Agenda – Health and Social Care Committee

Meeting Venue:
Remote via Zoom
Meeting date: 13 January 2022
Meeting time: 09.00

For further information contact:
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In accordance with Standing Order 34.19, the Chair has determined that the public are excluded from the Committee's meeting in order to protect public health. This meeting will be broadcast live on www.senedd.tv

Private pre-meeting (09.00 – 09.30)

1 Introductions, apologies, substitutions and declarations of interest

(09.30)

2 Welsh Government Draft Budget 2022-23: evidence session with the Minister for Health and Social Services, the Deputy Minister for Social Services and the Deputy Minister for Mental Health and Wellbeing

(09.30-11.45) (Pages 1 – 70)

Eluned Morgan MS, Minister for Health and Social Services
Julie Morgan MS, Deputy Minister for Social Services
Lynne Neagle MS, Deputy Minister for Mental Health and Wellbeing

Judith Paget, Director General for Health and Social Services and Chief Executive of NHS Wales – Welsh Government
Steve Elliot, Director, Finance – Welsh Government
Albert Heaney, Chief Social Care Officer for Wales – Welsh Government
Claire Bennett, Director, Communities and Tackling Poverty – Welsh Government

Tracey Breheny, Deputy Director of Mental Health, Substance Misuse and Vulnerable Groups – Welsh Government

Irfon Rees – Director of Population Health – Welsh Government

Research brief

Paper 1 – Welsh Government

3 Paper(s) to note

(11.45)

3.1 Letter from Chair, Petitions Committee regarding Petition P-05-1045: To make shared-decision making and monthly mental health care-plan reviews a legal requirement

(Pages 71 – 72)

3.2 Response from Chair to Chair, Petitions Committee regarding Petition P-05-1045: To make shared-decision making and monthly mental health care-plan reviews a legal requirement

(Pages 73 – 74)

3.3 Letter from the Chair to the Minister for Health and Social Services regarding waiting times

(Pages 75 – 77)

3.4 Response from the Minister for Health and Social Services to the Chair regarding waiting times

(Pages 78 – 84)

3.5 Letter from the Minister for Health and Social Services to the Chair regarding the finalised provisional Common Frameworks for Organs, Tissues and Cells, and for Blood Safety and Quality

(Pages 85 – 154)

3.6 Letter from the Minister for Health and Social Services to the Chair regarding the First Report on the Operationalisation of the Scheme for General Medical Practice Indemnity

(Pages 155 – 169)

3.16 Letter from Unison to the Chair regarding the health and social care workforce

(Pages 213 – 218)

3.17 Letter from the British Dental Association Wales to the Chair regarding the health and social care workforce

(Pages 219 – 220)

3.18 Letter from the Royal College of Nursing Wales to the Chair regarding the health and social care workforce

(Pages 221 – 226)

3.19 Letter from y Llywydd to Senedd Committee Chairs regarding the timetable for Senedd Committee Business

(Pages 227 – 233)

4 Motion under Standing Order 17.42(ix) to resolve to exclude the public from items 5, 6, 7, and 9 of today's meeting

(11.45)

5 Welsh Government Draft Budget 2022-23: consideration of evidence

(11.45–12.00)

6 Forward work programme

(12.00–12.15) (Pages 234 – 242)

Paper 2 – Forward work programme

7 Legislative Consent Memorandum for the Nationality and Borders Bill: consideration of approach

(12.15–12.30) (Pages 243 – 264)

Paper 3 – LCM for the Nationality and Borders Bill

Lunch (12.30–13.00)

8 Impact of waiting times backlog on people who are waiting for diagnosis or treatment: evidence session with The Royal College of Surgeons of England and The King's Fund

(13.00–14.00) (Pages 265 – 276)

Sue Hill, Acting Director in Wales – Royal College of Surgeons of England

Jonathon Holmes, Policy Adviser – The King's Fund

Danielle Jefferies, Analyst – The King's Fund

Research brief

9 Impact of waiting times backlog on people who are waiting for diagnosis or treatment: consideration of evidence

(14.00–14.15)

Agenda Item 2

Document is Restricted

Health & Social Care Committee

Date: 13th January 2022
Venue: Senedd Cardiff Bay
Title: Scrutiny of Health and Social Services Draft Budget 2022-23

1. Purpose

The Minister for Health and Social Services, the Deputy Minister for Social Services and the Deputy Minister for Mental Health and Wellbeing have agreed to attend the Health and Social Care Committee on the 13 January 2022 to give evidence on their Draft Budget proposals.

2. Introduction

This paper provides information for the Health and Social Care Committee on the Health and Social Services (HSS) Main Expenditure Group (MEG) future budget proposals for 2022-23 and also provides an update on specific areas of interest to the Committee as outlined in a letter from the Chair of the Committee dated 8th November.

3. Budget Overview

	2022-23
Revenue	**£m**
Revenue Baseline as @ Final Budget 2021-22	9,227.959
Baseline Adjustments	(445.000)
MEG allocation	1,018.819
Revised DEL as @ Draft Budget 2022-23	**9,801.778**
Capital	
Capital Baseline as@ Final Budget 2021-22	387.600
Baseline Adjustment	(52.600)
Revised DEL as @ Draft Budget 2022-23	**335.000**
Overall Total HSS MEG Draft Budget 2022-23	**10,136.778**

The table above does not include Annual Managed Expenditure (AME), which is outside the Welsh Government's Departmental Expenditure Limit (DEL).

Details of all transfers are shown in Annex A to this paper.

4. Approach to Budget proposals

The Health and Social Services MEG contains the core revenue and capital funding for NHS Wales, as well as funding to support public health, social care and supporting children. It supports our wellbeing objectives to provide effective, high quality and sustainable healthcare, and to protect, re-build and develop our services for vulnerable people. It also support the ongoing implementation of A Healthier Wales, our long term plan for health and social care.

This budget covers a three period from 22-23 to 24-25. The settlement is front loaded with a much larger increase in 2022-23 and lower relative uplifts in the second and third years. There are no specific Covid allocations but MEG settlements have been assessed through the budget setting process with agreement to prioritise delivery of the Programme for Government, funding for health, social care and local authorities; and to undertake a zero based review of capital to align capital budgets to the new Wales Infrastructure Investment Strategy (WIIS).

The HSS MEG will increase from a revenue baseline of £8.597 billion up to £10.05 billion by 2024-25.

The HSS MEG settlement for provides for an increase in baseline NHS revenue budgets in 2022-23 of £824m, with further increases of £250m and £200m in 2023-24 and 2024-25 respectively.

In addition to the £824m NHS funding uplift allocated for 22-23, the HSS MEG settlement also includes specific allocations for:

- Mental health £50m, increasing to £90m by 24-25
- Social care £45m, increasing to £60m by 24-25 and;
- Childcare and early years £28m, increasing to £30m by 24-25.

(See below for further information on these areas)

The core investment in the NHS will increase by an additional £1.274bn in this budget, taking our total baseline investment in 2024-25 to £9.683bn. This significant increase will provide the foundation for the NHS in its ongoing response to the pandemic and to support addressing the legacy on health and wellbeing.

Recurrent revenue funding of £150m for NHS recovery has already been committed from the NHS funding increase; this combined with £20m from baseline budgets will make up £170m per annum for recovery through this budget period. This funding will be allocated to the NHS to support the implementation of plans to strengthen planned care services.

To demonstrate our further commitment to addressing the impact of the pandemic on routine care, we will be investing a further £20m a year to support the implementation of a value-based approach to recovery over the medium term, with a focus on improving outcomes that matter to patients. This allocation will support NHS recovery, with a focus on delivery of high value interventions that ensure improved outcomes for patients and support service sustainability and reducing waits for treatment over the medium term. This investment will give greater focus on

delivery of outcomes that matter for patients and will complement the implementation of plans currently being developed to tackle the immediate backlog of patients waiting for treatment.

Taken together, these investments ensure we are on course to deliver against our commitment to invest £1bn for NHS recovery over the course of this Senedd.

We will also allocate £180m recurrently from 2022-23 onwards to help the NHS manage the financial impact of the pandemic on their underlying financial position, including recognising the impact the pandemic has had on productivity and efficiency. We expect the NHS to return to pre-pandemic efficiency levels as the impact of COVID on core services eases.

Whilst the future of the coronavirus pandemic is still very uncertain, we have set aside funding in this budget for ongoing Covid interventions, specifically contact tracing, testing, mass vaccination and provision of PPE to the NHS and social care. This funding will be kept under review as we work through the current challenges of the pandemic.

There will be a £31m increase in funding to support the Education and Training commissioning plan, investing in the future workforce of NHS Wales. We will also continue to provide £7m towards meeting our commitment to establish a new medical school in North Wales.

We are also investing a total of over £800m general capital for Digital Infrastructure, NHS Equipment, and NHS Infrastructure up to 2024-25.

Programme for Government

The Programme for Government (PfG) has underpinned our approach to budget setting, with significant budget allocations for some of our key commitments on NHS recovery, Mental Health support, Childcare, Social Care and the Real Living Wage for social care workers.

<u>NHS Recovery</u>
The NHS recovery programme started this year with an allocation of £200m of revenue and £48m of capital in 21-22. In addition to this there was an early commitment of recurrent revenue funding of £150m for recovery which has already been committed from the NHS funding increase. This was added to £20m from baseline budgets making a recurrent total of £170m per annum for recovery of planned care.
This investment will be complimented by a further £20m recurrently from 2022-23 to support NHS recovery, with a focus on delivery of high value interventions that ensure improved outcomes for patients and support service sustainability and reducing waits for treatment over the medium term.
When these are all combined this will mean a total of £818m will have been allocated towards NHS recovery over 4 of the 5 years of the current government.

<u>Mental Health</u>
We will continue to prioritise mental health and well-being in 2022-23 and we are providing an additional £50m to support this. Whilst this provision will primarily support front line mental health services and also make a contribution towards the prevention of mental ill health in areas

of primary public health prevention, substance misuse and employability related support, there are a much wider range of cross- government budgets needed to support our Programme for Government commitment to support the mental health and wellbeing of the nation.

Childcare and Early Years

Within the HSS MEG allocation there is additional funding for Childcare and Early Years of £28m in 22-23, rising to £30m recurrently from 23-24 onwards. This is part of a package of funding for Children & Families which also encompasses Flying Start and Families First in the Housing & Local Government MEG. In total across the two MEGs, there is £50m of additional funding in 22-23, rising to £70m by 24-25.

In the HSS MEG the additional £28m in 22-23 will be allocated to support our Programme for Government commitment on Early Years and Childcare, which includes supporting more families with the costs of childcare where parents are in education and training, and to increasing early year's provision to include all two year olds, with a particular emphasis on strengthening Welsh medium provision. Alongside the impacts on early years, we have also recognised the disproportionate effect on gender particularly linked to childcare. Our Childcare Offer already provides 30 hours of funded education and childcare to working parents of 3 and 4 year olds for 48 weeks a year.

Social Care – Reform Fund

A new Social Care Reform fund of £45m has been created. The Social Care Reform Fund will rise to £55m in 2023-24 and £60m in 2024-25 and will increase the funding available to promote reform and improvement in social care, to complement the uplift provided in the Local Government settlement. We will use this funding to support the reform set out following our 'Rebalancing Care and Support' White Paper, to improve delivery and increase the sustainability of services across the social care sector.

The funding will be used to help deliver the Programme for Government commitments to reform social care for looked after children and to protect, re-build and develop our services for vulnerable people

The Real Living Wage for Social Workers

One of our key pledges in the Programme for Government was to pay social care workers the Real Living Wage. We are now taking the necessary steps to make that happen.

Social care providers still face considerable challenges in both recruiting and retaining people with the skills needed to undertake these important roles. Improving the terms and conditions of the workforce is an important step towards improving recruitment and retention.

The uplift will be for registered social care workers in adults and children's services. That is, domiciliary care workers and social care workers in care homes. We intend that it will also reach personal assistants funded through direct payments.

We have provided funding, through the local government settlement and through the HSS MEG budget to enable local authorities and health board commissioners to commence

implementation of a Real Living Wage uplift. The funding will be available from April 2022 with workers beginning to feel the benefit in the following months.

In the New Year, we will be working closely with partners including local authority commissioners, complex care leads and others to work through all of those details about how the commitment will be implemented.

Well-being of future generations

Prioritise prevention/early intervention in Health and Social Care

Our focus in this budget is to protect the Welsh population by continuing to invest in our core NHS services for the long term. We are also continuing and increasing our investment in sustainable social services. Ensuring the long term stability of our health and care services is our priority for preventative investment in this budget.

The NHS Planning Framework, which is also the Minister's Direction to the NHS, always seeks to align with the Wellbeing of Future Generations Act and to continue to strengthen how organisations work to deliver their plans using the five ways of working. Since the beginning of the pandemic there has been a strong focus on four harms that have been the key quality context within which services and care must be provided. In June 2021, on the advice of the Technical Advisory Cell, a fifth harm was also recognised - the introduction or exacerbation of new or existing inequalities, either directly or indirectly from COVID-19.

All harms are relevant to the well-being of future generations but the need to prevent harm "from wider societal actions/lockdown" together with the new fifth harm relating to inequalities, provide a broader and longer term context to planning and investment in health and social care.

The NHS Planning Framework sets an expectation of a broad approach to prevention to be applied in all aspects of planning. This is supported by Welsh Government policy that is set out from a perspective of prevention, whether that is a more traditional public health perspective or in unscheduled care or planned care. Health Board Integrated Medium Term Plans, for example, also consider prevention in terms of models of care and decarbonisation including active travel schemes.

Preventative approaches to all physical and mental health and wellbeing will ultimately avoid escalation of conditions and illness. Opportunities for investment must be considered that will support future generations and inform future service provision. We have sadly learned throughout this public health crisis that those with underlying conditions have suffered disproportionately. Learning from COVID should provide foundations for the implementation of preventative initiatives that can make an impact on reducing all five harms.

Our aim is to take significant steps to shift our approach from treatment to prevention. The vision we have established in *A Healthier Wales* is to place a greater focus on prevention and early intervention.

Capital

The overall NHS capital budget for 2022-23 will decrease by £48m to £335m from the £383m provided in 2021-22. It is important to note that this reduced figure for 2022-23 includes £50m identified for Social Care which has not previously received capital funding through this budget. As a result, the NHS specific capital budget has reduced by £98m against the 2021-22 position – a 26% reduction. The capital funding available will continue to be invested in infrastructure to support the delivery of sustainable and accessible high quality services and to take forward the transformation of healthcare provision.

The new £50m capital fund for social care will support delivery of key programme for government commitments to include the development of 50 local community hubs and the strengthening of arrangements to support the integration of health and social care and rebalance the residential care estate. This social care capital allocation will enable the Welsh Government to directly influence the transformation of social care infrastructure in line with aspirations of the Social Services & Wellbeing (Wales) Act and 'A Healthier Wales'.

NHS capital investment next year will include the on-going redevelopment and modernisation works at Prince Charles Hospital along with the continued investment in primary and community care schemes across Wales to develop a new generation of integrated health and care centres.

The reduced capital allocation will restrict the opportunities available to the NHS around decarbonisation but, where possible, these will be incorporated into scheme designs so we will continue to make progress against the net zero target. Schemes that can deliver significant carbon reductions will be targeted through joint working with the Welsh Government Energy Service and the Carbon Trust.

Annex: request for information from the Welsh Government to inform scrutiny of the Draft Budget 2022-23

Commentary on actions and detail of Budget Expenditure Line (BEL) allocations.

1. A breakdown of the 2022-23 Health and Social Services MEG allocations by Spending Programme Area, Action and Budget Expenditure Line (BEL).

2. Indicative 2022-23 Health and Social Services MEG allocations.

3. Commentary on each of the Actions within the Health and Social Services MEG, including an analysis and explanation of changes between the Draft Budget 2022-23 and the First Supplementary Budget 2021-22 (June 2021).

4. It would be of assistance if the analysis could highlight what, if any, changes are additional resources specifically for the response to COVID in 2021-22 (consequential and guaranteed funding from the UK Government).

See attached annex which covers the requests above.

Local health boards' financial performance

5. Please provide an update on the overall financial performance of health boards. This should include:

a. Those that have continued to fail to meet their financial duties.

b. Those that have been in receipt of additional end of year and in-year financial support.

c. Details of how the Welsh Government is supporting and working with those health boards to both address short-term challenges, improve their underlying position, and secure sustained improvement.

   With the exception of Hywel Dda and Swansea Bay Health Boards, all other NHS organisations broke even at the end of the 2020-21 financial year. The net outturn for NHS Wales in 2020-21 was a deficit of £48m, an improvement from the deficit of £89m reported at the end of 2019-20. The improvement is due to the fact that Betsi Cadwaladr Health Board broke even for the first time in several years following the package of structural support announced by the former Minister for Health and Social Services in November 2020.

   Four Health Boards failed to meet their statutory duty to break even over three years at the end of 2020-21. In addition to Hywel Dda and Swansea Bay, Cardiff and Vale Health Board failed the duty due to their deficit in 2018-19. Providing they deliver their forecast break even outturn at the end of this current financial year, they will have achieved their three year break even duty at the end of 2021-22. Betsi Cadwaladr Health Board is also forecast to break even in 2021-22, but will again fail their three year duty at the end of this financial year due to the deficit they incurred in 2019-20.

Welsh Government provided Hywel Dda Health Board with £16m strategic cash support in 2020-21 to finance their deficit. In line with the announcement by the former Minister for Health and Social Services in July 2020, this support is not repayable.

The objective during the last two financial years has been to ensure that NHS organisations have the funding they need to respond to the Covid-19 pandemic, and therefore to ensure financial stability is maintained or improved. Welsh Government provided an additional £1.1bn revenue funding to the NHS in 2020-21, and have allocated a further £1.1bn in 2021-22. This has enabled all organisations to maintain or improve on the financial positions for 2019-20 before the impact of the pandemic. With the exception on Hywel Dda and Swansea Bay, all organisations are forecast to break even again at the end of this financial year.

Welsh Government is providing a range of support to all NHS organisations to manage the short term challenges as well as focusing on medium and long term financial sustainability. These include:

- Support from the NHS Finance Delivery Unit (FDU), we continue to develop and improve our financial planning and monitoring mechanisms. This includes providing clear and consistent planning assumptions, monthly monitoring, and mid-year reviews to confirm forecast positions.
- Monthly peer forums for NHS Directors of Finance, Welsh Government officials and the Finance Delivery Unit to keep appraised and manage emerging risks and issues
- The production and development of system level insight on opportunities to improve resource utilisation, whilst recognising some of the constraints of the pandemic in the ability to translate these opportunities into realisable savings in the last couple of years. We expect organisations going forward to maintain or improve on their forecast savings delivery for the current financial year, and we intend to extend the national supporting mechanisms to assist with the delivery of that expectation.
- Where necessary, the Finance Delivery Unit provides targeted support for individual organisations in higher levels of escalation.
- A Value Finance Leadership Group has been established, led by the Finance Delivery Unit and attended by all Health Board Finance Directors. This Group is providing a collective leadership to embed a value-based health care approach in the development and implementation of plans, with a focus on improving outcomes for patients with sustainable use of resources.

We are due to receive NHS plans covering 2022-23 to 2024-25 by the end of February 2022. Our package of financial support for the NHS outlined in this budget, and confirmed in the revenue allocation, provides financial stability for the NHS as well as providing support for NHS recovery and other Programme for Government commitments. As a consequence, we expect organisations to develop approvable financial sustainable medium term plans.

6. Please indicate the level of health reserves allocated within the Draft Budget, and how you anticipate the reserves being used.

We have not allocated health reserves within this budget. All funding will be deployed to deliver NHS financial stability, meet the ongoing costs of responding to the pandemic, and support delivery of Programme for Government commitments. We are holding funding centrally within the Health and Social Services MEG to support the ongoing planning deficits within Hywel Dda and Swansea Bay into 2022-23.

7. Please outline your expectations for how health boards should seek to reduce their fixed costs, and what guidance the Welsh Government is providing to assist with this.

As outlined above, we expect NHS organisations to plan to deliver cash-releasing efficiency savings year on year. Organisations are currently forecasting that they will deliver over £100m savings – equating to around 1.5% - in 2021-22, despite the ongoing impact of the pandemic. We expect organisations to plan to deliver this level as a minimum in 2022-23 and going forward.

The Finance Delivery Unit have developed a toolkit for organisations to benchmark their costs and outputs across a wide range of service areas. They are working with Finance Directors to ensure this information is used proactively in the development of savings plans to underpin their medium term financial plans. In addition, organisations are being encouraged to identify ambitious decarbonisation opportunities linked to all capital schemes. These schemes are looking at how both carbon and financial savings can be maximised.

The impact of COVID-19 on allocations

8. Please explain how the pandemic has influenced allocations to budget lines within the Health and Social Services MEG, and provide examples of any changes made to allocations as a result of COVID-19. In answering this question, please address:

a. The assumptions underpinning allocations made as a result of the pandemic.

b. Allocations that have been made to support additional service capacity or additional staff resource as the response to the pandemic continues, including primary, community and hospital services, social care, public health, and the vaccine programme.

As stated above, we will continue to maintain our direct COVID response for as long as is necessary. We are setting aside significant funding to continue our national responses to the ongoing pandemic including the Test, Trace and Protect programme, the ongoing vaccination programmes, and the provision of free PPE to health and social care for as long as is required. This funding will be kept under review as we work through the current challenges of the pandemic.

We have provided a significant uplift to the NHS which will provide them with financial stability as they continue to respond. There is also a significant recurrent investment in recovery to enable the NHS to refocus on treating backlog when the impact of the pandemic allows.

c. Allocations for mental health support services for the health and social care workforce.

In April 2020 we expanded the Health for Health for Professionals Wales Service. Staff experiencing symptoms of anxiety, depression, alcohol-use disorder, post-traumatic stress disorder and other conditions can benefit from the service provided. In its original form, this service was only provided to NHS doctors, but in April 2020 it was expanded in response to Covid-19, to cover the whole of the NHS workforce. Further contract developments mean that the service will be extended even further into the social care sector for 2022 to 2025 and will be provided with £4.5m of funding for that period.

The pandemic has had a significant impact on workplaces and the workforce in Wales. As the pandemic continues, a key priority is to offer support, to anyone in need, for their short and longer-term physical and mental wellbeing. The Healthy Working Wales programme provides universal support including specific Mental Health and Wellbeing across all of the public and private sector. The programme has recently updated and strengthened advice and information in the context of the pandemic and in response to insight from the literature that outlines the significant impacts the pandemic is having on mental wellbeing. Healthy Working Wales has also developed a mental wellbeing podcast for employers, to help address the key challenges and sets out how employers can best support the mental wellbeing needs of their workforce. The programme is allocated £2.3m funding for 2020 to 2023.

d. Allocations that have been made to ensure the maintenance of an adequate and appropriate supply of PPE.

The supply and distribution of high quality Personal Protective Equipment (PPE) to frontline health and social care workers continues to be a critical part of the global response to the ongoing COVID-19 pandemic and we will continue to secure sufficient PPE to meet our needs. In our Programme for Government, we have committed to provide free PPE for health and social care staff, for as long as is needed to deal with the pandemic. This, along with the maintenance of a usable contingency stockpile (currently 16 weeks based on the highest issue rate during the pandemic) will help to ensure Wales is fully resilience against future COVID-19 surges and/or future pandemics. The future costs associated with this commitment are difficult to predict with strong dependencies on the course of the pandemic, evolving Infection, Prevention & Control (IPC) guidance as well as Department for Health and Social Care (DHSC) advice on future pandemic preparedness. We are setting aside funding to continue our national responses to the ongoing pandemic including the provision of free PPE. This funding will be kept under review as we work through the current challenges of the pandemic.

Addressing the waiting times backlog

9. Please provide details of how the Draft Budget will support the delivery of more routine care, and contribute to addressing the waiting times backlog. This should include how any consequential and guaranteed funding from the UK Government will be used.

As stated above, we have allocated £170m of revenue funding recurrently from 22-23 as well as £20m focussed on high value interventions.

When combined with the allocations in 21-22, this will mean a total of £818m will have been allocated towards NHS recovery over 4 of the 5 years of the current government.

Our aim is to focus on rapid, clear and targeted work, firstly to stabilise the current volume increase and then to treat the number of patients waiting for review, assessment and treatment.

This will involve:

- Service transformation, to deliver now and sustainably for the future based on prudent and value-based principles including the development of regional hubs
- NHS activity levels to return to and then exceed pre-pandemic levels
- Workforce availability and expertise to be maximised and strengthened
- Treatment and diagnostic capacity to be developed at both local and regional level, including altering, repurposing and adding infrastructure
- The ability to work with other providers to enable more rapid access to facilities and in some cases staff.
- Integrated workforce plans that maximises recruitment opportunities (domestic and overseas), innovative ways of developing and extending existing workforce, whilst supporting wellbeing.
- Increased commissioning and capital.

The £248 million allocated in 2021-22 (£200m revenue and £48m capital) is aimed at helping health boards reduce the backlog of patients waiting that has built up due to the pandemic. Health boards have been working to reduce the backlog by using alternative providers, either through outsourcing to independent providers, or by using insourcing companies to carry out the work locally. Health boards have also used their own staff in local independent facilities, as these are safe green pathways for services and hired mobile units that have been used to carry out a number of day case procedures. Some of these actions in 21-22 have been short term, and we know they have not been sufficient to replace the capacity lost due to COVID-19. With the confirmation of the recurrent recovery funding Health Boards can now plan effectively for the medium and longer term.

Over the last 18 months, a number of transformational actions have been put in place, with more outpatient appointments being carried out virtually and group sessions being held to help reduce waiting lists. The scale and scope of these changes however will need to increase to support value based and sustainable planned care service for the future.

In October 2021, we confirmed the recurrent allocation of £170m, split across health boards to support planned care recovery, with details to be articulated in their 2022-25 Integrated Medium Term Plans (IMTP's) due in February 2022. The specific areas of focus for the plans, which the allocation should support are:

- Implementation of the recommendations of the National Endoscopy Programme
- Regional cataract services in line with advice from the Planned Care programme.
- Regional plans for aspects of orthopaedic services based on the clinical strategy work currently underway and due to report in February 2022.
- Strengthened Diagnostic and Imaging services based on advice commissioned from the National Imaging Programme.
- Implementation of the Critical Care Plan developed by the Critical Care Network.
- Plans for improving cancer and stroke services

The aim is to not only support recovery of planned care services (remove the backlog), but also to build sustainable models of delivery for the future.

Health and social care workforce

10. Please explain how the Draft Budget will contribute to the delivery of a sustainable health and social care workforce, and will reduce and control spend on agency staff.

The success of the NHS in Wales relies on developing a sustainable workforce, which responds effectively to the health and wellbeing needs of the Welsh population. The Welsh Government continues to increase investment in the education and training of healthcare professionals in order to provide effective, high quality and sustainable healthcare in Wales. More than £260m will be invested in 2022-23, a 15% increase from 2021-22 which will result in the highest number of training opportunities in Wales. The investment will further boost the NHS workforce and help reduce the need for agency staff.

The Health Education and Improvement Wales and Social Care Wales workforce strategy, launched in October 2020, sets out plans for a transformed and sustainable workforce for the future.

The Draft Budget includes a significant increase in the Local Government settlement which reflects our commitment to meeting the pressures we are seeing in social care and provides for our current estimates of the cost of introducing the real living wage in 2022-2023 which will contribute to a sustainable social care workforce.

Primary care

11. Please provide details of the budget allocated for primary care services and investment in the primary care estate, and how this compares to amounts allocated in the last three years. In answering this question, please address the extent to which these allocations will achieve the policy aim of shifting care from hospitals to primary care or community settings.

We continue to invest in primary care through the delivery of the Primary Care Model for Wales, and in 2022-23 will build on the agreed investment provided in 2021-22 for the primary care contracts.

Planning and implementing the rebalancing of the health and wellbeing system is complex and cannot simply be tracked in terms of budgets and recording of expenditure, but through demonstrating the shift of services being delivered in both primary and community settings. We will continue to support health boards to strengthen their whole system planning through the IMTP process.

Our definition of primary care is broad as set out in the Primary Care Model for Wales. As well as those services contracted from GPs, dentists, community pharmacists and optometrists, our definition also includes the wide range of services, care and support for people's health and wellbeing in the wider community.

The NHS Health Board accounts for primary care report spend for the last 3 years of:
2020-21 £989.422 million
2019-20 £947.338 million
2018-19 £911.739 million
These figures exclude GP prescribing and are net of dental patient changes recovered

Primary Care Capital
Some £72m (including £4.5m as part of the 2020-21 budget) has been made available for investment in a pipeline of 19 primary and community care projects as part of the implementation of the Taking Wales Forward commitment. This underpins the key messages set out in A Healthier Wales - the long term plan for health and social care and delivers the commitment in Prosperity for All, to invest in a new generation of integrated health and care centres.

Since the inception of the programme in 2017, some £54m has been allocated against projects, £48m of this over the last three years (see profile below).

As of December 2021, of the 19 schemes, 7 are complete, 5 are on site and 7 are in various stages of business case development. The programme has taken longer than expected to deliver, given the time to develop business cases and the inevitable impact of Covid on progress.

This programme of work continues to evolve in terms of the way in which a mix of services both health and others are delivered in a collaborative way. Whilst there has been a focus on the existing GP estate, the range of schemes have seen joined up working across portfolios, health, local authorities, housing, not only in terms of new developments but re-utilising and redeveloping existing assets. Considering the impact of delivering services closer to people's homes in a range of settings including town centres.

To fully enable this programme, we are exploring the potential for borrowing arrangements in order to facilitate further tranches of capital spend over a five year period.

General Medical Services (GMS)

- The GMS allocation to health boards funds the contractual commitment they hold with GMS contractors for the provision of GP practice services to patients.

- Welsh Government support the movement of services out of centralised secondary care into local primary and community settings as part of our prudent healthcare agenda. Health boards should be planning and supporting the movement of services with funding following from unified allocations into primary and community care.

Cluster Funding

- We show commitment to cluster level planning by allocating £20 million a year for clusters to invest in their own solutions to meeting the health and wellbeing needs of their local population.
- Cluster-level planning and delivery is the key to unlocking innovative solutions to sustainable local services and improving access to the right care, at the right time from the right source.

Social care

12. Please outline the planned allocation for social care, including:
a. Any additional funding identified for 2022-23, and how such funding will be targeted.

As stated above, a new Social Care Reform fund of £45m has been put in place for 22-23. The fund will rise to £60m by 2024-25 and will increase the funding available to promote reform and improvement in social care. This complements the significant uplift provided through the Local Government settlement.

Through the Fund we will invest:

- £10m in 2022-23 in preparation to deliver our commitment to eliminate private profit from the care of looked after children during the next Senedd term; and
- an additional £3m in Social Care Wales in 2022-23, to continue the expansion of the professional registration of the social care workforce and provide ongoing support for the stabilisation and recovery of the sector through delivery of the Health and Social Care Joint Workforce Strategy.

We will also invest in the establishment of health and social care community hubs to contribute to the prevention and early intervention agenda, as well as in the ongoing work under the Chief Social Care Officer for Wales to take forward action complementary to the Race Equality Action Plan, and provide further support for groups such as unpaid carers.

As stated above, in 2022-23 a new £50m capital fund will be launched for social care to support delivery of key programme for government commitments to include the development of 50 local community hubs and the strengthening of arrangements to support the integration of health and social care and rebalance the residential care estate. This social care capital allocation will enable the Welsh Government to directly influence the transformation of social care

infrastructure in line with aspirations of the Social Services & Wellbeing (Wales) Act and 'A Healthier Wales'.

b. How the allocations will ensure the ongoing viability and stability of social care services, including residential and domiciliary care.

Funding will support greater understanding and policy direction with regard to models of delivery and commissioning with respect to domiciliary care; connecting with equipment and assistive technology and the interface with reablement and allied health professionals.

c. What support the Draft Budget will provide for unpaid carers, including evidence of specific spend on respite care.

In 2022-23, £3million will be allocated specifically to increase opportunities for unpaid carers to access respite and take a break. Building on this year's £3million respite funding to local authorities, this money will encourage innovation and support more unpaid carers to focus on their own health and well-being.

Unpaid carers will also benefit from our annual £1.245m funding allocation; the continuing Social Services Third Sector Grant and support from Regional Partnership Boards.

We are also continuing to work in coproduction with local authorities and Carers Trust Wales to roll out a national Young Carers ID card project with funding of £200,000.

This will be alongside funds in the Sustainable Social Services Third Sector grant scheme for 2020-23 and support via Regional Partnership boards and their funding streams where they benefit all ages of unpaid carer.

d. Measures in the Draft Budget that will improve the sustainability of the social care workforce, including contributing towards achieving parity of esteem, pay, and terms and conditions with the health care workforce.

- The significant increase in the Local Government settlement reflects our commitment to meeting the pressures we are seeing in social care. It provides for our current estimates of the cost of introducing the real living wage in 2022-2023. We have also transferred £5m of the funding from the workforce grant in the HSS MEG which was uplifted last year to support Local Authorities moving towards paying the RLW.

- In addition to the new £45m Social Care Reform Fund, we will also retain a baseline budget of £45m for the Social Care Workforce Grant.

e. The anticipated impact of the UK health and social care levy, in particular any additional or consequential funding.

The Welsh Government's settlement for the next 3 years was set out in the UK Government's budget and spending review on 27 October. This reflected Barnett consequentials arising from expenditure decisions in England, including those financed by the new health and social care levy. The Welsh Government draft Budget for the next 3 years will determine how any additional resources are utilised in Wales in line with our devolved priorities, whilst confirming that funding for health and social care will remain a core priority of our budget preparations.

13. Please confirm whether the allocation for social care is adequate to meet all local authorities' standard spending assessments for 2022-23, and outline how you will monitor local authorities' spend in year.

The funding provided through the settlement for 2022-23 in recognition of social care pressures is adequate to meet local authorities' funding pressures for the forthcoming financial year. The local government settlement is unhypothecated, meaning it is up to authorities how they spend this funding, to meet local needs and priorities. Acknowledging this, however, through this settlement we are directing an amount through the social care element of the formula that is equal to the sum of the pressures outlined by the WLGA and the assessment of the additional costs to local authorities of introducing the Real Living Wage for care workers. This ensures that the funding is distributed in the most equitable way, to meet the pressures across the 22 local authorities. As the local government settlement is unhypothecated, there are no plans to specifically monitor any element of local authority spend in relation to the funding included within this settlement.

Mental Health and Wellbeing

14. Please explain how your priorities for mental health and wellbeing are reflected in the Draft Budget, and where the allocated/projected spend for these priorities can be found. In particular, the Committee would welcome details of allocations in the Draft Budget relating to:

a. Mental health services (including the Mental Health Service Improvement Fund, and how the Draft Budget will facilitate earlier intervention and improved access to mental health services).
b. Children and young people's mental health and wellbeing
c. Dementia.
d. Autism.
e. Obesity/implementation of 'Healthy Weight, Healthy Wales'.

a & b. <u>Mental Health Services & Children and Young People's</u>

We will continue to prioritise mental health and well-being in 2022-23 and to support this will be allocating an additional £50m in the Health & Social Services portfolio. This increase will rise to £90m by 24-25.

Included in this for 22-23, will be approximately £25m that will support direct mental health policy and service integration, this will include a significant amount being invested in the NHS. Supporting front line mental health services is only one element of a wider system that also

supports primary prevention in public health, education, social services, substance misuse and other protective factors such as supporting people to stay in employment.
The £50m allocated will make a significant contribution to support our Programme for Government commitment to prioritise service redesign to improve prevention, tackle stigma and promote an approach to mental health support that ensures people will be directed to the right advice and support at the right time.

As part of the £50m increase in funding in the HSS MEG, we will be providing around £8m next year to support the implementation of the UK Mental Capacity (Amendment) Act 2019/ Liberty Protection Safeguards which support the rights of people who lack mental capacity (for instance due to brain injury, a stroke, or dementia) to consent to their health and/or social care and treatment.

There is also an increasing investment in supporting young people's mental health and well-being within the Education portfolio, a £5.5m increase is allocated for 2022-23, rising to £11.5m by 2024-25. This additional resource will include directing support to the whole systems approach across health and education.

We will continue to work across government to ensure that we maximise the impact from supporting mental health across portfolios, ensuring that supporting and protecting mental health is a key factor in any investment decisions we consider.

The Covid pandemic has put increasing pressure on a number of mental health services, in particular for young people (CAMHS) and all-age Psychological Therapies. The evidence suggests that an increase in referrals and complexity will remain as we emerge from the pandemic.

Across the Health and Social Services and Education portfolios, we are committing to further increases in Mental Health funding, over the next three years, that will total over £100m by 2024-25.

Mental health continues to be the highest area of spending by the NHS in Wales. In 22-23 the ring-fenced Mental Health budget provided to Local Health Boards will be over £760m.

c. Dementia
The Dementia Action Plan published in February 2018, outlines our vision for dementia care and support in Wales. However we recognise that the pandemic and the required response has had an impact on both people living with dementia and their carers. As such officials worked closely with members of the Dementia Oversight and Implementation Group to consider the impact of the pandemic and to agree priorities over the coming months. This 'companion document' to the Dementia Action Plan was published on the 21 September 2021, affirms our priority areas for action over the coming months. We have seen pressures across the system, including access to diagnostic support services, and we will earmark support to provide increased capacity in areas of demand.

d. Autism and Neurodevelopmental conditions

The introduction of a Statutory Code of Practice on the Delivery of Autism Services is a Welsh Government Programme for Government Commitment. A demand and capacity of all neurodevelopmental services is currently underway and will be completed by March 2022, this review will include recommendations for improvement including workforce development. £5.73m is currently delivering the implementation of the statutory code, through supporting the National Autism Team, the Integrated Autism Service, and a demand and capacity review. Further investment of £5.185m will support future policy development and improvement in neurodevelopmental services, to include actions to address assessment and diagnostic waiting times and support and will seek to expand services to include conditions such as ADHD.

e. Healthy Weight: Healthy Wales strategy

£6.63m will be allocated in 22-23 to support the Healthy Weight: Healthy Wales strategy which is the Welsh Government's long term plan to prevent and reduce obesity across Wales. It sets out a 10 year plan to prioritise early intervention and behaviour change at all levels to change our habits and promote healthy activity. The strategy is a key commitment towards a cross-government approach to reducing obesity in Wales on a population scale. The strategy has been developed from evidence of what works. This has indicated the need for a new approach which combines individual behaviour change with environmental and system change. It will utilise a combination of funding, policies and legislation to develop approaches through our environment, settings and leadership to put a strong focus on prevention. It will also deploy targeted approaches in areas of deprivation and will assist those who are already overweight or obese through a range of prevention, early intervention and specialised services. A 2022-2024 Delivery Plan will be published in early 2022 which will set out a cross-government approach.

Through the funding there is a specific allocation which will support broader engagement across children and families, examples include:

- A Children and Families Pilot has been funded through the delivery plan and is taking place in three areas Cardiff, Merthyr Tydfil and Anglesey. These pilot programmes will adopt a whole systems approach, which is drawing together practice and best evidence. A core part of this approach is the implementation of a secondary prevention Home Based Intervention for families of children in the early years from 3 – 7 years of age in line with the foundation phase.

- £2.9 million per annum until 2023-2024 in funding has been made available for health boards to develop their local adaptations of the All Wales Weight Management Pathway which will support the development and delivery of weight management services in Wales. For the first time there will be children and families specialist level 3 services delivered across Wales and the development of services and approaches based upon early intervention at level 2, including specific approaches through maternity. The revised pathway will provide compassionate support in helping people on their weight management journey and will run alongside our Healthy Weight: Healthy Wales strategy to encourage people to make healthier choices and lead more active lives.

- Ministers have agreed to the development of a new Welsh Daily Active offer for schools. The offer will adopt an age specific whole school approach, underpinned by behaviour

change and range of adaptable approaches, to complement the new curriculum. This will be responsive to evidence, provide flexibility and build in evaluation to assess health outcomes. This will also link with proposals to extend the school day.

- We have established roles for Healthy Weight Ambassadors across Wales. They are working with us be a champion for the Healthy Weight: Healthy Wales strategy and inspire the delivery of its aims and objectives with partners across Wales, to listen, engage and promote the ethos and positive lifestyle messages of the strategy. This includes a youth Ambassador and a Family Ambassador who are broadening our engagement across the strategy.

15. The Committee would also welcome details of:

a. The percentage/proportion of the Draft Budget that is allocated to mental health and well-being, and how this compares to previous years.

	Draft Budget 2022-23 £m	**Draft Budget 2021-22 £m**	**Draft Budget 2020-21 £m**
Mental Health ring fence in main Health Board allocation	760.885	726.782	711.930
Mental Health central budget in HSS MEG (BEL 270)	88.212	36.260	3.029
Total	849.097	763.042	714.959
MEG total	9,801.778	8,791.128	8,366.438
Percentage	8.7%	8.7%	8.5%

It is important to note that whilst this represents a picture of what is visible at the Draft budget stage each year, Health Boards will spend more than the ring fenced amount on Mental Health services, as they also commit funding from their discretionary allocations.

b. Any reductions or increases relating to specific areas of the Draft Budget compared to previous years (e.g. grants being reduced or increased, or being introduced or ceasing to exist).

There have been no baseline reductions across the HSS MEG. Budget changes at BEL level are detailed in the annex attached.

Transformation, innovation and integration with social care

16. Please outline how the Draft Budget will support the development of a 'whole system approach', with greater integration of health and social care, as described in A Healthier Wales. In particular, please explain how the Draft Budget balances the need to meet existing service pressures with the need to transform services and develop new models of care.
How will service transformation and integration be supported in the longer term to achieve sustained progress on the transformation agenda, ensure a focus on rolling out and mainstreaming the learning from successful pilots, and avoid reliance on continued additional funding.

In 2022 the current Integrated Care Fund (ICF) (£89m) and the Transformation Fund(TF) (£50m) , administered through regional partnership boards (RPBs), will come to an end. A new 5 year 'Health and Social Care Regional Integration Fund' will be launched form the 1st April 2022 to build on the successes of the ICF and TF, learn from experiences to date, and continue to drive the integration and transformation of health and social care. This new fund, which will also be administered through RPBS to ensure an integrated cross sector approach, has been co-designed with a range of partners and will include mechanisms such as match funding to promote sustainability and embedding of new ways of working. The fund will be rooted in driving integrated, preventative models of care and support as close to home as possible.

Cross-government/sector working on prevention

18. Wales has high levels of chronic disease and significant concerns around unhealthy lifestyles. The pandemic has further highlighted and exacerbated this. Can you demonstrate how the Draft Budget:

a. Ensures that focus on prevention and early intervention is not being lost as a result of the pandemic.

Whilst we have to acknowledge that the delivery of some programmes have been affected by the events of the last 18 months we are maintaining investment in baseline budgets in the HSS MEG and planned programme spend in 22-23 can return to pre pandemic levels, where possible.

Current actions to address health inequalities are embedded across all activity owing to the strategic planning required by the Well-being of Future Generations (Wales) Act 2015 and through our health in all policies approach (supported by the Health Impact Assessment ('HIA') process). Consequently, it is often not possible to disaggregate budget which is specifically allocated to tackling health inequalities from the totality of government spending. However, some specific examples of government spending which contribute greatly to tackling health inequalities include interventions such as the Welsh Government's Flying Start programme.

Flying Start is a Programme for Government (PfG) Commitment. The Flying Start programme was developed based on evidence of 'what works' in providing children with the best start in life. There are four core components including funded, part-time, high quality childcare, enhanced health visiting, parenting support and speech, language and communication support. It is this combination of integrated support which is critical to its positive impact.

We are continuing to invest in our flagship Flying Start programme which reaches around 36,000 children under four, living in some of the most deprived areas across Wales. The evidence shows it is making a difference to those children who access the programme. Funding for Flying Start forms part of the Children and Communities Grant (CCG) in the Housing & Local Government MEG. An additional £40m revenue has been allocated up to 2024-25 for early help and support including for Flying Start, recognising the importance of supporting more children and families across Wales and to ensure we support our youngest children to have the best start in life.

We will also continue to invest in a range of other preventative approaches, some examples of which are detailed below:

Healthy Weight: Healthy Wales

The ten year Healthy Weight: Healthy Wales strategy was launched on 17 October 2019, with £6.63m funding per annum being made available for 2022-23 to 23-24. This will support the development of the plan and continue current funding commitments. The funding allocations below support children's health and wellbeing:

- Healthy Weight Pathway Transformation Fund (£2.9m)
- Children and families work with National Governing Bodies (£0.6m)
- Delivering a Systems Based Approach (£1.2m)
- Targeted Children and Families Intervention (£0.6m)

Early Years Integration Transformation Programme

The Early Years Integration Transformation Programme is focussed on developing a more joined-up, responsive early years system that puts the unique needs of each child at its heart, which covers the period of life from pre-birth to the end of the Foundation Phase (0-7).

We have been working with PSBs across Wales to explore how to deliver early years services in a more systematic way, applying the lessons from our existing programmes such as Flying Start and Families First.

The majority of the PSBs are now engaged in the programme as pathfinders. We are investing £6m in 2022-23 and 2023-24 to support PSBs across all Health Board regions in Wales, as they test the core components for an early years system and pilot different multi-agency delivery models and approaches, building on what works well in existing programmes such as Flying Start and Families First.

Healthy and Active Fund (HAF) in the HSS MEG.

Our £5.9m Healthy and Active Fund (HAF) available over 4 years (2019-2023) is funding 16 projects aiming to improve mental and physical health by enabling healthy and active lifestyles, with a particular focus on strengthening community assets. Priority has been given to projects that seek to reduce inequalities in outcomes for one or more of the following groups:

- Children and young people
- People with a disability or long-term illness
- People who are economically inactive or who live in areas of deprivation
- Older people and those around the age of retirement from work.

b. Reflects a 'whole system' joined up approach to improving people's health and well-being, and targeting key areas of concern.

Screening

National population screening programmes are a good example of effective equitable preventative health interventions as they are offered to all the eligible population across Wales. Approximately 45% of Public Health Wales' core budget is spent on national population screening programmes. This equates to around £35m in 2022-23. Approximate costs are provided as Public Health Wales' core funding is not ring-fenced, allowing the organisation flexibility to allocate resources according to need.

All national population screening programmes are assessed for cost effectiveness by the UK National Screening Committee (UK NSC) before recommendation. The cost assessment includes testing, diagnosis and treatment, administration, training and quality assurance costs to ensure all are economically balanced in relation to expenditure on medical care as a whole (i.e. value for money). Screening policies are subject to review by the UK NSC on a three-yearly basis unless new evidence comes to light in the intervening period. Once a recommendation is made by the UK NSC the Wales Screening Committee considers how best to implement in Wales.

Breast screening, bowel screening, cervical screening, abdominal aortic aneurysm screening and diabetic eye screening were paused for a few months at the start of the Covid-19 pandemic. Public Health Wales has received an additional £1m to support the recovery of the screening programmes and reduce backlogs.

Cervical Screening

Cervical screening is available to all people with a cervix who are aged 25 to 64. Currently, people aged 25 to 49 receive invitations every three years. People aged 50 to 64 receive invitations every five years. The UK National Screening Committee (UKNSC) recommended the use of high-risk human papilloma virus (HPV) screening as the primary screen in the cervical screening programme in November 2015. This is a more sensitive and specific test which means that a negative result is more accurate. There are over 100 different types of HPV, but only around 13 types are associated with cancer and these are known as 'high-risk' types. The new test looks for the 13 known high-risk HPV types, which cause 99.8% of cervical cancers. Public Health Wales (PHW) fully implemented HPV primary testing into the Cervical Screening Wales programme in September 2018 and Wales was the first UK nation to do so.

In January 2019 the UKNSC recommended a programme modification to extend screening intervals from three to five years for women who test HPV negative as part of their routine screen test. At its meeting on 21 July 2020, the Wales Screening Committee (WSC) agreed to preparations being made for the extension of the screening interval for HPV negative women. Once implemented in 2022, women aged 25 to 49 who have a negative result will be considered lower risk and recalled in five years rather than three. This policy change is being made in the best interests of women's health and is not related to cost.

Bowel Screening

Bowel Screening Wales (BSW) sends a bowel screening kit to men and women aged 60 to 74 every two years. The UKNSC first recommended bowel screening between the ages of 60 and 74 in 2011 which was subsequently implemented in Wales. However, in 2012 the UKNSC

recommended that the bowel screening programme should be expanded to include people between 50 and 74 years of age. At the time, the Wales Screening Committee (WSC) agreed that no expansion to the bowel screening programme could occur without increased health board colonoscopy capacity.

Following a review of the evidence in 2018, the UKNSC recommended FIT (faecal immunochemical testing) replace the existing gFOBt (guaiac faecal occult blood test) and be offered to men and women aged 50 to 74 years at as low a threshold as possible (down to 20µg/g). The expectation is that the sensitivity threshold will be set at a level according to the available colonoscopy capacity but with the aspiration to drive the threshold down with time. Since January 2019, BSW has been providing FIT at 150µg/g as part of the routine screening programme. This new screening test fully replaced gFOBt in September 2019.

Preparation was underway to reduce the starting age of the eligible screening population from 60 to 55 years from April 2020. However, the Covid-19 pandemic stopped this preparation and the optimisation progress of the bowel screening programme was halted in March 2020. Plans to optimise have now resumed with the intention to reduce the age range in smaller increments, which started by reducing to age 58 in October 2021. The intention is to implement the next stage by reducing the starting age for screening from 58 to 55 years during 2022-23.

Uptake of the screening programme has increased significantly since 2019 when the new easier to use and more accurate Faecal Immunochemical Test (FIT) was introduced, with the programme now achieving approximately 65% uptake (standard is 60%).

Immunisation programmes (non-Covid)

The national flu programme continues to be provided through health boards via core funding. Currently this includes a large set of cohorts of those prioritised by the Joint Committee on Vaccination & Immunisation (JCVI). For 2021-22 extra cohorts were included to aid the response to the pandemic. Secondary schools were included for 2021-22 and currently has an uptake of over 57%. Other expansions to the programme in 2021-22 were the inclusion of healthy 50-64 year olds and primary care workers. The cost of including the extra groups was £7m for 2021-22 which was transferred to health boards. There is an intention to continue vaccinating the expanded school age group in future years as a measure to reduce the transmission of flu.

Funding for other adult vaccination programmes (such as shingles) and childhood vaccinations (such as MMR and HPV) is located within health board core budgets. Childhood immunisation programmes continued as essential services during the coronavirus pandemic, with appropriate assurance to parents and infection control measures put in place by practices. Monthly enhanced immunisation reports developed by the Vaccine Preventable Disease Programme in Public Health Wales were used to monitor the impact of COVID-19 on uptake of routine childhood immunisations across Wales. Data suggests that vaccination uptake in young children and infants has remained stable throughout the pandemic. Vaccination uptake rates on programmes given in secondary school (such as HPV and MenACWY) have been most affected during the pandemic; priority will be given to catch-up programmes in 22-23.

Speech, Language & Communication – Early Years

We know Speech, Language and Communication (SLC) development is an important predictor of later progress in literacy. Children's poor SLC skills have an impact on a wide range of outcomes including behaviour and mental health, wellbeing and employability. That is why we have prioritised children's speech, language and communication skills as they are essential for positive long term outcomes. The Talk With Me: Speech, Language and Communication (SLC) Delivery Plan, published on 20 November 2020, seeks to drive improvement in the way in which children in Wales are supported to develop their SLC skills.

We are investing an additional £3.9m over three years to support the commitments in Talk with me the Speech, Language and Communication Delivery Plan to deliver our overarching commitment to improve outcomes for children through a fresh approach to promoting and supporting children's speech, language and communication needs.

Reduction of health inequalities

19. Please outline how the Draft Budget will contribute to the reduction of health inequalities, including those exacerbated by the pandemic, or those resulting from a disproportionate impact of the pandemic or lockdown measures on the health or wellbeing of particular groups (such as older adults, BAME communities, or people on low incomes or who are otherwise financially insecure). The Committee would also welcome details about how the Draft Budget will ensure that the most disadvantaged are prioritised, and that there is fair access to health and care services in rural areas.

Reducing health inequalities across Wales, including rural areas, remains a Ministerial priority and the COVID pandemic has brought reducing health inequalities into even sharper focus.

Rural areas often depend on wider collaborative arrangements for delivery of care and services for its patients and to create equity of access. For example Hywel Dda and Powys health boards have developed strong relationships with partner health boards to ensure patients have access to the services they need.

Technology enabled care and digital innovation, including video consultations and remote working, have become an integral part of primary, secondary and community care, supporting people in receiving care and advice safely in their own homes. For those patients and their families, who live in rural parts of Wales, this has been especially welcome, reducing time and travel costs.

Learning Disabilities

We are continuing our investment of £1 million to support services to support individuals with a learning disability. The pandemic impacted significantly on securing all of the improvement gains of the Improving Lives cross-government programme.

This additional investment will address the health inequalities that people with learning disabilities experience, resulting in a poorer quality of life and wellbeing outcomes than the general population. In particular, people with a learning disability are 6 times more likely to die of a treatable condition than the general population.

The key priorities will be:

- Increasing access to health checks which reduces morbidity and mortality rates;
- Implementing the recommendations of the review of learning disability specialist in-patient provision, i.e. reducing the length of stay in in-patient provision and supporting people to live in their communities;
- Reduce avoidable deaths due to diagnostic overshadowing;
- Improve the health of people with a learning disability through earlier identification of health conditions to which they are pre-disposed, eg, respiratory, gastro, cardiac, epilepsy, diabetes and early on-set dementia (from age of 40); and
- Improve community services and reduce the occurrence of crisis which leads to long term in-patient admission.

ICT

20. An assessment of the costs of delivering the Welsh Government's vision for digital and data, as described in A Healthier Wales, and including increased support for digital and virtual care.

• Welsh Government continues to work closely with Digital Health & Care Wales and digital leaders across NHS Wales to forecast the cost of delivering the Welsh Government's vision for digital and date, as described in A Healthier Wales.

• This has delivered a significant increase in digital investment since A Healthier Wales was published in 2018, through the Welsh Government's Digital Priorities Investment Fund (DPIF).

• The DPIF supports digital and data transformation at the all-Wales level, through revenue and capital funding, aligned to Ministerial priorities. It is managed by Welsh Government as a portfolio of digital programmes and activity. Funds are awarded to NHS Wales organisations through a scrutiny process. The total allocation over the last three years is as follows:

o 2019-20 £50m (£25m revenue; £25m capital)
o 2020-21 £50m (£25m revenue; £25m capital)
o 2021-22 £75m (£50m revenue; £25m capital)

• The costs of delivering digital transformation are not 'one off costs' and they are forecast and planned on a year by year basis. The DPIF is only part of wider digital transformation, alongside investment through Digital Health and Care Wales (DHCW), the national digital services delivery organisation established in April 2021. Additionally, NHS Wales organisations invest in digital transformation through their discretionary revenue and capital allocations.

• At the strategic planning level, digital investment is informed by the National Digital Architecture, by the All Wales Digital Infrastructure Programme, and by other planning tools such as the Cyber Assurance Frameworks prepared by each organisation. These provide common assessment criteria and a consistent target operating model for all NHS Wales organisations, which enables a structured approach to forecasting and planning investment requirements.

- Digital investment is discussed regularly at the national level through the NHS Wales Leadership Board and Chief Executives Group, and across NHS Wales, for example through Directors of Finance and Directors of Planning peer leadership groups.

- Digital has been an important part of the response to the pandemic, which has accelerated digital transformation and the development of new digital services. For example: national systems to support contact tracing and vaccine delivery; tools to support remote working; video consultation services; and improvements to digital infrastructure.

- Welsh Government is determined to maintain the pace of digital transformation, as part of recovery and to drive the future sustainability of health and care services. It is committed to supporting several major digital programmes over the coming years. For example: the Welsh Nursing Care Records Programme, Welsh Intensive Care Information Services Programme, National Data Resource, All-Wales e-Prescribing Programme, and a new NHS Wales App through the Digital Services for Public and Patients.

- The committee will wish to note that capacity of the digital profession and wider NHS workforce is limited, and has been stretched to its limit by the pandemic. In the short term NHS Wales organisations are working hard to recruit and to secure the capacity needed to deliver against increased funding and investment. In the medium term, a strategic review of the digital health workforce and its future requirements is under way and will make recommendations in the first half of 2022.

Withdrawal from the European Union

21. Information about any budget allocations within your portfolio as a result of the UK's exit from the EU.

Food Standards Agency for Wales

In 2022-23 we will invest some additional £1,500,000 (on a recurrent basis) to meet the additional functions and responsibilities required following EU Exit. The funding is split between Core funding and law enforcement. This funding will ensure that the continued pressures on the organisations in areas such as surveillance, regulated product claims, border controls, policy development and risk assessment can be successfully delivered.

Annex A

Health, Social Care and Sport Committee - Date: 13th January 2022

Commentary on each of the Actions within the Health and Social Services MEG, including an analysis and explanation of changes between the Draft Budget 2022-23 and the First Supplementary Budget (June 2021).

Action: Delivery of Core NHS Services		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
8,879.666	9,218.565	338.899

This Action supports the main funding to the NHS in Wales as well funding to Public Health Wales and the NHS body Health Education & Improvement Wales.

Explanation of Changes to Delivery of Core NHS Services Action
Removal of 21-22 in-year Covid Allocations & Adjustments

- **£(540.000)m** - in year COVID allocations

New allocations for 22-23

- **£786.971m –** Draft Budget 22-23 additional NHS funding
- **£6.353m -** Draft Budget 22-23 additional PHW funding
- **£29.365m –** Draft Budget 22-23 additional HEIW funding (commissioning numbers)
- **£71.819m –** Draft Budget Non fiscal resource funding 22-23

Allocations within MEG for 22-23

- **£(15.609m) –** technical adjustments Action to Action within HSS MEG, including 22-23 NHS allocation transfers and budget commitment realignments.

Action: Delivery of Targeted NHS Services		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
155.390	102.054	(53.336)

This action supports other various health budgets including NHS Workforce, *A Healthier Wales* and other health budgets.

Explanation of Changes to Delivery of Targeted NHS Services Action
Remove 21-22 one off in-year Adjustments

- **£(28.169)m** in year allocation of immigration surcharge income

New allocations for 22-23

- **£11.500m** – additional allocation to A Healthier Wales BEL (Childcare Early Years funding)
- **£(5.000m)** - adjustment to A Healthier Wales Baseline Social Services

Allocations within MEG for 22-23

- **£(31.667m)– t**echnical adjustments Action to Action within HSS MEG, including 22-23 NHS allocation transfers and budget commitment realignments.

Action: Support Education & Training of the NHS Workforce		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
27.375	27.295	(0.080)

Education and training is fundamental to securing sustainable NHS services in the future. This action supports a range of activities undertaken in support of ensuring a sustainable workforce with the skills to address the demands on the service both now and in the future. The majority of the funding within this action covers the additional costs incurred by NHS UHB and Trusts in Wales for teaching (hosting) medical and dental students as part of their undergraduate studies. In addition it supports the training of a number of postgraduate training places across Wales, including clinical academic posts. Funding within this action also support Consultants clinical excellence awards which are given for quality, excellence, and exceptional personal contributions.

Explanation of Changes to Support Education & Training of the NHS Workforce Action

New allocations for 22-23

- **£1.311** - additional allocation as part of Draft Budget 22-23 Workforce commissioning

Allocations within MEG for 22-23

- **£(1.391m) -**Technical adjustments Action to Action within HSS MEG, including 22-23 NHS allocation transfers and budget commitment realignments.

Action: Support Mental Health Policies & Legislation		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
34.157	88.212	54.055

This Action supports a variety of

- Mental health policy development and delivery, including Child and Adolescent Mental Health Services (CAMHS), psychological therapies, suicide and self-harm prevention, perinatal mental health support and funding for third sector organisations through the section 64 mental health grant

- Mental health legislation, including the Mental Health (Wales) Measure 2010 and Deprivation of Liberty Safeguards (DOLs)

- The healthcare needs of vulnerable groups, (those defined as having protected characteristics) including asylum seekers and refugees, support for veterans, offender health care, sexual assault referral centres, gypsies and travellers and transgender individuals.

Explanation of Changes to Support Mental Health Policies & Legislation Action
New allocations for 22-23

- **£50.000m** additional allocation as part of Draft Budget 22-23 Mental Health

Allocations within MEG for 22-23

- **£4.055m** Technical adjustments Action to Action within HSS MEG (Transfer of funding to ring fenced mental health budget contained in health board allocation)

Action: Deliver the Substance Misuse Strategy Implementation Plan		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
28.725	28.585	(0.140)

The majority of substance misuse funding within this action is allocated to Area Planning Boards (APBs) via a funding formula to help them address the priorities outlined in our Substance Misuse Strategy 'Working Together to Reduce Harm' and the most recent Substance Misuse Delivery Plan 2016-18.

Explanation of Changes to Deliver the Substance Misuse Strategy Implementation Plan Action
Allocations within MEG for 22-23

- **£(0.140m) -**Technical adjustments Action to Action within HSS MEG (22-23 NHS allocation transfer).

Action: Food Standards Agency

2021-22 First Supplementary Budget June 2021 £m	Draft Budget 2022-23 £m	Change £m
5.110	5.110	0

This Action provides funding for the Food Standards Agency (FSA) Wales. This budget allocation is provided to meet the cost of the work priorities set out in FSAs broad 'FSA Wales Service Delivery Agreement'. The funding is provided on the basis that where there is a joint interest FSA Wales will assist the Welsh Government to take forward its priorities, including continued assistance in delivery and implementation of a statutory food hygiene rating scheme in Wales, as established by the Food Hygiene Rating (Wales) Act 2013.

Funding remains at the same level as in the June Supplementary Budget.

Action: Public Health Programmes		
2021-22 First Supplementary Budget June 2021 £m	Draft Budget 2022-23 £m	Change £m
28.171	28.180	0.009

This action funds a variety of public health programmes such as Organ & Tissue Transplantation, Immunisation, Payments to Public Health England who provides a number of specialist health protection services and some reference laboratory services to Wales, Healthy Start and NICE

Explanation of Changes to Public Health Programmes
Allocations within MEG for 22-23

- **£0.009m –** Technical adjustments Action to Action within HSS MEG, including 22-23 NHS allocation transfers and budget commitment realignments.

Action: Effective Health Emergency Preparedness Arrangements		
2021-22 First Supplementary Budget June 2021 £m	Draft Budget 2022-23 £m	Change £m
6.007	6.007	-

This action enables Welsh Government to ensure that NHS Wales is fully prepared and resilient to deal with the full range of hazards and threats identified in National Risk Assessments. This includes the highest risk of influenza pandemic and managing the health consequences of a terrorist incident involving hazardous materials.

Funding remains at the same level as in the June Supplementary Budget.

Action: Develop & Implement R&D for Patient & Public Benefit		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
42.075	42.545	0.470

This action supports the work of the Welsh Government's Division for Research and Development (R&D) which sits within the Department for Health and Social Services and leads on strategy, policy, commissioning, funding, contract management and governance of health and social care R&D in Wales.

Through its 'external brand', Health and Care Research Wales, the R&D Division provides an infrastructure to support and increase capacity in R&D, runs a range of responsive funding schemes and manages resources to promote, support and deliver research. It also participates in partnership and cross-funder activities where these bring advantages to Wales. It supports translational research with a particular focus on applied and public health research. This includes research into the prevention, detection and diagnosis of disease; the development and evaluation of interventions; and the provision, organisation and delivery of health and social care services. The Division also works to support the implementation of research findings into practice.

The Division has key relationships within Welsh Government with the Department for Economy, Science and Transport's Life Sciences and Innovation teams, the Chief Scientific Adviser for Wales and the Department for Education and Skills. The Division also works very closely with colleagues with similar roles in the other UK nations, the UK research councils, other research funders and the European Commission.

Explanation of Changes Develop & Implement R&D for Patient & Public Benefit Action

Allocations within MEG for 22-23

- **£0.470m –** Technical adjustments Action to Action within HSS MEG (budget commitment realignment).

Action: Social Care & Support		
2021-22 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
5.335	6.035	0.700

This Action provides funding for both Safeguarding and Advocacy and Older People Carers and People with Disabilities.

It also funds programmes of work to support carers in carrying out their roles as carers whilst maintaining their own health and well-being. This is central to ensuring that the rights for carers in the Social Services and Well-being (Wales) Act 2014 make a real difference in supporting carers and involves a strong element of investing to save since informal, unpaid carers are estimated to provide 96% of the care in Wales, care that would otherwise have to be provided from social care budgets.

Funding to support taking forward programmes to improve the life chances of disabled people and in particular the Improving Lives Programme for People with a Learning Disability, launched in June 2018. Funding is also used to take forward actions within the Framework of Action for People with Integrated Framework for Action of Care and Support for People Who are Deaf or Living with Hearing Loss.

Explanation of Changes to the Social Care and Support Action Allocations within MEG for 22-23

- **£0.700m –** Technical adjustments Action to Action within HSS MEG (budget commitment realignment).

Action: Partnership & Integration		
2020-21 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
0.526	0.526	-

This Action provides funding to assist with the integration of health and social services and the implementation of the Social Services and Well-being (Wales) Act 2014. In addition it also funds improvements to advice and guidance on continuing healthcare which should help people to access the support they need to meet their health needs. It also supports the consideration of a social care levy contributing to the wellbeing goals of a prosperous and resident Wales by considering options to provide the anticipated funding required in future to meet the increasing demands for social care resulting from an ageing population.

Funding remains at the same level as in the June Supplementary Budget.

Action: Sustainable Social Services		
2020-21 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**

12.715	99.715	87.000

The majority of this Action funds the Sustainable Social Services Third Sector grant.

Funding in this Action is also used to support delivery of the Social Services and Well-being (Wales) Act 2014, implementation of the Regulation and Inspection of Social Care Act 2016 (RISCA) and improvement of Social Care Services which deliver the changes required to achieve our vision for a social care in Wales that improves well-being and puts people and their needs at the centre of all care and support. Our principles include cultivating practice that promotes voice and control, independence, coproduction, person-centred care and prevention and early intervention approaches.

For 2022-23 Social Care workforce grant has been transferred to this action, plus the new Social Care Reform Fund

Explanation of Changes to the Sustainable Social Services

New allocations for 22-23

- **£42.000m** additional allocation as part of Draft Budget 22-23 Social Care Reform

Allocations within MEG for 22-23

- **£45.000m-** Technical adjustment Action to Action within HSS MEG (budget commitment realignment).

Action: Social Care Wales		
2020-21 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
22.613	25.613	3.000

This Action provides grant in aid funding to Social Care Wales a Welsh Government Sponsored body.

Social Care Wales (SCW) is funded to regulate the social care workforce, build confidence in the workforce, and lead and support improvement in social care.

Key priorities include:

- set standards for the care and support workforce, making them accountable for their work
- develop the workforce so they have the knowledge and skills to protect, empower and support those who need help
- work with others to improve services for areas agreed as a national priority
- set priorities for research to collect evidence of what works well
- share good practice with the workforce so they can provide the best response
- provide information on care and support for the public, the workforce and other organisations.

Explanation of Changes to the Social Care Wales Action

New Allocation for 22-23

- **£3.000m –** New allocation for SCW Draft Budget 22-33

Action: Supporting Children		
2020-21 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
94.761	108.611	13.850

The bulk of funding in this action supports the childcare offer (which is subject to scrutiny by the CYP&E Committee). This action also contains his action funding for the Looked after Children Transition Grant (LACTG) which provides funding for a number of initiatives which improve outcomes for looked after children so that all children in care have the same life chances as other children. It also contains the Vulnerable Children budget which supports children who have been adopted to ensure they and their family have the necessary access to support services to begin their family life.

Explanation of Changes to the Supporting Children Action

Remove 21-22 in-year Covid Allocations & Adjustments

- **£(4.550)m** - in year COVID allocations (2nd Supp)

New allocations for 22-23

- **£16.500 -** New allocations as part of Draft Budget Childcare

Allocations within MEG for 22-23

- **£1.900m -** Technical adjustments Action to Action within HSS MEG (budget commitment realignment).

Action: CAFCASS Cymru		
2020-21 First Supplementary Budget June 2021 £m	**Draft Budget 2022-23 £m**	**Change £m**
13.652	14.725	1.073

Cafcass Cymru is a demand-led operational service delivers a statutory service to the Family Court in Wales on behalf of Welsh Ministers. Cafcass Cymru practitioners work with nearly 9,000 of the most vulnerable children and young people in the family justice system, ensuring our interventions promote the voice of the child, is centred on their rights, welfare and best interests to achieve better outcomes for the child involved in the Family Justice System in Wales.

The organisation seeks to influence the family justice system and services for children in Wales, providing high quality advice to Ministers and ensuring the needs of Welsh families and children are reflected in process and policy developments. Aside from staffing and running costs for the organisation, the budget provides grant funding to support separated parents, when directed by the Family Court, to have contact with their children. The budget also funds the provision of the Working Together for Children programme which supports parents who have separated, or are separating, to better manage their own behaviour to ensure the emotional, practical and physical needs and best interest of their children are paramount.

Explanation of Changes to the CAFCASS Cymru Action

Allocations within MEG for 22-23

- **£1.073m –** Technical adjustments Action to Action within HSS MEG (budget commitment realignment).

HEALTH AND SOCIAL SERVICES

RESOURCE BUDGET			£'000							
Action	**BEL No.**	**BEL Description**	**2021-22 Final Budget**	**Baseline Adjustments**	**2021-22 Revised Baseline**	**2022-23 MEG to MEG Transfers**	**2022-23 Transfers Within MEG**	**2022-23 Other Allocations from / Transfer to Reserves**	**2022-23 Draft Budget**	**COMMENTS**
Delivery of Core NHS Services	0020	Core NHS Allocations	8,129,759	-440,000	7,689,759		-47,616		8,499,783	Agreed technical transfers
								786,971		Draft Budget: additional NHS funding
								70,669		Draft Budget: Provisional Additional Non Fiscal Resource requirement
	0030	Other Direct NHS Allocations	269,744	0	269,744		-39,279		230,465	Agreed technical transfers
	0035	Digital Health and Care Wales	0	0	0		55,732		56,851	Agreed technical transfers
								1,119		Draft Budget: Provisional Additional Non Fiscal Resource requirement DHCW
	0050	Health Education Improvement Wales	261,478	0	261,478		11,610		302,484	Agreed technical transfers
								29,365		Draft Budget: additional funding (HEIW commissioning numbers)
								31		Draft Budget: Provisional Additional Non Fiscal Resource requirement HEIW
	0250	Public Health Wales	116,320	0	116,320		6,309		128,982	Agreed technical transfers
								6,353		Draft Budget: new funding for PHW 22-23
	Total Delivery of Core NHS Services		**8,777,301**	**-440,000**	**8,337,301**	**0**	**-13,244**	**894,508**	**9,218,565**	
Delivery of Targeted NHS Services	0186	Workforce (NHS)	34,528	0	34,528		-452		34,076	Agreed technical transfers
	0060	A Healthier Wales	133,826	-5,000	128,826		-52,780		87,546	Agreed technical transfers
								11,500		Draft Budget: Early Years services funding
	0682	Other NHS Budgets (Expenditure)	21,070	0	21,070		12,362		33,432	Agreed technical transfers
	0682	Other NHS Budgets (Income)	-53,000	0	-53,000				-53,000	
	Total Delivery of Targeted NHS Services		**136,424**	**-5,000**	**131,424**	**0**	**-40,870**	**11,500**	**102,054**	
Support Education & Training of the NHS Workforce	0140	Education and Training	25,680	0	25,680		-1,201		25,790	Agreed technical transfers
								1,311		Draft Budget: additional Education & training commissioning funding
	0185	Workforce Development Central Budgets	2,225	0	2,225		-720		1,505	Agreed technical transfers
	Total Delivery of Targeted NHS Services		**27,905**	**0**	**27,905**	**0**	**-1,921**	**1,311**	**27,295**	
Support Mental Health Policies and Legislation	0270	Mental Health	36,260	0	36,260		1,952		88,212	Agreed technical transfers
								50,000		Draft Budget: additional mental health funding
	Total Support Mental Health Policies and Legislation		**36,260**	**0**	**36,260**	**0**	**1,952**	**50,000**	**88,212**	
Deliver the Substance Misuse Strategy Implementation	1682	Substance Misuse Action Plan Fund	28,725	0	28,725		-140		28,585	Agreed technical transfers
	Total Deliver the Substance Misuse Strategy Implementation		**28,725**	**0**	**28,725**	**0**	**-140**	**0**	**28,585**	
Food Standards Agency	0380	Food Standards Agency	3,610	0	3,610		1,500		5,110	Agreed technical transfers
	Total Food Standards Agency		**3,610**	**0**	**3,610**	**0**	**1,500**	**0**	**5,110**	
Public Health Programmes	0233	Health Promotion	9,071	0	9,071		3,133		12,204	Agreed technical transfers
	0232	Targeted Health Protection & Immunisation	5,870	0	5,870		722		6,592	Agreed technical transfers
	Total Public Health Programmes		**14,941**	**0**	**14,941**	**0**	**3,855**	**0**	**18,796**	
Health Improvement	0231	Health Improvement & Healthy Working	8,514	0	8,514		870		9,384	Agreed technical transfers
	Total Health Improvement		**8,514**	**0**	**8,514**	**0**	**870**	**0**	**9,384**	
Effective Health Emergency Preparedness Arrangements	0230	Health Emergency Planning	6,025	0	6,025		-18		6,007	Agreed technical transfers
	Total Effective Health Emergency Preparedness Arrangements		**6,025**	**0**	**6,025**	**0**	**-18**	**0**	**6,007**	
Develop & Implement R&D for Patient & Public Benefit	0260	Research and Development	42,075	0	42,075		470		42,545	Agreed technical transfers
	Total Develop & Implement R&D for Patient & Public Benefit		**42,075**	**0**	**42,075**	**0**	**470**	**0**	**42,545**	
Social Care and Support	0460	Safeguarding & Advocacy	2,365	0	2,365				2,365	
	0661	Older People Carers & People with Disabilities	2,197	0	2,197		1,473		3,670	Agreed technical transfers
	Total Social Care and Support		**4,562**	**0**	**4,562**	**0**	**1,473**	**0**	**6,035**	
Partnership & Integration	0620	Partnership & Integration	227	0	227				227	
	0700	Care Sector	299	0	299				299	
	Total Partnership & Integration		**526**	**0**	**526**	**0**	**0**	**0**	**526**	
Sustainable Social Services	0920	Sustainable Social Services	12,715	0	12,715		45,000		99,715	Agreed technical transfers
								42,000		Draft Budget: additional Social Services funding
	Total Sustainable Social Services		**12,715**	**0**	**12,715**	**0**	**45,000**	**42,000**	**99,715**	
Social Care Wales	0582	Social Care Wales	22,613	0	22,613			3,000	25,613	Draft Budget: additional Social Services (Social Care Wales) funding
	Total Social Care Wales		**22,613**	**0**	**22,613**	**0**	**0**	**3,000**	**25,613**	
Supporting Children	0310	Support for Childcare and Play	80,251	0	80,251			15,500	95,751	Draft Budget: Allocation of funding Childcare Offer.
	0311	Support for Children's Rights	991	0	991			29	1,020	Draft Budget: Allocation of £0.29m in 2022-23 in respect of children's rights and funding towards Children in Wales.
	0410	Supporting Children	3,865	0	3,865				3,865	
	1085	Support for Families and Children	7,004	0	7,004			971	7,975	Draft Budget: Allocation of £0.971m in 2022-23 supporting a range of programmes aimed at helping children and parents.
	Total Supporting Children		**92,111**	**0**	**92,111**	**0**	**0**	**16,500**	**108,611**	
CAFCASS Cymru	1268	CAFCASS Cymru	13,652	0	13,652		1,073		14,725	Agreed technical transfers
	Total CAFCASS Cymru		**13,652**	**0**	**13,652**	**0**	**1,073**	**0**	**14,725**	
HEALTH AND SOCIAL SERVICES - TOTAL RESOURCE BUDGET			**9,227,959**	**-445,000**	**8,782,959**	**0**	**0**	**1,018,819**	**9,801,778**	

Senedd Cymru
Y Pwyllgor Deisebau
—
Welsh Parliament
Petitions Committee

Russell George MS
Chair
Health and Social Care Committee
Tŷ Hywel
Cardiff Bay
CF99 1SN

22 September 2021

Dear Russell

Petition P-05-1045 To make shared-decision making and monthly mental health care-plan reviews a legal requirement

The Petitions Committee is currently considered the following petition from Tesni Morgan, which we considered recently at our meeting on 13 September:

Text of Petition:

> *On the 27th of August 2020 our darling Bronwen took her life after a long battle with her mental health.*
>
> *We as a family truly believe that it could have been prevented. During the last 6 months of her life, Bronwen's mental health deteriorated drastically. She was making multiple attempts to take her life, putting herself in dangerous situations on a regular basis. Bronwen was hopeless, her current care-plan was not fit for purpose and she and the family were begging for something to change.*

At the meeting members agreed to write to you in order to request that you consider focusing on mental health support as highlighted by the petitioner as part of your forward work plan.

Further information about the petition, including related correspondence, is available on our website at: https://business.senedd.wales/ieIssueDetails.aspx?IId=29966&Opt=3.

I would be grateful if you could send your response by e-mail to the clerking team at petitions@senedd.wales.

If you have any queries, please contact the Committee clerking team at the e-mail address above, or on 0300 200 6454.

Yours sincerely

Jack Sargeant MS

Chair

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Y Pwyllgor Iechyd a Gofal Cymdeithasol
—
Health and Social Care Committee

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Jack Sargeant MS
Chair
Petitions Committee

26 November 2021

Dear Jack

Petition P-05-1045 To make shared-decision making and monthly mental health care-plan reviews a legal requirement

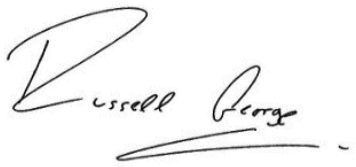
Thank you for your letter dated 22 September regarding the above petition, in which you asked the Health and Social Care Committee to consider undertaking work on mental health support during the Sixth Senedd.

As a member of the Health and Social Care Committee, you will be aware that:

- Mental health, including access to support services, was one of the priority areas emerging from our consultation on the Committee's priorities for this Senedd.
- In our strategy for the Sixth Senedd, we have identified mental health as a priority for the first year. The Committee will be considering the potential scope and approach of an initial inquiry into mental health at our meeting on 2 December.

We look forward to working collaboratively with the Petitions Committee on cross-cutting issues which fall within our remit during this Senedd.

Your sincerely



Russell George MS

Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Y Pwyllgor Iechyd a Gofal Cymdeithasol
–
Health and Social Care Committee

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Eluned Morgan MS
Minister for Health and Social Services
Welsh Government

22 November 2021

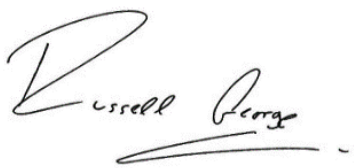
Dear Eluned

Additional funding for NHS planned care services

On 4 November 2021, you announced an additional £170m annual funding for planned NHS care and the creation of a £1m Planned Care Innovation Fund. While we welcome this additional funding, we would appreciate clarification on the issues set out in the annex to this letter. We would be grateful for a response by Thursday 2 December.

In addition, you will be aware that the Health and Social Care Committee is currently holding an inquiry into the impact of the waiting times backlog on people in Wales who are waiting for diagnosis or treatment. My clerk will be in contact with your officials shortly to issue an invitation for you to attend an oral evidence session in the new year, and to discuss the timescales for written evidence on the issues within the inquiry's terms of reference.

Yours sincerely



Russell George MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

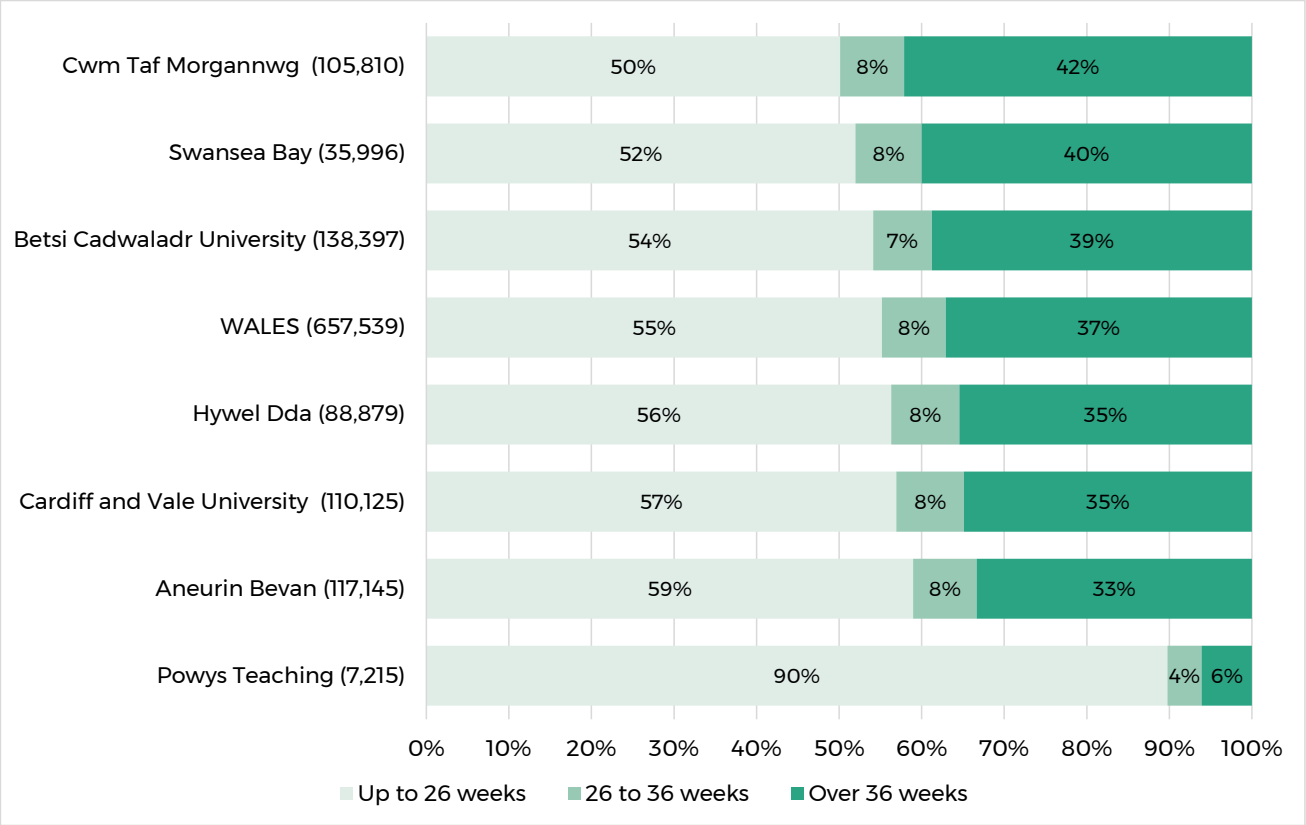
Annex: additional funding for NHS planned care services

Following the announcement on 4 November 2021 of additional funding for NHS planned care services, we would welcome further information on the matters listed below. We would be grateful to receive your response by Thursday 2 December.

Funding allocation

We note from the waiting times statistics published by StatsWales in October 2021, illustrated in the below figure prepared by Senedd Research, that there is some variation across health boards in respect of the percentage of patient pathways waiting over 36 weeks to begin treatment.

Figure 1 Percentage of patient pathways waiting less than 26 weeks, 26 to 36 weeks and over 36 weeks to start treatment by LHB; April 2019 to August 2021



Source: StatsWales, **Patient pathways waiting to start treatment by month, grouped weeks and stage of pathway** (figure prepared by Senedd Research)

1. What factors may be contributing to the variation in the length of time people are waiting to start treatment in different health board areas, and what role does the Welsh Government have in facilitating the sharing of learning and innovation between health boards?

2. The £170m is to be divided equally between health boards on a population basis. In determining this allocation, what account has been taken of any variation in the demographics, degree of deprivation or the extent of the waiting times backlogs in each health board?

3. The additional £170m is described as annual funding; for how many years do you expect this funding be available?

4. You have asked health boards to develop plans for how they will use this funding to transform their services; when do you anticipate these plans will be published, and what period do you expect the plans to cover?

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health and Social Care Committee

SeneddHealth@senedd.wales

3 December 2021

Dear Russell

I am writing in response to your letter of 22 November regarding additional funding for planned care services. I have addressed each query separately.

What factors may be contributing to the variation in the length of time people are waiting to start treatment in different health board areas, and what role does the Welsh Government have in facilitating the sharing of learning and innovation between health boards?

The reasons for the variation are multi factual, and in many cases existed prior to COVID-19. They include the ability to recruit staff, geography of local areas, and variation in deprivation rates across Wales.

The COVID-19 pandemic has further exposed these factors and in some cases, compounded the impact. It has also raised different issues.

Examples being:-

The geography and estate of hospital sites: the ability of health boards to provide safe green pathways segregated from acute sites to review and treat patients. National guidance provided during COVID-19 clearly indicated the importance of protecting patients from the risk of COVID-19 transmission and dividing the estate based on risk of transmission. Some health boards, such as Cardiff and Vale, were able to respond to this. Others such as Hywel Dda and Cwm Taf Morgannwg struggled as unscheduled care, urgent and planned care are all delivered on one site.

The availability of additional resources/capacity to support health board delivery: During the early part of the pandemic, health boards attempted to secure private sector capacity to deliver NHS treatments. They offered safer environments and additional staff to provide urgent appointments, follow-up reviews, diagnostics and treatments while NHS staff were

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deployed to deal with COVID-19 care. The geography and availability of these resources across Wales varied and as such, caused variation in resources available to each health board. Joint working across health board areas particularly for cancer was encouraged and supported through the cancer network. More recently, securing additional capacity has been the responsibility of each health board as part of their recovery plans, the level of availability across Wales however still varies.

Infection Prevention Control arrangements: National guidance has supported health boards to manage their estates to mitigate the risk of hospital acquired COVID -19 infection. While this has reduced incidents, it has not eradicated it. There has been a series of incidents across various sites, which has resulted in sites periodically closing to elective care, and affecting further the available capacity to treat patients.

Management of waiting lists focused on clinical risk rather than chronological order: Clinical need, in particular cancer care, has always taken priority on the use of planned care resources (outpatients, diagnostics and treatments). This approach has been the main guiding principle during COVID-19, and this has had a significant effect on the waiting lists. Waiting list management pre COVID used chronological (length of wait) to determine the next routine patient to be treated across each speciality area. At present, there is limited capacity available for routine patients for review and/or treatment. Pre-COVID-19, each specialty would be allocated an annual share of the planned care resources for them to manage their own waiting list. During COVID-19, planned care resources are pooled together and available theatre slots are allocated based on clinical risk, with emergency and urgent care taking priority. This has resulted in services such as planned orthopaedics having a wider disproportionate reduction of their traditional share of resources compared to areas such as colorectal surgery, who have a higher percentage of urgent cancer treatments. Pre-COVID-19, orthopaedics had an existing demand and capacity imbalance, an area of focus for the planned care programme, the imbalance has significantly widened during COVID-19.

The Welsh Government role has been to provide national guidance and policy support to ensure safe and effective delivery of NHS and social care during the COVID-19 pandemic. Where appropriate, health boards have been able to adapt and revise guidance based on local risk assessment. A recent impact is the ability, if safe to do so, to reduce social distancing in outpatient areas from two meters to one. Health boards with more modern estate and no recent hospital acquired transmission episodes have been able to do implement the change; this has not been possible for all across Wales.

The sharing and learning across health boards for planned care has mainly come through the work of the National Planned Care Programme. It has provided guidance and support to develop and implement innovation and new ways of working to maximise planned care activity while balancing issues affecting capacity.

Annex 1, gives some examples of variations across the specialities and demonstrates why and where there is variation, and gives examples of transformation and sharing of learning.

The £170m is to be divided equally between health boards on a population basis. In determining this allocation, what account has been taken of any variation in the demographics, degree of deprivation or the extent of the waiting times backlogs in each.

The allocation of the £170m uses the same formula share used for the NHS annual funding. This takes into account:

- Population
- Demographic factors (age / sex)
- Additional health needs (specifically standard mortality ratios and long- term

limiting illness).

Within the allocation letters to the health bodies, the priority for agreeing regional work/plans was stressed. This is to include proposed joint arrangements across organisations, including the role of national groups in providing advice, guidance and support. The aim of this regional working is to mitigate some of the issues than have created variation across health boards, such as ability to recruit, and the protection of resources, (regional centres will be separate from acute care and the effected by unscheduled care pressures)

The additional £170m is described as annual funding; for how many years do you expect this funding be available?

The funding is recurrent and it is expected to be used to fund a substantive increase in baseline NHS costs to support recovery of planned routine care through new delivery models and recruitment of additional permanent staff. As with the rest of the UK public sector, we only have certainty on the budget for the next three years, but that does not mean that this funding would end after the three years, it will form part of regular review of the national budget. I have been clear that planned care recovery will take the whole of the Senedd term.

You have asked health boards to develop plans for how they will use this funding to transform their services; when do you anticipate these plans will be published, and what period do you expect the plans to cover

Health Boards and NHS Trusts are normally required to develop three-year Integrated Medium Term Plans (IMTPs) setting out how they expect to deliver healthcare services for their local population. The usual planning and delivery arrangements for NHS Wales and social care, including the IMTP process, paused in March last year to ensure our health and social care organisations were able to respond to the outbreak of the Coronavirus pandemic.

During the pandemic, NHS organisations have instead been required to plan their services in line with a number of specific NHS Wales COVID-19 Operating Frameworks, which set the operating requirements focussing on essential services, urgent and emergency care, along with detailed capacity and workforce planning, aligned with the Ministerial priorities and focussed on the four harms. A NHS Wales Planning Framework followed these for 2021-22 requiring annual plans, which included the need to demonstrate how they plan for recovery.

Whilst the immediate priority is for our health and social care services to focus on the challenges we are facing during the winter, our services must also be able to plan the delivery of safe and sustainable services beyond this period. I therefore re-established the IMTP planning cycle and published the NHS Wales Planning Framework for 2022-25 on 9 November 2021.

The Framework signals both my ambition and commitment to look ahead to resetting services and driving recovery as we move forward into next year and beyond. The Framework reflects my priorities, which I communicated in the summer, and sets the direction for the year ahead. These will include the anticipated impact of the proposals against the additional funding provided by Welsh Government towards recovery and service transformation. I expect submission of the IMTPs for 2022-25 to Welsh Government by 28 February 2022, these will be robustly assessed to ensure we have clear delivery plans going forward. Health boards will be responsible for publishing their plans on their individual websites following approval by their Boards.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Appendix A:

Orthopaedics

At the end of September 2021, there were almost 9,500 patients waiting more than 105 weeks (two years) for treatment – the majority at treatment stage. Over 50% of the extreme long waiting patients are waiting for orthopaedic treatments.

It is recognised that the delivery of orthopaedic services in Wales has been significantly affected due to the lack of access to surgical theatres since March 2020, the availability of staff and infection control requirements the main limiting factor. For health boards which have returned to some levels of activity, they remain impacted by infection control restrictions which reduce number of patients treated on each list, as well as bed pressures from unscheduled care leading to postponements.

Prior to the pandemic, additional treatment capacity was routinely being provided into Orthopaedist services through Welsh Government waiting list initiative funding to support evening / weekend activity, as well as outsourcing to private providers. Despite the support, some health boards had not reduced their maximum waiting times below 12 months. The health boards with longer pre-pandemic lists continue to have the highest number of patients waiting more than 105 weeks for treatment. There are a complex set of issues, which has, and continues to affect the capability of health boards to provide timely treatment.

ABUHB has the largest total waiting list, and largest number of patients waiting over a year for first outpatient appointment. The health board also has the largest number of patients listed for treatment and around 1500 of whom have waited over 105 weeks. ABUHB have recently reopened their orthopaedic theatres with plans to reduce numbers in the coming months.

BCUHB has a higher proportion of patients at first outpatient stage (almost 2:1 ratio) and around 1,800 patients waiting over 105 weeks for surgery. Locally, teams are split across three localities although progress is being made in developing network arrangements across the areas to support collaboration. Surgery has not reopened to great volumes.

CVUHB has twice as many patients waiting for first outpatient review than for treatment. There are lower numbers of patients exceeding 105 weeks at both stages and the health board has returned some surgical capacity to the team.

CTMUHB has similar numbers of patients awaiting first outpatient to treatment, although there are low long waiting numbers for outpatients, around 1000 patients have waited over 105 weeks for surgery. Limited operating is occurring in CTM and the orthopaedic teams are working in a three site/ team model will little evidence of collaboration.

HDUHB has some of the lowest numbers of patients waiting at all stages, and those waiting longer. Only 660 patients are waiting over 105 weeks for surgery. This reflects the managed waiting list prior to COVID. In the health board, there is minimal surgery occurring and is not predicted to be available until spring 2022, although outsourcing has been commissioned.

SBUHB is not an outlier in terms of first outpatient waits, however they have some often highest long waiting patients, with around 2,400 waiting over 105 weeks for treatment and a further 2,000 waiting between 36 and 52 weeks. This reflects the challenges the health board faced prior to COVID with the loss of inpatient orthopaedic beds in 2019 and increased reliance on outsourced activity. Minimal inpatient surgery has been undertaken locally for a significant period and has adversely impacted complex patients requiring surgery in the main Morriston site.

The growth in the number of first outpatient waiting times has been impacted by requirements to physically examine / manipulate limbs as well as access radiographic imaging in order to plan treatment. In order to prevent multiple appointments the clinical consensus is that first outpatient appointments require a face to face appointment.

The priority of orthopaedic care against other clinical specialties has been reported to be low in all health boards, resulting in a low priority for access to limited outpatient and treatment facilities. The backlogs are especially challenging in hip / knee replacement surgery which requires inpatient facilities. The delay in surgery has also impacted on the overall health of patients who are generally being classified as more medically complex and requiring enhanced surgical / anaesthetic support.

Clinical pathways and the identification of alternative processes for the delivery of care have formed a central part of the Orthopaedic Clinical Strategy development and will be part of the orthopaedic “get it right first time” (GIRFT) review. There is an acknowledgement that radical rethinking of how services are provided is required to reduce waiting times.

Ear Nose & Throat (ENT)

ENT now has the 4th largest waiting list of all specialities. The Welsh ENT Board has identified that the size of the backlog in secondary care requires the NHS to work differently with primary care colleagues in order to support patients. Cardiff & Vale have been leaders in the development of health pathways, use of SOS/PIFU and specialist advice and guidance in order to realign resources to reduce demand. The board is working to spread this learning across Wales and standardise referral and support guidance where possible as there is unwarranted variation in place.

Unlike some other surgical specialities, the waiting list burden in ENT is at first outpatient stage rather than treatment. This reflects challenges in higher risk close airborne examination and diagnostics requiring PPE and room cleaning between patients which has significantly reduced patient flow. Suspected cancer referrals generally require laryngeal scoping and other diagnostics to exclude diagnosis and resources have been focused on these areas.

Like other surgical activity, return to pre-COVID levels have been variable. CVUHB / BCUHB have the highest activity levels at 58% compared to pre-COVID, while SB have the lowest at 22%

Ophthalmology

Prior to the pandemic, there were historical performance issues throughout Wales. Health boards including Cwm Taf Morgannwg, Betsi Cadwaladr and Hywel Dda were all struggling to perform against the Eye Care Measures. This poor performance was in part, due to the lack of utilisation of optometric services and the reliance on hospital eye services

Cardiff and Vale developed new technologies such ‘Open Eyes’ – an electronic patient record management system that allows clinicians and managers access to real time business intelligence to better manage their services. As a result, funding has been provided for the system to be rolled out to all health boards. It is expected to significantly improve the way in which care is delivered. They have also implemented See on Symptom (SOS) and Patient Initiated Follow Up (PIFU) to small cohorts of patients.

Swansea Bay University Health Board have undertaken extensive work on long waiting lists ensuring that all records are clinically validated and have commenced a diabetic referral refinement programme. This work has reduced the number of patients who require hospital

interventions, allowing for hospital capacity to be used elsewhere. The pilot has the potential to be used by other health boards.

Health boards who have utilised Ophthalmic Diagnostic Treatment Centres (ODTCs) to manage conditions such as glaucoma have been able to reduce waiting times and backlogs of patients.

The variation in waiting times for ophthalmology has been impacted by COVID – 19. At the start of the pandemic, all routine activity was halted. Eye care services were only available for patients who were at risk of sight loss and irreversible harm. This caused the backlog of patients waiting for treatment to increase. As health boards began to reinstate services, activity however is lower than desired due to COVID restrictions.

The Welsh Government has facilitated clinically led task and finish groups, involving all key stakeholders from all over Wales, to review and refine key pathways including utilising all available professionals such as Optometrists. This once for Wales approach to care ensures that all patients receiving treatment have equitable access to the relevant services, reducing inequalities in health care and embedding sustainable, best practice models of care into Ophthalmology. To facilitate this work and other areas of eye care services the Welsh Government has released funding for services to implement new innovative and sustainable ways of working.

In addition, the Royal College of Ophthalmology have undertaken a review of eye care services in Wales. The review concluded with ten key recommendations that the Welsh Government will work with the Welsh Ophthalmic Planned Care Board to review the recommendations and develop an action plan to take them forward.

Dermatology

The national review of dermatology services identified variation at the front of the pathway due to various teledermatology models, which are limited to expansion due to infrastructure, workforce and technology. A national programme of work is underway to establish a remote all wales pathway whilst organisations are managing those issues which will allow for expansion once the model has developed. Not all treatments (sub speciality conditions) within dermatology are offered at all health boards for example Biologics, Iontophoresis - due to several factors, including the recruitment of staff with expertise / interest in a treatment; the availability of facilities to perform specialist procedures; the collaboration with other specialist teams; and the number of cases to support the safe introduction of a service. The transition from a consultant delivered to a consultant led service model impacts on those waiting, and an integrated workforce plan is needed to use alternative practitioners and clinicians rather than the traditional dermatology consultant, whilst some organisations have embraced this model others are limited due to resource retention.

Urology

The Welsh Urology board have identified a significant number of benign conditions, which are waiting, particularly at the follow up pathway. Of the follow up cohort 30% being prostate cancer – currently only two health boards in Wales offer a supported self-management pathway. This approach has demonstrated to release approximately 60% of the prostate follow up capacity, a national programme of work is underway to implement an all Wales model. There are limited referral and follow up guidelines for Urology, following an audit of these services, the supporting and community services offered to support urology teams vary and with guidelines in place this will standardise those pathways to reduce the variation.

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3 December 2021

Dear Russell and Huw,

I am pleased to share with the Committee a finalised provisional Framework for Organs, Tissues and Cells, as well as a Framework for Blood Safety and Quality (the Frameworks). Also included are related Concordat documents.

These Frameworks establish common expectations around key areas of cooperation in relation to quality and safety standards for organs, tissues, cells and blood in the context of the UK's departure from the EU. All four UK administrations agreed to work together to establish common approaches, known as Common Frameworks, in policy areas that were previously governed by EU law, and which intersect with areas of devolved competence.

Officials in the Welsh Government, together with their counterparts across the UK, and with relevant stakeholders in these fields, have been working jointly to develop these Frameworks to share with their respective scrutiny Committees for Parliamentary scrutiny.

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The set of documents can be found at:

The Organs, Tissues and Cells (apart from embryos and gametes) Provisional Common Framework - GOV.UK (www.gov.uk)

The Blood Safety and Quality Provisional Common Framework - GOV.UK (www.gov.uk)

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

HM Government

The Organs, Tissues and Cells (apart from embryos and gametes) Provisional Common Framework

The Organs, Tissues and Cells (apart from embryos and gametes) Provisional Common Framework

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

December 2021

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The Organs, Tissues and Cells (apart from embryos and gametes) Provisional Common Framework

OUTLINE

SECTION 1: WHAT WE ARE TALKING ABOUT

1. Policy Area

Organs and Tissues and Cells (apart from embryos and gametes).

1.1 The Joint Ministerial Committee (EU Negotiations) agreed that officials should work together to develop arrangements for common frameworks (see Appendix I). This Framework relates to policy on the safety and quality of organs, tissues and cells, excluding reproductive tissues and cells. It encompasses elements of the EU Organs Directive (2010/53/EU) and the EU Tissues and Cells Directive (2004/23/EC) and the implementing acts which relate to the quality and safety of organs, tissues and cells for treating patients. This Framework sets out arrangements for co-operation between officials in the UK Government (UKG), Scottish Government (SG), Welsh Government (WG), and Northern Ireland Department of Health.

1.2 The Directives aim to establish minimum safety and quality standards for organs, tissues and cells to ensure a high level of health protection. For organs, it covers all steps in the organ transplantation process from donation, procurement, testing, characterisation, preservation, transport and finally transplantation. For tissues and cells, it covers issues such as donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells intended for human application. The Directives do not cover the use of organs, tissues and cells where they are not for human application (i.e. transplantation or transfusion) so do not regulate their use for e.g. research, education or training. The Directives that intersect with devolved competence in this policy area are listed in the section below.

1.3 In accordance with the retained EU law that implements the Organs and Tissues and Cells Directives, the UKG, SG, WG and NI Department of Health are obliged to ensure that quality and safety standards are maintained.

2. Scope

2.1 **Intersection with devolved competence:** This policy area (safety and quality of organs and tissues and cells) was previously governed by harmonised EU Directives (set out below). The EU Directives are implemented in domestic

legislation applicable across the whole of the UK. Enforcement of the implementing legislation is delegated to the UK-wide regulator, the Human Tissue Authority (HTA).

2.2 As the Transition Period has ended, the different governments have wider scope to use their powers to make changes to organs, tissues and cells safety and quality regulation.

2.3 This Framework will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK which shares a land frontier with the EU. It will also adhere to the Belfast Agreement.

2.4 **EU Legislation:** Retained EU legislation is currently implemented on a UK-wide basis. The two main pieces of EU legislation that intersect with devolved competence in this policy area are Directive 2004/23/EC ('the European Tissues and Cells Directive') and Directive 2010/53/EU ('the European Organ Directive').

2.5 The implementing directives below, that implement the main EU directives, also intersect with devolved competence (for Northern Ireland, Scotland and Wales).

2.6 **Tissues and cells**:

- **Commission Directive 2006/17/EC**: regarding certain technical requirements for the donation, procurement and testing of human tissues and cells.
- **Commission Directive 2006/86/EC**: concerning traceability requirements, notification of serious adverse reactions and events, additional technical requirements for the coding, processing, preservation, storage and distribution of human tissues and cells.
- **Commission Directive 2012/39/EU:** amending Directive 2006/17/EC as regards certain technical requirements for the testing of human tissues and cells. **Commission Directive 2015/565**: amending Directive 2006/86/EC as regards certain technical requirements for the coding of human tissues and cells.
- **Commission Directive 2015/566**: implementing Directive 2004/23/EC concerns the procedures for verifying the equivalent standards of quality and safety of imported tissues and cells.
- **Commission Decision 2010/453/EC**: establishing guidelines concerning the conditions of inspections and control measures, and on the training and qualification of officials, in the field of human tissues and cells.
- **Commission Decision (2015) 4460**: establishing a model for agreements between the Commission and relevant organisations on the provision of product codes for use in the Single European Code (SEC).

2.7 **Organs:**

- **Commission Directive 2012/25/EU:** regarding the information procedures for exchange of human organs intended for transplantation, between EU countries.

2.8 **Broadly, the retained EU law in this area** sets the quality and safety standards for organs, tissues and cells which include:

- the procurement, testing, processing, and storage of tissues and cells (including reproductive cells);
- organ and donor characterisation, meaning the collection of the relevant information on the characteristics of the donor and the organ, including tissue typing tests, needed to evaluate suitability for organ donation and optimise organ allocation;
- transportation conditions of organs and distribution conditions of tissues and cells, including labelling and documentation;
- traceability requirements in respect of organs for transplantation and tissues such as corneas or bone and stem cells; and
- notification requirements in the event of serious adverse events or reactions which may impact the quality and safety of organs, tissue and cells.

2.9 **Transfer of Commission Powers:** The safety and quality of organs and non-reproductive tissues and cells is an area of devolved competence. Statutory instruments made in 2019 under powers in the European Union (Withdrawal) Act 2018 transferred to the UKG, SG, WG and the NI Department of Health power to make regulations on matters previously included in implementing Directives made by the European Commission. This includes powers to update technical requirements, for example, requirements to ensure traceability in line with scientific and technical developments. These powers are limited to authorities in Great Britain by statutory instruments made in order to implement the Ireland/Northern Ireland Protocol as the 2018 Act confers the necessary powers on the NI department.

2.10 **Competence**: Legislative competence for non-reproductive human tissues, cells and organs is devolved to Scotland, Wales and Northern Ireland. Therefore, the Framework has been made on a UK-wide basis with the agreement of the UKG, SG, WG and NI Department of Health. This will facilitate the continuity of good working relations, open communication and the maintenance of a compatible minimum set of high standards of safety and quality for organs, tissues and cells. The UKG, SG, WG and NI Department of Health have agreed with the principles that will govern the development of the framework.

2.11 **Extent:** This Framework is UK-wide (covering England, Northern Ireland,

Scotland and Wales), but does not cover the Crown Dependencies or Overseas Territories.

2.12 **Scope within rules for different parts of the UK to do things differently:** Maintaining a compatible minimum set of safety and quality standards between the UKG, SG, WG and NI Department of Health will make it easier for organs, tissues and cells to continue to be shared across the UK. This Framework Agreement sets out a process by which a government can suggest future changes to the standards and how such a proposal will be collectively considered before one or more governments introduce a change. It will allow for necessary divergence by one or more governments, as required, in order to respond to needs such as location-dependent public health concerns.

2.13 **Interdependencies include:**

- **The Common Framework for the safety and quality of blood and blood components** as there are joint UK-wide groups that advise Ministers and health departments on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion/transplantation.

- **Medical devices legislation:** as reagents (medical devices) are used in the collection and processing of organs, tissues and cells.

3. Definitions

3.1 **Memorandum of Understanding (MoU) on Devolution:** The overarching MoU which sets out the understanding of, on the one hand, the UKG, and on the other, the Scottish Ministers, the Welsh Ministers, and the Northern Ireland Executive Committee of the principles that will underlie relations between them. This is separate to the Joint Ministerial Committee (EU Negotiations) Communique of October 2017.

3.2 **Joint Ministerial Committee (EU Negotiations) (JMC(EN)) Communique October 2017:** The committee members included representatives from the UKG, SG, WG and NIE. The group was established to provide a means for the devolved governments to be fully engaged in determining the UK's approach to EU and trade related issues. On 16 October 2017 agreement was reached on the principles and definitions for the Common Frameworks for areas where EU law intersected with devolved competence. In June 2020, NIE Ministers agreed to the principles set out in the communique, following the restoration of the NIE in January 2020.

3.3 **Concordat:** Joint non-legislative agreement that gives effect to the Common Framework.

SECTION 2: PROPOSED BREAKDOWN OF POLICY AREA AND FRAMEWORK

4. Summary of proposed approach

4.1. **Purpose and general principles[1]:** In 2018 it was agreed that a Common Framework in this area would be desirable across the UK. The JMC (EN) principles are described in the Joint Ministerial Committee's communique of 16 October 2017. The communique sets out that Common Frameworks will be established where they are necessary in order to:

- **enable the functioning of the UK internal market, while acknowledging policy divergence:** for organs, tissues and cells this will enable the transplant material to be shared around the UK;
- ensure compliance with international obligations: this does not apply to the Organs, Tissues and Cells Framework;
- ensure the UK can negotiate, enter into and implement new trade agreements and international treaties: this does not apply to the Organs, Tissues and Cells Framework;
- enable the management of common resources;
- administer and provide access to justice in cases with a cross-border element: this does not apply to the Organs, Tissues and Cells Framework;
- **safeguard the security of the UK:** for organs, tissues and cells, the sharing of serious adverse events or reactions (SAERs) information to maintain patient safety.

4.2. The outcomes of the intergovernmental relations review are in the process of being implemented. Once confirmation has been provided from each government, the outcomes of the review and appropriate intergovernmental structures will be reflected in this Common Framework.

4.3. A level of commonality would be beneficial particularly for organisations that operate across UK borders and therefore, as is currently the case, close collaboration between the governments should continue.

4.4. There is currently good information sharing and collaboration across the UK. This Framework agreement should support the continuation of this.

4.5. **EU Exit SIs:** Although competence in respect of organs, tissues and non-reproductive tissues and cells is devolved, it was agreed that there would be

[1] The principles that are relevant for organs, tissue and cell safety and quality are in bold.

UK-wide legislation regarding the safety and quality standards for organs, tissues and non-reproductive tissues and cells in the event of a 'no-deal' EU exit (The 2019 Organs, Tissues and Cells Safety and Quality EU Exit SIs[2]).

The legislation was made to ensure that the regulatory framework for organs, tissues and non-reproductive tissues and cells could operate as intended following the UK's departure from the EU, and to retain the safety and quality standards for organs, tissues and cells. The legislation also includes transfers of power to update certain aspects of the quality and safety regulations (such as updating safety and quality standards in response to technological advances) to either the Secretary of State for Health and Social Care on behalf of the UK (with the consent of Scottish and Welsh ministers and the Department of Health in Northern Ireland) or, to each of the Ministers in relation to their part of the UK.

4.6. The 2019 Organs, Tissues and Cells Safety and Quality EU Exit SIs were amended by the 2020 Organs, Tissues and Cells SIs[3] to implement the Protocol on Ireland/Northern Ireland. These SIs limit the regulation-making powers in the 2019 SIs to Great Britain, as the EU (Withdrawal) Act 2018 now contains regulation making powers (section 8C and paragraph 11M of Schedule 2) enabling the Secretary of State and the NI Department to make regulations to implement the Protocol including in response to future changes in EU law.

4.7. **Non-legislative:** As the UKG, SG, WG and NI Department of Health will have the power to diverge from UK Regulations should they choose, a concordat (Annex I) between the four nations will be put into place to formally agree the ways of working set out in this Framework.

4.8. **Four governments collaborative working:** The governments agree not to introduce changes to safety and quality standards legislation without first discussing proposals with each other and considering the UK-wide impact of such changes. They will follow the approach in this Framework to support collaborative decision making with a view to supporting continued sharing of organs, tissues and cells across the UK.

4.9. There is a need for continued robust policy development encompassing policy and technical expertise from all four governments, including the need to fully

[2] The Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2019/483 and The Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2019/481;

[3] The Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2020/1305 and The Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2020/1306.

assess the potential impacts of legislative changes on all affected stakeholders. Governments may wish to do this work individually or in collaboration before initiating a UK-wide discussion of a potential change to the standards.

4.10. **Risk assessment and management**: As stated above, maintaining a compatible minimum set of safety and quality standards between the UKG, SG, WG and NI Department of Health will make it easier for organs, tissues and cells to continue to be shared across the UK.

4.11. One or more governments may initiate a risk assessment process that should include discussions with the national transplant services and the regulator, as appropriate. The assessment should include seeking advice from the relevant scientific advisory bodies. Final decisions at the end of the risk assessment process should require collective sign-off (e.g. legislative or operational changes) by all Ministers across the UK. While the ability to diverge is always available to any individual government, it will be important for any diverging government to consider the impact on patient safety and confidence and the JMC(EN) Common Frameworks principles.

4.12. Where appropriate, joint recommendations may be made to Ministers. Ministers will ultimately retain the right to take individual decisions for their government. For Ministers and officials, for areas within the scope of the Framework, a consensus/discussion to inform the other parties should first be sought.

4.13. The dispute resolution process is outlined in section 13 of this document.

4.14. **Divergence:** Maintaining a compatible minimum set of quality and standards between the UKG, SG, WG and NI Department of Health will make it easier for organs, tissues and cells to continue to be shared across the UK. The Framework sets out a process by which any government can suggest changes to the standards and how such a proposal will be collectively considered before one or more governments introduce a change. It will allow for necessary divergence by one or more governments as required, in order to respond to needs such as location-dependent health concerns.

4.15. **Dispute Resolution:** All four governments will retain the ability to diverge from generally harmonised rules within their part of the UK. Where divergence is not considered acceptable by one or more governments in the UK, every effort will be made to address disagreement at the lowest level possible. Only when all opportunities for avoiding a dispute at the policy level have been sought will the dispute resolution mechanism be engaged. Dispute resolution

is anticipated to only be required in a very small number of cases and is set out in section 13 of this agreement should it be needed.

The Protocol on Ireland/ Northern Ireland

4.16. The Agreement on the Withdrawal of the United Kingdom from the EU sets out the current arrangements where, although remaining within the UK's custom territory, Northern Ireland will remain aligned with the EU. The following paragraphs of Annex 2 of the Northern Ireland Protocol are relevant to this framework.

- Paragraph 22 - substances of human origin

4.17. This Framework reflects the specific circumstances in NI that arise as a result of the Protocol and remains UK wide in its scope. As such decision making and information sharing will always respect the competence of all parties to the Framework and in particular the provisions in Article 18 of the Protocol on democratic consent in Northern Ireland.

4.18. Where one or more of UK Government, the Scottish Government or the Welsh Governments propose to change rules in a way that has policy or regulatory implications for the rest of the UK, or where rules in Northern Ireland change in alignment with the EU, the Framework is intended to provide governance structures and consensus-based processes for considering and managing the impact of these changes.

- As rules evolve to meet the emerging regulatory needs of the UK, Scottish and Welsh Governments, this Framework will ensure the full participation of Northern Ireland in discussions such that the views of the relevant Northern Ireland Executive Minister(s) are taken into account in reaching any policy or regulatory decisions by the UK, Scottish or Welsh Governments.

- Where rules in Northern Ireland change in alignment with the EU, the Framework will form the basis of a mechanism to ensure consideration by the four governments of any changes, and will enable them to determine any impacts and subsequent actions arising from these changes.

4.19. Where issues or concerns raised by the relevant Northern Ireland Executive Minister(s) in respect of GB-only proposals have not been satisfactorily addressed, they will have the right to trigger a review of the issue as set out in the dispute resolution process at section 13 of this document.

4.20. **The UK and EU Trade and Cooperation Agreement (TCA):** The area of policy covered by this Common Framework does not fall directly within the

provisions of the Trade and Cooperation Agreement, although both the Common Framework and that agreement will impact significantly on devolved and reserved responsibilities.

5. Detailed overview of proposed framework: legislation (primary or secondary)

5.1. N/A – no legislation to support the Framework is considered necessary.

6. Detailed overview of proposed framework: non-legislative arrangements

6.1. A concordat between UKG, SG, WG and NI Department of Health provides the basis for managing and maintaining the collaborative ways of working set out in this framework. Adopting a non-legislative approach maintains the existing good working relationships between the governments and allows for flexibility to adapt where change is needed.

6.2. The underlying principle is that the governments agree not to introduce changes to safety and quality standards legislation without first discussing proposals with each other and allowing sufficient scope for UK-wide discussion and decision making.

6.3. If one or more government wishes to diverge from the UK-wide standards for safety and quality, it is agreed that this should be done after consultation with the other UK governments and after consideration of the impact on the existing standards of safety and quality for organs, tissues and cells.

7. Detailed overview of areas where no further action is thought to be needed

7.1. Not applicable.

OPERATIONAL DETAIL

SECTION 3: PROPOSED OPERATIONAL ELEMENTS OF FRAMEWORK

8. Decision making

8.1. Individual governments will be able to make decisions (at a Ministerial level where it relates to changes in legislation or significant policy changes) on the safety and quality standards for organs, tissues and cells where these are not routine decisions made by the licenced establishments themselves. This includes, but is not limited to, the following:

For non-reproductive tissues and cells

- updating technical requirements relating to tissues and cells;

- prescribing traceability requirements and notification requirements in relation to SAERs; and
- verifying equivalent standards of safety and quality where tissues and cells are imported from third countries.

For Organs

- updating requirements for organ and donor characterisation to mitigate risk to human health, usually in response to an emerging disease outbreak; and
- responding to SAERs which present a serious risk to human health.

8.2. If a government wants to make a change to the organs and/or tissues and cells safety and quality legislation, they will:

- notify all governments, setting out details of the proposal and invite comments;
- arrange a meeting with policy officials to discuss the detail of the proposals if a government requests this;
- seek to agree a way forward on the issue; and
- depending on the issue, seek input from the following:
    - advice from an advisory body, the regulator, the donation or blood services; and
    - consultation with stakeholders.

8.3. Officials will share information, advice and views so that each government can advise Ministers on the proposal and its impacts and seek Ministerial decisions.

8.4. If agreement is not reached on a way forward to assess a proposal or on the factual information within the advice to Ministers, any government can escalate the issue so that it can be discussed at senior official level. If an agreement is not reached at senior official level and all alternatives have been exhausted, the proposal can be escalated to be discussed at Ministerial level.

9. Roles and responsibilities of each party to the framework

9.1. The following sets out the role and responsibilities of officials and Ministers in this Framework.

Officials:

9.2. Regular meetings will continue to take place around Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) meetings to provide an opportunity to discuss organs, tissues and cells policy, share updates and consider the short-term and long-term impact of any developments. This will provide an opportunity to discuss this policy and share updates and consider the short-term and long-term impact of any developments. Advice will be shared with Ministers with the rationale for the approach taken (e.g. a UK/GB-wide

approach), or why divergent policies may be necessary.

9.3. Specific ad-hoc meetings and day-to-day discussions on the policy covered by this Framework will continue. Advice will be put to Ministers outlining the rationale for the approach taken within this policy area (e.g. a UK/GB-wide approach), or why divergent policies may be arranged if/when a proposal arises. Officials across governments will convene to discuss policy issues as appropriate and keep colleagues regularly informed of any ramifications the policy may have on governments.

9.4. If officials do not agree when making decisions, issues discussed at a working level can be escalated to senior officials in line with the Framework's dispute avoidance and resolution mechanism (Appendix II).

Senior Officials:

9.5. Senior officials will provide strategic direction on the policy governed by this Framework. They may review an issue as per a framework's dispute avoidance and resolution mechanism if officials are not able to agree an approach, in another attempt to reach agreement. Senior officials should convene to discuss issues as appropriate where there is a dispute, either by meeting regularly or on an ad hoc basis.

Ministers:

9.6. Ministers may receive advice from their officials either concurrently across governments as issues arise or in the course of business as usual work for individual governments. If work is remitted to senior officials and an issue remains unresolved, the issue may be escalated to Ministers. Where Ministers are considering issues as part of the Framework's dispute avoidance and resolution mechanism this could be via several media, including inter-ministerial meetings or by correspondence.

Senior Ministers:

9.7. Terminology distinguishing Ministerial hierarchy is not universal across governments. Where there is a distinction, it is likely that advice presented to a Minister who is not a Senior Minister, will be copied to a Senior Minister who may provide an additional steer if needed. In some circumstances, the Senior Minister will also be the most appropriate Minister to make a decision and therefore the distinction between Senior Minister and Minister will not be relevant. In the case of UKG, a Senior Minister would be a Secretary of State (SofS).

Information sharing:

9.8. Each government will aim to provide each other with a full and open (as possible) access to scientific, technical and policy information including

statistics and research and, where appropriate, representations from third parties.

10. Roles and responsibilities of existing or new bodies

10.1. The current scientific advisory bodies are:

- **Joint United Kingdom (UK) Blood Transfusion and TissueTransplantation Services Professional Advisory Committee (JPAC)**

  The purpose of the JPAC is*:*
  - To ensure that all relevant aspects dealing with the safety of blood and tissues in the UK are covered, and that the professional advice emanating from JPAC is communicated appropriately and in a timely fashion.
  - To prepare detailed service guidelines for the United Kingdom Blood Transfusion Services, taking account of the Blood Safety and Quality Regulations (2005), the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and future UK legislation affecting the blood and tissue services. For example, the Tissue Donor Selection Guidelines - Deceased Donors.
  - To be an Advisory Committee to the United Kingdom Blood Transfusion Services, normally by reporting to the Medical Directors of the individual Services who are themselves individually accountable to the Chief Executives/ Directors of the Services. Decisions on policy and implementation would be vested in the individual Chief Executives/Directors and their Service boards and, where appropriate, their respective Health Departments.

- **Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO):** Provides policy advice to Ministers in the four governments of the UK on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion / transplantation.

10.2. Both of the groups above are independent from the UKG, SG, WG and NIEand provide advice to the whole of the UK.

10.3. **Official level meetings:** All parties will continue to regularly share information with one another in relation to the scope of this agreement and will continue to discuss:

- the impact of decisions on other governments, including any impacts oncross-cutting issues;
- prospective policy changes;
- emerging issues and intelligence, etc.

10.4. As mentioned in section 9, Senior Official meetings will be convened to provide strategic direction and to discuss issues as appropriate where there is adispute, either by meeting regularly or on an ad hoc basis. Officials or Senior Officials will then report to the relevant Ministers if necessary, to provide an update or to escalate an issue.

11. Monitoring and enforcement

11.1. Ad-hoc official level meetings will continue to take place to monitor the Framework, where it is not monitored in the course of routine business. The purpose of monitoring is to assess:

- intergovernmental co-operation and collaboration as a result of theFramework;
- whether parties are implementing and complying with the Framework;
- whether divergence has taken place in contravention of the Common Framework principles;
- whether divergence has taken place in contravention of the appropriate intergovernmental structures; and
- whether harmful divergence has taken place that impacts on the policy area covered by the Framework.

11.2. The outcome of this monitoring will be used to inform joint decision-making going forward and the next review and amendment process. If there is an unresolved disagreement, the dispute avoidance and resolution mechanism should be used.

12. Review and amendment

12.1. **Process:**

- The Review and Amendment Mechanism (RAM) ensures the Framework can adapt to changing policy and governance environments in the future.

- There are two types of review which are outlined below. The process for agreeing amendments should be identical regardless of the type of review.

- The RAM relies on consensus at each stage of the process from the Ministers responsible for the policy areas covered by the non-legislative agreement.

- Third parties can be used by any party to the framework to provide advice at any stage in the process. These include other government departments or bodies as well as external stakeholders such as non-governmental organisations (NGOs) and interest groups.
- At the outset of the review stage, parties to the framework must agree timelines for the process, including the possible amendment stage.

- If agreement is not reached in either the review or amendment stage, partiesto the Framework can raise it as a dispute through the Framework's dispute avoidance and resolution mechanism.

12.2. **Review Stage:**

- An initial review will take place one year after the Framework comes into effect; it will be used to determine if the arrangements are functional.

- Following the initial review, a periodic review of the Framework will take place every two years and will be, in line with official or, if required, ministerial-level meetings.
    - The period of two years starts from the conclusion of a periodic reviewand any amendment stages that follow.

    - During the periodic review, parties to the Framework will discuss whether the governance and operational aspects of the Framework are working effectively, and whether decisions made over the previous two years need to be reflected in an updated non-legislative agreement.

- An exceptional review of the Framework is triggered by a 'significant issue':
    - A significant issue must be time sensitive and fundamentally impact theoperation and/or the scope of the framework.
    - The exceptional review may include a review of governance structures if all parties agree it is required. Otherwise, these issues are to be handled in the periodic review.
    - The same significant issue cannot be discussed within six months ofthe closing of that issue.

- The amendment stage can only be triggered through unanimous agreement by Ministers. If parties agree that no amendment is required, the relevant time period begins again for both review types (for example, it will be [2] years until the next periodic review and at least 6 months until the same significant issue can trigger an exceptional review).

12.2 **Amendment Stage:**

- Following agreement that all parties wish to enter the amendment stage, parties will enter into discussion around the exact nature of the amendment. This can either be led by one party to the framework or all.

- If an amendment is deemed necessary during either type of review, the existing framework will remain in place until a final amendment has been agreed.
- All amendments to the Framework must be agreed by all parties and a new non-legislative agreement signed by all parties.

- If parties cannot agree whether or how a framework should be amended this may become a disagreement and as such could be raised through the framework's dispute avoidance and resolution mechanism.

12.3 Changes to the Framework and concordat will be communicated to stakeholders via the current communication channels.

13. Dispute resolution

13.1. The goal of the dispute avoidance and resolution mechanism is to avoid escalation to the appropriate intergovernmental structures, by resolving any disagreements at the lowest possible level. A disagreement between parties of this framework becomes a 'dispute' when it enters the formal dispute avoidance and resolution process through the appropriate intergovernmental structures.

13.2. This mechanism will only be utilised when genuine agreement cannot be reached, and divergence would impact negatively on the ability to meet the Common Frameworks principles (as defined by the JMC (EN) principles). In those areas where a common approach is not needed in order to meet these principles, an "agreement to disagree" could be considered an acceptable resolution.

Process

13.3 The below diagram (Figure 1) states the levels of escalation of a disagreementto a dispute and the interaction between each level.

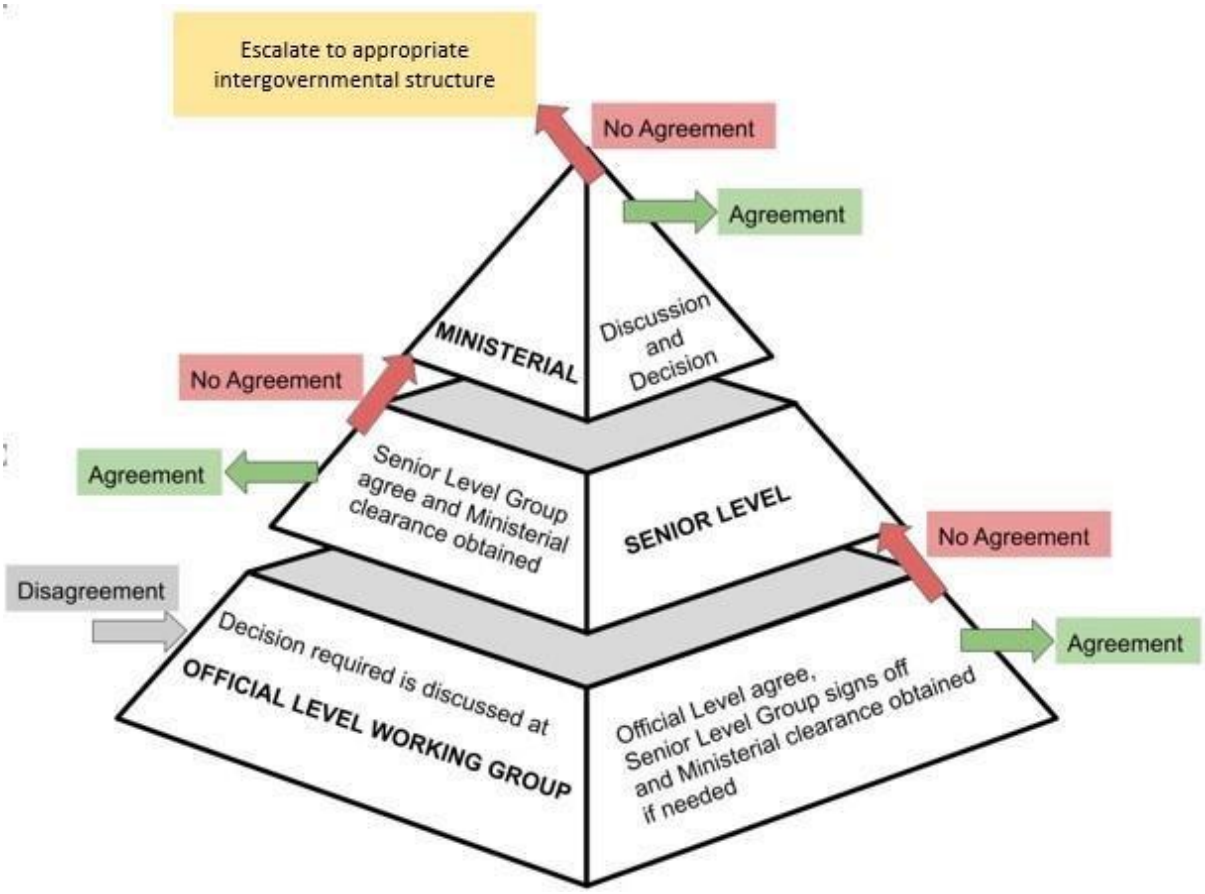


Figure 1: The levels of escalation for disagreements and disputes.

13.3.1 **Official level:** Following the approach set out in sections 8 and 9 and Appendix II of this Common Framework and within the spirit of the concordat, the four governments will seek every opportunity to resolve differences and reach agreement; either to recommend a UK-wide approach or to accept divergence, at official level through discussions. Regular official level meetings will continue to provide an opportunity to discuss organs and non-reproductive tissues and cells safety and quality policy, share updates and consider the short-term and long-term impact of any developments. Policy leads (e.g. Team Leaders) will provide strategic direction on the policy governed by this framework and take key operational decisions.

13.3.2 Where officials become aware of proposals, potential issues or areas of disagreement via any means, the first step will be to seek to resolve this amongst policy leads without escalation. This will usually be resolved via discussion with policy colleagues in each government, to determine the source of the disagreement, to examine evidence, to establish whether it is a significant concern and to work through possible solutions to the satisfaction of all parties. It is expected that most disagreements would be resolved at thispoint.

13.3.3 **Senior Official level:** Where it has not been possible to resolve any disagreement at official level, this will initially be referred to Senior Officials for resolution. At this stage Senior Officials can decide whether it would be appropriate to arrange a meeting with counterparts across governments. Alternatively, or after such a meeting, Senior Officials may determine that the issue cannot be resolved at this stage at which point the involvement of Ministers will be required.

13.3.4 **Ministerial level:** Any continuing disagreement, which cannot be resolved at official level in the ways set out above, will be referred to Portfolio Ministers for resolution and as set out in the Organs, Tissues and Cells Common Framework, the making of legislation may need to be postponed until all four governments are in agreement on how to proceed. The parties may conclude, having considered potential impacts on patient safety, the JMC (EN) principles and the appropriate intergovernmental structures, that divergence isappropriate.

13.3.5 **Resolve through appropriate intergovernmental structure:** As a last resort, where the above steps for resolving a disagreement have been unsuccessful, the issue will be escalated for resolution under the appropriate intergovernmental structures

Timescales for escalation

13.4 When a proposal is raised at official level, consideration will be given to the urgency of the proposal (i.e. how quickly a decision is required). This assessment will guide timescales for escalation of disagreement within the governance structure, with decisions requiring a more immediate resolution being escalated more quickly.

Evidence gathering

13.5 At each stage, further evidence may be requested from the preceding forum before the disagreement is discussed.

Third parties

13.6 JPAC and SaBTO may be used to provide scientific or technical advice to the UKG, SG, WG and the NI Department of Health.

SECTION 4: PRACTICAL NEXT STEPS AND RELATED ISSUES

14. Implementation

This Framework will take effect once agreed by all parties and approved by Ministers. The Common Framework will only be put in place once there is final ministerial sign off from all four governments.

APPENDIX I: Joint Ministerial Committee (EU Negotiations) Communique - October 2017

JOINT MINISTERIAL COMMITTEE (EU NEGOTIATIONS) COMMUNIQUE October 2017

The fifth Joint Ministerial Committee (EU Negotiations) met today in 70 Whitehall. The meeting was chaired by the Rt Hon Damian Green MP, First Secretary of State and Minister for the Cabinet Office.

The attending Ministers were:

From the UK Government: the First Secretary of State and Minister for the Cabinet Office, Rt Hon Damian Green MP; the Secretary of State for Exiting the EU, Rt Hon David Davis MP; the Secretary of State for Wales, Rt Hon Alun Cairns MP; the Secretary of State for Scotland, Rt Hon David Mundell MP; and, Parliamentary Under Secretary of State for Northern Ireland, Lord Bourne of Aberystwyth.

From the Welsh Government: Cabinet Secretary for Finance and Local Government, Mark Drakeford AM.

From the Scottish Government: the Minister for UK Negotiations on Scotland's Place in Europe, Michael Russell MSP.

In the absence of Ministers from the Northern Ireland Executive, a senior civil servant from the Northern Ireland Civil Service was in attendance.

The Chair opened the meeting by summarising the bilateral engagement and political

developments that had taken place since JMC(EN) last met. The Secretary of State for Exiting the EU provided an update on the previous rounds of negotiations with the EU and the Committee discussed forthcoming priorities and the future relationship with the EU. The Committee discussed the establishment of common frameworks.

Ministers noted the positive progress being made on consideration of common frameworks and agreed the principles that will underpin that work (attached).

Common Frameworks: Definition and Principles

Definition

As the UK leaves the European Union, the Government of the United Kingdom and the devolved administrations agree to work together to establish common approaches in some areas that are currently governed by EU law, but that are otherwise within areas of competence of the devolved administrations or legislatures. A framework will set out a common UK, or GB, approach and how it will be operated and governed. This may consist of common goals, minimum or maximum standards, harmonisation, limits on action, or mutual recognition, depending on the policy area and the objectives being pursued. Frameworks may be implemented by legislation, by executive action, by memorandums of understanding, or by other means depending on the context in which the framework is intended to operate.

Context

The following principles apply to common frameworks in areas where EU law currently intersects with devolved competence. There will also be close working between the UK Government and the devolved administrations on reserved and excepted matters that impact significantly on devolved responsibilities.

Discussions will be either multilateral or bilateral between the UK Government and the devolved administrations. It will be the aim of all parties to agree where there is a need for common frameworks and the content of them.

The outcomes from these discussions on common frameworks will be without prejudice to the UK's negotiations and future relationship with the EU.

Principles

Common frameworks will be established where they are necessary in order to:

- enable the functioning of the UK internal market, while acknowledging policy divergence;
- ensure compliance with international obligations;
- ensure the UK can negotiate, enter into and implement new trade agreements and international treaties;
- enable the management of common resources;
- administer and provide access to justice in cases with a cross-border element;
- safeguard the security of the UK.

1. Frameworks will respect the devolution settlements and the democratic accountability of

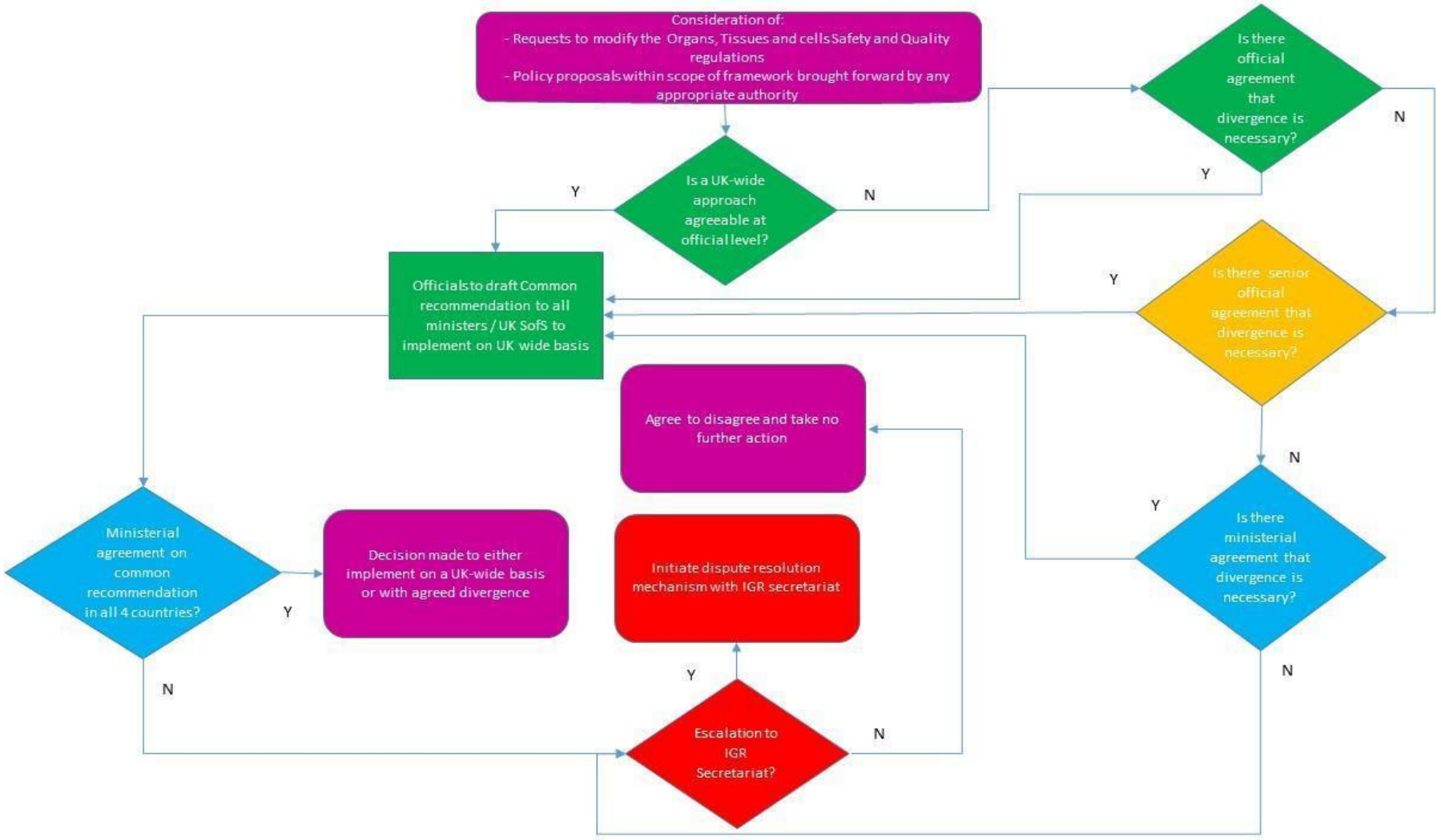
the devolved legislatures, and will therefore:

- be based on established conventions and practices, including that the competence of the devolved institutions will not normally be adjusted without their consent;
- maintain, as a minimum, equivalent flexibility for tailoring policies to the specific needs of each territory as is afforded by current EU rules;
- lead to a significant increase in decision-making powers for the devolved administrations.

2. Frameworks will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK that shares a land frontier with the EU. They will also adhere to the Belfast Agreement.

APPENDIX II: Joint Decision-making Dispute Avoidance and Dispute Resolution Process

Key							
	Inputs/Outputs		Senior Officials		Officials		Secretary of State (SofS)/ Portfolio Ministers		The ministerial committee outlined in the MoU on Devolution



Joint Decision-making	Dispute Avoidance	Dispute Resolution (THE MINISTERIAL COMMITTEE OUTLINED IN THE MOU level)
Framework process In accordance with section 9 of the Framework Outline Agreement policy colleagues will meet regularly. Requests to modify legislation and policy proposals within scope of the framework may be brought forward by the appropriate authority.	**1. Further discussions at official and senior official level.**	1. **Further discussion of issues.**
Decisions on divergence ● Scientific advice and wider risk management issues are considered to reach a consensus for a common recommendation to Ministers. ● All four governments submit the same common recommendations to Ministers for a decision (either for common approaches across the UK or divergent approaches). ● Where agreement cannot be reached at official level issues are referred to senior officials for consideration.	**2. Dispute avoidance initiated:** ● Pause work progressing implementation of Ministerial decision until differences are resolved. ● Senior officials from all four governments meet to consider ministerial views and determine whether there is any additional information available to support an agreed approach revert to consider any alternative approach. ● Officials submit risk management common recommendations, informing Ministers of the revisions with rationale for the approaches now being recommended across all four governments.	**2. Dispute avoidance initiated:** Escalation to highest level, dispute resolution process initiated • Pause work progressing implementation of SofS / Cab Sec / Perm Sec* level decision until differences are resolved. • Officials submit further/revised common recommendations, informing the appropriate intergovernmental structures of the approaches being recommended across all four governments. • The appropriate intergovernmental structures consider common recommendations and SofS / Cab Sec / Perm Sec views and consider any additional information available to support decision making. • If the approach being recommended is not the same across the UK, officials provide explanation of the different approaches being recommended and a summary rationale setting out why it is appropriate to diverge and why agreement has not been reached to date. If the approach being recommended is agreed across the UK, proceed to a ministerial decision. • The appropriate intergovernmental structures consider the common recommendation individually and provide a response to SofS / Min / Perm Sec private offices.

3. Ministers review recommendation seeking decisions. Officials will be asking Ministers to agree to the recommended approach.	**3. Recommendations made to Ministers in the four governments:** ● Officials submit further/revised common recommendations, informing Ministers of the approaches being recommended across all four governments. ● If the recommended approach differs across the UK, officials provide explanation and a summary rationale setting out why it is appropriate to diverge. ● If the approach being recommended is NOT agreed by Ministers and officials from the four governments meet again.	**3. SofS / Min/ Perm Sec reach agreed decision on common recommendation.** ● Private offices inform officials in their own respective government of the decision. ● Policy officials in all four governments share information on SofS / Min / Perm Sec decisions.
4. Ministers reach agreed decision on common recommendations.	**4. Ministers receive risk management common recommendation seeking decision.** ● Each Minister considers the common recommendation individually and provides a response. ● If the approach being recommended is NOT agreed across the UK, senior officials meet to discuss the issues.	
	5. Ministers reach agreed decision on common recommendations. ● If the approach being recommended (either for common approaches across the UK or divergent approaches) is agreed across the UK: o Private Offices inform officials in their own respective governments of the decision to implement agreed approach.	

	○ Policy officials in all four governments share information on the Ministers' decisions	

SofS / Cab Sec / Perm Sec = Secretary of State/Cabinet Secretary/Permanent Secretary

SofS / Min/ Perm Sec = Secretary of State/Ministers/Permanent Secretary

ANNEX I:

Concordat on the safety and quality of organs and tissues and cells (apart from embryos and gametes)

Introduction

1. This Concordat is an agreement between the UK Government (UKG), Scottish Government (SG), Welsh Government (WG), and Northern Ireland Department of Health in the area of safety and quality of organs and non-reproductive tissues and cells. It gives effect to the Organs, Tissues and Cells (apart from embryos and gametes)[4] Common Framework. It also sets out the continuation of good working relations, open communication; the maintenance of a compatible minimum set of high standards of safety and quality for organs and non-reproductive tissues cells; a dispute avoidance and resolution mechanism; and a review and amendment mechanism.

2. This agreement is a political commitment and is not intended to be legally binding or enforceable. It is in accordance with the overarching Memorandum of Understanding (MoU) on Devolution[5] and the Common Frameworks principles agreed at the Joint Ministerial Committee (EU Negotiations) (JMC(EN)) on 16 October 2017[6].

Scope

3. This agreement covers the subject matter of the EU Organs Directive (2010/53/EU) and EU Tissues and Cells Directive (2004/23/EC) and implementing acts. The 2019 Organs, Tissues and Cells safety and quality statutory instruments[7] retain the UK's safety and quality standards for organs and non-reproductive tissues and cells and amends the regulations to ensure that they will operate as intended following the UK's departure from the EU. The 2019 Organs, Tissues and Cells Safety and Quality EU Exit SIs were amended by the 2020 Organs, Tissues and Cells SIs[8] .

Principles for working together

4. This agreement will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK which shares a land frontier with the EU. It will also adhere to the Belfast Agreement.

5. The parties affirm their mutual commitment to work together on the application of retained EU law in relation to organs and non-reproductive tissues and cells safety and quality policy and their respective responsibilities. This co-operation is intended to give all parties the assurance, that working relationships will be conducted in a

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[4] References to non-reproductive tissues and cells means cells apart from embryos and gametes

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316157/MoU_between_the_UK_and_the_Devolved_Administrations.pdf

[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652285/Joint_Ministerial_Committee_communique.pdf

[7] The Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2019/483 and The Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2019/481.

[8] The Quality and Safety of Organs Intended for Transplantation (Amendment) (EU Exit) Regulations 2020 and The Human Tissue (Quality and Safety for Human Application) (Amendment) (EU Exit) Regulations 2020/1306.

manner that is both collaborative and helpful, aiming, where possible and appropriate, to achieve agreement on policy. In addition, all parties agree that regular contact will continue to discuss ongoing business of mutual interest.

6. This Concordat is intended to provide the basis for the management and maintenance of a compatible minimum set of safety and quality standards by setting out governance arrangements and a dispute resolution process. All parties to the Concordat agree that a Common Framework approach, that recognises the Common Frameworks principles agreed at JMC(EN) in 2017 and the finalised principles for intergovernmental relations, is highly desirable across the UK. The outcomes of the intergovernmental relations review are in the process of being implemented. Once confirmation has been provided from each government, the outcomes of the review and appropriate intergovernmental structures will be reflected in this Common Framework

7. Open communications will be maintained and information shared, to the extent permitted by law, at the earliest opportunity. This may include but is not confined to policy issues, stakeholder views, preparations for and outcome of consultations and research, media interest and lines to take, and emerging issues and intelligence (UK/EU/international).

8. The parties acknowledge that there may be a need for their separate responsibilities to be tackled with uniformity. For example, events could transpire that would require urgent action (such as, but not limited to, responding to emerging diseases). Each party shall consider promptly and thoroughly any concerns raised by the others. Where all agree that consistency is needed, consultation on a common approach shall be undertaken.

9. The parties shall inform each other at the earliest opportunity of any new policy proposals, before they are made public, to allow full consideration and a common approach to be reached wherever possible. Each party will also appraise the others of the ongoing development of such proposals. Where this will not be possible, each party will inform the others as soon as possible.

10. The parties to this agreement commit to resolving any issues at the lowest possible level and recognise that agreement to disagree can be an acceptable outcome, provided the JMC(EN) Common Frameworks principles remain upheld.

11. Where common recommendations may be made, Ministers will retain the right to take individual decisions for their government. For those areas within the scope of the Organs and Tissues and Cells (apart from embryos and gametes) Common Framework, the opportunity for consistency of approach across governments will be sought in the first instance. The ability for divergence must be retained, while taking account of its impact on patient safety and confidence, and the functioning of the UK internal market. Every effort will be made at working level to resolve any disagreements in difference of approach. Where a consensus cannot be reached by these arrangements (whether that is agreement to a UK wide approach or to accept divergence) the dispute avoidance and resolution mechanism would come into play.

Dispute avoidance and resolution

12. The goal of the dispute avoidance and resolution mechanism is to avoid escalation to formal processes through the appropriate intergovernmental structures, by resolving any disagreements at the lowest possible level. A disagreement between parties of

this Framework becomes a ‘dispute’ when it enters the formal dispute avoidance and resolution process through the appropriate intergovernmental structures.

13. This mechanism will only be utilised when genuine agreement cannot be reached, and divergence would impact negatively on the ability to meet the JMC (EN) Common Frameworks principles. In those areas where a common approach is not needed in order to meet these principles, an "agreement to disagree" could be considered an acceptable resolution.

Process

14. The below diagram (Figure 1) states the levels of escalation of a disagreement to a dispute and the interaction between each level.

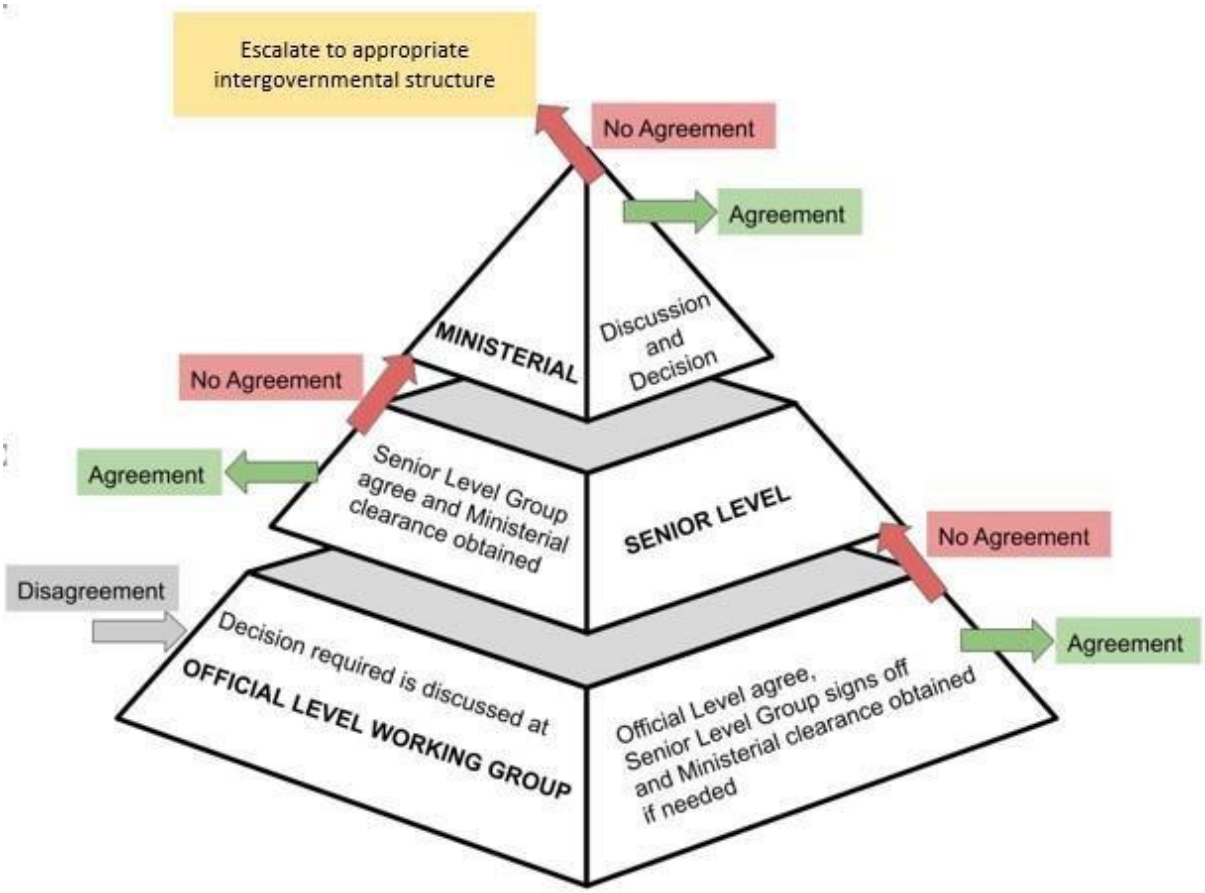

Figure 1: The levels of escalation for disagreements and disputes.

15. Following the approach set out in section 8 and 9 and Appendix II of the Organs, Tissues and Cells Common Framework and within the spirit of this Concordat, all governments will seek every opportunity to resolve differences and reach agreement; either to recommend a UK-wide approach or to accept divergence, at official level through discussions.

16. Where it has not been possible to resolve any disagreement in approach at official level, this will initially be referred to Senior Officials for resolution.

17. Any continuing disagreement, which cannot be resolved at official level in the ways set out above, will be referred to Portfolio Ministers for resolution and as set out in the Organs, Tissues and Cells Common Framework. The parties may conclude, having

considered potential impacts on patient safety and the JMC principles and reflecting appropriate intergovernmental structures, that divergence is appropriate.

18. As a last resort, where the above steps for resolving a disagreement have been unsuccessful, the issue will be escalated to appropriate intergovernmental structures for resolution under the dispute resolution process set out in the appropriate intergovernmental structures.

Timescales for escalation

19. When a proposal is raised at official level, consideration will be given to the urgency of the proposal (i.e. how quickly a decision is required). This assessment will guide timescales for escalation of disagreement within the governance structure, with decisions requiring a more immediate resolution being escalated quicker.

Evidence gathering

20. At each stage further evidence may be requested from officials at the preceding level, or from stakeholders (listed below), before the disagreement is discussed.

Third parties

21. The Human Tissue Authority (HTA), the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) and the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) may be used to provide advice on the most appropriate ways to ensure the safety of cells, tissues and organs for transfusion/transplantation.

Official level meetings

1. **Official level organs and non-reproductive tissues and cells meetings:** All parties will continue to regularly share information with one another in relation to the scope of this agreement and will continue to discuss:

    - the impact of decisions on other governments, including any impacts on cross-cutting issues;
    - prospective policy changes;
    - emerging issues and intelligence, etc.

22. As previously mentioned, Senior Official meetings will be convened to provide strategic direction and to discuss issues as appropriate where there is a dispute, either by meeting regularly or on an ad hoc basis. Senior Officials will then report to the relevant Ministers as necessary, to provide an update or to escalate an issue.

Review and amendment mechanism

Process

23. The Review and Amendment Mechanism (RAM) ensures the Framework can adapt to changing policy and governance environments in the future.

24. There are two types of review which are outlined below. The process for agreeing amendments should be identical regardless of the type of review.

25. The RAM relies on consensus at each stage of the process from the Ministers responsible for the policy areas covered by this non-legislative agreement.

26. Third parties can be used by any party to the Framework to provide advice at any stage in the process. These include other government departments or bodies as well as external stakeholders such as non-governmental organisations (NGOs) and interest groups.

27. At the outset of the review stage, parties to the Framework must agree timelines for the process, including the possible amendment stage.

28. If agreement is not reached in either the review or amendment stage, parties to the Framework can raise it as a dispute through the Framework's dispute avoidance and resolution mechanism.

Review stage

29. An initial review will take place one year after the Framework comes into effect, it will be used to determine if the arrangements are functional.

30. Following the initial review, a periodic review of the Framework will take place every two years.

    - The period of two years starts from the conclusion of a periodic review and any amendment stages that follow.
    - During the periodic review, parties to the Framework will discuss whether the governance and operational aspects of the Framework are working effectively, and whether decisions made over the previous two years need to be reflected in an updated non-legislative agreement.

31. An exceptional review of the Framework is triggered by a 'significant issue':

    - A significant issue must be time sensitive and fundamentally impact the operation and/or the scope of the Framework.

    - The exceptional review may include a review of governance structures if all parties agree it is required. Otherwise, these issues are to be handled in the periodic review.

    - The same significant issue cannot be discussed within six months of the closing of that issue.

32. The amendment stage can only be triggered through unanimous agreement by Ministers. If parties agree that no amendment is required, the relevant time period begins again for both review types (for example, it will be two years until the next periodic review and at least six months until the same significant issue can trigger an exceptional review).

Amendment stage

33. Following agreement that all parties wish to enter the amendment stage, parties will enter into discussion around the exact nature of the amendment. This can either be led by one party to the Framework or all.

34. If an amendment is deemed necessary during either type of review, the existing Framework will remain in place until a final amendment has been agreed.

35. All amendments to the Framework must be agreed by all parties and a new non-legislative agreement signed by all parties.

36. If parties cannot agree whether or how a Framework should be amended this may become a disagreement and as such could be raised through the Framework's dispute avoidance and resolution mechanism.

37. Changes to the Framework and Concordat will be communicated to stakeholders via the current communication channels.

The Protocol on Ireland/ Northern Ireland

38. The Agreement on the Withdrawal of the United Kingdom from the EU sets out the current arrangements where, although remaining within the UK's custom territory,

Northern Ireland will remain aligned with the EU. The following paragraphs of Annex 2 of the Northern Ireland Protocol are relevant to this framework.

Paragraph 22 - substances of human origin

39. This Framework reflects the specific circumstances in NI that arise as a result of the Protocol and remains UK wide in its scope. As such decision making and information sharing will always respect the competence of all parties to the Framework and in particular the provisions in Article 18 of the Protocol on democratic consent in Northern Ireland.

40. Where one or more of UK Government, the Scottish Government or the Welsh Governments propose to change rules in a way that has policy or regulatory implications for the rest of the UK, or where rules in Northern Ireland change in alignment with the EU, the Framework is intended to provide governance structures and consensus-based processes for considering and managing the impact of these changes.
    - As rules evolve to meet the emerging regulatory needs of the UK, Scottish and Welsh Governments, this Framework will ensure the full participation of Northern Ireland in discussions such that the views of the relevant Northern Ireland Executive Minister(s) are taken into account in reaching any policy or regulatory decisions by the UK, Scottish or Welsh Governments.

    - Where rules in Northern Ireland change in alignment with the EU, the Framework will form the basis of a mechanism to ensure consideration by the four governments of any changes, and will enable them to determine any impacts and subsequent actions arising from these changes.

41. Where issues or concerns raised by the relevant Northern Ireland Executive Minister(s) in respect of GB-only proposals have not been satisfactorily addressed, they will have the right to trigger a review of the issue as set out in the dispute resolution process at section 13 of this document.

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The Blood Safety and Quality Provisional Common Framework

The Blood Safety and Quality Provisional Common Framework

Presented to Parliament
by the Secretary of State for Health and Social Care
by Command of Her Majesty

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The Blood Safety and Quality Provisional Common Framework

OUTLINE

SECTION 1: WHAT WE ARE TALKING ABOUT

1. Policy Area

Blood Safety and Quality

1.1 The Joint Ministerial Committee (EU Negotiations) agreed that officials should work together to develop arrangements for Common Frameworks (see Appendix I). This Framework relates to blood safety policy. It encompasses elements of the Blood Directive (Directive 2002/98/EC) and the implementing acts which relate to the safety and quality of blood and blood components. This Framework sets out arrangements for co-operation between officials in the UK Government (UKG), Scottish Government (SG), Welsh Government (WG), and Northern Ireland Department of Health).

1.2 The Blood Directive aims to establish minimum safety and quality standards for human blood and its components to ensure a high level of health protection. It covers blood collection (including donation) and testing, as well as the processing, storage and distribution of blood when it is used in transfusions. The EU Directives that intersect with devolved competence in this policy area are listed in the section below.

1.3 In accordance with the retained EU law that implements the Blood Directive, the UKG, SG, WG and NI Department of Health are obliged to ensure that safety and quality standards are maintained.

1.4 **To note:** The safety and quality of blood products is regulated under separate legislation and is covered by Medicines policy. More information about this can be found in section 2.

2. Scope

2.1 **Intersection with devolved competence:** This policy area (blood safety and quality) was previously governed by harmonised EU Directives (set out below). The EU Directives are implemented in domestic legislation applicable across the whole of the UK. Enforcement of the implementing legislation is delegated to the UK-wide regulator, the Medicines and Healthcare products Regulatory Agency (MHRA).

2.2 As the Transition Period has ended, the different governments have wider scope to use their powers to make changes to blood safety and quality regulation.

2.3 This Framework will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK which shares a land frontier with the EU. It will also adhere to the Belfast Agreement.

2.4 **EU Legislation:** EU legislation is currently implemented on a UK-wide basis. The main piece of EU legislation that intersects with devolved competence in this policy area is Directive 2002/98/EC ("the Blood Directive"). The Blood Directive sets the safety and quality standards in relation to blood and blood components.

2.5 The implementing directives that intersect with devolved competence (for Northern Ireland, Scotland and Wales) in this policy area are:

- **Commission Directive 2004/33/EC** as regards certain technical requirements for blood and blood components;
- **Commission Directive 2005/61/EC** as regards traceability requirements and notification responsibilities in case of serious adverse reactions and events;
- **Commission Directive 2005/62/EC** as regards European Union standards and specifications relating to the quality system for blood establishments;
- **Commission Directive 2009/135/EC** which allows for temporary exemptions from the requirements set out in Commission Directive 2004/33/EC in light of a risk of shortage of blood and blood components caused by the Influenza A (H1N1) pandemic; and
- **Commission Directives 2011/38/EU, 2014/110/EU and 2016/1214** which make amendments to the implementing directives referred to above.

2.6 **Broadly the retained EU law in this area:**

- sets the standard for the safety and quality of blood and blood components;
- sets the technical requirements for blood and blood donation and the traceability requirements and notification responsibilities in case of serious adverse events or reactions (SAERs);
- sets out Community standards and specifications relating to the quality system for hospital blood banks and facilities; and
- addresses quality system standards and specifications for blood establishments and sets some further specific technical requirements.

2.7 **Transfer of Commission Powers:** The safety and quality of blood is an area of devolved competence. Statutory instruments made in 2019 under powers in the

European Union (Withdrawal) Act 2018 transferred to the UKG, SG, WG and the NI Department of Health power to make regulations on matters previously included in implementing Directives made by the European Commission. This includes powers to update technical requirements, for example, requirements to ensure traceability in line with scientific and technical developments. These powers are limited to authorities in Great Britain by statutory instrument made in order to implement the Ireland/Northern Ireland Protocol, as the 2018 Act confers the necessary powers on the NI Department.

2.8 **Competence**: Legislative competence for the safety and quality of blood and blood components is devolved to Northern Ireland, Scotland and Wales. Therefore, the Framework has been made on a UK-wide basis with the agreement of the UKG, SG, WG and NI Department of Health. This will facilitate the continuity of good working relations, open communication and the maintenance of a compatible minimum set of high standards of safety and quality for blood and blood components. The UKG, SG, WG and NIE have agreed with the principles that will govern the development of the Framework.

2.9 **Extent:** This Framework is UK-wide (covering England, Northern Ireland, Scotland and Wales), but does not cover the Crown Dependencies or Overseas Territories.

2.10 **Scope within rules for different parts of the UK to do things differently:** Maintaining a compatible minimum set of safety and quality standards between the UKG, SG, WG and NI Department of Health will make it easier for blood to continue to be shared across the UK. This Framework agreement sets out a process by which a government can suggest future changes to the standards and how such a proposal will be collectively considered before one or more governments introduces a change. It will allow for necessary divergence by one or more governments as required, in order to respond to needs such as location-dependent public health concerns.

2.11 **Out of Scope:** Blood products or plasma derivatives are covered by human medicines regulations. The manufacture of plasma-derived blood products is subject to pharmaceutical legislation as they are classified as medicines, while the donation, collection and testing of plasma is regulated by the same legislation as blood and blood components. Donated plasma, a component of blood, can be used to manufacture medicinal products like immunoglobulins, albumins and non-recombinant clotting factors (e.g. Factor VIII).

2.12 **Interdependencies include:**

- **The Common Framework for the safety and quality of organs, tissues and cells:** as there are joint UK-wide groups that advise Ministers and health departments on the most appropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion/transplantation.
- **Medicines Regulation**: UK plasma can be used for fractionation in order to produce some plasma-derived medicines, so there are also some interdependencies between the requirements of the Blood Safety and Quality Regulations 2005, which continue to govern the collection of plasma, and the Human Medicines Regulations 2012, which govern the manufacture of medicinal products from plasma.
- **Medical devices legislation:** as reagents (medical devices) are used in the collection and processing of blood and blood components.

3. Definitions

3.1 **Blood components:** A therapeutic constituent of human blood (red cells, white cells, platelets and plasma) that can be prepared by various methods.

3.2 **Blood products:** Any therapeutic product derived from human blood or plasma, this includes plasma derivatives manufactured from pooled plasma donations in plasma fractionation centres (such as albumin, coagulation factors and immunoglobulins). Plasma derivatives are covered by the Medicines Act and, like any other drug, must be prescribed by a licensed practitioner.

3.3 **Memorandum of Understanding (MoU) on Devolution:** The overarching MoU which sets out the understanding of, on the one hand, the UKG , and on the other, the Scottish Ministers, the Welsh Ministers, and the Northern Ireland Executive Committee of the principles that will underlie relations between them. This is separate to the Joint Ministerial Committee (EU Negotiations) Communique of October 2017.

3.4 **Joint Ministerial Committee (EU Negotiations) (JMC(EN)) Communique October 2017**: The committee members included representatives from the UKG, SG, WG and NIE. The group was established to provide a means for the devolved governments to be fully engaged in determining the UK's approach to EU and trade related issues. On 16 October 2017, agreement was reached on the principles and definitions for the Common Frameworks for areas where EU law intersects with devolved competence. In June 2020, NIE Ministers agreed to the principles set out in the communique, following the restoration of the NIE in January 2020.

3.5 **Concordat:** Joint non-legislative agreement that gives effect to the Common Framework.

3.6 **2019 Blood Safety and Quality EU Exit SI:** The Blood (Safety and Quality) (Amendment) (EU Exit) Regulations 2019 (as amended by the Blood (Safety and Quality) (Amendment) (EU Exit) Regulations 2020).

SECTION 2: PROPOSED BREAKDOWN OF POLICY AREA AND FRAMEWORK

4. Summary of proposed approach

4.1 **Purpose and general principles[1]:** In 2018 it was agreed that a Common Framework in this area would be desirable across the UK. The JMC (EN) principles are described in the Joint Ministerial Committee's communique of 16 October 2017. The communique sets out that Common Frameworks will be established where they are necessary in order to:

- **enable the functioning of the UK internal market, while acknowledging policy divergence:** for blood this will make it easier for blood and blood components to be shared around the UK.
- ensure compliance with international obligations;
- ensure the UK can negotiate, enter into and implement new trade agreements and international treaties;
- enable the management of common resources;
- administer and provide access to justice in cases with a cross-border element;
- **safeguard the security of the UK:** for blood the sharing of serious adverse events or reactions (SAERs) information to maintain patient safety.

4.2 The outcomes of the intergovernmental relations review are in the process of being implemented. Once confirmation has been provided from each government, the outcomes of the review and appropriate intergovernmental structures will be reflected in this Common Framework.

[1] The principles that are relevant for blood safety and quality are in bold.

4.3 A level of commonality would be beneficial particularly for organisations that operate across UK borders and therefore, as is currently the case, close collaboration between the governments should continue.

4.4 There is currently good information sharing and collaboration across the UK. This

Framework agreement should support the continuation of this.

EU Exit SIs:

4.5 Although competence in respect of blood is devolved, it was agreed that there would be UK-wide legislation regarding the safety and quality standards for blood in the event of a 'no-deal' EU exit (The 2019 Blood Safety and Quality EU Exit SIs[2]). The legislation was made to ensure that the regulatory framework for blood could operate as intended following the UK's departure from the EU, and to retain the safety and quality standards for blood. The legislation also transfers power to update certain aspects of the quality and safety regulations (such as updating safety and quality standards in response to technological advances) to either the Secretary of State for Health and Social Care on behalf of the UK (with the consent of Scottish and Welsh Ministers and the Department of Health in Northern Ireland) or, to each of the Ministers in relation to their part of the UK.

4.6 The 2019 Blood Safety and Quality EU Exit SI was amended by the Blood (Safety and Quality) (Amendment) (EU Exit) Regulations 2020 (2020 Blood SI[3]) to implement the Protocol on Ireland/Northern Ireland. The 2020 Blood SI limits the regulation-making powers in the 2019 SI to Great Britain, as the EU (Withdrawal) Act 2018 now contains regulation-making powers (section 8C and paragraph 11M of Schedule 2), enabling the Secretary of State for Health and the NI Department of Health to make regulations to implement the Protocol including in response to future changes in EU law.

Non-legislative:

4.7 As the UKG, SG, WG and NI Department of Health will have the power to diverge from the UK Regulations should they choose, a concordat (Annex I) between the four nations will be put into place to formally agree the ways of working set out in this Framework.

[2] The Blood Safety and Quality (Amendment) (EU Exit) Regulations 2019/4
[3] The Blood Safety and Quality (Amendment) (EU Exit) Regulations 2020/1304

Four governments collaborative working:

4.8 The governments agree not to introduce changes to safety and quality standards

legislation without first discussing proposals with each other and considering the UK-wide impact of such changes. They will follow the approach in this Framework to support collaborative decision making with a view to supporting continued sharing of blood and blood components across the UK.

4.9 There is a need for continued robust policy development encompassing policy and technical expertise from all four governments, including the need to fully assess the potential impacts of legislative changes on all affected stakeholders. Governments may wish to do this work individually or in collaboration before initiating a UK-wide discussion of a potential change to the standards.

Risk assessment and management:

4.10 As stated above, maintaining a compatible minimum set of safety and quality standards between the UKG, SG, WG and NI Department of Health will make it easier for blood and blood components to continue to be shared across the UK.

4.11 One or more governments may initiate the risk assessment process that should include discussions with the national blood services and the regulator, as appropriate. The assessment should include seeking advice from the relevant scientific advisory bodies. Final decisions at the end of the risk assessment process should require collective sign-off (e.g. legislative or operational changes) by all Ministers across the UK. While the ability to diverge is always available to any individual government, it will be important for any diverging government to consider the impact on patient safety and confidence, and compatibility with the JMC(EN) Common Frameworks principles.

4.12 Where appropriate, joint recommendations may be made to Ministers. Ministers will ultimately retain the right to take individual decisions for their government. For Ministers and officials, for areas within the scope of the Framework, a consensus/discussion to inform the other parties should first be sought.

4.13 The dispute resolution process is outlined in section 13 of this document.

Divergence:

4.14 Maintaining a compatible minimum set of quality and standards between the UKG, SG, WG and NI Department of Health will make it easier for blood and blood components to continue to be shared across the UK. The Framework sets out a process by which any government can suggest changes to the standards and how such a proposal will be collectively considered before one or more governments

introduces a change. It will allow for necessary divergence by one or more governments as required, in order to respond to needs such as location-dependent health concerns.

Dispute Resolution:

4.15 All four governments will retain the ability to diverge from generally harmonised rules within their part of the UK. Where divergence is not considered acceptable by one or more governments in the UK, every effort will be made to address disagreement at the lowest level possible. Only when all opportunities for avoiding a dispute at the policy level have been sought, will the dispute resolution mechanism be engaged. Dispute resolution is anticipated to only be required in a very small number of cases and is set out in section 13 of this agreement should it be needed.

The Protocol on Ireland/ Northern Ireland:

4.16 The Agreement on the Withdrawal of the United Kingdom from the EU sets out the current arrangements where, although remaining within the UK's custom territory, Northern Ireland will remain aligned with the EU. The following paragraphs of Annex 2 of the Northern Ireland Protocol are relevant to this framework.

- Paragraph 22 - substances of human origin

4.17 This Framework reflects the specific circumstances in NI that arise as a result of the Protocol and remains UK wide in its scope. As such decision making and information sharing will always respect the competence of all parties to the Framework and in particular the provisions in Article 18 of the Protocol on democratic consent in Northern Ireland.

4.18 Where one or more of UK Government, the Scottish Government or the Welsh Governments propose to change rules in a way that has policy or regulatory implications for the rest of the UK, or where rules in Northern Ireland change in

alignment with the EU, the Framework is intended to provide governance structures and consensus-based processes for considering and managing theimpact of these changes.

- As rules evolve to meet the emerging regulatory needs of the UK, Scottish and Welsh Governments, this Framework will ensure the full participation of NorthernIreland in discussions such that the views of the relevant Northern Ireland Executive Minister(s) are taken into account in reaching any policy or regulatory decisions by the UK, Scottish or Welsh Governments.

- Where rules in Northern Ireland change in alignment with the EU, the Frameworkwill form the basis of a mechanism to ensure consideration by the four governments of any changes, and will enable them to determine any impacts andsubsequent actions arising from these changes.

4.19 Where issues or concerns raised by the relevant Northern Ireland Executive Minister(s) in respect of GB-only proposals have not been satisfactorily addressed,they will have the right to trigger a review of the issue as set out in the dispute resolution process at section 13 of this document.

The UK and EU Trade and Cooperation Agreement (TCA):

4.20 The area of policy covered by this Common Framework does not fall directly withinthe provisions of the Trade and Cooperation Agreement, although both the Common Framework and that agreement will impact significantly on devolved andreserved responsibilities.

5. Detailed overview of proposed framework: legislation (primary orsecondary)

5.1 N/A – no legislation to support the framework is considered necessary.

6. Detailed overview of proposed framework: non-legislative arrangements

6.1 A concordat between UKG, SG, WG and NI Department of Health provides the basis for managing and maintaining the collaborative ways of working set out in this framework. Adopting a non-legislative approach maintains the existing goodworking relationships between the governments and allows for flexibility to adaptwhere change is needed.

6.2 The underlying principle is that the governments agree not to introduce changes tosafety and quality standards legislation without first discussing proposals with each other and allowing sufficient scope for UK-wide

discussion and decision making.

6.3 If one or more government wishes to diverge from the UK-wide standards for safetyand quality, it is agreed that this should be done after consultation with the other governments and after consideration of the impact on the existing standards of safety and quality for blood and blood components.

7. Detailed overview of areas where no further action is thought to beneeded

7.1 Not applicable.

OPERATIONAL DETAIL

SECTION 3: PROPOSED OPERATIONAL ELEMENTS OFFRAMEWORK

8. Decision making

8.1 Individual governments will be able to make decisions (at Ministerial level in relation to proposals for legislative change or other significant policy issues) on thesafety and quality standards for blood and blood components. This includes, but isnot limited to, the following:

- standards and requirements relating to a quality system for blood establishments;
- information to be provided to donors;
- information to be obtained from donors;
- blood quality and safety requirements;
- storage, transport and distribution requirements;
- quality and safety requirements;
- traceability requirements;
- deferral criteria for donors of blood and blood components. Deferral is defined in the Blood Safety and Quality Regulations 2005 and refers to the suspension (either permanent or temporary) of the eligibility of an individual to donate bloodor blood components;
- requirements applicable to autologous transfusions; and
- the procedure for notifying serious adverse reactions and events.

8.2 If a government wants to make a change to the blood safety and quality legislation,they will:

- notify all governments setting out details of the proposal and invite comments;

- arrange a meeting with policy officials to discuss the detail of the proposals, if angovernment requests this;
- seek to agree a way forward on the issue; and
- depending on the issue, seek input from the following:
    - advice from an advisory body or the regulator; and
    - consultation with stakeholders.

8.3 Officials will share information, advice and views so that each government can advise Ministers on the proposal and its impacts and seek Ministerial decisions.

8.4 If agreement is not reached on a way forward, to assess a proposal or on the factual information within the advice to Ministers, any government can escalate theissue so that it can be discussed at senior official level. If an agreement is not reached at senior official level and all alternatives have been exhausted, the proposal can be escalated to be discussed at Ministerial level.

9. Roles and responsibilities of each party to the framework

9.1 The following sets out the role and responsibilities of officials and Ministers in thisFramework.

Officials:

9.2 Regular meetings will be arranged by the Blood Safety team to take place around the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) meetings. This will provide an opportunity to discuss blood policy, share updates and consider the short-term and long-term impact of any developments. Advice willbe shared with Ministers with the rationale for the approach taken (e.g. a UK/GB- wide approach), or why divergent policies may be necessary.

9.3 Specific ad-hoc meetings and day-to-day discussions on the policy covered by thisFramework will continue. Advice will be put to Ministers outlining the rationale for the approach taken within this policy area (e.g. a UK/GB-wide approach), or why divergent policies may be arranged if/when a proposal arises. Officials across governments will convene to discuss policy issues as appropriate and keep colleagues regularly informed of any ramifications the policy may have on governments.

9.4 If officials do not agree when making decisions, issues discussed at a working levelcan be escalated to senior officials in line with the Framework's dispute avoidance and resolution mechanism (Appendix II).

Senior Officials:

9.5 Senior officials (e.g. Deputy Directors and Directors) will provide strategic directionon the policy governed by this Framework. They may review an issue as per a
Framework's dispute avoidance and resolution mechanism if officials are not able to agree an approach, in another attempt to reach agreement. Senior officials should convene to discuss issues as appropriate where there is a dispute, either bymeeting regularly or on an ad hoc basis.

Ministers:

9.6 Ministers may receive advice from their officials either concurrently across governments as issues arise or in the course of business as usual work for individual governments. If work is remitted to senior officials and an issue remainsunresolved, the issue may be escalated to Ministers. Where Ministers are considering issues as part of the Framework's dispute avoidance and resolution mechanism this could be via several media, including inter-ministerial meetings orby correspondence.

Senior Ministers:

9.7 Terminology distinguishing Ministerial hierarchy is not universal across governments. Where there is a distinction, it is likely that advice presented to a Minister who is not a Senior Minister, will be copied to a Senior Minister who may provide an additional steer if needed. In some circumstances, the Senior Minister will also be the most appropriate Minister to make a decision and therefore the distinction between Senior Minister and Minister will not be relevant. In the case ofUKG, a Senior Minister would be a Secretary of State (SofS).

Information sharing:

9.8 Each government will aim to provide each other with a full and open (as possible)access to scientific, technical and policy information including statistics and research and, where appropriate, representations from third parties.

10. Roles and responsibilities of existing or new bodies

10.1 The current scientific advisory bodies are:

- **Joint United Kingdom (UK) Blood Transfusion and Tissue TransplantationServices Professional Advisory Committee (JPAC)**

  The purpose of JPAC is:

  - To ensure that all relevant aspects dealing with the safety of blood and tissues in the UK are covered, and that the professional advice emanatingfrom JPAC is communicated appropriately and in a timely fashion.
  - To prepare detailed service guidelines for the United Kingdom Blood Transfusion Services, taking account of the Blood Safety and Quality Regulations (2005), the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and future UK legislation affecting the bloodand tissue services. For example, the Tissue Donor Selection Guidelines -Deceased Donors.
  - To be an Advisory Committee to the United Kingdom Blood TransfusionServices, normally by reporting to the Medical Directors of the individualServices who are themselves individually accountable to the Chief Executives/ Directors of the Services. Decisions on policy and implementation would be vested in the individual Chief Executives/Directors and their Service boards and, where appropriate, their respective Health Departments.

10.2 **Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO):** Provides policy advice to Ministers in the four governments of the UK on the mostappropriate ways to ensure the safety of blood, cells, tissues and organs for transfusion / transplantation.

10.3 Both of the groups above are independent from the UKG, SG, WG and NIE andprovide advice for the whole of the UK.

10.4 **UK Blood Services Forum:** The UK Blood Transfusion Services have a body to coordinate co-operation-the UK Blood Forum. The Forum comprises the chief executives and medical directors of the four Services. JPAC are accountable to themedical directors who themselves are accountable to their chief executives. Both the UK Blood Forum and JPAC ensure consistency in professional matters.

10.5 **Official level Blood Safety and Quality meetings:** All parties will

continue to regularly share information with one another in relation to the scope of this agreement. This is in order to: maintain public health and patient safety; allow foreffective collaborative working and consideration of the Framework Principles, while acknowledging policy divergence.

10.6 Official level blood safety and quality meetings will continue to discuss:

- the impact of decisions on other governments, including any impacts on cross-cutting issues;
- prospective policy changes;
- emerging issues and intelligence etc.

10.7 As mentioned in section 9, Senior Official meetings will be convened to provide strategic direction and to discuss issues as appropriate where there is a dispute,either by meeting regularly or on an ad hoc basis. Officials or Senior Officials willthen report to the relevant Ministers if necessary to provide an update or to escalate an issue.

10.8 The official level meetings will be arranged by the DHSC Blood Safety team andwill include colleagues from the devolved governments.

11. Monitoring and enforcement

11.1 Official level Blood Safety and Quality meetings with policy teams across the four nations will take place around SaBTO meetings, to monitor the Framework, wherenot monitoring in the course of routine business. The purpose of monitoring is to assess:

- inter-governmental co-operation and collaboration as a result of the Framework;
- whether parties are implementing and complying with the Framework;
- whether divergence has taken place in contravention of the CommonFramework principles;
- whether divergence has taken place in contravention of the principles of theintergovernmental relations review; and
- whether divergence has taken place that impacts on the policy area covered bythe Framework.

11.2 The outcome of this monitoring will be used to inform joint decision-making goingforward and the next review and amendment process. If there is an unresolved disagreement, the dispute avoidance and resolution mechanism should be used.

12. Review and amendment

12.1 **Process**:

- The Review and Amendment Mechanism (RAM) ensures the Framework canadapt to changing policy and governance environments in the future.
- There are two types of review which are outlined below. The process for agreeing amendments should be identical regardless of the type of review.
- The RAM relies on consensus at each stage of the process from the Ministersresponsible for the policy areas covered by the non-legislative agreement.
- Third parties can be used by any party to the Framework to provide advice at anystage in the process. These include other government departments or bodies as well as external stakeholders such as non-governmental organisations (NGOs) and interest groups.
- At the outset of the review stage, parties to the Framework must agree timelinesfor the process, including the possible amendment stage.
- If agreement is not reached in either the review or amendment stage, parties tothe Framework can raise it as a dispute through the Framework's dispute avoidance and resolution mechanism.

12.2 **Review Stage:**

- An initial review will take place one year after the Framework comes into effect; itwill be used to determine if the arrangements are functional.
- Following the initial review, a periodic review of the Framework will take placeevery two years and will be in line with official or, if required, ministerial-level meetings.
    - The period of two years starts from the conclusion of a periodic review andany amendment stages that follow.
    - During the periodic review, parties to the Framework will discuss

whether the governance and operational aspects of the Framework are working effectively, and whether decisions made over the previous two years needto be reflected in an updated non-legislative agreement.

- An exceptional review of the Framework is triggered by a ‘significant issue’:
    - A significant issue must be time sensitive and fundamentally impact theoperation and/or the scope of the Framework.
    - The exceptional review may include a review of governance structures ifall parties agree it is required. Otherwise, these issues are to be handledin the periodic review.
    - The same significant issue cannot be discussed within six months of theclosing of that issue.
- The amendment stage can only be triggered through unanimous agreement by Ministers. If parties agree that no amendment is required, the relevant time period begins again for both review types (for example, it will be 2 years until thenext periodic review and at least 6 months until the same significant issue can trigger an exceptional review).

12.3 **Amendment Stage:**

- Following agreement that all parties wish to enter the amendment stage, partieswill enter into discussion around the exact nature of the amendment. This can either be led by one party to the Framework or all.
- If an amendment is deemed necessary during either type of review, the existingFramework will remain in place until a final amendment has been agreed.
- All amendments to the Framework must be agreed by all parties and a new non-legislative agreement signed by all parties.
- If parties cannot agree whether or how a Framework should be amended thismay become a disagreement and as such could be raised through the
  Framework’s dispute avoidance and resolution mechanism.

12.4 Changes to the Framework and concordat will be communicated to

stakeholdersvia the current communication channels.

13. Dispute resolution

13.1 The goal of the dispute avoidance and resolution mechanism is to avoid escalationto formal processes through the appropriate intergovernmental structures, by resolving any disagreements at the lowest possible level. A disagreement betweenparties of this Framework becomes a ‘dispute’ when it enters the formal dispute avoidance and resolution process through the appropriate intergovernmental structures.

13.2 This mechanism will only be utilised when genuine agreement cannot be reached,and divergence would impact negatively on the ability to meet the Common Frameworks principles (as defined by the appropriate intergovernmental structures). In those areas where a common approach is not needed in order to meet these principles, an "agreement to disagree" could be considered an acceptable resolution.

Process

13.3 The below diagram (Figure 1) states the levels of escalation of a disagreement to adispute and the interaction between each level.

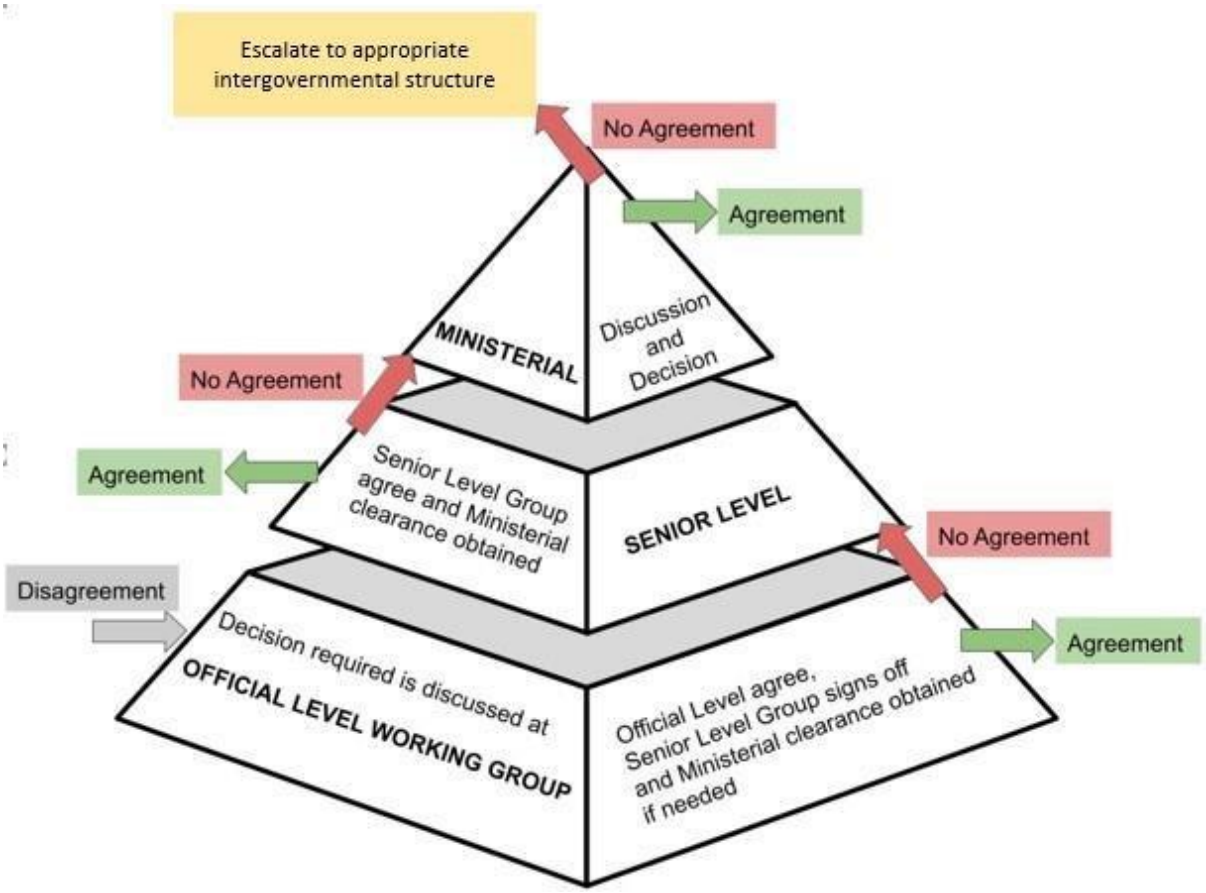


Figure 1: The levels of escalation for disagreements and disputes.

13.3.1 **Official level:** Following the approach set out in sections 8 and 9 and Appendix II of this Common Framework and within the spirit of the Concordat,the four governments will seek every opportunity to resolve differences and reach agreement; either to recommend a UK-wide approach or to accept divergence, at official level through discussions. Regular official level meetings will continue to provide an opportunity to discuss blood safety and quality policy, share updates and consider the short-term and long-term impact of any developments. Policy leads (e.g. Team Leaders) will provide strategic direction on the policy governed by this Framework and take key operational decisions.

13.3.2 Where officials become aware of proposals, potential issues or areas of disagreement via any means, the first step will be to seek to resolve this amongst policy leads without escalation. This will usually be resolved via discussion with policy colleagues in each government, to determine the source of the disagreement, to examine evidence, to establish whether it is a significant concern and to work through possible solutions to the satisfaction of all parties. It is expected that most disagreements would be resolved at thispoint.

13.3.3 **Senior Official level:** Where it has not been possible to resolve any disagreement at official level, this will initially be referred to Senior Officials forresolution. At this stage Senior Officials can decide whether it would be appropriate to arrange a meeting with counterparts across governments. Alternatively, or after such a meeting, Senior Officials may determine that the issue cannot be resolved at this stage, at which point the involvement of Ministers will be required.

13.3.4 **Ministerial level:** Any continuing disagreement, which cannot be resolved at official level in the ways set out above, will be referred to Portfolio Ministers for resolution and as set out in the Blood Safety and Quality Common Framework, the making of legislation may need to be postponed until all four governments are in agreement on how to proceed. The parties may conclude,having considered potential impacts on patient safety, the JMC (EN) principles and the finalised principles for Intergovernmental Relations, that divergence is appropriate.

13.3.5 **Resolve through appropriate intergovernmental structure:**

As a lastresort, where the above steps for resolving a disagreement have been unsuccessful, the issue will be escalated under the appropriate intergovernmental structures

Timescales for escalation

13.4 When a proposal is raised at official level, consideration will be given to the urgency of the proposal (i.e. how quickly a decision is required). This assessmentwill guide timescales for escalation of disagreement within the governance structure, with decisions requiring a more immediate resolution being escalated more quickly.

Evidence gathering

13.5 At each stage, further evidence may be requested from the preceding forum beforethe disagreement is discussed.

Third parties

13.6 JPAC and SaBTO may be used to provide scientific or technical advice to theUKG, SG, WG and NI Department of Health.

SECTION 4: PRACTICAL NEXT STEPS AND RELATED ISSUES

14. Implementation

14.1 This Framework will take effect once agreed by all parties and approved by Ministers. The Common Framework will only be put in place once there is finalministerial sign off from all four governments

APPENDIX I: Joint Ministerial Committee (EU Negotiations) Communique - October 2017

JOINT MINISTERIAL COMMITTEE (EU NEGOTIATIONS) COMMUNIQUE October 2017

The fifth Joint Ministerial Committee (EU Negotiations) met today in 70 Whitehall. The meeting was chaired by the Rt Hon Damian Green MP, First Secretary of State and Minister for the Cabinet Office.

The attending Ministers were:

From the UK Government: the First Secretary of State and Minister for the Cabinet Office, Rt Hon Damian Green MP; the Secretary of State for Exiting the EU, Rt Hon David Davis MP; the Secretary of State for Wales, Rt Hon Alun Cairns MP; the Secretary of State for Scotland, Rt Hon David Mundell MP; and, Parliamentary Under Secretary of State for Northern Ireland, Lord Bourne of Aberystwyth.

From the Welsh Government: Cabinet Secretary for Finance and Local Government, Mark Drakeford AM.

From the Scottish Government: the Minister for UK Negotiations on Scotland's Place in Europe, Michael Russell MSP.

In the absence of Ministers from the Northern Ireland Executive, a senior civil servant from the Northern Ireland Civil Service was in attendance.

The Chair opened the meeting by summarising the bilateral engagement and political developments that had taken place since JMC(EN) last met. The Secretary of State for Exiting the EU provided an update on the previous rounds of negotiations with the EU and the Committee discussed forthcoming priorities and the future relationship with the EU. The Committee discussed the establishment of common frameworks.

Ministers noted the positive progress being made on consideration of common frameworks and agreed the principles that will underpin that work (attached).

Common Frameworks: Definition and Principles

Definition

As the UK leaves the European Union, the Government of the United Kingdom and the devolved administrations agree to work together to establish common approaches in some

areas that are currently governed by EU law, but that are otherwise within areas of competence of the devolved administrations or legislatures. A framework will set out a common UK, or GB, approach and how it will be operated and governed. This may consist of common goals, minimum or maximum standards, harmonisation, limits on action, or mutual recognition, depending on the policy area and the objectives being pursued. Frameworks may be implemented by legislation, by executive action, by memorandums of understanding, or by other means depending on the context in which the framework is intended to operate.

Context

The following principles apply to common frameworks in areas where EU law currently intersects with devolved competence. There will also be close working between the UK Government and the devolved administrations on reserved and excepted matters that impact significantly on devolved responsibilities.

Discussions will be either multilateral or bilateral between the UK Government and the devolved administrations. It will be the aim of all parties to agree where there is a need for common frameworks and the content of them.

The outcomes from these discussions on common frameworks will be without prejudice to the UK's negotiations and future relationship with the EU.

Principles

1. Common frameworks will be established where they are necessary in order to:

    - enable the functioning of the UK internal market, while acknowledging policy divergence;
    - ensure compliance with international obligations;
    - ensure the UK can negotiate, enter into and implement new trade agreements and international treaties;
    - enable the management of common resources;
    - administer and provide access to justice in cases with a cross-border element;
    - safeguard the security of the UK.

2. Frameworks will respect the devolution settlements and the democratic accountability of the devolved legislatures, and will therefore:

    - be based on established conventions and practices, including that the competence of the devolved institutions will not normally be adjusted without their consent;
    - maintain, as a minimum, equivalent flexibility for tailoring policies to the specific

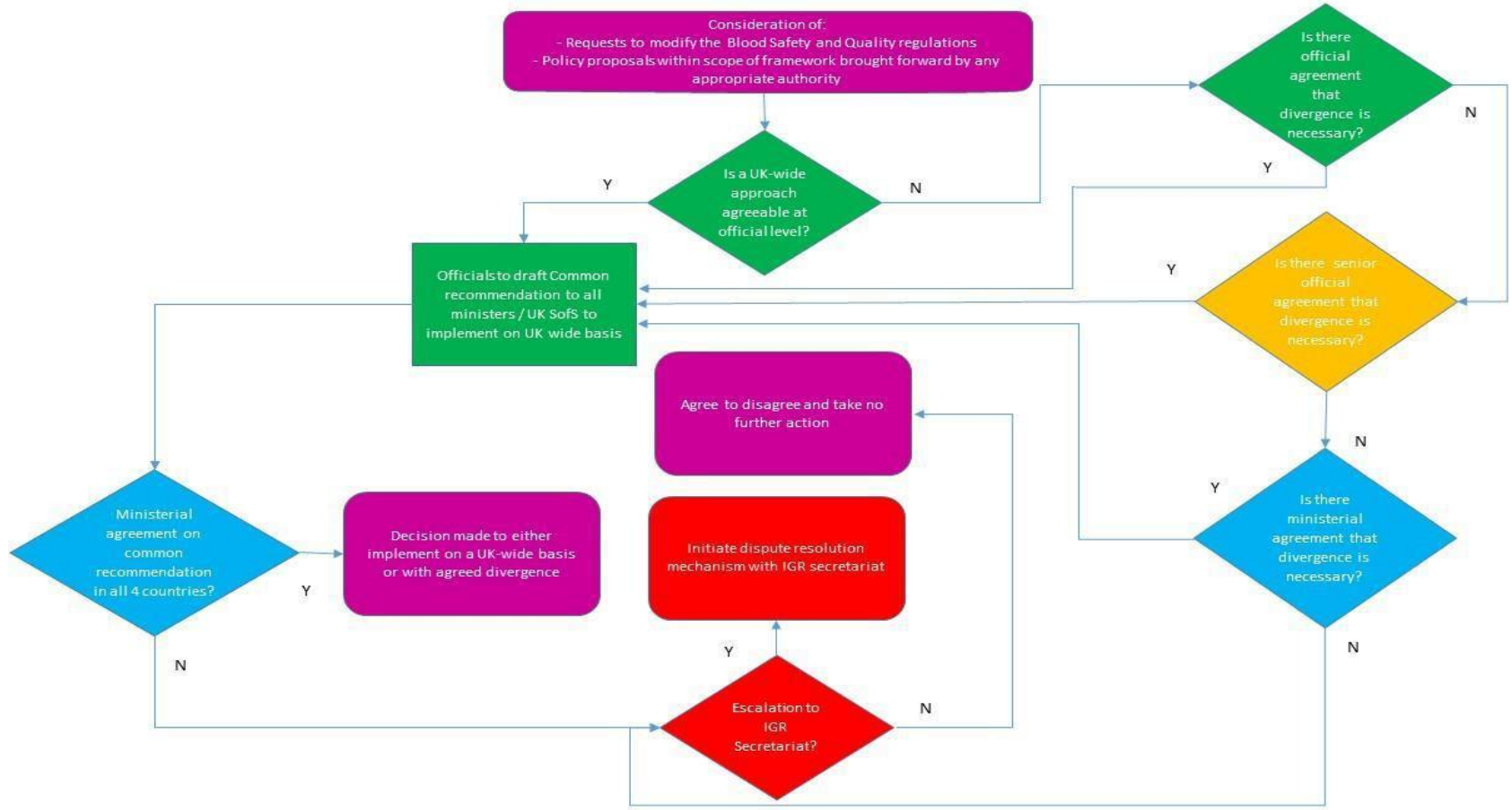
needs of each territory as is afforded by current EU rules;

- lead to a significant increase in decision-making powers for the devolved administrations.

3. Frameworks will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK that shares a land frontier with the EU. They will also adhere to the Belfast Agreement.

APPENDIX II: Joint Decision-making Dispute Avoidance and Dispute Resolution Process

Key							
	Inputs/Outputs		Senior Officials		Officials		Secretary of State (SofS)/ Portfolio Ministers		The ministerial committee outlined in the MoU on Devolution



Joint Decision-making	Dispute Avoidance	Dispute Resolution (THE MINISTERIAL COMMITTEE OUTLINED IN THE MOU level)
1. In accordance with section 9 of the Framework Outline Agreement policy colleagues will meet regularly. Requests to modify legislation and policy proposals within scope of the framework may be brought forward by the appropriate authority. 2. Scientific advice and wider risk management issues are considered to reach a consensus for a common recommendation to Ministers. 3. All four governments submit the same common recommendations to Ministers for a decision (either for common approaches across the UK or divergent approaches). Where agreement cannot be reached at official level issues are referred to senior officials for consideration. 4. Ministers review recommendation seeking decisions. Officials will be asking Ministers to agree to the recommended approach. 5. Ministers reach agreed decision on common recommendations.	1. **Further discussions at official and senior official level.** 2. **Dispute avoidance initiated:** ● Pause work progressing implementation of Ministerial decision until differences are resolved. ● Senior officials from all four governments meet to consider ministerial views and determine whether there is any additional information available to support an agreed approach revert to consider any alternative approach. ● Officials submit risk management common recommendations, informing Ministers of the revisions with rationale for the approaches now being recommended across all four governments. 3. **Recommendations made to Ministers in the four governments:** ● Officials submit further/revised common recommendations, informing Ministers of the approaches being recommended across all four governments.	**1. Further discussion of issues.** **2. Dispute avoidance initiated:** Escalation to highest level, dispute resolution process initiated ● Pause work progressing implementation of SofS / Cab Sec / Perm Sec* level decision until differences are resolved. ● Officials submit further/revised common recommendations, informing the appropriate intergovernmental structures of the approaches being recommended across all four governments. ● The appropriate intergovernmental structures consider common recommendations and SofS / Cab Sec / Perm Sec views and consider any additional information available to support decision making. ● If the approach being recommended is not the same across the UK, officials provide explanation of the different approaches being recommended and a summary rationale setting out why it is appropriate to diverge and why agreement has not been reached to date. If the approach being recommended is agreed across the UK, proceed to a ministerial decision. ● The appropriate intergovernmental structures consider the common recommendation individually and provide a response to SofS / Min / Perm Sec private offices. **3. SofS / Min / Perm Sec reach agreed decision on common recommendation.**

Joint Decision-making	Dispute Avoidance	Dispute Resolution (THE MINISTERIAL COMMITTEE OUTLINED IN THE MOU level)
	● If recommended approach differs across the UK, officials provide explanation and a summary rationale setting out why it is appropriate to diverge. ● If the approach being recommended is NOT agreed by Ministers and officials from the four governments meet again. **4. Ministers receive risk management common recommendation seeking decision.** ● Each Minister considers the common recommendation individually and provides a response. ● If the approach being recommended is NOT agreed across the UK, officials meet to discuss the issues. **5. Ministers reach agreed decision on common recommendations.** ● If the approach being recommended (either for common approaches across the UK or divergent approaches) is agreed across the UK: ○ Private Offices inform officials in their own	● Private offices inform officials in their own respective government of the decision. ● Policy officials in all four governments share information on SofS / Min / Perm Sec decisions.

Joint Decision-making	Dispute Avoidance	Dispute Resolution (THE MINISTERIAL COMMITTEE OUTLINED IN THE MOU level)
	respective governments of the decision to implement agreed approach. ○ Policy officials in all four governments share information on the Ministers' decisions.	

SofS / Cab Sec / Perm Sec= Secretary of State/ Cabinet Secretary /Permanent Secretary

SofS / Min / Perm Sec= Secretary of State/ Ministers /Permanent Secretary

ANNEX I

Concordat on blood (and blood components) safety and quality

Introduction

1. This Concordat is an agreement between the UK Government (UKG), Scottish Government (SG), Welsh Government (WG), and Northern Ireland Department of Health in the area of blood safety and quality. It gives effect to the Blood Safety and Quality Common Framework. It also sets out the continuation of good working relations, open communication; the maintenance of a compatible minimum set of high standards of safety and quality for blood and blood components; a dispute avoidance and resolution mechanism; and a review and amendment mechanism.

2. This agreement is a political commitment and is not intended to be legally binding or enforceable. It is in accordance with the overarching Memorandum of Understanding (MoU) on Devolution[4] and the Common Frameworks principles agreed at the Joint Ministerial Committee (EU Negotiations) (JMC(EN)) on 16 October 2017[5].

Scope

3. This agreement covers the subject matter of the EU Blood Directive (2002/98/EC) and implementing acts. The Blood Safety and Quality (Amendment) (EU Exit) Regulations 2019 retain the UK's safety and quality standards for blood and blood components and amends the regulations to ensure that they will operate as intended following the UK's departure from the EU. The 2019 Blood Safety and Quality EU Exit SI was amended by the Blood (Safety and Quality) (Amendment) (EU Exit) Regulations 2020.

Principles for working together

4. This agreement will ensure recognition of the economic and social linkages between Northern Ireland and Ireland and that Northern Ireland will be the only part of the UK which shares a land frontier with the EU. It will also adhere to the Belfast Agreement.

5. The parties affirm their mutual commitment to work together on the application of retained EU law in relation to blood safety and quality policy and their respective responsibilities. This cooperation is intended to give all parties the assurance that working relationships will be conducted in a manner that is both collaborative and helpful, aiming, where possible and appropriate, to achieve agreement on policy. In addition, all parties agree that regular contact will continue to discuss ongoing business of mutual interest.

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4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316157/MoU_between_the_UK_and_the_Devolved_Administrations.pdf

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/652285/Joint_Ministerial_Committee_communique.pdf

6. This Concordat is intended to provide the basis for the management and maintenance of a compatible minimum set of safety and quality standards by

setting out governance arrangements and a dispute resolution process. All parties to the Concordat agree that a Common Framework approach, that recognises the Common Frameworks principles agreed at JMC(EN) in 2017 and the finalised principles for intergovernmental relations, is highly desirable across the UK. The outcomes of the intergovernmental relations review are in the process of being implemented. Once confirmation has been provided from each government, the outcomes of the review and appropriate intergovernmental structures will be reflected in this Common Framework.

7. Open communications will be maintained and information shared, to the extent permitted by law, at the earliest opportunity. This may include but is not confined to policy issues, stakeholder views, preparations for and outcome of consultations and research, media interest and lines to take, and emerging issues and intelligence (UK/EU/international).

8. The parties acknowledge that there may be a need for their separate responsibilities to be tackled with uniformity. For example, events could transpire that would require urgent action (such as, but not limited to, responding to emerging diseases). Each party shall consider promptly and thoroughly any concerns raised by the others. Where all agree that consistency is needed, consultation on a common approach shall be undertaken.

9. The parties shall inform each other at the earliest opportunity of any new policy proposals, before they are made public, to allow full consideration and a common approach to be reached wherever possible. Each party will also appraise the others of the ongoing development of such proposals. Where this will not be possible, each party will inform the others as soon as possible.

10. The parties to this agreement commit to resolving any issues at the lowest possible level and recognise that agreement to disagree can be an acceptable outcome, provided the JMC(EN) Common Frameworks principles remain upheld.

11. Where common recommendations may be made, Ministers will retain the right to take individual decisions for their government. For those areas within the scope of the Blood Safety and Quality Common Framework, the opportunity for consistency of approach across governments will be sought in the first instance. The ability for divergence must be retained, while taking account of its impact on patient safety and confidence, and the functioning of the UK internal market. Every effort will be made at working level to resolve any disagreements in difference of approach. Where a consensus cannot be reached by these arrangements (whether that is agreement to a UK-wide approach or to accept divergence) the dispute avoidance and resolution mechanism would come into play.

Dispute avoidance and resolution

12. The goal of the dispute avoidance and resolution mechanism is to avoid escalation to formal processes through the appropriate intergovernmental structures, by resolving any disagreements at the lowest possible level. A disagreement between parties to this Framework becomes a ‘dispute’ when it enters the formal dispute avoidance and resolution process through the

appropriate intergovernmental structures.

13. This mechanism will only be utilised when genuine agreement cannot be reached, and divergence would impact negatively on the ability to meet the JMC (EN) Common Frameworks principles. In those areas where a common approach is not needed in order to meet these principles, an "agreement to disagree" could be considered an acceptable resolution.

Process

14. The below diagram (Figure 1) states the levels of escalation of a disagreement to a dispute and the interaction between each level.

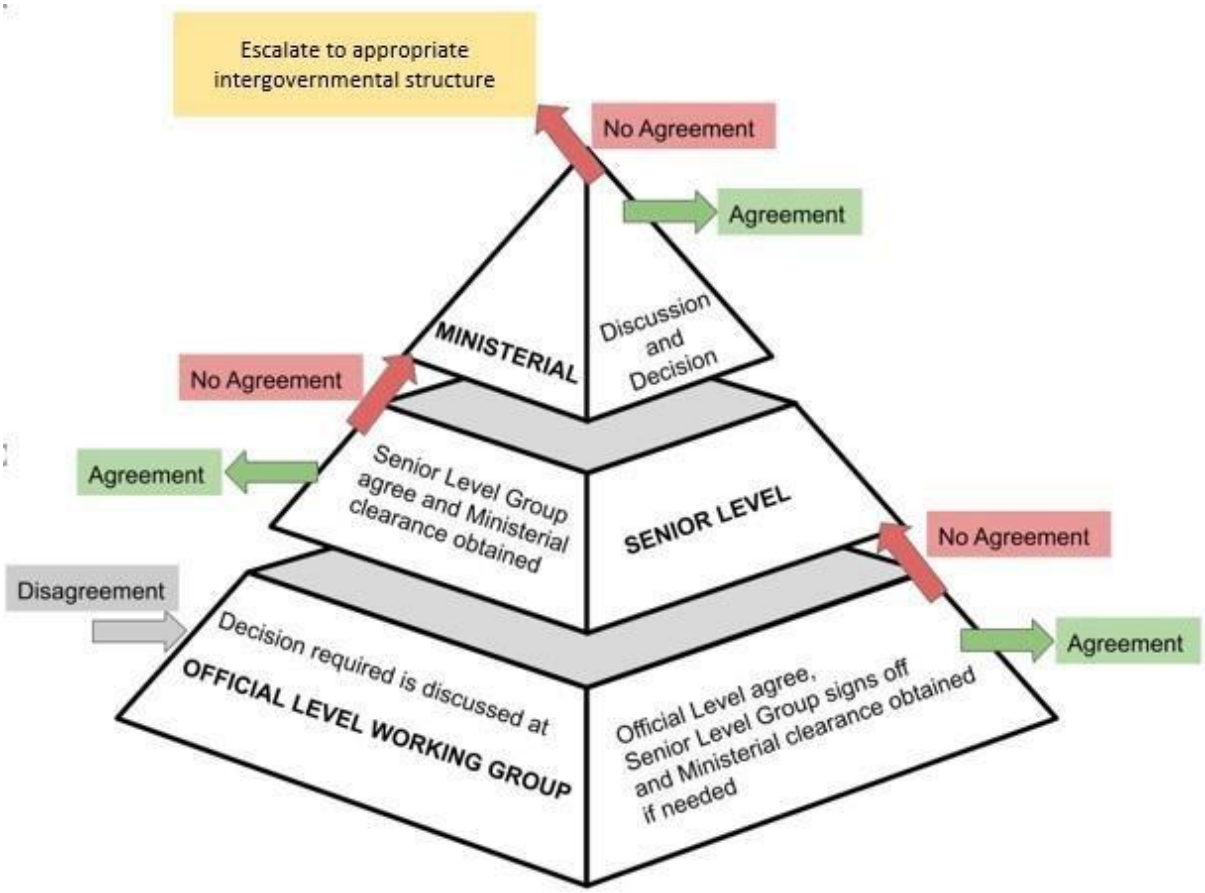

Figure 1: The levels of escalation for disagreements and disputes.

15. Following the approach set out in section 8 and 9 and Appendix II of the Blood Safety and Quality Common Framework and within the spirit of this Concordat, the all governments will seek every opportunity to resolve differences and reach agreement; either to recommend a UK-wide approach or to accept divergence, at official level through discussions.

16. Where it has not been possible to resolve any disagreement in approach at official level, this will initially be referred to Senior Officials for resolution.

17. Any continuing disagreement, which cannot be resolved at official level in the ways set out above, will be referred to Portfolio Ministers for resolution and as set out in the Blood Safety and Quality Common Framework. The parties may conclude, having considered potential impacts on patient safety and the JMC

principles and reflecting the appropriate intergovernmental structures, that divergence is appropriate.

18. As a last resort, where the above steps for resolving a disagreement have been unsuccessful, the issue will be escalated to the appropriate intergovernmental structures for resolution under the dispute resolution process set out in the appropriate intergovernmental structures.

Timescales for escalation

19. When a proposal is raised at official level, consideration will be given to the urgency of the proposal (i.e. how quickly a decision is required). This assessment will guide timescales for escalation of disagreement within the governance structure, with decisions requiring a more immediate resolution being escalated quicker.

Evidence gathering

20. At each stage further evidence may be requested from officials at the preceding level, or from stakeholders (listed below), before the disagreement is discussed.

Third parties

21. During policy development and dispute resolution, Medicines and Healthcare products Regulatory Agency (MHRA), the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) and the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) may be used to provide scientific or technical advice on the most appropriate ways to ensure the safety of blood for transfusion.

Official level meetings

22. **Official level blood safety and quality meetings:** All parties will continue to regularly share information with one another in relation to the scope of this agreement and will continue to discuss:

    - the impact of decisions on other governments, including any impacts on cross-cutting issues;
    - prospective policy changes;
    - emerging issues and intelligence etc.

23. As previously mentioned, Senior Official meetings will be convened to provide strategic direction and to discuss issues as appropriate where there is a dispute, either by meeting regularly or on an ad hoc basis. Senior Officials will then report to the relevant Ministers as necessary, to provide an update or to escalate an issue.

Review and amendment mechanism

Process

24. The Review and Amendment Mechanism (RAM) ensures the Framework can adapt to changing policy and governance environments in the future.

25. There are two types of review which are outlined below. The process for agreeing amendments should be identical regardless of the type of review.

26. The RAM relies on consensus at each stage of the process from the Ministers responsible for the policy areas covered by this non-legislative agreement.

27. Third parties can be used by any party to the Framework to provide advice at any stage in the process. These include other government departments or bodies, as well as external stakeholders such as non-governmental organisations (NGOs) and interest groups.

28. At the outset of the review stage, parties to the Framework must agree timelines for the process, including the possible amendment stage.

29. If agreement is not reached in either the review or amendment stage, parties to the Framework can raise it as a dispute through the Framework's dispute avoidance and resolution mechanism.

Review stage

30. An initial review will take place one year after the Framework comes into effect, it will be used to determine if the arrangements are functional.

31. Following the initial review, a periodic review of the Framework will take place every two years.

    - The period of two years starts from the conclusion of a periodic review and any amendment stages that follow.

    - During the periodic review, parties to the Framework will discuss whether the governance and operational aspects of the Framework are working effectively, and whether decisions made over the previous two years need to be reflected in an updated non-legislative agreement.

32. An exceptional review of the Framework is triggered by a 'significant issue':
    - A significant issue must be time sensitive and fundamentally impact the operation and/or the scope of the Framework.

    - The exceptional review may include a review of governance structures if all parties agree it is required. Otherwise, these issues are to be handled in the periodic review.

    - The same significant issue cannot be discussed within six months of the closing of that issue.

33. The amendment stage can only be triggered through unanimous agreement by Ministers. If parties agree that no amendment is required, the relevant time period begins again for both review types (for example, it will be two years until the next periodic review and at least six months until the same significant issue can trigger an exceptional review).

Amendment stage

34. Following agreement that all parties wish to enter the amendment stage, parties will enter into discussion around the exact nature of the amendment. This can either be led by one party to the Framework or all.

35. If an amendment is deemed necessary during either type of review, the existing Framework will remain in place until a final amendment has been agreed.

36. All amendments to the Framework must be agreed by all parties and a new non-legislative agreement signed by all parties.

37. If parties cannot agree whether or how a Framework should be amended this may become a disagreement and as such could be raised through the Framework's dispute avoidance and resolution mechanism.

38. Changes to the Framework and Concordat will be communicated to stakeholders via the current communication channels.

The Protocol on Ireland/ Northern Ireland

39. The Agreement on the Withdrawal of the United Kingdom from the EU sets out the current arrangements where, although remaining within the UK's custom territory, Northern Ireland will remain aligned with the EU. The following paragraphs of Annex 2 of the Northern Ireland Protocol are relevant to this framework.

    - *Paragraph 22 - substances of human origin.*

40. This Framework reflects the specific circumstances in NI that arise as a result of the Protocol and remains UK wide in its scope. As such decision making and information sharing will always respect the competence of all parties to the Framework and in particular the provisions in Article 18 of the Protocol on democratic consent in Northern Ireland.

41. Where one or more of UK Government, the Scottish Government or the Welsh Governments propose to change rules in a way that has policy or regulatory implications for the rest of the UK, or where rules in Northern Ireland change in alignment with the EU, the Framework is intended to provide governance structures and consensus-based processes for considering and managing the impact of these changes.

    - As rules evolve to meet the emerging regulatory needs of the UK, Scottish and Welsh Governments, this Framework will ensure the full participation of Northern Ireland in discussions such that the views of the relevant Northern Ireland Executive Minister(s) are taken into account in reaching any policy or regulatory decisions by the UK, Scottish or Welsh Governments.

    - Where rules in Northern Ireland change in alignment with the EU, the Framework will form the basis of a mechanism to ensure consideration by the four governments of any changes, and will enable them to determine any impacts and subsequent actions arising from these changes.

42. Where issues or concerns raised by the relevant Northern Ireland Executive Minister(s) in respect of GB-only proposals have not been satisfactorily addressed, they will have the right to trigger a review of the issue as set out in the dispute resolution process at section 13 of this document.

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Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Our Ref: MA/EM/3454/21

Russell George MS
Chair
Health and Social Care Committee

SeneddHealth@senedd.wales

6 December 2021

Dear Russell

National Health Service (Indemnities) (Wales) Act 2020

I am pleased to enclose the First Report on the Operationalisation of the Scheme for General Medical Practice Indemnity as at November 2021 in accordance with the commitment made during the passage of the Act through the Senedd in 2020.

Further Reports will be provided on an annual basis to the Committee.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Llywodraeth Cymru
Welsh Government

REPORT for the Health and Social Care Committee

First Report on the Operationalisation of the Scheme for General Medical Practice Indemnity

November 2021

Contents

1. The Scheme for General Medical Practice Indemnity - Future Liabilities Scheme (FLS)

1.1 On 1 April 2019, the Minister for Health and Social Services launched the Scheme for General Medical Practice Indemnity - Future liabilities Scheme (known as the GMPI). The discretionary GMPI Scheme is operated by NHS Wales Shared Service Partnership – Legal and Risk Services (NWSSP-L&R on behalf of the Welsh Ministers.

1.2 Guidance and support is provided for GPs in Wales and their employed or contracted staff, for actual or potential clinical negligence litigation arising from the provision of NHS Primary Medical Services. Some aspects of GP work are not be covered by the scheme, for which membership of a MDO remains necessary. Examples of such 'out-of-scope' activity includes private work, inquests, disciplinary issues, issues with the GMC or other Regulators and any non-clinical elements of Ombudsman referrals.

1.3 Nothing in the Scheme is intended to contradict other legal duties or professional obligations to which GPs and their staff may be subject. Furthermore, indemnity will not be withheld because a practitioner has taken reasonable action to comply with their ethical, professional or statutory obligations.

1.4. Full details of the Scheme and Guidance can be found here.

https://nwssp.nhs.wales/ourservices/legal-risk-services/areas-of-practice/general-medical-practice-indemnity-gmpi/

1.5 The GMPI guidelines and FAQs are regularly reviewed and revised as needed with GPs, Practice Managers and Health Boards advised of updates.

2. NHS Wales Shared Service Partnership – Legal & Risk Services

2.1 NWSSP–L&R is a team of in-house lawyers which has operated within the NHS in Wales for over 25 years, providing legal representation and legal advice for all of the health bodies in Wales. The team has specialist experience, knowledge and understanding of the legal, administrative and policy issues that affect the operation of the NHS in Wales. The team is particularly experienced in the management of clinical negligence claims having managed in excess of 15,000 such claims in the secondary care context since 2004.

2.2 NWSSP–L&R has achieved annual re-accreditation of the Lexcel Quality Assurance Standard since 2002 and the Customer Service Excellence Award since 2011.

2.3 NWSSP-L&R is committed to identifying and feeding back risk issues for learning and safety improvement in primary care and secondary care and has worked closely with NWSSP's Welsh Risk Pool service for over 25 years to ensure an integrated approach between claims management, reimbursement and the learning of lessons.

2.4 NWSSP-L&R has a dedicated Primary Care Clinical Negligence Team that operates both the Scheme for GMPI and the Existing Liabilities Scheme ("the GMPI Team"). The lawyers specialise in managing clinical negligence claims against GPs and GP Practice staff and work closely with NWSSP's in-house GP advisors for input on patient concerns and claims and for assistance with learning from events and training.

2.5 Since its inception in April 2019, the GMPI Team has been shortlisted as finalists in 3 external legal awards:

- The Law Society Awards 2021, shortlisted in the 'In-House Team of the Year' category;
- South Wales Law Awards 2021, Finalist in the 'Personal Injury (clinical negligence)' category – results awaited;
- Wales Legal Awards 2020, Finalist in the 'In-House Team of the Year' category.

2.6 In managing the scheme the GMPI Team currently:

- operate an email and telephone helpline used by GP Practice staff and Health Boards across Wales seeking information about indemnity arrangements and support with clinical negligence complaints/claims;
- handle clinical negligence claims brought against GP Practices in Wales;
- provide support to GP Practices by responding to patients' clinical concerns;
- seek input from in-house GP advisors;
- publish online FAQs which are regularly updated;
- provide bespoke virtual training to Health Boards and GPs/Practices/Trainee GPs across Wales. For example, tips for GP Referrals during COVID-19, effective handling of patient concerns, and the clinical negligence Legal Test, Case Studies, Confidentiality and Learning from Events in General Medical Practices.
- contribute articles to the Legal & Risk Newsletter sent to Health Boards and GP Practices.
- is integral to the robust learning from events process in General Medical Practice;
- meets regularly with other NWSSP divisions (including for example NWSSP Primary Care Services, NWSSP Employment Services and Welsh Risk Pool) and is a member of NWSSP's Primary Care Steering Group which has been set up to support sustainable primary care and

to contribute to the development and delivery of the primary care model in Wales.

3. Operation of the GMPI

3.1 During the launch year of the GMPI, the GMPI Team established their processes for implementing the scheme and created a programme for regular workshops / information sessions for Health Boards and GP Practices across Wales. Prior to the COVID-19 pandemic, the GMPI Team travelled across Wales with a roadshow, which delivered 19 training sessions/workshops about the new Scheme for GMPI, explaining how it would operate and included "question and answer" sessions. Originally provided on the traditional "face to face basis" these continue to be provided virtually.

3.2 The GMPI Team has provided and continues to provide a large amount of support to GP Practices and in September 2020 produced and circulated quick reference guides specifically aimed at GP Practices to resolve complaints at an early stage and to help avoid claims where possible. The guides reflect NHS Wales Putting Things Right (PTR) concerns procedure.

3.3 The GMPI Team regularly seek input from NWSSP's in-house GP medical advisors to assist with patient concern responses (and claims where appropriate) and feedback the GP advisors' comments and the suggested learning to GP Practices. The team has assisted GP Practices with over 210 patient concerns in the first 2 years of the Scheme and sought specific input from NWSSP's in-house GP medical advisors on around 50 matters. The GMPI Team also instruct independent medico-legal GP experts and other experts, as appropriate.

3.4 The GMPI Team has provided training to GPs, GP Practice Managers and Health Boards on handling patient concerns. The training is interactive supported by factual case studies. The training helps to prompt discussion and collaboration between the Health Board and GP Practice staff which is particularly beneficial in a scenario where a patient is critical of both the primary care and the secondary care received. If Practice staff would benefit from additional support from their relevant Heath Board, the GMPI Team is well placed to co-ordinate this from contacts in the Health Boards.

3.5 Training sessions are ongoing and include a mixture of legal, medical and practical points. Recent workshops / training sessions have included:

- April 2021 - Lunchtime Teams Webinar for GPs/ANPs on GMPI and 'Legalities of COVID with live Q&A', Woodland House Cardiff & Vale University Health Board;

- May 2021 - GP Trainees Half Day Teams Webinar which covered an introduction to NWSSP-L&R; the Scheme for GMPI, handling complaints, PTR the Clinical Negligence Legal Test, Case Studies, Confidentiality and Referrals. The team worked with the GP Training Team at Health Education and Improvement Wales (HEIW) to arrange and deliver this training, at which there were around 40 attendees;

- May 2021 - 2 x 1:15 hour informal and interactive concerns/complaints training sessions in for Swansea Bay University Health Board delivered by the GMPI team solicitors and an in-house GP. One session was tailored to GPs, Practice Managers and GP Practice staff and one for Health Board representatives. Approximately 70 individuals attended the sessions.

3.6 Through the support highlighted above, it is anticipated that early input by the GMPI Team with patient concerns will help to avoid clinical negligence claims in the longer term. However, it is recognised that some claims will, inevitably, be pursued, where for example, a Practice has made concessions or the claimant feels aggrieved and pursues the matter regardless of the merits of the claim. As at 31 March 2021, just 2 years after the introduction of the scheme, there had only been 2 patient concern matters, with which the Team had assisted, that developed into formal claims.

3.7 The GMPI Team has achieved good outcomes in FLS claims and received positive feedback from Health Boards and GP Practices. Feedback is obtained from GP Practices via 'Case Closure Client Satisfaction Questionnaires' that are issued at the end of an FLS claim. No responses had been received as at 31 March 2021, however, four responses have been received since in April and June 2021 and those responses indicated that the GP Practices were "Very Satisfied" with the overall management of the case and provision of advice. More information about the feedback received to date is set out in section 7 below.

3.8 The GMPI Team has led the successful defence of a claim at Trial. The claim brought against a GP Practice by a Litigant in Person who served court proceedings without notice. The damages sought by the claimant were low, but it was fundamental to defend the claim, supporting GP Practice staff who firmly disputed liability and to discourage similar unmeritorious claims. This was an example of the GP Practice, the Health Board and GMPI Team working together to manage a sensitive and difficult claim brought against a particular GP Practice.

3.9 NWSSP-L&R have a longstanding good working relationship and are in regular contact with Health Boards and NHS Trusts in Wales. There are systems in place for the Health Boards to feed back any questions or concerns about the GMPI. NWSSP's Medical Director attends the Heads

of Primary Care and Associate Medical Directors on a regular basis and is able to address any queries raised and feed back to the GMPI team.

3.10 The GMPI Team and NWSSP-L&R's Director also attend Health Board meetings to provide updates and discuss GMPI and learning from training / comms events that have been delivered. The GMPI Team have open lines of communication with GPC Wales and the RCGP and address queries as they arise in correspondence or via discussion.

3.11 Key Performance Indicators (KPIs) were introduced gradually as the new Scheme was implemented with the final KPIs relating to timelines (set out below) in place from October 2020. The initial target was to meet 90%of the KPIs increased to 93% in the year 2021-22. To date, the Team has achieved 100%.

The KPIs require the GMPI Team to:

(1) Review a new matter and inform the GP of whether the matter is in scope of GMPI within 3 working days of receipt of relevant information or as agreed; and

(2) Report to the Health Board and GP with NWSSP-L&R's file reference and case handler, decision on indemnity, next steps, within 10 working days of receipt of relevant information or as agreed.

3.12 During 2021, the GMPI Team will agree further key performance indicators that will be used to inform and complement the service level information and provide added assurance on value for money, efficiency gains and long-term sustainability of the service. KPIs relating to learning from events will be included within the suite. These will be in place by April 2022.

3.13 The GMPI Team look at ways to improve ways of working and to maximise efficiencies and effectiveness in how they operate resources. To this end, a new case management system will be developed during 2021-22 within NWSSP-L&R which will be flexible to meet the GMPI team needs and will support further monitoring of the KPIs.

4. Learning from events and improving patient safety - integrating with Welsh Risk Pool

4.1 NWSSP's Welsh Risk Pool service administers the risk pooling arrangement for losses arising against NHS bodies that was established in 1996 i.e. for clinical negligence claims relating to secondary care.

4.2 Where a settlement is negotiated or an adverse judgment is handed down at Trial in an FLS claim, the relevant Health Board will pay the damages and costs due to the claimant. The Health Board then seeks reimbursement of the monies paid from the Welsh Risk Pool by working

with the GP Practice to complete a Learning from Events Report. Welsh Risk Pool reimbursement requires clear evidence of effective learning from any mistakes or omissions that gave rise to the complaint, whether or not liability has been admitted. All Learning from Events Reports are scrutinised by a national panel which is drawn from experienced case handlers and clinicians. Staff from the Primary Medical Care Advisory Team (PMCAT) are invited to participate in panel discussions. To provide further primary care expertise, primary care clinicians are invited to participate within the panel process.

4.3 The decision to appoint NWSSP L&R as the scheme operator for the Wales state backed GP indemnity Scheme has enabled shared learning between primary care and secondary care on an "All Wales" basis for the first time. This co-ordinated approach to learning from events enhances the working relationship between the GP Practices and Health Boards with a particular focus on working together to agree and implement actions to improve patient safety.

4.4 The GMPI Team has worked with Welsh Risk Pool and NWSSP's in-house GP advisors/ PMCAT to develop and implement a tailored process for learning from events in primary care GP matters – including shared learning between primary and secondary care on an All Wales basis. Part of the procedure requires GP practices to commit to undertake any improvements identified and the Health Boards to monitor and verify the identified improvements. This training is being delivered across Wales.

4.5 To date, the GMPI Team has provided practical 'hands on' guidance to the GP Practices and Health Boards who are going through the "learning from events" procedure on claims. On a broader level, the team has met the Heads of Primary Care and Associate Medical Directors from Health Boards in Wales, presented at the Claims Management Safety & Learning Network Meeting and at the Heads of Patient Experience (HOPE) Network meeting and delivered an informal webinar to Betsi Cadwaladr University Health Board. These sessions were a useful way for GP Practice staff to meet the Health Board Local Claims Managers and Health Board clinical governance teams who will be required to work together in the claims and learning from events process.

4.7 On a practical level, in the Learning from Events Report, Health Boards report the issues that have been identified from a clinical claim and set out the actions taken to address the issues to reduce the risk of reoccurrence or reduce the impact of a future event. The Welsh Risk Pool monitors the themes and trends associated with the issues that are the subject of learning reports. The GMPI Team also monitor themes and trends arising out of patient concerns in order to feedback information to the Welsh Risk Pool for dissemination, for example in Welsh Risk Pool's newsletter and to highlight specific areas for training.

4.8 It is hoped that this additional support service around learning from events will help to prevent claims arising against Practices and Health Boards in the first place.

5. The Coronavirus Pandemic

5.1 The UK Government in consultation with the devolved nations developed the Coronavirus Act 2020 which gained Royal Assent on 25 March 2020. Clinical negligence indemnity relating to the pandemic in Wales is included at Section 11 of the Act.

5.2 The legislative mechanism underpinning the GMPI scheme enabled the Welsh Government to quickly establish emergency coronavirus indemnity. Furthermore NWSSP-L&R were able to make use of their communication channels to all GPs and GP practices in Wales to supplement the messaging from Welsh Government regarding the emergency actions being taken, thereby helping to maintain confidence for GPs and wider Primary Care.

5.3 NWSSP-L&R set up a dedicated Covid Hub led by a senior lawyer to deal with any queries on Covid indemnity. The GMPI Team also assisted GP Practices throughout the pandemic by answering queries surrounding indemnity and the implementation of the COVID vaccination rollout. The Team contributed to NWSSP's Guidance on Indemnity Arrangements during the Coronavirus Pandemic document which was initially produced at the start of the pandemic.

5.4 NWSSP-L&R has created a specialist COVID-19 legal team to deal with PTR matters and claims relating to COVID-19. The GMPI Team links in with the Covid19 Team on a regular basis to ensure consistency of advice and share best practice.

6. The Existing Liabilities Scheme

6.1 Under the Existing Liabilities Scheme, the Welsh Ministers assumed the historic clinical negligence liabilities (i.e., those that pre date 1 April 2019) of Wales's GPs from participating MDOs. The aim was to ensure stability in the market for clinical negligence and maintain alignment with England thereby ensuring Ps in Wales were not disadvantaged in comparison with GPs in England. The ELS is subject to completion of due diligence and negotiation with the MDOs. Satisfactory ELS arrangements have been concluded with the Medical Protection Society and the Medical and Dental Defence Union of Scotland.

6.2 Detailed guidance on the ELS is available here.

https://nwssp.nhs.wales/ourservices/legal-risk-services/legal-risk-services-documents/general-medical-practice-indemnity-gmpi-docs/scheme-guidelines/

The indemnity provided under the ELS is of a discretionary nature (in the same way as the GMPI) and relates to claims for clinical negligence that relate to any incident giving rise to a claim that predates 1 April 2019. Details as to eligible and non-eligible areas are the same as the GMPI. The GP remains the named Defendant in the ELS Scheme.

6.3 The GMPI Team handle the ELS claims under an 'ELS Scheme of Delegation' approved by Welsh Government, the Trust Board at Velindre University NHS Trust and which is approved and overseen by NWSSP's Senior Leadership Group (SLG).

6.4 Whilst there have been discussions, no agreement has been reached with the Medical Defence Union (MDU) on an ELS. At present, a GP or clinician who was an MDU member at the relevant time would continue to contact the MDU for advice.

7. Customer Satisfaction and Stakeholder Interaction

7.1 Feedback is obtained from GP Practices via 'Case Closure Client Satisfaction Questionnaires' that are issued at the end of an FLS claim. To date, all responses received indicate that the GP Practices were "Very Satisfied" with the overall management of the case/ the provision of advice giving the GMPI Team a rating of 5 out of 5 on the claims it has concluded to date.

7.2 In order to further inform this report and to obtain general feedback to help NWSSP-L&R improve the way it delivers it services, the GMPI team issued a short (anonymous) GMPI Client Satisfaction Survey (GP Survey) to all GPs, Locum GPs and GP Practices in Wales in May 2021, this was followed up to include those who had assisted in relation to GMPI FLS / ELS clinical claims and patient PTR concerns to gain a broader response rate. Overall, 82 responses were received, half of the people that responded had not had any previous contact with the GMPI Team.

7.4 The table below sets out the average star ratings received from GP Practice Staff and GPs (including locum GPs) in relation to NWSSP-L&R's assistance with GMPI FLS / ELS clinical negligence claims and PTR patient concerns:-

	Average star rating for how satisfied with the service received the GMPI team 5 = very satisfied 1 = very dissatisfied	Average star rating for how easy it is to contact the GMPI team 5 = very satisfied 1 = very dissatisfied	Average star rating for how satisfied with GMPI response times 5 = very satisfied 1 = very dissatisfied
NWSSP-L&R assistance with FLS / ELS clinical negligence claim	4.6 74% rated 5 16% rated 4 5% rated 3 5% rated 2 0% rated 1	4.7 85% rated 5 5% rated 4 5% rated 3 5% rated 2 0% rated 1	4.5 68% rated 5 21% rated 4 0% rated 3 11% rated 2 0% rated 1
NWSSP-L&R assistance with FLS / ELS patient concern under PTR	4.6 66.66% rated 5 26.66% rated 4 6.66% rated 3 0% rated 2 0% rated 1	4.4 53.33% rated 5 33.33% rated 4 13.33% rated 3 0% rated 2 0% rated 1	4.2 53.33% rated 5 13.33% rated 4 33.33% rated 3 0% rated 2 0% rated 1

7.5 The GMPI team received additional comments relating to its assistance with FLS and ELS claims / concerns as follows:

- *The GMPI service have been very supportive and prompt when requesting their help and advice*. (Practice Manager)
- *Always really helpful and advice has been sound and delivered in a timely manner*. (Practice Manager)
- *Very professional and helpful.* (Practice Manager)
- *Very good communication.* (Practice Manager)

- *Good service received.* (GP)

- *Excellent, timely response and thorough details provided* (Practice Manager)

- *We had got* [an MDO] *to read our response to the patient concern and when submitted to the GMPI the letter was altered and made I felt far more 'legalise' language, less understanding and more aggressive/defensive in tone which I felt was a shame.* (GP)

- *I have found the service to be excellent. The staff have all been very informative and helpful with a very friendly and approachable manner. Turnaround times are very quick from our perspective.* (Practice Manager)

- *Very helpful and timely responses* (GP)

- *Had problem with potential complaint and advice ensured that it was not taken further. Very satisfactory outcome and prompt response* (Practice Manager)

- *The adviser who I spoke to was very helpful, informative and reassuring. He dealt with my call within an hour of me contacting the service, which I thought was excellent.* (Locum GP)

- *We are having complaints handling training later this month from the Health Board* (GP)

- *Very supportive - plain English used when providing guidance.* (Practice Manager)

- *Good and thorough legal advice BUT long drawn out process which took us beyond deadline to answer complaint and as such i feel risked making the patient more annoyed (at US as GPs for being slow when in truth we were waiting on GMPI)* (GP)

- *Very good communication* (Practice Manager)

- *Always receive professional guidance from your knowledgeable advisers* (Practice Manager)

- *Recently had the complaint handling webinar, very well presented, tips on record keeping would help proactively* (GP)

7.6 The GP Survey showed there was a keen interest in further training including tips for handling patient concerns; a practical overview of the Scheme for GMPI; practical tips for record keeping and safety netting. The GMPI Team have already provided training on handling patient concerns and have further training planned.

7.7 Going forward the GMPI team will have an annual training programme, which will include the training topics set out above as well as GMPI refresher courses and learning from events. During 2021-22 the team will also develop a new communications plan with both stakeholders and ongoing communications. This will include looking at easier ways for GP Practices and other stakeholders to contact the GMPI Team.

7.8 The GMPI Team's training to GPs, GP Practices, GP trainees and Health Boards has received a good response from stakeholders. For example, training has been described as: excellent; relevant and useful content; delivered effectively; really informative and supportive. There were suggestions for some training to be slightly shorter; for small handouts and for more training to include case examples/factual examples (case studies were added to subsequent training).. Updated Quick Reference Guides to assist with responding to patient concerns were also prepared and sent to GP Practices regarding the:

(1) GMPI The Putting Things Right PTR Concerns Procedure Feb-2021
(2) GMPI Responding to Concerns under NHS Wales Putting Things Right PTR Feb 2021

7.9 Positive comments have been received to date from Health Board Primary Care colleagues and the Health Board Patient Experience/PTR Team contacts thanking the team for their advice and clarity; for help with matters and cases and for useful training e.g. on GMPI and Learning from Events in General Medical Practice.

8. Looking to the Future

8.1 The introduction of the GMPI has been a positive step for GPs and NHS Wales enabling lessons to be learnt and shared across primary and secondary care thereby supporting better patient care whilst GPs continue to be robustly defended against clinical negligence claims. It has addressed the risks associated with the rising costs of clinical negligence indemnity premiums. It contributes towards the long term sustainability of the provision of general medical service, ensuring that GP recruitment and cross border activity will not be adversely affected by different schemes operating in England and Wales.

8.2 The FLS set up phase is complete with processes embedded and adhered to. GP Practices and Health Boards are using the GMPI helpline and utilising the GMPI team with complex patient concerns to request assistance. The FLS claims are increasing and good results have been achieved to date with GP Practices reporting back that they were very satisfied with the GMPI Team's assistance in those claims.

8.3 The ELS files have been successfully transferred to NWSSP-L&R and are now being managed on a day to day basis by NWSSP-L&R in accordance with the ELS processes put in place.

8.4 Given its history, experience and in-depth knowledge of the NHS in Wales, NWSSP-L&R is uniquely placed to perform the role of operator of the two indemnity schemes for GPs in Wales. Going forward, the GMPI Team will continue to work with Welsh Risk Pool and GP in-house advisors/PMCAT to identify and feedback risk issues for learning and safety improvement in Primary Care whilst continuing to defend GPs against claims for clinical negligence.

8.5 The GMPI Team will continue to work closely with GP Practices, Health Boards and NHS Trusts to promote closer links and collaboration between primary care and secondary care to help to improve patient safety.

Y Pwyllgor Deddfwriaeth, Cyfiawnder a'r Cyfansoddiad
—
Legislation, Justice and Constitution Committee

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Russell George MS
Chair, Health and Social Care Committee

8 December 2021

Dear Russell

UK/Switzerland: Convention on social security coordination

As outlined in our letter of 9 November 2021 we considered the UK/Switzerland: Convention on social security coordination at our meeting on 1 November 2021.

Following the meeting we also wrote to the First Minister to seek further information on number of issues in relation to the Convention. We considered the First Minister's response at our meeting on 29 November 2021 and agreed to share the response with you for information.

Yours sincerely,

Huw Irranca-Davies

Huw Irranca-Davies
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

Y Gwir Anrh/Rt Hon Mark Drakeford AS/MS
Prif Weinidog Cymru/First Minister of Wales

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health and Social Care Committee
Cardiff Bay
Cardiff
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14 December 2021

Dear Chair

I am writing in respect of the arrangements for the upcoming UK-wide COVID-19 Public Inquiry, which is expected to commence in spring of 2022.

You will be aware of the public statement from the UK Government that a Chair to the Inquiry will be announced before Christmas and when that person is announced, we expect information on the Terms of Reference to follow swiftly afterwards. There will be a consultation on the Inquiry Terms, anticipated during the early part of 2022. I am keen that every opportunity is taken to shape the inquiry so the voices and experiences of the people of Wales play a significant part in the public inquiry from the very start.

I would find it helpful to understand what plans the Committee may have to engage more broadly and provide reflections on the Terms of Reference when the public consultation takes place.

Yours sincerely

Mark Drakeford

MARK DRAKEFORD

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Y Pwyllgor Iechyd a Gofal Cymdeithasol
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Health and Social Care Committee

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Mr Emrys Elias
Chair
Cwm Taf Morgannwg University Health Board

16 November 2021

Dear Emrys

Follow up questions after post-appointment scrutiny session on 4 November 2021

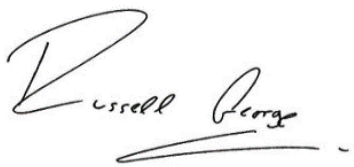
Thank you for attending the post-appointment scrutiny session on 4 November 2021. We welcomed the opportunity to discuss your key priorities for the role and how you plan to address some of the longer term issues facing the health board.

During the session, you agreed to write to the Committee to explain:

1. How you intend to improve information sharing and communication with patients.
2. How you will improve services for the local population in the Cwm Taf region, especially those who are hardest to reach, and generally have lower levels of fitness or experience poorer health outcomes.

It would be helpful if you could provide us with this information by Monday 13 December 2021.

Yours sincerely



Russell George MS

Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Your ref/eich cyf:
Our ref/ein cyf: EE/GG
Date/Dyddiad: 13 December 2021
Tel/ffôn: [redacted]
Fax/ffacs:
Email/ebost:
Dept/adran: Chair and Chief Executive

Russell George MS
Chair
Health and Social Care Committee
Welsh Parliament
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Dear Russell,

Follow up questions after post-appointment scrutiny session on 4 November 2021

Further to your letter dated 16 November, please see responses to your questions.

1. **How you intend to improve information sharing and communication with patients**

   As a public health organisation in a global health crisis, staff, patients and communities have turned to CTMUHB as a trusted source of information about the pandemic throughout 2020 and this has continued throughout 2021. We will continue to fulfil our 'warning and informing' obligations under the Civil Contingencies Act duties, whilst using a compassionate yet authoritative communications and engagement approach that will enable us to continue to improve the trust and confidence between CTMUHB, its staff, patients, communities and stakeholders throughout winter 2021/22

   Communications and Engagement will continue in much the same way it has done throughout the pandemic which has seen all owned channels (i.e. website and all socials)maximised and used heavily by staff, public, patients and stakeholders.

   Outlined below, are some of the ways in which we have continued to improve the way in which we communicate and engage with patients and public;

   - Patient and public-facing information will continue to be published on the CTMUHB website and social media channels which also includes sharing content from Public Health Wales and Welsh Government to reinforce the critical messages for public safety.
   - From the very start of the pandemic, a closer working arrangement has been established between our Health Board's communications team and those in the local authorities which enabled coherent and co-ordinated efforts that reflected localised issues whilst maintaining the central public safety messaging.

- This has been developed further when we commissioned an external agency specialising in behavioural science on behalf of our Health Board and three local authorities. This partnership work included the research, planning and delivery of a staff and public digital campaign to cut through the vast Covid-19 'social noise' when Covid-related messaging fatigue became evident. Engagement on this campaign has been extensive with partners and stakeholders and the results were very positive.

2. **How you will improve services for the local population in the Cwm Taf region, especially those who are hardest to reach, and generally have lower levels of fitness or experience poorer health outcomes.**

Under the Leadership of Professor Kelechi Nnoaham, Executive Director of Public Health, the Local Public Health Team has been leading on work to address inequalities in health in the population served by the Health Board and across the local system. There are a number of key pieces of work that will support this programme of work, including those listed below:

CTM is leading the Population Health Management Pilot for Wales
Population health as an approach seeks to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across whole populations. At the core of this approach is the goal of improving health outcomes for whole populations, not just for those seeking care, while paying attention to the distribution of those outcomes within the population. One of the key pillars of population health is person-centred integration of health and care systems, a reflection of the need to reduce fragmentation of care around the growing numbers of patients with multiple long-term conditions. Person-centred care is however not feasible if, in population health policy terms, it implies developing care pathways unique to every individual in the population.

Population segmentation, which involves grouping populations on the similarity of one or more proxies of health needs, potentially allows definition of population groups for whom integrated and tailored health and care interventions across the continuum of care. Risk Stratification and segmentation defines individuals most likely to benefit. Current systems of health & care categorise populations by: (1) the disease conditions they have, or (2) the kind of services they utilise at a point in time, e.g. non-elective admissions, primary care attendances etc. This categorisation does not respond efficiently to need, it creates waste and gaps. For example, about 25% of admissions from accident and emergency (A&E) do not require admission; they have accessed a service they do not need (waste). At the same time, mortality from cardiovascular disease (CVD) is higher in populations with the least access to preventative health care (gaps). Waste and gaps can be reduced (thus improving population health and reducing health disparities) by tailoring health and care services more closely to the needs of populations. This is what segmentation aims to achieve.

The pilot involves assessing data across the Health Board particularly in primary and secondary care for the entire population of CTM and grouping similar patients into these segments to ensure that appropriate services from prevention to treatment pathways can be tailored to each of these groups. It can identify patients, for example, that are at risk of emergency admission due to frailty and work, in particular with GP practices to identify these patients and provide pre-emptive assessment, treatment, care and services to prevent exacerbations.

Patients from each of these groups or segments will also be involved in designing new services, closer to home where possible. The data analysis and assessment is currently underway and we plan to work with our GPs next year to take this work forward.

Population Health Organisation
CTMUHB has committed to maximise opportunities to be a Population Health Organisation. The vision of the Health Board – becoming known as a population health organisation that works with its communities and partners to improve health and wellbeing - is already set out in key strategic planning documents. To move this from a concept to a tangible outcomes the Health Board has agreed population health goals as it ensures that the organisation is clear with itself and partners exactly what it is seeking to achieve by pursuing specific actions and how it will hold itself to account for delivering on the ambitions. It includes 37 projects to achieve this including clear population health outcomes and targets to improve health and reduce inequalities; improving care quality for key causes of inequalities e.g. cancer, cardiovascular disease, diabetes, stroke and mental health, becoming a health promoting organisation for staff and patients, combining the integration of health and care services with a population health approach and functioning as an anchor institution for our places and communities.

Early Years Vulnerability profiling – this is a pioneering approach sharing data across health, local authority and police to identify children at risk of poor outcomes and target family interventions as early as possible.

Investing in programmes of work to identify risk factors for the development of disease with support services for prevention and early intervention, including:

a. Inverse Care Law programme
b. Pre-diabetes screening programme
c. Health Weights
d. Inequalities in Covid Vaccination uptake
e. Inequalities in colorectal screening uptake

I hope this provides some reassurance that addressing inequalities is a high priority within CTMUHB and with partner organisations.

Yours sincerely,

Emrys Elias
Cadeirydd/Chair

Y Pwyllgor Iechyd a Gofal Cymdeithasol

–

Health and Social Care Committee

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Eluned Morgan MS
Minister for Health and Social Services
Welsh Government

22 November 2021

Dear Eluned

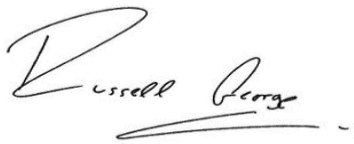
Public appointments process

Further to my letter of 28 October, the Committee held a useful and informative scrutiny session with Emrys Elias on 4 November 2021. Whilst we appreciate that the Committee held no formal role in the appointment of Mr Elias as interim Chair of Cwm Taf Morgannwg UHB, Members welcomed the opportunity to explore with Mr Elias how he intends to lead the health board, and what his priorities are.

Following the session, Members agreed to write to you with follow up questions, which are outlined in the annex to this letter. The Committee is aware that a number of similar vacancies are likely to arise during the Sixth Senedd, and would particularly welcome assurance that the public appointments process and associated Welsh Government Diversity and Inclusion Strategy for Public Appointments in Wales will ensure that the roles attract sufficient pools of high quality and diverse candidates.

We would be grateful for a response by 06 January 2022.

Yours sincerely



Russell George MS

Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Annex: follow up questions after scrutiny session with the interim Chair of Cwm Taf Morgannwg UHB on 4 November 2021

Following the post-appointment scrutiny session with Emrys Elias, interim Chair of Cwm Taf Morgannwg UHB, we would be grateful if you could provide information on the following areas. We would be grateful to receive your response by Thursday 6 January 2022.

Public appointments process

In March 2020, the Health, Social Care and Sport Committee of the Fifth Senedd held a pre-appointment hearing with the Welsh Government's preferred candidate for the role of Chair of Swansea Bay UHB. In its subsequent report, the Committee expressed disappointment that the advertising process for such a prominent position had needed to be re-run due to a lack of suitable candidates. It recommended that the Welsh Government should consider expanding the range of platforms or outlets with which notices were placed in an attempt to reach a wider audience and potentially attract a more diverse field of candidates.

1. An interim arrangement has been needed on this occasion because the substantive process failed to identify a suitable appointee to the Chair of Cwm Taf Morgannwg UHB. We would therefore be grateful if you could outline how you will ensure in future that similar roles attract a diverse range of high quality candidates, including what contribution will be made by the Welsh Government's Diversity and Inclusion Strategy for Public Appointments in Wales.

2. We would also welcome further information on the Welsh Government's approach to succession planning for senior leadership positions in the NHS in Wales.

Interim appointments

3. Whilst the Committee has no formal role in respect of interim public appointments, we would nevertheless welcome further information about how the Welsh Government makes such appointments, including how decisions are taken on the specification and duration of the role, and what factors are taken into account when identifying interim appointees.

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair, Health and Social Care Committee
Welsh Parliament

21 December 2021

Dear Russell,

Public appointments process

I write in response to your letter of 22 November 2021 sent following the scrutiny session with Emrys Elias, Interim Chair of Cwm Taf Morgannwg University Health Board, on 4 November.

I share the disappointment of the Committee in attracting individuals of a high calibre to apply for these very important roles which has led, in this case, to an interim appointment.

The need to ensure successful recruitment is even more important as the NHS continues to face the challenges presented by Covid-19. Action being taken in response to the Committee's observations and recommendations are outlined in the attached annex.

Yours sincerely,

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Annex: Response to follow up questions after scrutiny session with the interim Chair of Cwm Taf Morgannwg UHB on 4 November 2021.

Public appointments *process*

In March 2020, the Health, Social Care and Sport Committee of the Fifth Senedd held a pre-appointment hearing with the Welsh Government's preferred candidate for the role of Chair of Swansea Bay UHB. In its subsequent report, the Committee expressed disappointment that the advertising process for such a prominent position had needed to be re-run due to a lack of suitable candidates. It recommended that the Welsh Government should consider expanding the range of platforms or outlets with which notices were placed in an attempt to reach a wider audience and potentially attract a more diverse field of candidates.

1. *An interim arrangement has been needed on this occasion because the substantive process failed to identify a suitable appointee to the Chair of Cwm Taf Morgannwg UHB. We would therefore be grateful if you could outline how you will ensure in future that similar roles attract a diverse range of high quality candidates, including what contribution will be made by the Welsh Government's Diversity and Inclusion Strategy for Public Appointments in Wales.*

2. *We would also welcome further information on the Welsh Government's approach to succession planning for senior leadership positions in the NHS in Wales.*

Response

Question 1

- The Welsh Government is committed to undertaking public appointment exercises through fair and open competition in accordance with the Governance Code on Public Appointments. The Welsh Government has taken steps to extend the reach of public appointment publicity activity including targeting and engaging with diverse audiences. Public appointments are routinely advertised through online diversity platforms, and publicity is agreed with the Health and Social Services Group and tailored to an appointment campaign. All public appointments are shared with a diverse range of stakeholder organisations and individuals including those who informed the Welsh Government Diversity and Inclusion Strategy for Public Appointments. In addition, for some of the most significant chair appointments, the merits of using Executive Search consultants with experience of engaging with a wide and diverse field of candidates continues to be explored, and has been adopted for some recruitment exercises over the last 12 months.

- Executive Search consultants will be engaged to assist with the campaign for the Chair of the Welsh Ambulance Services NHS Trust, commencing early in the new year. The brief will require them to identify suitable candidates, paying particular attention to the Welsh Government's Diversity and Inclusion Strategy for Public Appointments. The effectiveness of this approach on the quality and quantity of candidates who subsequently apply for the role will be evaluated to help inform whether this approach should also be followed when recruiting future Chair's to NHS bodies in Wales.

- To further ensure the standards within Governance Code is maintained, at the beginning of 2021, the Welsh Government recruited a cohort of Senior Independent Panel Members to join the recruitment panels of the most significant public appointments. Members are drawn from a range of backgrounds, including protected groups - they have been invaluable in sharing their skills and perspectives on a number of recruitment campaigns this year.

- In early 2022, following a commitment to the Diversity and Inclusion Strategy for Public Appointments, two development programmes will commence initially aimed at disabled people and people from Black, Asian, Minority Ethnic communities. This will include a Near Ready Leadership Programme and a Leaders of the Future Programme. The programmes are aimed at showcasing public appointment opportunities along with developing and supporting individuals to apply for public appointments.

Question 2

I recognise the need to do more in relation succession planning for senior leadership positions and have agreed a Task and Finish Group, chaired by the Mark Polin, Chair of Betsi Cadwaldr University Health Board, be established. The remit of the Group includes the arrangements for public appointments to Boards, development of public appointees and succession planning. The group has representation from NHS Wales Independent Members and Welsh Government officials and will hold its first meeeting in January 2022. The Group will be time-limited and recommendations will be made within 6 months of establishment.

Interim appointments

- *Whilst the Committee has no formal role in respect of interim public appointments, we would nevertheless welcome further information about how the Welsh Government makes such appointments, including how decisions are taken on the specification and duration of the role, and what factors are taken into account when identifying interim appointees.*

Response

- The Welsh Government makes ‘interim public appointments’ without competition as a last resort in the majority of cases. These appointments are made by exception, under section 3.3 of the Governance Code on Public Appointments and must be agreed by the Commissioner for Public Appointments and Welsh Ministers. The appointments are most often made where it has been challenging to identify a suitable candidate through an open recruitment exercise, or where specific knowledge and expertise is required. Any consideration of the most suitable candidate will vary in order to reflect the nature of the appointment and the skills and expertise being sought. Appointments without competition are made for no more than 18 months, with a commitment to running a full and open recruitment exercise thereafter.

- When seeking an interim appointment the role specification is consistent with that of a substantive appointee. For this particular appointment the person specification and role profile had been agreed prior to advertising the role.

- When identifying potential appointees the Minister will take account of advice from officials on the required skills , experience and availablility to take up the post.

- Prior to agreeing the duration of an interim appointment it is necessary to consider a range of factors such as, the need to ensure stable leadership, the availability of the interim appointee and the time required to run and plan a successful campaign. As indicated above appintments without competition are made for no more than 18 months.

Y Pwyllgor Deddfwriaeth, Cyfiawnder a'r Cyfansoddiad
—
Legislation, Justice and Constitution Committee

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Chair, Children, Young People, and Education Committee
Chair, Climate Change, Environment, and Infrastructure Committee
Chair, Committee for the Scrutiny of the First Minister
Chair, Culture, Communications, Welsh Language, Sport, and International Relations Committee
Chair, Economy, Trade, and Rural Affairs Committee
Chair, Equality and Social Justice Committee
Chair, Finance Committee
Chair, Health and Social Care Committee
Chair, Local Government and Housing Committee
Chair, Public Accounts and Public Administration Committee

21 December 2021

Dear Chair

Inter-Institutional Relations Agreement

Last week our report on the Inter-Institutional Relations Agreement between Senedd Cymru and the Welsh Government was noted by the Senedd.

I would like to draw your attention to this report, which includes the Agreement.

The Agreement represents the agreed position of the Senedd and the Welsh Government on the information that the Welsh Government will, where appropriate, provide to the Senedd with regard to its participation in formal, ministerial-level inter-governmental meetings, agreements, concordats, and memorandums of understanding.

The Agreement is intended to support the Senedd's capacity to scrutinise Welsh Government activity

and to hold the Welsh Ministers to account in the intergovernmental arena. It therefore may be of interest to you in any future scrutiny work that you undertake.

Yours sincerely

Huw Irranca-Davies
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.
We welcome correspondence in Welsh or English.

Agenda Item 3.14

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

Gofal Cymdeithasol Cymru
Social Care Wales

Date: 16th December 2021

Russell George MS
Chair, Health and Social Care Committee

(By email only)

Dear Russell,

Thank you for the Health and Social Care Committee's correspondence, dated 23rd November 2021, requesting further information following our attendance at the evidence session of the Health and Social Care Committee on the 4th November.

As requested, we attach a written paper on behalf of both organisations, setting out our responses to the areas of additional information requested

If there is anything more you need then please get in touch.

Yours sincerely,

Alexandra Howells

Chief Executive

Health Education and Improvement Wales

Sue Evans

Chief Executive

Social Care Wales

1. **We discussed with you the impact of the pandemic on clinical placements and the ability of healthcare students to gain sufficient skills in clinical practice. Where access to clinical placements may have been restricted by the pandemic, for example in respect of dentistry, do we have assurance that newly-qualified practitioners have been able to gain the skills and experience to practice safely?**

   We do have assurance that newly qualified practitioners have been able to gain the skills and experience to practice safely. Health Education and Improvement Wales (HEIW) has been working with key university and placement provider partners throughout the pandemic to ensure our healthcare students continue to meet the proficiencies required of their professional programmes. These requirements are overseen through robust practice supervision and assessment processes that must meet regulatory standards. HEIW has continued to undertake contract monitoring with each university delivering healthcare programmes to review timely completion dates for all commissioned programmes.

   From the outset of the pandemic, HEIW set up an All-Wales Placement Reference Group comprising all University programme leads and education leads from all Health Boards in Wales. This group enabled timely intelligence on emerging academic and placement issues arising across nursing, allied health profession and healthcare science programmes. Group outcomes and issues were also reported through an internal HEIW Education and Training Cell. HEIW has been able to coproduce a wide range of organisational principles, position statements and wider learning resources through the All-Wales Placement Reference Group to support students to continue their programme journeys to the point of registration. This included university and placement providers facilitating placement learning opportunities that enabled students to achieve learning outcomes notwithstanding pandemic conditions which also included an initial student deployment period.

   In collaboration with university and placement provider partners, work has been directed to maximise existing placement capacity and to develop innovative placement capacity solutions. Through contract monitoring and application of a range of quality metrics, HEIW has been assured of robust and transparent supervision and assessment of students meeting relevant professional regulation standards, in terms of enabling achievement of proficiencies and fulfilling requirements for programme hours. Students are assessed on their proficiency and professional attitudes in each placement and during academic time by allocated supervisors, educators and assessors, and this includes a requirement for confirmation of progression at set points during a programme. HEIW also funds Practice Education Facilitators who are involved in all aspects of the quality management and assurance of students' practice learning.

   HEIW is assured that all nursing, midwifery, allied health profession and healthcare science students who are confirmed as having met programme requirements to enter a professional register have done so as a result of achievement of relevant professional learning outcomes confirmed at progression points throughout their programme and at final university programme award boards. Following issue of a notification to practice by the professional regulator, registrants then enter a period of supported preceptorship during the first period of their employment in order to consolidate their scope of practice and further professional development.

In respect of dentistry, we do not commission undergraduate training and are therefore not responsible for these healthcare students.

Our trainees are General Dental Council registered post graduate trainees (dental foundation, core and speciality) and are monitored closely in terms of progression through close supervision and completion of an e-portfolio which details their progress. This is monitored by both their Education Supervisor in the practice they are in, and their Training Programme Director who oversees their training. They all have formal Interim Reviews of Competence Progression mid-year and Final Reviews of Competence Progression at the end of their training where progress is formally reviewed and outcomes awarded and any necessary adjustments or remedial support is made.

The trainees were affected slightly differently depending on the context in which they were working. Dental Foundation trainees are placed in general dental practice and while they were not moved the clinical activity they would have been expected to undertake may have been impacted by restrictions to dental services, both in terms of the range of clinical procedures and also the reduction in patient throughput. Arrangements were made for the trainees to have phantom-head models in their practice placements to enable simulation to take place and not impede their training. This was supplemented by additional educational sessions and material being made available. When dental services resumed they were able to resume normal activity and progression. We were able to ensure that all Foundation Dentists satisfactorily completed their training.

Dental Core and Specialty trainees had a slightly different experience as they are placed in hospital or community dental services and their training is further on from basic clinical skills. Many were temporarily redeployed in the acute sector with the transferable skills they possess however they were able to use this work to form part of their portfolio of training and contribute towards their progression. We were able to ensure that all satisfactorily progressed or completed in their training.

2. What are your views on the role of non-medical prescribing, for example by pharmacists or allied health professionals, and what plans do you have in place to support this?

We are very supportive of the role of non-medical (independent) prescribing (IP). There are many examples where we have progressed this to date and we continue to develop this across the professions that are legally allowed to take this forward. Across the UK, discussions are ongoing about extending IP rights.

HEIW supports Health Boards and Trusts through an annual allocation of funding for the development of independent prescribers. This budget is allocated to support Health Boards and Trusts develop their independent prescriber capacity. We commission this education from 5 Higher Education establishments across Wales and work closely with the Health Boards and Trusts regarding the allocation and use of this budget.

As part of the implementation programme for the changes to the Initial Education and Training of Pharmacists (IETP), which includes Independent Prescribing, HEIW is leading on a collaborative piece of work with key stakeholders to consider how

pharmacy services and the pharmacy workforce need to transform to optimise the increasing prescribing skills of the whole workforce within a multi-disciplinary team. This is being considered across the whole integrated care pathway and will support the expected changes to the Community Pharmacy contract. The programme of work will be aligned to the themes within the workforce strategy for health and social care.

3. How will the workforce strategy or the associated implementation plans support the development of extended skills and advanced practice roles across professional groups, and ensure that health and care professionals are able to work at the 'top of their licence'

The workforce strategy's aim is to deliver a motivated, sustainable, competent, capable and confident workforce for Wales by 2030. All themes contribute to supporting the development of extended skills and advanced roles, but in particular the themes of education and learning (theme 5), professional leadership (theme 6), understanding the shape and subsequent workforce planning, and working seamlessly in new and different ways (theme 3) will have the greatest impact. We designed the strategy to take account of prudent healthcare principles – which is particularly important when developing new roles and extending practice so that people only do what only they can do – essentially therefore working at the 'top of their licence.'

HEIW's education commissioning remit supports post-graduate training for all registered healthcare professionals. As part of this we work closely with Health Boards and Trusts to understand their needs, plans and requirements with current priority areas including

- Community and primary care including GP Out of Hours and 111.
- Cancer services
- Mental health services
- Diagnostic services
- Hospital based Eye care
- Unscheduled care

In order to ensure people are able to develop advanced practice and extended practice skills, and work at top of their licence we are funding and supporting a range of initiatives and programmes across Health and Social Care in line with the ambitions set out in the Workforce Strategy. These include,

A new post qualifying framework for social workers which will be introduced in 2022, which is reflective of extensive engagement with the sector during 2021 to ensure that the framework is reflective of the current needs of the social work profession. Equally, there will be a comprehensive learning and development programme implemented in 2022, across health and social care, to meet the requirements of the new Liberty Protection Safeguards. This will involve not only "baseline" training to equip the workforce for the training, but it will contain new qualifications to support the development of increased capacity of the workforce.

The new suite of vocational qualifications implemented in September 2019 and September 2020 includes specialist pathways that allow the recognition of a wider range of competencies and provide progression particularly between level 3 and 4 and levels 4 and 5.

A scoping exercise is due to take place this financial year to understanding the current skills and capabilities of research and data analyst functions in social care with a view to developing an improved learning and development offer for those functions within social care.

We are currently developing career pathways for all of the pharmacy workforce beyond the post of registration as part of our integrated medium-term planning. We have already included the development of our existing pharmacist workforce with our IETP programme (see above) and a parallel programme of work will consider the development of the pharmacy technician workforce. The pharmacy workforce remodelling will consider how the whole pharmacy team will maximise their skills to do more for patients at all points of care.

As part of our joint work to progress a strategic workforce plan to support mental health services, HEIW commissioned a Level 7 Child/Adolescent mental health module at Bangor University, for any professional currently working with children and adolescents with mental health needs in a variety of environments which included CAMHS; School Nurses; Social Workers; Health Visitors; Occupational Therapists; Adult mental Health Nurses; Paediatric Nurses; Learning Disability practitioners; Art Therapists and Dieticians. The university delivered this programme through distance learning to ensure equality of access.

4. **During the session we discussed with you the strategy theme of 'Building a digitally ready workforce'. Please provide further details of what assessments have been made of the additional investment in training (financial and staff time) that may be required to ensure that the health and social care workforce is prepared and able to adopt new technologies and harness innovation**

Work in this area is progressing in health and social care sectors in parallel, ensuring shared learning as we go forward.

Within social care, the Social Care Wales Workforce Development Programme (SCWWDP) grant has a national priority linked to the development of digital skills and infrastructure which was introduced in 2021/2022 grant year – the monitoring reports that we will receive in July 2022 will outline the investment made and the impact of this investment.

Equally we are committed in 2022 to undertaking research that better understands the shift that has been made to digital learning and development from the more traditional face to face provision that existed prior to the pandemic

Across health, formal assessment of the additional investment in training (financial and staff time) has not been completed as a stand-alone exercise. The assessment is being complied as a result of a number of different pieces of work that are currently ongoing. These include

- Development of the digital skills capability framework for NHS staff will map the competencies of staff required to work in a digital environment and provide a self-

assessment tool to assess individual areas of competence and signpost to relevant training and education resources. If used for teams or group of staff this will be able to capture requirements above the individual level. First examples of this will be for Allied Health Professional and Healthcare scientist

- As part of the strategic objectives for 2022/23HEIW are developing the training and education requirements of the future doctor, this will assess the changes required to training and education frameworks
- The work programme for strategic review two will identify gaps in postgraduate education and identify new courses, e.g. genomics
- The review of the health informatics apprenticeship lead by HEIW and DHCW, will provide insight into the future training needs of staff
- Feedback from business cases developed by NHS organisations where time and resources have been included to support digital transformation
- Feedback from existing programmes and new digital education programmes such as the Masters in health informatics and the new digital transformation ILA

The output of these programmes of work will inform the additional investment required in the future

5. How does the workforce strategy and associated implementation planning take adequate account of the whole workforce across health and social care, including not just frontline practitioners but also ancillary staff and managers

The workforce strategy is applicable to the whole workforce, whether they are employed through statutory or private providers, voluntary providers, or are volunteers or carers. Our leadership theme is focussed on leadership at all levels, creating the right conditions and culture for people to thrive, supported by excellent working practices and opportunities for education and career development. There is an increasing and compelling body of evidence linking wellbeing, capability and engagement of the health and social care workforce to improved outcomes for the people we serve.

The SCWWDP grant is all sector regardless of role and our revised workforce data collection processes capture the profile of this part of the workforce so we can better understand it. Equally there is a range of management and leadership training available to those involved in managing social work teams as well as heads of service and senior leaders within Local Authorities.

Consideration is currently being given to providing learning and development opportunities at a national level through the national commissioning board for commissioning and contracting staff in social care services.

A range of provision is available to social care managers, both in terms of their own development needs but in support to their teams as well. A suite of vocational qualifications including specialist pathways exists at Level and 4 for managers, with a main audience of managers of social care settings and services.

We are both progressing the development of staff governance frameworks, during this first implementation phase, and wellbeing frameworks, which will apply to all staff. There is also a specific action on volunteers and carers, due towards end of the first

phase, that will be developed with partners through our implementation proposals – event in spring next year, co-design next phase of implementation.

As with our engagement phase of the strategy development, where we reached many staff from all different areas, our implementation plans will be developed with stakeholders which include staff and managers, to ensure appropriate engagement, coproduction, and representation. Key stakeholders also include our trade union colleagues with whom we have strong relationships.

6. **Evidence from the General Medical Council highlights that the exam pass rate for BAME trainees is 15 per cent lower than for white trainees across all medical specialties in Wales. Please outline what role HEIW and SCW have in tackling barriers experienced by students from ethnic minority backgrounds, and in particular what action is being taken to understand and address the attainment gap.**

HEIW is committed to encouraging and supporting diversity within the healthcare workforce and also promoting the widening access agenda to ensure that those we train are representative of the communities they serve. The diversity of UK graduates in regard to ethnicity and other protected characteristics continues to increase, which is to be welcomed and supported. Between 2018 and 2020, HEIW undertook significant research, data analysis and engagement with key stakeholders, including Students, Service Users, Health Boards and Trusts and Universities to ensure the future structuring of education across Wales and the content of health professional education and training would support diversity for all individuals with protected characteristics in line with equality law.

As a result, HEIWs new health professional contracts, which commence in 2022, embed measures that promote the recruitment and ongoing support of students from BAME backgrounds. Current HEIW data offers assurance that our partner HEIs are recruiting from a wide range of ethnic groups. However, to further support this HEIs will be required to implement a contextual admissions policy contained within the new contract, whereby programme entry tariffs will be lowered for students that hold a protected characteristic and are underrepresented in education. The new contracts will require our partners universities to provide specialist advice and support for students regarding diversity, inclusion and practising a religion; and also allow for the gathering HEIW of data and engagement with students which will allow for the identification of any potential variations in experience, perceptions, or attainment for different groups with protected characteristics.

The association between ethnicity and progression in postgraduate medical training has received particular attention in the UK over the last few years. There has been a focus on understanding and addressing the differential attainment gap which has been identified between graduates of IMG, UK BME and UK white backgrounds. The former two groups are more likely to experience issues impacting their progression. HEIW has established a programme of work to increase understanding of such differences and introduce a range of initiatives to address this; this includes ensuring that our trainers are appropriately trained and skilled in understanding cultural diversity and unconscious bias to better support these individuals. This work is essential as recruiting international medical graduates (IMGs) has been and continues to be an

important part of ensuring the sustainability of the medical workforce in Wales. Despite plans to increase UK and Wales medical student numbers, it is likely that this reliance on IMGs will continue to be a crucial component of our workforce plans and so requires particular attention. HEIW is also committed to fully understanding barriers and challenges faced by trainees with other protected characteristics, the impact this has on their training experience and where necessary to introduce measures to address any identified issues so that diversity, equality and fairness are fundamental to all aspects of training in Wales.

7. **During the session you mentioned that there were gaps in the equality and diversity monitoring data that you hold on the health and social care workforce, for example in respect of ethnic background and disability status. You acknowledged that there was a need to "push on completion of data so that we've got more accurate numbers". Please outline what actions will be taken to improve the completeness and robustness of this data.**

   For HB/Trust staff, the ESR data shows that currently 88% have completed the relevant ethnicity fields. 5% have 'not stated' (an active choice not to state) and 7% is currently unknown. In relation to disability, 3% of staff have stated that they have a disability, 4% have not disclosed, 70% have indicated no disability and 23% have not completed the field. While this is not a mandatory field in ESR, HBs and Trusts encourage their staff to complete the information to help improve planning and staff experience.

   For primary care, the National Workforce Reporting System Wales currently captures 3 protected characteristics, Age (96.8% complete), Race (Ethnicity) (85% Complete), Sex – Gender (96% complete).
   These are mandatory elements completed by GP Practices.

   NWSSP engages with General Practice Managers focusing on specific demographics to maintain data quality. Anonymised equality data analysis is available to healthcare leads to inform discussions and planning at a National, Health Board and Cluster level.

   We can draw a certain amount of data from the register in social care but this needs complementing with data from the wider workforce.

   The new workforce data collection process has improved the data sets to ensure consistency with other national metrics but this is an area that we recognise needs continual strengthening and improvement including being clear in our communications as to the reasons why this data is important and how it influences and impacts on policy development and priority setting.

   In terms of professional pathways, there has been an increase in the % of black, Asian and ethnic minority students pursuing the degree in social work (6.4% in 2017/18 to 8.3% in 20/21.)

8. **Please outline how the strategy, and associated implementation plans, recognise and will address the lack of diversity in some areas, for example social work, especially in senior management positions.**

The work of the WeCare Wales is consistently focusing on the diversity of workforce and the need to improve areas of under represented groups e.g. males, Welsh speakers, people from a Black, Asian, ethnic minority. Improved data collection will help profile accurate pictures, nationally, regionally and locally so that greater focus can be put on relevant and specific campaigns.

The review of the social work qualifying framework will provide data and insights into the current social work qualifying provision in terms of levels of attrition and attainment across various metrics which will lead to a series of improvement recommendations.

Our compassionate Leadership strategy embodies inclusion through its core. This is enhanced by the Compassionate Leadership Principles for Health and Care in Wales, developed through engagement and consultation and act as a route map guiding the creation of compassionate and inclusive cultures across health and cars in Wales. One of the seven Principles includes as leaders across health and care in Wales we will *'Improve equality, inclusion and diversity, consciously removing barriers and boundaries'*. To embed this principle a series of resources are being developed including master classes, learning modules, case studies, podcasts that will form part of a resource pack that will be provided to organisations to embed into leadership and management training as well as a means of embedding into systematic processes such as recruitment and appraisal.

To inject pace and highlight the importance of this work, HEIW have established a strategic national Talent Board Chaired by the Chief Executive of NHS Wales and Director General for Health and Social Services. This Board is supported by a strategic operational group with subgroups developed to progress work at pace around:

- Inclusion and Diversity
- Talent and Succession Pipeline Priorities ('At Risk' positions)
- Succession Strategy Review and update
- Access and assessment of Talent

The work of the WeCare Wales is consistently focusing on the diversity of workforce and the need to improve areas of under represented groups e.g. males, Welsh speakers, people from a Black, Asian, ethnic minority. Improved data collection will help profile accurate pictures, nationally, regionally and locally so that greater focus can be put on relevant and specific campaigns.

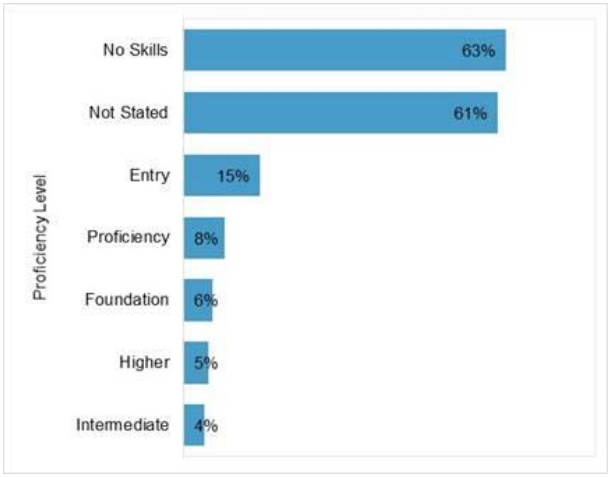
The review of the social work qualifying framework will provide data and insights into the current social work qualifying provision in terms of levels of attrition and attainment across various metrics which will lead to a series of improvement recommendations.

9. What processes are in place across health and care services to identify where Welsh language skills gaps are, and ensure that this information is systematically available to HEIW and SCW?

The NHS Electronic staff record currently has a field to identify Welsh Language competency. This is a self-assessed field based on the following categories.

Welsh Language Skill Level	Definition
No Skills / Dim Sgiliau	I cannot understand or speak any Welsh
Entry/ Mynediad	I can: Pronounce Welsh words, people's names, place names etc. Greet and understand a greeting Understand and use basic everyday words and phrases e.g. thank you, please, excuse me, may I speak to...etc.
Foundation / Sylfaen	I can: Understand the gist of Welsh conversations in work Understand, ask and respond to simple job related requests, questions and instructions Express opinions in a limited way as long as the topic is familiar
Intermediate / Canolradd	I can: Understand much of what is said in the workplace Keep up a simple conversation or answer simple questions on a work related topic but may need to revert to English to discuss complex or technical issues Offer advice on simple job-related matters
Higher / Uwch	I can: Keep up an extended casual work related conversation Give a presentation with a good degree of fluency but may need to revert to English to answer unpredictable questions or explain complex points.
Proficiency / Hyfedredd	I can: Advise on/talk about routine, non-routine, complex, contentious or sensitive issues related to own experiences Give a presentation/demonstration and deal confidently with hostile or unpredictable questions

To date 39% of all staff have completed this field with the results below. This will form part of the actions within the strategy's theme 7 to improve the quality of data and systems to enhance our workforce intelligence, however responsibility for this sits with statutory delivery bodies.



Improved workforce data collection will improve the understanding of the Welsh capability of the social care workforce.

Social Care Wales have been actively involved in a range of projects/initiatives with a couple of examples shown below.

'Welsh Language Skills in your workforce – using them effectively' has been designed to support providers to deliver the requirements of More than Just Words. The resources was produced as a direct response to requests from frontline workers in health and social care services. The resource enable employers to identify what Welsh language skills (1-5 ALTE) that already exist within their workforce. Sometimes these are hidden through lack of confidence or because no value has been placed on them. This pack aims to help make effective use of existing skills as one would any other workplace skill, for the benefit and well-being of people who use services, and is an integral part of workforce planning.

‘Language, dignity and Care’ has been developed as a ‘train the trainer’ resource to support language awareness training for people working in health and social care, and for people who are in further or higher education. The resource is equipped to help the trainer presenting to teach about language awareness whilst encouraging discussions on how best to work bilingually, educate and empower learners and workers on how to offer a valuable service to service users ensuring that language is always a central consideration.

Social Care Wales and partners have delivered a series of online, bitesize session on Welsh language and dementia. The sessions were open to anyone providing care to people living with dementia and in particular those who felt less confident to speak any Welsh with people they were delivering services to. There were 8 topics, lasting around half an hour where delegates could choose to attend as many of the sessions as they liked. At each session there was a speaker, signposting to resources and a chance to ask questions. A further drop in session was also arranged for delegates to come back together with other attendees to share anything they may have done differently as a result of attending and work through any barriers faced, or solutions found.

Whilst there are undoubtedly significant gaps in the data available, getting comprehensive, up to the minute data is just part of the solution. Staff also take part in awareness/ induction sessions on the Welsh language so that they can appreciate the importance of Welsh, they know how to make the active offer to patients and they know where to turn immediately for help if the need for a Welsh language service is identified.

Both HEIW and Social Care Wales are members of the Mwy na geiriau task and finish group and have action plans aligned to the findings of the evaluation of the Welsh Government overarching plan

10. **During the session, we discussed with you the availability of bilingual and Welsh medium nursing training and social work NVQs, including placements. Please provide details of the number of such training places and their distribution across Wales. We would also welcome information on the uptake of these training places, and how the level of demand for Welsh medium/bilingual training places is assessed**.

We do not specifically commission bi-lingual places for the Nursing, Allied Healthcare Professions and Healthcare Science profession. We have taken a very different approach. The HEIs are required to support ALL students to either have access to bi lingual provision or provide opportunity for students to enhance their Welsh language skills in practice.

From 2022 new education contracts have set clear expectations of the education provider in relation to the Welsh language support that all students can expect to see. This includes accepting written work as part of assessment or examination in Welsh, assessment of skills at beginning or course, providing opportunities to learn Welsh or develop existing skills free of charge. Services such as occupational health,

personal tutor and provision of policy information and support services through the medium of Welsh.

In the annual reporting, we will be asking each course in each university to make submissions on numbers of students sitting the Induction programme, and detailed statistics on the language levels (ALTE 1-5) for each course - will give us fairly accurate data on the language skills of each individual cohort. The reporting mechanism in turn involves the Coleg Cymraeg Cenedlaethol, and so any courses where a significant amount of Welsh speakers are represented will be flagged up to them, and result in proactive opportunities for the Coleg Cymraeg and the Welsh language officers within HEI's to have meaningful conversations on the growth of Welsh language provision based on robust, annual data. This will allow them to have meaningful conversations with the HEI's about establishing more Welsh language teaching provision. This in turn will feed in to the HEI's recruitment plans, and will be supported by our attraction work for example through Tregyrfa, our Welsh language digital careers platform.
A large proportion (approximately 90%) of Nursing and Midwifery teaching in Bangor is available in Welsh, and Aberystwyth are suggesting that at least 40% of the Nursing course there can be taught in Welsh

There is some provision across Cardiff Metropolitan and Glyndwr universities for sharing online teaching in Welsh as well, with a pilot having taken place last year, according to the Tender evaluation questionnaire. The questions we asked at the Tender Evaluation stage were more general, focussing on ideas on how HEI's intended to grow provision over coming years – more specific data can be gathered (on an ongoing basis, both qualitatively and quantitatively) when the reporting cycles start taking place.

Our recent review of the Social Care Workforce Development recognised that there is not sufficient training and learning resources available. We have a commitment to Mwy na geiriau and the active offer in our plans. We recognise that there is an opportunity for medium term implementation to take account of the work of the task and finish group looking at Mwy na geiriau evaluation findings.

In terms of professional pathways, in 2019/2020, 275 social work students undertook learning of 5 credits or more through the Welsh Language. (This figures included students who undertook a Welsh Language awareness eLearning module) and 146 took learning of 40 credits or more.

11. Some stakeholders have raised concerns that the funding of care does not take into account the cost of providing bilingual or Welsh language services, including increasing Welsh language skills in the workforce. What are your views on how this should be addressed?

To support ongoing, sustainable approaches we need to have a clear strategic intent to support the sector to upskill in their Welsh Language skills, so that it becomes part of an overall learning and development offer on a consistent basis. This will require both funding and the creation of capacity in terms of the workforce having time to improve their language skills, through courses, access to online resources, peer and group support to practice language skills, etc. It also requires role modelling and visible leadership at all levels, to continually embed the importance of language through every day working lives.

Additional Information

Data
In your evidence paper you refer to a new data collection system for social care that gathers data from statutory, private and voluntary providers. Please outline how the system will take account of the contribution of unpaid carers.

The new data collection system is only aimed at the paid workforce but Social Care Wales is a member of the Carers Ministerial Advisory Group and each of its sub group and is actively contributing the overall carers strategy in line with our remit and areas of responsibility.

Other issues
During the session, you agreed to share the following with the Committee:

A briefing paper on the We Care recruitment campaign is attached to the email .

Details of the national resources made available through the strategy to support health and social care staff wellbeing

The link to these resources is https://socialcare.wales/service-improvement/health-and-well-being-resources-to-support-you-during-the-coronavirus-covid-19-pandemic and at present these resources are contained within our Social Care Wales generic website but plans are underway to develop a dedicated online portal for health and well being which will be available in 2022.

Gofalwn .cymru | WeCare .wales

WeCare Wales

ADSS Cymru update

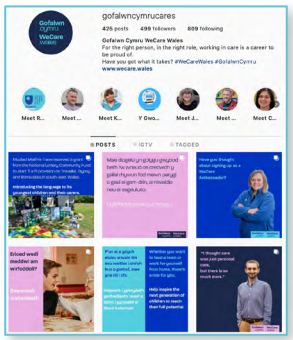
What is WeCare Wales?

WeCare Wales is the national attraction, recruitment and retention programme for social care and early years. It aims to raise the profile of the sectors and support recruitment and retention in the care workforce. Launched in March 2019 work to date has focussed on a range of key themes including:

- raising the profile of the sectors
- diversity in the workforce, including gender and the Welsh language
- focussed campaigns for Social Workers, Home Care and Nurses in social care settings
- campaigns focussed on younger audiences
- supporting entry into the sector, for example through apprenticeship routes.

Promoting WeCare Wales

- TV
- Newspapers
- Online
- Out of home
- Social media.



Statistics:

More than **30,000** engagements on social media since launch

Broadcast on Sky, ITV Wales, S4C, All 4

Public perception survey:

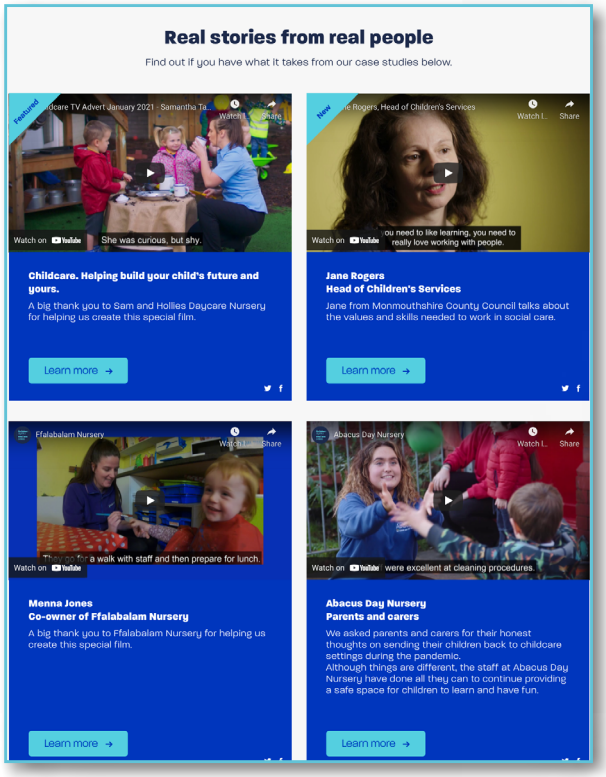
Adults – Improving the quality of life up to **28%** (2020) from **3%** (2018)

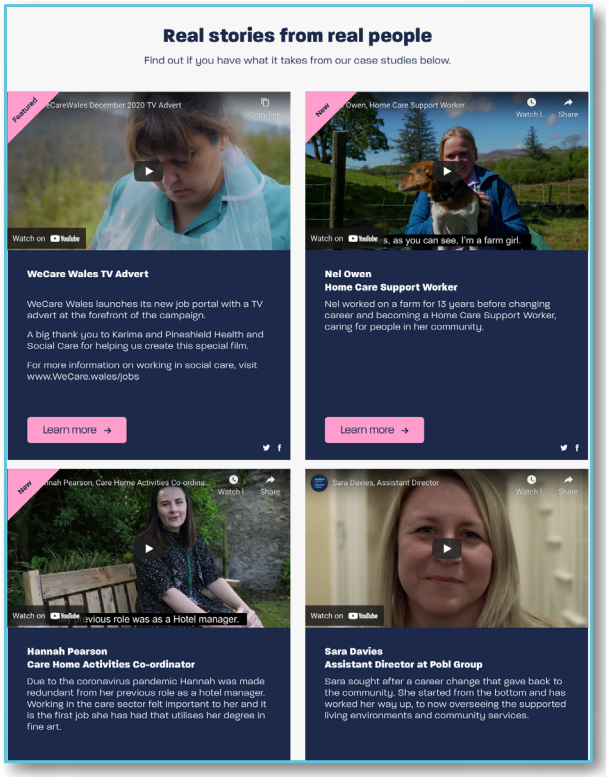
Children – Positive impact of child development **47%** (2020) from **8%** (2018)

Stories from practitioners

More than 50 videos of care professionals have been created to highlight the value of working in care. Case studies of Social Workers, Home Care Workers, Nursery Managers, Childminders and many more showcase the wide range of opportunities available in care.

Please contact us if you know someone who has a great story to share.





Statistics:

2.2+ million video views

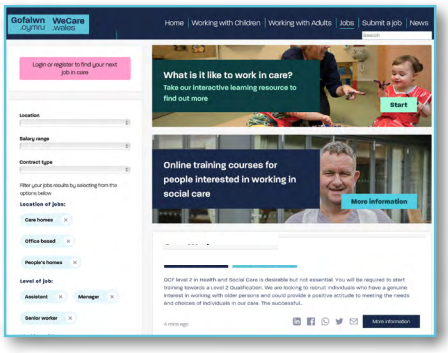
Supporting recruitment – WeCare Wales Jobs Portal

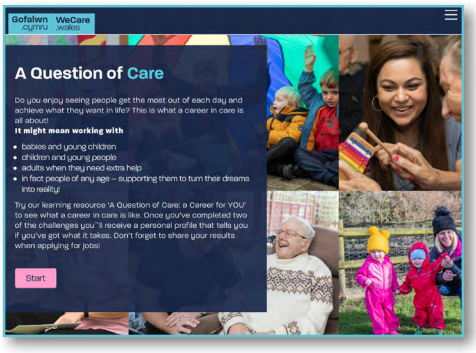
The WeCare Wales Jobs Portal is a free online resource advertising all jobs in care. Through a simple search function, jobseekers can find care vacancies in their area.

Jobseekers are encouraged to try the 'A Question of Care: a Career for YOU' quiz. This is a values-based online learning resource where people can experience what it's like working in care. Once two of the challenges have been completed, a personalised report is produced on how well the individuals values are suited to working in care. Employers can use resource as part of a values-based recruitment exercise.

The Jobs Portal has been widely promoted through TV adverts, in print, online and through social media.

If you have a vacancy and would like it to appear free of charge on the portal, visit the WeCare Wales website.





Introduction to Social Care Training

Piloted across South West Wales, this training programme helps jobseekers gain an insight into working in care and provides foundational learning to help them as they begin their career in care. This training programme is now available across Wales.

Statistics:

More than **3,000** jobs posted this year

96,000 visitors

Making connections

WeCare Wales have worked with DWP and Job Centre Plus to run sessions for over 500 work coaches. Resources have been created to help them better understand the care sectors and help jobseekers make an informed choice in beginning a career in care.

Working with organisations who are supporting redeployment from industries that are making redundancies.

Career Cards have been created and shared with all comprehensive schools in Wales, supported by Careers Wales, the cards help students gain an insight into the variety of roles and career paths available in care.

Working with the seven regions of Wales

Funded by Social Care Wales, there are WeCare Wales Regional Career Connectors in each of the seven regions of Wales. These roles are key to shape and inform the national programme of work through highlighting the pressures, challenges and learnings from each region. They develop relationships with schools, colleges and employability programmes in their area, ensuring the WeCare Wales brand is used to provide national consistency but with local and regional flexibility.

Statistics:

£350,000 investment per year into the regional roles

1,200 Career Card packs shared

How to access resources and support

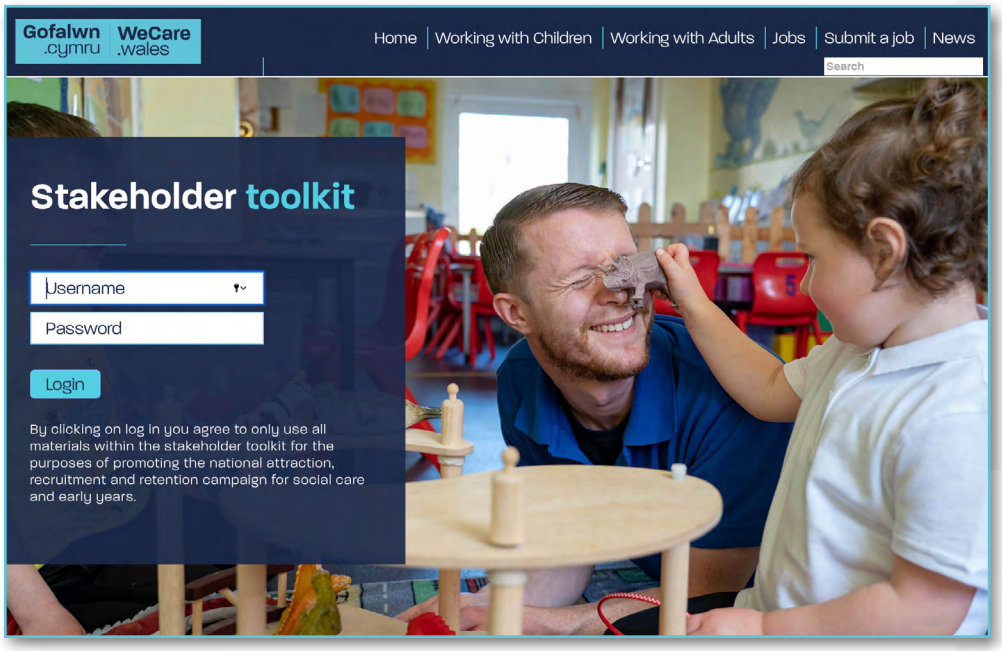
The WeCare Wales website has information about working with children and adults in Wales. People can learn about the roles available and watch videos of real people's experiences working in these roles.

The website also includes a stakeholder toolkit with ready to use materials.

To access the stakeholder toolkit go to www.wecare.wales/stakeholder-toolkit

Username: Stakeholders
Password: Toolkit_WeCare!

Use WeCare Wales materials on your website to help showcase the world of care and guide people to the wealth of information available on the WeCare Wales website.



Statistics:

More than **300,000** website visitors

WeCare Wales Awards

WeCare Wales Children Instagram competition

Launched on Instagram this September, members of the public have been asked to nominate a childcare team, play provider or childminder that they feel deserves to be recognised for their efforts.

To nominate a provider, they need to:

- post an image of their nominee on Instagram
- share why they're nominating them
- tag @gofalwncymrucares using the competition hashtags #PlantGofalwn and #WeCareChildren.

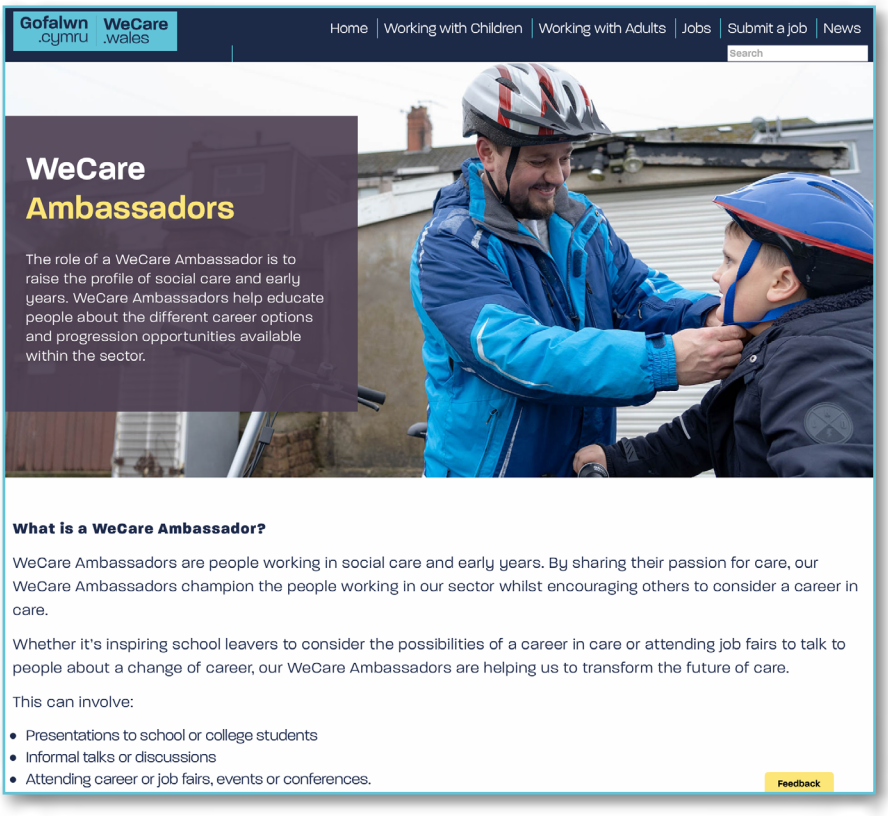
A panel of judges will then whittle them down to six finalists and the winner will be chosen by a public vote during WeCare Wales Week from 11 to 17 October 2021.

The WeCare Wales Accolades Award recognises the critical work carried out by individuals working in care. For more information visit Social Care Wales's website.

WeCare Ambassadors

The WeCare Ambassadors bring to life working in care for pupils in schools, colleges, and career events across Wales. Individuals who are currently working in the sector share their story about what working in care is really like.

If you know anyone who would like to become a WeCare Ambassador, visit www.wecare.wales/ambassadors



WeCare Wales Week

This year's WeCare Wales Week will be held between 11-17 October 2021.

The week will focus on supporting recruitment into care through promoting the WeCare Wales Jobs Portal and new Employers Portal, a careers event for jobseekers, and highlight the excellent work that goes on with children across Wales through the WeCare Children Instagram competition.

GIG CYMRU NHS WALES
Iechyd a Gofal Digidol Cymru
Digital Health and Care Wales

Tŷ Glan-yr-Afon
21 Heol Ddwyreiniol Y
Bont-Faen, Caerdydd
CF11 9AD

Tŷ Glan-yr-Afon
21 Cowbridge Road
East, Cardiff
CF11 9AD

16th December 2021

Dear Russell,

Please find attached our response to your letter dated the 26th November 2021 in which you asked for our views on the role of Digital Health & Care Wales in delivering a digital-ready health & care workforce.

Answers to the questions are provided in the accompanying document.

If you require any further information, please let me know.

Kind regards,

Professor Helen Thomas
CEO
Digital Health & Care Wales

One of the seven key themes which underpins the joint strategy: A Healthier Wales: our workforce strategy for health and social care is to build a digitally-ready workforce by 2030. To achieve this, the health and social care workforce will need to be fully supported.
During the evidence session, HEIW told us that they are working with partners, including Digital Health and Care Wales, to ensure that the infrastructure is aligned with expectations and ambitions. In terms of training, HEIW noted that this work included:

- *A digital skills and capabilities framework, including a self-assessment tool, which is being piloted with allied health professional workers to allow them to assess where they are and what sort of training that they need.*
- *Other training, which we were told was being "rolled out and delivered through our partner, DHCW".*

1. How are the workforce's current digital skills and capabilities and the future skills and capabilities requirements being assessed? What other methods are being considered in addition to the self-assessment toolkit being piloted with allied health professionals?

- The digital skills and capabilities framework, including self-assessment tools, is being taken forward by HEIW as part of their digital readiness programme. This will provide the national capability to test the digital skills of the NHS Workforce through a self-assessment, and once completed will signpost individuals to suitable resources to improve their skills.

- DHCW are supportive of the model and have been involved in the initiation workshop which took place in July 2021. This work aligns with the associated packages of work which Welsh Government has prioritised including:
  - The priorities of Digital Communities Wales, funded by Welsh Government, on ensuring patients and the public can access digital services in health and care settings

  - An independent review of the digital and data profession within NHS Wales, known as the Digital Workforce Review. The Review is being undertaken by the Federation of Informatics Professionals (FEDIP) and supported by DHCW to put in place a shared definition and common framework for the profession and undertake analysis into the key areas of demand which need to be addressed in the short, medium and long term.

- Welsh Government approved the use of the Digital, Data and Technology (DDaT) Plus' framework in December 2021 as an outcome of the Review's first phase. DDaT is a framework developed by the Government Digital Service and covers a wide range of technology roles such as software developers and data scientists. The 'plus' element will reflect the additional aspects which are found in health and care settings and not included in the main DDaT framework, such as

clinical coding and informatics. Other areas such as Cyber Security are being developed by UK Government's recently established UK Cyber Security Council (CSC) and DHCW, HEIW and Welsh Government officials will work alongside the UK CSC to ensure that these skills and competencies are also signposted to within the framework.

- National programmes and projects where DHCW are the lead organisation also consider the skills requirements of the workforce in their work. For example, within the Welsh Nursing Care Record (WNCR) programme, the team carried out baseline assessments on the digital skills and capabilities of the workforce, which were then considered in the planning and implementation of the programme, and actions such as providing training has addressed any identified skills gaps. In addition, DHCW undertakes an organisational wide annual training need analysis which identified continued and new priorities for training investment, and these are facilitated as part of the organisation's annual training activities

2. Could you explain your role in meeting the training needs identified through such skills and capabilities assessments?

- Once the self-assessment tools are launched, it is expected that they will be used prior to implementation of any new digital programme to assess the readiness of the workforce. Tailored support will then be put in place, based on an analysis of those results.

DHCW already provide access to training, some examples are below:

- We have provided our teams with on-line technical training materials
- As part of our Office 365 rollout, we have provided relevant on-line learning materials to all users in NHS Wales
- We have funded a number of specific training courses for DHCW staff

2a. Are you confident that the right training opportunities are available to support the health and social care workforce to become digitally ready?

- There is still further work to be done in this area, as the potential for digital transformation over the next few years is great. There are a number of training courses and support available to increase digital and data skills, some examples include:

  - A review by HEIW of postgraduate qualifications relating to digital;

  - A joint review of health informatics apprenticeships in NHS Wales by DHCW and HEIW, in partnership with wider users and providers;

- DHCW, in partnership with the Wales Institute for Digital Information (WIDI), are supporting existing staff and newly employed apprentices with study opportunities, funded through Welsh Government initiatives. These part-time qualifications range from level 3 course in Health Informatics through to Digital degrees;

- DHCW are also partnering with a number of external training agencies which provide a wide range of professional vocational courses that could be relevant to DHCW's staff across Wales. Professional courses available include both technical and non-technical subjects and offer a range of qualification levels;

- These training opportunities will be collated together as part of the digital capabilities self-assessment tool, where users will be able to easily find information on the range and scale of courses available;

- DHCW, HEIW, and Welsh Government are proactively working together to plan how the workforce elements of the proposed refresh to the 2015 digital and data strategy for health and care in Wales *'Informed Health and Care'* can be supported by a workforce oversight group. It is suggested that this group will provide advice and leadership in relation to the digital workforce;

- Cyber resilience is a key challenge within health settings and falls under the UK Government Network and Information System (NIS) Regulations. Welsh Government in collaboration with the National Cyber Security Centre (NCSC) has created a development session for NHS Wales Boards which is being rolled out across NHS Wales organisations. The feedback to date has been extremely positive.

- DHCW has facilitated online training on Cyber Security via the Electronic Staff Record (ESR) platform.

- DHCW develop and supply a range of training content and support on national digital systems to NHS provider organisations, with responsibility for implementation sitting with the provider organisation.

Investment in digital infrastructure and a digital ready workforce
One of the areas of concern highlighted in written evidence from stakeholders to inform the oral evidence session was investment in digital infrastructure and the development of a digital ready workforce. Concerns were also raised regarding the lack of financial detail and clarity associated with the strategy.

3. Please provide details of what assessments have been made of the additional investment (financial and staff time) required for

i) digital infrastructure and

ii) training to ensure that the health and social care workforce is prepared and able to adopt new technologies and harness innovation.

- The All-Wales infrastructure Programme (AWIP) builds on the findings of the all-Wales independent review into IT infrastructure, completed in February 2020, and aims to develop common standards and principles across NHS Wales for all aspects of digital infrastructure such as the use of cloud, digital identity management and digital networks. These principles and standards will be underpinned by detailed roadmaps to support digital professionals to implement them. Aligning security and information governance are important to making sure users can utilise digital services safely and efficiently.

- The Digital Workforce Review has recently completed its first phase, identifying a framework to define and analyse the digital workforce. This will be followed by an assessment of the size and makeup of the profession in NHS Wales, which will report by March 2022. The social care workforce will be scoped in phase three, and a workforce plan to identify actions to support the digital workforce in the short, medium and long term will be completed by the end of the summer term.

- In addition to funding the Digital Workforce Review, Welsh Government through the Digital Priorities Investment Fund (DPIF) are funding the following activity:

    - Programme support for the digital skills and capabilities framework programme run by HEIW;

    - Training on the importance of user-centred design of services is being developed by the Centre for Digital Public Services (CDPS) to support NHS Wales Boards;

    - Welsh Government officials are working with cyber security leads across NHS Wales and the NHS Wales Cyber Resilience Unit to secure licences for all NHS Wales staff to gain a foundational understanding of cyber resilience to aid in keeping systems safe from attempted attacks such as phishing;

    - In addition, via the NHS Wales Cyber Resilience Unit, dedicated training for clinicians and cyber security leads in NHS Wales is being developed to support health settings in understanding their obligations under the NIS Regulations;

    - Working with NHS Wales partners, the University of South Wales (USW) has launched a Digital Transformation Intensive Learning Academy in December 2021 to develop leaders in health and social care to deliver more effective

and efficient services to patients. This is part-funded by Welsh Government via the DPIF and aims to provide a range of flexible courses that include postgraduate and doctorate level opportunities covering Leading Digital Transformation;

- The DPIF also funds Digital Communities Wales; a programme led by the Wales Co-operative Centre to reduce digital exclusion in Wales so everyone has the skills, access and motivation to be a confident user of digital technology, which will be vital as digital technologies become more widely adopted in health and care settings.

Smaller health and social care providers

HEIW acknowledged during the evidence session that experience across health and social care of access to IT and digital technologies is mixed, and added that: "Obviously COVID has accelerated the deployment of digital approaches, and we've got to be really sure that we don't leave people behind as we rush to grab the latest bit of kit or technology."

4. **Please outline your views on the level of risk that smaller health or social care providers could be left behind when it comes to digital transformation compared to larger NHS organisations, and how this risk is being mitigated**

- Typically, the risk can relate to the investment ask in both monetary and staff capacity/skillset terms – smaller organisations are unlikely to have access to inhouse expertise. At a time where significant resource is allocated to covid response as well as maintaining core business activity the ring fencing of time to support transformational endeavours can be problematic. Whilst the case for financial investment can be justified on a strategic and benefits basis there remains a risk to these smaller organisations in terms of manpower and skillset to drive change. A mitigating action could be the establishment of a Health and Social Care Digital Change Hub/Network to provide the necessary expertise, support and guidance along the transformation journey. This would aid in embedding and sustaining the relevant skills for the required pace of change.

- From a digital transformation perspective the Digital Priorities Investment Fund includes primary and community care services, which are managed as part of a whole system approach.

- Of note Digital Health & Care Wales provides a fully managed and supported service to general practice including desktop and printing services, and the Choose Pharmacy programme has driven wider adoption of digital services in community pharmacy across Wales.

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- For smaller social care providers, such as independent residential care providers, the emphasis is on targeted support rather than on managed services. For example, during the pandemic this has included devices to support digital inclusion, through Digital Communities Wales.

- The Welsh Government's policy approach is based on open digital architecture, common standards, interoperable systems, and a user-centred design approach. There is also a shift to all-Wales services hosted in the cloud and delivered through apps and websites, which has been reflected in the digital response to the pandemic (for example, contact tracing, vaccine delivery, test booking and covid pass services). This will help digital transformation in smaller organisations firstly by making common services more accessible to them, and secondly by enabling third party services to connect to the national digital architecture. Welsh Government also provides general support to businesses to encourage digital transformation.

- Investment in the digital professional workforce in Wales will strengthen whole system capacity, as people move between sectors and employers throughout their careers. For example, DHCW and the Digital Intensive Learning Academy will support communities of practice, and the Digital Health Ecosystem Wales supports industry engagement targeted at smaller businesses. These activities strengthen our whole system capacity and benefit smaller health or social care organisations as well as larger NHS organisations.

Agenda Item 3.16

Dear Russell George MS,

Thank you for your recent request made on behalf of the Senedd Health and Social Care Committee seeking additional comments about *A Healthier Wales: our workforce strategy for health and social care.*

As you will be aware, UNISON Cymru Wales submitted a thorough response at an earlier stage of the consultation process. Therefore, the below response will not repeat comments and points previously submitted but will instead address the specific questions raised in your correspondence.

As always, UNISON is keen to engage throughout this consultation process and we would be happy to participate in any further oral evidence sessions or support the facilitation of a roundtable event with workers from the health and social care sector.

Thank you once again for contacting UNISON on this important matter.

Yours sincerely,

Alastair Gittins

UNISON Cymru/Wales response: A Healthier Wales – A Workforce Strategy for Health and Social Care

UNISON House, Custom House St, Cardiff, CF10 1AP

Alastair Gittins: UNISON Information Development Organiser

1. How effectively does A healthier Wales: our workforce strategy for health and social care address staff wellbeing?

1.1 UNISON Cymru Wales has submitted a thorough response to the strategy at an earlier stage of the consultation process and we guide members of the Senedd Health and Social Care Committee to the response for a full answer to the question posed above.

1.2 In terms of additional commentary to that already submitted, UNISON is broadly supportive of the strategy, however, the key element to a healthier workforce will be in the implementation of the strategy.

1.3 It is UNISON's view that the only genuine way to achieve the ambitions set out in the strategy is to ensure partnership working and employer engagement with trade unions across the board. Sadly, this is far from being realised – particularly in privatised elements of the social care sector there are too many examples of hostile employers and a lack of recognition of trade unions.

1.4 Trade unions are not and should not be viewed as separate entities – trade unions are the workers, and the worker voice must not be ignored.

2. What are your views on current approaches to assessing staff well-being? Are surveys as a standalone tool sufficient to provide an accurate picture of the wellbeing of the health and social care workforce? Are there other measures that you believe should be adopted?

2.1 UNISON disagrees that surveys alone are insufficient as a standalone too to provide an accurate picture of the wellbeing of the health and social care workforce. Whilst surveys can be useful, they should not be the only measure used to assess wellbeing.

2.2 Worker wellbeing goes beyond how an individual worker feels on any given day. Worker wellbeing includes, but is not limited to, good work, the values and principles of the employer, health, collective and social issues, personal growth, physical activity, financial wellbeing.

2.3 with each of these themes of wellbeing, there will be various measures that can be utilised to build a more holistic assessment of wellbeing across the health and social care workforce.

2.4 Taking the theme of health – this can relate to physical health, physical safety, and mental health. Assessment might include the levels of sickness within the workplace, the regularity of health safety assessments, the workplace policies in place, ability to access employee assistance programmes, referrals to occupational health, and many other examples. All this measures, and more, can help assess the overall wellbeing of the workforce.

2.5 Good work can be reviewed using various means including through the consideration of the work environment, the line management, the workplace policies available, change management processes, work demands, pay and reward, and autonomy. Access to a trade union is a major factor in determining good work – a unionised workplace is an indicator of the value the employer places on their employee's wellbeing. Good employers have nothing to fear in terms of allowing their workers to access trade unions and they clearly recognise the value of a strong worker voice. The benefits of unionised workplaces are well researched and includes staff wellbeing.

2.6 Values and principles can include the inclusion and diversity of an organisation and the ethical standards of that organisation. An audit of the diversity of an organisation can indicate the inclusivity of that organisation – an important feature of worker wellbeing.

2.7 The employee voice is integral to a healthy workplace – a unionised workplace is key, but in additional there must be genuine dialogue between employers and employees which should be supported by robust workplace policies. Involving worker in decision making is an essential part of developing strong and positive relationships and can support wellbeing in the workplace. An audit of current employer practices and policies will contribute to the broader picture of wellbeing.

2.8 Workers must have scope and opportunity for personal growth in the workplace. This may be through career development opportunities or lifelong learning. An absence of career development opportunities and lifelong learning demonstrates a lack of focus on wellbeing.

2.9 Financial wellbeing is integral to overall wellbeing. All workers deserve fair pay and just reward for their work, as well as fair work policies, retirement planning services, and employee financial support. Overall wellbeing can't be maintained without fair pay.

2.10 Other measures that can be used to monitor worker wellbeing include staff turnover, data around sickness absence, data on referral rates to occupational

health, the number of staff who have flexible working arrangements, whether there is a wellbeing strategy.

2.11 As identified, one tool alone cannot properly assess the wellbeing of a workforce and numerous measures and tools should be employed to gain a holistic perspective of workforce wellbeing.

3. In your view, are the partnership forums referred to above by HEIW operating effectively?

3.1 UNISON agrees the NHS Wales partnership forum is broadly effective. This forum has been long established and well-practiced but can be slow. The forum is a good policy making tool, but the operational implementation of the policies can be complex, and it is difficult to assess how well connected the forum is at health board level.

3.2 In some ways the social care fair work forum can be considered successful. Social care stakeholders have been brought together and found common interests. There is definite potential for the delivery of fair work in the social care sector.

3.3 However, the forum lacks transparency in terms of decision making and driving the work forward. Much of the decision-making appears to occur within an inter-Ministerial group, with little detail of who sits on this group and how it operates.

3.4 Furthermore, whilst the forum may be able to unite around issues such as the payment of the real living wage across the sector, there is no clarity on how this will be taken forward including scarce detail on how it will be funded.

3.5 Whilst the initial remit of the forum was to consider wider possibilities around fair work and collective bargaining, the forum has become consumed by trying to deliver the real living wage. Whilst UNISON welcomes the real living wage for care workers, we are clear it is only a starting block for fair pay in the sector and this alone will not resolve the issues across the sector and will not ensure worker wellbeing. Despite these caveats, the forum seems unable to move past this issue and since April, the forum has only actively pursued a task and finish group on pay and no other factor has been considered.

3.6 For clarity, UNISON is supportive of social partnership working and we believe there is enormous potential for the social care fair work forum, but the problems identified above need to be addressed.

4. To what extent is there sufficient staff capacity to ensure that workloads are manageable and that staff are able to take breaks, annual leave, access wellbeing support and undertake training and professional development? Is the picture improving or deteriorating, and do staff feel they are sufficiently supported in this respect by their organisations' leadership and management?

4.1 It is well documented that NHS and social care staff alike are under enormous, sustained, unacceptable pressures. There is not sufficient staff capacity, it is more common for health workers to miss their breaks rather than be able to take them, there are long-term staff vacancies across both the health and social care sector.

4.2 Many workers are struggling to find the time to take their annual leave without detrimentally impacting the rest of their team. Only this week (w/c13 Dec 2021) we have heard from the Health Minister that health workers will be asked to cancel annual leave to support the rollout of the vaccine booster programme. This comes in addition to the relentless pressure health workers have experienced since the start of the pandemic.

4.3 Waiting list pressures continue to grow and health workers are now faced with another gruelling winter ahead with a new unknown COVID variant on top of the usual winter pressures experienced in the sectors.

4.4 UNISON believes the situation is deteriorating with many experienced members of the workforce retiring early and acquiring work outside of the sectors because of the ongoing pressures.

4.5 Whilst the pandemic initially ignited a desire for some to work in the health and social care sector as a part of the effort against the virus, this does not appear to have translated on the ground – which is demonstrated by the ongoing long-term vacancies.

4.6 Under such sustained pressures, it is extremely hard to support workers properly in the workplace.

4.7 It is difficult to full appreciate the magnitude of the problems experienced by health and social care workers and we would urge the committee to seek oral evidence from key workers to gain a fuller understanding of the issues. UNISON can help facilitate this work.

5. What are your views on the pilot approach to assessing staff's digital skills, capabilities and training needs? Is a self-assessment tool sufficient to identify where there are skills gaps across health and social care, and what further action is needed to ensure the health and social care workforce have the digital skills required?

5.1 The self-assessment tool should not be the only mechanism for identifying skills gaps across the sector but should instead form part of a wider discussion. Discussion with manager or digital leaders should also play a part. It is not reasonable to place the full onus for assessing digital skills on the individual worker. It should be a joint process between the employer and employee.

5.2 UNISON believes digital champions should be considered to allow people to seek peer-to-peer support. Workers can also access digital training and development through the Wales Union Learning Fund projects.

5.3 These tools should complement the usual development review processes and a digital skills policy. Workplace development should be undertaken in partnership between the worker and employer.

A Healthier Wales Response

1. How effectively does A healthier Wales: our workforce strategy for health and social care address staff wellbeing?

   As discussed in BDA Wales's initial consultation response, while A healthier Wales refers to implementation plans that will be developed, these plans have not been published making discussion difficult. To ensure that staff wellbeing is effectively addressed, any plans must be accompanied by data monitoring staff wellbeing. The pandemic has had a significant impact on the mental health and wellbeing of this workforce and continues to do so. Prior to the COVID19 Pandemic, depression and anxiety in the general population had increased in recent years. BDA Wales conducted two surveys to capture the mental health impacts the pandemic has had on all dentists working in Wales, and the different sources of stress that they face. Overall, stress levels remain high within dentistry, with several aspects becoming more stressful. Working conditions have worsened, with breaks becoming more difficult to take. Enhanced PPE also been a strain for many dentists, particularly this summer. A concerningly high 70.5% stated that the pandemic led them to rethink their career in dentistry. Stress levels are high in NHS dentistry in Wales, it is vital that a healthier Wales effectively addresses staff wellbeing. As the workforce strategy develops, BDA Wales would be pleased to consult on this further.

2. What are your views on current approaches to assessing staff well-being? Are surveys as a standalone tool sufficient to provide an accurate picture of the wellbeing of the health and social care workforce? Are there other measures that you believe should be adopted?

   Surveys can be an effective standalone tool, provided that they are able to capture a true picture of the mental health. Open text responses must be utilised, and appropriately analysed, to assess staff well-being. Surveys provide the benefit of being anonymous, which will allow staff to speak more freely regarding their well-being. The approach taken in promoting surveys is also important. While multiple surveys are important to capture ongoing mental well-being, survey fatigue can be a problem. It will be important to inform staff of the outcomes of well-being surveys. If staff feel that the survey's make no impact, they will be less likely to complete them. Surveys can provide an accurate picture, provided that they are drafted, promoted and analysed appropriately.

3. In your view, are the partnership forums referred to above by HEIW operating effectively?

4. To what extent is there sufficient staff capacity to ensure that workloads are manageable, and that staff are able to take breaks, annual leave, access wellbeing support and undertake training and professional development? Is the picture improving or deteriorating, and do staff feel they are sufficiently supported in this respect by their organisations' leadership and management?

BDA Wales has carried out two surveys since the pandemic, which included questions on working conditions. These surveys took launched in January 2021 and September 2021. Breaks have been more difficult to take; while 13.7% of respondents were able to take breaks often in January 2021, just 8% have been able to over the last six months. While 30.5% were never able to take breaks in January 2021, that figure has risen to 40.2%. One respondent stated that even when breaks are scheduled, they are often filled by emergencies. Lunch breaks had also decreased in the last six months, with only 50% often being able to take a half an hour lunch break. 69.6% of respondents often do their admin at their desk during lunch. Back in January, 10% of respondents stated they never did admin at their desk in lunch, this figure has dropped to 3.6%. It was clear that the picture is not improving and is indeed deteriorating.

An increase in administrative tasks is in part to blame for this. Almost all respondents, 98.2%, had noticed an increase in administrative tasks. This has had an impact on the mental health of dentists, with 97.3% of respondents finding the increased admin at least mildly stressful. Concerns for patient backlog were also high, with 75% very concerned. One respondent shared that they had never needed a waiting list before, now it is 300 patients long. Patient demand was also evident, and a source of stress.

5. What are your views on the pilot approach to assessing staff's digital skills, capabilities and training needs? Is a self-assessment tool sufficient to identify where there are skills gaps across health and social care, and what further action is needed to ensure the health and social care workforce have the digital skills required?

   Within dentistry, a self-assessment tool should be sufficient in identifying skill gaps. However, it is also important to assess the IT equipment across NHS dentistry in Wales. Currently, the levels of technology available in dentistry vary, particularly in the CDS where IT capabilities can be poor. There is great variation clinic to clinic, as well as among Health Boards. The workforce planning is broad, covering many different roles under the umbrella of the Health and Social Care Workforce. It is important that the technological needs of each aspect of this workforce are understood and met. When discussing digital skill, it is also important to recognise that these skills can be limited by poor or outdated equipment.

Coleg Nyrsio Brenhinol Cymru
Royal College of Nursing Wales

Thank you for providing the Royal College of Nursing Wales the opportunity to respond to the evidence session held with Health Education and Improvement Wales (HEIW) and Social Care Wales (SCW). In your letter dated 29 November 2021, you asked for comments relating to the health and wellbeing of the workforce, digital skills and training.

Health and wellbeing of the workforce

How effectively does A healthier Wales: our workforce strategy for health and social care address staff wellbeing?

The Royal College of Nursing Wales appreciates the forward-thinking behind the workforce strategy as a starting point for the development of an inclusive, engaged, sustainable and flexible workforce. However, we do not believe the strategy effectively addresses staff wellbeing and does not go far enough to address the underlying challenges facing nursing.

In our response to the draft strategy, RCN Wales called upon HEIW and SCW to be more ambitious and to go further in their aims and actions to tackle the nursing workforce challenges across Wales. This ambition now urgently needs to be demonstrated in the delivery plans that will support the strategy.

The strategy does not go far enough to address the underlying issues that are currently challenging the nursing workforce including access to Continued Professional Development (CPD), flexible working and career pathways.

For example, Action 5 is to 'incorporate a set of workforce wellbeing and engagement measures in the performance framework for organisations, and the broader health and social care system'. There has been work ongoing on wellbeing and HEIW's website does list a variety of resources, but to our knowledge there has not been any external work on a performance framework for organisation. This shows a lack of ambition and delays to the progress of the strategy.

Action 21 simply expresses an ambition to 'continue to invest in increasing the numbers of health and social care professionals who are trained in Wales, with a focus on value.'[1] There is no information regarding how this will be achieved, the number of places that will be invested in, what professional groups would benefit from this and what a 'focus on value' means.

[1] Health and Social Care Workforce Strategy - HEIW (nhs.wales)

Action 24 aims to 'develop a clear strategy for Continuing Professional Development (CPD) across professional and occupational groups.'[2] While this is a vital step is recognising the importance of CPD, assess to CPD differs across professions, doctors have protected time, nurses do not. Therefore an inter-professional strategy lacks ambition and will not go far enough to address the profession specific challenges associated with accessing CPD.

What are your views on current approaches to assessing staff well-being?

There are a number of wellbeing initiatives being developed by health boards. For example in Aneurin Bevan, the health board has developed integrated capacity with the Employee Wellbeing Service to offer 'on the ground support'. The health board also aims to establish a wellbeing and education centre at the Grange University Hospital.

However it is our view that there is no concerted national approach to promoting staff wellbeing: it is this national leadership and drive that is missing. As part of this approach the Royal College of Nursing Wales strongly recommends the Welsh Government introduce a nursing retention strategy as a means of improving staff wellbeing and thereby improving nursing retention.

A 2020 RCN Wales member survey included the question, "how do you think nurses and nursing staff in the NHS could be encouraged to keep nursing?" Nearly 90% or respondents said higher pay was important, with 44% naming it the single most important thing the Welsh Government could do to keep nursing staff working for the NHS. The second most popular answer (chosen by 41%) was to recruit more staff to enable better care and create a less pressured environment. Other factors that are important to RCN Wales members are safer working conditions, more flexible working opportunities, and more opportunities for continuous professional development.

An NHS nursing retention strategy must consider:

- Expanding Section 25B of the Nurse Staffing Levels (Wales) Act 2016 to provide safer working conditions.
- Moving away from the traditional NHS rostering system and providing greater flexibility of hours.
- Planning and Development of better career opportunities, and access to Continuing Professional Development to be undertaken during working hours.
- Simplifying the documentation nursing staff need to complete.

Are surveys as a standalone tool sufficient to provide an accurate picture of the wellbeing of the health and social care workforce? Are there other measures that you believe should be adopted?

[2] Health and Social Care Workforce Strategy - HEIW (nhs.wales)

Anonymous surveys, with a large response rate are useful in providing quantitative snapshots of the current wellbeing of the health and social care workforce. As a data method that requires very little interaction, they are the quickest and easiest way of understanding complex matters. The Royal College of Nursing Wales has itself used surveys as a tool of member engagement.

However surveys only provide a snapshot of the workforce. It is important that to fully understand the wellbeing of the health and social care workforce qualitative data is gathered through various methods, i.e. focus groups. The Royal College of Nursing would also recommend ensuring survey findings are viewed alongside other data sets such as flexible working arrangements, exit interviews and issues raised at local partnership forums. This will provide a detailed analysis of the wellbeing of the workforce. For example if a survey finds that staff would prefer flexible working this needs to be viewed alongside current flexible working arrangements and what the employer offers.

Staff workload

"…working with trade union partners across the sector. Well-being is something that we do discuss through the partnership forums, and that's why we're really keen, as we're looking at the staff survey for next year, to see what else we can build in around the type of experience that staff are having."

In your view, are the partnership forums referred to above by HEIW operating effectively?

In 2021 HEIW created an 'External Advisory Group' (EAG) for stakeholders. The Royal College of Nursing was pleased to be included in this group. At the June 2021 meeting a presentation was given to EAG without advance notice on Education Training Plan purporting to set out plans for every single profession. In the presentation no pre or post registration nursing figures were shared, there was no information on Health Boards IMTPs or reference to the regulatory changes to the nursing pre-registration standards. Members of the group were informed that the plan would subsequently be ratified and then recommended to the Welsh Government. Subsequent to the EAG meeting a copy of the NHS Wales Training and Education Plan 20-222/23 marked 'final draft' was circulated to members by e-mail with no information as to the purpose of the circulation.

The Royal College of Nursing wrote to Alex Howells, Chief Executive of HEIW to express our concerns.

In October 2021 a Stakeholder Reference Group (SRG) was proposed to replace the EAG. The SRG would be established to build upon existing relationships with stakeholders, facilitate engagement, dialogue and feedback from stakeholder to inform HEIW's planning and decision making. The Royal College of Nursing is cautiously optimistic that this group will have a real input into the workings of HEIW.

To what extent is there sufficient staff capacity to ensure that workloads are manageable and that staff are able to take breaks, annual leave, access wellbeing support and undertake training and professional development?

No, there is not sufficient staff capacity to ensure workloads are manageable.

In 2020 Public Health Wales conducted a survey and found that over half (50.6%) of the nursing and midwifery workforce reported they frequently missed work breaks. To put this into context, a 'normal' shift for the nursing workforce is 12 hours. This demonstrates the physically demanding nature of the role. Furthermore despite 72.5% saying they had access to water on their shift, only 58.5% felt adequately hydrated.

Nurses and nursing staff have been on the forefront of the COVID-19 pandemic in every aspect of health and social care and many are feeling tired and burned out. A 2020 survey of 2,011 RCN Wales members found that the level of stress among respondents had increased, whilst the level of staff morale had decreased. Three quarters of members surveyed (75.9%) reported experiencing an increase in stress levels, whilst over half (58%) voiced that staff morale had worsened. The combination of stress and reduced morale is not conducive to a happy work environment and may lead to a worsening of the workforce shortage as nursing staff consider leaving the profession.

Furthermore, members are worried about their mental health. Over half (52%) of respondents to our 2020 survey were concerned about their mental health. This is extremely worrying.

Is the picture improving or deteriorating, and do staff feel they are sufficiently supported in this respect by their organisations' leadership and management?

The picture is deteriorating. In the RCN's 2021 Employment survey, 65.4% of Welsh responses felt there was too much pressure on them, and 62% said they were too busy to provide the level of care they would like to.

According to the NMC register 15.8% of the registered workforce is 51-55 and approaching retirement.

Since the start of the COVID-19 pandemic a significant number of RCN members feel less valued by the Welsh Government and senior executive management in their organisation compared to before the pandemic. In a (June) 2020 RCN survey we found that over a third (34%) of members felt less valued by the Welsh Government compared to before the COVID-19 pandemic. This is the highest rate amongst all UK nations. For the first time in the RCN's history in Wales, members are considering taking industrial action against the Welsh Government, and NHS employers. This demonstrates the strength of feeling within the nursing workforce.

27% of respondents also felt less valued by senior executive management in their health organisation. In comparison 74% of those surveyed that felt more valued by the general public.

Digital training

What are your views on the pilot approach to assessing staff's digital skills, capabilities and training needs? Is a self-assessment tool sufficient to identify where there are skills gaps across health and social care, and what further action is needed to ensure the health and social care workforce have the digital skills required.

Currently nursing staff do not feel they have enough time to provide the high quality patient care they would like, complete their mandatory training or take their breaks. If the use of the self-assessment tool is considered a priority there needs to be time allocated to facilitate this.

The Royal College of Nursing believes there is a need to recognise that many professions and sectors in health and social care lack access to basic technology such as email communication, mobile phones and cameras. Despite improving during the COVID-19 pandemic, a programme to ensure access to this type of technology in all areas where care is delivered would make a tremendous difference to the capabilities and productivity of the workforce. A structural governance connection and policy synergy are needed with the Informing Healthcare programme of work. In addition, any programme of technological development, including the self-assessment tool must take account of the need to function bilingually.

In additional when equipment is assessable, the nursing workforce have significantly difficulties accessing any form of professional development and learning due to current workforce pressures.

> "*All my staff complete e-learning at home as we do not have time in work also the system is not always accessible. I make sure they get the time back. We do not have protected time for study!" (RCN Member, 2019)*

Professional development and learning are fundamental career-long requirements for every nurse and it is a requirement for successful revalidation by the Nursing and Midwifery Council. Yet, because of the difficulty of backfilling nurses on the team, some health boards have stopped all access to Continued Professional Development (CPD) for nurses. This means that keeping up to date and learning new skills becomes something that nurses have to struggle to do at home and at their own cost. In contrast, doctors have access to CPD as part of their contracts.

Mandatory training includes equipment knowledge, emergency life support/CPR, and infection control. The 2021 RCN employment survey revealed that only 63.7% of nursing staff indicated that they had completed all their mandatory training in 2020. Only 37% completed their training exclusively in working hours.

If nurses cannot complete even their mandatory training in working hours, there is very little chance the uptake of new *optional* training will be successful.

About the Royal College of Nursing (RCN)

The RCN is the world's largest professional organisation and trade union of nurses, representing around 435,000 nurses, midwives, health visitors, healthcare support workers and nursing students, including over 27,000 members in Wales. RCN members work in both the independent sector and the NHS. Around two-thirds of our members are based in the community. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland.

The RCN represents nurses and nursing, promotes excellence in nursing practice and shapes health and social care policy.

Y Pwyllgor Busnes
—
Business Committee

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7 January 2022

To: Chairs of Senedd committees, via email

Review of the committee timetable and committee remits

You will recall that, on 16 December 2021, the Chairs' Forum considered, and endorsed, the Business Committee's suggested approach to conducting a review of the committee timetable and committee remits.

Chairs expressed a range of different views at the 21 December meeting, with some Chairs finding the current timetable challenging, whilst others expressed concerns about changing the current approach. There were no concerns raised about committee remits, although it is proposed that remits will continue to fall within the scope of this review.

To build on this, I invite you to discuss the review with your committees and to provide a written response to the review. The focus of this aspect of the review is to gather the agreed view of each committee.

In doing so, I would be grateful if you would consider the terms of reference for the review, and a number of specific questions. Whilst addressing the questions will be helpful, they are not intended to be prescriptive.

The terms of reference, and questions, are enclosed with this letter.

I also enclose a copy of the paper considered by the Business Committee and the Chairs' Forum.

Whilst you might wish to refer to feedback you have received from external stakeholders in your response, the Business Committee does not expect committees to consult with stakeholders in the time available for this review.

The timescale for this review is tight, as the Business Committee is aiming to implement any changes arising from the review at the start of the summer term 2022.

Consequently, as agreed at the Chairs' Forum meeting on 16 December 2021, the review will need to be completed in early March in order to provide committees with sufficient time to plan for any changes made.

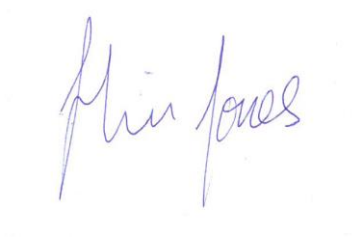
To enable this, please submit your written response by 12pm on Friday 4 February 2022. This is a week later than the original deadline proposed in the suggested approach.

Alongside this consultation with committees, Business Managers will be discussing the review with their Groups, and individual committee members will be surveyed too.

Draft proposals, based on the evidence gathered, will be discussed at the Chairs' Forum meeting on 17 February 2022. The Business Committee will then make decisions about the future timetable and committee remits in the light of that discussion.

If you require any further information, please contact the Clerk to the Chairs' Forum, Alun Davidson, who is supporting the Business Committee with this review.

Yours sincerely,



Elin Jones MS

Llywydd

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

[Enclosure 1]

Business Committee: Review of the committee timetable and committee remits

Terms of reference and consultation questions

Terms of reference

To review the current approach to the committee timetable, and committee remits, with a view to identifying any changes to the approach that could improve committee effectiveness, whilst maintaining an appropriate balance between the time committee members spend on committee work (in and outside committee meetings) and their wider responsibilities.

Consultation questions

Timetable – status quo

To what extent does the current approach to the committee timetable provide:

sufficient time for committees to undertake their work effectively?

sufficient flexibility to meet peaks in committee workloads and/or future business requirements for additional committee capacity?

an appropriate balance between the time Members spend on committee work (in and outside committee meetings) and their wider responsibilities?

Timetable – alternatives to the status quo

What changes could be made to the committee timetable to improve committee effectiveness, whilst maintaining flexibility to accommodate additional committee business, and an appropriate balance between the time Members spend on committee work (in and outside committee meetings) and their wider responsibilities?

If changes are to be made to the timetable, when should these changes be implemented?

Remits

Do you believe there is a need to adjust the remit of your committee? For example, to balance work across committees, and/or to improve lines of accountability.

Has your committee established a means of assessing the effectiveness of its work?

This question is posed in order to determine whether any changes made as a consequence of this review can be monitored in this context.

[Enclosure 2 – Business Committee paper]

Review of the committee timetable, and committee remits: Draft approach

Purpose

1. To provide a draft approach to the review of the committee timetable, and committee remits, for consideration by the Business Committee.

Background

2. The Business Committee agreed a fortnightly committee timetable at the start of the Sixth Senedd, on the basis that it would provide:

- sufficient meeting time for committees to perform their roles;
- a fair balance between the time members are expected to spend on committee work and their wider responsibilities;
- flexibility for committees to hold additional meetings when there is a need to complete time-limited work, and/or address peaks in workload; and
- sufficient flexibility to accommodate an additional committee in the system, if needed (currently the Special Purpose Committee).

3. In addition to a fortnightly timetable, the Business Committee increased the amount of time available during the week within which committees could meet – this includes Monday mornings and the occasional use of Fridays for Stage 2 consideration of Bills.

4. Protected weeks were retained, to provide dedicated time for the Chairs' Forum, Scrutiny of the First Minister Committee, and further additional meeting time for committees to request if needed.

5. A secondary objective, expressed at the time the timetable was agreed, was to encourage committees to make efficient use of their meeting time. For example, to hold one-off stakeholder roundtables to gather a range of evidence at once, rather than deploying the more traditional "panel after panel" approach to evidence gathering over a number of weeks.

6. The Business Committee previously agreed to review the committee timetable, and the remits of committees, at Easter 2022 i.e. after two terms of operation.

7. However, the volume of requests from committees for additional meetings, and the concerns expressed by some committees with the current timetable, have led to this review being brought forward.

8. The Llywydd has also indicated that the Chairs' Forum would be consulted on the review at its 17 February meeting.

9. Most concerns raised to date have been in relation to timetabling, rather than remits, though concerns have been raised about the breadth of the remit set for the Legislation, Justice, and Constitution Committee.

10. The proposals in this paper suggest reviewing both timetabling and remits at the same time, due to the possible interdependency between the two i.e. if a review of remits resulted in the creation of a new committee, the timetable would need to take account of this.

11. It would be possible to separate these reviews, should that be the Business Committee's preference, though a review of remits that took place at a later date might necessitate further changes to the timetable.

Draft terms of reference

12. Draft terms of reference are suggested in the box below:

Draft terms of reference

To review the current approach to the committee timetable, and committee remits, with a view to identifying any changes to the approach that could improve committee effectiveness, whilst maintaining an appropriate balance between the time committee members spend on committee work (in and outside committee meetings) and their wider responsibilities.

13. The review will consider the status quo and options for the future operation of the timetable.

14. Under the headings below are questions that expand on the terms of reference, and could be addressed during the course of the review:

Timetable – status quo

Does the current approach to the committee timetable provide:

- sufficient time for committees to undertake their work effectively?

- sufficient flexibility to meet peaks in committee workloads and/or future business requirements for additional committee capacity?

- an appropriate balance between the time Members spend on committee work (in and outside committee meetings) and their wider responsibilities?

Timetable – alternatives to the status quo

- What changes could be made to the committee timetable to improve committee effectiveness, whilst maintaining flexibility to accommodate additional committee business, and an appropriate balance between the time Members spend on committee work (in and outside committee meetings) and their wider responsibilities?

- If changes are to be made to the timetable, when should these changes be implemented?

Remits

- To consider whether committee remits should be adjusted. For example, to balance work across committees, and/or to improve lines of accountability.

Interdependencies

15. The review will need to consider:

- the resourcing and/or technological constraints on timetabling, and how this should be managed in the future e.g. the number (and type) of committee meetings that can be held concurrently; and

- the impact on Senedd Commission resources, including staffing, of any changes proposed as a consequence of this review (or maintaining the status quo, should that be the preferred option).

Committee effectiveness

16. The review could consider the extent to which Committees have established means of assessing the effectiveness of their work, so that any changes made as a consequence of this review can be monitored in this context.

17. This could be extended to capture any committee innovation that has arisen in response to a fortnightly (and more flexible) timetable e.g. alternative approaches to evidence gathering, work conducted outside meetings etc.

Evidence gathering

18. The following approach to evidence gathering is proposed:

- Committees – the Business Committee invites each committee to provide a written response to the questions posed by the review.

- **Committee members** – committee members will be invited to complete a survey to obtain their views on the time currently allocated for committee work, their view on what the correct balance should be between time spent on committee work and their wider responsibilities, and the level of priority they are able to dedicate to committee work.

- **Chairs** – the Chairs' Forum is consulted on any proposals for change that arise from the review, prior to proposals being finalised.

- **Party Groups** – Business Managers invite a view from their party groups.

- **Data** – data on the usage of allocated time, additional meeting time, and types of committee activity, can be provided.

Timescales

December 2021

- Consult the Chairs' Forum on the terms of reference and approach to the review (16 December).

January 2022

- Three-week period of evidence gathering (10 – 28 January).

February 2022

- The Business Committee considers draft proposals, based on the evidence received (8 February)
- The Chairs' Forum considers the draft proposals and the timing of the introduction of any changes to the timetable (17 February)).

March 2022

- The Business Committee confirms proposals (1 March).
  The Business Committee publishes a report and tables any motions needed to give effect to remit changes (should there be a need for any) (to be made in Plenary on 9 March).

April 2022

- Timetable changes to be implemented at the start of the summer term.

Consulting the Chairs' Forum

19. Whilst there is an appetite to resolve perceived issues with the timetable quickly, there is a tension between this and the lead-in time needed for committees to plan their work.

20. The Business Committee might wish to consult the Chairs' Forum, at its meeting on 16 December, on the scope and timescale for the review before taking a final decision.

Document is Restricted

Agenda Item 7

Document is Restricted

Agenda Item 8

Document is Restricted