best approach to overcoming constraints be brought to Business Executive Team (BET). **LP/HT**

Decision: The Committee **RECIEVED ASSURANCE** from the report on progress in university partnership activities.

DDIC(26)85 **Tritech Business Plan**

Dr Phillips presented the Tritech Business Plan, acknowledging financially sensitive elements had been redacted and would be shared IC-DDIC.

Dr Phillps stated that the Business Plan had been presented to the Formal Executive Team and the high-level feedback received has been reflected in the report, confirming to Mr Maynard Davies that caveats raised at FET had been responded to where possible and others were part of an ongoing process, in particular the establishment of an advisory group.

Decision:
The Digital Data and Innovation Committee **RECEIVED ASSURANCE** from the **TriTech Business Plan** for the period 2026–2031 and **APPROVED** for onward submission to Public Board on 26 March 2026 acknowledging that sensitive financial elements would be discussed during IC-DDIC.

DDIC(26)86 **Information Governance Sub-Committee (IGSC) 3A's Update**

Mr Tracey presented the Information Governance Sub-Committee (IGSC) 3A's Update.

Mr John Evans reported he was working with Mr Mark Henwood to improve medical staffing training compliance.

Mr Tracey reported that due to the IGSC meeting not being quorate, IGSC had scrutinised the extensions to the All-Wales IG policies (836, 837, 494 and 495), the 282 Network Security Policy, 319 Disposal of Digital Assets Policy and 422 Consumer Device Policy and recommended them to DDIC for approval. DDIC agreed to approve the policies.

Mr Tracey agreed to discuss quoracy challenges with Mr Maynard Davies and Mrs Wilson. **AT**

CS

Mrs Wilson reported that as DDIC was not quorate, the Executive Medical Director would need to ratify the Committee's decision to approve policies.

Decision:
The Committee:

- **APPROVED** the extensions to the All-Wales IG policies (836, 837, 494 and 495) the 282 Network Security Policy, 319 Disposal of Digital Assets Policy and 422 Consumer Device Policy, subject to the Executive Medical Director ratification.
- **NOTED** the items that the IGSC is advising them of
- **TOOK ASSURANCE** from the items the Committee is assuring them of.

DDIC(26)87 **Data Protection Impact Assessment (DPIA) Assurance Report**

Mr Tracy presented the DPIA Assurance Report, emphasising the rising volume of DPIA's being undertaken with around 70-80 per quarter and the increased complexity and resources required to complete them. He also outlined the newly revised DPIA procedure, which introduces tiered levels designed to streamline and accelerate the assessment process.

Mr Tracey advised that staff training on the importance of completing DPIAs including how to complete templates would be implemented shortly. He also reported that an additional team member had recently been appointed to provide dedicated support for DPIA activity.

Mr Maynard Davies thanked the Information Governance Team for the work they undertake to keep HDdUHB safe.

Decision: The Committee **TOOK 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.

DDIC(26)88 **Information Governance Training Update**

Mr Tracey presented the Information Governance Training Update noting overall compliance at 84.63%. Although two area remain rated red, both have shown improvements; Estates and Facilities has risen to 76% from 56%, and Medical and Dental has improved to 55% from 45%.

Mr Thomas emphasised it was unacceptable for half of Medical and Dental staff to remain non-compliant with Information Governance training and asked Mr Evans to raise the matter directly with Mr Mark Henwood. **JE/MH**

Mrs Wilson suggested that study leave should not be approved without mandatory training being completed first, proposing that this matter should be scrutinised by People Organisational Development Culture Committee. **JW**

Decision: The Committee **TOOK ASSURANCE** on the actions being implemented to address gaps with Information Governance Training.

DDIC(26)89 **Update on Impact of Flow System**

Mr Tracey provide an Update on Impact of Flow System rollout, reporting the system had gone live in November 2025 and thanks to the sterling work of the nurses, full adoption of phase one had successfully taken place.

Phase two of the project will evaluate how electronic handovers and internal referrals can be implemented, as well as a command view of the hospital site in totality, including surge beds, boarding beds and electronic observation.

Manual observations will be undertaken in the first instance in one ward and once the outcome of that pilot is understood HDdUHB intends to rollout electronic observation by summer 2026.

Mr Smith noted that additional contributions to the project would be welcomed. He confirmed that a medical lead had been appointed for phases two and three and that shortlisting for EPMA is currently underway.

Mr Tracey stressed the importance of involving a broad range of clinical voices in the project and highlighted the need to avoid designing a system based solely on a single clinician's perspective.

Mr Thomas thanked the team involved for the phenomenally fast rollout, emphasising the importance of co-designing the system with key clinicians alongside executive and operational oversite as well as the use of data. Mr Thomas stressed the need to shift operational oversite of flow to ensure the system is being used to its full potential and not as a parallel source with manual collection of data being continued alongside.

Mr Maynard Davies thanked the team for all their hard work regarding rollout.

Decision: The Committee **NOTED** the update on the Patient Flow rollout

DDIC(26)90 **Analytical and Modelling Work including Presentation**

Mr Gareth Jenkins joined the meeting.

Mr Gareth Jenkins presented the Analytical and Modelling Work presentation outlining the projects and tools already delivered to HDdUHB as well as defining the remit of Data Science and the definition of AI.

Mr Jenkins underlined the importance of defining a problem first and then looking to establish the correct tool to solve that issue. Clear communication and a collaborative working strategy were a vital part of this approach.

Mr Thomas recommended that members take a few hours to watch the innovative demonstrations being undertaken by Mr Jenkins and his

team, stressing that business change and adoption in HDdUHB needed further work.

Mrs Patel agreed with Mr Thomas on the opportunities that would be provided if long stay patients could be identified using technology.

Mrs Harraway sought clarification on the process for identifying issues and how these are subsequently escalated to him and the Data Science Team, as well as how the resulting impacts are measured. She referenced for example, the volume of ambulances presenting at ED and the role the predictive model played into the early-warning stage before ED's move to black alert. The Committee agreed that the measurable impact of such projects should be evaluated going forward. **AT/GJ**

Mr Jenkins acknowledged this was the next challenge, to ensure specific challenges were fed back to the Data Science Team to resolve. Mr Jenkins reported with regard to the ED example provided by Mrs Harraway, a meeting was taking place with Mr Andrew Carruthers, Chief Operating Officer and Mr Gareth Cottrell, Deputy Chief Operating Officer that afternoon.

Decision: The Committee **NOTED** the update on the Analytical & Modelling Work - Data Science.

Mr Gareth Jenkins left the meeting.

DDIC(26)91 **Assurance and Risk Report**

Mr Maynard Davies complemented Mrs Wilson on the clear format of the report.

Mrs Wilson noted that audit dates have recently changed and confirmed to Mr Maynard Davies that she would liaise with Audit Wales to verify the revised timings, adding that initial feedback had been positive. She also committed to working with Executive Leads to finalise the updated schedule. **JW**

Decision: The Committee with regards to:
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; and

• **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(26)92 **DDIC Workplan 2025/26**

Dr Philips confirmed he will provide an Oncology Update report to the next DDIC meeting 21 April 2026.

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

DDIC(26)93 **Any Other Business**

Decision:

Mr Maynard Davies advised that he will be unable to attend the DDIC meeting 21 April 2026 and that Mrs Patel will Chair the meeting.

Mrs Wilson reported the DDIC meeting was not quorate as the Caldicott Guardian was not present.

Date and Time of next meeting

9.30am-12.30pm Tuesday 21 April 2026

1.4

9:35 AM, 5 Mins

1.4 - Table of Actions from the meeting held on 15 January 2026

Chantal Patel (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

DDIC TOA April 2026.pdf

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

TABLE OF ACTIONS/TABL GWEITHREDOEDD

Key: AT-Anthony Tracey; CSt-Clare Strudwick; HT-Huw Thomas; JE-John Evans; JW-Joanne Wilson; LPh-Leighton Phillips; MD-Maynard Davies

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
22/04/2025	DDIC(25)07	Ms Patel enquired whether there would be an opportunity to see how digital systems are being adopted in clinical settings during Board Member Patient Safey walkabouts • To liaise with Sharon Daniel regarding incorporating within Board Member Patient Safey walkabouts how digital systems are being adopted in clinical settings.	HT	17/12/2025	Complete This has been agreed by Sharon Daniel.
22/07/2025	DDIC(25)44	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	21/04/2026	Complete Contact made but no response received. Will contact Rhian Bond. Update will be brought to the January DDIC meeting. Update (Jan meeting) - contact made but not response received.
22/07/2025	DDIC(25)44	The assurance and risk report provided updates on Welsh Health Circulars. No date was provided for WHC032-22. • To contact Jill Paterson to obtain an implementation date for Welsh Health Circular 03-22: Further extending the use of Blueteq in secondary care	AT	29/08/2025	Complete Update: Contact made but no response received. Update will be brought to the January DDIC meeting. Full rollout is expected by the end of March 2027.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
07/10/2025	DDIC(25)54	Table of Actions from 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	21/04/2026	Complete Update: Meeting scheduled with JW on 12.01.26. Update (Jan Meeting) Meeting with JW took place on 16.1.26
07/10/2025	DDIC(25)55	The Information Governance Sub-Committee 3As report to DDIC alerted members to the condition of the record storage facility. As part of this discussion Mr Thomas advised the business case would be completed. • To progress the business case for records storage facilities, as a priority, ensuring all requested information is incorporated.	AT	21/04/2026	Complete Issues to be addressed through the annual planning cycle 2026/2027. Update provided (Jan meeting) by AT, a full business case regarding options and associated cost pressures to be presented to Exec Team and reported to DDIC
07/10/2025	DDIC(25)57	As part of the data quality discussion, Mr Thomas stated that in a previous DDIC meeting Mr Anthony Tracey had discussed the possibility of adding quality 'kitemarks' to documentation. • To add quality kitemarks for documents to the Data Quality Deep Dive Workplan	AT	21/04/2026	In progress Update to be provided to 14 April 2026 DDIC.
07/10/2025	DDIC(25)59	Mrs Wilson queried the timescales and whether the proposal would be ready for submission to the Board in January 2026. • 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	21/04/2026	Complete AT 05/03/2026 - A way forward has been agreed.

MEETING DATE	MINUTE REF	ACTION	LEAD	TIME SCALE	PROGRESS
15/01/2026	DDIC(26)78	Digital Operation Plan • To add revised delivery dates to the timelines in the paper	AT	21/04/2026	Complete The timelines have been modified as requested

15/01/2026	DDIC(26)78	Digital Operation Plan • To rework the clarity of the wording in the paper regarding use of word 'phases'.	AT	21/04/2026	Complete The paper has been revised to provide clearer distinction and usage of the terms “phases” and “tranches”.
15/01/2026	DDIC(26)78	Digital Operation Plan • To bring paper to April IC- DDIC providing an update regarding the LIMS meeting taking place on 22/1/26	AT	21/04/2026	Complete Update included within the Digital Operational Report to DDIC on 21.04.26
15/01/2026	DDIC(26)79	Digital Partner Update • To ensure any contract agreements with CGI as a commercial supplier have taken legal advice via Mrs Sian-Marie James	AT	21/04/2026	Complete Actioned - a meeting has been held between CGI and the Corporate Team
15/01/2026	DDIC(26)80	Patient Services Centre • To clarify patient data security element in the next version of the Patient Services Centre business case.	AT	21/04/2026	Complete To be included within the next iteration of the business case, and part of the specification
15/01/2026	DDIC(26)80	Patient Services Centre • To amend the next version of the Patient Services Centre business case to reflect the DDIC decision to include Primary Care into the business case at the appropriate point.	AT	21/04/2026	Complete Actioned
15/01/2026	DDIC(26)80	Patient Services Centre • To share the full details of the Imperial College paper with Ms Meinir Jones	AT	21/04/2026	Complete Complete -report shared on 06.03.26
15/01/2026	DDIC(26)80	Patient Services Centre • To provide a verbal update to Board regarding the discussions by DDIC and the changes agreed to the Patient Services Centre business case to include Primary Care.	MD	21/04/2026	Complete Update provided to Board 29/1/26
15/01/2026	DDIC(26)81	Proposal for the introduction of Ambient AI into HDdUHB • To bring a discussion to Business Executive Team	AT	21/04/2026	Complete Presented to BET on 25.02.2026

15/01/2026	DDIC(26)83	Research & Development (R&D) Annual Framework Update • To provide assurance to April 2026 DDIC regarding funding allocation and if concerns remain to take this to Board.	LPh	21/04/2026	Complete Huw Thomas has reassigned to Leighton Philips to raise any concerns with Huw Thomas as and when required.
15/01/2026	DDIC(26)84	University Partnership Arrangements Update • A paper setting out the opportunities that research and innovation presents to the organisation and setting out the best approach to overcoming constraints be brought to Business Executive Team.	LPh	21/04/2026	Complete Scheduled for BET 25.03.26 but not taken due to time constraints; subsequently agreed to be managed outside BET and removed from the workplan.
15/01/2026	DDIC(26)86	Information Governance Sub Committee (IGSC) 3A's update • Due to DDIC quoracy not being met, the Executive Medical Director was required to ratify the Committee's decision to approve policies.	CSt	21/04/2026	Complete Email provided by Mark Henwood ratifying approval
15/01/2026	DDIC(26)86	Information Governance Sub Committee (IGSC) 3A's update • A discussion to be held regarding IGSC quoracy issues.	AT	21/04/2026	Complete A review of the IGSC TORs will be undertaken to remove the Independent member from being part of quorum recognising the attendance is in an observer/scrutiny. A follow up conversation with the relevant IM regarding attendance at the Committee
15/01/2026	DDIC(26)88	Information Governance Training Update • To discuss with the Executive Medical Director issues regarding half of Medical and Dental staff not having undertaken Information Governance training.	JE	21/04/2026	Complete Complete - a new process has been agreed to ensure that records are updated to evidence training credits.

15/01/2026	DDIC(26)88	Information Governance Training Update • To explore whether study leave should not be able to be undertaken without mandatory training being in place first, this would be work for PODCC to investigate	JW	21/04/2026	Complete The Executive Director of Workforce and OD has confirmed that mandatory training should be at 100% complaince before Managers grant study leave. It was agreed this matter did not need to be a substantive item of the PODCC due to the operational nature of the matter.
15/01/2026	DDIC(26)91	Assurance and Risk Report • To confirm timings of Audit Wales dates	JW	21/04/2026	Complete On the Audit Wales recommendation it has been agreed that the Audit Wales report relating to digital services will be brought to the May 2026 ARAC Meeting when the DDIC Chair will be in attendance

1.5

9:40 AM, 5 Mins

1.5 - Digital, Data and Innovation Committee (DDIC) Terms of Reference

Chantal Patel (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

DDIC ToRs SBAR April 2026.pdf

Digital Committee Terms of Reference.v.3 for DDIC.Approval21.04.26.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital, Data and Innovation Committee Terms of Reference
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Joanne Wilson, Director of Corporate Governance/Board Secretary Charlotte Wilmshurst, Assistant Director of Assurance and Risk

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of this paper is to ensure that the Digital, Data and Innovation Committee has clear terms of reference which detail its purpose, boundaries, role, composition and operating arrangements.

Cefndir / Background

According to its terms of reference, the Committee must review its terms of reference and operating arrangements on at least an annual basis to ensure they remain fit for purpose. These must be subsequently approved by the Board and will form part of the Health Board's Standing Orders.

The Committee last reviewed its terms of reference and operating arrangements in April 2025, and these were subsequently approved by the Board, on 29 May 2025.

Asesiad / Assessment

The Digital, Data and Innovation Committee Terms of Reference and operating arrangements (Appendix 1) have been reviewed since Board approval on 29 May 2025, and two changes and amendments to terms have been made. These are clearly marked on Appendix 1 and relate to the following:

Section	What has changed?	Why?
3.1.18	Operational responsibilities – section amended	To replace "targeted intervention" with the broader term "escalation", ensuring the terminology accurately reflects the current Welsh Government oversight and

		escalation framework applicable to the Health Board.
3.1.19	Operational responsibilities – section amended	To replace "Planning Objectives" with "Planning Goals", aligning the terminology with the Board-approved Annual Plan 2026/27 agreed on 26 March 2026.

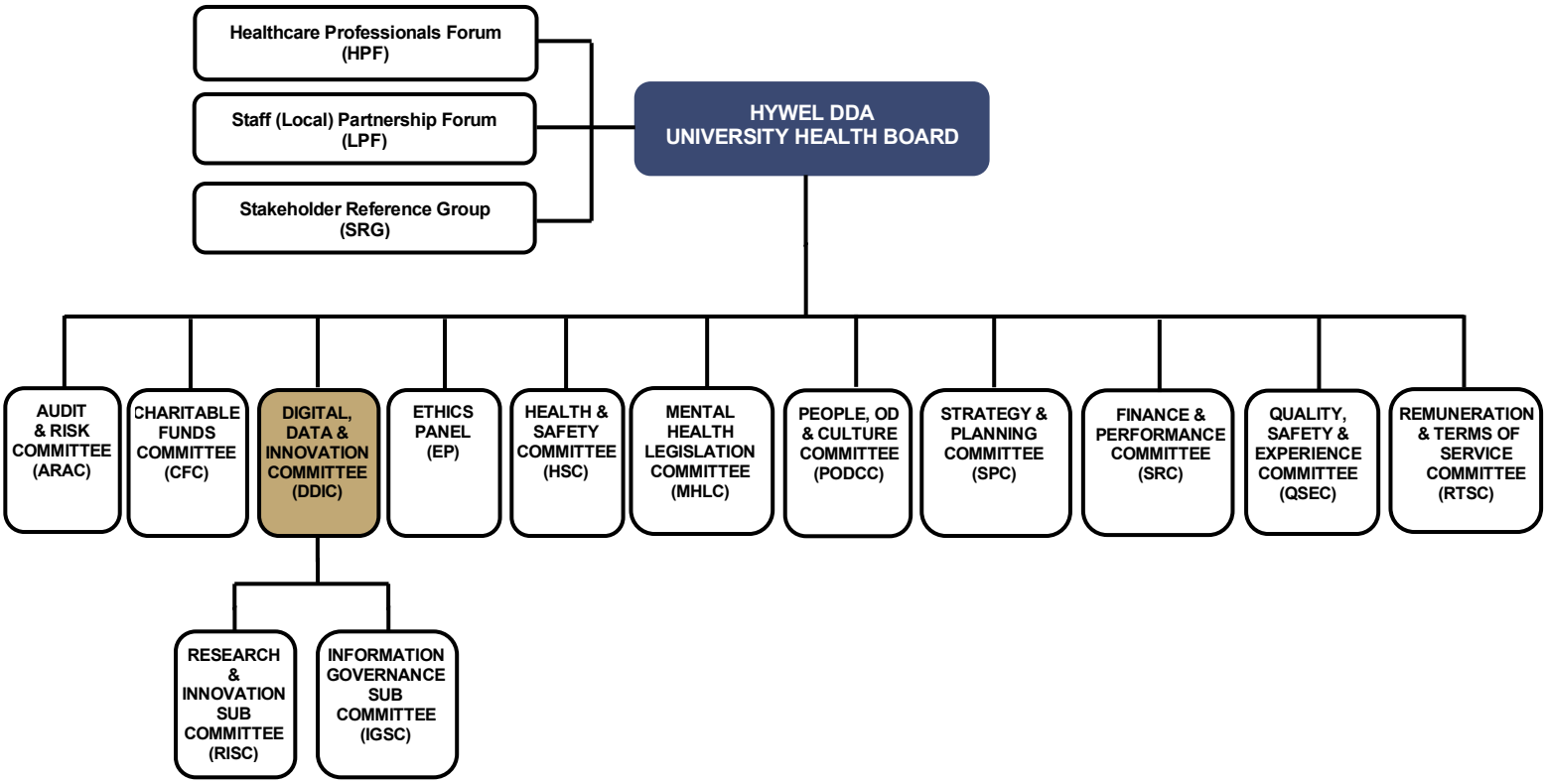
Argymhelliad / Recommendation

The Committee is asked to approve the Digital, Data and Innovation Committee's Terms of Reference (version 3) for onward ratification by the Board on 28 May 2026.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	1. Leadership
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Standing Orders
Rhestr Termau: Glossary of Terms:	Contained within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to Digital, Data and Innovation Committee:	Director of Corporate Governance/Board Secretary Executive Director of Finance

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable
Gweithlu: Workforce:	Not applicable
Risg: Risk:	Not applicable
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	Not applicable
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Not applicable



TERMS OF REFERENCE

DIGITAL, DATA AND INNOVATION COMMITTEE

Version	Issued to:	Date	Comments
V1	**Board**	30/01/2025	Approved
V2	**Digital, Data and Innovation Committee**	22/04/2025	Approved
V2	**Board**	29/05/2025	Approved
V3	**Digital, Data and Innovation Committee**	**21/04/2026**	**For approval**

DIGITAL, DATA AND INNOVATION COMMITTEE

1. Constitution

1.1 The Digital, Data and Innovation Committee (the Committee) was established as a Committee of the Hywel Dda University Local Health Board (the Health Board) and constituted from 1 April 2025.

2. Principal Duties

2.1 The purpose of the Digital, Data and Innovation Committee is to provide *advice* and *assurance* to the Board on the following:

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).

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.

2.1.3 That the Board's arrangements for information governance including creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information is in accordance with its stated objectives; legislative responsibilities, listed in Appendix 1; and any relevant requirements, standards and codes of practice.

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.

3. Operational Responsibilities

3.1 The Committee will, in respect of its provision of advice and assurance to the Board:

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).

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.

3.1.4 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.

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.

3.1.9 Seek assurance that the data on which performance is assessed is reliable and of high quality and that any issues relating to data accuracy are addressed.

3.1.10 Seek assurance of the organisation's arrangements for managing information and cyber security incidents including emergency preparedness, resilience and response and business continuity.

3.1.11 Seek assurance on the development, procurement and implementation of national and local digital systems.

3.1.12 Ensure that there is a process of Data Protection Impact Assessment in place in accordance with the Information Commissioner's guidance.

3.1.13 Seek assurance that the Health Board is meeting its responsibilities to ensure compliance with all relevant frameworks, UK Clinical Trials, Clinical

Investigations and other Regulations (transposed into UK law from European Union Directives) and reporting requirements.

3.1.14 Seek assurance on the promotion and support of Health Board's involvement in high quality, multi-disciplinary and multi-agency healthcare research and innovation, the promotion of evidence-based healthcare, the building of research and innovation capacity and fostering a research and innovation culture, including patient/public involvement where appropriate.

3.1.15 Receive the Research & Innovation Annual Report for approval prior to submission to the Health and Care Research Wales, to ensure the Health Board increases it research and innovation capacity, research output and research income.

3.1.16 Seek assurance that the university partnership arrangements are operating effectively and continue to protect the Health Board's 'university' designated status.

3.1.17 Seek assurance that the commercialisation of research, innovation, related developments are appropriately risk assessed and in accordance with health board duties, policies, and procedures.

3.1.18 Receive assurance on the delivery against the areas of ~~targeted intervention~~ escalation, and the required elements for de-escalation, that are aligned to the Committee.

3.1.19 Seek assurance on delivery against all Planning Goals ~~Objectives (Appendix 2)~~ aligned to the Committee, in accordance with the Board approved timescales, as set out in the Health Board's Annual Plan, considering, and scrutinising the plans and programmes that are developed and implemented, supporting and endorsing these as appropriate.

3.1.20 Seek assurance on the delivery of the requirements arising from the Health Board's regulators, WG and professional bodies.

3.1.21 Seek assurance on the management of risks within the Corporate Risk Register (CRR) and Directorate Risk Registers (including for hosted services and through partnerships and Joint Committees as appropriate) aligned to the Committee and its sub-committees, and report any areas of significant concern e.g. where risk tolerance is exceeded, lack of timely action. Where risks cannot be brought within the Health Board's risk appetite/tolerance, recommend acceptance of risks to the Board.

3.1.22 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).

3.1.23 Seek assurance that recommendations made by internal and external reviewers are considered and acted upon on a timely basis.

3.1.24 Approve organisational policies, procedures, guidelines and codes of practice (within the scope of the Committee) to support consistent standards-based processing of data and information to meet legislative responsibilities.

3.1.25 Review and approve the annual work plans for any Sub-Committee which has delegated responsibility from the Digital, Data and Innovation Committee and oversee delivery.

4. Membership

4.1 The membership of the Committee shall comprise:

Member
Independent Member (Chair)
Independent Member (Vice-Chair)
2 x Independent Members

4.2 The following should attend Committee meetings:

In attendance
Executive Director of Finance (Senior Risk Information Officer (SIRO))
Executive Medical Director (Caldicott Guardian)
Executive Director of Strategy and Planning
Associate Medical Director Professional Standards/ Deputy Caldicott Guardian
Digital Director (Deputy SIRO)
Director Research, Innovation and Value
Chief Clinical Information Officer
Chief Nurse Information Officer
Allied Health Professions and Health Science representative
Workforce and Organisational Development representative

4.3 The membership of the Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with a half of the In attendance Members, which must include SIRO or Deputy SIRO, Caldicott Guardian or Deputy Caldicott Guardian, and Director Research, Innovation and Value or Deputy.

5.2 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board – taking into account the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

5.3 Any senior officer of the Health Board or from a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting to assist with discussions on a particular matter.

5.4 The Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any officer Member be unavailable to attend, they may nominate a deputy, with full voting rights, to attend in their place subject to the agreement of the Chair.

5.6 The Chairman of the Health Board reserves the right to attend any of the Committee's meetings as an ex officio member.

5.7 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Committee.

5.8 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.9 The Committee may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Committee Secretary is to hold an agenda setting meeting with the Chair and the Lead Director (Executive Director of Finance) at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Committee Members. Following approval, the agenda and timetable for request of papers will be circulated to Committee Members.

6.3 All papers must be approved by the relevant Lead Director.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 A draft Table of Actions will be issued within **two** days of the meeting. The minutes and Table of Actions will be circulated to the Lead Director within **seven** days to check the accuracy, prior to sending to Members (including the Committee Chair) to review within the next **seven** days.

6.6 Members must forward amendments to the Committee Secretary within the next seven calendar days. The Committee Secretary will then forward the final version to the Committee Chair for approval.

7. In Committee

7.1 The Committee can operate with an In Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Committee will meet quarterly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Committee in discussion with the Lead Executive.

8.2 The Chair of the Committee, in discussion with the Committee Secretary, shall determine the time and the place of meetings of the Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

9.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

9.3 The Committee shall embed the Health Board's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

9.4 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Committee.

10. Reporting

10.1 The Committee, through its Chair and Members, shall work closely with the Board's other Committees, including joint and Sub-Committees and groups to provide advice and assurance to the Board through the:

10.1.1 Joint planning and co-ordination of Board and Committee business.

10.1.2 Sharing of information

10.2 In doing so, the Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Committee, may, subject to the approval of the Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. The Committee will receive an update following each meeting providing an assurance on business undertaken on its behalf. The Sub-Committees reporting to this Committee are:

10.3.1 Research and Innovation Sub-Committee

10.3.2 Information Governance Sub Committee

10.4 The Committee Chair, supported by the Committee Secretary, shall:

10.4.1 Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes the submission of a Committee update report, as well as the presentation of an Annual Report within **six** weeks of the financial year.

10.4.2 Bring to the Board's specific attention any significant matter under consideration by the Committee.

10.4.3 Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Health Board.

10.5 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation including that of any Sub-Committees established. In doing so, account will be taken of the requirements set out in the NHS Effective Board Committees Guide.

11. Secretarial Support

11.1 The Committee Secretary shall be determined by the Director of Corporate Governance/Board Secretary.

12. Review Date

12.1 These terms of reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

Appendix 1

List of Legislative Responsibilities

- Caldicott Guardian Principles
- Cyber Security and Resilience Bill
- Data Protection Act 2018
- Environmental Information Regulations 2004
- Freedom of Information Act 2000
- Human Rights Act 1998
- Information Commissioner's Office Codes of Practice
- Public Records Act 1958
- Telecommunications (Security) Act 2021
- the Common Law Duty of Confidentiality
- The Network and Information Systems Regulations 2018
- The section 46 Code of Practice on Record Keeping
- UK General Data Protection Regulation
- Wales Accord on the Sharing of Personal Information (WASPI) Framework

List of Legislative Responsibilities for Research

- UK Policy Framework for Health and Social Care Research (v3.3, 07/11/2017)
- The Medicines for Human Use (Clinical Trials) Regulations 2004 (and all subsequent amendments)
- ICH E6 (R3) Guideline for good clinical practice (GCP) (and all subsequent amendments)

List of Legislative Responsibilities for Medical Technologies, Software and AI within Healthcare

- The Medical Devices Regulations 2002 (SI 2002 No. 618) as amended. This also includes Artificial Intelligence (AI) as a Medical Device (AIaMD) and Software as a Medical Device (SaMD)

1.6

9:45 AM, 5 Mins

1.6 - Digital, Data and Innovation Committee (DDIC) Annual Report

Chantal Patel (Hywel Dda UHB - Independent Board Member)

For approval

Attachments

DDIC Annual Review 2025-26 Draft.pdf

DIGITAL, DATA AND INNOVATION COMMITTEE

ANNUAL REVIEW REPORT

2025/2026

1. Introduction and Chair's summary

In line with Standing Orders the Digital, Data and Innovation Committee (DDIC) must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Sub-Committees it has established, setting out how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework

Chair's Reflections

The Digital, Data and Innovation Committee was established in April 2025 because the Health Board recognised the growing importance of these areas in improving the health of our population.

Digital is becoming pervasive, both in promoting good health and delivering our health services. Good quality data is fundamental to decision making. Innovation, research and development are key to providing the best available healthcare and attracting the best staff.

During its first year the Committee has learnt much about the Board's position in each of these areas. It has seen the strengths and weaknesses of each and sought assurance on the work being undertaken. We have seen how our strategic digital partner has helped us successfully implement key systems and developed the organisation's thinking.

The first year of the Committee has provided a firm base on which the committee can build for the future. During the coming year we will need to move forward with the Health Board's digital strategy in support of A Healthier Mid and West Wales. We will need to continue to improve our data quality and analytics. We will need to expand our innovation.

I believe all three of these areas are key to improving the Health Board's services and the health of the population.

This report takes a look back at the last year in order that we can see the way forward

2. Terms of Reference (TOR) and Workplan

The TOR for the Digital, Data and Innovation Committee is reviewed on an annual basis or following any significant changes. The TOR were last reviewed on 22 April 2025.

Link to Digital, Data and Innovation Terms of Reference

The Digital, Data and Innovation Committee has a work plan to enable forward planning for the forthcoming year. The work plan is produced to incorporate the duties outlined in the Committee's Terms of Reference and any suggested areas of focus identified during the Committee's self-assessment process.

The Digital, Data and Innovation Committee work plan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support the Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

Link to Digital, Data and Innovation Workplan 2025-26

3. Sub-Committees

The **Information Governance Sub-Committee** reports into the Digital, Data and Innovation Committee with its own Terms of Reference and work plan for the year.

The Sub-Committee's TOR were last reviewed on 22 April 2025.

In line with their Terms of Reference, the Sub-Committee is required to provide a report after each meeting, as well as produce an annual report which was presented to the Committee on 22 July 2025, reporting on activity throughout the year.

The **Research and Innovation Sub-Committee** also reports into the Digital, Data and Innovation Committee with its own Terms of Reference and work plan for the year.

The Sub-Committee's TOR were last reviewed on 22 April 2025.

In line with their Terms of Reference, the Sub-Committee is required to provide a report after each meeting, as well as produce an annual report which was presented to the Committee on 22 April 2025, reporting on activity throughout the year.

4. Table of attendance

Membership		22/04/25	22/07/25	07/10/25	15/01/26
Maynard Davies	Independent Member (Committee Chair)	✓	✓	✓	✓
Chantal Patel	Independent Member	✓	✓	✓	✓

	(Committee Vice Chair)				
Eleanor Marks	Independent Member	✓	✓	x	✓
Winston Weir	Independent Member	x	✓	✓	x
Sarah Harraway	Independent Member	N/A	✓	✓	✓
In Attendance		22/04/25	22/07/25	07/10/25	15/01/26
Huw Thomas	Executive Director of Finance	✓	✓	✓	✓
Mark Henwood	Executive Medical Director	✓	X	X	x
Lee Davies	Executive Director of Strategy and Planning	x	x	✓	✓
Joanne Wilson	Director of Corporate Governance/Board Secretary	x	✓	✓	✓
Dr June Picton	Associate Medical Director for Professional Standards /Deputy Caldicott Guardian	✓	X	✓	X
Anthony Tracey	Director of Digital	✓	✓	x	✓
Dr Leighton Phillips	Director of Research Innovation and Value	✓	x	✓	✓
Dr Tony Smith	Consultant Anaesthetist	✓	X	✓	✓
Lesley Hewer	Head of Nursing	X	✓	X	X
Jo Bradburn	Deputy Director of Allied Health Professions	X	X	X	X
Jonathan Arthur	Deputy Director of Health Sciences	X	X	X	X
Deputies		22/04/25	22/07/25	07/10/25	15/01/26
Shaun Ayers	Director of Delivery	**For Lee Davies**			

Charlotte Wilmshurst	Assistant Director of Assurance and Risk	**For Joanne Wilson**			
Sally Hore	Head of Research and Development		**For Leighton Phillips**		
Daniel Warm	Head of Planning		**For Lee Davies**		
Gavin Jones	Head of Digital Operations			**For Anthony Tracey**	
Gareth Beynon	Head of Information Services			**For Anthony Tracey**	
John Evans	Deputy Director, Medical Directorate				**For Mark Henwood**
Lil Bennett,	Senior Clinical Informatics Nurse				**For Lesley Hewer**
Meeting quorate		Yes	Yes	Yes	No (see below)

Given that the 15 January 2026 meeting was not quorate, approval items were ratified by the Chair following relevant approvals from the Executive Medical Director (Caldicott Guardian). To mitigate recurrence, members have been reminded of the Attendance and Quoracy Requirements for Health Board Committees, including the requirement to nominate an appropriate deputy when unable to attend the full meeting.

A quorum shall consist of no less than two of the membership and must include as a minimum the Chair or Vice Chair of the Committee and one other Independent Member, together with a half of the In attendance Members, which must include the Senior Information Risk Owner (SIRO) or Deputy SIRO, Caldicott Guardian or Deputy Caldicott Guardian, and Director of Research, Innovation and Value, or their Deputy.

5. Committee Activities – alert, advise and assure.

The Committee is required to report to the Board after each Committee meeting by presenting a report highlighting the key discussion items at the Committee.

Alert – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team*

to resolve and were alerting the Board as engagement action or because intervention was required.

- **University Partnership Arrangements** – in April the Committee alerted the Board that the Memoranda of Understanding (MoU) with Swansea University, Aberystwyth University and University of Wales Trinity Saint David had expired. New MoUs were subsequently completed and signed in June 2025.

- **Laboratory Information Management System (LIMS)** – in July the Committee alerted the Board that due to delays in replacing the Laboratory Information Management System (LIMS), a revised implementation strategy had been agreed. Rather than adopting an organisation-wide approach, the deployment would now proceed on a discipline-by-discipline basis, enabling faster rollout across NHS Wales. The total financial cost was estimated at approximately £1.6m, with Hywel Dda University Health Board's (HDdUHB) financial commitment being £176k. This approach was endorsed by the Executive Team, and the associated risk reflected in the updated risk register. The Committee was informed in January 2026 that LIMS continued to experience delays with an update scheduled for the Committee in April 2026.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

- **Digital Partner Update** – in April the Committee advised the Board that a change of pace was required with stronger operational and clinical leadership input to Board Approved Business Cases and further discussions on the Electronic Prescribing (ePMA) and Electronic Patient Flow (eFlow). Further information on the governance arrangements would be brought to a future meeting. Ongoing management oversight is being maintained through established weekly and monthly meetings take place with CGI, its Digital Strategic Partner.

- **Research and Innovation** – in July the Committee advised the Board that there was a £300k shortfall within the Research and Innovation (R&I) Department with a result that decisions may need to be made regarding the feasibility of opening certain studies within the Health Board. A management approach was agreed with the Executive Director of Finance, with the associated risk subject to routine monitoring through the Research and Innovation Sub-Committee and reported through the 3As framework.

- **Radiology Informatics System Programme (RISP)** – in July the Committee advised the Board that whilst other Health Boards in Wales were experiencing delays in going live with the RISP, HDdUHB successfully implemented this in December 2025, following a request from the national programme to move

from October to December.

- **Laboratory Information Management System (LIMS)** – in July the Committee advised the Board that a request had been submitted to Welsh Government for the LIMS funding to be prioritised for slippage allocation from the 2025/26 Digital Priorities Investment Fund (DPIF). It was reported that HDdUHB would be required to allocate £176k in 2025/26 to support the revised discipline-based deployment model, if the request was unsuccessful
- In January, the Committee advised that the LIMS programme presented a potential high financial and delivery risk for NHS Wales, due to factors outside the Health Board's control, and was subject to ongoing mitigation and negotiation. Given the risk in terms of ongoing funding solutions for this project, it was agreed that a further update would be presented to the Committee in April 2026.

- **Digital Operational Plan** – in January, the Committee advised that two areas were a high risk, Laboratory Information Management System (LIMS) and the Single Sign On, as these were behind schedule. Projects were progressing through stages simultaneously, with separate teams working on readiness and implementation. Further updates will be presented to the Committee in April 2026.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

Assurance and Risk Report – the Committee reviewed the corporate and operational risks which are aligned to DDIC. As part of its review, the Committee considered the status of each risk and the current scores. An overarching report (which incorporates Corporate and Operational Risks, Operational, Monitoring of Ministerial Directions and Monitoring of Welsh Health Circulars) was submitted in July 2025, October 2025 and January 2026.

- **Ministerial Directions (MDs)** – In April, the Committee noted the re-alignment of digital-related Ministerial Directions following the establishment of the Digital, Data and Innovation Committee (DDIC) in line with revised governance arrangements approved by the Board in January 2025.

- **Monitoring of Welsh Health Circulars (WHC)** – in April the Committee discussed the WHC items and felt that the "Further extending the use of Blueteq in secondary care" item would be removed from the WHCs once ePMA was fully rolled out. The Committee received only limited assurance on this item as further information could not be provided within the meeting.

However, a more detailed narrative was provided within the Assurance and Risk report submitted to the Committee in July 2025.

- **Corporate Risk 2079: Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS / Corporate Risk 1352 - Risk of business disruption and delays in patient care due to a cyber-attack** – in July it was reported that there were two corporate risks aligned to DDIC. Assurance was received 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. Due to the sensitive nature of Risk 1352 *Risk of business disruption and delays in patient care due to a cyber*-attack, detailed discussions took place during the DDIC In-Committee meeting.

- **Operational Risk 1719: Risk of loss of Radiology services across the Health Board** – In July, the Committee was assured regarding the management of the five operational risks aligned to DDIC. This included consideration of Risk 1719, associated with delayed RISP implementation, which was discussed under the LIMS agenda item. Ongoing review arrangements for the remaining risks were confirmed.

- **Corporate Risk 1352: Risk of business disruption and delays in patient care due to a cyber-attack** – in October, while the Committee noted that the risk remained elevated, due to the sensitive nature of Risk 1352, further discussion took place during the DDIC In-Committee session.

Planning Objectives – in April assurance was taken relating to the Planning Objectives Closure Report and the Committee agreed to close the previous year's objective.

In July, the Committee received assurance that the 2024/25 Planning Objective for DDIC had been completed.

In January, the Committee noted progress on Electronic Prescribing and Medicines Administration (EPMA), Digital Maternity, and Open Eyes, noting successful implementation of functionality supporting Outpatient Flow and Radiology. LIMS Deployment was highlighted as a continued high-risk area, with potential financial implications should delivery not be achieved by March 2027. It was noted that engagement with suppliers and senior oversight discussions continue. Concerns remain regarding capacity and timescales for BadgerNet's. Delivery outcomes and benefits realisation were to be monitored through operational arrangements. Increased confidence was noted in the Digital Analytics Centre of Excellence, supporting wider organisation priorities through the hub-and-spoke model.

Digital Context – in April discussions took place on the digital context which included the potential radical use of the contract with the digital partner to obtain

clinical devices, which would have removed risk from HDdUHB. Further review of this potential model was to take place. It was noted that approval had been received to appoint a Digital Organisational Development (OD) Manager. The Committee took assurance that work would be undertaken to improve Health Board staff digital literacy.

Digital Strategic Plan – in April assurance was taken on the proposed approach, and the timescale to finalise the Digital Strategic Plan. It was noted that in terms of adopting national systems, the Digital Team would consider a Digital Leadership Framework and expand this to include Therapy departments. This year, significant additional funding had been allocated to Radiology services.

In October, the Committee discussed the Digital Strategic Plan and were assured by the proposed approach. The plan was submitted to Board for information in January 2026.

In January, the Digital Strategic Plan highlighted challenges around digital deficit, cultural change, workforce readiness, cyber safety and regional alignment, particularly with Swansea Bay University Health Board (SBUHB). It was agreed that the final Plan would be further developed over the next five months, supported by comprehensive engagement with staff and the public.

Digital Annual Plan – in April the Committee took assurance on the proposed Digital Annual Plan and the current pace of delivery with work being undertaken on a number of key systems. It was confirmed that a Clinical Advisory Group (CAG) would be established and form part of the digital governance structure going forward.

Progress Against Board Approved Business Cases – in April a Summary of Progress Against Board Approved Business Cases was discussed and assurance was taken on the process of the roll out of the eFlow system, and that work on Medicines Administration (ePMA) was progressing at pace. A detailed ePMA project plan was made available. Phase 1 of the programme Patient Flow went live in December 2025, and Phase 2 of the programme (eObservations) has been scheduled to go live in June/July 2026.

Data Context – in April the Committee noted the need for digital quality and operational clinical responsibility. A robust process for making information requests had been established with the intention to transfer towards a self-service approach within set boundaries and guidelines. The Data Quality Team conducted regular deep dives and reports to the Information Governance Sub-Committee, ensuring data quality was scrutinised and improved.

Artificial Intelligence (AI) – in April the Committee took assurance on work undertaken to review the current use of AI. The Committee approved the establishment of an AI Governance Task and Finish Group to provide the appropriate governance around the use of AI within the Health Board.

Research & Development Implementation of the New Strategic Plan– in April assurance was taken on the Research and Development Strategic Plan 2025-30 which was launched in June 2025.

Digital Partner Update – in July the Digital Partner Update report provided assurance on digital improvement opportunities, expenditure, new initiatives such as 360 view, patients services centre, e-forms and virtual wards. Whilst a number of workstreams were paused due to lack of capacity, plans were in place to continue in 2026. Funding was confirmed as either new or within the Digital Team's current budget, and regional collaboration has also been explored.

In January, the Committee was advised that the Health Board was working in partnership with CGI, to clarify roles, responsibilities, and governance arrangements in order to support value and strengthen intelligent oversight. CGI's work included consideration of the use of AI, enhanced project management support for EPMA and Electronic Observations (eOBS) delivery and a review of Microsoft Azure cyber security. The requirement for appropriate contractual and legal oversight was noted and assurance received that the £825,000 expenditure was within budget and would be reported transparently. Further discussions were planned regarding digital support for the replacement of the Electronic Staff Record (ESR) system.

TriTech – in July the Committee took assurance on the results of a recent peer review of TriTech. In January, the Committee received assurance from the Tritech Business Plan for the period 2026-2031 and approved this for onward submission to Board on 26 March 2026.

Digital Operational Plan – in July assurance was received that work had commenced on the Digital Operational Plan, with projects scheduled across multiple phases, using the 'Must Do, Should Do, Could Do, and Won't Do' prioritisation framework. The Committee was informed that various elements of funding are provided by WG, however the 'must dos' relate to capacity in teams which includes funding from the Digital Team's own resources.

In October, assurance was received on the In Year Delivery of Programmes - Digital Operational Plan report. The implementation of the Radiology programme had been delayed; however, it later went live in December 2025. The Committee noted that the deployment of the Laboratory Information Management System (LIMS) remained very challenging.

In January, assurance was received on the proposed approach to the Digital Operational Plan with most programmes progressing. However red risks were highlighted in relation to LIMS and Single Sign On and given the level of risk and external dependencies, it was agreed to advise the Board on LIMS.

Digital Inclusion – in July a report highlighted progress in staff training, community

engagement, and efforts to improve rural connectivity, with plans to embed digital skills in PADRs and track programme milestones. The Health Board partnered with University of Wales Trinity Saint David to produce a proposal to undertake research on the digital divide in Wales and funding was approved for this work. The Digital Inclusion programme released a digital skills and confidence readiness framework to be used to assess and build digital readiness as part of a system and pathway roll out.

Patient Flow and E-Obs – in July assurance was received that the Patient Flow and E-Obs project had gone live in 2025.

In January, the Committee noted the impact of Flow System rollout with the system having gone live in November 2025 with full adoption of phase one successfully taking place. Phase two of the project would evaluate how electronic handovers and internal referrals could be implemented, as well as a command view of the hospital site in totality, including surge beds, boarding beds and electronic observation. Manual observations would be undertaken in the first instance in one ward and once the outcome of the pilot understood, HDdUHB intends to rollout electronic observation by Summer 2026.

Ambient AI – in July, the Committee received assurance that the Health Board would continue to explore the potential application of Ambient AI, with plans for the Ethics Panel to review its potential. It was noted that Health Education and Improvement Wales (HEIW) is also undertaking research on the benefits of using AI Scribes.

In January, the Committee considered the Proposal for the Introduction of Ambient AI into the Health Board and endorsed the proposed pilots and noted the need to manage cyber and information governance risks, secure patient data protection consent, and proceed in a controlled manner. The four to six-month pilot, would involve selected services, generate patient feedback, and include early co-production with patients, supported by the Digital Inclusion Team, to enable an informed assessment of this emerging technology.

Data Quality – in July the Committee was assured that a number of Data Quality roadshows had taken place across Health Board sites, focusing on a key challenge of duplicate data entries, particularly within Emergency Departments (ED). Targeted training sessions had also taken place with health records staff, secretaries, ward clerks and ED administration staff.

In October, the Committee was informed that a number of Data Quality Deep Dives had taken place with multidisciplinary teams, and a number of recommendations were presented to services.

Information Governance (IG) Assurance Report – in October assurance was taken on the IG assurance report. The Committee noted that work was continuing on

improving compliance on Information Governance training. The Committee acknowledged the hard work of the Information Governance team.

Digital Leadership with Allied Health Professionals and Health Scientists – in October the Committee noted the lack of digital representation within the areas of Allied Health Professionals and Health Scientists. Two new part time roles, Chief Allied Health Professional Information Officer (CAIO) and a Chief Health Scientist Information Officer (CHSIO) are planned for Quarter 2 of 2026/27, using the Digital Team's existing budget.

Digital Innovation and Transformation Benefits Realisation Report 2024/25 – in October the Committee took assurance from the report which set out the key elements of the benefits realisation methodology adopted within Digital Services. The Committee acknowledged the hard work of the Digital Inclusion team.

National and Regional Landscape – in October assurance was taken on the report setting out collaborative processes for developing regional transformation. The Committee noted the importance of ensuring the views of the Committee were reflected in regional and national groups.

Patient Services Centre – in January, assurance was received from the proposed approach to the Patient Services Centre and Patient Relationship Management Tool. The inclusion of Primary Care was strongly advocated for seamless patient pathways, with the business case amended accordingly. It was noted that the project aligns with national programmes such as the NHS Wales App. The Committee recommended Board approval of the outline business case, with Primary Care added, to proceed with market engagement before finalisation. The Board approved the Patient Service Centre and 360° View Outline Business Case on 29 January 2026, subject to no immediate commitment to additional resource and the requirement for a Final Business Case, including market tested costs and benefits, to be returned to the Board for approval prior to any expenditure or contractual commitment.

Research & Development Annual Framework – in January assurance was received from the annual performance assessment against the national Health Care Research Wales (HCRW) NHS framework, as set out in the Research and Development Annual Framework Update.

Data Protection Impact Assessment (DPIA) Assurance Report – in January the DPIA report highlighted rising volume and complexity of DPIAs, a revised tiered procedure, forthcoming staff training, and additional team capacity. The Committee received assurance that plans were in place to improve transparency and responsiveness, including development of a DPIA tracking dashboard.

Information Governance Training Update – in January, the Committee was

informed that training compliance had reached 84.63%. There had been positive improvements in the Estates and Facilities, as well as the Medical and Dental areas, although Medical and Dental still presented some challenges. Assurance was taken on the actions being implemented to address gaps with training.

Analytical and Modelling Work including Presentation – in January, the Committee noted the Analytical and Modelling Work presentation outlining the projects and tools already delivered to HDdUHB as well as defining the remit of Data Science and the definition of AI. The Committee agreed that the measurable impact of such projects should be evaluated going forward.

Sub-Committees:

Information Governance Sub-Committee (IGSC) – the Committee took assurance from the Information Governance Sub-Committee (IGSC) 3A's update outlining the IGSC's activity and the management of its functions.

In April, the Committee noted the IGSC Work plan and approved the IGSC Terms of Reference and ISGC Annual Report which outlined the Information Governance activity during 2024/25.

In October, the Committee was advised of the condition of the local record storage facility, which required improvements. A proposal was submitted to the Executive Team and progress is now being made. It was noted that the development of a Health Records Hub at Dafen would provide a centralised, resilient base for the Health Records service, supporting the transition to a more digital, paper light operating model. The hub would bring together off site storage, an in house scanning bureau, and operational teams to improve record availability, reduce reliance on paper movement, mitigate estate and fire risk, and enable more timely access to patient information at the point of care as the Digital Health Records Programme progresses.

In January, the Committee noted work was being undertaken to improve medical staffing training compliance. As the IGSC January meeting had not been quorate, quoracy challenges would be discussed with the DDIC Chair and Director of Corporate Governance/Board Secretary.

Research and Innovation Sub-Committee (RISC) – the Committee took assurance from the RISC Update Reports which outlined the research and innovation activity and the management of its functions.

Assurance was also taken from the Research and Innovation University Partnership Updates.

In April, the Committee discussed the importance of ensuring any research was ethical and aligned to the social model for health and wellbeing. The Committee also noted the RISC work plan, approved the RISC Terms of Reference and the RISC

Annual Report which outlined the research and innovation activity during 2024/25.

In July, the Committee discussed how lack of funding for research opportunities could affect recruitment/retention of staff. It was agreed that this was an issue for the Executive Team to reflect upon. The Board was also advised of the shortfall.

In October, the Committee noted the need to support clinical academics with protected time for research to attract and retain staff.

In January, the Committee received assurance from the R&ISC 3As Update which outlined the Sub-Committee's activity.

For Approval

The following were approved by the Committee:

- Approval of the following policies:
  - 347 Corporate Records Management Policy
  - 281 Mobile Working Policy

- Approval of extensions to the following policies:
  - 282 Network Security Policy
  - 319 Disposal of Digital Assets Policy
  - 422 Consumer Device Policy
  - All-Wales Information Governance policies:
    - 836 All Wales Information Governance Policy
    - 837 - All Wales Information Security Policy
    - 494 - All Wales Email Use Policy
    - 495 - All Wales Internet Usage Policy

- The establishment of an AI Governance Task and Finish Group to provide the appropriate governance around the use of AI within the Health Board.
- Information Governance Sub-Committee Terms of Reference and Annual Report.
- Research and Innovation Sub-Committee Terms of Reference and Annual Report.

6. Committee Effectiveness - Feedback from self-assessment process

As stipulated within Standard Orders, the Board introduced a process of regular and rigorous self-assessment and evaluation of the performance of Committees For the Digital, Data and Innovation Committee, this involved the completion of a short digital form which requested feedback on the following areas:

- Oversight and Strategic Leadership
- Data, Information and Assurance
- Digital Risk, Cyber Security and Governance
- Capability, Adoption and Culture

- Continuous Improvement and Committee Effectiveness

Themes Identified from Survey Responses

What has gone well

- Strong and effective chairing, creating a supportive environment with constructive challenge.
- Clear strategic oversight and growing maturity of the Committee's role within the Board's governance framework.
- High-quality papers and information to support understanding, scrutiny and assurance.
- A positive culture that encourages innovation, learning and forward-thinking discussion.
- Effective visibility and oversight of digital risk, cyber security and information governance arrangements.

What to strengthen going forward

- Greater focus on outcomes, benefits realisation and real-world impact of digital investment.
- Stronger line of sight between digital initiatives, service transformation and patient, workforce and organisational benefit.
- Increased space for forward-looking strategic discussion, with less routine or operational reporting.
- Continued development of organisational capability, adoption and digital culture.
- Clearer articulation of alignment to national strategies and priorities.

The results from this are due to be presented at the next DDIC meeting on 21 April 2026. The Committee will also receive an update on progress at the mid-year point in October 2026.

7. Conclusion

The Committee is satisfied that it continues to operate effectively and in line with its Terms of Reference. Issues have been escalated to Board as appropriate, and the Committee uses feedback from the self-assessment process to evolve and continually improve.

1.7 **9:50 AM, 5 Mins**

1.7 - Digital, Data and Innovation Committee (DDIC) Self Assessment Report

For approval

Attachments

DDIC Self Assessment Report Revised 100426.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital, Data and Innovation Committee Annual Self-Assessment Report 2025/26
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Joanne Wilson, Director of Corporate Governance/Board Secretary
SWYDDOG ADRODD: REPORTING OFFICER:	Charlotte Wilmshurst, Assistant Director of Risk and Assurance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Penderfyniad/For Decision

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the report is to present the outcome of the Digital, Data and Innovation Committee (DDIC) Self-Assessment 2025/2026 process to the Committee.

Cefndir / Background

In line with Section 10.2.1 of the Standing Orders, the Board is required to introduce a process of regular and rigorous self-assessment and evaluation of its Committees and Advisory Groups. Section 10.2.2 further requires each Committee to submit an annual report to the Board through the Chair, setting out its activities during the year and including a review of its performance.

The Digital, Data and Innovation Committee (DDIC) has completed its first full year of operation. Given the relative maturity of the Committee, this year's self-assessment has focused on gaining assurance around core governance behaviours, strategic oversight, quality of information, risk management and committee effectiveness, while also identifying areas for ongoing development.

To avoid unnecessary survey burden and to support proportionate assessment, a short digital questionnaire was circulated to members. This was supported by ongoing reflective discussions and qualitative feedback from members throughout the year.

The self-assessment focused on five core areas:

- Oversight and Strategic Leadership
- Data, Information and Assurance
- Digital Risk, Cyber Security and Governance
- Capability, Adoption and Culture
- Continuous Improvement and Committee Effectiveness

Asesiad / Assessment

Members were asked to score their level of agreement with five key statements using a scale of 1–5 (1 = strongly disagree, 5 = strongly agree), with the opportunity to provide supporting qualitative commentary.

A total of 9 responses were received. This equates to a 60% response rate (2 out of 9 responses received from Independent Members, therefore it must be recognised that the majority of feedback has been provided by Officer Members of the Committee.)

Average Ratings

Area and Statement	Average Rating
Oversight and Strategic Leadership	
The Committee provides effective strategic oversight and constructive challenge aligned to organisational and national priorities.	**4.3**
Data, Information and Assurance	
The Committee receives relevant, high-quality information to support assurance and evidence-based decision-making.	**4.1**
Digital Risk, Cyber Security and Governance	
The Committee effectively oversees digital, cyber and information governance risks.	**4.4**
Capability, Adoption and Culture	
The Committee supports capability development, adoption and a positive digital culture.	**3.8**
Continuous Improvement and Committee Effectiveness	
The Committee reflects on its effectiveness and continues to mature.	**4.2**

Themes Identified

What has gone well

- Strong and effective chairing, creating an encouraging environment with constructive challenge that supports effective decision-making.
- Clear strategic oversight and growing maturity of the Committee's role within the Board's governance framework.
- High quality papers and information to support understanding, scrutiny and assurance with the Triple A (Alert, Advise, Assure) reporting format ensuring increased focus.
- A positive culture that encourages innovation, learning and forward thinking discussion.
- Effective visibility and oversight of digital risk, cyber security and information governance arrangements.

What we want to strengthen going forward

- Greater focus on outcomes, benefits realisation and real-world impact of digital investment.
- Stronger line of sight between digital initiatives, service transformation and patient, workforce and organisational benefit.
- Increased space for forward looking strategic discussion and assurance oversight, with less routine or operational reporting.
- Continued development of organisational capability, engagement, adoption and digital culture.

- Increased coverage of cybersecurity, through an In Committee session of the meeting if necessary.
- Clearer articulation of alignment to national strategies and priorities.
- Adoption of a more proactive approach, particularly in the development of strategic initiatives.

Suggestions from respondents

- Use more impact focused case studies to demonstrate benefits of digital, data and innovation.
- Increase proactive discussion on emerging risks and future opportunities, including cybersecurity and artificial intelligence.
- Improve visibility of “business as usual” digital activity and its cumulative impact.
- Strengthen clinical and workforce engagement to support adoption and cultural change through greater and broader clinical input at meetings and through workforce representation on the Committee.

Overall Conclusion

The Digital, Data and Innovation Committee is performing strongly, particularly in relation to strategic oversight, governance and risk assurance. Feedback reflects a positive culture, effective leadership and high-quality information to support assurance.

As a relatively new Committee, there is a clear opportunity in the coming year to further strengthen its strategic influence by increasing focus on outcomes and benefits realisation, reducing routine operational reporting, and creating additional space for forward-looking discussion and proactive assurance.

Areas for Improvement and Actions

Area for Improvement	By Whom	By When
Strengthen outcome-focused reporting and benefits realisation, including clearer impact metrics and case studies.	Executive Leads	30/9/2026
Increase forward-looking strategic discussion by reducing routine operational reporting.	Committee Chair / Executive Leads	30/6/2026
Increase line of sight between digital initiatives, service transformation and improved patient care and organisational performance within reporting.	Executive Leads	30/9/2026
Strengthen focus on adoption, capability and culture through enhanced workforce and clinical engagement.	Executive Leads	31/3/2027

Argymhelliad / Recommendation

The Committee is asked to:

- **CONSIDER** the outputs from the Committee Self-Assessment process
- **AGREE** the actions identified to further improve Committee effectiveness

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committees performance and operation, including that of any sub-committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.
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)	Not Applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	Not Applicable
Amcanion Strategol y BIP: UHB Strategic Objectives:	Not Applicable
Amcanion Cynllunio Planning Objectives	Not Applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	DDIC Terms of Reference DDIC Self-Assessment digital form results
Rhestr Termau: Glossary of Terms:	Included within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Digidol, Data ac Arloesi	Director of Corporate Governance

Parties / Committees consulted prior to Digital, Data and Innovation Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	No direct impacts
Ansawdd / Gofal Claf: Quality / Patient Care:	No direct impacts
Gweithlu: Workforce:	No direct impacts
Risg: Risk:	No direct impacts
Cyfreithiol: Legal:	No direct impacts
Enw Da: Reputational:	No direct impacts
Gyfrinachedd: Privacy:	No direct impacts
Cydraddoldeb: Equality:	No direct impacts

1.8

9:55 AM, 10 Mins

1.8 - Assurance and Risk Report

Huw Thomas (Hywel Dda UHB - Director of Finance), Andrew Carruthers (Hywel Dda UHB - Chief Operating Officer), Mark Henwood (Hywel Dda UHB - Executive Medical Director)

For assurance

Attachments

DDIC PublicGovernance Arrangements April 2026 FINAL.pdf

Appendix 1 - DDIC Corporate Risk - Mar 26.pdf

Appendix 2 - DDIC Operational Risk Register - Mar26.pdf

Appendix 3- Overdue Audit and Inspection Recommendations.pdf

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

Assurance and Risk Report

Digital, Data and Innovation Committee – 21 April 2026

Situation

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
7
(3 reportable)

Audit and Inspection Reports
7
(3 In-committee)

Welsh Health Circulars
3

Ministerial Directions
1

Risk Management - Overview

Effective risk management requires a ‘monitoring and review’ structure to be in place to ensure that risks are effectively identified and assessed, and that appropriate controls and responses are in place.

The Health Board’s risk management process is recorded via the Datix Risk Register module, and enables risks to be recorded at either principal, corporate or operational level. An escalation process is in place to ensure that risks which require escalation or de-escalation are done via appropriate approval processes and governance arrangements.

The Health Board operates within the widely accepted “Three Lines of Defence” model to ensure the appropriate responsibility is allocate for the management, reporting and escalation of risk.

Risks are aligned to an appropriate Clinical Care Group or Executive Function (hereto referred to as “Functions”), and each has a designated risk lead responsible for reviewing in a timely and comprehensive manner.

The Board’s Committees are responsible for the monitoring and scrutiny of corporate and operational risks within their remit and providing assurance to the Board that risks are being managed effectively and report areas of significant concern (eg where the risk appetite is exceeded, or there is a lack of action).

Committees are also responsible for reviewing risks over tolerance and where appropriate, recommend the ‘acceptance’ of risks that cannot be brought within risk appetite.

Corporate Risks Assigned to DDIC

Hywel Dda Risk Heat Map					
	LIKELIHOOD →				
Impact ↓	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Catastrophic 5				2079 (→)	
Major 4			1988 (→)		
Moderate 3					
Minor 2					
Negligible 1					

Each risk on the Corporate Risk Register (CRR) has been mapped to a Board level Committee to ensure that risks on the CRR are being managed appropriately, taking into account gaps in controls, planned actions and agreed tolerances, and to provide assurance to the Board through their update report on the management of these risks.

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 2 risks currently aligned to DDIC (out of the 24 that are currently on the CRR).

Due to the sensitive nature of risk 1988 which relates to Cyber Security, the detail is being reported to in-committee to provide discussion and assurance.

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.

Corporate Risks assigned to DDIC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	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 LIMS	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20 → (Reviewed 27/02/2026)	5 →	~~01/04/2026~~ 31/08/2026

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 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 were 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 DHCW hardware, the project involves development on the InterSystems Cloud as the software and hardware becomes end of life in August 2026.

Rationale for the Target Risk Score on next slide

Corporate Risks assigned to DDIC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Clinical Care Group / Executive Function	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 LIMS	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	20 → (Reviewed 27/02/2026)	5 →	~~01/01/2026~~ ~~01/04/2026~~ 31/08/2026

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. In September 2025, the original date for achieving the Target Risk Score (TRS) was revised from January 2026 to **April 2026**. The timeline was further extended in November 2025 to **August 2026**, as reported to and discussed by the LIMS Programme Board aligning with the end-of-life date of the existing system. The implementation of Tranches 1 and 2 has resulted in delays to the full deployment of the new system, with completion of Tranche 3 is currently scheduled for May 2026.

Operational Risks assigned to DDIC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

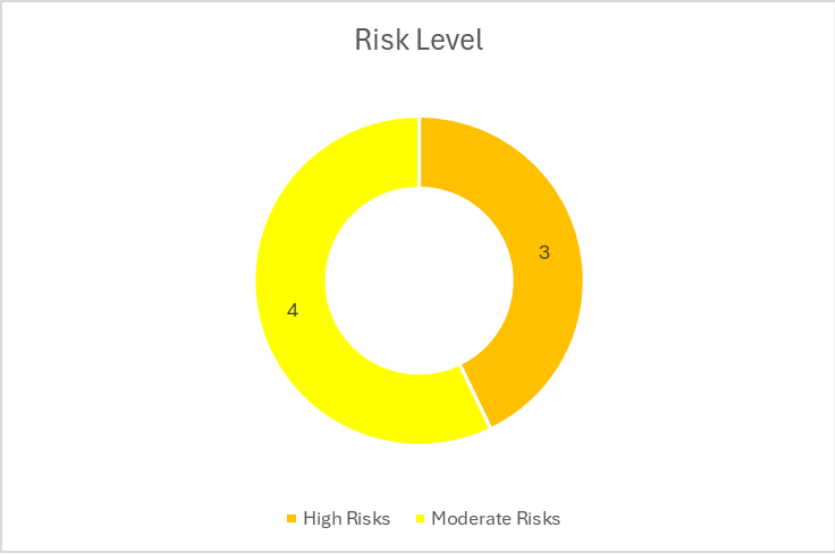
Seven operational risks on Datix have been aligned to DDIC which are all within review date. Reporting of these risks is currently under review by the risk lead.

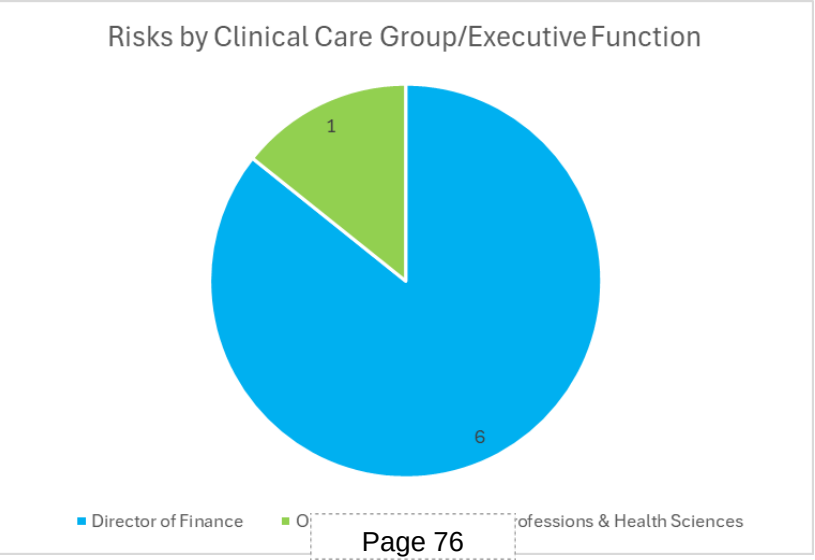
Of these, three have been identified as reportable to DDIC based on the following criteria:

- 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	3
New risks since last reported to DDIC	0
Closed risks since last reported to DDIC	1
Risks no longer reportable to DDIC	0
Increase in risk score since last reported to DDIC →	0
Decrease in risk score since last reported to DDIC ↑	1
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')	3





Risks closed since last report

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Rationale for risk closure	Date Risk Closed
1719 – Risk of loss of Radiology services across the Health Board from 31 March 2025 due to delayed implementation of RISP	Operational Allied Health Professions & Health Sciences	Chief Operating Officer	Radiology Information Systems Procurement (RISP) system went live 1 December 2025.	27/01/2026

Risks with decreased CRS ↓

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Previous Risk Score	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 (Digital)	Executive Director of Finance	12	9	9	31/03/2026	30/03/2026

Rationale for Current Risk Score

The current risk score reflects the importance of planning and prioritising however, due to funding cuts in the public sector and the fact that the Health Board remains in targeted intervention, it is still likely that some projects will not be supported due to limited funding.

Rationale for Target Risk Score

The work with the strategic partner has provided support for the implementation of the current projects and work is progressing well.

Whilst the development of a Digital response to the Health Board Strategy will provide planning and prioritising, there will always be an element of this risk due to the funding mechanisms from Welsh Government which do not currently allow for long term planning. Additionally, there may be unidentified 'in year' requests from Welsh Government which need to be implemented and encompassed within existing resources.

Risks with no change in CRS →

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Risk Reference & Title	Overseeing Clinical Care Group / Executive Function	Lead Director	Current Risk Score	Target Risk Score (TRS)	Expected Date to Achieve TRS	Date of last risk review
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	6	~~01/01/2026~~ 30/04/2026	01/03/2026
1480 - Risk of losing touch with National work programmes and not meeting statutory reporting obligations due to capacity	Finance (Digital)	Executive Director of Finance	9	3	~~31/10/2025~~ 01/05/2026	30/03/2026

Operational Risks assigned to DDIC sub committees

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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 3 operational risks (which includes those with a moderate current risk score) are reported. These were last reported to RISC in March 2026.

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 13 reportable risks, last reported to IGSC in March 2026.

Risk themes

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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. Risks are allocated to a committee based on their main impact on reporting. Risk themes are assigned based on any additional impacts or contributory factors, with each theme aligned to the appropriate committee for oversight. Risk themes provide assurance that a holistic approach to risk management is undertaken and enables the Health Board to better identify the risk appetite, risk capacity and total risk exposure in relation to each risk, group of similar risks, or generic type of risk.

Theme owners are provided with a thematic risk register on a bi-monthly basis to identify trends, or risk clusters, and to consider whether there are gaps in controls in the Health Board's control framework, and to determine whether further action is required to prevent risks from materialising.

The following themes are currently aligned to DDIC as of March 2026:

Theme	Definition	Number of risks	Date themed Risk Register last shared
Capital-Digital	A risk that could occur as a result of a lack of capital funding towards the procurement or development of a specific digital system.	14	31/03/2026
Digital Transformation	Risks related to the strategic adoption of digital technologies that are used to improve processes and productivity, deliver better care and staff experiences, manage business risk, and control costs.	16	31/03/2026
ICT (Information and Communications Technology)	A risk related to any of the organisation's digital networks or information systems that would compromise security, technology dependent tools or processes, assets, operational processes, or the provision of services reliant on these technologies.	29	27/02/2026

Audits and Inspections - Overview

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

The Health Board remains in Level 4 status with Welsh Government (WG) as a result of challenges relating to financial sustainability, strategy and planning, service delivery and organisational performance. Whilst the Health Board has been de-escalated for 'Leadership and Governance' from Level 3 to Level 1, the Health Board must meet the revised criteria:

- Evidence that all recommendations from the Royal Colleges, Health Inspectorate Wales (HIW) and other reviews specific to Hywel Dda UHB are discharged and either verified or delivered or scheduled for delivery within the Health Board's longer-term improvement plan;
- Support the implementation and realisation of GIRFT and the national programme reviews opportunities;
- Support the implementation and realisation of the three Ps policy, GIRFT, theatre optimisation, CIN optimisation programmes and related national improvement recommendations;
- Develop a prompt response to any HIW unannounced inspections, Audit Wales and Royal College recommendation, developing and completing action plans that demonstrate sustainable evidence.

All reports from audits, inspections and reviews undertaken across the Health Board are logged and tracked on Audit Management and Tracking (AMaT), with progress updated by relevant service leads against each recommendation, with evidence required to be uploaded to demonstrating progress and implementation, and any barriers to completion clearly noted.

AMaT enables services to directly update progress against all recommendations via one central system, promoting a consistent approach with regards to processes and reporting, improvement in transparency and accountability, supporting services with their governance arrangements, and improvement in information flow. Progress is monitored via the utilisation of a traffic light system based on performance against original completion dates.

Status Category	Definition
Overdue	The recommendation is behind schedule to the timescale provided by the lead officer.
Unable to Complete	The recommendation cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.
Pending Decision	The recommendation is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.
In Progress	The recommendation is currently in progress, and within the agreed original timeframe for implementation.
Reliant on External Factors	The recommendation is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.
Complete Pending Formal Approval	The Service / Function have completed the recommendation and currently awaiting formal approval to close.
Complete	The recommendation has been confirmed as completed by the CCG / Function Lead and formal approval to close has been received.

Audits and Inspection Reports assigned to DDIC

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

There are **7 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.

Full detail of recommendations that are overdue are included in **Appendix 3.** *Overdue recommendations in the table below have revised implementation dates provided.*

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 recommend-ations 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~~ ~~Mar-23~~ ~~Mar-26~~ ~~Apr-26~~ Jul-26	19	1	0	17	1	0	0	0	n/a - Electronic Prescribing & Medicines Administration (ePMA) system currently being rolled out.
Oct-22	Internal Audit	IT Infrastructure	Reasonable	Director of Finance	Director of Finance	Mar-24	~~Mar-24~~ ~~Jul-24~~ ~~Dec-24~~ ~~Apr-26~~ Dec-26	6	1	0	5	0	0	0	0	Recruitment to Contract Manager post will 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~~ Apr-26	4	1	0	3	0	0	0	0	n/a - Health Board's Data Strategy to be presented at DDIC in April 2026.
Dec-25	Internal Audit	Cyber Security Internal Audit Report 2025/26	Substantial	Director of Finance	Director of Finance	Mar-26	Mar-26	1	0	1	0	0	0	0	0	n/a- evidence being collated.

Due to their sensitive nature the following 3 reports are presented via in-committee to provide discussion and assurance:

- 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

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

All Welsh Health Circulars (WHCs) are managed via the AMaT system, which gives leads direct access to update and upload relevant evidence to demonstrate compliance with their requirements. Each WHC is assigned a status category. The table below outlines the definition of each category, the number of WHCs assigned to each as of 13 March 2026 and the number completed since the previous report.

Status Category	Definition	Number of WHCs
Overdue	The WHC is behind schedule to the timescale provided by the Lead officer or as stipulated in the WHC, or a plan (with date for implementation) is not yet in place.	0
Unable to Complete	The WHC cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The WHC is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the WHC is overdue or not whilst decision pending.	0
In Progress	The WHC is currently in progress, and within the agreed original timeframe for implementation.	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.	3
Complete Pending Formal Approval	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 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 Reliant on External Factors

WHC	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
032-22: Further extending the use of Blueteq in secondary care	21/03/23	Medical Director	Medical Director	~~April 2024~~ March 2027	**External Factors**	Progress continues with the national rollout of Blueteq, and there are now 57 forms live across a range of specialties. The national Blueteq Steering Group is reviewing the inclusion and exclusion criteria for mandatory form completion, which will inform the future direction of the programme. The Health Board continues to work closely with the All-Wales Therapeutics and Toxicology Centre (AWTTC) to ensure readiness and remains actively involved in the development of drug specific forms. Full rollout is expected by the end of March 2027.
034-25: Implementation of the Planned Care Referrals DSCN (DSCN 2024/11)	01/10/25	Director of Finance	Executive Director of Finance	N/K	**External Factors**	The Health Board has partially implemented this WHC, but have been unable to provide all the required data due to limitations in the functionality of the Welsh Patient Administration System (WPAS). Further updates are awaited to WPAS to ensure full compliance but no date currently known. The Health Board have not been able to develop a manual workaround which would cause significant duplication and additional risk in the absence of a technical solution being provided by DHCW. Head of Information Services has raised this with NHS Performance & Improvement. This is highlighted in risk 1474 (Risk of missing clinical information and increasing user workloads due to lack of appropriate system integration), current risk score 8).
002-26: Modernised Outpatient Dataset Phase 2: Planned Care activity	04/03/26	Director of Finance	Executive Director of Finance	N/K	**External Factors**	The Health Board are reliant on DHCW to provide a WPAS upgrade that meets the requirements of this WHC. The Health Board are in discussions with WG around this dependency, but as yet no release notes or indicative dates for User Acceptance Testing (UAT) versions from DHCW single record team have been released to Health Boards to progress this.

Implementation of Ministerial Directions

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Ministerial Directives (MDs) are legislative in character as they alter legal rights and duties. MDs are issued by Welsh Ministers and include codes of practice and guidance. In complying with the requirements of various governance codes and the Annual Governance Statement requirements, the Health Board has a duty to provide assurance of compliance with MDs.

The table below shows the number of MDs assigned to each category as at 13 March 2026, summarised over the next slides. To provide a more accurate reflection of MD's progress, three new status categories have been introduced since the last Committee report to mirror those used on the Audit & Inspection tracker. Definitions for these new categories are included in the table below.

Status Category		Number of MDs
Overdue	The MD is behind schedule to the timescale provided by the lead officer.	0
Unable to Complete	The MD cannot be implemented due to existing barriers and/or it is no longer relevant/appropriate for the Health Board. Formal sign-off by the CCG/Function Lead is required prior to escalation to the Executive Team for formal approval via operational governance structures.	0
Pending Decision	The MD is pending a decision in order to implement e.g. outcomes of annual planning process, approval of funding requests, outcome of a QIA panel. Committee updates will detail whether the recommendation is overdue or not whilst decision pending.	0
In Progress	The MD is currently in progress, and within the agreed original timeframe for implementation.	0
Reliant on External Factors	The MD is considered to be outside the gift of the Health Board to currently implement, e.g. reliant on an external organisation to implement.	1
Complete Pending Formal Approval	The Service / Function have completed the MD and 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

MDs included within this report are based on the following criteria:

3.1.19 Seek assurances on the requirements arising from the Health Board's regulators, Welsh Government and professional bodies

Progress updates relating to the implementation of MDs are extracted from the AM

Ministerial Directions Reliant on External Factors

MD	Issued On	Lead CCG / EF	Lead Director	Implementation Date	Progress Status	Progress Update
WG23-08: Local health boards and NHS Trusts reporting on the introduction of new medicines into the National Health Service in Wales Directions 2023	24/03/23	Medical Director	Medical Director	~~April 2024~~ March 2027	**External Factors**	Implementation of this MD is aligned to Welsh Health Circular 032-22 - "Further extending the use of Blueteq in secondary care" (see slide 15) which is also aligned to DDIC. The Health Board continues to work closely with the All-Wales Therapeutics and Toxicology Centre (AWTTC) to ensure readiness and remains actively involved in the development of drug specific forms. Full rollout is expected by the end of March 2027.

Recommendations

The Committee is requested, in relation to the areas presented in this paper to **RECEIVE ASSURANCE** from the Lead Director or Supporting Officer:

Risk Management

- that identified controls are in place and working effectively;
- 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

- 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

- 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

- that the Health Board is compliant with the NSIs (MDs) issued by Welsh Government.

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Risk Ref	Risk (for more detail see individual risk entries)	Executive Director	Domain	Previous Risk Score	Risk Score Mar-26	Trend	Target Risk Score (tolerable score)	Expected Date of achieving Target Risk Score	Risk on page no...
2079	Risk of loss of Pathology services across the Health Board due to delayed implementation of LIMS	Carruthers, Andrew	Service/Business interruption/disruption	4×5=20	4×5=20	→	1×5=5	31/08/2026	6

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.**	**Increase in length of hospital stay by >15 days.**	**An event which impacts on a large number of patients.**
			Agency reportable incident.	**Mismanagement of patient care with long-term effects.**	
			An event which impacts on a small number of patients.		
Quality, Complaints or Audit	**Peripheral element of treatment or service suboptimal.**	**Overall treatment or service suboptimal.**	**Treatment or service has significantly reduced effectiveness.**	**Non-compliance with national standards with significant risk to patients if unresolved.**	**Totally unacceptable level or quality of treatment/service.**
	Informal complaint/inquiry.	**Formal complaint.**	**Formal complaint -**	**Multiple complaints/ independent review.**	**Gross failure of patient safety if findings not acted on.**
		Local resolution.	**Escalation.**	**Low achievement of performance/delivery requirements.**	**Inquest/ombudsman inquiry.**
		Single failure to meet internal standards.	**Repeated failure to meet internal standards.**	**Critical report.**	**Gross failure to meet national standards/performance requirements.**
		Minor implications for patient safety if unresolved.	**Major patient safety implications if findings are not acted on.**		
		Reduced performance if unresolved.			

Workforce & OD	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/ service due to lack of staff.	Uncertain delivery of key objective/service due to lack of staff.	Non-delivery of key objective/service due to lack of staff.
			Unsafe staffing level or competence (>1 day).	Unsafe staffing level or competence (>5 days).	Ongoing unsafe staffing levels or competence.
			Low staff morale.	Loss of key staff.	Loss of several key staff.
			Poor staff attendance for mandatory/key training.	Very low staff morale. No staff attending mandatory/ key training.	No staff attending mandatory training /key training on an ongoing basis.
Statutory Duty or Inspections	No or minimal impact or breach of guidance/ statutory duty.	Breach of statutory legislation.	Single breach in statutory duty.	Enforcement action	Multiple breaches in statutory duty.
		Reduced performance levels if unresolved.	Challenging external recommendations/ improvement notice.	Multiple breaches in statutory duty.	Prosecution.
				Improvement notices.	Complete systems change required.
				Low achievement of performance/delivery requirements.	Low achievement of performance/delivery requirements.
				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

IMPACT ↓	LIKELIHOOD →				
	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	
	Detailed review of relevant information
	Medium level review
	Cursory or narrow scope of review

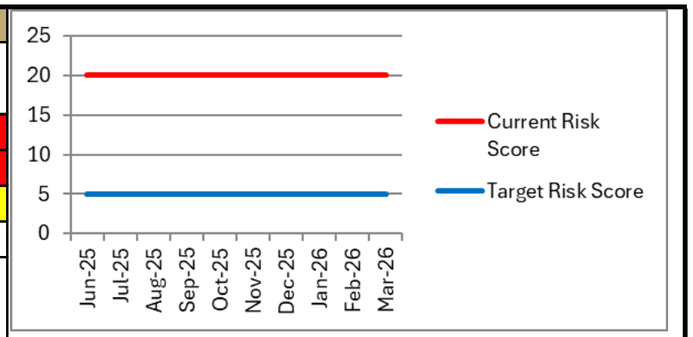
NB Assurance Map will tell you if you have sufficient sources of assurance not what those sources are telling you

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	**Executive Director Owner:**	Carruthers, Andrew	**Date of Review:**	Feb-26
Strategic Objective:	3. Great Care	**Lead Committee:**	Digital, Data and Innovation Committee	**Date of Next Review:**	Mar-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 £2m for hardware upgrade, these costs are circulated to CEOs and yet to be agreed by Health Boards. 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** Further action necessary to address the controls gaps	**By Who**	**By When**	**Progress**
Project plans in place both locally and nationally, they are monitored monthly. Local concerns are escalated to programme board. The Health Board have also raised concerns directly to the SRO. Project teams in place both locally and nationally, both meet weekly. Weekly meetings scheduled: HDU/SBU Leads, Technical Delivery and Testing Progress Regional Risks, Assumption, Issues and Decisions (RAID) Log is updated weekly and discussed monthly in the regional programme board including representatives from DHCW and InterSystems. Governance process are in place, Hywel Dda have raised and escalated the risk to LIMS 2.0 Programme board and direct to the national SRO on multiple occasions including in Feb 2025 with a proposal of an alternative plan. A joint all Wales Health Board letter to the SRO on 7th April 2025 led to agreement that the project plan needs to be re-set. Local contingency plans are in place for short term LIMS downtime.	Only high level plans in place after tranche 3 go live (microbiology). Awaiting conformation of Tranche 4&5 plans. A local contingency plan is in place but will only enable continuity for up to 5 days. More long term contingencies would involve reliance on supplier middleware solutions 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	All Health Boards to work alongside DHCW and ISC to approve a national contingency plan, including extension of hardware and software provision for current system with costs and mechanisms to enact.	Jones*, Dylan	Completed	DHCW presented the current position to Health Board CEOs on 8th April and they have requested a detailed, costed, contingency plan is developed by DHCW and ISC for review by Health Boards. 28/05/2025 - No contingency plan agreed at last LIMS Programme Board. Revised plan and costings to be provided by next programme board. 26/06/2025 - Mitigation plan agreed in June Programme Board, changing from HB deployment to discipline deployment with Microbiology commencing in July and the final discipline (Blood transfusion) going live in Jan 2026. National contingency plan inc costings has been submitted to Health Board CEOs via DHCW.

	Blood transfusion (BT) legacy data unavailable due to inaccuracies on upload, therefore BT testing cannot be completed and the service will not meet regulatory compliance via the Medicines and Healthcare products Regulatory Authority (MHRA). 26/06/2025 - Draft national contingency plan circulated to Health Board CEOs but not yet agreed. Additional funding will be required to support contingency plan, extending implementation into early 2026. 17/07/2025 - LIMS Programme Board wrote to CEOs requesting approval for the new service by service mitigation plan. The proposal will take the programme into 2026 and consequently will have financial impact. DoD has circulated summary paper of proposal to execs, waiting CEO decision. 26/09/2025 - All Health Boards have agreed with extension of mitigation plan to March 2026. Currently we have timelines for tranche 1,2 (Cell Path go live -Nov 25) and 3 (Micro Go Live - Jan 26) but yet to determine timelines for tranche 4,5 (Blood Science and Transfusion) 28/11/2025 - Further delays with Tranche 1 and 2 (go live now likely in Jan 26). This will push the programme beyond March 26. 27/02/2026 - Gone live with tranche 1&2 (cell Pathology), Tranche 3 scheduled for May 18th. Concerns remain with Blood Science and Transfusion.	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.
		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.

Agree Telepath LIMS extension for Blood Transfusion from Dec 2025 - Dec 2026.	Jones*, Dylan	Completed	Oracle order has been approved. Once confirmation of extension has been received from company, this action can be closed.
Sign off Tranche 1 and 2 prior to Cell Path Go live (19th Jan 2026)	Jones*, Dylan	Completed	New Action T1 - Dylan signed off on this for Cell Path. T2 - Dylan and Craig signed off on this for Cell Path. All internal approvals were collated via email (and saved as DHCW were having issues with electronic signatures)
Sign off tranche 3 (Microbiology - Feb 26)	Jones*, Dylan	~~30/01/2026~~ ~~30/04/2026~~ 31/05/2026	tranche 3 moved to later in 2026
Understand cost implications associated with extension to programme as a result of missing March deadline. DHCW to collate costs and impact to Health Boards.	Jones*, Dylan	26/03/2026	costings collated and sent to CEO for decision.
Escalated BT options SBAR to Execs for decision. include financial impact of decision.	Jones*, Dylan	31/03/2026	SBAR drafted and discussed with CCG and DoD.

ASSURANCE MAP				Control RAG Rating (what the assurance is telling you about your controls	Latest Papers (Committee & date)
Performance Indicators	Sources of ASSURANCE	Type of Assurance (1st, 2nd, 3rd)	Required Assurance / Current Level		
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			

Gaps in ASSURANCES				
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

	Regular Communication with DHCW	2nd							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	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 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.	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	30-Mar-26
																Ensure that any national requests for local intelligence or feedback are addressed and responded to in a timely manner	Beynon, Gareth	Completed	Ongoing							
																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 Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	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
															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.	Backfill of posts that have since become vacant following the appointment to other posts	Beynon, Gareth	29/05/2026	Vacancy currently going through the advert and recruitment process							
2222	Operational Allied Health Professions & Health Sciences	AHP&HS: Occupational Therapy	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	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	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		01-Mar-26
																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	Davies, Sharon	**Completed**	Sharon to feedback following the meeting today. JA discussed meeting outputs with Sharon and JA had follow up call with Carolyn Williams. New actions added							
																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	Davies, Sharon	**Completed**	to be discussed by service leads Process continuing and mitigating actions in place							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	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
									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 Service to monitor implementation and review in 4 weeks with digital team any snags identified	Davies, Sharon	Completed	Review in 4 weeks 31/12/25 Inpatients Team monitor system daily for Referrals that have not been sent through the usual system and contact referrers to advise. 01/03/26 Ongoing meetings with digital team to review progress							
																Occupational Therapy Service to monitor snags with referral processes and other issues during implementation of Miyer Flow system and report back to strategy group	Adams, Jon	Completed	Monitor snags. 01/03/26 on going meetings with digital team to review progress and monitor snags							
																Acute Occupational Therapy staff to attend Miyer Flow System Training	Adams, Jon	Completed	Staff to book on training prior to launch of the Miyer Flow system and attend any mop up sessions							
																Digital team to reinforce during training sessions for roll out of Miyer 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~~ 30/04/2026	Site teams continuing to action. Ongoing liaison with Digital Team and Informatics Nurses to ensure accurate communication of any change to referral processes.							
																IT Team are building occupational therapy dashboard which has been designed to the OT service requirements. This will need to be tested once built.	Darby, Katie	30/04/2026	Further meetings to be arranged with OT colleagues							

Risk Ref	Clinical Care Group / Executive Function	Clinical Service Group / Executive Function Service	Clinical Service Sub-Group / Executive Function Service	Executive Director	Clinical Care Group Director / Executive Function Lead	Clinical Service Group Lead / Executive Function Service Lead	Clinical Service Sub-Group Lead / Executive Function Service Lead	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	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	Delivery plan for 2026 has been shared with CGI and DDIC. Updated digital response due May 2026.	Digital, Data and Innovation Committee	3	3	9	The work with the strategic partner has provided support for the implementation of the current projects and work is progressing well. Whilst the development of a Digital response to the Health Board Strategy will provide planning and prioritising, there will always be an element of this risk due to the funding mechanisms from Welsh Government which don't currently allow for long term planning. In addition there may be unidentified 'in year' requests from Welsh Government which need to be implemented and encompassed within existing resources.	Treat	30-Mar-26
																Publish and share the DI&T delivery roadmap.	Williams, Carolyn	Completed	The roadmap has been updated for Feb 25 and is being shared with directorates during strategic meetings as well as the Digital Programme Group on a monthly basis. Strategic partner procurement is now completed -awaiting sign off from Board Nov 2024. This will feed into the digital strategy , which the DI&T roadmap is a component. Roadmap - plan on a page provided and conversations around the structure updated. Delivery plan for this year shared with CGI and DDIC.							
																Publish a refreshed Digital Response to the Health Board Strategy.	Tracey, Anthony	30/06/2025 28/2/2026 31/05/2026	An operational Digital plan has been drafted for 2026/27 and has been shared with operational and clinical leads. The overall Health Board Digital response (for the next five years) is currently being developed by the Digital Director with input from CGI. Approximate revised date of 31st May 2026, awaiting steer from Digital Director.							

Report Issued By	Report Title	Recommendation Reference	Priority Level	Recommendation	Management Response	Recommendation Owner	Original Completion Date	Revised Completion Date	RAG Status
Audit Wales	Medicines Management in Acute Hospitals	AW_295A2015_002	High	R4a: Set out a clear timescale and funding plan for implementing inpatient electronic prescribing, electronic discharge and rolling out access to the Individual Health Record (IHR).	The Medicines Management Group will lead on the discussion and the inter-professional work needed so that a plan of action can be implemented. This recommendation will need an All Wales approach as it will be a huge project. All staff involved with medicines will have to be part of the project and there will need to buy in from director level down.	Owain Williams	Jun-16	~~N/K~~ ~~Mar-25~~ ~~Mar-26~~ ~~Apr-26~~ Jul-26	Overdue
Internal Audit	IT Infrastructure	HDUHB-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~~ Dec-26	Overdue
Internal Audit	Data Quality Final Internal Audit Report 2024/25	HDU-2425-28_004	Medium	R4. Information / Intelligence Strategy The health board does not currently have a formal information / intelligence strategy that outlines not only what the organisation aims to achieve with data but also how it intends to collect, manage, analyse and apply that data effectively to ensure a coordinated and systematic approach to utilising intelligence across teams and services. This absence impacts the ability to align efforts, prioritise key areas and effectively use data for decision-making.	The Digital Response requires refreshing, and “data” will be a key element to be document. As part of the data management and analytics plan, we will look to expand how the organisation will use this information to make informed decisions and create machine learning (ML) or generative artificial intelligence (AI)	Anthony Tracey	Aug-25	~~Oct-25~~ ~~Jan-26~~ Apr-26	Overdue

2

10:05 AM, 0 Mins

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2 - Research and Innovation

2.1

10:05 AM, 15 Mins

2.1 - Research and Innovation Sub-Committee (RISC) 3A's update, RISC ToRs and RISC Annual Report

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

For approval

Attachments

Committee Update (3As) R_ISC 2 MARCH 2026 - Copy.pdf

Appendix 1 R_I Sub-Committee ToR v15 2026-2027.pdf

Appendix 2 Welsh Government Compliance Update R_I Sub Commi~.pdf

Appendix 3 Final Cancer Trials SBAR R_ISC March 2026.pdf

Research and Innovation Sub-Committee Annual Review Report - 2025-2026.pdf

COMMITTEE UPDATE REPORT/ ADRODDIAD DIWEDDARU'R PWYLLGOR

RESEARCH AND INNOVATION COMMITTEE/ CYFARFOD IS-BWYLLGOR YMCHWIL AC ARLOESI

Date of last meeting/ Dyddiad y cyfarfod diwethaf/: 02 March 2026

Quoracy/ Cworwm/: Met

Report by/ Adroddiad gan: Mark Henwood, Chair

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

Alert[1] (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.

Advise[2] (to monitor)/ **Cynghori** (i fonitro)

The Research and Innovation Sub-Committee wish to **advise** members of the Digital, Data and Innovation Committee that:

- The Research & Development (R&D) and TriTech & Innovation (T&I) Divisions continue to experience delays in relation to digital clearances for research and innovation projects. The issues have been reflected in the TriTech Risk Register and discussions continue to take place to seek appropriate solutions.

Assure[3] **(to note)/ Sicrhau (i nodi)**

Research and Innovation Sub-Committee wish to **assure** members of the Digital, Data and Innovation Committee that:

- Members approved the RISC Terms of Reference for onward ratification by DDIC (Appendix 1).
- The R&D annual reports, Research Quality & Sponsorship Group and T&I provided assurance on the governance arrangements in place.
- Assurance was provided on the Research and Development financial position with any shortfall to be met from the Research Capacity Account funds.
- Progress was noted in commercial research activity, including success in securing additional Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) funding to support commercial respiratory research. The funding will support an academic research fellow, in partnership with Swansea

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[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.*

University, additional capacity for radiology support, and investment in equipment and facilities.

- Members noted strong performance within the R&D delivery and support functions, recognising a continued positive recruitment figure to date for 2025/26 and recent success in recruiting to the SANDBOX study. SANDBOX is a commercial research study that combines blood-based biomarkers, genetic testing and artificial intelligence to support faster and more accurate diagnosis of dementia and reduce waiting times. The study will be delivered across Health Boards in Wales, alongside sites in England and Scotland, making it one of the most comprehensive real-world dementia research programmes in the UK. Strong collaboration between the Memory Service and Research teams was also noted, with the Memory Service providing invaluable support by facilitating timely access to referral information and the Research Team demonstrating their adaptability thus enabling patients to be approached promptly and efficiently.
- Assurance was received that the agreed solutions are in place to increase radiology capacity to approve studies, supported by a recent collaboration agreement and successful ILS2 funding with Swansea University for radiology services and staffing.
- Hywel Dda has submitted three applications for the Emerging Researcher Award (ERA), the outcome of which will be in April 2026.
- An update on the Research and Innovation (R&I) Strategic Plan 2025-30, and its annual assessment against the national HCRW research framework, was noted, with progress against objectives accepted.
- Received assurance by the activities of the Research Quality and Sponsorship Group (RQSG).
- Noted the intent from Welsh Government to audit NHS organisations on their compliance with Research Delivery Funding grant award and HCRW R&D finance policy. Outcomes and feedback will be discussed at the face-to-face meeting with Welsh Government 07 May 2026
- The Welsh Government review of R&D adherence to the NHS Research and Development Framework (2023) and Hywel Dda's annual self-assessment of progress against the 10 pillars were noted. No concerns were raised against current progress and adherence. Feedback to be discussed with Welsh Government on 7 May 2026. The R&ISC paper is attached as Appendix 2.
- Members noted and approved the draft Cancer Pathways Project report, subject to minor amendments to ensure all professional groups are appropriately reflected. The project, led by a dedicated task and finish group and supported by Welsh Government and Health and Care Research Wales will identify barriers to equitable access to cancer trials across the region and propose solutions. The R&ISC agreed to explore funding options to support continuation of the project. The R&ISC paper is attached as Appendix 3, with the full report available on request.
- Plans are in place to rotate the university representative for the coming year.
- Members received assurance from the TriTech and Innovation (T&I) financial position and the T&I activity report, which detailed the performance and activity across the reporting period.
- While assurance was received on the T&I progress against the original business plan (2021-2025), KPI 9 (Intellectual Property (IP)) was not met due to recent contracted projects not including new IP.

- Received an update on national developments for both Research and Development, and TriTech and Innovation.
- Members noted progress with the Centre for Social Innovation (CfSI) at University of Wales Trinity Saint David (UWTSD) and were informed that a revised collaboration agreement was signed in February 2026. The annual report and Work Plan are currently in progress. It was agreed that CfSI would be added to the Research & Innovation Sub-Committee work plan.
- The Pentre Awel project has experienced further delays and expected occupancy for Research and Innovation into Block D is likely quarter 3 of 2026/27. An interim agreement to occupy space in Block B at Pentre Awel is progressing with relocation likely by June 2026.

Review of Risks/ Adolygiad o Risgiau

The Research and Development (R&D) Risk Register was discussed, and members were advised risk 1492 (Risk to research delivery funding) was increased in December 2025 and will be formally reviewed once confirmation of 2026/2027 Research Delivery Funding. Research Capacity funds are being utilised to support the in-year overspend. 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.

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) remains at 12 due to delays in digital support for projects. These delays have the potential to impact approval timelines, which in turn creates financial exposure and threaten delivery against agreed milestones. The R&ISC explored steps that could be taken to de-risk, including the inclusion of timelines and service standards. The Director of Research, Innovation and Value and the Executive Medical Director have initiated discussions with relevant colleagues to facilitate a solution.

Sharing of learning/ Rhannu dysgu

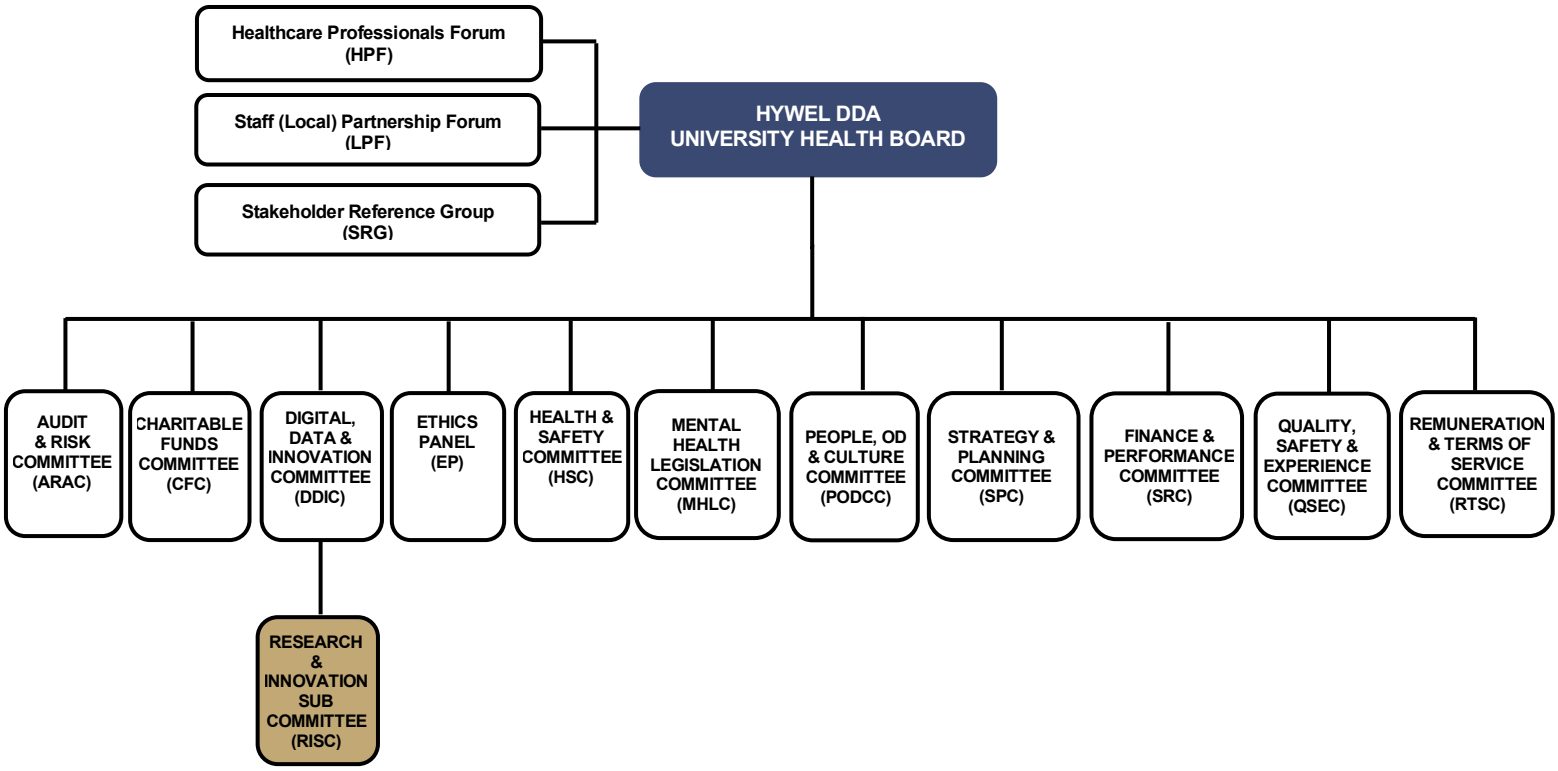
Recommendation/ Argymhelliad

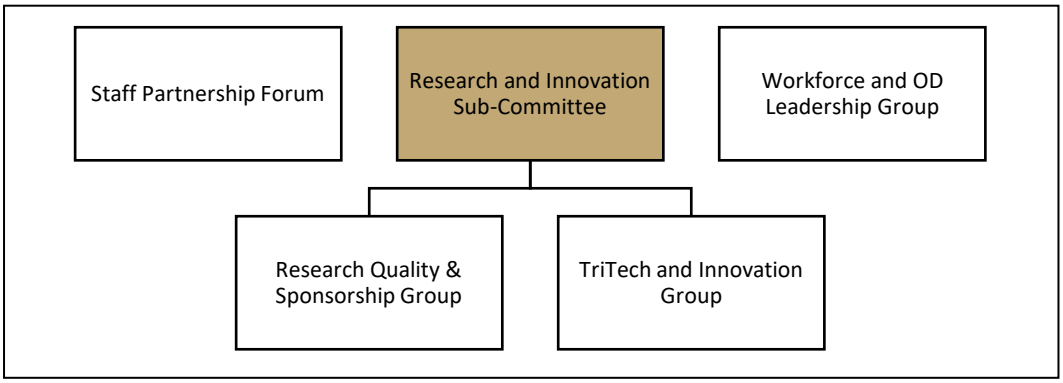
The Board/Committee is asked to:

- Approve the Research and Innovation Sub-Committee Terms of Reference.
- Note the items the Committee is advising them of
- Be assured on the items that the Committee is providing assurance on

Date of next meeting/ Dyddiad y cyfarfod nesaf: 08 June 2026

Agenda, papers and minutes are available on request





TERMS OF REFERENCE

RESEARCH & INNOVATION SUB-COMMITTEE

Version	Issued to:	Date	Comments
V0.2	Research & Development Committee	07.10.2013	Approved
V0.3	Research & Development Committee	24.10.2014	Approved
V0.4	University Partnership Board	16.11.2015	Approved

V0.5	Research & Development Sub-Committee	27.11.2015	Approved
V0.6	Research & Development Sub-Committee	22.02.2016	Approved
V0.7	Research & Development Sub-Committee	13.02.2017	Approved
V0.8	Research & Development Sub-Committee	21.05.2018	Approved
V0.9	Research & Development Sub-Committee	14.09.2020	Approved
V0.9	Quality, Safety & Experience Assurance Committee	06.10.2020	Approved
V10.0	Research & Innovation Sub-Committee	08.03.2021	Approved
V10.0	Quality, Safety & Experience Assurance Committee	13.04.2021	Approved
V11.0	Research & Innovation Sub-Committee	14.03.2022	Approved
V11	People, Organisational Development and Culture Committee	04.04.2022	Approved
V12	Research & Innovation Sub-Committee	13.03.2023	Approved
V12	People, Organisational Development and Culture Committee	03.04.2023	Approved
V13	Research & Innovation Sub-Committee	11.03.2024	Approved
V13	People, Organisational Development and Culture Committee	15.04.2024	Approved
V14	Research & Innovation Sub-Committee	10.03.2025	Approved
V14	Digital, Data and Innovation Committee	22.04.2025	Approved
V15	Research & Innovation Sub-Committee	02.03.2026	Approved
V15	Digital, Data and Innovation Committee	21.04.2026	For approval

RESEARCH & INNOVATION SUB-COMMITTEE

1. Constitution

1.1. The Research & Innovation Sub-Committee (R&ISC) is a Sub-Committee of the Digital, Data & Innovation Committee (DDIC).

2. Purpose

2.1. The purpose of the Research & Innovation Sub-Committee is to assure the Board, via the Digital, Data & Innovation Committee, that it is discharging its functions and meeting its responsibilities with regards to the quality and safety of research, development and innovation activity carried out within the organisation.

The guiding principles will be:

2.1.1 a clear strategy;
2.1.2 clear governance and performance management
2.1.3 working within budget constraints.

2.2. The Research & Innovation Sub-Committee will promote and support involvement in high quality, multi-disciplinary and multi-agency healthcare research, development and innovation, promote evidence-based healthcare, build research

and innovation capacity and foster a research and innovation culture, including patient/public involvement where appropriate.

2.3. The Research & Innovation Sub-Committee will facilitate collaboration with the Research and Academic community to maximise outcome and impact for the Health Board and the patients it serves.

3. Key Responsibilities

3.1. Assure the Board, through the DDIC, in relation to arrangements for ensuring compliance with all relevant frameworks, UK Clinical Trials, Clinical Investigations and other Regulations (transposed into UK law from European Union Directives) and reporting requirements.

3.2. Assure the Board, through the DDIC, that the sponsorship of research studies by Hywel Dda University Health Board follows a robust scientific review and complies with all relevant regulations.

3.3. Assure the Board, through the DDIC, that the arrangements for undertaking real world evaluations are robust and comply with all relevant regulations.

3.4. Assure the Board, through the DDIC, that Research and Innovation funding is being spent according to requirements.

3.5. Receive assurance on the management of operational risks that have been aligned to the Sub-Committee and provide assurance to the DDIC that risks are being managed effectively and report any areas of concern, e.g. where risk tolerance is exceeded, lack of timely action.

3.6. Receive assurance on the progress of HDdUHB hosted and sponsored research studies.

3.7. Receive assurance on the progress of real-world evaluations taking place in the HDdUHB.

3.8. Receive and comment on financial, performance management and data reports from the Research and Innovation Operational Teams.

3.9. Oversee the development and implementation of the Health Board's Research & Innovation Strategic Plan.

3.10. Oversee the development and approval of research and innovation written control documents (policies, plans, Standard Operating Procedures, etc) within the scope of the Sub-Committee, obtaining ratification as and where appropriate.

3.11. Consider the implications for the Health Board of the outcomes arising from relevant review, audit or inspection carried out by external regulatory authorities, review progress with resulting Corrective and Preventative Action plans (CAPAs) and authorising their completion.

3.12. Ensure strong relationships and effective communication with associated Higher Education Institutions and other external organisations.

3.13. Support Universities with their research & innovation agenda, including undergraduate /postgraduate work, research impact, and their Research Excellence Framework submission.

3.14. Ensure the HDdUHB maintains its University status by monitoring and driving improvement in those metrics associated with University status against which it will be judged by Welsh Government:

- University Links
- Health Education and Training Contribution
- Contribution to Quality Care
- Contribution to Health Research
- Contribution to other Health Related activities

3.15. Report on research and innovation activity to relevant health community committees and the Health Board via the Director of Research, Innovation and Value, or a nominated deputy.

3.16. Agree issues to be escalated to the DDIC, with recommendations for action.

4. Membership

4.1 The membership of the Research & Innovation Sub-Committee shall comprise:

Title
Medical Director (Chair)
Director Research, Innovation & Value (Vice Chair)
Independent Member
Clinical Director Research & Development
Head of Research & Development
Head of TriTech & Innovation
Research & Innovation Finance Business Partner
Head of Data Science
Assistant Director of People Planning
Head of Nursing (with a responsibility for research)
Deputy Director of Health Sciences (with a responsibility for research)
A representative from one University Partner organisation
Executive Director of Public health
Representative from a 3rd Sector Organisation
Head of Culture and Workforce Experience
Research active representatives as required

4.2 The membership of the Sub-Committee will be reviewed on an annual basis.

5. Quorum and Attendance

5.1 A quorum shall consist of no less than a third (5) of the membership and must include as a minimum the Chair or Vice Chair of the Sub-Committee and a research active clinician.

5.2 An Independent Member shall attend the meeting in a scrutiny capacity.

5.3 Any senior officer of the HDdUHB or a partner organisation may, where appropriate, be invited to attend, for either all or part of a meeting, to assist with discussions on a particular matter.

5.4 The Sub-Committee may also co-opt additional independent external 'experts' from outside the organisation to provide specialist skills.

5.5 Should any member be unavailable to attend, they may nominate a fully briefed deputy to attend in their place, subject to the agreement of the Chair.

5.6 The Chair of the Research & Innovation Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

5.7 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. Agenda and Papers

6.1 The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and the Sub-Committee Lead at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Sub-Committee work plan, identified risks matters arising from previous meetings, issues emerging throughout the year and requests from Sub-Committee Members. Following approval, the agenda and timetable for papers will be circulated to all Sub-Committee Members.

6.3 All papers must be approved by the Director of Research, Innovation and Value.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **ten** days to check the accuracy.

6.6 Members must forward amendments to the Sub-Committee Secretary within the next **seven** days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7 Frequency of Meetings

7.1 The Sub-Committee will meet quarterly and shall agree an annual schedule of meetings. Additional meetings will be arranged as determined by the Chair of the Sub-Committee in discussion with the Director of Research, Innovation and University Partnerships.

7.2 The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary, shall determine the time and the place of meetings of the Sub-Committee and procedures of such meetings.

8. Accountability, Responsibility and Authority

8.1 The Sub-Committee will be accountable to the Digital, Data & Innovation Committee for its performance in exercising the functions set out in these terms of reference.

8.2 The Sub-Committee shall embed the HDdUHB's vision, corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8.3 The requirements for the conduct of business as set out in the HDdUHB's Standing Orders are equally applicable to the operation of the Sub-Committee.

9. Reporting

9.1 The Sub-Committee, through its Chair and Members, shall work closely with the Board's other committees, including joint /sub committees and groups to provide advice and assurance to the Board through the:

9.1.1 Joint planning and co-ordination of Board and Committee business;
9.1.2 Sharing of information.

9.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

9.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The Sub-Committee will receive updates following each meeting, detailing the business undertaken on its behalf. The following management groups have been or will be established:

- Research Quality and Sponsorship Group
- TriTech and Innovation Group

9.4 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

9.4.1 Report formally, regularly and on a timely basis to the Digital, Data & Innovation Committee on the Sub-Committee's activities. This includes the submission of a Sub-Committee update report for information after every meeting, as well as the presentation of an Annual Report within 6 weeks of the end of the financial year;
9.4.2 Bring to the Digital, Data & Innovation Committee's specific attention any significant matters under consideration by the Sub-Committee;
9.4.3 Ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive, or Chair of other relevant Committees, of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the UHB.

10. Secretarial Support

10.1 The Sub-Committee Secretary shall be determined by the Director of Research, Innovation and Value.

11. Review Date

11.1 These terms of reference shall be reviewed on at least an annual basis by the Sub-Committee for approval by the People, Organisational Development and Culture Committee.

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IS-BWYLLGOR YMCHWIL A DATBLYGU
RESEARCH AND INNOVATION SUB-COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 March 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	Adherence to NHS Wales Research and Innovation Framework
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Sally Hore, Head of Research and Development

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 assessment of Hywel Dda UHB's adherence to the requirements of the NHS Wales Research and Development Framework, as required by 31 March 2026. The Research and Innovation Sub-Committee is asked to receive assurance in the update.

Cefndir / Background

The NHS Wales Research and Development (R&D) Framework (WHC/2023/026) sets out national expectations for embedding research as a core and routine component of health and care services across Wales. Welsh Government emphasises that active participation in research improves the quality and safety of care and contributes directly to better population health outcomes.

Following publication of the Framework in 2023, all NHS organisations completed an initial baseline assessment. In Hywel Dda UHB, the baseline assessment was considered by the Research and Innovation Sub Committee in October 2023, which was assured by the update.

Welsh Government has now confirmed that a "two-year on" assessment of progress against implementation of the Framework must be completed by 31 March 2026, with findings forming part of the next annual R&D review meetings with each NHS organisation in the Spring.

The assessment process, template and accompanying guidance have been co-developed with NHS Wales R&D colleagues through two national workshops held in October–November 2025. The purpose is to evaluate organisational progress against each of the ten pillars of the NHS R&D Framework, identify achievements and challenges since 2023, and outline forward-looking plans aligned to the NHS Planning Framework 2026–2029.

Welsh Government expects this assessment to be a cross-organisational exercise, with contributions from planning teams, clinical and operational services, finance, workforce, communications, digital services and public involvement teams. The completed return must describe:

- the internal process used to compile the assessment;
- progress against each of the ten pillars since the 2023 baseline;
- planned priorities for the next 1–3 years (these are set out within Hywel Dda UHB's Research and Innovation Strategic Plan); and
- supporting evidence, including metrics, governance documents, and strategic plans.

The assessment section describes the process that the Division has gone through and a detailed assessment of the current position when compared to the baseline in 2023 is also provided.

Asesiad / Assessment

While Welsh Government has asked for this periodic review, the R&D Division routinely examines performance against the framework as a core part of its business. This is done through the Research and Innovation Sub-Committee at every one of its meetings, with a 3As report then going into the Digital, Data, and Innovation Committee (DDIC) before its ultimate consideration at the Board. The 'pillars' of the framework are embedded within Hywel Dda UHB's new Research and Innovation Strategy (2025-2030), which means that they are becoming an integral and core part of how we operate. The R&ISC and DDIC have representatives planning teams, clinical and operational services, finance, workforce, communications, digital services and public involvement teams. They therefore ensure that research is an embedded part of all that we do.

In advance of knowing of the Welsh Government's requirement, the DDIC received its annual update of performance against the Framework at its meeting on 16 January 2026 and reported that it was assured with reported progress.

In discussion around the framework, the DDIC questioned the financial environment within which the R&D Division operates and specifically why Hywel Dda UHB's grant allocation was lower than other Health Boards in Wales, particularly in view of its population size, disease burden and good research activity levels. The DDIC asked for the Finance and Research and Innovation Director to raise this issue with the Welsh Government during the annual performance review. The DDIC also asked for the Executive Team to consider how constraints to undertaking more research and innovation could be overcome. A Business Executive Team meeting will be scheduled for the Spring.

The review of Hywel Dda UHB's adherence to the R&D framework is included at Appendix A. It should be noted that while the first two columns of the table were considered at the DDIC meeting, the third column summarising the reported position at 2023 was not included. This is due to only being aware of this Welsh Government requirement upon receipt of a letter from the Chief Medical Officer setting out the same dated 19 December 2025, after the deadline for DDIC paper submission. It is for this reason that a further update is being provided to the DDIC for assurance.

Argymhelliad / Recommendation

To receive assurance from the update of Hywel Dda UHB's adherence to the requirements of the R&D Framework.

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

Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	Version 14.0
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable.
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Set out within main body of report
Rhestr Termau: Glossary of Terms:	Included in the body of the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw yr Is-Bwyllgor Ymchwil A Datblygu: Parties / Committees consulted prior to R&I Sub-Committee	Digital, Data, and Innovation Committee (16 January 2026)

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not Applicable
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable

Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Not Applicable
Enw Da: **Reputational:**	Not Applicable
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Not Applicable

APPENDIX A – Adherence to the NHS Wales R&D Framework		
Framework Pillar	**Hywel Dda UHB adherence 2026**	**Hywel Dda UHB adherence in 2023 (summarised)**
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	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 resides within the Medical Directorate and strategic aims are reflected in the annual planning cycle /IMTP.	Our overall position was described as strong. Hywel Dda UHB has a well established Research & Innovation Strategy (2021–24), with clear goals, Board oversight, annual implementation plans, and regular performance reporting. The organisation already sees this as an area of strength and is preparing early for the next strategy.

• 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).		
2. Governance and Leadership Supportive organisations: 2.1. Demonstrate clear board commitment to research, with evidence of members contributing 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	Overall position described as strong with one improvement area. Robust governance structures were described, including the Research and Innovation Sub Committee, supported by refreshed membership and university representation. Leadership structures are clear and active, with regular

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	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). 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)	reporting to Board committees. We reported in 2023 that we needed better public facing communication about research opportunities.

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	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	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.	In 2023, our position was described as rapidly maturing. We set out that Hywel Dda UHB has strong partnerships aligned to strategic priorities (e.g., cancer, ophthalmology, orthopaedics, TriTech). These partnerships have raised the organisation's profile and secured external opportunities. One development area was to strengthen relationships with research funders and expand links with public sector partners.

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)	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.	

• 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. 3.3. 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	For example, the Director sits on the Commercial Research Wales Delivery Board.	

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	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	We described improving research support functions, including improved processes, dedicated facilities, job planned time, and team stability. We also pointed to some risks, including workforce pressures, corporate support capacity (in areas including IG) and limited flexibility around fixed term staffing.

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	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 vision for high-quality and impactful research and innovation,	

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.	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 strengths and research groups,	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 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.	We described our position as being good, with robust prioritisation and study selection, good clinical engagement and recruitment to target performance in several areas. Our ongoing challenge is how to run an efficient R&D service in view of geography, which presents some unique challenges when compared to urban centres. We described the need to work on a structure that enables succession planning, and to adopt a stronger approach to regional working, particularly in areas like Oncology.

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.		

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. 6.4. Have a commitment to generate research income for non-commercial studies (i.e. from research funders, research councils and third sector organisations) and commercial	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, as our view remains that we are underfunded relative to other organisations when considering population size, disease burden, and trial activity. 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	A strong financial governance position was described, with the transparent use of HCRW funds, strengthened financial tracking and good income generation (mainly through innovation portfolio). We highlighted the need for external financial support for our research development function and a desire for deeper engagement with the new research faculty.

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.	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. We now target two HCRW faculty awards a year.	
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	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.	A moderately strong position was described, requiring continued development. R&D governance in 2023 resided with the People Organisational Development and Culture Committee, enabling integration with workforce planning. A growth in honorary appointments and job-planned research time was reported. However, we also pointed to some gaps including job descriptions

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	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 and innovation strategic plan. This will be a priority over the coming strategic planning period. R&D is represented on the staffing and workforce fora within the organisation. Some recent success includes the appointment of clinical research fellows in collaboration with Swansea University.	detailing research and the need to continue expanding protected research time.

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 clinical governance and best practice. o adopt national polices 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, 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	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, including the stakeholder advisory committee.	We described partially meeting expectations against this pillar, with strong PPI in areas including respiratory and diabetes research. A clear area for improvement was described around engaging with the public around the strategic direction of research and innovation.

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	9.1 Substantial work has been undertaken with the communications team, including press releases to coincide with the strategic plan	We described the position as developing but behind where it needs to be. Good internal communications were

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. 9.4. 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	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 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.	described (SharePoint, engagement sessions, campaigns). External communications were described as improving with a marketing agency providing support. We described the need to improve public facing communication around research opportunities.

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.	9.5. This is an active part of how we plan and manage research and innovation.	
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	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	A mixed position was described. A strong publication record exists where expertise is defined (notably where we have dedicated Chief Investigators), and the TriTech Institute was assisting improve communication reach. However, a gap still exists in demonstrating the impact research and innovation can have to service delivery across the organisation.

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. 10.3. 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.	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 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.	

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

IS-BWYLLGOR YMCHWIL A DATBLYGU
RESEARCH AND INNOVATION SUB-COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	02 March 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Improving access to oncology research
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Leighton Phillips, Director of Research, Innovation and Value
SWYDDOG ADRODD: REPORTING OFFICER:	Sally Hore, Head of Research & Development

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 Research & Innovation Sub Committee (R&ISC) are provided with a report setting out the findings of a regional review assessing the reasons for inequity of access to oncology clinical trials across South West Wales and practical actions that could be taken to improve the situation. This report proposes a response to the report and is brought to R&ISC for assurance.

Cefndir / Background

Hywel Dda University Health Board's (HDdUHB) new Research and Innovation Strategic Plan (2025-2030) commits to improving access to high-quality research and innovation that improves services, health and wellbeing. Clinical research and innovation are recognised within the strategic plan as vital drivers of improved patient outcomes and enhanced quality of care. Some services in South West Wales depend upon regional working between HDUHB and Swansea Bay University Health Board (SBUHB), which has implications for improving access to research and innovation.

One example of this is the delivery of non-surgical oncology services, with SBUHB acting as the central provider through the South West Wales Cancer Centre (SWWCC). This centre has a strong track record in research, supported by a dedicated cancer research delivery team. Over recent years, SBUHB has led and participated in practice-changing trials, including global partnerships with major pharmaceutical companies and pioneering work in radiotherapy trials.

Despite these achievements, access to oncology clinical trials across the wider South West Wales region covering Carmarthenshire, Pembrokeshire and Ceredigion remain inequitable, largely determined by a patient's postcode. For example, patients in the SBUHB region benefit from significantly more opportunities to participate in interventional drug trials than those in HDdUHB. While some HDdUHB patients can access trials at SBUHB - particularly those requiring radiotherapy - many are excluded for reasons including capacity constraints, lack of dedicated oncology research staff in HDdUHB, and gaps in supporting services.

Recognising the unacceptable nature of this inequity and supported by a commitment within HDdUHB's research and innovation strategic plan, a dedicated task and finish group was convened, led by Dr Sarah Gwynne, and financially supported by Welsh Government and Health and Care Research Wales. The group's remit was to identify the barriers to equitable trial access and propose solutions. Their work builds on previous strategic initiatives, including the South West Wales Cancer Centre Strategic Programme Case and an options appraisal developed by R&D leads from both health boards. These earlier efforts highlighted the need for a regional approach to research delivery, improved documentation of policies, and investment in workforce and infrastructure.

The R&ISC were provided with findings from the report. The report reflects extensive engagement with clinical and research teams, mapping progress against strategic aims and identifying areas where further work is required. It acknowledges the enthusiasm among teams to participate in oncology research, despite operational challenges. The findings underscore the importance of establishing robust structures, investing in dedicated personnel, and coordinating health boards with national strategies to ensure equitable access to clinical trials and position South West Wales as a leader in cancer research.

The assessment section summarised the key findings from the report and given the magnitude of the work programme required, proposes some practical next steps to maintain momentum. As a condition of funding the report will need to be submitted to the Welsh Government for consideration, and it is therefore important that both Health Boards are content with its content and the proposed next steps.

The Welsh Government is also interested in the findings as it has set out ambitious new cancer research targets, which aim to significantly expand clinical trial participation and innovation. Key goals include increasing patient recruitment to commercial trials by 400%, prioritising later-phase studies to accelerate access to advanced treatments, and boosting Phase III trials to over half of the portfolio. The Cancer Research Strategy (CReSt) focuses on six priority areas: precision oncology, immuno-oncology, radiotherapy innovation, clinical trials, palliative care, and prevention with early diagnosis. These ambitions are underpinned by commitments to reduce health inequalities, attract investment, and integrate digital and data-driven approaches for personalised care and faster diagnosis.

Asesiad / Assessment

The report at Doc One provides a candid assessment of the main constraints to improving access to oncology studies across South West Wales. The key findings include:

- **Evidence of Inequitable Access:** There is significant variation in access to oncology clinical trials across South West Wales, with patients' access to trials largely determined by where they live. An assessment of oncology clinical trial activity over the past four years provides evidence of SBUHB patients having greater access to interventional trials than those in HDdUHB.
- **Capacity Constraints:** Both health boards face insufficient capacity in key areas including systemic anticancer therapy (SACT) delivery, pharmacy, radiology, pathology, and consultant time. These constraints are exacerbated by the additional workload of clinical trial activity, which will need to be carefully planned and worked through.
- **R&D Workforce Gaps:** HDdUHB currently lacks dedicated oncology research delivery staff, and existing vacancies and gaps in supporting services further limit the ability to open and run trials. There are differences in the way in which R&D is organised within

HDUHB reflecting its geography and the distributed nature of service delivery that add further complexity when striving for improved access to oncology clinical trials.

- **Policy and Governance Issues:** There are gaps in documentation of policies around trial access, no overarching oversight of clinical trial activity across the region, and limited recognition of research activity in service agreements. The latter is an impediment to building trust and confidence between HDdUHB and SBUHB, particularly in relation to the reimbursement for care provided to non-resident clinical trial participants.
- **Enthusiasm and Opportunity:** Despite operational challenges, there is strong enthusiasm among clinical teams to participate in research, and recent strategic initiatives have laid the groundwork for improvement. The report contains an important survey of consultants to explore the steps that could be taken to improve their participation in leading oncology clinical trials.

In response to these and other findings, the report makes several recommendations, grouped under eight themes. The report contains significant detail on why each of the following areas is considered important:

1. **Securing Regional Recognition and Support.** The report proposes:
   - Establishing an oncology clinical trials steering group with representation from both SBUHB and HDdUHB.
   - Developing clear, regularly reviewed policies for patient access to trials across health board boundaries.
   - Seeking investment to increase trial activity in HDdUHB, including dedicated research staff and infrastructure.

2. **Developing the workforce.** The report proposes:
   - Building resilience and career development in both research and medical workforces.
   - Recognising clinical trial activity in job planning and support cross-cover arrangements for consultants.
   - Encouraging improved participation in schemes such as the NIHR Associate PI programme.

3. **Aligning support services.** The report proposes:
   - Investing in pharmacy, radiology, and pathology to address current shortages and prepare for increased trial activity.
   - Ensuring new facilities (e.g., aseptic units) open on time and are adequately staffed.
   - Increasing collaboration between pharmacy staff across the region to improve resilience and share working practices.

4. **Developing collaboration and information sharing agreements.** The report proposes:
   - Reinstating joint meetings between research teams in both health boards.
   - Establishing mechanisms for sharing best practice, resources, and information governance agreements.
   - Promoting awareness of clinical trials among staff and patients.

5. **Getting the necessary collaboration agreements in place.** The report proposes:
   - Ensuring ongoing access to trials outside the region, including phase 1 trials at Velindre Cancer Centre and other UK sites.

- Reviewing Long Term and Service Level agreements to ensure reciprocal financial agreements that enable funding to follow the patient within the region.

6. **Developing innovative clinical trial delivery models.** The report proposes:
   - Exploring novel approaches such as virtual clinics, remote consent, and mobile services to overcome geographical barriers.
   - Considering hub-and-spoke models and participant identification centres to streamline trial delivery.

7. **Developing programme leadership.** The report proposes:
   - Maintaining dedicated programme leadership and project management capacity to oversee implementation of recommendations.
   - Tracking progress through a shared risk register and regular review meetings.

8. **Aligning with national initiatives.** The report proposes:
   - Connecting with other relevant projects and leaders in Wales for co-production and ensure regional representation.
   - Aligning with national strategies and taskforces, such as the Less Survivable Cancers Taskforce and Moondance Cancer Initiatives.
   - Maximising the investment secured through national investment schemes (e.g. VPAG) designed to support increases in cancer research activity.

The report is comprehensive and sets out a thoughtful and reasonable set of recommendations to address long standing issues. However, its recommendations vary in complexity. Some recommendations are relatively easy to implement, requiring minimal appraisal, as there is only one approach that can be taken, and the level of resource investment is minimal and can be covered within existing budgets (e.g. convening a regional oncology research meeting twice a year). Other recommendations are considerably more complex, where several options are likely to be available and the selected option will have a significant influence on cost (e.g. improving capacity within support areas or enhance R&D delivery staff within HDUHB).

For these reasons, the following three step approach will be taken to advance the report's key proposals:

1. Confirm the content of the report and the broad shape of its recommendations, recognising that further refinement and appraisal will be required as the recommendations are implemented. This paper provides the basis for the confirmation, to be agreed by the R&D Leadership Group and then taken through the governance arrangements of HDdUHB and SBUHB, including the R&ISC, for assurance. The paper and recommendations will also be considered by the Regional Joint Committee for South West Wales. For the avoidance of doubt, agreeing the broad shape of the recommendations does not mean that all will be implemented regardless of implications and costs. When health board requirements have been satisfied, the report will be submitted to the Welsh Government.

2. Continue and enhance the programme leadership arrangements and establish a clinical trial steering group. The past 12 months has resulted in significant momentum in the work to identify what needs to be done to improve patient access to oncology studies across south-west Wales. This has been in no small part due to having dedicated capacity in place, including clinical leadership, nursing, and project management input. This needs to be maintained and ideally increased with the appointment of a clinical fellow (who would report to the consultant oncologist leading the work), for the extensive list of recommendations to be implemented in a timely manner. The addition of steering

group for clinical trials, with full representation from both health boards, will facilitate rapid and efficient review of any oncology clinical trials that might open/are open in either health board. The costs for this are in the table below:

Role	Band	WTE	Cost (pa)	Justification
Research coordinator	B7	0.2	£12,454	Maintain momentum from the task and finish group Act as liaison between the two health boards e.g. implementing hub and spoke models
Research Officer	B5	0.2	£6,798	Support research coordinator post in Hywel Dda
Admin support	B4	0.1	£3,502	Provide admin support for the team and the clinical trials steering group
Clinical lead/chair	Consultant pay scale, mid point	0.2	£33,172	Provide the oversight needed to maintain momentum To act as the liaison between the research teams and regional and national leadership/stakeholders
Clinical Fellow	ST5	0.4	£31,324	Provide support to the clinical lead and other members of the clinical trial steering group to achieve their aims Support for the education, clinical and administrative aspects of the implementation Future planning, building future leaders
Total			£87,250	

The total costs to continue the work would be £87,250. The responsibility for meeting the proposed costs would be shared equally between the research and development functions of both health boards, who will jointly apply to Welsh Government for funding to meet this commitment. There is a strong prospect of this being successful. If this is not the case, the research and development function in HDdUHB will have to consider committing its own discretionary funding to ensure its contribution of £43,625k in 2026/27 can be met. When discussed at the R&D Leadership Group on 9 February 2026, while supporting this important work was endorsed, concerns were raised about the financial pressure it could put on an already pressurised Division. It was therefore agreed, in the event of the Welsh Government not supporting the request, discussions would take place within the Medical Directorate about the best way of meeting the costs at a reduced level. The reduced level would remove the cost of a clinical fellow. This would ensure at least some momentum would be maintained around the trials steering group. The revised total cost would be £55,926, with a Hywel Dda UHB contribution of £27,963. Please note this is slightly less than the level discussed at leadership group, due to refinement of costs between the meeting and the date of the R&ISC.

3. Implement the remaining recommendations, subject to their appraisal, in line with the timeline proposed within the main report. Where recommendations require new

business cases, the same will be brought back through the decision making and governance arrangements of SBUHB and HDdUHB in accordance with the proposed timeline. An immediate opportunity has presented to apply for VPAG national funding to support infrastructure and staffing requirements that would enable an increase in commercial clinical trial activity. Both SBUHB and HDdUHB have collaborated on a VPAG bid to fund principal radiographer time at the imaging suite of ILS2 at Swansea University.

The progression of this work will showcase research and development work at a regional level, putting the patient at the centre, regardless of where they live. Should the status quo remain, inequity of access of clinical oncology trials will continue, which will impact on the ability of patients in west Wales to access new treatments which could improve outcomes or quality of life, as well as inform future standards of care.

The main regional governance route for the work will be through the Regional Research, Innovation and Excellence Delivery and Oversight Group, which reports into the Regional Joint Committee. This will receive regular updated from the steering group as well as support the development and submission of bids for funding/business cases to take forward specific recommendations.

Argymhelliad / Recommendation

The R&ISC is asked to:

- Confirm the content of the overall report and broad shape of the recommendations, allowing its submission to the Digital Data & Innovation Committee for assurance.
- Support the R&D Leadership Groups position to continue the clinical leadership time, nursing time and administrative support. If financially viable, increase this capacity through the appointment of a clinical research fellow. R&ISC are asked to support the position reached that an application will be made to Health and Care Research Wales for the funding required to support this arrangement. In the event of this being unsuccessful, discussions will take place with the Medical Directorate, to identify the best route for discretionary funding to ensure the minimum commitment level of £27,963 can be met for 26/27 financial year, allowing continued momentum and time to identify the resources for the medium term.
- Note the implementation of the programme of work documented within the report in line with the associated timelines and acknowledging that further work and appraisal will be required to translate some of the recommendations into fully worked through and implementable actions.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.2
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	3.3 Quality Improvement, Research and Innovation
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2018-2019	9. All HDdUHB Well-being Objectives apply

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Within report
Rhestr Termau: Glossary of Terms:	Within report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw yr Is-Bwyllgor Ymchwil A Datblygu: Parties / Committees consulted prior to R&I Sub-Committee	Leadership Group

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	The financial implications are considered within the main body of the report. Any expenditure will be committed in accordance with Hywel Dda UHB Finance Policies and Procedures.
Ansawdd / Gofal Claf: Quality / Patient Care:	No negative impacts expected. Positive impacts can be expected through widening access to oncology research studies.
Gweithlu: Workforce:	Workforce implications are considered within the main report. All staffing changes will be made in accordance with Hywel Dda UHB policies and procedures.
Risg: Risk:	Potential risks considered. The risk of not doing is greater than doing. Widening access to clinical trials can improve care quality and clinical outcomes.

Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	No immediate reputational risks.
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	N/A

Research and Innovation Sub-Committee

ANNUAL REVIEW REPORT

2025/2026

1. Introduction and Chair's summary

In line with Standing Orders the Research and Innovation Sub-Committee (R&ISC) must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Groups it has established, setting out how the Sub-Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework:

Chairs Reflections

The Research and Innovation Sub-Committee has overseen a substantial work programme in 2025/2026. It has stewarded the delivery of key research and innovation performance and financial indicators, while adopting a thorough approach to risk management. There have been numerous key achievements, including:

- delivering the new Research and Innovation Strategic Plan 2025-2030;
- advancing regional oncology work plans;
- delivering research on behalf of the Welsh NHS Executive;
- winning commercial research investment;
- developing a new business plan for the TriTech Institute; and
- winning substantial research and innovation investment to deliver projects through the TriTech & Innovation Division.

The priorities for 2026/2027 will include

- Delivery of the commercial research objectives associated with successful voluntary scheme for branded medicines pricing, access and growth (VPAG) funding
- Re-establishing researcher development function
- Implementing findings from oncology review
- Delivering first year objectives from the new TriTech Business Plan
- Securing one additional and substantial industry partnership
- Delivering first phase of national breathlessness work

2. Terms of Reference and Workplan

The TOR for the Research and Innovation Sub-Committee is reviewed on an annual basis or following any significant changes. The TORs were last reviewed on 2 March 2026.

The Research and Innovation Sub-Committee has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the Sub-Committee's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The Research and Innovation Sub-Committee workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

3. **Group/s** (if applicable)

The Research Quality and Sponsorship Group (RQSG) and the TriTech and Innovation Group (TIG) report into the R&I Sub-Committee with their own terms of reference and workplans for the year.

The Group's TOR were last reviewed on 2 March 2026.

In line with their Terms of Reference, the Group is required to provide a report after each meeting.

4. Table of attendance

Membership	Date 09/06/25	Date 15/09/25	Date 10/12/25 Extraordinary	Date 18/12/2025	Date 02/03/26
Medical Director (Chair)	x	x	x	✓	x
Director Research, Innovation & Value (Vice Chair)	✓	✓	✓	x	✓
Independent Member	✓	✓	✓	x	✓
Clinical Director Research & Development	✓	✓	✓	x	x
Head of Research & Development	✓	x	x	x	✓
Head of TriTech & Innovation	✓	✓	✓	x	✓
Deputy Head of Business Control	✓	✓	x	x	x

(Finance Business Partner)					
Research active representatives as required	N/A	N/A	N/A	N/A	N/A
Head of Data Science	✓	✓	x	x	x
Assistant Director of People Development	x	x	✓	✓	x
Assistant Director of Nursing (with a responsibility for research)	x	x	x	x	x
Assistant Director of Health Science (with a responsibility for research)	✓	x	x	x	x
University representative	x	✓	x	x	x
Head of Medical Education and Knowledge	x	x	x	x	x
Representative from a 3rd Sector Organisation	x	✓	x	✓	x
Head of Research, Innovation & Improvement, Regional Partnership Board	x	x	x	x	x
In Attendance	**09/06/25**	**15/09/25**	**10/12/25**	**18/12/2025**	**02/03/26**
Deputy Head of TriTech	x	x	x	✓	✓
Head of Nursing	✓	✓	x	✓	✓
Assistant Head of Research Support	x	P	P	P	x
Assistant Head of Research Delivery	x	P	x	P	P
Specialist Projects – Medical Directorate	P	P	P	x	P
Head of Culture and Workforce Experience	x	x	x	x	x
Executive Director of Public Health	P	x	x	x	x
Deputy Director of Health Sciences	P	x	P	P	x
R&D Operations Support Officer	P	P	P	P	P

Meeting quorate?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

A quorum shall consist of no less than a third (7) of the membership, or a nominee and must include as a minimum the Chair or Vice Chair of the Sub-Committee and a research active clinician.

5. Sub-Committee Activities – alert, advise and assure.

The Sub-Committee is required to report to the Committee after each Sub-Committee meeting by presenting a report highlighting the key discussion items.

Alert – *The following matters were areas where the Sub-Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve, and were alerting the Board as engagement action or intervention was required.*

The Research and Innovation Sub-Committee **alerted** Digital, Data and Innovation Committee (DDIC) members on 22 July 2025 that Research Delivery Funding (RDF) from Health and Care Research Wales (HCRW) for 2025/2026 identified a funding gap and cost pressure for R&D to manage in year. This gap would be met by a further R&D account called 'Research Capacity Building'.

While it was anticipated that that this would reduce throughout the year and would not present a pressure to the wider Health Board, Research and Innovation Committee agreed a meeting with HCRW would take place to clarify the position, notify of any potential risks, and request a review. It was agreed by DDIC members on 22 July 2025 that the Director of Finance would join the meeting with HCRW.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

The Research and Innovation Sub-Committee **advised** members of the DDIC of the following issues:

- On the 9 June 2025:
  - The approval of the Good Clinical Practice Policy (Policy 822)
  - Progress and close monitoring of the Social Innovation Project
- On 15 September 2025:
  - Management and monitoring plans around risk 1492 (continued monitoring of the financial position of R&D).
- On 2 March 2026:
  - Delays associated with digital clearances and capacity for R&D and Innovation projects.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

On 9 June 2025, 15 September 2025, 18 December 2025 and 2 March 2026, Research and Innovation Sub-Committee members discussed and took assurance on reports covering:

- The financial positions of R&D and TriTech and Innovation Divisions;
- The operational activities of the R&D and TriTech and Innovation Divisions, including the key decisions made by the TriTech and Innovation Sub-Group;
- Key risks and management plans for the R&D Division and TriTech and Innovation Division. There was one exception. On the 15 September 2025, R&ISC members were not assured by the risk register as it was not reflective of the financial report update. They asked for the risk score to be reconsidered. This was undertaken and assurance was subsequently received in the meeting on the 18 December 2025;
- The activities of the Research Quality and Sponsorship Group;
- University partnership activities, including refreshing the memorandum of understanding (MoU) and work plans of regionally based university partners.

In addition, Research and Innovation Sub-Committee members discussed and received assurance on several issue specific reports throughout the year, covering:

- An update on Hywel Dda UHB's performance against the national R&D Framework at the R&ISC meeting on 18 December 2025;
- A Commercial Research update at the R&ISC meeting on 2 March 2025;
- The final report from the Regional Oncology Research Pathways report, including actions and next steps on 18 December 2025.
- At an extraordinary meeting on 10 December 2025, the new TriTech Institute Business Plan.

Discussed and Noted

On 9 June 2025, 15 September 2025, 18 December 2025 and 2 March 2026, Research and Innovation Sub-Committee members discussed and noted verbal and written reports covering the following:

- Health and Care Research Wales and Innovation National Updates;
- Updates against the Tritech Business Plan;
- Updates on Pentre Awel and the proposed movement of Research and Innovation activities to the scheme;
- Updates on the Centre for Social Innovation.

In addition, Research and Innovation Sub-Committee members discussed and took assurance on several issue specific reports throughout the year, including:

- On the 9 June 2025:
    - An update on the R&D Strategic Plan 2025-30;
    - An overview of the Novel Technologies study and key considerations concerning commercialisation;

  - Feedback provided from the R&D's annual review with HCRW;
  - A close down report for the 2021-24 Research and Innovation Strategic Plan;
  - A VPAG commercial research update, including funding awarded.
- On 15 September 2025:
  - A further commercial research/VPAG update;
  - An update on the Organisational Change Process within R&D;
  - An overview of the Regional Cancer Pathways project;
  - An R&I Strategic Plan (2025-2030) update;
  - A discussion paper on Digital Research and Innovation activities.
- On 18 December 2025:
  - Correspondence relating to HCRW's annual review and proposed audit of financial compliance.
- On 2 March 2026:
  - The new HCRW finance policy;
  - An update on the R&D OCP;
  - An overview of how the R&D Division is complying with Welsh Government requirements, including with the NHS research framework.

Approved

Items approved by the Research and Innovation Sub-Committee during the year.

- Minutes of R&ISC meetings in 2025/26;
- Issues to escalate to DDIC;
- Meeting 2 March 2026:
  - Annual review of R&ISC ToR, v15.0
  - Annual review of RQSG ToR, v3.0
  - Annual review of TriTech & Innovation Group (TIG) ToR, v1.7
  - R&ISC Annual report 2025/26. Approved subject to utilisation of correct format and reflecting key decisions made during the meeting.
  - RQSG Annual report 2025/26
  - TIG Annual report 2025/26

6. **Conclusion**

   The Research and Innovation Sub-Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to the Committee as appropriate to evolve and continually improve.

2.2

10:20 AM, 15 Mins

2.2 - Research Project Presentation

Leighton Phillips (Hywel Dda UHB - Director Research, Innovation and Value), Daniel Harris (Hywel Dda UHB - Lead Pharmacist - Cardiac Services), Helen Tench (Hywel Dda UHB - Assistant Head of Research Delivery)

For assurance

Attachments

DDIC SBAR Research Impact presentation April 2025.pdf

Appendix 1 - Optimising Management of Modifiable CVD Risk Factors in High-~.pdf

Appendix 2 - Research Impact Bronglais Roche Commerical Trials.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Research and Innovation Impact
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Mark Henwood, Executive Medical Director
SWYDDOG ADRODD: REPORTING OFFICER:	Leighton Phillips, Director of Research, Innovation and Value

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

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Committee will receive two brief Research and Innovation case studies demonstrating their impact within Hywel Dda University Health Board (HDdUHB). The Committee is asked to note the case studies.

Cefndir / Background

Research and innovation are fundamental to the National Health Service because they directly improve patient outcomes, enhance service quality, and strengthen the health system's ability to adapt and evolve. Nurturing research and innovation ensures that patients have access to new treatments, health inequalities are reduced, and care is grounded in robust, up-to-date evidence, helping deliver safer and more effective services. Research and innovation active organisations also see wider benefits, including higher staff satisfaction, improved recruitment and retention, and stronger organisational learning cultures. UK-wide policy documents highlight that research is essential for generating innovation, informing service redesign, and enabling the NHS to remain resilient and sustainable, particularly through periods of rapid change. Research also brings significant economic value to the NHS through funding, commercial income, and efficiencies generated by evidence-based practice, reinforcing its role as a strategic investment in both population health and the long-term viability of NHS services.

In recognition of this, the NHS Wales Research and Development (R&D) Framework emphasises that research impact is achieved when organisations make research findings openly accessible, ensure that evidence from Wales, the UK and internationally is routinely used to influence clinical practice and service delivery, and embed research within service redesign to inform new models of care. The framework states that supportive organisations actively strengthen their ability of research to shape high-quality, evidence-based services and work with Health and Care Research Wales to develop mechanisms that measure the economic and societal value of research, ensuring its benefits are fully realised across the health system. A similar framework does not exist for innovation, but several of the principles apply.

At their meeting on 16 January, the Digital, Data, and Innovation Committee (DDIC) members asked for a routine programme of presentations to demonstrate the actual impact that research and innovation is having in HDdUHB. At their meeting on 21 April 2026, DDIC members will receive two five-minute presentations setting out research and innovation case studies.

The assessment sections provide a very brief overview of the case studies.

Asesiad / Assessment

Case Study 1 – Innovation in Cardiovascular Disease Management

The Committee will receive an overview of a major innovation strategic partnership between Amgen Biotechnology, HDdUHB, Swansea Bay University Health Board (SBUHB), and Swansea University, established to address the growing burden of atherosclerotic cardiovascular disease (ASCVD) across Wales. The Committee will be presented with the rationale for the collaboration, highlighting rising disease prevalence, persistent inequalities, and significant gaps in risk factor management. The approach taken to the innovation spanned two phases.

Phase 1 involved using Wales' rich informatics infrastructure, particularly the SAIL databank at Swansea University, to map national trends in CVD and lipid/blood pressure management, uncovering declining prescribing rates, suboptimal LDLC control, and widespread under documentation of key parameters such as LDLC and QRISK. These findings demonstrated the scale of unmet need and the necessity of more sophisticated risk stratification tools, leading to the development of a new approach to understanding risk, the REACT score, as a secondary prevention risk calculator.

Phase 2 tested a series of specialist pharmacist led CVD prevention clinics delivered across secondary care hubs, community settings, and GP practices. The evaluation showed strong clinical effectiveness, with meaningful reductions in LDLC (≈0.9–1.18 mmol/L) and systolic blood pressure (≈16–30 mmHg). Patient retention rates were high, and both patient and staff feedback demonstrated that the service was experienced as supportive, holistic, and motivational. The analysis also confirmed the feasibility of point of care lipid testing, with strong correlation to laboratory methods. Economic evaluation found that the secondary care hub model was the most cost effective (ICER £3,087/QALY), while other models were more resource intensive and delivered fewer QALYs.

The Committee will hear that together, the findings show that combining advanced informatics, high intensity clinical intervention, and structured pharmacist led optimisation produces significant clinical gains and has the potential to reduce 10 year CVD risk by around 20%. The programme demonstrates the value of a "learning laboratory" approach, which uses real world data to test, refine, and evaluate targeted interventions within a controlled environment. The report concludes that a ringfenced, multidisciplinary service can address treatment gaps, improve outcomes, and inform future population health strategy for Wales. The partnership model also offers a blueprint for scalable national adoption and for further collaboration with industry and academic partners.

SBUHB and HDdUHB are now considering how best to sustain this model, with a high level of input from respective Value Based Health Care teams.

Case Study 2 – Commercial Research at Bronglais General Hospital

Commercial research refers to industry sponsored clinical trials and studies delivered by HDdUHB on behalf of pharmaceutical, biotech, medtech, or life sciences companies. Unlike publicly funded research, these studies operate on a contracted, full cost recovery basis. The studies require clear governance, regulatory compliance, and dedicated delivery capacity. Hywel Dda's Research & Innovation Strategy (2025–2030) positions commercial research as a key growth area, with national VPAG investment (a fund aimed to improve organisational capacity for commercial research) now strengthening trial capacity across respiratory, metabolic, and oncology specialties.

Participating in commercial research brings substantial benefits. Patients gain early access to advanced treatments and technologies, improving outcomes and enhancing equity of access. Staff benefit through specialist training, enhanced skills, and greater job satisfaction, while clinical services strengthen through evidence based practice and exposure to innovative care models. Commercial trials also generate valuable income to reinvest in services, workforce, and research infrastructure, while raising the organisation's profile, influence, and partnerships across the NHS, academia, and industry.

The Committee will receive an overview of the impact that participating in commercial research has had for staff and patients at Bronglais General Hospital.

Argymhelliad / Recommendation

The Committee is asked to note the impact case studies.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	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:	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)	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:	N/A
Rhestr Termau: 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:	N/A

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Not applicable – paper provided for information
Ansawdd / Gofal Claf: Quality / Patient Care:	Not applicable – paper provided for information
Gweithlu: Workforce:	Not applicable – paper provided for information
Risg: Risk:	Not applicable – paper provided for information
Cyfreithiol: Legal:	Not applicable – paper provided for information
Enw Da: Reputational:	Not applicable – paper provided for information

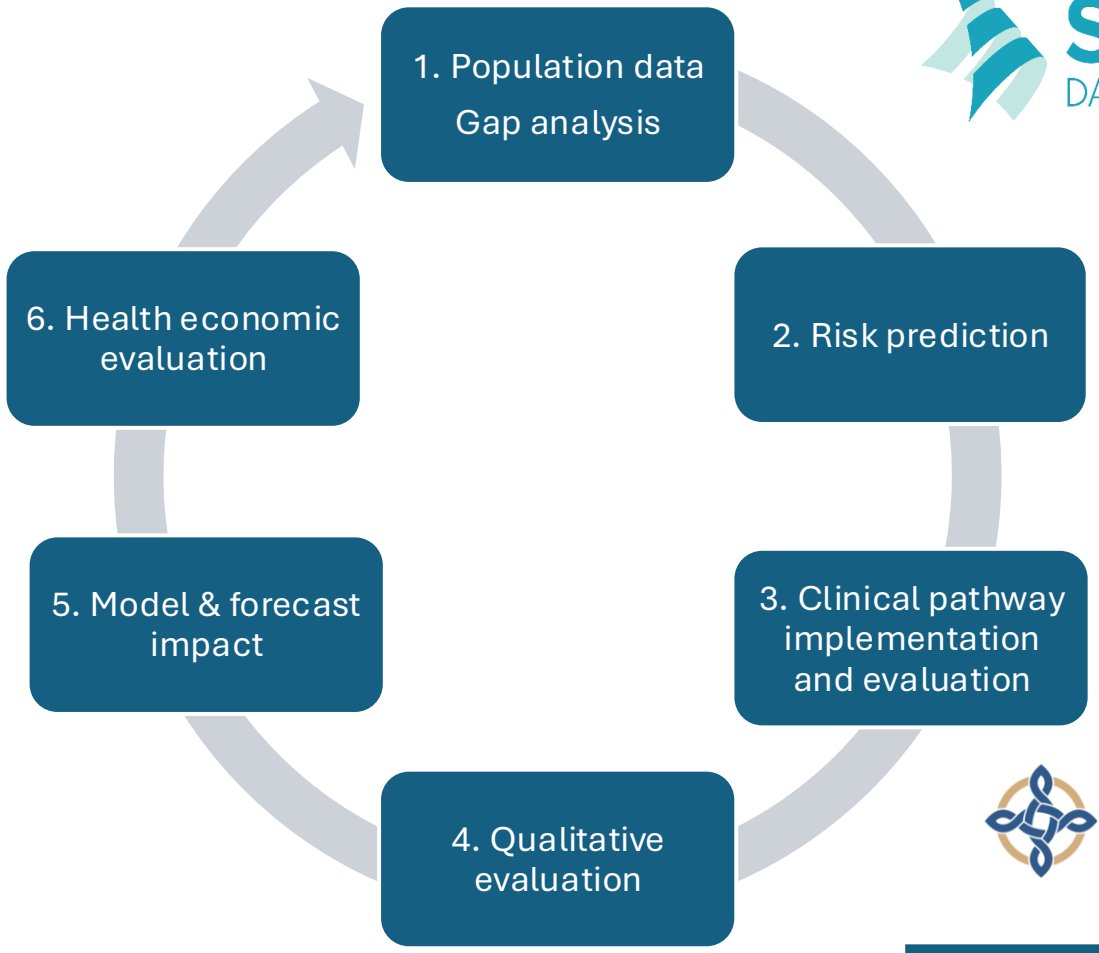
Gyfrinachedd: **Privacy:**	Not applicable – paper provided for information
Cydraddoldeb: **Equality:**	Not applicable – paper provided for information

Atherosclerotic Cardiovascular Disease (ASCVD) the most common cause of death:

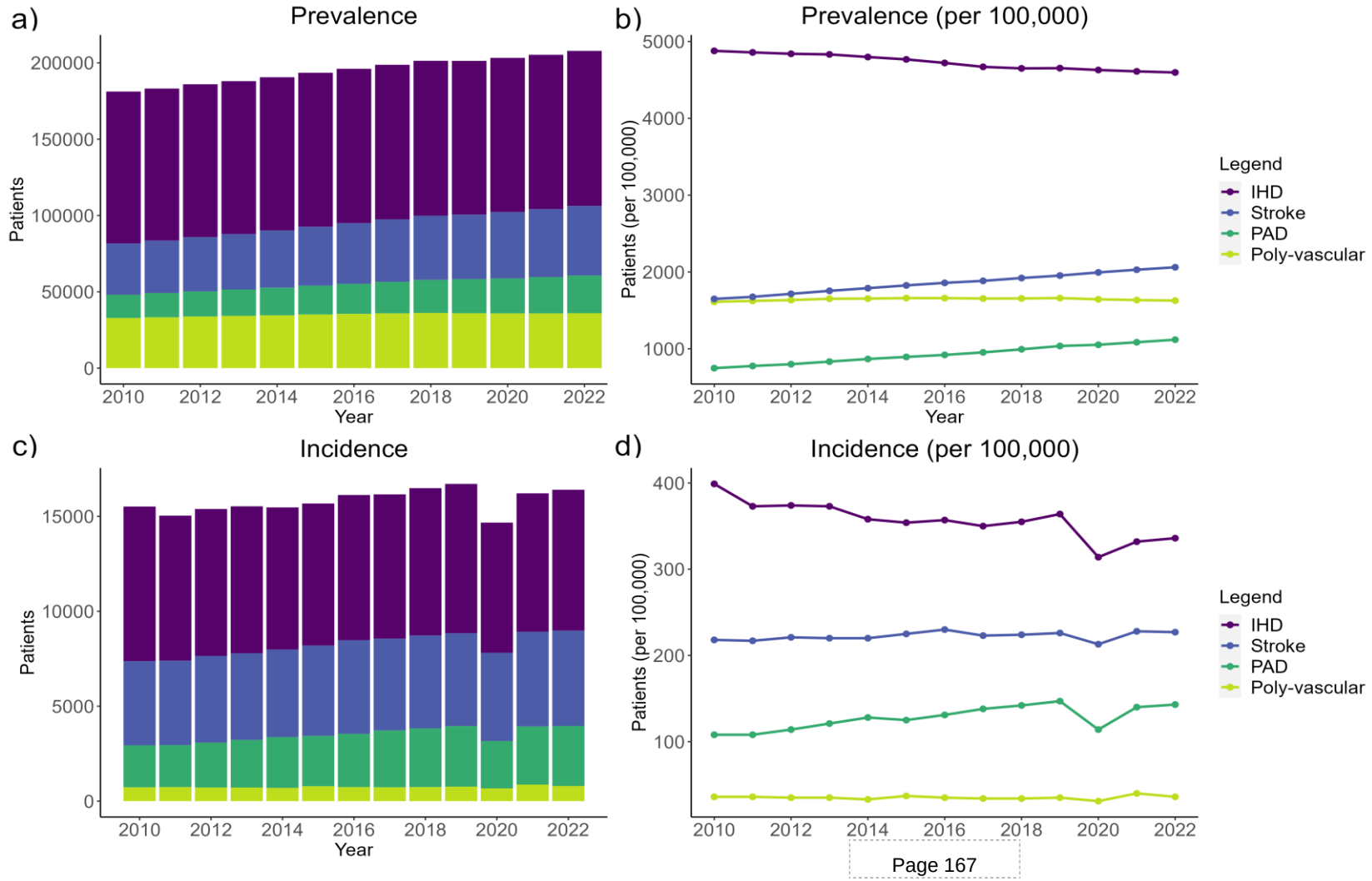
Effective preventive care (BP, Lipid, Antithrombotic Therapy, Lifestyle) in patients with and at high risk of ASCVD is

- Globally **THE** most effective and best value way
- To save lives and reduce life-changing morbidity

Programme blueprint:



Trends in IHD, stroke, PAD and poly-vascular disease 2012



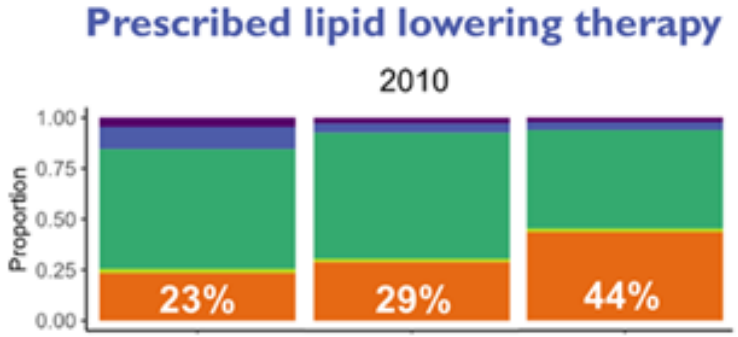
- Prevalence increased 181K (8.8%) to 207K (9.4%)
  - 14% increase in ‘N’ & 6% per 100K
- Stroke greatest absolute increase (1647- 2058 per 100K)
- PAD increase (749 to 1121 per 100K)
- DM: 15% to 21% (2010 – 22)

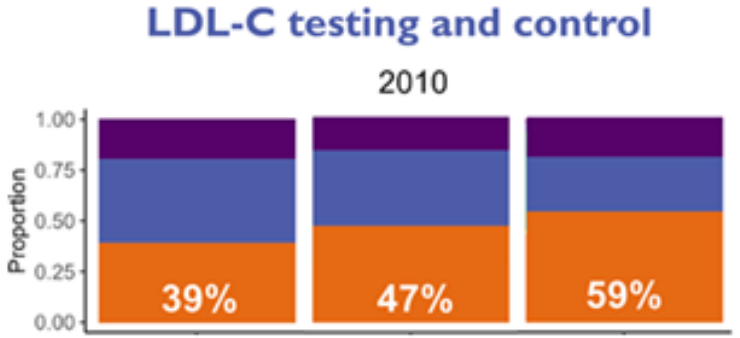
Phase 1: Trends in ASCVD and lipid management

Harris et al. EJPC 2024

Analysis of trends in ASCVD and management of lipids in Wales between 2010-2022

NB: NOT TREATED



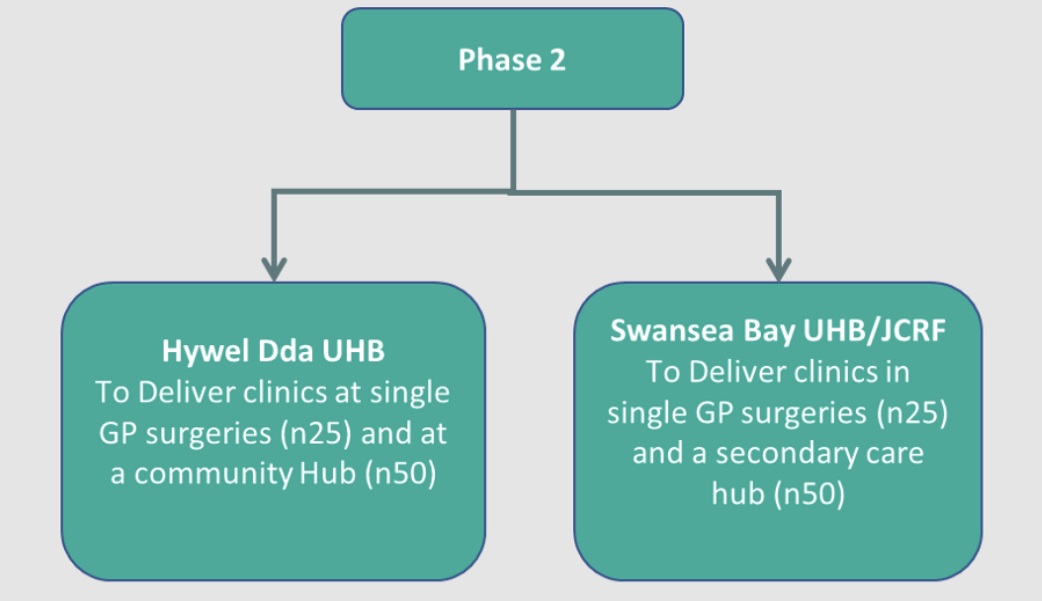


NB: NOT Tested

NB: NOT Controlled

- **Overall prevalence of ASCVD increased by 6% across the time period but the portion of patients prescribed lipid lowering therapy (LLT): had LDL-C tested or at target decreased.**
- **Patients with IHD were more efficiently managed than patients with stroke; and PAD patients were the least effectively managed**

Phase 2 Innovation in Practice: Focused Clinic to Address Lipid and BP Rx Gap



- 150 Very High Risk Patients (>20% 10y risk)
- Uncontrolled BP and or Lipids
- 1y NICE guidance recommended care
- Pharmacist Delivered
- Consultant Cardiologist supported

Systolic BP lowering

Patients with uncontrolled BP:

- **-16mmHg (primary prevention pts)**
- **-19mmHg (secondary prevention)**
- **(~30-40% CVD risk reduction)**

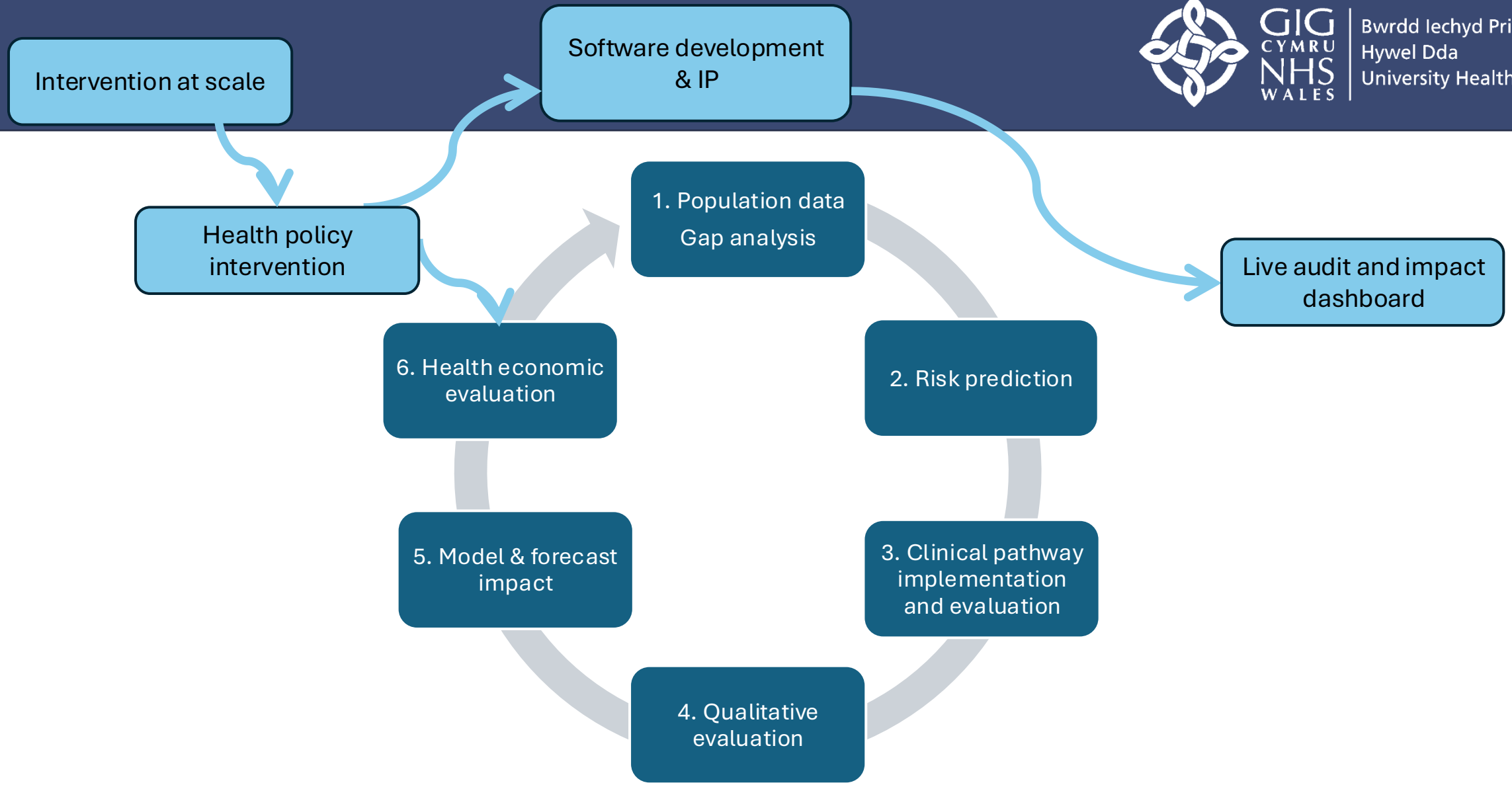
Lipid Lowering

Pts w LDL-C uncontrolled (>2.0mmol/L)

- **-1.4mmol/L**
- **(~30% CVD risk reduction)**

Overall population

- **-1.0mmol/L**
- **(~20% CVD risk reduction)**



Impact- moving towards a regional service pathway

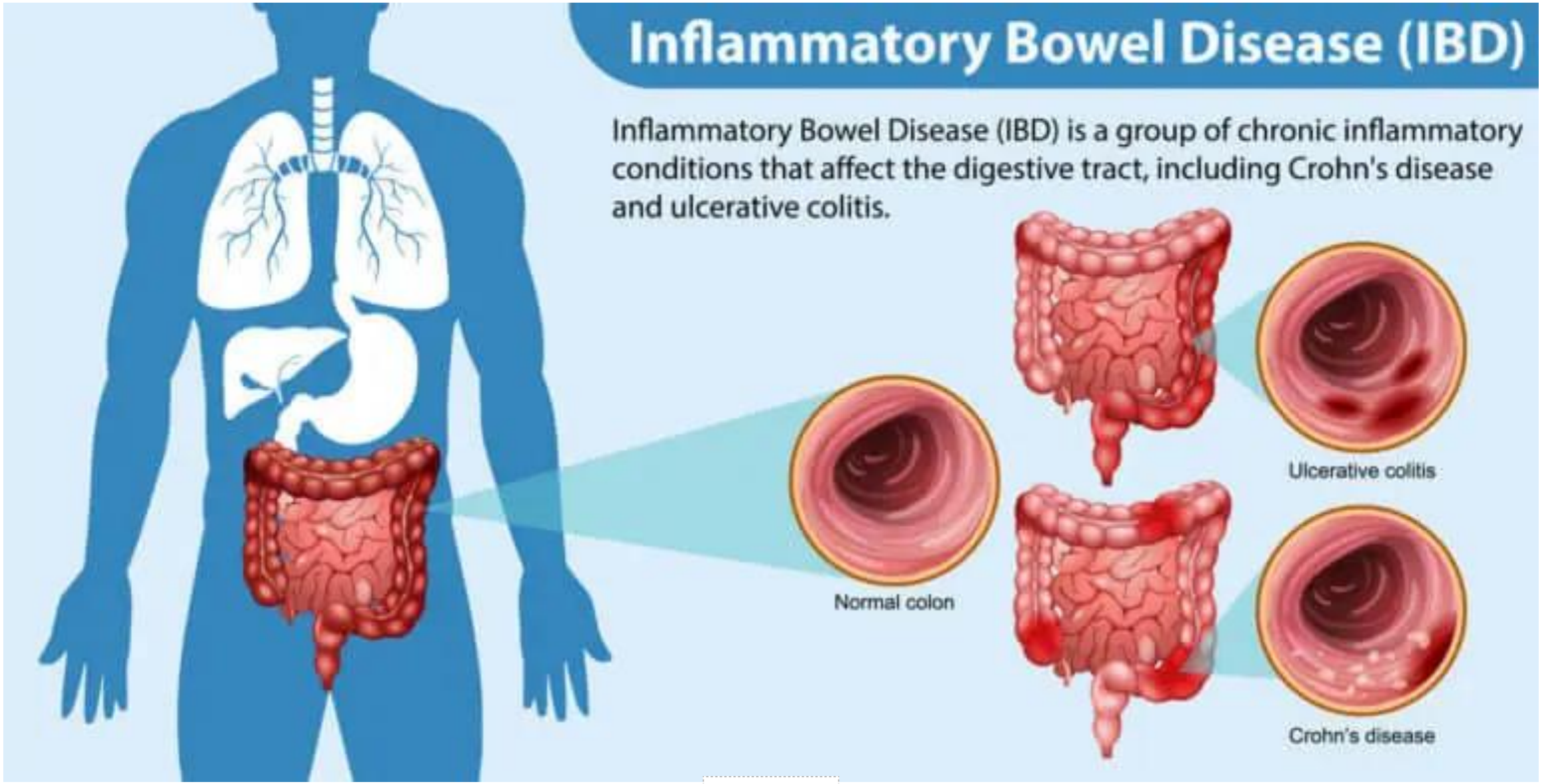
DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

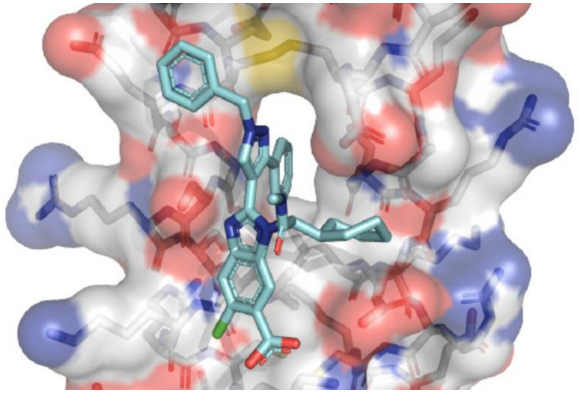
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

National recognition for Hywel Dda as Bronglais excels in Roche IBD commercial trials


Inflammatory Bowel Disease (IBD)
Inflammatory Bowel Disease (IBD) is a group of chronic inflammatory conditions that affect the digestive tract, including Crohn's disease and ulcerative colitis.
Normal colon
Ulcerative colitis
Crohn's disease



Roche

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

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

Llywodraeth Cymru
Welsh Government

"RVT-3101 has the potential to be the first therapy that offers both high efficacy and safety for people with IBD and the convenience of an at-home, subcutaneous administration"

Our strengths

- Specialist Consultant and Clinical Nurse Specialist
  strong trusted patient-clinical relationship
- Streamlined efficient, quick local R&D set-up and approvals
- Flexible, close-knit clinical teams -
  good communication and supportive culture
- **Consistent long-term population** in rural areas
- Pool of potential participants who have not previously taken part in commercial research: **research-naive**
- Rural communities **ready for research growth**

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG

SAFE | SUSTAINABLE | ACCESSIBLE | KIND

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

3

10:35 AM, 0 Mins

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3 - Data

3.1

10:35 AM, 15 Mins

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

Anthony Tracey (Hywel Dda UHB - Digital Director)

For approval

Attachments

DDIC- IGSC Sub-Committee (3As) - April2026.pdf

Appendix 1 IGSC Tor V.19.pdf

Appendix 2 174-ReuseofPublicSectorInformationPolicy-v5 draft.pdf

IGSC Annual Report DDIC SBAR April 2026.pdf

IGSC Annual Review 2025_2026 _v1.0.pdf

INFORMATION GOVERNANCE SUB-COMMITTEE COMMITTEE UPDATE REPORT

Date of last meeting: 18 March 2026

Quoracy: Not Quorate

Report by: Patrycja Duszynska, Head of Information Governance (Vice Chair)

KEY DISCUSSION POINTS AND MATTERS TO BE ESCALATED FROM THE DISCUSSION AT THE MEETING:

Alert (may require discussion)

The Information Governance Sub-Committee had no matters of which to **alert** members of the Digital, Data and Innovation Committee.

Advise (to monitor)

The Information Governance Sub-Committee wishes to **advise** members of the Digital, Data and Innovation Committee that:

- The IGSC Terms of Reference were reviewed and approved by Chairs Action due to IGSC not being quorate (Appendix 1)
- The **Welsh Information Governance Toolkit submission 2025–26** was assured by IGSC, achieving 96% overall compliance, with all minimum expectations met. A pragmatic evidencing approach was adopted where national question design no longer fully reflects operational reality.
- Separate **Information Governance Toolkit submissions** for managed General Practitioner (GP) practices were noted. All practices met minimum expectations; however, some did not meet “expectations exceeded” thresholds for training compliance following nationally increased benchmarks. Improvement actions are planned for 2026–27.
- Due to IGSC not being quorate, the Sub-Committee scrutinised the 174 - Reuse of Public Sector Information Policy for DDIC to approve.

Assure (to note)

Information Governance Sub-Committee wishes to **assure** members of the Digital, Data and Innovation Committee that:

- The **annual review of Information Governance training and communications arrangements** confirms that appropriate, role-based training and monitoring arrangements remain in place, with continued improvement in training compliance.
- The **annual review of privacy notices** identified only minor administrative amendments, with all notices remaining accurate, compliant and fit for purpose.

Review of Risks

The Sub-Committee reviewed the risks aligned to its remit. Risks with increased scores, including those relating to **Information Commissioner’s Office (ICO)**

enforcement and **end-of-life clinical systems**, were discussed and acknowledged as requiring continued monitoring and escalation through DDIC. Other risks were reviewed and remain under active management.

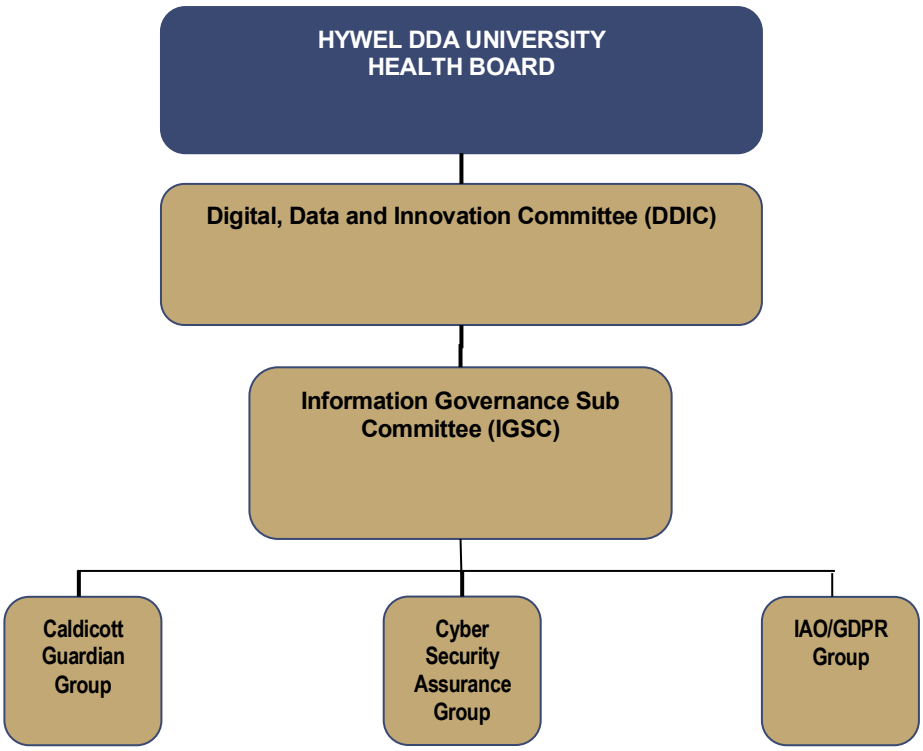
Sharing of learning

Not applicable.

Recommendation

The Committee is asked to:

- **APPROVE** the Information Governance Sub-Committee ToRs (Appendix 1)
- **APPROVE** 174 Reuse of Public Sector Information Policy (Appendix 2)
- **NOTE** the items the Sub-Committee is advising them of
- **TAKE ASSURANCE** from the items that the Sub-Committee is providing assurance on



INFORMATION GOVERNANCE SUB-COMMITTEE

TERMS OF REFERENCE

Version	Issued to:	Date	Comments
V.1	Information Governance Sub Committee Integrated Governance Committee	25th November 2010 21st December 2011	Approved Approved
V.2	Information Governance Sub Committee Integrated Governance Committee	11th November 2011 20th December 2012	Approved Approved
V.3	Information Governance Sub Committee Integrated Governance Committee	14th March 2013 23rd April 2013	Approved Approved
V.4	Information Governance Sub Committee Integrated Governance Committee	14th March 2014 22nd April 2014	Approved Approved
V.5	Information Governance Sub Committee Integrated Governance Committee	13th March 2015 28th April 2015	Approved Approved
V.6	Information Governance Sub Committee	19th June 2015	Approved
V.7	Information Governance Sub Committee	27th July 2015	Approved
V.8	Business Planning & Performance Assurance Committee	25th August 2015	Approved
V.9	Information Governance Sub-Committee	27th November 2015	Approved
V.10	Business Planning & Performance Assurance Committee	22nd August 2017	Approved
V.11	Information Governance Sub-Committee	30th July 2018	Approved
V.12	Information Governance Sub-Committee	11th December 2019	Approved

V.12	Business Planning & Performance Assurance Committee	17th December 2019	Approved
V.13	Information Governance Sub-Committee	2nd September 2020	Approved
V.14	People Planning & Performance Assurance Committee	Via Chair's Action	Approved
V.15	Information Governance Sub-Committee	12th October 2021	Approved
V.15	Sustainable Resources Committee	28th October 2021	Approved
V.16	Revised by Digital Director	17th May 2022	Approved
V.16	Information Governance Sub-Committee	11th October 2022	Approved
V.16	Sustainable Resources Committee	10th November 2022	Approved
V.17	Revised by Digital Director	07th February 2024	Approved
V.17	Information Governance Sub-Committee	07th February 2024	Approved
V.17	Sustainable Resources Committee	27th February 2024	Approved
V.18	Information Governance Sub-Committee	26th March 2025	Approved
V.18	Digital, Data and Innovation Committee	22nd April 2025	Approved
V.19	Information Governance Sub-Committee	18th March 2026 25th March 2026	Approved by the meeting and, Approved by Chair's action
V.19	Digital, Data and Innovation Committee	21st April 2026	

INFORMATION GOVERNANCE SUB-COMMITTEE (IGSC)

1. Constitution

1.1. The Information Governance Sub-Committee (IGSC) has been established as a Sub-Committee of the Digital, Data & Innovation Committee (DDIC), and was constituted from 25th November 2010.

2. Membership

2.1 The membership of the Sub-Committee shall comprise:

Title
Digital Director (Deputy SIRO) (Chair)
Medical Director (Caldicott Guardian)
Associate Medical Director for Professional Standard /Deputy Caldicott Guardian (Vice Chair)
Independent Member
Head of Information Governance
Head of Information Services
Health Records Manager

Information Governance Manager(s)
Assistant Director People Management
Head of Digital Operations
Cyber Security Manager
Mental Health Representative
Nursing Representative
Therapies & Health Sciences Representative
County/Community Representative
Primary Care Representative
Risk and Assurance Representative
Legal Services Representative
Freedom of Information Service Representative
Estates and Facilities Representative
Clinical Engineering Representative
Senior Corporate Records Management Officer
In Attendance
Information Governance Officer(s)
Senior Information Governance Officer(s)
Information Asset Owners

2.2 The membership of the Sub-Committee will be reviewed on an annual basis.

3. Quorum and Attendance

3.1 A quorum shall consist of no less than 6 and must include as a minimum either the Chair (Digital Director) or the Vice Chair (Associate Medical Director for Professional Standard), either the Caldicott Guardian (Medical Director) or the Deputy Caldicott Guardian (Associate Medical Director for Professional Standard).

3.2 An Independent Member shall attend the meeting in a scrutiny capacity.

3.3 Additional members may be co-opted to contribute to specialised areas of discussion.

3.4 Any senior manager of the UHB or partner organisation will, where appropriate be invited to attend.

3.5 Should any member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.

3.6 The Head of Internal Audit shall have unrestricted and confidential access to the Chair of the Information Governance Sub-Committee.

3.7 The Sub-Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4. Purpose

4.1 The purpose of the Information Governance Sub-Committee is to provide assurance to the Digital, Data & Innovation Committee (DDIC), which is a Committee of the Board, on compliance with information governance legislation, guidance, and best practice, and to:

4.1.1 Provide evidence based and timely advice to assist the University Health Board (UHB) in discharging its functions and meeting its responsibilities with regard to the quality and integrity; safety and security; and appropriate access and use of information (including patient and personal information) to support its provision of high-quality healthcare.

4.1.2 Provide assurance in relation to the Board's arrangements for creating, collecting, storing, safeguarding, disseminating, sharing, using and disposing of information in accordance with its stated objectives; legislative responsibilities, e.g., the Data Protection Act 2018, UK General Data Protection Regulation 2016 (implemented May 2018),Freedom of Information Act 2000 and Network and Information Systems Regulation 2018; and any relevant requirements, standards and codes of practice.

4.1.3 Provide assurance that risks relating to information governance are being effectively managed across the whole of the UHB's activities (including for hosted and contracted services, through shared services, partnerships, independent contractors, and Joint Committees as appropriate).

5. Operational Responsibilities

5.1 The Information Governance Sub-Committee will:

5.1.1 Promote and develop a robust information governance and security framework within the UHB and encourage a strong information governance and security culture across the organisation.

5.1.2 Ensure that good information governance practice is integrated into service and project delivery plans and pathways across the UHB.

5.1.3 Ensure openness, security, quality, and legal compliance in all information produced, utilised and reported by the UHB and its partners.

5.1.4 In conjunction with key Committees / sub-committees / groups develop appropriate systems, policies, work plans, procedures and accountability based on innovation and best practice for the effective management of information, including (but not restricted to) the areas of:

- Information and Cyber Security (Inc. SIRO related issues)
- Information Sharing Protocols
- Contracts, partnership and third party and supplier agreements
- Confidentiality and Data Protection
- Freedom of Information
- Subject Access Requests

- Records Management
- Information Quality Assurance / Data Quality
- Risk Management and Incident Management
- Data Protection Impact Assessments
- Patient records
- Clinical Coding

5.1.5 The Sub-Committee is responsible for recommending policies and procedures relating to information governance to the Digital, Data & Innovation Committee (DDIC), for approval.

5.1.6 Monitor the UHB'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 Internal / External Audit reviews including the implementation of Welsh Audit Office, Health Inspectorate Wales and Internal Audit recommendations.

5.1.7 Provide appropriate information governance assurance in relation to any high-level projects and plans that are monitored through and reported to the Digital, Data & Innovation Committee (DDIC), including the UHB's performance management framework and reporting template.

5.1.8 Develop, and performance manage action plans to achieve information governance and security objectives and direct and co-ordinate the work of the individuals and Groups involved with aspects of information governance within the UHB. Ensure that action plans and work programmes align with the UHB's Integrated Medium Term Plans (IMTP) where appropriate.

5.1.9 Inform and report the UHB's performance, action plans, and identified risks connected to information governance and information security to the Digital, Data & Innovation Committee (DDIC).

5.1.10 Provide assurance to the Digital, Data & Innovation Committee (DDIC) in relation to the organisation's arrangements for managing information and cyber security incidents including emergency preparedness, resilience and response and business continuity.

5.1.11 Provide a forum for discussion and debate on any ad-hoc information governance issues. This will include receiving and enacting information governance issues arising from the implementation of national systems directed for use within the UHB.

5.1.12 Develop an annual work plan and report, for sign off by the Digital, Data & Innovation Committee (DDIC), that addresses identified risks and priorities, meets relevant statutory and good practice requirement and is consistent with the strategic direction and organisational objectives of the organisation, including the IMTP where appropriate.

5.1.13 Provide assurance to the Digital, Data & Innovation Committee (DDIC), that, wherever possible, work plans are aligned with partnership plans and developed with Local Authorities, Universities, Collaboratives, Alliances, and other key partners.

5.1.14 Take forward any work identified by the Digital, Data & Innovation Committee (DDIC), as required to feed into the UHB's planning cycle.

5.1.15 Agree issues to be escalated to the Digital, Data & Innovation Committee (DDIC), with recommendations for action.

5.1.16 Consider the information governance implications for the Health Board of review reports and actions arising from the work of external reviewers.

5.1.17 Ensure that there is a process of Data Protection Impact Assessment in accordance with Information Commissioner's guidance.

5.1.18 The Health Board is meeting its legislative responsibilities, e.g., Data Protection and Freedom of Information Legislation, as well as complying with national Information Governance policies and Information Commissioners Office guidance.

Cyber Security

5.1.19 The promotion of information security throughout the Health Board.

5.1.20 The review and recommendation for the approval of all information security related policies and procedures.

5.1.21 The monitoring of progress in programmes to achieve compliance / certification with ISO27001.

5.1.22 The monitoring of progress in programmes to achieve compliance / certification with Cyber Essentials Plus.

5.1.23 The review and monitoring of security incidents both locally and nationally, identifying their root cause, any resolution and future prevention.

5.1.24 Reviewing information security risk assessments and improvement plans.

5.1.25 Consideration of solutions to improve security.

5.1.26 Monitoring and auditing compliance with standards and policies.

5.1.27 Receiving and reviewing information security related reports (e.g. internal audit).

5.1.28 Reviewing and commenting upon the security impact of information system development.

5.1.29 Reviewing, and recommending for approval, the information security elements of the annual IG toolkit submission.

6. Agenda and Papers

6.1 The Sub-Committee Secretary is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Lead Executive Director (Digital Director, at least **six** weeks before the meeting date.

6.2 The agenda will be based around the Sub-Committee work plan, matters arising from previous meetings, issues emerging throughout the year and requests from Sub-Committee members. Following approval, the agenda and timetable for papers will be circulated to all Sub-Committee members.

6.3 All papers must be approved by the relevant Officer.

6.4 The agenda and papers for meetings will be distributed **seven** days in advance of the meeting.

6.5 The minutes and action log will be circulated to members within **ten** days of the previous meeting to check for accuracy.

6.6 Members must forward amendments to the Sub-Committee Secretary within the next **seven** days. The Sub-Committee Secretary will then forward the final version to the Sub-Committee Chair for approval.

7. In Committee

7.1 The Sub-Committee can operate with an In-Committee function to receive updates on the management of sensitive and/or confidential information.

8. Frequency of Meetings

8.1 The Sub-Committee will meet on a bi-monthly basis.

8.2 The Chair of the Sub-Committee, in discussion with the Sub-Committee Secretary shall determine the time and the place of meetings of the Sub-Committee and procedures of such meetings.

9. Accountability, Responsibility and Authority

9.1 The Sub-Committee will be accountable to the Digital, Data & Innovation Committee (DDIC), for its performance in exercising the functions set out in these terms of reference.

9.2 The Sub-Committee shall embed the UHB's corporate standards, priorities, and requirements, e.g. equality and human rights through the conduct of its business.

9.3 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Sub-Committee.

10. Reporting

10.1 The Sub-Committee, through its Chair and members, shall work closely with the Board's other committees, including joint /sub committees and Groups to provide advice and assurance to the Board through the:

10.1.1 Joint planning and co-ordination of Board and Committee business;
10.1.2 Sharing of information.

10.2 In doing so, the Sub-Committee shall contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

10.3 The Sub-Committee may establish groups or task and finish groups to carry out on its behalf specific aspects of Sub-Committee business. The following Groups have been established:

10.3.1 Information Asset Owners/General Data Protection Regulation (IAO/GDPR) Group
10.3.2 Cyber Security Assurance Group
10.3.3 Caldicott Guardian Group

10.4 The Sub-Committee will receive the minutes following each Group's meetings detailing the business undertaken on its behalf.

10.5 The Sub-Committee Chair, supported by the Sub-Committee Secretary, shall:

10.5.1 Report formally, regularly and on a timely basis to the Digital, Data & Innovation Committee (DDIC), on the Sub-Committee's activities. This includes the submission of Sub-Committee minutes, as well as the presentation of an annual report within 6 weeks of the end of the financial year;

10.5.2 Bring to the Digital, Data & Innovation Committee (DDIC), specific attention any significant matters under consideration by the Sub-Committee.

11. Secretarial Support

11.1 The Sub-Committee Secretary shall be determined by the Lead Director (Digital Director).

12. Review Date

12.1 These terms of reference shall be reviewed on at least an annual basis by the Sub-Committee for approval by the Digital, Data & Innovation Committee (DDIC).

Reuse of Public Sector Information Policy

DRAFT

Policy information

Policy number: **174**
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 ensure that requests for the re-use of public sector information are managed in accordance with the Re-use of Public Sector Information Regulations 2005 (the Regulations

Scope:
This policy applies to:

- All employees, including permanent, temporary, contractual and agency, and Independent Members;
- Volunteers, students or any other authorised people working with or for the UHB
- Those who hold information on behalf of the UHB.

To be read in conjunction with:
173 – Freedom of Information and Environmental Information Policy – opens in a new tab

Patient information:

Owning group:
IGSC

31/01/2023

Executive Director job title:
Joanne Wilson, Board Secretary

Reviews and updates:
1 – new policy 1.3.2011
2 – revised 2.12.2014
3 – full review
4 – Full review

Keywords
Re-use, public sector information, RPSI

Glossary of terms
UHB – Hywel Dda University Health Board
OGL - Open Government Licence
URI - Uniform Resource Indicator
URL - Uniform Resource Locator
SIRO - Senior Information Risk Officer

Contents

INTRODUCTION

The purpose of this policy is to ensure that requests for the re-use of public sector information are managed in accordance with the Re-use of Public Sector Information Regulations 2015 (the Regulations). The purpose of the Regulations is to establish a framework that provides for effective re-use of public sector information and is based on the principles of fairness, transparency, non-discrimination and consistency of application.

Most information supplied in response to information access regimes such as the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 will be protected by copyright and permission to re-use it will be required as the provision of information does not confer any automatic right to re-use the information. The Regulations provide a framework for re-use of information once access has been obtained. However, the Protection of Freedoms Act 2012 which amends S102 of the Freedom of Information Act contains provisions under which certain public sector owned datasets will be reusable at the point of access by means of a specified licence.

Re-use of information occurs where information is used for a purpose other than the original purpose for which it was created by a public sector body within its public task. Re-use helps to deliver three key government priorities: public sector transparency; increased public involvement in achieving government objectives; and increased economic growth (UKGLF, 2013).

SCOPE

This policy applies to:

- All employees, including permanent, temporary, contractual and agency, and Independent Members;
- Volunteers, students or any other authorised people working with or for the UHB
- Those who hold information on behalf of the UHB.

AIM

This policy is to ensure that Hywel Dda University Health Board (UHB) is compliant with the Re-use of Public Sector Information Regulations 2015.

OBJECTIVES

This policy will set out the arrangements for the following:

- Dealing with applications for re-use within 20 working days in a non-discriminatory way
- To publish terms of re-use, usually in the form of a licence
- Not to enter into exclusive arrangements other than in exceptional circumstances
- To provide information about what information is available for re-use. This should be in the form of an information asset list

DEALING WITH APPLICATIONS FOR RE-USE

Copyright

Most information produced by the UHB is subject to copyright protection and the UHB has the right to authorise the re-use of the information it produces under UK copyright legislation. The Regulations only apply to copyright and related rights (database rights, publication rights and rights in performances). They do not apply to other intellectual property rights such as patents, trade marks and design rights.

Documents

All documents held by the UHB fall within the scope of the Regulations with the exception of those which:-

- fall out of the public task of the UHB
- contain content in which the relevant intellectual property rights are owned or controlled by a person or controlled by a person or organisation other than the UHB, eg photographs
- are exempt from release under the Freedom of Information Act (except where s21 applies), Environmental Information Regulations and any other access legislation

The Regulations define 'document' by relating it to 'content' which is information recorded in any form.

Request for re-use

The provision of information does not confer any automatic right to re-use the information. Regulation 6 states that applicants should:

- Make requests for re-use in writing, including email. Requests must be legible and usable for subsequent reference
- Provide their name and address
- Specify which documents they want to re-use
- State the purpose for which the document is to be re-used

Where the requester cannot provide the request in writing, assistance can be provided to the applicant whereby the request can be drafted and confirmed with them. Once confirmation is received, it is considered to be a written request and the UHB is obliged to respond.

Requests in Welsh and other languages will also be accepted and the UHB will adhere to relevant equality legislation when providing information requested. (See section also 'processing requests for reuse')

Responding to a request for re-use

Regulation 8 sets out how public sector bodies should respond to requests, including timescales. In response to requests for re-use, the UHB can issue one of the following responses:

- A refusal to give permission to re-use
- Supply the document to the applicant, if it has not already been supplied under access to information legislation, ie Freedom of Information.
- Offer terms and conditions for re-use, often in form of a licence

In terms of timescales, documents will fall under 2 broad categories:

Readily available documents

This covers documents that have already been made available and would include those which have already been published or are identified as being available for re-use on an asset list. These must be responded to within 20 working days.

Under the Regulations, the UHB is allowed up to 20 working days following the date of receipt of the request for re-use to finalise any licence offer.

Previously Unreleased Documents

This covers unpublished documents and information that has not been identified as being available for re-use. Permission for re-use is subject to access issues being resolved.

If the request for access and re-use is combined, it must be dealt with fully in terms of access to the information before a final decision on re-use can be taken. Where requests for re-use are extensive in terms of the number of documents requested, or raise complex issues, the UHB may extend the response time. However, it must be prepared to justify that the time taken to respond is reasonable. The UHB must also inform the applicant before the expiry of the 20 working days that it is unable to respond to the request within the standard timeframe and provide an indication of when a response can be expected.

Notification of Refusal

Under Regulation 9, when the UHB refuses a request for re-use, it must:-

- Set out the reasons for refusal in writing
- Explain what forms of redress are open to the applicant, both internal and independent
- Where the refusal is based on the fact that copyright or other relevant intellectual property rights (IPRs) are owned by a third party, the owner must be identified (where known)
- Where the owner of the third party copyright is not known, the name of the person from whom the document was obtained should be provided (where known). If it is not known, this fact should be stated.

Processing requests for re-use

Under Regulation 10, requests for re-use should be dealt with electronically, where possible, and should take advantage of existing licensing systems that are available. However, Regulation 11 does not require public bodies to make documents available in a format other than the format or language in which the document already exists (unless it has duties to do so under other legislation such as the Equality Act and the Welsh Language Standards). Regulation 11 also confirms there is no obligation to:

- create or adapt a document to comply with a request for re-use
- provide extracts of documents where this would entail disproportionate effort
- continue producing a document purely for re-use by others

Conditions

Regulation 12 allows the UHB to set conditions on the re-use of documents. Conditions should not unnecessarily restrict the way in which a document can be re-used nor should it seek to restrict competition between re-users.

Terms and conditions are set out within the licences below. There are 3 different types of licence that can be issued:-

Open Government Licence (OGL)

The Open Government Licence is an open licensing model and tool for public sector bodies to license the re-use of their information and data easily. It consists of a simple set of terms and conditions to which public sector bodies simply point as the relevant licence. Use of information under the OGL is free and allows information to be used and re-used for commercial and/or non-commercial purposes. Licensees are required to include an attribution statement in any use of the information. An attribution statement identifies the name, creator and date of information, and acknowledges them appropriately. It demonstrates further the source of the information and its use under the OGL. Public bodies are

encouraged to use the OGL symbol on their websites and in publications wherever possible. Templates on how to apply the OGL to UHB online information resources and print publications can be found at Appendix 1 – opens in a new tab.

Non-Commercial Government Licence

The default position is that public sector information should be licensed for use and re-use free of charge under the OGL. However, there are specific circumstances where information may only be released for use and re-use for non-commercial purposes. The Non-Commercial Government Licence has been developed to meet those circumstances. When a public sector body licenses its information under the Non-Commercial Government Licence, it should insert a visible statement asserting this and provide the Non-Commercial Government Licence URI (Uniform Resource Indicator) or URL (Uniform Resource Locator) in the information.

Templates on how to apply the Non-Commercial Government Licence to the UHB online information resources and print publications can be found at Appendix 2.

Charged Licence

As indicated in previous sections, public sector information should be licensed for use and re-use free of charge under the OGL. However, there are circumstances where it is appropriate to charge for use and re-use. The Charged Licence is designed for use in situations such as the context of s102 of the Protection of Freedoms Act 2012. Legal advice should be sought before offering information for use and re-use where charges are made.

Licensing software and source code

The public sector produces software or source code as well as types of content such as documents and data. Software is protected by copyright and this makes licensing considerations important. Many developers release their work under open source licences, which enable software to be re-used freely and free of charge.

Public sector bodies that are involved in developing their own software and source code are encouraged to make them available as openly as possible. Developers may choose to release their software and source code under OGL or alternatively, the Open Source Initiative maintains a list of approved open source licences covering software and source code that can be used (https://opensource.org/licenses).

Non-discrimination

Under Regulation 13, the UHB must not discriminate in the conditions applied between applicants who re-use documents for similar purposes. The emphasis is on the use of the documents rather than the re-user. The only exception to this is where a particular user or group of users have a statutory right to re-use material. For example, libraries, archives and educational establishments enjoy special privileges under the Copyright, Designs and Patents Act 1988, which also includes special provisions for the reproduction of material for visually impaired persons.

Prohibition of Exclusive Arrangements

Under Regulation 14, the UHB should not enter into exclusive arrangements as it prevents others from re-using the document and inhibits competition. This covers appointing publishers to publish versions of documents. An important exception to this is where a service in the public interest cannot be provided

other than by means of granting an exclusive licence. However, the terms of the arrangement must be published and the justification regularly reviewed (at least every 3 years).

Charging

Although there is no obligation on the UHB to charge for re-use, it retains the right to do so, and where a charge is made it will be noted on the UHB Publication Scheme. Under the Regulations, the UHB is permitted to charge for re-use. However, the total income should not exceed the cost of collection, production, reproduction and dissemination of documents and a reasonable return on investment. As much of the information held by the UHB is available in digital format, the costs of allowing for re-use will often not involve any additional costs.

The UHB should be able to justify any charges that are applied for re-use and if the charge includes supplying of the document, or that it has been subject of a request under Access to Information Legislation (ie Freedom of Information Act), then the access fee should be deducted from the fee for re-use.

Nominal charges may cover basic costs relating to:

- The collection, production, reproduction and dissemination of the documents including relevant copyright work, eg, copying, printing and postage
- The cost of conversion of the information to a different format or extraction from a larger dataset

Information to be published by the UHB

Public bodies must be open, transparent and fair in processing applications for re-use. Under Regulation 16, the UHB is required to publish asset lists, standard licence terms and details of any charges, electronically where possible.

Internal review procedure

The Regulations require that the UHB has an effective procedure to consider any complaints that arise from the application of the Regulations. Regulation 17 requires that complaints are responded to 'within a reasonable time'. The UHB aims to provide a response to a complaint relating to re-use within 20 working days unless there are good reasons why this is not possible.

All complaints must be made in writing to the UHB in the first instance, providing all the relevant information. The UHB response must also be in writing, clearly setting out the reasons behind its decision, within the timeframe outlined above. If the internal process fails to resolve the issue, the complainant can refer the issue to the Office of Public Sector Information at the National Archives (Further information can be found on the following link: Comments and complaints procedure - Contact us).

RESPONSIBILITIES –

Chief Executive

Overall responsibility for compliance with the Regulations lies with the Chief Executive.

Executive Director of Finance/Senior Information Risk Officer (SIRO)

The responsibility for ensuring arrangements are in place for compliance with the Regulations has been devolved to the Executive Director of Finance/Senior Information Risk Officer (SIRO).

Head of Corporate Legal Services and Public Affairs
The responsibility for ensuring that there are day to day arrangements in place for managing requests for re-use and reviews into complaints received in relation to the re-use of information lies with the Head of Corporate Legal Service and Public Affairs.

Freedom of Information Team
The responsibility for the day to day management of requests for re-use and providing advice to UHB staff lies with the Freedom of Information Team. This involves developing and maintaining this policy, managing requests for re-use, maintaining a record of requests for re-use, issuing licences and any related fees notices.

All staff
Staff are responsible for ensuring that requests for re-use are passed to the Freedom of Information Team and that documents are appropriately licensed before publication.

TRAINING
The Freedom of Information Team can provide advice and assistance to staff on the management of requests for re-use and licensing arrangements.

IMPLEMENTATION
The Freedom of Information Team will be responsible for implementing this policy ensuring that requests for re-use are managed in accordance with the Regulations.

FURTHER INFORMATION
The Re-use of Public Sector Information Regulations 2015
National Archives
UK Government Licensing Framework for Public Sector Information 2013

REVIEW
This Policy will be reviewed after 3 years, or sooner, as required.

APPENDIX 1 – TEMPLATE COPYRIGHT NOTICES AND STATEMENTS UNDER OGL

Online information resources (including website statements)

© Hywel Dda University Local Health Board

This [*insert name of information resource*] is licensed under the Open Government Licence 2.0 OGL - opens in a new tab

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Print publications

This information is licensed under the Open Government Licence v3.0. To view this licence, visit Open Government Licence OGL - opens in a new tab - or write to the Information Policy Team, The National Archives, Kew, Richmond, Surrey, TW9 4DU.

Any enquiries regarding this publication should be sent to: Hywel Dda University Local Health Board, Corporate Governance Department, Second Floor, Block C, Government Buildings, Picton Terrace, Carmarthen, SA31 3BT

When you use this information under the Open Government Licence v3.0, you should include the following attribution: [*Insert name of information resource*, Hywel Dda University Local Health Board, *date of publication*], licensed under the Open Government Licence - opens in a new tab.

APPENDIX 2 – TEMPLATE COPYRIGHT NOTICES AND STATEMENTS FOR NON-COMMERCIAL GOVERNMENT LICENCE

Online information resources (including website statements)

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Print publications

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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Information Governance Sub-Committee (IGSC) Annual Report 2025 - 2026
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

In line with Standing Orders the IGSC must submit an Annual Report to the Digital, Data and Innovation Committee through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Groups it has established, setting out how the Sub-Committee has met its Terms of Reference during the financial year.

Cefndir / Background

The IGSC annual report confirms Information Governance compliance, assuring the Health Board and Executive Team that strong governance and security standards have been maintained, and decisions align with all regulatory requirements.

Asesiad / Assessment

This report introduces the Information Governance Sub-Committee (IGSC) Annual Report for the Financial Year 2025–2026, confirming that the IGSC's activities throughout the year were conducted in accordance with its Terms of Reference. The report consolidates and summarises all reports previously presented to the DDIC over the past year, drawing attention to significant issues relevant to the Health Board, particularly in the areas of Information Governance and Cyber Security, and aligning with both national and local objectives.

Argymhelliad / Recommendation

The Committee is asked to APPROVE the Information Governance Sub-Committee Annual Report confirming that the Sub-Committee is operating effectively and in line with the Terms of Reference.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	3.1.22 Receive assurance through Sub-Committee Update Reports and other management/task & finish group reports that risks relating to their areas are being effectively managed across the whole of the Health Board's activities (including for hosted services and through partnerships and Joint Committees as appropriate).
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)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	9 Digital plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	2. Develop a skilled and flexible workforce to meet the changing needs of the modern NHS

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	N/A
Rhestr Termau: Glossary of Terms:	IGSC - Information Governance Sub-Committee IG – Information Governance
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Mewn Pwyllgor Digidol, Data ac Arloesi Parties / Committees consulted prior to In-Committee Digital, Data and Innovation Committee:	IGSC

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	N/A
Ansawdd / Gofal Claf: **Quality / Patient Care:**	N/A
Gweithlu: **Workforce:**	N/A
Risg: **Risk:**	N/A
Cyfreithiol: **Legal:**	N/A
Enw Da: **Reputational:**	N/A
Gyfrinachedd: **Privacy:**	N/A
Cydraddoldeb: **Equality:**	N/A

INFORMATION GOVERNANCE SUB-COMMITTEE (IGSC)

ANNUAL REVIEW REPORT

2025/2026

1. Introduction and Chair's summary

In line with Standing Orders the Information Governance Sub-Committee must submit an Annual Report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any Sub-Committees it has established, setting out how the Committee has met its Terms of Reference during the financial year.

The Board uses this annual report to inform:

- The ongoing development of its governance arrangements, including its structures and processes:
- Its Board Development Programme, as part of an overall Organisation Development framework.

Chairs Reflections

As Chair of the Information Governance Sub-Committee, I am pleased to reflect on another year of steady progress and strengthening assurance across Hywel Dda University Health Board. Throughout 2025 – 2026, the Sub-Committee has continued to provide robust oversight of information governance arrangements, supporting compliance with statutory requirements while responding to emerging organisational risks and priorities.

The Sub-Committee has maintained a strong focus on governance and assurance, overseeing the review and approval of a wide range of Information Governance, Information Security, Records Management, and Digital policies. This has ensured that written control documentation remains current, aligned with national standards, and responsive to developments in cyber security, mobile working, and digital asset management.

A significant achievement during the year has been the completion of the repatriation of all records previously held in external storage, bringing records fully under Health Board control. This represents an important reduction in information risk and strengthens compliance with records management and data protection standards. Continued scrutiny of internal storage arrangements reflects the Sub-Committee's commitment to sustainable and secure information management.

Information Governance training compliance has exceeded the national benchmark for the first time, demonstrating positive progress in workforce awareness and engagement. While variation across services remains, the Sub-Committee will continue to monitor this closely and support targeted improvement activity.

Oversight of data quality, clinical coding, audits, and information governance risks has remained central to the Sub-Committee's work. Despite operational challenges, year-end clinical coding performance exceeded national targets, and audit activity continues to inform learning, improvement actions, and training priorities.

Looking ahead, the Sub-Committee will focus on sustaining improvements, strengthening assurance around information assets and third-party risk, and supporting digital transformation while ensuring information governance remains embedded across all services.

I would like to thank Sub-Committee members and colleagues across Information Governance, Records, Digital, and Cyber teams for their continued commitment and professionalism. I am confident that the Sub-Committee will continue to provide strong assurance and leadership in support of safe, lawful, and effective use of information.

Anthony Tracey
Chair of Information Governance Sub-Committee
Digital Director

2. Terms of Reference (ToRs) and Workplan

The ToRs for the Information Governance Sub-Committee is reviewed on an annual basis or following any significant changes. The TORs were last reviewed on 18 March 2026.

The IGSC has a work plan to enable forward planning for the forthcoming year. The workplan is produced to incorporate the duties outlined in the IGSC's Terms of Reference and any suggested areas of focus identified during the self-assessment process.

The IGSC's workplan covers a range of activities including statutory reporting duties, regular items of business and priority planned pieces of work which support Board and Committee's objectives.

The work plan is regularly updated throughout the year to ensure it remains responsive to emerging issues and risks.

	Agenda Items:	Meeting Dates:					
		05/06/2025	16/07/2925	24/09/2025	26/11/2025	21/01/2026	18/03/2026
	Part A: GOVERNANCE						
1	Apologies	V	V	V	V	V	V
2	Declaration of Interests	V	V	V	V	V	V
3	Attendance Register	V	V	V	V	V	V
4	Schedule of Meetings	V	V	V	V	V	V
5	Minutes of the previous Meeting	V	V	V	V	V	V
6	Matters Arising and Table of Actions from previous Meeting	V	V	V	V	V	V
7	IGSC - Terms of Refernece Review	X	X	X	X	X	V
8	Digital, Data and Innovation Committee (DDIC) - Key Actions and Discussions	V	V	V	V	V	V
9	All Wales Information Governance Management Advisory Group (IGMAG) - Key Actions and Discussions	V	V	V	V	V	V
10	All Wales OSSMB - Key Actions and Discussions	V	V	V	V	V	V
11	All Wales Health Records Management Advisory Group (HRMAG) - Key Actions and Discussions	V	V	V	V	V	V
12	Caldicott Guardian Group (CGG) Meeting - Key Actions and Discussions	V	V	V	V	V	V (TORs)
13	Information Asset Owners Group (IAOG) Meeting - Key Actions and Discussions	V	V	V	V	V	V (TORs)
14	Cyber Security Assurance Group (CSAG) Meeting - Key Actions and Discussions	V	V	V	V	V	V (TORs)
15	Policies and Procedures for Approval	As Required	As Required	As Required	As Required	As Required	As Required
16	IGSC Annual Report	V	X	X	X	X	X
17	IGSC Assurance Report	V	X	X	X	X	X
18	Welsh IG Toolkit Submission (HDUHB)	X	X	X	X	X	V
19	Welsh IG Toolkit Submission (Managed Practices)	X	X	X	X	X	V
20	IGSC Risk Register Update	X	V	X	V	X	V
	Part B: Information Services						
22	Clinical Coding Update	X	V	X	V	X	V
23	Data Quality Update	V	X	V	X	V	X
	Part C: Information Governance						
24	HDUHB – Information Governance Audits Update.	V	V	V	V	V	V
25	HDUHB's Corporate and Medical Records Storage Assurance Report – Update.	V	V	V	V	V	V
26	Data Protection Impact Assessments Update Report 2025-2026 (Q1 - Q4)	V (Q4)	V (Q1)	X	V (Q2)	V (Q3)	X
27	Caldicott Guardian Register.	V (Q4)	V (Q1)	X	V (Q2)	V (Q3)	X
28	IG Activity Report, Q2 2025-2026 (Including the IG Workplan 2025 - 2026)	V (Q4)	V (Q1)	X	V (Q2)	V (Q3)	X
29	IG Compliance Update.	V	V	V	V	V	V
30	HDUHB's Privacy Notices Annual Review	X	X	X	X	X	V
31	IG Training and Communications Plan Annual Review	X	X	X	X	X	V
	Part D: Cyber Security						
32	Cyber Security Update.	V	V	V	V	V	V
33	Cyber Security incidents Update.	V	V	V	V	V	V
34	Vulnerability Summary Update.	V	V	V	V	V	V

3. **IGSC Sub-Groups**
   - The **Information Asset Owners Group (IAOG)** reports into the IGSC with its own terms of reference and workplan for the year.

     The IAOG's ToRs were last reviewed on 18 March 2026.

     In line with their Terms of Reference, the IAO Group is required to provide a report after each meeting.

   - The **Caldicott Guardian Group (CGG)** reports into the IGSC with its own terms of reference and workplan for the year.

     The CCG's ToRs were last reviewed on 18 March 2026.

     In line with their Terms of Reference, the CCG is required to provide a report after each meeting.

   - The **Cyber Security Assurance Group (CSAG)** reports into the IGSC with its own terms of reference and workplan for the year.

     The CSAG's ToRs were last reviewed on 26 March 2026.

     In line with their Terms of Reference, the CSAG is required to provide a report after each meeting.

4. **Table of attendance**

Membership	05/06/2025	16/07/2025	24/09/2025	26/11/2025	10/02/2026	18/03/2026
Digital Director (Deputy Siro) (Chair)	✓	✓	✓	✓	✓	Apologies
Medical Director (Caldicott Guardian)	✓	✓ (Represented)	X (Not Represented)	✓ (Represented)	X (Not Represented)	✓ (Represented)
Associate Medical Director for Professional Standard (Deputy Caldicott Guardian) (Vice Chair)	Apologies	✓	Apologies	✓	✓	✓
Independent Member	✓	Apologies	Apologies	Apologies	Apologies	✓
Head of Information Governance	✓	✓	✓	✓	✓	✓
Head of Information Services	X	✓	Apologies	X	X	Apologies
Health Records Manager	✓	✓	✓	Apologies	✓	Apologies
Information Governance Manager(SB)	✓	✓	✓	Apologies	✓	✓
Information Governance Manager(AE)	Apologies	✓	✓	✓	Apologies	✓
Information Governance Manager(SE)	✓	✓	✓	✓	✓	✓
Assistant Director of Workforce and OD (HH)	Apologies	✓	Apologies	X	✓	✓
Head of Digital Operations	✓	✓	Apologies	✓	✓	✓
Cyber Security Manager	✓	Apologies	✓	✓	✓	✓
Mental Health Representative	X	X	X	✓	✓	Apologies
Nursing Representative	X	X	X	X	X	X
Therapies & Health Sciences Representative	X	X	X	X	X	X
County/Community Representative	X	X	X	X	X	X
Primary Care Representative	X	X	X	X	X	X
Risk and Assurance Representative	X	✓	✓	✓	✓	Apologies
Legal Services Representative	X	X	X	X	X	X
Freedom of Information Service Representative	✓	X	✓	X	✓	✓
Estates and Facilities Representative	X	X	X	X	X	X
Clinical Engineering Representative	X	X	X	X	X	X
Corporate Archivist / Senior Corporate Records Management Officer	✓	✓	✓	Apologies	Apologies	Apologies
In Attendance						
Senior Information Governance Officer (SG)					✓	✓
Senior Information Governance Officer (SF)	Apologies	✓	✓	✓	✓	✓
Information Governance Officer(LJ)	✓	✓	✓	✓	✓	✓
Information Asset Owners (Pharmacy and Medicine Management)	✓	Apologies	✓	Apologies	Apologies	Apologies
Information Asset Owners (Workforce - Resourcing and Utilisation)	Apologies	Apologies	Apologies	✓	✓	✓
Information Asset Owners (Digital Innovation and transformation)						
Information Asset Owners (Infection Prevention)						
Information Asset Owners (Telecom Operations)						
Information Asset Owners (Pathology)						
Head of Digital Business and Engagement (SB)	✓					
Meeting quorate?	**YES**	**NO**	**NO**	**NO**	**NO**	**NO**

5. Committee Activities – alert, advise and assure.

The IGSC is required to report to the DDIC after each meeting by presenting a report highlighting the key discussion items at the Sub-Committee.

Alert – *The following matters were areas where the Committee was unable to take an assurance or had a lack of confidence that the action in place was sufficient to address the issue satisfactorily and/or it was within the scope of the operational team to resolve and were alerting the Board as engagement action or intervention was required.*

Records Storage Facilities – Internal Estate

- The Sub-Committee noted the successful completion of the repatriation of all records previously held with external storage providers, bringing records fully under Health Board control.
- However, concerns were raised regarding the condition, suitability, and long-term sustainability of some local internal records storage facilities, where initial assessments indicate that environmental, security, and operational standards require further review.

- The Sub-Committee agreed that a formal assessment of internal storage facilities is required to inform future investment and planning, and has requested that this work be progressed as part of the 2026–2027 Digital Operational Plan.

Information Governance Training – Residual Departmental Gaps

- While overall Information Governance training compliance has exceeded the national benchmark, the Sub-Committee was unable to take full assurance that compliance is consistently embedded across all departments.
- Variability remains within certain services, posing a residual risk to compliance and assurance. The Sub-Committee has therefore alerted the DDIC to the need for continued organisational focus and oversight, including escalation through the Mandatory Training Group where required.

Committee Quoracy and Continuity of Assurance

- The Sub-Committee noted that several meetings during the reporting year were not quorate, which limited formal decision-making and assurance in-meeting.
- While scrutiny and escalation mechanisms remained in place, the Sub-Committee highlighted the risk to sustained assurance and governance effectiveness if quoracy challenges persist and requested continued attention to membership attendance and quorum requirements.

Policies and Written Control Documentation

- The Sub-Committee undertook scrutiny of a significant volume of Information Governance, Information Security, Records Management, and Digital policies during the year, including extensions to several All-Wales policies and approval of updated Health Board written control documentation.
- The Sub-Committee highlighted the ongoing risk associated with the volume and frequency of policy renewals, particularly All-Wales policies, and emphasised the need for continued organisational support to ensure timely review, approval, and implementation.

Advise – *The following matters were areas of concern where assurance had been taken on actions in place but required close monitoring.*

- In some instances, particularly where meetings were not quorate, the Sub-Committee was unable to provide formal approval and therefore alerted the Digital, Data and Innovation Committee to ensure that policy extensions and approvals were progressed without delay, maintaining organisational compliance with statutory and regulatory requirements.

Assure – *The following matters were areas where there was confidence that robust actions are in place and are sufficient to address the issues to operate effectively.*

- Across the 2025 – 2026 reporting period, the Information Governance Sub-Committee provided assurance to the Digital, Data and Innovation Committee that effective controls, oversight, and improvement activity were in place across a range of core information governance functions.
- The Sub-Committee provided assurance that the **Information Governance Annual Report** for 2024 – 2025 had been reviewed and approved, recognising the contributions of Information Governance, Records Management, Information Services, Cyber Security, and Digital teams in delivering the programme of work and assurance for the year.
- Assurance was given that **clinical coding** performance recovered and exceeded the national target by year end, achieving 98.3% against a 98% target, demonstrating resilience following earlier workforce challenges and effective service recovery planning.
- The Sub-Committee provided assurance that all records previously held with external storage providers had been fully repatriated, ensuring that **corporate and medical records** are now under full Health Board control and aligned with data governance and compliance requirements.
- Assurance was also taken from sustained improvements in **Information Governance training compliance**, which increased from 77% to over 85%, marking the first time the Health Board achieved the national benchmark and evidencing increased workforce awareness and engagement with IG requirements.
- The Sub-Committee was assured that the **Information Governance audit programme** for 2025 – 2026 was completed, with a thematic review undertaken to identify key strengths, risks, and areas for improvement. Audit findings are being embedded into training plans and guidance to support continuous improvement.
- Regular review of the **Information Governance risk register** confirmed that aligned risks remained within tolerance, with assurance noted regarding the effectiveness of mitigation actions, particularly in relation to records storage risks and cyber security oversight.
- The Sub-Committee provided assurance relating to the governance framework, including the review and approval of the **IGSC Terms of Reference**, and oversight of its sub-groups (Caldicott Guardian Group, Information Asset Owners Group, Cyber Security Assurance Group), confirming that reporting and escalation arrangements remained effective.
- Assurance was also provided that a wide range of **Information Governance, Information Security, Records Management, and Digital policies** were either approved, updated, or extended in line with national requirements, ensuring the Health Board remained compliant with statutory and regulatory expectations despite the volume and frequency of policy renewals.

Information Governance Toolkit Submissions for 2025 – 2026: The Sub-Committee approved the submissions of the Information Governance Toolkits for the Health Board and Managed Practice

Privacy Notice: The annual review of HDUHB's Privacy Notices, as published online, has been completed.

6. Conclusion

The Sub-Committee is satisfied that it continues to operate effectively and in line with the Terms of Reference. Issues have been escalated to DDIC as appropriate.

4

10:50 AM, 0 Mins

---

4 - Digital

4.1

10:50 AM, 15 Mins

4.1 - Digital Operation Plan

Anthony Tracey (Hywel Dda UHB - Digital Director)

Digital Operation Plan to reflect actions outlined in DDIC ToA's 15 January 2026.

For information

Attachments

4.1 -DDIC - Operational Plan - Delivery Dates - April 2026.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 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

Sefyllfa / Situation

The purpose of this paper is to present the Committee 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.

Cefndir / Background

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.

Asesiad / Assessment

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.

Appendix 1 provides an overview of the key delivery programmes and their current status. For the purposes of committee scrutiny, the following programmes have been highlighted by exception and are set out below to support consideration and provide additional assurance where required.

1. Laboratory Information Management System (LIMS) Replacement

Current Position

The LIMS programme remains **Red** due to continued national delivery risk, particularly around Blood Transfusion (BT). While discipline-by-discipline deployment is progressing, the national timetable has extended beyond March 2026 into 2026/27, with ongoing concerns around clinical assurance, data migration (notably BT), and supplier readiness.

Key Issues

- Repeated national slippage and dependence on Digital Healthcare Wales (DHCW)/ISC delivery assurance
- BT module remains the highest risk, with a revised decision checkpoint now planned for August 2026
- Financial risk transfers to Health Boards beyond current funding envelope if delays persist
- Clinical safety sign-off of Minimum Viable Product (MVP) remains a critical dependency

Mitigation / Actions

- Discipline-based rollout already implemented to reduce system-wide risk
- Formal Situation, Background, Assessment, and Recommendations (SBARs) continue to be escalated through Executive Team and DDIC
- August 2026 review point established to confirm whether to remain on LIMS2 or consider alternative options

DDIC is asked to note: Risk remains external-dependency driven and requires continued close oversight and escalation via national governance routes.

2. Switchboard Alarm Digitisation / Modernisation

Current Position

Despite previous progress, this remains **Red** due to complex site-by-site technical dependencies, particularly around legacy alarm systems, estates fire compliance, asbestos constraints and network capacity.

Key Issues

- Alarms are non-standardised with multiple third-party vendors
- Some sites require additional estates works (fire stopping, asbestos mitigation) before full digitisation
- Dependency on successful completion of network integration

Mitigation / Actions

- Detailed site plans exist and are being worked through sequentially
- We are also seeking a supplier for an Alram Receiving Centre (ARC)
- Cyber and network assurance already completed for core solutions
- Programme remains aligned to the wider **Switchboard Modernisation** roadmap

DDIC is asked to note: Risk is **deliverable but constrained by estates interdependencies**, not technology failure.

3. Implementation of an Eye Care System (OpenEyes)

Current Position

OpenEyes remains **Red** due to clinical capacity constraints, historic programme disruption, and delayed sign-off of configuration, despite recent recovery actions.

Key Issues

- Ophthalmology service capacity fragile (single-handed subspecialties, sickness, leave)
- Historic loss of technical and programme continuity
- Dependence on limited specialist technical resource

Mitigation / Actions

- Full-time Project Manager (PM) now in post through March 2027
- Joint Digital/Scheduled Care funding agreed for technical resource
- Revised phased delivery approach confirmed (initial MVP, sub-specialty rollout)
- Local assurance provided to Welsh Government (WG) through formal response

DDIC is asked to note: Programme recovery is underway, but pace is constrained by clinical availability rather than digital delivery alone.

4. Virtual Ward – Remote Monitoring (H@H) Integration

Current Position

The Virtual Ward programme is clinically established; however digital integration remains **Red**, particularly around system interoperability and data flow between monitoring platforms and core clinical systems.

Key Issues

- Remote monitoring platforms (e.g. digital remote patient monitoring and virtual ward platform, Doccla) largely operate as stand-alone systems
- Limited integration with Wi-Fi Protected Access (WPAS) restricts scalability and command-level oversight
- Workforce and operational models vary by county footprint

Mitigation / Actions

- Programme aligned to wider Patient Flow, and eObservations (eObs) work
- Digital integration is sequenced within the Phase 2 roadmap rather than treated as a point solution
- Legal and clinical governance for remote monitoring clarified and standardised

DDIC is asked to note: Current risk is **strategic integration maturity**, not service safety.

5. Single Sign-On (SSO)

Current Position

SSO remains **Red** not due to solution availability, but due to scale, licensing cost, and prioritisation pressures across a growing application estate (e.g. Electronic Prescribing and Medicines Administration (ePMA), OpenEyes, national services).

Key Issues

- Imprivata licensing is **per-user**, with unavoidable cost growth
- Multiple programmes competing for SSO dependency
- Need to balance user experience improvements against financial constraints

Mitigation / Actions

- Phased, risk-based prioritisation in place (e.g. ePMA first)
- Alignment with NHS Wales Identity Provider standards
- Ongoing Executive oversight of affordability and sequencing

DDIC is asked to note: SSO is a **cross-cutting enabler** and will remain Red until funding and sequencing are stabilised.

6. Planned Care Transformation Work (Waiting List Management)

Current Position

Digital support to Planned Care remains **Red**, reflecting, data integrity concerns, and dependency on national rulesets and a reprioritisation of digital activity.

Key Issues

- Waiting list processes under review
- Data quality and historical resets limit confidence in digital presentation of waiting lists
- National RTT guidance continues to evolve

Mitigation / Actions

- Digital teams supporting validation, dashboards and reporting
- Alignment with review of Waiting Lists
- Future digital enhancements aligned to NHS Wales App and Patient Service Centre approach

DDIC is asked to note: Digital is **an enabler**, but risk ownership remains with Planned Care governance.

7. CCTV Installation

Current Position

CCTV remains **Red** due to estates, IG and network readiness dependencies, despite strong progress across A&E and community sites.

Key Issues

- Some sites delayed due to asbestos and fire compliance requirements
- Contractor sequencing and quality assurance issues at specific locations

Mitigation / Actions

- Majority of acute sites now installed and live
- Phased completion plan agreed with Estates and Security

DDIC is asked to note: Risk is **delivery sequencing**, not strategic failure.

What Has Been Delivered and Why It Matters

Significant progress has been made across a number of foundational and enabling programmes within the 2025/26 Digital Operational Plan. These delivered and substantially progressed initiatives collectively underpin system resilience, clinical safety, regulatory compliance, and the Health Board's ability to scale future service transformation.

Foundational Infrastructure and Digital Resilience

Key elements of the Health Board's core digital infrastructure have been delivered or are well advanced, including cyber security audits and remediation activity, resilience assurance,

integration platform development, network modernisation, and the early phases of telecoms and switchboard modernisation. These programmes are critical enablers that ensure the availability, security, and continuity of digital services across clinical and corporate environments. Without this foundation, delivery of clinical systems and digitally enabled models of care would not be safe or sustainable.

Clinical and Operational Enablement
Progress has been achieved in a number of clinically significant programmes, including Radiology Informatics, maternity system implementation (BadgerNet), Patient Flow Phase 1, urgent and emergency care digital support, and early eObs capability. These programmes directly support safer care delivery, improved clinical oversight, and better flow through acute and community settings. Importantly, they also lay the groundwork for more advanced functionality, interoperability, and data-driven decision-making in subsequent phases.

Access, Identity, and User Experience Improvements
Delivery across network upgrades, community site connectivity, estate-linked digital infrastructure, and application optimisation has improved access to digital systems for staff and reduced operational friction caused by legacy constraints. While some user-facing enablers such as SSO remain constrained by scale and affordability, progress to date has improved reliability and consistency of access, supporting workforce productivity and experience.

Data, Information, and Performance Insight
The continued development of dashboards, reporting platforms, performance assurance tooling, and the Information Services data platform migration represents a significant step forward in improving the quality, availability, and timeliness of management and clinical information. These capabilities are essential for operational grip, regulatory reporting, and supporting national and local planning priorities, particularly in high-risk areas such as planned care, urgent care, and patient safety.

Why These Programmes Are Important
Collectively, the programmes delivered or advanced to date represent the minimum viable digital foundation required for a modern healthcare organisation. They reduce single points of failure, improve system safety, support compliance with national standards, and increase organisational resilience. Importantly, they also protect future delivery by ensuring that higher-risk transformational programmes are built on stable, assured platforms rather than legacy or unsupported infrastructure.

Digital Operational Plan 2026/27 – Forward Look
The 2026/27 Digital Operational Plan represents a transition year, moving from a period of stabilisation and foundational delivery towards greater clinical integration, optimisation, and digitally enabled service transformation. Building on the infrastructure, platforms, and capabilities established in 2025/26, the focus for 2026/27 will be on consolidating delivery, reducing technical debt, and maximising value from existing and emerging digital investments. The plan has been shaped by a clear understanding of organisational capacity, national dependencies, and financial constraint. As such, it emphasises sequencing, realism, and benefits realisation rather than the introduction of large numbers of new standalone initiatives.

Key Priorities for 2026/27

- **Completion and Stabilisation of Major Programmes -** A number of complex, multi-year programmes will continue into or conclude during 2026/27, including national and regionally dependent systems and large estates-linked deployments. The operational focus will be on safe completion, embedding into business-as-usual operations, and ensuring clinical and operational ownership is fully transitioned. This

includes strengthening post-implementation support, benefits tracking, and assurance processes.

- **Clinical System Optimisation and Integration -** Rather than large-scale system expansion, 2026/27 will prioritise optimising existing clinical systems, improve interoperability, and addressing usability and workflow issues raised by services. This includes progressing integration between clinical platforms, remote monitoring solutions, and core patient administration systems to improve visibility, flow, and clinical decision-making.
- **Data, Performance, and Decision Support -** The 2026/27 plan places increased emphasis on data quality, information maturity, and the use of timely intelligence to support operational grip and planning. This includes further development of dashboards, performance reporting, and advanced analytics capability, aligned to national reporting requirements and local service priorities. Strengthening data governance and assurance will be a critical enabler of this work.
- **Digital Enablement of Service Transformation -** Digital will continue to act as an enabler for wider service transformation programmes, particularly in urgent and emergency care, planned care, community services, and out-of-hospital models. The operational plan will align closely with clinical and operational programmes to ensure digital solutions are sequenced appropriately and do not operate in isolation from service redesign.
- **Cyber Security, Resilience, and Compliance -** Given the growing threat landscape and increasing reliance on digital services, maintaining cyber security, resilience, and regulatory compliance will remain a non-negotiable core priority for 2026/27. This will include ongoing audit response, technology refresh where required, and continued staff awareness and assurance activity.
- **Workforce Capability and Sustainable Operating Model** - The 2026/27 plan will continue to address workforce sustainability through targeted investment in skills, clearer operating models, and prioritisation discipline. This includes ensuring specialist digital, data, and clinical informatics capacity is aligned to organisational priorities and that the digital workforce is structured to support both delivery and long-term optimisation.

Principles Underpinning the 2026/27 Plan

The 2026/27 Digital Operational Plan will be underpinned by the following principles:

- Deliver what has been started well, before committing to new complexity
- Align digital activity to service and clinical priorities, not the other way around
- Be realistic about capacity and affordability, particularly in the context of national dependency
- Focus on outcomes, not outputs, with clear benefits realisation and assurance
- Strengthen resilience and safety as a foundation for transformation

The 2026/27 Digital Operational Plan is intended to be stabilising, value-focused, and enabling. It reflects a deliberate shift from rapid expansion to consolidation and optimisation, ensuring that digital continues to support safe, efficient, and sustainable care delivery. The plan will remain subject to ongoing review and refinement through the year in response to emerging national direction, financial position, and service pressures.

Summary

The 2026/27 Digital Operational Plan provides a structured and prioritised roadmap for delivering the next phase of the Health Board's digital transformation, with a strong emphasis on foundational infrastructure, clinical enablement, and regulatory compliance. The plan reflects a pragmatic approach to delivery in the context of constrained resources, national dependencies, and an increasingly complex digital and clinical environment.

A significant proportion of the plan is progressing as intended; however, a small number of high-impact programmes remain **Red**. In all cases, this reflects a combination of national delivery risk, external dependencies (notably estates, clinical capacity, interoperability, and national timetables), and the scale and complexity of implementation rather than a lack of strategic alignment or clinical safety concerns. These programmes have been deliberately highlighted by exception to provide the Committee with transparency and assurance.

Key programme risks are actively managed through phased delivery approaches, executive escalation, and alignment with national governance and assurance frameworks. Where delays have occurred, mitigation actions are in place and delivery routes have been adjusted to minimise patient, safety, and operational risk. Importantly, several of the Red-rated items represent enabling capabilities that cut across multiple programmes and will remain under close executive oversight until sequencing, funding, or national dependencies are resolved.

Despite these pressures, the Digital Operational Plan continues to provide a clear and credible framework for strengthening digital foundations, supporting service transformation, and enabling safer, more efficient, and more integrated care delivery. The plan remains aligned with Health Board strategic objectives, national digital priorities, and the longer-term ambition to create a resilient, digitally enabled healthcare system that can adapt to future demand and innovation.

Argymhelliad / Recommendation

The Committee are requested to consider:

- **NOTE** the update on progress relating to the Digital Operational Plan.

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-centered system of care that aligns with national digital standards and local healthcare priorities. Each of the trenches, and projects will be subject to further business cases.
Ansawdd / Gofal Claf: Quality / Patient Care:	The digital plan will bring about substantial improvements in the quality of care and patient outcomes. By leveraging advanced digital technologies, we have created a more efficient, safe, and patient-centered healthcare system that aligns with our commitment to delivering high-quality care to our communities.
Gweithlu: Workforce:	The digital plan has significantly transformed our workforce by enhancing productivity, fostering skills development, and improving overall well-being and engagement. These efforts reflect our commitment to

	creating a modernised, efficient, and supportive work environment that aligns with our strategic goals and enhances the quality of care we provide
Risg: **Risk:**	The digital plan carries several risks, proactive risk management and mitigation strategies are in place to address these challenges. By continuously monitoring and managing these risks, the organisation aims to ensure the successful implementation of the digital plan and the achievement of its strategic objectives.
Cyfreithiol: **Legal:**	Not applicable
Enw Da: **Reputational:**	The successful execution of the digital plan can greatly enhance our organisations reputation as a leader in digital innovation within the healthcare sector. By integrating advanced digital tools and platforms, we demonstrate our commitment to improving patient care, operational efficiency, and data security. This proactive approach can attract positive media coverage, bolster public trust, and strengthen relationships with stakeholders, including patients, staff, and partners. The digital plan's emphasis on enhancing service delivery and patient outcomes aligns with our mission to provide high-quality, value-based healthcare, further solidifying our reputation as a forward-thinking and patient-centered organisation.
Gyfrinachedd: **Privacy:**	Not applicable
Cydraddoldeb: **Equality:**	All business cases / projects will be subject to an equality assessment

Appendix 1

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	April 26
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, they are key to ensuring smooth operations and improved clinical workflows.

Project	Proposed Timeline	Project Status		
		Oct 25	Dec 25	April 26
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	April 26
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 – Elizbeth 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	

4.2

11:05 AM, 15 Mins

4.2 - Digital Strategic Plan (PO9)

Anthony Tracey (Hywel Dda UHB - Digital Director)

For information

Attachments

4.2 - DDIC - Strategic Plan April 2026.pdf

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

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	21 April 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)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

This paper provides the Digital, Data and Innovation Committee (DDIC) with an update on the direction of travel of the Health Board's Digital Strategic Plan, reflecting learning and progress from work undertaken during 2025, and outlines the proposed approach to external partnership with CGI to support the next phase of delivery.

The Digital Strategic Plan previously presented to the committee sets out a clear and ambitious roadmap for digital transformation across Hywel Dda, moving from strategy design into staged, executable delivery. This update confirms how the work undertaken during 2025 has shaped that plan, strengthened its realism, and informed a deliberate shift toward a capabilities-led, phased transformation approach.

The paper also explains why, as the organisation transitions from planning and early implementation into more complex system-wide delivery, there is a need for time-limited specialist delivery and architectural support, and how a proposed engagement with CGI would complement internal capacity rather than replace it.

Cefndir / Background

The original **Digital Response (2020)** provided the first cohesive strategic view of digital investment for the Health Board. However, its early implementation coincided with the COVID-19 pandemic, requiring rapid reprioritisation toward business continuity, Microsoft 365 enablement, and urgent operational response.

Over the subsequent four years, and particularly during **2025**, the Health Board has:

- Delivered significant elements of foundational digital capability
- Gained a far clearer understanding of the constraints within the current digital estate
- Identified the organisational, data and architectural prerequisites for safe transformation

During 2025, work focused on:

- Consolidating learning from patient flow, eObservations (eObs), and core clinical systems

- Testing assumptions around workforce readiness and digital maturity
- Assessing the impact of fragmented data, legacy platforms, and interoperability gaps
- Strengthening alignment between digital ambition and service redesign

This learning has directly informed the redrafting of the Digital Strategic Plan, which will now place greater emphasis on:

- Foundations before acceleration
- Capabilities rather than technology alone
- Sequential, phased delivery aligned to organisational readiness

Asesiad / Assessment

Direction of Travel of the Digital Strategy

The Health Board's digital strategy is entering a new phase, moving decisively from ambition and planning into structured, outcome-focused delivery. Building on the progress achieved since the original Digital Response in 2020 and informed by the learning and assurance gained through work undertaken during 2025, the direction of travel now reflects a more mature, realistic and capability-led approach. The digital strategy is explicitly aligned to the Health Board's Health & Care Strategy, *A Healthier Mid and West Wales: Our Future Generations Living Well*, and is a key enabler of delivery against the Integrated Medium-Term Plan (IMTP) planning objective for digital.

The emphasis is no longer on digital as a collection of individual systems or technical programmes, rather as a core enabler of service transformation, workforce productivity and system sustainability. This approach recognises that successful digital transformation depends on strong foundations, sequenced investment, organisational readiness and the embedding of digital into everyday clinical and operational practice, ensuring the Health Board is well positioned to safely adopt more advanced digital, data and Artificial Intelligence (AI)-enabled capabilities over time in support of IMTP delivery and long-term population health outcomes.

The strategic direction is now clear and consistent:

- Digital is positioned as a core enabler of service transformation, not an isolated technical function
- The focus has shifted from digitising existing models to redesigning how care is delivered
- Investment priorities are aligned to building enduring organisational capabilities
- Advanced technologies (AI, real-time analytics, integrated records) are explicitly dependent on foundational readiness

The strategy continues to be anchored around **four strategic pillars**, which remain valid but are now underpinned by a more realistic delivery model:

1. Citizen engagement and a single digital front door
2. Coordinated health and care delivery across settings
3. Digital operations, flow and system control
4. A regional data fabric enabling insight, intelligence and population health

This direction reflects both national expectations and local operational reality.

Learning and Progress from Work Undertaken During 2025

The work undertaken during 2025 represented a critical period of learning, consolidation and assurance for the Health Board's digital agenda. During this time, the organisation moved beyond strategy formulation and early implementation into a more informed understanding of what is required to deliver sustainable digital transformation at scale. Progress made across

foundational clinical systems, data, and digital operations provided tangible benefits, but equally exposed the practical constraints associated with legacy platforms, fragmented data flows, workforce readiness and adoption. This experience has been instrumental in shaping a more grounded and deliverable digital strategy, ensuring that future ambition is matched with organisational capability, realistic sequencing and a clearer focus on foundations, standardisation and benefits realisation. The learning from 2025 now underpins the revised direction of travel, the phased roadmap, and the approach to delivery set out in the Digital Strategic Plan.

Work during 2025 has provided critical insight in three key areas:

a. Foundational Clinical Systems

- Progress toward a more integrated digital health record has demonstrated tangible benefits in safety, flow and clinical decision-making
- Patient flow and eObs implementations have shown that digital capability must be matched by pathway standardisation and operational ownership
- Preparation for electronic prescribing (2026) has reinforced the need for sequencing and readiness

b. Data, Architecture and Interoperability

- Fragmented data flows and legacy platforms are now the primary constraint on transformation
- Consistent information standards, integration and architecture are prerequisites for AI, automation and real-time insight
- Without these foundations, further innovation introduces risk rather than value

c. Organisational Readiness

- Digital success depends on workforce capability, clinical leadership, and adoption
- Technology deployment without corresponding change management limits benefit realisation
- Digital transformation is increasingly recognised as an organisation-wide change programme

These lessons are explicitly reflected in the phased roadmap set out in the Digital Strategic Plan.

Alongside areas of progress, the work undertaken during 2025 also highlighted where it was necessary to pause, reset or defer elements of the digital agenda in order to protect value, reduce risk and ensure readiness. In particular, activity that assumed higher levels of data maturity, interoperability or workforce adoption than currently exist was deliberately slowed or re-sequenced. This included deferring the large-scale deployment of advanced analytics, automation and AI-enabled use cases until stronger data foundations, governance and architectural standards are in place. Similarly, some digital solutions that risked reinforcing existing service models or introducing additional complexity without clear benefits were stopped or reset, with emphasis redirected toward standardisation, pathway consistency and core system optimisation. These decisions reflect increased organisational maturity, recognising that sustainable digital transformation depends not on doing more, but on doing the right things in the right order. This disciplined approach has directly informed the phased roadmap within the Digital Strategic Plan and ensures future investment is aligned to readiness, benefit realisation and long-term deliverability.

Proposed Role of CGI

As the Digital Strategic Plan moves from strategic articulation into sustained delivery at scale, there is a clear requirement to strengthen the Health Board's capacity to design, sequence and deliver complex, interdependent digital change while maintaining operational stability. Future

working with CGI is therefore proposed as a targeted partnership to support the Health Board's digital approach, providing specialist expertise in enterprise architecture, data integration, and large-scale transformation delivery. This support is intended to complement strong internal leadership and clinical ownership, accelerate delivery of agreed priorities, and reduce delivery risk as the organisation progresses through successive tranches of the digital roadmap. The partnership model is aligned to the strategic pillars of the digital strategy and is focused on building sustainable capability within the organisation, ensuring that digital investment translates into tangible improvements in patient care, workforce experience and system efficiency.

As the programme moves into sustained, multi-year delivery, the Health Board faces constraints in:

- Specialist digital architecture and integration capacity
- Managing interdependencies across complex programmes
- Scaling delivery pace while maintaining operational stability

The proposed engagement with CGI is intended to:

- Provide enterprise architecture and capability design support, aligned to the strategic pillars
- Strengthen delivery assurance and roadmap sequencing, reducing programme risk
- Support data integration and interoperability design to enable the regional data fabric
- Augment internal teams during periods of peak delivery demand

The proposed partnership model is deliberately:

- Outcomes-focused
- Designed to build internal capability but also provide support with managed partnerships
- Accountable through Health Board governance and programme controls

Conclusion

The work undertaken during 2025, together with the development of the Digital Strategic Plan throughout 2026, marks a clear point of transition in the Health Board's digital journey. The organisation has moved from articulating digital ambition to establishing a realistic, phased and capability-led approach to delivery that is explicitly aligned to the Health & Care Strategy and the Integrated Medium-Term Plan. Learning from recent implementation has strengthened the focus on foundations, sequencing and organisational readiness, ensuring that future investment is directed toward sustainable change rather than isolated technological solutions.

The revised direction of travel recognises that digital transformation is inseparable from service redesign, workforce development and data maturity, and that success depends on doing the right things in the right order. The phased roadmap provides clarity on priorities, dependencies and timing, while maintaining flexibility to respond to emerging system pressures and opportunities. Importantly, the strategy reflects increased organisational maturity, demonstrated through informed decisions to pause, reset or defer activity where readiness or value could not yet be assured.

As the Health Board moves into the next phase of delivery, the proposed approach to working with CGI represents a pragmatic and proportionate response to the scale and complexity of the transformation agenda. Targeted external support is intended to complement strong internal leadership, reduce delivery risk and accelerate progress against agreed priorities, while building sustainable capability within the organisation. Collectively, this approach positions the Health Board to deliver meaningful digital transformation that supports safe, high-quality care, improves workforce experience, and enhances system sustainability for the population of Mid and West Wales.

Argymhelliad / Recommendation

The Committee is requested to:

- **RECEIVE ASSURANCE** from the direction of travel of the Digital Strategic Plan and the shift to a phased, capabilities-led delivery model
- **NOTE** the learning from work undertaken during 2025 and how this has informed strategic priorities and sequencing
- **ACKNOWLEDGE** that delivery will continue to be underpinned by strong benefits realisation, cyber security, information governance and clinical leadership

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:	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 trenches, and projects will be subject to further business cases.
Ansawdd / Gofal Claf: Quality / Patient Care:	The digital plan will bring about substantial improvements in the quality of care and patient outcomes. By leveraging advanced digital technologies, we have created a more efficient, safe, and patient-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

4.3

11:20 AM, 15 Mins

4.3 - Closure of Planning Objective (PO) and Confirmation of new Planning Goals

Anthony Tracey (Hywel Dda UHB - Digital Director)

For assurance

Attachments

4.3 Planning Objective Highlight Reports - Digital (Qtr 4).pdf

DIOGEL | CYNALIADWY | HYGYRCH | CAREDIG
SAFE | SUSTAINABLE | ACCESSIBLE | KIND

Submitted By: Anthony Tracey

Date Submitted: March 2026

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

Planning Objective: Planning Objective PO9

Executive Lead: Huw Thomas, Executive Director of Finance

Reporting Period: Quarter 4

Overall status: On-track

Rationale for overall status

Whilst the Health Board 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 see table below

Activities completed in previous reporting period

- Readiness for Electronic Prescribing and Medicines Administration (ePMA)
- Rollout of Digital maternity and Open Eyes
- Phase 1 rollout of Patient flow and eObservations
- Radiology (RISP) rollout
- First draft of proposal for Patient Services Centre
- Continue with the implementation of patient flow/eObservations

Activities planned for next milestone and reporting period

- Further adoption of Laboratory information management system (LIMS)

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 *Low*. 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 *High* 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 *low to medium* 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 *low to medium* 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 *medium* 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 *medium* based on the timescales of implementation by **31 March 2026**. Progress at Swansea Bay UHB provides a workable blueprint, but Hywel Dda'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 *medium* based delivery is exposed to near-term risks around rota standardisation and training, infrastructure resilience (power / rooms / 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 *medium* 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 *Low* as all sites have been migrated onto the new telephony system. Work is continuing on rolling out the softphone approach	

Digital – Annual Reflection Against the 2025/26 Operational Plan and Digital Objective 2025

Overview

2025/26 represented a year of consolidation, maturity, and disciplined delivery for Digital. The Digital Operational Plan deliberately shifted focus from rapid expansion to stabilisation, optimisation, and value realisation, in recognition of financial constraints, increasing regulatory scrutiny, and sustained operational pressure across the organisation. Against this context, Digital has delivered the core intent of Digital Objective 2025: ensuring that digital is a safe, reliable, and resilient enabler of care, rather than a source of operational or clinical risk.

Delivery Against the Digital Operational Plan

1. Strengthening Digital Foundations

The year prioritised investment in foundational digital capability:

- Improved stability and resilience of core infrastructure.
- Progression of critical upgrades using phased, risk-managed approaches.
- Closer alignment between digital operations, cybersecurity, and information governance.

These activities, while less visible, materially reduced risk and created a safer platform for clinical and corporate systems.

Delivery Against the Digital Operational Plan

2. Clinical Digital Enablement

Key clinical programmes progressed broadly as planned, recognising national dependencies and workforce constraints:

- Clinical systems were sequenced to protect patient safety and service continuity.
- Delivery routes were adapted where required, maintaining momentum while mitigating risk.
- Stronger links were established between technology delivery, clinical capacity, and informatics leadership.

This reinforced the importance of organisational readiness alongside [illegible]plementation.

Delivery Against the Digital Operational Plan

3. Governance and Assurance

Digital governance matured significantly during the year:

- Clearer articulation of digital and cyber risk within corporate risk structures.
- More transparent reporting to Committees by exception, focusing on dependencies and mitigations.
- Improved alignment with national assurance frameworks and regulatory expectations.

This represents a shift from activity-based reporting to **risk- and outcome-focused assurance**.

Digital – Annual Reflection Against the 2025/26 Operational Plan and Digital Objective 2025

Progress Against Digital Objective 2025

Value and Sustainability

- Increased focus on benefits realisation and operational impact.
- Digital positioned as an enabler of wider organisational transformation rather than a parallel programme.

Workforce and Capability

- Clearer understanding of future capability needs across digital, data, and clinical informatics.
- Improved integration across digital operations, data, information governance, and transformation.
- Foundations laid for a more sustainable, clinically-informed digital operating model.

Progress Against Digital Objective 2025

Managing Risk and Constraint

A small number of high-impact programmes experienced delay at points during the year. These reflected:

- External and national dependencies.
- Estates and workforce capacity constraints.
- The scale and complexity of implementation.

Importantly, risks were **actively managed, transparently reported, and mitigated**, with patient safety and service continuity consistently prioritised over pace of delivery.

Overall Assessment

2025/26 can be characterised as a **credible and necessary consolidation year**. The organisation ends the year with:

- More resilient and reliable digital foundations.
- Stronger governance and assurance.
- Greater clarity on how digital, data, and clinical informatics enable safe, efficient care.

While challenges remain, particularly around capacity and affordability, the Health Board is **better positioned to move into the next phase of digital and clinical transformation with confidence, discipline, and**

4.4

11:35 AM, 10 Mins

4.4 - Digital Partner Update

Huw Thomas (Hywel Dda UHB - Director of Finance), Anthony Tracey (Hywel Dda UHB - Digital Director)

Attachments

4.4 - DDIC - Digital Partner Update - April 2026.pdf

Appendix 1 - Partnership Charter CGI Hywel Dda v2.0.pdf

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

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

DYDDIAD Y CYFARFOD: DATE OF MEETING:	21 April 2026
TEITL YR ADRODDIAD: TITLE OF REPORT:	Digital Partner Update
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: REPORTING OFFICER:	Anthony Tracey, 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 Committee an update on the digital partner to support its digital transformation initiatives. This report outlines the spending and impact of the digital partner in line with Board-approved programmes.

Cefndir / Background

Working with our new strategic partner (CGI) 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 Health Board will set out the 10-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 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 Hywel Dda 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 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.

Expenditure

The costs associated with these work packages are necessary for achieving the desired outcomes. The investment in CGI's services is expected to bring significant value to HDdUHB by enhancing digital capabilities, improving patient care pathways, and ensuring the successful deployment of foundational systems. The financial commitment reflects the Health Board's dedication to modernising healthcare delivery and leveraging technology to improve operational efficiency and patient care.

The costs associated with the CGI work packages are detailed in Appendix 1. Overall expenditure with CGI totals £1,542,649, of which £462,073 was supported through external funding, reducing the direct financial impact on the Health Board.

Argymhelliad / Recommendation

The Committee is requested to **take assurance** on the content of the Digital Partner Update report and the Digital Charter approach.

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.
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	Digital Development and Innovation Committee (DDIC) Executive Team

Parties / Committees consulted prior to Digital, Data and Innovation Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Value cases will be assessed for each individual business cases prior to utilising the supplier. A wider strategic benefit will be that the healthcare systems will be more efficient, processes are faster, and wasteful processes can be decreased or eliminated supporting longer-term sustainability for the health board.
Ansawdd / Gofal Claf: Quality / Patient Care:	The implementation of the transformation and digital enablement plan, will provide the following positive impact on quality and patient care: • Patient safety increased - Increased timeliness and availability of relevant clinical information decreased transcription errors and decreases risk to patients' safety • Positive patient outcomes increased - Easy access increases speed and of diagnosis, care, treatment plan and onward referral • Patient confidence increased - The availability and targeting of accurate and relevant information at the point of contact • Reducing delay, improving waiting times and access to treatment
Gweithlu: Workforce:	Having a modern digital system, will attract and retain the workforce within the Health Board. A key component of this work is the assessment of operational readiness for organisational and digital change, the digital roadmap required and recommended service redesign principles for a whole system approach, which will enable the change the workforce urgently need. As part of the transformation plan there will be a change management, service redesign and digital enablement programme designed to co-produce and design services for people through a professional integrated and upskilled workforce across health and care.
Risg: Risk:	Without the necessary investment in transformation and digital there is a risk that the current complex system will become even slower stifling innovation that the Health Board has progressed and urgently needs.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	The ambitious transformation and digital enablement plan will progress the Health Board forward to becoming a fully integrated digital organisation, and propelling Hywel Dda to become the first system-wide digital exemplar within NHS Wales.
Gyfrinachedd: Privacy:	At the centre of the transformation and digital enablement plan is inclusivity, and the requirement to ensure that staff,

	patients, and the people of our region are included in the development of any service with strong information governance and cyber security.
Cydraddoldeb: Equality:	Not applicable

Appendix 1

Work Package Number	Title	Cost	Detail
WP29	Rhapsody Support	£22,550	A 7-month extension to CGI's existing integration support, adding second-line application support for Rhapsody (incident investigation and resolution), as an interim measure until a longer-term strategic solution is implemented.
WP9	Shadow Information Technology (IT) Discovery and Assessment	£87,120	The high-level scope of the discovery exercise will include: • Eliminating redundant tools – Reduce costs associated with duplicate software and unnecessary licensing. • Improving interoperability – Standardised digital environments prevent siloed systems and fragmented workflows. • Reducing Shadow IT support burden – IT team spends less time troubleshooting (or picking up) unauthorised apps and can focus on strategic initiatives. • Reducing potential for data breaches – Unauthorized applications often lack enterprise-grade security controls, making them prime targets for cyber threats. • Encouraging innovation through appropriate processes – the business is encouraged to propose new tools through official processes, ensuring better security and scalability.
WP38	Artificial Intelligence (AI) Readiness Assessment	£99,602	conduct an 8-week AI readiness assessment, which will provide a comprehensive, structured approach to evaluating the Authority's AI readiness and make recommendations for the establishment of a robust AI governance framework to guide responsible, ethical, and scalable AI implementation.
WP36	Welsh Community Care Information System (WCCIS) Procurement Support *(external funded)*	£250,000	The procured system will need to transform all community, therapy and mental health service delivery by staff having a single view of the patient record (including data from third parties such as Social Care) and automated workflow.
WP1.6	Strategic Advice and Guidance 2026	£148,625	This work package will be based upon a call off order as part of daily live service operation, providing access to key resources and the generation of key programme artefacts and business readiness activities. Involving roles including but not limited to: • Senior Solution Architect

Work Package Number	Title	Cost	Detail
			• Senior Business Analyst • Managing Architect / workstream lead • Enterprise Architect • Project / Service delivery manager • Project Management Office support
WP1.7	Patient Service Centre Procurement	£282,690	Procurement support to select a PSC supplier/solution (including requirements capture, ITT/RFP pack, running the competition, evaluation/moderation, and preparing the procurement outcome recommendation).
WP28.2	Azure Support	£57,812	This work package will include the cost of 12-months of support and associated licensing for the Contractor's MS Azure environment and MS Sentinel tooling.
WP28.1	Cyber Security Operations Centre (SOC) Monitoring	£53,570	This Work package is for the provision of the appropriate Cyber Security monitoring and security assurance activities to be setup and maintained for the first year of operational service.
WP31	ITSM Capability Assessment	£11,518	IT Service Management (ITSM) capability assessment • Establish a baseline of ITSM process maturity across core practices. • Identify priority improvement areas that deliver value and risk reduction. • Define the risks and dependencies associated with current maturity levels. • Produce a practical roadmap for maturing service management capability. • Capture Authority and stakeholder perceptions to ensure improvement is user centred. • Determine where the Contractor can add value in operational, design, and consultancy capacities to strengthen overall service management maturity.
WP23	AI Transformation Value Assessment - Radiology	£131,190	Value Assessment (Phase 1) activities required to enable the co-design and implementation of a set of priority AI use cases across target Authority Departments. These activities will deliver: • A volumetrics assessment and set of value propositions aligned to each of the five priority AI use cases identified in the Radiology (two) and Urgent & Emergency Care (three) workshops • An additional set of outputs for Radiology, selected for a deeper dive to illustrate the next step in a structured engagement model that will establish a replicable pattern for other departments, supporting a scalable and interoperable deployment to follow. These additional outputs will include:

Work Package Number	Title	Cost	Detail
			○ High-level to-be process maps for the two priority AI use cases in Radiology ○ Technology recommendations and associated ROM costs aligned to this priority use cases ○ Return on Investment (ROI) position for each of the above technology recommendations to support development of a strategic outline business case
WP28	Service Desk & ITSM initiation	£162,239	Technical application support for the Mirth integration platform and integration messaging services at second and third levels, to ensure the continued running of the Integration Layer solution, and timely resolution of incidents. Used for Patient Flow, eObservations and Electronic Prescribing and Medicines Administration (ePMA)
WP27	Azure Infrastructure Assessment and Solution	£15,320	provide a resource for operational Azure support & will also provide a resource for Azure architectural support on an ad-hoc basis to work alongside the operational team from a design review perspective.
WP25 CCN	Staff Augmentation *(external funded)*	£3,850	Project Manager (PM) support for the Open Eyes implementation
WP25	Staff Augmentation *(external funded)*	£59,400	PM support for the Open Eyes implementation
WP25 CCN	Addition of Business Change Support for ePMA *(external funded)*	£69,480	Additional PM Support to accelerate programme delivery
WP2 CCN	Addition of CGI delivery resources *(external funded)*	£79,343	Additional PM and technical Support to accelerate programme delivery
WP40	Safehand Safety Training	£8,160	This has included the training and development of a number of clinical and project staff in clinical safety, strengthening organisational capability to identify, assess and manage clinical risk associated with digital systems and change. This has supported safer system design, implementation and assurance, and reinforced clinical safety as a shared responsibility across digital, clinical and programme teams.
Total		£1,542,469	

Partnership Charter

CGI & Hywel Dda University Local Health Board

2025-04-24

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1 Partnership Charter

Between:

CGI IT UK LTD (hereinafter referred to as "CGI")

A company incorporated in England & Wales under number 947968, whose registered office is at 14th Floor, 20 Fenchurch Street, London EC3M 3BY, United Kingdom

And:

Hywel Dda University Local Health Board of Ystwyth, Hafan Derwen, St David's Park, Carmarthen SA31 3BB (hereinafter referred to as "Hywel Dda")

1.1 Vision

A 10-year partnership to transform healthcare services across Mid and West Wales, through jointly achieving the goal of Hywel Dda becoming a fully digitally enabled health board, empowering excellence in care for patients and communities across the region.

1.2 Purpose of the Partnership

The purpose of this partnership is to establish CGI as the Digital Partner for Hywel Dda, strengthening the existing relationship to deliver innovative, sustainable, safe and impactful solutions that align with Hywel Dda's vision for the future.

This partnership aims to:

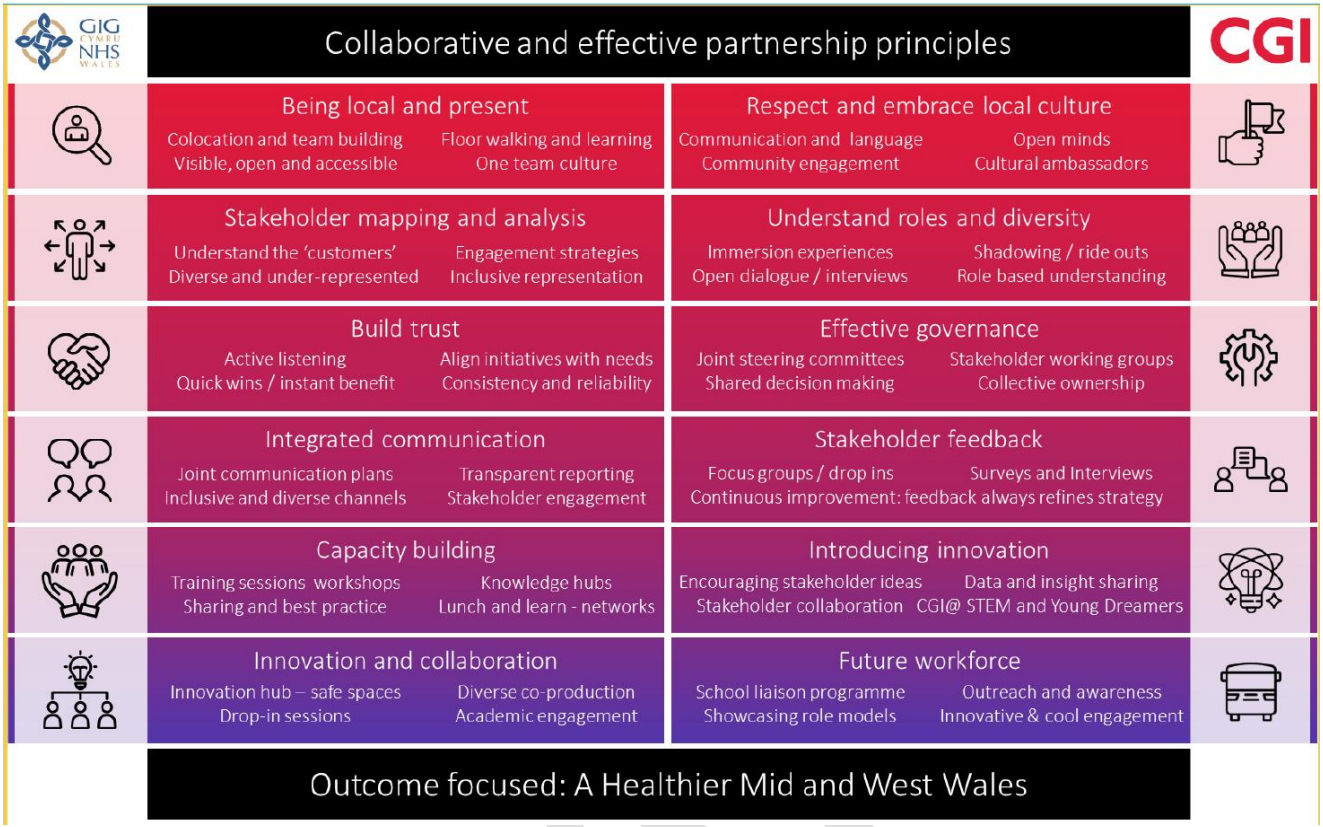
1. Enhance Hywel Dda's digital capabilities to support efficient, patient-centred healthcare services.
2. Work with partner vendors to foster innovation and leverage digital technologies to achieve the strategic goals of the Health Board.
3. Promote a collaborative, outcomes-driven approach to improving health services across the region.

1.3 Guiding Principles

CGI agrees that it will, through its partnership model with Hywel Dda, always act as a Trusted Advisor and work collaboratively towards the Health Board's strategic goals, doing so through applying the following guiding principles:

1. Collaboration: Foster a culture of mutual respect, open communication, and teamwork.
2. Innovation: Commit to exploring and implementing innovative digital solutions.
3. Transparency: Ensure open and honest communication regarding goals, progress, and challenges.
4. Accountability: Remain accountable for agreed responsibilities and deliverables.
5. Patient-Centricity: All initiatives will prioritize the well-being and experience of patients.
6. Simplicity: Creating solutions that make it easier for staff and patients to achieve their goals.

The following diagram highlights the collaborative partnership principles that will support a successful long term strategic partnership for both organisations:



1.4 Scope of Collaboration

CGI and Hywel Dda will work together throughout this partnership to achieve the Health Board's strategic objectives, addressing all areas of digital collaboration, including:

1. Digital Transformation Initiatives: Design, develop, and implement technology solutions that improve healthcare delivery.
2. Data Integration: Analytics and Insights: Use data-driven approaches to optimize operational efficiency and patient care, sharing information to create a single view of the patient/citizen.
3. Training and Capacity Building: Enhance digital skills among Hywel Dda staff and citizens to ensure long-term sustainability.
4. Innovation Projects: Co-create and deliver projects to explore new digital healthcare solutions.
5. Cybersecurity: Ensure the integrity and security of all digital systems and patient data.
6. Outcomes and benefits realisation: Agree and track the benefits that should accrue from implemented solutions.
7. Social Value: Promoting a healthier mid & West Wales by putting people at the heart of our partnership activities, contributing to the local economy.

1.5 Key Roles and Responsibilities

The Parties have entered into a Framework Agreement signed on the 23rd December 2024, for the execution of a Strategic Digital Partnership Framework based on Initial Services and Future Services. CGI will work with Hywel Dda in the provision of such services, based on a division of responsibilities as outlined below.

Service Delivery Option	Description
Retained	Digital operations that are owned and performed by Hywel Dda only, predominantly inflight and tactical projects by nature.
Blended (Hywel Dda led)	Digital operations are owned by Hywel Dda, with Hywel Dda being responsible for leading the delivery of services. Hywel Dda will request any CGI input and/or resources needed to support the change and delivery of the service.
Blended (CGI Led)	Digital operations are owned by Hywel Dda, with CGI having delegated responsibility to deliver services. The Supplier will involve Hywel Dda resources or have Hywel Dda resources assigned to them to deliver the service.
Fully externally delivered by CGI	Digital operations are owned by Hywel Dda, with delegated responsibility to CGI to fully deliver the day-to-day operations, maintenance, performance and decommissioning of the service with no Hywel Dda members supporting the day-to-day delivery of these services. Hywel Dda remain involved in the governance and decision-making of these services.

Expected key roles and responsibilities to be undertaken across the service delivery options are highlighted below:

CGI IT UK LTD:

1. Provide technical expertise, architectural overview, and programme and project management for digital initiatives.
2. Ownership of the digital roadmap, delivering cutting-edge digital tools and platforms tailored to Hywel Dda's operational and strategic needs, ensuring compliance with healthcare regulations and standards.
3. Ongoing transformation governance for the regional digital delivery model and engagement with ecosystem of partners and service providers.
4. Conduct training sessions and workshops for Hywel Dda staff to support ongoing service capability.
5. Monitor and evaluate the effectiveness of implemented solutions, considering all benefits realization.

Hywel Dda University Health Board:

1. Define clear objectives and priorities for digital transformation, ensuring alignment with the strategic goals of the Health Board.
2. Facilitate access to relevant data, infrastructure, and stakeholders, including stakeholders that are external to the Health Board.
3. Provide feedback and insights to guide the development of solutions.
4. Ensure organisational readiness and staff engagement in digital projects.
5. Support joint decision-making processes.

1.6 Governance Structure

CGI and Hywel Dda will create the appropriate governance model and structure to support Digital Partnership. Programme Delivery will be managed through rigorous monitoring, regular reviews, risk assessments and transparent reporting mechanisms.

Effective governance will be controlled through the CGI Client Partnership Management Framework (CPMF), providing management structures, performance metrics, and review points to ensure alignment and transparency among stakeholders, to ensure, collaboratively, that potential issues are identified and timely mitigation measures implemented.

The governance approach will follow the below steering group approach:

1. **Monthly exec steering group**
   Purpose: Strategic alignment and leadership oversight.
   Agenda: High-level review of the programme's progress, risks, and financials. Make decisions on scope changes or additional investments. Approve major deliverables or milestone sign-offs.
   Agree Communicate to broader stakeholders (e.g., town halls). Share programme progress, success stories, and next steps.
2. **Weekly Project Updates**
   Purpose: Programme-level updates and cross-team alignment.
   Agenda: Status updates using RAG reporting (People, Process, Technology). Address cross-functional dependencies and risks. Highlight delivery milestones and upcoming priorities.
3. **Escalation Protocol**
   Purpose: A clear process for addressing and resolving disputes or issues.

For each package of work to be undertaken by CGI, CGI will support the creation of the appropriate business case, and will assist in presenting this to the Hywel Dda executive committee. CGI will create and own a number of key artefacts to support the governance of this programme for the partnership. These include:

Programme Definition Document

Contains vision and objectives, governance principles, current state, outcomes and benefits, stakeholders, tranches, risks, roles and responsibilities, and projects.

Programme Plan

Controls and tracks progress and delivery, shows sequencing, timelines, resourcing, dependencies and outputs for tranches and projects.

Blueprint

Describes the desired transformation and business change, the current, incremental and future states, the technology, processes, organisation and data operating model.

Benefits Realisation Plan

Describes the desired benefits, the sequential relationship between them, the approach to realizing benefits, the plan for tracking benefits and benefit reports.

To foster a successful working relationship at every level, the Parties will endeavour to implement the following:

- CGI will appoint an Account and Programme Delivery Manager aligned to gain deeper understanding of the business and ensure alignment of Services to business strategy and needs.
- Co-locate personnel wherever practicable to maximise communication, collaboration and deep business understanding at all levels.
- Agree communication channels and access to relevant Hywel Dda forecasting and planning data to ensure access to the right information to develop the Services.
- An approach to business development, designed to avoid wastage of both Hywel Dda and CGI resources in nugatory quotation work allowing rapid understanding of likely impact of cost and timescales.
- CGI to undertake one or more Satisfaction Surveys per quarter to inform and influence Continuous Service Improvement.

1.7 Expected Behaviours

The principal foundation of this digital strategic partnership is based on the common core values and the Parties agree to act in accordance with these values when performing their obligations under the Agreement:

CGI core values are: Partnership and Quality, Objectivity and Integrity, Intrapreneurship and Sharing, Corporate Social Responsibility and Respect.

Hywel Dda personal values are: Dignity, respect and fairness; Integrity, honesty and openness; Caring, kindness and compassion.

In addition to the above personal organisation values, as a Digital Partnership we will strive to abide by the following core principles:

- Putting people at the heart of everything we do.
- Working together to be the best we can be.
- Striving to deliver and develop excellent services.

To foster a successful long term Digital Partnership, the following behaviours are expected from both Parties during the Term of the Agreement, working with each other cooperatively in partnership to discharge their responsibilities in relation to the Services and to apply their respective specialist knowledge, skill and expertise, in accordance with the terms of the Agreement:

A. Make a sincere effort to understand the other Party's obligations, goals, expectations, duties and objectives;

B. Be open, honest, transparent and professional in all dealings relating to the Agreement and to give a true account of such dealings;

C. Work within a spirit of cooperation to enable the delivery of the Services to a high standard;

D. Resolve differences that may arise in relation to the Agreement by discussion and negotiation wherever possible;

E. Communicate clearly and effectively, and in a timely manner, on all matters relating to the Framework Agreement and associated Call Off Contracts;

F. Make the most efficient use of resources, and seek to achieve tangible savings to the benefit of both partners;

G. Commit to providing continuous improvement ideas;

H. Give an early warning to the other Party of any matter that they become aware of that could affect the achievement of any shared objective.

1.8 Successful partnership measures

This Partnership charter is to be referred to at key governance meeting checkpoints to ensure both parties are living up to the approach and values as identified and agreed within this document. As a way of formally measuring the success of this partnership the following measures will be undertaken as part of the periodic reviews:

		Description	Target	Measured by
Relationship	01	Both parties abide by the core Principles and Behaviours defined in the Partnership Charter and seeks to address issues.	Score 9/10	Assessment undertaken and agreed by both parties at the appropriate Supplier Review Meeting
	02	The VoC will be administered annually by CGI and the CSAP conducted on a quarterly basis	95%	VoC and CSAP's conducted as agreed by both parties.
	03	CGI will deliver the actions arising from the CSAP process	95%	Actions delivered within a timeframe agreed by both parties.
Perform	04	Response to requests for Service and Support. All responses are returned within the timescales agreed by both parties	90%	Response time to Request for Service and support
	05	All Business cases to be supplied to Hywel Dda within the timescales agreed by both parties.	90%	Confirmation of receipt and time of receipt by Hywel Dda
Financial	06	All invoices are submitted and paid within the timescales agreed by both parties, are accurate and are completed in accordance with agreed instructions	90%	Confirmation of receipt and time of receipt by Hywel Dda, and of payment by CGI.
	07	Value for Money and Benefits generated by CGI as Digital Partner	N/A	Additional benefits and value contributed by the Digital Partner outside of charters

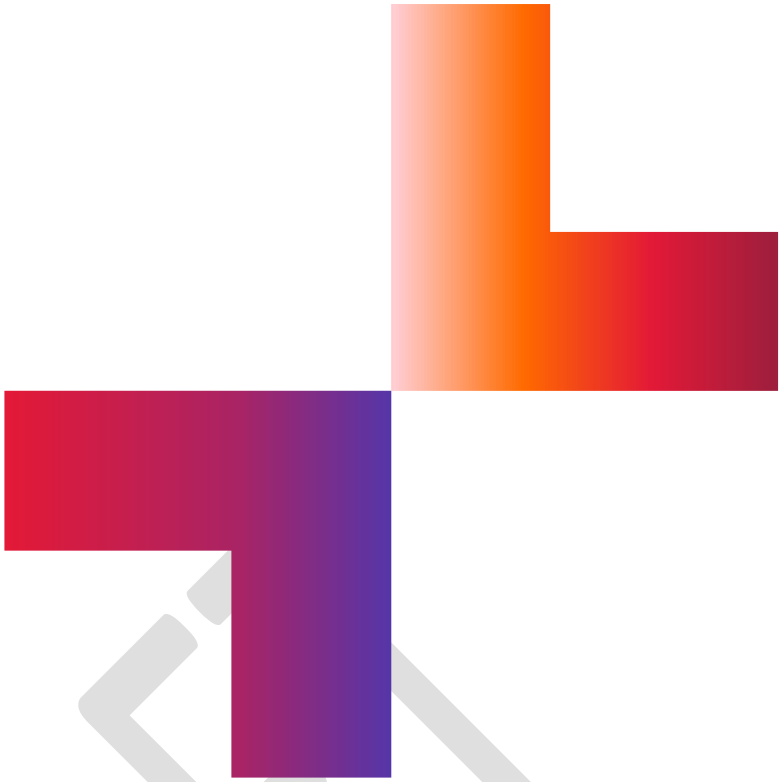
1.9 Duration and Review

Initial Term: This partnership will commence in December 2024 and remain effective during the Term of the Framework Agreement signed on the 23 December 2024 for 10 years (7+3).
Renewal and Review: Regular governance reviews will be conducted aligned to the Programme drumbeat to assess delivery progress, benefits realised through work conducted and redefine goals and approach where necessary.

1.10 Signatories

For CGI IT UK LTD:
Name: _____
Title: _____
Date: _____
Signature: _____

For Hywel Dda University Local Health Board:
Name: _____
Title: _____
Date: _____
Signature: _____



5

11:45 AM, 5 Mins

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5 - For Information

5.1

11:50 AM, 0 Mins

5.1 - DDIC Workplan 2025/26

Chantal Patel (Hywel Dda UHB - Independent Board Member)

For information

Attachments

DDIC Work plan 2026 27.pdf

DIGITAL, DATA AND INNOVATION COMMITTEE WORK PLAN APRIL 2026 – MARCH 2027

Currently, Digital, Data and Innovation Committee (DDIC) meets quarterly. Based on this, the following table represents a proposal to incorporate the duties as outlined in the Committee's Terms of Reference into a basic work plan April 2026 – March 2027.

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	21 Apr 2026	21 Jul 2026	20 Oct 2026	21 Jan 2027
Governance						
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	✓			
Self-Assessment of Committee Effectiveness: 6 month Report	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	✓	✓	✓	✓
Digital						
Planning Objective (PO) Update Report (3.1.18): • Closure report • General update report	HT	DW	✓	✓	✓	✓
Digital Annual Plan	HT	AT				
Digital Strategic Plan (2.1.1 & 3.1.1) (PO9)	HT	AT	✓	✓	✓	✓
Digital Operation Plan	HT	AT	✓			✓
Digital Partner Update	HT	AT	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	21 Apr 2026	21 Jul 2026	20 Oct 2026	21 Jan 2027
Summary of Progress Against Board Approved Business Cases	HT	AT				
Digital Inclusion	HT	AT		✓		
Current use of AI	HT	AT				
In Year Delivery of Programmes	HT	AT			✓	
Digital Innovation & Transformation Benefits Realisation Report 2025/26	HT	AT			✓	
RISP – Radiology Informatics System Programme	HT	AT		✓		
Patient Services Centre Business Case	HT	AT		✓		
Proposal of Ambient AI within the Health Board • Proposal on the use of AI Scribes	HT	DW		✓		✓
In-Committee Cyber Security Updates incl CAF compliance (3.1.8 & 10)	HT	AT	✓	✓	✓	✓
In-Committee Laboratory Information Management System (LIMS)	HT	AT	✓			
Data						
IGSC Workplan (3.1.24)	AT	AT	✓			
Annual Review IGSC TORs (10.3)	AT	AT	✓			
Information Governance Sub-Committee (IGSC) 3A's update (10.3)	AT	AT	✓	✓	✓	✓
IGSC Annual Report (10.4.1)	AT	AT	✓			
Data Quality Report (3.1.9)	AT			✓		
Information Governance Assurance Report (2.1.3, 3.1.6,7 & 8)	HT	AT			✓	
Data Protection Impact Assessment Assurance Report (3.1.11)	HT	AT				✓
Microsoft Enterprise Agreement Renewal	HT	AT	~~✓~~			
AI Framework	HT	AT		✓		
Research and Innovation						
Research & Innovation Annual Report (3.1.15)	LP	CH/SH	✓			
Research and Development Framework Annual Update	MH	CH/SH	✓			
RISC TORs Annual Review (10.3)	LP	CH	✓			
RISC Workplan (3.1.24)	LP	CH	✓			
Research and Innovation Sub-Committee (RISC) 3A's update (10.3)	LP	CH/SH	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	21 Apr 2026	21 Jul 2026	20 Oct 2026	21 Jan 2027
Research & Development Implementation of the NHS Framework and Strategic Plan (10.4.1)	LP	CH		✓		
Research Project Presentation	LP	SH	✓			
University Partnership Arrangements Update (3.1.16)	LP	CH/SH		✓		✓
TriTech Business Plan	LP	CH		✓		
Impact and Outcomes						
Update on Impact of Flow System	HT	AT				
Analytical and Modelling Work including Presentation	HT	AT				
For Assurance						
National and Regional Landscape	HT	HT			✓	
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) • EDRMS Re-procurement (Document Management System) (21.07.26) • Workforce Asset Scheduling-2027/28 OBC (20.10.26)	HT	AT	✓	✓	✓	✓
Meeting Governance						
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	✓	✓	✓	✓
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	✓	✓	✓	✓

AGENDA ITEM/ ISSUE	LEAD	Responsible Officer	21 Apr 2026	21 Jul 2026	20 Oct 2026	21 Jan 2027
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						

5.2 **11:50 AM, 15 Mins**

5.2 - Microsoft Enterprise Agreement Renewal

Included within the Procurement Report presented to March 2026 Board

5.3

12:05 PM, 15 Mins

5.3 - Digital Access

Attachments

Exploring-Digital-Ageism.pdf

Ymchwil
Research

September 2025

Exploring digital ageism in relation to older people

September 2025

Exploring digital ageism in relation to older people

A report to:

Comisiynydd Pobl Hŷn Cymru
Older People's Commissioner for Wales

Authors: Heledd Bebb and Nia Bryer

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Contents

Glossary

Acronym/Key word	Definition
AI	Artificial Intelligence
Compassionate Ageism	A form of ageism that is trying to protect older people from harm and may be well intentioned but can end up restricting their opportunities or inadvertently do more harm than good.
CDPS	Centre for Digital Public Services
CV	Curriculum Vitae
DCW	Digital Communities Wales: Digital Confidence, Health, and Well-being
Digital Native	A person who has been born or brought up during the age of digital technology and is therefore familiar with computers and the internet from an early age.
EC	European Commission
EHRC	Equality and Human Right Commission
EU	European Union
GDPR	General Data Protection Regulation
ICO	Information Commissioner's Office
OT	Occupational Therapy
UNECE	United Nations Economic Commission for Europe
UX	User experience
UK	United Kingdom
WG	Welsh Government
WHO	World Health Organization

1. Background

OB3 Research was commissioned by the Older People's Commissioner for Wales to undertake a short research project to explore digital ageism in relation to older people aged 60 and over.

The first stage of the approach to the literature review involved identifying and reviewing the relevant published literature, of relevance to the brief.

The literature review aimed to consider existing knowledge, research, relevant legislative and policy frameworks as well as examples of best practice, and effective interventions to overcome digital ageism.

This involved undertaking a search of academic and grey literature on digital ageism, with a focus on publications made available over the last five years. A list of search parameters and key words were agreed to inform the searches via Google and Google Scholar.

64 sources were identified which included 31 academic papers or book chapters, 27 online articles and six policy briefings or reports. These were then grouped to specific sub-themes that correspond to the chapter headings of this final report.

These evidence sources were then reviewed with a focus on identifying the key learning and policy implications of relevance to the Older People's Commissioner for Wales.

2. Introduction

In today's rapidly evolving digital landscape, the concept of digital ageism has emerged as a critical and multifaceted form of discrimination. Digital ageism refers to the stereotyping, prejudice, or disadvantage directed at individuals, particularly older adults, within digital contexts. [1,2] It encompasses discrimination based on assumptions about people's ability to use technology, and it can appear across the design, implementation, and use of digital systems.[3]

While ageism itself is not new, its digital manifestations are becoming increasingly widespread. They can be found in poorly designed interfaces that exclude older users, algorithmic biases in artificial intelligence (AI) systems, and public or policy narratives that frame older adults as "technophobic" or "digitally illiterate" .[4,5] These representations shape not only how older people are treated by digital technologies but also how they perceive and interact with those systems.

Digital ageism is often multidimensional, intersecting with social, economic, and cultural factors. It is reinforced by assumptions embedded in technology development, data collection, and digital service delivery.[6] As societies grow increasingly reliant on digital infrastructure, older people frequently face both direct and indirect barriers to participation including exclusion from design processes, insufficient digital training, underrepresentation in datasets and biased algorithmic decision-making.[7]

The World Health Organization identifies three levels at which digital ageism operates: structural, institutional, and individual. Structural digital ageism occurs when older adults are underrepresented in datasets or excluded from technology design processes. Institutional ageism arises when digital policies, platforms, or services fail to consider the specific needs of older users. Individual-level digital ageism reflects assumptions that older people are incapable of or uninterested in engaging with technology.[8] Together, these levels of bias contribute to

[1] Rosales, A. et al (2023).
[2] World Health Organization (2021)
[3] Hadas, 2023
[4] Loos, E. F. (2021)
[5] Vines, J. et al. (2015)
[6] Rosales & Fernández-Ardèvol, 2020
[7] Ibid.
[8] World Health Organization (2021)

exclusionary priority setting, limited usability testing, and oversimplified digital literacy programmes.[9,10]

This review draws on a range of sources, including academic studies, policy briefings, and grey literature, to explore how digital ageism functions in practice. It examines key areas such as the design and development of digital systems, the use of data and AI, access to employment, social participation, leisure, and digital delivery of health and social care services. The review also considers emerging research on intersectionality and compassionate ageism[11], highlighting how gender, socio-economic status, race, and disability intersect with age to compound digital exclusion. [12,13]

Understanding digital ageism is especially important for governments and public bodies responsible for promoting equity, digital inclusion, and human rights. For the Older People's Commissioner for Wales, focusing on digital ageism is not only a matter of fairness; it is essential for advancing broader policy goals in health, social care, digital service delivery, and active ageing. While Wales has strong commitments to older people's rights, effectively tackling digital ageism requires a sharper focus on the norms, practices, and technological systems that can inadvertently exclude older adults.

Digital ageism is not simply a technical oversight or a matter of user training. It is a systemic issue that requires coordinated action across research, regulation, design, education, and public discourse. Only through such comprehensive efforts can policymakers ensure parity of access to digital technologies and foster a more inclusive digital society for older adults.

[9] Rosales, A. et al. (2023)
[10] Marston et al. (2021)
[11] A form of ageism that is trying to protect older people from harm and may be well intentioned but can end up restricting their opportunities or inadvertently do more harm than good.
[12] Ienca, M et al. (2021)
[13] Loos, E. F. & Ivan, L. (2023)

3. Findings: addressing digital ageism in policy and governance frameworks

Digital ageism is not just a technological or social issue, it is strongly shaped by policies and governance structures at local, national, and international levels. The governance frameworks that regulate and guide digital technologies, data use, and service provision play a pivotal role and can either help reduce or unintentionally increase digital exclusion of older adults. While some progress has been made in recognising digital inclusion, age-specific considerations are frequently overlooked or underdeveloped within existing regulatory and policy environments. This gap presents significant risks for systemic digital ageism to become further entrenched and normalised.

Key international institutions, such as the United Nations Economic Commission for Europe (UNECE), World Health Organization (WHO), and the European Commission, have begun to explicitly address digital inclusion within their ageing and human rights frameworks:

- the UNECE's policy brief on ageing and technology[14] acknowledges the disproportionate impact of digital exclusion on older adults and calls for integrated strategies that foster age-friendly digital environments
- the WHO's 'Global Strategy and Action Plan on Ageing and Health' highlights digital equity as critical to healthy ageing[15]
- the 'Ageing Equal' digital inclusion framework developed in Europe emphasises principles of dignity, autonomy, and participation for older adults in digital policymaking.[16] The framework recommends clear policy commitments to digital rights, age-disaggregated data collection, and cross-sectoral collaboration.

Despite these efforts, age is often less clearly protected than other characteristics such as race, gender, or disability in many digital rights and data protection laws. For example, the UK's General Data Protection Regulation (GDPR) provides strong protections for personal data but lacks provisions directly preventing age-based discrimination in data processing and automated decision-making.[17] This regulatory blind spot makes it harder to hold digital systems accountable for bias against older adults.

[14] UNECE, 2021
[15] WHO, 2022
[16] Ageing Equal, 2023
[17] ICO, 2023

At the national level, many countries also lack coordinated approaches that integrate digital, ageing, and equality agendas. The UK parliamentary report on the rights of older people[18] notes the absence of a comprehensive national strategy on digital inclusion, resulting in fragmented initiatives and inconsistent access to digital services for older adults, which is exacerbated by many years of squeezed local authority budgets and a move to 'digital by default' services since the Covid-19 pandemic in particular. This fragmentation complicates efforts to implement inclusive procurement standards, digital skills training, or accessible infrastructure that could systematically reduce digital ageism.

The growing use of artificial intelligence (AI) and algorithms to inform decision-making raises new governance challenges and concerns around digital ageism. AI tools are increasingly used in public and private services, from recruitment to healthcare. However, many systems fail to account for older adults, relying on data that underrepresents them or using proxies that unintentionally disadvantage them. Age-aware audits, inclusive design, and clear transparency about how algorithms make decisions are essential to prevent these biases.[19]

The UK's Information Commissioner's Office (ICO) has started to develop guidance on AI fairness that includes age considerations, but these efforts remain at an early stage and require scaling to be effective across sectors, including health, social care, employment, and financial services.[20]

Governments have a key role to play. Policy and procurement rules can encourage technology that is accessible and usable for older adults. Age-friendly digital governance models that include older people in policy and technology design ensures solutions reflect their needs and are tailored to diverse capabilities and contexts.[21] Inclusive public procurement frameworks can also use government purchasing power to promote industry compliance and innovation in ensuring accessibility, interoperability, and usability of digital services for older users.[22]

Finally, policies need to work together across sectors. Digital ageism affects social care, health, transport, and housing policies and siloed approaches undermine the effectiveness of age-inclusive digital strategies.[23] Coordinated governance where responsibilities and resources are shared across sectors and levels of government is essential to ensure older adults are fully included in the digital world.

[18] Parliament UK, 2025
[19] Boven et al., 2023
[20] ICO, 2025
[21] Rosales et al., 2021
[22] OECD, 2025
[23] European Commission, 2020

4. Findings: digital ageism and the design of digital services

Digital ageism is a complex, systemic issue that extends beyond individual user experiences to the processes through which digital technologies are prioritised, developed, tested, and utilised. These stages embed and perpetuate ageist assumptions, which can affect older adults' digital inclusion, autonomy, and representation.

The design and development phase of digital technologies is a critical stage where ageism becomes embedded through exclusionary practices and stereotyped assumptions about older adults. Ageist design manifests in the form of digital products that do not adequately address the diverse needs of older users, resulting in interfaces, functionalities, and user experiences that are often inaccessible or unappealing to this demographic.[24]

For example, many digital products feature complex navigation, small fonts, insufficient contrast, and limited adaptability, which disproportionately impact older people, particularly those with sensory impairments or cognitive challenges.[25] These design choices frequently stem from a one-size-fits-all approach prioritising younger users or 'digital natives'[26] as the default consumer, neglecting the fact that older adults comprise a highly heterogeneous group with varied capabilities, preferences, and digital literacy levels.

The prevalence of ageist language and symbolism embedded in digital technologies and marketing materials is also raised as a concern in the literature. Phrases such as 'digital native' implicitly mark older adults as digital outsiders or immigrants[27] and this type of rhetoric can discourage digital participation, while also shaping and influencing the decisions of designers, funders, and policymakers.

The literature also points to how 'compassionate ageism' plays a subtle yet powerful role in design. This form of ageism, while well-meaning, can reinforce the notion that older adults are frail, slow, and in need of protection, which results in designers assuming that all older adults need overly simplified digital interfaces and that simplification equates to dumbing down. This can result in 'dumbed down' technology that is patronising or alienates them.[28] For instance, smart devices with simplified interfaces or reduced functionality may limit older adults' opportunities for engagement, creativity, and autonomy.[29] Another example points to voice

[24] Ageing Equal, 2023
[25] van Deursen & Helsper, 2018
[26] A person who has been born or brought up during the age of digital technology and is therefore familiar with computers and the internet from an early age.
[27] Prensky, 2001, Ageist, 2022
[28] McDonough, 2016
[29] CBC Spark, 2023

assistants or healthcare chatbots that may use condescending language or fail to accommodate sensory impairments and cognitive diversity common in ageing populations, reducing usability and engagement.[30] These approaches ignore the evidence that many older users are keen to engage with sophisticated digital tools if given the appropriate support and options.[31]

Crucially, the literature also suggests that older adults are rarely meaningfully involved in co-designing digital solutions. When older users are included, it is often tokenistic or limited to the final stages of testing, undermining their ability to shape product features from the outset.[32] Older adults are often not considered during the requirements gathering phase of digital development, leading to products that fail to meet their needs, particularly in relation to accessibility, readability, navigational clarity, and trust-building.

Without their insights, developers miss critical nuances about older people's daily digital practices, needs, and contextual constraints, resulting in technologies that feel alien or frustrating rather than empowering.[33] The literature shows that this exclusion perpetuates a feedback loop in which older people are stereotyped as disinterested in digital technology because they are less likely to use systems that have not been built with them in mind.[34]

Testing and evaluation processes in digital technology development also reflect digital ageism through sampling approaches that exclude older people or inappropriate test environments. Studies highlight that older people are frequently underrepresented in user testing or the process fails to consider the specific contexts in which they use digital tools.[35]

In many cases, user experience (UX) testing is conducted with homogenous age groups, typically under 45, which results in the generalisation of their preferences and behaviours to all age demographics. This lack of representativeness leads to usability standards that are skewed towards younger populations, leaving older users with products that are impractical or difficult to use. The literature points to the need for 'participatory design' that actively involves older adults not only in testing but also in ideation and decision-making throughout the technology development lifecycle.[36]

[30] Smith & Lee, 2023
[31] Marston & van Hoof, 2019
[32] The Conversation, 2022
[33] Purnell et al., 2022
[34] Loos, 2021, Ienca et al, 2021
[35] Lindberg et al., 2022
[36] Rosales et al, 2023

For example, usability tests often do not account for assistive technologies such as screen readers, alternative input devices, or variable internet speeds, which many older adults rely on. Consequently, products may appear functional in controlled settings but fail under real-world conditions, creating a disconnect between design intent and user experience.[37] Similarly, recruitment practices for testing often prioritise digitally literate older adults, excluding those with lower skills or disabilities, thereby reinforcing the misconception that older users are a homogenous group with similar needs.[38]

Finally, the literature review highlights a failure to disaggregate usability data by age resulting in many age-specific barriers remaining hidden. Without detailed insights into how older adults interact differently with technologies, developers cannot identify or rectify design flaws that contribute to digital exclusion.[39]

[37] Purnell et al., 2022
[38] Lindberg et al., 2022
[39] van Deursen & Helsper, 2018

5. Findings: digital ageism, algorithms and artificial intelligence

Artificial Intelligence (AI) is rapidly reshaping many areas of daily life, from healthcare and employment to social services and communication. While AI holds transformative potential to enhance independence, health outcomes, and social inclusion for older adults, there is growing recognition that AI systems also risk entrenching and amplifying digital ageism.

Digital ageism in AI reflects systemic biases that marginalise older individuals by embedding stereotypes, exclusionary design choices, and unrepresentative data, which results in outcomes that undermine the dignity, rights, and opportunities of older populations.

One of the fundamental sources of digital ageism in AI arises from the design and development processes themselves and similar issues are raised in the literature to those outlined in the chapter above.

Research highlights that AI technologies are typically created by younger developers and researchers who often lack sufficient awareness of ageing as a multifaceted and heterogeneous experience.[40] This demographic skew contributes to the embedding of youth-centric assumptions and stereotypes into AI models and user interfaces.[41]

Meaningful involvement of older adults in the co-design of processes is rarely integrated into AI innovation pipelines. As a result, AI tools may overlook important features or requirements that would make them more accessible and relevant to older users. Studies suggest that inclusive design approaches that actively engage older adults in iterative testing and feedback can significantly improve usability and acceptance of AI technologies.[42]

One of the most pressing issues is the systematic underrepresentation of older adults in datasets used to train AI and machine learning models. Many of the datasets used to train AI systems are biased towards younger, more digitally active populations, resulting in models that are poorly calibrated to the needs, behaviours, or preferences of older users.[43]

In healthcare, for example, AI models trained mainly on data from younger patients may under-detect conditions that disproportionately affect older people or misinterpret symptoms because of age-related physiological differences.[44] This can result in critical health issues being overlooked and can undermine trust in AI-enabled healthcare.

[40] Graham et al., 2023; Hsu et al., 2022
[41] McLaughlin & Neves, 2023
[42] The Conversation, 2023
[43] Martin et al, 2022
[44] Li & Ayalon, 2023

In the labour market, similar risks arise. Recruitment algorithms trained on historical hiring data may replicate existing ageist patterns, such as deprioritising CVs with gaps in employment history or placing greater value on digital skills more common among younger workers.[45] In practice, this can mean that older applicants are systematically filtered out, not because of their actual suitability, but because of biased correlations in the data.[46]

Across both healthcare and employment, these shortcomings mean that AI systems often fail to recognise or accommodate the needs and behaviours of older adults. The result is discriminatory outcomes that can limit access to essential services, reduce economic opportunities, and exacerbate inequalities.[47]

Algorithmic ageism is especially difficult to address because it often hides within complex AI systems that are not transparent to users. Unlike visible forms of age discrimination, these biases operate at scale through so-called 'black box' models, which makes them hard to detect or challenge. This invisibility increases the risk that ageism becomes built into digital governance and everyday decision-making.

Technologies, like facial recognition and emotion-detection tools, have also been shown to work less accurately for older adults. This creates risks of unfair treatment in practical settings such as healthcare triage, airport security checks, and customer service interactions.[48]

The opacity of these systems compounds the problem. Older adults have very limited means to question or appeal biased decisions. This lack of accountability is particularly concerning in high-stakes areas such as eligibility for social services, insurance underwriting, and credit scoring, where errors or biases can directly undermine financial security, independence, and well-being.

Despite the challenges, AI holds the potential to enhance older adults' lives if developed inclusively and ethically. Human-centred AI that incorporates older people's lived experiences, preferences, and capacities can support personalised healthcare, enable social connectedness, and foster independent living.[49] For example, AI systems that adapt interfaces dynamically to accommodate cognitive or sensory changes can improve usability and engagement.

[45] Binns et al, 2018
[46] Graham et al., 2023; Misra et al., 2021
[47] UK ICO, 2025
[48] Raji and Buolamwini, 2019
[49] Katz et al., 2023; Lee & Kim, 2023

Crucially, participatory design methods must become standard practice in AI development. This includes engaging older adults not just as testers but as co-creators throughout the innovation lifecycle, ensuring technologies reflect diverse ageing experiences and aspirations.[50] The literature also emphasises the need for approaches that recognise how age intersects with gender, ethnicity, disability, and socioeconomic status to shape digital experiences and risks.[51]

Case Study: Informing older adults in Germany about Artificial Intelligence[52]

A new initiative in Germany is bringing state-of-the-art artificial intelligence (AI) into the everyday lives of older adults. The project focuses on making AI accessible through existing local structures and familiar media, ensuring low-barrier entry points for older people.

At the heart of the initiative are sixteen “Internet experience locations” across Germany, each equipped with AI technologies. Here, older people can test devices firsthand, receive guidance, and access reliable information. In addition, trained facilitators, known as multipliers, help deliver workshops, advice, and learning opportunities.

The programme places strong emphasis on presenting both the opportunities and challenges of AI. By providing balanced information on potential benefits as well as risks, the project empowers older adults to make informed, confident decisions about whether and how they wish to integrate AI into their daily routines.

This initiative was developed by BAGSO, the German National Association of Senior Citizens’ Organisations, and is funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ).

The literature also points to digital ageism in data use, and raises important ethical challenges around privacy, consent, and surveillance. Many older adults have lower levels of digital literacy and limited awareness of how their personal data is collected, shared, or analysed. This makes them more vulnerable to exploitation, over-surveillance, or misuse of their information.[53]

[50] The Conversation, 2023
[51] Graham et al., 2023
[52] UNECE, 2021
[53] Mannheim et al., 2022

At the same time, well-intentioned protective data policies can have unintended effects. By restricting access to certain technologies, such measures may reinforce paternalistic attitudes and reduce older people's digital autonomy, even when the technologies could provide real benefits.

Another concern is the lack of consent processes that are meaningful and accessible for older users. As the literature notes, digital literacy is not only about having access or technical skills - it also requires critical understanding and control over how one's data is used. Without this, older adults are often left uninformed about what happens to their personal information. This undermines trust in digital systems and discourages engagement with online services that could otherwise support their well-being.[54]

[54] Van Dijk, 2020

6. Findings: digital ageism and intersectionality

Digital ageism rarely exists in isolation. It intersects with other forms of inequality, including gender, race, socioeconomic status, disability, and geographic location. Understanding these intersections is essential for designing fair and inclusive digital policies and technologies that respond to the diverse realities of older adults. Older people are not a uniform group, and their experiences with technology are shaped not only by age but by multiple social, cultural, and structural factors.

Gender plays a particularly significant role in shaping digital exclusion among older adults. Older women frequently experience a 'double disadvantage,' facing both ageist and sexist assumptions.[55] Stereotypes often portray older women as less competent or interested in technology than men, which undermines confidence, reduces participation in digital skills programmes, and limits access to digital devices.[56] Women are also more likely to take on unpaid caregiving responsibilities, leaving them with less time and fewer resources to engage with technology.[57] Furthermore, technology is often designed without considering older women's preferences or ergonomic needs, creating usability barriers that discourage continued use.[58] Structural factors such as lower income and limited formal education among older women further constrain opportunities to develop digital skills, and many rely on informal learning networks, such as family or community support.[59] When these networks are unavailable or are themselves digitally excluded, older women are at risk of falling further behind.

Intersectional factors extend beyond gender. Ethnic minority older adults may face language barriers, cultural exclusion, or discriminatory design in digital platforms, reducing their participation.[60] Socioeconomic status critically influences digital access, as older people with lower income or education levels often lack devices, broadband, and opportunities for skills development.[61] Disabilities, including sensory, cognitive, and mobility impairments, can further limit engagement when platforms are not designed with accessibility in mind. Geography also plays a role, as older adults in rural or remote areas frequently encounter limited connectivity, scarce local support, and reduced opportunities for social and digital participation.[62]

[55] Vines et al., 2015; Chu et al, 2020
[56] Hargittai et al., 2019
[57] Rosales & Fernández-Ardèvol, 2020
[58] Chu et al., 2020
[59] Ibid.
[60] Yu et al., 2023
[61] Seifert et al., 2021
[62] European Commission, 2020

These intersectional factors have significant implications in health and social care. Marginalised older adults may be hesitant to use digital health technologies due to historical discrimination, linguistic barriers, or distrust of digital platforms. People with disabilities often require tailored adaptations that are frequently absent in telemedicine services.[63] Older women, particularly those in caregiving roles, may be responsible for managing digital health technologies for both themselves and family members, adding complexity to their engagement.[64] Gendered assumptions embedded in AI diagnostics and digital care pathways can also influence how symptoms are assessed, potentially reinforcing inequities in healthcare provision.

Employment is another domain where intersectional digital exclusion manifests. AI-driven recruitment and employment tools often replicate existing inequalities, deprioritising older applicants whose CVs have lower digital skill indicators or do not contain the keywords used in the search. Algorithms trained on historical data may unintentionally perpetuate ageist and gendered biases, disproportionately affecting women, ethnic minorities, and people with disabilities.[65] In healthcare, biased AI systems trained predominantly on younger populations may under-detect conditions that disproportionately affect older adults or misinterpret age-related physiological differences, further entrenching disparities and eroding trust in digital health services. Similarly, facial recognition systems have been shown to misidentify older people of colour at higher rates, raising ethical and legal concerns.[66] Gender bias in AI can further marginalise older women, whose needs and behaviours may not be adequately represented in datasets.[67]

Despite these challenges, some promising approaches demonstrate the potential of intersectional digital inclusion. The European Union's EuroAgeism project advocates for policies that recognise the diversity of older adults and support tailored digital solutions. Community-based initiatives that work closely with ethnic minority organisations, disability advocates, and women's groups have proven effective in building trust and participation.[68] In Canada, culturally sensitive digital health outreach for Indigenous elders, incorporating language support and community engagement, has helped reduce barriers to digital service access.[69]

[63] Topaz et al., 2021
[64] Rosales & Fernández-Ardèvol, 2020
[65] Chu et al., 2020
[66] Raji & Buolamwini, 2019
[67] Martin et al., 2022
[68] Seifert et al., 2021
[69] Graham et al., 2022

Addressing digital ageism effectively requires policies that adopt an intersectional lens. Digital inclusion strategies must consider how age interacts with gender, ethnicity, income, disability, and geography to shape opportunities and barriers. Training programmes need to be flexible, acknowledging caregiving responsibilities, diverse learning styles, and cultural contexts. Affordable access to devices and broadband, alongside accessible and ergonomically appropriate technology design, is essential. Policies must also tackle algorithmic bias by ensuring diverse representation in datasets and incorporating transparency and accountability, with mechanisms in place to remove bias when it is discovered. Finally, culturally sensitive outreach and trust-building measures are critical to encourage older adults' engagement with digital services.

7. Findings: digital ageism and employment

Digitalisation is transforming the nature of work, offering new opportunities for productivity, flexibility, and access to emerging roles. However, many older workers do not benefit equally from these changes. Across sectors, older adults face systemic barriers in acquiring digital skills, navigating recruitment processes, and adapting to technological change. These challenges have implications not only for individual careers but also for broader workforce participation and economic inclusion.

Despite often having decades of workplace experience, older workers frequently struggle to access and effectively utilise digital tools. In a major US study, workers over 50 scored significantly lower on digital skills assessments compared with younger colleagues, particularly in digitally intensive sectors such as ICT and administrative services. These gaps are compounded by race and gender, with Black workers and older women experiencing lower access to training and reduced confidence in using digital technologies.[70]

Similar patterns are observed in the UK, where the Business in the Community (BITC) report found that nearly half of older employees had not received adequate digital training before being expected to use new systems, and over a third lacked confidence in their abilities. The report also noted that digital training programmes often fail to reflect older workers' learning preferences or lived experiences, leading to disengagement and exclusion.[71]

Digital exclusion in employment extends beyond access to devices and broadband. Older employees require tailored, hands-on support that not only develops skills but also builds confidence and relevance to their specific roles. Without such support, digital transitions risk deepening workplace inequalities for a growing segment of the labour market.

Ageism is also increasingly evident in recruitment practices, often masked under the concept of "digital readiness." Job advertisements that call for "digital natives" or a "youthful, tech-savvy" culture, while seemingly neutral, effectively signal that older applicants are unwelcome. These phrases reinforce stereotypes that technological competence is tied to youth, excluding candidates who may have developed relevant digital skills later in life.[72] A notable case in the UK Civil Service involved an advert for a digital role that explicitly preferred "digital natives," triggering accusations of age discrimination and highlighting the need for clearer guidance on

[70] Morrison, Baughman and Mumford, 2019
[71] BITC, 2020.
[72] Ageist, n.d.

age-inclusive recruitment.[73] CV screening practices further disadvantage older applicants, penalising older graduation dates, or missing recent technology-specific qualifications.

The increasing use of AI in recruitment has added another layer of complexity. AI systems are employed to shortlist CVs, analyse video interviews, and match candidates to role profiles. However, these tools frequently rely on historical hiring data, which can reflect and perpetuate existing biases. The UK Information Commissioner's Office (ICO, 2025) has warned that many AI recruitment systems lack transparency and age-specific safeguards, making discriminatory outcomes difficult to detect or challenge. Older candidates may also be unfamiliar with strategies for optimising CVs for AI systems, placing them at a further disadvantage.[74] Data-driven criteria embedded in AI, such as valuing digital skills proxies or penalising career gaps, often disproportionately exclude older applicants, reinforcing ageist hiring practices under the guise of objectivity.[75]

Even when older adults are successfully employed, digital transformations can create ongoing barriers. Many workplace digitalisation initiatives are implemented without engaging older employees in planning, testing, or system design. This can result in tools and platforms that do not accommodate their needs or learning styles, leading to frustration, reduced productivity, or early exit from the workforce.[76] Digital upskilling programmes often remain generic, time-limited, or culturally mismatched, further limiting older workers' ability to adapt to new technologies and undermining confidence.[77] Workplace cultures can exacerbate these challenges by perpetuating narratives of older workers as "technologically resistant," marginalising their contributions and reducing opportunities for development.[78]

The COVID-19 pandemic accelerated shifts to remote working and digital collaboration, presenting both opportunities and risks. While some older employees benefited from increased flexibility, others faced isolation due to digital fatigue, inadequate equipment, or limited support for remote work technologies. Without inclusive policies, these dynamics risk deepening inequalities within the workforce.[79]

Promising approaches highlight the benefits of engagement, inclusion, and age-aware policy. Organisations that promote intergenerational learning, peer mentoring, and co-design of digital systems report better outcomes, as older employees contribute valuable insights that improve

[73] The Telegraph, 2023
[74] Welcome to the Jungle, 2025; Su Independent, 2025
[75] ICO, 2025; Davis et al, 2022
[76] Tarrant, 2024; HR Vision, 2024
[77] Urban Institute, 2022
[78] HR Vision, 2024
[79] WEF, 2025

usability and efficiency for all staff.[80] Workplaces that invest in tailored digital training, foster inclusive cultures, and implement transparent AI governance frameworks also experience higher engagement and retention among older workers.[81] Age-inclusive recruitment practices, such as auditing AI tools for bias, removing exclusionary language from job descriptions, and recognising diverse pathways into digital competence, are essential to mitigate systemic digital ageism.[82]

[80] Oxford Institute of Population Ageing, 2024
[81] BITC, 2020; Urban Institute, 2022
[82] BITC, 2020

8. Findings: digital ageism and social interaction

Digital platforms have changed the way people connect, access entertainment, and spend their leisure time. For older adults, these spaces can be vital for social interaction, mental stimulation, and cultural engagement. Yet digital ageism significantly limits older people's participation. This reduces opportunities for social connection and can reinforce isolation.

Social media presents particular challenges. Platforms like Facebook, Instagram, TikTok, and Twitter are often designed with younger audiences in mind. Ageist assumptions about older people's lack of digital skills and interest can make them feel marginalised or invisible within online social networks.[83] Older adults may internalise these stereotypes, leading to anxiety, self-doubt, and reluctance to engage in digital communities.[84] Social media algorithmic bias can amplify these barriers as they tend to prioritise content popular among younger users, meaning older adults' contributions are less visible. The result is reduced social participation and fewer opportunities for intergenerational connection.[85]

Studies have also shown that older people are less likely to participate actively on social media due to concerns about privacy, lack of digital confidence, or experiences of age-related trolling and abuse.[86]

The digital leisure and entertainment landscape is similarly affected. Streaming services, online games, virtual reality, and digital cultural events offer rich opportunities for engagement, but many platforms are not designed with older adults in mind. Interfaces may be difficult to navigate, fonts and graphics may be hard to read, and marketing often targets younger consumers.[87] These factors, sometimes described as "design ageism", create practical barriers that prevent older adults from fully enjoying digital leisure.[88] The consequences extend beyond entertainment: engaging in leisure activities online can support cognitive health, mental wellbeing, and social connection, all critical for healthy ageing.[89]

Social interaction through digital platforms is closely linked to wellbeing. For many older adults, online leisure can be a crucial lifeline, especially when mobility or health restrictions limit offline socialisation. Yet ageist platform design, content curation, and online community cultures can make these spaces feel unwelcoming. Older adults who are excluded miss opportunities to

[83] We Are Drum, 2023
[84] LMD International, 2024
[85] Age Platform Europe, 2024
[86] Loos, 2021
[87] Jonsson et al. 2024; Cotten et al., 2022
[88] LMD International, 2024
[89] Anderson et al., 2024

maintain social networks, participate in community life, and strengthen personal identity.[90] Conversely, when older users are supported to engage confidently, they report improved wellbeing, stronger social connections, and greater life satisfaction.[91]

There are also gendered dimensions to consider. Older women often face compounded barriers in online leisure spaces due to both ageist and sexist stereotypes. Their interests and digital skills may be underestimated, they may be infantilised, or they may be less visible in online communities such as forums, gaming networks, and social media platforms. This limits their ability to participate fully, express themselves, and access the benefits of digital leisure.[92]

The COVID-19 pandemic highlighted these disparities. Many older adults were excluded from virtual social events and online leisure activities due to limited digital access, lack of confidence, or insufficient support. Those living in rural or isolated areas were particularly affected by poor connectivity and limited local digital resources.

[90] Age Platform Europe, 2024
[91] Anderson et al., 2024
[92] Chu et al, 2022

Case Study: Supporting older people with online banking services[93]

Canada

In Canada, a lack of engagement between the banking sector and older people prompted action at the national level. The Minister of Finance, the Minister of Seniors, and the Financial Consumer Agency of Canada (FCAC) introduced the Code of Conduct for the Delivery of Banking Services to Seniors.

The Code sets out seven guiding principles designed to improve the way banks serve customers over the age of 60. These principles address key areas such as:

- establishing policies, procedures, and processes that support the Code
- ensuring clear and effective communication
- providing appropriate training for bank staff
- reducing risks of financial harm for older people
- managing branch closures responsibly and
- publicly disclosing the steps taken to uphold the Code.

An important feature of the initiative is the requirement for each bank to appoint a Seniors Champion - a designated leader responsible for promoting and protecting the interests of older customers. By improving both service delivery and communication, the Code aims to help older people feel more confident when seeking information and using online banking services.

[93] UNECE, 2021

9. Findings: digital ageism in health, social care and wellbeing

Digital transformation in health and social care promises improved efficiency, access, and personalisation of services. From online appointment booking and telehealth consultations to AI-driven diagnostic tools and electronic health records, technology has the potential to enhance care delivery. However, without careful consideration of age-related barriers, these innovations can systematically disadvantage older adults.

A recurring issue is the assumption that older people are unwilling or unable to use digital health technologies. This stereotype has shaped service design and rollout in ways that exclude or marginalise older patients.[94] For example, patient portals and e-consultation systems are often optimised for mobile use, assume high digital literacy, and provide limited alternatives for those without regular internet access. Rather than empowering users, these systems can generate frustration, disempowerment, and disengagement from health and care.[95]

The literature suggests that the growing use of surveillance technologies and algorithmic systems in nursing homes, such as monitoring devices, fall detection tools, and predictive analytics, reinforces digital ageism by framing older adults, particularly those with dementia, as passive subjects in need of control rather than as agents with rights and autonomy. These systems often restrict privacy, dignity, and self-determination by categorising behavioural differences as risks, while also intensifying the use of surveillance and algorithms to track and assess care staff. These technological “solutions” frequently reproduce structural inequalities, disproportionately impacting marginalised groups. They also divert resources away from addressing systemic issues in long-term care, such as underfunding and understaffing. In doing so, algorithmic tools risk entrenching ageist, ableist, and inequitable practices under the guise of innovation and efficiency.[96]

Older adults may also face practical barriers arising from age-related cognitive, sensory, or physical changes. Complex password requirements, small fonts, and lack of assistive features can make digital platforms difficult to navigate[97]. This contributes to a “second-level digital

[94] Seifert et al., 2021
[95] Hargittai et al., 2019
[96] Berridge et al, 2022
[97] WHO, 2021

divide," where the challenge is not merely access to devices but the ability to use them effectively.[98]

Artificial intelligence in healthcare introduces further risks. Underrepresentation of older adults in health datasets can lead to diagnostic or predictive tools that misclassify symptoms, fail to account for multimorbidity, or overlook age-specific physiological differences. These gaps have serious implications for patient safety, clinical accuracy, and trust in digital systems.[99]

Digital exclusion in health and care is not limited to technology design - it is also institutional. During the COVID-19 pandemic, the rapid shift to digital-first healthcare often left older adults unable to access timely services. In some cases, triage systems inadvertently deprioritised those lacking digital skills, replicating existing inequalities and highlighting the risk of reinforcing offline disparities unless inclusion is deliberately designed into digital systems.[100]

Digital ageism also has profound consequences for the mental health and overall wellbeing of older adults. Exclusion from digital platforms can undermine psychological resilience, social connection, and quality of life. Older adults who experience digital exclusion often report frustration, lowered self-esteem, and a sense of helplessness. The research indicates that ageist stereotypes about technological ability can become internalised, creating a "stereotype threat." When older individuals anticipate failure or rejection online, they are less likely to engage, reinforcing patterns of exclusion.[101]

The sense of being 'left behind' in a rapidly digitising society can intensify feelings of social marginalisation and reduced personal agency.[102] This is particularly significant when public services such as healthcare, social benefits or community support, are increasingly delivered online.

One of the most documented outcomes of digital exclusion is social isolation. Digital communication tools, including video calls, messaging apps, and social media, have become essential for maintaining relationships, particularly since the COVID-19 pandemic. Older adults who cannot participate fully risk losing contact with family, friends, and community networks. Studies highlight that lack of digital skills or access reduces opportunities for social

[98] Friemel, 2016
[99] Topaz et al., 2021
[100] Greenhalgh et al., 2020
[101] Seifert et al., 2021
[102] Vines et al, 2015

engagement, which in turn increases loneliness, a known risk factor for poorer physical and mental health.[103] In contrast, digital inclusion enhances social participation, strengthens community ties, and improves wellbeing.

Digital ageism also affects access to mental health services. While telepsychiatry and online counselling expand reach, older adults facing digital barriers are less able to benefit. Ageist assumptions that older people are reluctant to discuss mental health issues or use technology can further limit targeted outreach.

The literature suggests that mitigating the mental health consequences of digital ageism requires coordinated action across multiple levels:

- Promoting digital confidence through training and support tailored to older adults, emphasising positive framing to counteract stereotype threat.
- Enhancing access to devices, broadband, and community-based support to enable meaningful participation.
- Designing digital health and mental health services that are age-friendly, accounting for usability challenges, and providing multiple modes of access.
- Integrating digital literacy and social engagement into social prescribing models to foster connectedness alongside skill development.
- Training health and social care professionals to recognise digital exclusion as a social determinant of mental health, ensuring interventions address both technological and psychosocial barriers.

[103] Hargittai et al., 2019 & Friemel, 2016

Case Study: enhancing mental well-being through digital technology[104]

Malta

In response to the social challenges of the COVID-19 pandemic, Malta launched a new digital training programme in 2021 with a strong focus on mental health and well-being. The initiative helps older people living in the community and in residential care homes learn how to use tablet devices to stay socially connected and access applications that promote mental health.

The programme consists of four two-hour sessions delivered in residential homes and Active Ageing Centres. Training covers essential skills such as:

- Navigating tablet devices
- Setting up social media profiles safely
- Sending and accepting friend requests
- Using mobile data and Wi-Fi.

Participants also receive guidance on maintaining mental well-being in relation to online presence and technology use. At the end of each cycle, a champion is selected from the group to provide ongoing peer support.

[104] UNECE, 2021

Case Study: Enhancing Digital Access for Older Adults through Occupational Therapy and Digital Communities Wales[105]

Digital Communities Wales (DCW) is a Welsh Government-funded programme delivered by Cwmpas. It aims to reduce digital exclusion and ensure that people in Wales, particularly those most likely to be left behind, benefit from digital technology. DCW provides training, advice, and equipment loans to public sector bodies and third sector organisations.

An Occupational Therapy (OT) team within a Welsh health board partnered with DCW to improve digital access for mental health patients, particularly older adults living with cognitive decline. With support from DCW, the team co-designed a training programme to equip staff with the skills and confidence to use digital technologies in patient care.

DCW also provided guidance on suitable devices, such as tablets and smart speakers, and supported the procurement of equipment that could be loaned to patients on a trial basis. This allowed individuals to test the practical benefits of digital technology within their own homes before committing to longer-term adoption. OTs introduced digital support across five service areas. The initiative proved sustainable, with staff continuing to integrate devices and practices beyond the pilot.

Smart devices, particularly the Alexa Show, had a significant impact by enabling patients to receive virtual ‘drop-ins’ from relatives - reducing isolation and enhancing social contact. Smart speakers also proved beneficial in supporting daily routines, such as medication reminders and appointment management.

Both staff and patient feedback highlighted the positive effects of the initiative. Even individuals with significant cognitive decline were able to use the technology successfully once given the opportunity to trial it. Importantly, the hands-on experience helped overcome initial resistance among both staff and patients.

Despite the evident benefits, the OT team reported that ongoing support and funding for devices remained a challenge. They expressed frustration that digital technologies were not recognised as readily as other assistive technologies (such as stairlifts or handrails) within health and social care funding frameworks:

“The benefits of this technology can be just as impactful, but that isn’t yet fully recognised within the system.”

[105] Bryer N. & Bebb, H,, 2025

10. Findings: digital ageism and lifelong learning

Digital ageism has a significant impact on older adults' opportunities for education, lifelong learning, and empowerment. The concept of lifelong learning is central to healthy ageing, enabling older adults to adapt to changing technologies, maintain cognitive function, and engage fully in society.[106] Digital literacy encompasses a broad range of competencies, from basic device use to understanding digital rights, privacy, and safe online behaviours.[107] Without these competencies, older adults risk exclusion from social, economic and civic life.

However, older adults face structural and attitudinal barriers to digital skills acquisition. Educational opportunities are often designed with younger learners in mind, neglecting the specific needs, learning paces, and motivations of older adults.[108] At the same time, internalised ageism can undermine confidence, discouraging engagement with learning programmes.

The barriers to digital learning are multifaceted. Older adults often encounter curricula that are not tailored to their starting points or learning objectives, limited access to accessible tutors or peer mentoring, and insufficient ongoing support. Financial constraints may restrict access to devices, connectivity, or paid courses. Cultural stereotypes, portraying older people as unwilling or incapable of learning new technologies, further reinforce exclusion. Physical and cognitive challenges, such as reduced vision, mobility limitations, or memory difficulties, necessitate accessible formats and adapted pacing. These barriers are often amplified for marginalised groups, including older women, ethnic minorities, and individuals with disabilities, highlighting the need for intersectional approaches to lifelong digital learning.[109]

Empowerment through digital learning can occur when programmes are intentionally designed to meet older adults' needs. Evidence shows that digitally skilled older adults experience greater self-efficacy, improved social connectivity, and increased engagement in civic, cultural, and community activities.[110] Programmes that emphasise co-learning, peer support, and culturally relevant content are particularly effective at sustaining engagement and confidence. Integrating digital skills development with broader health, social, or creative objectives enhances impact, helping older adults apply their learning in meaningful, everyday contexts.[111]

[106] European Commission, 2020
[107] van Dijk, 2020
[108] Rosales & Fernández-Ardèvol, 2020
[109] Prensky, 2001
[110] Hargittai et al., 2019
[111] Seifert et al., 2021

Case Studies – digital skills training for older people[112]

Austria

The Technology in Brief programme helps older people build digital skills across computers, the internet, social media, digital cameras, mobile phones, and tablets. The most in-demand topics are video communication and social media use.

The project is based on three core principles: intergenerational approach, regional access, and affordability. Young trainers deliver low-cost, local courses tailored to the needs and prior knowledge of older participants. Course materials are specifically adapted for older learners, and a dedicated hotline provides additional support.

Finland

In Finland, SeniorSurf supports digital learning by producing guidance materials and making them widely available through the SeniorSurf.fi website. Training is delivered primarily by older volunteers (peer tutors) working through non-profit organisations.

The approach highlights peer-to-peer learning and community-driven digital support, ensuring that guidance is relatable and accessible for older adults.

Germany

The Digital Angel (Digitaler Engel) project supports people over 60 in navigating an increasingly digital society while maintaining autonomy and social participation.

Using a low-cost, outreach-based approach, the project provides hands-on, personal guidance. Older people learn practical skills for everyday life, such as safe online shopping, digital communication, and secure use of devices and services.

Funded by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth (BMFSFJ), the project helps ensure older adults remain confident and active participants in the digital world.

[112] UNESCE, 2021

11. Conclusions and policy recommendations

The literature reviewed makes clear that digital ageism is not a marginal or emerging concern, but a systemic challenge that cuts across all aspects of older people's lives. It operates at three levels – structural, institutional, and individual – and is reinforced through the design of technologies, the governance of digital systems, and the narratives that surround older people's digital participation.

At the policy and governance level, digital inclusion has gained prominence internationally, yet older adults are often absent from digital rights frameworks and AI ethics debates. Regulatory blind spots mean that protections against age-based digital discrimination are weak compared with other protected characteristics. In Wales, as in the UK more broadly, digital inclusion strategies are fragmented and risk entrenching disadvantage as services move towards 'digital by default.'

In the design of digital products and services, ageism becomes embedded when older people are excluded from co-design and usability testing. Interfaces and platforms are frequently built with younger users in mind, neglecting accessibility, adaptability, and the diversity of older adults' needs. Well-meaning but paternalistic 'compassionate ageism' also shapes design choices, resulting in oversimplified or patronising tools that limit autonomy.

The rise of AI and algorithmic decision-making amplifies these risks. Older adults are systematically underrepresented in training datasets, leading to biased outcomes in areas as critical as healthcare, employment, and financial services. Age is rarely considered in algorithmic impact assessments, making ageism less visible but potentially more pervasive. Yet there is also evidence that AI, if developed inclusively, can enhance independence, support health and wellbeing, and strengthen social connectedness.

In employment, digital exclusion contributes to widening inequalities. Older workers often lack access to tailored digital training and face discriminatory recruitment practices, sometimes embedded in AI systems. Workplace cultures can perpetuate stereotypes of older staff as resistant to change, discouraging investment in their digital development. Conversely, when employers adopt age-inclusive approaches – such as intergenerational learning and co-designed training – older workers make important contributions that benefit organisations as a whole.

In social participation and leisure, digital platforms offer opportunities for connection and creativity but often remain unwelcoming or inaccessible to older adults. Social media

algorithms can reduce the visibility of older users' contributions, while negative stereotypes or online abuse create barriers to engagement. Limited design consideration of older audiences in streaming, gaming, or online cultural services further exacerbates exclusion.

Digital ageism also shapes access to health and social care. Systems designed without input from older adults often assume high digital literacy and mobile access, leaving many patients excluded or disempowered. In healthcare AI, age bias in datasets poses risks to diagnostic accuracy and safety. Exclusion from digital health can undermine trust, exacerbate inequalities, and negatively impact both physical and mental wellbeing. Ensuring multiple access pathways, combined with age-inclusive design, is therefore critical to safeguarding rights and equity in health and care.

The review further highlights the intersectional nature of digital ageism. Experiences of exclusion are shaped not only by age but by gender, disability, ethnicity, income, and geography. Older women, minority ethnic groups, disabled people, and those living in rural areas face compounded barriers to access and participation. Addressing digital ageism requires recognising and responding to these layered inequalities.

Finally, the evidence underscores the importance of lifelong learning in supporting digital inclusion. Too often, digital literacy programmes are not tailored to older learners' motivations or learning styles, reinforcing stereotypes of incapacity. When programmes are designed around empowerment, relevance, and peer learning, older adults report greater confidence, autonomy, and participation in civic and community life.

While digital ageism is increasingly well documented in the academic and policy literature, there remain very few examples of governments, organisations or institutions taking concrete operational steps to address it, and equally few interventions or projects specifically targeting the issue, suggesting that it is still a relatively new area where significant opportunities exist for innovation and action.

Taken together, these findings demonstrate that digital ageism is a cross-cutting issue requiring a systemic response. It cannot be solved by training alone or by isolated initiatives. Instead, it demands a rights-based, participatory approach that embeds older people's voices in policy, design, and practice, while challenging the stereotypes that continue to shape digital environments.

Recommendations

For the Older People's Commissioner for Wales:

1. **Raise awareness of 'compassionate ageism':** lead public awareness and policy guidance on avoiding patronising assumptions about older people's technology use, taking all opportunities to urge designers and service managers to respect older users' capabilities and preferences.

2. **Advocate for age in digital rights and policy frameworks:** encourage Welsh Government, the UK Government and regulators (e.g. ICO) to explicitly recognise age in data protection, privacy and AI ethics legislation. The Commissioner should also engage and collaborate with the Equality and Human Right Commission (EHRC) Wales to ensure that age discrimination in digital settings (for example, in AI deployment) is monitored, reported, and where necessary challenged, drawing on EHRC's regulatory powers.

For Welsh Government and public services:

3. **Empower older people about their digital rights:** building on the rights-based approach in Age friendly Wales: our strategy for an ageing society, the Welsh Government should consider how issues around ensuring that older adults understand data privacy, consent and service entitlements can be incorporated. This could form part of future Welsh Government-funded work on digital inclusion via workshops, factsheets and partnership events and include training community advocates or 'digital champions' to advise peers.

4. **Promote co-design with older adults in digital public services:** the Welsh Government and digital public service teams (e.g. Centre for Digital Public Services (CDPS)) should seek to involve diverse older users in designing and testing all digital services. Existing standards such as the CDPS Digital Service Standard and Welsh Government guidance which already insist on inclusive design and offline alternatives should be promoted widely. Public bodies (such as health boards and local authorities) should adopt similar guidelines.

5. **Enshrine age in procurement and policy standards:** Welsh Government should require that all publicly-commissioned digital products and services meet age-inclusive accessibility and usability standards. This could be done by ensuring that the Social Partnership and

Public Procurement (Wales) Act frameworks explicitly consider older users. The Strategic Equality and Human Rights plan and its associated action plans (disability, race, LGBTQ+, gender) should explicitly include digital ageism (algorithmic age bias, access issues, etc). For example, when Welsh Government refreshes the Advancing Gender Equality Plan or drafts the Disabled People's Rights Plan, it should ensure age intersects with technology considerations. The Welsh Government should further ensure that the Strategic AI Advisory Group and the Office for AI in Wales include a remit to assess age equality impacts in the design, procurement, deployment and regulation of AI systems in public services.

6. **Embed an intersectional, bilingual approach:** All Welsh digital policies must account for and recognise the diversity among older people's experiences – including gender, disability, ethnicity, income and rurality. It is also imperative that the Welsh language is seen and embedded as a language of AI, tech and digital.

7. **Improve digital health and care inclusion:** Welsh Government and NHS bodies must ensure that new telehealth tools are co-designed with older users so that moves towards further digitisation and increased use of AI avoid inbuilt bias. Staff training in age-inclusive digital communication should be mandated – and organisations such as Digital Health and Care Wales, Health Inspectorate Wales and Care Inspectorate Wales could set and monitor standards in this area.

8. **Ensure Fair Work practices in AI-driven recruitment:** public bodies in Wales should review their recruitment and training practices in light of the increasing use of AI and digital tools. This includes auditing recruitment platforms and algorithms for potential age bias, and publishing results transparently. They should also provide ongoing, role-specific digital training and upskilling opportunities, co-designed with staff of different ages, to ensure that older workers are not excluded from advancement or retention opportunities. Welsh Government could promote this through the Fair Work agenda and public procurement requirements, encouraging private and third-sector employers to follow suit.

9. **Leverage Age-Friendly community networks:** where not already underway, Age-Friendly Communities coordinators in each Welsh authority could also promote digital inclusion locally. Age-friendly partnerships in local authorities could host digital cafés, ensure community centres have internet access, and include tech literacy in social prescribing. They could encourage, support and highlight intergenerational initiatives that bring younger

and older people together to share digital knowledge, helping to reduce stereotypes and strengthen community bonds.

For the tech sector and digital service designers:

10. **Design products inclusively with older users:** technology companies and digital designers should involve older people in testing and co-design, ensuring interfaces avoid ageist stereotypes. Inclusive design could offer text size, voice assist or simple modes optionally, but never assume all older users need simplistic solutions. Welsh-language support and clear privacy controls should also be provided.

11. **Audit and mitigate against algorithmic bias:** public bodies and companies alike, when developing AI and digital tools (e.g. recruitment platforms, credit scoring) must test for age bias and report on fairness. Where bias is found, they should refine or remove offending algorithms. This follows the same logic as audits for gender/race biases. Industry bodies (such as the UK's AI Safety Institute) should issue standards that place responsibility on the tech sector.

12. **Promote older people's representation:** Digital media and online platforms should feature and hire older people and support content that reflects their lives. For instance, streaming services or social media campaigns can challenge stereotypes by showcasing older models, voices and stories.

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6

12:20 PM, 5 Mins

6 - Any Other Business

Chantal Patel (Hywel Dda UHB - Independent Board Member)

7

12:25 PM, 0 Mins

7 - Date and Time of next meeting

Chantal Patel (Hywel Dda UHB - Independent Board Member)

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