

AGENDA

Education Committee Agenda 16 May - Open (F) (002).docx

- 1 PRELIMINARY MATTER
 - 1.1 Welcome and Introductions
 - 1.2 Apologies for Absence
 - 1.3 Declaration of Interest
- 2 STRATEGIC ISSUES
 - 2.1 Review of the Committee's Terms of Reference
 - 2.1 Review of the Committees terms of reference.docx
 - 2.1 Appendix 1 Education Committee ToFR.docx
 - 2.2 Strategic review of Health Professional Education
 - 2.2 Strategic review of health professional education May 2019.docx
- 3 EDUCATION PERFORMANCE AND QUALITY
 - 3.1 Monthly QA review of Postgraduate Medical Education
 - 3.1 (Monthly QA) Exec Report April 2019.docx
 - 3.2 Future quality reporting mechanisms
- 4 FOR INFORMATION
 - 4.1 NHS Wales bursary for 2020/21 – implications for HEIW
 - 4.1 NHS Bursary for Healthcare students May 2019.docx
 - 4.2 Business Cases
 - 4.2.1 Eye Care
 - 4.2.1 Business Case Template - Higher cert glaucoma, Med Ret and IP April 2019 Draft v7.docx
 - 4.2.2 General Practice
 - 4.2.2 Business Case GP Training Final PLM for June 3rd.docx
 - 4.2.3 Pharmacy Pre Reg
 - 4.2.3 20190220 Business Case Pre-Reg Pharmacists Final.docx
 - 4.3 Forward Work Programme
 - 4.3 Future work programme v2.1.docx
 - 4.4 GMC Quality Response
 - 4.4 GMC Review Self Assessment Questionnaire.xlsx
- 5 CLOSE
 - 5.1 Any Other Business
 - 5.1.1 Reflection on today's Committee



**EDUCATION, COMMISSIONING AND QUALITY
COMMITTEE (Open)
Thursday, 16 May 2019
10.30am – 12.30pm**

HEIW Meeting Room 11

AGENDA

PART 1	PRELIMINARY MATTERS	10.30-10.35
1.1	Welcome and Introductions	Chair/Oral
1.2	Apologies for Absence	Chair/Oral
1.3	Declarations of Interest	Chair/Oral
PART 2	STRATEGIC ISSUES	10.35-11.20
2.1	Review of the Committee's terms of reference	Board Secretary / Attachment
2.2	Strategic review of health professional education	Director of Nursing / Attachment
PART 3	EDUCATION PERFORMANCE AND QUALITY	11.20-11.50
3.1	Monthly QA review of Postgraduate Medical Education	Medical Director / Attachment
3.2	Future quality reporting mechanisms	Medical Director and Director of Nursing / Oral
PART 4	FOR INFORMATION	11.50-12.05
4.1	NHS Wales bursary for 2020/21 – implications for HEIW	Director of Nursing / Attachment

4.2	Business cases: <ul style="list-style-type: none"> - Eye care - General Practice - Pharmacy pre reg 	Director of Nursing / Attachment Medical Director / Attachment Medical Director / Attachment
4.3	Forward Work Programme	Board Secretary/ Attachment
4.4	GMC quality response	Medical Director / Attachment
PART 5	CLOSE	12.05-12.10
5.1	Any Other Business <ul style="list-style-type: none"> - Reflection on today's Committee 	Chair/Oral



GIG
CYMRU
NHS
WALES

Addysg a Gwella Iechyd
Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

Meeting Date	16 May, 2019	Agenda Item	2.1
Report Title	Review of Education, Commissioning and Quality Committee's Terms of Reference		
Report Author	Dafydd Bebb		
Report Sponsor	Dafydd Bebb		
Presented by	Dafydd Bebb		
Freedom of Information	Open		
Purpose of the Report	The purpose of the report is to invite the Education, Commissioning and Quality Committee (Committee) to review its own terms of reference.		
Key Issues	<ul style="list-style-type: none"> The Committee's terms of reference form a part of HEIW's Standing Orders which were approved at March Board. The inaugural meeting of the Committee is to review its own terms of reference and, if deemed appropriate, to propose any amendments to the Board. 		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
		✓	
Recommendations	<p>Members are asked to:</p> <p>Discuss the Committee's terms of reference and identify any amendments;</p> <p>recommend the proposed amendments for approval by the Board.</p>		

Review of the Education, Commissioning and Quality Committee's terms of reference

1. BACKGROUND

As this is the inaugural meeting of the Education, Commissioning and Quality Committee this is the first opportunity for the Committee to review its own terms of reference. Should any amendments be identified by the Committee, then these will be considered by the Board for approval.

The Committee's terms of reference shall then be reviewed annually in line with HEIW's governance framework and good governance principles.

2. GOVERNANCE AND RISK ISSUES

The terms of reference are required to be reviewed at the inaugural meeting of the Committee in line with good governance principles. Failure to do so could result in the Committee not discharging its duties appropriately putting HEIW's governance arrangements at risk.

3. FINANCIAL IMPLICATIONS

There are no financial implications for the Committee to consider.

4. RECOMMENDATION

Discuss the Committee's terms of reference and recommend any amendments to then be considered by the Board for its approval.

Governance and Assurance				
Link to corporate objectives <i>(please ✓)</i>	As a new organisation establishing HEIW as a valued and trusted partner, an excellent employer and a reputable and expert brand	Building a sustainable and flexible health and care workforce for the future.	With Social Care Wales shaping the workforce to deliver care closer to home and to better align service delivery.	Improving quality and safety by supporting NHS organisations find faster and more sustainable workforce solutions for priority service delivery challenges.
	✓			
	Improving opportunities for use of technology and digitalisation in the delivery of education and care.	Reinvigorating leadership development and succession planning across health and social care in partnership with Social Care Wales and Academi Wales	Demonstrating value from investment in the workforce and the organisation.	
Quality, Safety and Patient Experience				
Ensuring the Committee's terms of reference are appropriate and aligned with Standing Orders is a key factor in the quality, safety and experience of patients receiving care.				
Financial Implications				
No financial implications for the Committee to be aware of.				
Legal Implications (including equality and diversity assessment)				
It is essential that the Committee complies with its Standing Orders, for which its responsibilities are outlined in the terms of reference.				
Staffing Implications				
No staffing implications for the Committee to be aware of.				
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)				
na				
Report History	The Committee's terms of reference were considered at March Board.			
Appendices	The Committee's terms of reference are attached at Appendix 1. Please note this is an extract of the relevant provisions from the Standing Orders.			



Terms of Reference and Operating Arrangements **Education, Commissioning and Quality Committee**

Date: 1st April 2019

Review Date: Annually

1. Introduction

In line with Section 3 of the Standing Orders, the Board shall nominate annually a committee which covers education, education commissioning and quality management of education provision and contracts. This Committee will be known as the **Education, Commissioning and Quality Committee**.

The terms of reference and operating arrangements set by the Board in respect of this Committee are detailed below.

These terms of reference and operating arrangements are to be read alongside the standard terms of reference and operating arrangements applicable to all HEIW committees.

2. Purpose

The purpose of the Education, Commissioning and Quality Committee ("the Committee") is to:

- **Advise** and **assure** the Board and the Chief Executive (who is the Accountable Officer) on whether effective arrangements are in place to plan, commission, deliver and quality manage education systems and quality assurance framework procured and delivered on behalf of the organisation
- Where appropriate, **advise** the Board and the Chief Executive on where, and how, its education systems and assurance framework may be strengthened and developed further

- **Approve** on behalf of the Board education training plans including investment in new programmes and disinvestment in others which shall be recommended to Welsh Government for approval.
- **Recommend** the specification of tender documents in respect of Education to the Board

3. Delegated Powers

With regard to its role in providing advice to the Board, the Committee will:

- i. Provide assurance to the Board as to the effective management and improvement of the quality of HEIW's education and related research activities
- ii. Identify and approve areas for investment/disinvestment in education and training plans on behalf of the Board taking into account value based commissioning
- iii. On behalf of the Board agree the the national annual education and training plan and recommend to Welsh Government for approval
- iv. Alert the Audit and Assurance Committee and the Board to any matters requiring governance action, and oversee such action on behalf of the Board
- v. Oversee the development, implementation and updating of strategies, policies, structures and processes for the governance of education and training which shall including taking a forward looking and strategic view
- vi. Establish robust mechanisms to be assured of the effective monitoring and management of education and training programmes, including the identification and management of related risk
- vii. Monitor compliance of education and training activities with equity:
- viii. a. statutory and regulatory requirements, including equality legislation and Welsh language requirements and;
- ix. b. with NHS Wales policy and other relevant policies and HEIW's priorities in relation to equality and diversity, person-centred care and participation, and educational quality
- x. Monitor HEIW's compliance with delegated responsibilities given to it by health regulators i.e. GMC, GDC and GPhC as delegated to HEIW

- xi.
- xii. Promote collaboration within HEIW and with external agencies in relation to educational and training governance which shall include wellbeing
- xiii. To work collaboratively with other HEIW Board standing committees
- xiv. Recommend the specification of tender documents to the Board for Education
- xv. Recommend undertaking research on Education, Quality and Commissioning to the Board

The Committee will review and agree the programme of work on an annual basis, and will recommend it to the Board for approval.

4. Membership, Attendees Quorum and Term

4.1 Members

A minimum of two members, comprising:

- Chair - Independent Member
- Members - 1 Independent Member in addition to the Chair

The Chair of the organisation shall not be a member of the Committee, but may be invited to attend by the Chair of the Committee as appropriate.

4.2 Attendees

In attendance:

- Director of Nursing
- Medical Director
- Director of Finance and Corporate Services
- Board Secretary
- Head of Education, Commissioning and Quality

In addition to this, others from within or outside the organisation who the Committee considers should attend, will be invited taking account of the matters under consideration at each meeting.

The Chief Executive shall be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance

Statement.

4.3 Quorum

At least **two** members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair (or Vice Chair where appointed).

4.4 Terms

Immediately following the establishment of HEIW the Members shall be appointed for an initial period of two years. Thereafter Members shall be appointed for a term of one year.

5. Frequency of Meetings

Meetings shall be held no less than quarterly and otherwise as the Chair of the Committee deems necessary – consistent with HEIW's annual plan of Board Business.

6. Relationships and accountabilities with the Board and its Committees/Groups:

The Committee must have an effective relationship with other committees or sub-committees of the Board so that it can understand the system of assurance for the Board as a whole. It is very important that the Committee remains aware of its distinct role and does not seek to perform the role of other committees.

The Committee will maintain effective working relationships with HEIW'S Audit and Assurance Committee (AAC), and with HEIW's other Board committees and subcommittees. To strengthen liaison with the AAC, one non-executive member will serve on both committees.

The Committee will review these Terms of Reference after its initial six months.



GIG
CYMRU
NHS
WALES

Addysg a Gwella Iechyd
Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

Meeting Date	16.5.2019	Agenda Item	2.2
Report Title	Strategic Review of Health Professional Education		
Report Author	Stephen Griffiths		
Report Sponsor	Stephen Griffiths		
Presented by	Stephen Griffiths		
Freedom of Information	Open		
Purpose of the Report	To advise the Committee of the work underway to ensure future education provision for the health professional workforce across Wales.		
Key Issues	<ul style="list-style-type: none"> • This is a significant procurement exercise to secure future health professional education • Additional resource has been secured to support this work • Robust project management arrangements are in place • Stakeholder engagement has commenced through the work of an external agent • The timescale for delivery is challenging and will need to be actively managed. 		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
			✓
Recommendations	Members are asked to consider the contents of this report and the proposed actions.		

STRATEGIC REVIEW OF HEALTH PROFESSIONAL EDUCATION

1. INTRODUCTION

To advise the Committee of the work underway to ensure future education provision for the health professional workforce across Wales.

2. BACKGROUND

The health professional education and training budget has experienced significant investment over the last three years. This has seen the growth in the number of new students supported grow from 2,498 in 2016/17 to 3,409 in 2018/19. The overall funding to support this increase has grown from £85m (2016/17) to £107m (2018/2019).

The main components of the budget cover education contracts with Universities for tuition fees, student bursaries, student salaries and related support costs e.g. travel, childcare payments etc. there are contracts in place with six universities in Wales (listed below):

- University of South Wales
- Cardiff University
- Cardiff Metropolitan University
- Swansea University
- Bangor University
- Glyndwr university

These contracts are “umbrella” contracts that host individual course contracts, negotiated annually in terms of student numbers and fee per student.

The anticipated value of the contracts over the next 5 years will be in the region of £320m - £350m dependent upon future commissioning levels, which is a significant investment for NHS Wales.

The existing contracts were renewed in July 2013 following the identification that the previous contracting process was not compliant with NHS Wales’s procurement procedures and Standing Financial Instructions.

The education contracts had originally been let by the Welsh Government as it directly managed this function prior to the transfer of this responsibility to the National Leadership and Innovation Agency for Healthcare (NLIAH) in 2006/7. The contracts (circa 60 in total) were for different lengths of time, ranging from 3, 5 and 7 years, with many terminating at different times.

During 2011/12 procurement and legal advice was sought regarding the way forward and the advice provided was to develop a new contract for a period of 5 years, commencing July 2013 and for all existing contracts to be novated. This provided a single contracting date and demonstrated that the existing contracts had been reviewed and updated. It also at this time set a timetable for the future whereby all existing contracts would have to go through a procurement process in 2018.

As the contracts were due to expire in July 2018, at the same time HEIW was in the process of being established it was agreed with Welsh Government that the best course of action was to extend the contracts for a period of 3 years (the maximum term allowed). This would enable HEIW to manage the procurement of contracts and afford it the opportunity to set the education agenda in line with its strategic objectives.

In establishing new contracts for the provision of health, professional education HEIW has an opportunity to consider the breadth and configuration of education provision required across Wales to deliver the health and care workforce of the future in response to A Healthier Wales.

Specifically, the procurement process will enable HEIW to:

- Undertake a review of current provision to determine whether it provides high quality education for the investment made
- Review the spread of current education provision across Wales and determine whether different models should be considered to ensure flexible education pathways and ease of access to education regardless of geographical location.
- Identify whether there are gaps in the current education provision commissioned and conversely whether there is education being delivered which no longer meets the needs of the service
- Identify best practice models for the delivery of inter-professional education, for example a regional education hub
- Determine on the viability for the commissioning of Welsh only language provision
- Determine future education provision in order to meet stakeholder/students expectations and which are in line with the future strategic direction for health and care systems in Wales

Desired Outcomes and Benefits realisation

The desired outcomes of this work align with the goals set out in A Healthier Wales and include:

- Provide more education in primary and social care settings. As service delivery moves to primary/community care we need to ensure the workforce is prepared to deliver care within this context. Therefore, increasing levels of education will need to be delivered and facilitated in this setting.
- Enhanced usage of new technology and digitalisation to modernise ways of learning and delivery
- Improved measurement of the impact and added value of the investment in education to Wales, not just focusing on financial added value but the patient experience and pathway, quality of care, staff leadership development.
- A contracting process which has been robustly managed and which results in no contractual, legal or political challenge
- Continued provision of health education with no gap in provision which would have a major detrimental impact on workforce supply
- Development of new flexible career pathways available across different locations in Wales

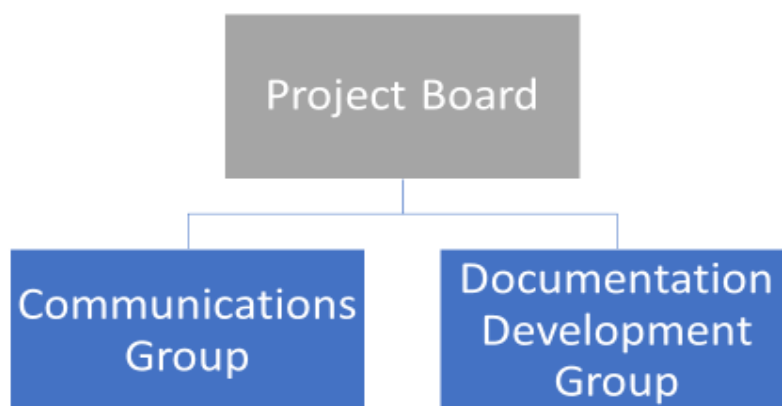
- Provision of inter-professional learning enabling staff across different professions and staff groups to learn together to better enable them to work in multidisciplinary teams when in employment
- Increased use of simulation facilities, improving learners skills prior to face to face contact with patients, increasing the use of technology in the learning experience and upskilling the workforce in the use of technology
- Deliver education in partnership with Social Care Wales to ensure the seamless provision of service across the existing organisational boundaries. Learning together will be a key enabler to removing the boundaries for service provision as individuals and teams deliver care to clients where ever this is based.
- Provision of education locally to enable staff to learn close to home will enable existing staff to develop careers within the health sector and enable the NHS to be recognised as an employer of choice. The provision of local education will significantly improve local recruitment to what are sometimes difficult to recruit to posts.
- Development of intensive learning academic hubs, the procurement process will enable HEIW to explore the feasibility of establishing academic hubs across Wales. The delivery of HEIW Corporate objective as previously identified

3. GOVERNANCE AND RISK ISSUES

Project Management Arrangements

In order to ensure HEIW has robust project arrangements in place the Director of Nursing (SRO) with advise from NWSSP procurement, NWSSP legal team and senior staff from HEIW has devised the following arrangements as illustrated in the diagram below.

Strategic Review of Commissioned Education



The terms of reference for each of these group has been drafted and are being reviewed as part of the initial set up of these groups.

The Project Board will **advise** and **assure** the Chief Executive and the Board on whether effective arrangements are in place to:

- Effectively plan and deliver the strategic review
- To determine future health professional education commissioning requirements
- Successfully procure service providers for the range of education as determined above
- Ensure the timely and successful delivery of these projects goals.

The two supporting groups will enable the project board to achieve the stated objectives as identified above.

Timeline / Document Set

The high-level proposed timeline is set out within Annex 1.

During the same phase as the consultation, there is an expectation for a significant amount of detailed work to commence which will require a substantial input from members of the project team. The project team will be required to support the drafting of all associated procurement documentation, which will include:

- approval to Procure documents (Briefing Papers (approval request) and Welsh Government);
- specification of services for all education requirements: to include service models;
 - Pre-Qualification Questionnaire (which will test regulatory coverage; financial position; Broad capability to undertake such services; Basic criteria to assess legal status of supplier to undertake such services)
 - Invitation to Tender (Compliance to specification of requirements & Service Standards; financial submission regards sustainability and value for money; Policies and procedures in place; Compliance with draft Terms and Conditions of Contract)
- bespoke commercial terms & conditions;
- contractual structure;
- evaluation methodology; and
- Deployment/transition approach.

Following the conclusion of the consultation phase and reporting on the 30th June 2019 there will be a requirement to read the result into the above detailed documents to bring them to a final draft state and then a final state following the pre procurement engagement with interested providers (Aug 2019).

4. FINANCIAL IMPLICATIONS

The financial implications of undertaking this work have been agreed with Welsh Government and additional funding provided.

5. RECOMMENDATION

The Committee is asked to consider the content of this report and the approach being adopted to secure future education provision for the health professional workforce.

Governance and Assurance				
Link to corporate objectives (please ✓)	As a new organisation establishing HEIW as a valued and trusted partner, an excellent employer and a reputable and expert brand	Building a sustainable and flexible health and care workforce for the future.	With Social Care Wales shaping the workforce to deliver care closer to home and to better align service delivery.	Improving quality and safety by supporting NHS organisations find faster and more sustainable workforce solutions for priority service delivery challenges.
		✓		✓
	Improving opportunities for use of technology and digitalisation in the delivery of education and care.	Reinvigorating leadership development and succession planning across health and social care in partnership with Social Care Wales and Academi Wales	Demonstrating value from investment in the workforce and the organisation.	
Quality, Safety and Patient Experience				
The Quality of education directly effects the quality and safety of patients as this is the future health care workforce.				
Financial Implications				
The financial implications of undertaking this work have been agreed with Welsh Government and additional funding provided.				
Legal Implications (including equality and diversity assessment)				
This is a large procurement exercise involving contracts worth hundreds of millions of pounds. It is essential that robust legal and procurement advice is taken and this has been built into the project management arrangements.				
Staffing Implications				
Staff within HEIW will focus on this work and additional resource has been secured to build the teams capacity to accommodate the additional work. this has been agreed through a previous business case.				

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
Not known at this time	
Report History	Business case submitted to Welsh Government for additional funding
Appendices	

Annex 1

Task Description	Estimated start date	Estimated finish date
Run Pre market consultation	Mid-March 2019	30 June 2019
Develop all procurement documentation	Mid-March 2019	Aug 2019
HEIW Sub Committee and Board Approval (informal decision pending market engagement)	Jul 2019	Jul 2019
Undertake pre procurement engagement with interested providers (3 events South; North; and West Wales)	Aug 2019	Aug 2019
HEIW Sub Committee and Board Approval (formal approval following market engagement)	Sept 2019	Sept 2019
Place OJEU Notice to trigger procurement (Open Procedure 24 days with PIN; 40 days without)	1 st Oct 2019	1 st Dec 2019
Issue of Pre-Qualification Questionnaire (Short listing process) & Tender as an Open Procedure	1 st Oct 2019	1 st Dec 2019
Clarification with bidders	Jan 2020	Jan 2020
Evaluation of bids	Feb 2020	March 2020
Clarifications	April 2020	April 2020
Award procedures/sign off	May 2020	May 2020
Engrossing all contractual documents	June 2020	June 2020
Award of Contracts	1 st July 2020	-
Contract Commencement and ongoing contract management	1 st Sept 2021	-

- **Pre procurement engagement** - within and outside of Wales: Clinical/ Service presentation and Procurement Process
- **OJEU Notice** – Notice of tender exercise within the Official Journal of the European Union
- **Open Procedure**
 - **Pre-Qualification Questionnaire** - to short list bidders, ensuring compliance and due diligence (evidence of delivering Health & Social Care). This will be undertaken by the project team plus a wider stakeholder team (to demonstrate impartiality)

- **Tender** – may include ongoing dialogue and discussion/ clarification with bidders
- **Evaluation of bids** – information securely shared with the project team plus a wider independent stakeholder team. May include a clarification and interview stage.
- **Award procedures/sign off** – HEIW Board; NWSSP and Welsh Government
- **Engrossing all contractual documents** – engrossment of all contractual agreements and schedules

Quality Management Update Report: April 2019

Context:

This summary document is broken down into the following four sections:

- Part A – Concerns summary data: Quantitative visit summary by Local Education Provider and specialty group.
- Part B – GMC enhanced monitoring summary.
- Part C – Update on recent Targeted Visits.
- Part D – Summary of future Targeted Visits being scheduled.

Part A: Concerns Summary Data

The two tables below provide a quantitative summary of the number of visits planned and undertaken in the current calendar year as well as providing an overview of the available outcomes to date. Table one provides the information by specialty group and table two provides the information by Local Education Provider.

In considering both tables, it is important to be aware that the number of planned visits can change in line with new intelligence around training environments. In particular, it is predictable that the number of planned visits typically increases following scrutiny of the GMC National Training Surveys results. Additional areas identified for visits following such scrutiny is part of prudent quality management and should not be considered as a cause for concern.

In reviewing both tables it should be noted that it is foreseeable that one department may be visited twice in a year. This is usually to enable the Quality Unit to continue to collaborate with the Local Education Providers and is often part of planned monitoring arrangements, and not necessarily due to concerns over progress. A brief narrative overview of the outcome of recent visits can be seen within part c of this document.

Table One: 2019 Targeted Visits Overview Year To Date By Specialty Group

Specialty Group	Total Number of Visits Planned (Future Date)	Total Number of Targeted Visits Undertaken	Total Visits Planned & Undertaken	Visit Type		Targeted Visit Outcome By Status			
				Number of New Visits	Number of Follow Up Visits	Monitoring Progress	De-escalated to Routine Monitoring	Concerns Over Progress	Visit Outcome Awaited
Surgery	6	4	10	3 (30%)	7 (70%)	2 (20%)	1 (10%)	1 (10%)	6 (60%)
Obstetrics & Gynaecology	2	1	3		3 (100%)			1 (33%)	2 (67%)
Paediatrics/ Paeds Surgery	1		1		1 (100%)	1 (100%)			
Radiology		1	1		1 (100%)		1 (100%)		
Emergency Medicine	1	3	4	2 (50%)	2 (50%)	1 (25%)	2 (50%)		1 (25%)
Medicine	3		3	1 (67%)	2 (33%)				3 (100%)
Anaesthetics/ Intensive Care Medicine	0	1	1	1 (100%)			1 (100%)		
Totals	13	10	23	7 (30%)	16 (70%)	4 (17%)	5 (22%)	2 (9%)	12 (52%)

Table Two: 2019 Targeted Visits Overview Year To Date By Health Board

Health Board	Total Number of Visits Planned (Future Date)	Total Number of Targeted Visits Undertaken	Total Visits Planned & Undertaken	Visit Type		Targeted Visit Outcome By Status			
				Number of New Visits	Number of Follow Up Visits	Monitoring Progress	De-escalated to Routine Monitoring	Concerns Over Progress	Visit Outcome Awaited
Aneurin Bevan UHB	2	1	3	2	1		1		2
Betsi Cadwaladr UHB	1	1	2		2		1		1
Cardiff & Vale UHB	2	2	4	1	3	1	1		2
Cwm Taf Morgannwg UHB	5	3	8	3	5	2		1	5
Swansea Bay UHB	2	2	4	1	3		1	1	2
Hywel Dda UHB	1	1	2		2	1			1
Velindre NHS Trust			0						
Totals	13	10	23	7 (30%)	16 (70%)	4 (13%)	4 (13%)	2 (9%)	13 (65%)

Part B: Enhanced Monitoring Issues

The table on the next page provides an overview of the issues which are currently in Enhanced Monitoring status with the GMC. Where there has been a recent escalation of concerns which may warrant specific discussion by the Executive team this is noted in the Board Action column.

Table Three: Enhanced Monitoring Issues

Ref	Specialty & Site	Key Concerns	Status	Board Action
TP242	Paediatric Surgery	<ul style="list-style-type: none"> Access to relevant experience. Paediatric radiology on call cover availability. Sustainable rota's Learning environment 	<p>Monitoring Progress</p> <p>The Health Board have continued to make progress in addressing this issue since the last visit in November. A further visit with GMC and SAC presence took place on 20th March 2019 in order to consider the appropriateness of re-allocating the trainees. Whilst it was evident that there had been a significant improvement in the training environment there was insufficient evidence around the extent to which ST trainees could achieved the required number of cases if reallocated. Further evidence is currently being collected by the Health Board and we will review the interim data within HEIW in May with the full data set being reviewed with the SAC in July 2019. Following this a decision around the potential to reallocate trainees for October 2019 will be made.</p>	To note
TP245	Obstetrics & Gynaecology Royal Glamorgan Hospital	<ul style="list-style-type: none"> Clinical supervision Embedding training into service reconfiguration. 	<p>Checking sustainability</p> <p>A significant improvement has been identified at the last Targeted Visit and this improvement has been reflected in the GMC National Trainee Survey results. Obstetrics & Gynaecology are due to reconfigure across the Health Board in March 2019 and we are currently arranging a visit in order to monitor the training experience following this reorganisation.</p>	To note
TV170	Medicine Ysbyty Ystrad Fawr	<ul style="list-style-type: none"> Rota challenges History of access to experience concerns. 	<p>Checking sustainability</p> <p>The Health Board have implemented changes to improve the training experience. A further Targeted Visit will take place on 2nd May and a review of the need for ongoing Enhanced Monitoring status will be considered as part of that process.</p>	To note
TP308	Trauma & Orthopaedics Morriston Hospital	<ul style="list-style-type: none"> Clinical Supervision Supportive environment Clinical Supervision 	<p>Monitoring Progress</p> <p>A visit to review progress was undertaken on 16th January 2019. At the meeting it was noted that patient safety was being</p>	To note

		<ul style="list-style-type: none"> • Adequate Experience • Induction • Workload 	compromised due to inadequate clinical supervision on the wards. In addition, there were ongoing difficulties in ensuring that trainees could access the required level of experience. The Health Board has provided a full response to the concerns. A further visit will be arranged for November 2019 in order to monitor progress more formally with remote monitoring in the interim.	
TP344	Obstetrics & Gynaecology Princess of Wales Hospital	<ul style="list-style-type: none"> • Clinical supervision • Adequate experience • Curriculum coverage 	Monitoring Progress The third in a series of visits was undertaken to review progress on 16 th January 2019. Whilst at the previous visit progress had been made in relation to some of the initial concerns, there were persistent concerns around the ability of trainees to access experience relevant to their needs and patient safety concerns were also identified. Therefore, this issue has been escalated to Enhanced Monitoring status with the GMC. A further visit will be arranged for November 2019 in order to monitor progress more formally with remote monitoring in the interim. An initial response to the immediate patient safety recommendations has been received.	To note

Part C: Recent visits Update:

- **Paediatric Surgery, University Hospital of Wales**

As indicated within the Enhanced Monitoring section above a further visit was undertaken with a specific focus upon the reallocation of Paediatric Surgery ST trainees to the University Hospital of Wales. The visit included presence from the GMC as well as the SAC (Specialty Advisory Committee). At the visit it was evident that there had been a significant improvement in the overall training environment with more sustainable rotas, a supportive learning culture and steps had been taken to ensure that aspects such as departmental induction and teaching were in place. However, there was a lack of clarity around the extent to which ST trainees would be able to achieve the requirements of the curriculum. Consequently, the decision around reallocation was deferred whilst additional evidence is collected by the Health Board. An internal review of the interim data will be undertaken within HEIW during May followed by a review with the SAC in July 2019. A decision around reallocating trainees for October 2019 will be made following the review of data with the SAC in July 2019.

- **Intensive Care Medicine, Morriston Hospital**

A Targeted Visit was undertaken on 29th April 2019 in order to review the training experience. At the visit it was noted that rotas had improved and the trainees were well supported clinically and educationally with trainee feedback being particularly positive around the level of support. The visit

report is currently being prepared with the key recommendations being focussed around the need to ensure ACCP's (Advance Critical Care Practitioners) who have been key in supporting the trainees, the need to ensure the provision of simulation training to support the delivery of the curriculum and to ensure that job planning for all lead educational roles.

Part D: Planned Visit Activity:

Over the coming months the following visits are planned in order to review the training experience. The table below excludes any visits which may be part of the Enhanced Monitoring issues highlighted in table one:

Table Four: Targeted Visit Schedule

Ref	Specialty & Site	Grade	Key Issues	Current Status	Visit Timeframe
TP232	General Surgery University Hospital of Wales	Higher	<ul style="list-style-type: none"> New rota intensity with implications for patient safety and trainee exposure. Undermining Management of rota gaps. 	Checking sustainability	Follow up visit to be arranged for November 2019
TP063	Trauma & Orthopaedics Ysbyty Gwynedd	Foundation Core	<ul style="list-style-type: none"> Access to theatre and clinics Staffing levels Concern around ability to deliver IST 	Monitoring Progress	Feedback obtained in the coming months will inform the need for a revisit.
TP256	Emergency Medicine Prince Charles Hospital	All	<ul style="list-style-type: none"> Supervision Staffing levels 	Monitoring Progress	Follow up visit to be arranged for November 2019
TP123	Emergency Medicine Morriston Hospital	All	<ul style="list-style-type: none"> Workload Handover Rotas 	Monitoring Progress	Follow up visit being arranged for November 2019
TP299 & TP206	Trauma & Orthopaedics & General Surgery Nevill Hall Hospital	All	<ul style="list-style-type: none"> Clinical Supervision Workload Induction Handover 	Monitoring Progress	Initial visit taking place on 14 th May 2019
TP340	General Surgery Princess of Wales Hospital	Foundation	<ul style="list-style-type: none"> Clinical Supervision 	Monitoring Progress	Initial visit taking place on 14 th May 2019.
TP365	Medicine University Hospital of Wales	All	<ul style="list-style-type: none"> Emphasis upon service provision impacting upon the ability of the 	Monitoring Progress	Initial visit taking place on 1 st May 2019.

			trainees to achieve the necessary competencies.		
TP078	Ophthalmology Royal Glamorgan Hospital	Foundation & Higher	<ul style="list-style-type: none"> • Curriculum coverage • Adequate experience • Teamwork • Local Teaching • Rotas • Educational Supervision 	Action Planning	Follow up visit to be arranged for November 2019.
TP192 & TP278	General Surgery Glangwili Hospital	All	<ul style="list-style-type: none"> • Clinical Supervision 	Monitoring Progress	Follow up visit to be arranged for November 2019
TP303	Medicine Wrexham	All	<ul style="list-style-type: none"> • Induction • Handover • Workload • Adequate Experience • Time for educational roles 	Monitoring Progress	Follow up visit being arranged for June 2019 potential to Enhanced Monitoring status with the GMC.

Mandy Martin, April 2019



GIG
CYMRU
NHS
WALES

Addysg a Gwella Iechyd
Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

Meeting Date	16.5.2019	Agenda Item	4.1
Report Title	NHS Wales Bursary for Healthcare Students		
Report Author	Stephen Griffiths		
Report Sponsor	Stephen Griffiths		
Presented by	Stephen Griffiths		
Freedom of Information	Open		
Purpose of the Report	This report sets out for the Committee the current position regarding the NHS Wales Bursary.		
Key Issues	<p>The Welsh Government has committed to retain the NHS bursary in Wales for 2019/20.</p> <p>A consultation has been undertaken to consider the financial package to be offered to students/trainees for 2020/21 and beyond.</p> <p>England have removed the NHS Bursary with a subsequent drop in student numbers studying health programmes.</p>		
Specific Action Required (please ✓ one only)	Information	Discussion	Assurance
	✓		
Recommendations	Members are asked to note the content of this report.		

NHS WALES BURSARY FOR HEALTHCARE STUDENTS

1. INTRODUCTION

This report sets out current funding arrangements to support healthcare students whilst they undertake their healthcare education programmes.

2. BACKGROUND

The Welsh Government through the NHS, fund the education and training for a range of health education courses. There are a number of funding schemes of which one is the NHS Wales Bursary Scheme; The funding available through this scheme includes the following:

- the cost of tuition fees
- a bursary for living costs, including
 - a £1,000 non means tested grant,
 - a means tested bursary
 - In addition students are supported for costs such as travel, accommodation (whilst on placement), Childcare, Disabled Student Allowance, Dependents Allowance and Parental Learning Allowance.
- If eligible, you will have access to a reduced student loan (subject to Student Loans Company Regulations)

This is collectively known as the NHS Wales Bursary Scheme. The purpose of the NHS Wales Bursary Scheme ("the Scheme") is to provide financial support for students who are studying Health Education Courses and to incentivise them following qualification to work within the health care sector in Wales.

The bursary scheme for EU nationals includes the provision of tuition fees only. Students have to meet all other costs associated with studying in Wales. EU nationals who commit to work in Wales can access funding for tuition fees but will not be eligible to access the full NHS Wales Bursary Scheme. EU nationals who are unable to commit to work in Wales will have to secure funding for all tuition fees.

EU nationals that have been ordinarily resident in the UK for three years prior to the start of the course are eligible to the same package of support as UK nationals.

Students will have to record their intent on the NWSSP Student Awards Services Welsh Health Education Registration System.

Students commencing their studies in academic year from September 2017 and who commit to work in Wales for the two years following the completion of their course (different timescales apply for course longer or shorter than three years) will be able to access NHS funding as set out above to meet the cost of training.

Individuals who do not feel they can commit to this specified period of employment will not be eligible to receive the benefits of the NHS Wales Bursary Scheme; however they will still be able to study in Wales and will be able to access the following support:

- Welsh domiciled students, who do not wish to commit to work in Wales on completion of their course, will have access to the standard student support package available from Student Finance Wales. Please note that individuals who already have a first degree and are undertaking a pre-registration programme e.g. Physicians Associate, MSc/PG Dip Nursing, PG Dip Dietetics and PG Dip Occupational Therapy programmes are not eligible to apply for a reduced student loan, however they will have access to all other elements of the NHS Wales Bursary Scheme.
- Non-Welsh domiciled students, who do not wish to commit to work in Wales will continue to be eligible to study in Wales but will need to secure funding from an alternative sources, this may include funding from the relevant funding body in their home country or self finance etc.

Once students have received an offer of a training place from a NHS Wales agreed provider they will need to decide whether they wish to commit to work in Wales prior to applying for either the NHS Wales Bursary or the standard student finance package.

3. GOVERNANCE AND RISK ISSUES

Changes to arrangements in England

On 25th November 2015 the Chancellor of the Exchequer announced that students studying nursing, midwifery and allied health subjects from September 2017 would be moved on to the standard student support system, with the details subject to consultation. In addition, he confirmed the cap on the number of student places universities can offer for these subjects in England is to be removed. The driving reason for these fundamental changes as set out by the government is twofold:

1. to 'remove the cap' off the number of nurses and AHP which can be trained and thereby address in part workforce shortages
2. to increase students disposable income and remove students from financial hardship whilst studying

The position in Wales

The Welsh Government have committed to maintaining the Scheme up to the academic year 2019/20, with a further decision to be announced on the position for 2020/21 and beyond. The Welsh Government undertook a consultation during the summer of 2018 and published the findings of the consultation late last year. The Education sector now awaits the Governments decision on the future of the NHS bursary scheme in Wales.

The recruitment process for education programmes commencing September 2020, commences in April 2019 so the decision from Welsh Government is now becoming pressing and HEIW is working with Welsh Government Colleagues to expedite an announcement.

The Impact of the changes

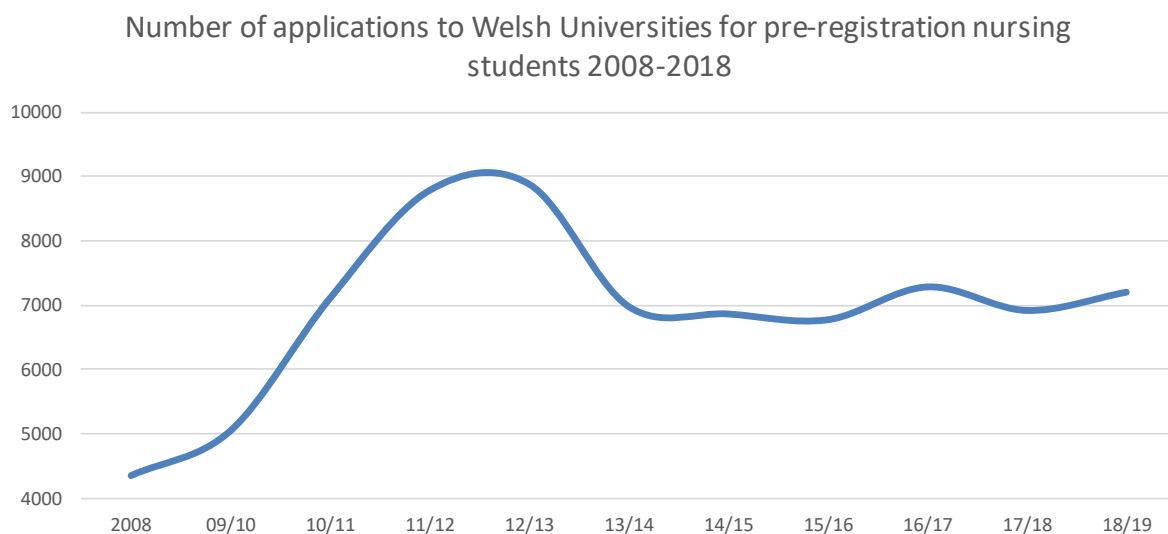
From September 2017 Health Education England no longer provided NHS Bursary's for health education programmes. This covers tuition fees and the bursary. As a consequence healthcare students in England now self-finance their education.

The University and Colleges Admissions Service (UCAS) revealed in August 2018 that the number of nursing degree applications in England has fallen by 12%. Numbers applying to begin training in England in September 2018 dropped by 4,800 compared to 2017, resulting in a total decline of 16,580 since March 2016, the last commissioned intake.

The Welsh Government confirmed that students who commit to work in Wales for 2 years post-graduation will continue to have access to the Welsh NHS Bursary scheme. Students who do not commit to work in Wales will have access to the standard student support package. This has resulted in applications have, in most areas remained buoyant.

The graph below identifies that applications to Welsh health funded courses has remained constant over the last 3 academic years. Since the peak in applications in 2011-2013 there has been little change in the number of applications to Welsh funded courses.

This is positive news and the continuance of the bursary scheme has avoided the declines being reported in England.



England has also reported a fall in mature student numbers (over 26 years old). This has been more extreme than the general decline in healthcare course applications. A 16% reduction has been forecast between 2017 and 2018 with an unprecedented total decline of 40% since June 2016.

By contrast, in Wales, the percentage of mature students recruited has increased from 35% of the student nursing commissions in 2015 to 41% in 2017. These students are predominantly Welsh domiciled and therefore more likely to have “roots” in Wales and be embedded into the local community - thus increasing the probability that they will work

locally upon graduation. 5 years ago a third of all students were above the age of 26. This has risen to 41%. It is documented in England that fewer mature students are applying for courses. In England the fall in mature student numbers (over 26 years old) with an unprecedented total decline of 40 percent since June 2016. The removal of the bursary scheme is cited as one of the main reasons for the decline. In Wales, where the bursary scheme remains, the number of mature students gaining places on funded healthcare courses is at its highest recorded level.

The impact on the changes in England on smaller courses a case study – Learning Disability Nursing

In May 2018 the Nursing Times reported, following a survey by the Council of Deans of Health, that almost half of universities with pre-registration learning disability nursing courses in England have discussed terminating their programmes next year due to student recruitment difficulties. The survey results were based on responses from 15 of the 29 LD Nursing providers in England. It stated that three quarters of universities had, at that stage (May 2018), not been able to make enough offers to applicants to fill all their spaces for courses starting in September 2018.

No universities in London are offering a LD nursing course for September 2018.

Wales has also experienced difficulty recruiting to LD nursing. Application rates are low compared to the other fields of nursing. However, whilst the two Universities in Wales have failed to fill all their commissioned places, the viability of the programmes are not in question. Commissioning numbers are increasing and although these are not being achieved, the Universities are recruiting more students onto their LD courses than in previous years. Part of this is due to the bursary scheme remaining in Wales but part is also due to the innovative collaborative approach to marketing and development employed by the two LD Nursing providers and the Commissioner.

Bursary Scheme v Diamond Package

It is probable that, under the Bursary Scheme, students will graduate with no or little debt (and certainly less debt than under the English system or Diamond). However, Diamond does allow the student access to more funding whilst they are studying. Although this will result in students repaying student loans for longer into their careers and will affect their borrowing rights once they commence employment it will also alleviate stress and financial pressures during their study. Financial pressure and stress related to this is a cause of attrition and therefore the Diamond package, for some students, may be more attractive and enable students to complete their studies and graduate to work within their chosen profession within Wales.

The key findings from the WG consultation are summarised below;

- 96% of respondents agreed that support to those studying health care related programmes should continue.
- 87% of respondents agreed the format of healthcare courses should be recognised and addressed through any future arrangements.

- 85% of respondents agreed placement capacity should be led through a commissioning process led by HE&IW.
- 85% of respondents agreed that any package of enhanced support for individuals should continue to be based on a commitment to working in Wales for a post qualification employment period (PQEP).
- 52% of respondents agreed that an exception should be made to allow first degree holders wishing to study a second degree on a healthcare programme in England to have access to student support.
- 81% of respondents agreed that support provided for second and subsequent support packages for health related programmes should be conditional upon individuals committing to work in Wales post qualification.
- 57% of respondents agreed that the student support programmes for medical and dental programmes should be aligned with those for other health related programmes in the future.
- In terms of future options, Option 3 was the most popular choice, with 40% of respondents agreeing for Healthcare students to receive the standard maintenance support package offered by Student Finance Wales, and an NHS Bursary to cover the funding of full tuition fees up to a maximum and an additional funding element for additional costs for clinical placements – subject to agreeing a post-qualification employment period.

The results of the consultation and the WG policy are expected later this year.

4. FINANCIAL IMPLICATIONS

HEIW is currently developing the education and training plan for 2020/21 and this is to be submitted to Welsh Government during July of this year. Understanding the bursary offer is critical to this as it determines the financial cost of training students/trainees.

5. RECOMMENDATION

Members are asked to note the content of this report and will be updated when the Welsh Government issues further statements and policy intent.

Governance and Assurance				
Link to corporate objectives (please ✓)	As a new organisation establishing HEIW as a valued and trusted partner, an excellent employer and a reputable and expert brand	Building a sustainable and flexible health and care workforce for the future.	With Social Care Wales shaping the workforce to deliver care closer to home and to better align service delivery.	Improving quality and safety by supporting NHS organisations find faster and more sustainable workforce solutions for priority service delivery challenges.
		✓		
	Improving opportunities for use of technology and digitalisation in the delivery of education and care.	Reinvigorating leadership development and succession planning across health and social care in partnership with Social Care Wales and Academi Wales	Demonstrating value from investment in the workforce and the organisation.	
Quality, Safety and Patient Experience				
The supply of the next generation of the healthcare workforce is critical to patient experience and patient safety. Changes to the student finance system could impact on the recruitment to training places and the future workforce supply.				
Financial Implications				
HEIW is currently developing the education and training plan for 2020/21 and this is to be submitted to Welsh Government during July of this year. Understanding the bursary offer is critical to this as it determines the financial cost of training students/trainees.				
Legal Implications (including equality and diversity assessment)				
None known at this time				
Staffing Implications				
None known at this time				

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
None known at this time	
Report History	None
Appendices	None



Title of Business Case:	Developing Cluster Based Optometry Services - Commissioning of postgraduate modules in Medical Retina, Glaucoma and independent prescribing.
Submitted to Welsh Government by	Alex Howells
Executive Sponsor:	Stephen Griffiths
Document Author:	Nik Sheen, Eye Care Transformation Lead
Date:	25th April 2019

1. Executive Summary

This case puts forward a simple approach to commission qualifications designed to facilitate additional community optometry practice management of: patients with suspect glaucoma and ocular hypertension; triage referrals for Wet Age related Macular Degeneration (AMD); acute eye care presentations, through the prescribing of medication. A unique approach to training placements for qualifications is proposed where optometrists would work in hospital glaucoma and acute services with an NHS contract. By ensuring that qualifications are offered to optometrists working in every cluster in Wales we would achieve national coverage, targeting a reduction in demand for secondary care across Wales.

The present configuration of eye care services is predominantly hospital based and faces pressures of increasing demand and insufficient capacity due to the treatment and subsequent monitoring of patients. This results in:

- Long referral to treatment times
- Delays to follow-up in ophthalmology secondary care
- Risk of irreversible sight loss from eye diseases such as glaucoma.
- Underutilisation of alternative pathways in the community
- High cost premiums for the system as a result of reliance on waiting list initiatives
- Impact on staff morale and wellbeing in secondary care

Placing glaucoma and medical retina services in community requires personnel with appropriate training and qualifications to manage patients. NICE guidance provides clear evidence-based guidance for eye conditions such as glaucoma and sets out how patients can be monitored and managed independently or in an integrated care scenario by optometrists. A framework of the necessary competencies for glaucoma and medical retina has been devised, see Appendices (The Royal College of Ophthalmologists, 2017) and there are existing qualifications meeting these requirements. Additionally, having more optometrists in the community capable of independent prescribing, facilitates the transfer of services and enables greater numbers of patients to be treated in community without onward referral and reducing demand on General Practice.

Patient access to community optometry practice is excellent with practices in all areas of Wales, both rural and urban services all cluster populations. Optometry practices are well equipped with the majority of optometry practices in Wales having advanced equipment such as the Ocular Coherence Tomography (OCT). Finally, levels of patient satisfaction with optometry services is very high and enabling more services in community will lead to continuity of the patient experience.

Glaucoma

Glaucoma Ophthalmic Diagnostic and Treatment Centres (ODTCs) have been established in all health boards in Wales. ODTCs currently enable nurses, orthoptists and/ or optometrists to assess and manage patients with varying levels of virtual review by a consultant. In most health boards ODTCs are also situated in community optometry practices with the necessary equipment and technology set up to do this. The present model of virtual review by consultants takes up valuable clinic time when a suitably trained and qualified optometrist could make autonomous treatment and management decisions. This could be carried out community ODTCs or practices that have suitable equipment.

Age related Macular Degeneration (AMD)

At present there is one AMD pathfinder optometry practice in Wales which screens AMD patient referrals from across the health board. However, optometrists in the practice do not make decisions on referral and triage but instead use equipment to take images and send these images off for virtual review by a consultant. With suitable training and qualifications, optometrists could reduce the numbers of patients needing to be referred into secondary care. If this could be repeated in each cluster it would substantially reduce the numbers of patients being referred into the AMD secondary care service.

Independent Prescribing

Enhanced eye care services, such as the Eye Health Examinations Wales (EHEW) enable patients with acute eye care problems to attend an optometry practice. Last year (2018-2019) 81,804 patients were seen by optometrists in primary care with acute eye problems (EHEW data; NHS SSP). This reduces the numbers of patients attending GP surgeries or secondary care. However instigating treatment options for many eye conditions is not possible without an optometrist holding an Independent Prescribing qualification. Currently there are two options; referral to the GP for medication provision or refer onto secondary care treatment. If optometrists in all clusters in Wales had an Independent Prescribing qualifications this would reduce the numbers of patients presenting to the GP for treatment and being referred into secondary care.

If optometrists working in ODTs and pathfinder optometry practices had the necessary glaucoma, medical retina and independent prescribing qualifications, they could make autonomous patient management and treatment decisions using numbers of patients referred to secondary care. Furthermore, once the principle is established, patients with eye disease such as glaucoma can be managed in community optometry practices instead of secondary care; moving patients out into the community. Furthermore with an electronic referral and review system, seamless, integrated care could be established in community optometry.

In order to make this happen, it is necessary for optometrists in Wales to be trained to the appropriate standard in medical retina, glaucoma and independent prescribing. Fortunately, NICE endorsed qualifications are available at Cardiff University and other Universities and we can identify optometrists to take these qualifications. Once qualified, these optometrists could prevent up to a third of referrals into secondary care for Wet AMD and could manage thousands more patients with suspect glaucoma and acute eye disease in primary care.

Whilst electronic patient records (EPR) are a potential barrier to the transfer of services, a Wales-wide bid to develop and refine an EPR is approved and it is expected to be delivered within 2 years. Currently, most secondary care ophthalmology units do not have an EPR but demonstrate that it is possible to run eye care services in different geographical locations without an EPR.

The Higher Certificate glaucoma and Independent Prescribing qualifications do require a placement in secondary care of 6 month duration at 1 session per week; a total of 24 sessions or 12 whole days. Whilst it may be challenging to find placements. We propose a unique method to achieve this; not available anywhere else in the UK (see below).

Placements in hospital eye care clinics

We propose for each optometrist studying for Independent Prescribing and Higher Certificate in Glaucoma qualifications, the required placements are carried with an NHS contract with a Health Board. HEIW would pay for a 7 month NHS contracted position within

Draft v7

an eye hospital in Wales. This ensures that optometrist are paid for their work and that the health board has an additional staff member to see patients. Where optometrists work in glaucoma clinics/ eye casualty for 7 months, they become an asset for the Trust because they will start to become more autonomous after the first 1-2 months and can increase capacity of the clinics by seeing patients. Whilst there needs to be supervision, it is far less than Foundation Level and early career specialist trainees requirements.

1.1 Link to HEIW Strategic Priorities

This business case directly supports HEIW's strategic priorities and objectives set out in its annual plan for 2019/20, including:

Strategic Objective 4A (iii)

By the end of 2019/20 we will have developed workforce solutions to support NHS Organisations in improving Eye Care. To provide an increase in the number of optometrists with nationally recognised eye care higher qualifications by commissioning of higher qualifications education for optometrists.

1.2 Summary of Financial Costs and Funding to support Business Case

Funding requirement for commissioning of 83 places on 3 courses plus payment to cover time spent on a placement and 0.4 FTE post to manage course places and placements.

Yr 1: £73,224
Yr 2: £152,955
Yr 3: £118,688
Yr 4: £30,454

Total =£375,321 over 4 years.

1.3 Timescale

September 2019 –September 2023

2. Outline Business Case

2.1 Purpose

This case sets out proposals to invest in additional education for optometrists to provide a viable alternative to present models of care, supporting the shift to community with development of an integrated eye care pathway with sustainable high quality patient service accessible in community settings.

2.1 Current Service Provision

Glaucoma and glaucoma related eye disease and Age related Macular Degeneration represent the majority of all ophthalmology work. Despite significant investment in eye care, demand is outstripping current capacity of the workforce (see Section 2.2). This trend of increasing need for services will continue alongside an increasing opportunity and demand for new treatments in eye care. There have been some annual increases in capacity in new and follow-up cases for ophthalmology outpatients. However, the increase in activity has not kept in step with the increase in demand. Additionally, the current service provision for patients is based largely in secondary care hospital sites meaning care is not closer to home. Optometrists in primary care are a contractor NHS service with a terms of service agreement for basic eye care services. They are not NHS employees and so cannot gain access to funds for training available for NHS staff. Optometrists currently provide enhanced eye care

services such as the Eye Health Examinations Wales (EHEW) service where they manage over two thirds of patients presenting with acute eye care problems without onward referral. However, there is scope and potential to upskill optometrists to provide more services in primary care transferring patients to care closer to home.

2.1.1 Wet Age related Macular Degeneration

At present, wet AMD is treated by injecting anti-VEGF drugs directly into the eye. This treatment slows or arrests the progress of wet (AMD) but it is not a cure for the condition. Optometrists refer patients with suspected Wet age related macular degeneration (AMD) within 2 weeks to be seen and treated. Patients with wet AMD need 4 to 8 weekly review and injections into the eye. Currently, when patients with potential wet AMD are referred, at least a third are discharged (Chris Blyth, personal communication). The Ocular Coherence Tomography (OCT) scanner is crucial for clinical decision making in deciding if a patient has Wet AMD or not. Ophthalmologists make these decisions. Other professional groups can be trained to read the OCT scans and examine patients to determine if treatment is required. Increasingly, primary care optometry practices are equipped with OCTs (current estimate is over 50% of practices in Wales) and it would be appropriate for them to be used to monitor patients in primary care optometry. However, interpretation of the results is challenging, and further qualifications are required. The College of Optometrists Professional Certificate in Medical Retina is an appropriate qualification for this role and is recognised in the College of Ophthalmology Clinical Competency Framework.

Currently, one optometry primary care practice in Aneurin Bevan University Health Board, all AMD referrals in the area are diverted to this practice where data is gathered and processed before being sent virtually to a Consultant. However, with the Medical Retina qualification much of the clinical decision-making could be done without Consultant input, resulting in freeing up capacity for Medical Retina Consultants. The regular review of patients once treatment has been instigated could also be carried out in primary care according to local protocols.

2.1.2 Glaucoma, Ocular Hypertension and Suspect Glaucoma

Patients with suspect glaucoma, ocular hypertension (raised eye pressure without glaucoma damage) and glaucoma are referred into secondary care hospital eye services for diagnosis, management and treatment. Glaucoma Ophthalmic Diagnostic and Treatment Centres (ODTCs) are increasingly established in primary care optometry practices and provide a mechanism for patients with OHT, suspect glaucoma and low risk glaucoma to be managed. Furthermore, with the Higher Certificate in Glaucoma qualification and independent prescribing, optometrists can manage and change treatment for these patients.

2.1.3 Independent Prescribing

Enhanced eye care services in Wales currently enable optometrists to manage approximately two thirds of patients presenting with acute eye problems. However, where ocular medication is required for ocular conditions such as Herpes Simplex keratitis, the optometrists must either co-manage with the GP or refer to secondary care. With independent prescribing these cases could be managed in primary care. This releases capacity for GPs and secondary care eye casualty.

2.2 Case for change – Service need

Nearly 10% (9 million annually) of all outpatient appointments are for eye clinics in the UK. Research undertaken by NHS Digital in 2017–18 found that ophthalmology is now the busiest outpatient speciality. Research undertaken by The Way Forward Project for ophthalmology (2017) looking at prevalence of disease and population projections suggests

an increase in demand over the next 10 years of 30% for medical retina services and 22% for glaucoma services. The demand for glaucoma and medical retina services is not currently manageable within secondary care and this is unlikely to change in the near future. For example, age related macular degeneration (AMD), a medical retina condition, is the leading cause of sight loss in Wales. The workload associated with wet AMD treatment is growing rapidly due to the ageing population and the requirement for regular long term follow up visits for patients post treatment.

In Wales, the Planned Care Programme in Welsh Government, in agreement with the clinical leads for eye care, has agreed a number of priorities for eye care services. The general consensus is if these actions are fully implemented then services should start to improve:

- For Wet AMD, an integrated clinical pathway, to include refinement systems based on OCT equipment
- Glaucoma follow-up. Health board compliance with recommended follow-up and new patient targets

Additionally, the use and expansion of ophthalmic diagnostic treatment centres (ODTCs) was recommended. Furthermore, the recommendations of a Pathfinder evaluation of Wet AMD services in Wales (2018) is to increase capacity by streamlining the patient journey. This includes increase capacity in wet AMD services by reducing the number of unnecessary referrals into the hospital eye service (Referral Refinement).

To enact these recommendations, transformation at primary care optometry practices with appropriately qualified staff on hand needs to occur. With the ODTC models in all health boards transformation at the practices has begun. Training optometrists to operate referral refinement in AMD and the management of patients with glaucoma and glaucoma related eye disease can achieve service transformation in a sustainable manner in all cluster regions.

2.3 Impact on other services/ departments

2.3.1 Optometry

In primary care, there is currently no wait for appointments and capacity is available to meet the demand. A recent survey of the profession in Wales, undertaken by Optometry Wales in 2018, indicated that whilst some optometry practices are struggling to meet demand for optometry services there is an equal number that has some spare capacity. This indicates that the optometric workforce is well placed to deliver further enhanced services. The Eye Health Examination Wales (EHEW) service is currently used as a payment mechanism to optometrists to deliver enhanced eye care services and could also be used to pay for additional services such as glaucoma monitoring. The impact of additional training for the optometry professional adds value by increasing confidence in clinical decision making, the opportunity to discuss with peers challenging cases in training and encouraging further education. This would result in better service delivery in primary care eye care services through improved clinical decision making and confidence in managing more patients resulting from additional learning.

2.3.2 Ophthalmology

Wet AMD services would potentially see a 33% drop in numbers of cases being referred for intra-vitreous injections. Glaucoma outpatients would have capacity released as patients

would be seen in primary care. Qualified independent prescribing optometrists would refer fewer patients to eye casualty thereby reducing unmet demand.

2.3.3 GPs

GPs last year (2018-2019) sent 18,202 patients to optometrists for eye problems. Approximately 20% of these were then co-managed with the GP for medication (EHEW data; NHS SSP). This demand on GPs for provision of ocular medication would be reduced if optometrists had Independent Prescribing qualifications and WP10 pads to prescribe. A plan is in place to provide these pads via an NHS Shared Service Partnership budget from September 2019.

2.4 Evidence Base (eg: From Pilots/ Quality Improvements)

2.4.1 Medical Retina

An independent evaluation of several pathfinder models of Wet Age Related Macular Degeneration services in the community (Pathfinder evaluation, 2018) in Wales made 7 recommendations, two of which related to community optometrists and their training:

1. To expand capacity and reduce the pressure on ophthalmologists' workload, non-medical health care professionals should be trained to provide elements of the care pathway. Community optometrists are ideally situated for patient convenience and for carrying out referral refinement and monitor stable patients in their practices.
2. Nationally agreed competencies and training for non-medical Health Care Professionals

An evaluation of 708 consecutive patient presentations in the pathfinder treatment centre in ABUHB found that the time from referral to first treatment for Wet AMD suspects was reduced from a mean of 36.7 days for the traditional pathway to 22.8 days for the refinement pathway (Chris Blyth, personal communication).

For the qualifications, the College of Optometrists Professional Certificate Medical Retina is the UK-agreed training for optometrists to carry out referral refinement and monitoring of stable patients with wet AMD in their practice. It is endorsed by NICE and the Royal College of Ophthalmologists for this purpose.

2.4.2 Glaucoma

All Health Boards have been running at least one Ophthalmic Diagnostic Treatment Centres (ODTC) manned by non-medical professionals in hospitals for some time. Aneurin Bevan University Health Board has 5 primary care sites in optometry practices. An evaluation of the ODTCs (Lee, 2015) found that waiting times between appointments was reduced and patient satisfaction was almost universal. However, the ODTC sites are currently using virtual review rather than autonomous decision making by optometrists. With the appropriate qualifications, optometrists can make the clinical decisions necessary to keep patients out of outpatients and either reviewed or discharged to primary care.

For qualifications themselves, NICE (2016) has reviewed the evidence and advised that optometrists with higher certificate in glaucoma can be more autonomous and make decisions. Specifically:

- Management of OHT and suspected glaucoma including changing treatment where necessary if they also have an Independent Prescribing qualification.

- Manage and monitor patients with low risk glaucoma if provided with a management plan

Adoption and implementation of these nationally recognised competency framework for extended roles will be possible provided optometrists achieve the aforementioned qualifications. This would provide sustainability and flexibility in the workforce and enable mobility of personnel within Wales, and it is essential to ensuring safe patient care.

2.4.3 Independent Prescribing

In Scotland, all optometrists are funded to take Independent Prescribing qualification. The impact has mainly been on eye casualty and walk-in emergency centres. For example, in 2009 the level of walk-ins at one hospital in Grampian was at 6,000 annually and increasing, leading to long travel times and waits for patients, a chaotic environment, and specialist resources being used to treat non-urgent cases. An audit demonstrated that over 90% of patients could have been treated within community optometrists. Following the introduction of independent prescribing and signposting of patients, nearly all patients care is provided by optometrists.

2.5 Service Demand & Capacity Analysis (including workforce analysis and challenges)

2.5.1 Ophthalmology

Glaucoma and Age related Macular Degeneration (AMD) are amongst the most prevalent eye conditions in Wales. By 2030 there will be a large increase in the number of new patients needing eye health care services because of the aging population, particularly in glaucoma and AMD – see Table below.

Eye Condition	Estimated number of people in Wales living with the condition in 2015	Estimated number of people in Wales living with the condition in 2030	Percentage increase 2015 to 2030
Late stage dry AMD	10,660	15,320	44%
Late stage wet AMD	21,870	31,890	46%
Glaucoma	27,230	29,940	10%

Health Boards received 91,846 referrals for ophthalmology in 2016-17. In outpatients in ophthalmology, there have been some annual increases in capacity in new and follow-up cases. However, the increase in activity has not kept in step with the increase in demand.

At the end of the financial year 2017-18, 2,549 patients were waiting longer than 26 weeks for their first outpatient appointment. By the end of October 2018, this had risen by 89% to 4,811. At the end of the financial year 2017-18, 247 patients were waiting longer than 36 weeks at the treatment stage of their pathway. By the end of September 2018, this had risen by 93% to 477.

Follow up appointments for patients, pre and post treatment continues to increase. At the end of the financial year 2017-18, 114,913 follow-up patients were waiting for an appointment. This is an increase of 44% from 79,560 follow-up patients waiting at the end of 2016-17. By the end of October 2018, this had risen by 1,743 patients to 116,656.

The current ophthalmology workforce in Wales would not be sufficient to keep up with increasing demand with the ophthalmology workforce census (2018) suggesting there should be 22% more consultants to meet expected demands. In Wales, there have been struggles to attract consultants to posts. In ABUHB, for example, there have been 2 glaucoma consultant posts available and unfilled for 2 years. Ophthalmology will require other ways of delivering services.

2.6 Service Performance - Baseline Information (Productivity and efficiency measures and metrics, bench-marking)

The following metrics can be monitored to provide evidence of effectiveness.

Direct

1. The number of optometrists with the Higher Certificate in Glaucoma before and after in each cluster
2. The number of optometrists with the Medical Retina Certificate before and after in each cluster
3. The number of optometrists with the Independent Prescribing Certificate before and after in each cluster
4. The proportion of suspect glaucoma, OHT and glaucoma patients discharged to community optometry practices in each cluster
5. The proportion of AMD referral refinements received in secondary care from community and development ODTCS
6. Analysis of optometrist ocular medication prescribing data per cluster compared with the numbers of GP ocular medication prescribing data.
7. Comparative analysis of clusters with and without services to evaluate the impact of the new services on patient numbers.

Indirect

Ophthalmic Planned Care Board Monitoring:

1. Waiting times for new and follow-up for patients with Glaucoma
2. Waiting times for new and follow-up for patients with AMD
3. The number of new referrals received in eye casualty from optometrists.

The increased value from additional qualifications, such as: Improved clinical decision making; confidence in clinical decision making; improved diagnostic capabilities and change in clinical practice are difficult to measure but pre and post qualification qualitative questionnaires will be in place to test optometrist perceived benefits and change to practice. In addition qualitative analysis of patient satisfaction with services can be carried out.

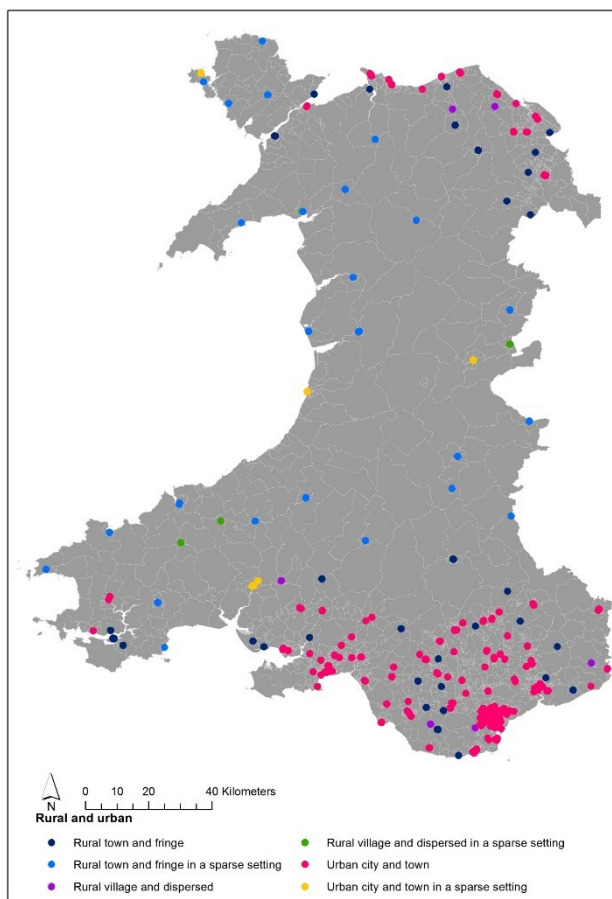
2.6 Workforce Implications

When registered optometrists were asked about their aspirations in specific clinical and professional areas, the two top areas, chosen by half or more of respondents, are the management of specific conditions such as glaucoma and medical retina (68%) (AOP workforce survey, 2018) indicating a willingness of the profession to train in these areas. In Wales, OW workforce survey (2018) also demonstrated that there is an appetite to study

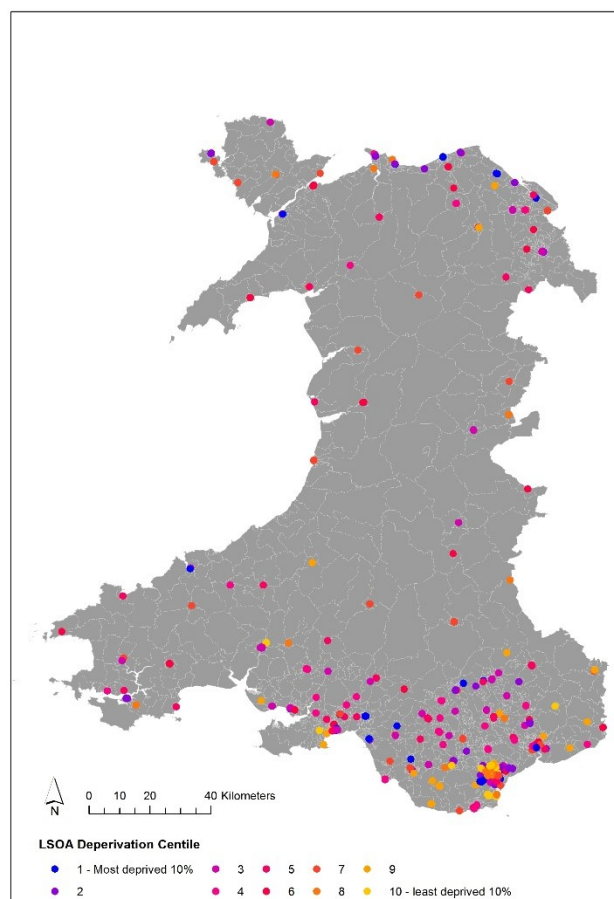
Draft v7

Higher qualifications across all age groups. Geographically, optometry practice coverage is excellent in all areas of Wales, including in deprived areas and rural populations (see maps below). In analysis of journey times to an optometrist practice taken from real visits between 2017-2018, the average was 10.6 minutes and the distance between a patient's home and the optometrist practice was 4.2 miles. Additionally, patients in more deprived areas travelled less distance to reach an optometry practice.

Practices by rurality



Practices by deprivation score (WIMD)



Current numbers of optometrists with higher qualifications.

Health Board and of numbers clusters	Independent Prescribing	Medical Retina	Glaucoma
ABMUHB 11 clusters	3 in 3 clusters	6 in 4 clusters	8 in 7 clusters
ABUHB 12 clusters	12 in 12 clusters	0	7 in 5 clusters
BCUHB 14 clusters	1 in 1 cluster	8 in 8 clusters	1 in 1 cluster
CTUHB 4 clusters	4 in 4 clusters	6 in 4 clusters	5 in 4 clusters
CVUHB 11 clusters	6 in 5 clusters	5 in 4 clusters	5 in 5 clusters

HUHB 7 clusters	4 in 3 clusters	7 in 7 clusters	6 in 5 clusters
Powys 3 clusters	3 in 2 clusters	0	6 in 5 clusters
TOTAL	33	32	38

62-33 = 29

62-32 = 30

62-38=24

In Wales there are a number of optometrists already trained in the higher qualifications necessary to provide services in the community (see table above). However, if the services are going to be equitable for patients and scalable it is necessary over the next 3 years to have at least 1 optometrist qualified in Independent Prescribing and Medical Retina qualifications in each of the 62 clusters. This will ensure there is coverage in all areas of Wales and ensure a reliable, consistent and equitable service. Optometrists working in primary care optometry practices with an ODC or referral refinement centre will be prioritised to take up qualifications.

3. HEIW Strategic Priorities

This business case directly supports HEIW's following strategic priorities and objectives set out in its annual plan for 2019/20.

Link to HEIW Annual Plan/ Integrated Medium Term Plan/Corporate Objectives	<p>Strategic Objective 2 - Building a sustainable and flexible health and care workforce for the future. 2B Developed and improved the education and training available to (i) Health professionals and healthcare staff.</p> <p>Strategic Objective 3. With Social Care Wales shaping the workforce to deliver care closer to home and to better align service delivery. 3B Developed a workforce plan for the new primary care model based on enhanced and extended multidisciplinary teams.</p> <p>Strategic Objective 4A (iii). By the end of 2019/20 we will have developed workforce solutions to support NHS Organisations in improving Eye Care.</p>
---	---

4. Desired Outcomes and Benefits Realisation Plan

The desired outcomes are to:

1. Patients managed closer to home
2. Improve patient experience and satisfaction
3. Improve services in eye hospital for patients by:
 - Releasing capacity in secondary care in wet AMD services
 - Releasing capacity in secondary care in glaucoma outpatients
 - Releasing capacity in secondary care in eye casualty.
4. Improve utilisation, career pathways, recruitment and retention of optometrists

5. Extend capacity in hospital eye care outpatient clinics when optometrists are on placement in these clinics.

Outcome 3 are complex measures that are challenging as services are already at capacity and effectively we will release unmet capacity which is unknown. However, as a surrogate measure we can determine the numbers of patients seen in primary care as this gives us a measure of what the potential of released unmet capacity is in secondary care.

5. Option Appraisal

Cost/Benefit Analysis of Options

5.1 Option 1 - Do Nothing (baseline):

Benefits/Value: No finance allocated to qualification commissioning. Maintains the status quo with services in primary and secondary care so that no shifts in services are carried out. Continuation of current service provision is familiar and reporting mechanisms pre-exist in health boards and clusters.

Pay & Non Pay Costs: No change, although waiting list initiative clinics and outsourcing are increasingly likely and are associated with increased costs to health boards.

There would be no business case and no associated pay and non pay costs.

Risks including consequence, likelihood and mitigating action/s:

There will be no incentive for health boards to move patients with glaucoma to primary care. Ophthalmology services will continue to fail to meet RTT and new prioritisation targets and patients will be at risk of blindness whilst on waiting lists. Consequently, there is a risk of patient litigation and the associated costs and increasing funding given to waiting list initiatives and outsourcing.

Referral refinement of patients with Age related macular degeneration (AMD) will not take place in primary care continuing the trend of 33% of unnecessary referrals going in to secondary care. Further AMD monitoring services in primary care will not happen. The impact in secondary care will be to continue to put pressure on patient waiting targets.

The numbers of ocular medications prescribed by GPs will remain the same and there will be no decrease in the time that GPs would spend on eye care; including co-management of patient medications with optometrists.

There will be continue to be barriers between primary and secondary care as the workforces will not be working together to manage patients.

5.2 Option 2 – Qualification commissioning only with no costs for placements given

Benefits/Value: Optometrists complete higher qualifications providing an additional resource in primary care to manage more patients.

This would have the following benefits:

- There would be fewer unnecessary patient referrals into secondary care for Age related Macular Degeneration (AMD)
- More patients could be managed in primary care for acute eye problems because of access to a full range of ocular medications
- Some patients with glaucoma could be managed in primary care

This is the cheapest option to provide training only.

Pay & Non Pay Costs: The costs will only include commissioning for qualifications. See below

Risks including consequence, likelihood and mitigating action/s: The major risk is that optometrists will not complete the placements. Optometrists are asked to attend the course and carry out many hours of study time without payment. Optometrists are business owners and do not hold NHS contracts and whilst optometry is protected through a terms of service agreement with the NHS, nearly all optometrists are employed by private businesses. Primary care optometrists are not paid to do the placements or paid for any study time. Attending placements for at least 6 months for half day per week without any pay adds financial pressure. Previous optometrists who have done courses have pulled out due to financial reasons at the placement stage. Providing a payment mitigates against this.

COSTS BASED ON OPTION 2					
<i>Financial Assessment, including Value for Money</i>	Summary	Year 1	Year 2	Year 3	Year 4
		£	£	£	£
	Income/ Disinvestment in existing service/s?	0	0	0	0
	*Pay costs (backfill to cover placements)	0	0	0	0
	*Non Pay costs				
	Total – Recurring Costs (*To include support costs & overheads)				
	Non-recurring costs: Pay costs (modules)	£41,947	£75,020	£44,770	£8,873
	Non Pay costs (*To include support costs & overheads)				
	Total Cost	41,947	75,020	44,770	8,873

5.3 Option 3 – Qualification commissioning with additional backfill costs given to cover placements

Benefits/Value:

Optometrists complete higher qualifications providing an additional resource in primary care to manage more patients.

This would have the following benefits:

- There would be fewer unnecessary patient referrals into secondary care for Age related Macular Degeneration (AMD)
- More patients could be managed in primary care for acute eye problems because of access to a full range of ocular medications
- Some patients with glaucoma could be managed in primary care

Optometrists will be provided with a mechanism to do the course and complete placement time with backfill payments to ensure they complete the placements. They will attach value to the idea of studying and working alongside ophthalmologists. By having funding to cover their time out of practice they will not be at a financial disadvantage by spending half a day per week out of practice. Many optometrists are practice owners and they need to arrange cover for time out of the business. A locum fee of 250 pounds per day is the national average (Association of Optometrists).

Pay & Non Pay Costs: See below.

Risks including consequence, likelihood and mitigating action/s: Optometrists will not complete the placements but receive funding. Contracts with the optometrists will be exchanged to ensure any payments made must be repaid if the course and placement is not completed. Alternatively, placement payments will only be paid on completion of the placement. Completion of courses and placements evidence is readily obtainable from Universities and/ or the regulator.

There is a risk that health boards and clusters will not move services to primary care for glaucoma. This can be mitigated by involvement of the health boards at an early stage of negotiations.

There is a risk that eye hospitals do not facilitate and provide placements. Hospitals would not be mandated to provide placements, instead this would need to be negotiated individually with each health board.

COSTS BASED ON OPTION 3					
<i>Financial Assessment, including Value for Money</i>	Summary	Year 1	Year 2	Year 3	Year 4
		£	£	£	£
	Income/ Disinvestment in existing service/s?	0	0	0	0
	*Pay costs (backfill to cover	32,645	77,749	70,531	20,104

	placements and project worker)				
	*Non Pay costs				
	Total – Recurring Costs (*To include support costs & overheads)				
	Non-recurring costs: Pay costs (modules)	41,947	75,020	44,770	8,873
	Non Pay costs (*To include support costs & overheads)				
	Total Cost	74,592	152,766	115,301	28,977
TOTAL COST = 371,636					

5.4 Option 4 – Qualification commissioning with NHS contract for placement

Benefits/Value:

There are the same benefits and value as Option 3 with the additional benefit that a paid post with the NHS for the 7 month time of the placement would ensure that HBs provide the placements and that optometrists are committed to the placement whilst receiving payment. HBs employing the optometrists would gain an asset because optometrist will start to become more autonomous after the first 1-2 months and eye clinics can then increase capacity of the clinics. Whilst there needs to be supervision it is less than Foundation Level trainees and early career specialist trainees. Effectively the Health Board gets a net gain from the placement.

Additionally, optometrists undergoing placement will have access to medical journals and other NHS provisions.

Pay & Non Pay Costs:

See below.

Risks including consequence, likelihood and mitigating action/s:

Most risks previously detailed are mitigated by having an NHS contract so that placements are available in health boards.

There is a risk that optometrists will not complete their training. To mitigate against this we would ask that optometrists who do not have extenuating circumstances would have to pay back their costs for the module.

There is a risk that the training placements in secondary care would not be fit for purpose. We would produce training contracts in place with the health boards so that an identified Mentor would need to provide an appropriate and safe training environment. A designated

Draft v7

mentor will provide supervision, support and appropriate clinical exposure so that the trainee can develop links between theory and practice.

COSTS BASED ON OPTION 4					
Financial Assessment, including Value for Money	Summary	Year 1	Year 2	Year 3	Year 4
		£	£	£	£
	Income/ Disinvestment in existing service/s?	0	0	0	0
	*Pay costs NHS contract and project manager	31,277	77,935	73,918	21,580
	*Non Pay costs				
	Total – Recurring Costs (*To include support costs & overheads)				
	Non-recurring costs: Pay costs (modules)	41,947	75,020	44,770	8,873
	Non Pay costs (*To include support costs & overheads)				
	Total Cost	73,224	152,955	118,688	30,454
TOTAL = 375,321					

6. Financial Summary

Financial costs

Number of places required on each course (NB: Years are academic years from Sept-Sept and, therefore, costs are spread over 4 years).

Medical Retina Cert (20 credits level 7)	30	(academic Year 1,2,3)
Glaucoma Higher Cert (Cert + 20 credits level 7)	24	(academic Year 2 & 3)
Therapeutic Prescribing Cert (60 credits level 7)	29	(academic Year 1 & 2)

Approximate costs of modules to meet need:*

Draft v7

Medical Retina Certificate (20 credits level 7)	=	£36,300
Glaucoma Higher Certificate (Cert + 20 credits level 7)=		£29,040
Therapeutic Prescribing Certificate (60 credits level 7) =		£105,270
TOTAL Spend for modules	=	£170,610

** Cost of modules is correct as of 29/04/19, however, this does not include any future increase in fees that may occur. Additionally the module costs are based on Cardiff University only. A procurement process to examine costs elsewhere may be required.*

Placement requirements

For both the Glaucoma Higher Certificate and Independent Prescribing courses (but not for Medical Retina), there is a minimum 6 month requirement of 1 session per week; a total of 24 sessions or 12 whole days for a placement. The minimum requirement is to ensure that enough patient numbers are gained. In order to ensure patient numbers we have put a contingency of 7 months placements.

We have outlined two methods of carrying out placements in this business case:

1. Protected time for optometrists or backfill payments
2. Paid employment via contract for 7 months for each optometrist (preferred option)

1. Protected time to attend placements or backfill payments:

In order for optometrists to backfill their time in practice and to encourage them to commit an incentive of 12 days cover at a locum fee average rate of £250 per day would cost £3000 per optometrist undertaking the training. Optometrists in primary care are not paid by the NHS to do the placement. They do up to a hundred hours of study time and attend practical days on the course without any payment. Then to ask them to complete a placement at half a day per week for no payment for 6 months can significantly affect their earnings.

Optometrists would be funded to do the courses directly by HEIW but if they did not complete the placement they would have to refund the money.

- Placement for Higher Certificate in glaucoma to precede the start of course (as required by module) = 24 students x 3000 = £72,000 (over years 1, 2 and 3)
- Placements for IP = 29 students x 3000 = £87,000 (over years 2, 3 and 4)

Total for all placements = £3000 x 53 placements = £159,000

2. Paid employment via NHS contract for placement

To ensure placements take place then a paid employment post for 7 months within an eye hospital is an option. This has the advantage of the optometrist being paid for the sessional work, the hospital having an employee who can see patients in increasing number as the confidence and competence of the optometrist increases. A contract for the employment would be considered either through 100% paid to health board post or managed centrally through NHS Shared Service Partnership. A training contract from HEIW would be used to detail the requirements of the placement.

Mid Band 7 post 1 session per week for each student.

financial years	19/20	20/21	21/22	22/23
Med Ret	£ -	£ -	£ -	

IP		£ 28,468	£ 47,186	£ 16,476
Glaucoma Higher Cert	£ 22,632	£ 35,718	£ 12,201	
total	£ 22,632	£ 64,186	£ 59,387	£ 16,476

total costs	Aug-19	Aug-20	Aug-21
Placements			
Med Ret	£ -	£ -	£ -
IP*	£ -	£ 42,703	£ 49,428
Glaucoma Higher Cert*	£ 33,949	£ 36,602	£ -

Total for placements = £162,681

Management of course places and placements

As part of the management of placement finances and student course allocation, it would be necessary to employ a manager to oversee the project. It is estimated that this would be 2 days per week work.

Project manager NHS Bnd 5	19/20	20/21	21/22	22/23
0.4 wte over 3 years of project	£ 8,645	£ 13,749	£ 14,531	£ 5,104

7. Impact Assessment

Quality, Safety and Patient Experience

Any patient presenting with either glaucoma or glaucoma related disease or AMD related disease to an optometrist who has gained the new qualification should receive a better patient experience and better quality examination as they will better diagnostic and management skills by virtue of completing the course. Patient safety is unlikely to be adversely affected and more likely to be enhanced.

However, the aim of upskilling optometrists is that they are utilising their skills in primary care services. This creates a risk profile where regular audit and governance is necessary to evaluate the service.

Legal Implications (including equality and diversity assessment)

Qualifications themselves would not be exposed to legal implications. Places on the course would be allocated in order of priority;

- | |
|--|
| <ol style="list-style-type: none">1. Pre-existing ODTs/ glaucoma or AMD refinement service practice personnel.2. Optometrists working solely within HB areas where there are no optometrists with these qualifications3. Optometrists working solely within cluster areas where there are no optometrists with these qualifications. |
|--|

All applicants would be assessed on this criteria only. Any new primary care service would need to complete the Health Board impact assessment. Previously, all primary care ODTs in ABUHB, for example, were required to complete a tendering document and demonstrate necessary governance training. This is outside the scope of this document.
--

Risk Assessment

The following are potential risks to the commissioning of postgraduate modules
--

Risk ID	Risk	Risk description	Risk mitigation
1	Courses not available	There may not be courses available within the timeframe	Confirmation from Cardiff University that there are places available for the courses has been received
2	Following qualifications services will not be moved into primary care	Glaucoma services that could be moved to primary care are not	Independent prescribing qualifications will allow increased numbers of patients to be managed through ocular medication provision and does not rely on transfer of services but, instead, increases capacity of optometrists to manage what they do in primary care already. Additionally, the medical retina qualifications will enable optometrists to prevent unnecessary referrals into hospital even if future services are not transferred. However, not putting glaucoma services into primary care is a real risk which can only be mitigated by ensuring health boards are fully behind the transfer of services.
3	Shared electronic patient records between primary and secondary care	A lack of an electronic patient record (EPR) in primary and secondary care is a potential barrier to the transfer of services,	A Wales-wide bid to develop and refine an EPR is approved and it is expected to be delivered within 2 years. Currently, most secondary care ophthalmology units do not have an EPR and it is possible to run eye care services in different geographical

			locations without an EPR as demonstrated in secondary care.
4	Placements cannot be found	Placements are essential for the Higher Certificate in glaucoma and Independent Prescribing qualifications. There is a risk that optometrists are denied placements by eye hospitals	This is a real threat. Currently, optometrists have been able to access placements in some parts of Wales so there is a precedent. However, a if option 4 is chosen then this threat is mitigated by having an NHS contract through the health board.
5	Optometrists not completing courses	Optometrists fail the course or fail to complete the course	There is an acceptable level of risk that course fails may be possible (previously less than 5% of attendees on the courses who completed have failed). Normal procedures will be in place for extenuating circumstances. Failure to complete can be mitigated by withholding payments to attend placements. Contracts between HEIW and student that ensure course fees will be repaid if candidates drop out without having extenuating circumstances. The University extenuating circumstances committees would rule on this.
Appendices		The Common Clinical Competency Framework for Non-medical Ophthalmic Healthcare Professionals in Secondary Care –Glaucoma. Accessed at https://www.rcophth.ac.uk/wp-content/uploads/2016/06/Glaucoma-Commissioning-Guide-Long-June-2016-Final.pdf	

	<p>Workforce census for ophthalmology. Accessed at https://www.rcophth.ac.uk/wp-content/uploads/2019/02/RCOphth-Workforce-Census-2018.pdf</p> <p>The Way Forward - January 2017 The Royal College of Ophthalmologists. Accessed at https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/</p> <p>AOP Optometrists' futures service survey report. Accessed at https://www.aop.org.uk/career-development/optometrists-futures</p> <p>Wet Age Related Macular Degeneration Services in the Community. A pathfinder evaluation. May 2018.</p> <p>Lee H. Expanding Community Care for Glaucoma: A Pilot Ophthalmic Diagnostic and Treatment Centre, RNIB: London, 2015.</p>
--	--

8. Implementation Plan

	Task Description	Named Lead	Estimated start date (ESD)	Estimated finish date (EFD)	Dependent on any preceding task/s	Status
1.	Complete* mapping of optometry practices with Medical retina, IP and glaucoma qualified optometrists in Wales	Project manager and eye care transformation lead	June 2019	September 2019	See*	Partially complete currently*
2.	Commission course places for medical retina – first cohort of	Project manager and finance	September 2019	March 2020	No	

	students (10 places)					
3.	Commission course places for IP – first cohort of students (14 places)	Project manager and finance	September 2019	September 2020	No	
4.	Begin NHS contracts for Glaucoma Higher cert placements – first cohort of students (6 places)	Project manager and finance	September 2019	March 2020	No	
5.	Begin contracts for Glaucoma Higher cert placements – second cohort of students (6 places)	Project manager and finance	April 2020	September 2020	No	
6.	Commission course places for Higher Cert in Glaucoma – first cohort (12 students)	Project manager and finance	September 2020	September 2021	Yes – dependant on successful completion of placement	
7.	Commission course places for IP – second	Project manager	September 2020	September 2021	No	

	cohort of students (15 students)	and finance				
8.	Commission course places for Medical Retina – second cohort of students (10 students)	Project manager and finance	September 2020	September 2021	No	
9.	Begin payments to backfill for IP placements – first cohort of students (14 places)	Project manager and finance	September 2020	September 2021	Yes – dependant on successful completion of IP course	
10.	Commission course places for Higher Cert in Glaucoma – second cohort (12 students)	Project manager and finance	September 2021	September 2022	Yes – dependant on successful completion of placement	
11.	Begin NHS contracts for IP placements – second cohort of students (15 places)	Project manager and finance	September 2021	September 2022	Yes – dependant on successful completion of IP course	
12.	Confirm final numbers and locations of	Project manager	April 2023			

	fully qualified professionals					
--	-------------------------------	--	--	--	--	--

* There are already existing HB mapping but cluster mapping would need completing

9. Conclusion & Recommendation:

Recommend adaption of Option 4.

- To commission places on existing postgraduate modules in medical retina, glaucoma and independent prescribing.
- To fund training placements through an NHS contract.
- To recruit a manager for the project.

Total costs over 4 years = 375,321

Title of Business Case:	The proposal to increase the number of GP training places utilising a new model of GP training in Wales
Submitted to Welsh Government by:	Alex Howells, Chief Executive of HEIW
Senior Executive Sponsor:	Professor Push Mangat, Medical Director
Document Author:	Professor Phil Matthews
Date:	2 May 2019

1. Executive Summary

- 1.1 This business case describes a proposal to increase the number of GP training places utilising a changed model of GP specialty training in Wales. This increase and changed model will support efforts to increase the number of qualified GPs working in NHS Wales thus making a significant contribution to the delivery of a sustainable and flexible primary care service
- 1.2 Currently, trainees spend 18 months in hospital based posts and 18 months in General Practice but it is proposed to rebalance the training experience such that trainees spend 12 months in hospital based posts and 24 months in General Practice (a “1 + 2 model”). This would reduce the training requirement in hospital environments by 6 months and increase the need for training experience in the General Practice environment by 6 months. In parallel, to support the implementation of changing the training model will be a requirement to increase the educational infrastructure in terms of GP practices, staffing requirements and support costs needed to manage the increased number of trainees and the expanded training environment which would support both the initial and increasing numbers of trainees.
- 1.3 The revised model of GP training will initially be rolled out in 5 of the 12 schemes in Wales, These 5 schemes are those where expansion is most urgently needed in terms of GP trainee numbers to Local Health Board population ratios. This will produce a fairer distribution of advertised GP trainee placements throughout Wales, countering previous logistical, hospital placement barriers and idiosyncratic historical imbalances. As a hoped for, and anticipated, further increase in GP trainee applicant numbers comes about over the next few years (and with the requisite resource) it will become practical to spread the “1 + 2” model to other GP training schemes in Wales.
- 1.4 One of the key anticipated benefits to be gained from this new model will be an increase to the number of GP Trainees working in NHS Wales which will significantly enhance medical service provision in primary care helping to stabilise the GP workforce and make a positive impact on both day time and Out of Hours patient care.
- 1.5 The new model, complies fully with UK statute and with GMC requirements. Moreover, it will enhance GP trainees’ guided experience in the environment most pertinent to their chosen career, by providing exposure to an additional high quality GP training practice in their 3 year programme.

- 1.6 This business case therefore supports implementation of ‘*A Healthier Wales*’, through increasing opportunities for education and training within the primary care setting and supporting the *Strategic Programme for Primary Care (November 2018)*. This also aligns with *The Well-Being of Future Generations (Wales) Act 2015* in building a more sustainable workforce. It also fits in with several of HEIW’s high level corporate strategic objectives but predominantly Strategic Objective 3, which focuses on delivering care closer to home.
- 1.7 The current baseline recruitment target for GP trainees is 136 per year. The recruitment year consists of 3 individual recruitment episodes – Round 1 (R1) and Round 1 Re-advert (R1R) for posts commencing in August ;and Round 2 (R2) for posts commencing the following February. The majority of trainees commence in August each year. Welsh Government has agreed to extend the number to around 160 for the August 2019/February 2020 intake if there are sufficient applications with funding to follow. Increasing the number of training places can only be delivered by having the opportunity to implement the new training model and work has already commenced to do so. Without doing so, there would be insufficient hospital based training posts available in Wales. This business case looks to potentially raise this recruitment target further to 200 per annum, which, depending on application numbers and having had time to increase training practice capacity by then, would be feasible from the August 2021 /Feb 2022 intake. Key stakeholders such as the Royal College of General Practitioners (RCGP) Wales, GPC Wales, GP Programme Directors and GP Trainers have already been engaged and are in principle receptive to the proposed changes.

2 Background

- 2.1 The fragility in general practice has been widely documented and is affecting service delivery now. As we know, there is an ageing population in Wales with an increasing number of multiple, long-term conditions. At the same time, we are seeing a number of unfilled GP posts across Wales due in part to the diminishing pool of qualified GPs. In order to address this, there is an urgent need to transform general practice training in Wales and to build a sustainable profession, fit for the future and to give patients the care they need. GPs are critical to the delivery of the strategic direction set out in *A Healthier Wales* and the implementation of the strategic programme for primary care. The number of GP trainees in Wales has a critical relationship with the shape of the future GP workforce.
- 2.2 The annual target for entrants to GP Specialty Training in Wales was set 15 years ago and stood at 136 trainees per annum. Fill rates, in common with most other parts of the UK, have been sub-optimal in the decade prior to 2017, with a low of 76% of this target in Wales in 2012. A major contributory factor to these low numbers was the change in Home Office immigration rules just over a decade ago, resulting in large numbers of International Medical Graduates (IMGs) no longer being eligible to apply for GP training in the UK.
- 2.3 Over the last few years however, the GP training application trend has begun to reverse throughout the UK. In Wales, this is in part due to the “Train, Work, Live” campaign and recent Welsh Government financial incentives for GP trainees which has started to make a difference to GP trainee recruitment. In 2017, Wales achieved a recruitment overfill rate of 106%. In 2018, after 2 late drop outs, there was a 99% fill rate. In Round 1 of the 2019 recruitment, there were 24 more “first choice in an area of Wales” GP training applications than in 2018. There are now signs that the trend for part time working, and hence the lengthening of average time in training before qualifying as a GP may be near to its eventual plateau.
- 2.4 In recent years, in response to UK-wide pressures, England, Scotland and Northern Ireland have increased their targets for entry to GP training programmes (England from 2,750 to 3,400; Scotland from 250 to 425; and Northern Ireland from 65 to 85). This data highlights that the GP Trainee to population ratio is significantly lower in Wales than in the other home nations. For example, the annual GP trainee recruitment target to population ratio for

Scotland is 85 GP trainees per 1 million residents, whilst for Wales it is 45 GP trainees per 1 million residents.

- 2.5 The latter disparity between the 4 nations is coupled with an imbalance of advertised GP training programmes within Wales. The number of GP trainee placements advertised in some parts of Wales over several decades has for historical and logistical reasons (such as hospital and/or GP training placement availability) been significantly lower compared to population served in 5 of the current 12 GP training Schemes in Wales. These 5 district GP training schemes are Bangor, Cardiff, Dyffryn Clwyd, Gwent and Wrexham. For example the Aneurin Bevan Health Board has had 12% of the total number of GP Training places advertised, whilst serving 21% of the population of Wales.
- 2.6 Over the last few years, the Wales Deanery, RCGP Wales and BMA Wales have examined the question of how many more trainees are needed annually in Wales. All these organisations suggested a figure of around 200 entrants to GP training per annum, as being a minimum number that could help stabilise Welsh General Practice, deliver future workforce requirements, and align Welsh trainee numbers more closely with the average for other UK nations.
- 2.7 Only a few individuals leave the GP training programme prior to the completion of their training. Individuals have left the programme for reasons such as switching to another specialty, transferring out of Wales to be nearer family support, or reaching the limit in terms of repeated failure of one or more mandatory exams. There is however an increasing trend, aligned with feminisation of the workforce, that means more have been taking maternity leave or undertaking Less Than Full-Time (LTFT) training. This is producing a time lag in the number of individuals qualifying as GPs. Given that it will take longer for these trainees to qualify and they will be most likely to work LTFT once qualified, this further strengthens the case for increasing the total number of trainees within the pipeline. It is anticipated that as the level of maternity leave and LTFT stabilises, so the output of qualified GP trainees will more closely follow the number of trainees entering training over the coming years.
- 2.9 Unfortunately, the decline in GP trainees completing training within a full time 3 year envelope in Wales over successive years has occurred at the same time as high numbers of GP retirements, compounding service provision problems in many parts of Wales.

3. Strategic Priorities

- 3.1 HEIW's intention is to
 - increase the number of doctors entering GP specialty training in Wales overall
 - better align the proportion of GP training posts advertised for each Health Board area with the proportion of the population of Wales the Health Board serves
 - ensure the education available to GP trainees in Wales becomes even better
- 3.2 This vision aligns with 'A Healthier Wales', in that this proposal includes the development of a mechanism to increase opportunities for education and training within the primary care setting. The proposal also aligns with the Primary Care Plan for Wales 2015-18, the work being undertaken to fully implement the Primary Care Model for Wales and also aligns to the Strategic Programme for Primary Care (November 2018).
- 3.3 It also fits in with several of HEIW's high level corporate strategic objectives:
 - Strategic Objective 2 which aims to build a sustainable and flexible health and care workforce for the future.
 - Strategic Objective 3 which aims to shape the workforce to deliver care closer to home.
 - Strategic Objective 4 which aims to improve quality and safety by supporting NHS organisations attain faster and more sustainable workforce solutions for priority service delivery changes particularly within General Practice.

4. Proposed new GP Training Model

- 4.1 Currently, the UK-wide norm is that GP Specialty Registrars (GP Trainees) undertake 18 months training in hospital-based posts, approved specifically for GP specialty training, together with a further 18 months in GP practices approved for GP specialty training. The statutory framework for General Practice Specialty Training stipulates that at least 12 months of the mandatory 3 year training is spent in appropriate hospital posts and at least the final 12 months in a GP training practice. The remaining 12 months however, can be spent in either approved hospital posts or in approved GP practices or some combination of these environments. The 12 GP Training Schemes in Wales have a finite number of approved hospital posts available to them.
- 4.2 Previous attempts to increase the number of hospital-based posts affiliated to GP Specialty Training, by any significant amount, have proved logistically impossible over many years because of the lack of availability of more secondary care training posts, pertinent to and legally appropriate for GP training programme requirements. Thus, in order to achieve the increase in GP trainee numbers that Wales needs, the current GP training model needs to be adjusted to trainees spending 12 months in hospital based posts and 24 months in General Practice posts.
- 4.3 Where an increase in the number of GP trainees recruited and the application of the new model has been applied on a piecemeal basis in Wales, it has been ascertained that:
- GP trainees receive a longer proportion of their apprenticeship based in general practice, the well supervised environment in which they intend spending their future careers.
 - Potential GP recruits wishing to spend a greater proportion of their training in general practice, particularly where they have transferred from secondary care training programmes, find the model attractive
 - The programme provides early exposure to general practice in the first year of specialty training, thus helping trainees, particularly those with little or no experience of UK primary care, can focus the hospital based elements of their training on learning which will be most relevant to the GP environment; and this may well help mitigate risks of differential attainment.
 - With careful implementation the model does not compromise junior doctor hospital rotas.
- 4.4 Currently, 3 Health Boards - Aneurin Bevan, Cardiff and Vale and Betsi Cadwaladr - have a significantly lower proportion of advertised trainee places to population ratios than the others in Wales. HEIW has therefore advertised more places in R1 in the Cardiff, Gwent, Wrexham, Bangor and Dyffryn Clwyd GP Training Schemes for an August 2019 start, to begin to redress this imbalance. The first phase of increasing GP recruitment in Wales will thus be heavily skewed to these areas; and this is where the "1+2" model will be introduced first.
- 4.5 **In phase 1 (up to 160 entrants)**, District schemes other than these five, may initially have only a few trainees using the 1+2 model, so that affiliated hospital posts continue to be utilised and hospital rotas are not compromised. In phase 2 (the potential uplift to up to 200 entrants per annum) and when these other schemes attract more applicants, many more of their training programmes will be able to utilise the 1+2 model.

Please N.B. Because, the Welsh Government decision to advertise more than 136 places was only made in January 2019, and UK wide advertisement had already taken place, a few Round 1 2019 appointees in these 3 Health Boards may wish to (and will be entitled to) take up the conventional 18 month/18 month programme structure as originally advertised.

- 4.6 As stated, with careful implementation, this modified training structure will not impact on hospital posts and service delivery in those hospital directorates, which currently support GP training. Hospital posts approved for GP training and attached to the 12 GP Training Schemes in Wales will continue to be utilised as trainee numbers increase. Moreover, GP training affiliated hospital posts will also continue to be required for trainees returning from maternity leave and illness or those that have their training programmes extended to enable them to pass requisite summative assessments and examinations. These latter circumstances collectively apply to a large proportion of GP Specialty trainees at some time during their training programmes
- 4.7 In terms of the educational infrastructure for GP training, there are currently 343 accredited GP Trainers in 143 approved GP Training Practices accommodating approximately 200 GP Trainees under the current model of GP training. An increase to around 160 entrants per annum rising to an eventual 200 can only be accommodated if the existing GP training practice infrastructure is expanded in several areas. Within five years, at least 100 new GP trainers will be needed and existing trainers will need to be replaced as they retire. Preparations for the increased trainer/training practice capacity will need to commence immediately to ensure additional training places are available to accommodate the increase in trainees. Additional GP educator and administrative staff will be required immediately to provide educational and administrative support to the increased numbers of trainees and trainers.
- 4.8 In order to become an approved GP Training Practice, two doctors must successfully complete the three module Prospective Trainers Course (PTC) and the practice must have a formal visit from a team led by an Associate Dean. We have a high demand from doctors and practices wishing to be approved for training and the increase in PTC places can only be accommodated by running more courses each year.

5. Option Appraisal

- 5.1 The current baseline position for 2018/19 is 136 GP training places, with a commitment from Welsh Government at the end of January 2019 to up to 160 GP training places from 2019/20.
- 5.2 Several complicating factors make it difficult to make financial projections at this stage of the annual recruitment process. These are as follows:
- only the first of three rounds of a UK wide, specialty training, annual recruitment process is complete. R1R will conclude in mid-May 2019 and R2 in mid-October 2019.
 - there are deferred programme starts in 2019, as requested by 2018 appointees; and 2019 appointees can similarly choose to defer to 2020 (the number of these deferrals may differ significantly)
- 5.3 The following four options have been fully considered and the key benefits and value are captured below:
- 5.4 **Option 1 - Maintain the number of GP training places at 160, utilising the new GP training model where appropriate:**

This option considers maintaining the number of GP training places at 160 from 1 August 2019 and immediately introducing the new training model in the 5 schemes specified above. This option incorporates costs for the associated additional HEIW staff and non-staff resource required to deliver this new training model.

Benefits:

- Increase in GP trainees will help improve medical service provision in primary care and once qualified, trainees will help improve patient care.

- Increase in GP training places will help increase the number of GPs gaining their Certificate of Completion of Training (CCT) each year.
- Strong appeal of the new model will attract more applicants to train in Wales.
- Supporting and developing GPs for the future offering a training environment that is highly valued by GP trainees.
- Extended experience in General Practice posts will help attract and retain qualified GPs in Wales.
- Drive quality and ensure that GMC standards are exceeded and aligned to the established NHS training standards.
- Increase number of GP Trainees within Betsi Cadwaladr; Aneurin Bevan and Cardiff and Vale Local Health boards, which have less than the Welsh average ratio of numbers of trainees to the populations they serve.

Disadvantages:

- Marginal increase in numbers will only make a marginal impact on building a workforce that is able to deliver the requirements of *A Healthier Wales*.
- Limited impact on medical service provision in primary care.
- Once qualified, the number of trainees can only make a limited impact on patient care.

5.5 Option 2 – Increase the number of GP training places to 180, further utilising the new GP training model as appointee numbers increase:

This option considers increasing the number of GP trainees from 160 to 180 (an increase of 20 places) from 1 August 2021 and continue to resource the new GP training model staff and non-staff infrastructure.

Benefits:

- The increase in numbers to 180 makes the workforce model more sustainable than option 1 and is therefore more aligned to the delivery of *A Healthier Wales*.
- Increase in GP trainees will help to improve medical service provision in primary care in the short term and help make a positive impact on patient care in the longer term.
- Increase in GP training places will help increase the number of GPs gaining their CCT each year.
- Strong appeal of the new model will attract more applicants to train in Wales.
- Supporting and developing GPs for the future offering a training environment that is highly valued by GP trainees.
- Extended experience in General Practice posts will help attract and retain qualified GPs in Wales.
- Drive quality and ensure that GMC standards are exceeded and aligned to the established NHS training standards.
- With this level of increase in number of GP Trainees, this option would allow us to make an impact within Betsi Cadwaladr; Aneurin Bevan and Cardiff and Vale Local Health boards, which have less than the Welsh average ratio of numbers of trainees to the populations they serve.

Disadvantages:

- Whilst this option considers a larger increase in the number of trainees than in option 2 it remains insufficient to make the necessary contribution to the delivery of a sustainable and flexible NHS primary care service in Wales.
- Not fully able to deliver the requirements of *A Healthier Wales* as the number of trainees is not as significant as option 3 or option 4 and does not reach the target number as recommended by key stakeholders in Wales.

5.6 Option 3 – Increase the number of GP training places to 200, further utilising the new GP training model as appointee numbers increase:

This option considers increasing the number of GP trainees to 200 (an increase of 40 places) from 1 August 2021 and continue to resource the new GP training model staff and non-staff infrastructure.

Benefits:

- Delivers the vision of an increase in the number of GP training places offered in Wales and the subsequent output of the number of qualified GPs thus making a significant contribution to the delivery of a sustainable and flexible NHS primary care service in Wales.
- Increase in GP Trainees will significantly enhance medical service provision in primary care in the short term.
- Once qualified, will help stabilise the GP workforce and make a significant impact on patient care in the longer term.
- Increase in GP training places will significantly increase the number of GPs gaining their CCT each year.
- Strong appeal of the new model will attract significantly more applicants to train in Wales.
- Supporting and developing GPs for the future offering a larger more wide-ranging training environment that is highly valued by GP trainees.
- This new GP training model aligns with *A Healthier Wales* and HEIW's strategic objectives and enable Wales to be the first to adopt this model on a countrywide basis.
- This option will support NHS Wales in terms of transforming future strategic workforce planning requirements and improvements to patient care.
- Extended experience in welsh General Practice posts will help attract and retain home grown qualified GPs to stay in Wales.
- Drive quality and ensure that GMC standards are exceeded and aligned to the established NHS training standards.
- This option reaches the minimum number that could help stabilise Welsh General Practice, deliver future workforce requirements, and align Welsh trainee numbers more closely with the average for other UK nations.
- If accepted to recruit to up to 200 GP trainees per year, this will help us reach the number of GP trainees required in the pipeline.
- With this level of increase in number of GP Trainees, this option would allow us to make a significant impact within Betsi Cadwaladr; Aneurin Bevan and Cardiff and Vale Local Health boards, which have less than the Welsh average ratio of numbers of trainees to the populations they serve.

Disadvantages:

- Supporting this increase over a short period of time will be challenging and will need effective implementation and project planning.

5.7 Option 4 - Increase the number of GP training places to 240:

This option considers increasing the number of GP trainees to 240 (an increase of 80 places) from the 1 August 2021 and continue to resource the new GP training model staff and non-staff infrastructure.

Disadvantages:

Whilst this option is the most ambitious, it cannot be delivered as it is considered highly unlikely that we would be able to fill these places, as there are insufficient hospital posts for more than 200 entrants per annum (even under the new model) and we would be unable to create enough training practice capacity in the required time frame.

6. Preferred Option – Non-Financial Analysis

Based on the non-financial analysis undertaken above, it would seem prudent to reject option 1 as the ultimate goal will not provide enough GPs to stabilise the Welsh GP workforce or be sufficient to help deliver the aspirations of *A Healthier Wales*. Whilst option 2 would increase the number of GP trainees to 180 and would provide a welcome improvement on Option 1, it would not provide the same level of likely sufficiency as Option 3 which proposes 200 training places. Whilst Option 4 would bring Wales more in line with the ratio of training places to population as Scotland has introduced, the reality is that logistically this would be extremely difficult, if not impossible, to deliver in the medium term. If we are to stabilise the workforce and enable delivery of the aspirations portrayed in *A Healthier Wales*, **Option 3 provides the necessary solution and would therefore be the preferred option from the non-financial analysis.**

7. Expected benefits of Option 3

- 7.1 The already introduced increase in the number of GP trainee places has only been logistically feasible because the GP specialty training model in Wales has also been changed. The combination of increased training time in the GP environment, under the new model, as well as the extra entrants to GP training each year will greatly increase the number of trainee doctors contributing to service provision in Welsh primary care.
- 7.2 The subsequent increased output of qualified GPs will help stabilise the workforce and enable delivery of the aspirations portrayed in *A Healthier Wales*.
- 7.3 The increase in number of GP Trainees will increase the number of GP trainees gaining their CCT in Wales each year.
- 7.4 The introduction of the new GP Training model will have a strong appeal to prospective applicants and help attract applicants to GP training in Wales, particularly as this new model is has only been utilised on an ad hoc basis elsewhere in the UK. Additionally, the introduction of increased training time in GP environments for GP trainees is strongly supported by the Junior Doctor Committee of The BMA.
- 7.5 This option will signal to GP trainees that Wales is committed to being at the forefront of supporting and developing GPs for the future by offering a training environment that is highly valued by GP trainees.
- 7.6 This option will bring Wales more in line with increases in the number of GP trainee places already introduced in Scotland and England.
- 7.7 The introduction of the new GP training model delivers a longer proportion of the statutory 3 year GP apprenticeship, resulting in well supervised GP Training Practice environments. This will drive quality and give the assurance that GMC standards are exceeded and aligned to the established NHS training standards.
- 7.8 With this level of increase in number of GP Trainees, this option would allow us to make an impact within Betsi Cadwaladr; Aneurin Bevan and Cardiff and Vale Local Health boards, which have less than the Welsh average ratio of numbers of trainees to the populations they serve.
- 7.9 The new model also removes the impossible task of affiliating requisite additional hospital posts to GP Training programmes that would otherwise have been needed for an attempted expansion of GP Training under the current model.

8. Financial Analysis

- 8.1 The GP Registrar budget in Wales for 2018/19 is £14.94m, based on recruitment of 136 trainees per annum and delivery of the current model of GP training (18mth plus 18mth). This budget only caters for the GP based element of GP Specialty Training programmes as hospital placements are covered through the Training grade salary (TGS) budget. The estimated actual cost for 2018/19 is £15.1m. The indicative budget for 2019/20 of £15.3m includes a Doctors and Dentists Remuneration Board (DDRB) and trainers grant award of 2% and 4% respectively.
- 8.2 In order to implement this strategy successfully, additional staff and non-staff resource is required to prepare and support the increasing numbers of educational supervisors and training environments that will be required after the first year. There is capacity to accommodate the increase in trainee numbers during the first year of this change, in terms of physical space and supervisor availability.
- 8.3 To support an increase in trainees to 160, above the 2018/19 baseline of 136, HEIW will require an investment in staffing to support the additional numbers recruited. At this time, it is anticipated and has been costed as such that this investment would continue to manage and support additional increases up to 200 and further work is required to understand the infrastructure requirements over a 200 trainee model.
- 8.4 In order to deliver and support all options require an infrastructure investment for staff and non-staff as detailed below:
- Full time Band 4 administrator for increased clerical activities.
 - Full time Band 3 administrator to assist with increased clerical activity.
 - An additional 4 session GP Associate Deans, to support increased professional development work; the increased monitoring of training environments and performance; and to serve the Cwm Taf Health Board area specifically. Currently each LHB has an allocated GP Associate Dean, except for Cwm Taff and Cardiff & Vale LHBs, which share one. Both LHBs already have many GP trainers; but both need a further expansion of trainers and training practices.
 - Additional GP Programme Director sessions, to support and deliver regular peer group education for the markedly increased number of trainees.
- 8.5 The full breakdown of costs can be found at **Appendix 1**.
- 8.6 In its simplest form, changing the model of GP training, across the range of Options, will require an additional GP registrar budget cost of £37.5k (an additional 6 months in GP practice) of trainees in year 1 of their 3 year training programme; supported by additional resources to the GP training team to manage the delivery of this programme. As the “1 + 2” model is being rolled out on a phased basis (as the hoped for number of successful applications increases), in the first and probably second years (2019 and 2020), very approximately, about half to two thirds of doctors accepting GP training places in Wales will be utilising this model. Thus, we anticipate between 70 and 105 doctors requiring funding for a 6 month GP training post in each of entry years 2019 and 2020.
- 8.7 For each full-time equivalent (FTE) GP Registrar, the full year cost is circa £75,000. This is made up of the salary costs of circa £65k including banding, plus on costs, GP trainers grant (£9,300 per annum) and relocation costs. In essence a full-time GP Registrars will utilise £37.5k from the GP Registrar budget in the 2nd year and £75k from the GP Registrar budget in their 3rd year.
- 8.8 Applying an increase in trainees and implementing the new model of training as indicated does require additional investment compared to existing GP registrar budget allocations. This option includes both the increase in recruitment, alongside a training model adjustment

which results in further investment of £2.9m in Year 1 (2019/20) and £5.1m in year 2 (2020/21) rising to £13.3m in 22/23. In reality, the trainee costs are split across academic and financial years.

8.9 The financial impact assessment of all options is considered in the table below:

Table 1 - Summary of Infrastructure Costs and Commissioning Costs for Option 3

Staff Costs	2019/20	2020/21	2021/22	2022/23
GP Associate Dean (0.4 fte)	£ 50,557	£ 51,567.94	£ 52,599.29	£ 53,651.28
GP Programme Director (0.6 fte)	£ 68,674	£ 70,047.68	£ 71,448.64	£ 72,877.61
Grade 4 Administration Officer (1 fte)	£ 27,654	£ 28,207.08	£ 28,771.22	£ 29,346.65
Grade 3 Administration Assistant (1 fte)	£ 23,617	£ 24,089.34	£ 24,571.13	£ 25,062.55
Staff Total	£ 170,502	£ 173,912	£ 177,390	£ 180,938
Non Staff Costs				
Locum Costs to backfill (2 PD's per day) for GP Trainer Course	£ 11,200	£ 11,200	£ 11,200	£ 11,200
Refreshment Costs (as above)	£ 360	£ 360	£ 360	£ 360
CPD Trainer Grant £750 per trainer	£ 75,000	£ 75,000	£ 75,000	£ 75,000
Honey and Mumford Learning Needs Assessment	£ 612	£ 612	£ 612	£ 612
Additional Allocation to PGC's in respect of the additional training programme for trainees on the new model	£ 30,000	£ 30,000	£ 30,000	£ 30,000
PC's and Laptops	£ 6,000			
Non Staff Total	£ 123,172	£ 117,172	£ 117,172	£ 117,172
TOTAL	£ 293,674	£ 291,084	£ 294,562	£ 298,110
Trainee Costs				
Effects of increase to 160 Cohort (start Aug 19) - 105	£ 2,625,000	£ 2,142,000	£ 1,228,973	£ 417,853
Effects of to staying to 160 Cohort (start Aug 20) - 105		£ 2,677,500	£ 2,184,840	£ 1,253,552
Effects of moving to 200 Cohort (start Aug 21) - all 200			£ 5,202,000	£ 6,048,886
Effects of to staying to 200 Cohort (start Aug 22)				£ 5,306,040
TOTAL	£ 2,625,000	£ 4,819,500	£ 8,615,813	£ 13,026,330
SUB TOTAL	£ 2,918,674	£ 5,110,584	£ 8,910,375	£ 13,324,440
The model above is based upon the notion of a proportion (105 trainees) of the new cohort (2019) starting on the new model in August 2019. This will increase to the full cohort starting on a 1:2 model in 2021				

As indicated above, costs for Option 3 have been provided based an assumed 105 trainees commencing the new model of training in August 19 and with the same numbers doing so in Aug 2020 with all trainees assumed to commence the new model from August 2021.

8.10 Costs are shown over a four-year period to demonstrate the full effect of additional numbers in the programme. In simple terms, each trainee could undertake the GP training scheme in three years assuming they are in post full time, with no absences, no change in working hours, maternity or extensions. This financial model assumes training runs on an academic year; and the costs apportioned to a financial year, hence the need to demonstrate over a five-year period. On average 45% of STR3's are less than full time; 8% of those in GP training take maternity leave each year and there is an average of 8 extensions of 6 months each year. (The full breakdown of costs split year by year can be found at **Appendix 1**).

8.11 The preferred option (Option 3) is to increase the annual recruitment target to 200 in August 2021 with the aspiration of increasing capacity across primary care in Wales. The offering of a new 1+2 model will differentiate Wales from the other three nations, give trainees greater exposure and experience, which should lead to a model delivering sustainable service provisions and enhancing patient care pan Wales. Assuming all trainees follow a simple full-time three-year programme, the net effect of the additional numbers will require a staggered approach to commissioned funding up to £17.7m. Please see table 2 below which highlights how the additional trainee cohorts will increase over time.

- 8.10 Not factored into the costings is the potential impact of employing more trainees by the Single lead employer: NHS Wales Shared Services Partnership. This would need to be considered and costed separately as it would be dependent upon which model was adopted, but as an estimate, the likely additional contribution from Welsh Government to Shared Services for the increase in numbers is at least £35k per annum.
- 8.11 At this stage, we do not anticipate additional costs within HEIW other than those identified in the costing model, but this is subject to review should costs materialise or be realised.

9. Investment Appraisal and Value

- 9.1 The return on investment from this proposal will enable an increase in the number of GP trainee places and the implementation of a new GP training model in Wales. The 2019 direction to change to 160 entrants per annum, requires an ongoing investment in terms of infrastructure and commissioning costs.

Adopting the preferred model of Option 3, will require additional investment from 2020/21 which will greatly increase the number of trainee doctors contributing to service provision in Welsh primary care. The increased output of qualified GPs will help stabilise the workforce and enable delivery of the aspirations portrayed in *A Healthier Wales*. The increase in number of GP Trainees will also facilitate an increase in the number of GP trainees gaining their CCT each year.

The introduction of the new GP Training model will have a strong appeal to prospective applicants and will help attract applicants to GP training in Wales, particularly as this new model is not widely utilised elsewhere in the UK. This option will signal to GP trainees that Wales is committed to be at the forefront of supporting and developing GPs for the future, offering a training environment that is highly valued by GP trainees. This option will bring Wales in line with increases in the number of GP trainee places already introduced in Scotland and England. The introduction of the new GP training model will drive quality and promote even more effective GP training in Wales. This business case will also enable three Welsh LHBs (Betsi Cadwalader; Aneurin Bevan and Cardiff and Vale), which have less than the Welsh average ratio of numbers of trainees to the populations they serve, to attract a greater number of entrants in these localities.

10. Timescale

- 10.1 A decision in principle needs to be made in June 2019. This is so that the additional HEIW staffing can be put in place to support both the 2019 and 2020 increase in GP trainee recruitment that will take place under all of the options. The latter level of increased HEIW staff resource is also however, sufficient to support the even larger scale increase in GP training practices and GP trainers needed, if the Option selected involves increases to 180 or even 200 entrants per annum.
- 10.2 Following agreement of the business case, a significant programme of work will then be undertaken over the next twelve months to agree the detail of the proposed changes. This is outlined in **Appendix 1**.

11. Major risks

The major risks to the implementation of this plan have been considered as follows:

- 11.1 If applicant numbers to GP training in Wales do not rise as anticipated, or if HEIW is oversubscribed with applications but by the end of the recruitment round there are insufficient pool of high quality candidates there is a risk that HEIW will be unable to fill the set target of

200 GP trainees. This would mean that HEIW would fail to deliver our strategic vision to deliver *A Healthier Wales* enhancing medical service provision in primary care. The action required to mitigate this would be to:

- further develop the initiatives previously designed to encourage application numbers and encourage recruitment including the implementation of the national “Train, Work, Live” campaign and the Welsh Government financial incentives for GP trainees.
- it is anticipated that there will be a larger pool of applicants given the increasing output of trainees from the new Medical Schools that have been set up. Furthermore, recent changes in Home Office visa regulations have removed the previously restrictions placed on overseas doctors and this pool is also likely to increase. However, further work will be required to target the medical students and to communicate the visa changes to overseas doctors in order attract them to train in Wales.
- take the opportunity to build on the recent upward trend in recruitment to GP Specialty Training in Wales. Market the benefits of the improvements being made to the expanded educational infrastructure in Wales (i.e. the increased number and wide variety of GP practices and the GP Trainers available to help manage the training programme).

11.2 As stated in 2.8, there remains a risk that having increased the output of GP Trainees in Wales, and once qualified, a small number leave Wales or leave the profession altogether. Once the training model is changed and trainees spend additional time in the GP environment they will be encouraged to stay in Wales and this will greatly increase the number of trainee doctors contributing to service provision in Welsh primary care.

11.3 Brexit has already had an impact on the recruitment and retention of EU nationals in some parts of the workforce which is contributing to shortages of key staff. The ongoing debate in parliament and the uncertainty about whether a deal can be agreed mean considerable work has gone into preparations for a no-deal Brexit. This may have an impact in terms achieving the target of 200 GP trainees if there is no deal, but work is ongoing in monitoring the impact of Brexit and developing the necessary steps taken to mitigate this risk.

11.4 There is a risk that HEIW might be unable to recruit the additional staff resources within HEIW required to manage the training programme within the required timescales. The action required to mitigate this risk would be to commence the recruitment process in March 2019 with a view to having the staff in place well before the first cohort of 160 trainees commence their posts in August 2019.

11.5 There is a risk that if HEIW is unable to identify sufficient GP practices to offer the number of training places that there will be a significant impact on the programme. In order to mitigate this, a large piece of work will be undertaken by the GP team to work with a project implementation group to work with General Practices to significantly increase the existing training capacity and to increase the number of Prospective Trainers Courses where required.

12. Recommendation

12.1 To approve

- an increase to 200 GP Training places in Wales per annum from 2021 and
- the additional staff, non-staff, trainee salary and supervision costs which will be incurred (for the chosen level of uplift from 136 entrants per year to between 160 to 200 entrants per year), as portrayed in this paper

Appendix 1

	Task Description	Named Lead	Estimated start date (ESD)	Estimated finish date (EFD)	Dependent on any preceding task/s	Status
1.	Business Case submitted to Welsh Government for approval	AH	06/03/19	06/03/19		
2.	Welsh Government to confirm additional funding.	WAG				
3.	Project Board and Project Manager identified from within existing team and project plan developed.	PLM	07/03/19	07/03/19		
3.	Scoping capacity in individual training schemes undertaken.	PLM /MB and GP Associate Deans	10/03/19	17/03/19	Subject to approval by WG	
4.	Refine planning for the GP training recruitment cycle and establish implementation group.	HEIW GP Training Team	ongoing	ongoing		
5.	Undertake recruitment for additional HEIW GP staff to establish this new team.	PLM/MB/People Team	07/03/19	30/06/19		
6	Undertake Recruitment of GP Trainees Round 1 Readvert	HEIW GP Team	21/02/19	14/05/19		
a	<i>HEIW to notify GP National Recruitment Office (GP NRO) of increased training places.</i>	<i>PLM/SD</i>	<i>21/02/19</i>	<i>21/02/19</i>	<i>WG approval in principal already given for increase</i>	<i>Completed. GP NRO notified on 11/02/19</i>
b	<i>R1 Readvert appears and applications open (for August 2019 start).</i>	<i>SD</i>	<i>13/02/19</i>	<i>14/03/19</i>		
c	<i>GP NRO make offers to successful candidates from Round 1 (for August 2019 start).</i>	<i>SD/KJ</i>	<i>21/02/19</i>	<i>15/03/19</i>		
d	<i>Accepted offers from R1 confirmed.</i>	<i>SD/PLM</i>	<i>25/03/19</i>	<i>2/04/19</i>	<i>N/A</i>	
e	<i>Actual fill rates from R1 established</i>	<i>SD/PLM</i>	<i>01/04/19</i>	<i>07/04/19</i>		

	<i>(taking into account deferrals/maternity leave etc.).</i>					
f	<i>GP NRO make offers to successful candidates from R1R.</i>	SD/KJ	25/04/19	3/05/19		
6.	Accepted offers from R1R confirmed.	SD/PLM	07/05/19	14/05/19		
7.	Hold training for new GP Trainers (first 3 module Prospective Trainers Course for 18 participants).	GHL/MH/SD/LL	02/05/19	26/07/19		
8.	Actual starters from Round 1 and Round 1 Readvert commence.	SD/KJ	07/08/19	-		
9.	Round 2 recruitment of GP Trainees.	HEIW GP Training Team				
a	<i>Round 2 advert appears and applications open (for February 2020 start).</i>	SD/KJ	17/07/19	15/08/19		
b	<i>R2 Selection Centre held in N Wales.</i>	SD/KJ	25/09/19	25/09/19		
10.	Hold training for new GP Trainers (Prospective Training course for 18 participants).	GLH/MH/SD/LL	26/09/19	29/11/19		
c	<i>GP NRO make offers to successful candidates from R2.</i>	SD/KJ	01/10/19	11/10/19		
d	<i>Accepted offers from R2 confirmed.</i>	SD/PLM	18/10/19	25/10/19		
11.	Total number of accepted offers for 2019 recruitment round (R1, R1R, R2) confirmed.	PLM	18/10/19	25/10/19		
12.	Vacancy numbers submitted to GP NRO for Round 1 recruitment (for August 2020 starters).	SD/PLM	01/09/19	-		
13.	Round 1 Advert & applications open (August 2020 starters).	SD	Approx. 05/11/19	-		
14.	Hold training for new GP Trainers (Prospective Trainers Course for 18 participants).	GHL/MH/SD/LL	19/12/19	14/02/20		

15.	R1 Selection Centre.	PLM/SD	February 19	R1 Selection Centre		
16.	Actual starters from R2 commence.	SD/KJ	05/02/20	-		

Title of Business Case:	Business Case for the implementation at pace of a new model of Pre-Registration Pharmacist Training in Wales.
Submitted to Welsh Government by:	Alex Howells
Senior Executive Sponsor:	Push Mangat
Document Author:	Margaret Allan
Date:	20 February 2019

1. Executive Summary

- 1.1 The business case describes a proposal to move at pace to implement the piloted and evaluated transformational model for a centralised Pre-Registration Pharmacy Training programme in Wales. This proposal will deliver the vision for a one year Pre-Registration Pharmacist Training programme with meaningful multi-sector experience delivered through quality assured training sites. Key changes are to introduce a centralised recruitment process, central employment of trainees, centralised training programme and enhanced quality management processes. Trainee numbers would be managed to meet workforce demand. This is the first phase of a change strategy to move towards a five year integrated MPharm undergraduate degree programme designed to transform the pharmacy workforce in Wales.
- 1.2 One of the anticipated benefits to be gained from this new model will be the transformation from a model that produces registrants to work in either hospital or community practice to a multi-sectoral programme that will develop registrants who can flexibly move between sectors, including primary care, and take up new roles being developed across all sectors. The role of pharmacists within the multi-disciplinary primary care team is an area of significant growth within Wales and across the UK. Currently pharmacists are not well prepared for these roles and significant time and resource is required to support the workforce to acquire the confidence and skills to maximise their contribution to patient care. The new model will ensure that, at the point of registration, a pharmacist will have started the journey to developing the necessary skills and competence to work within GP practice and provide the building blocks for further development of their confidence and skills during the pharmacist foundation years. This unique offering within the UK would be a premium training programme that would attract the best trainees to Wales preparing them for the increasing expectations from all sectors of patient care. Additional benefits to be gained from this model would include a fair and equitable centralised recruitment process for all trainees in Wales, central employment of all trainees with equity in terms of pay (all at entry point Band 5 salary), equitable terms and conditions and access to multi-sector experience across the patient care pathway. The new model will quality assure all aspects of the programme which addressing current variation in certain areas and ensuring that the proposed new General Pharmaceutical Council (GPhC) standards for initial training and standards are not only be met but maximised and aligned to the established NHS training standards.

- 1.3 Not implementing the piloted and evaluated new model would mean that Wales would miss the opportunity to be a UK leader for pre-registration pharmacist training to further develop the pharmacy workforce and to transform pharmacy education in Wales to meet the future needs of patients. In addition there could be an impact on the ability of Wales to recruit into training posts, which would adversely affect workforce planning and patient care.
- 1.4 This proposal aligns to several of HEIW's high level corporate strategic objectives which aim to build a sustainable and flexible health and care workforce for the future and our intention to develop and improve the education and training available to pharmacists in Wales. Particularly, it aligns to Strategic Objective 3 which aims to shape the workforce to deliver care closer to home and to better align service delivery with Social Care Wales. In this case we hope to expand education and training in primary and community care settings across all professional groups including pharmacy. It aligns to our strategic objective to improve quality and safety by supporting NHS organisations find faster and more sustainable workforce solutions for priority service delivery challenges. Part of this objective is about reshaping HEIW's professional development resources and programmes to address key priorities identified by staff, NHS organisations and key policy matters (including prevention).
- 1.5 The proposal is to implement the change by the August 2020 intake of trainees. To meet the current recruitment cycle, an agreement to support the change and commit to the new model of training is required by March 2019. The key stakeholders have already been engaged and are in principle receptive to the proposed change.

2. Reasons

- 2.1 The purpose of this business case is to move at pace to implement an All Wales model of Pre-Registration Pharmacist Training.

Multi sector approach

- 2.2 Pharmacists are now playing increasingly important roles in multi-professional teams across all settings. There is an urgent and agreed need to transform pre-registration pharmacist training to equip the future pharmacy workforce with the skills to be able to work in and across all sectors e.g. hospital, community and primary care.
- 2.3 The current pre-registration pharmacist training programme produces registrants to work in hospital or community pharmacy and does not allow registrants to move between these sectors or to move into new roles that are being developed across all sectors and most importantly emerging roles in GP practice.
- 2.4 There is a need to make significant improvements to the current pre-registration training programme to address concerns about the variation of experiential learning across Wales and between the sectors and the variable access to and quality of support for tutors and trainees between the practice sectors.
- 2.5 Changing the pre-registration training model will enable Wales to do things differently and to produce pharmacists that can better meet the changing needs of patient care. It will prepare new registrants for practice in the hospital, community and general practice sectors.
- 2.6 The Chief Pharmaceutical Officer's Modernising Pharmacy Careers Wales Programme Board has accepted recommendations for maximising the outcome of the current 4 + 1 pre-registration model and there is also support in principle from Welsh Government, Modernising Pharmacy Careers Board and the GPhC.

- 2.7 In 2017, the Wales Centre for Professional Pharmacy Education (WCPPE) was commissioned by WEDS to evaluate the multi-sector Pre-Registration Pharmacist training programme developed in partnership between WCPPE and Betsi Cadwaladr UHB. The evaluation outcomes provided proof of concept for the multi-sector approach to pre-registration training. The offering of multi-sector experience bringing together hospital, GP practice and community pharmacy based programmes has been implemented in three health boards for 15% of NHS employed trainees and is being rolled out in the remaining Health Boards over the next two years to 20% of trainees. In 2017, the multi-sector approach was given support by the Minister for Health and Social Services.¹

¹<https://gov.wales/about/cabinet/cabinetstatements/2017/educationcommissioning/?lang=en>

Variations between sectors

- 2.8 The requirement for pre-registration training places within the Health Boards is identified within their Integrated Medium Term Plans (IMTP), determined via the education commissioning process and funded by HEIW. In the community sector pre-registration training places are determined by individual community pharmacies, are funded via the Drug Tariff grant and as such are not workforce planned in a similar structured way. This makes workforce planning challenging and results in different terms and conditions in the different sectors. Similarly, recruitment, whilst moving towards an integrated approach via the Oriel system, is not yet a fully centralised system between the two sectors.
- 2.9 National values based recruitment has also been fully implemented across Health Boards and partially implemented in community pharmacies.
- 2.10 In Scotland, a centralised quality assured training programme is delivered, which has been recognised for many years as the gold standard in the UK for trainees and the GPhC. Scotland has also introduced an element of experiential learning in general practice for about 10% of trainees, but historically non centralised employment status and indemnity liabilities have constrained how the trainees can move easily between placements in hospital and community. In England, recruitment was centralised in 2017 for hospital placements and offered as optional for community pharmacy. Some regions of England hold an element of quality assurance for premises and tutors and within the last twelve months, 5% of training posts offer training in General Practice for a period of three to six months.
- 2.11 Managing the change to the multi-sectorial model could be achieved by significantly reducing the numbers of community pharmacy pre-registration training places, thus offsetting the drug tariff shortfall between the drug tariff grant and the current salaries of NHS trainees. This would be counter to the trend of increasing NHS trainee numbers and the increasing requirement for pharmacists working in primary care. Whilst managing the financial impact, the multi-sector experiential learning would be significantly compromised and not achieve the overall goals of pharmacists having the skills and competence to provide care across the patient pathway and closer to home.

Future Growth

- 2.12 There is likely to be increased demand for pharmacists over the forthcoming years with expansion in the scope and practice of pharmacists across the whole system and increases in the volumes of prescribing, especially in primary care. Development of the multi-disciplinary team in clusters and the roll out of the 111 service across Wales are increasing demand for pharmacists with extended skills and the drive to provide more services within a community setting is also changing the skills sets

required of community pharmacists. Health Board IMTPs indicate that pharmacists are seen as being a key workforce solution across a number of areas, whilst indicating that there are emerging recruitment difficulties at the same time.

- 2.13 It is of interest that in terms of employment following graduation, the landscape across the UK is changing at pace. In Northern Ireland, every GP Practice already has a pharmacist and in Scotland the numbers of Pharmacists in GP practice are steadily increasing. NHS England has just announced a further increase in GP practice pharmacists from the first phase of 450 to a second phase of additional 1,500. Whilst NHS Wales needs to consider how the current workforce can be developed to for roles in GP practice it is important that we bring through the new workforce to ensure the whole pharmacy workforce does not destabilise as pharmacist move into new roles.
- 2.14 Pharmacy students from the new School of Pharmacy, Swansea University will graduate in 2024 and will potentially increase the number of students seeking pre-registration training placements in Wales. Recent student surveys have indicated that pharmacy students' long term career aspirations are linked to working in a particular sector or portfolio careers, therefore the opportunity to provide early exposure to different care settings will be advantageous.
- 2.15 The long term impact of this proposal aligns with our ambition to develop a more sustainable workforce that meets the needs of future service delivery models and which reduces the reliance on short term, expensive solutions which often have a negative impact on the well-being of staff. This new approach to pre-registration training will ensure that Wales has a sustainable pipeline of suitably skilled and experience pharmacy registrants who can work in a variety of settings to deliver changing patient needs; a key objective of *A Healthier Wales* (2018) which encourages the development of sustainable plans and actions to deliver care closer to home, through strengthening primary and community services, and refocusing on prevention.
- 2.16 The table below shows the number of pre-registration pharmacists (both NHS and community practice).

Year	NHS Pre-Registration Pharmacist trainees	Community Practice Pre-Registration Pharmacist trainees	Total
2018/19	41	83	124
2019/20	50	76 (advertised in Oriel)	126
2020/21	60	64	124
2021/22*	60*	100+*	-

*Estimate

(Note: Community Practice numbers are only reflecting those advertised in Oriel and that further recruitment for Community Practice can be achieved outside Oriel. Furthermore the numbers for 2019/20 cannot be capped, therefore the numbers could potentially increase depending on level of recruitment in Community Practice. The number of community practice trainees increases to 100 in 2021/22 in anticipation of the level of demand and given the increase in NHS trainees).

- 2.17 Investing in the initial education of pharmacist trainees for the future models of practice ensures at point of registration the workforce will have the skills and competence to provide more for patients at earlier stage of their career. Over the next five years the initial education and training of pharmacists will continue to change to produce pharmacists with clinical, therapeutic and diagnostic skills to manage in hours and out of hours services, be able to have complex interactions with patients and be either on the path or qualified as Independent Prescribers. Educational

investment post-registration can then be focused on developing the skills and competence of pharmacists to perform at the highest level within a multi-disciplinary team offering a range of more complex interventions with patients.

- 2.18 Key influencers come from the high level policy drivers the *Well-Being of Future Generations (Wales) Act 2015* and *A Healthier Wales (2016)*. Thinking long term the impact of this proposal aligns with our ambition to develop a more sustainable workforce that meets the needs of future service models and which reduces the reliance on short term, expensive solutions which often have a negative impact on the well-being of staff. This proposal will support our existing workforce to acquire new skills as well as ensuring that the pipeline into pharmacy careers is as wide as possible. *A Healthier Wales (2016)* encourages the development of sustainable plans and actions to deliver care closer to home, through strengthening primary and community services, and refocusing on prevention. To build a sustainable and flexible pharmacy workforce of the future and to improve quality and safety. It also emphasises the importance of quality improvement in a transformational system. The programme has also been designed to embrace Prudent Healthcare principles in terms of what pharmacists need to do, and how we deliver the skills that they need to get maximum value.
- 2.19 This proposal aligns to several of HEIW's high level corporate strategic objectives including Strategic Objective 2 which aims to build a sustainable and flexible health and care workforce for the future. It is our intention to develop and improve the education and training available to pharmacists in Wales. It also aligns to Strategic Objective 3 which aims to shape the workforce to deliver care closer to home and to better align service delivery with Social Care Wales. An element of this objective is around the creation of a framework to expand education and training in primary and community care settings across all professional groups. It also aligns to Strategic Objective 4 which aims to improve quality and safety by supporting NHS organisations find faster and more sustainable workforce solutions for priority service delivery challenges. Part of this objective is to reshape HEIW's professional development resources and programmes to address key priorities identified by staff, NHS organisations and key policy matters (including prevention).

3. Business Options

Four options have been fully considered and are outlined below.

3.1 Option 1 - Do Nothing

This option considers making no changes to the current pre-registration pharmacists training programme remaining with variation in training experience and standards particularly in primary care sector and no management of primary care and community trainee numbers.

3.2 Option 2 - Invest in new model of training but reduce the number of trainees to offset the drug tariff grant shortfall

This option considers introducing the multi-sectoral model but reducing the number of trainees in order to offset the drug tariff grant shortfall (see section 2.11).

Additional funding would be required to pay the organisation acting as the single lead employer, to cover the cost of a multi-sectorial training placement fee, to manage the central quality assurance process, additional HEIW staff costs and the development and maintenance of a new database.

3.3 Option 3 - Invest in new model of training but keep trainee numbers static at 124

This option considers investing in a new model of training that introduces a centralised recruitment process, central employment, multi-sector centralised training programme and enhanced quality management but keeps trainee numbers static at 124. This would require additional funding to cover an increase in trainee salary costs and additional monies to top up the drug tariff grant. Additional funding would also be required to pay the organisation acting as the single lead employer, to cover the cost of a multi-sectorial training placement fee, to manage the central quality assurance process, additional HEIW staff costs and the development and maintenance of a new database.

3.4 **Option 4 - Invest in new model of training and increase trainee numbers to 160**

This option considers investing in a new model of training that introduces a centralised recruitment process, central employment, centralised multi-sector training programme and enhanced quality management but increases the number of trainees from 2020/21. This would require additional funding to cover an increase in trainee salary costs and additional monies to top up the drug tariff grant. Additional funding would also be required to pay the organisation acting as the single lead employer, to cover the cost of a multi-sectorial training placement fee, to manage the central quality assurance process, additional HEIW staff costs and the development and maintenance of a new database.

Advantages / Benefits	Option 1 Do Nothing	Option 2 Introduce the multi-sectoral model but reduce the numbers to offset the drug tariff grant shortfall	Option 3 Introduce the multi-sectoral model keeping the number of trainees static at 124.	Option 4 Introduce the multi-sectoral model but increase the number of trainees to 160.
	Costs and numbers can be controlled for the NHS employed trainees.	-	Structure to manage workforce numbers.	Structure to facilitate ability to flex trainee numbers to meet workforce needs. Increase in trainees aligns to the direction of future workforce planning requirements
	Quality standards for training maintained for hospital trainees.	-	Transformation of the current model will develop a unique premium offering in the UK helping to improve recruitment and retention.	Transformation of the current model will develop a unique premium offering in the UK helping to improve recruitment and retention.
	-	-	-	A single recruitment process will help to recruit the best trainees to Wales.
	-	A centralised recruitment process will ensure that recruitment is fair and equitable for all trainees.	A centralised recruitment process will ensure that recruitment is fair and equitable for all trainees.	A centralised recruitment process will ensure that recruitment is fair and equitable for all trainees.
	-	A Single Lead Employer will mean that all trainees are	A Single Lead Employer will mean that all trainees are	A Single Lead Employer will mean that all trainees are

		centrally employed and have equity in terms of pay (all at entry point Band 5 salary), T&Cs and access to multi-sector placements.	centrally employed and have equity in terms of pay (all at entry point Band 5 salary), T&Cs and access to multi-sector placements.	centrally employed and have equity in terms of pay (all at entry point Band 5 salary), T&Cs and access to multi-sector placements.
-		A central commissioning process for all pre-registration posts.	A central commissioning process for all pre-registration posts.	A central commissioning process enabling Wales to manage the workforce demand and meet the changing needs of the workforce.
-		A single lead employer will ensure that a trainee's indemnity insurance will be covered as they move across sectors.	A single lead employer will ensure that a trainee's indemnity insurance will be covered as they move across sectors.	A single lead employer will ensure that a trainee's indemnity insurance will be covered as they move across sectors.
-		-	All trainees have multi-sector experience across the patient care pathway.	All trainees have multi-sector experience across the patient care pathway.
-		Central management of training programme provides opportunity to flex content of training to meet the changing roles of pharmacists now and into future	Central management of training programme provides opportunity to flex content of training to meet the changing roles of pharmacists now and into future	Central management of training programme provides opportunity to flex content of training to meet the changing roles of pharmacists now and into future
-		Investment in initial education and training, developing the right skills and competence to meet the job roles of the future, ensures investment in post registration can move pharmacist further along the career path. This means pharmacist will be able to provide more patient services earlier in their career.	Investment in initial education and training, developing the right skills and competence to meet the job roles of the future, ensures investment in post registration can move pharmacist further along the career path. This means pharmacist will be able to provide more patient services earlier in their career.	Investment in initial education and training, developing the right skills and competence to meet the job roles of the future, ensures investment in post registration can move pharmacist further along the career path. This means pharmacist will be able to provide more patient services earlier in their career.

Disadvantages	No structure to allow trainee numbers to flex to meet workforce needs.	If numbers will not meet workforce demand now or by 2025 and could result in agency and locum staff, or impact on other staff groups	If numbers are not increased there is a risk that numbers will not meet workforce demand by 2025.	-
	Centralised quality assured recruitment process for NHS employed but not required for primary care.	Significant reduction in trainee numbers in the primary/community sector.	Increase in NHS employed training numbers already agreed for next two years. Holding static position for overall numbers will mean numbers of community pharmacy placements will decrease.	-
	Disparity of training standards between hospital and primary care.	-	-	-
	Investment in developing the necessary skills and competence will be required post registration reducing the level of patient services that pharmacist can offer from day1. This has a training cost and a release cost.	-	-	-
	Limited opportunities to flex the training programme to reflect the changing landscape of NHS services.	-	-	-
	Unpredictable workforce planning continues	-	-	-

3.5 Preferred Option – Non Financial Analysis

Based on the non-financial analysis undertaken above, it would seem prudent to reject option 1 as it offers very few benefits. Option 2 is also rejected as although it would deliver the new model of delivery the number of trainees coming through the system would have to significantly reduce which would not be in line with future workforce planning. Option 3 and 4 both deliver a number of benefits however **Option 4 provides maximum flexibility for the future workforce and would therefore be the preferred option from the non-financial analysis.**

4. Expected benefits of Option 4

- 4.1 Invest in the initial education of all pharmacist trainees for the future models of practice ensuring at point of registration the workforce will have the skills and competence to provide more for patients at earlier stage of their career.
- 4.2 Provide the foundation for the vision over the next few years that the initial education and training of pharmacists will produce pharmacists with clinical, therapeutic and diagnostic skills to manage in hours and out of hours services, be able to have complex interactions with patients and be either on the path or qualified as Independent Prescribers.
- 4.3 Ensure educational investment post registration can be focused on developing the skills and competence of pharmacists to perform at the highest level offering a range of more complex interventions with patients within a multi-disciplinary team.
- 4.4 Align workforce planning for pharmacists over next five years across the whole integrated care pathway, ensures that de-stabilisation of any part of the pharmacy workforce is not comprised.
- 4.5 Signal to UK pharmacy undergraduates that Wales is committed to be at the forefront of supporting and developing the registrants for the future offering a training environment that is highly valued by students.
- 4.6 Builds on existing working partnership with NHS Wales Shared Services Partnership, who are currently acting as the single lead employer for GP trainees, negotiating similar for dental trainees and have given a positive indication to work in partnership to develop a process for pharmacy. This aligns to the draft IMTP 2019/22 for shared services which states a desired expansion of their services to other healthcare professions.
- 4.7 Drive quality, addressing current variation and ensuring that GPhC standards will be exceeded and aligned to the established NHS training standards.

5. Costs

- 5.1 The current Pre-Registration Pharmacist training programme is funded by the following sources:*

 - HEIW commissioned NHS band 5 salaries - Funded training placements.
 - HEIW funded central training programme - Staff and Non Staff.
 - HEIW funded recruitment platform and recruitment days (Oriel) - Non staff.
 - WG drug tariff community pharmacy training monies - Drug Tariff.

- 5.2 This business case therefore seeks funding from Welsh Government to deliver a new model of Pre-Registration Pharmacist Training in Wales. Additional funding is required:
 - To enable all trainees to be employed centrally as band 5 salaries - Commissioned expenditure.
 - To cover additional recruitment costs - Non staff.
 - To cover the core central training programme for all trainees - Non staff.
 - To enhance QM processes - Non staff.
 - To cover additional HEIW staff costs – Staff.
 - To cover the development of a new database and ongoing maintenance costs - Non staff.

*Full breakdown of costs at Appendix 1.

5.3 The financial impact assessment of all options is considered in the table below:

Financial Impact Assessment of Options considered	Option 1	Option 2	Option 3	Option 4	Option 4 over 3 years		
	2019-20	2020-2021	2020-2021	2020-2021	2021-2022	2022-2023	2023-2024
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Staff	£ 130	£ 273	£ 273	£ 273	£ 278	£ 284	£ 290
Non staff	£ 130	£ 182	£ 227	£ 236	£ 241	£ 245	£ 250
Commissioned expenditure							
Funded training placements @ grade 5 afc	£ 1,470	£ 1,799	£ 1,799	£ 1,799	£ 1,835	£ 1,872	£ 1,910
Top up of salary to Grade 5 (@£11,503 with 2% Inc)		£ 141	£ 751	£ 1,173	£ 1,291	£ 1,408	£ 1,525
Drug Tariff Costs (£18,440) for x trainees	£ 1,365	£ 221	£ 1,180	£ 1,844	£ 2,028	£ 2,213	£ 2,397
Trainer Grants/ Placement Fee's	£ -	£ 432	£ 744	£ 960	£ 1,020	£ 1,080	£ 1,140
Shared Service (Single lead employer)	£ -	£ 50	£ 50	£ 50	£ 50	£ 50	£ 50
Total Cost	£ 3,096	£ 3,098	£ 5,025	£ 6,336	£ 6,743	£ 7,152	£ 7,561
Additional Funding requirement		£ 2	£ 1,927	£ 3,240	£ 3,648	£ 4,056	£ 4,466
NHS Pre-Registration Pharmacist trainees	50	60	60	60	60	60	60
Community Practice Pre-Registration Pharmacy trainees	74	12	64	100	110	120	130
Total	124	72	124	160	170	180	190

	Option 1	Option 2	Option 3	Option 4
Cost per Trainee	NHS employed £34,600 Community Pharmacy £18,440	£43,027	£40,524	£39,600

- 5.4 Option 1 is the existing model in terms of numbers and funding.
- 5.5 Option 2 includes an assessment of the impact of introducing the multi-sectoral model within existing funding. The reduction in numbers to offset the drug tariff grant shortfall would see 74 Community Pharmacy Pre-registration trainees reduce to 12.
- 5.6 Option 3 shows the additional financial requirement if total numbers are maintained at 124 but the multi-sectoral model is introduced.
- 5.7 Option 4 includes an assessment of the additional funding required to introduce the multi sectoral model and increase numbers to 160. Following the introduction of a multi-sectoral model it is anticipated that demand would grow further over a four year period and the anticipated financial impact of this is also shown.
- 5.8 The proposal is to have a single point of employment for all trainees. Currently trainees are either NHS employed or by community pharmacy contractors. The rationale for single central employment enables equitable terms and conditions for all trainees, which does not exist at present. The higher salary within the NHS employed sector perpetuates the trainee perception that a hospital training post is more desirable than a post within primary care. Whilst there is clear evidence that training experience within the NHS is of a higher standard, it is important to ensure that the same standards are achieved within primary care particularly as care is delivered closer to home. An additional cost forecast of £50K would be required for the organisation providing the central HR resource.
- 5.9 Rotating trainees across sectors has its challenges when trainees have different employers. In particular liability issues are a concern for the training sites. In addition employers can view the trainee as "their" trainee and be more reluctant to allow trainees to have meaningful experiential learning within other areas of practice.
- 5.10 Central recruitment via Oriel is mandatory for NHS employed trainees but optional for community employers. For 2020, there will be increased costs for requiring all training posts to be advertised via Oriel. The cost is currently pro-rata on percentage of total number of posts across England and Wales. Wales's percentage currently stands at a cost of £13K. Assuming number of HEE training posts remain the same, Wales costs will rise to circa £50K dependant on numbers of training posts offered across Wales.

- 5.11 Based on recruitment evaluation, the opportunity to engage in a multi-sectorial programme with equity of pay and conditions is an attractive offer to students. Wales would be the first UK country to offer these benefits with the potential for Wales to retain and attract the best students. Central employment and commissioning of posts would enable Wales to manage the workforce demand for pharmacists providing a responsive environment which can flex to changing NHS service requirements. Central employment would also provide a once for Wales approach reducing the HR and contractual workload of employers and placing the emphasis on high quality training within the workplace.
- 5.12 The current contribution to the costs of trainee salaries are provided centrally from Welsh Government. For the NHS employed, trainees are paid at entry level band 5. The salary cost per trainee is circa £30K with on costs. The Drug Tariff training grant to community pharmacy has remained the same for several years at £18,440 per trainee. The proposal would be for all trainees to be recruited to entry level band 5 salary resulting in a deficit of circa £11,500 per trainee.
- 5.13 The agreed commissioned numbers for NHS employed trainees for 2019/20 is 60. This demonstrates the recognition within Health Boards that trainee numbers need to increase year on year to meet workforce demand. If the numbers of posts available were held static at 2019/20 level the increase in expenditure for salaries would be circa £900K. However £390K has already been committed for increase to 60 NHS employed and the balance of £410K is the additional monies to top up the drug tariff grant and reduction in number drug tariff training grants. If the numbers were increased to 160 comprising of 60 agreed commission and 100 via Drug Tariff grant then the increase in expenditure on salaries would be circa £2M with £390K already committed and £1.6M combining increase of £400K drug tariff money and £1.13M additional monies to top up drug tariff grant.
- 5.14 Currently all NHS employed trainees are supported centrally with off-site training days which are designed to cover all aspects of the training plan in conjunction with the work based learning. Some community pharmacy trainees attend the study days if their employer decides to offer this support. The off-site study days provide an opportunity for trainees to learn and apply new skills in a safe environment. The trainees are evaluated and assessed on their performance on the study days and reports are provided to tutors to discuss with trainees and form part of their assessment of competence prior to final sign off after twelve months. Additional educational resources are provided via a learning platform for trainees to access as they require.
- 5.15 Support to training sites is provided to develop the multi-sectorial training plans to ensure that all areas of skills and competence are covered during the training period. The training plans also clearly lay out the areas of competence to be achieved within each sector of practice. During the evaluation of the multi-sectorial training it was shown that the training site management of the trainees required additional resource to manage multiple trainees rotating across sectors. Therefore it is proposed that in recognition of the additional impact on sites a multi-sectorial training placement fee of £6K per trainee per annum should be made available to all training sites pro rata aligned to trainee time spent within site. If the 2018/19 numbers of trainees are retained for 2020 intake the total cost would be £744K and if numbers were increased in line with the expected increase in workforce demand the cost would be £960K.
- 5.16 The proposal is to build on the success of the training programme to date and to provide the same support and training for all posts. In addition the training sites and tutors will be approved via a quality assurance process to ensure consistency of standards across Wales and sectors. Standardised training for tutors and trainee feedback will be part of the quality measures. The aim would be to satisfy the requirements of the regulator, GPhC, and establish a memorandum of understanding with the regulator that the quality management of the training would be devolved to HEIW.

- 5.17 The use of a trainee e-portfolio has been established during 2018/19 as an essential tool to support the multi-sectorial training and it is proposed that this is offered to all trainees from 2020. The e-portfolio is currently being licensed from NHS Education Scotland for 47 trainees at a fee of £45 per trainee per annum at cost of £2K. It is proposed that all trainees will use an e-portfolio at a cost of £5.5K if numbers are maintained or £7K if numbers increase in line with demand. The use of an e-portfolio allows tutors and educational supervisors to read and write into the trainees' portfolio wherever the trainee is based. This is essential for standardisation of the learning and visibility at every point of the training programme.
- 5.18 It is proposed that all training sites, tutors and supervisor will have to meet a set of quality standards. HEIW will ensure that the standards are met via site visits and ongoing monitoring. Any site that falls below any of the standards will be supported to achieve the standards. If a site still fails to meet the standards after a period of support then the site approval will be removed and trainees will not be placed at the site until the standards are met. HEIW will work with colleagues and other healthcare partners to align standards to avoid duplication and increase the opportunities for multi-professional supervision of trainees.
- 5.19 To support the quality assurance process and co-ordinate trainee placements, training site visits and training programme across Wales, it is proposed that additional staff resource would be required. The current HEIW workforce comprises of 1FTE Head of Pre-registration pharmacists, 0.6FTE operational lead and 0.4FTE regional support. This supports the off-site training programme and tutor support. The proposed additional resource is 0.6FTE North Wales, 0.6FTE West Wales, 0.8FTE South East and Mid Wales and 1FTE administrative lead. The current staff costs are £130.5K and would increase by £142.5K to £273K and would not be dependent on increasing numbers within the current forecast. The additional staff resource would also manage the recruitment and marketing strategy and process, trainee progress, trainee database and communications.
- 5.20 There would be a need to build a central trainee database at a forecasted cost of £25K per year for first two years and then a maintenance cost of £5K per annum.

6. Investment appraisal

- 6.1 The return on investment from transforming the model to the central management of the initial education and training of pharmacists ensures at point of registration the workforce will have the skills and competence to provide more for patients at earlier stage of their career. The vision over the next few years will be initial education and training of pharmacists will produce pharmacists with clinical, therapeutic and diagnostic skills to manage in hours and out of hours services, be able to have complex interactions with patients and be either on the path or qualified as Independent Prescribers. The current model requires an investment to develop the necessary skills within post registration phase of career pathway at an additional cost of training, release from the work place, length of time for workforce to maximise their skills and potential impact on patient services. Moving to the new model will enable post registration education investment to focus on pharmacists acquiring the skills and competence to operate at the highest level within the multi-disciplinary team providing increasing complex interventions to patients.

7. Timescale

- 7.1 A decision in principle to invest in the new model of training for 2020 needs to be made by the 1 March 2019 in order to meet the current recruitment cycle.
- 7.2 In order to implement the change by the August 2020 intake data needs to be cleansed by regional leads by the 5 April 2019 and recruitment numbers need to be confirmed in the system by mid-May.

- 7.3 Following agreement of the business case, a significant programme of work will then be undertaken over the next twelve months to agree the detail of the proposed changes.

No	Task	Lead	Start Date	Finish Date	Dependent on any preceding task/s	Status
1	Identify single lead employer and associated costs.	HEIW Finance	April 2019	January 2020		
2	Develop a service level agreement with the single lead employer.	HEIW Finance/Legal	April 2019	January 2020		
3	Arrange for each approved site to receive a training grant.	HEIW Finance	April 2019	March 2020		
4	Agree commission numbers for 2020.	HEIW	March 2019	May 2019		
5	Plan for recruitment cycle in place for 2020 intake.	HEIW Head of pre-registration pharmacist (PRP)	March 2019	January 2020		
6	Retendering for recruitment process for 2021 intake.	HEIW Pharmacy Dean + NWSSP	Ongoing	November 2019		
7	Recruitment of HEIW pre-registration posts.	HEIW People	May 2019	August 2019		
8	Plan for developing quality assurance standards and process.	HEIW Head of Pre-Registration Pharmacy	May 2019	January 2020		
9	Database build.	HEIW Digital	January 2020	May 2020		
10	Tutor training.	HEIW Head of Pre-Registration Pharmacy	May 2020	June 2020		
11	Develop core training programme and any resources required.	HEIW Head of Pre-Registration Pharmacy	April 2019	May 2020		
12	Develop a communications and engagement strategy to notify key stakeholders of the change.	HEIW Communications	February 2019	April 2019		
13	Revise the Train, Work Live recruitment strategy.	HEIW Communications	February 2019	April 2019		
14	Develop marketing strategy for 2021 intake.	HEIW Communications	July 2019	September 2019		

- 7.4 Several benefits will be realised by 2021 when first cohort register but will be ongoing as the benefits to the change are maximised over next five years to ten years.

8. Major risks

The major risks to the implementation plan are:

- 8.1 If preferred option 4 is not agreed by March 2019, the impact would be that any significant change to registrant's skills would not be realised until at least the cohort completing their training in 2022 during which time other parts of the UK will have caught up with Wales. It is proposed that Welsh Government commitment for preferred option by March 2019 will mitigate this risk.
- 8.2 If agreement with single lead employer is not in place by January 2020. The risk has been mitigated by early conversations with NWSSP which has established an in principle agreement to work with HEIW to provide a single lead employer service similar to that for GP and foundation dental trainees.
- 8.3 The possible lack of resource within HEIW to build database for quality management of training programme by March 2020. HEIW would mitigate this risk by identifying an external supplier and to check at start if tendering process will be required.
- 8.4 The possible inability to recruit HEIW staff resources to manage the new model of delivery. Proposals to mitigate this risk would be to identify opportunities to restructure internal staff resource and starting recruitment process by May 2019.

Appendix 1

	Option 1	Option 2	Option 3	Option 4	Option 4 Over 3 years		
	2019-20	2020-21	2020-21	2020-21	2021-22	2022-23	2023-24
Staff Costs							
Head of Pre Registraion (8b)	£ 40,000	£ 68,328	£ 68,328	£ 68,328	£ 69,695	£ 71,089	£ 72,511
5 Regional Leads @ 0.6fte each (3 fte- 8a)	£ 77,000	£ 175,916	£ 175,916	£ 175,916	£ 179,434	£ 183,023	£ 186,683
1 fte Administrator (grade 4)	£ 13,000	£ 28,559	£ 28,559	£ 28,559	£ 29,130	£ 29,713	£ 30,307
Total Staff	£ 130,000	£ 272,804	£ 272,804	£ 272,804	£ 278,260	£ 283,825	£ 289,501
Non Staff							
Staff travel	£ 4,500	£ 8,000	£ 8,000	£ 8,000	£ 8,160	£ 8,323	£ 8,490
Venue costs	£ 60,000	£ 50,000	£ 60,000	£ 60,000	£ 61,200	£ 62,424	£ 63,672
Tutor Training Events		£ 15,000	£ 15,000	£ 15,000	£ 15,300	£ 15,606	£ 15,918
Speakers' fees	£ 15,500	£ 15,500	£ 15,500	£ 15,500	£ 15,810	£ 16,126	£ 16,449
Speaker travel	£ 2,000	£ 2,000	£ 2,000	£ 2,000	£ 2,040	£ 2,081	£ 2,122
Commissioning of learning materials	£ 20,000	£ 20,000	£ 20,000	£ 20,000	£ 20,400	£ 20,808	£ 21,224
Database build and maintenance	£ -	£ 20,000	£ 25,000	£ 25,000	£ 25,500	£ 26,010	£ 26,530
Photocopying	£ 3,000	£ 3,000	£ 3,000	£ 3,000	£ 3,060	£ 3,121	£ 3,184
Marketing	£ 2,500	£ 2,500	£ 2,500	£ 2,500	£ 2,550	£ 2,601	£ 2,653
Stationery	£ 200	£ 200	£ 200	£ 200	£ 204	£ 208	£ 212
Misc Office Expenses/IT Support Costs	£ 8,000	£ -	£ -	£ -	£ -	£ -	£ -
E portfolio costs	£ 1,796	£ 5,431	£ 5,431	£ 5,431	£ 5,540	£ 5,651	£ 5,764
Trainee Travel costs	£ -	£ 15,000	£ 24,800	£ 29,800	£ 30,396	£ 31,004	£ 31,624
Oriel Recruitment	£ 13,000	£ 26,000	£ 46,000	£ 50,000	£ 51,000	£ 52,020	£ 53,060
Total Non Staff	£ 130,496	£ 182,631	£ 227,431	£ 236,431	£ 241,160	£ 245,983	£ 250,903
Commissioned							
Commissioned expenditure							
Funded training placements @ grade 5 a/c	£ 1,470,150	£ 1,799,465	£ 1,799,464	£ 1,799,464	£ 1,835,453	£ 1,872,162	£ 1,909,605
Top up of salary to Grade 5 (@£11,503 with 2% inc)		£ 141,000	£ 751,000	£ 1,173,000	£ 1,291,000	£ 1,408,000	£ 1,525,000
Drug Tariff Costs (£18,440) for x trainees	£ 1,364,560	£ 221,000	£ 1,180,160	£ 1,844,000	£ 2,028,400	£ 2,212,800	£ 2,397,200
Trainer Grants/ Placement Fee's	£ -	£ 431,000	£ 744,000	£ 960,000	£ 1,020,000	£ 1,080,000	£ 1,140,000
Shared Service (Single lead employer)	£ -	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000	£ 50,000
Total Cost	£ 3,095,606	£ 3,098,485	£ 5,024,858	£ 6,335,475	£ 6,744,272	£ 7,152,770	£ 7,562,209
Additional Funding requirement		£ 2,879	£ 1,926,374	£ 3,239,869	£ 3,648,667	£ 4,057,164	£ 4,466,604

HEIW Education, Commissioning and Quality Committee

Forward work programme

30.4.2019 draft v2.1

16 May 2019	July 2019	October 2019	February
<p><u>Strategic issues</u> Strategic review of health professional education</p> <p>Future ways of working – means of engaging</p> <p><u>Education Performance and Quality</u> Quality assurance process GMC</p> <p>Future quality reporting mechanisms</p> <p><u>For information</u> Briefing on Business case: <ul style="list-style-type: none"> - Eye Care - General practice - Pharmacy technicians NHS Wales Bursary for 2020/21 – implications for HEIW</p>	<p><u>Strategic issues</u> 1. Strategic review of health professional education 2. National Education and Training plan for 2020/21</p> <p><u>Education Performance and Quality</u> 3. Performance management framework for Health Professional Education</p> <p><u>For information</u></p>	<p><u>Strategic issues</u> 1. Strategic review of health professional education 2. Regulatory changes to education provision 3. Widening access to education – apprenticeships, alternative education routes etc.</p> <p><u>Education Performance and Quality</u></p> <p><u>For information</u></p>	<p><u>Strategic issues</u> 1. Strategic review of health professional education 2. Impact/opportunities of digitalisation on health education</p> <p><u>Education Performance and Quality</u></p> <p><u>For information</u></p>

[illegible]

<p>1 Background</p> <p>2 Introduction</p> <p>3 Methodology</p> <p>4 Results</p> <p>5 Discussion</p> <p>6 Conclusion</p> <p>7 References</p> <p>8 Appendix</p> <p>9 Index</p> <p>10 Table of Contents</p> <p>11 Figure 1</p> <p>12 Figure 2</p> <p>13 Figure 3</p> <p>14 Figure 4</p> <p>15 Figure 5</p> <p>16 Figure 6</p> <p>17 Figure 7</p> <p>18 Figure 8</p> <p>19 Figure 9</p> <p>20 Figure 10</p> <p>21 Figure 11</p> <p>22 Figure 12</p> <p>23 Figure 13</p> <p>24 Figure 14</p> <p>25 Figure 15</p> <p>26 Figure 16</p> <p>27 Figure 17</p> <p>28 Figure 18</p> <p>29 Figure 19</p> <p>30 Figure 20</p> <p>31 Figure 21</p> <p>32 Figure 22</p> <p>33 Figure 23</p> <p>34 Figure 24</p> <p>35 Figure 25</p> <p>36 Figure 26</p> <p>37 Figure 27</p> <p>38 Figure 28</p> <p>39 Figure 29</p> <p>40 Figure 30</p> <p>41 Figure 31</p> <p>42 Figure 32</p> <p>43 Figure 33</p> <p>44 Figure 34</p> <p>45 Figure 35</p> <p>46 Figure 36</p> <p>47 Figure 37</p> <p>48 Figure 38</p> <p>49 Figure 39</p> <p>50 Figure 40</p> <p>51 Figure 41</p> <p>52 Figure 42</p> <p>53 Figure 43</p> <p>54 Figure 44</p> <p>55 Figure 45</p> <p>56 Figure 46</p> <p>57 Figure 47</p> <p>58 Figure 48</p> <p>59 Figure 49</p> <p>60 Figure 50</p> <p>61 Figure 51</p> <p>62 Figure 52</p> <p>63 Figure 53</p> <p>64 Figure 54</p> <p>65 Figure 55</p> <p>66 Figure 56</p> <p>67 Figure 57</p> <p>68 Figure 58</p> <p>69 Figure 59</p> <p>70 Figure 60</p> <p>71 Figure 61</p> <p>72 Figure 62</p> <p>73 Figure 63</p> <p>74 Figure 64</p> <p>75 Figure 65</p> <p>76 Figure 66</p> <p>77 Figure 67</p> <p>78 Figure 68</p> <p>79 Figure 69</p> <p>80 Figure 70</p> <p>81 Figure 71</p> <p>82 Figure 72</p> <p>83 Figure 73</p> <p>84 Figure 74</p> <p>85 Figure 75</p> <p>86 Figure 76</p> <p>87 Figure 77</p> <p>88 Figure 78</p> <p>89 Figure 79</p> <p>90 Figure 80</p> <p>91 Figure 81</p> <p>92 Figure 82</p> <p>93 Figure 83</p> <p>94 Figure 84</p> <p>95 Figure 85</p> <p>96 Figure 86</p> <p>97 Figure 87</p> <p>98 Figure 88</p> <p>99 Figure 89</p> <p>100 Figure 90</p> <p>101 Figure 91</p> <p>102 Figure 92</p> <p>103 Figure 93</p> <p>104 Figure 94</p> <p>105 Figure 95</p> <p>106 Figure 96</p> <p>107 Figure 97</p> <p>108 Figure 98</p> <p>109 Figure 99</p> <p>110 Figure 100</p> <p>111 Figure 101</p> <p>112 Figure 102</p> <p>113 Figure 103</p> <p>114 Figure 104</p> <p>115 Figure 105</p> <p>116 Figure 106</p> <p>117 Figure 107</p> <p>118 Figure 108</p> <p>119 Figure 109</p> <p>120 Figure 110</p> <p>121 Figure 111</p> <p>122 Figure 112</p> <p>123 Figure 113</p> <p>124 Figure 114</p> <p>125 Figure 115</p> <p>126 Figure 116</p> <p>127 Figure 117</p> <p>128 Figure 118</p> <p>129 Figure 119</p> <p>130 Figure 120</p> <p>131 Figure 121</p> <p>132 Figure 122</p> <p>133 Figure 123</p> <p>134 Figure 124</p> <p>135 Figure 125</p> <p>136 Figure 126</p> <p>137 Figure 127</p> <p>138 Figure 128</p> <p>139 Figure 129</p> <p>140 Figure 130</p> <p>141 Figure 131</p> <p>142 Figure 132</p> <p>143 Figure 133</p> <p>144 Figure 134</p> <p>145 Figure 135</p> <p>146 Figure 136</p> <p>147 Figure 137</p> <p>148 Figure 138</p> <p>149 Figure 139</p> <p>150 Figure 140</p> <p>151 Figure 141</p> <p>152 Figure 142</p> <p>153 Figure 143</p> <p>154 Figure 144</p> <p>155 Figure 145</p> <p>156 Figure 146</p> <p>157 Figure 147</p> <p>158 Figure 148</p> <p>159 Figure 149</p> <p>160 Figure 150</p> <p>161 Figure 151</p> <p>162 Figure 152</p> <p>163 Figure 153</p> <p>164 Figure 154</p> <p>165 Figure 155</p> <p>166 Figure 156</p> <p>167 Figure 157</p> <p>168 Figure 158</p> <p>169 Figure 159</p> <p>170 Figure 160</p> <p>171 Figure 161</p> <p>172 Figure 162</p> <p>173 Figure 163</p> <p>174 Figure 164</p> <p>175 Figure 165</p> <p>176 Figure 166</p> <p>177 Figure 167</p> <p>178 Figure 168</p> <p>179 Figure 169</p> <p>180 Figure 170</p> <p>18</p>
--

Promoting excellence theme	Question
All themes	<p>1 Please list quality management activities, processes and/or policies that demonstrate your ability to check whether standards are being met, in particular:</p> <p>a How you collect and assess evidence on training environments, including from other organisations</p> <p>b How level of risk and subsequent actions are determined</p>
Learning environment and culture	<p>2 Please list quality management activities, processes and/or policies that demonstrate your ability to check whether standards are being met with regard to:</p> <p>a Patient safety concerns</p> <p>b Learners working with the right supervision and within their level of competence</p> <p>c Induction (postgraduate: at post and programme level; undergraduate: at programme and clinical placement level)</p> <p>d Adequate learning opportunities including inter-professional learning and technology enhanced and simulation-based learning</p> <p>e Feedback loops from learners and educators</p>

	f Facilities
Educational governance and leadership	<p>3 Please list mechanisms, processes and/or policies that demonstrate that:</p> <p>a You have a published, up-to-date, organisational structure that shows learners who is responsible for what within education in your organisation</p> <p>b How information is shared between relevant organisations (including HEE, other medical schools and trusts where relevant)</p> <p>c How you feed information back to training environments and how you monitor progress</p> <p>d Learners are represented in different educational governance levels within your organisation and in the local education providers</p> <p>e Learners have power to influence decision making, raise concerns and resolve concerns</p> <p>f You are aware of the educational governance structures of the local education providers (PG: in the region) ((UG: LEPs you use)</p> <p>g Educational governance is discussed at board level in the LEPs in the region</p> <p>h You are aware of, and able to manage, progression and fitness to practice issues</p> <p>i Learners and educators receive feedback after they have raised a concern about education or training.</p> <p>4 Please list quality management activities, processes and/or policies that demonstrate you are committed to tackling unfairness in:</p>

	<p>a Medical school curricula</p> <p>b Undergraduate assessment and selection</p>
Supporting learners	<p>5 Please list mechanisms, processes and/or policies that demonstrate that:</p> <p>a The health and wellbeing of learners is promoted and that concerns about the health and wellbeing of learners are monitored and addressed</p> <p>b Learners are supported at transition points in their training pathway (eg from medical school to foundation training, or from foundation into core training)</p> <p>c Feedback on performance promotes learning and is constructive.</p>
Supporting educators	<p>6 Please list mechanisms, processes and/or policies that demonstrate that:</p> <p>a The selection of educators is made against suitable criteria.</p> <p>b Educators are appropriately trained and inducted and that their training is kept up-to-date</p> <p>c A monitoring process for the development of trainers as set out in GMC requirements for recognising and approving trainers</p> <p>d Educators have appropriate time in their job plans to meet their educational responsibilities.</p> <p>e Educators have access to educational resources and funds.</p>

	<p>f Educators have the opportunity to liaise and connect with other trainers.</p> <p>g Educators have access to support when dealing with concerns.</p> <p>h You intervene when local education providers fail to comply with the above</p>
Developing and implementing curricula and assessments	<p>7 Please provide us with a curriculum map that demonstrates outcomes for graduates have been met across the whole programme and students have:</p> <p>a Early contact with patients that increases in duration and responsibility as they progress through the programme.</p> <p>b Experience in a range of specialties in different settings.</p> <p>c The opportunity to gain knowledge and understanding of the needs of patients from diverse social, cultural and ethnic backgrounds.</p> <p>d Learning opportunities to enable them to develop generic professional capabilities.</p> <p>e At least one student assistantship that prepares them to start working as a foundation doctor.</p> <p>8 Please list mechanisms, processes and/or policies that demonstrate that:</p> <p>a Your assessments are fair, reliable and mapped to your curriculum.</p> <p>b You appropriately select, support and appraise assessors.</p>

We don't expect you to fill in all four columns below. You may decide that the best way to share your experience is by telling us about the activity in Column C; inviting us to observe an activity in Column D; or by telling us about the activity in Column E. You may also choose to share any good practice, reflections or

Please feel free to resize the rows so you can see your responses. You may add or delete rows as needed. You may also merge cells across multiple items in column B. (Highlight the cells you want to merge and click the Merge & Center button in the ribbon.)

Answer

Please answer these questions as succinctly as possible and whenever possible respond in bullet points rather than paragraphs.

The diagram consists of a vertical stack of eight rectangular sections. The top four sections are colored: grey, light blue, light blue, and grey. The bottom four sections are white, each preceded by a horizontal line.

[illegible]

[illegible]

[illegible]

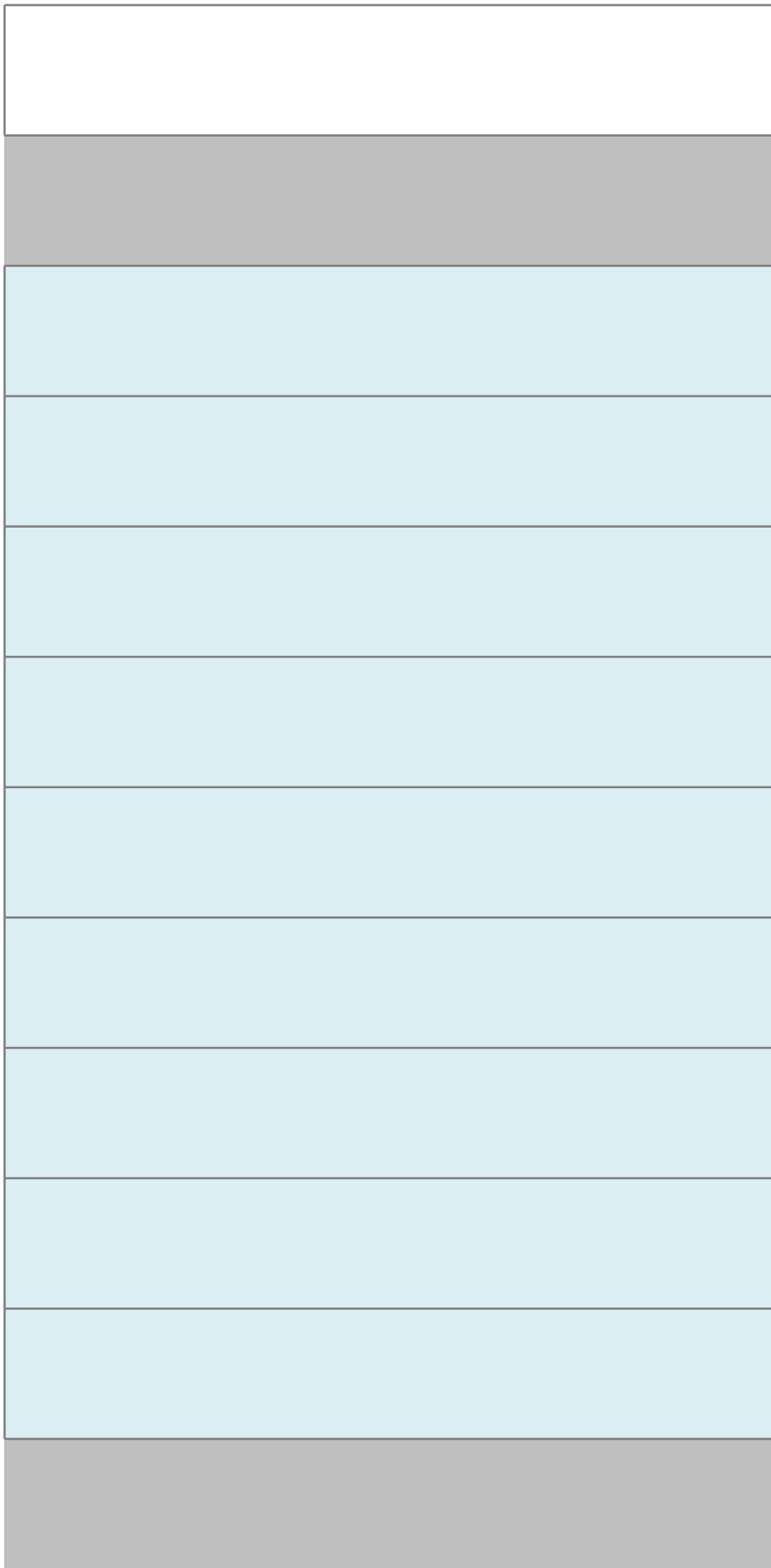
The question is best addressed by writing a short paragraph or bullet points in Column E. Submit a document that demonstrates you are meeting the requirement in Column F.

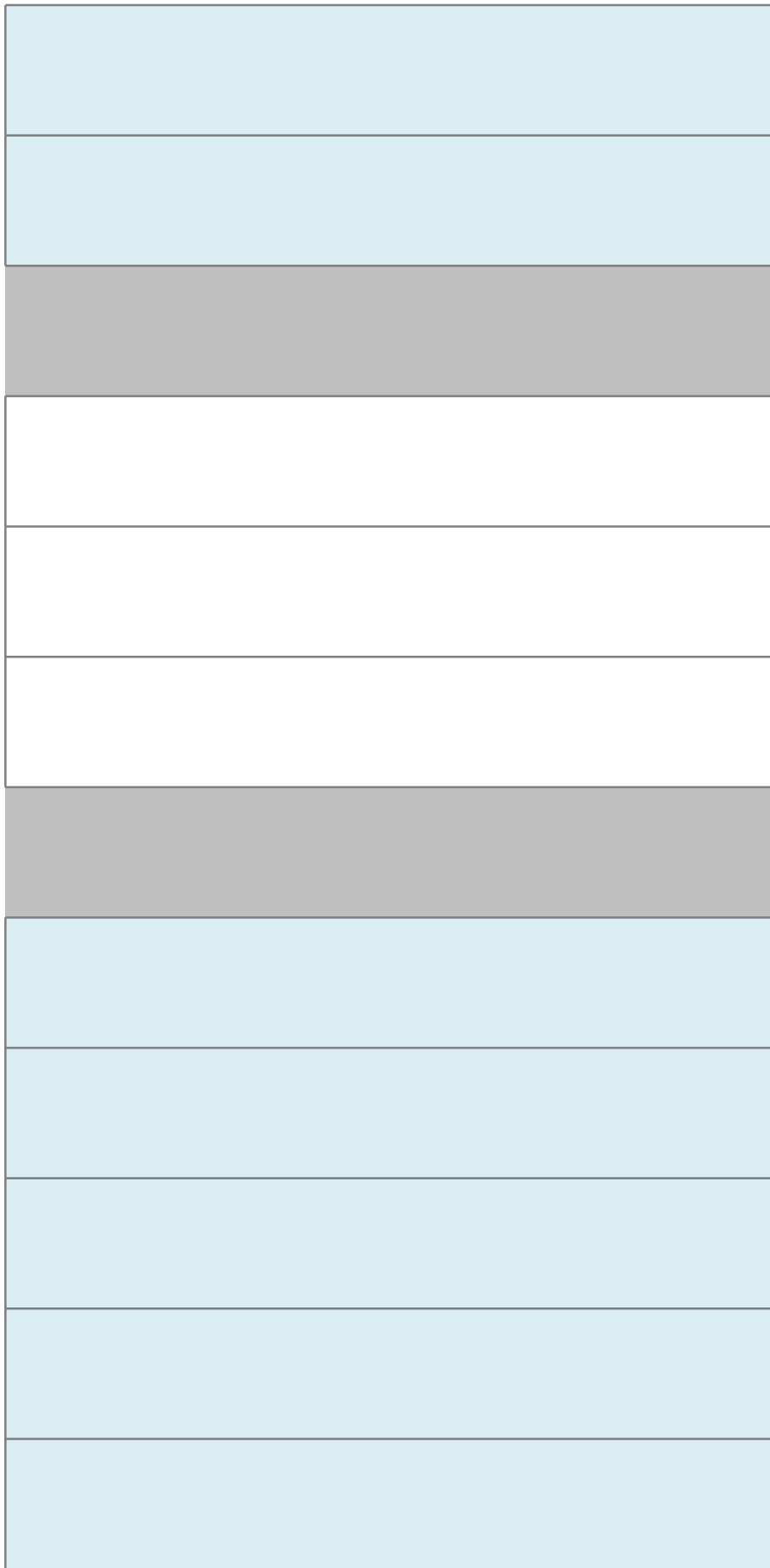
Also wish to merge cells within a column (C, D, E or F) if your answer applies (click "Merge & Center").

Planned activities we could observe

Please list activities we could observe and provide any dates when these activities will take place (if possible).

[illegible]





[illegible]

List or describe any documents that demonstrate you are meeting the requirements.

Please don't attach any documents at this stage.

--

--

--

--

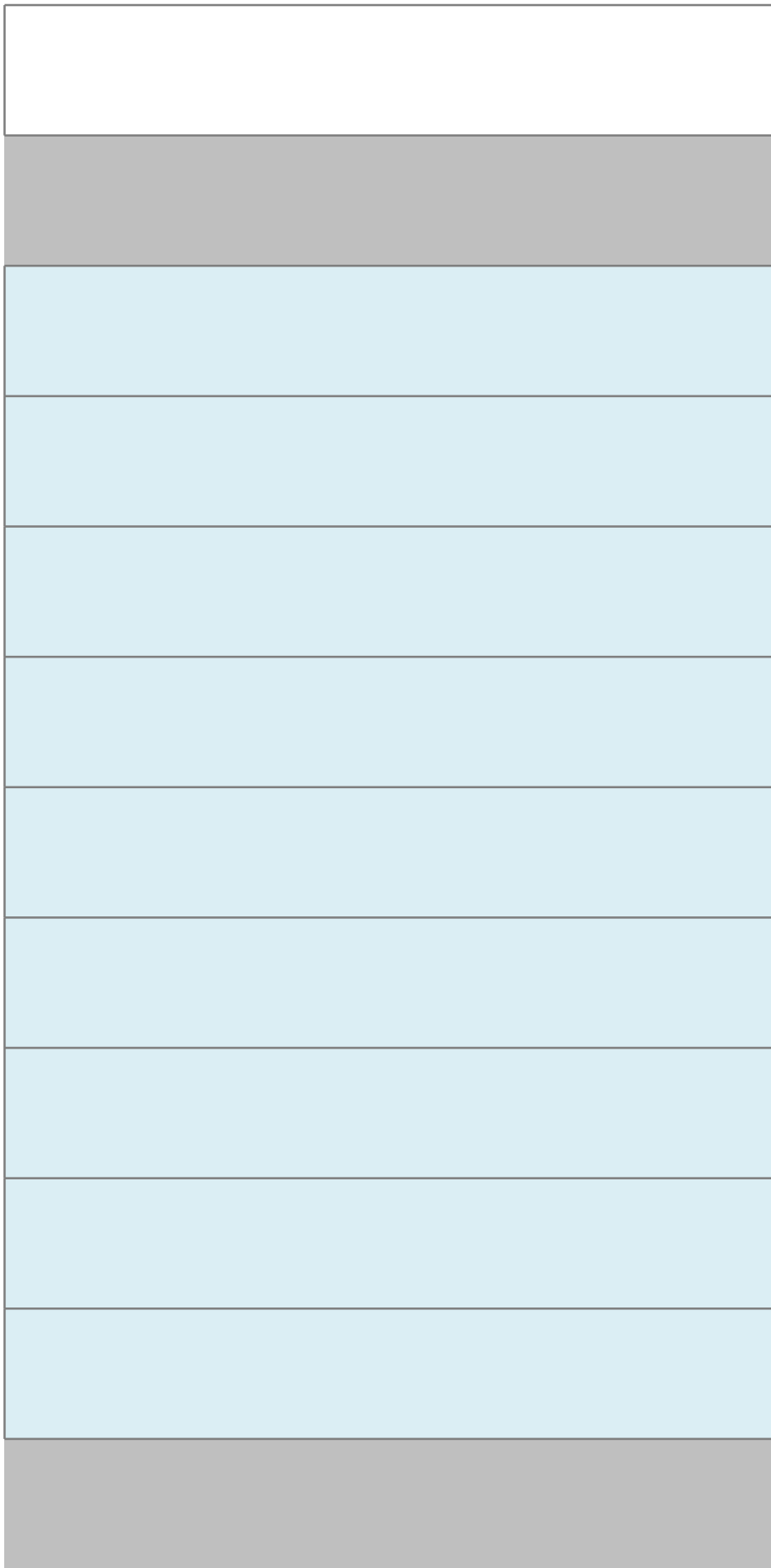
--

--

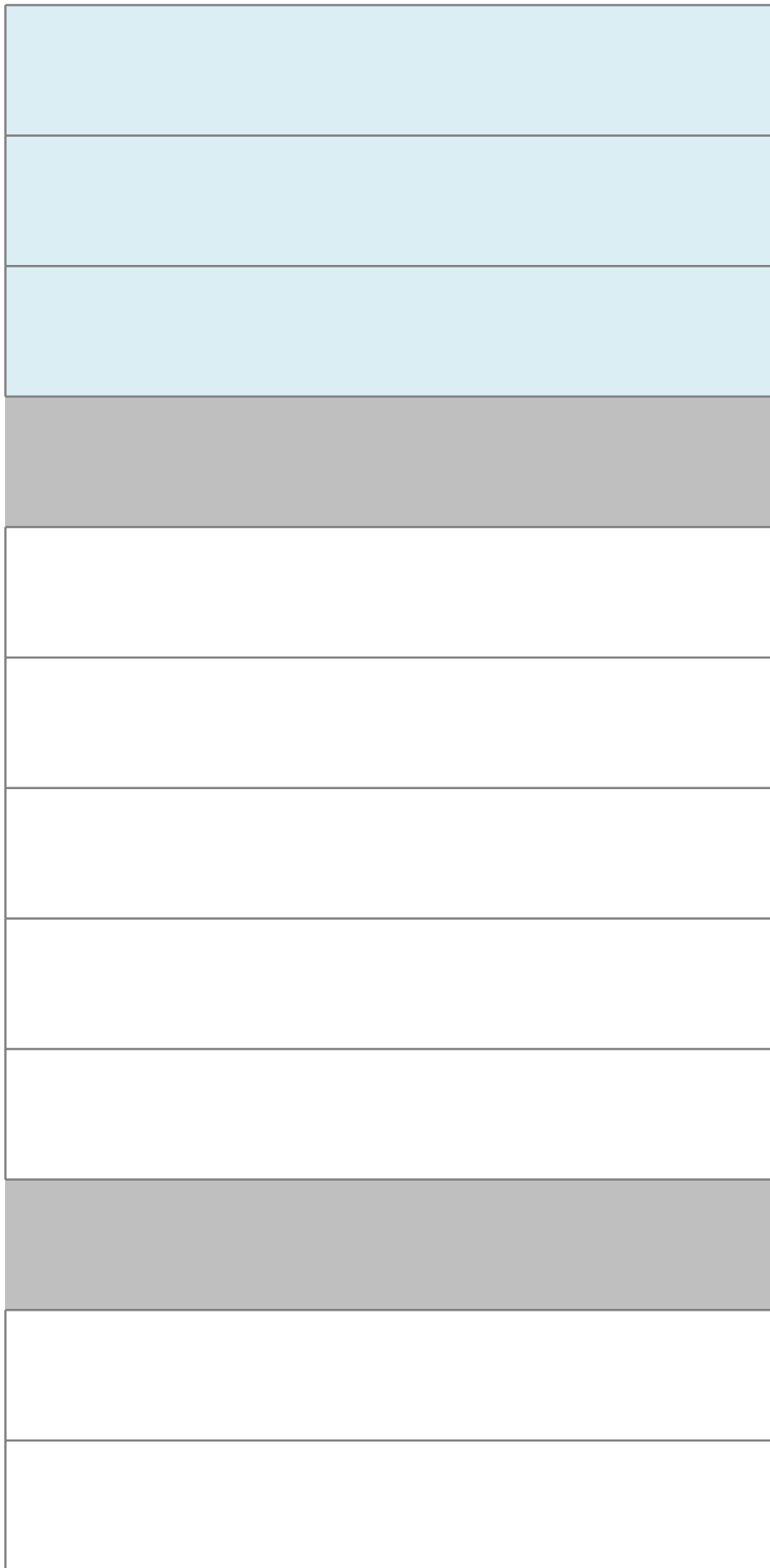
--

--

--







--

OPTIONAL: examples of notable practice, reflections or challenges
--

--

--

--

--

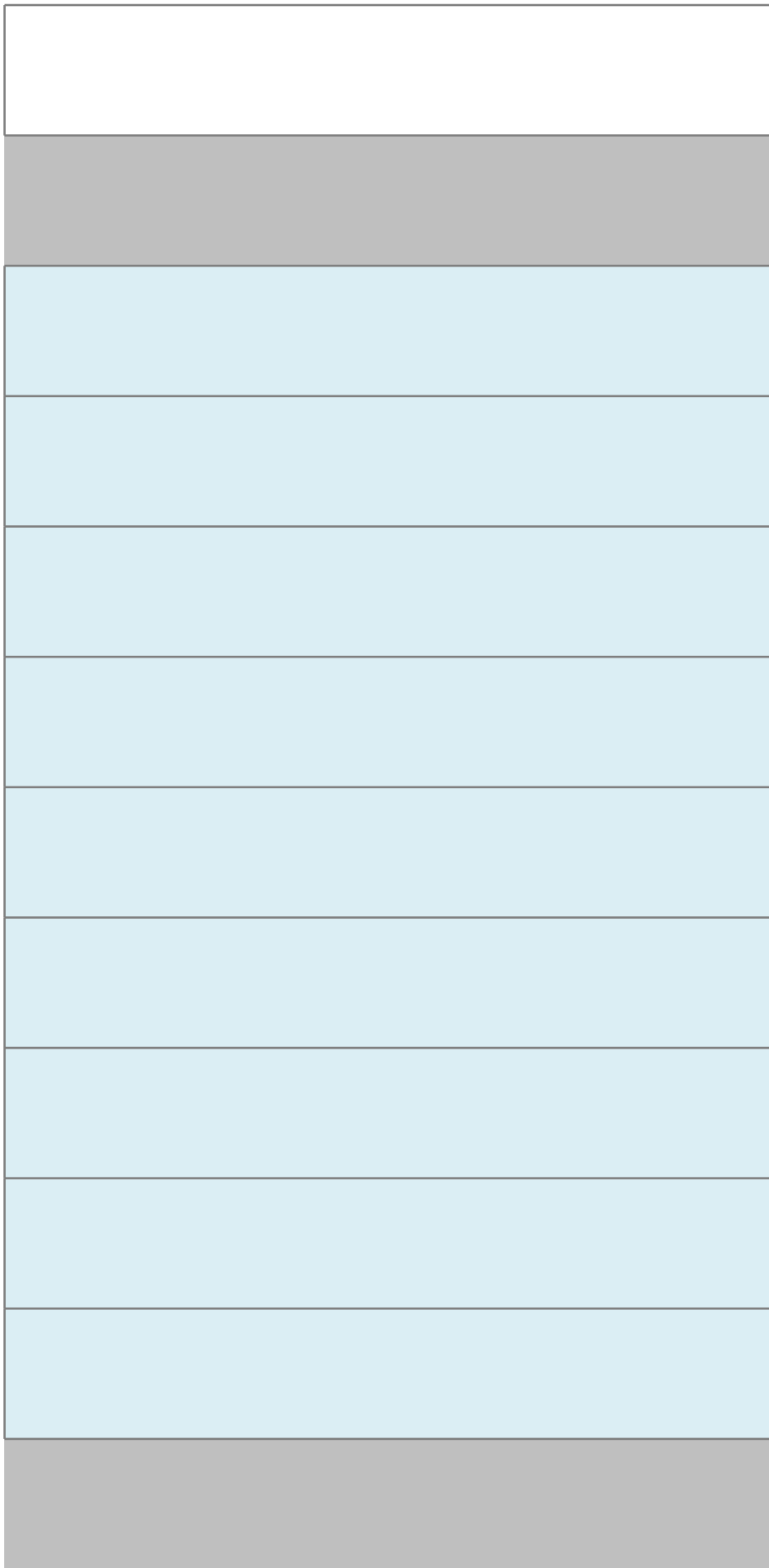
--

--

--

--

--





[illegible]

