

HEALTH EDUCATION AND IMPROVEMENT WALES (HEIW)

Open Board Meeting – 11:30-1:30

**to be held on Thursday, 26 January 2022
Conference Room, Ty Dysgu**

AGENDA

PART 1	PRELIMINARY MATTERS	11:30-11:45
1.1	Welcome and Introductions	Chair/Verbal
1.2	Apologies for Absence	Chair/Verbal
1.3	Declarations of Interest	Chair/Verbal
1.4	Draft Minutes of the Board meeting held on 24 November 2022	Chair/Attachment
1.5	Action Log from the Board meeting held on 24 November 2022	Chair/Attachment
1.6	Matters Arising	Chair/Verbal
PART 2	CHAIR AND CHIEF EXECUTIVE REPORTS	11:45-11:55
2.1	Chair's Report	Chair/Attachment
2.2	Chief Executive's Report	Chief Executive/ Attachment
PART 3	STRATEGIC MATTERS	11:55-12:50
3.1	Approval of the Digital Strategy	Director of Digital Development
3.2	Update on supporting International Medical Graduates and ensuring fair training pathways	Medical Director / Attachment
3.3	Critical Care Workforce Report	Director of Nursing and Health Professional Education /Attachment
3.4	Impact of Duty of Quality and Candour on HEIW	Medical Director and Director of Nursing and Health Professional Education/Attachment
3.5	Introduction to Genomics	Chief Executive/Attachment
PART 4	GOVERNANCE, PERFORMANCE, AND ASSURANCE	12:50-1:25
4.1	Review of Education and Training Activity 22/23	Interim Director of Finance, Medical Director and Director of Nursing and Health Professional Education/Attachment
4.2	Director of Finance Report Month 9	Interim Director of Finance and Corporate Services/Attachment
4.3	Welsh language update	Board Secretary/ Attachment

4.4	Corporate Risk Register	Board Secretary/ Attachment
4.5	In Committee Decisions	Board Secretary/ Attachment
4.6	To Receive Key Issues Report from: 4.5.1 – Education Commissioning and Quality Committee held on 6 December 2022	Committee Chair/ Attachments
PART 5	FOR NOTING	
	No papers for noting	
PART 6	OTHER MATTERS	1:25-1:30
6.1	Any Other Urgent Business	Chair/Verbal
6.2	Dates of Next Meetings: - HEIW Board Development Session to be held on 16 February 2023 via Conference Room, Ty Dysgu, Nantgawr, CF15 7QQ Board to be held on 30 March 2023 via Conference Room, Ty Dysgu, Nantgawr, CF15 7QQ	

In accordance with the provision of Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960 it shall be resolved that representatives of the press and other members of the public be excluded from the latter part of the meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting is to be held in private session.

Unconfirmed Minutes of the HEIW Board Meeting
held at 11am on 24 November 2022
via Conference Room, Ty Dysgu

Present:

Dr Chris Jones	Chair
Dr Ruth Hall	Independent Member/Vice-Chair
Gill Lewis	Independent Member
Tina Donnelly	Independent Member
Jonathan Morgan	Independent Member
John Gammon	Independent Member
Alex Howells	Chief Executive
Julie Rogers	Director of Workforce and OD/Deputy Chief Executive
Lisa Llewelyn	Director of Nurse and Health Professional Education
Rhiannon Beckett	Interim Director of Finance and Planning and Performance
Professor Pushpinder Mangat	Medical Director.

In attendance:

Sian Richards	Director of Digital
Anton Saayman	Director of Educational Improvement and Governance in Medical Deanery
Angharad Price	Head of Communication and Engagement
Catherine English	Corporate Governance Manager (Secretariat)
Dafydd Bebb	Board Secretary

PART 1	PRELIMINARY MATTERS	Action
2411/1.1	Welcome and Introductions	
	The Chair welcomed everyone to the meeting and a quorum was confirmed as present.	
2411/1.2	Apologies for absence	
	No apologies were received.	
2411/1.3	Declaration of interest	
	No declarations were received.	
2411/1.4	To receive and confirm the minutes of the Board Meeting held on 29 September 2022	
Resolved	The September Board minutes were received and approved as an accurate record of the meeting.	
2411/1.5	Action Log from the Board meeting held on 29 September 2022	
	The Board received the Action Log and noted that all the actions were either complete or in progress.	
Resolved	The Board noted the Action Log	
2411/1.8	Matters Arising	
	There were no matters arising.	
PART 2	CHAIR AND CHIEF EXECUTIVE REPORTS	
2411/2.1	Chairs Report	

	The Board received the report. Introducing the report, the Chair highlighted the challenges currently facing Wales including that the economy was likely to be in recession with high interest rates and a tight labour market. He also noted that high fuel costs, the war in Ukraine, disruption of food chains and recovery from a pandemic, were impacting across the globe. The Chair also highlighted that the recent financial statement by the Chancellor signaled increasing taxation and real pressure on public service spending. The Chair explained that the latest NHS monthly performance statistics had been published on the 17th of November and demonstrated intense pressure on the health and care system. He explained that NHS activity was now at pre-pandemic levels and that attracting and expanding the workforce would take time so there needed to be a focus on retaining and valuing existing NHS staff. It was noted that the NHS continued to work to address the immediate challenges and was focused on meeting these demands. However, it was crucial to underline the importance of giving energy and effort to plan for future workforce to address the needs over the next 10 years. The Chair confirmed that October and November had been a busy period and thanked HEIW staff for the professional way they were working to develop support and deliver education, training, leadership and workforce planning. It was noted that the Board had held a development session on the 26 October and that HEIW had hosted a visit from Sir Frank Atherton, the Chief Medical Officer, on the 13th of October. The Chair highlighted a number of engagements over the reporting period. This included laying a wreath on behalf of NHS Wales for those who served in a medical capacity and attended the launch of the Windrush Cymru Exhibition, opened by Mark Drakeford, the First Minister, and the Windrush community elders in Wales. It was confirmed that the Chairs Stakeholder Reference Group (SRG) had gone ahead on the 21st of November. The meeting had been well attended with a host of key stakeholders and partners from across the NHS, education, and third sector.	
Resolved	The Board noted the report for information.	
2411/2.2	Chief Executives Report	
	The Board received the report. Providing a brief update, Alex Howells confirmed that HEIW had developed a systematic approach for developing future workforce plans and would be developing increased capacity and capability to undertake workforce modelling and scenario planning. It was noted that the Strategic Mental Health Workforce Plan had been formally launched by Lynne Neagle (Deputy Minister for Mental Health and Wellbeing), on 7 November and that three further key strategic	

	workforce plans were under development for nursing, pharmacy and dental as priorities for 22/23. The Board considered the report and discussed the mechanisms for deciding how HEIW prioritised its support for the challenges in the system. It was confirmed that the Executive Team discussed and agreed on those initiatives aligned to the IMTP and that anything material which was out of scope of the IMPT was brought to Board for discussion and approval. It was noted that HEIW's work was in line with ministerial priorities. The Board considered that it would be helpful to report on how HEIW has delivered on the ministerial directives to ensure HEIW's engagement was meaningful and having the desired impact.	
Resolved	The Board noted the report for information.	
PART 3	STRATEGIC MATTERS	
2411/3.1	Approval of Simulation Strategy	
	The Board received the report and presentation. Pushpinder Mangat introduced the report and Anton Saayman (Director of Educational Improvement and Governance in Medical Deanery) and explained that it set out the All-Wales Simulation-Based Education and Training Strategy for the Healthcare Workforce to the HEIW Board for approval. Anton Saayman confirmed that this strategy aligned with Strategic Aim 2 and specifically Strategic Objective 2.10, to lead the development and implementation of a multi-professional strategy for Simulation-Based Education. It was noted that the draft strategy was considered at the Simulation Steering Group on 10 January 2022 and had been considered by the Executive Team. It was confirmed stakeholder consultation meetings took place between May and August 2022 and that the benefits of the strategy were clearly defined. It was noted that the strategy would be supported by an implementation plan and well-defined objectives and milestones. The Board considered the strategy and noted the need to emphasize the fact that simulation training provided a safe environment for trainees. The Board discussed how HEIW was going to ensure the strategy aligned to other strategies being developed by health boards and the opportunities for using digital platforms to deliver simulation training. It was confirmed by Sian Richards that HEIW was looking at different partnership models for developing digital solutions, not based on a purchase arrangement. Discussions were ongoing with Legal and Risk on how it could be taken forward. The Board considered the opportunities to emphasize the impact of simulation to the multi-professional teams and the scope to marry this with digital initiatives. The importance of standardising assessments was emphasised and it was confirmed the team was working on this to align approaches across Wales.	

	The Board indicated their commitment and support for the strategy and congratulated the team for their hard work.	
Resolved	The Board approved the All-Wales Simulation-Based Education and Training Strategy for the Healthcare Workforce.	
2411/3.2	Maternity and Neonatal Workforce, Education and Training Programme of Work Update	
	The Board received the report. Introducing the report, Lisa Llewelyn explained it provided an update on a new programme of work designed to support the maternity and neonatal workforce and improve the quality and safety of care in those areas. It was noted that several reports had been published highlighting failings in maternity and neonatal services across the UK, and that these reports all had similar themes and made recommendations for immediate action. Through engagement with maternity and neonatal colleagues from across NHS Wales, HEIW had identified and agreed the priorities for HEIW over the next six months to support health boards in implementing some of the key recommendations from the reports. It was confirmed that a joined-up approach was needed and that the feedback from the workshops had been positive. The Board considered the report and emphasized the need to ensure there was a joined-up partnership approach to tackling these issues. It was confirmed that the Maternity and Neonatal Network was going through a period of transition and that Welsh Government had established a safety programme with Improvement Cymru. The Board stressed the importance of ensuring there were robust leadership and ownership for this work as that stewardship would be fundamentally important to delivering the improvements needed in the system.	
Resolved	The Board: noted the contents of the paper, proposal, progress and developments to date.	
2411/3.3	Strategic Workforce Plans Update	
	Introducing the report, Julie Rogers explained the paper provided an update on the collective work to develop strategic workforce plans in areas of priority need, in line with HEIW's Workforce Strategy for Health and Social Care 2020-30 and the Integrated Medium-Term Plan (IMTP). It was confirmed that HEIW had developed a systematic approach for the development of future workforce plans following work on the Mental Health Workforce Plan. In addition to the three plans in development, HEIW has started scoping further plans relating to primary care, maternity and neonatal, and genomics. The Board considered the report and was encouraged by the work being reported and the efforts to develop a robust methodology for workforce planning. It was confirmed that within the workforce strategy for the entire workforce a number of areas needing attention had been	

	identified and these targeted workforce plans had been developed in response. It was explained that this approach offered another way to get underneath some of the assumptions feeding the Education and Training Plan and that there was a need to bring transparency to the process.	
Resolved	The Board noted the report for assurance.	
2411/3.4	Implementation of Workforce Strategy for Health & Social Care Update	
	The Board received a presentation on the implementation of the Workforce Strategy for Health and Social Care. The Board welcomed the presentation and highlighted the importance of promoting the good work delivered to date. The Board noted that the WG draft national workforce implementation plan had not been issued by Welsh Government and that it was unclear when that would be released. The Board considered how best to engage with Welsh Government in respect of the implementation plan.	
Resolved	It was agreed: • The Chair would write to the Minister to share HEIW's progress to date . • The Chair will also request a meeting with WG so we can ensure HEIW's work and Ministerial priorities are aligned. The Board noted the update for information.	CJ CJ
2411/3.5	Integrated Medium Term Plan 23-26 Update	
	The Board received the report. Introducing the report, Rhiannon Beckett confirmed it provided an update on the development of the Strategic Framework for the IMTP (2023-26) and the Strategic Aims, Strategic Objectives, Enabling Plans, and revised timeline. These had been shared with the Board at the Board Development Session in October. It was confirmed that the NHS Planning Framework was due to be issued in mid-November and that it was likely to confirm that the IMTP submission date would be 31st of March 2023. The Board considered the report and noted the considerable engagement undertaken. The Board acknowledged the work to bring the plan and methodology together and extended its thanks to the teams.	
Resolved	The Board: • noted the vision, purpose and value statement. • noted the strategic aims, strategic objectives and enabling plans. • noted the revised timeline which accounts for a revised submission date of 31 March 2023.	
PART 4	GOVERNANCE, PERFORMANCE AND ASSURANCE	

2411/4.1	HEIW Integrated Performance Report September 2022	
	The Board received the report. Introducing the report, Rhiannon Beckett confirmed it provided the Board with the mid-year performance position for 2022/23. It was noted that the report followed an in-depth discussion on progress at the Board Development Session in October. It was confirmed that mid-year reviews with directorates and deaneries confirmed that HEIW anticipated delivering on the 55 strategic objectives by the end of the year. However, there had been some in-year delays related to certain strategic objectives and plans had been put in place to rectify progress in the next half of the year. It was noted that education and training commissioning activity continued to be positive, although fill rates in some areas have been challenging. There was a continued focus on some hotspots around Operating Department Practitioner programme and Learning Disability Nursing. The Board considered the report and was encouraged by the improvements in reporting style. The Board noted the importance of linking spending with activity and considered the variations in reported attrition rates. It was suggested a review of the attrition rates for each higher education institution be undertaken by the Education, Commissioning, and Quality Committee.	
Resolved	The Board noted the content of the report and welcomed the progress being made in its development.	
2411/4.2	Director of Finance Report	
	The Board received the Director of Finance Report. Presenting the report, Rhiannon Beckett explained it provided an update on the financial position as at month 7 of the 2022/23 financial year and any actions needed to break even at year-end. It was highlighted that as at Month 7, HEIW was £749,000 underspent, and this position had been reported to Welsh Government in accordance with the requirements of the monitoring return submission. It was confirmed that the underspend related to pay costs, where there were various vacant posts within the establishment and the under-recruitment of Clinical Fellows, non-pay costs relating to travel and training where activity was lower than budgeted and against commissioning budgets where the underspend represented a small percentage of the cumulative budget. It was noted that HEIW had handed back £7m of underspend to Welsh Government earlier in the year and that it was recommended a further £7.5m be handed back at this point in the financial year. The reasons for the underspend included under recruitment in the Autumn Cohort for Healthcare Professional Education courses, under recruitment in Dental foundation training and changes in GP training with more trainees initially undertaking posts in secondary care. Underspend was also evident across pay and non-pay budgets.	

	A final assessment will be made in February of any further hand back required to enable achievement of the breakeven duty at year end. The Board considered the report and suggested the position be reported against the original budget to provide greater clarity around the funding handed back to Welsh Government. The Board noted that cumulatively 91.76% of NHS invoices had been paid within 30 days and it was confirmed processes were in place to look at ways of improving the NHS figures for future months.	
Resolved	The Board: • Noted the underspent financial position reported for HEIW at month 7. • Noted the actions already progressed to be in balance at year end including an initial hand back of £7m to Welsh Government. • Considered and approved the recommendation to hand back an additional £7.5m in this financial year • Noted the summarised explanation of key variations by Directorate, • Noted the Capital allocation, spend to date, and development of plans; • Note the Balance Sheet position; and • Recommended that in future the position be reported against the original budget to provide transparency around the funding handed back to Welsh Government.	RhB RhB
2411/4.3	Corporate Risk Register and Strategic Risks	
	The Board received the report. Introducing the report, Dafydd Bebb confirmed there were currently twelve risks on the Corporate Risk Register (CRR): of those risks, two were red status, eight were amber status, and two were green status. It was confirmed that three new risks had been added to the CRR since the last report, risks 14, 15, and 16. The Board considered the report, and the Chair highlighted the importance of ensuring there were business continuity plans in place should HEIW fall victim to a cyber security attack. The Board considered the Strategic Risks Register and agreed the format would be further developed at a future Board Development Session.	
Resolved	The Board: • Noted the report for assurance. • Noted HEIW's Strategic Risks for information. • Agreed to review the Strategic Risk Register at a future Board Development Session.	DB
2411/4.4	In Committee Decisions	
Resolved	The Board noted the report for information.	
2411/4.5	Key Issues Reports	
2411/4.5.1	Audit and Assurance Committee held 17 October 2022	

	The Board received the report. The Chair of the Committee noted that they continued to receive reasonably good scores from Internal Audit and that the Structured Assessment from Audit Wales had been reasonably assuring. It was noted that there had been a number of recommendations arising from the Structured Assessment and it was confirmed that these were included in the Audit Recommendations Tracker and were being progressed. The Chair of the Committee confirmed that the fraud risk assessment was still being progressed and was due to be reviewed at the committee meeting in February. It was noted that HEIW was still reporting salary overpayments and that the Committee would invite officers to attend the Committee and outline the reasons for the overpayments should they persist. It was noted that the Information Governance and Information Management Group meeting had been postponed prior to the committee meeting in October but that these meetings were now back in the diary following temporary recruitment to the Information Governance Manager position.	
Resolved	The Board noted the content of the report for assurance.	
PART 5	For Noting	
2411/5.1	Update on preparation for the COVID-19 Public Inquiry	
	The Board • noted the report for information. • to be kept informed as to how HEIW will be represented in the public inquiry and which route we decide to take.	DB
2411/5.2	Shared Services Partnership Committee Assurance Report – July 2022	
Resolved	The Board noted the report for information.	
PART 6	OTHER MATTERS	
2411/6.1	Any Other Urgent Business	
	There was no other urgent business.	
2411/6.2	Date of next meeting	
	Dates of Next Meetings: • HEIW Board Development Session to be held on 15 December 2022 via Conference Room, Ty Dysgu, Nantgarw, CF15 7QQ • Board to be held on 26 January 2023 via Conference Room, Ty Dysgu, Nantgarw, CF15 7QQ	

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Dr Chris Jones (Chair)

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Date:

HEIW Board (Open)
24th November 2022
Action Log

(The Action Sheet also includes actions agreed at previous meetings of the Open HEIW Board and are awaiting completion or are timetabled for future consideration for the Board. These are shaded in the first section. When signed off by the Board these actions will be taken off the rolling action sheet.)

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Minute Reference	Agreed Action	Lead	Target Date	Progress/ Completed
2807/3.2	HEIW Equality, Diversity, and Inclusion Overview			
	Independent Members would be invited to attend Equality, Diversity, and Inclusion Group meetings.	Director of Workforce and OD	Jan 2023	An invite will be issued to the next meeting of the HEIW EDI Network which will take place in January 2023. Independent Members have also been invited to attend equality and diversity training.
2411/3.4	Implementation of Workforce Strategy for Health & Social Care Update			
	The Chair would write to the Minister to share HEIW's progress to date.	The Chair	December	Completed
	The Chair will also request a meeting with WG so we can ensure HEIW's work and Ministerial priorities are aligned.	The Chair	December	Completed
2411/4.2	Director of Finance Report			
	Recommended that in future the position be reported against the original budget to provide transparency around the funding handed back to Welsh Government.	Interim Director of Finance	Jan 2023	Completed
2411/4.3	Corporate Risk Register and Strategic Risks			



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	Agreed to review the Strategic Risk Register at a future Board Development Session.	Board Secretary	December	Completed. The Strategic Risks were considered at the December Board Development Session.
2411/5.1	Update on preparation for the COVID-19 Public Inquiry			
	to be kept informed as to how HEIW will be represented in the public inquiry and which route we decide to take.	Board Secretary	Ongoing	Completed. HEIW has determined not to apply for Core Participant status in respect of Module 3.



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Meeting Date	26 January 2023	Agenda Item	2.1
Report Title	Chair's Report		
Report Author	Dr Chris Jones, Chairman		
Report Sponsor	Dr Chris Jones, Chairman		
Presented by	Dr Chris Jones, Chairman		
Freedom of information	Open		
Specific action required	The Board is asked to: • Note the report for information.		

Chair's Report - January 2023

Overview

Across the United Kingdom, the last few months have underlined the challenges of providing health and care services fit for the needs and demands of now and the future. The NHS in Wales is currently dealing with the most pressure it has ever experienced, with red (immediately life-threatening) calls to 999 the highest on record, over 1,000 people medically fit for discharge in hospitals across Wales, and high levels of flu and other winter viruses which are affecting both patients and staff. The significant ambulance delays and queues as seen in the media, are a real and tangible signal of the pressures facing our front-line staff. We are all experiencing the cost-of-living impact on our everyday lives – the greatest impact born by those least able to cope. There are significant episodes of Industrial action in the shape of one day strikes by some of the staff working in the NHS. This is an unparalleled situation brought about by the impact of inflation and living costs on pay, together with the very pressured work environment. There is of course an impact on the services and staff morale and wellbeing. **Let us all hope that resolving these matters comes sooner than later.** The impacts of how staff are valued, and the demands of the intensity of work have potential to be felt in recruitment and retention going forward. The cost-of-living impact could also have an impact on career choices. The workforce is one of the key strategic issues that needs real focus and attention as we respond to today's challenges and plan for the NHS of the future. We will all need to work together across the system to deliver on the "Workforce Plan for Health and Social Care".

We very much welcome the Minister's approval of the Education and Training Plan 2023/2024. This is a significant and important investment, (even more so given the economic and financial pressures) building on the increasing numbers over the last few years:- <https://www.gov.wales/written-statement-expansion-training-places-health-professional-workforce-wales-0>

We will need to work together closely with our partners in the NHS and education bodies to attract and recruit increasing number of students and trainees into professional roles in the NHS in Wales. The NHS of the future must be as relevant and valued to future generations as it has been to date – this is a legacy worth investing energy, innovation and renewal. Based in public service and free at the point of care, it is a fundamental part of Welsh society and core values as laid out in our Future Generations Act.

I would like to recognise and thank all of our NHS professionals involved in education, training and mentoring the healthcare students and trainees across the Welsh NHS. They are supporting the future workforce whilst providing direct patient care in the here and now. This is such an important contribution to the NHS.

NHS Chairs have focused their meetings on responses to the present demands on the services. There was a meeting held with the minister Eluned Morgan and Deputy Minister Julie Morgan on 20th December. Together with Local Authority Leaders we

discussed the pressures on the health and social care system over the coming months.

On the 12th December I attended an NHS Confederation meeting of UK Chairs in which we were updated on the Covid Pandemic Public Enquiry.

On the 9th January the chairs of Public Health Wales, Digital Health Care Wales (DHCW) and HEIW together with the respective digital directors met and discussed the future impact and direction of AI technologies in health care. This was a really useful and informative session. Whilst DHCW will have the lead role in advancing this agenda, it is very clear that there will be significant impact on ways of working and clinical care going forward. This was a timely discussion and is reflected in our Digital and Data Strategy coming to Board today. (Objective 2.4 Strategic Workforce Planning and Next Generation Services).

Board Matters

I am pleased to say that the advert for a new Independent Member for HEIW is now live . [Independent Member -Health Education and Improvement Wales - Welsh Government \(tal.net\)](https://tal.net)

On the 15th December the Board held a development session in which we discussed the HEIW Engagement Plan, The developing Integrated Medium Term Plan (IMTP) and the HEIW Digital and Data strategy.

On the 24th November the Board held a special briefing session on workforce planning. On the 12th January a special briefing session for independent members on the Performance Framework, and on the 17th January we held a special board briefing session focusing on the Pharmacy Workforce Plan. These single focus briefing sessions are a really useful and productive way for officers and independent members to explore and develop issues that will come to full Board in due course. Together with the bimonthly development session, the special briefing sessions are an excellent vehicle for in depth discussion, understanding and influencing in these important areas.

Independent members continue to meet informally twice a month and I have regular weekly meetings with Ruth as Vice Chair. This report includes a brief update from Ruth as Vice Chair below.

Ruth and I attended the HEIW virtual staff conference on December 19th which comprised informative and moving presentations as well as a seasonal Christmas theme.

There have been no Chairs Actions to report since the November Board

Vice Chair's report.

Vice chairs met with the Minister Eluned Morgan and Deputy Minister Lynne Neagle on Dec 1st. We discussed the severe, growing pressures on health and care services, and responses particularly in primary and social care, and mental health

services, to address these. The health impacts of cost-of-living pressures and proposed industrial action were a source of much concern. The Minister was emphasised preventative as well as short-term remedial measures.

Vice Chairs also held two peer group meetings, which I attended on December 14th and January 11th. HEIW staff were commended in both meetings, for contributions to the Strategic Programme for Primary Care, and the Community Infrastructure Programme.

On December 15th and January 23rd, I met with executive colleagues (Pushpinder Mangat and Anton Saayman) to discuss HEIW's research & development programme and related work, prior to a wider Board presentation later this spring.

Together with other Board members, I attended very useful Board briefings on the development of HEIW's performance framework, on January 12th, and HEIW's Pharmacy Workforce Plan, on January 17th. These sessions were particularly valuable in facilitating understanding of some complex pieces of our current work agenda.



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Meeting Date	26 January 2023	Agenda Item	2.2
Report Title	Chief Executive's Report – January 2023		
Report Author	Dafydd Bebb, Board Secretary		
Report Sponsor	Alex Howells, Chief Executive		
Presented by	Alex Howells, Chief Executive		
Freedom of Information	Open		

CHIEF EXECUTIVE'S REPORT – JANUARY 2023

1. INTRODUCTION

Unprecedented demand and pressures have been the consistent theme of the winter months for NHS Wales, with operational colleagues dealing with the combined impact of respiratory infections, capacity and workforce constraints and industrial action. As usual the health and care workforce have made extraordinary efforts to keep people as safe as possible, but the underlying workforce challenges are evident across the system and once again reinforce the importance of our work in HEIW. Workforce is not an enabling issue; it is a strategic and central issue. This underlies the importance of the work being undertaken by HEIW to . The most useful thing for us to do at a time like this is to work even harder and faster on the plans and developments that are underway to support recruitment, retention, education and redesign, finding effective, innovative and sustainable ways of balancing workforce supply and demand.

2. KEY ACTIVITIES

- **£281.98 M Education and Training Plan approved**

We are now implementing the proposals contained in the Education and Training Plan for 2023/24, which was approved by the Minister for Health and Social Care on 18 January. The Plan will deliver further increases and record investment in healthcare professional training in Wales. A robust implementation plan is being developed to reflect emerging changes in the popularity and attractiveness of some health professional undergraduate programmes. We will be working closely with Health Education Institutions and NHS partners to ensure that our ambitions for expanding the domestic supply pipeline are achieved.

- **Joint Executive Team (JET) meeting**

A mid-year JET meeting was held with the Welsh Government on 9 December. The meeting was a very constructive session and a good opportunity to discuss some of the strategic work programmes we are progressing in key policy areas. We will share the outcome of the meeting with Board Members when it is received.

- **Joint meetings with DHCW and Velindre NHS Trust**

We have held joint executive team meetings to share plans and priorities, and to identify opportunities to work together on key strategic developments.

- **Planned Care, Diagnostics and Cancer Forum**

In December we established an internal group to bring together all of our work related to planned care, diagnostics and cancer so that we can take a coherent approach to the requirements of various national programmes and ensure we deliver on the Ministerial priorities. Key areas of work to date include cancer nurse specialists, cellular pathology, imaging workforce plan and advanced therapeutics.

- **Genomics**

One of the key areas included within the above forum is genomics. Genomics is a new area of work for HEIW but reflects the pace of change in this area and the wide-ranging implications for the workforce. As this work was not included in our IMTP an update is provided for the Board in today's papers.

- **Digital and Data Strategy**

We are pleased to present the first Digital and Data Strategy for HEIW, which was developed following an engagement process, and based on evidence, research and horizon scanning. The Board had the opportunity to discuss and contribute to the Strategy at the December Board Development Session.

The strategy is an enabling and transformation document that supports the delivery of the HEIW vision of 'transforming the workforce for a healthier Wales' and its purpose is to set out the priority areas for our digital and data team over the next five years.

- **International Medical Graduates (IMG)**

Included in the papers is an update on an increasing programme of work associated with supporting IMGs, eliminating differential attainment, and developing further approaches to promote fair training pathways. The proportion of IMG trainee doctors commencing in speciality training has steadily increased over recent years and the importance of the support work being undertaken in this cannot be overstated.

- **Critical Care Workforce Report**

A final report on the work completed by the Workforce Transformation Team to support critical care is on today's agenda. The report describes the current workforce model within critical care as unsustainable and outlines the solutions framework that has been developed in response to these challenges. The framework is divided into two programmes with recommended solutions for future workforce models together with a standardised approach for the future provision of education. The report is due to be presented to the NHS Leadership Board in the next few months as part of an update on the work of the Critical Care Network.

- **Impact of Duty of Care and Quality**

The Duty of Quality and Candour will come into force on 1 April 2020. A report is provided within the papers outlining the implications of these new duties for HEIW and how we will proceed to implement, monitor and embed them in practice.

The report highlights the launch of the Genomics Delivery Plan for the NHS in Wales together with HEIW's plans to work closely with Genomics Partnership Wales to continue to improve and extent the education and training available and to develop a strategic workforce plan.

- **Developing the Pharmacy Workforce Plan**

We held a Board briefing on the development of the Pharmacy Workforce Plan on 17 January. The plan will encompass the wider pharmacy workforce, across all settings,

and is our first profession specific plan. As reported to the Board at its last meeting in November this plan is being developed in accordance with the HEIW model for developing workforce plans drawing on our previous experience and methodology in this area. It is intended that a six week consultation process be undertaken in respect of the draft Pharmacy Workforce Plan in Q4.

- **Development of the Integrated Medium Term Plan (IMTP)**

We will submit our IMTP for 2023-26 to Welsh Government on 31 March. Given this, the draft IMTP will be considered in detail at the February Board Development Session. Work to develop the plan is progressing well with some key engagement meetings before our discussion in February. The planning guidance was issued in December clarifying the Minister's priorities for the year ahead.

- **Director of Finance Planning and Performance**

I also wanted to confirm that we are currently re-advertising the Director of Finance, Planning and Performance role. Members will be aware that the initial campaign to recruit in Q3 was unsuccessful. I am grateful to Rhiannon Becket for continuing to undertake the interim Director of Finance role since 1 January 2022.

- **Finance**

A paper outlining the month nine position is on the agenda. The financial position of HEIW as at month nine (December) is an underspend of £691,337.

A further forecasted underspend has been identified within our budget and our recommendations for this are included within the paper for Board decision and explained in a specific paper which provides a review of education and training activity. Members will be aware that this is in the context of an extremely difficult financial position for NHS Wales.

- **Risk**

The Corporate Risk Register is considered for noting at today's Board. There are currently twelve risks on the Corporate Risk Register, of which one is assessed as red: cyber security.

3. RECOMMENDATION

The Board is asked to **note** this report.

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
There are no direct quality, patient safety and experience issues relating to this report.			
Financial Implications			
There are no direct financial implications of this report.			
Legal Implications (including equality and diversity assessment)			
There are no direct legal implications of this report.			
Staffing Implications			
There are no direct staffing implications of this report			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
The range of activities outlined in the report will contribute to HEIW's approach to the Well Being of Future Generations Act. However, the contributions will be specific to each of the individual areas covered in overview in this report.			
Report History	The CEO report is presented at each open Board session which is held once every two months.		
Appendices	N/A.		

Health Education and Improvement Wales Digital and Data Strategy (2023-2028)

1. Introduction

This document sets out the Health Education Improvement Wales (HEIW) strategy and approach to digital and data business intelligence over the next five years (2023-2028). It is recognised that technology and data will continue to advance, rapidly, digital innovation is an enabler of transformation and redesign.

Digital technology and data insight was at the forefront of the response to the pandemic, it will now be central to how health and social care services are re-built and remobilised in the recovery from Covid-19. Technology and the better use of data will influence and improve the future of work, training, education, and the delivery of care and wellbeing. It will enable responsive and continuous improvement, innovation and good decision making. The level of required transformation is set against a backdrop of increasing demand on health services from an aging population with more complex needs, a competitive workforce market, staff shortages and a workforce that is recovering from the pandemic; there is a necessity to maximise on the potential for innovation and transformation.

Research indicates that the speed at which technology is growing by 2x every 18 months when computing is measured. Over 89% of big data has been produced within the last 2 years. The future of technology and data does not appear to be slowing down and only looks to be increasing. Advances in technology have grown at what appears to be an exponential rate throughout the past 10 years, and there has been a shift in the use and importance of data in informing business decisions and service re-design. Given the rate of change and technological advancement, this strategy is not about reaching a set intended destination. It is instead, a focus on the priority areas that will over time improve, practices, culture, processes and technologies to respond to raised expectations within HEIW.

The purpose of this strategy is to set out a vision and provide direction and clarity about the areas of priority and the aims that will guide the digital and data team in HEIW over the next five years. This strategy sets the digital vision which enables delivery of HEIW's corporate vision of ***Transforming the workforce for a healthier Wales***. Detailed in the strategy are five missions, each are specialist areas required to deliver the Vision. Each mission has several objectives, and these will be delivered via implementation plans. To ensure an integrated approach, the implementation plans will form part of the IMTP process as strategic objectives and enabling plans. The approach provides a framework of measurable objectives to be delivered against which progress can be assessed.

2. Organisational and Strategic Context (HEIW)

2.1 Organisational Context

Health Education and Improvement Wales (HEIW) is a Special Health Authority within NHS Wales and plays a leading role in the education, training, development, and shaping of the healthcare workforce in Wales, to ensure high-quality care for the people of Wales and ‘transform the workforce for a healthier Wales’.

The role of the workforce is pivotal in building sustainable healthcare for the people of Wales in the future. HEIW is an all-Wales organisation employing over 380+ core members of staff and 187 sessional staff who work for other organisations. HEIW has an annual budget in excess of £300 million. 91% of the budget is spent on education and training and associated activity. HEIW supports the education and training of a wide-ranging trainee and student population including:

- 3,000 training-grade staff and associate specialist doctors and dentists
- 2,500+ pharmacists, 1,600+ pharmacy technicians, 70+ Pre-Registration pharmacists and pharmacy technicians’ trainees
- 3,300 new Nursing and Allied Health professional students
- 1,600 dentists and 3,400 dental care professionals
- 700+ optometrists
- 9,500 (total number) Nursing and Allied Health Professionals.

HEIW VISION - To develop a skilled and sustainable workforce that improves care and population health.

HEIW PURPOSE - As part of the NHS, to work with partners to plan, develop, educate and train the current and future workforce

HEIW ADDED VALUE - Develop national strategic solutions for workforce demand and supply

2.2 Strategic Context

Wales 4.0 a Welsh Government assessment suggests that we are in the fourth industrial revolution facilitated by advances in digital technologies, including AI, machine learning, robotics, biotech which has the potential to transform the Welsh economy. Technology will play a significant role in reshaping how we work and where we work and the skills, training and education required to be successful.

The [Topol Review](#) (2019) explored how technology would impact healthcare, specifically, and concluded that the NHS should focus on “building a digitally ready workforce that is fully engaged and has the skills and confidence to adopt and adapt new technologies in practice and in context” (p.82) because within 20 years, “90% of all jobs in the NHS will require some element of digital skills”, and “staff will need to be able to navigate a data-rich healthcare environment” (p.5). However, the predicted timeframe to improve infrastructure and upskill staff has been drastically reduced as rapid transformation is catalysed by the pandemic.



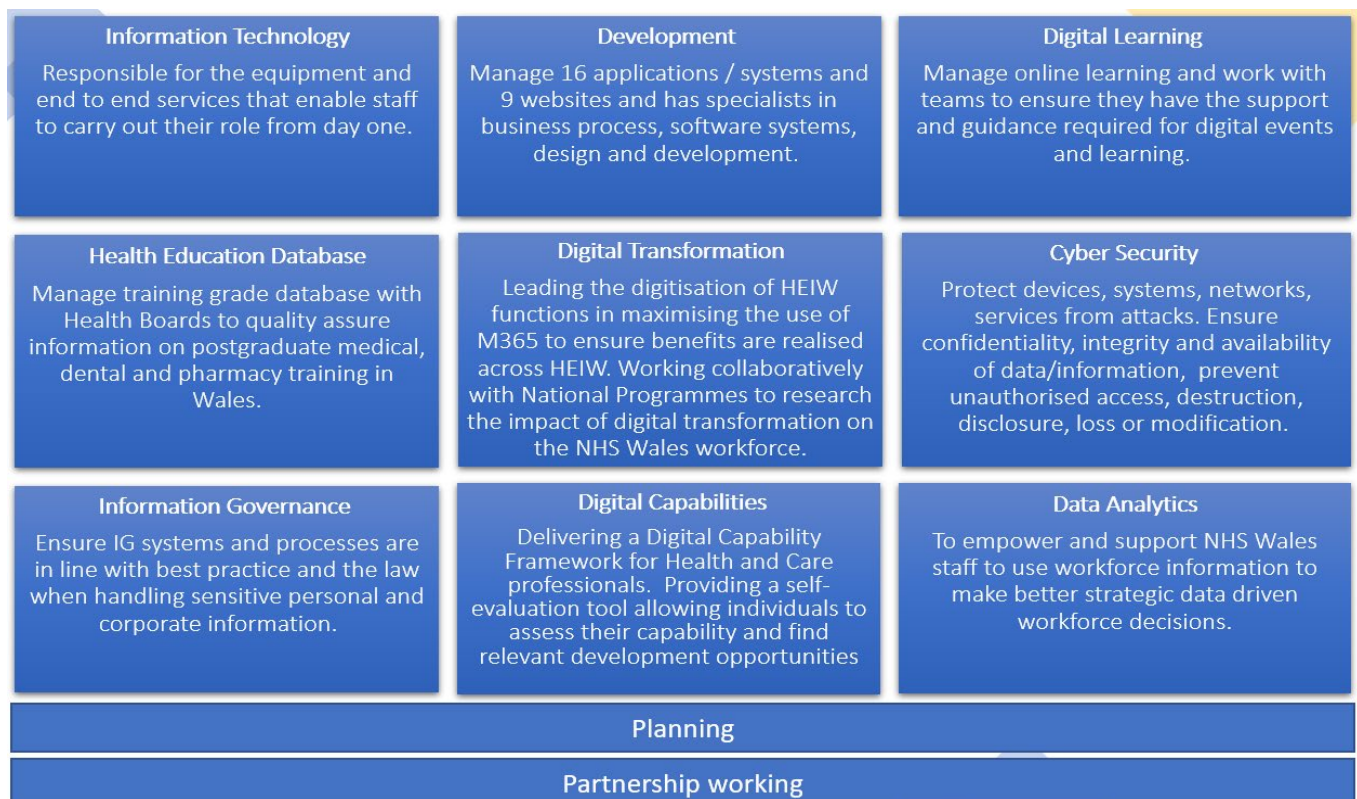
The Health and Social Care Workforce Strategy was launched in 2020, developed jointly by HEIW and SCW, with substantial input from partners, it sets out the vision, ambition and approaches that put wellbeing at the heart of plans for the NHS and social care workforce in Wales. The ambition is that we will have a motivated, engaged and valued, health and social care workforce, with the capacity, competence and

confidence to meet the needs of the people of Wales. The workforce strategy set out HEIW's ambition, that by 2030, the digital and technological capabilities of the workforce will be well developed and in widespread use to optimise the way we work, to help us deliver the best possible care for people. This theme highlights the need to raise the profile of digital literacy, skills and capabilities as an integral part of service and digital transformation, and the parallel need to invest in education and organisational development if we are to accelerate the pace of change.

3. Digital In HEIW

3.1 Current Digital Service

The following are the core functions that make up the digital service in HEIW



Since the beginning of HEIW the digital team have grown, capability has increased and the team matured. The digital team have already been successful in delivering an ambitious work programme. These successes included the

- migration of all digital application to cloud native platforms,
- improvements in cyber and information governance of the organisation.
- Development of robust governance, programme, performance and risk management approaches
- Strong lifecycle management approaches to software development
- Innovative digital learning approaches
- Innovation and business improvement through O365 and enabling remote working

3.2 Digital and Data Maturity

The digital culture of HEIW is important as a foundation that will positively impact the potential benefits and value of digital transformation. Culture and digital transformation go hand in hand. Research conducted by Gartner found that scaling the benefits of digital will continue to be elusive if the challenges associated with transition and culture are not tackled, these included organisational silos, risk averse culture, a lack of funding and the digital skills gap. These have therefore been addressed in the strategy and will support the maturing digital and data culture of HEIW. To accelerate transformation Gartner recommend developing a culture that is focused on collaboration, empowerment and customer centric. These are in line with HEIW values and will be reinforced through the missions on implementation plans that support this strategy.

A recent assessment of our digital maturity by internal audit has indicated that, *‘Overall, HEIW is well positioned to take forward the use of digital technologies. The organisation is well placed to enable the redesign of service delivery’*. The report also recognised the need to strengthen the digital culture to ensure service users own and challenge the status quo. HEIW needs to grow and mature its Business Intelligence and advanced analytics discipline and data science to maximise the use of data internally and externally to ensure the full achievement of its statutory functions.

4. HEIW Digital Vision

HEIW’s Digital Vision is

To deliver high quality, innovative, accessible digital and data solutions supporting the development of a digitally skilled workforce which improves care and population health

HEIW's vision encompasses several component parts and includes an internal organisational focus and a national external focus.

Internally, it ensures delivery of excellent high quality innovative digital and data solutions to staff and users of HEIW services across Wales. This will deliver excellent education and training solutions, innovative and digitally enabled learning and a digitised and improved way HEIW runs its operations and functions. Digital transformation provides the opportunity to increase organisational agility, sustainability, simplify the user experience, manage security risks and balance productivity and security. At the heart of this vision will be a commitment to increase data quality, availability and usage to move towards being a data driven organisation that is informed and gains insight and knowledge from data to drive continuous improvement.

Externally, it will also prepare the wider NHS workforce with the digital skills required to work in a digitally transformed environment. HEIW will not be responsible for the delivery of digital health and care systems for front line services, that is the remit of Health Boards, Trusts and DHCW. HEIW will work with those service partners to ensure collectively we champion and build approaches to demonstrate the transformative ability that digital has to change, improve, make more efficient and re-shape the way work is done in the NHS and therefore the shape of workforce and education and training.

Out of Scope is the development of the digital professional workforce, this work programme is being progressed for NHS Wales by Digital Health and Care Wales.

5. HEIW Digital Missions

To achieve the digital vision, five digital missions have been identified in consultation with staff and stakeholders. Several organisational wide drop-in sessions were held in which staff were able to share views and opinions. The objectives have been tested and refined in several engagement sessions, including the Digital Transformation Leadership Group and a Board Development Session where all Board members were present. The missions will remain consistent across the period of the strategy. The milestones and deliverables will be detailed in the IMTP and departmental plans.

Missions

MISSIONS

	1. Delivering high quality innovative digital solutions to enable HEIW to transform service delivery of its statutory and operational functions Outcome: HEIW delivers the best technology following industry best practice standards. This will enable delivery of excellent digital solutions that will enable HEIW to transform its core business and strategic functions. This will create an organisation that has a strong technology foundation
	2. Developing a digital ready and skilled workforce and championing the transformative impact of technology on the shape of work and the future workforce. Outcome: The current and future healthcare workforce have the appropriate skills, knowledge and resources to provide quality care to the people of Wales to deliver and ensure evolving, improving and sustainable healthcare workforce
	3. Delivering excellent innovative digital learning experiences for HEIW staff students, trainees, NHS and care staff. Outcome: Online learning experiences of the current and future healthcare workforce are innovative, challenging, engaging and streamlined to enable effective and efficient training and education. The best devices, products and tools are enabled to deliver high-quality, innovative training and education to help develop and engage the current and future healthcare workforce.
	4. Delivering effective and secure data capabilities that can drive actionable insights, intelligence and improvement. Outcome: Data is one of HEIW's most valuable assets. HEIW continues to grow and improve its Business Intelligence and advanced analytics capability and capacity. Data is available to a high standard and proactively used to maximise impact and inform insight and decision making internally and externally. This is enabled by improved data architecture and improved data skills and literacy.
	5. Continuously strengthening HEIW's cyber security and information governance posture and resilience to attack Outcome: There are established governance arrangements, engagements and improvement methodology with clear accountability enabling effective management of cyber and information governance risks at all levels. All digital and data services are monitored against recognised standards and legal directives to improve posture and responses. The level of control is commensurate to the risk profile will be deployed to ensure that risks are managed proportionately. HEIW is prepared to respond to cyber and data protection incidents organisationally and as a part of NHS Wales.

MISSION ONE



Delivering high quality innovative digital solutions to enable HEIW to transform service delivery of its statutory and operational functions

Currently, HEIW has several siloed systems that are aging and need ongoing maintenance, modernisation and improvement. The technical debt of the organisation is growing and there is a need to transition systems and applications into newer technology and refresh the estate. This will enable HEIW to maximise the potential of its digital capability, improve the technical infrastructure and systems by following robust design and principles.

HEIW will achieve this by delivering the following objectives

Objective 1.1 – Deliver Core Digital Products and Systems

In this period (2023-2028) the strategy will focus on the delivery of a core set of HEIW digital systems and services. Each service will be directed by a Senior Responsible Officer and will develop roadmaps and improvement plans. Each service will comply with the principles outlined above. The priority areas will be:

1. **Provide and maintain an integrated platform of digital functions for postgraduate students medial, dental and pharmacy trainees.**
 - HEIW will deliver an online platform to support the postgraduate training journey in NHS Wales that provides a seamless user experience. It will bring together functions from existing applications (provided by HEIW Digital and Data), and new requirements gathered via a series of stakeholder workshops. Improved access to real time data and reporting will inform new ways of planning and structuring the healthcare workforce. The platform will maximise the use of cloud for better availability, reliability, safety, security, speed and agility.
2. **Provide and maintain a national learning platform to support the delivery of excellent learning and continued professional development.**
 - Partnering with an experienced commercial supplier, HEIW in this period will implement and roll out the 'Y Ty Dysgu' learning management system (capacity 160k Health and Social Care workers). This will enhance HEIW's reputation as a provider of high-level education and training to the NHS workforce in Wales,
 - It will provide a standardised approach of course management and delivery of online learning activities. 100% of online courses and virtual learning originating in HEIW being delivered through this system providing learning platforms and experiences that will build a compelling and dynamic experience for the learner increasing their appetite for learning

- It will include KPI reporting and will act as a vehicle for the operational delivery of HEIW's CPD strategy and digital capabilities work.
 - Once embedded the SRO will explore opportunities of interoperability with other core NHS workforce systems in NHS Wales such as ESR.
- 3. Provide and maintain a national platform to support leadership and talent management – Gwella**
- Gwella is a modern, national leadership portal. It provides open access to compassionate leadership materials, with a learning eco-system. It offers a suite of compassionate leadership, talent and succession management resources, and development and leadership networks. Gwella is a critical digital resource to enable HEIW to achieve the creation of compassionate cultures across health and social care in Wales.
- 4. Transformation and digitisation of HEIW business processes and ways of working to improve quality and effectiveness**
- NHS Wales has invested heavily in an all-Wales Microsoft Enterprise Agreement, which brings significant opportunity to enable digital transformation. This offers the technology options to digitise departmental processes with automation and move away from paper and manual systems and allow the sophisticated reporting through the power BI platform where data will be captured once and used many times.
 - In this period there will be assessment and review of the opportunity to transform offered by Robotic Process Automation (RPA) and Artificial intelligence AI. Robotic Process Automation (RPA) which will enable people to do more value-added work, by having robots take on repetitive, time-consuming, mundane tasks taking learning from other NHS organisations. There will be a full assessment to consider future potential and opportunity.
 - Digital leads and champions will work collectively to actively horizon scan for innovative solutions to consistently review the ways of working and improve delivery in a digital first approach
- 5. Deliver improved data infrastructure that enables the delivery of a data informed organisation.**
- There will need to be a review of the data architecture across all systems. Currently HEIW does not have sufficient data warehouse capacity and does not benefit from the full functionality of the Microsoft 365 power BI platform. There will be an assessment of the data architecture required to meet the requirement that HEIW becomes a data driven organisation. The defined data architecture must be fit-for-purpose and is also scalable to achieve future changes in usage. The architecture will need to support flexibility, scalability and governance whilst also mapping to other important national initiatives such as the National Data Resource (NDR) and the re-procurement of the Electronic Staff Record.

6. Deliver solutions to support the placement of undergraduate and post graduate trainees and students.

- Improving the cooperation and interoperability with partners will be a key area of development. One of these areas will be to improve the flow of information and data about the students that HEIW commissions. The digital team will work with Stakeholders to define and develop student placement systems that share information in relation to quality, capacity, and experience of student placements. This solution should provide HEIW and partners the ability to capture, store, analyse and report upon key data to improve reporting and management of placements.

7. Deliver excellent website and communication tools

- HEIW's online presence and communication will have a significant impact on stakeholder perception. The digital team will work closely with the Communications and Engagement team to ensure that the websites and communication tools support the HEIW communication and engagement strategy.

Objective 1.2 – Design and develop all applications and systems based on best practice standards and approaches.

- **User research and design** - HEIW platforms, products and services will offer a joined-up and personalised experience to the users and provide intelligence to the organisation. They will be built from a detailed understanding of the perspective of the user. Built into the design will be the commitment to the Welsh Language and accessibility standards ensuring equal access to all.
- **Cloud first** - HEIW will leverage the cloud platform progress that it made during the 2021/22 period and continue to build at pace and scale. This means moving away from overly complex, siloed bespoke systems to more standardised architecture that can be easily understood, adapted and scaled out when our needs, or the needs of our users change. A cloud approach / strategy will be developed to share and direct this objective.
- **Best solutions and partners** - There will always be robust technical and financial assessments conducted to ensure the right technology is in the right place. This will maximise the use of off the shelf technology where it meets HEIW needs rather than building bespoke solutions. There will be a strong partnership approach, that sees partnering with suppliers and NHS Providers to develop and maintain an ecosystem that supports the full range of technology requirements. HEIW will continue to partner with DHCW to provide desktop and network infrastructure through a Service Level Agreement so that HEIW can benefit from their national perspective and scope. There will be a considerable effort to maximise the use of Microsoft 365
- **Privacy and security** - Clear and mandated standards, guidance and frameworks for this will underpin the delivery of the best services and outcomes that meet user need and are based on the General Data Protection Regulation

(GDPR) and Network and Information System (NIS) Regulations. Further details are outlined in the Cyber and information assurance sections.

- **Interoperability and openness** - The data and technology standards will be open so that anyone can see them, and the standards are transparent to partners and providers. Solutions will be built based on strong user authentication models which provide a means to authenticate practitioners onto the platform, and an index of users so that they can seamlessly progress their training and career.
- **Develop an agile product approach** - The product approach recognises the need to maintain and develop applications through the life of the product (possibly through many iterations) until such time as the product is no longer deemed to provide value and is decommissioned or replaced. These models deliver quicker results and adapt to change in a shorter time frame to meet business and operational needs. This will be supported with a robust Lifecycle management approach and design and an agile development approach to software development.
- **Skills and Resources** - Digital teams in HEIW and those that we partner with will have the right skills and opportunity to continuously learn and improve. Skills competency and resources will be periodically reviewed, and target operating models put in place with appropriately trained and skilled resources either internal to the organisation or in partnership with external providers in order that digital teams can meet the organisation needs to rapidly transform. This will align with the organisation staff development approach and people and OD strategy.

Mission One Outcome

Delivering this mission will ensure that HEIW delivers the best technology following best practice standards. In turn delivery of excellent digital solutions will enable HEIW to transform its core business and strategic functions.

This will create an organisation that has a strong technology foundation on which it can build and continue to evolve, improve and innovate. There is a strong ambition to deliver world class digital solutions based on excellent principles of governance and innovation.

MISSION TWO



Developing a digital ready and skilled workforce and championing the transformative impact of technology on the shape of work and the future workforce

Digital Skills, Transformation and Participation

Over the course of the pandemic the adoption of digital technologies was greatly accelerated by years, as many organisations were forced to quickly digitise products and services. This demonstrated the capacity for rapid transformation, with many long-term plans, like telehealth, executed in a matter of days or weeks. To address the challenges facing the NHS this type of transformation will need to continue at pace and scale. To benefit from the opportunity of digital transformation a digital skilled and ready workforce will be essential. HEIW will lead the development of a digital ready workforce, by developing digital capabilities of the workforce

As well as having the skills and confidence to engage in a digital workplace, individuals are also learning how to participate outside of work and given the role of friends and family in developing digital skills, each individual could lead to others around them participating digitally. In Wales this is particularly important as despite progress, 7% of the population of Wales are not online, and 23% lack essential digital skills, increasing to 64% for people over 75. This presents a real challenge for Wales as those offline are not just likely to have poorer outcomes, but lack of access is a significant barrier to effective digital transformation. Those unable to work, learn, or access critical services online tend to be already disadvantaged, and so the increased reliance on technology has had a compounding effect on inequality, and on health and wellness. Therefore, developing the healthcare workforce could act as a catalyst to realising the benefits of digital technologies and improving outcomes, more broadly.

Objective 2.1 National Digital Capability Framework

To address and improve the digital skills of the NHS Workforce, HEIW will lead, develop and implement a digital capability framework for healthcare in Wales (for those who are not digital professionals), in partnership with healthcare professionals. A self-evaluation tool will provide individuals with the opportunity to understand and develop the skills and behaviours required to help them to succeed in the digital environment. This tool will also provide a baseline, and a range of data, which will further inform and evidence the HEIW approach to building a digitally ready workforce and implement the national approach to digital skills capability frameworks. This work will align and be cognisant of the many existing digital skills initiatives.

The framework approach builds consensus around skills and capabilities, whilst allowing for contextualisation within different professions and contexts. It provides common language through the complex pathways in and out of the health and care sector, providing structure and cohesiveness, and makes developing digital capability accessible and actionable for individuals, mapping to a range of professions, resources, and tools. A framework approach also allows HEIW to work better in

partnership with other organisations employing a similar approach, allowing for easy cross-referencing and signposting to existing resources and support. The digital capability framework, and self-evaluation tool, will evolve into a comprehensive toolkit to support developing digital capabilities more broadly.

The toolkit will support future digital transformation programmes in Trusts and Health boards to provide a proactive tool to baseline digital competency and training and development needs. The outcome of the assessment will identify training and skills gaps and those will feed into training and commissioning requirements.

Objective 2.2 Upskilling and Reskilling the Current Workforce

In the context of rising demand, increased health and wellbeing inequalities, higher public expectations, recruitment and resource challenges, and rapid technological advancements, the Workforce Strategy for Health and Social Care recognises the need to transform the way we work by expanding existing roles and developing new roles. If the workforce needs more opportunities to upskill and reskill, then the way training and development is delivered (and funded) must reflect that need. Technology will play a pivotal role in ensuring every individual has all the training, tools, support and information required to perform their (existing, expanded, or new) role, to the highest standard, anywhere, anytime, from any device.

Opportunities to develop digital skills and capabilities are already available and being collated and mapped to a framework (see 2.1 above). Support to deliver training and skills development in new, and more effective, technology-rich ways is also available, with ambitious plans to expand that offering (see Mission 3).

In addition, we intend to extend our network of Digital Champions to influence and lead digital workforce transformation, beginning, in the first instance, with the Mental Health Workforce. Effective leadership is essential to ensure change is well managed, people are protected and supported, and that the benefits of digital technologies are fully realised. Digital Champions will be appropriately resourced and developed to ensure they have the skills and capabilities required to lead digital innovation and influence and inform future changes. A peer network will be set up and Digital Champions will have access to a range of training and resources including opportunities to undertake formal education.

Applications for Topol Fellows, and HEIW Leadership Fellows with a digital focus, will also be encouraged and supported, all with a view to developing and evidencing our digital capacity and capability. They will act as ambassadors for the digital strategy.

Objective 2.3 Education and Development for Next Generation Healthcare Professionals

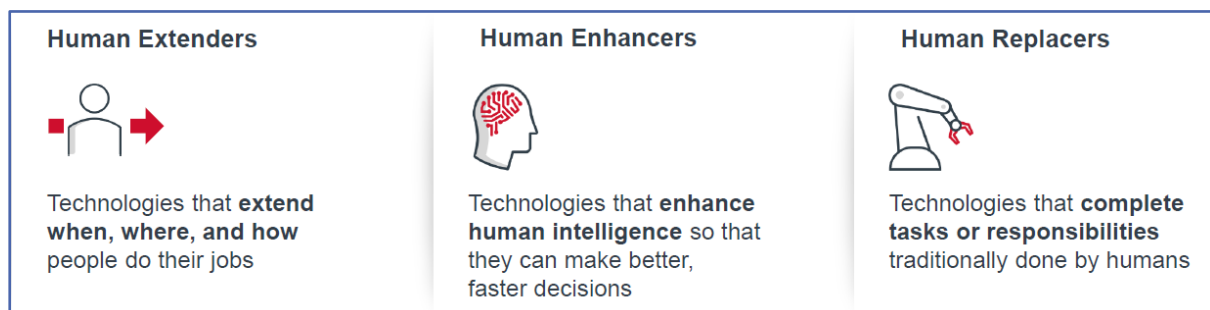
HEIW will ensure that the next generation of healthcare professionals are highly digitally capable by mandating that students gain an appropriate level of digital literacy whilst undertaking their education. Genomics, data analytics and artificial intelligence (AI) are already requirements in undergraduate curricula, and students must understand the possibilities of digital healthcare technologies and the ethical and patient safety considerations.

Educating the healthcare current and future workforce to develop, implement and use AI effectively and safely will be a multidimensional challenge, involving undergraduate education, postgraduate training, and lifelong learning. Working in partnership across NHS Wales, industry and academia HEIW will develop a framework approach to influence, resource, design and deliver an educational offering for NHS Wales. This will address the need for all NHS staff to have widespread basic understanding and knowledge, with a large proportion having general training and skills acquisition, whilst also establishing advanced resources and role development and career pathways for specialist technical teams.

A current constraint in the development of future healthcare professionals is the availability and quality of placements, HEIW will maximise the use of virtual placements to offer alternative methods of training. This will be subject to robust evaluation and feedback.

Objective 2.4 Strategic Workforce Planning and Next Generation Services

The coming years will see healthcare experience significant challenges in relation to increasing demand from an aging population with complex health needs, recruitment, the profile of the workforce, and accelerating technological change. These challenges are unlikely to be resolved within the current operating model of the NHS. To address these challenges, HEIW will consider the impact of digital technology on the workforce, including ways of working, job roles and responsibilities. Whilst also ensuring that all strategic workforce plans maximise the opportunity of digital change and transformation. Gartner describes three categories of technology that have the biggest impact of workforce these are:



This will pay attention to the transformation and opportunity happening locally, nationally and internationally, examples include:

- Telemedicine
- Smartphone apps
- Sensors and wearables
- Reading the genome / Writing the genome
- Speech recognition and natural language processing
- Virtual and augmented reality
- Automated image interpretation using artificial intelligence (AI) . KPMG survey highlighted 2020m highlights that there is work still to be done to prepare clinicians for the adoption of AI and will require AI to be built into service design and workforce planning. There is significant potential for AI to reshape

administrative workflows in which tasks are automated to support decision making and diagnosis

- Interventional and rehabilitative robotics
- National Programmes e.g. National Data Resource, Digital services for the Patient and Public, Wales nursing care record, e-prescribing and medicine management
- Predictive analytics using AI. .

Sufficient capacity for transformation also needs to be included into workforce plans and solutions, organisations need to have the capacity to transform. Too few staff, staff burnout and workload slow the pace of any transformation project. It is vital to give staff time and space to think about, prepare for and engage with interoperability projects.

This will influence and direct the future shape of work, the shape of the workforce and the training and educational requirements. HEIW will ensure the workforce implications of these changes are reflected in workforce plans and solutions.

Mission Two Outcome

The current and future healthcare workforce have the appropriate skills, knowledge and resources to provide quality care to the people of Wales. This mission also ensures an evolving, developing and sustainable healthcare workforce

MISSION THREE



Delivering excellent, innovative digital learning experiences for HEIW staff, student trainees, NHS and Care Staff

Digital Learning

Digital learning is defined as the acquisition of knowledge or skills using technology. The COVID-19 pandemic rapidly accelerated the adoption of technology, forcing many organisations to quickly switch to delivering education and training remotely to ensure continuity. This emergency 'pivot' to online, as it was known, created several opportunities and challenges. It galvanised educators into engaging with online tools, but with mixed results. It takes time and skills to plan and deliver instruction online effectively, and well-designed online learning experiences are meaningfully different from what was offered during the pandemic. Between this and the now ubiquitous online compliance training many have a very negative impression of online learning, and yet research shows that quality online courses are as effective as face-to-face classes (DETA, 2019; CIPD/Accenture,).

HEIW will capitalise on the benefits offered via digital learning. In the context of HEIW this is specifically related to the appropriate use of technology in healthcare education and training, where traditional methods of classroom based, out of time out of context delivery is not fit for purpose when the NHS is facing increasing workforce shortages, excessive pressure and a growing level of new and inexperienced staff.

Objective 3.1 Maximising the Opportunity of Digital Learning

HEIW will deliver excellent online learning (which is the use of online platforms and digital tools to deliver and facilitate learning e.g., websites, eBooks, social media and online communities, online lectures, webinars, podcasts and microblogging or a distinct piece of online learning). This will increase networking and collaborating across boundaries, across organisations, irrespective of location or complex organisational structures. This opens up opportunities for participation providing a more equitable experience. Online learning will support a range of approaches from wide-scale delivery across a broad geography and large numbers, to small group or cluster-based learning, with opportunities for peer-to-peer learning. It will also be inherently more accessible than face-to-face education and training, as long as it is well designed with accessibility and inclusion in mind, ensuring compliance with accessibility standards requirements and our obligation to meet the Welsh language standards, and recognising and responding to any potential barriers.

A significant improvement in the quality of online learning will be driven by improved reporting and analysis providing evidence and insights into engagement and participation. At the core of good online learning will be empowering learning creators to put the learner at the centre of the content design to deliver high quality digital learning that is educationally coherent, innovative and evidence based.

The instant access to online knowledge has transformative potential: whether that is in the delivery of 'just in time' instruction, where a learner can review some guidance at the time and place they need it; or providing access to peers in your online network; or a 3D model generated from medical imaging data and projected onto the patient; all of these applications reduce or remove the need for some instances of formal training.

All of this is absolutely dependant on equipping staff with right skills and resources. Making online learning available to unprepared and unsupported learners is unlikely to be effective. Any online learning must be appropriately resourced to be effectively designed, delivered, and supported. Access, whether that is access to the internet or access to devices, remains a critical issue, as is ensuring time to participate, and providing appropriate learner support and motivation.

With all of this in mind, HEIW's first aim is to advance high-quality, intentionally designed online health education and training. This will be driven by the central team of learning technologists who are responsible for ensuring the quality of online learning by providing advice and guidance to staff, as well as providing hands on support with more complex technical development. They oversee the learning management system and related technologies, and are experts in the latest industry standards, relevant legislation, online pedagogies, and general best practice in online learning.

Objective 3.2 Maximising the use of Emerging Technologies

New technologies have the potential to transform, or even disrupt, health education and training. For example, augmented reality is a virtual overlay onto the physical environment with applications for real-time instruction and just-in-time learning, which could replace or reduce the need for some instances of formal instruction. A nurse might use projection-based AR to view a virtual image of the underlying vasculature on the surface of the skin making it easier to locate a vein; or a surgeon might fuse digitally enhanced images directly into the microscope of a surgical device; or even superimpose the patient's anatomy in 3D directly onto the surgeon's retina. This kind of simulation and remote collaboration has implications for both learning and for placement activity. In terms of formal learning, it is now possible to give students a totally unique 3D perspective of every part of the body, and studies show that students learn in half the time as those in the cadaver lab, as well as showing a dramatic improvement in long-term retention of knowledge. Other software combines both virtual reality environment and haptics (sense of touch) to provide real-time feedback on individual medical procedures, providing a safe, virtual environment where practitioners can perform and train and develop skills, and research, again, shows this to be more effective and more efficient.

When other technologies like machine learning and artificial intelligence (AI) are added then that experience becomes highly personalised as interactions are tracked and analysed informing individualised pathways and interventions based on specific gaps in knowledge and skills analysed during the activity. Another example is when AI and natural language processing (NLP) are added to patient simulation which means the responses become much more realistic.

Another idea that has gained traction is the idea of incorporating techniques from gaming to improve motivation and engagement. Given that many games are in fact

learning pathways it seems a sensible approach, however recent meta-analyses show mixed results.

There are numerous applications for the use of emerging technologies in developing technical and soft skills, as well as clinical applications. Clearly the impact on digital learning could be profound and HEIW has a role in ensuring that this technology is appropriately adopted across the sector. The challenge with emerging technology is the risk attached. Early adopters find that it is often expensive, and there is little understanding of best practice or support available to them.

HEIW has a unique position with broad oversight, capacity, and reach, to horizon scan, and research and test and evaluate new digital learning technologies to lead, support, and guide the sector. During this period the HEIW digital team will work with the simulation team to test and evaluate immersive technology in the delivery of HEIW training and education.

Objective 3.3 Maximising Innovation and Impact

Digital Learning must be an integral part of a wider learning strategy to ensure digital learning is embedded into working practice. New ways of learning will be required if we are to respond to the ever-changing skills landscape, and, in the context of resource challenges and time pressures, we must find more efficient and effective approaches to delivering scalable education and training.

HEIW will work as a system leader and partner in persuading internal and external stakeholders to move to digital learning is reliant by developing and producing, guidance base evidence and good news stories. HEIW will use the new learning management system to establish communities of practice to share knowledge and guidance. Working in conjunction with the simulation team the digital team will research and evaluate new approaches and standards to delivering effective scalable education and training to respond to increasing resource challenges and time pressures.

Mission Three Outcome

Online learning experiences of the current and future healthcare workforce are innovative, challenging, engaging and streamlined to enable effective and efficient training and education.

The best devices, products and tools are enabled to deliver high-quality, innovative training and education to help develop and engage the current and future healthcare workforce.

MISSION FOUR



Delivering effective and secure data capabilities that can drive actionable insights and intelligence to deliver improvement.

The ambition is to deliver effective data capabilities in a governed, secure manner that can drive actionable insights and intelligence for HEIW and NHS Wales. This will mean that HEIW has the right information in the right place, accessed and used effectively by the right people to make informed strategic and operational decisions about the organisation. HEIW recognises that Business Intelligence and advanced analytics are the methods and systems by which the organisation can achieve insight and deliver improvement. These methods can answer business related questions, propose new questions, learn, adapt, improve and gain actionable insights and intelligence that drive improved performance and continuous learning and adaption.

HEIW will grow and mature its Business Intelligence (BI) and advanced analytics discipline to maximise the use of data internally and externally to ensure the full achievement of HEIW statutory functions and strategic ambitions to transform the workforce of NHS Wales.

As a strategic workforce organisation this will also mean a dedicated focus on the role and importance of workforce data across NHS Wales. In the context of what has been described by a recent House of Commons document that “The National Health Service and the social care sector are facing the greatest workforce crisis in their history”, the strategic importance of workforce data has never been so important and will only continue to grow. HEIW is not the data controller of workforce information across NHS Wales and therefore partnership working with employers and NWSSP will be essential. HEIW will work in partnership to ensure transparency and availability of workforce data to inform strategic workforce planning and to influence service planning and inform resource allocation, and contribute to workforce research. This will be based on a detailed understanding and analysis of workforce supply and demand issues.

HEIW Data Maturity and Direction

The ‘Advisory Board’ BI Maturity Model is a self-assessment tool that is intended to highlight organisational strengths and weaknesses in a BI programme. The model is based on four stages of maturity to improve technology and analytics capabilities. HEIW was assessed as having **Fragmented Analytics** (first stage of maturity) which is dominated by local, departmental thinking and disconnected silos of data housed in what are sometimes called “point solutions.” This is a result of legacy data management approach held across previous organisations that have resulted in silo data collection methods, predominately in spreadsheets or narrative documents and therefore data voids exist.

The objectives outlined in this strategy will progress HEIW through the maturity model and over the next five years move to an environment where data is treated as a

strategic enterprise asset. This will mean that there are multiple sources of data merging in a consistent view, with measurable results. This will be done through changes and improvements in data governance, a new and approved architectural strategy that maximises the use of standardised platforms and warehousing of data from cross-departments in order to provide a single version of the truth. This data will be made available via easy to access dashboards maximising use of the Microsoft 365 power BI platform. The capability will be developed internally and with external support to grow advanced level predictive and prescriptive modelling techniques. This will create high-quality models for better demand, supply, capacity, financial, and operational outcomes. Achieving this will progress the organisation to level 3 Advanced Analytics of the maturity model.

Objective 4.1 – Providing the right content, at the right time, in the right format to support users.

To improve the availability of data, there will be a review of all current data sources and reporting, to better understand the data that is available, its limitations, definitions, how it is captured, stored and transformed. Work will happen across all departments to review existing data feeds and look for opportunities to improve those data with new data items that add value. There will be a review of how data is shared and made accessible, analysed, presented and visualized. As a result dashboards will be published and readily available, making data more accessible and reducing ad hoc queries. This will create platforms and pipelines of data that allow HEIW to change rapidly and serve up the information as it is required.

This is a significant programme of work as HEIW already manages many disparate data sources and the expectation is that this number will continue to grow and become more complex. Underpinning this programme of work will be stakeholder engagement to determine requirements and gaps in current data availability. New data sources will be added to answer the strategic performance and strategic workforce planning questions of the organisation.

There will be prominent focus on data relating to supply and demand of the workforce and data required to deliver strategic workforce plans across all professions aligned to the priorities detailed in the IMTP. In relation to workforce supply information there will be a focus on data that supports attraction, education and training, redesign and retention. A demand model will be developed to consider wider determinants such as demography and population, interface with service models and performance, technology, skill mix and quality.

Objective 4.2 – Delivering Agile and Scalable Data Architecture.

To enable robust data provision there will need to be a suitable and adaptable data architecture that allows HEIW to manage the scale and type of data required. This will be achieved via an architecture review that will describe the best methods of data storage, acquisition, organisation, analysis and be robust enough to meet the needs of internal teams and existing and future needs of stakeholders. This approach will maximise the use of Power BI dashboard to make data accessible and scalable,

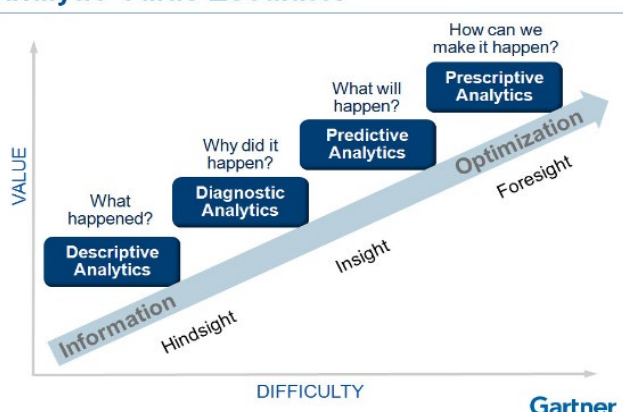
moving the organisation away from capturing and analysing data in siloed excel spreadsheets that will lead to better predictive modelling capability.

This will move the architecture from a fragmented approach to an enterprise perspective and establish the correct data warehousing capability and techniques for handling large volumes of data. The design will align to the national data architecture that is supporting the National Data Resource to ensure that HEIW becomes an integrated part of the NHS national data architecture.

Objective 4.3 – Moving to predictive and prescriptive Analytics.

HEIW will develop its capability and capacity to carry out predictive and prescriptive analytics. Prescriptive analytics can be used to test and better understand what is now and what will happen if we change resources and/or processes. This will inform strategy and resource decisions, workforce planning and services redesign.

Analytic Value Escalator



There will be a need to build and increase the skills internally and collaborate externally with academia, DHCW and industry to ensure we have a reliable pool of expert advisors, users and developers. This will include the need for more informational analysts, data scientists, statisticians and software developers to ensure workforce perspective predictive tools are being used to assess strategic staffing issues and provide models of the future taking into consideration supply and demand. To create a partnership between the Analytics team and Business Leaders to create data stories that inspire action. This approach will allow business leaders to clearly articulate business problems and encourage analysts to solve the problem using data driven insights. This collaboration provides the opportunity to create compelling data stories that results in better business outcomes.

4.3 Data Standards, Quality and Governance

It is essential that the data meets recognised quality standards for use. Processes, standards and governance will be reviewed to ensure that data used is, complete, accurate, timely, consistent and available. Data in HEIW will be effectively managed so people understand the quality, integrity and their responsibility and supported by appropriate governance structure.

Internally a data improvement plan will be developed to improve data quality and data standards. It is recognised that with the demand for data and analytics growing at a substantial rate it will be essential that HEIW develop a demand prioritisation framework with an agreed criteria and benefits plan.

Externally, HEIW will work to raise the importance and standards of workforce data as a strategic issue and a fundamental requirement of good strategic decision making. HEIW will work with partners and in particular NWSSP, to review current governance

structures to ensure the representation and reporting is fit for purpose and groups can clearly resolve, or when required, escalate defined challenges and questions. Through partnership working HEIW will review and establish mechanisms for how workforce data is shared and collated. HEIW will work with partner to inform the ESR re-procurements. HEIW will develop data sharing agreements with our partners and ensure this adheres to information governance, ethics, standards and best practice.

4.4 Resource and Data Literacy

In order to deliver the requirements of this strategy it is recognised there is a need to increase the volume, scale and skill of our data teams appropriately to provide excellent services near to real time delivery of insights and intelligence. There will be a need to grow the data literacy of the organisation. Work will happen to incorporate data literacy into the annual training and development plans for HEIW. This work will support creation of the right conditions so that the workforce can flourish in a data rich environment

Nationally, HEIW will work with partners such as the National Data Resource (NDR) programme to support education and improvement initiatives. The NDR strategy has clearly described the varying levels of data literacy across the NHS which impact the analyst and architect ability to deliver the NDR programme. To address this our ambition is to improve the data skills of the NHS through networks and sharing and formal education programmes. This will equip staff with the ability to understand and interrogate data-driven recommendations and decision support tools, including those powered by Artificial Intelligence.

Mission Four Outcome

Delivering this mission will ensure data is one of HEIW's most valuable assets. HEIW will grow and continuously improve its Business Intelligence and advanced analytics capability and capacity. Data will be proactively used to maximise impact and inform insight and decision making internally and externally. This will improve the use of data in relation to strategic workforce planning and design. HEIW will benefit from improved data availability and standards across NHS Wales. The outputs from the data will mature towards advanced analytics and more complex data modelling. There will be improved data architecture and improved data skills and literacy.

MISSION FIVE



Continuously strengthening the cyber security, information governance posture and resilience to attack

Good cyber and information assurance practices will reduce the risk posed by cyber-attacks and data breaches. Cyber-attacks are a present and persistent danger to all organisations in NHS Wales and beyond in today's increasingly connected and technology-enabled world. Security of assets and information is not a technical problem to be 'resolved', it will be ever present with no definitive finishing line and therefore action and mitigation is a constant requirement.



HEIW's cyber security and information governance objectives set out the dimensions of the security and resilience. The Cyber Assessment Framework (CAF) for Health provides a consistent and rational framework for the appropriate management of cyber security risk. The cyber security objectives as directed in the CAF for Health and the U.K. Governments Cyber Security Strategy 2022-30. The Data Protection Act 2018 controls how personal information is used by organisations, businesses or the government and the Welsh Information Governance Toolkit is a self-assessment tool enabling organisations to measure their level of compliance against national Information Governance standards and legislation. To operate effectively there are five objectives, these include:

Objective 5.1: Manage cyber security and Information Governance Risk

Appropriate organisational structures, policies, and processes will continue to be in place to understand, assess, and systematically manage security risks to networks and information systems. To effectively manage security risk, HEIW must first ascertain, understand, and value its assets. Assets are considered items of value to HEIW (both tangible and intangible) and include people, processes, hardware, software, systems, devices, functions, data, information, intellectual property, reputation and so forth. Appropriate visibility and profiling of these assets is the foundation from which an accurate risk assessment can be derived. Clear accountability for risk and robust governance will ensure that risks are appropriately managed, directed and communicated throughout HEIW.

Objective 5.2: Protect against cyber-attack and Information Governance Breaches

HEIW will ensure that there is continuous improvement and proportionate security measures in place to protect HEIW's network, information systems and data. The integrity of information will be assured, monitored and maintained, so that it is of expected quality and reliable for use for the purposes that it is collected and used for. The security of HEIW's estate and assets will be continually assured throughout their lifecycle and with supply chain and partners. This will include the deployment of security controls and measures which are commensurate with the criticality, sensitivity and value of assets and their risk profile to ensure that risks are appropriately managed. Security baselines will be established which define the minimum level of protection which is required based upon asset classification.

Objective 5.3: Detect Cyber Security Events and IG Issues

HEIW will ensure that capabilities exist to ensure security defences remain effective to detect cyber security events affecting, or with the potential to affect HEIW's network and information systems. HEIW will develop capabilities to appropriately monitor its estate and assets (e.g devices, networks, platforms, services, data, systems, users) to detect cyber security and potential information governance issues events before they become incidents. Enhanced detection capabilities and monitoring of key data points and inputs will enable detection at pace and the ability to logically respond to cyber security events and to detect more sophisticated cyber-attacks or information breaches.

Objective 5.4: Minimise Impact of Cyber Security Incidents and Data Breaches

HEIW will ensure that capabilities exist to reduce the adverse impact of a cyber security incident or data breach on the operation of HEIW's network and information systems, including the restoration of those functions where necessary. Effective risk management, robust audit, appropriate and proportionate protective measures, and enhanced detection capability will make HEIW a considerably hardened target. However, HEIW will also improve its ability to respond and recover from incidents when they do happen to ensure the continuity of essential functions and services. There will be a commitment that systems and assets impacted will be restored as quickly as possible to minimise disruption. Lessons learned from any incidents will be documented and shared to drive improvements

Objective 5.5: Develop A Cyber and Information Governance Aware Workforce

HEIW will ensure that capabilities exist to ensure a cyber-aware and information governance culture is developed and driven forward, promoting an open and transparent environment supported by continuous security, data protection engagement and interaction. HEIW will work in partnership with other NHS bodies to ensure the implementation of the standards as set out in Network Information System Directive and the Data Protection regulations. To assess compliance HEIW will complete the cyber assessment framework (CAF) and the IG toolkit to inform assessment and continuous improvement. Cyber skills and information governance requirements will be understood and supported with an effective team and capacity in HEIW. The HEIW team will be supported by a workforce development plan and benefit from strong partnership with DHCW and CRU to deliver a collective approach to cyber skills and knowledge.

Mission Five Outcome

HEIW will have established governance arrangements, strong engagements and improvement methodology with clear accountability for effective management of cyber and information governance risks. The security of HEIW digital and data services will be continually monitored against recognised standards and legal directives to improve posture and responses. A level of control commensurate to the risk profile will be deployed to ensure that risks are managed proportionately. HEIW will be prepared to respond to cyber and data protection incidents and will be able to respond organisationally and as a part of NHS Wales.

6. Digital Timeline

Digital Roadmap					
	Mission One	Mission Two	Mission Three	Mission Four	Mission Five
2023-2024 Stabilise	- Review digital operating model & structure & strategy launch - Product Roadmap in place with Identified RO - Deliver Single platform business case - Continue 'Y Ty Dysgu' roll out up to 50K users health and care - Deliver Gwella improved functionality - Digitisation HEIW business processes - Cloud strategy	- Increased usage and reporting of National digital Capability Framework - Launch Digital skills capability self-assessment tool with resources and training needs assessment - Digital fellows in place - Technology Horizon Scanning to inform strategic workforce planning and service redesign - All strategic workforce plans to have digital component to describe transformation opportunities	- Delivery of high-quality, intentionally designed online health education and training - Improved reporting and analysis of online learning providing evidence and insights into engagement and participation - ensuring the quality of online learning across HEIW providing advice and guidance and support with more complex technical development	- Data gap analysis and improvement plan - Increased data availability from multiple sources in easy to access dashboards - Increased data sources available for reporting - Workforce supply and demand modelling being tested through iterative cycles of improvement - Collaboration with commercial and academic partners - Growing internal and external capacity	- Completion of the Cyber Assessment framework and IG toolkit - Improved Digital and Data Governance and assurance model and processes - Risk and assets management profiling
2024-2026 Develop and Grow	- Implement Single Platform and improved trainee experience - Evaluate and improve Y TY Dysgu - Improved placement management solutions - Scope further Gwella functions and alignment to YTD - Roll out of capital IT refresh plan - Data architecture review and improvement plan aligned to NDR and ESR re-procurement - Ongoing review and improvement programme for websites - Review of commercial partners	- Ongoing base line of digital skills and training needs analysis - Integrate Digital transformation initiatives into strategic Workforce plans and benefits model - Align digital skills programme with national digital transformation initiatives - Mature digital skills champions - Assessment and guidance on new digital skills required for new ways of working - Expand digital champions network - Digital readiness assessments and guidance published	- Improved digital learning experience based on standards and best practice - Addressing barriers and constraints to excellent digital learning - Horizon scan, conduct and publish research and test and evaluate new digital learning technologies to lead, support, and guide the sector - development of online learning networks	- Improved data architecture and data warehousing aligned to NDR. - Increased data analytics capabilities and predictive analytics - Increased workforce dashboard - Development of Data literacy improvement programmes	- Improved disaster recovery and business continuity approaches - Improved protection from cyber attack
2024-2026 Develop and Grow	- Delivery of benefits realisation framework - Review of achievements to assess strategy refresh and revised investment model - Research and development of Robotics Process Automation, establishing HEIW's Robotic Operating Model for future developments for digital first approach	- Development of AI education, training and skills framework and career pathways - Maximise use of virtual placements	- Opportunities and impact of immersive technology on the HEIW learning experience is understood and maximised - Increase delivery of excellent digital learning experiences	- Improved national and HEIW workforce data standards, governance and reporting - Improved data literacy in HEIW	A competent and aware cyber and IG HEIW workforce

7. Benefits, Value, and Investment

Benefits and Outcomes

Whilst digital transformation is critical to the success, the transformation isn't simple, it is multifaceted, complex, and filled with challenges. However, by aligning HEIW business strategy and technology there are positive outcomes to be gained. Depending on the programme of work this can include:

- Financial efficiencies and cost savings – however significant research has been done that demonstrated that return on investment from digital transformation is difficult and does not immediately show as a monetary impact
- Improved Quality
- Employee / staff productivity
- Encourages collaboration and improved communication
- Creating better stakeholder and staff experiences
- Improved business continuity
- Enhanced security
- Reduction of technical debt and outdated technology
- Improved decision making, risk management, monitoring and performance management through better data and analytics. This recognises the ability of technology to generate value and is dependent on the quality of data.
- Improved legal compliance with regulations and guidelines
- Limits human error or eliminating time consuming manual data entry and human inefficiencies
- Enables future digital growth - The final benefit of digital transformation is the most fundamental. Digital transformation is the initial act that sets the stage for all subsequent business growth.

A strong focus on realising benefits through digital programmes is essential to ensure programme goals are achieved and that value is delivered. It is also necessary for a sustainable cycle of investment and transformation. To achieve this there will need to be collaboration and coordination with the IMTP process and business case submissions. The HEIW Digital Directorate will utilise the NHS Wales Benefits Framework to ensure benefits of all digital programmes and projects are identified, measured, and reported upon in accordance with the national framework.

Investment and Resources

HEIW is committed to investment in digital systems and services to underpin the visions and strategic aims. The Board has recognised the need for increased investment in the digital capability of the organisation, and since the beginning of 2021 has invested in growing the in-house digital team and supporting business cases to investment in commercial arrangements and partnerships.

Any additional funding required during the duration of the strategy will be assessed through detailed business cases or investment plans for each strategic objective, examples include business cases supporting the trainee single platform, the expansion of the data and analytics function and data infrastructure improvements. Any digital investments decision making will follow a set of principles to prioritize, fund and deliver digital initiatives. The business case will need to set out a compelling case for investment, which requires an understanding of its financial impact.

The current capital allocation from Welsh Government will also need to be reviewed to support a technical refresh programme of hardware that was bought at the inception of HEIW as this will be coming to end of life during the period. Detailed investment plans will be drafted and taken through digital governance forums. In the current economic climate consideration will be given to digital inflation as this will place a significant increase on costs and forecasting. The Digital Team will work nationally with Welsh Government Colleagues to ensure use of the Digital Priorities Investment Fund.

8. Governance and Decision Making

To support the digital programmes, governance is vital to assurance and transparency. For digital, this is provided in three primary ways.

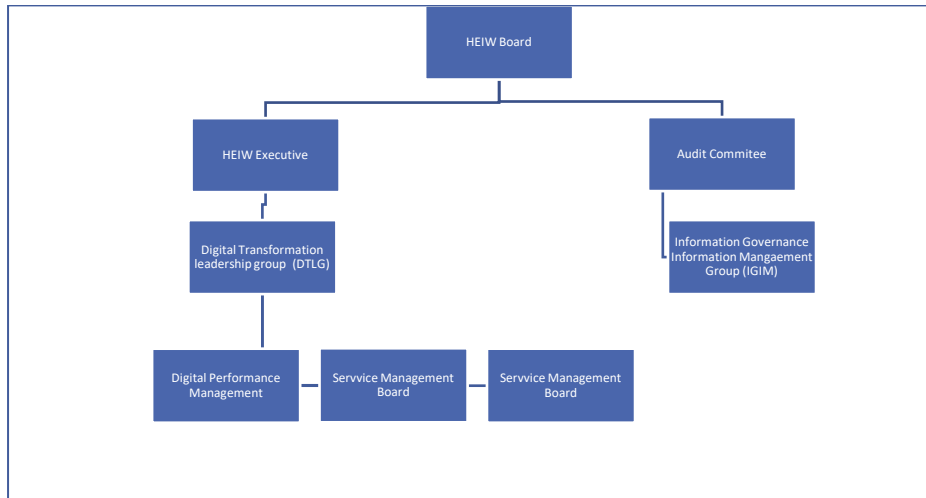
The first pillar is the Information Governance and Information Management Group (IGIM) providing oversight of issues relating to Information Governance and Cyber, the group is chaired by the Board secretary in his capacity as SIRO and chair assurance reports are presented to Audit Committee.

The second pillar of governance is the Digital Transformation Leadership Group (DTLG). Reporting to the Executive Team and informing Audit Committee when appropriate. The purpose of the DTLG is to provide robust governance and assurance for the delivery of HEIW's digital vision. DTLG, is charged with steering, governing, supporting and performance managing the planning and execution of the Digital Roadmap and Strategic Plan. This governance mechanism guards against silo working and reduces the impact of 'shadow IT', it ensures full advantage of the digital opportunity across HEIW. this is supported by a Digital Services Management Board and Digital and Data Change Advisory Board, these boards will ensure the appropriate governance and assurance is in place around all digital and data products and services, with Service Catalogues, Service Level Agreements and Business Continuity Plans all in place.

The third pillar is the Digital Risk Management Group, this manages the digital risk of the organisation and escalates issues to DTLG when required. The overview of the risk register is a standard item on the agenda of DTLG. In addition to these three

mechanisms there is robust integration with the HEIW IMTP planning and performance frameworks.

Digital Governance Framework



9. Roles and Responsibilities

91. HEIW Digital team, is a moderate sized internal team that is continuously learning, whose skills and experience is improved and enriched through partnership and procurement relationships with external private, public and academic organisations. The team will leverage procurement services to engage providers to free up internal IT capacity for transformational work and find partners capable of supporting innovation and transformation. The team have responsibility to:

- Deliver the strategy
- Deliver effective digital operational services and solutions
- Work with partners that are responsible for delivering digital transformation in health and social care
- Integrate implementation into the IMTP and departmental planning process to ensure performance management of delivery against the objectives
- Ensure governance and monitoring is in place to regularly review implementation and ensure delivery remains responsive to needs
- Ensure financial resources (including skills and capability), technical plans and strategies are in place to support delivery
- Evaluate the impact of the strategy on stakeholders

9.2 HEIW Digital Champions

Digital Champions across HEIW will hold an important role in ensuring their Directorates are kept abreast of digital developments and changes, ensuring best practice and local level support for certain digital products, including, but not limited to:

- SharePoint – team level administration, permissions, support, and training
- MS Teams – team level administration, permissions, support, and training
- Power Platform – team level training and initial support

Champions will play a role in linking the digital team with the wider staff group and ensuring alignment of digital goals and plans with the needs of the organisation. HEIW have recognised the role of digital champion and accountable officer at Board level with the Digital Director being part of the Executive team reporting to the Chief Executive and the digital portfolio being assigned to a named Independent Member.

9.3 Health Boards, Trusts and DHCW:

- To acknowledge the strategy and work in collaboration on the national initiatives detailed in the strategy
- To support, evaluate and feedback on the impact of the strategy on staff, learners and service users
- To share knowledge and best practices

10. Partners and Collaboration

As a strategic organisation it is important that HEIW builds strong and effective partnerships to deliver the vision. HEIW takes proactive steps to be recognised as an excellent partner, influencer and leader. The implementation and success of the digital strategy will require excellent partnership working. There will be collaboration with all HEIW partners to deliver the best solutions for our stakeholders. There will be proactive steps taken to learn from each other and share ideas and experiences so that the digital technology that is offered benefits from a wide-ranging perspective of views and opinions. Through the course of the strategy, it is expected that partnerships are developed and strengthened with a range of stakeholders including those referenced below (not an exhaustive list):

• Patients and Service users • Health Boards, Trusts • NWSSP • Trainees, Trainers, students and Staff • Digital Health and Care Wales • Social Care Wales • Health Technology Wales • Value Based Health and Care Academy • Centre for Public Digital Services	• Improvement Cymru • Education providers across all sectors • Royal colleges and governing bodies • Life Sciences Hwb / Digital Health Ecosystem Wales (DHEW) • Providers of digital services to HEE and NHS Scotland • Commercial technology providers • All Wales intensive learning academy for innovation In Health and Social Care
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11. Conclusion

The strategy sets out an ambitious and transformative direction of travel for digital and data over the next five years. Progress will be reviewed through reporting through governance structure and the HEIW Board.

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

Meeting Date	26th January 2023	Agenda Item	3.1
Report Title	Digital and Data Strategy		
Report Author	Sian Richards, Director of Digital Development		
Report Sponsor	Sian Richards, Director of Digital Development		
Presented by	Sian Richards, Director of Digital Development		
Freedom of Information	Open		
Purpose of the Report	Following a number of engagement sessions and feedback, this paper presents the updated HEIW Digital and Data Strategy for approval		
Key Issues	The HEIW Digital and Data Strategy is an enabling and transformational strategy that supports delivery of the HEIW vision of ‘transforming the workforce for a healthier Wales.’ The draft strategy was considered at a number HEIW wide engagement events, Digital Transformation Leadership Group, DDG and the Executive Team. The strategy will may be subject to further formatting / styling after the content is approved and prior to publication.		
Specific Action Required (please ✓ one only)	Information	Discussion	Assurance
			Approval
			✓
Recommendations	Members are asked to: Note this paper that provides an overview of the digital and data strategy and are asked to approve the strategy for publication.		

HEIW DIGITAL AND DATA STRATEGY

1. INTRODUCTION

This paper updates the Board on the development and engagement completed on the digital and data strategy. The paper briefly describes the approach to development and engagement of the strategy. Board members are asked to approve the strategy.

2. BACKGROUND

2.1 Developing the strategy

The strategy has been developed following a significant amount of research into best practice and current technology standards. In addition there have been a number of working groups considering recent best practice and advice. A detailed interactive discussion was held in the October Digital Transformation Leadership Group (DTLG) to shape the vision and missions. The Strategy has been shared with members of Deputies and Deans Group (DDG) and the Executive Team for further engagement, comments and amendments.

In addition HEIW wide drop in engagement sessions were held in December, attendance was from a broad range of departments and the feedback was positive and supportive. The potential of the strategy was recognised and participants were supportive of the direction and approach. A Board Development Session Workshop was held in December 2022 with the full Board in attendance to review the strategy approach, feedback has been collated and the strategy was updated accordingly. The session was positive and there was support for the strategy. A summary of the feedback from these sessions and how they have been addressed is detailed in appendix one.

2.2 Strategy content and approach

The purpose of this strategy is to set out a vision and provide direction and clarity about the areas of priority and the aims that will guide the digital and data team in HEIW over the next five years. Given the rate of change and technological advancement, this strategy is not about reaching a set intended destination. It is instead, a focus on the priority areas that will over time improve, practices, culture, processes and technologies to respond to raised expectations within HEIW over the next five years.

The strategy sets the digital vision which enables delivery of HEIW's corporate vision of ***Transforming the workforce for a healthier Wales***. Detailed in the strategy are

five missions, each are specialist areas required to deliver the Vision. The five Visions are as follow:

1. Delivering high quality innovative digital solutions to enable HEIW to transform service delivery of its statutory and operational functions
2. Developing a digital ready and skilled workforce and championing the transformative impact of technology on the shape of work and the future workforce
3. Delivering excellent innovative digital learning experiences for HEIW staff students, trainees, NHS and care staff.
4. Delivering effective and secure data capabilities that can drive actionable insights, intelligence and improvement.
5. Continuously strengthening HEIW's cyber security and information governance posture and resilience to attack

Each mission has several objectives, and these will be delivered via implementation plans. To ensure an integrated approach, the implementation plans will form part of the IMTP process as strategic objectives and enabling plans. The approach provides a framework of measurable objectives to be delivered against which progress can be assessed. Detailed in the strategy are the expected outcomes and benefits that each mission will deliver and these collectively will deliver the overall vision.

In practice there is an internal and external focus to the strategy. **Internally**, it ensures delivery of excellent high quality innovative digital and data solutions to staff and users of HEIW services across Wales. This will deliver excellent education and training solutions, innovative and digitally enabled learning and a digitised and improved way HEIW runs its operations and functions. Digital transformation provides the opportunity to increase organisational agility, sustainability, simplifying the user experience, managing security risks and balancing productivity and security. At the heart of this vision will be a commitment to increase data quality, availability and usage to move towards being a data driven organisation that is informed and gains insight and knowledge from data to drive continuous improvement.

Externally, the strategy will also prepare the wider NHS workforce with the digital skills required to work in a digitally transformed environment. HEIW will not be responsible for the delivery of digital health and care systems for front line services, that is the remit of Health Boards, Trusts and DHCW. HEIW will work with those service partners to ensure collectively we champion and build approaches to demonstrate the transformative ability that digital has to change, improve, make more efficient and re-shape the way work is done in the NHS and the supporting education and training.

3. GOVERNANCE AND RISK ISSUES

The strategy has a section that describes the governance mechanism that will support the delivery of the strategy. Good governance, engagement and partnership working are crucial to successful delivery. During the first year of the strategy the governance approach will be reviewed to ensure it remains robust. It is expected that in the second year, the strategy will be an area for review by Internal Audit.

In terms of risks, it's prudent to say that given the current economic climate and a competitive labour market there is a risk of funding and resourcing the actions and plans to deliver the strategy. The plan will need to consider a range of actions that focus on maximising the skills within our current internal digital workforce as well as assessing the need for additional skills and capabilities from outside the current in-house team. Good governance and risk management will be delivered by balancing the implementation plan against the availability of all resources, this will be actively managed and reported.

4. FINANCIAL IMPLICATIONS

There are no current financial implications of this paper. It is recognised that the strategy will require investment to support its delivery and all future funding requirements will be incorporated into business cases, workforce plans and full financial plan delivery plans with the constraints and risks as detailed above.

5. RECOMMENDATION

Members are asked to **Note** this paper and approve the Digital and Data strategy

Appendix One – Feedback from Engagement Sessions

Comment	Response	Action
NHS Software is generally old, out dated and clunky. Need to ensure we're creating user friendly software/systems, using user centric design	The need for user-based design is reference in the principles section of the first mission	Out of scope - NHS patient facing and administrative systems are out of scope of the strategy and will not be referenced No strategy action - system within scope of HEIW digital team will be already referenced in strategy and user design principles already included
Huge agenda / constraints on pace / is it too ambitious	This will be balanced against a 5 year implementation plan	Action - Review implementation plan and review risks
There will be advances in AI / Clinical Services / Digital Support in this time for service delivery, education and learning – we need to ensure we can keep pace with this	Agreed - This is identified in mission two and will form a core part of our digital response to strategic workforce plans	Action – already included but strengthen reference to AI
Need to strengthen the potential of digital solutions to transform the delivery of education	Agreed – the digital solutions are detailed in the strategy, they will also need to play a core role when the education strategy is developed in 2023/4	Action – to work with the development of the education strategy
It is key we link with partners – to keep advanced of developments for learning and development. Getting the strategy recognised by partners	Agreed. There is a section to reference partnership working	No strategy action – already included in strategy. Action required as part of implementation to ensure good representation and engagement of partners
Suggested the work of the Simulation team may be more further ahead on the horizon	Agreed a close working relationship will be required especially around immersive technology to support digital learning	No strategy action – already included in strategy and the working relationship on immersive technology already in place.
Consider implications for recruitment and availability of staff to deliver the requirements	Agreed this will be a key dependency and potential rate limiting factor . Resource for increases in staff numbers will be included in business cases and supporting workforce plans will be developed	No strategy action - already included as a potential dependency in strategy
How do we benchmark against best practice	This will be done through benefits realisation and evaluation approach	No strategy action - already included Action – reporting benefits and baseline as part of implementation

Cost / Finance / capital and revenue investment/ links to efficiencies of training and education	Agreed the strategy will require investment, this will be managed via business cases and outline investment plans	No strategy action – already referenced Action – develop costed business cases to support the strategy implementation
Income generation	This is generally not a model followed as it detracts from core business, but will be explored if the opportunity arises	Action - To be considered in implementation plans if appropriate
Information Governance to be included	Agreed this is important and is included in a combined cyber and IG mission	No action – already included
Digital competencies will need to engage HR teams and understand the baseline of the current abilities of staff in the service	Yes agreed – the workforce support groups and being established to support the implementation and spread of the work . the digital capabilities tool will provide baseline functionality	No action – already included
Digital maturity of the core NHS Service is important	This is outside of the remit of the HEIW strategy. However DHCW are leading a digital maturity review of NHS Wales based on the HIMSS HIMSS Maturity Models: Models for Digital Health Transformation assessment criteria. HEIW will work in partnership with NHS organisation to understand the outcome. However, digital readiness of staff is considered in the strategy	Out of scope
Importance of alignment to strategic workforce plans	The alignment is core to the strategy and roles have been identified in digital to be the link to the workforce planning processes	No action – already included
There is a need to improve the data architecture in HEIW	Agreed – this is included in two of the missions in the strategy	No action – already included
Need to be clear on the roles and responsibilities of the strategy for HEIW	Agreed – this is an important distinction and is described in the strategy document (if not covered in detail in the presentation overview)	No action – already included
The role of digital champions and those clinical interested parties to engage the workforce. There is potential to use case studies.	Agreed this will be very important to delivering the strategy and is detailed in the strategy . case studies can be used as part of the evaluation	No action – already included in relation to champions and clinical lead Action - include case studies in evaluation
Strategy needs to describe risk and the risk of not taking action	Agreed risk is a strategic consideration that will influence and shape the implementation plan	Action – revisit risk section

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
n/a			
Financial Implications			
The financial implication of the strategy will be addressed through individual business cases			
Legal Implications (including equality and diversity assessment)			
There are no direct legal implications as a result of this paper.			
Staffing Implications			
Resource implications of the strategy will be addressed through business cases and workforce plans			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
The strategy has a potential to impact positively on sustainability and the foundational economy.			
Report History	Strategy developed following a number of engagement events.		
Appendices	HEIW Digital and Data Strategy		



UNIVERSITY OF LINCOLN

How is performance at selection to general practice related to performance at the endpoint of GP training?

Report to Health Education England

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Aloysius Niroshan Siriwardena

April 7, 2022

Contents

1	Study Advisory Group	4
2	Acknowledgements	5
3	Summary	6
4	Introduction	7
5	Methods	9
5.1	Design	9
5.2	Ethical approval	9
5.3	Data collection and processing	9
5.4	Statistical analysis	10
6	Results	11
6.1	The predictive validity of MSRA scores for outcomes of GP training	11
6.2	The predictive validity of the MSRA and the selection centre (SC)	17
6.3	Reassessing threshold scores in MSRA for access to the Direct Pathway using ROC curve analysis	21
6.4	Pass rates and demographics	22
7	Discussion	24
7.1	Main findings	24
7.2	Comparison with previous research	24
7.3	Strengths and limitations	25
7.4	Implications for policy, practice and future research	26
7.5	Conclusions	26

List of Figures

1	Percentage of fail rates per MSRA score band for AKT, CSA, and RCA	12
2	Average number of ARCP outcomes 2, 3, and 4 per person (y-axis) for each MSRA band (x-axis)	14
3	Percentage of individuals with at least one of the ARCP outcomes 2, 3, or 4 (y-axis) for each MSRA score band (x-axis)	15
4	Fail rates at the 5 year data collection point expressed as percentages (x-axis) per SC score bands (y-axis) for each outcome of GP training	18
5	Average Number of ARCP outcomes 2, 3, and 4 per person (y-axis) for each SC score band (x-axis)	18
6	Percentage of individuals with at least one of the outcomes 2, 3, or 4 (y-axis) for each SC score band (x-axis)	19
7	ROCs of MSRA scores against binary outcome (pass/fail) on each assessment . .	21
8	Pass rates for each assessment	22
9	Pass rates per number of attempts for each assessment	23

List of Tables

1	MSRA scores as predictors of AKT, CSA, and RCA scores and number of ARCP outcomes 2, 3, and 4.	11
2	MSRA scores as predictors of AKT, CSA, and RCA pass rates and presence of at least one of the ARCP outcomes 2, 3, or 4	11
3	MSRA score bands and demographic characteristics as predictors of AKT pass rates	13
4	MSRA score bands and demographic characteristics as predictors of CSA pass rates	14
5	MSRA score bands and demographic characteristics as predictors of RCA pass rates	15
6	MSRA score bands and demographic characteristics as predictors of the number of ARCP outcomes 2, 3, and 4	16
7	MSRA score bands and demographic characteristics as predictors of the presence of only standard ARCP outcomes	17
8	MSRA score bands as predictors of the number of ARCP outcomes 2, 3, and 4 .	20
9	Characteristics of candidates taking the MSRA and accessing the Direct Pathway	23

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Summary

Background

The selection process for entry to speciality training for general practice (GP) in the UK was changed in 2016. Doctors scoring above an agreed threshold in the computer-marked Multi-Specialty Recruitment Assessment (MSRA) were deemed appointable on that score alone and were offered a direct pathway (DP) to training, exempting them from further assessment at the final Selection Centre (SC). The SC was subsequently suspended in response to the COVID-19 pandemic and has yet to be reinstated. We aimed to evaluate the relationship between performance at selection and outcomes of GP training at licensing, to reassess the threshold score in MSRA used to bypass the SC, and to estimate the incremental predictive value of the SC after MSRA.

Methods

We used a longitudinal design linking selection, licensing and demographic data from doctors applying to enter GP specialty training in 2016. MSRA scores were divided into 12 score bands and SC scores into seven score bands to better identify MSRA or SC scores that corresponded to differing GP performance on licensing assessments. Multivariable logistic regression models were used to establish the predictive validity of the MSRA scores and score bands for passing or failing the Membership of the Royal College of General Practitioners (MRCGP) licensing assessments including the Applied Knowledge Test (AKT), Clinical Skills Assessment (CSA) or Recorded Consultation Assessment (RCA), Workplace Based Assessment - Annual Review of Competence Progression (WPBA-ARCP), and performance overall. The model adjusted for sex, ethnicity, country of qualification, and declared disability. Receiver Operating Characteristic (ROC) curves of MSRA scores against performance outcomes were constructed to determine the optimal MSRA threshold scores for achieving licensing.

Results

We included 3338 doctors who entered specialty training for general practice in 2016 of different sex (female 63.81% vs male 36.19%), ethnicity (White British 53.95%, minority ethnic 43.04% or mixed 3.01%), country of qualification (UK 76.76%, non-UK 23.24%), and declared disability (disability declared 11.98%, no disability declared 88.02%). MSRA scores or score bands were highly predictive for all assessments of GP training outcome (AKT, CSA, RCA, and WPBA-ARCP). Lower SC score bands were predictive of lower pass rates on summative assessments and /or ARCP outcomes 2, 3, or 4. Adding SC scores did not change the predictive validity of the MSRA, and therefore the SC did not add further information to MSRA scores. An MSRA threshold of 500 (or, more precisely, 497) was optimal for correctly identifying pass/fail rates on the AKT, RCA, and CSA within the study period, and only standard outcomes on WPBA-ARCP. Thirty-five percent of candidates in the lowest two MSRA Bands (i.e., scores below 420) had at least one developmental outcome (2, 3) or outcome 4. Ethnicity did not reduce the chance of passing GP licensing tests once sex, place of primary medical qualification, declared disability and MSRA scores were taken into account.

Conclusion

MSRA scores predict licensing outcomes for AKT, CSA, RCA, and WPBA-ARCP within five years of starting training. The optimal MSRA threshold score for predicting an uncomplicated training pathway to licensing was around 500 in this large cohort. The SC added little to the predictive validity of the MSRA. Doctors scoring below this threshold may need additional support during training to maximise their chances of achieving licensing.

Introduction

Any doctor providing proof of eligibility for UK specialty training is entitled to take part in the selection process. This process is important to ensure that those chosen are likely to successfully complete postgraduate medical education and gain a licence to practice in their chosen speciality. Considerations include the financial cost of training, the challenges of providing extra support when needed and the impact on trainees who fail to complete in a specialty where there is no long term 'middle grade'. Failure to complete training is wasteful of training places and resources and detrimental to trainees and schemes (Plint & Patterson 2010, Davison et al. 2016).

The current system of selection to GP training in the United Kingdom (UK) has three phases:

- Stage 1 Administrative: Candidates provide proof of eligibility for UK specialty training, including proof of Foundation Level competence.
- Stage 2 Multi-Specialty Recruitment Assessment (MSRA): a computer-based Multiple Choice Question examination, developed and delivered by the National Recruitment Office (NRO) as a shortlisting tool for many medical specialties, including General Practice (GP). The MSRA contains both Clinical Problem-Solving items and Situational Judgement Tests.
- Stage 3 Selection Centre (SC): A GP-specific face-to-face assessment using Objective Structured Clinical Examination (OSCE) style simulations and a written test.

All three stages are centrally organised. Stage 2 is delivered through Pearson Vue centres at many locations. Stage 3, SC, is delivered by individual deaneries: each OSCE station is graded on multiple domains by a single assessor, usually a GP.

GP specialty training after this selection process is a planned three-year whole time equivalent programme of primary and secondary care placements. At exit, competence for independent practice is assessed in a three-part assessment, the MRCGP. The three strands are:

- Applied Knowledge Test, AKT (clinical problem solving).
- Clinical Skills Assessment CSA: in 2020, this was replaced by the Recorded Consultation Assessment RCA due to Covid measures.
- Work Place Based Assessment, WPBA, as judged by the Annual Reviews of Competence Progression, ARCP.

In 2020/21 the average time taken to complete GP training (including maternity leave, less than full time training and supportive extensions) was 3.8 years. Only 1.2% of those admitted to training left the programme without achieving a licence to practice. The current study followed a large cohort for 5 years.

The MSRA has been positively evaluated as a method of shortlisting (Patterson et al. 2009). Predictive validity was assessed using supervisor ratings of job performance after one year in addition to results of the AKT and CSA (Patterson et al. 2013). The SC was validated through trainer ratings of trainee job performance after three months (Patterson et al. 2005). Both MSRA and SC were considered to be fair tests for selection (Patterson et al. 2011).

There is limited evidence on outcomes in other assessments such as the Workplace Based Assessment Annual Review of Competence Progression (WPBA-ARCP), overall performance,

or the Recorded Consultation Assessment (RCA), an assessment which replaced the CSA from mid- 2020 in response to the Covid pandemic (Botan et al. 2021).

Prior to 2016, all candidates who achieved an agreed 'score' at MSRA progressed to the SC as the final step in selection. In 2016, a change was introduced, allowing candidates who achieved a threshold score of 575 or above on the MSRA (10-13% of top scorers) access to the Direct Pathway (DP). They were deemed appointable on MSRA score alone and exempt from attending the Stage 3 Selection Centre (Ooi & Ooi 2021). The MSRA threshold score for accessing the DP was based on statistical modelling which showed that 100% of candidates undertaking the MSRA in 2013, 2014 and 2015 who achieved a score of 575 or more in Stage 2 were subsequently deemed appointable at Stage 3.

By the time of data collection (2021), trainees from the 2016 selection cohort would be expected to have completed training in 2019, 2020, and 2021. This provided an opportunity for this study to evaluate the process of selection to identify outcomes of DP (Stage 1 and 2 alone) versus Stages 1-3 and to reassess the 575 threshold score at MSRA for determining eligibility for Direct Pathway.

Recent studies have suggested that factors such as specific learning difficulties, ethnicity (and place of primary medical qualification), and gender should be taken into consideration when developing predictive models (Asghar et al. 2019, 2018). Hence this study also considered those factors, particularly looking at any changes in differential attainment between entrance and endpoint assessments.

The research question was 'How is performance at selection to general practice related to performance at the endpoint of GP training?'

Our objectives were:

1. To determine the predictive validity of the MSRA for outcomes of GP training including performance at the MRCGP AKT, CSA, RCA and WPBA-ARCP.
2. To determine the predictive validity of the MSRA and the Selection Centre for those who were required to undertake both for outcomes of GP training.
3. To reassess the threshold score in MSRA for determining eligibility for Direct Pathway.

Methods

5.1 Design

We used a longitudinal design, which tracked doctors from selection to the end of GP training by linking selection, licensing and demographic data from UK doctors entering GP specialty training in 2016.

5.2 Ethical approval

Independent ethical review was sought, and approval gained from the University of Lincoln Human Ethics Committee (reference 2020_3645).

5.3 Data collection and processing

MSRA (Multi-Specialty Recruitment Assessment) and Selection Centre (SC) scores (available only for those scoring less than 575 on the MSRA) for doctors undertaking selection tests in 2016 were linked with their AKT (Applied Knowledge Test), CSA (Clinical Skills Assessment), RCA (Recorded Consultation Assessment), WPBA - ARCP (Workplace Based Assessment - Annual Review of Competence Progression) outcomes up to 2021. Demographic data were pseudonymised and securely transferred to the research team under data sharing agreements for analysis.

The datasets comprised individual candidate data. Candidates were assigned a unique (non-personally identifiable) number which allowed linkage between the various assessments, demographic data including gender, ethnicity, country of graduation, and declared disability with results for each assessment including overall scores, scores for assessments' sub-domains and outcomes of pass (1) or fail (0). The declared disability data included mainly declared specific learning difficulties (SpLDs), but there was also a smaller proportion (about 10%) which included other disabilities such as hearing impairments or other physical disabilities. Ethnicity was divided into three categories: white ethnicity background, ethnic minority background, and mixed minority background. Binary variables included: country of graduation (UK or non-UK graduates), gender (male or female), and declared disability (not having a declared disability or having a declared disability).

Evidence for WPBA is collected by the trainee throughout the year and a summative judgement of progress is made annually at the ARCP. The following Outcomes are available to the panel:

- 1 Achieving progress and competences at the expected rate.
- 2 Development of specific competences required - additional training time not required.
- 3 Inadequate progress by the trainee - additional training time required.
- 4 Released from training programme with or without specified competences.
- 5 Incomplete evidence presented - additional training time may be required.
- 6 Has gained all the required competences for the completion of training.
- 7 N1/2 - Sick or maternity/paternity leave.
- 8 Out of Programme Pause (OOP).

9 N21/22 - Resignation.

10 Satisfactory progress.

Outcomes 2 and 3 were considered developmental outcomes and Outcome 4 occurred when the trainee was released from training. A successful completion of the ARCP was considered if only standard outcomes had been achieved after removing outcomes 2, 3, and 4 determined by a failure on one of the licensing tests (AKT, CSA, or RCA).

MSRA scores were divided into 12 score bands and SC scores were divided into 7 score bands to better identify specific MSRA or SC scores that may have corresponded to differing GP training outcomes. The score bands were chosen based on the distribution of the data and in order to achieve bands that were narrow enough to precisely identify candidates with differing performance.

5.4 Statistical analysis

Multivariable linear regression models were used to establish the predictive validity of the MSRA scores for each assessment's overall score. The variables sex, ethnicity, country of primary medical qualification (medical graduation), and declared disability were used as predictors together with the MSRA scores. Assumptions of no multicollinearity and no outliers were checked.

Multivariable logistic regression models were used to establish the predictive validity of the MSRA scores and score bands for each assessment's outcome (i.e., pass or fail). The variables sex, ethnicity, country of graduation, and declared disability were used as predictors together with the MSRA scores or score bands.

For the multivariable linear regression models, the unstandardised Beta coefficients (B) representing the slope of the regression line, the standard error (S.E.) of B representing the spread of the observations from the fitted regression line, the r-squared (R^2) representing the proportion of the variance in the outcome explained by the predictor(s), and 95% confidence intervals (CI) representing the range of values that contains the true mean of the population with 95% confidence were reported. For the multivariable logistic regression models, the odds ratio (OR) representing the odds that the outcome will occur given a predictor, compared to the odds of the outcome occurring in the absence of that predictor (i.e., at baseline) and pseudo r-squared (pseudo R^2) representing the certainty with which the model can predict the dichotomous outcome ($y=0$ or $y=1$) were reported.

To determine changes in the predictive validity of the MSRA for those who had gone through the Selection Centre, further multivariable logistic models were run with the SC scores added to the statistical models.

To reassess the threshold score in MSRA for determining eligibility for Direct Pathway to GP training, receiver operating characteristic (ROC) curve analysis was used. MSRA scores were plotted against the outcome (i.e., pass or fail) for AKT, CSA, RCA, and ARCP (where a failure represented the presence of at least one developmental outcome or outcome 4 after removing those corresponding to exam failure) and against the overall outcome of all these assessments (i.e., pass – if all the assessments had been passed; fail – if at least one assessment had been failed). To interpret the ROC curve results, both the maximum specificity approach and the equivalence between specificity and sensitivity approach were considered. Descriptive statistics indicating number and percentages of candidates were used to describe the demographic data for each assessment.

Results

In total, 3,429 candidates took the MSRA, 2,883 the AKT, 2,313 the CSA, and 545 the RCA.

6.1 The predictive validity of MSRA scores for outcomes of GP training

Table 1: MSRA scores as predictors of AKT, CSA, and RCA scores and number of ARCP outcomes 2, 3, and 4.

Outcomes	Predictor: MSRA Score			
	Unstandardised beta (B)	Standard error of B (S.E.)	95% Confidence Interval (CI) of B	p-value
AKT Score	0.14	0.01	0.13, 0.16	<0.001
CSA Score	0.05	0.00	0.04, 0.06	<0.001
RCA Score	0.07	0.01	0.04, 0.10	<0.001
ARCP Outcomes 2, 3, and 4	-0.01	0.00	-0.01, -0.00	<0.001

N.B. These results are the summary of multivariable regression models which accounted for the demographic covariates sex, ethnicity, country of qualification, and disability.

MSRA scores were significant predictors for all GP training outcome scores and for the number of in-training ARCP outcomes 2, 3, and 4. As indicated by the unstandardised beta coefficient (B), an increase of 1 mark on the MSRA corresponded to an increase of 0.14 on the average mark on the AKT, of 0.05 on the average mark of CSA, of 0.07 on the average mark of RCA. After excluding outcomes 2, 3, and 4 due to failures in AKT, CSA, or RCA, an increase of 1 mark on the MSRA was also associated with an average increase of 0.01 on the total number of standard ARCP outcomes. These were all statistically significant ($p < 0.001$) as seen in Table 1. Moreover, the standard error of B indicated a low spread of the observations from the fitted regression line. There was also a significant positive correlation between MSRA scores and AKT ($r = 0.61$, $p < 0.001$), CSA ($r = 0.54$, $p < 0.001$), and RCA ($r = 0.57$, $p < 0.001$) and a negative correlation between MSRA scores and the number of ARCP outcomes 2, 3, and 4 ($r = -0.35$, $p < 0.001$).

Table 2: MSRA scores as predictors of AKT, CSA, and RCA pass rates and presence of at least one of the ARCP outcomes 2, 3, or 4

Outcomes	Predictor: MSRA Score			
	Odds Ratio (OR)	Standard error (S.E.)	95% Confidence Interval (CI) of OR	p-value
AKT Pass	1.03	0.00	1.02, 1.04	<0.001
CSA Pass	1.01	0.00	1.00, 1.01	<0.001
RCA Pass	1.01	0.20	0.27, 1.16	=0.087
Presence of ARCP Outcomes 2, 3, or 4	1.01	0.00	1.01, 1.01	<0.001

N.B. These results are the summary of multivariable regression models which accounted for the demographic covariates sex, ethnicity, country of qualification, and disability.

MSRA scores had predictive validity for the pass rates on the AKT and CSA, but not the RCA. As shown by the odds ratio (OR), an increase of one mark on the MSRA increased the

likelihood of passing the AKT by 0.03 and the likelihood of passing the CSA by 0.01. It also increased the likelihood of passing the RCA by 0.01, but this was non-significant. MSRA scores were a significant predictor for ARCP outcomes, increasing the likelihood of having only standard (satisfactory) outcomes on the ARCP by 0.01. These results can be seen in Table 2.

Overall, MSRA scores had predictive validity for all GP training outcomes scores, for AKT and CSA pass rates, and ARCP in-training performance.

MSRA scores were divided into 12 score bands and fail rates for each of the outcomes of GP training were calculated for each band as seen in Figure 1. MSRA score bands had predictive validity for AKT pass rates. Bands 2 and above significantly increased the likelihood of passing the AKT compared to Band 1, which corresponded to MSRA scores lower than 400, as seen in Table 3. Bands 10, 11, and 12 perfectly predicted passing the AKT thus they were not included in the model. MSRA Bands 2 and above increased the likelihood of passing the CSA, but only Bands 7 and 10 reached significance, whilst Bands 9 and 12 perfectly predicted pass rates as seen in Table 4. Bands 2 and above significantly increased the likelihood of passing the RCA, except for Bands 5, 8, 10 and 11 as seen in Table 5. Odds ratios for Bands 8, 10, and 11 indicated an eight to nine times higher likelihood of passing the RCA compared to Band 1, but the low numbers of observations in these bands led to high variability and lack of statistical significance.

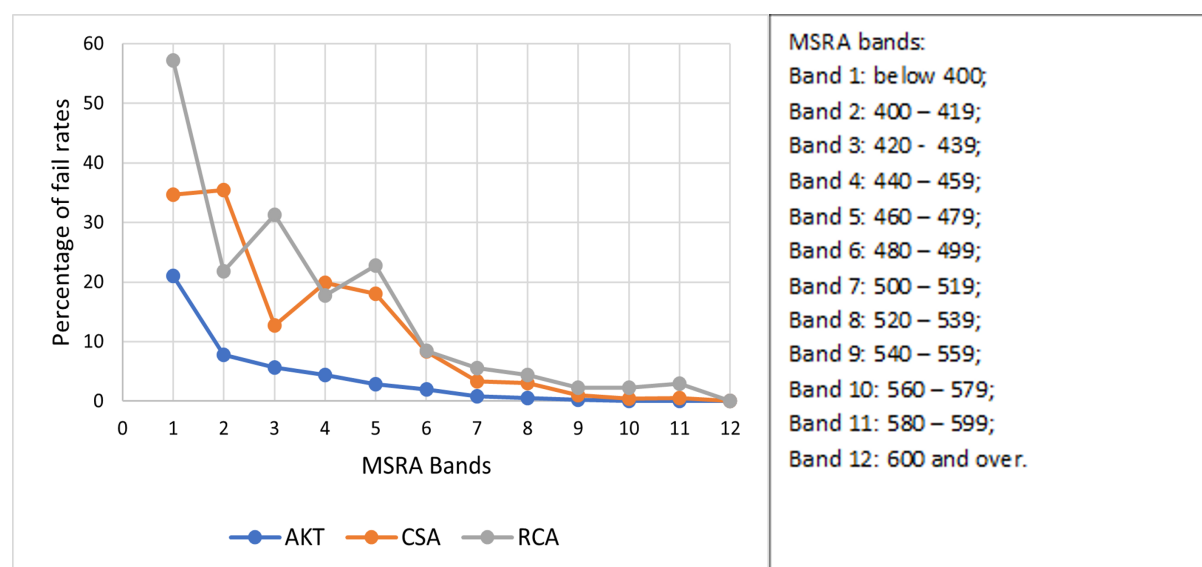


Figure 1: *Percentage of fail rates per MSRA score band for AKT, CSA, and RCA*

MSRA score bands were the main predictors of AKT pass rates. MSRA scores of 480 and above increased more than 15 times the chances of passing the AKT. When MSRA scores were taken into account, sex, country of qualification and declaration of disability were not independently associated with AKT performance as seen in Table 3. When MSRA scores and other demographic factors were taken into account, ethnic minority doctors were more likely than white British candidates to pass the AKT within five years of entering training (OR 2.05, 95% CI 1.03, 4.10, $p=0.042$.) This result indicates that, although the overall AKT pass rate is approximately 1% lower in ethnic minority doctors, adjustment for MSRA scores, which are affected by prior education and training, eliminates and reverses this difference.

MSRA score bands corresponding to scores higher than 400 increased the chances of passing the CSA, but this reached significance for scores ranging from 500-519 and 560-579, whilst score bands between 540-559 and over 600 perfectly predicted pass rates (i.e., all candidates

Table 3: MSRA score bands and demographic characteristics as predictors of AKT pass rates

Predictors	AKT pass rates			
	OR	S.E.	95% CI of OR	p-value
Sex (Female)	1			
Male	1.29	0.40	0.70, 2.36	=0.411
Ethnicity (White)	1			
Ethnic Minority	2.05	0.72	1.03, 4.10	=0.042
Mixed	1.20	1.30	0.14, 10.00	=0.865
Qualification Country (UK)	1			
Not-UK	1.17	0.46	0.54, 2.54	=0.686
Declared Disability (No)	1			
Yes	0.86	0.32	0.42, 1.77	=0.687
MSRA Bands (under 400)	1			
400-419	3.47	1.76	1.28, 9.36	=0.014
420-439	4.29	2.42	1.42, 12.94	=0.010
440-459	6.86	3.68	2.40, 19.11	<0.001
460-479	9.93	5.77	3.18, 31.03	<0.001
480-499	15.34	9.86	4.35, 54.08	<0.001
500-519	37.53	28.75	8.37, 168.40	<0.001
520-539	53.30	46.67	9.58, 296.52	<0.001
540-559	104.06	117.95	11.28, 959.69	<0.001
Cons	1.69	0.97	0.55, 5.21	<0.001
<i>pseudoR</i> ² = 0.13, <i>X</i> ² (13) = 56.78, <i>p</i> <0.001				

that obtained those scores passed the CSA) as seen in Table 4. In general, scores higher than 500 increased the likelihood of passing the CSA. When MSRA scores were taken into account, ethnicity was not associated with differential CSA performance. However, male sex (OR 0.58, 95% CI 0.39, 0.86, *p*=0.007), country of qualification outside the UK (OR 0.27, 95% CI 0.16, 0.45, *p*<0.001) and declaration of disability (OR 0.38, 95% CI 0.24, 0.61, *p*<0.001) were associated with a reduced chance of passing the CSA.

MSRA bands corresponding to scores higher than 480 increased the chances of passing the RCA five times or more. Scores between 480 and 519 significantly increased the likelihood of passing the RCA as seen in Table 5. When MSRA scores were taken into account, sex, ethnicity or declaration of disability were also not associated with RCA performance, but a non-UK country of qualification was associated with a reduced chance of passing the RCA (OR 0.30, 95% CI 0.11, 0.80, *p*=0.017).

MSRA score bands predicted both the number of ARCP in-training outcomes 2, 3, and 4 and the presence of at least one of these outcomes. MSRA score Bands 1 and 2 (i.e., scores lower than 420) corresponded to a higher average number of ARCP outcomes 2, 3, or 4 per person and to a higher percentage of individuals with at least one of these outcomes as seen in Figures 2 and 3. MSRA Band 6 and above (scores higher than 480) were significant predictors of a lower number of ARCP outcomes 2, 3, and 4 and MSRA Band 8 and above (scores higher than 520) significantly increased the likelihood of having only positive ARCP outcomes compared to Band 1 as seen in Tables 6 and 7. Importantly, being a male, not graduating in the UK, and having a disability were significant predictors of a poorer performance on the ARCP.

MSRA scores were good predictors of the number of ARCP outcomes 2, 3, and 4. MSRA

Table 4: MSRA score bands and demographic characteristics as predictors of CSA pass rates

Predictors	CSA pass rates			
	OR	S.E.	95% CI of OR	p-value
Sex (Female)	1			
Male	0.58	0.12	0.39, 0.86	=0.007
Ethnicity (White)	1			
Ethnic Minority	0.72	0.19	0.43, 1.20	=0.201
Qualification Country (UK)	1			
Not-UK	0.27	0.07	0.16, 0.45	<0.001
Declared Disability (No)	1			
Yes	0.38	0.09	0.24, 0.61	<0.001
MSRA Bands (under 400)	1			
400-419	0.92	0.39	0.40, 2.10	=0.848
420-439	2.58	1.29	0.97, 6.88	=0.059
440-459	1.04	0.43	0.47, 2.33	=0.915
460-479	0.99	0.41	0.44, 2.22	=0.972
480-499	1.48	0.67	0.61, 3.60	=0.389
500-519	4.00	2.28	1.31, 12.23	=0.015
520-539	2.47	1.34	0.85, 7.15	=0.097
560-579	11.58	12.67	1.36, 98.83	=0.025
580-599	6.86	7.53	0.80, 58.98	=0.080
Cons	17.76	8.66	6.83, 46.20	<0.001
pseudoR ² = 0.21, X ² (13) = 178.87, p<0.001				

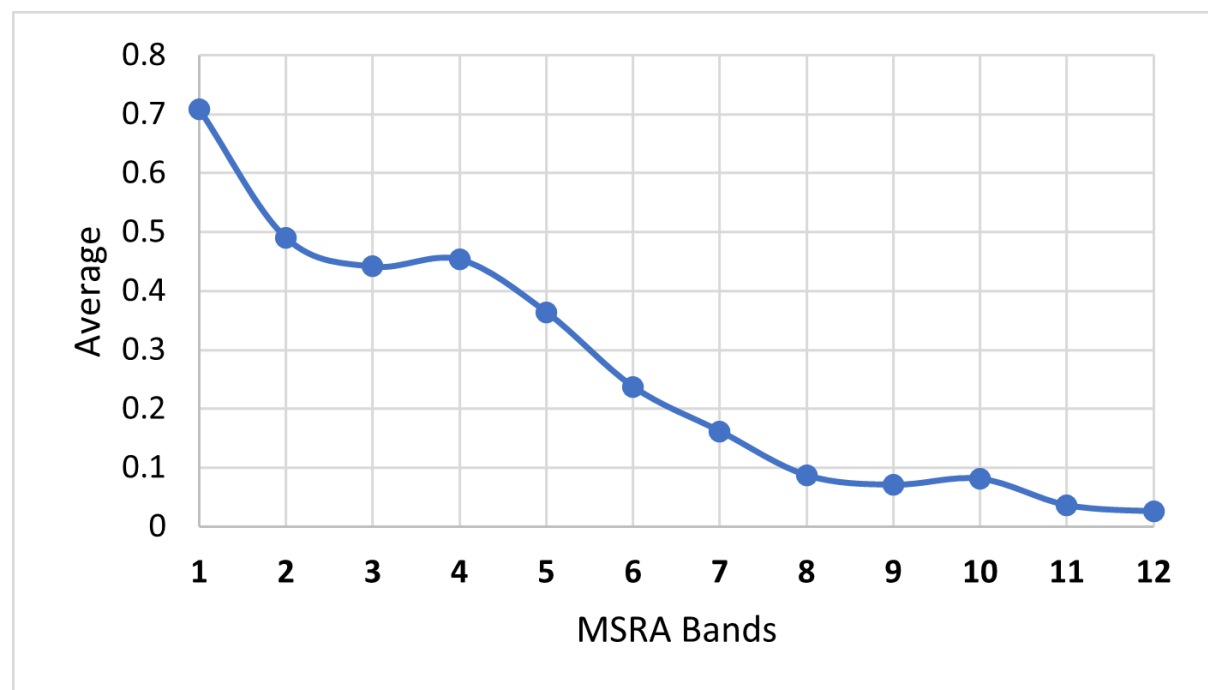


Figure 2: Average number of ARCP outcomes 2, 3, and 4 per person (y-axis) for each MSRA band (x-axis)

scores above 480 significantly reduced the number of these ARCP outcomes as seen in Table 6. Analogously, MSRA score bands corresponding to scores above 520 significantly increased by at least three times the likelihood of having only standard ARCP outcomes as seen in Table 7.

Table 5: MSRA score bands and demographic characteristics as predictors of RCA pass rates

Predictors	RCA pass rates			
	OR	S.E.	95% CI of OR	p-value
Sex (Female)	1			
Male	0.74	0.25	0.37, 1.45	=0.377
Ethnicity (White)	1			
Ethnic Minority	0.48	0.25	0.18, 1.32	=0.156
Mixed	0.14	0.13	0.20, 0.94	=0.043
Qualification Country (UK)	1			
Not-UK	0.30	0.15	0.11, 0.80	=0.017
Declared Disability (No)	1			
Yes	0.58	0.22	0.27, 1.23	=0.156
MSRA Bands (under 400)	1			
400-419	5.46	3.40	1.61, 18.51	=0.006
420-439	5.98	4.73	1.27, 28.18	=0.024
440-459	5.00	3.07	1.50, 16.65	=0.009
460-479	2.60	1.53	0.81, 8.24	=0.107
480-499	6.24	4.54	1.50, 25.95	=0.012
500-519	5.95	4.96	1.16, 30.47	=0.032
520-539	9.89	12.15	0.89, 109.88	=0.062
560-579	9.97	13.52	0.71, 142.06	=0.090
580-599	8.03	10.16	0.67, 95.92	=0.100
Cons	7.69	6.30	1.55, 38.28	=0.013
pseudoR ² = 0.18, X ² (14) = 54.75, p<0.001				

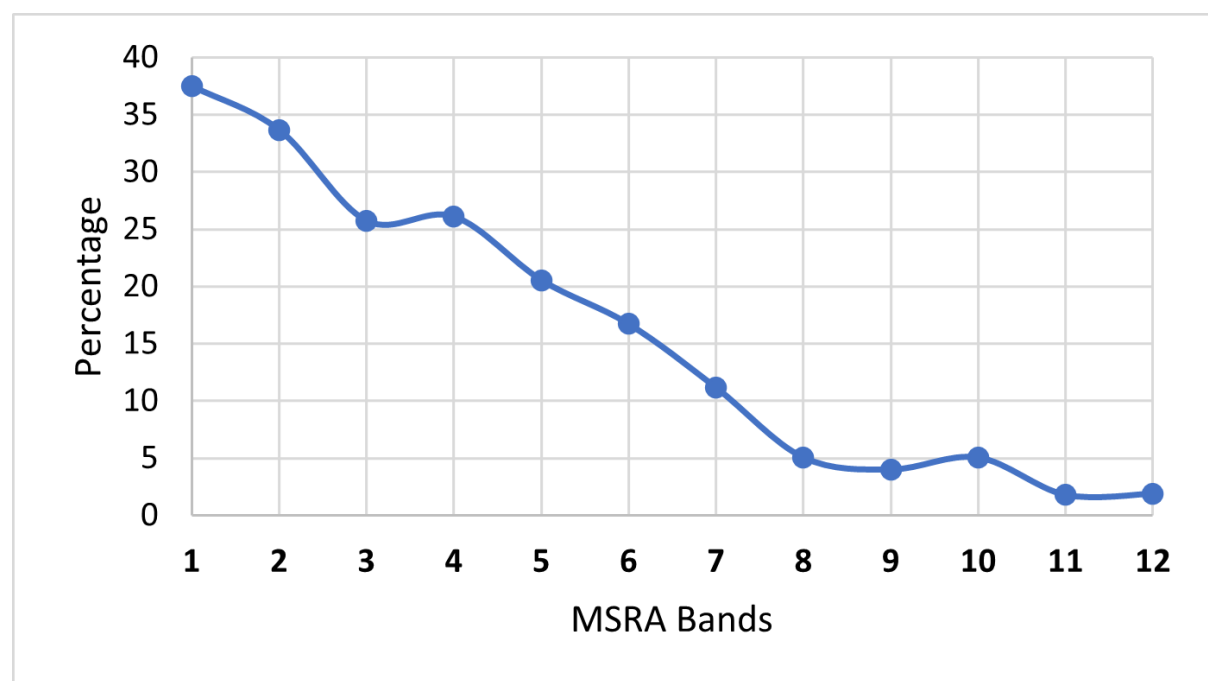


Figure 3: Percentage of individuals with at least one of the ARCP outcomes 2, 3, or 4 (y-axis) for each MSRA score band (x-axis)

When MSRA scores were taken into account, ethnicity was not associated with presence of ARCP outcomes 2, 3, or 4, but male sex (OR 0.50, 95% CI 0.37, 0.68, p<0.001), country of

Table 6: *MSRA score bands and demographic characteristics as predictors of the number of ARCP outcomes 2, 3, and 4*

Predictors	Number of ARCP outcomes 2, 3, 4			
	B	S.E.	95% CI of B	p-value
Sex (Female)	0			
Male	0.13	0.03	0.08, 0.19	<0.001
Ethnicity (White)	0			
Ethnic Minority	0.07	0.03	0.01, 0.14	=0.025
Mixed	0.05	0.07	-0.09, 0.19	=0.499
Qualification Country (UK)	0			
Not-UK	0.12	0.04	0.04, 0.21	=0.004
Declared Disability (No)	0			
Yes	0.35	0.04	0.26, 0.44	<0.001
MSRA Bands (under 400)	0			
400-419	-0.09	0.12	-0.32, 0.14	=0.434
420-439	-0.06	0.12	-0.29, 0.16	=0.585
440-459	-0.11	0.11	-0.33, 0.10	=0.300
460-479	-0.17	0.11	-0.39, 0.04	=0.104
480-499	-0.27	0.11	-0.48, -0.06	=0.012
500-519	-0.25	0.11	-0.47, -0.05	=0.017
520-539	-0.35	0.11	-0.57, -0.14	=0.001
540-559	-0.29	0.11	-0.52, -0.08	=0.007
560-579	-0.32	0.11	-0.54, -0.10	=0.004
580-599	-0.35	0.12	-0.58, -0.12	=0.003
600 and over	-0.34	0.13	-0.58, -0.09	=0.008
Cons	0.31	0.11	0.10, 0.52	<0.001
$R^2 = 0.12, F(16, 1, 754) = 15.06, p < 0.001$				

qualification outside the UK (OR 0.50, 95% CI 0.34, 0.74, $p=0.001$) and declaration of disability (OR 0.33, 95% CI 0.23, 0.49, $p<0.001$) were associated with a reduced chance of having only standard ARCP outcomes.

Table 7: MSRA score bands and demographic characteristics as predictors of the presence of only standard ARCP outcomes

Predictors	Presence of only ARCP standard outcomes			
	OR	S.E.	95% CI of OR	p-value
Sex (Female)	1			
Male	0.50	0.08	0.37, 0.68	<0.001
Ethnicity (White)	1			
Ethnic Minority	0.70	0.13	0.49, 1.01	=0.057
Mixed	0.62	0.27	0.26, 1.46	=0.274
Qualification Country (UK)	1			
Not-UK	0.50	0.10	0.34, 0.74	=0.001
Declared Disability (No)	1			
Yes	0.33	0.07	0.23, 0.49	<0.001
MSRA Bands (under 400)	1			
400-419	0.81	0.36	0.34, 1.94	=0.639
420-439	1.14	0.51	0.47, 2.76	=0.775
440-459	1.14	0.48	0.50, 2.61	=0.754
460-479	1.56	0.67	0.67, 3.60	=0.303
480-499	1.58	0.68	0.68, 3.69	=0.292
500-519	1.72	0.76	0.72, 4.07	=0.217
520-539	4.18	2.07	1.59, 11.01	=0.004
540-559	3.30	1.66	1.24, 8.83	=0.017
560-579	3.32	1.73	1.20, 9.21	=0.021
580-599	12.06	9.96	2.39, 60.87	=0.003
600 and over	5.65	4.72	1.10, 29.06	=0.038
Cons	8.04	3.54	3.39, 19.05	<0.001
pseudoR ² = 0.23, X ² (16) = 455.88, $p<0.001$				

6.2 The predictive validity of the MSRA and the selection centre (SC)

Lower SC score bands corresponded to poorer GP training outcomes as seen in figures 4, 5 and 6.

Adjusting for SC scores did not change the predictive validity of MSRA score bands as seen in Table 8. SC score bands do not have predictive validity for AKT nor RCA ($p>0.05$ for all score bands). SC score bands 2 and above predicted better outcomes on the CSA when compared to Band 1 ($p<0.05$). Being successful on ARCP (i.e., having only standard outcomes after removing outcomes 2, 3, and 4 due to failure on other examinations) was not predicted by SC scores (OR: 1.00, 95%CI: 1.00, 1.01, $p=0.06$). Lower numbers of ARCP outcomes 2, 3, and 4 were predicted only by SC band 6 which corresponded to scores between 48-50 ($r= -0.11$, 95%CI -0.22, -0.01, $p=0.04$). Adding SC scores to MSRA scores did not explain additional variance in AKT scores (variance remained at 26%) or in the number of ARCP outcomes 2, 3, and 4 (variance remained at 12%). It slightly increased the variance explained in CSA scores by 2% and in RCA scores by 1%.

How is performance at selection to general practice related to performance at the endpoint of GP training?

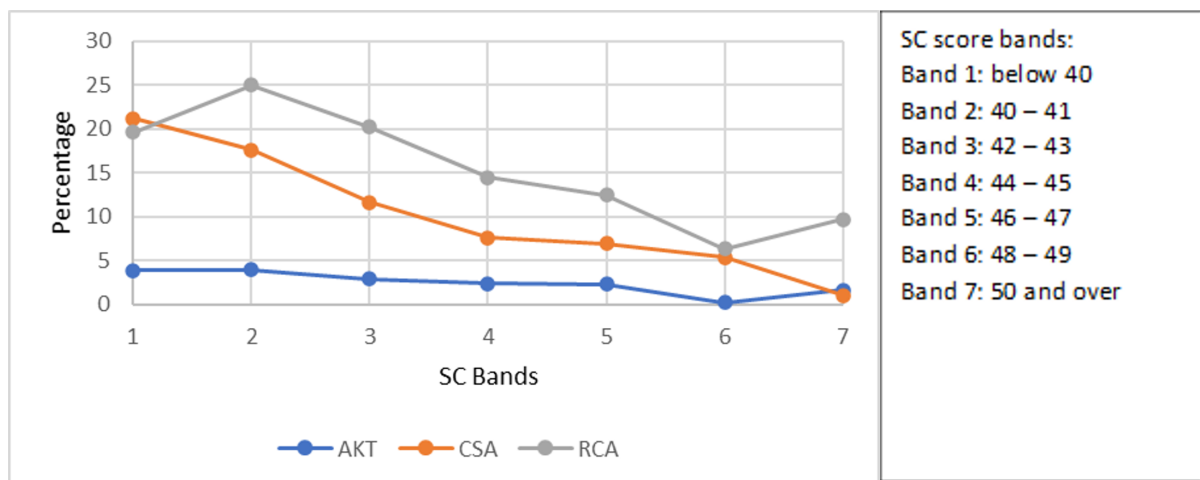


Figure 4: Fail rates at the 5 year data collection point expressed as percentages (x-axis) per SC score bands (y-axis) for each outcome of GP training

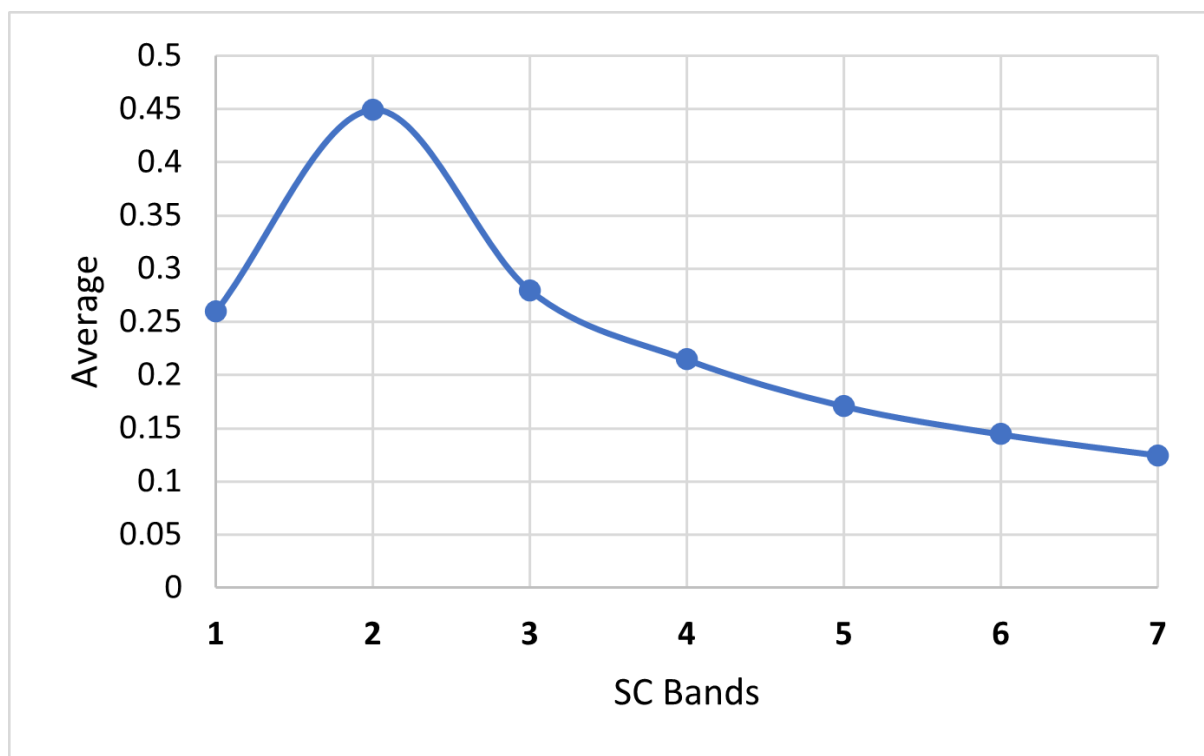


Figure 5: Average Number of ARCP outcomes 2, 3, and 4 per person (y-axis) for each SC score band (x-axis)

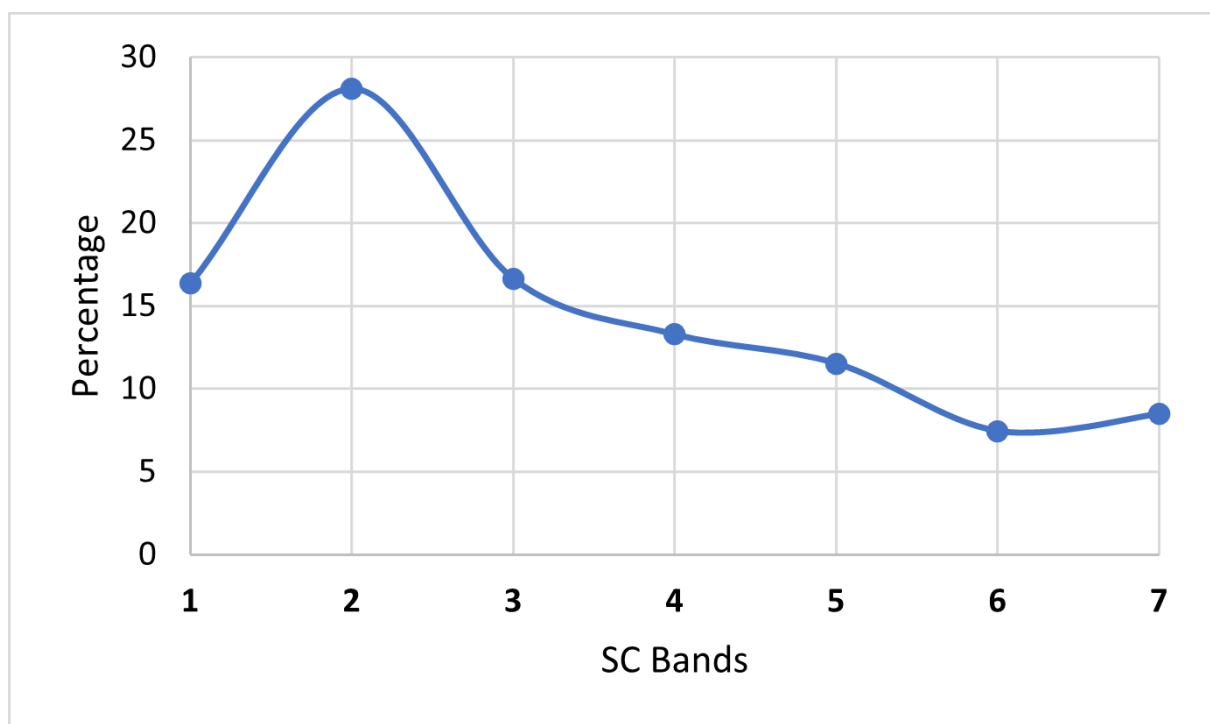


Figure 6: *Percentage of individuals with at least one of the outcomes 2, 3, or 4 (y-axis) for each SC score band (x-axis)*

Table 8: MSRA score bands as predictors of the number of ARCP outcomes 2, 3, and 4

	AKT			CSA			RCA			ARCP negative outcome		
	without SC	with SC		without SC	with SC		without SC	with SC		without SC	with SC	
	OR (95% CI)	OR (95%CI)		OR (95% CI)	OR (95% CI)		OR (95% CI)	OR (95% CI)		OR (95% CI)	OR (95% CI)	
MSRA scores	1.03** (1.02, 1.04)	1.03** (1.02, 1.03)		1.01** (1.00, 1.01)	1.01** (1.00, 1.01)		1.01* (1.01, 1.02)	1.01** (1.01, 1.02)		1.01** (1.01, 1.01)	1.01** (1.00, 1.01)	
MSRA Bands (under 400)												
400-419	3.47* (1.28, 9.36)	3.09* (1.14, 8.40)		0.92 (0.40, 2.10)	0.81 (0.35, 1.91)		5.46* (1.61, 18.51)	5.35* (1.50, 19.11)		0.81 (0.34, 1.93)	0.82 (0.34, 1.97)	
420-439	4.29* (1.42, 12.94)	4.33* (1.41, 13.24)		2.58 (0.97, 6.88)	2.59 (0.93, 7.13)		5.98* (1.27, 28.18)	5.36* (1.10, 26.04)		1.14 (0.47, 2.76)	1.10 (0.45, 2.67)	
440-459	6.86** (2.40, 19.66)	6.36** (2.21, 18.31)		1.04 (0.47, 2.33)	1.00 (0.44, 2.31)		5.00* (1.50, 16.64)	5.03* (1.45, 17.42)		1.14 (0.50, 2.61)	1.07 (0.47, 2.46)	
460-479	9.93** (3.18, 31.03)	9.58* (3.03, 30.27)		0.99 (0.44, 2.22)	0.91 (0.39, 2.13)		2.59 (0.81, 8.25)	2.41 (0.72, 8.06)		1.55 (0.67, 3.69)	1.53 (0.66, 3.58)	
480-499	15.34** (4.35, 54.08)	14.60** (4.11, 51.85)		1.48 (0.61, 3.60)	1.43 (0.57, 3.59)		6.24* (1.51, 25.95)	6.30* (1.46, 27.22)		1.58 (0.68, 3.69)	1.46 (0.62, 3.44)	
500-519	37.53** (8.37, 168.40)	35.72** (7.84, 162.79)		4.00* (1.31, 12.23)	3.67* (1.17, 11.50)		5.95* (1.16, 30.47)	6.42* (1.16, 35.39)		1.72 (0.73, 4.07)	1.61 (0.68, 3.84)	
520-539	53.30** (9.58, 296.52)	52.15** (9.23, 294.50)		2.47 (0.85, 7.15)	2.28 (0.77, 6.78)		9.89 (0.89, 109.88)	11.03 (0.96, 127.27)		4.18* (1.59, 11.01)	4.13* (1.57, 10.91)	
540-559	104.06 (11.28, 959.69)	90.99** (9.70, 853.30)		/	/		/	/		3.30* (1.24, 8.82)	3.00* (1.11, 8.06)	
560-579	/	/		11.58* (1.36, 98.83)	7.31 (0.84, 63.46)		9.98 (0.70, 142.06)	10.08 (0.59, 172.28)		3.32* (1.20, 9.21)	2.49 (0.89, 6.96)	

6.3 Reassessing threshold scores in MSRA for access to the Direct Pathway using ROC curve analysis

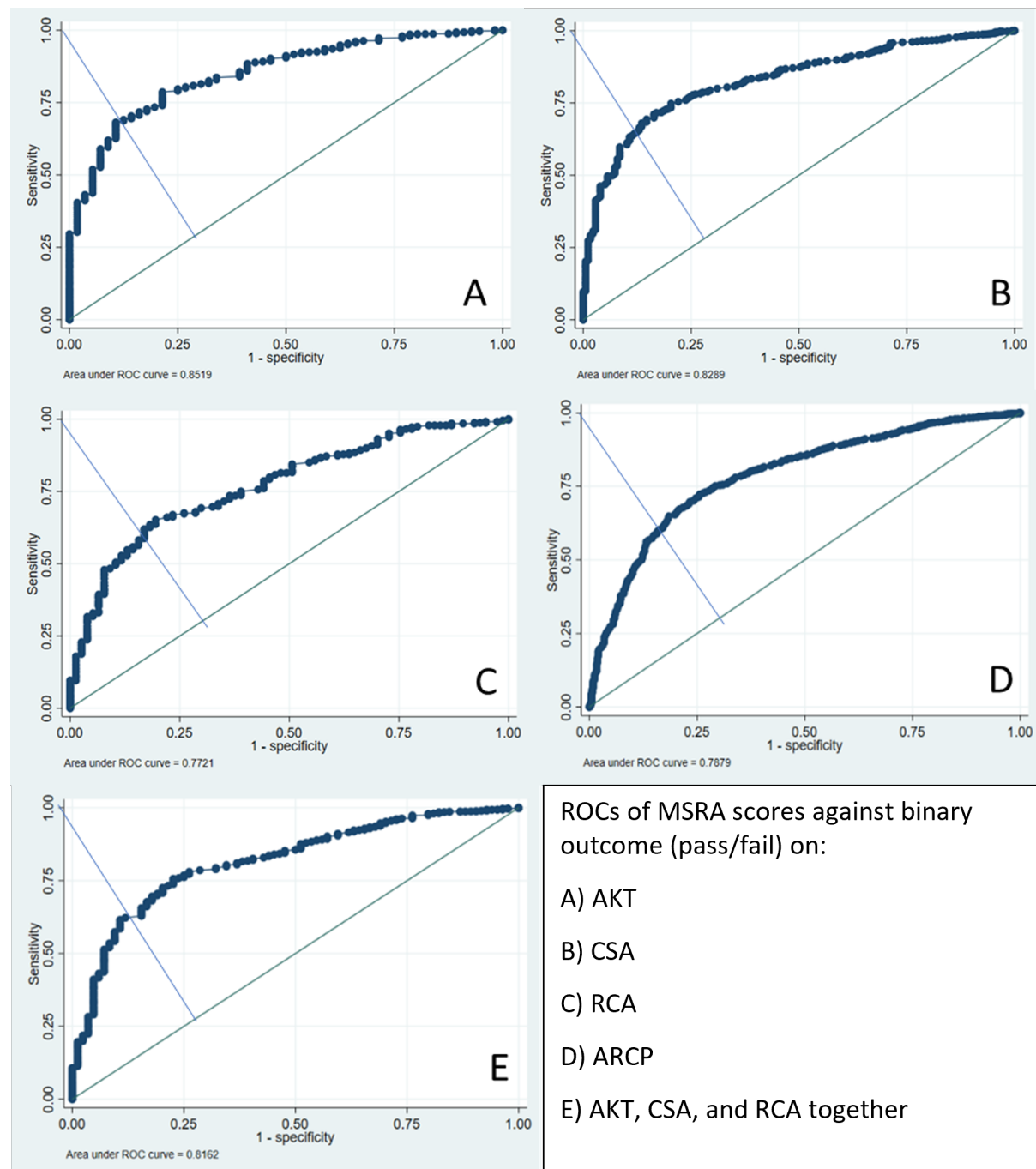


Figure 7: ROCs of MSRA scores against binary outcome (pass/fail) on each assessment

An MSRA threshold of 555 maximises specificity for AKT pass within a five-year period of data collection, whereas an MSRA threshold of 585 maximises specificity for CSA and/or RCA. This means that all candidates scoring above this threshold passed these training assessments during this time period. If we choose to maximise specificity for ARCP (only standard in training outcomes) the MSRA threshold would be 650.

If we chose equivalence between specificity (Sp) and sensitivity (Se), then an optimal

threshold score for DP of 472 should be selected for AKT, 483 for CSA, 466 for RCA, and 495 for ARCP. An MSRA threshold score of 483 should be chosen for correctly identifying pass/fail rates for AKT, RCA, and CSA combined.

A threshold of 497 (or a round score of 500) should be chosen for correctly identifying pass/fail rates for AKT, RCA, and CSA and only standard outcomes on the ARCP during the 5 years after entering training.

In this cohort, 93.5% of candidates that scored 500 or more performed well on all the assessments within five years whilst only 65.1% of those who scored below 500 achieved the same.

6.4 Pass rates and demographics

Pass rates were the highest for AKT, with 98% of candidates passing this assessment within the study period. This was followed by the CSA (92% pass rate) and the RCA (86% pass rate, but candidates only had a maximum of three attempts of a maximum allowed 4) as seen in Figure 8. Pass rates were lowest for the RCA, but the number of possible attempts was the lowest (3 compared to 5 for AKT and CSA) and the circumstances were different due to the new context of the COVID-19 pandemic. Pass rates decreased as the number of attempts increased as seen in Figure 9.

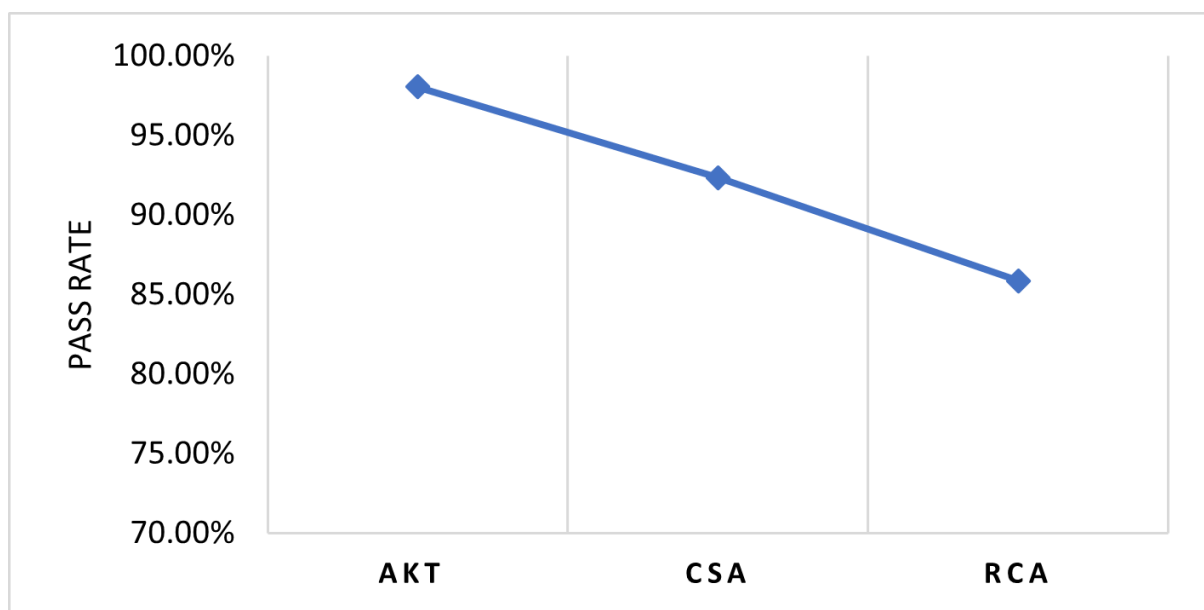


Figure 8: *Pass rates for each assessment*

Demographic data showed that a higher percentage of female candidates, candidates of white ethnicity, UK medical graduates and those without a declared disability took the MSRA and accessed the Direct Pathway as seen in table 9.

How is performance at selection to general practice related to performance at the endpoint of GP training?

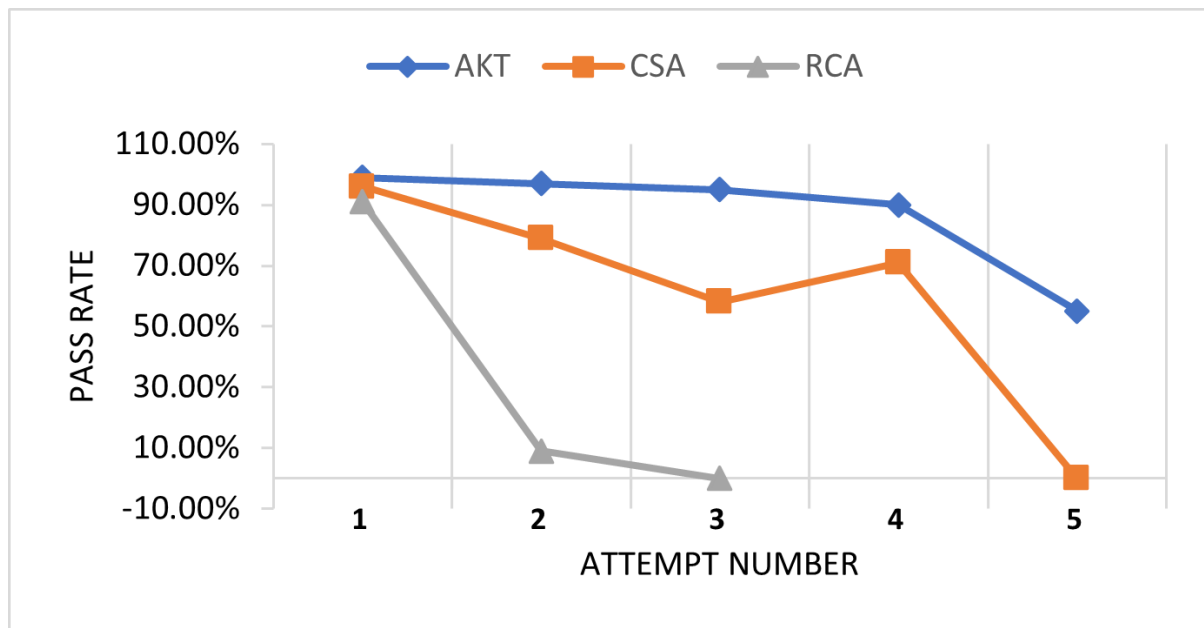


Figure 9: *Pass rates per number of attempts for each assessment*

Table 9: *Characteristics of candidates taking the MSRA and accessing the Direct Pathway*

MSRA			
Direct Pathway			
	Yes	No	Total
Gender			
Female	402 (18.87%)	1,728 (81.13%)	2,130 (63.81%)
Male	136 (11.26%)	1,072 (88.74%)	1,208 (36.19%)
Ethnicity			
White	444 (25.30%)	1,311 (74.70%)	1,755 (53.95%)
Ethnic Minorities	71 (5.07%)	1,329 (94.93%)	1,400 (43.04%)
Mixed	15 (15.31%)	83 (84.69%)	98 (3.01%)
Qualification			
UK	547 (20.98%)	2,085 (79.22%)	2,632 (76.76%)
non-UK	3 (0.40%)	794 (99.60%)	797 (23.24%)
Disability			
No	248 (13.61%)	1,574 (86.39%)	1,822 (88.02%)
Yes	14 (5.65%)	234 (94.35%)	248 (11.98%)

Discussion

7.1 Main findings

MSRA scores or score bands were predictive for all GP licensing outcomes at the five-year point (AKT, CSA, RCA, and WPBA-ARCP). Lower SC score bands corresponded to poorer GP training outcomes but adding SC scores did not change the predictive validity of the MSRA, and therefore the SC did not add further information to MSRA scores.

MSRA Bands 1 and 2 were most susceptible to ARCP outcomes 2, 3, and 4 with about 35% of candidates that fall within these bands having at least one of these outcomes that was not due to a failure on the AKT or CSA/RCA.

Our analysis suggests that an MSRA threshold of 500 (or, more precisely, 497) is the optimal for correctly identifying successful outcomes on the AKT, RCA, and CSA within the study time frame and only standard outcomes on ARCP at the five-year point. Importantly, 93.5% of candidates that scored 500 or more performed well on all the assessments.

Whatever the future of DP system, this figure might be useful for educational planning purposes and as indicator for individuals more (or less) likely to need extra support in training. This has implications for the training community and might open opportunities to explore the efficacy of different interventions at an early stage.

An interesting finding from this study is that differences in licensing assessments for ethnic minority doctors were no longer apparent when scores at selection and other demographic factors (sex, country of qualification and declared disability) were taken into account.

7.2 Comparison with previous research

This study confirmed that the MSRA scores were predictive of performance at licensing assessments, not only for AKT and CSA as previous investigators have found (Patterson et al. 2013), but also for RCA total score (not pass/fail rates) and for WPBA ARCP standard outcomes. Furthermore, it revealed that the SC added little to the predictive validity of the MSRA.

A previous study combined MSRA and SC scores to investigate prediction of performance in AKT and CSA in UK and International Medical Graduates in one deanery, and found good prediction for the combined score (Wakeford 2012) whereas this study was able to separate MSRA and SC for all candidates and found little additional predictive value of the SC.

This study also justified the use of the threshold score employed to bypass the SC from 2016 to 2020, when the SC was suspended because of COVID-19. No previous publications have looked at this issue.

There has been a longstanding debate about ethnicity as a factor in GP licensing in the UK (Wakeford et al. 1992) culminating in a study which asserted, despite lack of evidence to support this, that the 'subjective bias due to racial discrimination' in the clinical skills assessment may be a cause of failure for UK trained ethnic minority candidates (Esmail & Roberts 2013). This conclusion was at odds with a judicial review which found against evidence of bias (Rendel et al. 2015) and a narrative review which also concluded that evidence of racial bias was lacking (de Bere et al. 2015). Qualitative studies have found more complex educational and social factors affecting the training pathway and performance (Woolf et al. 2016).

A problem with previous studies is that, although gender and place of primary medical

qualification have been considered, other important factors which are also related to ethnicity, such as declared disability, have not been accounted for in regression models (Asghar et al. 2019, 2018). Importantly, the multivariable predictive models in this study showed that the MSRA was one of the main factors that influenced endpoint assessments' outcomes and that ethnicity ceased to be a significant predictor for all endpoint assessments when taking MSRA scores into account. When looking at country of qualification, International Medical Graduates (IMGs) were just as likely to pass AKT but less likely to pass CSA, RCA or achieve only standard ARCP outcomes once the MSRA scores and other demographic factors were accounted for.

It is important to notice that differential attainment (DA) is present throughout the training journey, being similar in both selection and licensing assessments. The explanations are complex and multiple but due most 'likely to difference in training experience and other cultural factors between candidates trained in the UK and abroad' (Esmail & Roberts 2013). These may include: differences in experiences of recruitment, training and assessments, more limited professional networks (lack of mentorship or peer support), cultural barriers (language difficulties, lack of understanding of cultural norms, bias against seeking support or additional training), social challenges (poor work-life balance, separation from family and social support outside the work setting), and psychological difficulties (stress, anxiety, burnout) (Woolf et al. 2016). Another factor affecting performance of non-UK graduates in clinical licensing tests may be differences in initial medical training, where a doctor-centred rather than patient-centred approach to consulting may be taught and learnt (Jalal et al. 2019).

Doctors declaring disability (mostly commonly Specific Learning Difficulty [SpLD]) were not different in AKT pass rates but were less likely to achieve a CSA pass and an ARCP standard outcome once MSRA and other demographic factors were taken into account. These confirm findings from previous studies where no differences in AKT outcomes were found for candidates with SpLD once other factors were accounted for, but where differences were found in the CSA (Asghar et al. 2019, 2018).

7.3 Strengths and limitations

The study benefitted from accurate data linkage using GMC numbers to link selection and outcome data for AKT, CSA, RCA and WPBA (ARCP) performance and high rates of completeness for demographic data including sex, ethnicity, place of primary qualification and declared disability.

The data allowed us to separately explore the impact of MSRA and SC on licensing outcomes which has been a criticism of previous approaches (Wakeford 2014).

The 'Standard' GP training programme is three years whole time equivalent. This study followed the 2016 cohort to 2021 as it was anticipated that most participants would by then have attempted their licensing assessments. However, in that time period, not all participants that attempted the licensing tests and were unsuccessful had the opportunity to take them the permitted four times. Whilst for AKT and CSA this number was small (only 6% of candidates), it involved all participants for the RCA who could only attempt this assessment three times by the end of the study. Thus, this was a factor that influenced the lower pass rates particularly for RCA. Candidates on training extensions, maternity leave etc may have successfully completed after the study end.

The absence of significant differences for IMGs and those with declared disabilities in the RCA may have been due to the smaller numbers of candidates who were able to take this assessment. Only 545 attempted the RCA compared to 2,883 for AKT and 2,313 for the CSA.

7.4 Implications for policy, practice and future research

The SC is currently suspended (2020-2022) because of the COVID-19 pandemic. This study suggests that it adds little predictive validity to the MSRA in terms of future performance in GP licensing assessments. So, unless the SC can be changed to increase predictive validity (for all candidate groups), the MSRA used alone may be sufficient. It could also be argued that the balance of the two components of the MSRA (SJT and CPS) may widen access by reducing the inherent disadvantage to candidates of lower socioeconomic backgrounds seen in purely cognitive assessments (Lievens et al. 2016).

Our analysis, using a large cohort of doctors, suggests an optimal score at MSRA to predict an uncomplicated training journey without need for additional support. Although pressure to recruit to GP specialty training schemes will vary with workforce needs, cut scores for selection need to take into consideration the likelihood of a doctor selected for training passing their licensing examinations against the costs to trainees and deaneries, as educational providers, of failure with remediation or extensions to training. Doctors admitted to training with lower scores may need additional support during training to maximise their chances of successful licensing.

Further research is needed to investigate the initial cause of the DA and the effect of possible interventions to mitigate this (e.g., exam preparation, information available to candidates etc.).

The MSRA exam is currently used as a shortlisting tool by many different specialties. It might be of use to repeat a similar scrutiny comparing entrance and exit assessments in other specialties.

This study examined the relationship between two adjacent steps in the educational journey. It could be useful to extend that enquiry in the other direction to the Foundation Programme. Findings in GP Equalities Impact Reports (2009-11) indicate that candidates attending Foundation Programmes (FP) were more successful in GP selection. In addition, past literature suggests overseas doctors who enter speciality training without having attended a UK FP have greater difficulty adapting to the UK healthcare system (Jalal et al. 2019). Links between these two findings could be explored to determine how the FP contributes to more effective performance in selection.

7.5 Conclusions

MSRA scores predict licensing outcomes for AKT, CSA, RCA, and WPBA-ARCP within five years of starting training.

The optimal MSRA threshold score for predicting an uncomplicated training pathway to licensing was around 500 in this large cohort.

Doctors admitted to GP speciality training who score below this threshold may need additional support during training to maximise their chances of achieving licensing.

SC scores did not add further information to MSRA scores which supports the decisions both to institute the Direct Access process in 2016 and the subsequent suspension of the SC in 2020 during the pandemic.

Ethnicity did not reduce the chance of passing GP licensing tests once gender, place of primary medical qualification, declared disability and MSRA scores were taken into account. Comparing candidate scores by ethnicity creates a false impression of differential attainment which should be addressed by routinely taking these factors into account.

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Meeting Date	27th January 2023	Agenda Item	3.2
Report Title	Supporting IMGs and ensuring fair training pathways		
Report Authors	Dr Ian Collings, Director of Medic Professional Support and Development Professor Tom Lawson, Postgraduate Medical Dean Professor Pushpinder Mangat, Medical Director		
Report Sponsor	Professor Tom Lawson Postgraduate Medical Dean		
Presented by	Professor Pushpinder Mangat, Medical Director		
Freedom of Information	Open		
Purpose of the Report	To update the Board on progress in supporting IMGs, eliminating differential attainment and developing further approaches to promote fair training pathways.		
Key Issues	- Addressing differential attainment is one of the actions attributed to HEIW in the Anti Racist Wales Action Plan - Importance of accurate data to identify those doctors who are likely to require additional support to progress through training. - Establishing appropriate governance structures to support fair training pathways. - Ensure appropriate resource is in place to support this work.		
Specific Action Required (please ✓ one only)	Information	Discussion	Assurance
	✓		
Recommendations	The Board are invited to consider and note - the outlined approach to enhanced support and promoting fair training pathways for all doctors in training. - the alignment with an action for HEIW in the Anti-racist Wales Action Plan - that the proposal of a specialty school lead for fair training pathways (to be remunerated from existing Specialty School Lead budget).has been approved by the executive Team - the recommendation of the future appointment of a new associate dean role for fair training pathways. This will be subject to a business case.		

Supporting IMGs and ensuring fair training pathways for all.

INTRODUCTION

This paper presents the ongoing, and future work programme within the Medical Deanery to promote fair training pathways and reduce differential attainment in doctors, including IMGs. Much of the principles discussed can provide templates for other professional areas.

This work aligns with an action in the Race Equality Action Plan (REAP) which has been replaced by the Anti-Racist Wales Action Plan (ArWAP).

- HEIW will ensure all commissioned programmes provide evidence of anti-racist principles and reflect HEIW's Strategic Equality Plan in order to meet objectives regarding differential attainment, widening access and under-representation of Black, Asian and Minority Ethnic people in NHS Wales.

The proportion of IMG trainee doctors commencing in specialty training programmes in Wales has steadily increased over recent years. 2022 recruitment data suggests, approximately 35% of General Practitioner (GP) trainees, 71% of psychiatry trainees, 53% of obstetrics & gynaecology trainees and 47% of internal medicine trainees are International Medical Graduates (IMGs). Of the total number of doctors recruited through specialty training in 2022, 29% of doctors recruited in round 1 were IMGs and 43% in round 2. According to recent General Medical Council (GMC) figures there are approximately 452 medical trainees and 1900 Specialist, Associate Specialist, & Specialty (SAS) grade and locally employed doctors in Wales that are IMGs. The highest proportion of these doctors are working in Hywel Dda and Betsi Cadwaladr Health Boards (figure 1). The proportion of IMGs recruited into secondary care specialties in 2022 can be seen in figure 2.

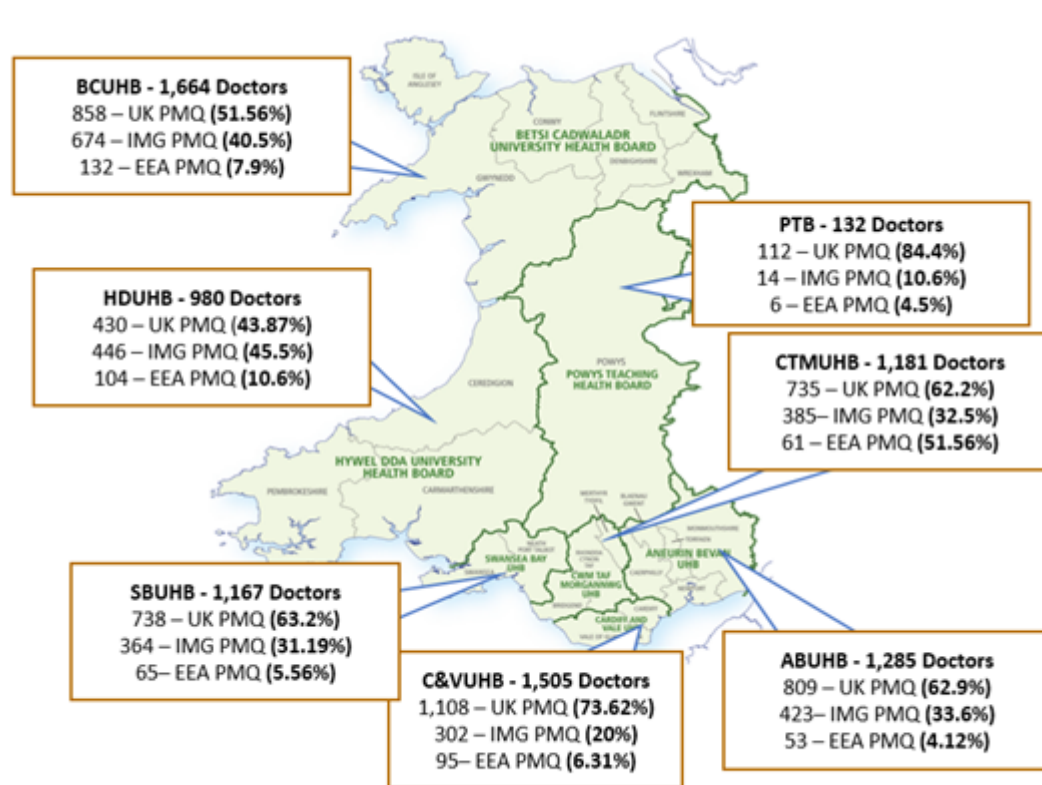


Figure 1: Total proportion of IMGs in all grades in each Health Board (courtesy of the GMC - 2022)

Schools	Final Number of posts advertised	Final position offers accepted	% Fill rate	Number of starters on the programme as of changeover/rotation date	Proportion of appointees whose Primary Medical Qualification was obtained outside of the UK
Anaesthetics	46	43	93%	42	0%
Emergency Medicine	26	25	96%	24	4%
Medicine	150	138	92%	132	47%
Obstetrics & Gynaecology	19	19	100%	17	53%
Paediatrics	26	23	88%	23	39%
Pathology	7	7	100%	7	43%
Psychiatry	55	42	76%	42	71%
Public Health	8	6	75%	6	0%
Radiology	18	18	100%	17	17%
Surgery	74	69	93%	65	16%
Grand Total	429	390	91%	375	

Figure 2: Proportion of IMGs entering secondary care training in 2022.

Differential attainment in doctors is defined as the gap between groups of doctors in attainment in several areas, such as Royal College exam pass rates, Annual Review of Competency Progression (ARCP) outcomes and overall satisfaction in the GMC National Training Survey (NTS) survey. Whilst traditionally differential attainment has focussed on protected characteristics such as ethnicity and gender, other considerations such as location of primary medical qualification and even socioeconomic status have also been considered. For example, it has long been recognised that there are gaps in the pass rates of Royal College examinations, with the highest pass rates in UK in white graduates and the lowest in international medical graduates but also with lower rates in the UK graduate Black And Minority Ethnic (BAME) group. Where differential attainment is present, it often identifies individuals or groups with complicated training pathways characterised by recurrent exam failure and issuing of developmental outcomes (Outcome 2 or Outcome 3) at ARCP. There is often a significant impact on health and wellbeing and trainees in this position are offered the input of the Professional Support Unit (PSU).

The GMC has embarked upon a programme of work entitled “Fairer Training Cultures”. This will be a programme of work aiming to eliminate discrimination and unfairness from undergraduate and postgraduate medical education by 2031. The approach to this work will include:

- Measuring impact on key educational outcomes
- Responding to research identifying key barriers and enablers
- Applying equality and diversity lens to GMC standards and requirements
- Looking for incremental improvements across the entire training pathway
- Building evidence of success through pilots and sharing the lessons learned to build across all organisations with responsibility for the design or delivery of medical education and training

In this programme, an equality lens will be specifically focused on recruitment and selection, trainee support, training environments, faculty development, curricula, and assessments.

There is increasing evidence that the concept of ensuring equity within training progression should be considered in a broader more holistic manner. Success at specialty training recruitment processes/assessments such as the multi-specialty recruitment assessment has been positively correlated with progression through training. However, the inverse is also true. This has particularly been highlighted in a Lincoln University study exploring the link between scores at the Multi-Specialty Recruitment Assessment (MSRA) for GP recruitment and subsequent progression through training.

Acknowledging that differential attainment exists, we need to consider the factors which contribute to this. Furthermore, we need aim to for the introduction of appropriate steps to eliminate differential attainment by ensuring fairer pathways for doctors who are at increased risk of complicated training journeys. Any support needs to be proactive rather than retrospective. and implementing proactive support rather than retrospective training. Work needs to consider all causes of differential attainment such as those doctors that graduate overseas and those that have neurodiversity for example.

Many of the interventions we have in place currently are blunt and non-specific based on certain characteristics rather than the likelihood of those trainees having complicated training pathways. For example, it would be wrong to assume that all IMGs or UK BAME graduates will struggle to progress. More nuanced and individualised interventions to support all doctors at risk of a complicated training pathways are required.

- **BACKGROUND**

Differential Attainment

The GMC routinely collects data on differential attainment on BAME doctors including those that have a primary medical qualification from the UK and from overseas. Each statutory education body is required to develop an action plan to address differential attainment and measure the impact of interventions. They are required to report on the success of interventions annually.

UK Initiatives

- ***RCPsych exam preparation course pilot*** – this initiative is jointly funded by the GMC and HEE. The pilot is made up of core psychiatry trainees from Deaneries with a lower-than-average Clinical Assessment of Skills and Competencies (CASC) pass rate. 79.9 % (including 72.2% of doctors that graduate overseas) have subsequently passed the CASC exam. The average CASC pass rate is 74.85, (33.5% for doctors that graduate overseas). In Wales several trainees and educators have been involved in this pilot.
- ***GP Clinical Skills Assessment (CSA) exam preparation courses*** – there have been several courses that have been developed and delivered in areas of the UK such as the Northwest “Clinical Skills Assessment – Support on Extension” programme. This programme, established in 2016 with funding from HEE has resulted in a significant increase in the proportion of trainees passing the CSA examination at their third attempt, increasing from 35% pass rate before the intervention to 71% pass rate following the intervention. In Wales the GP section were given permission by Welsh Government in 2019 to increase the number of new GP trainee recruits. This increase inevitably led to an increase in the number of GP

trainees needing examination support and extended training. Additional GP Educator sessions have been granted and will be used for trainees with the lowest recruitment scores, to increase examination pass rates. These trainees will have extra teaching sessions on consultation skills for the first two years of their training programme. The content of the additional training has been used in other parts of the UK for trainees who have failed an exit examination and the evidence demonstrates that the intervention leads to a doubling of the chance of passing the next sitting of the examination. The intervention will be evaluated to ensure it delivers as expected. (see below for more details)

In Wales we have developed this action plan in partnership across the Medical Deanery to address three principal areas: faculty development, trainee support and partnership working across NHS Wales. This includes the following areas.

Faculty Development

The Professional Support Unit (PSU) have been delivering a variety of educational modules under the heading of differential attainment. Since 2021 approximately 1500 healthcare professionals have attended including trainers, trainees, and the wider healthcare workforce. The modules are evaluated using attendee feedback and continuously developed. These modules are:

- Differential attainment
- Active bystander training
- Unconscious bias
- Mentoring and being a mentee
- Civility in the workplace
- Examination preparation
- Managing imposter syndrome
- Holding crucial conversations

These modules were designed to support the development of compassionate leaders and help to create a culture of inclusion and compassion in the training environment where diversity is valued. We know that relationships with trainers are perceived as crucial to learning. A compassionate trainer can give trainees confidence by providing them with opportunities, giving constructive feedback and reassuring about problems including examination failure. These modules remind us that diversity, equity and inclusion is everyone's business and requires everyone's leadership and invite participants to lean into the feeling of discomfort, to reframe it as a signal that there is an opportunity for learning and growth.

There is a piece of work ongoing to explore the optimum delivery of these modules in the future to ensure the PSU can focus on core business including the proactive support of trainees and developing faculty.

Trainee Support

Trainees in Wales new to UK practice are given appropriate NHS induction information prior to commencing training including signposting to several useful online resources. We

continue to finalise the Welcome to Wales handbook which provides a range of information targeted at the pastoral support of trainees.

Recruitment teams identify all newly recruited trainees who are living outside the UK and Ireland at the point of recruitment. Each of these trainees are provided with a named contact in the lead employer who can offer support with the move to the UK and signpost to key resources.

In GP training, those with the least NHS experience will be prioritised for a GP placement as their first post to provide a closer and more supportive induction and early formation of the supervisor/trainee relationship. The GP Wales Enhanced Support for Trainees (WEST) programme offers GP trainees new to UK practice enhanced education related to the expectation of being a GP in Wales during 3 one day modules throughout the year. The programme began in August 2021 and has yet to be evaluated but feedback from individuals has been positive. There is no equivalent for secondary care trainees.

We continue to develop a range of HEIW induction videos for all new to practice IMGs, including introduction to foundation, primary, secondary care and PSU.

Partnership Working

The establishment of the HEIW Medical Deanery IMG/SAS support expert advisory group has been critical to ensure effective partnership working with Health Boards and the GMC. The function and successes of this group will be discussed later in this update.

• FUTURE PLANS

In addition to what has already been established, the Medical Deanery is currently working in several areas to promote fairer training pathways. The critical ingredients to ensure success is robust governance and reporting structures, underpinned by good quality data.

Medical Deanery Governance

The establishment of the HEIW medical deanery IMG/expert advisory group ensures that work in this area is shared across NHS Wales to avoid replication and develop best practice. Employers have a responsibility to ensure that all doctors, particularly those that graduate overseas and are new to UK practice have access to enhanced induction and ongoing support. The level of support in the Health Boards is variable with some Health Boards leading on the development of enhanced induction programmes (ABUHB, HDdUHB). In other Health Boards there are examples of sub regional or departmental good practice, but this isn't translated uniformly across those whole Health Board footprints.

The group is currently working on developing a best practice guidance document that can be used to develop enhanced support for doctors at all career points.

The other key benefit of the group is to act as a focal point so that information can be shared and disseminated in a bidirectional way in the Deanery and with employers and the GMC. The work of the group is reported to the Medical Deanery senior management team. Please see figure 1 for the current structures in place to support this work

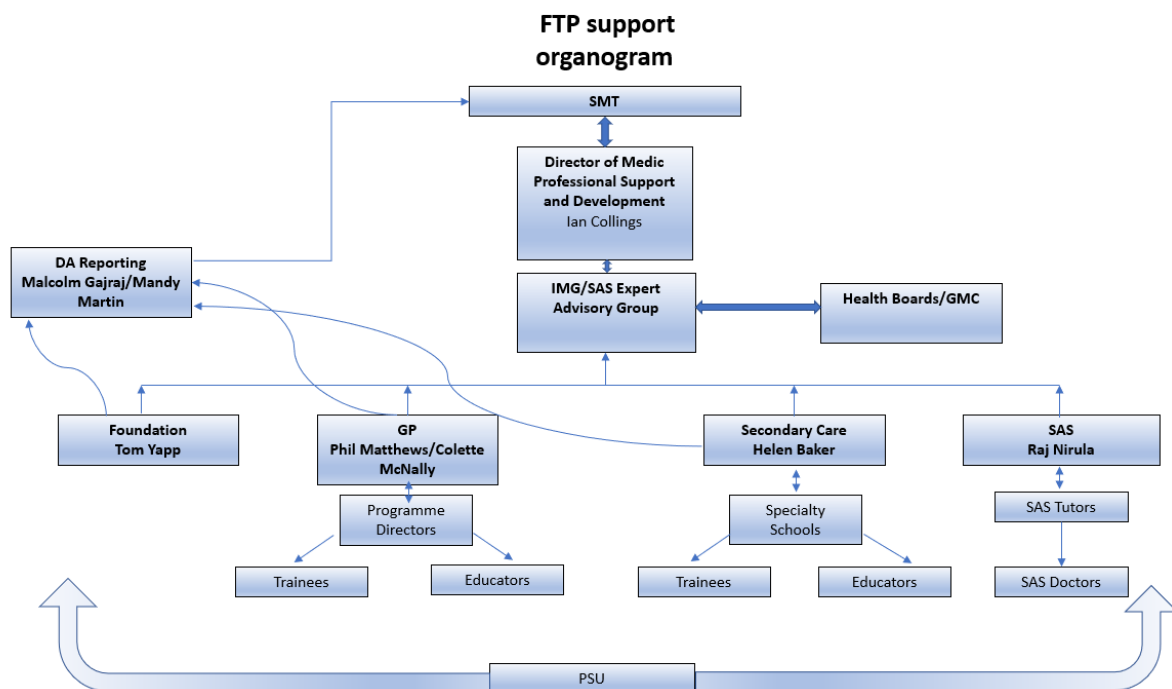


Figure 1 Medical deanery fairer training pathways governance/reporting structures.

Data

Identification of trainees that are likely to have complicated training pathways is crucial to developing effective enhanced support strategies. Evidence suggests that the most useful point to collect data is at the point of recruitment. All speciality training programmes in the UK have a recruitment process which is characterised by completion of the MSRA or equivalent and/or a specialty training recruitment interview/simulated patient. This leads to an overall score for each applicant and subsequent ranking. A minimum cut off score enables applicants to be appointable. Ranking level determines choice of specialty training post. The higher the ranking the higher the likelihood of the trainee securing their first-choice post. As highlighted earlier there is good quality evidence available of the link between recruitment performance and successful progression through training in some specialties like GP. Heads of school have been asked to explore existing evidence linking recruitment scores for their specialties with subsequent performance. We also need to be aware that some regions of the UK, including Wales, have a higher proportion of trainees that have performed less well on average in specialty training recruitment i.e. a higher proportion in the lower quartile and potentially more trainees allocated to Wales who did not have it as their first choice destination.

Analysing this data and identifying those at need, regardless of what driving factors are involved, is a crucial component of this work in Wales.

Flexible Portfolio Training Medical Education Fellow Project

The flexible training pilot programme has recently been established and is currently recruiting five flexible training fellows to begin in February 2023. One of the projects expected to be delivered is the development of an enhanced induction and support programme for international medical graduates commencing training in Wales. The first phase of this will be to scope out best practice examples from elsewhere in the UK and learn lessons from similar programmes in Wales such as the WEST programme for GP trainees.

Phase 2 will involve developing the programme including, identifying faculty, and evaluating the impact. Phase 2 is expected to begin in the second quarter of the 2023/24 financial year.

Maximising GP Trainee Throughput Project

The UK National Recruitment Office (NRO) coordinate recruitment for the four nations of the UK. The NRO, along with the RCGP and HEE commissioned Lincoln University to conduct research in 2016 exploring the relationship between scores at the MSRA and the likelihood of having a complicated training pathway. The work concluded that the optimal Multi-Specialty Recruitment Assessment (MSRA) threshold score for predicting an uncomplicated training pathway to licensing was around 500. An uncomplicated training pathway was defined as both RCGP assessments being passed on the first attempt, in addition to positive workplace-based assessment outcomes.

Recruits scoring less than 480 on the MSRA show a significant increase in the risk of failing RCGP examinations and subsequent extensions of training which are costly. Furthermore, identifying appropriate posts is more challenging with increasing GP training numbers particularly in Wales.

For the Wales August 2022 intake, 47 out of 155 (30%) trainees scored below 480 at selection. The average costs of an extension for GP training is approximately £50000 per trainee. In 2021/22 the GP school had forty extensions of training amounting to an additional cost of 1.7 million pounds.

The GP school has recently had a proposal agreed to recruit a further eighteen sessions of GP educator time. The additional time would be used to focus on developing a programme of enhanced support for trainees who fall into this category. This programme could continue into ST3 year for trainees with specific needs.

Specialty School Fairer Training Pathway Leads

Within secondary care specialty schools there are currently leads for portfolios such as Less than full time (LTFT)/flexible training, PSU, and quality. We recently proposed the establishment of a further role, a fairer training lead, leading this work on behalf of speciality schools. This was approved by the Executive Team.

To begin with, these roles will be piloted in the specialty schools with the highest proportion of IMGs (medicine, psychiatry, O&G, pathology and paediatrics). Funding for these roles would be identified from the education and training plan and remunerated on a sessional basis. The primary aim of the role would be to analyse and gain a deeper understanding of recruitment data, which would lead to the development of bespoke support packages to enhance training for these individuals. Furthermore, the role would be responsible for evaluating any approaches including impact on complicated training pathways.

A New Associate Dean for Fairer Training Pathways?

Establishing a role to provide leadership in the Medical Deanery on what is a diverse and extensive portfolio would help provide the impetus and focus to drive this crucial work programme forward in a co-ordinated way. An associate dean leading the portfolio would have the following main roles and responsibilities:

1. Lead on all aspects of equality, diversity, and inclusion across specialty schools in relation to Specialty Training Committee (STC) and ARCP panel composition and promoting equality across training.
2. Develop a network with the specialty school fairer training pathway leads and link in with GP educators.
3. Work with HEIW colleagues to develop effective data repositories related to recruitment performance.
4. Drive the development of education and other interventions in this area.
5. Provide supervision and mentorship to the medical education flexible training fellow who will be working in developing enhanced educational interventions for trainees.
6. Matrix working across the medical deanery (for example with the associate dean for SAS doctors) and further across HEIW to provide leadership to this portfolio.

It is likely that any new post would also require appropriate administrative support which could also be used to support work in other areas of the Medical Deanery such as supporting the additional GP educator time.

The new role will be explored as part of our planning for the next financial year.

- **GOVERNANCE AND RISKS**

None of note

- **FINANCIAL IMPLICATIONS**

There are likely to be additional costs incurred by the appointment of an associate dean and administrative support. However, to offset these costs, a full economic analysis would need to occur to articulate the likely cost saving based on a reduced number of trainees having a complicated training pathway.

- **RECOMMENDATIONS**

The Board are invited to consider and note:

1. the outlined approach to enhanced support and promoting fair training pathways for all doctors in training.
2. the alignment with an action for HEIW in the Anti-racist Wales Action Plan
3. that the proposal of a specialty school lead for fair training pathways (to be remunerated from existing Specialty School Lead budget).has been approved by the executive Team
4. the recommendation of the future appointment of a new associate dean role for fair training pathways. This will be subject to a business case.

Governance and Assurance			
Link to IMTP strategic aims <i>(please ✓)</i>	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
Quality, Safety and Patient Experience Celebrating success across all trainees and learners will help to ensure we have an engaged, motivated, capable, flexible and sustainable workforce to improve quality, safety, and patient experience.			
Financial Implications Dependent on future agreement by executive team to develop an AD and admin support.			
Legal Implications (including equality and diversity assessment) Any proposal will be subject to an EIA			
Staffing Implications N/A			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
Report History			
Appendices			
1. Lincoln Paper How is performance at selection to general practice related to performance at the endpoint of GP training?			



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

Meeting Date	26th January 2023	Agenda Item	3.3
Report Title	Critical Care Programme Final Report		
Report Author	Charlette Middlemiss, Interim Deputy Director Workforce Transformation		
Report Sponsor	Lisa Llewelyn, Director of Nurse and Allied Health Professional Education and Push Mangat, Medical Director		
Presented by	Lisa Llewelyn, Director of Nurse and Allied Health Professional Education		
Freedom of Information	Open		
Purpose of the Report	This is the final report on work completed to support critical care services in NHS Wales. The work programme was managed by the Workforce Transformation Team and supported by two Critical Care Clinical leads on secondment for 12 months to HEIW. The report identifies the workforce and education challenges and provides solutions and the recommendations required to achieve these.		
Key Issues	Caring for some of the sickest patients within the acute setting, critical care services continue to be under sustained and significant pressure. The critical care workforce has been under relentless pressure as a result of the pandemic with high attrition, vacancy and sickness rates compounding the situation. Current workforce models within critical care are unsustainable and a solutions framework has been developed. This was divided into two programmes of work delivered over 12 months. • A review of the current workforce with recommended solutions for future workforce models and roles for Critical Care services. • A review of current education provisions within Wales and recommendations to ensure a standardised approach to the provision of education in the future.		

	Work by the clinical leads between January and March 2023 when the secondments end is focusing on promoting the report and the resources across NHS Wales.			
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance	Approval
	✓		✓	
Recommendations	The Board is asked to note the report.			

1. Introduction

Attached is the final report on the work programme which focused on supporting the workforce and education development needs of clinical staff working in NHS Wales critical care services.

Engagement with critical care units across Wales suggest staffing challenges have significantly increased due to an increase in sickness rates, high attrition and difficulty in recruiting experienced critical care staff.

To address these growing concerns HEIW included a strategic objective within our IMTP for 2022/3 to 'Modernise workforce models to deliver service transformation arising from the NHS Wales Collaborative strategic programmes Critical Care'.

2. The Approach

The work programme was managed by HEIWs Workforce Transformation Team and led by two experienced clinical critical care senior nurses who were seconded into the team. These clinicians engaged with key stakeholders within critical care units and the Critical Care Network across Wales to obtain information regarding service priorities, developmental plans, and service/workforce constraints. This report is based on those meetings, anecdotal knowledge of critical care and through a review of published evidence-based workforce research. It outlines findings and recommended solutions focusing on:

1. Current critical care workforce and future workforce roles and models to be considered within Critical Care.
2. Education provisions within Wales and recommended solutions to ensure a standardised approach to education delivery, hence assuring the quality and standardisation of education.

New workforce models are included to demonstrate how the skill mix of the MDT can be reconfigured as services adapt following the Covid-19 pandemic. A clear action plan and an interactive workforce compendium resource is included to ensure work is taken forward. The work has been supported through a series of engagement events which has informed both the content and the recommendations of the report.

3. Communication and Promotion

Work by the clinical leads between January and March 2023 when the secondments end is focusing on promoting the report and the resources developed to support the implementation of the recommendations across Wales. The clinical leads and other members of the Transformation Team are attending local, national and professional groups to share and discuss the report.

The Board will recall receiving an update on this work at a Board development session in 2022, when a constructive discussion took place, and several points were raised. Feedback from this development session and further dialogue between independent members and the Director of Nurse and Health Professional Education has contributed to the final report. In addition, a paper on the commissioning of a new post registration educational programme for critical care nurses was received by the Board in December 2022.

4. Recommendation

The Board is asked to note the completion of this work programme .

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓		
Quality, Safety and Patient Experience			
Underpins all aspects of our work			
Financial Implications			
none			
Legal Implications (including equality and diversity assessment)			
None			
Staffing Implications			

None	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
Well-Being goals	Impact of contract includes
A Prosperous Wales	Development of a skilled, multi-disciplinary workforce Working closely with partners and key stakeholders and planning ahead to ensure the Health and Care workforce meets the needs of the NHS and people of Wales, now and in the future. Monitoring of social and environmental clauses in contracts, for example community benefits on an annual basis.
A Resilient Wales	Supporting social resilience through delivering high quality patient care.
A Healthier Wales	Strengthening of support, training, development and services available to the NHS Wales. Transforming the workforce vision, ambition and approaches to deliver an inclusive, sustainable, flexible and responsive workforce in this essential service.
A More equal Wales	Improve equality of health outcomes for critical care patients across Wales.
A Wales of Cohesive communities	Supporting new workforce models using the resource to embrace changes, and to build a sustainable Health and Social care system.
A Wales of Vibrant culture and thriving Welsh language	The education and training commissioned by Health Education and Improvement Wales requires education providers to create opportunities for students to learn to speak Welsh at all levels and provide enhanced learning opportunities through the medium of Welsh both in the academic and placement settings.
A Globally Responsible Wales	Provide opportunities for education to be provided throughout Wales. Ensure through the contract that successful education providers have fair and ethical supply chains. Provide flexibility on the number of students that can be commissioned on an annual basis.
Report History	Builds on previous Board Development session and the approval to commission a new educational programme for critical care nurses in Wales.
Appendix	<i>Informing the Future Workforce for Critical Care Services</i>



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Health Education and
Improvement Wales (HEIW)

2022

Informing the Future Workforce for Critical Care Services





Foreward

“



The delivery of critical care services is dependent upon a highly skilled, multi-professional workforce. Without this workforce, delivery of high-quality care could not be provided for the population of Wales.



It is widely recognised that the covid-19 pandemic placed our critical care services under immense pressure. These pressures encouraged the NHS to look for novel solutions to the workforce challenges. Many health professionals had opportunities to work in critical care for the first time. We should learn from these experiences for the future as we enter the post pandemic phase where significant challenges remain, as demand and the backlog of services increase.

Working to support our colleagues within critical care, Health Education and Improvement Wales undertook a programme of work to address the longstanding workforce challenges experienced across many units within Wales. This was facilitated by engaging the assistance of two critical care nurses from within the service, who have been largely responsible for the production of this resource document.

Feedback by stakeholders from critical care services heavily influenced and directed the priorities described in the document to support the multi-disciplinary team. In setting out solutions to resolve longstanding workforce challenges within critical care services, this programme places workforce expansion and education at the centre of future critical care service development. Challenges experienced over the last couple of years necessitated multi-professional and cross-departmental collaborative working. A review of traditional workforce models has provided an opportunity to develop new workforce roles within critical care units. Implementation and evaluation of these new roles will supplement our existing workforce and help to provide a more sustainable future for critical care services. We hope service colleagues will find this resource helpful in setting the future direction of the multi-disciplinary workforce throughout Wales.

”

Lisa Llewelyn, Director of Nurse and Health Professional Education at HEIW

Push Mangat, Medical Director at HEIW



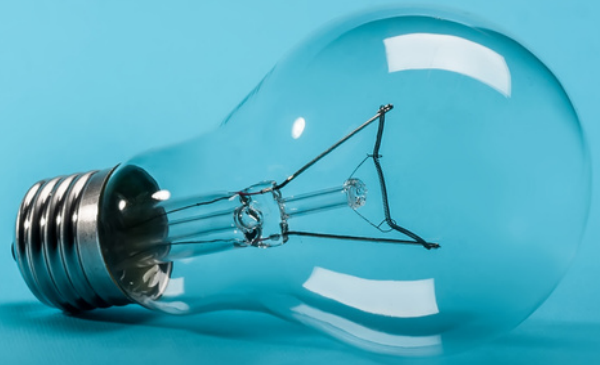
Executive Summary

Caring for some of the sickest patients within the acute setting, critical care services have been under sustained and significant pressure as a result of the Covid-19 pandemic and collaborative working enabled critical care services to cope with the surge in demand¹. Rapid change in the delivery model of care highlighted the ability of the NHS to move away from traditional service models and transform to meet the demands of a changing population. Changes within population demographics and expectations, increased prevalence of co-morbidities along with the emergence of new diseases and treatments has seen sustained demand for critical care services¹.

Expansion of critical care capacity will not be resolved by funding alone. Delivery of appropriate critical care capacity goes beyond physical infrastructure, as sufficient numbers of highly skilled healthcare professionals are required to meet the needs of the critically ill². The healthcare workforce is the NHS's most precious resource³. Prior to COVID-19, critical care nurse staffing levels were already problematic with a national vacancy rate of 9% across the UK⁴, therefore it is unsurprising nursing workforce is considered the largest constraint within critical care capacity. Engagement with critical care units across Wales suggest staffing challenges have significantly increased due to an increase in sickness rates, high attrition and difficulty in recruiting experienced critical care staff. Unless immediate action is taken to address current service provision shortfalls, workforce limitations on critical care capacity will negatively impact upon timely access to critical care services.

To address these growing concerns the Critical Care Transformation Managers employed by Health Education Improvement Wales have engaged with key stakeholders within Critical Care Units and the Critical Care Network across Wales to obtain information regarding service priorities, developmental plans, and service constraints. This resource is based on these meetings, anecdotal knowledge of critical care and through the review of published evidence-based workforce research, it outlines findings and recommended solutions focusing on:

1. Current critical care workforce and future workforce roles and models to be considered within Critical Care.
2. Education provisions within Wales and recommended solutions to ensure a standardised approach to education delivery, hence assuring the quality and standardisation of education.



Findings and Solutions

Workforce roles



ITU Practitioner

Redeployment into critical care during the pandemic of Health Care Professional Council (HCPC) registrants to perform traditional nursing roles, provided an opportunity to develop the ITU practitioner role. The Step Framework for Adults Critical Care Nurses⁵ has been developed by Critical Care Networks - National Nurse Leads (CC3N). This standardised framework contains the core critical care skills required by critical care nurses to deliver high quality patient care. The Guidelines for the Provision of Intensive Care Services (GPICS)⁶ state level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care, with level 2 patients having a minimum ratio of 1:2. Reliance upon nursing staff alone to achieve this model of care is unobtainable in an endemic era⁷. Provision of this specialist need can be created by empowering staff groups with transferable skills to consider career opportunities in critical care.

Stakeholder events held in summer 2022 with representatives from the six Health Boards within Wales responsible for the delivery of critical care services were held to obtain service user opinions on an ITU practitioner role. Using the Step Framework, the needs of the critical care patient were mapped to the skillset of HCPC registrants. The ITU practitioner role was positively received by those in attendance.

Recommended solution:

- With minimal additional training recruitment of HCPC registrants into an ITU practitioner role would supplement the critical care nursing workforce. Skillset mapping of the HCPC registrants identified Operating Department Practitioners and Paramedics as the HCPC registrants who could transition seamlessly into the ITU practitioner role.

Assistant Practitioners (Band 4)

The Assistant Practitioner role is becoming more widely established across different healthcare settings and this role is underpinned and supported by the Code of Conduct for Healthcare Support Workers⁸. In England the Nursing Associate role has been introduced in many critical care units. Whilst not currently adopted in Wales, Welsh Government are commencing a piece of work to revisit the nursing associate role. CC3N have developed critical care nursing associate competencies, which significantly overlap with Step 1 competencies for registered nurses. Concern has been raised by a small number of members of the critical care community within Wales regarding the introduction of the assistant practitioner role however, significant support has also been voiced regarding its introduction. One senior nurse stated, '*a skilled non-registered member of staff who is familiar with the environment and the team would bring significant benefits.*' It is recognised however that a clear education pathway is required⁶.

Recommended solutions:

- Introduce the Assistant Practitioner role into the critical care environment to support the critical care workforce in delivering patient care and provide expertise in the non-registered workforce.

- Develop an education and career pathway for Critical Care Band 2 Health Care Support Workers to progress into Assistant Practitioner Roles, with opportunities to develop and train further into registered roles should they wish to do so.
- Review the CC3N Nursing Associate competencies, establishing if they can be adapted for the assistant practitioner role.

Allied Health Professionals (AHPs)

Allied Healthcare Professionals (AHPs) provide critical care patients with a vast range of services and treatments. There is variation in AHP service provision in critical care services across Wales. The Critical Care Transformation Managers have heard examples of no occupational therapist service for critical care patients, lack of daily access to physiotherapy services and long waits for dietician referrals. The importance of early rehabilitation in critical care patients is recognised for improving patient's functional outcome and reducing length of stay. AHPs have a large role to play in caring for critically ill patients and can deliver a significant proportion of the care covered in the Step Framework.

Recommended solution:

- An increase in therapy provisions within critical care units to ensure an equitable service across Wales.

Therapy Support Worker/ Rehabilitation Technician Role

The therapy support worker role is not designed to replace the registered AHP. However, there are UK wide examples demonstrating the benefit of these roles. Therapy support workers can work independently, delivering therapy sessions as prescribed by the registered therapist. Many therapy support workers can work across professional boundaries with case studies demonstrating patients receive more rehabilitation treatment time, whilst releasing registered therapists to spend more time addressing the most complex issues (NICE, 2016)⁹. One unit in Wales reported only 5% of patients historically had the suggested 45 mins of rehab per day. This has increased to 100% following the introduction of rehabilitation technicians.

Furthermore, case studies in England have suggested a small reduction in length of stay within critical care as well as improvement in patient experience (NICE, 2016)⁹. In an audit of 40 patients completed in a critical care unit in Wales, following the introduction of these roles, average length of stay has fallen from 22 days to 19 days (Morrison Unit Data, 2020)¹⁰ highlighting the important contribution of this role.

Recommended solution:

- Develop and introduce the therapy support worker role within critical care units across Wales.

Patient Flow Co-ordinator

Approximately 50% of patients have experienced a delay in discharge to the ward following critical care since April 2019 (data provided by the Welsh Critical Care Network 2022). Not only does this impact on patient experience and capacity in critical care, it also places a significant additional workload on the critical care workforce.

The Task and Finish Report¹¹ encouraged development of the discharge co-ordinator post in critical care which has not been implemented. The patient flow co-ordinator role would fulfil this requirement whilst also supporting the multi-disciplinary workforce.

This clinical role could support processes around admissions and discharges, safe handovers of care and help reduce workforce pressures. This role may vary slightly depending on the size and demands of the critical care unit but would offer greater flexibility to respond to changing clinical situations.

Recommended solution:

- Introduction of a newly developed patient flow co-ordinator role within critical care units.

Administrative Support Staff

Administrative processes undertaken by trained healthcare professionals impacts upon the delivery of patient care. Critical care units within Wales currently have a combined WTE nursing establishment of 1034.76 at bands 5 to 7. If each WTE nurse was released for one hour per week from performing duties which could be undertaken by administrative staff, this would equate to 26.9 WTE of nursing hours being released back into critical care services per week.

In June 2022 administrative staff within NHS Wales accounted for 23% of the total workforce (ESR Workforce Data). Commonly employed on bands 2 to 4 of agenda for change, insufficient investment in training and development has traditionally limited career progression¹². High quality administrative processes impact directly on standards of care, patient and staff experience¹³.

Administrative support staff cover an array of roles such as ward clerks and data analysts, through to personal assistants, departmental managers and service leads. Transferrable skills provide potential to recruit into these posts from outside of the current NHS workforce.

Recommended solution:

- Administrative staff must be considered core members of the workforce team to release all members of the MDT to undertake the clinical work they are trained to deliver and focus on strategic planning such as service development.

Medical Staffing

Whilst recommendations for levels of medical staffing within the critical care units are clearly set out⁶, attainment of the recommended levels, along with delivery of sustainable rotas is proving challenging for critical care units within Wales. The need to consider succession planning, trainee allocation and expansion of critical care services were identified as areas of concern by clinical directors throughout Wales. Innovative ways of working within some Health Boards now enable critical care consultants to work across specialities and across different Health Boards. However geographical distance does not make cross Health Board working an option for all. It is anticipated increased trainee numbers, changes to SAS contracts and alterations to FICM guidelines, will help to address some of the concerns raised in relation to medical staffing. Changes to medical trainee programmes will now see all the trainees in this group undertake a rotation within critical care units. Whilst it is important to note this is for the trainees own educational requirement, improvements in care delivery outside of critical care units will positively impact upon demands placed upon critical care units and the overall patient experience.

Recommended solutions:

- Enable medical staff to work more flexibly by reducing the administration burden experienced by staff holding contracts in two different Health Boards
- Expedite the development and education of new posts developed to support the medical rota such as the ACCP role.

Advanced Critical Care Practitioner

There is wide variation in how established the ACCP role is across Wales. Only one critical care unit has an established 24/7 rota, whilst in others, the role is yet to be introduced. Units with established ACCP's recognise the important contribution of the role, whilst units without ACCP's are keen to explore the role further. As part of this programme of work the ACCP role has been discussed with colleagues across critical care services throughout Wales to understand the role in further depth and the education and training requirements. It is apparent that overwhelmingly the response to this role has been positive and any minimal concerns raised has focused on depleting a nursing workforce that is already stretched and around progression in this role to ensure sustainability.

The education and training requirement to undertake this role is significant and it is acknowledged that there is currently only one FICM accredited course available across the UK (Plymouth University). Two units within Wales have taken the decision to send trainee ACCPs on the accredited course, while other units continue to use local HEIs delivering Advanced Practice courses. Trainee ACCP's who do not undertake the accredited course must submit a completed portfolio to FICM to obtain ACCP registration, however concern has been raised about continuation of this process. The ACCP role is a huge asset to critical care services, offering advanced skills and supporting the critical care workforce across professions, whilst

bringing significant benefit to patient care. Expansion of the ACCP role is required across Critical Care Services in Wales.

Recommended solutions:

- Further discussion with Higher Education Institutions in Wales and FICM is needed to further understand the accreditation requirements of advanced practice courses for ACCPs.
- As part of this work the numbers for ACCPs and the preferences of the units have been scoped out and this background work has been provided to HEIW colleagues leading on the Medical Associate Professions.

Physician Associate (PA)

The Physician Associate (PA) role is still considered relatively new in the UK despite introduction in 2003¹⁴. PA's are generalist healthcare professionals, trained in the medical model, who work alongside doctors and provide medical care as an integral part of the multidisciplinary team. Whilst PA's have been adopted in many acute settings, their integration into critical care has been limited. One PA working in Critical Care in a London Hospital described their role to include advanced skills such as conducting lumbar punctures and independent reviews of the patient prior to ward round. PA's are currently unable to prescribe or request ionising radiation (e.g., chest x-ray or CT scan), potentially limiting their role in critical care. It is acknowledged The Department of Health and Social Care (DHSC) recently announced the introduction of statutory regulation of Medical Associate Professionals (MAPs), including PA's, under the General Medical Council, with a working group developed to consider how PA's may be able to prescribe as part of their role. FICM has also released a statement recognising that PA's may be able to undertake AACP training when their regulating bodies allow independent prescribing.

Recommended solutions:

- PA's trained in critical care could provide depth to the critical care workforce, supporting expansion of critical care units.
- Education requirements for PA's to work in a specialised complex area such as critical care needs to be examined.
- Examine findings of the PA review and the impact for role changes to further benefit service.

Anaesthesia Associates

Introduced in 2004 as Physicians' Assistants (Anaesthesia) the Anaesthesia Associate (AA) traditionally works under the direction and supervision of a consultant anaesthetist in perioperative care. With a background as a registered health care professional, typically an operating department assistant or nurse, or a graduate with a biomedical science or a biological science degree, AA's complete a two-year postgraduate diploma. With utilisation of local training

policies and governance procedures AA's can train to perform specific tasks further enhancing their clinical skills. Whilst there are no examples to be found of AA's working within critical care, with some additional training it is envisaged this group of staff have the potential to supplement the current critical care workforce.

At present it must be noted as with the PA's, AA's are currently unable to prescribe, and this therefore limits their role. However, with this under review if the ability to prescribe becomes an option, there is potential for the AA to work within critical care.

Recommended solutions:

- With appropriate training AA's could provide depth to the critical care workforce and support expansion of critical care units.
- Examine the findings of the AA review and the impact for role changes to further benefit service.

Critical Care Scientist

Comprising approximately 5% of the NHS workforce⁶, little is known about the role performed by healthcare scientists. These highly skilled and expert clinicians have the potential to positively impact upon the quality of patient care, whilst completing tasks traditionally undertaken by medical and nursing teams¹⁵. Covering a breadth of specialities such as cardiac, neuro and respiratory physiologists, most input into critical care services on an ad-hoc basis.

This can result in delayed diagnosis, treatment and prolonged critical care stays. Early indicators following the direct employment of a cardiac physiologist by a critical care unit within Wales, demonstrates the positive impact upon speed of access to diagnostics and improved clinical governance procedures.

Establishment of a scientist training programme has seen the development of an MSc Clinical Science (Critical Care) qualification, and a move towards establishing a critical care scientist role. This accredited course is currently being provided by only one HEI within the UK. Inability to undertake the MSc Clinical Science (Critical Care) must not be seen as a barrier to healthcare scientists working within critical care. Healthcare scientists are ideally placed to support existing teams within critical care⁶ and must be viewed as an opportunity to expand and supplement the pre-existing workforce.

Recommended solution:

- Assessment regarding clinical need of the population served by individual critical care units, along with a review of data relating to delayed access to diagnostics should be undertaken within each health board. Knowledge gained from this will identify units where direct employment of healthcare scientists is required to facilitate improved patient diagnosis and treatment and improve patient flow.

Nurse Consultant

Nurse consultant roles were initially established to retain senior nurses and midwives at the bedside¹⁶. Delivering expert nursing practice whilst disseminating learning in the workplace, they provide clinical and strategic leadership. Required to spend 50% of their time clinically nurse consultants have a strategic role, whilst ensuring systems are in place to support workforce and preserve safe care for patients¹⁷.

Discussion with an experienced critical care nurse consultant identified three key benefits of the nurse consultant role:

- Fill a vacuum in nursing leadership at a national level for critical care services.
- Promotion of nursing research within critical care.
- Ability to stand back from service demands and undertake strategy planning and service development.

In April 2022 the Chief Nursing Officer for Wales priorities for 2022 to 2024 set a goal of increasing nurse consultant posts throughout Wales¹⁸. Currently there are no consultant nurses employed within critical care throughout Wales. In March 2022 the BACCN set out to establish the number of nurse consultants working within critical care units throughout the UK and understand the role they perform¹⁹. Data obtained from this study is currently being analysed and will be presented at the BACCN conference in October 2022. The outcome from this research will need to be reviewed to further guide recommendations in regard to critical care nurse consultant posts within Wales.

Recommended solutions:

- Further exploration of the nurse consultant role within critical care is required following publication of the BACCN critical care nurse consultant project in October 2022.
- Critical Care units to consider the impact a nurse consultant would have on critical care services and the development of the nursing workforce.

**Current critical care workforce and future workforce roles
and models to be considered within Critical Care.**



Post Graduate Certificate in Critical Care & Step Competency Framework

The lack of a standardised education programme for the critical care nursing workforce in Wales is acknowledged. Work has been led by the Education Commissioning team in HEIW to secure 200 places at English Universities on the Standardised Post Graduate Critical Care Course devised by HEE.

HEIW has engaged with four English Universities to provide education for staff from Welsh

Critical Care Units. A total of 77 critical care nurses are currently registered on the courses with further intake due in September 2022. To further support the standardisation of critical care training and education, work was undertaken to map the Step framework with the All-Wales Critical Care Competencies. Following discussion with Senior Nurses, Practice Educators and the Critical Care Network, a request to transition to the Steps Framework has been agreed by the Directors of Nursing within Wales.

Recommended solutions:

- Individual units to develop local processes to support transition to the Step Competency Framework.
- Localised provision of standardised course provided in 3 locations across Wales commencing in September 2023.

Unregistered Clinical Staff Education

Utilisation of unregistered clinical staff to deliver direct patient care must be supported with appropriate induction, training and competency processes, along with the provision of clinical oversight from suitably trained registered staff⁶.

Due to the vast range of roles undertaken by the unregistered clinical staff within critical care, provision of educational training will need to be guided at a local level to meet specific service needs and role definition. It is essential the unregistered clinical workforce have competencies which cover the requirements of the role to be undertaken. These competencies will ensure appropriate care is delegated to staff and patient safety maintained.

As with registered staff the introduction of the CC3N Step competency for Health Care Support Workers has been supported by the All-Wales Critical Care Education Network and this will provide standardised clinical competencies.

For unregistered clinical staff supplementing other registered professionals, such as allied health professionals, agreed standardised competencies are not currently available.

Recommended solutions:

- Further work is required within HEIW regarding education pathways for unregistered staff working within critical care services.
- Individual units to develop local processes to support the introduction to the Step Competency Framework for unregistered clinical staff.

Educating the Educators

Having a critical care workforce who are trained to an agreed standard is paramount in ensuring an equitable delivery of care²⁰. The requirement for a practice educator within each critical care unit, who takes responsibility for coordinating the training and development of nurses, is key in the development of a skilled nursing workforce.

In March 2022 a survey was undertaken to identify current roles and responsibilities, and to obtain information regarding the professional qualifications held by practice educators within Wales. Generating a 94% response rate, 53% of respondents were in Band 6 posts, with 47% in Band 7 posts. 53% of all respondents had been in post less than two years, therefore a significant number of educators within Wales only have experience of undertaking the role during the COVID-19 pandemic. As anticipated, variance in the possession of professional qualifications was identifiable between Band 6 and Band 7 respondents.

All critical care educators must be in possession of a post registration course in critical care nursing, alongside a post graduate certificate in education or equivalent²⁰. With Welsh Government keen to quality assure the delivery of post compulsory education in support of covid-19 recovery throughout all education settings¹, it seems appropriate to advocate for a standard of education across practice educators. Whilst educating our educators will provide clinical governance around individual educator teaching skills, survey results also demonstrated practice educators currently have very little time available in the working week to provide the clinical education and support required by the critical care nursing workforce due to administrative tasks. There is a strong focus from within critical care upon educator and staff ratios.

GPICS currently recommends an educator staffing ratio of one educator per 75 WTE nursing staff. Within this recommendation consideration must be given to an increased ratio of educator to staff numbers when there are periods of high staff turnover and junior skill mix. Whilst there is call for an ideal educator to nurse ratio of 1:50¹, it is for local units to ultimately decide upon educator ratios based upon maximising efficient ways of working and the educational needs of their workforce.

Recommended solutions:

- Staff ratios at a minimum of one WTE educator to 75 staff should be implemented in units throughout Wales. The educator element of this ratio combines both Band 6 and Band 7 educators.
- Staff should be in possession of a Post Graduate Critical Care qualification prior to commencing a Band 6 or Band 7 education role within Critical Care.
- Staff employed in a Band 7 education role should be in possession of a Postgraduate Certificate in Post Compulsory Education and Training (PcET) or an equivalent work-based learning and delivery education qualification or demonstrate willingness to

complete within twenty-four months of commencing in post.

- Band 6 educators should have a strong focus on clinical support and education. The role should incorporate some classroom teaching for their own personal development and succession planning.
- Staff employed in a Band 6 role should be in possession of an accredited learning and development [qualification](#) and an education & training [qualification](#), such as those offered via Agored Cymru. These qualifications should be completed within twenty-four months of commencing in post.
- Administrative support should be provided for all education teams to maximise efficient use of educator's time.

Professional Nurse Advocates

The Professional Nurse Advocate (PNA) programme delivers training and restorative supervision for nursing colleagues. Launched in England in March 2021, it is the first clinical model of restorative supervision for nurses that equips PNA-trained staff to listen and understand the challenges fellow colleagues are facing, and to provide and deliver quality improvement initiatives in response²². A similar programme exists for maternity services where outcomes suggest improved staff wellbeing and retention, along with improved compassion and job satisfaction²³. The importance of staff well-being is recognised in ensuring safe, high quality patient care²⁴.

The Critical Care Transformation Managers have presented the PNA role to Critical Care Senior Nurses across Wales. With significant interest in the role, HEIW agreed to fund one member of staff per Health Board to attend the PNA course. The course is a 20-credit level 7 course delivered at HEIs. All Health Boards have supported the introduction of this role.

Recommended solutions:

- Health Boards to support the introduction of the PNA role and ensure the PNA is given adequate time and support to introduce this service.
- Establish a PNA critical care network to share good practice across Wales. The group will be set up by the Critical Care Transformation Managers, with the Wales Critical Care Network supporting this going forward.
- HEIW to undertake a robust evaluation process following completion of the PNA course by the first cohort, assessing the course and the impact of the role within critical care.
- Following this evaluation process to consider if the PNA model could be widened further to include the multi-disciplinary team.

Leadership & Culture

The role of the senior nurse is instrumental in the promotion of high-quality clinical care and maintenance of patient safety, workforce recruitment, retention and staff development, whilst simultaneously displaying compassionate and inclusive leadership²⁵. Concerns regarding leadership are commonly cited in public inquiries following failings in healthcare services^{26, 27, 28} however leadership within critical care services is not exclusively concerned with nursing or those directly employed in a position of leadership. Every member of the workforce irrespective of the role they are employed to undertake, or banding must be empowered to develop their leadership skills.

Leadership and culture of an organisation are intrinsically linked. Good NHS organisations are representative of the communities they serve, with organisational leaders reflective of the workforce²⁹. There is a notable absence of Black, Asian and Minority Ethnic staff within senior roles throughout critical care service within Wales. In nursing alone Health Boards are actively recruiting experienced critical care nurses from overseas. SAS doctors often join the NHS from overseas. These are experienced clinicians who must be supported and empowered to work at the top of their license.

Recommended solutions:

- Staff employed in senior roles should be in possession of a recognised leadership qualification (such as ILM Level 5 Award in Leadership & Management : Management Training : [Scheduled Courses : trainingwales or equivalent](#)) within 24 months of commencing the post.
- Consideration should be given to utilisation of the [NHS England » The matron's handbook](#) for all senior nurses throughout Wales.
- Future leadership planning must incorporate the development needs of people from ethnic minority backgrounds to ensure a diverse and equitable leadership workforce.

Critical Care Passports

During the pandemic, support staff were often redeployed to critical care units without warning. This presented significant challenges for the critical care units, such as ensuring appropriate allocation of staff and skill mix on a shift and managing large numbers of staff who were unfamiliar with the environment. Significant time and effort was required to equip these staff with the required skills and orientate them to critical care. The critical care passport has been developed in England for Trusts to have a record of the workforce's skills and ability to support any future surges in critical care. It also serves as a record for the individual to record skills individual competency.

Upskilling the workforce outside of critical care services not only benefits critical care in times of surge, but also enhances patient care throughout the entire patient pathway.

Introduction of the critical care passport however requires engagement throughout the individual health boards, as staff need to be released from their clinical areas to maintain their skills. The critical care passport developed in collaboration with HEE, using the current electronic platform would be available without any costs should Health Boards wish to participate until March 2023. Following this there would be a cost of £5000 per annum to continue using this platform, in current climates it is recognised that Health Boards may be unable to fund this for individualised areas.

Recommended solution:

- Health Boards and critical care units should develop a mechanism to record individual staff skills, and for organisations to have oversight of the workforces' skills.

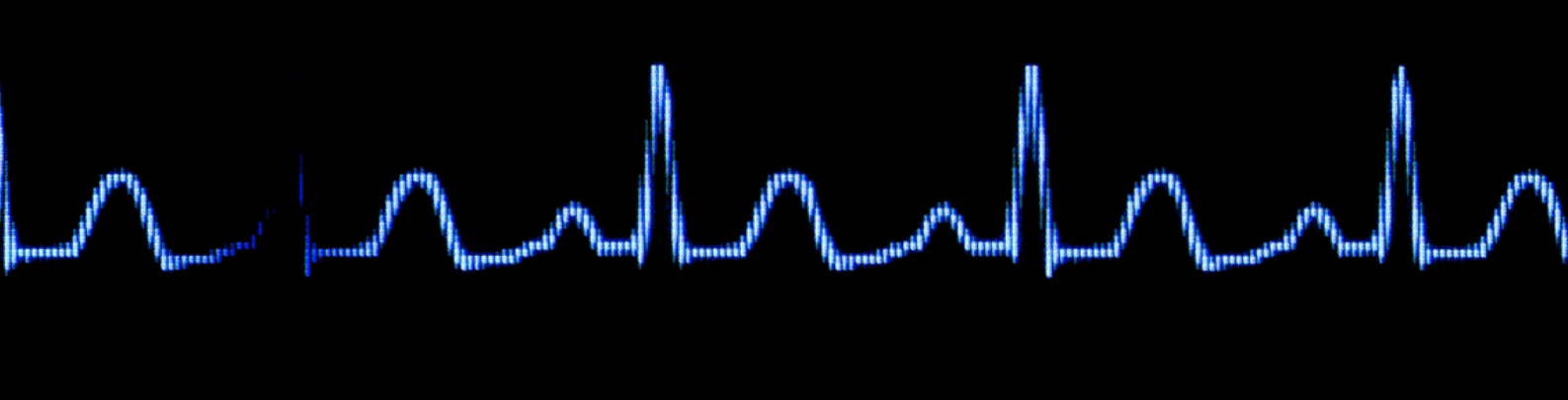
Critical Care Engagement Events

Examples of innovative and high-quality practice have been identified across Wales and the importance of developing mechanisms for the sharing of good practice is recognised. A series of critical care engagement events have been developed to share examples of good practice. The first two event delivered titled 'Caring for Current Workforce' and 'Retaining our Current Workforce' received extremely positive feedback from delegates. As a result of these events Senior Nurses have arranged visits to other units to implement some of the ideas shared such as creating small teams within critical care units. Furthermore, these events informed the programme for a Critical Care Conference entitled 'Changing the Future of Critical Care Services' held in September 2022. This event included a session from the HEIW leadership team on Compassionate Leadership.

Recommended solution:

- Welsh Critical Care Network to support critical care services with the continuation of engagement events.

Education provisions within Wales and recommended solutions to ensure standardised approach to education delivery, hence assuring the quality an standardisation of education.



Conclusion

In this resource there are many recommended solutions. Potential staffing models (Appendix 1) has been included to demonstrate how staff models can be reconfigured as services adapt following the Covid-19 pandemic using some of the recommendations set out in this resource. A clear action plan is also included in Appendix 2 to ensure work is taken forward and the momentum of this work continues.

Throughout this programme of work critical care colleagues have been consulted and it is strongly believed that the recommended solutions would offer a benefit to the development of the workforce and ultimately have a positive impact on patient care. It is vital that this work is taken forward and Critical Care Services take note of these recommended solutions and consider how they can be implemented into the local areas.

It is vital that this work is taken forward and Critical Care Services take note of these recommended solutions and consider how they can be implemented into the local areas.



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Appendices

Appendix 1

Examples of Critical Care Staffing Models:

The below staffing models are based the requirements for one shift (12 hours) on an eight bedded critical care unit.

Traditional Staffing Model:

1 x band 7 supernumerary nurse-in-charge
3 x band 6 & 5 x band 5 registered nurses providing 1:1 care for level 3 pt
1 x band 2 HCSW
= (9 registered professionals / total staff numbers 10 / Cost per shift: £2440.32)

Alternative Staffing Models:

Model A:

1 x band 7 supernumerary nurse-in-charge
3 x band 6 & 3 x band 5 registered nurses providing 1:1 care for level 3 pt
1 x band 5 ITU practitioner providing 1:1 care for level 3 pt
1 x band 4 assistant practitioner providing 1:1 care for an appropriate level 3 pt (competency-based allocation)
1 x band 2 HCSW
1 x band 4 Therapy support worker
= (8 registered professionals / total staff numbers 11 / Cost per shift: £2617.68)

Alternative Staffing Models:

Model B:

1 supernumerary nurse-in-charge (Band 7)
2 x band 6 & 3 x band 5 registered nurses providing 1:1 care for level 3 pt
2 x band 5 ITU practitioner providing 1:1 care for level 3 pt
1 x band 4 assistant practitioner 1:1 care for an appropriate level 3 pt
1 x band 2 HCSW
1 x band 4 Therapy support worker
= (8 registered professionals / total staff numbers 11 / Cost per shift: £2566.92)

Model C:

1 x band 7 supernumerary nurse-in charge/ ITU practitioner in charge.
1 x band 6 registered nurse / ITU practitioner
2 x band 6 & 1 band 5 registered nurses providing 1:1 care for level 3 pt
2 x band 5 ITU Practitioners providing 1:1 care for level 3 pt
3 x band 4 Assistant Practitioners providing 1:1 care for level 3 pt
1 x band 2 HCSW
1 x band 4 Therapy Support Worker
= (7 Registered professionals / total staff numbers 13 / Cost per shift: £2795.04)

Model D:

1 x band 7 supernumerary nurse-in charge/ ITU practitioner in charge.
1 x Patient Flow coordinator/ Band 4 Assistant practitioner (Support for NIC in am to release for clinical time and able to support admission/ discharge in pm)
2 x band 6 registered nurse / ITU practitioner
2 x band 5 registered nurses providing 1:1 care for level 3 pt
3 x band 5 ITU practitioners/ registered nurses providing 1:1 care for level 3 pt
3 x band 4 Assistant Practitioners providing 1:1 care for level 3 pt
1 x band 2 HCSW
1 x band 4 Therapy Support Worker
= (8 Registered professionals / total staff numbers 14 Cost per shift: £3168.12)

Appendix 2

Action Plan:

Local Actions for Critical Care Units & University Health Boards.	
Review current workforce establishment considering all roles identified within this report. <u>Particular focus</u> must be given to roles which are not currently part of agreed establishments.	• Completion Spring 2023.
Develop a mechanism to record individual staff skills throughout the health board, giving organisations an oversight of the workforces' skills to support major incident planning.	• Completion Summer 2023.
Provision within IMTP for the commissioning of extra places to support the recruitment of staff in the new roles, such HCPC registrants into the ITU practitioner role.	• Yearly review.

Actions for Health Education & Improvement Wales.	
Commissioning of standardised PG Certificate in Critical Care for delivery within Wales.	• Commissioning process to be completed October 2022. • Delivery of PG Cert to commence August 2023.
Provision of x1 funded place per health board on a professional nurse advocate course to commence in November 2022.	• September 2022.
Undertake a robust evaluation with stakeholders following completion of professional nurse advocate course by first cohort.	• Evaluation completed March 2023. • Review data obtained during evaluation process and consider extension of funding for course to more staff / staff groups.
Provide recommendation for standardised education pathways for unregistered staff working within critical care services.	• For completion March 2023.
Commission appropriate healthcare professional training places to meet the demands as set in individual health board IMTP's.	• Yearly review.
Ensure HEIW representation attendance at Critical Care Network Board meetings.	• Quarterly.
Work collaboratively with the Welsh Critical Care Network to support strategic development of critical care services throughout Wales.	• Yearly review.

Actions for Welsh Critical Care Network.	
Facilitate multidisciplinary sharing of good practice events.	• Biannual events with individual critical care unit presenting local work.
Set the strategic direction for critical care services throughout Wales, with particular focus given to expansion critical care capacity.	• Yearly review.
Work collaboratively with HEIW to support strategic development of critical care services throughout Wales.	• Yearly review.

Actions for Welsh Government.	
Work collaboratively with the Welsh Critical Care Network and local Health Boards to ensure appropriate funding for future commissioning of critical care services.	• Yearly review.
Provide recommendations to inform a policy position in Wales on registered band 4 roles.	• Beginning of 2024.



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WG46246



Llywodraeth Cymru
Welsh Government

**The Duty of Quality Statutory Guidance 2023
and Quality Standards 2023**

The Health and Social Care (Quality and Engagement) (Wales) Act 2020

Date of issue: October 2022

CONTENTS

	Page number
Glossary	3
Foreword	4
1 Introduction	6
2 Purpose of the guidance	8
3 Legislative background	9
4 Strategic and policy context	12
5 Who does the duty of quality apply to?	14
6 Defining quality	19
7 Quality Standards	25
8 Meeting the duty of quality	27
9 Quality reporting requirements	30
10 Decision-making, monitoring and assurance	34
11 Welsh language	36
12 Conclusion	37

Figure 1

Diagram to demonstrate the quality management cycle

Figure 2

Diagram to demonstrate the central strategic context of the duty

Figure 3

Diagram to illustrate the six domains of quality supported by the five quality enablers.

Glossary

Interpretation, in this guidance:

- The 2003 Act means the Health and Social Care (Community Health and Standards) Act 2003.
- “Health care” for the purposes of the 2003 Act means (a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and (b) the promotion and protection of public health.
- The 2006 Act means the National Health Service (Wales) Act 2006;
- The Act means the Health and Social Care (Quality and Engagement) (Wales) Act 2020.
- NHS body, in the context of the duty of quality in Wales, means -
 - (a) a Local Health Board.
 - (b) an NHS Trust.
 - (c) Wales-only Special Health Authority.
- Where the word **must** is used, it refers to actions that are a legal requirement, as set out in Part 2 of the Act;
- Part 2 of the Act amends the National Health Service (Wales) Act 2006 to insert new provisions 1A, 12A, 20A and 24A into the 2006 Act. For the purposes of those new provisions:
 - “Health services” means any services provided or secured in accordance with the 2006 Act: and
 - “Quality” includes, but is not limited to, quality in terms of –
 - (a) The effectiveness of health services,
 - (b) The safety of health services, and
 - (c) The experience of individuals to whom health services are provided.

FOREWORD

Introducing a duty of quality through the Health and Social Care (Quality and Engagement) (Wales) Act 2020 ¹ ('the Act'), highlights the Welsh Government's commitment to safe, effective and person-centred health services. The Act places an overarching duty of quality on the Welsh Ministers regarding their health-related functions. It broadens the existing duty on NHS bodies (Local Health Boards, NHS Trusts and Welsh Special Health Authorities).

Ultimately, the purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. The duty represents our ambition of achieving ever-higher standards of person-centred health services in Wales.

Quality is more than just meeting service standards. It needs to be a system-wide way of working. Quality means safe, timely, effective, efficient, equitable and person-centred health care which is embedded within a culture of continuous learning and improvement.

The duty requires Welsh Ministers and NHS bodies to actively consider these domains of quality when making decisions about health services so that improved outcomes are secured. This supports the five ways of working (long term, integration, involvement, collaboration and prevention) within the Well-being of Future Generations (Wales) Act 2015 ² as well as promoting the well-being goal of A Healthier Wales³.

The Welsh Government published the Quality and Safety Framework⁴ in September 2021. This was intended to serve as a steppingstone to the new duties of quality and candour under the Act whilst we emerged from the coronavirus pandemic.

The duty of quality is interdependent with the Health and Care Standards (April 2015) for Wales. To build clear connections between the duty and the standards, this guidance now incorporates the new Quality Standards 2023 that will replace the Health and Care Standards (April 2015). This new approach sets out a clear and simple framework for quality management that will strengthen the connection between the duty, standards and the wider quality management process in Welsh health services.

I am proud that 'Putting quality and safety above all else' is the first core value described in "A Healthier Wales", our long-term strategy for integrated health and care in Wales. As Dr Tedros Adhanom Ghebreyesus, World Health Organisation

¹ Welsh Government (2020) Health and Social Care (Quality and Engagement) (Wales) 2020 Act
<https://www.legislation.gov.uk/asc/2020/1/contents>

² Welsh Government (2015) Well-being of Future generation (Wales) Act
<https://www.futuregenerations.wales/about-us/future-generations-act/>

³ Welsh Government (2019) A Healthier Wales: our Plan for Health and Social Care
<https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf>

⁴Welsh Government (2021) Quality and Safety Framework: Learning and Improving
https://gov.wales/sites/default/files/publications/2021-09/quality-and-safety-framework-learning-and-improving_0.pdf

Director General recently reminded us, “Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic.”⁵

We have a significant opportunity to refresh and strengthen our commitment to “A Healthier Wales” through the new duty of quality. We have a collective responsibility to achieve improved quality of services and outcomes for our population.

Eluned Morgan, Minister for Health and Social Services

⁵ World Health Organisation (2022) Fundamentals of Quality <https://qualityhealthservices.who.int/quality-toolkit/new-to-health-system-quality-thinking/fundamentals-of-quality>

1. Introduction

- 1.1 The duty of quality, as part of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, will come into force on 1 April 2023. It is a lever for improving and protecting the health, care and well-being of the current and future population of Wales. It aims to ensure a stronger citizen voice and to improve the accountability of services to deliver a better experience and quality of care. Doing so contributes to a healthy and more prosperous country. The Act is intended to have positive benefits for everyone in Wales, supporting a culture and the conditions needed to drive improvements in health care.
- 1.2 This statutory guidance aims to help NHS bodies in Wales deliver the requirements of the duty of quality.
- 1.3 The legal basis for the duty is set out in Part 2 of the Act.
- 1.4 The duty of quality supports all people in Wales. The new duty of quality requires the Welsh Ministers and NHS bodies to think and act differently by applying the concept of “quality” across all functions within the context of the health service and health needs of their populations. It requires quality-driven decision-making and planning, to ultimately deliver better outcomes for all people who require health services. It requires involving people in decisions that affect them, balancing short-term needs with planning for the longer-term, with action to prevent problems occurring or getting worse.
- 1.5 The duty also supports the application of prudent and value-based healthcare principles, referred to in the National Clinical Framework as ‘prudent in practice’. This increasingly shifts the focus to person centred care that can support people to stay well, self-manage their condition and, when necessary, provide seamless and appropriate specialist support. The focus is on the person rather than the setting in which the service is delivered.
- 1.6 Value-based health care encourages us to focus on meeting the goals of our patients and to help manage expectations throughout their care or treatment⁶. Value in health encourages us to improve how patients are involved in decision making using the best evidence available, avoiding any unnecessary variation in care, and becoming more creative to determine where our resources are best spent to improve patient outcomes. By working with patients and teams from across the healthcare system in Wales, and collaborating with industry and third sector, we can deliver the outcomes that matter to people with the resources available to us in a way that is sustainable.

⁶ Welsh Value in Health Care (2022) Value-based Healthcare for Wales at <https://vbhc.nhs.wales/value-based-healthcare-for-wales/policy-and-culture/>

- 1.7 The prevailing intention is to build on the positive culture of quality at the heart of the Welsh health system⁷, enacting a broader system-wide duty of quality which strengthens decision-making, action, improvement and ultimately, improved outcomes for the population.

⁷ Organisation for Economic Co-operations and Development (OECD) Reviews of Health Care Quality: United Kingdom 2016: Raising Standards at [OECD Reviews of Health Care Quality: United Kingdom 2016 : Raising Standards](https://www.oecd-ilibrary.org/health-care/oecd-reviews-of-health-care-quality-united-kingdom-2016-raising-standards) | [OECD iLibrary \(oecd-ilibrary.org\)](https://www.oecd-ilibrary.org/)

2. Purpose of the guidance

- 2.1 Improving the quality of our services to achieve better outcomes for people is the right thing to do.
- 2.2 The guidance sets out best practice to assist Welsh Ministers with regards to their health-related functions and NHS bodies in the implementation and application of the duty of quality. NHS bodies must have regard to the guidance issued by the Welsh Ministers.
- 2.3 The guidance provides a foundation on which quality management systems, relevant policies and procedures, training and support requirements will be built. It facilitates clarity about the duty of quality, consistency of approach and equity of response by promoting an 'All-Wales' approach to improve the quality of health services.
- 2.4 The guidance sets out a definition of quality and describes the overarching requirements to strengthen our quality management systems with quality-driven decision-making and planning. In turn, this strengthens our learning and sharing responsibilities and opportunities. The purpose of the duty overall is to improve outcomes for our population.
- 2.5 It is intended as a reference for our workforce as well as our population and partner organisations, so we develop a common understanding about the duty of quality.
- 2.6 It is not intended to be a prescriptive document, nor is it intended to be a quality manual or 'how to' guide. It is ultimately for NHS bodies to satisfy themselves that they are complying with the new duty to secure quality in the provision of health services imposed on them in the 2006 Act, though it is envisaged that this guidance will provide a helpful framework to assist such bodies accordingly. Furthermore, the guidance also sets out six domains of quality and the five quality enablers which will replace the Health and Care Standards (April 2015) issued under section 47(1) of the 2003 Act (which is a power which permits the Welsh Ministers to publish statements of standards in relation to the provision of health care). NHS bodies will be required to take these new standards into account for the purpose of discharging the duty of quality.
- 2.7 It is acknowledged that implementation of the duty of quality will need to be monitored over the course of several years to determine its success. Welsh Ministers and NHS bodies will need to be able to demonstrate incremental improvements aligned to the duty for implementation to be assessed and monitored.
- 2.8 To that end, Welsh Ministers and NHS bodies must publish an annual quality report on the steps they have taken to comply with the duty of quality.

3. Legislative background

- 3.1 The key purpose of Part 2 of the Act is to reframe and broaden the duty of quality which was first set out in section 45(1) of the Health and Social Care (Community Health and Standards) Act 2003⁸ (“the 2003 Act”). Section 45(1) of the 2003 Act imposes a duty on Welsh NHS bodies to ensure that appropriate arrangements are in place to monitor and improve the quality of health care⁹ provided by or for those bodies.
- 3.2 Section 45(1) of the 2003 Act will be repealed and replaced with a revised duty to secure quality in health services in sections 1A (Welsh Ministers’ duty), 12A (Local Health Board’s duty), 20A (NHS Trust’s duty) and 24A (Special Health Authority’s duty) of the National Health Service (Wales) Act 2006¹⁰ (“the 2006 Act”). The 2006 Act will also require those bodies to publish an annual report on the steps it has taken to comply with the duty of quality.
- 3.3 The 2006 Act (as amended by Part 2 of the Act) requires that the Welsh Ministers issue guidance to the Welsh NHS bodies in relation to the duty of quality and the requirement to publish an annual report. Therefore, this guidance is issued by the Welsh Ministers under Sections 12A (5), 20A (5) and 24A (5) of the 2006 Act in pursuance of that requirement.
- 3.4 The revised duty of quality (which also applies to the Welsh Ministers, as well as NHS bodies) reframes the concept of “quality” by ensuring that it is used in its broader definition. Quality includes quality in terms of the effectiveness and safety of health services and the quality of the experience of users of health services. However, it is not limited to the quality of services provided to an individual nor to service standards. It relates to securing improvement in the quality of “health services” which means any services provided or secured in accordance with the 2006 Act. Accordingly, the revised duty intends quality to be a system-wide way of working with focus placed on outcomes. Inserting the new duty into the 2006 Act reflects the importance that the Welsh Ministers place on the new, broader duty, and the Welsh Ministers’ wish to further strengthen and embed quality at the heart of decision making for health services.
- 3.5 Welsh Ministers have a duty to exercise any of their functions that relate to the health service with a view to securing improvement in the quality of health services.¹¹

⁸ UK Government (2003) Health and Social Care (Community Health and Standards) Act
<https://www.legislation.gov.uk/ukpga/2003/43/contents>

⁹ For the purposes of the 2003 Act, “health care” means (a) services provided to individuals for or in connection with the prevention, diagnosis or treatment or illness; and (b) the promotion and protection of public health.

¹⁰ UK Government (2006) National Health Service (Wales) Act.
<https://www.who.int/publications/i/item/9789240011632>

¹¹ Section 1A of the 2006 Act

- 3.6 Local Health Boards¹², NHS Trusts¹³ and Welsh Special Health Authorities¹⁴ have a duty to exercise **all** of their functions with a view to securing improvement in the quality of health services provided. The duty of quality applies to all clinical and non-clinical functions and therefore differs from the duty in section 45(1) of the 2003 Act.
- 3.7 Reframing and strengthening the duty of quality represents a further step on the journey towards ever-higher standards of person-centred health services in Wales.
- 3.8 Part 2 of the Act also makes consequential amendments to section 47 and section 70 of the 2003 Act.
- 3.9 Section 47(1) of the 2003 Act permits the Welsh Ministers to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Welsh Ministers are required to keep the standards under review and may publish amended statements whenever it considers appropriate. The last standards were published under this provision in April 2015.¹⁵ Section 47(4) of the 2003 Act require that the standards set out in statements are to be taken into account by every Welsh NHS body in discharging its duty under section 45 of the 2003 Act. Given that section 45(1) is repealed, section 47(4) is amended such that the standards set out in statements are to be taken into account by a Welsh NHS body in discharging the revised duty of quality in the 2006 Act.
- 3.10 To fulfil the Welsh Ministers' duty to review and the power in section 47 of the 2003 to publish amended statements of standards, the Health and Care Standards (April 2015) are withdrawn and replaced with the six domains of quality and the five quality enablers as set out in this guidance. This is to reflect the inextricable relationship that exists between the duty of quality and the standards, albeit that the standards themselves relate only to the provision of "health care"¹⁶ whereas the duty of quality applies to the exercise of all functions. Accordingly, the six domains of quality and the five quality enablers have a far wider remit and will be relevant when exercising non-clinical functions, as well as clinical functions.
- 3.11 Furthermore, section 70(1) of the 2003 Act provides that the Welsh Ministers have the function of conducting reviews of, and investigations into, the provision of health care by and for Welsh NHS bodies. In practice this function is carried out by Health Inspectorate Wales (HIW) on behalf of the Welsh Ministers. Section 70(3) of the 2003 Act also imposes a specific function of conducting reviews into the arrangements made by Welsh NHS bodies for the

¹² Section 12A of the 2006 Act

¹³ Section 20A of the 2006 Act

¹⁴ Section 24A of the 2006 Act

¹⁵ [Health standards framework English \(wales.nhs.uk\)](https://www.wales.nhs.uk/health-standards-framework-english)

¹⁶ See footnote above on the definition of "health care" for the purposes of the 2003 Act

purpose of discharging the duty of quality. Section 70(3) is amended such that this relates to the revised duty of quality under the 2006 Act.

Key messages

- The key purpose of the Act is to reframe and broaden the duty of quality which was first set out in the 2003 Act
- The duty of quality set out in section 45(1) of the 2003 Act is repealed and replaced with a revised duty to secure quality in health services in the 2006 Act
- The revised duty requires that the Welsh Ministers must exercise their health-related functions with a view to secure improvement in the quality of health services
- The revised duty also requires that NHS bodies must exercise all of their functions with a view to securing improvement in the quality of health services
- The Act makes consequential amendments to section 47 and section 70 of the 2003 Act such that any standards that are issued under the 2003 Act are taken into account by an NHS body in discharging the revised duty of quality in the 2006 Act, and that the Welsh Ministers has the function of conducting reviews of the steps taken by an NHS body for the purpose of discharging the revised duty of quality. The latter function is delegated to Health Inspectorate Wales (HIW).
- The Health and Care Standards (2015) that were issued under section 47 of the 2003 Act are withdrawn and replaced with the six domains of quality and five quality enablers to reflect the inextricable relationship between the duty of quality and the standards

4. Strategic and policy context

- 4.1 A Healthier Wales: our Plan for Health and Social Care ("A Healthier Wales") sets out the vision for a whole system approach to health and social care in Wales.
- 4.2 It lays out the Welsh Government's ambitions for progress and improvement and describes the core values that underpin the NHS in Wales. These are:
 - Putting quality and safety above all else
 - Integrating improvement into everyday working
 - Focusing on prevention, health improvement and inequality
 - Working in true partnerships
 - Investing in our staff
- 4.3 The Act supports the ambitions in A Healthier Wales by setting out the requirements for the improvement in the quality of health services.
- 4.4 The Act describes that quality includes, but is not limited to, the safety and effectiveness of health services and the experience of individuals who receive health services.
- 4.5 The Welsh Government published the Quality and Safety Framework in September 2021¹⁷.
- 4.6 It provides an overview of quality principles and arrangements that need to be in place to ensure high quality services are being delivered.
- 4.7 It requires the NHS to establish effective quality management systems that focus on learning and driven by their boards. It explains how Quality Control, Quality Planning, Quality Improvement and Quality Assurance must work together to form the quality management system that is required.
- 4.8 The intention was for the Framework to provide a steppingstone to the new duty of quality.

4.9 Figure 1

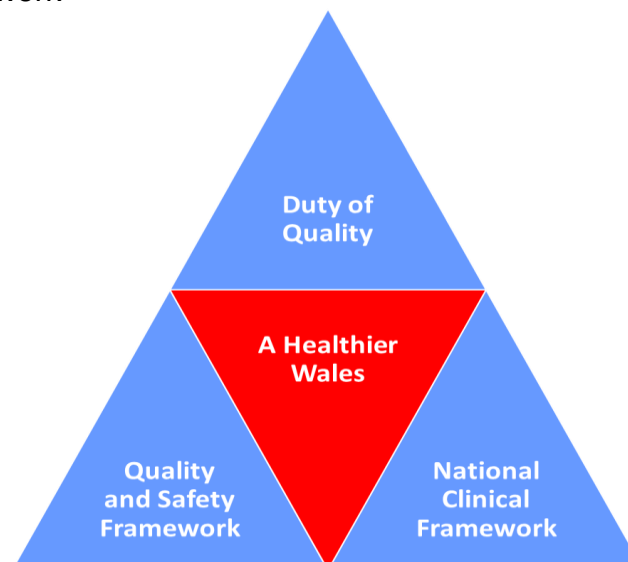
¹⁷ Welsh Government 2021 Quality and Safety Framework learning and improving. <https://gov.wales/nhs-quality-and-safety-framework>

Diagram to demonstrate the quality management cycle



4.10 Figure 2

Diagram to demonstrate the central strategic context of A Healthier Wales alongside the duty of quality, National Clinical Framework and Quality and Safety Framework



Key messages

- We must put the quality and safety of our health services above everything else
- The duty of quality influences many health-related policies and frameworks
- In turn, these also affect how we approach delivering quality in healthcare services
- Strengthening our quality management system helps us make sure our decision-making focuses on improving the quality of health services

5. Who does the duty of quality apply to?

5.1 The Act lists the following individuals and NHS bodies in Wales as being subject to the duty in Part 2 of the Act:

- Welsh Ministers (in relation to their health functions).
- Local Health Boards.
- NHS Trusts.
- Special Health Authorities that operate on a Wales-only basis.

5.2 The duty of quality and Welsh Ministers

The Welsh Ministers with regards to their health-related functions have responsibility for oversight of the NHS in Wales. They must ensure that health services are organised and delivered in such a way that system-wide, continuous improvement in the quality of health services is achieved.

5.3 Welsh Ministers will have to actively consider whether their decisions in relation to the health service are taken with a view to securing improvement in the quality of health services.

5.4 Welsh Ministers must ensure that national bodies with regulatory, performance management or support responsibilities have a cohesive and collaborative approach to system-wide improvement.

5.5 Welsh Ministers must issue guidance to NHS bodies in relation to the requirement to exercise of their functions with a view to securing improvement in the quality of health services, and the requirement to publish an annual report on the steps they have taken to comply with this duty. The latter is described in section 9 Reporting requirements.

5.6 Welsh Ministers will also be required to publish an annual report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health service and within that report to include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

5.7 The duty of quality and NHS bodies

The NHS in Wales delivers health services through 7 Local Health Boards and 3 NHS Trusts.

5.8 The Health Boards and Trusts work in partnership with 2 Special Health Authorities – Health Education and Improvement Wales (HEIW) and Digital Health and Care Wales (DHCW).

5.9 Several Local Health Boards and NHS Trusts host national organisations that support the delivery of health services. In hosting the national organisations, the Local Health Boards and NHS Trusts are exercising functions in relation to the health service and therefore must do so with a view to securing

improvement in the quality of health services. Therefore, the host organisations will ultimately be caught by the duty of quality in delivering the services and should therefore have regard to the duty.

5.10 The duty of quality applies to Local Health Boards who are responsible for planning and delivering NHS services in their areas with the aims of:

- Improving physical and mental health outcomes.
- Promoting well-being.
- Reducing health inequalities across their population.
- Commissioning services from other organisations to meet the needs of their residents.

5.11 The 3 NHS Trusts and 2 SHAs have their own specific service delivery responsibilities to which the duty of quality will apply.

5.12 Accountability for compliance with the duty of quality ultimately rests with the Chief Executive of an NHS body.

5.13 Similar in approach to other legislation, it is recommended that NHS bodies designate appropriate senior leads to hold responsibility for the strategic implementation and oversight of the duty of quality. An officer member of the board should be delegated the responsibility to ensure the necessary strategic implementation and oversight. It should be noted however, that the responsibility to ensure due consideration is given to the duty of quality applies to all officer and non-officer board members whilst exercising the functions within their roles.

5.14 A designated operational lead to support the implementation of the duty of quality is also suggested.

5.15 There is a collective responsibility of all Board members to support the Chief Executive to: -

5.15.i) comply with the duty of quality by internal governance and assurance arrangements that are structured within a robust quality management system;

5.15.ii) ensure that health services are organised and delivered in such a way that system-wide, continuous improvement in the quality of health services is achieved;

5.15.iii) actively consider whether the Board's decisions will improve service quality and secure improvement in outcomes for the population;

5.15.iv) demonstrate how they have exercised their functions and improved the quality of services in accordance with the duty of quality. This is described in section 9 Quality reporting requirements.

5.16 The duty of quality applies to all health service functions in both clinical and non-clinical settings. Therefore, all staff have responsibility for complying with

the duty within their role and service function. It is a collective responsibility to comply with the duty of quality.

5.17 The duty of quality in commissioned services

It is recognised that health services may be provided across geographical boundaries through commissioning arrangements with NHS and non-NHS service providers. Local Health Boards, NHS Trusts and SHAs must exercise their functions with a view to securing improvement in the quality of health services. The NHS body that is commissioning the health service is exercising its functions and must therefore ensure it is doing so with a view to securing improvement in the quality of the health service. Regardless of who is delivering health services when they are commissioned, the duty is the responsibility of the commissioning body.

5.17.i) Services commissioned by an NHS body from another NHS body in Wales:

The NHS body that is commissioning the health service is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The duty of quality is the responsibility of the commissioning body. The commissioning body will wish to ensure that health services delivered by the alternative provider will secure improvement in the quality of health services. The Welsh NHS body providing services on behalf of the commissioner must also ensure that they are compliant with the duty that will also apply directly to them for the services they are providing.

5.17.ii) Services provided by primary medical, dental, optical and pharmaceutical services in Wales:

In accordance with the 2006 Act, each Local Health Board must meet all reasonable requirements to provide primary medical, dental, optical and pharmaceutical services within its area. Contractual arrangements are provided for within the 2006 Act. The duty of quality does not directly apply to primary care providers. The duty of quality rests with the Local Health Boards to secure improvement in the quality of health services, and this extends to the services that are delivered by primary care providers on behalf of the Local Health Board. Local Health Boards will wish to ensure that health services delivered by primary care providers will secure improvement in the quality of health services.

5.17.iii) Services commissioned from non-NHS bodies:

The NHS body that is commissioning the health service is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The duty of quality is the responsibility of the commissioning body. The commissioning body will wish to ensure that health services delivered by the alternative provider will secure improvement in the quality of health services.

5.17.iv) Services commissioned outside of Wales:

The Welsh NHS body that is commissioning the health service is exercising its functions and must ensure it is doing so with a view to securing improvement in the quality of the health service. The commissioning body will wish to ensure that health services delivered by the alternative provider will secure improvement in the quality of health services. The service provider will be responsible for the quality of health services they directly provide under the relevant jurisdiction within which the services are provided.

- 5.18 Welsh Ministers and NHS bodies have a responsibility to encourage shared learning and expertise as they progress along their quality improvement journey. Much can also be learnt from high performing care systems globally.
- 5.19 There is a need at all levels to ensure that the health system has the resources, capacity, time and autonomy needed to develop their approaches to improving quality. This is supported by the World Health Organisation's Quality health services: a planning guide in the foundational requirements for quality initiatives¹⁸.

¹⁸ World Health Organisation (2020) Quality Health Services: a planning guide
<https://www.who.int/publications/i/item/9789240011632>

Key messages

- The duty of quality applies to Welsh Ministers (in relation to their health functions)
- The duty of quality also applies to Local Health Boards, NHS Trusts and Special Health Authorities that operate on a Wales-only basis
- Accountability for the duty of quality ultimately rests with the Chief Executive of an NHS body who may designate a lead officer and senior operational lead to oversee the implementation of the duty in the organisation
- All Board members are collectively responsible for the implementation of the duty of quality
- Several Local Health Boards and NHS Trusts host national organisations that support the delivery of health services. The host national organisations will ultimately be caught by the duty of quality in delivering the services and should therefore have regard to the duty. The duty does not apply directly to primary care providers, non-NHS providers of health services or to NHS providers outside of Wales
- The NHS bodies are responsible for exercising their functions with a view to securing improvement in the quality of health services. This includes services that they commission from other providers
- The duty of quality will ensure that health services are organised and delivered in a way that seeks to secure continuous improvement in quality and improves outcomes for the population
- Welsh Ministers and NHS bodies will have to actively consider whether their decisions will improve service quality and improve outcomes
- Welsh Ministers and NHS bodies will need to be able to demonstrate, supported by evidence, how they have complied with the duty of quality
- All staff have a role in achieving improved service quality; the duty of quality applies to all health service functions in both clinical and non-clinical settings
- System-wide learning and sharing is actively encouraged

6. Defining quality

- 6.1 Numerous definitions of quality relating to health and care services have been described by various global organisations, including the Institute for Healthcare Improvement¹⁹ and World Health Organisation²⁰.
- 6.2 For Welsh Ministers regarding their health-related functions and NHS bodies, quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve. In achieving this, Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable and person-centred**²¹.
- 6.3 NHS bodies and Welsh Ministers will need to continually seek to understand the needs of their population to inform their decision-making and secure improvement in outcomes. The population too, will have their own part to play to inform the process.

6.4 Domains of quality

Welsh Ministers and NHS bodies should ensure the decisions they make deliver care that is **safe, timely, effective, efficient, equitable and person-centred**. These quality dimensions (so-called STEEEP) provide a framework to assess quality and guide improvement. Therefore, it is important to explain what the quality dimensions aspire to achieve and what we intend them to mean in Wales as part of the duty of quality.

6.4.1 Safe

Safe

Our health care system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored, where possible, risks to safety are reduced or prevented and this is delivered by appropriate numbers of suitably skilled workforce,

¹⁹ Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. Boston: Institute for Healthcare Improvement; 2021. <https://www.ihl.org/resources/Pages/IHIWhitePapers/whole-system-quality.aspx>.

²⁰ WHO (2020) Quality health services: a planning guide <https://www.who.int/publications/i/item/9789240011632>

²¹ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, D.C: National Academy Press; 2001.

6.4.2 Timely

Timely

Our health care system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.

6.4.3 Effective

Effective

Our health care system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal outcomes possible for them and that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.

6.4.4 Efficient

Efficient

Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments targeted at those likely to gain the most benefit, ensuring any interventions represent the best value that will improve outcomes for people.

6.4.5 Equitable

Equitable

Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation; the organisation that provides care; or location where care is delivered. We embed equality and human rights in our health care system and promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.

6.4.6 Person-centred

Person-centred

Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

6.5 Quality enablers

A system-wide approach to quality requires a culture that embeds continuous learning and improvement at its heart. This should be underpinned by a clear definition and understanding of what good looks like utilising national and benchmarked standards, peer review and audit.

6.6 Learning from internationally recognised organisations that have well-established and effective approaches to quality provides a blueprint for what good quality should look like. The quality enablers underpin and influence this blueprint to ensure a system-wide approach to improving quality.

6.7 Experience has shown that maturing and embedding these concepts can take a number of years. It is recognised that there has been a positive culture with quality being “at the heart of the Welsh health system”²².

6.8 The quality enablers that underpin this blueprint to ensure a system-wide approach to improving quality are:

6.8.1 Leadership

Leadership

Embed a clear vision for the organisation that creates the conditions for a functioning quality management system ensuring that governance, leadership and accountability are fully matured and embedded.

Our health care system has visible and focused leadership at all levels, with its activities driven by the organisations' vision and values for quality. Our leaders and managers take a long-term, stakeholder-centric view to develop a clear organisational vision. They have the appropriate skills and capacity to create the conditions for a functioning quality management system. We ensure our

²² Organisation for Economic Co-operations and Development (OECD) Reviews of Health Care Quality: United Kingdom 2016: Raising Standards at <https://www.who.int/publications/i/item/9789240011632>

governance, leadership and accountability is effective in sustainably delivering care within which the domains of quality are embedded.

6.8.2 Culture and valuing people

Culture and valuing people

Create a culture across the organisation that encourages quality and system safety in a supportive, inclusive, collaborative way that welcomes the sharing of new ideas and raising of concerns.

Our health care system creates the right climate and culture to nurture and encourage quality and system safety, valuing people in a supportive, collaborative and inclusive workplace so that our people feel psychologically safe to raise concerns and try out new ideas and approaches. Relationships within teams and with the people we serve are effective and based on transparency, accountability, ethical behaviour, trust and just culture. Our workforce is inclusive, engaged, sustainable, flexible and responsive.

6.8.3 Data to knowledge

Data to knowledge

Triangulate data into information and knowledge to develop an understanding of the quality of services which will inform learning, strategic decision-making and guide quality improvement.

Our health care system ensures information is available and shared appropriately for all who need it. We use information to triangulate quantitative, qualitative, performance, experience and outcome measures to understand the quality of services, efficacy of improvement work and impact of decisions made. We monitor, report and escalate indicators and measures through our governance structures to ensure that appropriate action is taken at every level in terms of learning, improvement and accountability.

6.8.4 Learning, improvement and research

Learning, improvement and research

Create and embed opportunities for system-wide learning from quality improvement to deliver improved quality services and outcomes for the population.

Our healthcare system creates the conditions and capacity for an organisation and system-wide approach to continuous learning, quality improvement and innovation, which it actively promotes. We use new knowledge to influence improvements in practice and to inform our decision-making. We ensure our learning and improvement activity is linked to our strategic vision to deliver transformational, organisation-wide change. We commit to participating in research because research-active organisations provide improved quality of care and outcomes for people.

6.8.5 Whole-systems perspective

Whole-systems perspective

Commit to improved quality across the healthcare system by learning from quality planning, quality control and quality improvement activities to deliver the goal of improved outcomes for the population.

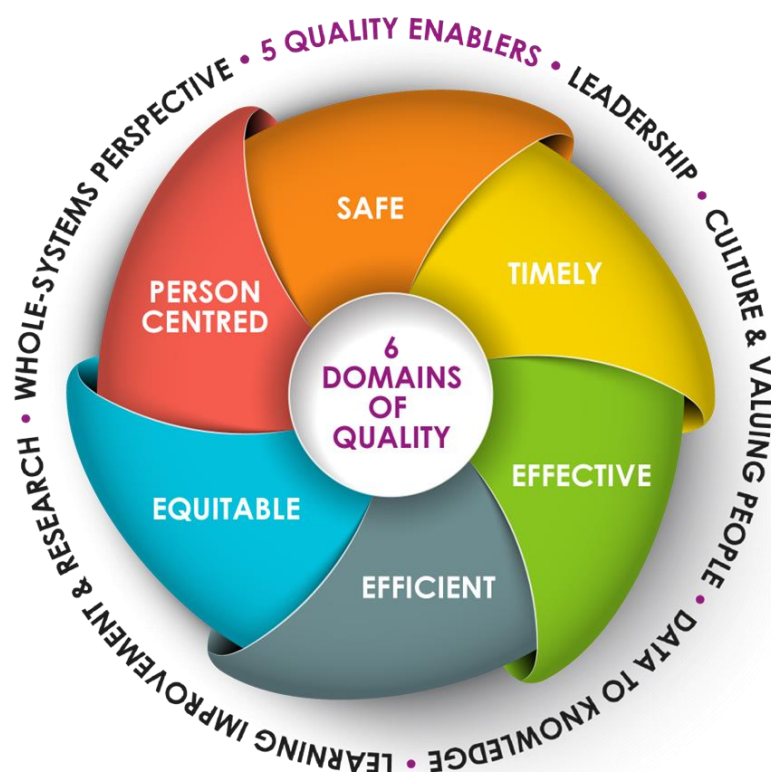
Our healthcare system ensures safety in healthcare goes beyond individual patient safety. We will look within and beyond our organisational boundaries to learn how we can continually, reliably and sustainably meet the evolving needs of people. We will strengthen relationships and work with all of our partners to achieve the outcomes expected across the domains of quality. Our policies incorporate the broader ambitions within the seven well-being goals and five ways of working in the Well-being of Future Generations Act.

- 6.8.6 The five quality enablers complement the implementation of a methodology and approach to managing quality, as set out in the Quality and Safety Framework (2021).
- 6.8.7 Welsh language needs and choice of people must be considered through the quality lens. See also section 11.
- 6.8.8 The insights, learning and expertise created within NHS organisations across primary, community and secondary care will drive improvements in quality

within Regional Partnership Board footprints and accelerate efforts to improve quality across the whole health and care system in NHS Wales.

6.9 Figure 3

Diagram to illustrate the six domains of quality supported by the five quality enablers.



Key messages

- Quality is defined as continuously, reliably, and sustainably meeting the needs of the population that we serve
- Welsh Ministers and NHS bodies will need to ensure that health services are **safe, timely, effective, efficient, equitable and person-centred**
- These quality dimensions (so-called STEEEP) provide a framework to assess quality and guide improvement
- Quality enablers have been identified which underpin and influence a blueprint to ensure a system-wide approach to improving quality
- The quality enablers are **leadership; culture and valuing people; data to knowledge; learning, improvement and research and whole-systems perspective**
- Maturing and embedding the quality management system takes time, vision, ambition, and an active commitment to learning and improving

7. Quality Standards

- 7.1 Section 47(1) of the 2003 Act permits the Welsh Ministers to prepare and publish statements of standards in relation to the provision of health care by and for Welsh NHS bodies. The Welsh Ministers are required to keep the standards under review and may publish amended statements whenever it considers appropriate. The last standards were published under this provision in April 2015.²³
- 7.2 Section 47(4) of the 2003 Act (as amended by Part 2 of the 2006 Act) requires that the standards set out in statements are to be taken into account by a Welsh NHS body in discharging its duty of quality in the 2006 Act. Accordingly, there is an inextricable relationship that exists between the duty of quality and the standards issued under section 47(1) and such standards should therefore align with and support the duty of quality. In developing the Duty of Quality Guidance and reviewing the April 2015 Standards the Welsh Ministers have withdrawn the Health and Care Standards (April 2015) and replaced them with the Quality Standards 2023 (i.e. the six domains of quality and the five quality enablers) as set out in section 6 of this guidance. This change is being made as the introduction of the Duty of Quality provides an opportunity to directly align the standards not only with the duty but with wider quality management practice in health. The domains as described in this guidance are widely used in health care and are being implemented in the wider Welsh health system. Feedback from stakeholders indicates the 2015 Standards are overly detailed, often secondary care specific and limited in their relevance to the wide range of services provided by the integrated health boards. The new Quality Standards 2023 are designed to simplify the requirements and be flexible with the wide remit of the Duty of Quality.
- 7.3 Health Inspectorate Wales (who exercise functions on behalf of the Welsh Ministers) will also have to take these standards into account for the purpose of undertaking reviews and investigations relating to Wales under section 70 of the 2003 Act. Therefore, the six domains of quality together with the five quality enablers provide a high-level framework for describing, implementing and monitoring the duty of quality, as well as comprising the high-level Quality Standards 2023 that people in Wales can expect when they access health services.
- 7.4 The Quality Standards 2023 provide a structure on which to implement the duty of quality, whether at a national policy level or by service providers. NHS bodies should be aware that whilst the standards issued under the 2003 Act relate to the provision of “health care” by and for Welsh NHS bodies, the duty of quality applies to the exercise of all functions in relation to the health service. Accordingly, the six domains of quality and the five quality enablers have a far wider remit in the context of the duty of quality as a whole and will be relevant in all clinical and non-clinical services and settings.

²³ [Health standards framework english \(wales.nhs.uk\)](https://www.wales.nhs.uk/health-standards-framework-english)

- 7.5 It should be noted that A Healthier Wales introduced 'quality statements' to describe the outcomes and standards expected in high quality, person-focussed services, setting out the ambitions to be delivered consistently across Wales.
- 7.6 This was further described in the National Clinical Framework. It explained that quality statements will set out the policy expectations for the future planning and accountability arrangements for the NHS in Wales.
- 7.7 The expectation is that service specifications will be developed through the NHS Executive structures to form the NHS response to quality statements in due course.

Key messages

- **Welsh Ministers have a duty to review standards issued under section 47 of the 2003 Act and may publish amended statements of standards whenever it considers appropriate**
- **The Health and Care Standards (2015) are withdrawn and replaced with the six domains of quality and five quality enablers collectively called the Quality Standards 2023 to reflect the inextricable relationship between the duty of quality and the standards**
- **The new Quality Standards 2023 simplify the framework so it can be widely and flexibly applied and also directly align the standards to the duty.**
- **The six domains of quality and five quality enablers set out the high-level standards that people in Wales can expect when they access health services**
- **The wide remit of the six domains of quality and five quality enablers is intended to provide a structure on which to implement the duty of quality whether at national policy level or by service providers and are intended to apply to all clinical and non-clinical services and settings**
- **Quality statements were introduced in 'A Healthier Wales'; they set out policy direction and expectations. Service specifications will be developed as the NHS response to the quality statements. This will be coordinated through the NHS Executive structures in due course**
- **It is anticipated that the duty of quality through the six domains of quality and five quality enablers will complement each other to ensure a collaborative approach to improving the quality of our services to achieve better outcomes for the population**

8. Meeting the duty of quality

8.1 The duty of quality requires:

8.1.1) Welsh Ministers to exercise their functions in relation to the health service with a view to securing improvement in quality of health services.

8.2 Each Local Health Board, NHS Trust and Wales-only Special Health Authority to exercise their functions with a view to securing improvement in the quality of health services. This means that the duty of quality requires the Welsh Ministers (in respect of its functions in relation to the health service) and NHS bodies (in respect of all its functions) to:

8.2.1) Ensure that all strategic decisions are made through the lens of improving the quality of health services and outcomes for the population.

8.2.2) Exercise their functions in a way that considers how they will improve quality and outcomes on an ongoing basis.

8.2.3) Actively monitor progress on the improvement of quality services and outcomes and routinely share this information with their population.

8.2.4) Strengthen governance arrangements by reporting annually on the steps taken to comply with the duty of quality and assess the extent of improvements in outcomes.

8.2.5) Ensure that NHS organisations develop their quality management system with appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment; and Create a culture of quality within organisations.

8.3 NHS bodies will have regard to the Quality Standards 2023 described in this guidance and issued under section 47(1) of the 2003 Act.

8.4 Furthermore, there are six steps that an NHS body should take to plan, deliver and sustain the necessary focus on improving quality, which should be underpinned by a clear understanding of what good quality looks like for the organisation²⁴:

8.4.1) Securing Board support

The Board has collective responsibility for ensuring the duty of quality is delivered and they must demonstrate this in their actions and behaviours. They must demonstrate their long-term commitment to improving quality when setting

24 The Health Foundation (2019) The improvement journey: Why organisation-wide improvement in health care matters, and how to get started <https://www.health.org.uk/publications/reports/the-improvement-journey>

the strategic direction and seeking assurance of delivery. This should be underpinned by a willingness and financial support to develop the skills and infrastructure for implementation. The Board should prioritise national and regional initiatives along with recommendations that fit the organisation's way of working. The Board needs to ensure they adhere to the duty of quality in their decision-making and seek assurance with regard to decisions made by others.

8.4.2) Assessing readiness

There needs to be system-wide understanding of what good quality looks like for the broad range of services. NHS bodies should understand their 'readiness for change' to be clear about where the capability gaps are and have a plan to address them. They should use regular assessments, investigations and measurement over time to identify areas to improve quality. The NHS body should consider psychological readiness in addition to having the infrastructure, governance, system understanding and leadership in place for change.

8.4.3) Securing wider organisational buy-in and co-creating a vision

NHS bodies should create a compelling vision for improved quality that is recognised and intrinsically motivates staff at each level of the organisation. A culture of distributed leadership gives staff at all levels the permission, opportunity and confidence to test new ideas to improve quality that are aligned to the organisation's vision. Leaders should champion improvements in quality that are strategically aligned, driven and owned by the teams responsible for delivering health services.

8.4.4) Developing improvement skills and infrastructure

NHS bodies need a systematic approach to managing quality that includes building improvement capability to ensure teams at each level of the organisation have the general and specialist improvement skills needed. This should be accompanied by a suite of measures and a system that collects, analyses and feeds back on the impact of the improvements. Standard operating models to standardise core processes and activities should also be developed to address variations in quality.

8.4.5) Aligning and coordinating activity

NHS bodies need to ensure that initiatives to improve quality are consistent with their overall strategy and mission and barriers are identified and unlocked. A leader with oversight of all the organisation's activity should ensure that all strands of activity align over time. They should ensure that learning from success and weaker areas continue to shape the improvements in quality that are required.

8.4.6) Sustaining an organisation-wide approach

NHS bodies must invest in maintaining the momentum for improvements in quality and recognise that this is a longer-term journey. A focus on early wins shifts to the challenge of maintaining success and continuing to engage staff and stakeholders, with the Board managing expectations and supporting staff to maintain a focus on improvements aligned to the organisation's purpose. The Board should seek assurance that quality improvement activities are sustainable with appropriate assurance mechanisms to maintain the improvements.

- 8.5 Examples of awards or certification programmes that recognise organisations for their quality efforts will be available in supporting resources. These examples will act as a helpful roadmap for NHS bodies to work through these six steps of the improvement journey.

Key messages

- **Welsh Ministers must exercise their functions in relation to the health service with a view to secure improved quality of health services**
- **NHS bodies must exercise its functions with a view to securing improvement in the quality of health services**
- **Welsh Ministers and NHS bodies will need to ensure that strategic decisions are made through a quality lens**
- **Welsh Ministers and NHS bodies must exercise their functions in a way that considers improvement in quality and outcomes on an ongoing basis**
- **The focus must be on improving the quality of services and outcomes for the population**
- **NHS bodies should develop their quality management system and create a culture of quality within their organisations**
- **There are six steps an NHS body should take to plan and sustain the focus on improving quality, underpinned by a clear understanding of what good quality looks like for the organisation. These are:**
 - 1. Securing Board support**
 - 2. Assessing readiness**
 - 3. Securing wider organisational buy-in and co-creating a vision**
 - 4. Developing improvement skills and infrastructure**
 - 5. Aligning and coordinating activity**
 - 6. Sustaining an organisation-wide approach**

9. Quality reporting requirements

- 9.1 The Welsh Ministers are required to publish an annual report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps, and the Welsh Ministers must lay a copy of the report before the Senedd.
- 9.2 Each Local Health Board, NHS Trust and Wales-only Special Health Authority is required to publish an annual report on the steps it has taken to comply with the duty to exercise its functions with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps. This section of the guidance provides detail on the requirement to publish an annual report, the evidence to be used in support of an assessment and in the conduct of an assessment.
- 9.21 The annual report allows actions taken by Welsh Ministers and NHS bodies and quality improvements to be monitored transparently. NHS bodies should describe the progress and challenges on their quality journey to their population and stakeholders. Quality reporting needs to be meaningful for NHS bodies, their stakeholders and our population if it is to optimise real time learning, improvement and sharing opportunities. Quality reporting should also reflect the breadth of the domains of quality, quality enablers and quality management system within its structure and content.
- 9.3 In addition to the annual reporting requirement, it is proposed that NHS bodies develop a so-called ‘always on’ reporting mechanism. ‘Always on’ means that organisations collate, monitor and make information about the quality of their services readily available to their population.
- ‘Always on’ reporting requires organisations to have a whole system approach to the routine use of information across their quality management system. ‘Always on’ encourages recognition and sharing of good practice and early escalation and intervention when signals suggest that action is necessary.
- 9.4 NHS bodies may choose to use various qualitative and quantitative data and information to support their quality reporting duty. They should focus on information that will demonstrate the duty of quality in decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population. The six domains of quality, five quality enablers and quality management system components provide a quality report structure.
- 9.5 It is recognised that there is already significant work underway across the health system relating to indicators and measures. The intention is that NHS bodies

will make use of information and reporting mechanisms already in place wherever possible. They will need to adopt an agile approach to mature their quality report as outcome measures develop, aligned to the six domains of quality and five quality enablers.

- 9.6 The annual quality report is intended to summarise and reflect an NHS body's progress to improve the quality of their services and population outcomes. It is anticipated that NHS bodies will sign-post readers to the information provided through the 'Always on' reports that outline learning and improvements that have been made at regular intervals through the year.
- 9.7 The annual quality report should include a look back at what has been achieved, including where things may not have gone well, together with a forward look about the organisation's quality priorities and ambitions for the upcoming year, alongside how progress will be monitored. There should be continuity between annual reports across subsequent years.
- 9.8 The annual quality report will describe what key strategic decisions have been taken by the NHS body, and how the duty of quality has informed these decisions.
- 9.9 The annual quality report should be prepared as soon as practicable after the end of each financial year. To streamline reporting requirements and reduce duplication, it is suggested that NHS bodies align the annual quality report to their Annual Report and Accounts process.
- 9.10 Additional information will be available in a supplementary reporting framework, as a supporting resource.

9.11 Examples of evidence to be used to assess the duty of quality and improvement in outcomes includes:

- 9.11.1) Existing performance, outcome and delivery indicators and measures from the QMS
- 9.11.2) Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)
- 9.11.3) Mortality data
- 9.11.4) Information contained within the Once for Wales Concerns Management System such as incidents and concerns
- 9.11.5) Patient and staff stories
- 9.11.6) Strategic decision-making that has been driven by the quality principles outlined in this guidance
- 9.11.7) Reports following external reviews or inspections by inspectorate and licensing bodies

9.11.8) Consideration of the recommendations and implications of significant national reports, for example, following national inquiries

9.11.9) It should be noted that this list provides illustrative examples and is not exhaustive

9.12 NHS bodies will conduct the assessment of the extent of any improvement in outcomes achieved through:

9.12.1) Self-assessment

9.12.2) Peer review and feedback

9.12.3) National clinical audit

9.12.4) Internal audit

9.12.5) External review, for example, Wales Audit Office

9.12.6) Inspections, for example, Healthcare Inspectorate Wales

9.12.7) It should be noted that this list provides illustrative examples and is not exhaustive

9.13 Information about the provision of services through the Welsh language should be included in quality reports. Uptake of the Active Offer and capturing people's experience through patient and staff stories provide monitoring opportunities through quality reporting requirements.

9.14 It is important to ensure that UK General Data Protection Regulation (UK GDPR) is adhered to when accessing and processing information to prepare for the duty of quality reports.

Key messages

- **Welsh Ministers and NHS bodies must exercise their functions with a view to secure improved quality of health services**
- **Welsh Ministers and NHS bodies must publish an annual quality report that sets out the steps they have taken to secure improved quality of health services**
- **The annual quality report must include an assessment of the extent of any improvement in outcomes achieved**
- **This Guidance sets out information about the conduct of this assessment and evidence to support it, as well as the requirement to submit an annual report**
- **Annual quality reports must be a transparent reflection of progress and challenges on the quality journey. Forthcoming quality priorities and how they will be monitored should be set out**
- **The annual quality report must assess any improvement in outcomes**
- **It should demonstrate how the duty of quality has informed strategic decision-making**
- **It should outline action taken as a result of learning and describe how that has been shared**
- **The annual quality report should be prepared as soon as practicable after the end of the financial year to coincide with the Annual Report and Accounts process**
- **It is recognised that data to support the quality reporting process is a developing area and it will take time for a suite of outcome measures to be in place. Therefore, an agile approach to use of indicators and measures will be required**
- **In addition to annual quality reporting, NHS bodies are encouraged to develop an ‘always on’ reporting process where they collate, monitor and share quality information with their population at regular intervals during the year**
- **‘Always on’ reporting promotes routine use of information to inform decision-making and quality improvement. It helps with recognition and sharing of good practice as well as allowing early escalation and intervention when action is necessary**

10. Decision-making, monitoring and assurance

- 10.1 The duty of quality requires the Welsh Ministers and NHS bodies to think and act differently by applying the concept of quality across all functions within the context of the health services and health needs of their populations.
- 10.2 The duty requires quality-driven decision-making and planning to ultimately deliver better outcomes for all people who require health services. It means involving people in decisions that affect them and balancing short-term needs with planning for the longer-term; it requires action to prevent problems occurring or getting worse.
- 10.3 It needs a system-wide approach with acknowledgement that the duty of quality is a collective responsibility.
- 10.4 The focus of the duty of quality is on learning and improving, not on punitive sanctions when those to whom the duty applies fall short in their implementation of it.
- 10.5 However, NHS bodies must consider how effective implementation and monitoring of the duty of quality can be integrated into existing corporate governance frameworks, processes and procedures. This includes existing performance and quality reports.
- 10.6 When designing or introducing new structures and processes it will be necessary to embed the duty of quality within them.
- 10.7 When considering review processes and assurance mechanisms they must also take account of the duty of quality. This includes, for example, planning of the annual internal audit and clinical audit programmes.
- 10.8 In respect of NHS bodies, the Board will be required to seek assurance that the duty of quality is being appropriately discharged as a system-wide and collective responsibility. As such, it is for all committees to report to the Board regarding the duty of quality; it is not only for the quality and safety committee.
- 10.9 In seeking assurance in NHS bodies, the committees will look to ensure that sustainable quality improvement is being made and quality improvements are maintained.
- 10.10 When the Board considers and agrees the Board Assurance Framework and strategic risk register, it will also have due regard to meeting the duty of quality.
- 10.11 Implementation of, and compliance with the duty will be scheduled for discussion at quality and delivery group meetings between Welsh Government and individual NHS bodies, the national quality and delivery group and will inform the Joint Executive Team (JET) meetings and the Minister for Health and Social Service's appraisals with the Chairs of Health Boards, Trusts and Special Health Authorities.

- 10.12 The Welsh Government will monitor the content of annual quality reports alongside other sources of information which will help triangulate the application of the duty across policy areas.
- 10.13 Compliance with the duty will also form part of the matters considered by Healthcare Inspectorate Wales (HIW) when inspecting and reviewing the provision of health care.
- 10.14 The annual quality report and 'always on' approach provides information to the public, the Welsh Government and other key partners about the duty to ensure transparency and accessibility to information about the implementation of the duty of quality.

Key messages

- **The duty of quality requires Welsh Ministers and NHS bodies to ensure quality-driven decision-making and planning is in place to ultimately deliver better outcomes for all people who require health services**
- **Quality needs to be system-wide; applied across all clinical and non-clinical services within the context of the well-being and health needs of the population**
- **The focus is on learning and improvement rather than punitive sanctions when the duty of quality has been compromised**
- **The duty must be integrated into existing corporate procedures, including but not limited to, planning, performance, quality, Internal Audit reviews**
- **It must be embedded within all structures and processes that are established**
- **The Board will be required to seek assurance that the duty of quality is being appropriately discharged as a system-wide and collective responsibility**
- **The Board will need to seek assurance that sustainable quality improvement is being made, with appropriate assurance mechanisms in place to ensure that quality improvements are maintained**
- **When the Board considers and agrees the Board Assurance Framework and strategic risk register, it will also have due regard to meeting the duty of quality**
- **Compliance with the duty of quality will be monitored. It will be integrated into existing monitoring mechanisms. The various monitoring mechanisms across the health system must embed the duty of quality within their processes**
- **The annual quality report and 'always on' approach will be integral to the monitoring process to ensure the duty of quality is being delivered**

11. Welsh Language

- 11.1 It is recognised that health services in Wales are delivered within a bilingual nation.
- 11.2 More than just words is the Welsh Government's plan to strengthen Welsh language provision in health and social care. Its aim is to support Welsh-speakers to receive services in their first language, because receiving services in Welsh should be an integral part of person-centred care.
- 11.3 The ambition is to Actively Offer people their care in Welsh. It is the responsibility on health and social providers to offer services in Welsh rather than people having to request it.
- 11.4 Being able to access services in the Welsh language makes a significant positive difference to the quality of the overall experience and health and well-being outcomes for many Welsh-speakers.
- 11.5 People have reported that it can be difficult to access services they need in the Welsh language and can feel reluctant to ask if Welsh-language services are not offered.
- 11.6 The Welsh Government's plan to strengthen the provision of Welsh language in health and social care aligns to the duty of quality. It is important for Welsh language considerations to be embedded in culture and leadership, quality planning, supporting and developing the skills of the workforce and sharing best practice through an enabling approach.
- 11.7 Welsh language requirements must also be considered through the lens of the six quality domains and as an integral component of the quality management system.
- 11.8 Welsh language must also be included in quality reports. Uptake of the Active Offer and capturing people's experience through patient and staff stories provide monitoring opportunities through quality reporting requirements.

Key messages

- **Being able to access services in the Welsh language makes a significant positive difference to the overall experience for many Welsh-speakers**
- **Being able to access services in the Welsh language can improve the quality, safety and outcomes for Welsh-speakers**
- **Welsh language considerations must be embedded in the culture of quality**
- **Welsh language responsibilities must be embedded in quality reports**

12. Conclusion

- 12.1 The fundamental intention of the duty of quality is to build on the positive culture of quality at the heart of the Welsh health system.
- 12.2 The duty of quality strengthens system-wide decision-making, action, improvement with the intention of ultimately improving outcomes for the population.
- 12.3 The duty of quality applies to Welsh Ministers with regards to their health-related functions and NHS bodies (Local Health Boards, NHS Trusts and Special Health Authorities that operate on a Wales-only basis).
- 12.4 The duty of quality does not directly apply to primary care services or non-NHS providers of health services. The NHS body that directly provides or commissions the service holds the duty of quality responsibility.
- 12.5 Whilst accountability for implementing the duty of quality ultimately rests with the Welsh Ministers and Chief Executive of an NHS body, responsibility for operational implementation and oversight may be delegated to appropriate leaders.
- 12.6 Implementation of the duty of quality is a collective responsibility. It applies to everyone in clinical and non-clinical services, including Welsh Government policy makers.
- 12.7 The guidance provides a definition for quality. It outlines a framework through which quality can be assessed and improved using the six domains of quality and five quality enablers. The domains and enablers in turn support the maturing of our quality management systems.
- 12.8 The quality domains and enablers are high level aspirations that describe what people in Wales can expect when they access health services. To directly align the standards with the duty as well as the wider quality management system, the Health and Care Standard (April 2015) are being removed and replaced with the quality domains and enablers in this guidance collectively called the Quality Standards 2023.
- 12.9 There are several steps an organisation should take to prepare to meet the duty of quality²⁵.
- 12.10 Welsh Ministers with regards to their health-related functions and NHS bodies will be placed under a duty to report on the steps they have taken to comply with the duty of quality on an annual basis.

²⁵ The Health Foundation (2019) The improvement journey: Why organisation-wide improvement in health care matters, and how to get started <https://www.health.org.uk/publications/reports/the-improvement-journey>

- 12.11 NHS bodies should develop a so-called 'always on' reporting mechanism to provide timely information about the quality of their services to their population.
- 12.12 Welsh Ministers and NHS bodies must ensure the effective implementation and monitoring of the duty of quality. It must be integrated into existing governance frameworks, processes and procedures with regular updates to the relevant committees and board meetings for assurance purposes.
- 12.13 Welsh language considerations must be embedded in the culture of quality.
- 12.14 It is acknowledged that culture change takes time. Developing the infrastructure to progress 'always on' quality reporting with appropriate outcome-focused measures will need to be an agile and iterative process. The duty of quality is closely aligned to other policy areas that are developing over different timeframes; this has influence over the implementation of the duty.
- 12.15 Essentially however, principles of quality improvement methodology will need to be robustly in place for Welsh Ministers and NHS bodies to build quality as a broad system-wide way of working that is embedded in a culture of continuous learning and improvement.
- 12.16 Our active and heightened efforts to ensure a relentless focus on quality and safety, as a priority above all else, are needed more than ever in the history of the NHS.

Appendix 2

Action	Desired Outcome	Position in HEIW
Implementation ownership • Designate an [officer] member of Board to hold responsibility for strategic implementation and oversight of duty • Designate operational lead to support implementation of duty	Senior responsible leadership in place and driving implementation work	Medical Director is the Executive Lead for Duty of Quality
Vision and cascade/engagement • Create compelling vision for improved quality (that is recognised and intrinsically motivates staff at all levels) • Determine Quality roles and responsibilities for all staff	All staff recognise and understand the organisation's Quality vision, and their roles within it	In HEIW this will need to be revisited and re-enforced
Infrastructure • Provide willingness and financial support to develop skills and infrastructure to implement DoQ • Consider infrastructure, governance, system understanding and leadership in place for change • Create appropriate infrastructure for Quality • Provide support for implementing Duty	Commitment, resources and infrastructure in place to implement Duty effectively	In HEIW we are considering the dissemination of the Quality functions across the organisation at the present time
Board Decision making • Develop processes and systems for informing and structuring Board decision-making to demonstrate consideration of quality (i.e. improved services and outcomes; Quality Standards 2023) • Develop processes and systems for capturing and recording decisions made by Board to	Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens	In HEIW this needs to be re-enforced

provide evidence of quality considerations (for future reporting)		
Board Reporting Ensure agendas of, and reports to Board from, all sub-committees and structures include Duty of Quality considerations (i.e. improved services and outcomes; Quality Standards 2023)	Board are assured that DoQ is being considered across system	In HEIW this needs to be re-enforced
Governance Documentation - Review Risk Registers to ensure they support Duty of Quality - Review existing performance and quality reports to ensure they support Duty of Quality - Review any other existing standard governance documentation to ensure it supports Duty of Quality	Routine governance documentation is DoQ-ready	In HEIW this needs to be re-enforced
External reporting / information - Identify / develop appropriate channel (web presence / infrastructure) for reporting DoQ progress externally - Develop and share roll-out plan for the publication of routine “always on” qualitative and quantitative information to include for example: - Patient experience information / PREMS - Progress against quality priorities - Infections and mortality rates etc “You said, we did”	Mechanism and publication schedule / plan in place for sharing DoQ progress information externally	In HEIW external reporting needs to be implemented, it will be along different lines to what is described above
Internal Reporting Ensure processes in place for escalating quality-related information by exception (outside tolerances) through internal structures	Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level	In HEIW this is largely already in place

• Ensure Boards and sub-committees understand their roles in considering escalated quality-related information		
Commissioning Arrangements • Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements)	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements	In HEIW this is largely already in place
Hosting Arrangements • Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements)	A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into hosting arrangements	In HEIW this needs to be re-enforced
Quality Infrastructure • Review existing quality tools, processes, systems and improvement activity to identify current alignment with Health and Care Standards 2015, and therefore required realignment with Quality Standards 2023 • Develop a plan to align existing quality tools, processes, systems and improvement activity to Quality Standards 2023	A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023	In HEIW, these changes are not necessary as we have been using these new standards as the basis of our quality activity already
QMS General • Provide commitment to develop a quality management system in line with Duty of Quality and Quality and safety Framework 2021. • Start to review and consider what needs to be in place to develop a fully-functioning quality management system	A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps	In HEIW, we are already committed to a quality system aligned to the Duty of Quality

Communication & engagement • Develop local comms and engagement plan • Develop local comms and engagement material, building on national comms • Cascade DoQ messages throughout organisation	All staff are aware of key DoQ messages tailored to their organisation	In HEIW this needs to be implemented
Training and Education • Ensure at least nominated individuals at Board level have undergone training	At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ	In HEIW this needs to be implemented once the training programme by Improvement Cymru has been developed

Duty of Quality implementation in the NHS

Themes (and related Q&S Programme actions)	NHS organisation – <i>implementation task</i> and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - milestones to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
Leadership and culture (Q&SP Action 12b – Board development; Q&SP Action 14 – Workforce engagement to create quality-led system)	• Designate appropriate senior leads to hold responsibility for strategic implementation and oversight of duty (an officer member of Board) • Designate operational lead to support implementation of duty is also suggested • Provide willingness and financial support to develop skills and infrastructure to implement DoQ • Consider psychological readiness as well as the infrastructure, governance, system understanding and leadership in place for change • Create compelling vision for improved quality (that is recognised and intrinsically motivates staff at all levels) • Create a culture of quality within organisations – demonstrate responsibility for delivering DoQ in actions and behaviours • Think and act differently by applying the concept of quality across all functions • Ensure health services are organised and delivered in such a way that system-wide continuous improvement in the quality of health services is achieved • Encourage system-wide shared learning and expertise • Ensure “system” has resources, capacity, time and autonomy needed to develop approaches to improving quality • Exercise functions in a way that considers how quality and outcomes will be improved on an ongoing basis • All staff (clinical and non-clinical) have responsibility for complying with the duty in their role • Give staff at all levels the permission, opportunity and confidence to test new ideas to test quality that are aligned to organisation’s vision • Embed Welsh language considerations in the culture of quality	Implementation ownership • Designate an [officer] member of Board to hold responsibility for strategic implementation and oversight of duty • Designate operational lead to support implementation of duty Outcome: Senior responsible leadership in place and driving implementation work Vision and cascade / engagement • Create compelling vision for improved quality (that is recognised and intrinsically motivates staff at all levels) • Determine Quality roles and responsibilities for all staff Outcome: All staff recognise and understand the organisation’s Quality vision, and their roles within it Infrastructure • Provide willingness and financial support to develop skills and infrastructure to implement DoQ • Consider infrastructure, governance, system understanding and leadership in place for change • Create appropriate infrastructure for Quality • Provide support for implementing Duty Outcome: Commitment, resources and infrastructure in place to implement Duty effectively	• Ongoing work to achieve Business As Usual position
Decision-making	• Ensure that all strategic decisions are made through the lens of improving the quality of health services and outcomes for the population • Actively consider whether decisions made will improve service quality and secure improvement in outcomes for the population • Involve people in decisions that affect them	Board decision making • Develop processes and systems for informing and structuring Board decision-making to demonstrate consideration of quality (i.e. improved services and outcomes; Quality Standards 2023) • Develop processes and systems for capturing and recording decisions made by Board to provide evidence of quality considerations (for future reporting) Outcome: Processes and systems in place to provide demonstrable evidence that Board decisions have been made through Quality lens	All strategic decision-making – BY SEPTEMBER 2023 • Develop processes and systems for informing and structuring all strategic decision-making (to include organisational planning) to demonstrate consideration of quality (i.e. improved services and outcomes; Quality Standards 2023) • Develop processes and systems for capturing and recording all strategic decisions to provide evidence of quality considerations (for future reporting) Outcome: Demonstrable evidence that all strategic decisions and plans have been made through Quality lens • Ongoing work to achieve Business as Usual position

Themes (and related Q&S Programme actions)	NHS organisation – <i>implementation task</i> and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - milestones to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
Governance and accountability structures (Q&SP Action 10a – Quality Assurance Framework; Q&SP Action 11 – Quality indicators and measures; Q&SP Action 12b – Board development)	• <i>Integrate effective implementation and monitoring of DoQ into existing corporate governance frameworks, processes and procedures – including existing performance and quality reports</i> • Accountability for compliance rests with Chief Executive of NHS bodies • Responsibility to ensure due consideration to the duty applies to all officer and non-officer board members • Ensure internal governance and assurance arrangements are structured within a robust quality management system • Embed DoQ when designing or introducing new structures and processes • All committees must report to the Board on DoQ – not just Q&SC so that Board can seek assurance that DoQ is being discharged across system • Committees will need to ensure sustainable quality improvements are being maintained • Board Assurance Framework and strategic risk register must have due regard to meeting DoQ • Take account of DoQ when reviewing processes and assurance mechanisms e.g. planning of audit programmes	Board reporting • Ensure agendas of, and reports to Board from, all sub-committees and structures include Duty of Quality considerations (i.e. improved services and outcomes; Quality Standards 2023) Outcome: Board are assured that DoQ is being considered across system Governance documentation • Review [Board / Trust / SHA] Assurance Frameworks to ensure they support Duty of Quality • Review Risk Registers to ensure they support Duty of Quality • Review existing performance and quality reports to ensure they support Duty of Quality • Review any other existing standard governance documentation to ensure it supports Duty of Quality Outcome: Routine governance documentation is DoQ-ready	• Ongoing work to achieve Business As Usual position
Reporting and information (data to knowledge) (Q&SP Action 11 – Quality indicators and measures)	• Demonstrate [with evidence] how they exercised their functions and improved the quality of services in accordance with duty • Actively monitor progress on the improvement of quality services and outcomes and routinely share this information with their population • Report annually on the steps taken to comply with the duty of quality and assess the extent of improvements in outcomes • Annual report – describe progress and challenges on quality journey. Focus on information that will demonstrate the DoQ in decision-making, action taken following learning, quality improvement and improved outcomes. Signpost readers to “always on” reporting. Look back and look forward – ensuring continuity between years. Align annual report to Annual Report and Accounts process • Quality reporting must reflect the breadth of domains of quality, quality enablers and QMS • Develop “always on” reporting • Collate, monitor, and make information available within and outside of organisation – across QMS – recognition and sharing of good practice and early escalation and intervention in response to signals • Develop suite of measures and processes / systems that collect, analyse and feedbacks impact of improvement • Make use of information and reporting mechanisms already in place wherever possible • Adopt agile approach to mature quality reporting	External reporting / information • Identify / develop appropriate channel (web presence / infrastructure) for reporting DoQ progress externally • Develop and share roll-out plan for the publication of routine “always on” qualitative and quantitative information to include for example: ○ Patient experience information / PREMS ○ Progress against quality priorities ○ Infections and mortality rates etc ○ “You said, we did” Outcome: Mechanism and publication schedule / plan in place for sharing DoQ progress information externally Internal reporting / information • Ensure processes in place for escalating quality-related information by exception (outside tolerances) through internal structures • Ensure Boards and sub-committees understand their roles in considering escalated quality-related information Outcome: Quality-related information escalation mechanisms in place, with plans for review and consideration at appropriate level	Annual narrative report – POST MARCH 2024 • Draft content and structure for annual report to describe steps taken to comply with the duty of quality and assess the extent of improvements in outcomes • Finalise and publish report Outcome: First DoQ Annual report published • Ongoing work to achieve Business As Usual position

Themes (and related Q&S Programme actions)	NHS organisation – <i>implementation task</i> and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - milestones to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
	Welsh language considerations must be embedded quality reports		
Commissioning	- The duty is always the responsibility of the commissioning body - Ensure that services delivered by alternative providers (including primary care contractors and non-NHS organisations) will secure improvement in quality and outcomes	Commissioning arrangements Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements) Outcome: A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into all commissioning arrangements	Commissioning arrangements – BY SEPTEMBER 2023 - Amend commissioning arrangements to support DoQ Outcome: All commissioning arrangements incorporate DoQ requirements - Ongoing work to achieve Business As Usual position
Hosting	The DoQ remains the responsibility of host organisations	Hosting arrangements Review existing commissioning arrangements to identify where changes will be required to support DoQ (existing definitions in contracts, roles and responsibilities and DoQ reporting requirements) Outcome: A clear and corporately agreed understanding of changes required to incorporate DoQ requirements into hosting arrangements	Hosting arrangements – BY SEPTEMBER 2023 - Amend hosting arrangements to support DoQ Outcome: All hosting arrangements incorporate DoQ requirements - Ongoing work to achieve Business As Usual position
Quality Standards (Q&SP Action 2 – Health and Care Standards)	- Create system-wide understanding of what good quality looks like for the broad range of services - Take [new] quality standards into account for the purpose of discharging the duty - Need to ensure health services are safe, timely, effective, efficient, equitable and person-centred - Understand and have regard to the six domains and five enablers of quality within DoQ	Quality infrastructure - Review existing quality tools, processes, systems and improvement activity to identify current alignment with Health and Care Standards 2015, and therefore required realignment with Quality Standards 2023 - Develop a plan to align existing quality tools, processes, systems and improvement activity to Quality Standards 2023 Outcome: A clear understanding of changes required to existing quality infrastructure and agreed programme of work to align with Quality Standards 2023	Quality infrastructure – BY SEPTEMBER 2023 - Migrate quality infrastructure from Health and Care Standards 2015 to Quality Standards 2023 Outcome: Quality infrastructure clearly aligned to Quality Standards 2023 Local Quality Statements – FROM DECEMBER 2023 - Create local statements of what good looks like against the Quality Standards 2023 informed by Quality Statements from WG, NICE guidelines, professional standards etc with plan to regularly review / refresh. - Create processes to monitor progress and compliance with local quality statements Outcome: Routinely monitored, system-wide understanding of what good quality looks like for the broad range of services. - Ongoing work to achieve Business As Usual position
Quality management system – general (Q&SP Action 12a – Local development of QMS; Q&SP Action 13 – Toolkit for assurance of QMS)	- Strengthen quality management systems with quality-driven decision making and planning - Ensure that NHS organisations develop quality management system with appropriate focus on quality control, quality planning, quality improvement and quality assurance with the aim of achieving a learning and improving environment	QMS – General - Provide commitment to develop a quality management system in line with Duty of Quality and Quality and safety Framework 2021. - Start to review and consider what needs to be in place to develop a fully-functioning quality management system Outcome: A clear understanding of, and commitment to, a quality management system, with plans in place to identify requirements and current gaps	QMS – General – BY SEPTEMBER 2023 - Develop a roadmap for establishing quality management system - Implement roadmap Outcome: Quality Management System road map agreed and implemented - Ongoing work to achieve Business As Usual position

Themes (and related Q&S Programme actions)	NHS organisation – <i>implementation task</i> and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - milestones to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
Quality management system – Planning (Q&SP Action 8 – Planning for Quality)	• Understand readiness for change – identify capability gaps and have plan to address them • Continually seek to understand the needs of their population to inform their decision-making and secure improvement in outcomes • Demonstrate long-term commitment (and investment) to improving quality when setting strategic direction • Prioritise national and regional initiatives and recommendations that fit the organisation’s way of working • Ensure initiatives to improve quality are consistent with their overall strategy, and identify and unlock barriers • Plan to deliver the outcomes that matter to people with the resources available in a way that is sustainable	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Improvement (Q&SP Action 9 – Capacity and capability for improvement; Q&SP Action 14 – Workforce engagement to create quality-led system)	• Leaders champion improvements in quality that are strategically aligned, driven and owned by teams • Develop systematic approach to managing quality that includes building improvement capability – general and specialist improvement skills • Ensure learning from success and failures (weaker areas)	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Control (Q&SP Action 11 – Quality indicators and measures; Q&SP Action 14 – Workforce engagement to create quality-led system)	• Use regular assessments, investigations and measurement over time to identify areas to improve quality • Develop operating models to standardise core processes and activities to address variations in quality • Collate, monitor, and make information available within organisation – across QMS – recognition and sharing of good practice and early escalation and intervention in response to signals	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Quality management system – Assurance (Q&SP Action 10a – Quality Assurance Framework; Q&SP Action 11 – Quality indicators and measures; Q&SP Action 13 – Toolkit for assurance of QMS)	• Satisfy themselves that they are complying with the duty • Demonstrate long-term commitment to improving quality when seeking assurance of delivery • Seek assurance that quality improvement activities are sustainable • NHS bodies will conduct an assessment of the extent of any improvement in outcomes achieved, through e.g. self-assessment, peer review, clinical audit etc (quality assurance)	Development area – no specific minimum requirements by April 2023	• Ongoing work to achieve Business As Usual position
Communication and engagement (Q&SP Action 14 – Workforce engagement to create quality-led system)	Not in Statutory Guidance but enabling activity	Communication and engagement • Develop local comms and engagement plan • Develop local comms and engagement material, building on national comms • Cascade DoQ messages throughout organisation Outcome: All staff are aware of key DoQ messages tailored to their organisation	Ongoing communication and engagement

Themes (and related Q&S Programme actions)	NHS organisation – <i>implementation task</i> and Business As Usual. Taken directly from draft Statutory Guidance	NHS organisation - milestones to be completed BY APRIL 2023	NHS organisation – subsequent actions AND TIMESCALES
Training and education (Q&SP Action 12b – Board development; Q&SP Action 14 – Workforce engagement to create quality-led system)	Not in Statutory Guidance but enabling activity	Training and education • Ensure at least nominated individuals at Board level have undergone training Outcome: At least one member of Board trained, knowledgeable and able to influence Board in relation to DoQ	Training and education – BY JUNE 2023 • Undertake organisational training needs analysis • Develop training plan • Ensure full Board has undergone training Outcome: Board trained, knowledgeable and operationalising DoQ requirements Training and education – BY DECEMBER 2023 • Train remaining staff in line with training needs analysis and training plan. Outcome: All staff trained to determined appropriate level
Tools and methodologies (Q&SP Action 13 – Toolkit for assurance of QMS)	Not in Statutory Guidance but enabling activity	Development area – no specific minimum requirements by April 2023	



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

Meeting Date	26th January 2023	Agenda Item	3.4
Report Title	New Welsh Government Duty of Quality and Candour and its relevance to HEIW		
Report Authors	Professor Pushpinder Mangat, Medical Director, Lisa Llewelyn, Director of Nursing & Health Professional Education		
Report Sponsor	Professor Pushpinder Mangat, Medical Director		
Presented by	Professor Pushpinder Mangat, Medical Director Lisa Llewelyn, Director of Nursing & Health Professional Education		
Freedom of Information	Open		
Purpose of the Report	To update the Board of HEIW on the Duty of Quality and Candour Legislation and its relevance to HEIW		
Key Issues	• The Duty of Quality and Candour through the Health and Social Care (Quality and Engagement (Wales) Act 2020, will come into force on 1st April 2023 using new Quality Standards which will supersede the Quality standards 2015 • This duty applies to HEIW. • This duty incorporates Prudent and Value Based Principles		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
	✓		
Recommendations	The Board is asked to 1. Note the draft expectations from Welsh Government and timelines 2. Note the creation of an internal Steering group to implement the Duties of Quality and Candour in HEIW 3. Support the need for a full update on implementation at the March Board.		

New Welsh Government Duty of Quality and Candour and its relevance to Health Education and Improvement Wales.

1. INTRODUCTION/ BACKGROUND

Ultimately, the purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide.

On the 25th October 2022, the Minister for Health in Welsh Government, Eluned Morgan launched a consultation about the duty of quality. This is intended to come into force on first April 2023.

This strengthened duty of quality which supersedes the Healthcare Standards of 2015, will apply to all NHS bodies in Wales including HEIW as well as on Welsh government and Welsh ministers in their health related functions.

2. WHAT DO WE MEAN BY DUTY OF QUALITY

Quality is defined by the six domains of healthcare with a much greater emphasis on improvement - it is more than just meeting service standards. It needs to be a system-wide way of working. The purpose of this legislation is to secure ongoing improvements in the quality of services provided within healthcare.

Quality means **safe, timely, effective, efficient, equitable and person-centred** health care - 6 domains of healthcare as defined by the Institute of Medicine (IOM) in Crossing the Quality Chasm (2001) and further refined by the Institute of Healthcare Improvement (IHI), who further reinforced this as an improvement approach – ‘which is embedded within a **culture of continuous learning and improvement**’

The guidance describes the overarching requirements to **strengthen our quality management systems with quality-driven decision-making and planning**. In turn, this strengthens our learning and sharing responsibilities and opportunities.

The proposed Duty of Quality is currently out to consultation and HEIW have been granted an extension to the end of January 2023 for final submission.

3. DEFINITION OF QUALITY

Six Domains

Safe	S
Timely	T
Effective	E
Efficient	E
Equitable	E
Person centred	P

Five Enablers

Leadership
Culture and Valuing People
Data to Knowledge
Learning, Improvement & Research
Whole System Perspective

These six domains and 5 enablers are collectively called the **Quality Standards 2023, which supersede the Quality Standards that were in place from 2015.**

These will be used to create a “golden thread” used by Welsh Government, The NHS bodies, Health Inspectorate Wales (HIW) and the new NHS Executive (via the new National Clinical Framework).

4. DUTY OF QUALITY AND RELEVANCE TO HEIW

The duty of quality applies to ***Special Health Authorities*** that operate on a Wales-only basis including HEIW.

Accountability for the duty of quality ultimately rests with the Chief Executive of an HEIW who may designate a lead officer and senior operational lead to oversee the implementation of the duty in the organisation. However, all Board members are collectively responsible for the implementation of the duty of quality.

All NHS bodies are responsible for exercising their functions with a view to securing improvement in the quality of health services. ***This includes services that they commission from other providers*** - NHS partners and Higher Education Institutions in our case.

Welsh Ministers and ***NHS bodies will need to be able to demonstrate, (supported by evidence), how they have complied with the duty of quality***

All staff have a role in achieving improved service quality; the duty of quality applies to all health service functions in both clinical and ***non-clinical settings***

System-wide learning and sharing is actively encouraged

5. HEIW MEETING THE DUTY OF QUALITY

There are six steps that HEIW needs to plan to sustain the focus on improving quality, underpinned by a clear understanding of what good quality looks like for the organisation.

These are:

1. Securing Board support
2. Assessing readiness
3. Securing wider organisational buy-in and co-creating a vision

4. Developing improvement skills and infrastructure
5. Aligning and coordinating activity
6. Sustaining an organisation-wide approach

We received DRAFT guidance and expectations from Welsh Government in mid January 2023 on which steps are expected by 1st April 2023. There are further deadlines in June, September and December 2023. There is a new deadline for submitting an annual report which is after March 2024. (**Appendix 3**)

The reporting from HEIW will be unique as our Duty of Quality will be related to our supportive functions and to our Education and Training responsibilities.

A Steering Group will be established to oversee implementation of the actions included in the guidance. This will be chaired by the Medical Director and will involve all relevant Directorates.

6. ACTIONS REQUIRED BY HEIW BY 1st APRIL 2023 FOR DUTY OF QUALITY

These are summarised in **Appendix 2**

7. EXISTING QUALITY ACTIVITY IN HEIW

a. Postgraduate Clinical Training

Existing Quality Assurance process for Postgraduate Medical Training governed by the General Medical Council (GMC) that has been recently reviewed by the regulator and subjected to Internal Audit Scrutiny as fit for purpose.

Using this as a baseline we are close to finalising a multiprofessional Quality

Within the HEIW 2022-2023 IMTP there is an objective to develop an HEIW wide Multiprofessional Quality Framework. This is on track to be completed by quarter 4.

b. Quality Management Hub

We are in the process of mainstreaming our Quality Activity across HEIW so that the Quality Framework can be applied to all areas of HEIW activity.

c. Quality Improvement Skills Training

We have a very mature Quality Improvement Skills Training programme. This programme was originally created for postgraduate medical trainees. It has now been extended across all postgraduate deaneries and all HEIW staff.

d. Evaluation, Research, Innovation & Improvement Collaborative (ERIIC)

We are developing and infrastructure for evaluation, research, innovation, and improvement within a single function called ERIIC.

e. Governance

Quality reports are regularly provided to the executive team and to the Education Commissioning & Quality Committee (ECQC) which is a committee of the full Board.

f. Other Elements

Within HEIW we have an established leadership function which delivers training for aspiring leaders across the whole of Wales.

We have an expanding function in the digital arena which includes the appointment of the executive director for digital and an increasing responsibility for gathering data relating to workforce.

We have aligned all our functions to the Welsh language act. Where possible we are providing education through the medium of Welsh. Our public meetings offer Welsh translation, and our aim is to continue embedding the Welsh language across all that we do.

8. DUTY OF CANDOUR AND RELEVANCE TO HEIW

The Duty of Candour is applicable to an NHS body where both of the following conditions are met:

- A person (the 'service user') to whom health care is being or has been provided by the body has suffered and adverse outcome
- The provision of the health care was or may have been a factor in the service user suffering that outcome

(S 3 Health and Social Care (Quality and Engagement) (Wales) 2020)

As Health Education and Improvement Wales does not provide direct patient care it is acknowledged that the Duty of Candour will rarely if ever be applicable to the organisation in a direct sense. However, it is possible that the Duty of Candour may be applicable where there is an issue involving educational supervision, although it should be emphasised that no such issue has arisen since HEIW was established. Given this, the organisation has a legal responsibility to comply with the requirements of the Duty of Candour principles.

9. HEIW SATISFYING THE DUTY OF CANDOUR

Lisa Llewelyn, Director of Nurse and Health Professional Education is the executive lead for implementing the Duty of Candour. Discussions are underway to agree the infrastructure to support the implementation of the Duty of Candour.

To enable the Duty to be enacted from April 2023, an implementation plan for the Duty is in development and will be agreed by the Executive Team and Board.

Various education and training materials have been developed nationally and will be made available to raise awareness for all staff about their responsibilities; as well as specific training to relevant staff involved in reporting requirements.

As a commissioner of education and training, Health Education and Improvement Wales will also have a role to play in ensuring the provision of education and training to trainees and students in respect of the Duty of Candour.

10. GOVERNANCE AND RISK ISSUES

Welsh Government expect that building and embedding these concepts can take a number of years. New structures and processes that are established must embed the duty of quality requirements.

Our reporting responsibilities on the duty of Quality will be via regular IQPD meetings with Welsh government, via the two joint executive team meetings with Welsh government and by the publication of the annual quality report alongside the annual report and accounts

We will create an internal Steering group in HEIW to implement the requirements of Duty of Quality and Candour.

11. FINANCIAL IMPLICATIONS

There may be financial risks where investment is required to satisfy the duty of Quality and Candour.

- We will be required to ensure that our trainees and staff are familiar with the requirements, which may entail a financial cost.
- There may be costs related to supporting our research and evaluation ambitions
- There may be costs related to fully implementing our quality functions within HEIW.

12. RECOMMENDATIONS

The Board is asked to:

1. Note the draft expectations from Welsh Government and timelines
2. Note the creation of an internal Steering group to implement the Duties of Quality and Candour in HEIW
3. Support the need for a full update on implementation at the March Board.

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
Quality, Safety and Patient Experience			
A duty of Quality is Intrinsic in the provision of Safe Quality Care			
Financial Implications			
Not known at this stage			
Legal Implications (including equality and diversity assessment)			
This will be a legal requirement from April 2023			
Staffing Implications			
None known at the present time.			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
Report History	None		
Appendices	1. The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023 2. Summary of required actions by HEIW by April 2023 3. DRAFT Roadmap from WG on implementation of Duty of Quality		



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Health Education and
Improvement Wales (HEIW)

Meeting Date	26 January 2023	Agenda Item	3.5
Report Title	Genomics in NHS Wales		
Report Author	Dorothy Edwards, Programme Director – National Programmes		
Report Sponsor	Alex Howells, Chief Executive		
Presented by	Alex Howells, Chief Executive		
Freedom of Information	Open		
Purpose of the Report	This report provides the Board with an update with regards to genomics setting out: • our involvement in the national Genomics Partnership Wales Programme • the UK Government Strategy and 4 nations shared commitments re workforce • workforce actions within the Welsh Government Genomics Delivery Plan • workforce themes and priorities that HEIW are progressing.		
Key Issues	Genomics medicine is a rapidly advancing discipline that offer opportunities to transform the delivery of health care and public health. A UK wide Genome Strategy is in place and Welsh Government have recently launched a Genomics Delivery Plan for Wales. The Genomics Delivery Plans set out actions for the period 2022-25 including a requirement for HEIW to work in partnership with Genomics Partnership Wales (GPW) to develop a Strategic Workforce Plan that ensures that Wales has the right level of specialist expertise within the workforce to benefit, but also that the non-specialist workforce is up-skilled. This action will be a specific objective within the IMTP from 2023-24. There is likely to be a separate national plan around pharmacogenomics which is advancing rapidly. We will need to consider the infrastructure needed within HEIW to ensure that the workforce plan can be developed and implemented, drawing on access to UK wide commitments including benefiting from the Genomics Education Programme (GEP).		

	Some work has been initiated during 2022/23 to develop educational resources including reshaping the previous Masters in Genomics programme to a modular approach and the development of an e-learning package which will be launched shortly. It is likely that genomics will continue to rapidly grow and advance subject to constraints around workforce capacity in key areas (including laboratory medicine) and the availability of specialist skills to analyse and interpret data.			
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance	Approval
		✓		
Recommendations	Board members are asked to: • note the launch of a Genomics Delivery Plan for the NHS in Wales and the requirement for HEIW to work in partnership with Genomics Partnership Wales to develop a strategic workforce plan which will be a specific IMTP objective for 2023/24 • note the UK wide arrangements that underpin the UK Genome Strategy • note the initial work to develop specific educational resources within Wales to support emerging requirements.			

GENOMICS IN NHS WALES

INTRODUCTION

This report provides the Board with an update with regards to genomics setting out:

- our involvement in the national Genomics Partnership Wales Programme
- the UK Government Strategy and 4 nations shared commitments re workforce
- workforce actions within the Welsh Government Genomics Delivery Plan
- workforce themes and priorities that HEIW are progressing.

BACKGROUND

Genomics

For decades, developments in genetics have appeared a future ambition with a small specialist focus. Genomics is now revolutionising the way we think about healthcare. It is providing us with a far more detailed understanding of what causes illness and infectious disease and is underpinning the development of new inventions that would have been unobtainable a decade ago.

In recent years these have moved at such a pace that genomic testing is now increasingly becoming a reality for people diagnosed with cancer, living with rare diseases or with other conditions, with sequencing of full genomes now available.

For the genomics specialist healthcare scientists, genetic counsellors and medical consultants, demand on their service is rapidly increasing as understanding, testing, treatments and uptake grow at pace. Across the whole NHS, there is now the need to understand the roles of genomics in all services. This will have a significant impact on both the specialist genomics workforce but also other working within a range of non-specialist areas where clinical pathways and treatment options will be impacted by advances in genomics medicine.

Genome UK Strategy & 4 Nations Shared Commitments

In 2020, UK Government published the 10 year Genome UK strategy, a vision for transformation of genomic healthcare. This includes a cross-cutting theme of “Workforce development and engagement with genomics through training, education and new standards of care”.

This theme details a vision to:

- support the NHS workforce to develop and acquire the necessary scientific and clinical skill sets and understanding of genomics, including bioinformatics
- communicate about genomics in an accessible way
- prioritise workforce and training in spending and policy considerations
- implement a framework of skills across the sectors, identifying the major skills shortages in each and propose new ways of training to keep up with demand.
- develop clinical pathways and standards of care that fully incorporate the latest genomic testing and results.

The strategy describes that to achieve, maintain and measure success over the next 10 years, the UK will:

- ensure that all new graduating doctors, nurses, midwives, pharmacists, allied health professionals, dental and relevant nonclinical staff have a level of awareness and knowledge of genomics that is relevant to their role
- ensure that the healthcare science workforce continues to have advanced genomic training and education within their programmes
- put in place continuing professional development programmes to ensure all relevant staff maintain an up-to-date and role-appropriate understanding of genomics
- utilise workforce modelling data to inform investment decisions for training numbers across all professions and support workforce growth to meet the needs of the genomic medicine service particularly in specialist scientific and medical workforce areas
- establish and invest in training pipelines for in-demand occupations such as bioinformatics to build capacity within the health service and the wider sector
- redevelop clinical pathways and standards of care to that fully incorporate the latest genomic testing and results.
- support the NHS workforce by providing simple, practical, informatics solutions for training, genomic analysis and decision-support.

In 2014, Health Education England (HEE) launched a 4-year £20 million Genomics Education Programme (GEP), working with services across the 4 nations to develop online materials and training approaches.

Genomics Partnership Wales

Genomics Partnership Wales (GPW) was established in 2018 with partners including:

- Patients and the public
- All Wales Medical Genomics Service
- Pathogen Genomics Unit (PenGU), Public Health Wales
- Wales Gene Park
- HEIs in Wales
- Welsh Health Specialised Services
- NHS Wales Informatics Service
- Health Education Improvement Wales
- Welsh Government

The aim is to ensure that genomics for precision medicine became mainstreamed across health and care in Wales, recognising the importance of earlier and more personalised diagnostics to prevent illness, intervene appropriately and prolong independent living.

Although there is a clear commitment to work at a UK level on the development of workforce programmes, this has probably not been progressed as originally

envisaged and there is a need to build relationships between HEIW and the other home nations to identify opportunities to work together and share approaches.

A Genomics Workforce and Training Group established within the governance of Genomics Partnership Wales has focussed on development of supplementary online learning for Wales to detail processes and referrals relevant here, and on a new commission for multi-professional Level 7 modules, to replace a previous, poorly accessed clinical masters programme.

Welsh Government Genomics Delivery Plan 2022

In December 2022, Welsh Government released the Genomics Delivery Plan for Wales covering the period 2022 –2025. The plan sets out a range of actions across 4 delivery pillars:

- Delivery theme 1 – People
- Delivery theme 2 - Clinical Services
- Delivery theme 3 – Research and Innovation
- Delivery theme 4 – Enablers.

HEIW will play a critical role in delivery theme 1 with specific actions focussing on:

- Attracting, developing and retaining a highly-skilled, motivation and dedicated genomics workforce including that there are clear career routes for scientific and clinical roles
- Determining the training needs of the wider healthcare and academic workforce in genomics and providing training opportunities for NHS Wales staff to up-skill the non-genomics healthcare workforce.

There is a requirement to produce, in partnership with GPW, a strategic genomics workforce plan to include:

- development of all professions in the specialist genomic workforce to meet increased demand for genomics; this will be in alignment with other workforce plans and national developments, and include increasing staff numbers, reviewing skill mix, development of the data/digital workforce, and considering other ways to increase capacity to meet patient demand such as extended working hours for the clinical and diagnostic service.
 - details and a set of tools to upskill the wider healthcare workforce in genomics that may include:
 - Providing new training packages;
 - Identifying a dedicated genomics education and training officer in every hospital/postgraduate centre;
 - Setting up a network of dedicated genomics quality leads across Wales;
 - Ensuring there are national genomics leads for core specialties and alignment to workforce plans across relevant areas including oncology, pharmacy, cardiology, psychiatry, paediatrics, neurology, ophthalmology.

- Supporting staff to be both confident and competent about taking consent for genomic tests and interpreting the results as well as discussing the implications of the results with patients.
- the development of clinical research in genomics by increasing the Research and Development workforce, including the creation of new clinical and non-clinical lecturer and/or senior lecturer posts, high-level degree studentships and post-doctoral research officer positions.
- links to UK-wide workforce and education initiatives as part of the UK Shared Commitments with collaboration through the Genomics Training Academy.

HEIW Current Developments

HEIW has recently finalised the procurement of Level 7 modules and work is also nearly completion on an e-learning resource to educate the broader workforce and to act as a bridge to the development of more advanced knowledge via the modular approach. The first cohort of students will start February 2023.

An e-learning resource to up-skill the workforce is being developed and should be available for launch during Q4 on the Y Ty Dysgu platform.

These two pieces will only be the first step in what will be required as a comprehensive programme to prepare the workforce in NHS Wales for the future.

Recognising that HEIW needs to grow its expertise in this field to support the development of the broader workforce plan and to network effectively with other UK nations, HEIW are proposing to investment in clinical leadership so that by the start of April 2023, work on the strategic workforce plan can commence and that good progress can be made during 2023/24.

GOVERNANCE AND RISK ISSUES

Nationally, governance of the Genomics programme sits within the National Diagnostics Board chaired by the Deputy Chief Executive of NHS Wales. The governance of this board has recently been refreshed.

Internally, the genomics work will be coordinated through the new Planned Care, Cancer and Diagnostics Forum. There are gaps in key workforce area (such as laboratory medicine and bioinformatics) that could act as a brake on progress and it is critical that sufficient attention is paid to this rapidly advancing area of medicine. There is a risk that the non specialist workforce lacks the appropriate skills to be able to adapt to new treatment pathways and that benefits from the investment in genomics will not be realised.

A strategic approach is needed that recognises HEIW's role as an enabler of quality education and training within NHS Wales working with employers and partner organisations.

FINANCIAL IMPLICATIONS

The improved collaborative approach to strategic development will enable clarity of vision and need for the professions at the core of diagnostics to be incorporated into the 2024/25 Education and Training Plan.

The cost of clinical leadership will be factored into budgets for 2023/24.

RECOMMENDATION

Board members are asked to:

- note the launch of a Genomics Delivery Plan for the NHS in Wales and the requirement for HEIW to work in partnership with Genomics Partnership Wales to develop a strategic workforce plan which will be a specific IMTP objective for 2023/24
- note the UK wide arrangements that underpin the UK Genome Strategy
- note the initial work to develop specific educational resources within Wales to support emerging requirements.

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development, and wellbeing of a competent, sustainable, and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	√	√	
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer, and leader
	√		√
Quality, Safety and Patient Experience			
Genomics will have a significant impact on the delivery of patient care over the medium term and through personalised treatment options will improve the quality and safety of treatments offered as well as improving patient experience.			
Financial Implications			
There will be financial implications to securing clinical leadership and investing in quality education and training. These will be fully scoped as part of the development of a comprehensive workforce plan for genomics.			
Legal Implications (including equality and diversity assessment)			
There are no legal implications identified at this stage.			
Staffing Implications			
A part time Clinical lead role is needed to start to develop a work programme.			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
These will be assessed as part of the development of a strategic workforce plan.			
Report History	N/A		
Appendices			



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Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

Meeting Date	26th January 2023	Agenda Item	4.1
Report Title	Review of Education & Training Activity 2022/23		
Report Author	Joe Draper-Orr, Head of Resources; Sophie Fuller. Planning and Performance Business Partner.		
Report Sponsor	Rhiannon Beckett, Interim Director of Finance, Push Mangat, Medical Director and Lisa Llewellyn, Director of Nursing and Health Professional Education		
Presented by	Rhiannon Beckett, Interim Director of Finance; Push Mangat, Medical Director and Lisa Llewellyn, Director of Nursing and Health Professional Education		
Freedom of Information	Open		
Purpose of the Report	To provide the HEIW Board with a report on Education & Training Activity and the financial impact of that activity in the 2022/23 financial year.		
Key Issues	Since establishment HEIW has secured significant additional investment in education and training with support from Welsh Government, with funding increasing from £185m in 2019/20 to £248m in 2022/23. The investment has created additional places in education and training programmes and with the benefit of expanding pipelines into employment as well as enabling transformation work to redesign and reset education and training to aid in developing a sustainable service fit for the future. The work undertaken by HEIW in collaboration with Health Education Institutes (HEI's) and NHS Organisations strives to ensure that Wales is the best place to Train, Work and Live. 2022/23 has been an exceptionally challenging year for a range of external and environmental factors which have contributed to a dip in application rates and fill rates, and an increase in attrition from some health professional programmes. Additionally, the economic environment has eroded the appeal of the student bursary package with a continued trend of more students choosing to opt out of the scheme.		
Specific Action Required	Information	Discussion	Assurance
(please ✓ one only)	✓		

Recommendations	The Board is asked to: • note the recent trends in education & training activity and the actions in progress to improve the position for subsequent academic cycles • note that this has resulted in an exceptional in year underspend in 2022/23 • support the repatriation of additional funding to Welsh Government as detailed in the Finance paper that is also on the agenda.
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REPORT OF THE DIRECTOR OF FINANCE

1. INTRODUCTION

Since establishment HEIW has secured significant additional investment in education and training with support from Welsh Government, with funding increasing from £185m in 2019/20 to £248m in 22/23. The investment has secured the benefits of creating additional places in education and training programmes and expanding pipelines into employment as well as enabling transformation work to redesign and reset education and training. Work undertaken by HEIW in collaboration with HEIs and NHS Organisations strives to ensure that Wales is the best place to Train, Work and Live.

Notwithstanding this, 2022/23 has been an exceptionally challenging year for a range of external and environmental factors which have contributed to a dip in fill rates and increase in attrition from health professional programmes and potentially in a dip application rates for the next academic year. Additionally, the economic environment has eroded the appeal of the student bursary package with a continued trend of more students choosing to opt out of the scheme than ever before.

The actions being taken to understand, adapt and respond to these delivery challenges are set out in the body of the report below.

2. BACKGROUND

Spend on education and training has increased by 34% between 2019/20, the first full year since HEIW was established, and 2022/23 the current year, as shown in Table 1 below. The increased level of funding has been supported by WG through prioritised investment in HEIW's baseline through the process of submission and approval of the Education and Training Commissioning plan. Increases have been seen across all the professional groups included in Table 1.

Fig 1 Education and Training spend by year

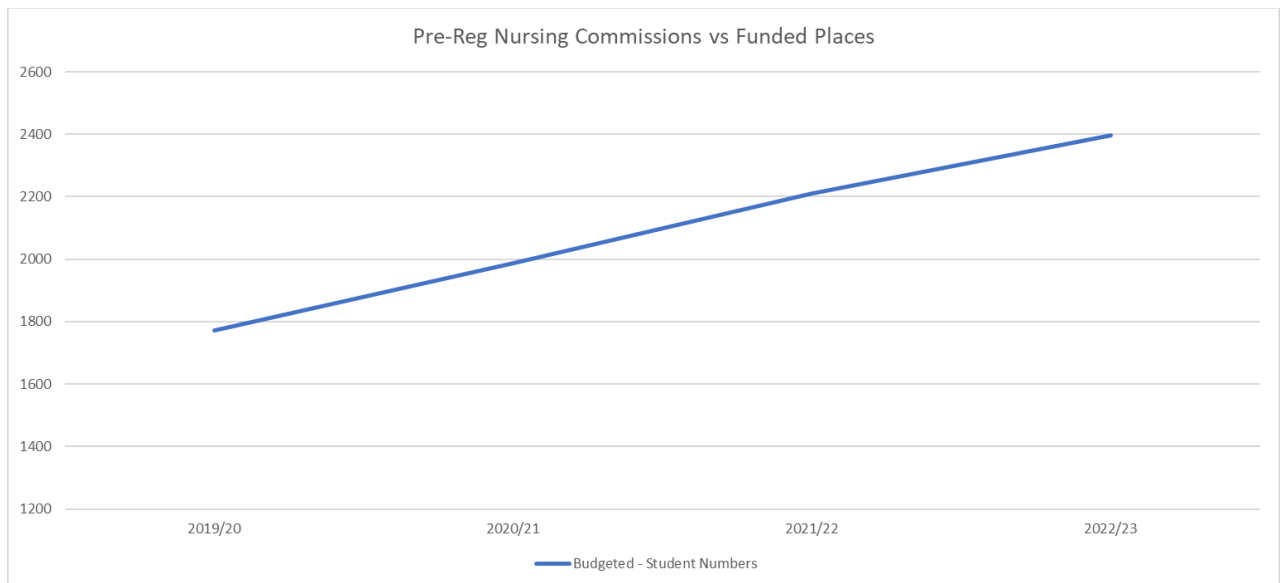
Commissioning Area	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 Forecast £m
Health Professional Education	105.16	108.23	120.18	123.67
GP	18.56	24.56	30.67	35.47
Dental*	0.00	4.07	8.54	9.01
Medical	56.41	58.86	63.81	68.41
Pharmacy	5.28	7.34	8.87	11.66
Total	185.41	203.07	232.08	248.22

*It should be noted that Dental Foundation Training transferred into HEIW from WG part way through the 2020/21 year and fully in 2021/22.

2.1 Healthcare Professional Education

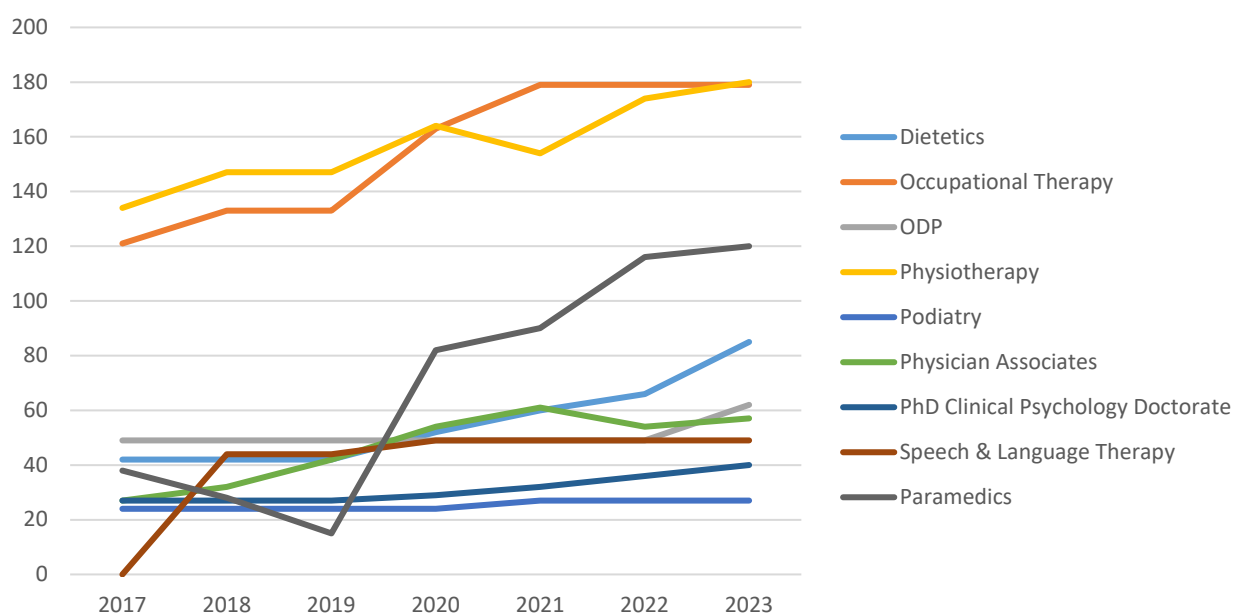
The increased investment has enabled additional places to be commissioned across programmes, with the most significant increase in commissioned numbers seen in pre-registration nursing places.

Fig 2 Increase in Pre-Registration Nursing Commissioned Places



The chart below shows the increase in commissioning numbers across other Health Professional Courses through deployment of the additional investment made by Welsh Government and enacted through HEIW's commissioning arrangements with HEIs and in partnership with other NHS Organisations.

Fig 3 Increase in commissioning number across Health Professional work areas



During the 2022/23 financial year particular challenges have been experienced that, following detailed analysis and investigation, can be attributed to a range of external and environmental factors.

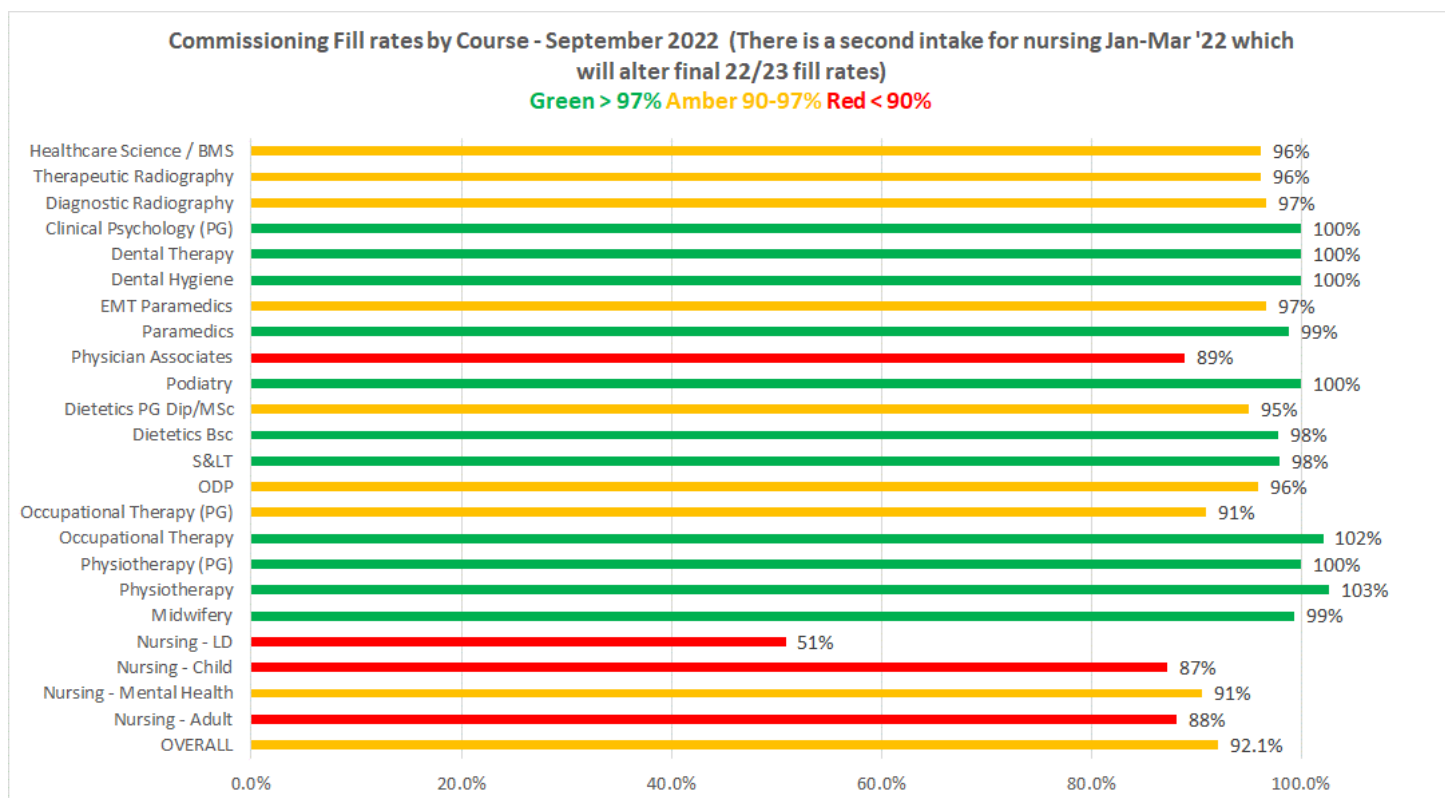
A dip in fill rates and increase in attrition from health professional programmes has been identified which is impacting on the ability of HEIs to deliver the commissioned numbers and generating an underspend position against commissioning budgets within HEIW. Additionally, the economic environment has eroded the appeal of the student bursary package with more student choosing to opt out of the scheme.

Recruitment

Traditionally fill rates have been very high for the September cohort in each academic year with a 98.5% rate in 2020 and 99.4% in 2021. This dropped to 94.5% in September 2022, and the detail is shown on Fig 4. However, this recruitment figure does represent the recruitment of 2,533 healthcare professionals which is the highest number ever recruited in a September cohort.

The spring cohort has traditionally been more difficult to recruit to with a lower fill rate in 2022/23. This is due to a number of factors, firstly students attracted to the spring cohort are typically those that are non-traditional students looking for the university experience. It is also an opportunity for those that weren't able to join the September cohort to still begin the education. As commissioning numbers increase in September recruitment the requirement to accommodate those that didn't join in the spring has reduced.

Fig 4 Fill rates by course for September 2022



Universities are reporting the reasons for the decrease in applications being negative media coverage of the NHS, and attractiveness of the bursary package and cost of living issues. Health Education England is also reporting that challenges for clinical student numbers are beginning to emerge, with local intelligence suggesting that the combination of economic factors and NHS service pressures are reducing training uptake.

An extract from the HEE performance report states that

“Regions have been supporting Education Providers as they recruit clinical students to the new academic year. This year has been particularly challenging with Education Providers reporting that students are deferring or deciding not to apply due to issues such as the cost of living. HEE collects data from Education Providers on training uptake from the end of October, however, the complete data is not expected to be available until January.”

Commissioning arrangements are different in the other home nations which makes detailed benchmarking more difficult however, through our good relationships we understand they are experiencing similar issues.

Funding for commissioning within Health Professional Education is deployed across three categories of spend:

- Payment of University Tuition Fees for Students who opt to take the bursary

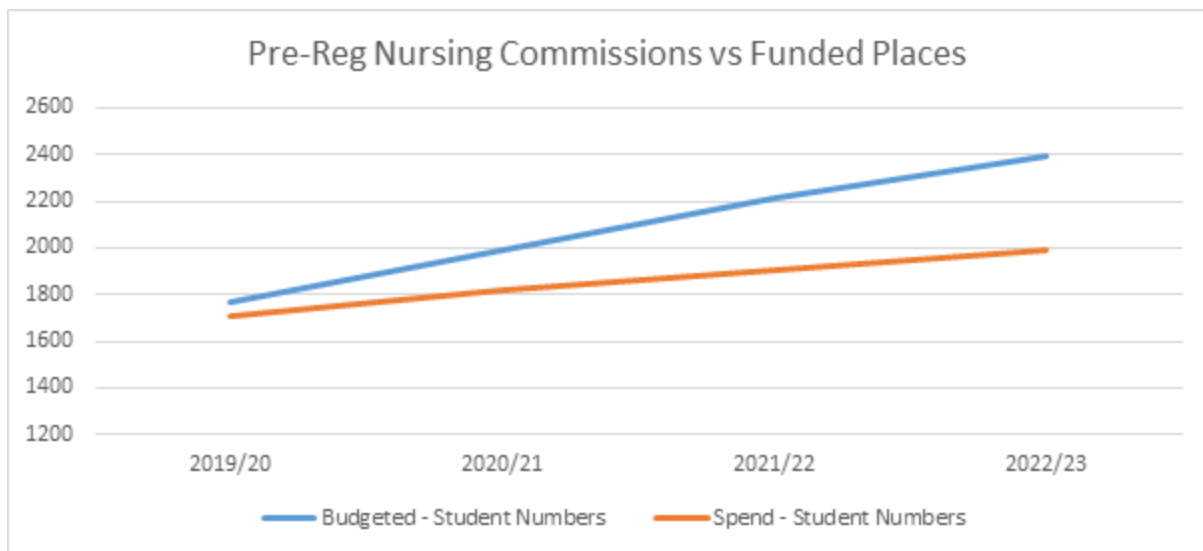
- Payment of maintenance Bursaries for University Students which can include payments for childcare, Travel and Subsistence
- Payment of Salary Costs for backfill of students who are employed and undertaking training

Underspend is generated when fewer students are recruited than planned, fewer students take up bursaries than planned and students drop out of courses part way through the term of the course. When Universities delay the start date of newly commissioned courses for any reason an underspend also occurs, and contract change notices are issued to allow for these changes in contract delivery

The number of student places commissioned at the beginning of a financial year against the actual number of students in places

Although the following chart is only in respect of Pre-Registration Nursing, it does show the gap between the numbers of commissioned places and the challenge in the current academic year.

Fig 5 Pre-registration nursing commissions vs funded places



For 2022/23, across education and commissioning the impact of the under recruitment to the Spring and Autumn cohort totals £6.98m.

Attrition

Attrition is the term widely used to report the number of students recruited to a healthcare degree that either did not graduate or failed to do so within the expected timeframe.

The following data refers to attrition across the lifecycle of learning which is when students start but don't complete the course.

Area of commissioning	% Of students
Nursing	16.9
Midwifery	6.2
Allied Health Professional (AHP)	5

Within nursing we have seen a five percent increase in attrition across the lifecycle of the learning since 2018/19 when it was 11.8%. Feedback indicates that this is linked to the rise in cost of living and the structure of the bursary offer remaining the same, and leavers reporting stress.

Midwifery attrition spiked slightly in 2019/20 but returning to around 6% for 2020/21 and 2021/22.

AHP lifecycle attrition remained largely the same at 5%.

Historically levels of attrition have been reasonable and better than in other parts of the UK, subject to the availability of published comparable data, with England reporting more than 20%. The financial impact of attrition for this financial year totals £3.373m.

Bursary Uptake

Finally, there is a financial impact in relation to the take-up rates of the bursary for recruited students. If a student chooses to self-fund then there will be no cost to HEIW which could result in an underspend should the number exceed our assumptions which are based on historical rates of take up.

Fig 6 numbers recruited into the Bursary Packages and those who choose to self-fund

	2020.21			2021.22			2022.23		
	Numbers Recruited Into the NHS Bursary Package - Zyr tie In	Percentage of those that opted for NHS Bursary Package	Numbers Recruited - Self-funders	Numbers Recruited Into the NHS Bursary Package - Zyr tie In	Percentage of those that opted for NHS Bursary Package	Numbers Recruited - Self-funders	Numbers Recruited Into the NHS Bursary Package - Zyr tie In	Percentage of those that opted for NHS Bursary Package	Numbers Recruited - Self-funders
Total	2266	84.43%	418	2254	81.90%	499	1836	82.50%	390

The table below shows the uptake of bursary and the spend on bursary costs for each of the past 5 academic years. As above, the 2022/23 financial year does not include the spring cohort and so the total spend will increase at the end of the year once these are confirmed.

Fig 7 Uptake of and spend on bursary

Bursary take up	Numbers Recruited into the Bursary Package - 2yr tie in	Numbers Recruited - Self-funders	% Of Students Recruited into the Bursary Package	Spend on Bursary Costs (Financial Year)
2018.19 Academic Year (Year 1 students)	2,198	172	92.7%	£23,842,516

2019.20 Academic Year (Year 1 students)	2,107	336	86.2%	£23,125,913
2020.21 Academic Year (Year 1 students)	2,251	418	84.3%	£23,092,561
2021.22 Academic Year (Year 1 students)	2,254	499	81.9%	£24,872,594
2022.23 Academic Year (Year 1 students)	1,836	390	82.5%	£22,208,514

Reduced fill rates, increased attrition and lower bursary uptake as a percentage, all impact on the financial position. For the Spring 2022 cohort, the impact of students choosing to self-fund, against the assumptions for those who would take the bursary, totalled £0.890m.

In addition, a large element of the bursary is means tested and as such subject to change in line with the profile of the students who apply. Although an assumption is made in terms of the average student bursary, for 2022/23 the indicative figures show that the means tested bursary provided is on average less than that assumed by a total of £0.559m.

Delays in Course Dates

The final area where changes have impacted on financial performance is where HEI's change or delay the start date for a particular course. This may be due to the numbers of students applying for the course being less than the minimum to run it or due to delays in the course being approved as ready to run.

For 2022/23, the impact of these delays is £2.863m.

2.2 General Practice and Dental Foundation Training

General Practice

Trainees on the General Practice Training Programme undertake three years of training, of which 1 year is based within a Secondary Care Setting and 2 years are based in a GP Training Practice. The numbers recruited have exceeded the commissioned baseline of 160 by agreement with WG in previous years with variation in numbers and the split of trainees by setting, assumed to be 50% at start, both having an impact on the financial position. In this financial year the balance of starters was tipped towards secondary care which impacted on our financial position by £1m because these posts are part funded by NHS organisations

Fig 8 Fill rates for GP

Year	Number of Posts Advertised in whole year	Number of Posts Filled in whole year
2018	136	134

2019	186	186
2020	200	200
2021	184	184
2022 (Only autumn Intake)	175	162

Dental

Funding is for 74 places in the Dental Foundation Training Programme with the table below showing the numbers of trainees recruited into these posts over the past four years:

Fig 9 Fill rates for Dental Foundation Trainees

Financial Year	Funded Places	Trainees Recruited
2019/20	74	68
2020/21	74	71
2021/22	74	70
2022/23	74	67

2022/23 has been a challenging year in terms of recruitment which has impacted on the financial position by generating an underspend of c.£0.649m. Actions are in place to address this in future years.

2.3 ACTIONS BEING TAKEN IN 2022/23

HEIW are leading on the following pieces of work in collaboration with universities.

1. We have employed an experienced senior nurse to lead on developing programmes to support international students in each of the contracted Universities in Wales. In 23/24 we aim to recruit in excess of 100 international nurse students and integrate them into wider cohorts.
2. We have set up a group to explore developing collaborative co-ordinated national marketing materials and campaigns.
3. In September 2023 we are quadrupling the number of HCSW that can access the Level 4 nursing programme from 100 to more than 400. The new programme has been mapped against the first year of all nurse degree programmes. A plan is being developed for 75% of these to join year 2 of a nursing degree in Wales therefore, graduating as registrants at the same time as those students entering the 3 year degree programme.
4. A scoping exercise is being undertaken on the reasons some potential students, with the right behaviours and values, narrowly miss out on gaining places on nursing programmes. Materials and learning packages will be developed to support these potential students to acquire the necessary skills and qualifications to successfully re-apply.

5. A group has been established to scope under-represented groups entering nurse education with specific campaigns to attract these students. This includes military veterans, men, people living in remote and rural areas as well as ethnic minorities.
6. Closer working relationships with Colleges of Further Education are being developed with an objective of developing bridging modules into Health Professional education.
7. We are developing an innovative approach to attracting more students into Learning Disability Nursing (LD), which is the field that potential students know the least about on application to programmes. This involves raising awareness of the field during year 1 and offering more LD placements to a wider range of nursing students. There will be the opportunity to switch fields at the end of year 1 with important but minimal work for the students.
8. HEIW will be going out to tender for a part-time nursing distance learning programme to supplement all other expanded nurse provision. This work is being undertaken via a steering group and task and finish groups which report into the wider Nursing Workforce Planning work.

Although we understand the reasons why applications and so fill rates were lower in 22/23 it is anticipated that the work above will increase applications in 23/24 and give the best opportunity to fill places commissioned.

HEIW are a key member of a Programme Board led by WG that has been set up to review the Bursary package in Wales. In November a detailed proposal for consideration was submitted by HEIW highlighting Bursary issues and a proposed way forward. The Board will be updated on future developments.

3. PROPOSAL

3.1 Allocation of Funding for Education & Training

The allocation of funding from Welsh Government for 2022/23 was deployed across HEIW budgets in line with requirements for the financial year as set out in the resource plan that was agreed by the Board at the beginning of the financial year. In each year HEIW works closely with WG to manage any underspend associated with commissioning, ensuring an open and transparent approach with regard to this investment. The table below shows the allocation, against the full year forecast outturn for the main commissioning programmes.

Fig 10 HEIW allocation and forecast outturn across all education and training commissioning

Commissioning Area	Resource Plan Allocation £m	Full Year Forecast as at Dec 2022 £m	Forecast Underspend £m
Health Professional Education	139.820	123.673	-16.147
GP	35.000*	35.465	0.465
Dental	9.450	9.005	-0.445

Medical	68.710	68.417	-0.293
Pharmacy	11.750	11.659	0.091
Total	264.730	248.219	-16.511

*NB The £35.0m allocated for GP Training at the beginning of the year does not include £1.1m provided by Welsh Government for Pay award during the year

Of this underspend of £16.5m identified in the table above with £14.5m already returned to Welsh Government to date in this financial year by agreement.

Fig 11 Underspend returned to Welsh Government by area of activity

Activity Area	Allocation Returned £m
Health Professional Education	12.880
GP Training	0.820
GP Induction and Returners	0.200
Dental Foundation Training	0.600
Total	14.500

3.2 Pharmacy Undergraduate Placements and Primary Care Academy Funding

At the time of budget setting at the start of the financial year a reassessment of the requirement to resource the commissioned numbers for Healthcare Professional Programmes was made and the calculation resulted in a lower resource requirement than the allocation made by WG which had been based on figures provided in the 2022/23 Education and Training Plan.

Discussions were also underway about additional funding from WG in support of the Pharmacy undergraduate placement programme and development of Primary Care Academies. It was agreed with WG at the time that the programmes could be resourced from existing HEIW baseline recurrently instead of returning the funding. In 2022/23 the first year of Pharmacy placements there is non-recurrent slippage on the programmes that is contributing £1.5m to the underspend position in this financial year.

3.3 Pay and Non-Pay Budgets

Underspends in pay and non pay budgets because of vacancies in core establishments or underspend due to changes in the pattern of activity and face to face training post pandemic contribute £2.2m to the forecast underspend in 2022/23. Further development of the capacity in our Digital and Workforce teams funded in this financial year has generated underspend of £0.593m non recurrently with posts established expected to be recruited to in 2023/24.

The Board is asked to note the recent trends in education and training activity that have resulted in an exceptional in year underspend and to support the repatriation of

this funding to Welsh Government as detailed in the Finance paper that is also on the agenda.

4. FINANCIAL IMPLICATIONS

The financial implications are as set out above.

5. GOVERNANCE AND RISK ISSUES

HEIW monitors education and training activity via its commissioning arrangements, and contractual mechanisms. Escalation processes are in place to ensure corrective action is taken in partnership with education providers.

HEIW has a statutory financial duty to break even at year-end and the WG will monitor the reported position in terms of this duty and against the current year financial plan submitted within the 2022-25 IMTP.

6. RECOMMENDATION

The Board is asked to:

- Note the recent trends in education & training activity and the actions in progress to improve the position for subsequent academic cycles
- Note that this has resulted in an exceptional in year underspend in 2022/23
- Support the repatriation of additional funding to Welsh Government as detailed in the Finance paper that is also on the agenda.

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
There are no implications for Quality, Safety and Patient Experience			
Financial Implications			
The financial implications are set out above in the body of the report.			
Legal Implications (including equality and diversity assessment)			
HEIW has a statutory responsibility to break even at year end the report sets out the reasons for underspend against activity within Education and Training.			
Staffing Implications			
There are no staffing implications of this report.			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
The report briefly describes how HEIW are seeking to adopt a sustainable approach to financial management that will enable HEIW to meet its long-term objectives.			
Report History	The report references other reports produced for the Board during 2022/23, specifically the Finance Report for the period to M9.		
Appendices			

REPORT OF THE DIRECTOR OF FINANCE

The variances for each directorate are explained below:

1. Board & Executive

There is an overall underspend of £44k within the Board and Executive directorate due to underspends in pay of £41k because of a small number of vacancies and a member of the team working at less than full time, some of which is offset by £6k of agency spend. There is also £4k of underspend in non-pay budget lines due to travel and subsistence being less than budgeted.

2. Finance

Within Finance, there is an underspend of £100k, of which £94k relates to Pay budgets. This is made up of a band 5 vacancy for £33k and a band 7 post which was vacant for the first three months of the year £15k, a Band 4 £7k and Band 3 £22k offset by agency spend of £36k

There is also an underspend of £48k because of the Interim Director of Finance arrangements.

The underspend of £4k in non-pay is made up of lower bank charges than budget of £3k, underspend within travel & subsistence, books & journals etc of £6k offset by an overspend of £5k against SLA Costs in respect of services provided in checking valid motor insurance by the expenses team in NWSSP and an agreed increase in Finance Academy contributions.

3. Planning & Performance

There is an underspend in pay of just over £48k which is made up of an underspend of £8k against Band 3, a Band 4 post of £4k which is offset against agency usage of £4k.

There is a small overspend of less than £1k which is an underspend against Travel & Subsistence costs offset against an overspend of conference costs due to costs for IMTP events being higher than planned.

4. Digital & IT

The outturn for Digital as at the end of December is an underspend of £28k. This is made up of pay underspends totalling £93k associated with vacant posts at Band 3, 5, 6, 7 and 8a most of which have either been filled or will be filled during the year. The vacant posts are being offset with agency spend of £102k to date.

This pay underspend is being offset by an overspend of £66k in non-pay because of:

- £9k underspend against Travel costs
- £2k against photocopiers due to low usage and rental charge reduction
- £9k as a result of savings on the SLA with DHCW

These underspends are offset by

- £27k of overspend against computer software, hardware, and network costs.
- £6k in relation to the installation and licence costs for a new telephone software system
- £16k overspend against training expenses where underspend is being utilised
- £39k overspent in relation to Y Ty Dysgu costs which are higher than budgeted levels.

5. Medical, Dental & Pharmacy

The underspend within this directorate of £417k is made up of an underspend against pay of £278k a non-pay underspend of £374k, and a overspend on commissioning of £235k and an underachievement of income of £65k. The underspends and overspends are broken down into a few areas:

- The underspend of £278k within pay budgets represents mostly vacancies across the directorate from Band 2 to Consultant Level. These underspends have been offset by spend on Agency staff of £46k and additional costs for assessors for the Technician Project within Pharmacy as well as a small number of staff acting up into higher bands and costs for Maternity backfill.

The underspend on non-pay of £374k is due to:

- Overspend of £3k related to the allocation of additional phones within Pharmacy
- £307k of underspend against conference, travel, and training catering budgets. It is likely that this underspend will continue over the coming months.
- Underspend of £14k against Printing, Stationery, Books, Journals and Subscriptions due to less activity than budgeted in this area.
- An underspend of £15k under Salary Reimbursements because of Faculty Leads, SAS and Dental admin posts being vacant which totals £179k offset against overspends in LTFT and PSU posts for £55k and £109k respectively
- £46k underspend against locums which is partially offset against pay lines,
- Underspend of £83k against GP payments split into underspends of £36k for GP Appraisal payments, £50k in CPD and Educational Support payments for Hospital Placements

These underspends are offset by an overspend of £73k against the additional costs within the PSU as well as costs for website support costs with Cardiff University in relation to WOPEC for £7k which was not budgeted as well as overspend against dental consumables of £8k which has been agreed in year.

In relation to commissioning, the overall position is an overspend of £235k which is made up of the following variances:

- GP Training – there is now an overspend of £229k showing against budget allocation to date. This is due to the number of extensions being approved being much higher than expected and above those in previous years. It should be noted that £800k was taken from this budget and returned to Welsh Government as part of the latest £7.5m hand back, as such against full allocation there remains an underspend.
- Underspend of less than £1k against GP induction and returners due to only one being in post with a budget for five. It should be noted that £200k was handed back during the month as approved at Board in November.
- TGS allocations, an underspend of £5k due to posts unfilled and budget not being fully allocated. This has moved from £116k underspent last month due to

an update of the allocations reflecting additional posts which started in August to October.

- An underspend of £345k within Pharmacy due to a range of small variances. The Pharmacy Technician Cohort starting in September had one less entrant.
- A minor overspend of £4k against Dental Foundation training due to travel expenses being claimed. It should be noted that £600k was handed back during the month as approved at Board in November.
- An overspend of £411k in relation to relocation expenses. Costs in this area have increased over the past year or so and this trend is expected to continue in the following months.

6. Nursing & Health Professional Education

As at the end of December there was an underspend of £58k. This relates to an underspend in pay of £96k because of several vacancies including agency spend of £89k and an underspend in non-pay of £28k which is mostly because of underspends under travel & subsistence and training expenses due to reduced activity in these areas totalling £19k plus a delay in work associated with work-based learning materials.

Finally, there is also a small overspend against budget of £66k for commissioning. This is as a result of a number of factors, but this area will end with an underspend against overall budget at year end.

7. Workforce and Organisational Development

As at the end of December there was an underspend of £61k. Of this, pay costs are underspent by £48k as there are several vacancies from band 3 to 7 and within the Welsh Clinical Leadership Fellows where there has been an under recruitment. Underspend in these pay areas is offset by agency cost of £43k.

For non-pay there is an underspend of £6k which relates to underspend on travel & subsistence and training courses totalling £9k, some underspend in minor works and health & safety costs offset by an overspend in relation to some membership costs for the leadership team.

VALIDATION SUMMARY 2022-23

Your organisation is showing as :	HEIW
Period is showing :	DEC 22
TABLE A : MOVEMENT	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A1 : UNDERLYING POSITION	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE A2: RISKS	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B : MONTHLY POSITIONS	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B2 : PAY & AGENCY/LOCUM	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE B3 : COVID-19	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE C, C1 & C2 : SAVINGS SCHEMES	HEIW IS CURRENTLY SHOWING 1 ERRORS FOR THIS TABLE
TABLE C3 : TRACKER	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E : RESOURCE LIMITS	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE E1 : INVOICED INCOME	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE F : STATEMENT OF FINANCIAL POSITION	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE G : MONTHLY CASHFLOW	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE I : CAPITAL RESOURCE / EXPENDITURE LIMIT	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE J: CAPITAL IN YEAR SCHEMES	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE K : CAPITAL DISPOSALS	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE L : EFL	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE N : GENERAL MEDICAL SERVICES	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TABLE O : GENERAL DENTAL SERVICES	HEIW IS CURRENTLY SHOWING 0 ERRORS FOR THIS TABLE
TOTAL ERRORS FOR YOUR DEC 22 RETURN IS	1 ERRORS ON 1 DIFFERENT TABLE/S

Summary Of Main Financial Performance

Revenue Performance

		Actual YTD £'000	Annual Forecast £'000
1	Under / (Over) Performance	691	0

Period : Dec 22

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG

Lines 1 - 14 should not be adjusted after Month 1

Lines 1 - 14 should not be adjusted after Month 1		In Year Effect £'000	Non Recurring £'000	Recurring £'000	FYE of Recurring £'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	0	0	0	0
2	Planned New Expenditure (Non Covid-19) (Negative Value)	-30,883	0	-30,883	-30,883
3	Planned Expenditure For Covid-19 (Negative Value)	0	0		
4	Planned Welsh Government Funding (Non Covid-19) (Positive Value)	30,883	0	30,883	30,883
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	0	0		
6	Planned Provider Income (Positive Value)	0	0		
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Savings Plan	0	0	0	0
9	Planned (Finalised) Net Income Generation	0	0	0	0
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Planning Assumptions still to be finalised at Month 1	0	0		
14	Opening IMTP / Annual Operating Plan	0	0	0	0
15	Reversal of Planning Assumptions still to be finalised at Month 1	0	0		
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive)	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	0	0	0	0
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	0	0	0	0
20	Additional In Year Identified Savings - Forecast	0	0	0	0
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 (Positive Value - additional)	0	0		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Positive Value - reduction)	0	0		
25	In Year Accountancy Gains (Positive Value)	0	0	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0		
27		0	0		
28		0	0		
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36	Forecast Outturn (- Deficit / + Surplus)	0	0	0	0
37	Covid-19 - Forecast Outturn (- Deficit / + Surplus)	0			

[illegible]

Table A1 - Underlying Position

This table needs completing monthly from Month: 1

This Table is currently showing 0 errors

Section A - By Spend Area		IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated	IMTP
		Underlying Position b/f £'000	Recurring Savings (+ve) £'000	Recurring Allocations / Income (+ve) £'000	Subtotal £'000	£'000	Underlying Position c/f £'000
1	Pay - Administrative, Clerical & Board Members				0		0
2	Pay - Medical & Dental				0		0
3	Pay - Nursing & Midwifery Registered				0		0
4	Pay - Prof Scientific & Technical				0		0
5	Pay - Additional Clinical Services				0		0
6	Pay - Allied Health Professionals				0		0
7	Pay - Healthcare Scientists				0		0
8	Pay - Estates & Ancillary				0		0
9	Pay - Students				0		0
10	Non Pay - Supplies and services - clinical				0		0
11	Non Pay - Supplies and services - general				0		0
12	Non Pay - Consultancy Services				0		0
13	Non Pay - Establishment				0		0
14	Non Pay - Transport				0		0
15	Non Pay - Premises				0		0
16	Non Pay - External Contractors				0		0
17	Health Care Provided by other Orgs – Welsh LHBs				0		0
18	Health Care Provided by other Orgs – Welsh Trusts				0		0
19	Health Care Provided by other Orgs – WHSSC				0		0
20	Health Care Provided by other Orgs – English				0		0
21	Health Care Provided by other Orgs – Private / Other				0		0
22	Total	0	0	0	0	0	0

Section B - By Directorate		IMTP	Full Year Effect of Actions			New, Recurring, Full Year Effect of Unmitigated	IMTP
		Underlying Position b/f £'000	Recurring Savings (+ve) £'000	Recurring Allocations / Income (+ve) £'000	Subtotal £'000	£'000	Underlying Position c/f £'000
1	Primary Care				0		0
2	Mental Health				0		0
3	Continuing HealthCare				0		0
4	Commissioned Services				0		0
5	Scheduled Care				0		0
6	Unscheduled Care				0		0
7	Children & Women's				0		0
8	Community Services				0		0
9	Specialised Services				0		0
10	Executive / Corporate Areas				0		0
11	Support Services (inc. Estates & Facilities)				0		0
12	Total	0	0	0	0	0	0

This Table is currently showing 0 errors

Table A2 - Overview Of Key Risks & Opportunities		FORECAST YEAR END	
		£'000	Likelihood
	Opportunities to achieve IMTP/AOP (positive values)		
1	Red Pipeline schemes (inc AG & IG)		
2	Potential Cost Reduction		
3	Total Opportunities to achieve IMTP/AOP	0	
	Risks (negative values)		
4	Under delivery of Amber Schemes included in Outturn via Tracker		
5	Continuing Healthcare		
6	Prescribing		
7	Pharmacy Contract		
8	WHSSC Performance		
9	Other Contract Performance		
10	GMS Ring Fenced Allocation Underspend Potential Claw back		
11	Dental Ring Fenced Allocation Underspend Potential Claw back		
12	Potential additional underspend - Return of Funding 21-22	(6,000)	High
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26	Total Risks	(6,000)	
	Further Opportunities (positive values)		
27	Potential additional underspend - Return of Funding 21-22	6,000	High
28			
29			
30			
31			
32			
33			
34	Total Further Opportunities	6,000	
35	Current Reported Forecast Outturn	0	
36	IMTP / AOP Outturn Scenario	0	
37	Worst Case Outturn Scenario	0	
38	Best Case Outturn Scenario	6,000	

Table B - Monthly Positions

YTD Months to be completed from Month: 1
Forecast Months to be completed from Month: 1

Period : Dec 22

This Table is currently showing 0 errors

A. Monthly Summarised Statement of Comprehensive Net Expenditure / Statement of Comprehensive Net Income			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Forecast year-end position
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Revenue Resource Limit	Actual/F'cast	21,545	22,631	21,872	19,932	23,364	25,229	24,828	22,660	24,426	27,100	25,600	33,726	206,487	292,913
2	Capital Donation / Government Grant Income (Health Board only)	Actual/F'cast													0	0
3	Welsh NHS Local Health Boards & Trusts Income	Actual/F'cast												85	0	85
4	WHSSC Income	Actual/F'cast													0	0
5	Welsh Government Income (Non RRL)	Actual/F'cast												239	0	239
6	Other Income	Actual/F'cast	29	20	19	80	8	28	37	35	36	68	45	111	292	516
7	Income Total		21,574	22,651	21,891	20,012	23,372	25,257	24,865	22,695	24,462	27,168	25,645	34,161	206,779	293,753
8	Primary Care Contractor (excluding drugs, including non resource limited expenditure)	Actual/F'cast													0	0
9	Primary Care - Drugs & Appliances	Actual/F'cast													0	0
10	Provided Services - Pay	Actual/F'cast	1,841	1,902	1,844	1,897	1,922	2,264	2,053	2,015	2,110	2,225	2,221	2,365	17,848	24,659
11	Provider Services - Non Pay (excluding drugs & depreciation)	Actual/F'cast	584	767	832	850	842	868	850	869	1,042	1,772	980	5,503	7,504	15,759
12	Secondary Care - Drugs	Actual/F'cast													0	0
13	Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
14	Non Healthcare Services Provided by Other NHS Bodies	Actual/F'cast													0	0
15	Continuing Care and Funded Nursing Care	Actual/F'cast													0	0
16	Other Private & Voluntary Sector	Actual/F'cast	19,004	19,791	19,075	17,086	20,342	21,785	21,969	19,775	21,261	23,335	22,648	26,402	180,088	252,473
17	Joint Financing and Other	Actual/F'cast													0	0
18	Losses, Special Payments and Irrecoverable Debts	Actual/F'cast													0	0
19	Exceptional (Income) / Costs - (Trust Only)	Actual/F'cast													0	0
20	Total Interest Receivable - (Trust Only)	Actual/F'cast													0	0
21	Total Interest Payable - (Trust Only)	Actual/F'cast													0	0
22	DEL Depreciation/Accelerated Depreciation/Impairments	Actual/F'cast	48	96	72	72	72	72	72	72	72	72	72	71	648	863
23	AME Donated Depreciation/Impairments	Actual/F'cast													0	0
24	Uncommitted Reserves & Contingencies	Actual/F'cast													0	0
25	Profit/Loss Disposal of Assets	Actual/F'cast													0	0
26	Cost - Total	Actual/F'cast	21,477	22,556	21,823	19,905	23,178	24,989	24,944	22,731	24,485	27,404	25,921	34,340	206,088	293,753
27	Net surplus/ (deficit)	Actual/F'cast	97	95	68	107	194	268	(79)	(36)	(23)	(236)	(276)	(179)	691	0

B. Cost Total by Directorate			1	2	3	4	5	6	7	8	9	10	11	12		
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
28	Primary Care	Actual/F'cast													0	0
29	Mental Health	Actual/F'cast													0	0
30	Continuing HealthCare	Actual/F'cast													0	0
31	Commissioned Services	Actual/F'cast													0	0
32	Scheduled Care	Actual/F'cast													0	0
33	Unscheduled Care	Actual/F'cast													0	0
34	Children & Women's	Actual/F'cast													0	0
35	Community Services	Actual/F'cast													0	0
36	Specialised Services	Actual/F'cast	20,731	21,803	21,181	19,048	22,320	24,174	24,033	21,844	23,472	26,454	25,040	31,070	198,606	281,170
37	Executive / Corporate Areas	Actual/F'cast	367	276	58	244	229	246	252	252	269	289	251	2,159	2,193	4,892
38	Support Services (inc. Estates & Facilities)	Actual/F'cast	331	381	512	541	557	497	587	563	672	589	558	1,040	4,641	6,828
39	Reserves	Actual/F'cast													0	0
40	Cost - Total (Excluding DEL & AME Non-Cash Charges)	Actual/F'cast	21,429	22,460	21,751	19,833	23,106	24,917	24,872	22,659	24,413	27,332	25,849	34,269	205,440	292,890

C. Assessment of Financial Forecast Positions

Year-to-date (YTD)	£'000
28 - Actual YTD surplus/ (deficit)	691
29. Actual YTD surplus/ (deficit) last month	714
30. Current month actual surplus/ (deficit)	(23)
31. Average monthly surplus/ (deficit) YTD	77
32. YTD /remaining months	230
Trend ▼	

Full-year surplus/ (deficit) scenarios	£'000
33. Extrapolated Scenario	622
34. Year to Date Trend Scenario	921

D. DEL/AME Depreciation & Impairments

[illegible]

E. Accountancy Gains

[illegible]

F. Committed Reserves & Contingencies

[illegible]

HEIW

Period : Dec 22

YTD Months to be completed from Month: 1

This Table is currently showing 0 errors

Forecast Months to be completed from Month: 1

Table B2 - Pay Expenditure Analysis

A - Pay Expenditure

A - Pay Expenditure		1	2	3	4	5	6	7	8	9	10	11	12		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	1,114	1,149	1,145	1,176	1,206	1,427	1,315	1,256	1,287	1,438	1,438	1,453	11,075	15,404
2	Medical & Dental	475	496	454	464	466	578	470	501	540	514	509	583	4,444	6,050
3	Nursing & Midwifery Registered	44	49	36	53	44	52	45	53	39	48	48	53	415	564
4	Prof Scientific & Technical	177	177	178	173	173	174	196	179	216	190	190	190	1,643	2,213
5	Additional Clinical Services	13	13	13	13	14	12	13	10	9	11	11	4	110	136
6	Allied Health Professionals	18	18	18	18	18	21	14	16	20	25	25	81	161	292
7	Healthcare Scientists													0	0
8	Estates & Ancillary													0	0
9	Students													0	0
10	TOTAL PAY EXPENDITURE	1,841	1,902	1,844	1,897	1,921	2,264	2,053	2,015	2,111	2,226	2,221	2,364	17,848	24,659

Analysis of Pay Expenditure

[illegible]

B - Agency / Locum (premium) Expenditure

- Analysed by Type of Staff

B - Agency / Locum (premium) Expenditure		1	2	3	4	5	6	7	8	9	10	11	12		
- Analysed by Type of Staff		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	Forecast year-end position
REF	TYPE	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	Administrative, Clerical & Board Members	33	47	43	42	30	12	40	31	57	43	40	40	335	458
2	Medical & Dental													0	0
3	Nursing & Midwifery Registered													0	0
4	Prof Scientific & Technical													0	0
5	Additional Clinical Services													0	0
6	Allied Health Professionals													0	0
7	Healthcare Scientists													0	0
8	Estates & Ancillary													0	0
9	Students													0	0
10	TOTAL AGENCY/LOCUM (PREMIUM) EXPENDITURE	33	47	43	42	30	12	40	31	57	43	40	40	335	458

11	Agency/Locum (premium) % of pay	1.8%	2.5%	2.3%	2.2%	1.6%	0.5%	1.9%	1.5%	2.7%	1.9%	1.8%	1.7%	1.9%	1.9%
----	---------------------------------	------	------	------	------	------	------	------	------	------	------	------	------	------	------

C - Agency / Locum (premium) Expenditure

- Analysed by Reason for Using Agency/Locum (premium)

[illegible]

This Table is currently showing 0 errors

Table B3 - COVID-19 Analysis

A - Additional Expenditure

[illegible]

[illegible]

Table C - Identified Expenditure Savings Schemes (Excludes Income Generation & Accountancy Gains)

This Table is currently showing 1 errors

Some errors will be resolved when complete rows have data or associated tables are completed

[illegible]

Table C1- Savings Schemes Pay Analysis

	Month		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY YTD variance as %age of YTD Budget/Plan	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings £'000
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	
1	Changes in Staffing Establishment	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Variable Pay	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Changes in Bank Staff	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
20		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
21		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

Table C2- Savings Schemes Agency/Locum Paid at a Premium Analysis

	Month		1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY YTD variance as %age of YTD Budget/Plan	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings £'000
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar				Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
2		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
3		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			

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Dec 22

This Table is currently showing 0 errors

Table C3 - Tracker

[illegible]

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Period : Dec 22

Table D - Income/Expenditure Assumptions

Annual Forecast

	LHB/Trust	Contracted Income	Non Contracted Income	Total Income	Contracted Expenditure	Non Contracted Expenditure	Total Expenditure
		£'000	£'000	£'000	£'000	£'000	£'000
1	Swansea Bay University		5	5		15,540	15,540
2	Aneurin Bevan University		43	43		12,552	12,552
3	Betsi Cadwaladr University		43	43		18,745	18,745
4	Cardiff & Vale University		125	125		23,945	23,945
5	Cwm Taf Morgannwg University		98	98		13,485	13,485
6	Hywel Dda University		3	3		9,773	9,773
7	Powys		3	3		973	973
8	Public Health Wales		153	153		1,641	1,641
9	Velindre		14	14		52,476	52,476
10	NWSSP			0			0
11	DHCW		3	3		697	697
12	Wales Ambulance Services		43	43		639	639
13	WHSSC		39	39		0	0
14	EASC			0			0
15	HEIW			0			0
16	NHS Wales Executive			0			0
17	Total	0	572	572	0	150,466	150,466

Table E - Resource Limits

1. BASE ALLOCATION

HCMS £'000	STATUS OF ISSUED RESOURCE LIMIT ITEMS			Total Revenue Resource Limit £'000	Recurring (R) or Non Recurring (NR)	Total Revenue Drawing Limit £'000	Total Capital Resource Limit £'000	Total Capital Drawing Limit £'000	WG Contact and Date Item First Entered into Table
	Pharmacy £'000	Dental £'000	GMS £'000						

1 LATEST ALLOCATION LETTER/SCHEDULE REF:	10								
2 Total Confirmed Funding	306,589				306,589	306,016	226	226	

2. ANTICIPATED ALLOCATIONS

3 DEL Non Cash Depreciation - Baseline Surplus / Shortfall					0 R				
4 DEL Non Cash Depreciation - Strategic					0				
5 DEL Non Cash Depreciation - Accelerated					0				
6 DEL Non Cash Depreciation - Impairment					0				
7 DEL Non Cash Depreciation - IFRS 16 Leases	287				287 R				A Hughes - May 2022
8 AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)					0				
9 AME Non Cash Depreciation - Donated Assets					0				
10 AME Non Cash Depreciation - Impairment					0				
11 AME Non Cash Depreciation - Impairment Reversals					0				
12 Removal of Donated Assets / Government Grant Receipts					0				
13 Total COVID-19 (see below analysis)	0	0	0	0	0				See below analysis
14 Removal of IFRS-16 Leases (Revenue)	(304)				(304) R	(304)			A Hughes - May 2022
15 Energy (Price Increase)					0				
16 Employers NI Increase (1.25%)					0				
17 Real Living Wage					0				
18					0				
19					0				
20					0				
21 Faculty of Sustainable Healthcare for Wales	56				56 NR	56			R Dudley
22 WG - Digital Priorities Investment Fund for Building a Digitally Ready Work	103				103 NR	103			As per letter from Ryan Parry dated 01/10/22
23 WG -Project Co-ordinator and Project Support Officer for Mental Health	87				87 NR	87			As per letter from Tracey Braheny dated 25/09/22
24 WG - National Programme for the Allied Health Professions (AHP) Framework	299				299 NR	299			As per letter from Alex Slade dated 25/09/22
25					0				
26 WG Allocation Adjustment - Nursing	(12,880)				(12,880) NR	(12,880)			R Dudley - Nov 22
27 WG Allocation Adjustment - GP	(820)				(820) NR	(820)			R Dudley - Nov 22
28 WG Allocation Adjustment - I & R	(200)				(200) NR	(200)			R Dudley - Nov 22
29 WG Allocation Adjustment - Dental	(600)				(600) NR	(600)			R Dudley - Nov 22
30 IFRS16 Working Balances Case Request					0				304 A Hughes - October 2022
31 22/23 DFT Income (Non Pay)	236				236				R Dudley - Dec 22
32 WCLTF - Optom	60				60				
33					0				
34					0				
35					0				
36					0				
37					0				
38					0				
39					0				
40					0				
41					0				
42					0				
43					0				
44					0				
45					0				
46					0				
47					0				
48					0				
49					0				
50					0				
51					0				
52					0				
53					0				
54					0				
55					0				
56					0				
57					0				
58 Total Anticipated Funding	(13,676)	0	0	0	(13,676)	(14,259)	0	304	

3. TOTAL RESOURCES & BUDGET RECONCILIATION

59 Confirmed Resources Per 1. above	306,589	0	0	0	306,589	306,016	226	226	
60 Anticipated Resources Per 2. above	(13,676)	0	0	0	(13,676)	(14,259)	0	304	
61 Total Resources	292,913	0	0	0	292,913	291,757	226	530	

ANALYSIS OF WG FUNDING FOR COVID-19 INCLUDED ABOVE

	Allocated Total £'000	Anticipated HCMS £'000	Anticipated Pharmacy £'000	Anticipated Dental £'000	Anticipated GMS £'000	Total RRL £'000	WG Contact and date item first entered into table.
62 Testing (inc Community Testing)						0	
63 Tracing						0	
64 Mass COVID-19 Vaccination						0	
65 PPE						0	
66 Extended Flu						0	
67 Cleaning Standards						0	
68 Long Covid						0	
69						0	
70						0	
71						0	
72						0	
73						0	
74						0	
75						0	
76						0	
77						0	
78						0	
79						0	
80						0	
81						0	
82						0	
83						0	
84						0	
85						0	
86						0	
87						0	
88						0	
89						0	
90						0	
91						0	
92 Total Funding	0	0	0	0	0	0	

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Period : Dec 22

This Table is currently showing 0 errors

Table E1 - Invoiced Income Streams - TRUSTS ONLY

Ref		Swansea Bay ULHB £'000	Aneurin Bevan ULHB £'000	Betsi Cadwaladr ULHB £'000	Cardiff & Vale ULHB £'000	Cwm Taf Morganwg ULHB £'000	Hywel Dda ULHB £'000	Powys LHB £'000	Public Health Wales NHS Trust £'000	Welsh Ambulance NHS Trust £'000	Velindre NHS Trust £'000	NWSSP £'000	DHCW £'000	HEIW £'000	WG £'000	EASC £'000	WHSSC £'000	Other* (please specify) £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
1	Agreed full year income																		0	
	Details of Anticipated Income																			
2	DEL Non Cash Depreciation - Baseline Surplus / Shortfall																		0	
3	DEL Non Cash Depreciation - Strategic																		0	
4	DEL Non Cash Depreciation - Accelerated																		0	
5	DEL Non Cash Depreciation - Impairment																		0	
6	DEL Non Cash Depreciation - IFRS 16 Leases																		0	
7	AME Non Cash Depreciation - IFRS 16 Leases (Peppercorn)																		0	
8	AME Non Cash Depreciation - Donated Assets																		0	
9	AME Non Cash Depreciation - Impairment																		0	
10	AME Non Cash Depreciation - Impairment Reversals																		0	
11	Total COVID-19 (see below analysis)														0				0	See below analysis
12	Removal of IFRS-16 Leases (Revenue)																		0	
13	Energy (Price Increase)																		0	
14	Employers NI Increase (1.25%)																		0	
15	Real Living Wage																		0	
16																			0	
17																			0	
18																			0	
19																			0	
20																			0	
21																			0	
22																			0	
23																			0	
24																			0	
25																			0	
26																			0	
27																			0	
28																			0	
29																			0	
30																			0	
31																			0	
32																			0	
33																			0	
34																			0	
35																			0	
36																			0	
37	Total Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

ANALYSIS OF WG FUNDING DUE FOR COVID-19 INCLUDED ABOVE		Allocated £'000	Anticipated £'000	Total £'000	WG Contact, date item first entered into table and whether any invoice has been raised.
38	Testing (inc Community Testing)			0	
39	Tracing			0	
40	Mass COVID-19 Vaccination			0	
41	PPE			0	
42	Extended Flu			0	
43	Cleaning Standards			0	
44	Long Covid			0	
45				0	
46				0	
47				0	
48				0	
49				0	
50				0	
51				0	
52				0	
53				0	
54				0	
55				0	
56				0	
57				0	
58				0	
59				0	
60				0	
61				0	
62				0	
63				0	
64				0	
65				0	
66				0	
67				0	
68	Total Funding	0	0	0	

HEIW

Period : Dec 22

This table needs completing monthly from Month: 3
This Table is currently showing 0 errors

Table F - Statement of Financial Position For Monthly Period

	Opening Balance Beginning of Apr 22 £'000	Closing Balance End of Dec 22 £'000	Forecast Closing Balance End of Mar 23 £'000
Non-Current Assets			
1 Property, plant and equipment	1,940	3,064	2,924
2 Intangible assets			
3 Trade and other receivables			
4 Other financial assets			
5 Non-Current Assets sub total	1,940	3,064	2,924
Current Assets			
6 Inventories			
7 Trade and other receivables	2,125	1,037	1,997
8 Other financial assets			
9 Cash and cash equivalents	5,955	1,953	1,998
10 Non-current assets classified as held for sale			
11 Current Assets sub total	8,080	2,990	3,995
12 TOTAL ASSETS	10,020	6,054	6,919
Current Liabilities			
13 Trade and other payables	8,418	12,819	7,110
14 Borrowings (Trust Only)			
15 Other financial liabilities			
16 Provisions			
17 Current Liabilities sub total	8,418	12,819	7,110
18 NET ASSETS LESS CURRENT LIABILITIES	1,602	(6,765)	(191)
Non-Current Liabilities			
19 Trade and other payables	125	1,382	1,304
20 Borrowings (Trust Only)			
21 Other financial liabilities			
22 Provisions			
23 Non-Current Liabilities sub total	125	1,382	1,304
24 TOTAL ASSETS EMPLOYED	1,477	(8,147)	(1,495)
FINANCED BY: Taxpayers' Equity			
25 General Fund	1,477	(8,147)	(1,495)
26 Revaluation Reserve			
27 PDC (Trust only)			
28 Retained earnings (Trust Only)			
29 Other reserve			
30 Total Taxpayers' Equity	1,477	(8,147)	(1,495)

EXPLANATION OF ALL PROVISIONS	Opening Balance Beginning of Apr 22	Closing Balance End of Dec 22	Closing Balance End of Mar 23
31			
32			
33			
34			
35			
36			
37			
38			
39			
40 Total Provisions	0	0	0

ANALYSIS OF WELSH NHS RECEIVABLES (current month)

	£'000
41 Welsh NHS Receivables Aged 0 - 10 weeks	165
42 Welsh NHS Receivables Aged 11 - 16 weeks	11
43 Welsh NHS Receivables Aged 17 weeks and over	25

ANALYSIS OF TRADE & OTHER PAYABLES (opening, current & closing)

	£'000	£'000	£'000
44 Capital	0	1,689	1,612
45 Revenue	8,543	12,512	6,802

ANALYSIS OF CASH (opening, current & closing)

	£'000	£'000	£'000
46 Capital	0	0	0
47 Revenue	5,955	1,953	1,998

HEIW

Period : Dec 22

This Table is currently showing 0 errors

This table needs completing monthly from Month: 2

Table G - Monthly Cashflow Forecast

		April £'000	May £'000	June £'000	July £'000	Aug £'000	Sept £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £,000	Total £,000
	RECEIPTS													
1	WG Revenue Funding - Cash Limit (excluding NCL) - LHB & SHA only	15,000	21,500	21,500	22,000	21,000	21,500	23,000	26,500	24,000	24,500	25,500	45,757	291,757
2	WG Revenue Funding - Non Cash Limited (NCL) - LHB & SHA only													0
3	WG Revenue Funding - Other (e.g. invoices)								193		49		97	339
4	WG Capital Funding - Cash Limit - LHB & SHA only										114	86	330	530
5	Income from other Welsh NHS Organisations	132	6	6	2	107	35	48	21	37	28	6	25	453
6	Short Term Loans - Trust only													0
7	PDC - Trust only													0
8	Interest Receivable - Trust only													0
9	Sale of Assets													0
10	Other - (Specify in narrative)	35	24	53	827	1,829	30	30	36	34	30	30	30	2,988
11	TOTAL RECEIPTS	15,167	21,530	21,559	22,829	22,936	21,565	23,078	26,750	24,071	24,721	25,622	46,239	296,067
	PAYMENTS													
12	Primary Care Services : General Medical Services													0
13	Primary Care Services : Pharmacy Services													0
14	Primary Care Services : Prescribed Drugs & Appliances													0
15	Primary Care Services : General Dental Services													0
16	Non Cash Limited Payments													0
17	Salaries and Wages	1,252	1,742	1,744	1,284	1,785	1,908	2,067	1,936	1,902	2,105	2,099	2,312	22,136
18	Non Pay Expenditure	17,533	20,675	19,521	21,842	19,993	22,119	20,776	21,867	23,299	23,531	22,591	43,673	277,420
19	Short Term Loan Repayment - Trust only													0
20	PDC Repayment - Trust only													0
21	Capital Payment									242	114	86	26	468
22	Other items (Specify in narrative)													0
23	TOTAL PAYMENTS	18,785	22,417	21,265	23,126	21,778	24,027	22,843	23,803	25,443	25,750	24,776	46,011	300,024
24	Net cash inflow/outflow	(3,618)	(887)	294	(297)	1,158	(2,462)	235	2,947	(1,372)	(1,029)	846	228	
25	Balance b/f	5,955	2,337	1,450	1,744	1,447	2,605	143	378	3,325	1,953	924	1,770	
26	Balance c/f	2,337	1,450	1,744	1,447	2,605	143	378	3,325	1,953	924	1,770	1,998	

Table H - PSPP

This table needs completing on a quarterly basis
NOTE: Data to 1 decimal place

30 DAY COMPLIANCE		ACTUAL Q1			ACTUAL Q2		ACTUAL Q3		ACTUAL Q4		YEAR TO DATE		FORECAST YEAR END	
	PROMPT PAYMENT OF INVOICE PERFORMANCE	Target %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Actual %	Variance %	Forecast %	Variance %
1	% of NHS Invoices Paid Within 30 Days - By Value	95.0%	94.5%	-0.5%	97.7%	2.7%	99.1%	4.1%		-95.0%	97.1%	2.1%	95.0%	0.0%
2	% of NHS Invoices Paid Within 30 Days - By Number	95.0%	96.1%	1.1%	88.5%	-6.5%	93.5%	-1.5%		-95.0%	92.8%	-2.2%	95.0%	0.0%
3	% of Non NHS Invoices Paid Within 30 Days - By Value	95.0%	99.5%	4.5%	99.8%	4.8%	99.5%	4.5%		-95.0%	99.7%	4.7%	95.0%	0.0%
4	% of Non NHS Invoices Paid Within 30 Days - By Number	95.0%	93.5%	-1.6%	97.0%	2.0%	95.6%	0.6%		-95.0%	95.5%	0.5%	95.0%	0.0%

10 DAY COMPLIANCE			ACTUAL Q1		ACTUAL Q2		ACTUAL Q3		ACTUAL Q4		YEAR TO DATE		FORECAST YEAR END	
	PROMPT PAYMENT OF INVOICE PERFORMANCE		Actual %		Actual %		Actual %		Actual %		Actual %		Actual %	
5	% of NHS Invoices Paid Within 10 Days - By Value		74.1%		72.9%		68.0%				71.7%		72.0%	
6	% of NHS Invoices Paid Within 10 Days - By Number		31.1%		26.4%		35.8%				31.7%		31.0%	
7	% of Non NHS Invoices Paid Within 10 Days - By Value		70.5%		69.5%		70.0%				70.0%		70.0%	
8	% of Non NHS Invoices Paid Within 10 Days - By Number		26.7%		43.6%		33.3%				35.1%		35.0%	

This Table is currently showing 0 errors

Table I - 2022-23 Capital Resource / Expenditure Limit Management

£'000 226
 Approved CRL / CEL issued at : 4/5/22

Ref:	Performance against CRL / CEL	Year To Date			Forecast		
		Plan £'000	Actual £'000	Variance £'000	Plan £'000	F'cast £'000	Variance £'000
	<i>Gross expenditure</i>						
	All Wales Capital Programme:						
	Schemes:						
1				0			0
2				0			0
3				0			0
4				0			0
5				0			0
6				0			0
7				0			0
8				0			0
9				0			0
10				0			0
11				0			0
12				0			0
13				0			0
14				0			0
15				0			0
16				0			0
17				0			0
18				0			0
19				0			0
20				0			0
21				0			0
22				0			0
23				0			0
24				0			0
25				0			0
26				0			0
27				0			0
28				0			0
29				0			0
30				0			0
31				0			0
32				0			0
33				0			0
34				0			0
35				0			0
36				0			0
37				0			0
38				0			0
39				0			0
40				0			0
41				0			0
42	Sub Total	0	0	0	0	0	0
	Discretionary:						
43	I.T.			0	200	200	0
44	Equipment			0			0
45	Statutory Compliance			0			0
46	Estates			0			0
47	Other			0	26	26	0
48	Sub Total	0	0	0	226	226	0

	Other (Including IFRS 16 Leases) Schemes:							
49				0				0
50				0				0
51				0				0
52				0				0
53				0				0
54				0				0
55				0				0
56				0				0
57				0				0
58				0				0
59				0				0
60				0				0
61				0				0
62				0				0
63				0				0
64				0				0
65				0				0
66				0				0
67				0				0
68				0				0
69	Sub Total	0	0	0		0	0	0
70	Total Expenditure	0	0	0	226	226		0
	Less:							
	Capital grants:							
71				0				0
72				0				0
73				0				0
74				0				0
75				0				0
76	Sub Total	0	0	0	0	0		0
	Donations:							
77				0				0
78	Sub Total	0	0	0	0	0		0
	Asset Disposals:							
79				0				0
80				0				0
81				0				0
82				0				0
83				0				0
84				0				0
85				0				0
86				0				0
87				0				0
88				0				0
89				0				0
90	Sub Total	0	0	0	0	0		0
91	Technical Adjustments			0				0
92	CHARGE AGAINST CRL / CEL	0	0	0	226	226		0
93	PERFORMANCE AGAINST CRL / CEL (Under)/Over		(226)			0		

Table J - In Year Capital Scheme Profiles

This Table is currently showing 0 errors

Ref:	All Wales Capital Programme: Schemes:	Project Manager	In Year Min. £'000	Forecast Max. £'000	Capital Expenditure Monthly Profile												YTD £'000	Total £'000	Risk Level
					April £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000			
1	End of year funding November 2022		150	150										64	86		0	150	Low
2																	0	0	
3																	0	0	
4																	0	0	
5																	0	0	
6																	0	0	
7																	0	0	
8																	0	0	
9																	0	0	
10																	0	0	
11																	0	0	
12																	0	0	
13																	0	0	
14																	0	0	
15																	0	0	
16																	0	0	
17																	0	0	
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26																	0	0	
27																	0	0	
28																	0	0	
29																	0	0	
30																	0	0	
31																	0	0	
32																	0	0	
33																	0	0	
34	Sub Total		150	150	0	0	0	0	0	0	0	0	0	64	86	0	0	150	
Discretionary:																			
35	I.T.	*	50	50										50			0	50	Low
36	Equipment	*															0	0	
37	Statutory Compliance	*															0	0	
38	Estates	*															0	0	
39	Other	TBC	26	26												26	0	26	Low
40	Sub Total		76	76	0	0	0	0	0	0	0	0	0	50	0	26	0	76	
Other Schemes (Including IFRS 16 Leases):																			
41																	0	0	
42																	0	0	
43																	0	0	
44																	0	0	
45																	0	0	
46																	0	0	
47																	0	0	
48																	0	0	
49																	0	0	
50																	0	0	
51																	0	0	
52																	0	0	
53																	0	0	
54																	0	0	
55																	0	0	
56																	0	0	
57																	0	0	
58																	0	0	
59																	0	0	
60																	0	0	
61	Sub Total		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
62	Total Capital Expenditure		226	226	0	0	0	0	0	0	0	0	0	114	86	26	0	226	

Table K - Capital Disposals

This Table is currently showing 0 errors

A: In Year Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 22)	MM/YY (text format, e.g. Apr 22)	MM/YY (text format, e.g. Feb 23)	£'000	£'000	£'000	£'000	
1								0	
2								0	
3								0	
4								0	
5								0	
6								0	
7								0	
8								0	
9								0	
10								0	
11								0	
12								0	
13								0	
14								0	
15								0	
16								0	
17								0	
18								0	
19								0	
	Total for in-year				0	0	0	0	

B: Future Years Disposal of Assets

	Description	Date of Ministerial Approval to Dispose (Land & Buildings only)	Date of Ministerial Approval to Retain Proceeds > £0.5m	Date of Disposal	NBV	Sales Receipts	Cost of Disposals	Gain/ (Loss)	Comments
		MM/YY (text format, e.g. Apr 23)	MM/YY (text format, e.g. Apr 23)	MM/YY (text format, e.g. Feb 24)	£'000	£'000	£'000	£'000	
20								0	
21								0	
22								0	
23								0	
24								0	
25								0	
26								0	
27								0	
28								0	
29								0	
30								0	
31								0	
32								0	
33								0	
34								0	
35								0	
36								0	
37								0	
38								0	
	Total for future years				0	0	0	0	

This Table is currently showing 0 errors

This table needs completing monthly from Month: 3

Table L: EXTERNAL FINANCING LIMIT

		Full Year Per WG £'000	Full Year Per Trust £'000	Planning Variance £'000	Actual to date £'000
REF	NET FINANCIAL CHANGE	A	B	C	D
1	Retained surplus/(deficit) for period			0	
2	Depreciation			0	
3	Depreciation on Donated Assets			0	
4	DEL and AME Impairments			0	
5	Net gain/loss on disposal of assets			0	
6	Profit/loss on sale term of disc ops			0	
7	Proceeds of Capital Disposals			0	
8	Other Income (specify)			0	
9	APPLICATION OF FUNDS				
10	Capital Expenditure			0	
11	Other Expenditure			0	
	MOVEMENTS IN WORKING CAPITAL				
12	Inventories			0	
13	Current assets - Trade and other receivables			0	
14	Current liabilities - Trade and other payables			0	
15	Non current liabilities - Trade and other payables			0	
16	Provisions			0	
17	Sub total - movement in working capital	0	0	0	0
18	NET FINANCIAL CHANGE	0	0	0	0
	EFL REQUIREMENT TO BE MET BY				
19	Increase in Public Dividend Capital			0	
20	Net change in temporary borrowing			0	
21	Change in bank deposits and interest bearing securities			0	
22	Net change in finance lease payables			0	
23	TOTAL EXTERNAL FINANCE	0	0	0	0

Table M - Debtors Schedule

	Period:
11 weeks before end of Dec 22 =	15 October 2022
17 weeks before end of Dec 22 =	03 September 2022

[illegible]

Invoices paid since the end of the month		
--	--	--

Total outstanding as per MR submission date	10,475.22	25,492.50
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HEIW

Period : Dec 22

Table N - General Medical Services
Table to be completed from Q2 / Month:

6

This Table is currently showing 0 errors

Operating Expenditure - ring fenced GMS budget

SUMMARY OF GENERAL MEDICAL SERVICES FINANCIAL POSITION		WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
	LINE NO.					
Global Sum	1					
Practice support payment	2					
Total Global Sum and MPIG	3				0	0
QAIF Aspiration Payments	4					
QAIF Achievement Payments	5					
QAIF - Access Achievement Payments	6					
Total Quality	7				0	0
Direct Enhanced Services (To equal data in Section A (i) Line 31)	8				0	
National Enhanced Services (To equal data in Section A (ii) Line 41)	9				0	
Local Enhanced Services (To equal data in Section A (iii) Line 94)	10				0	
Total Enhanced Services (To equal data in section A Line 95)	11		0	0	0	0
LHB Administered (To equal data in Section B Line 109)	12				0	
Premises (To equal data in section C Line 138)	13				0	
IM & T	14				0	
Out of Hours (including OOHDF)	15				0	
Dispensing (To equal data in Line 154)	16				0	
Total	17	0	0	0	0	0
SUPPLEMENTARY INFORMATION						
Directed Enhanced Services Section A (i)	LINE NO.	£000's	£000's	£000's	£000's	£000's
Learning Disabilities	18				0	
Childhood Immunisation Scheme	19				0	
Mental Health	20				0	
Influenza & Pneumococcal Immunisations Scheme	21				0	
Services for Violent Patients	22				0	
Minor Surgery Fees	23				0	
MENU of Agreed DES						
Asylum Seekers & Refugees	24				0	
Care of Diabetes	25				0	
Care Homes	26				0	
Extended Surgery Opening	27				0	
Gender Identity	28				0	
Homeless	29				0	
Oral Anticoagulation with Warfarin	30				0	
TOTAL Directed Enhanced Services (must equal line 8)	31		0	0	0	0
National Enhanced Services A (ii)	LINE NO.	£000's	£000's	£000's	£000's	£000's
INR Monitoring	32				0	
Shared care drug monitoring (Near Patient Testing)	33				0	
Drug Misuse	34				0	
IUCD	35				0	
Alcohol misuse	36				0	
Depression	37				0	
Minor injury services	38				0	
Diabetes	39				0	
Services to the homeless	40				0	
TOTAL National Enhanced Services (must equal line 9)	41		0	0	0	0

Local Enhanced Services	A (iii)	LINE NO.	£000's	£000's	£000's	£000's	£000's
ADHD		42					0
Asylum Seekers & Refugees		43					0
Cardiology		44					0
Care Homes		45					0
Care of Diabetes		46					0
Chiropody		47					0
Counselling		48					0
Depo - Provera (including Implanon & Nexplanon)		49					0
Dermatology		50					0
Dietetics		51					0
DOAC/NOAC		52					0
Drugs Misuse		53					0
Extended Minor Surgery		54					0
Gonaderlins		55					0
Homeless		56					0
HPV Vaccinations		57					0
Immunisations (inc Pertussis excluding DES - Childhood Imm & Influenza & Pneumococcal Imm)		58					0
Learning Disabilities		59					0
Lithium / INR Monitoring		60					0
Local Development Schemes		61					0
Mental Health		62					0
Minor Injuries		63					0
MMR		64					0
Multiple Sclerosis		65					0
Muscular Skeletal		66					0
Nursing Homes		67					0
Orthopaedic (Upper Limb GPwSi/Clinical Assessments)		68					0
Osteopathy		69					0
Phlebotomy		70					0
Physiotherapy (inc MT3)		71					0
Referral Management		72					0
Respiratory (inc COPD)		73					0
Ring Pessaries		74					0
Sexual Health Services		75					0
Shared Care		76					0
Smoking Cessation		77					0
Substance Misuse		78					0
Suturing		79					0
Swine Flu		80					0
Transport/Ambulance costs		81					0
Vasectomy		82					0
Weight Loss Clinic (inc Exercise Referral)		83					0
Wound Care		84					0
Zoladex		85					0
		86					0
		87					0
		88					0
		89					0
		90					0
		91					0
		92					0
		93					0
TOTAL Local Enhanced Services (must equal line 10)		94		0	0	0	0
TOTAL Enhanced Services (must equal line 11)		95		0	0	0	0

GENERAL MEDICAL SERVICES
Operating Expenditure

LHB Administered	Section B	LINE NO.	WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
Seniority		96					
Doctors Retention Scheme Payments		97					
Locum Allowances consists of adoptive, paternity & maternity		98					
Locum Allowances : Cover for Sick Leave		99					
Locum Allowances : Cover For Suspended Doctors		100					
Prolonged Study Leave		101					
Recruitment and Retention (including Golden Hello)		102					
Appraisal - Appraiser Costs		103					
Primary Care Development Scheme		104					
Partnership Premium - GP partners		105					
Partnership Premium - Non GP Partners		106					
Supply of syringes & needles		107					
Other (please provide detail below, this should reconcile to line 128)		108					
TOTAL LHB Administered (must equal line 12)		109				0	0

Analysis of Other Payments (line 108)	LINE NO.	£000's	£000's	£000's	£000's	£000's
Additional Managed Practice costs (costs in excess of Global Sum/MPIG)	110					
CRB checks	111					
GP Locum payments	112					
LHB Locality group costs	113					
Managing Practice costs (LHB employed staff working in GP practices to improve GP services)	114					
Primary Care Initiatives	115					
Salaried GP costs	116					
Stationery & Distribution	117					
Training	118					
Translation fees	119					
COVID vaccination payments to GP practices	120					
	121					
	122					
	123					
	124					
	125					
	126					
	127					
TOTAL of Other Payments (must equal line 108)	128					0

Premises	Section C	LINE NO.	£000's	£000's	£000's	£000's	£000's
Notional Rents		129					
Actual Rents: Health Centres		130					
Actual Rents: Others		131					
Cost Rent		132					
Clinical Waste/ Trade Refuse		133					
Rates, Water, sewerage etc		134					
Health Centre Charges		135					
Improvement Grants		136					
All other Premises (please detail below which should reconcile to line 146)		137					
TOTAL Premises (must equal line 13)		138				0	0

Analysis of Other Premises (Line 137)	LINE NO.	£000's	£000's	£000's	£000's	£000's
	139					
	140					
	141					
	142					
	143					
	144					
	145					
TOTAL of Other Premises (must equal line 137)	146					0

Memorandum item						
Enhanced Services included above but in dispute with LMC (TOTAL)	147					
Enhanced Services included above but not yet formally agreed LMC	148					

GENERAL MEDICAL SERVICES
Dispensing

	LINE NO.	WG Allocation £000's	Current Plan £000's	Forecast Outturn £000's	Variance £000's	Year to Date £000's
Dispensing Data						
Cost of Drugs and Appliances, after discounts and plus container allowance (and plus VAT where applicable)						
Dispensing Doctors	149					
Prescribing Medical Practitioners - Personal Administration	150					
Dispensing Service Quality Payment	151					
Professional Fees and on-cost						
Dispensing Doctors	152					
Prescribing Medical Practitioners - Personal Administration	153					
TOTAL DISPENSING DATA (must equal line 16)	154				0	0

HEIW

Period : Dec 22

Table O - General Dental Services

This Table is currently showing 0 errors

Table to be completed from Q2 / Month:

6

Operating Expenditure from the revenue allocation for the dental contract

SUMMARY OF DENTAL SERVICES FINANCIAL POSITION		WG Allocation	Current Plan	Forecast Outturn	Variance	Year to Date
Expenditure / activities included in a GDS contract and / or PDS agreement	LINE NO.	£000's	£000's	£000's	£000's	£000's
Gross Contract Value - Personal Dental Services	1				0	
Gross Contract Value - General Dental Services	2				0	
Emergency Dental Services (inc Out of Hours)	3				0	
Additional Access	4				0	
Business Rates	5				0	
Domiciliary Services	6				0	
Maternity/Sickness etc.	7				0	
Sedation services including GA	8				0	
Seniority payments	9				0	
Employer's Superannuation	10				0	
Oral surgery	11				0	
OTHER (PLEASE DETAIL BELOW)	12				0	
TOTAL DENTAL SERVICES EXPENDITURE	13		0	0	0	0
OTHER (PLEASE DETAIL BELOW) - Activities / expenditure not included in a GDS contract and / or PDS agreement. This includes payments made under other arrangements e.g. GA under an SLA and D2S, plus other or one off payments such as dental nurse training	LINE NO.		£000's	£000's	£000's	£000's
Emergency Dental Services (inc Out of Hours)	14					
Additional Access	15					
Sedation services including GA	16					
Continuing professional development	17					
Occupational Health / Hepatitis B	18					
Gwen Am Byth - Oral Health in care homes	19					
Refund of patient charges	20					
Design to Smile	21					
Other Community Dental Services	22					
Dental Foundation Training/Vocational Training	23					
DBS/CRB checks	24					
Health Board staff costs associated with the delivery / monitoring of the dental contract	25					
Oral Surgery	26					
Orthodontics	27					
Special care dentistry e.g. WHC/2015/002	28					
Oral Health Promotion/Education	29					
Improved ventilation in dental practices	30					
Attend Anywhere	31					
	32					
	33					
	34					
	35					
	36					
	37					
	38					
	39					
	40					
	41					
	42					
TOTAL OTHER (must equal line 12)	43			0		0
RECEIPTS						
TOTAL DENTAL SERVICES INCOME (Enter as a negative value)	44				0	



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

Meeting Date	26 January 2023	Agenda Item	4.2
Report Title	Report of the Director of Finance		
Report Author	Joe Draper-Orr, Head of Resources		
Report Sponsor	Rhiannon Beckett, Interim Director of Finance, Planning and Performance		
Presented by	Rhiannon Beckett, Interim Director of Finance, Planning and Performance		
Freedom of Information	Open		
Purpose of the Report	To provide the HEIW Board with a report on the financial position for December 2022 (Month 9).		
Key Issues	HEIW has a statutory duty to break even at year end. This report should assist the Board, Executives and Budget Holders in understanding the financial position reported for Month 9 of the 2022-23 financial year and actions required in order to be in balance at year end.		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
			Approval ✓
Recommendations	The Board is asked to: • Note the underspent financial position reported for HEIW at month 9 • Note the actions progressed to be in balance at year end, being a return of £14.5m to Welsh Government • Agree the recommendation to hand back a further £6.7m this financial year • Note the summarised explanation of key variations by Directorate, • Note the Capital allocation and spend to date, and • Note the Balance Sheet position.		

REPORT OF THE DIRECTOR OF FINANCE

1. INTRODUCTION

The report sets out the financial position as at the end of December 2022, reported against updated budgets. The delegated budgets have been derived from the 2022-23 Resource Plan which was drawn from the 2022-25 Integrated Medium-Term Plan (IMTP). The IMTP was approved by the HEIW Board, and the Resource Allocation letter received from Welsh Government (WG). The reported financial position of HEIW as at Month 9 is £691,337 underspent and this position was reported to WG in accordance with the requirements of the monitoring return submission.

2. BACKGROUND

This report identifies the reasons for any financial variation against the budgets set. The Director of Finance and her team will continue to take 'Deep Dive' exercises into the financial position on a quarterly basis and the Executive Team informed of any non-recurrent opportunities that present.

3. PROPOSAL

The Board is asked to note the financial position reported by HEIW for Month 9 and consider the summarised explanations of the key variations described for each Directorate. The Board is also asked to consider and approve the recommendation to return a further £6.7m to Welsh Government for the 2022/23 financial year. Further information is provided in the Review of Education and Training Activity 22/23 paper that is also on the agenda.

4. GOVERNANCE AND RISK ISSUES

HEIW has a statutory financial duty to break even at year-end and the WG will monitor the reported position in terms of this duty and against the current year financial plan submitted within the 2022-23 Annual Plan.

5. FINANCIAL IMPLICATIONS

5.1 Revenue Financial Position as at Month 9

HEIW is reporting an underspend of £691,337 against profiled budgets as at 31st December 2022. The underspend is split between pay costs, where there are various vacant posts within the establishment and the under-recruitment of Clinical Fellows, non-pay costs which relate to travel, training, and Conference activity where activity is lower than budgeted and against commissioning budgets where there is this month a slight overspend compared to the cumulative budget. The financial plan included anticipated allocations from WG, as set out in the Resource Plan that are regularly reassessed.

For month 9, the financial position was reported to WG on day 5, and the monitoring return was submitted in accordance with the required Welsh Health Circular (WHC)

reporting timetable. The monitoring return that was submitted to WG is included as Appendix 2.

The table below shows the high-level variance on the delegated budgets of the Executive Directors.



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As at 31st December 2022

	Year to Date			Month 8	
	Budget	Actual	Variance to Date	Variance to Date	Movement
	£	£	£	£	
INCOME:					
Welsh Government	(206,257,569)	(206,257,569)	0	0	0
Other Income	(586,932)	(521,527)	65,405	58,782	6,623
Total Income	(206,844,501)	(206,779,096)	65,405	58,782	6,623
Expenditure					
Board & Executive	1,777,686	1,733,504	(44,182)	(35,582)	(8,600)
Finance	1,597,747	1,498,107	(99,640)	(84,611)	(15,030)
Planning & Performance	467,090	418,702	(48,388)	(36,347)	(12,041)
Digital and IT	2,851,555	2,824,009	(27,546)	(53,570)	26,025
Medical & Pharmacy	104,725,430	104,308,112	(417,318)	(508,003)	90,684
Nursing	91,219,315	91,161,022	(58,293)	(31,769)	(26,524)
Workforce and Organisation Development	4,205,678	4,144,304	(61,374)	(23,282)	(38,092)
Sub-Total Expenditure	206,844,501	206,087,759	(756,742)	(773,164)	16,422
Total Board & Executive	0	(691,337)	(691,337)	(714,382)	23,045

The following table provides a further breakdown of the financial variance by expenditure category.

	Income	Expenditure			Total
		Pay	Non Pay	Commissioning	
Directorate	£	£	£	£	£
Board and Executive		(40,571)	(3,611)		(44,182)
Chief Executive Reserve					
Finance		(94,030)	(5,610)		(99,640)
Planning and Performance		(48,725)	336		(48,388)
Digital and IT		(93,490)	65,944		(27,546)
Medical & Pharmacy	65,405	(277,508)	(374,438)	234,628	(351,913)
Nursing and Health Professional Education		(95,902)	(28,856)	66,465	(58,293)
Human Resources and Organisation Development		(47,795)	(13,579)		(61,374)
Total	65,405	(698,022)	(359,813)	301,093	(691,337)

The analysis attached as Appendix 1, provides the key reasons for the variation by Directorate. The key reasons for the underspends are vacancies in pay budgets, reduced activity in areas such as conferencing and training as well as travel and

subsistence and low levels of overspend within commissioning budgets in the year to date position due to a higher level of extensions to training than anticipated.

5.2 Forecast Position

As the Board is aware HEIW's financial position is particularly sensitive to the variances in our commissioning activity which can arise from a number of external factors, and as a consequence we work closely with Welsh Government during the course of each financial year to manage any under spends appropriately and to give early notification of any resource that needs to be handed back. In this current year the Board has already supported recommendations to hand back £14.5m to Welsh Government within the 2022/23 financial year to date. This relates largely to commissioning, with exceptional issues related to recruitment and attrition in 22/23 as well as a continuation of the recent trend for fewer students opting for the bursary. The Board made these decisions in stages, with £7m in September, and £7.5m in November. The decisions were made in the context of the wider financial pressures affecting NHS Wales and the actions already undertaken by HEIW to explore alternative education and training initiatives that could utilise the in year under spend.

Following the month nine month end close process, having adjusted the resource plan and budget in the financial ledger by a total of £14.5m, a reassessment of the forecast position highlighted a further underspend of £7.0m.

The further underspend is made up of £1.350m against pay budgets, £0.931m against non-pay budgets and £3.1m against commissioning budgets as well as a £0.082m under-achievement of income. This is in addition to £1.753m held in reserves that was allocated to resource developments including the Primary Care Academies and Pharmacy Undergraduate Placements. Spend is being incurred in these programmes and the full resource allocation will be required in future years but slippage in this financial year has created the underspend now calculated.

The pay underspend is due to vacant posts across the organisation and has increased over the past few months. Although it is difficult to predict, and individual recruitment exercises can take varying lengths of time, processes are managed efficiently in line with agreed KPIs and opportunities for further improvements have been identified.

The underspend in non-pay is due to a variety of issues including reduced activity in respect of conferences, travel & subsistence due to changes in activity post covid as well as reduced activity in a number of areas due to the level of vacancies.

Within commissioning there have been a variety of factors such as under-recruitment, attrition and take up of bursaries within Nursing and Health Care Professionals as well as within GP and Dental where the recruitment fell below commissioned levels. Full detail of the exceptional issues affecting education and training are included in a separate paper on the agenda, along with the actions that are in train to address these issues going forward

5.3 Budget Allocation Movement

In year, as is usual every year there have been a number of budget movements as a result of changes in the WG allocation, partly due to the return of funding back to Welsh Government as agreed with Executives and Board, as well as adjustments to anticipated income also agreed with Welsh Government during the year and the receipt of further funding for agreed pay awards.

The table below shows the original annual budget agreed with Board via the Resource Plan paper for 2022/23 at the beginning of the financial year compared to the current allocation as at the end of December 2022.

	Annual Budget		
	Resource Plan Annual Budget	Current Annual Budget	Movement in Year
	£m	£m	£m
INCOME:			
Welsh Government	(307.569)	(292.914)	14.655
Other Income	(0.516)	(0.839)	(0.323)
Total Income	(308.084)	(293.753)	14.332
Expenditure			
Board & Executive	8.419	4.238	(4.181)
Finance	2.861	2.154	(0.707)
Planning & Performance	0.604	0.651	0.047
Digital and IT	3.740	4.240	0.500
Medical & Pharmacy	143.796	145.645	1.849
Nursing	143.372	130.146	(13.226)
Workforce and Organisation Development	5.293	6.680	1.387
Sub-Total Expenditure	308.084	293.753	(14.332)
Total	0.000	0.000	0.000

This shows a reduction in Welsh Government funding of £14.655m and the table below shows this movement showing the breakdown in this movement:

Movement in Budget Set 2022/23	£m
Budget Set in line with Resource Plan for 2022/23	307.569
Additional Welsh Government Allocation - Pay Award	2.247
Additional Welsh Government Allocation - Depreciation	0.053
Additional Welsh Government Allocation - Anticipated	0.043
Anticipated Income agreed not to receive	(2.481)
Non-Cash Adjustments re IFRS16	(0.017)
Return of Welsh Government Allocation	(14.500)
Budget Set for WG Allocation at month 9	292.914

Welsh Government have provided additional allocations for pay awards of £2.247m as well as £0.053m as additional allocation for depreciation. The final additional allocation is £0.043m which is non recurrent funding that had been anticipated from Welsh Government in relation to Clinical Fellows and the Digital Capacity Framework.

A total of £2.481m was anticipated as additional non recurrent income from Welsh Government at the beginning of the financial year and included in the Resource Plan.

This included £1.8m for the development of Primary Care Academies and other areas of additional non recurrent funding. As part of the ongoing discussion with Welsh Government around resourcing HEIW's strategic plans, it was agreed that the costs of Primary Care and some other areas of activity would be funded out of the existing allocation instead of requesting additional funding.

In addition, a reduction of allocation of £0.017m was agreed in line with the impact of IFRS16.

Finally, we have accounted for the £14.5m which has been agreed to be handed back to Welsh Government during October and November and this is reflected in the budget for month 9.

The Board are asked to support the hand back of an additional £6.7m to Welsh Government to allow HEIW to deliver a break even position at the end of 2022/23.

5.4 Commissioning Funding

It should be noted that commissioning budgets are based on the existing student cohorts in the system and the commissioned student numbers for 22/23.

5.5 Balance Sheet

The balance sheet as at 31st December 2022 is shown below:

	2022/23 Opening Balance	31st December 2022	Movement
	£000s	£000s	£000s
Non-Current Assets:			
Fixed Assets	1,940	3,064	1,124
Current Assets:			
Trade and other receivables	2,125	1,037	(1,088)
Cash & bank	5,955	1,953	(4,002)
Total Assets	10,020	6,054	(3,966)
Liabilities:			
Trade and other payables	(8,543)	(14,201)	(5,658)
Provisions	0	0	0
Total Liabilities	(8,543)	(14,201)	(5,658)
	1,477	(8,147)	(9,624)
Financed by:			
General Fund	1,477	(8,147)	(9,624)
Total Funding	1,477	(8,147)	(9,624)

- The movement on non-current assets reflects:
 - Depreciation charged during the month.
 - The transfer of the Ty Dysgu lease onto the balance sheet as a result of the introduction of IFRS16 from 1st April 2022. This is a change in accounting policy that affects all public sector bodies. The increase in assets is matched with a corresponding increase in the liability to pay the lease costs, which is reflected within 'Trade & Other Payables'.
- Trade and Other Receivables stand at £1.0m as at 31st December 2022.
- Trade and Other Payables – Overall increase of £5.7m since the start of the year. The balance of £14.2m is made up of:
 - £1.2m of invoices on the accounts payable system awaiting payment in line with the 30 day payment policy.
 - £7.9m in respect of other NHS Wales organisations, of which £5.7m are estimated accruals.
 - £1.9m payable to non-NHS creditors.
 - £0.4m relates to technical accounting accruals such as the annual leave provision.
 - £0.7m of HMRC and pension creditors due in the month following the payroll period.
 - £1.7m relating to the lease liability following the implementation of IFRS16 from 1st April 2022.

The cash balance at the end of December 2022 was £1.9m.

5.6 Capital Expenditure

HEIW has a discretionary capital allowance of £76k for the year and a further £150k 'End of Year Funding' was awarded in November 2022.

The purchase of capital items was approved by the Executive Team and orders have been placed. Deliveries of the equipment has started and all will be received by the end of March 2023.

5.7 Public Sector Payment Policy

All NHS bodies are expected to meet the Public Sector Payment Policy, which requires organisations to pay 95% of all non-NHS invoices within 30 days (by number). For the period April 2022 to December 2022 HEIW cumulatively paid 95.51% of non-NHS invoices and 92.76% of NHS invoices within 30 days.

Non-NHS Invoices

	By Number			By Value		
Month	Number Passed	Number Failed	% Passed	Value Passed £	Value Failed £	% Passed
April	330	8	97.63	7,221,258	5,223	99.93
May	334	21	94.08	8,119,129	65,308	99.2
June	421	47	89.96	7,734,526	41,413	99.47
Quarter 1	1,085	76	93.45	23,074,914	111,944	99.52
July	473	12	97.53	9,457,372	14,570	99.85
August	601	16	97.41	8,952,309	15,988	99.82
September	383	17	95.75	9,715,736	18,623	99.81
Quarter 2	1,457	45	97.00	28,125,417	49,181	99.83
October	456	22	95.40	9,173,595	18,901	99.79
November	658	25	96.34	10,519,546	43,588	99.587
December	578	31	94.91	10,775,373	97,957	99.099
Quarter 3	1,692	78	95.59	30,468,514	160,446	99.48
Total	4,234	199	95.51	81,668,845	321,571	99.61

NHS Invoices

	By Number			By Value		
Month	Number Passed	Number Failed	% Passed	Value Passed £	Value Failed £	% Passed
April	239	5	97.95	6,557,522	46,818	99.29
May	120	4	96.77	9,231,954	48,316	99.48
June	64	8	88.89	7,244,445	1,235,225	85.43
Quarter 1	423	17	96.14	23,033,921	1,330,360	94.54
July	151	8	94.97	8,523,309	36,900	99.57
August	130	31	80.75	7,449,254	171,687	97.75
September	118	13	90.08	8,462,081	361,870	95.9
Quarter 2	399	52	88.47	24,434,644	570,457	97.72
October	124	16	88.57	6,265,288	124,935	98.04
November	238	14	94.44	9,834,231	68,169	99.31
December	252	13	95.09	9,052,371	48,452	99.47
Quarter 3	614	43	93.46	25,151,890	241,556	99.05
Total	1,436	112	92.76	72,620,455	2,142,373	97.13

6. RECOMMENDATION

The Board is asked to:

- Note the underspent financial position reported for HEIW at month 9
- Note the actions progressed to be in balance at year end, being a return of £14.5m to Welsh Government.
- Agree the recommendation to hand back an additional £6.7m in this financial year in the context of the Review of Education and Training Activity contained in a separate report.
- Note the summarised explanation of key variations by Directorate,
- Note the Capital allocation and spend to date, and
- Note the Balance Sheet position.

Governance and Assurance			
Link to IMTP strategic aims <i>(please ✓)</i>	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
There are no implications for Quality, Safety and Patient Experience			
Financial Implications			
The financial implications are set out above in the body of the report.			
Legal Implications (including equality and diversity assessment)			
HEIW has a statutory responsibility to break even at year end the report sets out the financial position for December 2022. There are no equality and diversity implications of this report.			
Staffing Implications			
There are no staffing implications of this report.			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			

The report briefly describes how HEIW are seeking to adopt a sustainable approach to financial management that will enable HEIW to meet its long-term objectives.

Report History

The report references and updates the previous finance update shared with the HEIW Board in November 2022.

Appendices

Further detail is included in Appendix 1.
The Monitoring return is included as Appendix 2.



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Health Education and
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Meeting Date	31 January 2023	Agenda Item	4.3
Report Title	Welsh Language		
Report Author	Huw Owen, Welsh Language Services Manager		
Report Sponsor	Dafydd Bebb, Board Secretary		
Presented by	Dafydd Bebb, Board Secretary		
Freedom of Information	Open		
Purpose of the Report	To update the Board on progress on the Welsh language Agenda. This report looks at the following areas of work undertaken by HEIW in respect of the Welsh Language: 1. translation, 2. compliance with our Language Plan 3. work on the More Than Just Words initiative 4. a general round up of other activities. HEIW has two main area of focus in terms of the Welsh language – ensuring internal compliance towards our language plan (published by the Board in November 2021); and externally, supporting the Welsh language skills of the workforce.		
Key Issues	• Our Translation processes. • Progress towards compliance against our language plan. • Our progress on the More Than Just Words five-year plan initiative. • A brief roundup of other key activities.		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
	✓		
Recommendations	Members are asked to: • Note the report for information.		

Welsh Language

1. INTRODUCTION

This report looks at three distinct areas of activity and progress as far as the Welsh Language is concerned – Translation, Compliance with our Language Plan and our work on the MTJW initiative, as well as a general round up of other activities.

2. BACKGROUND

Our Welsh Language Plan, which comes under the Welsh Language Act of 1993, was approved for Publication by our Board in October 2021. We hope to come under Welsh Language Standards set by Welsh Government in due course. Nevertheless, our Welsh Language Plan, is based on the Standards so that HEIW's language policy is in line with those of other Welsh NHS organisations who do come under the Standards.

What are we doing to comply with our Welsh Language Plan, how are we doing it – and what are the implications for HEIW and the broader NHS in Wales?

Translation

Translation is the bedrock of most of what we do internally to ensure compliance – and to ensure that we are able to offer learners and ultimately patients a service in the language of their choice.

Over the past two years (2021 and 2022), we have translated well over 4 million words each year – from a standing start at the end of 2018. We now have a team of 4 internal translators, who are translating more than 66% of that total between them. Therefore a team of 4 internal translators are producing almost 3 million words a year, and a further 1 million is being bought in from the external market.

On average, it is between 33% and 75% cheaper to translate internally than it is to buy from the external market. The average rate for translations per 1000 words on the external market is around £75, whereas internally the cost varies from £40 - £55 per thousand (depending on the salary of the translator, and their annual output).

Improving the quality of translation

We have developed and refined a HEIW “house process” of translating, and we train our translators thoroughly in this process, whilst also investing in training with Aberystwyth Universities' Professional Translation suite of courses.

HEIW is continually developing our translation function including significant progress in the technical side of translation to speed up the process as well as ensuring greater accuracy. This has had a positive impact on progress. Team members are undertaking the MA (Cert) in Professional Translation with Aberystwyth University this semester – giving us greater mitigation against risk within the translation function as well as increasing the skills base of the group.

This is an experience which we are already trying to promulgate on a broader scale – we have already encouraged translators from other NHS Wales bodies to attend the courses at Aberystwyth. We are exploring offering people relatively new to the profession an unrivalled suite of training and qualifications – something that will not only attract and retain people to a career within the NHS in Wales, but will broaden, improve and deepen the pool of translators across the Public Sector in Wales.

Through offering high quality training and development and enabling the use of cutting-edge technology we hope to make translation services a more attractive, accessible and sustainable profession.

Translation Technology and ensuring Quality

There is a danger with enhanced technology, as the speed of translation increases and human intervention decreases, that quality standards and processes can be affected. AI cannot currently deal with many of the ambiguities found in any language, nor is it sensitive enough to context – therefore, some element of human intervention is still needed even where the “machine” (memory software) has processed the translation work. To address this, the team has introduced a quality assurance process on all translations. This is a three-phase process:

1. Everything we translate is run through the machine (this provides a certain series of checks and balances in itself)
2. Anything outstanding is run against the industry standard online dictionary – the ‘Porth Termaw’. If a word appears here, we know it is compliant – and this is fed back into the memory software.
3. If there is no word, or if there is more than one seemingly appropriate word on the Porth Termaw, we put the word up for peer review and discussion. We then decide on the most appropriate use of the word – and feed this back into the translation memory.

The translation team also add a lot of value above and beyond their functional roles as translators – they help with the informal learners’ chatting sessions, they attend networking events and meetings (particularly around Careers) and they play a full role in the social side of life at HEIW.

Broader Compliance issues

Compliance can be seen by many as an onerous task, something which is more stick than carrot, something which people only fail at – but at HEIW, we try and make it something which everyone can succeed at, something to be enjoyed rather than feared, and something where doing simple things brings out very positive results. So therefore we will look briefly at some of the activities which we deliver, and some key data around our legal compliance.

Some data first of all:

In the past quarter, the Welsh Language Services Manager (WLSM) has responded to and resolved;

42 calls on Teams regarding points of compliance with the law.

113 messages on Teams from 45 people regarding compliance

Over 140 e mails regarding points of compliance with the law.

And;

He has also attended 6 team meetings and 12 network meetings where compliance issues have been presented and discussed.

We have had no formal complaints about breaches in our Language Plan.

We have 72 registered learners across the organisation, at all levels from complete beginners to “hyfedredd” (Fluent, but lacking in confidence) levels. This is around 15% of our staff undertaking Welsh lessons which means that HEIW has a higher percentage of staff learning Welsh than any other NHS organisation. It is good to note that, when our Welsh learners are added to the number who already speak Welsh at various levels, this equates to over a third of our staff .

The amount of translation undertaken, and the amount of activity from staff regarding compliance issues shows a growing awareness of the needs of our language plan. Our long term goal is to see this activity lessening whilst maintaining no breaches as “doing things bilingually” becomes business as usual within HEIW. The Welsh Language Service Manager’s stated aim is to make his post redundant – but there is a lot more work to go before we can reach that happy state!

More than Just Words

We reported on the More than just Words 5 year Action Plan to the September Board. Further to this, we have now established a working group which has been meeting regularly. Good progress has been made against the responsibilities given to us through the report.

The Welsh language team

The team continues to support the Higher Education Institutions (HEIs) in the first year of the implementation of the Welsh language requirements in the HEI contracts (Phase 1 of the Strategic Review of Health Professional Education). Initial data will start filtering through in the next few months which will give us a first indication of progress by each of the HEIs.

We have been actively supporting the Careers team in their development of the Tregyrfa platform. This has involved attendance at public events, contributions to the Careers Network and sourcing of new content.

We have successfully held two further pilots of the “Raising Confidence” course, now delivering the course to 35 colleagues across 8 health boards. Turnaround in these courses in many instances has been remarkable – colleagues who have lost all confidence in using Welsh at work since leaving school years previously, and who lack the confidence even to introduce themselves in Welsh at the beginning of the session, conduct full clinical consultations through the medium of Welsh by the end of the half day course. It is hoped that we can broaden the provision of this course over the coming years.

The WL Services Manager continues to deliver simultaneous translation to a growing number of public events and meetings, and another member of the team has now commenced training in the skill. These include both the public events hosted by HEIW (where translation has been delivered both in plenary sessions and in some the breakout workshops around Wales) and in smaller, formal and informal presentations. A number of third parties have remarked how impressed they are that HEIW offers this at all of their public meetings, and that it reflects exceptionally well on us as an organization in terms of being inclusive “practising what is preached” in terms of embracing bilingualism.

3. GOVERNANCE AND RISK ISSUES

Our Welsh Language Plan comes under the Welsh Language Act of 1993. Any breach in compliance to this plan can lead to an investigation by the Welsh Language Commissioner. Any such investigation would create incremental bureaucratic activity amongst HEIW staff, as well as potentially risking a monetary punishment and reputational damage.

Poor quality or non-translation of documents can directly lead to non-compliance also. Given the current position and the steps taken in terms of the implementing HEIW’s Welsh Language Plan, the risk is currently considered to be low.

4. FINANCIAL IMPLICATIONS

Some of the actions proposed in the MTJW Five Year Plan could have resource implications for HEIW. It is currently difficult to assess how many further Welsh language courses will need to be commissioned in accordance with the requirements of the Plan and associated costs. As stated above HEIW will seek, where possible, to meet any such requirement from existing resource. Where it will not be possible for these additional costs to be met by HEIW we will raise these areas with Welsh Government and seek confirmation as to whether any additional resource will be made available.

5. RECOMMENDATION

Members are asked to:

Note the report for information .

Governance and Assurance			
Link to IMTP strategic aims <i>(please ✓)</i>	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
At HEIW we promote bilingual working practice as we know that it can lead to better clinical outcomes. Every patient in Wales has the right to receive treatment in the language of their choice; and members of the public (including our students and other stakeholders) equally have the right to receive services in the language of their choice.			
Financial Implications			
There are no direct financial implications of this paper.			
Legal Implications (including equality and diversity assessment)			
There are no direct legal implications of this paper.			
Staffing Implications			
There are no direct staffing implications of this paper.			
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)			
This activity feeds into Strategic our IMTP. This objective meets the Wellbeing of Future Generations 5 ways of working in that it promotes the Welsh language and culture. This also aligns with <i>A Healthier Wales</i> in terms of prevention, safety, higher value within the system through enabling us to prepare the workforce to give patients care in the language of their choice or need .			
Report History			
Appendices			



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

Meeting Date	26 JANUARY 2023	Agenda Item	4.4
Report Title	Corporate Risk Register		
Report Author	Dafydd Bebb, Board Secretary		
Report Sponsor	Dafydd Bebb, Board Secretary		
Presented by	Dafydd Bebb, Board Secretary		
Freedom of Information	Open		
Purpose of the Report	To provide an overview of the risks currently detailed within the Corporate Risk Register (CRR).		
Key Issues	The report provides an update on the CRR, which is attached at Appendix 1. The CRR confirms that HEIW currently has a total of twelve risks assessed as follows: ○ One 'red' status risk ○ Eight 'amber' status risks and ○ Three 'green' status risks Risk 12 has been reassessed. This has resulted in the score decreasing from 9 to 4, the risk status is now 'Green'. Risk 16 has been reassessed. This has resulted in the score decreasing from 20 to 4, the risk status is now 'Green'.		
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance
			✓
Recommendations	The Board is asked to: • Note the report for assurance.		

CORPORATE RISK REGISTER (JANUARY 2023)

1. INTRODUCTION

The Board is asked to note the current position regarding the Corporate Risk Register (CRR) (**Appendix 1**) as outlined in this report.

2. ASSESSMENT

There are currently **12** risks on the CRR, and these risks have been assessed as follows: **1** 'Red' status risks, **8** 'Amber' status risks, and **3** 'Green' status risks. Except for paragraph 2.1, which provides an update on the pre-existing Red Risks, the commentary below highlights the changes to the CRR since the last report.

2.1. Red Risk

Risk 1 – If HEIW does not ensure that all reasonable steps are taken in respect of cyber security it may be vulnerable to a data breach, possible fines from the Information Commissioners Office and associated bad publicity.

Mitigation: This requires the implementation of recommendations highlighted within HEIW's Cyber Security Assessment Report. Cyber Security Implementation Plan to be drafted and implemented.

Progress: The recommendations within HEIW's Cyber Security Assessment Report have or are being implemented. Activities to support the delivery of the Cyber Security Plan are underway.

Recent developments: Activities to support the delivery of the cyber security plan are underway and recent developments include:

- Prioritisation efforts are underway to deliver against our security governance, people security, asset protection and posture management security imperatives which include several security improvements. The CAF for Health risk register has been reviewed and updated. Vacancy request for the band 7 cyber security team lead post closed in December 2022. Shortlisting and interview activities will be carried out in January 2023. Work continues to prioritise security efforts to increase assurances across security imperatives and reduce risk. Several security initiatives at this time are being cultivated and expected to be delivered in Q4 2022.

2.2. Risks with an Increased Score

There have been no risks with an increased score since the last report.

2.3. Risks with a Reduced Score

There have been two risks with a reduced score since the last report.

Risk 12 – GP Training excess funding Requirements - If the costs of the increased recruitment of GPs continues to exceed the amounts forecast, due to them taking longer to reach qualification (due to increased uptake of

Parental leave, less than full time training, and other issues relating to difficulties experienced by International medical graduates) and pay protection, there could be a financial and reputational risk to HEIW if we cannot deliver the programme and agree a new funding stream with Welsh Government.

Mitigation: Medical Deanery and Finance Colleagues have done a deep dive to ascertain the causes of the overspend. Analysis of the data has provided clear reasons for the overspend.

The overspend has been mitigated by significant underspends in other budgets. The over-recruitment above 160 will be carefully managed in the future to reduce the overall financial risk with increased numbers while remaining on target to recruit at least 160 trainee GPs each year.

Progress: As Welsh Government has approved the Education and Training Plan for 2023/24 this risk has been mitigated and can be re-assessed as a green status risk.

Assessment: The risk was assessed as 9 giving an 'Amber' status. However, the risk has been reassessed and resulted in the score decreasing to 4. The risk status is now 'Green'.

Risk 16 – Delay in approval of Education & Training Plan - The delay in signing off the recommendations for additional commissioned numbers in the Education and Training plan has led to risk in respect of the ability to recruit to certain specialties in Wales through National recruitment processes. This could make Wales a less attractive place to train. An extended delay could also impact on other commissioned courses.

Mitigation: Escalation of the issues described at a national level. Risk assessments by commissioning programme are being undertaken and will be submitted to WG.

Continued dialogue to gain clarity. Decision likely to be linked to 17th November budget statement and impact assessment of it for Wales.

Progress: As Welsh Government has approved the Education and Training Plan for 2023/24 this risk has been mitigated and can be re-assessed as a green status risk.

Assessment: The risk was assessed as 20 giving a 'Red' status. However, the risk has been reassessed and resulted in the score decreasing to 4. The risk status is now 'Green'.

2.4. Risk Removal

No risks have been removed from the CRR since the last report.

2.5. New Risks

No new risks have been added to the CRR since the last report.

3. GOVERNANCE AND RISK ISSUES

Risk management through the CCR is a core tool for the governance of risk within HEIW.

4. FINANCIAL IMPLICATIONS

Risk management through the CRR is a core function of HEIW as a Special Health Authority. There are no anticipated additional cost implications.

5. RECOMMENDATION

The Board is asked to:

- **Note** the report for assurance.

Governance and Assurance			
Link to IMTP strategic aims <i>(please ✓)</i>	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To transform healthcare education and training to improve opportunity, access and population health.	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓
Quality, Safety and Patient Experience The CRR is the core tool to ensure effective risk management within HEIW. A robust approach to the management of risk is more likely to impact favourably on the safety and experience of patients and staff.			
Financial Implications Risk management is a core function of HEIW as a Specialist Health Authority. There are no anticipated additional costs.			
Legal Implications (including equality and diversity assessment) There are no legal implications associated with this report.			
Staffing Implications			

There are no staffing implications associated with this report.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
The CRR is HEIW's core tool to manage risk.	
Report History	The CRR is presented to the Executive Team and Senior Leadership Team on a monthly basis. The Audit and Assurance Committee review it on a quarterly basis. The CRR is provided for noting at each meeting of the Board.
Appendices	Appendix 1 – CRR

HEIW CORPORATE RISK REGISTER - 2022/23 - November

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
			Impact	Probability	Overall Score				Impact	Probability	Overall Score		
1	1	If HEIW does not ensure that all reasonable steps are taken in respect of cyber security it may be vulnerable to a data breach, possible fines from the Information Commissioner's Office and associated bad publicity. Board Secretary	5	5	25	LOW	This requires the implementation of recommendations highlighted within HEIW's Cyber Security assessment report. This includes the recruitment of a Head of Cyber Security. Cyber Security Implementation Plan to be drafted and implemented	Ongoing	5	4	20	R	October 2022 Activities to support the delivery of the cyber security plan continue. Prioritisation efforts are underway to deliver against our security governance, people security, asset protection and posture management security imperatives which include several security improvements. The CAF for Health risk register has been reviewed and updated. Resource implications in IG have recently affected the availability of the Head of Cyber Security & Information Assurance. We have since made an offer of employment for the permanent IG Manager post. The vacancy request for the band 7 cyber security team lead role will go out to advert mid-November. November 2022 Vacancy request for the band 7 cyber security team lead post has since been advertised a little later than anticipated (30th Nov). December 2022 Vacancy request for the band 7 cyber security team lead post closed in December 2022. Shortlisting and interview activities will be carried out in January 2023. Work continues to prioritise security efforts to increase assurances across security imperatives and reduce risk.

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
													Several security initiatives at this time are being cultivated and expected to be delivered in Q4 2022.
2 July 2020	1.	If HEIW is unable to access workforce data from other NHS organisations, then its workforce will not be able to provide modelling data and fail to meet expectations in respect of the same and have an adverse impact on NHS workforce planning. Director of Digital and Data	4	3	12	LOW	HEIW to request access to live data from ESR and other workforce information systems as well as the current Data Warehouse information Requests for additional access to information in line with NHS Digital/Health Education England.		4	2	8	A ↔	January 2023 A re-coding workshop for Health Care Scientists has been undertaken to help develop guidance and formulate implementation plans. Plans for implementation have been scheduled for April 2023. NWSSP and HEIW have signed a Non-Disclosure Agreement enabling HEIW to have access to key data fields in the Wales National Workforce Reporting System (WRWNS). These field will enhance workforce modelling and planning capabilities. A Primary care dashboard had been created to make this data available across HEIW.
3 July 2020	1.	If HEIW does not have sufficient capacity this may have an impact on its ability to support the NHS, delivery of Annual Plan commitments and levels of performance. Director of Workforce and Organisational Development	4	4	16	LOW	Assessment & costing of workforce requirements made as part of the development of the IMTP.		4	2	8	A ↔	January 2023 'New Ways of Working' structures went live on 5/9/22. Recruitment of additional capacity to support the changes and to strengthen corporate teams is well underway in most areas. The WG Planning Guidance issued late Nov has been assessed. We are working to a tight IMTP timetable, to ensure final draft for Board approval in March and submission to WG by 31 March 2023. Part of this process requires SROs to assess capacity to deliver.
4	2	If there are insufficient employment opportunities available for graduating	3	5	15	HIGH	• Appeals process in place	31/1/23	3	3	9	G	December 2022

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
Aug 2020		Allied Health Professionals (AHP's) and Health Care Science (HCS) students who have opted into the bursary tie in the investment in education for these students may be lost. Director of Nurse and Health Professional Education					- Quarterly written reports to Executive; - Engagement/stakeholder events with 1st and final year students					↓	- Monthly drop in sessions commenced with good engagement to support and respond to student queries. - Meeting with HB and Trust recruitment managers arranged for mid Jan to discuss recruitment activity for AHPs ad HCS and understanding job opportunities - Work continues to document employment destination of all 2022 graduates.
5 Dec 2020	2	Strategic Review 2 If we continue to commission post reg and post grad education from HEI's in England and Wales without a contract, then HEIs may withdraw education provision or fail to provide high quality education that can be performance managed in the usual contractually governed way. Director of Nurse and Health Professional Education	3	4	12	MEDIUM	Strategic Review 2 Board, reporting to Executive Team. Strategic review 2 Project plan, timetable, and risk register. HEIW subject experts linked to programmes, supported by strategic education adviser Strategic review phase 2 to be a standing item in contract meetings with HEI's. Engage with regular discussions with the National School (4 countries meetings held quarterly) Phased approach with those programmes most at risk in first wave.	Ongoing	3	3	9	A ↔	December 2022 - PT PTP: Stakeholder engagement with health boards, professional body and education providers complete - HCSW L 4: award delayed due to ETP delay (risk 16) - Genomics: Successfully awarded, first learners February 2023. - Critical Care education: Evaluation completed. Approval to award being sought. - CAAPs/Clinical Psychology/CBT education: Tender documentation developed, on track for tender to go live January 2023 - SCPHN and SPQ: Stakeholder engagement has been undertaken. Development of All Wales PAD's to be discussed with Council of Deans

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
													Ultrasound Options paper presented to PB further work prior to going to HEIW Exec Clinical Photography: Stakeholder event undertaken December 2022. Trainees to enrol on new WBL education Autumn 2023 Independent Authorisation of Blood Transfusion (IABT) HB stakeholder engagement undertaken. Education provider stakeholder event December 2022
6	2	Strategic Review 1 If successful HEIs fail to mobilise the new programmes within the time specified by contract, then new students will be unable to benefit from programmes in 2022. Director of Nurse and Health Professional Education	3	4	12	Medium	- Strategic Review 1 Board, reporting to Executive Team and ECQC. - Strategic review 1 Project plan, timetable, and risk register. - Performance management framework agreed with each HEI. - Monthly performance management of the new contracts.	Ongoing	2	4	8	A ↔	December 2022 – Fill rates show good recruitment across most professions, apart from nursing. Programme of work to maximise applications to nursing programme Focussed work with Comms and Careers in relation to Spring 2023 recruitment Distance learning contract at Bangor University last programme to achieve NMC approval Dec 22. Dispersed learning programme in Swansea Uni being managed through performance framework. Meeting held with HDUHB Performance of Bangor University quality of learning - meeting arranged to review in January.
8 Oct 2021	4	Single Lead Employer arrangements via NWSSP If implementation of the single lead employer model processes does not meet expected standards and impacts on trainee experience, then this would potentially have an adverse	4	5	20		Group established between NWSSP, HEIW and UHBs to begin process mapping of data flow and other employment processes to identify weaknesses		3	4	12	A ↔	September 2022 SLE issues discussed with NWSSP at Joint Exec meeting. A Review led by NWSSP MD of the August intake is to occur and HEIW will be represented in the review.

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
		reputational impact for HEIW and for Wales as a place to train. Medical Director					- Paused roll out for secondary care specialties from December 2021 until clarity on resolution of existing issues - NWSSP to review and where appropriate address internal capacity to deliver the service - Weekly updates for HEIW executive team on progress						Risk to remain at amber until review is complete December 5th 2022 Waiting for Review to occur January 11th 2023 Review has commenced. Third meeting imminent. Current projection is that Report will be available at the end of February. Internal Audit engaged to look at HEIW roles in ensuring we are providing our information in the best way to support NWSSP.
12 March 2022	4	GP Training excess funding Requirement If the costs of the increased recruitment of GPs continues to exceed the amounts forecast, due to them taking longer to reach qualification (due to increased uptake of Parental leave, less than full time training, and other issues relating to difficulties experienced by International medical graduates) and pay protection, there could be a financial and reputational risk to HEIW if we cannot deliver the programme and agree a new funding stream with Welsh Government. Medical Director	5	3	15		- Medical Deanery and Finance Colleagues have done a deep dive to ascertain the causes of the overspend - Analysis of the data has provided clear reasons for the overspend - The overspend has been mitigated by significant underspends in other budgets - The over-recruitment above 160 will be carefully managed in the future to reduce the overall financial risk with increased numbers while remaining on target to recruit at least 160 trainee GPs each year.		2	2	4	G ↓	As Welsh Government has approved the proposals in the annual Education and Training plan this risk has been mitigated and can be re-assessed as a green status risk December 5th 2022 No change as Education and Training plan approval still awaited. January 18th 2023 As Welsh Government has approved the Education and Training Plan for 2023/24 this risk has been mitigated and can be re-assessed as a green status risk.
13 May 22		Midwifery at the University of South Wales	5	4	20		Formal request by Director of Nurse and HPE for		3	2	6	G	December 2022: Concerns about supervision of students within Cwm Taf Morgannwg UHB raised by HEI are

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
		If the Sept 2021 student midwifery cohort (USW) does not progress onto year 2 of the future midwife programme they will not register with future midwifery proficiencies and skills in line with all other HEI midwifery programmes in Wales. Director of Nurse and Health Professional Education					assurance and improvement plan. - USW improvement plan - Major modification review of midwifery programme by the Nursing and Midwifery Council (NMC) - HEIW ECQ meetings monitor progress on the action plan. - Reports to HEIW Exec Team and ECQC					↓	now being managed collaboratively with HoM. All signed up to a new supervision standards document. Improvement plan updated, all actions progressing well.
14		Merger of Health Education England (HEE) with NHS England and NHS Digital If the merger is not managed well there is a risk to the delivery of a number of national roles that HEE currently perform such as National recruitment Medical Director	5	3	15		Regular 4 nation meetings of Statutory Education Body Medical Directors/GMC and Academy of Medical Royal Colleges to maintain dialogue and mitigate risks as they appear	Ongoing till April 2023	3	3	9	A ↔	November 10th 2022 We have been re-assured by current HEE colleagues that all the National Functions are being transferred to a new section within the new English organisation which will continue to provide these UK wide functions. Risk can be reduced to amber. November 25th 2022 No change envisaged until April 2023 December 5th 2022 MoU has been Issued for HEIW and WG to sign by 16th December. Once done risk can be reduced to green January 11th 2023 Awaiting confirmation from WG that MoU has been signed.
15		Merger of Health Education England (HEE) with NHS England and NHS Digital	5	3	15		Regular 4 nation meetings of Statutory Education Body Medical Directors/GMC and	Ongoing till April 2023	3	3	9	A ↔	November 10th 2022 We are in ongoing discussions with our Medical Deanery colleagues in

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
		If the merger is not managed well, there is a risk to trainees who access opportunities in HEE – particularly in HEE NW Medical Director					Academy of Medical Royal Colleges to maintain dialogue and mitigate risks as they appear						England (mostly HEENW) where we place trainees to ensure continuity of training. The current position is that they do not see any HEE changes affecting their interfaces with us. Risk can be reduced to amber. November 25th 2022 No change envisaged until April 2023 December 5th 2022 No change envisaged until April 2023 January 11th 2023 No change envisaged until April 2023
16		Delay in approval of Education & Training Plan The delay in signing off the recommendations for additional commissioned numbers in the Education and Training plan has led to risk in respect of the ability to recruit to certain specialties in Wales through National recruitment processes. This could make Wales a less attractive place to train. An extended delay could also impact on other commissioned courses. Interim Director of Finance, Planning and Performance	3	5	15	LOW	Escalation of the issues described at a national level. Risk assessments by commissioning programme are being undertaken and will be submitted to WG Continued dialogue to gain clarity. Decision likely to be linked to 17th November budget statement and impact assessment of it for Wales.		4	1	4	G ↓	November 10th 2022 Waiting for further clarity following the budget statement and assessment of the impact of what could be a revised funding settlement for Wales. November 25th 2022 Although the budget statement did include additional funding for Wales, a decision on how the additional funding will be deployed across Main Expenditure Groups by the cabinet in WG will be required. Approval of the E&T plan is linked to the availability of resources for the NHS in 23-24 and so is subject to ongoing delay.

Date Added	Ref SO	Risk Description and Executive Owner	Inherent Risk			Risk Appetite	Mitigating Actions	Date of impact	Residual Risk			RAG Status	Progress
		Details of the risk. If... then... impact	Impact	Probability	Overall Score	None Low Moderate High Very High	Summary of action to date or proposed action to reduce risk, impact, or proximity – this should include a deadline or timetable for completing actions.		Impact	Probability	Overall Score	R/A/G & Trend	
													January 18th 2023 As Welsh Government has approved the Education and Training Plan for 2023/24 this risk has been mitigated and can be re-assessed as a green status risk.

Risk Scoring Matrix

L I K E L I H O O D	Probable	5	10	15	20	25
	Likely	4	8	12	16	20
	Possible	3	6	9	12	15
	Unlikely	2	4	6	8	10
	Rare	1	2	3	4	5
		Negligible	Minor	Moderate	Major	Critical
		IMPACT				

Level	Colour	Score Range
Low	G	1 – 6
Moderate	A	7 – 14
High	R	15 – 25

Risk Appetite Levels

Appetite Level	Described as:	What this means

None	Avoidance of risk and uncertainty is a key organisational objective.	Avoidance of loss is key objective, play safe, avoidance of developments. Priority for tight controls and oversight.
Low	Minimal, or as little as reasonably possible, is preferred for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.	Prepared to accept the possibility of very limited financial loss if essential. Win any challenges re compliance. Innovations avoided unless essential.
Moderate	Cautious is preferred for safe delivery options that have low degree of inherent risk and may only have limited potential for reward.	Prepare to accept some possibility of some financial loss. Limited tolerance for sticking neck out. Tendency to stick with status quo, innovation in practice avoided unless really necessary
High	Open and willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and Value for Money).	Prepared to invest for return & minimise the possibility of financial loss. Value and benefits considered. Gains outweigh adverse consequences. Innovation supported.
Very High	Seek and be eager to be innovative and too chose options offering potentially higher business rewards (despite greater inherent risk). Or also described as mature and confident in setting high levels of risk appetite because controls, forwards scanning, and responsiveness systems are robust.	Investing for best possible return & acceptance of possibility of financial loss. Chances of losing any challenge are real and consequences would be significant. Desire to break the mould. High levels of devolved authority – management by trust, not control.

Strategic Aims

1	To lead the planning, development, and well-being of a competent, sustainable, and flexible workforce to support the delivery of 'A Healthier Wales'
2	To transform healthcare education and training to improve opportunity, access, and population health.
3	To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
4	To develop national workforce solutions to support the delivery of national service priorities and high-quality patient care.
5	To be an exemplar employer and a great place to work
6	To be recognised as an excellent partner, influencer and leader



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Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)

Meeting Date	26 JANUARY 2023		Agenda Item	4.5
Report Title	In-Committee Decisions			
Report Author	Dafydd Bebb, Board Secretary			
Report Sponsor	Dafydd Bebb, Board Secretary			
Presented by	Dafydd Bebb, Board Secretary			
Freedom of Information	Open			
Purpose of the Report	To set out key issues discussed at the In-Committee Board Meeting held on 24 November 2022.			
Key Issues	In accordance with Standing Orders, HEIW is required to report any decisions made in private session to the next available public meeting of the Board. This report sets out the decisions made by Board In-Committee on 24 November 2022.			
Specific Action Required <i>(please ✓ one only)</i>	Information	Discussion	Assurance	Approval
	✓			
Recommendation	The Board is asked to note the report for information.			

DECISIONS MADE DURING THE IN-COMMITTEE BOARD MEETING HELD ON 24 NOVEMBER 2022

1. INTRODUCTION

The purpose of the paper is to report on items considered by the In-Committee Board Meeting held on 24 November 2022.

2. BACKGROUND

The Board shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public. In such cases, the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observer withdraw from the meeting. In doing so, the Board shall resolve:

'That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'

In these circumstances, when the Board is not meeting in public session, it shall operate in a private session, formally reporting any decisions taken at the Board's next public session meeting.

3. PROPOSAL

The following matters were discussed in the in-committee meeting of the HEIW Board on 24 November 2022:

- **Chair's Report** – The Board received and noted a verbal update from the Chair.
- **Chief Executive's Report** – The Board received and noted a verbal update from the Chief Executive.
- **Update on the Education and Training Plan Reassessment 22-23.** The Board **noted** the report which outlined the current position in respect of the Education and Training Plan 23-24.
- **Report of the Director of Finance: Utilisation of Resources.** The Board considered the report and **agreed** that that HEIW should ensure that clear communications were in place to explain the context and reasons behind HEIW's underspend.
- **Contract approval for the Design, Education and Provision of an NHS Wales Executive Development Centre.** The Board **approved** the award of the Executive Development Centre.

- **Key Issues Report from Audit and Assurance Committee held on 17 October 2022.** The Board received and noted the Chair's Key issue report for the Audit and Assurance Committee.
- **Key Issues Report from Remuneration and Terms of Service Committee held 27 October 2022** - The Board received and noted the Chair's Key issue report for the Remuneration and Terms of Service Committee held on 27 October 2022. The Board approved the proposed recruitment to the Post of Director of Finance, Planning, and Performance as outlined within the report. The Board approved the Implementation of the higher banding for the post of Director of Finance, Planning and Performance following re-evaluation.

4. GOVERNANCE AND RISK ISSUES

The report provides an overview of matters considered by the In-Committee Board Meetings held on 24 November 2022 and is intended to further demonstrate HEIW's commitment to open and transparent decision-making.

5. FINANCIAL IMPLICATIONS

There are no direct financial implications associated with this report.

6. RECOMMENDATION

The Board is asked to **note** the report for **information**.

Governance and Assurance			
Link to IMTP strategic aims <i>(please ✓)</i>	Strategic Aim 1: To lead the planning, development, and wellbeing of a competent, sustainable, and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff, ensuring that it meets future needs	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer, and leader
	✓	✓	✓
Quality, Safety and Patient Experience			
Ensuring the Board and its Committees make fully informed decisions is dependent on the quality and accuracy of the information presented and considered by those making decisions. Informed decisions are more likely to impact favourably on the quality, safety and experience of patients and staff.			

Financial Implications	
There are no direct financial implications associated with this report.	
Legal Implications (including equality and diversity assessment)	
There are no legal implications associated with this report.	
Staffing Implications	
There are no direct staffing implications associated with this report.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
There are no direct implications on the Act.	
Report History	This report is provided at each meeting of the Board.
Appendices	None.



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

Meeting Date	26 January 2023	Agenda Item	4.6.1
Report Title	Key Issues Report – Education, Commissioning and Quality Committee		
Report Author	Dafydd Bebb, Board Secretary		
Report Sponsor	Dafydd Bebb, Board Secretary		
Presented by	Tina Donnelly, Chair		
Freedom of Information	Open		
Purpose of the Report	The report aims to outline discussions undertaken by the Education, Commissioning and Quality Committee.		
Key Issues	This report focuses on the key issues raised at the Education, Commissioning, and Quality Committee meeting held on 6 December 2022.		
Specific Action Required	Information	Discussion	Assurance
			✓
Recommendations	The Board is asked to: • Note the content of the report for assurance		

KEY ISSUES REPORT – EDUCATION, COMMISSIONING AND QUALITY COMMITTEE, 6 DECEMBER 2022

1. INTRODUCTION

The purpose of the report is to provide an update on matters considered by the Education, Commissioning and Quality Committee at its meeting on 6 December 2022. The Board is asked to note the summary report from the Chair together with the recommendations made by the Committee.

2. BACKGROUND

The Board will be aware that three committees have been established under HEIW's standing orders; the Audit and Assurance Committee; the Remuneration and Terms of Service Committee, and the Education, Commissioning and Quality Committee. Each Committee will present reports to the Board during the year outlining key discussions, issues and risks discussed during meetings.

3. PROPOSAL

The Education, Commissioning and Quality Committee met on 6 December 2022. Appendix 1 provides the Board with a summary of the areas considered at the meeting. The formal record of the meeting remains the approved minutes.

4. GOVERNANCE AND RISK ISSUES

Any governance risks and issues are managed via the committee meetings, and exception reports will be provided to the Board by the respective chairs.

5. FINANCIAL IMPLICATIONS

There are no financial implications for the Board to consider/approve.

6. RECOMMENDATION

Members of the Board is asked to:

- **Note** the content of the report for **assurance**

Governance and Assurance			
Link to IMTP strategic aims (please ✓)	Strategic Aim 1: To lead the planning, development and wellbeing of a competent, sustainable and flexible workforce to support the delivery of 'A Healthier Wales'	Strategic Aim 2: To improve the quality and accessibility of education and training for all healthcare staff ensuring that it meets future needs	Strategic Aim 3: To work with partners to influence cultural change within NHS Wales through building compassionate and collective leadership capacity at all levels
	✓	✓	✓
	Strategic Aim 4: To develop the workforce to support the delivery of safety and quality	Strategic Aim 5: To be an exemplar employer and a great place to work	Strategic Aim 6: To be recognised as an excellent partner, influencer and leader
	✓	✓	✓

Quality, Safety and Patient Experience	
Ensuring the Board carries out its business appropriately through its Committees and aligned with its standing orders is a key factor in enabling the quality, safety and experience of patients receiving care.	
Financial Implications	
None	
Legal Implications (including equality and diversity assessment)	
The Board must comply with its Standing Orders, which includes receiving updates from its committees.	
Staffing Implications	
None	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
The report outlines work undertaken by the Committee to advise and assure the Board in relation to education, education commissioning and quality management of education provision and contracts. The Committee governance structure aims to identify issues early to prevent escalations, work closely with the Audit and Assurance Committee and integrate into the overall Board arrangements.	
Report History	This report shall be a standing item on the Board's agenda.
Appendices	Appendix 1 - Chair's Summary – Education, Commissioning and Quality Committee

Appendix 1

Meeting Date	26 January 2023	Agenda Item	4.6.1
Freedom of Information Status	Open		
Reporting Committee	Education, Commission and Quality Committee		
Report Author	Dafydd Bebb, Board Secretary		
Chaired by	Tina Donnelly, Independent Member		
Lead Executive Director(s)	Lisa Llewelyn, Director of Nurse and Health Professional Education; and Professor Pushpinder Mangat, Medical Director		
Date of last meeting	6 December 2022		
Summary of key matters considered by the Committee and any related decisions made:			
Declarations of interest were received from :			
- Gill Lewis for agenda item 2.1.1 Multi-Professional Education and Training Quality Assurance Update for Medicine. - John Gammon for agenda item 2.1.4 - Multi-Professional Education and Training Quality Assurance Update for Nursing and Health Professional Education.			
The Committee received and noted the verbal update from the Chair in respect of the meeting of the Stakeholder Reference Group held on 25 November. The update confirmed that the meeting had considered a number of items including a presentation on the development in primary care, an overview of the Integrated Medium Term Plan and an update on leadership and talent.			
The Committee received and noted the Medical Deanery Education and Training Quality Update report using the multiprofessional HEIW Quality Framework as a basis for reporting. The Committee considered HEIW’s role in respect of enhanced monitoring and focussed upon the level of detail provided within the report to support assurance. It was reported that the GMC national training survey response rates in Wales were the highest in the UK in respect of both trainees and trainers. The Committee considered the reported burnout rates for trainees within the GMC survey. It was confirmed that HEIW was working with health boards and providers in this regard and supporting flexible and part time working.			
The Committee received and noted the Dentistry Deanery Education and Training Quality Update report. It was reported that progression for all trainees remained on track and that there were no major quality issues to report.			
The Committee received and noted the Pharmacy Deanery Education and Training Quality Update report. The Committee welcomed the pass rate of 96.4% for Foundation Trainee Pharmacists which was confirmed as the highest rate in the UK. Good progress was reported in respect of the development of the draft Pharmacy Workforce Plan. Consideration was given to the process for assessing the quality of placements.			
The Committee received and noted the Nursing and Health Professional Education and Training Quality Update report in particular in respect of progress			

made in implementing the quality performance framework and of the roll-out of the contracts relating to Phase 2 of the Strategic Review of Education. It was confirmed that the development of clinical placement capacity continued to be an area of focus for HEIW and that the organisation was actively addressing this. The Committee welcomed the reference within the report to the national campaign to address fill rates.

The Committee received and considered the draft **Committee self-assessment questionnaire**. It was agreed that subject to the question relating to the Committee's subgroups being removed, that the self-assessment questionnaire be **approved**.

The Committee received and **approved** the Committee's **Forward Work Programme for 2023/24**.

Key risks and issues/matters of concern of which the Board needs to be made aware:

N/A

Recommendation for Board consideration

N/A

Delegated action by the Committee
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N/A

Main sources of information received

- | |
|--|
| <ul style="list-style-type: none"> • Multi-Professional Education and Training Quality Assurance Updates • Draft self-assessment questionnaire • Draft Forward Work Programme for 2023/24 |
|--|

Highlights from sub-groups reporting into this Committee

N/A

Matters referred to other Committees

N/A
